MARYLAND Department of Health

HealthChoice
Maryland's Medicaid Managed Care Program

Medicaid Managed Care Organization

CY 2018 Annual Technical Report

Qlarant

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Executive Summary

Introduction

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible participants in contracted Managed Care Organizations (MCOs) through the Maryland Medicaid Managed Care Program, known as HealthChoice. HealthChoice has been operational since June 1997 pursuant to Title 42 of the Code of Federal Regulations (CFR), Section 438.204 and the Code of Maryland Regulations (COMAR) 10.09.65. HealthChoice's guiding principle is to provide quality health care that is patient focused, prevention oriented, coordinated, accessible, and cost-effective.

MDH's HealthChoice and Acute Care Administration (HACA) is responsible for oversight of the HealthChoice program. HACA ensures that the the MCOs are in compliance with the initiatives established in 42 CFR 438, Subpart D. The functions and infrastructure of HACA support efforts to identify and address quality issues efficiently and effectively. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care oversight process. The Division of HealthChoice Quality Assurance (DHQA) within HACA is primarily responsible for monitoring the quality activities involving external quality review and Centers for Medicare and Medicaid Services (CMS) quality improvement requirements for the HealthChoice program.

MDH is required to annually evaluate the quality of care provided to HealthChoice participants by contracting MCOs in accordance with Federal law [Section 1932(c) (2) (A) (i) of the Social Security Act]. MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided by each contracted MCO to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice Program. For this purpose, MDH contracts with Qlarant Quality Solutions, Inc. (Qlarant) to serve as the EQRO.

Qlarant is a non–profit organization established in 1973 as a Professional Standards Review Organization. Over the years, the company has grown in size and in mission. Qlarant is designated by CMS as a Quality Improvement Organization (QIO)–like entity and performs External Quality Reviews and other services to State of Maryland and Medicaid agencies in a number of jurisdictions across the United States. The organization has continued to build upon its core strength to develop into a well–recognized leader in quality assurance and quality improvement.

Qlarant is committed to supporting the Department's guiding principles and efforts to provide quality and affordable health care to HealthChoice recipients. As the EQRO, Qlarant maintains a cooperative and collaborative approach in providing high quality, timely, and cost–effective services to the Department.

As of December 31, 2017, the HealthChoice program enrolled 1,182,879 participants. The Department contracted with nine MCOs during this evaluation period. Those MCOs evaluated during this period were:

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

*ABH joined HealthChoice in October 2017.

ABH began participating in the HealthChoice program in October 2017. The EQRO's evaluation of ABH for calendar year (CY) 2017 included only a baseline Systems Performance Review of the MCO.

Pursuant to 42 CFR 438.364, the 2018 Annual Technical Report describes the findings from Qlarant's External Quality Review activities for years 2016–2017 which took place in CY 2018. The report includes each review activity conducted by Qlarant, the methods used to aggregate and analyze information from the review activities, and conclusions drawn regarding the quality, access, and timeliness of healthcare services provided by the HealthChoice MCOs.

HACA Quality Strategy

The overall goals of the Department's Quality Strategy are to:

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

The Department works collaboratively with MCOs and stakeholders to identify opportunities for improvement and to initiate quality improvement activities that will impact the quality of health care services for HealthChoice participants. The following activities have been implemented by MDH and have identified multiple opportunities for quality improvement.

EQRO Program Assessment Activities

Federal regulations require that three mandatory activities be performed by the EQRO using methods consistent with protocols developed by the CMS for conducting the activities. These protocols specify that the EQRO must conduct the following activities to assess managed care performance:

- Conduct a review of MCOs' operations to assess compliance with State and Federal standards for quality program operations;
- Validate State required performance measures; and

- Validate State required Performance Improvement Projects (PIPs) that were underway during the prior 12 months.

Qlarant also conducted an optional activity, validation of encounter data reported by the MCOs. As the EQRO, Qlarant conducted each of the mandatory activities and the optional activity in a manner consistent with the CMS protocols during CY 2018.

Additionally, the following five review activities were completed by Qlarant:

- Conduct the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews;
- Develop and produce an annual Consumer Report Card to assist participants in selecting an MCO;
- Conduct a market research study to determine any needed enhancements to the Consumer Report Card
- Conduct quarterly focused reviews of MCO grievances, appeals, and denials; and
- Validate MCO Network Adequacy.

In aggregating and analyzing the data from each activity, Qlarant allocated standards and/or measures to domains indicative of quality, access, and timeliness of care and services. The activities are:

- Systems Performance Review
- Value Based Purchasing
- Performance Improvement Projects
- Encounter Data Validation
- EPSDT Medical Record Review
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Consumer Report Card
- Focused Review of MCO Grievances, Appeals, and Denials
- Network Adequacy

Separate report sections address each review activity and describe the methodology and data sources used to draw conclusions for the particular area of focus. The final report section summarizes findings and recommendations to HACA and the MCOs to further improve the quality of, timeliness of, and access to health care services for HealthChoice participants.

General Overview of Findings

Assessment of Quality, Access, and Timeliness

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

- **Quality**, as it pertains to external quality review, is defined as “the degree to which an MCO or Prepaid Inpatient Health Plan increases the likelihood of desired health outcomes of its participants (as defined in 42 CFR 438.320[2]) through its structural and operational

characteristics and through the provision of health services that are consistent with current professional knowledge." ([CMS], *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et. al. Subpart D– Quality Assessment and Performance Improvement,* [June 2002]).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services." *(2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*).
- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care." (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." *(Envisioning the National Health Care Quality Report, 2001)*.

Table 1 outlines the review activities conducted annually that assess quality, access, and timeliness.

Table 1. Review Activities that Assess Quality (Q), Access (A), and Timeliness (T)

Systems Performance Review	Q	A	T
Standard 1 – Systematic Process of Quality Assessment and Improvement	√		
Standard 2 – Accountability to the Governing Body	√		
Standard 3 – Oversight of Delegated Entities	√		
Standard 4 – Credentialing and Recredentialing	√	√	√
Standard 5 – Enrollee Rights	√	√	√
Standard 6 – Availability and Accessibility		√	√
Standard 7 – Utilization Review	√	√	√
Standard 8 – Continuity of Care	√	√	√
Standard 9 – Health Education Plan	√	√	
Standard 10 – Outreach Plan	√	√	
Standard 11 – Fraud and Abuse	√		√
Value Based Purchasing	**Q**	**A**	**T**
Adolescent Well–Care	√	√	√
Adult BMI Assessment	√		
Ambulatory Care Services for SSI Adults Ages 21–64 Years	√	√	
Ambulatory Care Services for SSI Children Ages 0–20 Years	√	√	
Asthma Medication Ratio	√	√	√
Breast Cancer Screening	√	√	√
Childhood Immunization Status (Combo 3)	√	√	√
Comprehensive Diabetes Care – HbA1c Testing	√	√	√
Controlling High Blood Pressure	√		√
Immunizations for Adolescents	√		√
Lead Screenings for Children Ages 12–23 Months	√		√
Postpartum Care	√	√	√
Well–Child Visits for Children Ages 3–6 Years	√	√	√

Performance Improvement Projects	Q	A	T
Asthma Medication Ratio PIP	√		
Lead Screening PIP	√	√	√
Encounter Data Validation	**Q**	**A**	**T**
Inpatient, Outpatient, Office Visit Medical Record Review	√		
EPSDT Medical Record Review	**Q**	**A**	**T**
Health and Developmental History	√		√
Comprehensive Physical Examination	√		√
Laboratory Tests/At–Risk Screenings		√	√
Immunizations	√		√
Health Education and Anticipatory Guidance	√		√
Focused Review of Grievances, Appeals, & Denials	**Q**	**A**	**T**
Grievances	√		√
Appeals	√		√
Denials	√		√
Network Adequacy	**Q**	**A**	**T**
Correctness of Provider Directories	√		
Compliance with Routine Care Appointment Requirements		√	√
Compliance with Urgent Care Appointment Requirements		√	√
HEDIS®	**Q**	**A**	**T**
Weight Assessment and Counseling for Nutrition and Physical activity for Children/Adolescent	√	√	√
Childhood Immunization Status	√		√
Immunizations for Adolescents	√		√
Appropriate Treatment for Children with Upper Respiratory Infection	√		
Appropriate Testing for Children with Pharyngitis	√		
Breast Cancer Screening	√		√
Cervical Cancer Screening	√		√
Chlamydia Screening in Women	√		√
Comprehensive Diabetes Care	√		√
Standardized Healthcare-Associated Infection Ratio	√		
Use of Imaging Studies for Low Back Pain	√		
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	√		
Adult BMI Assessment	√		√
Controlling High Blood Pressure	√		√
Annual Monitoring for Patients on Persistent Medications	√		√
Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	√		
Medication Management for People with Asthma	√		
Adults' Access to Preventive/Ambulatory Health Services	√	√	√
Children and Adolescents' Access to Primary Care Practitioners	√	√	√
Prenatal and Postpartum Care	√	√	√
Ambulatory Care		√	
Well–Child Visits in the First 15 Months of Life	√	√	√
Well–Child Visits in the 3rd, 4th, 5th and 6th Years of Life	√	√	√
Adolescent Well–Care Visits	√	√	√
Ambulatory Care		√	

HEDIS®	Q	A	T
Statin Therapy for Patients with Diabetes	√		
Statin Therapy for Patients with Cardiovascular Disease	√		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	√		√
Pharmacotherapy Management of COPD Exacerbation	√		√
Asthma Medication Ratio	√		
Persistence of Beta–Blocker Treatment After a Heart Attack	√		√
Lead Screening in Children	√	√	
Non–Recommended Cervical Cancer Screening in Adolescent Females	√	√	
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	√	√	
Diabetes Monitoring for People with Diabetes and Schizophrenia	√	√	
Frequency of Selected Procedures		√	
Inpatient Utilization – General Hospital/Acute Care	√	√	
Antibiotic Utilization	√	√	
Use of Opioids at High Dosage - ***New***	√		
Use of Opioids From Multiple Providers - ***New***	√		
Board Certification	√		
Enrollment by Product Line		√	
Enrollment by State		√	
Language Diversity of Membership		√	
Race/Ethnicity Diversity of Membership		√	
Total Membership		√	
CAHPS®	**Q**	**A**	**T**
Getting Needed Care		√	
Getting Care Quickly			√
How Well Doctors Communicate	√		
Customer Service	√	√	
Shared Decision Making	√		
Access to Prescription Medicine*		√	
Access to Specialized Services*		√	
Family Centered Care: Personal Doctor Who Knows Your Child*	√		
Family Centered Care: Getting Needed Information*	√		
Coordination of Care for Children with Chronic Conditions*	√		

*Additional Composite Measures for Children with Chronic Conditions

Section I
Systems Performance Review

Introduction

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care (QOC) provided by Managed Care Organizations (MCOs) to HealthChoice enrollees. Qlarant, as the contracted External Quality Review Organization (EQRO), performs an independent annual review of MCO services provided to participants in order to ensure that they meet the standards set forth in the regulations governing the HealthChoice Program. COMAR 10.09.65 requires that all HealthChoice MCOs comply with the Systems Performance Review (SPR) standards and all applicable federal and state laws and regulations. This section describes the findings from the SPR for Calendar Year (CY) 2017. All nine MCOs were evaluated during this review period:

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

*ABH joined HealthChoice in October of 2017; therefore the CY 2017 SPR was a baseline review for this MCO.

Purpose and Process

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

The CY 2017 SPR was the second Interim Desktop Review conducted as part of the new triennial onsite review process. This assessment was completed by applying the systems performance standards defined for CY 2017 in the Code of Maryland Regulations (COMAR) 10.09.65.03B(1). The focus of the review was primarily on three areas: standards that were not fully met in the CY 2016 review, standards that were scored as baseline in the CY 2016 review, and new standards introduced during CY 2017.

The performance standards used to assess the MCOs' operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; Code of Maryland Regulations (COMAR); the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care;" Public Health Code of Federal Regulations; and Department requirements. The HealthChoice and Acute Care Administration leadership and the Division of HealthChoice Quality Assurance (DHQA) approved the MCO performance standards used in the CY 2017 review before application.

The review team that performed the annual SPRs consisted of health care professionals: a nurse practitioner and two masters prepared reviewers. The team has a combined experience of more than 45 years in managed care and quality improvement systems, 35 years of which are specific to HealthChoice. Feedback was provided to the DHQA and each MCO with the goal of improving the care provided to HealthChoice enrollees.

Methodology

In September 2017, Qlarant provided the MCOs with the Medicaid Managed Care Organization Systems Performance Review Orientation Manual for CY 2017 and invited the MCOs to direct any questions or issues requiring clarification to Qlarant and DHQA. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2017 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- CY 2017 Systems Performance Review Standards and Guidelines, including specific changes

Prior to the review, the MCOs were required to submit a completed pre-site survey form and provide documentation for various processes such as quality, utilization management, delegation, credentialing, enrollee rights, coordination of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Qlarant.

During the desktop reviews conducted in January 2018, the team reviewed all relevant documentation needed to assess the standards. A follow-up letter was provided to each MCO describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Qlarant; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the review, Qlarant documented its findings for each standard by element and component. The level of compliance for each element and component was documented with a review determination of either: “Met,” “Partially Met,” or “Unmet.”

A corrective action plan (CAP) was required for each performance standard that did not receive a finding of “Met.”

If an MCO chose to have standards in their policies and procedures that were higher than what was required by MDH, the MCO was held accountable to the standards which were outlined in their policies and procedures during the SPR.

The Department had the discretion to change a review finding to “Unmet” if the element or component had been found “Partially Met” for more than one consecutive year.

The CY 2017 SPR Interim Desktop Review included:

- All MCO CAPs from the CY 2016 SPR within any of the following areas:
  - Standard 1: Systematic Process of Quality Assessment
  - Standard 2: Accountability to the Governing Body
  - Standard 3: Oversight of Delegated Entities
  - Standard 4: Credentialing and Recredentialing
  - Standard 5: Enrollee Rights
  - Standard 6: Availability and Accessibility

  - Standard 7: Utilization Review
  - Standard 8: Coordination of Care
  - Standard 9: Health Education
  - Standard 10: Outreach
  - Standard 11: Fraud and Abuse
- Standards that were reviewed as baseline in CY 2016, were scored in the CY 2017 review:
  - Standard 5: Enrollee Rights – Element 5.8 requiring CAB annual reports and recommendations to be forwarded to MDH, not the Secretary.
  - Standard 7: Utilization Review – Component 7.4i requiring appeal decisions made by healthcare professionals with appropriate clinical expertise.
  - Standard 7: Utilization Review – Element 7.5 requiring updated adverse determination letter components.
  - Standard 11: Fraud and Abuse – Component 11.1f documenting a process to ensure that services billed to the MCO were actually received by the enrollee.
- New/revised standards introduced by MDH in CY 2017, were reviewed and scored as baseline:
  - Standard 5: Enrollee Rights – New Element 5.9 regarding advanced directives.
  - Standard 5: Enrollee Rights – New Element 5.10 regarding marketing activities.
  - Standard 6: Availability and Accessibility – Revised Component 6.1b to specify quarterly monitoring of access and availability standards.
  - Standard 7: Utilization Review – New Component 7.4h regarding prompt verbal notice to members of denial of expedited resolution.
  - Standard 7: Utilization Review – New Element 7.8 regarding written policies and procedures for establishing a corrective managed care plan for covering an enrollee's abuse of benefits, both pharmacy and non-pharmacy.
  - Standard 8: Coordination of Care – Revised Element 8.6 to require coordination of care with substance use vendors.
  - Standard 8: Coordination of Care – New Element 8.7 to ensure policies and procedures are in place to comply with the Continuity of Health Care Notice sent out to new enrollees.
  - Standard 11: Fraud and Abuse – New Component 11.5d regarding evidence of initial and monthly database checks.

For CY 2017, each MCO was expected to receive a finding of "Met" for all elements/components reviewed. The MCOs were required to submit a CAP for any element/component that did not receive a finding of "Met."

Preliminary results of the SPR were compiled and submitted to MDH for review. Upon the Department's approval, the MCOs received a report containing individual review findings. After receiving the preliminary reports, the MCOs were given 45 calendar days to respond to Qlarant with required CAPs. The MCOs could have also responded to any other issues contained in the report at its discretion within this same time frame, and/or requested a consultation with MDH and Qlarant to clarify issues or ask for assistance in preparing a CAP.

Corrective Action Plan Process

Each year, the CAP process is discussed during the annual review meeting. This process requires that each MCO must submit a CAP which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the preliminary report. CAPs are reviewed by Qlarant and determined to be adequate only if they address the following required elements and components:

- Action item(s) to address each required element or component
- Methodology for evaluating the effectiveness of actions taken
- Time frame for each action item, including plans for evaluation
- Responsible party for each action item

In the event that a CAP is deemed unacceptable, Qlarant provides technical assistance to the MCO until an acceptable CAP is submitted. Seven MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, UMHP, and UHC) were required to submit CAPs for the CY 2017 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2018 will determine whether the CAPs from the CY 2017 review were implemented and effective. In order to make this determination, Qlarant will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH will be notified for further action.

Following MDH's MCO Performance Monitoring Policy whereby an MCO that has a CAP for two or more consecutive years in the same element/component requires quarterly monitoring by the EQRO, five MCOs (ACC, KPMAS, PPMCO, UMHP and UHC) were required to submit quarterly updates of their CAPs to Qlarant throughout CY 2016 and into CY 2017. Progress was reported quarterly to MDH. Two MCO's (ACC and UMHP) CAPs were recommended to be closed. However, after the CY 2017 SPR, it was found that three MCOs (KPMAS, PPMCO, and UHC) continue to require quarterly updates on the CAPs. Additionally, one MCO (MSFC) is required to begin submitting quarterly updates on the CAPs.

Findings

If the MCOs did not receive a finding of "Met," a CAP was required. One MCO (JMS) received findings of "Met" in all standards reviewed. ACC, KPMAS, MPC, MSFC, PPMCO, UMHP, and UHC were required to submit CAPs for CY 2017. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. As the review for ABH was a baseline review, all areas were scored as baseline with recommendations provided as applicable in order for the MCO to become compliant for the CY 2018 SPR.

Table 2 provides the required CAPs for each of the MCOs as a result of the CY 2017 review.

Table 2. CY 2017 MCO CAP Requirements

Standard	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
3. Oversight of Delegated Entities					3.3c*	3.3b*		
5. Enrollee Rights	5.8 c		5.8c 5.8d	5.8a 5.8d	5.8d	5.8d		5.8b 5.8d
6. Availability and Access			6.1d*					
7. Utilization Review				7.5	7.4i	7.4e* 7.4f*	7.4e* 7.5	7.5
11. Fraud, Waste, and Abuse	11.1f		11.1f					11.1f
CAPs Required	**2 CAPs**	**0 CAPs**	**3 CAPs**	**2 CAPs**	**3 CAP**	**3 CAPs**	**1 CAPs**	**2 CAPs**

*Quarterly updates required on CAP per MDH MCO Performance Monitoring Policy

For each standard assessed for CY 2017, the following section describes:

- The requirements reviewed
- The overall MCO findings
- The individual MCO opportunities for improvement and CAP requirements, if applicable
- The follow up, if required

Standard 3: Oversight of Delegated Entities

Requirements. The MCO remains accountable for all functions, even if certain functions are delegated to other entities. There must be a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO. The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided. The MCO must also provide evidence of continuous and ongoing evaluation of delegated activities.

Results. Two MCOs (PPMCO and MSFC) had opportunities for improvement in the area of oversight of delegated entities. These MCOs will require quarterly updates on the CAPs as these are continued opportunities from CY 2016.

Findings. MCOs continue to demonstrate opportunities for improvement in this standard regarding delegation policies and procedures and in the monitoring and evaluation of delegated functions.

PPMCO Opportunities/CAPs:

Component 3.3 b. Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. PPMCO received a finding of Unmet and is required to provide quarterly updates on the CAPs.

For Component 3.3b, in response to the CY 2016 SPR findings, PPMCO was required to develop a CAP and submit quarterly updates to demonstrate compliance that the appropriate committee meeting minutes formal quarterly review and approval of quarterly grievance and appeal

reports from all applicable delegates. Continued opportunities for improvement exist in demonstrating compliance.

Grievances and appeals are delegated to Superior Vision. In 2016, PPMCO created the Interdepartmental Policy and Delegation Committee, which includes among its responsibilities review and approval of delegate reports.

There was evidence of Interdepartmental Policy and Delegation (IPAD) Committee review and approval of Superior Vision quarterly grievance and appeal reports in the meetings of May 11, 2017, (fourth quarter 2016), and September 7, 2017, (first and second quarter 2017). There was no evidence of Interdepartmental Policy and Delegation Committee approval of third quarter grievance and appeal reports.

Subsequent to the CY 2017 Interim Desktop Review, PPMCO submitted additional documentation to support review and approval of the third quarter grievance and appeal report from Superior Vision. This component, however, remains partially met as delegate quarterly grievance and appeal reports must be reviewed on a quarterly basis. Quarterly review did not occur as the first and second quarterly reports were not reviewed quarterly, but rather were presented together at the September 7, 2017, IPAD meeting.

In order to receive a finding of met in the CY 2018 Review, PPMCO must demonstrate in the appropriate committee meeting minutes formal review and approval of quarterly grievance and appeal reports from all applicable delegates on a quarterly basis. Superior Vision first and second quarter reports were reviewed and approved by the Interdepartmental Policy and Delegation Committee on September 7, 2017, which does not meet the requirement for review of quarterly reports on a quarterly basis. Documentation must specify the report being approved and the time frame, such as third quarter 2017 Superior Vision grievance and appeal reports.

MSFC Opportunities/CAPs:

Component 3.3 c. Review and approval of claims payment activities at least semi-annually, where applicable. MSFC received a finding of Unmet and is required to provide quarterly updates on the CAPs.

For Component 3.3 c, in response to the CY 2016 Interim Desktop Review, MSFC was required to develop a CAP to demonstrate that claims activities reports from all applicable vendors are reviewed and approved on at least a semi-annual basis by the specific committee(s) identified in its policies. Continuing opportunities for improvement exist.

As documented in past reviews, the Quality Improvement/Utilization Management Committee and Executive Operations Team are responsible for the review and approval of claims activities reports from all delegated entities except Vestica. Vestica claims payment activities reports are reviewed and approved exclusively by the EOT. According to the CY 2017 MCO Pre-Site Visit Survey MSFC reported there were no changes to the committee(s) that review and approve delegate reports in the CY 2017 review year.

There was evidence of review and approval of quarterly claims activities reports from Superior Vision by the Quality Improvement/Utilization Management Committee on April 20, 2017, (fourth quarter 2016). The approval authority of the Quality Improvement/Utilization Management Committee appeared to change mid-year as minutes for July 20, 2017, (first quarter 2017), and October 19, 2017, (second quarter 2017) stated "reviewed and recommended for approval at the Executive Operations Team." First and second quarter 2017, Caremark reports were reviewed in the October 19, 2017, Quality Improvement/Utilization Management Committee with a recommendation for approval at the Executive Operations Team. The December 7, 2017, Quality Improvement/Utilization Management Committee minutes noted that the Superior Vision and Caremark meetings for third quarter 2017 were pending and would be reported at the next Quality Improvement/Utilization Management Committee in 2018.

Superior Vision claims activities reports were reviewed and approved by the Executive Operations Team as follows:

- April 24, 2017 - Fourth quarter 2016
- October 16, 2017 - First quarter 2017
- November 3, 2017 - Second quarter 2017

Caremark claims activities reports were reviewed and approved by the Executive Operations Team as follows:

- April 24, 2017 - Third and fourth quarters 2016
- There was no evidence that Caremark claims activities reports for first and second quarters 2017, were reviewed and approved.

There was evidence of Executive Operations Team review and approval of Vestica claims activities reports in 2017 meeting minutes as follows:

- February 14, 2017 - It was reported that the January Vestica report was not complete and would be available at the next meeting.
- March 24, 2017 - February claims activities report was reviewed and approved. No mention of the January Vestica report was found.
- April 24, 2017 - March claims activities report was reviewed and approved.
- July 17, 2017 - June claims activities report was reviewed and approved.
- August 17, 2017 - July claims activities report was reviewed and approved.
- September 21, 2017 - August claims activities report was reviewed and approved.
- October 16, 2017 - September claims activities report was reviewed and approved.
- December 12, 2017 - October claims activities report was reviewed and approved.

No Executive Operations Team minutes were submitted for May and June 2017, and there was no evidence that the Executive Operations Team reviewed and approved Vestica claims activities report for April and May 2017, in any subsequent Executive Operations Team meetings. Additionally, there was no evidence that the Executive Operations Team reviewed and approved the delayed January 2017, Vestica claims report.

Subsequent to the interim review, MSFC submitted additional documentation to support compliance. It noted that its Contracted Delegated Quality Improvement Functions Policy states "delegated entities summary reports are presented to the Quality Improvement/Utilization

Management Committee for review and approval at least semi-annually. The reports will then be submitted to the Executive Operations Team Meeting for review and approval." It argued that the Quality Improvement/Utilization Management Committee minutes noting "review and recommended for approval at the Executive Operations Team" indicate the action to be taken per policy, as the Quality Improvement/Utilization Management Committee would not recommend approval if in fact the reports were not reviewed and approved. The wording, however, in the Quality Improvement/Utilization Management Committee minutes implies that the Quality Improvement/Utilization Management Committee does not have separate approval authority from the Executive Operations Team. The wording "review and recommend for approval" is used by lower level committees that do not have approval authority, which is not the case for MSFC as noted in their policy.

MSFC reported that Superior Vision's third quarter 2016 claims activities report was reviewed and approved by the Quality Improvement/Utilization Management Committee and the Executive Operation Team on December 15, 2016, which is outside of the 2017 review period. There was evidence of review and approval of third and fourth quarter Caremark claims activities reports by the Quality Improvement/Utilization Management Committee on April 20, 2017. Additionally, MSFC reported that the Executive Operations Team reviewed and approved the first and second quarter 2017 Caremark claims activities reports on November 13, 2017, however, review of the redacted minutes from this meeting was unsuccessful in finding any reference to this review and approval.

In order to receive a finding of met in the CY 2018 SPR, MSFC must demonstrate that the Quality Improvement/Utilization Management Committee and Executive Operations Team reviews and approves all delegate claims activities reports consistent with its policies. Minutes must clearly document the delegate report being reviewed and the time frame such as Superior Vision claims activities report for third quarter 2017. Additionally, the approval authority of the Quality Improvement/Utilization Management Committee needs to be clearly documented by noting the "review and approval" of all delegate reports.

Follow-Up:

- PPMCO and MSFC were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- PPMCO and MSFC are required to provide quarterly updates on the CAPs in CY 2018 in adherence with MDH's MCO Performance Monitoring Policy.
- The approved CAPs will be reviewed in CY 2018 SPR.

STANDARD 5: Enrollee Rights

Requirements. The organization demonstrates a commitment to treating participants in a manner that acknowledges their rights and responsibilities. The MCO must have a system linked to the Quality Assurance Program for resolving participants' grievances. This system must meet all requirements in COMAR 10.09.71.02 and 10.09.71.04. Enrollee information must be written to be readable and easily understood. This information must be available in the prevalent non-English languages identified by the Department. The MCO must act to ensure that the confidentiality of specified patient information and records are protected. The MCO must have written policies regarding the appropriate treatment of minors. The MCO must, as a result of the enrollee satisfaction surveys, identify and investigate sources

of enrollee dissatisfaction, implement steps to follow-up on the findings, inform practitioners and providers of assessment results, and reevaluate the effectiveness of the implementation steps at least quarterly. The MCO must have systems in place to assure that new participants receive required information within established time frames.

Results. Six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) had opportunities for improvement in the area of enrollee rights. These MCOs will require CAPs to become compliant for the CY 2018 SPR.

Findings. MCOs continue to demonstrate opportunities for improvement in this standard regarding notifying enrollees and prospective enrollees about their nondiscrimination rights.

ACC Opportunities/CAPs:

Component 5.8 c. Notices and Taglines must be posted in significant communications and publications.

For Component 5.8c, in the CY 2016 Interim Desktop Review, ACC provided a copy of its fourth quarter 2016 newsletter and its proposed member handbook with changes submitted to MDH as evidence of enrollee material distributed with nondiscrimination notices. The member handbook appeared to have the required notice with translation information in the required languages. However, the newsletter included interpreter services in the required languages, but the nondiscrimination notice was not included. It was required as a result of the review that ACC provide evidence of posting notices and taglines in all significant communications and publications.

For the CY 2017 Interim Desktop Review, ACC provided the Spring and Fall Member Newsletter and the provider directory. The provider directory included the required notices and taglines, however, the newsletter again failed to include the appropriate nondiscrimination notice. It did include interpreter services in the required languages.

In order to receive a finding of met in the CY 2018 SPR, ACC must provide evidence of posting notices and taglines in all significant communications and publications.

KPMAS Opportunities/CAPs:

Component 5.8 c. Notices and Taglines must be posted in significant communications and publications.

For Component 5.8c, KPMAS provided a sample of marketing material mailed to members, however, the mailer did not meet the requirements for a small publication which follow:

- A "Statement of Nondiscrimination" informing persons that the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities; and
- Taglines in at least the top two languages spoken by individuals with limited English proficiency in the relevant state, presumably Spanish and one other non-English language.

A sample tagline informs individuals with limited English proficiency of language assistance services. An example follows:

> ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Subsequent to the interim review, KPMAS provided a brochure on 24/7 supports that included the appropriate notices and taglines.

In order to receive a finding of met in the CY 2018 SPR, KPMAS must ensure that all significant member communications and publications include the required notices and taglines.

Component 5.8 d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

For Component 5.8d, KPMAS did not provide evidence of notices and taglines being posted in conspicuous physical locations where the MCO interacts with the public.

Subsequent to the interim review, KPMAS provided a snapshot of Federal Nondiscrimination Information, however, the MCO did not explain where this information was located or posted. An example of evidence that would demonstrate compliance with the requirement would be a picture of notices and taglines posted during community events that the MCO facilitates.

In order to receive a finding of met in the CY 2018 SPR, KPMAS must provide evidence of posting notices and taglines, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

MPC Opportunities/CAPs:

Component 5.8 a. Materials distributed by the MCO to the enrollee will include a nondiscrimination notice in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency of Maryland.

For Component 5.8a, MPC provided several samples of member materials that were distributed to enrollees, however, not all consistently included the appropriate nondiscrimination notice and notice of translation services in the required languages. Both the member handbook and a telemedicine flyer included the required information. The member newsletter only included information regarding language services. This information was not in the required languages and there was no nondiscrimination notice. The dental and vision flyer provided for review included a nondiscrimination notice and information regarding translation services but not in all of the required languages.

In order to receive a finding of met in the CY 2018 SPR, MPC must ensure that all enrollee materials include a nondiscrimination notice and information regarding translation services in English and at least the top 15 non-English languages spoken by individuals with limited English proficiency as required by the state of Maryland.

Component 5.8 d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

For Component 5.8d, MPC did not provide evidence of notices and taglines being posted in conspicuous physical locations where the MCO interacts with the public.

In order to receive a finding of met in the CY 2018 SPR, MPC must provide evidence of notices and taglines being posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public. Notices and taglines must be in English and in at least the top 15 non-English languages spoken by individuals with limited English proficiency in Maryland.

MSFC Opportunities/CAPs:

Component 5.8 d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

For Component 5.8d, MSFC provided a photograph of the posting of the nondiscrimination and language accessibility notices, however, the MCO did not provide an explanation as to where these were posted. It is necessary to know this information in order to evaluate compliance with this component.

In order to receive a finding of met in the CY 2018 SPR, MSFC must provide evidence of Notices and Taglines being posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

PPMCO Opportunities/CAPs:

Component 5.8 d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

For Component 5.8d, PPMCO did not provide evidence of notices and taglines being posted in conspicuous physical locations where the MCO interacts with the public, for example, during community events, education events, health fairs, etc.

Subsequent to the interim review, PPMCO provided a screenshot of the MCO's member website showing a link to the Notice of Nondiscrimination and a brochure that the MCO states is shared at health education and redetermination events. However, the reviewer needs evidence that this is occurring, such as a photograph of notices and taglines being posted during the events.

In order to receive a finding of met in the CY 2018 SPR, PPMCO must provide evidence of notices and taglines being posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

UMHP Opportunities/CAPs:

Component 5.8 b. Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page.

For Component 5.8b, UMHP did not provide any documentation to support compliance with this element.

In order to receive a finding of met in the CY 2018 SPR, UMHP must provide evidence that notices and taglines are posted in a conspicuously visible location on websites accessible from the home page.

Component 5.8 d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

For Component 5.8d, UMHP provided a "community event material" which was a flyer stating that enrollment is always open and included the notice and tagline. It is not clear how this flyer is used.

In order to receive a finding of met in the CY 2018 SPR, UMHP must provide evidence of the nondiscrimination notice and taglines being posted, where appropriate, in conspicuous locations where the MCO interacts with the public. Evidence could include a picture of the outreach staff at community events with the community event materials displayed on a table.

Follow-up. Overall, MCOs have policies and procedures in place that demonstrate their commitment to treating members in a manner that acknowledges their rights and responsibilities. Evidence of enrollee information was reviewed and found to be easily understood and written in Spanish as required by the Department. Additionally, all MCOs provided evidence of their complaint, grievance, and appeals processes. However, opportunities for improvement did exist regarding policies and procedures, complaints/grievances, and satisfaction surveys.

- All six MCOs were required to submit CAPs for the above noted components. Qlarant reviewed and approved the CAP submissions.
- The approved CAPs will be reviewed in CY 2018 SPR.

STANDARD 6: Availability and Accessibility

Requirements. The MCO must have established measurable standards for access and availability. The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services. The MCO must have a list of providers that are currently accepting new participants. The MCO must implement policies and procedures to assure that there is a system in place for notifying participants of due dates for wellness services.

Results. One MCO (KPMAS) had a continuing opportunity for improvement in the area of availability and accessibility. This MCO will require quarterly updates on the CAP as this is a continued opportunity from the CY 2016 SPR.

Findings. One MCO continues to demonstrates opportunities for improvement in this standard regarding monitoring enrollee call center performance.

KPMAS Opportunities/CAPs:

Component 6.1d. The MCO has documented review of the Enrollee Services Call Center performance.

For Component 6.1d, as a result of the CY 2017 Interim Desktop Review, KPMAS was required to submit a CAP along with quarterly monitoring to correct the inconsistency between the Achieving Call Metrics Policy that indicated an abandonment rate of 3% or less and the RQIC minutes that were monitoring an abandonment rate of 4% or less. KPMAS submitted a revised policy in November 2017 that noted a 5% abandonment rate which was not in alignment with industry standards. Therefore, the MCO was requested to revise the policy. A second revision was made to the policy and accepted in December of 2017.

Since Regional Quality Improvement Committee meetings to monitor the call standards have not taken place to date, this CAP with quarterly monitoring will continue for the next two quarters to ensure consistent monitoring of the revised abandonment rate.

In order to receive a finding of met in the CY 2018 SPR, KPMAS must ensure consistent monitoring against accurate Enrollee Services Call Center performance standards.

Follow-Up. Overall, MCOs have established appropriate standards for ensuring access to care and have fully implemented a system to monitor performance against these standards. All MCOs have current provider directories that list providers that are currently accepting new participants, along with websites and help lines that are easily accessible to members. Each MCO has an effective system in place for notifying members of wellness services.

- KPMAS was required to submit a CAP for Component 6.1d. Qlarant reviewed and approved the submission.
- KPMAS is required to provide quarterly updates on the CAP in CY 2018 in adherence with MDH's Quality Monitoring Policy.
- The approved CAP will be reviewed in CY 2018 SPR.

STANDARD 7: Utilization Review

Requirements. The MCO must have a comprehensive Utilization Management Program, monitored by the governing body, and designed to evaluate systematically the use of services through the collection and analysis of data in order to achieve overall improvement. The Utilization Management Program must specify criteria for Utilization Review/Management decisions. The written Utilization Management Plan must have mechanisms in place to detect over utilization and underutilization of services. For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that: preauthorization, concurrent review, and appeal decisions are made and supervised by appropriate qualified medical professionals; efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate; the reasons for decisions are clearly documented and available to the enrollee; there are well publicized and readily available appeal mechanisms for both providers and participants; preauthorization and concurrent review decisions are made in a timely manner as specified by the State; appeal decisions are made in a timely manner as required by the exigencies of the situation; and the MCO maintains policies and procedures pertaining to provider appeals as outlined in COMAR 10.09.71.03. Adverse determination letters must include a description of how to file an appeal and all other required components. The MCO must also have policies, procedures, and reporting mechanisms in place to evaluate the effects of the Utilization Management Program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

Results. Five MCOs (MPC, MSFC, PPMCO, UHC, and UMHP) have opportunities for improvement in the area of Utilization Review. Two MCOs (PPMCO and UHC) will require quarterly updates on the CAP as these are continued opportunities from the CY 2016 SPR.

Findings. MCOs continue to demonstrates opportunities for improvement in this standard regarding monitoring compliance of UR decisions.

MPC Opportunities/CAPs:

Element 7.5 - Adverse determination letters include a description of how to file an appeal and all other required components.

Element 7.5 was scored as baseline for the CY 2016 review as a result of the requirement to include a notice of nondiscrimination in all adverse determination letters. The Prior Authorization Policy lists the content to be included in the Notice of Action (adverse determination letter) which does not address all of the 16 components required for Maryland HealthChoice members. For example, the list does not include member access to his/her medical records, an explanation that it is assumed the member received the letter five days after it was dated, a notice of nondiscrimination, and the availability of a free copy of any guideline, code or similar information used in making the determination. The member pre-service letter template included 15 of the required components. The last component, a notice of nondiscrimination, was provided separately.

A sample of 10 adverse determination letters were reviewed for compliance. The notice of nondiscrimination was included in eight of the 10 letters. An additional 20 letters were reviewed with 10 demonstrating compliance. Overall compliance for the 30 letters reviewed was 60% for the nondiscrimination notice requirement.

Additionally, the PCP was not copied in all of the letters. In the initial sample of 10, eight letters evidenced that the PCP was copied. An additional sample of 20 letters were reviewed with 16 demonstrating compliance with this component. Overall, for the component requiring that the letter is copied to the PCP compliance was at 80%. Five of the six non-compliant letters were related to National Imaging Associates reviews. In reviewing the case notes it was documented that PCP notification was not required and that PCP information was not available. In addition to these missing components, letters did not always reflect the current HealthChoice Help Line that replaced the former Enrollee Help Line.

Subsequent to the review, MPC provided additional documentation to support compliance. It reported that the Prior Authorization Policy was revised to include all missing components and was approved by the policy committee on February 14, 2018. It also noted that the letter template was revised to include the HealthChoice Help Line effective February 1, 2018. Since these changes are outside of the CY 2017 review period the revised policy and letter template will be reviewed in the CY 2018 SPR.

In order to receive a finding of met in the CY 2018 review, MPC must revise the Prior Authorization Policy to reflect the 16 required components in all adverse determination letters. Additionally, all adverse determination letters must demonstrate compliance with all 16

required components. Any references to the former Enrollee Help Line in policies or letter templates must be updated to reflect the current HealthChoice Help Line.

MSFC Opportunities/CAPs:

Component 7.4 i. Appeal decisions are made by health care professionals who have the appropriate clinical expertise in treating the member's condition or disease consistent with the MCO's policies and procedures.

For Component 7.4i, the Appeals - Member Policy requires that when necessary for clinical appeals, the Appeal Reviewer will be someone in the same or a similar specialty on the second level who typically treats the medical condition, performs the procedure or provides the treatment under review. This requirement is insufficient in demonstrating compliance with this component.

A review of a sample of 10 member appeal records demonstrated compliance with the requirement for appeal decisions to be made by health care professionals with appropriate clinical expertise.

Subsequent to the interim review, MSFC submitted additional documentation to support compliance. It referenced the same section of the policy previously reviewed. This policy statement is inadequate as it only addresses the requirement for the appeal reviewer to be someone in the same or a similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under review for second level appeals.

In order to receive a finding of met in the CY 2018 review, the Appeals - Member Policy needs to be revised to require appeal decisions be made by health care professionals who have the appropriate clinical expertise in treating the member's condition or disease at any level of appeal.

PPMCO Opportunities/CAPs:

Component 7.4 e. Preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

For Component 7.4e, in response to the CY 2016 Interim Desktop Review findings, PPMCO was required to develop a CAP to demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations. This CAP is being monitored quarterly since non-compliance has occurred for two consecutive review periods. The CAP was partially implemented and continued opportunities for improvement exist.

The Preservice Turnaround Time for Pharmacy and Utilization Management spreadsheet identified monthly compliance with decision and notification time frames for routine and urgent preservice requests by approval status. Overall compliance rate was combined for both determinations and notifications and reported separately for routine and urgent requests. Individual results for determinations and adverse determination notifications reported for routine and urgent requests are as follows:

- For routine approvals compliance with decision time frames was not met in any of the 12 months with rates ranging from 25.2% in April to 67.5% in August.
- For routine denials compliance with decision time frames was met in one of 12 months. Compliance rates ranged from 88% in February to 95% in December.
- For routine denials compliance with the adverse determination notification time frame was met in 11 out of 12 months with May the only outlier at 93.7%.
- For urgent approvals compliance with decision time frames was met in three of the 12 months. Compliance rates ranged from 76.2% in October to 98.5% in July.
- For urgent denials compliance with decision time frames was met in two of 12 months. Compliance rates ranged from 88.8% in February and June to 99.1% in December.
- For urgent denials compliance with the adverse determination notification time frame was met in 11 of the 12 months. The one outlier month was May at 92.9%.

PPMCO provided an updated CAP and multiple documents to demonstrate completion of CAP deliverables. Interim solutions have been implemented in response to ongoing delays in implementation of the new utilization management platform due to configuration issues. PPMCO attributed high employee turnover as the cause of productivity and turnaround issues in 2017. It noted that the business continuity plan to address staff turnover was completed on November 27, 2017. In view of ongoing non-compliance with determination and notification time frames quarterly CAP review will continue until PPMCO demonstrates compliance for three consecutive quarters.

In order to receive a finding of met in the CY 2018 SPR, PPMCO must consistently demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations.

Component 7.4 f. Appeal decisions are made in a timely manner as required by the exigencies of the situation.

For Component 7.4f, in response to the CY 2016 Interim Desktop Review findings, PPMCO was required to develop a CAP to demonstrate compliance with State required time frames for appeal resolution or MCO time frames if more stringent. This CAP is being monitored quarterly since non-compliance has occurred for two consecutive review periods. The CAP was partially implemented and continued opportunities for improvement exist.

The Standard and Expedited Appeal Compliance - CY 2017 spreadsheet identifies monthly compliance with resolution time frames for standard and expedited appeals. Standard appeals demonstrated compliance with the resolution time frame in 10 of the 12 months in 2017. Outlier months were February at 97.7% and September at 97.5%. Requests for an expedited appeal were submitted in only four of the 12 months in 2017. All expedited appeals were resolved within the resolution time frame.

PPMCO provided an updated CAP to demonstrate completion of CAP deliverables. Two deliverables, tracking appeals volume by sources and comparing appeal turnaround time among appeals received through different sources, had an initial completion date of August 15, 2017, which was later revised to October 30, 2017. No update was provided for either deliverable in the latest CAP submission.

While PPMCO has demonstrated improvement in 2017, the CAP will remain in place with quarterly reporting until PPMCO demonstrates compliance for three consecutive quarters.

In order to receive a finding of met in the CY 2018 SPR, PPMCO must demonstrate consistent compliance with appeal resolution time frames. The resolution time frame for standard appeals was not met for the months of February and September in 2017.

Element 7.5 - Adverse determination letters include a description of how to file an appeal and all other required components.

Element 7.5 was scored as baseline for the CY 2016 Interim Desktop Review as a result of the requirement to include a notice of nondiscrimination in all adverse determination letters. A sample outpatient adverse determination letter submitted for the CY 2017 review included this and the additional 15 required components.

The Clinical and Administrative Denial Policy includes some, but not all, of the required components for member adverse determination letters. The policy notes that additional elements may be included in letter templates to meet requirements for each line of business or governing agency. The Step Therapy, Prior Authorization and Quantity Limits Policy requires the denial letter to include the reason for the denial, information regarding the member's appeal rights, including information on how to initiate an appeal, and information on obtaining criteria used in making the denial decision.

A sample of 10 adverse determination letters was reviewed for compliance. In the initial sample of 10 only five letters included the notice of nondiscrimination. Additionally, none of the letters included evidence that both the requesting provider and the PCP were copied. An additional 20 letters were reviewed for compliance. Twelve of the 20 letters included the notice of nondiscrimination. Three of the 20 letters evidenced that both the PCP and requesting provider were copied. The overall compliance rate for the notice of nondiscrimination was 53% and for evidence that the PCP and requesting provider were copied the overall compliance rate was 10%. Additionally, letters referenced the former Enrollee Help Line which was replaced by the HealthChoice Help Line.

In order to receive a finding of met in the CY 2018 SPR, PPMCO must demonstrate that member adverse determination letters include all required components. Additionally, PPMCO must either list the letter components in the appropriate policies or attach a letter template to the policy. All references to the former Enrollee Help Line need to be replaced by the current HealthChoice Help Line.

UHC Opportunities/CAPs:

Component 7.4 e. Preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

For Component 7.4e, in response to the CY 2016 Interim Desktop Review findings, UHC was required to develop a CAP to demonstrate consistent compliance with regulatory time frames for medical and pharmacy preservice determination and notifications. This CAP is being

monitored quarterly since non-compliance has occurred for two consecutive review periods. The CAP was partially implemented and continued opportunities for improvement exist.

UHC provided separate tracking of compliance with determination and notification time frames for medical and pharmacy, by month, from January through December 2017. Results are detailed for each area below.

In reviewing the Prior Authorization Medical Turnaround Time Compliance Report for 2017, compliance was reported as follows:

- Determinations (emergent and non-emergent) – All 12 months in 2017 met or exceeded the 95% threshold.
- Notifications (emergent and non-emergent) – The last seven months of 2017 met or exceeded the 95% threshold.

In reviewing the Prior Authorization Pharmacy Turnaround Time Compliance Report for 2017, compliance was reported as follows:

- Expedited determinations – Eleven out of 12 months met or exceeded the 95% threshold. The outlier month was May 2017, at 93.3%.
- Routine determinations within two business days – Nine out of 12 months met or exceeded the 95% compliance threshold. Outlier months were April, May, and October 2017.
- Written notification within 24 hours – Seven out of 12 months met or exceeded the 95% compliance threshold. Outlier months were April, May, June, July, and October 2017.
- Written notification within 72 hours – Eleven out of 12 months met or exceeded the 95% threshold. Outlier month was May 2017, at 89%.

There were no pharmacy requests which required additional clinical information so no compliance percentages were reported for the seven-calendar day time frame.

Updated CAPs were provided for both medical and pharmacy compliance which included increased staffing and oversight and some process changes. One of the contributing factors to pharmacy non-compliance was cited as the additional opioid review that is now required. While UHC has demonstrated improvement in 2017, the CAP will remain in place for 2018 with quarterly monitoring until UHC demonstrates consistent compliance over at least three quarters.

In order to receive a finding of met in the CY 2018 SPR, UHC must consistently demonstrate compliance with regulatory time frames for medical and pharmacy preservice determination and notifications at the 95% threshold.

Element 7.5 - Adverse determination letters include a description of how to file an appeal and all other required components.

Element 7.5 was scored as baseline for the CY 2016 Interim Desktop Review as a result of the requirement to include a notice of nondiscrimination in all adverse determination letters. The sample enrollee adverse determination letter submitted for the CY 2017 review included this

and the additional 15 required components, however, this notice was not included in all of the letters within the sample reviewed.

The Initial Adverse Determination Notices Policy which references UnitedHealthcare Community Plan-Maryland in its title includes some, but not all, of the components required in adverse determination letters for HealthChoice members. The policy states that letters specifically required by state/federal law, contract, or government programs will be accepted as meeting the written notice elements required by this policy. The Member Pre-Services Denial letter template was provided and included all 16 required components.

A sample of ten adverse determination letters was reviewed for compliance. The notice of nondiscrimination was included in five of the 10 letters within the initial sample. An additional 20 letters were reviewed with 11 demonstrating compliance with inclusion of the nondiscrimination notice. Overall compliance for this component in the 30 letters reviewed was 53%.

It is recommended that UHC include the list of required components for member adverse determination letters in the Initial Adverse Determination Notices Policy.

In order to receive a finding of met in the CY 2018 SPR, UHC must demonstrate that member adverse determination letters consistently include the notice of nondiscrimination. Additionally, all references to the former Enrollee Help Line need to be replaced with the current HealthChoice Help Line.

UMHP Opportunities/CAPs:

Element 7.5 - Adverse determination letters include a description of how to file an appeal and all other required components.

Element 7.5 was scored as baseline for the CY 2016 Interim Desktop Review as a result of the requirement to include a notice of nondiscrimination in all adverse determination letters. UMHP did not submit any policy that identified the 16 required components for the member adverse determination letters.

An initial sample of 10 adverse determination letters was reviewed for compliance. Fifteen of the 16 components were included within this sample. The notice of non-discrimination was not found within any of the 10 letters reviewed. An additional sample of 20 adverse determination letters was reviewed for compliance. Thirteen of the 20 letters included the notice of nondiscrimination. The overall compliance rate for the sample of 30 adverse determination letters is 43% for this component. Additionally, letters reflected inconsistent reference to the HealthChoice Help Line which has replaced the former Enrollee Help Line.

Subsequent to the review, UMHP submitted additional documentation to support its compliance. In the 2017 Qlarant System Performance Review Narrative Summary, UMHP explained that it utilizes a filler form process, noting that the template format was tested successfully with the addition of the nondiscrimination language. UMHP's quality assurance process included a registered nurse reviewing the adverse determination letters on the SharePoint site for release to print and mail. It was discovered during a mid-year audit that the

printed letters did not include the nondiscrimination notice. It immediately performed a root cause analysis of the printing discrepancy and included in its process manual review of the printed letter on an ongoing basis. It also reported that it could find no reference to the change in the language replacing the Enrollee Help Line with the HealthChoice Help Line which was revised by MDH on March 31, 2016. This oversight, however, had no impact on the scoring. Although UMHP has identified and corrected the letters to include the nondiscrimination notice this element remains partially met for the CY 2017 review.

In order to receive a finding of met in the CY 2018 SPR, UMHP must demonstrate that all adverse determination letters include all required 16 components. Additionally, if UMHP does not have a policy addressing the required adverse determination letter components one needs to be developed. All references to the former Enrollee Help Line need to be replaced by the current HealthChoice Help Line.

Follow-Up. Overall, MCOs have strong Utilization Management Plans that describe procedures to evaluate medical necessity criteria used, information sources, procedures for training and evaluating staff, monitoring of the timeliness and content of adverse determination notifications, and the processes used to review and approve the provision of medical services. The MCOs provided evidence that qualified medical personnel supervise preauthorization and concurrent review decisions. The MCOs have implemented mechanisms to detect over and underutilization of services. Overall, policies and procedures are in place for providers and participants to appeal decisions. However, continued opportunities were present in the areas of monitoring compliance of UR decision.

- All five MCOs were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- PPMCO (7.4e and 7.4f) and UHC (7.4e) will provide quarterly updates on the CAPs for Standard 7 to Qlarant in adherence with MDH's Quality Monitoring Policy.
- The approved CAPs will be reviewed in CY 2018 SPR.

STANDARD 11: Fraud, Waste, and Abuse

Requirements. The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.

Results. Three MCOs (ACC, KPMAS, and UMHP) have opportunities for improvement in the area of Fraud and Abuse.

Findings. MCOs have continued opportunities for improvement in documenting processes and procedures for verification of services.

ACC Opportunities/CAPs:

Component 11.1 f. A documented process to ensure that services billed to the MCO were actually received by the enrollee.

Component 11.1f was scored as baseline in the CY 2016 Interim Desktop Review. ACC was required to provide documentation of the Member Verification of Service or Explanation of Medical Benefits process and evidence that the process is being executed. ACC provided the Member Verification of Services Process - MD Policy which was dated November 21, 2017, and a template of a letter to a member (Explanation of Benefits). However, there was no evidence presented of members actually being mailed these letters to date.

Additionally, the policy states that a random sample and the type of claims will be pulled quarterly, but it does not state how many claims will be included in the sample.

Subsequent to the interim review, ACC provided a revised Member Verification of Services Process - MD Policy which included the number of Explanation of Benefits included in the quarterly sample.

Response rates on member verification letters or explanation of benefit letters are typically very low and most times do not solicit responses from members at all. Using this process is not considered a best practice to ensure that services billed were actually received by the member. It is recommended that MCOs attempt to contact members personally and target the scope of the review, such as sampling data/claims for services such as durable medical equipment, substance use, radiology, or pain management. Member verification of services should be completed no less frequently than quarterly.

In order to receive a finding of met in the CY 2018 SPR, ACC must provide evidence that explanation of benefits were actually mailed to members and that the process is actually being monitored through the quality workgroups.

KPMAS Opportunities/CAPs:

Component 11.1 f. A documented process to ensure that services billed to the MCO were actually received by the enrollee.

For Component 11.1f, KPMAS stated that Maryland Medicaid will be added to the Health Information Management Services audit scope in the second quarter of 2018. The MCO states that the audit will take place annually to ensure that services billed to the MCO were actually received by the enrollee.

KPMAS did not provide an explanation of the “audit scope.” Should this include member explanation of benefit letters, it should be noted that response rates on member verification letters or explanation of benefit letters are typically very low and most times do not solicit responses from members at all. Using this process is not considered a best practice to ensure that services billed were actually received by the member. It is recommended that MCOs attempt to contact members personally and target the scope of the review, such as sampling data/claims for services such as durable medical equipment, substance use, radiology, or pain management. Member verification of services should be completed no less frequently than quarterly.

In order to receive a finding of met in the CY 2018 SPR, KPMAS must provide a written process for ensuring that services billed to the MCO were actually received by the enrollee. Additionally, KPMAS must provide evidence that this process was implemented.

UMHP Opportunities/CAPs:

Component 11.1 f. A documented process to ensure that services billed to the MCO were actually received by the enrollee.

For Component 11.1f, UMHP was notified in the CY 2016 SPR that the MCO was required to document its process to ensure that services billed to the MCO were actually received by the member. UMHP submitted its Fraud, Waste, and Abuse Reporting Policy that was not revised until December of 2017 which states that members with recent claims are to be provided verification letters. A copy of the letter template was provided for review. It requests that members verify they received the services. The first letters were not anticipated to be distributed until April 2018.

The policy is silent on how many members will receive the letters, at which interval the letters will be mailed to members, a goal for survey response rate, what action will be taken if the response rates do not meet the goal, and corrective actions. Response rates on member verification letters are typically very low and using this type of member verification to document if services were received is not a best practice.

Response rates on member verification letters or explanation of benefit letters are typically very low and most times do not solicit responses from members at all. Using this process is not considered a best practice to ensure that services billed were actually received by the member. It is recommended that MCOs attempt to contact members personally and target the scope of the review, such as sampling data/claims services for durable medical equipment, substance use, radiology, or pain management. Member verification of services should be completed no less frequently than quarterly.

In order to receive a finding of met in the CY 2018 SPR, UMHP must provide evidence of a complete documented process to ensure that services billed to the MCO were actually received by the member and evidence that the process has been implemented.

Follow-Up. All MCOs were found to have comprehensive compliance programs designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. Fraud and abuse plans articulated the organization's commitment to comply with all applicable Federal and State laws, regulations, and standards. The MCO also demonstrated procedures for timely investigation, and tracking of reported suspected incidence of fraud and abuse. There were designated Compliance Officers and active Compliance Committees. All staff, subcontractors, and participants were clearly communicated to regarding disciplinary guidelines and sanctioning of fraud and abuse. Additionally, the MCO demonstrated it has a process which allows employees, subcontractors, and participants to report fraud and abuse without the fear of reprisal.

- ACC, KPMAS, and UMHP were required to submit CAPs for the above component. Qlarant reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2018 SPR.

Conclusions

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. Although numerical scores were not provided in CY 2017, improvement was seen for three MCOs (ACC, UHC, and UMHP) and a slight decrease in performance was seen for four MCOs (MPC, MSFC, PPMCO, and KPMAS). JMS continued to receive a perfect score in the CY 2017 SPR.

Beginning in CY 2016, MDH implemented its Quality Monitoring Policy whereby any MCO that has had a CAP for two or more consecutive years in the same element/component is required to provide quarterly updates to Qlarant. In following with this policy, four MCOs (KPMAS, PPMCO, UHC, and UMHP) are required to submit quarterly updates of their CAPs to Qlarant. Additionally, all CAPs will be reviewed during the CY 2018 SPR.

Maryland has set high standards for MCO quality assurance systems. HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees.

Qlarant will conduct a comprehensive SPR for CY 2018 onsite at the MCO facilities in January through March of 2019.

Section II
Value Based Purchasing

Introduction

The Maryland Department of Health (MDH) worked with the Center for Health Care Strategies in 1999 to develop a Value Based Purchasing initiative (VBP) for HealthChoice, Maryland's Medicaid managed care program. VBP improves quality by awarding business and incentives to contractors based on their performance along a range of dimensions. The goal of Maryland's purchasing strategy is to achieve better enrollee health through improved managed care organization (MCO) performance. Appropriate service delivery is promoted by aligning MCO incentives with the provision of high-quality care, increased access, and administrative efficiency. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice.

MDH contracted with Qlarant and MetaStar, Inc. (MetaStar), an NCQA–Licensed Organization, to perform a validation of the CY 2017 VBP measurement data. Validation is the process by which an independent entity evaluates the accuracy of reported performance measure data and determines the extent to which specific performance measure calculations followed established specifications. A validation (or audit) determination is assigned to each measure, indicating whether the result is fully compliant, substantially compliant, or not valid. MetaStar performed the validation of the HEDIS®–based VBP measurement data for all of the HealthChoice MCOs using the NCQA's HEDIS® Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures. Qlarant validated the measures developed by MDH and calculated by The Hilltop Institute of University of Maryland Baltimore County (Hilltop).

Performance Measure Selection Process

MDH identifies legislative priorities in selecting the performance measures. Measures may be added or removed, based upon evolving MDH priorities and participant health care needs.

MDH selects measures that are:

1. Relevant to the core populations served by HealthChoice, including children, pregnant women, special needs children, adults with disabilities, and adults with chronic conditions;
2. Prevention–oriented and associated with improved outcomes;
3. Measurable with available data;
4. Comparable to national performance measures for benchmarking;
5. Consistent with how CMS is developing a national set of performance measures for Medicaid; and
6. Possible for MCOs to affect change.

Value Based Purchasing Validation

Several sources of measures (Table 3) are included in the CY 2017 VBP program. They are chosen from NCQA's HEDIS® data set, encounter data, and data supplied by the HealthChoice MCOs, and subsequently validated by Qlarant and MetaStar. The measure type and the presence of an existing audit or validation process determined the validation activities undertaken.

Table 3. CY 2017 VBP Measures

Performance Measure	Domain	Measure	Reporting Entity
Adolescent Well Care	Use of Services	HEDIS®	MCO
Adult BMI Assessment	Effectiveness of Care	HEDIS®	MCO
Ambulatory Care Services for Supplemental Security Income (SSI) Adults	Access to Care	Encounter Data	MDH
Ambulatory Care Services for Supplemental Security Income (SSI) Children	Access to Care	Encounter Data	MDH
Asthma Medication Ratio	Effectiveness of Care	HEDIS®	MCO
Breast Cancer Screening	Effectiveness of Care	HEDIS®	MCO
Childhood Immunization Status (Combo 3)	Effectiveness of Care	HEDIS®	MCO
Comprehensive Diabetes Care – HbA1c Testing	Effectiveness of Care	HEDIS®	MCO
Controlling High Blood Pressure	Effectiveness of Care	HEDIS®	MCO
Immunizations for Adolescents (Combo 1)	Effectiveness of Care	HEDIS®	MCO
Lead Screenings for Children Ages 12–23 Months	Effectiveness of Care	Encounter, Lead Registry, & Fee For Service Data	MDH
Postpartum Care	Access to Care	HEDIS®	MCO
Well Child Visits for Children Ages 3–6	Use of Services	HEDIS®	MCO

HEDIS® Measures Validation Process

HealthChoice MCOs are required to produce and report audited HEDIS® data under Code of Maryland Regulations (COMAR) 10.09.65.03B(2). Ten of the CY 2017 VBP measures are HEDIS® measures and are validated under the HEDIS® Compliance Audit. The goal of the HEDIS® audit is to ensure accurate, reliable, and publicly reportable data.

The HEDIS® Compliance Audit is conducted in three phases: offsite, onsite, and post onsite (reporting). The offsite audit phase includes a review of each MCO's HEDIS® Record of Administration, Data Management and Processes (Roadmap). The Roadmap is used to supply information about an MCO's data systems and HEDIS® data reporting structure and processes. Other activities of the offsite audit process include the selection of HEDIS® measures to audit in detail (results are then extrapolated to the rest of the HEDIS® measures), investigation of measure rotation strategies, and validation of the medical record review process by the certified audit firm.

Prior to the onsite phase, MetaStar holds annual auditor conference calls with all MCOs to address any NCQA changes or updates to the audit guidelines and provide technical assistance.

During the onsite phase, auditors investigate issues identified in the Roadmap and observe the systems used to collect and produce HEDIS® data. The audit team interviews MCO staff; reviews MCO information system structure, protocols, and processes; and reviews MCO measure-specific data collection processes with the MCO staff.

The post onsite and reporting phase of the HEDIS® Compliance Audit includes the issuance of a follow-up letter to the MCO that lists any items the auditors still require to complete the audit; a list of corrective actions for problems found in the Roadmap or onsite, as well as the necessary completion dates; and preliminary audit findings specifically indicating the measures at risk for a *Not Reportable* designation. When the MCO has provided all requested documents and performed the recommended corrective actions, the auditor completes a final audit report and assigns audit designations indicating the suitability of measures for public reporting. The four possible audit designations are explained in Table 4. The final activity of the post onsite phase of the audit consists of the MCO submitting data to NCQA, using NCQA's Interactive Data Submission System (IDSS).

Table 4. HEDIS® Compliance Audit Designations

Audit Findings	Description	Rate/Results
Reportable rate or numeric result for HEDIS® measures.	Reportable Measure	0-XXX
The MCO followed the specifications but the denominator was too small to report a valid rate.	Denominator <30.	NA
The MCO did not offer the health benefits required by the measure (e.g., specialty mental health).	No Benefit	NB
The MCO calculated the measure but the rate was materially biased, or the MCO was not required to report the measure.	Not Reportable	NR

In order to avoid duplicating efforts and placing undue administrative burden on the HealthChoice MCOs, MDH used ten of the HEDIS® audit measure determinations as VBP measure determinations. The HEDIS® measures in the VBP program are:

- Adolescent Well Care
- Adult BMI Assessment
- Asthma Medication Ratio

- Breast Cancer Screening
- Childhood Immunization Status (Combo 3)
- Comprehensive Diabetes Care – HbA1c Testing
- Controlling High Blood Pressure
- Immunizations for Adolescents (Combo 1)
- Postpartum Care
- Well Child Visits for Children Ages 3–6

EQRO Measures Validation Process

Three CY 2017 VBP measures were calculated by The Hilltop Institute of University of Maryland Baltimore County (Hilltop), using encounter data submitted by the MCOs, Maryland Department of the Environment's Lead Registry data, and Fee-for-Service data. The measures are:

- Ambulatory Care Services for SSI Adults
- Ambulatory Care Services for SSI Children
- Lead Screenings for Children Ages 12–23 Months

Qlarant validated the measurement data for each of the above VBP measures, including the specifications for each encounter data-based measure, source code to determine algorithmic compliance with the measure specifications, information regarding the encounter data processing system, and analysis of the encounter data process. Clarifications and corrections to source code were conducted to ensure algorithmic compliance with VBP measure specifications.

Validation determinations were used to characterize the findings of the EQRO. Table 5 indicates the possible determinations of the EQRO-validated measures. To validate the rates calculated, two analysts and an analytic scientist with Qlarant reviewed and approved the measure creation process and source code.

Table 5. Possible Validation Findings for EQRO-Validated Measures (Encounter Data)

Validation Determination	Definition
Fully Compliant (FC)	Measure was fully compliant with State specifications and reportable.
Substantially Compliant (SC)	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid (NV)	Measure deviated from state specifications such that the reported rate was significantly biased. This designation is also assigned to measures where no rate was reported, although reporting of the rate was required.
Not Applicable (NA)	Measure was not reported because the entity did not have any Medicaid enrollees that qualified for the denominator.

Validation Results

Validation of the VBP measures results in a determination of the effect of bias on the resulting statistic. Validation determinations by MetaStar are reported using the audit designations and rationales outlined by NCQA as part of the HEDIS® Compliance Audit.

All of the VBP measures audited by MetaStar were determined to be reportable for all MCOs.

Table 6 shows the results of the EQRO-led validation activities related to the VBP measures. Hilltop was responsible for producing these VBP measures at the MCO level and working with the EQRO to validate the measurement data. During the validation process undertaken by Qlarant, no issues were identified that could have introduced bias to the resulting statistics.

Table 6. EQRO VBP Measure Validation Determinations

Measure	Validation Determinations
Ambulatory Care Services for SSI Adults	Fully Compliant
Ambulatory Care Services for SSI Children	Fully Compliant
Lead Screenings for Children Ages 12–23 Months	Fully Compliant

CY 2017 Incentive/Disincentive Target Setting Methodology

The following target setting methodology has been developed for the CY 2017 VBP measures:

- Targets for incentive, disincentive, and neutral ranges are based on the enrollment-weighted performance average of all MCOs from two years prior (the base year). The enrollment weight assigned to each MCO is the 12-month average enrollment of the base year.
- The midpoint of the incentive and disincentive targets for each measure is the sum of the weighted average of MCO performance on each measure in the base year and 15% of the difference between that number and 100%.
- The incentive target is calculated by determining the sum of the midpoint and 10% of the difference between the midpoint and 100%.
- The disincentive target is equal to the midpoint minus 10% of the difference between the midpoint and 100%.
- If the difference between the incentive target and disincentive target is less than 4 percentage points, then the incentive and disincentive targets will be the midpoint +/-2 percentage points.

CY 2017 Incentive/Disincentive Targets

Table 7. CY 2017 VBP Measures and Targets

Performance Measure	Data Source	2017 Target
Adolescent Well Care: % of adolescents ages 12-21 (enrolled 320 or more days) receiving at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	HEDIS®	Incentive: ≥ 76% Neutral: 72%–75% Disincentive: ≤ 71%
Adult BMI Assessment: % of enrollees ages 18 to 74 who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	HEDIS®	Incentive: ≥ 91% Neutral: 88%–90% Disincentive: ≤ 87%
Ambulatory Care Services for SSI Adults Ages 21–64 Years: % of SSI adults (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year	Encounter Data	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%
Ambulatory Care Services for SSI Children Ages 0–20 Years: % of SSI children (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year	Encounter Data	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%
Asthma Medication Ratio: % of enrollees ages 5–85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	HEDIS®	Incentive: ≥ 71% Neutral: 66%–70% Disincentive: ≤ 65%
Breast Cancer Screening: % of women 50–74 years of age who had a mammogram to screen for breast cancer	HEDIS®	Incentive: ≥ 75% Neutral: 71%–74% Disincentive: ≤ 70%
Childhood Immunization Status (Combo 3): % of children who turned 2 years of age during the measurement year who were continuously enrolled for 12 months immediately preceding their second birthday and who had 4 DTaP, 3 IPV, 1 MMR, 2 H influenza type B, 3 hepatitis B, 1 chicken pox vaccine (VZV), and pneumococcal conjugate by the time period specified and by the child's 2nd birthday	HEDIS®	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%
Comprehensive Diabetes Care – HbA1c Testing: % of enrollees 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) test	HEDIS®	Incentive: ≥ 91% Neutral: 88%–90% Disincentive: ≤ 87%
Controlling High Blood Pressure: % of enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year	HEDIS®	Incentive: ≥ 68% Neutral: 62%–67% Disincentive: ≤ 61%
Immunizations for Adolescents (Combo I): % of adolescents 13 years of age during the measurement year who had one dose of meningococcal vaccine and either one Tdap or Td vaccine by their 13th birthday	HEDIS®	Incentive: ≥ 90% Neutral: 87%–89% Disincentive: ≤ 86%
Lead Screenings for Children Ages 12–23 Months: % of children ages 12–23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year	Lead Registry, Encounter & Fee for Service Data	Incentive: ≥ 70% Neutral: 64%–69% Disincentive: ≤ 63%
Postpartum Care: % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS®	Incentive: ≥ 78% Neutral: 74%–77% Disincentive: ≤ 73%
Well-Child Visits for Children Ages 3–6 Years: % of children ages 3–6 (enrolled 320 or more days) receiving at least one well-child visit during the measurement year, consistent with American Academy of Pediatrics & EPSDT recommended number of visits	HEDIS®	Incentive: ≥ 89% Neutral: 86%–88% Disincentive: ≤ 85%

2017 Performance Measure Results

The performance measure results were validated by Qlarant and MDH's contracted HEDIS® Compliance Audit™ firm, MetaStar. The contractors determined the validity and the accuracy of the performance measure results. All measures were calculated in a manner that did not introduce bias, allowing the results to be used for public reporting and the VBP program. In CY 2017, eight HealthChoice MCOs qualified to participate in the initiative:

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

Table 8 represents the CY 2017 VBP results for each of the MCOs.

Table 8. MCO CY 2017 VBP Performance Summary

Performance Measure	CY 2017 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
		Incentive (I); Neutral (N); Disincentive (D)							
Adolescent Well Care	Incentive: ≥ 76% Neutral: 72%–75% Disincentive: ≤ 71%	73% (N)	81% (I)	59% (D)	55% (D)	60% (D)	66% (D)	64% (D)	57% (D)
Adult BMI Assessment	Incentive: ≥ 91% Neutral: 88%–90% Disincentive: ≤ 87%	92% (I)	99% (I)	98% (I)	88% (N)	96% (I)	91% (I)	94% (I)	93% (I)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	83% (D)	90% (I)	65% (D)	84% (N)	82% (D)	86% (N)	80% (D)	85% (N)
Ambulatory Care Services for SSI Children	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%	84% (N)	91% (I)	70% (D)	82% (D)	78% (D)	86% (I)	78% (D)	86% (I)
Asthma Medication Ratio	Incentive: ≥ 71% Neutral: 66%–70% Disincentive: ≤ 65%	63% (D)	71% (I)	78% (I)	63% (D)	65% (D)	59% (D)	63% (D)	60% (D)
Breast Cancer Screening	Incentive: ≥ 75% Neutral: 71%–74% Disincentive: ≤ 70%	69% (D)	78% (I)	82% (I)	59% (D)	67% (D)	69% (D)	60% (D)	75% (I)
Childhood Immunization Status (Combo 3)	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	83% (D)	84% (N)	70% (D)	65% (D)	83% (D)	78% (D)	71% (D)	75% (D)
Comprehensive Diabetes Care – HbA1c Testing	Incentive: ≥ 91% Neutral: 88%–90% Disincentive: ≤ 87%	91% (I)	95% (I)	92% (I)	81% (D)	90% (N)	88% (N)	86% (D)	82% (D)
Controlling High Blood Pressure	Incentive: ≥ 68% Neutral: 62%–67% Disincentive: ≤ 61%	62% (N)	75% (I)	85% (I)	46% (D)	73% (I)	53% (D)	65% (N)	52% (D)

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Performance Measure	CY 2017 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
		Incentive (I); Neutral (N); Disincentive (D)							
Immunizations for Adolescents (Combo 1)	Incentive: ≥ 90% Neutral: 87%–89% Disincentive: ≤ 86%	89% (N)	90% (I)	84% (D)	85% (D)	89% (N)	87% (N)	87% (N)	88% (N)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 70% Neutral: 64%–69% Disincentive: ≤ 63%	67% (N)	75% (I)	58% (D)	57% (D)	63% (D)	65% (N)	61% (D)	60% (D)
Postpartum Care	Incentive: ≥ 78% Neutral: 74%–77% Disincentive: ≤ 73%	72% (D)	84% (I)	85% (I)	69% (D)	74% (N)	69% (D)	66% (D)	74% (N)
Well Child Visits for Children Ages 3–6	Incentive: ≥ 89% Neutral: 86%–88% Disincentive: ≤ 85%	89% (I)	91% (I)	78% (D)	77% (D)	77% (D)	86% (N)	82% (D)	70% (D)

2017 VBP Financial Incentive/Disincentive Methodology

As described in the COMAR 10.09.65.03, MDH uses financial incentives and disincentives to promote performance improvement. There are three levels of performance for all measures: incentive, neutral, and disincentive. Financial incentives are earned when performance meets or exceeds the incentive target for a measure. Conversely, disincentives are assessed when performance is at or below the disincentive target. All measures are evaluated separately and are of equal weight in the methodology. For any measure that the MCO does not meet the minimum target, a disincentive of 1/13 of 1 percent of the total capitation amount paid to the MCO during the measurement year shall be collected. For any measure that the MCO meets or exceeds the incentive target, the MCO shall be paid an incentive payment of 1/13 of 1 percent of the total capitation amount paid to the MCO during the measurement year. The amounts are calculated for each measure and the total incentive payments made to the MCOs each year may not exceed the total amount of disincentives collected from the MCOs in the same year plus any additional funds allocated by MDH for a quality initiative.

Table 9 represents the incentive and/or disincentive amounts for each performance measure and the total incentive/disincentive amount by MCO for the CY 2017 VBP Program.

Table 9. MCO CY 2017 VBP Incentive/Disincentive Amounts

Performance Measure	MCO							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Adolescent Well Care	$0	$150,660.99	($198,702.30)	($854,283.66)	($329,535.50)	($1,070,748.10)	($551,260.84)	($159,526.79)
Adult BMI Assessment	$843,005.68	$150,660.99	$198,702.30	$0	$329,535.50	$1,070,748.10	$551,260.84	$159,526.79
Ambulatory Care Services for SSI Adults	($843,005.68)	$150,660.99	($198,702.30)	$0	($329,535.50)	$0	($551,260.84)	$0
Ambulatory Care Services for SSI Children	$0	$150,660.99	($198,702.30)	($854,283.66)	($329,535.50)	$1,070,748.10	($551,260.84)	$159,526.79
Asthma Medication Ratio	($843,005.68)	$150,660.99	$198,702.30	($854,283.66)	($329,535.50)	($1,070,748.10)	($551,260.84)	($159,526.79)
Breast Cancer Screening	($843,005.68)	$150,660.99	$198,702.30	($854,283.66)	($329,535.50)	($1,070,748.10)	($551,260.84)	$159,526.79
Childhood Immunization Status (Combo 3)	($843,005.68)	$0	($198,702.30)	($854,283.66)	($329,535.50)	($1,070,748.10)	($551,260.84)	($159,526.79)
Comprehensive Diabetes Care – HbA1c Testing	$843,005.68	$150,660.99	$198,702.30	($854,283.66)	$0	$0	($551,260.84)	($159,526.79)
Controlling High Blood Pressure	$0	$150,660.99	$198,702.30	($854,283.66)	$329,535.50	($1,070,748.10)	$0	($159,526.79)
Immunizations for Adolescents (Combo 1)	$0	$150,660.99	($198,702.30)	($854,283.66)	$0	$0	$0	$0
Lead Screenings for Children Ages 12–23 Months	$0	$150,660.99	($198,702.30)	($854,283.66)	($329,535.50)	$0	($551,260.84)	($159,526.79)
Postpartum Care	($843,005.68)	$150,660.99	$198,702.30	($854,283.66)	$0	($1,070,748.10)	($551,260.84)	$0
Well Child Visits for Children Ages 3–6	$843,005.68	$150,660.99	($198,702.30)	($854,283.66)	($329,535.50)	$0	($551,260.84)	($159,526.79)
Total Incentive/ Disincentive Amount	($1,686,011.36)	$1,807,931.88	($198,702.30)	($9,397,120.26)	($1,977,213)	($4,282,992.40)	($4,961,347.56)	($638,107.16)

Section III
Performance Improvement Projects

Introduction

The Maryland Department of Health (MDH) is responsible for the evaluation of the quality of care provided to Medical Assistance recipients in the HealthChoice program. MDH contracts with Qlarant as the External Quality Review Organization (EQRO). Qlarant is responsible for evaluating the Performance Improvement Projects (PIPs) submitted by the Managed Care Organizations (MCOs) according to Centers for Medicare and Medicaid Services' (CMS') *External Quality Review Protocol 3: Validating Performance Improvement Projects.*

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

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

PIP Purpose and Objectives

Each MCO was required to conduct PIPs that were designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care, or non-clinical care areas that were expected to have a favorable effect on health outcomes. The PIPs included measurements of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement. In addition to improving the quality, access, or timeliness of service delivery, the process of completing a PIP functions as a learning opportunity for the MCO. The processes and skills required in PIPs, such as indicator development, root cause analysis, and intervention development, are transferable to other projects that can lead to improvement in other health areas.

Topics Selected

MDH initiated the Asthma Medication Ratio PIP in February 2017 using HEDIS® 2017 measurement rates as the baseline measurement for MCOs in developing interventions due in fall 2017. The measure seeks to increase the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Asthma is a chronic lung disease that affects Marylanders regardless of age, sex, race, or ethnicity. Although the exact cause of asthma is unknown and it cannot be cured, it can be controlled with self-management, education, appropriate medical care, and avoiding exposure to

environmental triggers. In Maryland, asthma results in millions of dollars in health care costs — costs that are largely preventable through an evidence-based, public health approach to asthma control. Maryland's Asthma Control Program and its partners have demonstrated success through an evidence-based, public health approach to asthma control by focusing on communities with the greatest needs.

MDH initiated the Lead Screening PIP in March 2018 using HEDIS® 2018 and CY 2017 Maryland encounter data measure rates as the baseline measurements for MCOs in developing interventions due September 30, 2018. The HEDIS® measure seeks to increase the percentage of children 2 years of age who had one or more capillary or venous blood level tests for lead poisoning by their second birthday. The Maryland encounter data measure seeks to increase the percentage of children ages 12-23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year. Childhood lead poisoning is a completely preventable disease. Exposure to lead is the most significant and widespread environmental hazard for children in Maryland. Children are at the greatest risk from birth to age 6 while their neurological systems are developing. Exposure to lead can cause long-term neurological damage that may be associated with learning and behavioral problems and with decreased intelligence. According to the Maryland Department of the Environment's Annual Surveillance Report, statewide data indicates only 20.6% of the 535,094 children between ages zero to 72 months were tested for lead in 2015. This PIP aims to support lead testing and ensure that providers and MCOs are aware of the funds that are available for both environmental lead investigations and lead abatement.

Validation Process

The guidelines utilized for PIP review activities were CMS' *External Quality Review Protocol 3: Validating Performance Improvement Projects.* The tool assists in evaluating whether the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

Each MCO was required to provide the study framework and project description for each PIP. This information was reviewed to ensure that each MCO was using relevant and valid study techniques. Annual PIP submissions were required in September. The annual submissions included results of measurement activities, a status report of intervention implementations, analysis of the measurement results using the defined data analysis plan, as well as information concerning any modifications to (or removal of) intervention strategies that may not be yielding anticipated improvement. If an MCO decided to modify other portions of the project, updates to the submissions were permitted in consultation with Qlarant and the Department.

Reviewers evaluated each project submitted using a standard validation tool that employed the CMS validation methodology, which included assessing each project in the following ten critical areas. The 10-step validation is summarized in Table 10.

Table 10. 10–Step Validation Methodology to PIP Validation

Validation Steps	Qlarant's Validation Process
Step 1. The **study topic** selected must be appropriate and relevant to the MCO's population.	Review the study topic/project rationale and look for demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO–specific data should support the study topic.
Step 2. The **study question(s)** must be clear, simple, and answerable.	Identify a study question that addresses the topic and relates to the indicators.
Step 3. The **study indicator(s)** must be meaningful, clearly defined, and measurable.	Examine each project indicator to ensure appropriateness to the activity. Numerators/denominators and project goals should be clearly defined.
Step 4. The **study population** must reflect all individuals to whom the study questions and indicators are relevant.	Examine the study population (targeted population) relevancy, which is provided in the project rationale and indicator statements.
Step 5. The **sampling method** must be valid and protect against bias.	Assess the techniques used to provide valid and reliable information.
Step 6. The **data collection procedures** must use a systematic method of collecting valid and reliable data representing the entire study population.	Review the project data sources and collection methodologies, which should capture the entire study population.
Step 7. The **improvement strategies**, or interventions, must be reasonable and address barriers on a system level.	Assess each intervention to ensure project barriers are addressed. Interventions are expected to be multi–faceted and induce permanent change. Interventions should demonstrate consideration of cultural and linguistic differences within the targeted population.
Step 8. The **study findings**, or results, must be accurately and clearly stated. A comprehensive quantitative and qualitative analysis must be provided.	Examine the project results, including the data analysis. Review the quantitative and qualitative analysis for each project indicator.
Step 9. Project results must be assessed as **real improvement**.	Assess performance improvement to ensure the same methodology is repeated. Improvement should be linked to interventions, as opposed to an unrelated occurrence. Review statistical testing results, if available.
Step 10. Sustained improvement must be demonstrated through repeated measurements.	Review the results after the second re–measurement to determine consistent and sustained improvement when compared to baseline.

As Qlarant staff conducted the review, each of the components within a step was rated as "Yes," "No," or "N/A" (Not Applicable). Components were then aggregated to create a determination of "Met," "Partially Met," "Unmet," or "Not Applicable" for each of the 10 steps. Table 11 describes the criteria for reaching a determination in the scoring methodology.

Table 11. Rating Scale for PIP Validation

Determination	Criteria
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

Beginning with the Lead Screening PIP, all new PIPs will be using the new Rapid Cycle PIP Process to provide MCOs with a quality improvement method that identifies, implements, and measures changes over short periods. This PIP process aligns with the CMS EQR PIP Validation Protocol.

Qlarant assists the MCOs in the Rapid Cycle PIP process and breaks down the process into manageable steps based on the PIP development and implementation requirements:

1. **Develop an appropriate project rationale** based on supporting MCO data.
2. **Develop clear and measurable study questions**.
3. **Identify performance measures** that address the project rationale and reflect the study questions. Our performance measurement and performance improvement team work collaboratively to ensure MCOs have the right performance measures and data collection methodologies in place that will facilitate accurate and valid performance measure reporting.
4. **Identify barriers** including member, provider, and MCO barriers.
5. **Develop improvement strategies** or interventions.
6. **Measure, assess, and analyze the impact of the interventions**. MCOs must measure performance frequently (such as on a monthly or quarterly basis). Using performance measure results, it is critical to study the impact of interventions to determine which interventions may be effective and which interventions may need to be modified, replaced, or eliminated.

The Rapid Cycle PIP approach is continuous and allows the PIPs to monitor their improvement efforts over short time periods (monthly or quarterly). Frequent monitoring allows for quick intervention, when necessary. The ultimate goal is for MCOs to improve performance in a short amount of time and sustain improvement resulting in a positive impact on member health outcomes.

Implementing a quarterly schedule to guide MCOs' activities facilitates a meaningful Rapid Cycle PIP process, particularly in the first year of deployment.

PIP Results

This section presents an overview of the findings from the validation activities completed for each PIP submitted by the MCOs. Each MCO's PIP was reviewed against all components contained within the 10 steps. Recommendations for each step that did not receive a rating of "Met" follow each MCO's results in this report.

Asthma Medication Ratio PIPs

All Asthma Medication Ratio PIPs focused on increasing the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year, according to HEDIS® technical specifications.

Table 12 represents the CY 2018 Validation Results for all Asthma Medication Ratio PIPs.

Table 12. Asthma Medication PIP Validation Results for CY 2018

Step/Description	CY 2018 Asthma Medication Ratio PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1. Assess the Study Methodology	Met	Met	Met	Met	Met	Met	Met	Met
2. Review the Study Question(s)	Met	Met	Met	Met	Met	Met	Met	Met
3. Review the Selected Study Indicator(s)	Met	Met	Met	Met	Met	Met	Met	Met
4. Review the Identified Study Population	Met	Met	Met	Met	Met	Met	Met	Met
5. Review Sampling Methods	NA	NA	NA	NA	NA	NA	NA	NA
6. Review Data Collection Procedures	Met	Met	Met	Met	Met	Met	Met	Met
7. Assess Improvement Strategies	PM	Met	Met	Met	PM	PM	PM	PM
8. Review Data Analysis & Interpretation of Study Results	PM	Met	Met	Met	Met	PM	PM	PM
9. Assess Whether Improvement is Real Improvement	PM	PM	PM	PM	PM	PM	PM	Met
10. Assess Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA

PM – Partially Met; NA – Not Applicable

All MCOs received a rating of "N/A" for Step 5 (Review Sampling Methods) because the entire study population was included.

Five MCOs (ACC, MSFC, PPMCO, UHC, and UMHP) received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies) because member interventions did not address cultural differences. Additionally, PPMCO's interventions were not robust enough or responsive to the identified system-wide barriers, based upon an analysis of the MCO's data.

Four MCOs (ACC, PPMCO, UHC, and UMHP) received a rating of "Partially Met" for Step 8 (Review Data Analysis & Interpretation of Study Results) because they did not include all required components of the data analysis plan in their data analysis.

All MCOs, with the exception of UMHP, received a rating of "Partially Met" for Step 9 (Assess Whether Improvement is Real Improvement) because there was no documented quantitative improvement in the rate compared to the previous measurement year.

All MCOs received a rating of "N/A" for Step 10 (Assess Sustained Improvement) because two remeasurements are required before sustained improvement can be determined.

Asthma Medication Ratio PIP Identified Barriers

Annually, the HealthChoice MCOs perform a barrier analysis to identify root causes, barriers to optimal performance, and potential opportunities for improvement. The annual analysis identifies barriers to care for members, providers, and the MCOs. Common barriers across all MCOs for the Asthma Medication Ratio PIP were identified as follows.

Member Barriers

- Knowledge deficits
- Lack of medication compliance
- Lack of follow-up with primary care provider (PCP) or asthma specialist after emergency department (ED) visit
- Cultural practices, beliefs, values
- Presence of allergens in the home
- Lack of transportation for office appointments and prescription needs
- Cost associated with multiple medications

Provider Barriers

- Lack of awareness of patient ED visits for asthma
- Lack of staff to provide member education and outreach
- Knowledge deficit of MCO resources/initiatives to assist with member compliance
- Knowledge deficits relating to appropriate asthma treatment
- Knowledge deficits relating to member adherence

MCO Barriers

- Inaccurate member demographic information negatively impacting member outreach
- Increased denials of medications at point of service due to frequent formulary changes
- Inaccuracy of pharmacy data provided

Asthma Medication Ratio Interventions Implemented

Below are examples of interventions implemented by the HealthChoice MCOs for the Asthma Medication Ratio PIPs:

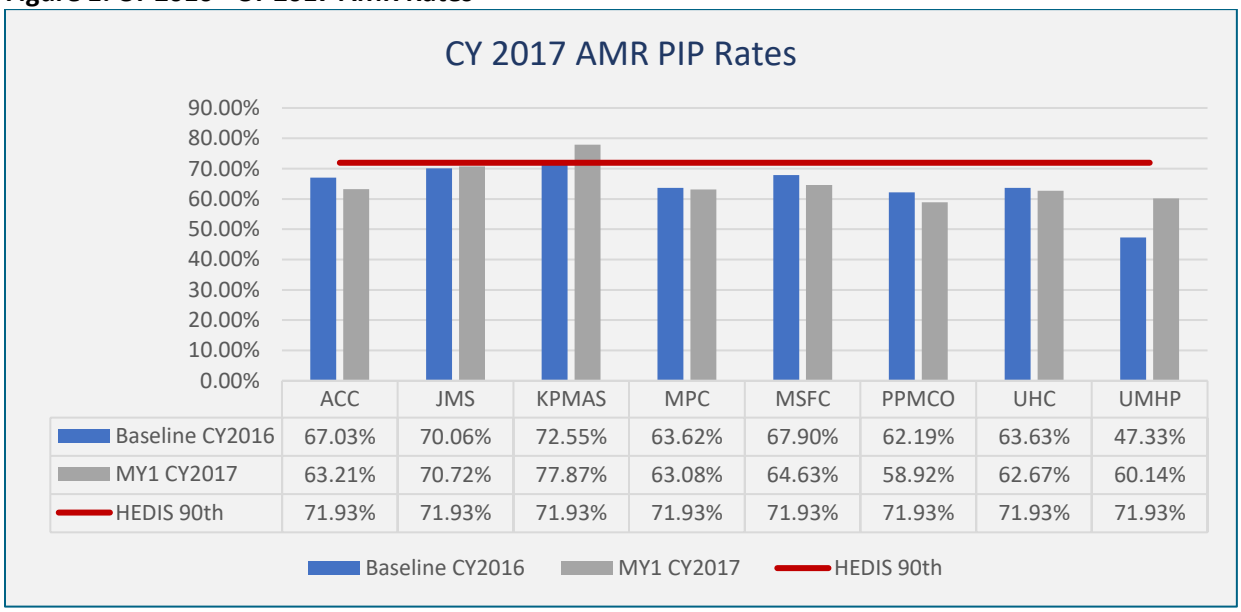
- Member education and outreach, including targeting members who meet specific criteria.
- Use of CRISP (Chesapeake Regional Information System) data by MCOs and providers to identify and target members with ED usage.
- Disease/case management.
- Health coaches.
- Provider education.
- Provider care opportunity reports.
- Electronic medical record supplemental data from high volume provider sites.
- Transportation for office appointments and prescription needs; pharmacy delivery of prescriptions.
- Transitional care coordination to facilitate PCP follow-up after emergency department visit.
- Required review of member demographics upon each member contact.

- Asthma Adherence Monitoring Program through retail pharmacists.
- Onsite appointment scheduling.
- Chart review/patient assessment/recommended interventions by allergist of pediatric patients discharged from ED or hospital for asthma.
- Creation of an electronic medical record tool to require decision-making/chart review before refilling rescue medications.
- Referrals to Green and Healthy Homes for home assessment of asthma triggers.
- Collaboration with school-based health centers.

Asthma Medication Ratio Indicator Results

CY 2017 is the first remeasurement year of data collection for the Asthma Medication Ratio PIP. Figure 1 represents the Asthma Medication Ratio PIP indicator rates for all MCOs.

Figure 1. CY 2016 - CY 2017 AMR Rates



	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Baseline CY2016	67.03%	70.06%	72.55%	63.62%	67.90%	62.19%	63.63%	47.33%
MY1 CY2017	63.21%	70.72%	77.87%	63.08%	64.63%	58.92%	62.67%	60.14%
HEDIS 90th	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%

There is wide variation among the MCOs in their performance relative to the 2018 HEDIS® Medicaid 90th Percentile benchmark. KPMAS is performing above the 90th percentile. JMS is performing slightly below the 90th percentile. ACC, MPC, MSFC, and UHC are performing slightly above the 50th percentile. PPMCO and UMHP are performing below the 50th percentile.

Three MCOs demonstrated improvement in performance rates over their baseline measurements:

- JMS' rate increased by 0.66 percentage points.
- KPMAS' rate increased by 5.32 percentage points.
- UMHP's rate increased by 12.81 percentage points, which was statistically significant.

The remaining five MCOs experienced a decline in performance over their baseline measurements:

- ACC's rate declined by 3.82 percentage points, which was statistically significant.
- MPC's rate declined by 0.54 percentage points.

- MSFC's rate declined by 3.27 percentage points.
- PPMCO's rate declined by 3.27 percentage points, which was statistically significant.
- UHC's rate declined by 0.96 percentage points.

Lead Screening PIPs

All Lead Screening PIPs focused on increasing the percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday and the percentage of children ages 12-23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year.

Table 13 represents the CY 2018 Validation Results for all Lead Screening PIPs.

Table 13. Lead Screening PIP Validation Results for CY 2018

Step/Description	CY 2018 Lead Screening PIP Validation Results							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1. Assess the Study Methodology	Met	Met	Met	Met	Met	Met	Met	Met
2. Review the Study Question(s)	Met	Met	Met	Met	Met	Met	Met	Met
3. Review the Selected Study Indicator(s)	Met	Met	Met	Met	Met	Met	Met	Met
4. Review the Identified Study Population	Met	Met	Met	Met	Met	Met	Met	Met
5. Review Sampling Methods	NA	NA	Met	Met	Met	NA	NA	Met
6. Review Data Collection Procedures	Met	Met	Met	PM	Met	Met	Met	PM
7. Assess Improvement Strategies	PM	Met	Met	PM	Met	PM	Met	PM
8. Review Data Analysis & Interpretation of Study Results	Met	Met	Met	PM	Met	PM	Met	PM
9. Assess Whether Improvement Is Real Improvement	NA	NA	NA	NA	NA	NA	NA	NA
10. Assess Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA

PM – Partially Met; NA – Not Applicable

Two MCOs (MPC and UMHP) received a rating of "Partially Met" for Step 6 (Review Data Collection Procedures) because they did not identify the qualifications and relevant experience of the staff that collect the data.

Four MCOs (ACC, MPC, PPMCO, and UMHP) received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies). MPC, PPMCO and UMHP did not implement sufficient interventions to address system-wide barriers in a meaningful way. Additionally, ACC, PPMCO, and UMHP did not demonstrate implementation of targeted interventions in response to any cultural barriers identified among its population subgroups.

Three MCOs (MPC, PPMCO and UMHP) received a rating of "Partially Met" for Step 8 (Review Data Analysis & Interpretation of Study Results). MPC did not accurately report indicator results, while PPMCO and UMHP did not provide an analysis of their data consistent with their data analysis plan.

All MCOs received a rating of "N/A" for Steps 9 (Assess Whether Improvement is Real Improvement) and 10 (Assess Sustained Improvement) as CY 2017 was the baseline measurement year. Indicator improvement and sustained improvement will be assessed in subsequent years.

Lead Screening PIP Identified Barriers

Below are common barriers identified among the HealthChoice MCOs for the Lead Screening PIP:

Member Barriers

- Knowledge deficit
- Lack of transportation for routine care and lead testing
- Financial challenges impeding efforts to maintain a safe, clean, livable environment
- Housing that is not lead-free
- Difficulty communicating with providers as a result of language and/or reading preferences/abilities
- Non-adherence with preventive care visits

Provider Barriers

- Knowledge deficit regarding different HEDIS® and MDH requirements
- Providers do not trust Medtox results due to false positives
- Competing priorities during member office visits
- Lack of point of care testing resources
- Lack of resources for patient follow-up
- Inability to coordinate care with the targeted population

MCO Barriers

- Home visit providers are not available in 12 counties
- Lack of data sharing across MCOs
- Insufficient or inaccurate member contact and demographic data
- Inability to proactively identify lead care gaps
- Limited understanding of cultural and linguistic barriers
- Lack of resources to outreach members with gaps in care, such as lead testing

Lead Screening PIP Interventions Implemented

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

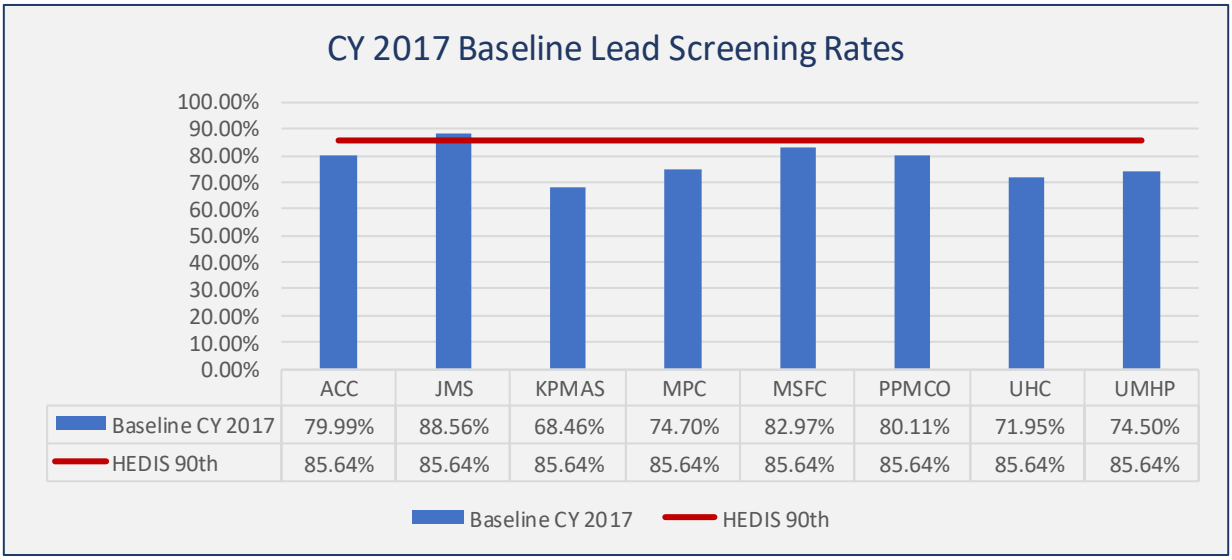
- Member education.
- Clinic Days at provider sites with phlebotomy services.
- Member outreach and assistance with appointment scheduling.
- In-home lead testing.
- Community health worker home visits.

- Referrals to Baltimore City Childhood Lead Poisoning Prevention Program for home assessments and education.
- Referrals to county health departments for environmental and medical home visits, telephonic case management, and education.
- Community events, which include education and on-site blood level testing.
- Member incentives.
- Provider education.
- Case Management.
- Bulk lab lead orders.
- State lead testing registry review and reconciliation.
- Transportation assistance to labs for testing.
- Provider incentive program.
- Provider feedback on lead screening performance.

Lead Screening Indicator Results

CY 2017 is the baseline measurement year for the Lead Screening PIP. Figure 2 represents the HEDIS® indicator rates for the eight MCOs participating in this PIP.

Figure 2. CY 2017 HEDIS® Lead Screening Indicator Rates

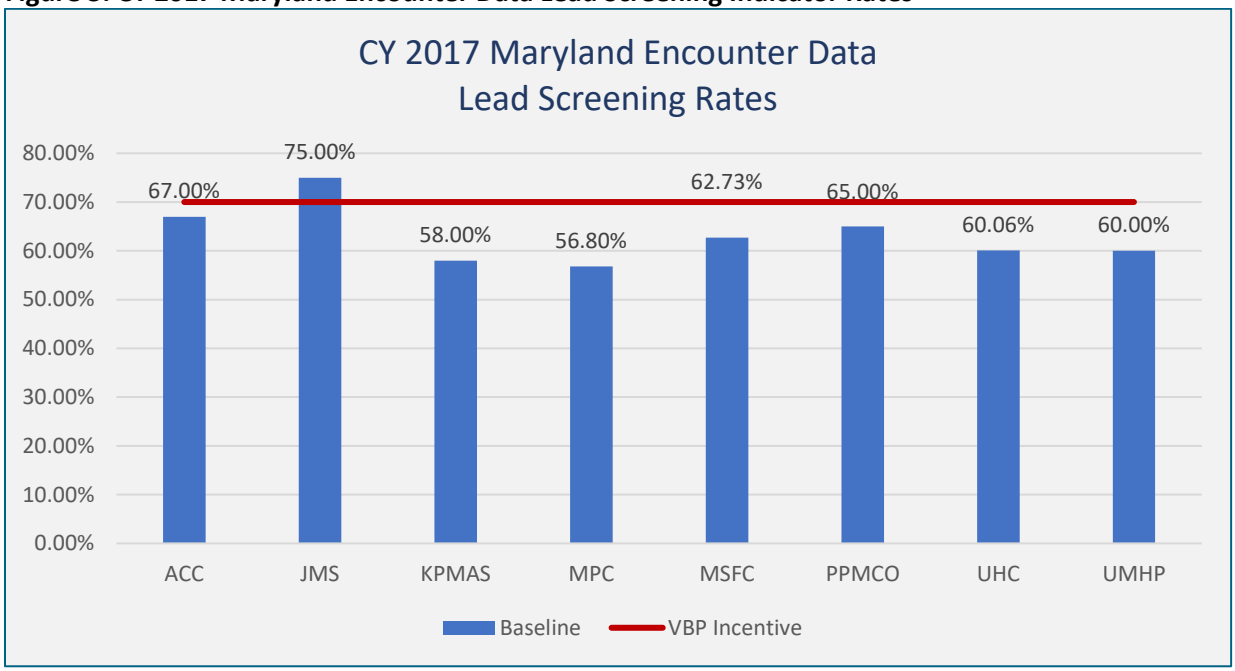


	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Baseline CY 2017	79.99%	88.56%	68.46%	74.70%	82.97%	80.11%	71.95%	74.50%
HEDIS 90th	85.64%	85.64%	85.64%	85.64%	85.64%	85.64%	85.64%	85.64%

There is wide variation among the MCOs in the baseline rates relative to the 2018 HEDIS® Medicaid 90th Percentile benchmark. JMS exceeds the 90th percentile benchmark for the Lead Screening rate. Three MCOs (ACC, MSFC and PPMCO) are performing close to or above the 75th percentile for this measure. Baseline rates for MPC, UHC, and UMHP are performing close to or above the 50th percentile. KPMAS is performing mid-range between the 25th and 50th percentiles.

Figure 3 represents the Maryland encounter data indicator rates.

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



JMS is the only MCO with Maryland encounter data rates for lead screening that are in the incentive benchmark range of ≥ 70% for Maryland's Value Based Purchasing Initiative. Two MCOs (ACC and PPMCO) have rates within the VBP neutral benchmarks (64%-69%). The remaining five MCOs (KPMAS, MPC, MSFC, UHC, and UMHP) have rates within the VBP disincentive benchmark (≤ 63%).

PIP Recommendations

Qlarant recommends that the HealthChoice MCOs concentrate efforts on:

- **Completing annual in-depth barrier analysis** to identify root causes of suboptimal performance, which will direct where limited resources can be most effectively used to drive improvement. Barrier analysis continues to be conducted at a high-level by many MCOs, resulting in little or no improvement in indicator rates.
- **Developing robust, system–level interventions** responsive to identified barriers, which include educational efforts, changes in policy, targeting of additional resources, or other organization–wide initiatives. Face–to–face contact is usually most effective. To improve outcomes, interventions should be systematic (affecting a wide range of members, providers and the MCO), timely, and effective. Since members generally view their PCP as their trusted advisor, PCP interventions may be the most effective in influencing health-related behavior change in members.
- **Ensuring that interventions address differences among population subgroups**, such as differences in health care attitudes and beliefs among various racial/ethnic groups within the MCO's membership. Although Qlarant provided training to all MCOs on the process for identifying disparities based on analysis of MCO-specific data in May 2018, the majority of MCOs continue to demonstrate a lack of in-depth analysis to identify root causes for informing targeted interventions.
- **Assessing interventions for their effectiveness**, and initiating adjustments where outcomes are unsatisfactory. Consideration should be given to small tests of change to assess intervention

effectiveness before implementing across the board. MCOs generally focus at the activity level rather than at the process or outcome level when assessing the impact of interventions.

- **Ensuring that data analysis is consistent with the data analysis plan**, both quantitative and qualitative.

Conclusions

All MCOs are required to participate in two PIPs, Asthma Medication Ratio and Lead Screening. CY 2017 results were submitted in September 2018, representing the first remeasurement year for the Asthma Medication Ratio PIP and the baseline measurement year for the Lead Screening PIP. Eight of the nine HealthChoice MCOs participated in both PIPs. ABH's participation was not required since the MCO did not initiate operations until October 2017. A separate HEDIS® audit of all PIP indicator results was conducted by an independent NCQA-certified organization. Maryland encounter data rates were also validated by Qlarant.

An assessment of the validity and reliability of the PIP study design and results reflects a detailed review of each MCO's PIPs and audited HEDIS® and Maryland encounter data measure findings and conclusions for the selected indicators. Tables 14 and 15 identify the level of confidence Qlarant has assigned to each MCO's Asthma Medication Ratio and Lead Screening PIPs for CY 2018.

Table 14. CY 2018 Asthma Medication Ratio PIP Validation Results - Level of Confidence

Level of Confidence in Reported Results	Asthma Medication Ratio PIP							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
High Confidence		X	X	X				
Confidence	X				X		X	X
Low Confidence						X		
Not Credible								

A low confidence level was assigned to PPMCO's Asthma Medication Ratio PIP as their interventions were not robust enough, not always linked to an identified barrier, and the MCO did not assess the interventions for their impact. A level of confidence was assigned to PIPs submitted by ACC, UHC, and UMHP due to inconsistencies with their data analysis based on their data analysis plan. MSFC's PIP was assigned a level of confidence due to the lack of robust, timely interventions not implemented as planned. Additionally, all MCOs that were assigned a level of low confidence or confidence did not demonstrate implementation of targeted interventions in response to identified cultural or linguistic barriers.

Table 15. CY 2018 Lead Screening PIP Validation Results - Level of Confidence

Level of Confidence in Reported Results	Lead Screening PIP							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
High Confidence	X	X	X		X		X	
Confidence				X		X		X
Low Confidence								
Not Credible								

The Lead Screening PIP submitted by MPC was assigned a level of confidence because it did not evidence sufficient interventions to improve outcomes in a meaningful way, describe the qualifications and experience of individuals that collect the data, and report accurate indicator rates. PPMCO's PIP was assigned a level of confidence since it did not implement more than one new intervention or address system-wide barriers, and there was no evidence that this intervention was assessed for effectiveness. Reported results for UMHP's PIP were assigned a level of confidence due to the absence of stated qualifications and experience of individuals used to collect medical record data, lack of interventions to address provider and member cultural/linguistic barriers, and data analysis inconsistencies with data analysis plan.

Section IV
Encounter Data Validation

Introduction

The Medicaid Managed Care Provisions of the Balanced Budget Act of 1997 (BBA) directed the U.S. Department of Health and Human Services to develop protocols to serve as guidelines for conducting External Quality Review Organization (EQRO) activities. Beginning in 1995, the Centers for Medicare and Medicaid Services (CMS) began developing a series of tools to help State Medicaid agencies collect, validate, and use encounter data for managed care program oversight. Encounter data can provide valuable information about distinct services provided to enrollees that can be used to assess and review quality, monitor program integrity, and determine capitation rates. CMS strongly encourages states to contract with EQROs to conduct encounter data validation (EDV) to ensure the overall validity and reliability of its encounter data.

In compliance with the BBA, the Maryland Department of Health (MDH) contracts with Qlarant to serve as the EQRO for the HealthChoice Program. The EDV review was conducted according to the CMS EDV protocol, *Validation of Encounter Data Reported by the MCO, Protocol 4, Version 2.0, September 2012.* Qlarant conducted EDV for calendar year (CY) 2017, encompassing January 1, 2017 through December 31, 2017 for all nine HealthChoice MCOs:

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

Purpose

The purpose of EDV is to assess the completeness and accuracy of encounter data submitted by MCOs to the State. Encounter data are the electronic records of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provide substantially the same type of information that is found on claim forms (e.g., UB-04 or CMS 1500), but not necessarily in the same format. States use encounter data to assess and improve quality, monitor program integrity, and determine capitation payment rates.

Encounter Data Validation Process

The CMS approach to EDV includes the following three core activities:

- Assessment of health plan information system (IS).
- Analysis of health plan electronic encounter data for accuracy and completeness.
- Review of medical records for additional confirmation of findings.

The EDV protocol makes the following assumptions:

- An encounter refers to the electronic record of a service provided to a health plan enrollee by both institutional and non-institutional providers.
- The State specifies the types of encounters (e.g., physician, hospital, dental, vision, laboratory, etc.) for which encounter data are to be provided. In addition, the type of data selected for review (inpatient, outpatient, etc.) is directly proportionate to the total percent of encounter types per calendar year.
- Encounter data is considered "complete" when the data can be used to describe the majority of services that have been provided to Medicaid beneficiaries who are health plan enrollees. HealthChoice required managed care organizations (MCOs) to submit CY 2017 encounter data by June 2018.
- Encounter data completeness and accuracy requires continued monitoring and improvement. States need to develop encounter data standards and monitor for accuracy and completeness. Ultimately, it is the State that establishes standards for encounter data accuracy and completeness.

Qlarant completed the following five sequential EDV activities:

Activity 1: Review of State requirements for collection and submission of encounter data.
Activity 2: Review of health plan's capability to produce accurate and complete encounter data.
Activity 3: Analysis of health plan's electronic encounter data for accuracy and completeness.*
Activity 4: Review of medical records for additional confirmation of findings.
Activity 5: Analysis and submission of findings.
* MDH elected to have Activity 3 completed by The Hilltop Institute, University of Maryland Baltimore County.

A description of how each sequential EDV activity was conducted, along with detailed results, follow.

Activity 1: Review of State Requirements

Qlarant reviewed information regarding Department of HealthChoice Quality Assurance's (DQA's) requirements for collecting and submitting encounter data. DQA provided Qlarant with:

- DQA's requirements for collection and submission of encounter data by MCOs (specifications in the contracts between the State and the MCO)
- Data submission format requirements for MCO use
- Requirements regarding the types of encounters that must be validated
- DQA's data dictionary
- A description of the information flow from the MCO to the State, including the role of any contractors or data intermediaries
- DQA's standards for encounter data completeness and accuracy
- A list and description of edit checks built into DQA's Medicaid Management Information System (MMIS) that identifies how the system treats data that fails edit checks
- Requirements regarding time frames for data submission
- Prior year's EQR report on validating encounter data (if available)
- Any other information relevant to encounter data validation

Results of Activity 1: Review of State Requirements

MDH sets forth the requirements for collection and submission of encounter data by MCOs in Appendix E of the MCO's contract. It includes all of the COMAR provisions applicable to MCOs, including regulations concerning encounter data. The regulations applying to encounters in CY 2017 are noted in Table 16.

Table 16. CY 2017 COMAR Requirements for Encounter Data

COMAR	Requirement
10.09.64.11B	A description of the applicant's operational procedures for generating service-specific encounter data.
10.09.64.11C	Evidence of the applicant's ability to report, on a monthly basis, service-specific encounter data in UB04 or CMS1500 format.
10.09.65.03A(1)	An MCO shall have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services delivered to enrollees including individuals with special health care needs. At a minimum, the MCO shall comply with all applicable federal and state laws and regulations.
10.09.65.03B	An MCO shall participate in all quality assessment activities required by MDH in order to determine if the MCO is providing medically necessary enrollee health care.
10.09.65.15B	Encounter Data ○ An MCO shall submit encounter data reflecting 100% of provider-enrollee encounters, in CMS1500 or UB04 format or an alternative format previously approved by MDH. ○ An MCO may use alternative formats including: ▪ ASC X12N 837 and NCPDP formats; and ▪ ASC X12N 835 format, as appropriate. ○ An MCO shall submit encounter data that identifies the provider who delivers any items or services to enrollees at a frequency and level of detail to be specified by CMS and MDH. ○ An MCO shall report encounter data within 60 calendar days after receipt of the claim from the provider. ○ An MCO shall submit encounter data utilizing a secure on-line data transfer system.

The electronic data interchange, or EDI, is the automated system that includes rules dictating the transfer of data from each MCO to MDH. MDH uses the HIPAA EDI transaction sets and standards for data submission of 835 and 837 files. The 837 contains patient claim information while the 835 contains the payment and/or explanation of benefits for a claim. MDH receives encounter data from the MCOs in a format that is HIPAA 837 compliant—via an EDI system—and then executes validations to generate exception reports that are in both HIPAA 835 compliant file format, as well as an MDH summarized version known to MDH as the "8ER" report.

MDH processes encounters through the Electronic Data Interchange Translator Processing System (EDITPS). Encounters are first edited for completeness and accuracy using the HIPAA EDI implementation guidelines. Successfully processed encounters are mapped for further code validation based on MDH requirements that identify the criteria each encounter must meet in order to be accepted into MMIS.

MDH provided an abridged data dictionary and described the process of encounter data submission from the MCOs to the state. MCOs can submit encounter data through a web portal or through a secure file transfer protocol (SFTP). Each MCO may have contractors or data intermediaries that submit encounters.

Although MDH does not maintain a list and description of the edit checks, the system treats encounters that fail the MMIS edit checks in the following manner:

- All denied and rejected encounters are reported back with the MMIS Explanation of Benefit (EOB) code and description in an EDI error report known as the 8ER file.
- The 835 file contains all paid and denied encounters. The denied encounters use the HIPAA EDI Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARC) codes to report back denied reason codes. Encounters marked as suspended are not included in the 835.
- In addition, a MMIS summary report is generated and sent to each MCO.

MDH sets forth requirements regarding time frames for data submission in COMAR 10.09.65.15B (4), which states that MCOs must report encounter data within 60 calendar days after receipt of the claim from the provider. For daily data exchanges, the cutoff time is 3 PM for transmission of a single encounter data file for an MCO to receive an 835 the next day.

Activity 2: Review of MCO's Ability to Produce Accurate and Complete Encounter Data

Qlarant assessed each MCO's capability for collecting accurate and complete encounter data. Prior to examining data produced by the MCO's information system, a determination must be made as to whether the MCO's information system is likely to capture complete and accurate encounter data. This was completed through two steps:

1. Review of the MCO's Information Systems Capabilities Assessment (ISCA).
2. Interview MCO personnel.

Review of the ISCA. Qlarant reviewed the MCO's ISCA to determine where the MCO's information systems may be vulnerable to incomplete or inaccurate data capture, integration, storage, or reporting. MCOs were provided a crosswalk between the HEDIS Roadmap completed as part of the HEDIS Compliance Audit and the ISCA required as part of the EDV. Qlarant reviewed the ISCA findings for the following:

- Information Systems: Data Processing and Procedures
  - Data Base Management System (DBMS) Type
  - Programming language
  - Process for updating the program to meet changes in State requirements

- Claims/Encounter Processing
  - Overview of the processing of encounter data submissions
  - Completeness of the data submitted
  - Policies/procedures for audits and edits
- Claims/Encounter System Demonstration
  - Processes for merging and/or transfer of data
  - Processes for encounter data handling, logging and processes for adjudication
  - Audits performed to assure the quality and accuracy of the information and timeliness of processing
  - Maintenance and updating of provider data
- Enrollment Data
  - Verification of claims/encounter data
  - Frequency of information updates
  - Management of enrollment/disenrollment information

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

Any issues that may contribute to inaccurate or incomplete encounter data were identified. Examples of issues include MCO use of non-standard codes or forms, inadequate data edits, or the lack of provider contractual requirements that tie payment to data submission. Based on the ISCA review, Qlarant noted all concerns about the encounter data for each encounter type listed in the Acceptable Error Rates Specification Form. MCO staff should follow-up on any identified issues.

Results of Activity 2: Review of MCO's Ability to Produce Accurate and Complete Encounter Data

Qlarant completed an assessment of each HealthChoice MCO's ISCA. Overall results indicate that:

- All MCOs appear to have well-managed systems and processes.
- All MCOs use only standard forms and coding schemes.
- All MCOs are capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service.
- All MCOs appear to have information systems and processes capable of producing accurate and complete encounter data.
- Five MCOs (ACC, KPMAS, PPMCO, UHC, and UMHP) process claims and encounters with in-house systems while the remaining three MCOs (JMS, MSFC, and MPC) contract with third party administrators for processing claims and encounters.
- The HealthChoice MCO average auto-adjudication was 82.23%, with MCO-specific rates ranging from 56% to 94%.
- The HealthChoice MCO average rate for processing clean claims in 30 days was 98.5%, with MCO-specific rates ranging from 90.41% to 100%.
- On average, the HealthChoice MCOs received 87.74% of professional claims and 87.95% of facility claims electronically.

MCO-specific results pertaining to the ISCA Assessment were provided to MDH and each MCO.

Activity 3: Analysis of MCO's Electronic Encounter Data

MDH has an interagency governmental agreement with The Hilltop Institute of University of Maryland Baltimore County (Hilltop) to serve as the data warehouse for its encounters. Therefore, Hilltop completed Activity 3 of the EDV.

Activity 3 contains the following four required analyses:

1. Develop a data quality test plan
2. Verify the integrity of the MCOs' encounter data files
3. Generate and review analytic reports
4. Compare findings to state-identified standards

Step 1. Develop a Data Quality Test Plan
The development of a data quality test plan incorporates information gathered in Activity 1. Specifically, the "plan should account for the edits built into the State's data system so that it pursues data problems that the State may have overlooked or allowed" (Centers for Medicare & Medicaid Services, 2012, p. 7). In August 2018, Hilltop obtained pertinent information from MDH regarding the process and procedure used to receive, evaluate, and report on the validity of MCO encounter data. Hilltop interviewed Department staff to document state processes for accepting and validating encounter data. Topics discussed during this meeting included but were not limited to the following:

- MCO submission of encounter data, the upload of data to MDH's mainframe for processing and validation checks, and the upload of accepted data to MMIS2
- Encounter data fields validated through the EDI process, such as validation of recipient ID, sex, age, diagnostic codes, and procedure codes
- MDH processes incoming data from the MCOs within 1 to 2 business days
- Error code reports generated for MCOs by the validation process
- As a result of the August 2018 meeting, the EDI error report data for CY 2017 (the 8ER report) was transmitted to Hilltop for analysis and included the number and types of errors for encounter submissions for each MCO. Analysis of the frequency of different error types and rejection categories is included in this report. The 8ER error descriptions were used to provide a comprehensive overview of the validation process.

Step 2. Verify the Integrity of the MCOs' Encounter Data Files
Hilltop compared the number of participants to total encounters, assessing whether the distribution is similar across MCOs. The percentage of participants with encounters was also considered for inpatient visits, observation stays, and emergency department (ED) visits. Selected fields not verified by MDH during the EDI process in Step 1 were assessed for completeness and accuracy. Finally, the MCO provider number was evaluated to ensure that encounters received and accepted are only for MCOs currently active within the HealthChoice program. Encounters received and accepted with MCO provider numbers not active within the HealthChoice program were not included in the analysis. Because Aetna joined the HealthChoice program in late 2017, its encounters were not included in the analysis due to limited data.

Step 3. Generate and Review Analytic Reports
The analysis addressing volume and consistency of encounter data is focused in four primary areas: time, provider, service type, and the age and sex appropriateness of diagnostic and procedure codes. MDH helped identify several specific analyses for each primary area related to policy interests.

Analysis of encounter data by time dimensions allows for an evaluation of consistency. Trends in encounter submission and dates of service are included. Hilltop completed a comparison of time dimension data between MCOs to determine whether MCOs process data within similar time frames. Provider analysis evaluates trends in provider services and seeks to determine any fluctuation in visits during CY 2017. Provider analysis is focused on primary care visits, specifically the number of participants who had a visit within the year.

The service type analysis concentrated on three main service areas: inpatient hospitalizations, observation stays, and ED visits. The CY 2017 analysis provides baseline data and allows MDH to identify any future changes in utilization patterns for these types of services.

Finally, Hilltop analyzed age and sex appropriateness. The age analysis includes evaluation of enrollees over age 66 with a diagnosis related to pregnancy or dementia. There is a generally accepted age range for these two conditions. Participants over the age of 65 are ineligible for HealthChoice, so any encounters received for this population were noted, which may indicate a participant date of birth issue. Analysis of a sex-appropriate diagnosis was conducted in terms of pregnancy.

Step 4. Compare Findings to State-Identified Standards
In both Steps 2 and 3, Hilltop performed the analyses by MCO, allowing benchmarking from MCO to MCO. The analyses compared outlier data with overall trends, and the results are presented along with each analysis.

Results of Activity 3: Analysis of MCO's Electronic Encounter Data

Step 1. Develop a Data Quality Test Plan
MDH initiates the evaluation of MCO encounter data with a series of validation checks on the encounter data received through the EDI. These validation checks include analysis of critical data fields, consistency between data points, duplication, and validity of data received. Encounters failing to meet these standards are reported back to the MCO for possible correction and re-submission. Both the 835 report and the 8ER report are returned to the MCOs.

MDH provided the CY 2017 8ER reports to Hilltop for analysis of encounters failing initial EDI edits. Table 17 provides an overview of the 8ER data. Rejected encounters were classified into five categories: duplicates, inconsistent data, missing data, participant not eligible for service, and value not valid for the field.

Table 17. Distribution of Rejected Encounter Submissions by Category, CY 2017

Category for Rejection	Number of Rejected	Percentage of All Rejected Encounters
Missing	677,840	36.8%
Not Eligible	558,483	30.3%
Not Valid	276,763	15.0%
Inconsistent	244,463	13.3%
Duplicate	86,127	4.7%
Total	1,843,676	100.0%

The primary reason encounters were not accepted is due to missing data (36.8%) and participant not being eligible (30.3%), followed by invalid data (15.0%). Checks on critical fields for missing or invalid data include provider number, units of service, drug number, drug quantity, revenue code, procedure code, and diagnosis code. Eligibility issues refer to a participant not being eligible for MCO enrollment at the time of the service. Inconsistent data was similar in frequency to invalid data (13.3%). Inconsistent data refers to an inconsistency between two data points. Examples of inconsistency include discrepancies between dates, inconsistencies between diagnosis and age or sex, and inconsistencies between original and re-submitted encounters. Duplicate data accounts for approximately 4.7% of rejected encounters. The most common duplicates identified on encounters were encounter numbers and drug codes.

Evaluating the rejected encounters by MCO is useful for assessing trends, as well as identifying issues particular to each MCO. This type of analysis will allow MDH to focus on working with each MCO on any identified issues. Table 18 illustrates the distribution of rejected and accepted encounter submissions across MCOs.

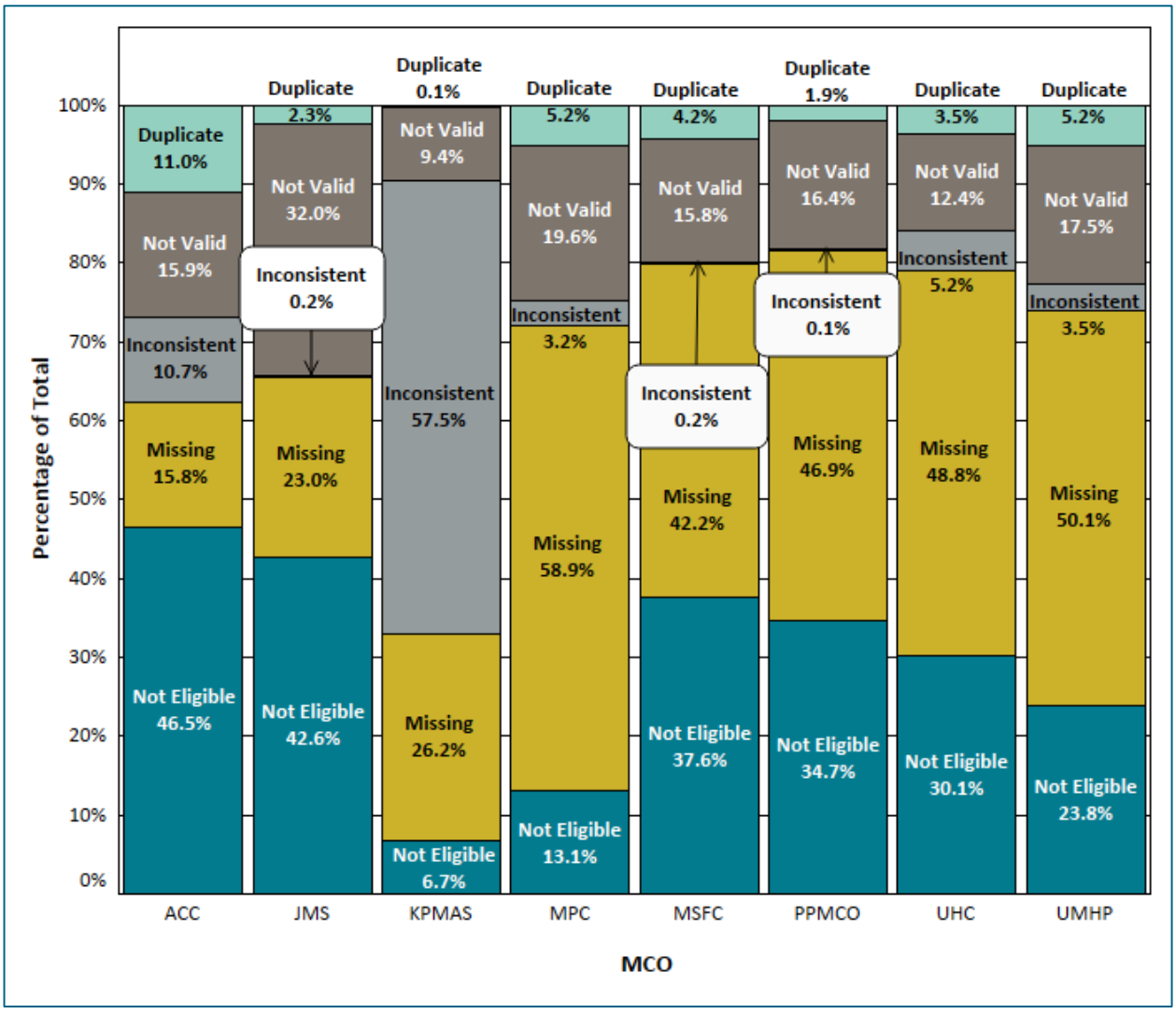
Table 18. Distribution of Rejected and Accepted Encounter Submissions by MCO, CY 2017

	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	Total
Number of Rejected	439,491	27,402	302,080	138,900	150,129	389,589	280,033	116,052	1,843,676
Percentage of All Rejected	23.8%	1.5%	16.4%	7.5%	8.1%	21.1%	15.2%	6.3%	100.0%
Number of Accepted Encounters	7,972,430	1,163,215	1,807,238	7,301,579	3,151,760	10,422,589	5,444,030	1,387,424	38,650,265
Percentage of All Accepted Encounters	20.6%	3.0%	4.7%	18.9%	8.2%	27.0%	14.1%	3.6%	100.0%

ACC and PPMCO each account for over 20% of the total rejected encounters. Both KPMAS and UHC have around 15% of the rejected encounters (16.4% and 15.2%, respectively). MSFC, MPC, UMHP, and JMS have less than 10% of rejected encounters (8.1%, 7.5%, 6.3%, and 1.5%, respectively). This distribution is reasonable given the MCO accepted encounter distribution as presented in Table 2. However, KPMAS accounts for 16.4% of rejected encounters but only 4.7% of accepted encounters. As KPMAS is a newer MCO compared to other HealthChoice plans, some of these issues may have been resolved in 2018. MDH should continue to monitor 8ER reports to identify trends and encourage MCO data quality.

Although the analysis of the EDI encounter rejection reason reveals variation between MCOs, some overall trends can be identified as displayed in Figure 4.

Figure 4. Percentage of Encounters Rejected by EDI per Rejection Category by MCO, CY 2017



Duplicate rejections are small across all MCOs. ACC, JMS, MPC, MSFC, PPMCO, UHC, and UMHP all display similar proportions across the categories for rejection. KPMAS primarily had encounters rejected for inconsistent data (57.5%) or missing data (26.2%). MPC encounters were rejected mostly due to missing data (58.9%) or data not being valid (19.6%). MDH should work with each MCO to address their top errors.

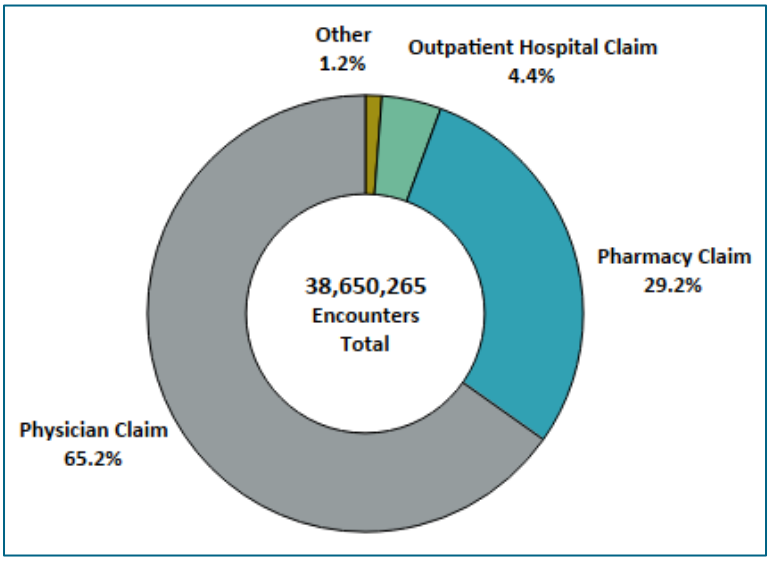
Step 2. Verify the Integrity of the MCOs' Encounter Data Files

During CY 2017, the MCOs submitted a total of 38 million accepted encounters. While the 8ER EDI data received do not include date of service, it is possible to estimate the total number of encounters submitted during CY 2017 by adding the accepted encounters to the rejected encounters in the 8ER file. Thus, roughly 40 million encounters were submitted during CY 2017, and approximately 95% of these were accepted into MMIS2.

Hilltop receives a monthly copy of all encounters accepted by MMIS2. Upon receipt of the encounters from MMIS2, several validation assessments of the data are performed, including whether there is an invalid end date of service or other fatal errors. These files are removed before being added to Hilltop's data warehouse. A total of 543 encounters were identified with an MCO provider number of "000000000" or "ACC PAC" and removed from subsequent analysis.

The total accepted encounters by claim type were reviewed. The percentage of accepted encounters submitted by claim type for CY 2017 is displayed in Figure 5.

Figure 5. Percentage of Accepted Encounter Submissions by Claim Type, CY 2017



Most encounters are from physician encounters, which include home health services (65.2%), as shown in Figure 2. Pharmacy encounters and outpatient hospital encounters are the other two largest types of accepted encounters (29.2% and 4.4%, respectively). Other encounters (1.2%) include inpatient hospital stays, community-based services, long-term care services, and dental services. Table 19 provides the percentage and number of claims by type for each MCO in CY 2017.

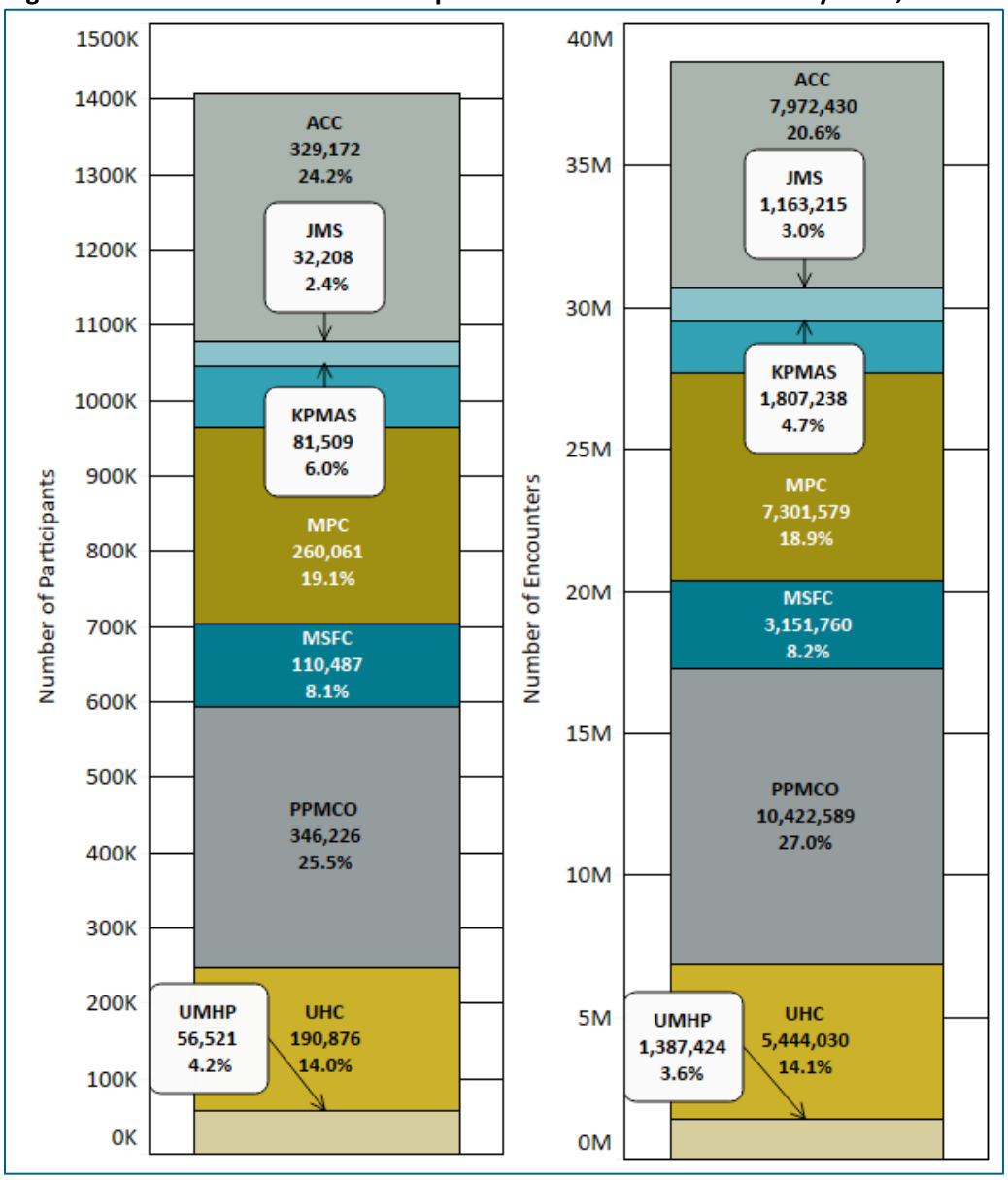
Table 19. Percentage and Count of Claim Type by MCO, CY 2017

MCO	Physician Claim	Pharmacy Claim	Outpatient Hospital Claim	Other	Total
AmeriGroup	**67.2%** 5,358,249	**27.2%** 2,165,826	**4.8%** 379,686	**0.9%** 68,669	**100.0%** 7,972,430
JAI Medical Systems	**58.4%** 679,329	**36.6%** 426,312	**4.5%** 52,804	**0.4%** 4,770	**100.0%** 1,163,215
Kaiser	**71.8%** 1,297,859	**23.2%** 418,584	**1.6%** 28,151	**3.5%** 62,644	**100.0%** 1,807,238
Maryland Physicians Care	**63.2%** 4,611,977	**31.3%** 2,284,909	**4.4%** 318,877	**1.2%** 85,816	**100.0%** 7,301,579
MedStar Family Choice	**61.4%** 1,936,747	**31.0%** 976,952	**4.3%** 135,609	**3.3%** 102,452	**100.0%** 3,151,760
Priority Partners	**64.9%** 6,763,482	**29.6%** 3,089,710	**4.7%** 485,270	**0.8%** 84,127	**100.0%** 10,422,589
United Healthcare	**66.9%** 3,641,194	**28.5%** 1,553,692	**3.8%** 209,156	**0.7%** 39,988	**100.0%** 5,444,030
Univ of MD Health Partners	**65.5%** 908,883	**26.5%** 367,416	**6.7%** 93,072	**1.3%** 18,053	**100.0%** 1,387,424
Total	**65.2%** **25,197,720**	**29.2%** **11,283,401**	**4.4%** **1,702,625**	**1.2%** **466,519**	**100.0%** **38,650,265**

The distribution of encounters is mostly consistent across MCOs. Physician services ranged from 58.4% of encounters (JMS) to 71.8% of encounters (KPMAS). JMS had the largest percentage of pharmacy claims (36.6%), while KPMAS had the lowest percentage (23.2%). Outpatient hospital claims ranged from a low of 1.6% for KPMAS to a high of 6.7% for UMHP.

Figure 6 illustrates the volume of accepted encounters and Medicaid participants for each MCO.

Figure 6. Distribution of Total Participants Enrolled and Encounters by MCO, CY 2017



PPMCO and ACC are the largest MCOs, followed by MPC, UHC, MSFC, KPMAS, UMHP, and JMS. The number of accepted encounters reflects the participant distribution, with PPMCO and ACC having 10.4 million encounters (27.0%) and nearly 8 million encounters (20.6%), respectively. MPC has roughly 7.3 million encounters (18.9%), UHC has 5.4 million (14.1%), and MSFC has 3.1 million (8.2%). JMS, KPMAS, and UMHP each have fewer than 2 million Medicaid encounters. The proportion of encounters submitted by each MCO is consistent with the proportion of participants enrolled with each MCO. Analysis in subsequent years will evaluate MCOs in comparison to this baseline data.

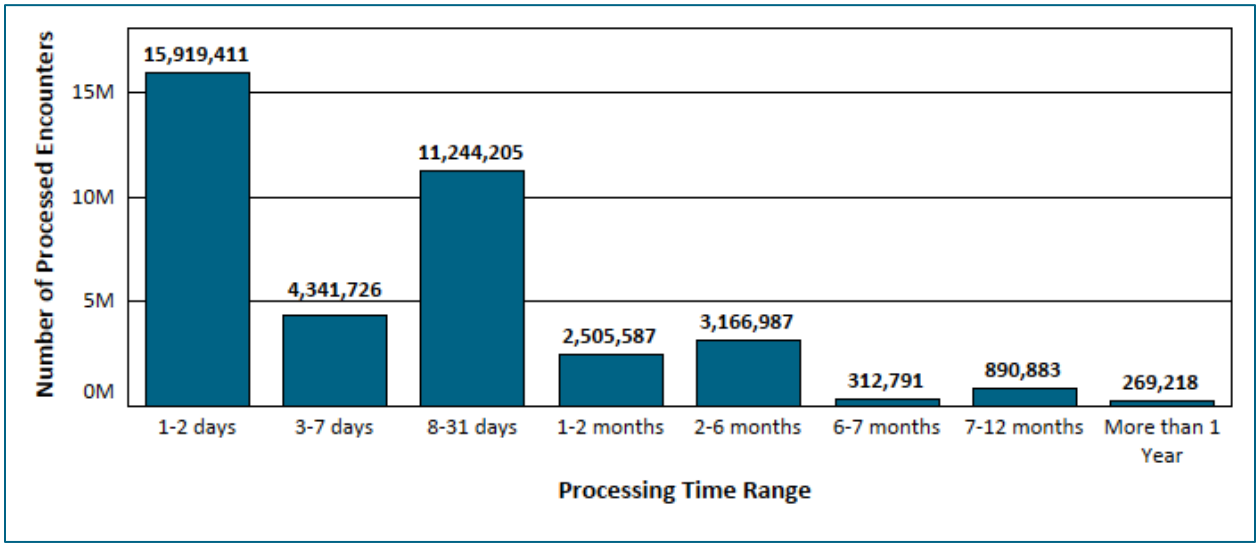
Step 3. Generate and Review Analytic Reports

Time Dimension Analysis

Effective analysis of the Medicaid program requires complete and accurate data. The processing time spans the interval between the end date of service and when the encounter is submitted to MDH. Once a provider has provided a service, they are required to submit a claim to the MCO within six months. Once invoiced, the MCO must adjudicate clean claims within 30 days. Maryland regulations require MCOs to submit encounter data based on its claims to MDH "within 60 calendar days after receipt of the claim from the provider". Therefore, the maximum time allotted for an encounter to be submitted to MDH from the date of service is eight months.

In CY 2017, MDH did not receive the date an MCO receives the claim for a service on the encounter. MDH revised its regulations and contract in CY 2019 to require this data in future encounter submissions. For this analysis, timeliness of processing time is assessed with relation to the entire processing period—an eight-month maximum. The processing time is calculated by the length of time between the date of service and the date on which the encounter is submitted to MDH by the MCO. Figure 7 provides information pertaining to the timeliness of encounter submission from the date of service.

Figure 7. Processing Time for Encounters Submitted, CY 2017

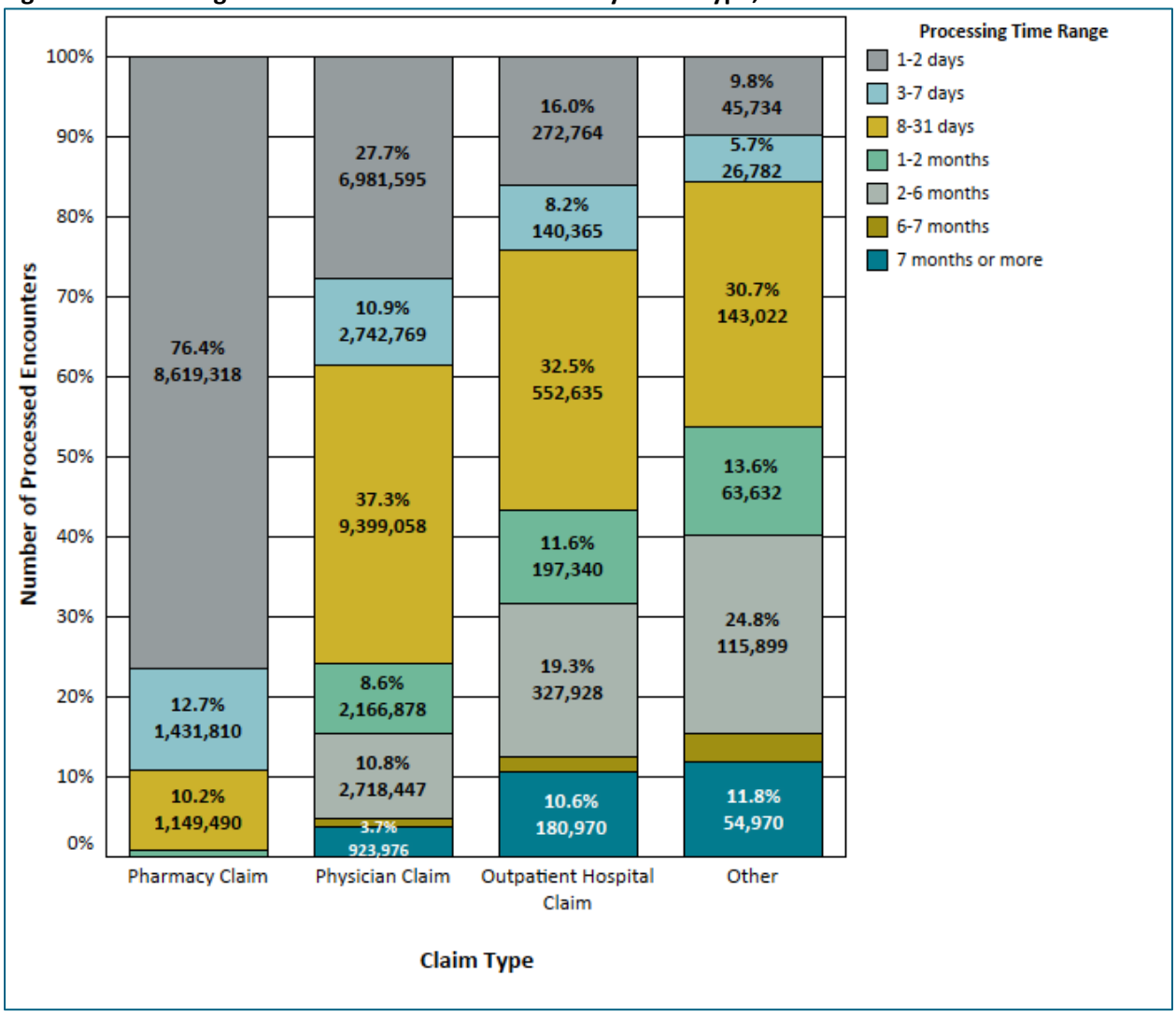


Note for Figures 7-10: An encounter is labeled as "1-2 months" if the encounter was submitted between 32 and 60 days after the date of service; "2-6 months" if the encounter was submitted between 61 and 182 days after the date of service; "6-7 months" if the encounter was submitted between 183 and 212 days after the date of service; and "7-12 months" if the encounter was submitted between 213 and 364 days after the date of service.

While it is reasonable to assume that delays in submission will occur, MDH requires MCOs to submit encounters in a timely fashion. Variation from month to month is expected; however, noticeable changes related to timeliness may indicate irregular submission of encounter data. Most MCOs submit encounters to MDH within 1 to 2 days of the date of service, followed by encounters submitted within 8 to 31 days of the date of service (Figure 7). Very few encounters are submitted more than 7 months past the date of service.

Processing times for encounters submitted by claim type for CY 2017 are displayed in Figure 8.

Figure 8. Processing Time for Encounters Submitted by Claim Type, CY 2017



Most pharmacy claims (76.4%) were processed within 1 to 2 days, and most physician (37.3%), outpatient hospital (32.5%), and other claims (30.7%) were processed with 8 to 31 days as displayed in Figure 8.

The monthly processing time for submitted encounters in CY 2017 is displayed in Figure 9.

Figure 9. Processing Time for Encounters Submitted by Month, CY 2017

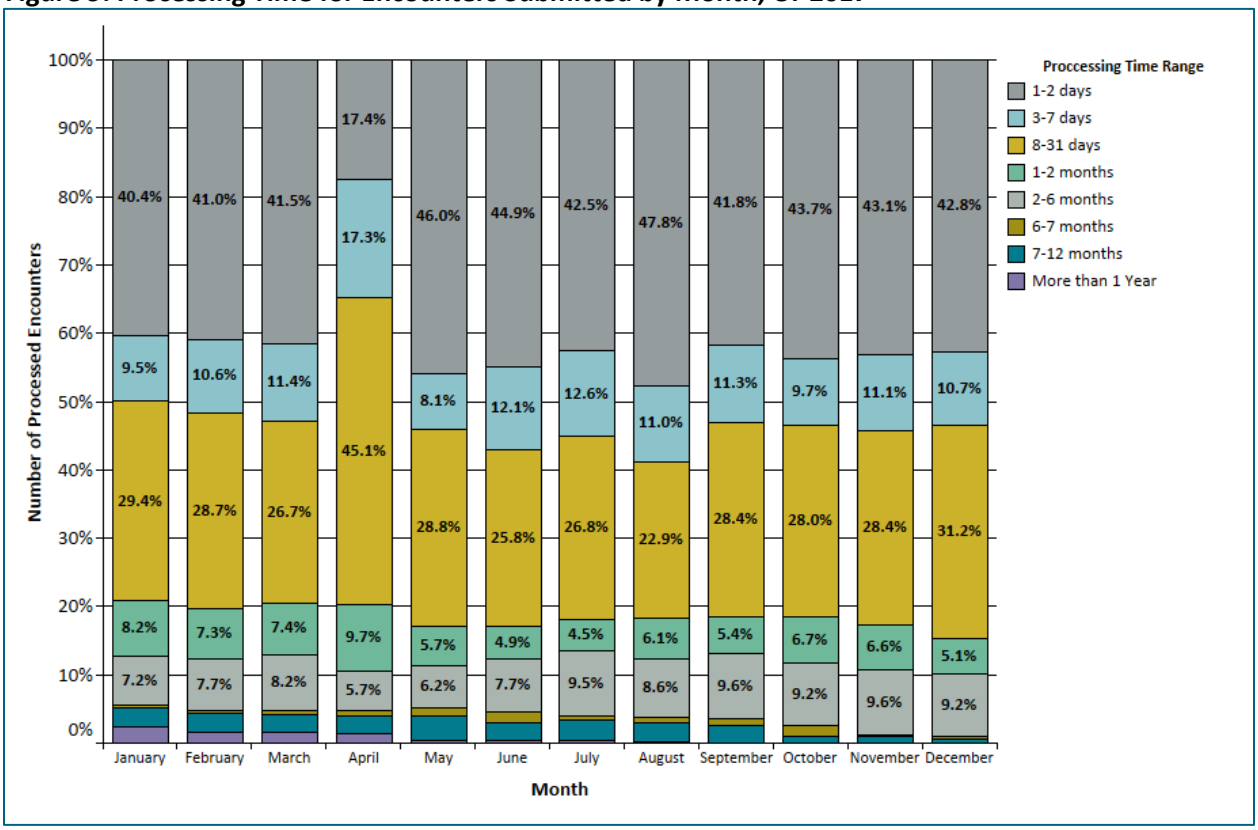
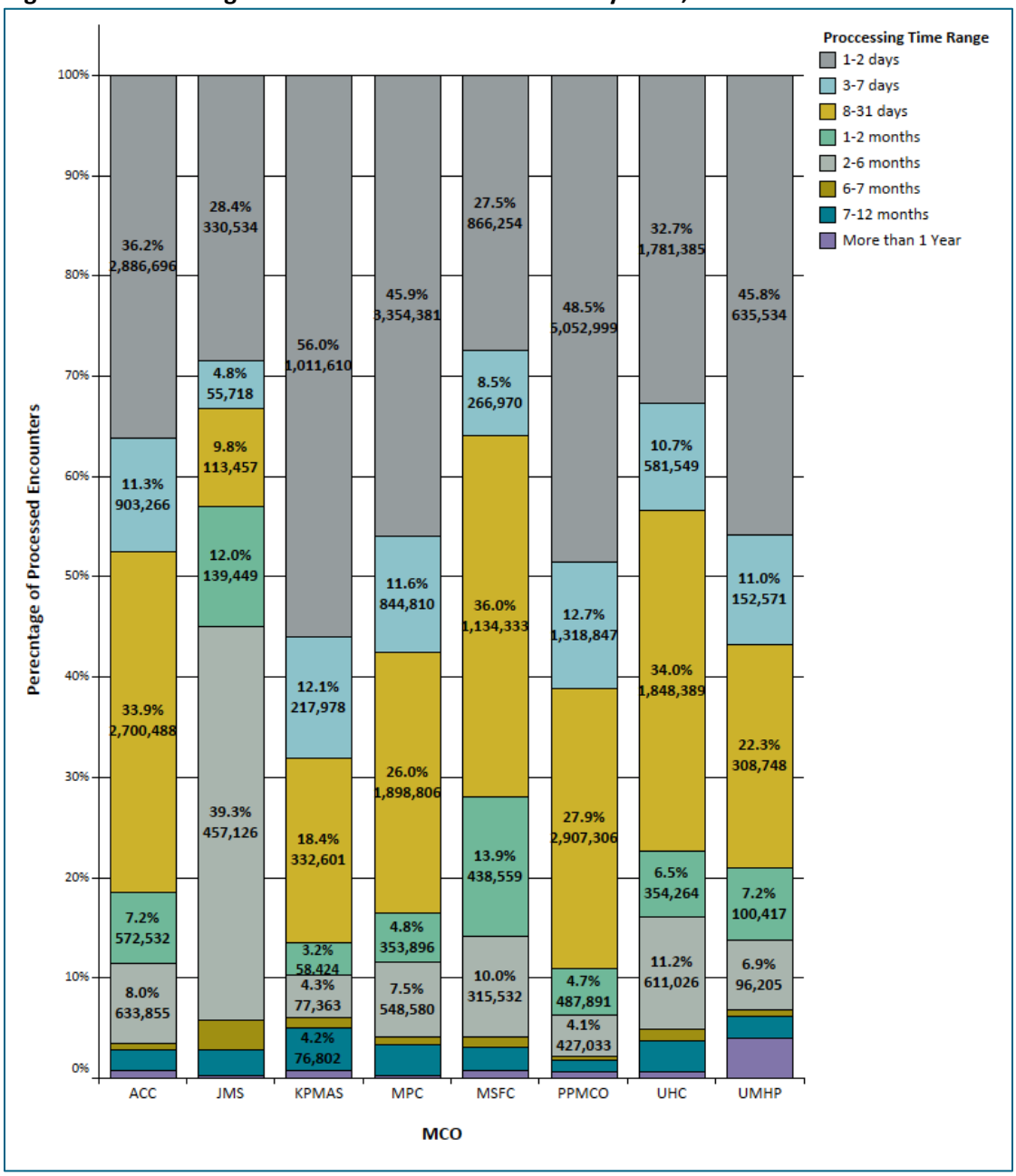


Figure 10 displays processing times for MCOs for encounters submitted to MDH in CY 2017.

Figure 10. Processing Time for Encounters Submitted by MCO, CY 2017



Of all encounters submitted in CY 2017, 41.2% of them were processed within 1 to 2 days of receipt by MDH. KPMAS submitted most of its encounters within 1 to 2 days (56.0%), while JMS only submitted 28.4% of its encounters within the same period. Nearly 30% of all encounters were processed within 8 to 31 days of the date of service, with MCOs ranging from 9.8% (JMS) to 36.0% (MSFC).

The MCOs varied significantly in terms of processing encounters within 1 to 2 months after the date of service, which accounted for 6.5% of all encounters in CY 2017. During the 1-2 month processing period, KPMAS submitted 3.2% of its encounters, while MSFC submitted 13.9% of its encounters.

Encounters processed more than 6 months after the end date of service are rare (less than 4% of all encounters). All MCOs processed less than 1% of their encounters more than a year after the date of service, except for UMHP: nearly 4% of its encounters were submitted more than a year after the date of service.

Provider Analysis

The following provider analysis examines encounter data for primary care providers (PCPs) and establishes a baseline to be used as a comparison rate of PCP visits in HealthChoice in future analyses (Centers for Medicare & Medicaid Services, 2012, p. 9). Evaluating encounters by provider type for fluctuations across MCOs helps to assess encounter data volume and consistency. Table 20 shows the number of participants within each MCO that received a PCP service during CY 2017. It considers all participants enrolled for any length of time within CY 2017.

Table 20. Percentage of HealthChoice Participants (Any Period of Enrollment) with a PCP Visit by MCO, CY 2017

	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	Total
Number of Participants (Any Period of Enrollment)	328,265	31,842	80,858	259,140	109,884	345,541	189,658	55,968	1,401,156
Percentage of Participants with a Visit with their Assigned PCP	41.5%	23.5%	45.0%	30.4%	26.0%	19.8%	38.1%	22.8%	30.9%
Percentage of Participants with a Visit with their Assigned PCP, Group Practice, or Partner PCPs	58.7%	51.4%	50.3%	49.3%	39.3%	22.0%	52.0%	36.0%	44.9%
Percentage of Participants with a Visit with Any PCP	75.2%	66.1%	54.5%	68.0%	60.0%	71.1%	69.7%	58.9%	65.4%

Notes: Because a participant can be enrolled in multiple MCOs during the year, the total number of participants shown above is not a unique count. Counts do not include fee-for-service claims.

The total count of participants for each MCO in Table 3 differs from the totals shown previously in Figure 3 because this provider analysis is based not on MMIS2 data but on monthly PCP assignment files submitted by the MCOs to Hilltop. For this analysis, Medicaid identification numbers the MCOs provided for their members were matched with eligibility data in MMIS2. Only participants listed in an MCO's files and with enrollment in MMIS2 were incorporated into this analysis.

Please read PPMCO's results with caution; our analysis relied heavily on matching providers using a National Provider Identifier (NPI), and PPMCO's files had missing NPIs.

Roughly half of each MCO's population saw a PCP during CY 2017. Using the broadest definition of a PCP visit possible—a visit to any PCP within any MCO's network—the MCOs' percentage of participants with at least one PCP visit ranged from 54.5% (KPMAS) to 75.2% (ACC).

The analysis of inpatient hospitalizations, observation stays, and ED visits establishes baseline data to compare trends in subsequent encounter data validation analyses. Table 21 shows the number of encounter visits for each service type by MCO.

Table 21. Inpatient Visits, ED Visits, and Observation Stays by MCO, CY 2017

	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	Total
Number of All Visits	4,132,631	498,738	751,725	3,954,165	1,530,576	5,373,077	2,712,108	649,151	19,602,171
Percentage of All Visits	21.1%	2.5%	3.8%	20.2%	7.8%	27.4%	13.8%	3.3%	100.0%
Number of Inpatient Visits	24,702	3,564	4,964	24,691	9,297	33,945	15,904	4,509	121,576
Percentage of Visits that were Inpatient	0.6%	0.7%	0.7%	0.6%	0.6%	0.6%	0.6%	0.7%	0.6%
Number of ED Visits	178,774	26,028	16,895	168,083	59,954	204,714	105,954	28,002	788,404
Percentage of Visits that were ED	4.3%	5.2%	2.2%	4.3%	3.9%	3.8%	3.9%	4.3%	4.0%
Number of Observation Stays	8,435	1,444	719	9,871	3,040	8,705	6,088	1,250	39,552
Percentage of Visits that were Observation Stays	0.2%	0.3%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%

Note: Visits were not unduplicated between inpatient visits, ED visits, and observation stays.

For this analysis, a visit is defined as one encounter per person per provider per day. Both inpatient hospitalizations and observation stays are less than 1% of total visits. ED visits, which are 4% of all visits, range from 2.2% of all visits (KPMAS) to 5.2% of all visits (JMS).

Analysis by Age and Sex

An analysis of CY 2017 encounter data by MCO was conducted in three areas to determine the effectiveness of encounter data edit checks:

- Individuals over 65 with encounters, since this population is ineligible for HealthChoice
- Age-appropriate and sex-appropriate diagnoses and services for pregnancy
- Age-appropriate dementia screenings and diagnoses.

Individuals Over 65 Enrolled in HealthChoice

Because participants older than 65 are ineligible for HealthChoice, data was reviewed for any encounters for those aged 66 or older. Due to small cell sizes (10 or fewer enrollees), the number of enrollees aged 66 or older with a HealthChoice encounter cannot be reported by MCO. Across all MCOs, encounters were submitted for 44 participants who were over age 66 or who did not have a reported date of birth.

There are expected age ranges for pregnancy and dementia, which can be used for identifying potential outliers within MMIS2 encounter data. High percentages of enrollees with these diagnoses outside of the established appropriate age range and sex could indicate potential errors within the data. Very few outliers were discovered as a result of this analysis. Individual level reports of the few outliers identified have been provided to MDH for further investigation.

Age-Appropriate and Sex-Appropriate Diagnoses for Pregnancy

The first pregnancy analysis checked the percentage of participants who had a diagnosis for pregnancy by age group. Participants aged 0 to 12 and 51 or older typically are outside of the expected age range for pregnancy. This analysis only considers female participants with a pregnancy diagnosis in CY 2017;

male participants are evaluated for pregnancy in the following analysis. Across all MCOs, only 61 participants were identified as being pregnant outside of the expected age ranges. All MCOs have similar distributions, with most participants between the ages of 12 and 50 years. Several MCOs have participants outside this age range with a pregnancy diagnosis; however, the number of outliers is negligible. The data substantiate that the encounters are age-appropriate for pregnancy.

The second analysis validated encounter data for pregnancy diagnosis being sex-appropriate. A diagnosis for pregnancy should typically be present on encounters for female participants. All MCOs have similar distribution, with nearly 100% of all pregnancies being reported for females. The analysis indicates that while there are pregnancy diagnoses for male participants in the encounter data, the numbers are negligible (43 pregnancies for male participants were reported across all MCOs).

Age-Appropriate Diagnoses of Dementia

The dementia analysis focused on age appropriate screenings and diagnoses of dementia. While dementia is a disease generally associated with older age, early onset can occur as early as 30 years of age. Thus, prevalence of dementia diagnoses should increase with age after 30. The number of participants having an encounter with a dementia diagnosis aged 30 and under compared to those over the age of 30 were identified. Table 22 displays the distribution of participants with a dementia diagnosis by MCO.

Table 22. Number of Participants with Dementia by MCO and Age Group, CY 2017

Age	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	Total
0 to 18	*	*	*	*	*	14	*	*	28
19 to 29	*	*	*	*	*	15	*	*	50
30 and Older	163	30	46	200	90	224	158	33	944
Total	181	33	49	213	94	253	164	35	1022

Note: Small counts (10 or fewer) are omitted per MDH's cell suppression policy.

As expected, the majority (92.4%) of participants with a diagnosis of dementia are over the age of 30. While each MCO does have participants under the age of 30 with a dementia diagnosis, the numbers are relatively small. ACC, MPC, PPMCO, and UHC have participants aged 0 to 18 with dementia-related encounters.

Step 4. Compare Findings to State-Identified Standards

In both Steps 2 and 3, Hilltop performed the analyses by MCO, allowing benchmarking from MCO to MCO. The analyses compared outlier data with overall trends, and the results are presented along with each analysis.

Activity 4: Medical Record Validation

Medical Record Sampling. Qlarant requested and received a random sample of HealthChoice encounter data for hospital inpatient, outpatient, and physician office (office visit) services that occurred in CY 2017 from Hilltop. The sample size used was determined to achieve a 90% confidence interval. Oversampling was used in order to ensure adequate numbers of medical records were received to meet the required sample size. The hospital inpatient and outpatient encounter types were oversampled by 500%, while the office visit encounter types were oversampled by 200% for each MCO.

Medical Record Validation. Medical records were first validated as being the correct medical record requested by verifying the patient name, date of birth, date of service, and gender. Valid medical records were then reviewed to ensure that documentation for services matched the submitted encounter data. The documentation in the medical record was compared to the encounter data to determine if the submitted encounter data (diagnosis, procedure, and/or revenue codes) could be validated against the findings in the medical record.

The medical records were reviewed by either a certified coder or a nurse with coding experience. Reviewers completed medical record reviewer training and achieved an inter-rater reliability agreement score of above 90%. Reviewers enter data from the medical record reviews into the Qlarant EDV Tool/Database.

Documentation was noted in the database as to whether the diagnosis, procedure, and revenue codes were substantiated by the medical record. Determinations were made as either a "match" when documentation was found in the record or a "no match" when there was a lack of documentation in the record. For inpatient encounters, the medical record reviewers also matched the principal diagnosis code to the primary sequenced diagnosis. A maximum of 9 diagnosis codes, 6 procedure codes, and 23 revenue codes were validated per record for the EDV. A definition of EDV terms are provided in Table 23.

Table 23. EDV Definition of Terms

Term	Definition
Encounter	A unique date of service with coded diagnoses and procedures for a single provider or care/service provided on a unique date of service by the provider.
Review element	Specific element in the encounter data which is being compared to the medical record; elements in this review include diagnosis, procedure, and revenue codes.
Match rate	Rate of correct record elements to the total elements presented as a percent.

Medical Record Review Guidelines. The following reviewer guidelines were used to render a determination of "yes" or "match" between the encounter data and the medical record findings:

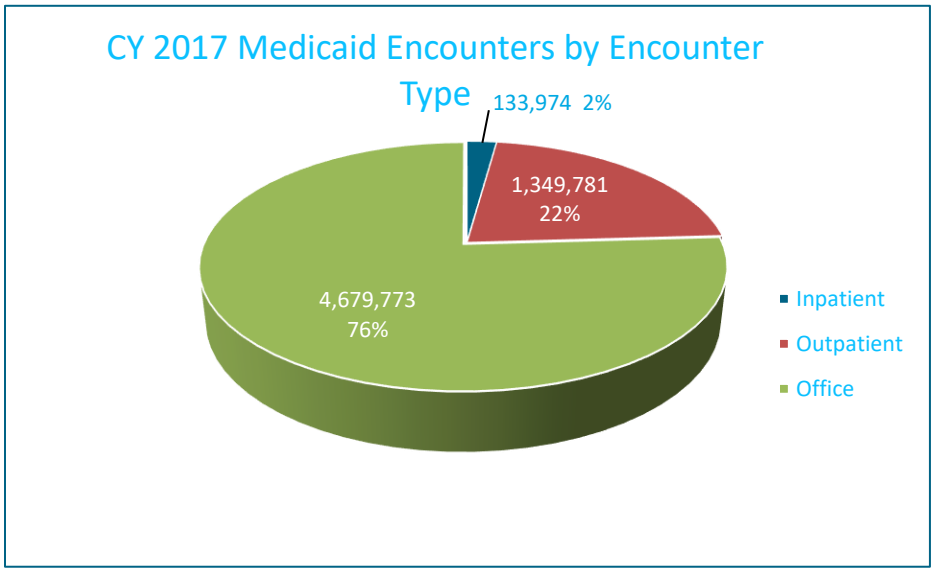
- As directed by the CMS Protocol, medical record reviewers cannot infer a diagnosis from the medical record documentation. Reviewers are required to use the diagnosis listed by the provider. For example, if the provider recorded "fever and chills" in the medical record, and the diagnosis in the encounter data is "upper respiratory infection," the record does not match for diagnosis even if the medical record documentation would support the use of that diagnosis.

- For inpatient encounters with multiple diagnoses listed, the medical record reviewers are instructed to match the first listed diagnosis (as the principal diagnosis) with the primary diagnosis in the encounter data.
- Procedure data is matched to the medical record regardless of sequencing.

Results of Activity 4: Medical Record Validation

Medical Record Sampling. Qlarant requested and received the CY 2017 random sample of hospital inpatient, outpatient, and physician office services that occurred in CY 2017. The sample drawn was determined to achieve a 90% confidence interval with a 5% margin of error. A representation of the total CY 2017 encounters by setting is demonstrated in Figure 11.

Figure 11. Total CY 2017 Medicaid Encounters by Encounter Type



The majority of the CY 2017 encounters were office visits at 76% (4,679,733), followed by outpatient encounters at 22% (1,349,781), and inpatient encounters making up the smallest portion at 2.2% (133,974). Please refer to Table 24 for the distribution of the EDV sample by encounter type from CY 2015 to CY 2017.

Table 24. CY 2015 - CY 2017 EDV Sample by Encounter Type

Encounter Type	CY 2015			CY 2016			CY 2017		
	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size
Inpatient	131,129	1.5%	6	126,905	1.4%	42	133,974	2.2%	48
Outpatient	1,408,486	15.7%	60	1,337,141	14.4%	458	1,349,781	21.9%	467
Office Visit	7,418,915	82.8%	318	7,809,270	84.2%	2,572	4,679,773	75.9%	1,653
Total	**8,958,540**	**100.0%**	**384**	**9,273,316**	**100.0%**	**3,072**	**6,163,528**	**100.0%**	**2,168**

The proportion of inpatient and outpatient visits has remained consistent from CY 2015 through CY 2017. However, the office visit encounters in CY 2017 appears considerably lower than in CY 2015 and CY 2016 due to a change in how office visits were identified. In prior years, the data were generated at the service level, whereas each procedure provided on the same date of service was treated as one

encounter. This year, the data was generated at the visit level, whereas all procedures provided on one date of service were collectively treated as one encounter to provide a more thorough review of the physician encounter data.

The total number of records reviewed increased in CY 2016 as MDH went from a statewide review to an MCO-specific review. For CY 2017, the sampling methodology was revised to reflect a 90% confidence level with a 5% margin of error. This resulted in a slight decrease in records reviewed per MCO.

Once sampling was complete, Qlarant faxed requests for medical records to the service providers. Non-responders were contacted by the MCOs to comply with this audit by submitting their medical records. Table 25 outlines the total number of records reviewed and required by MCO and encounter type.

Table 25. CY 2017 MCO EDV Medical Record Review Response Rates by Encounter Type

MCO	Inpatient Records			Outpatient Records			Office Visit Records		
	# Reviewed	Minimum Reviews Required	Sample Size Achieved?	# Reviewed	Minimum Reviews Required	Sample Size Achieved?	# Reviewed	Minimum Reviews Required	Sample Size Achieved?
ACC	5	5	Yes	55	55	Yes	217	211	Yes
JMS	7	7	Yes	94	93	Yes	185	171	Yes
KPMAS	5	5	Yes	19	19	Yes	246	246	Yes
MPC	6	6	Yes	66	66	Yes	199	199	No*
MSFC	5	5	Yes	48	47	Yes	227	220	Yes
PPMCO	6	6	Yes	69	67	Yes	207	198	Yes
UHC	7	7	Yes	59	57	Yes	210	207	Yes
UMHP	7	7	Yes	64	63	Yes	204	201	Yes
Total	**48**	**48**	**Yes**	**474**	**467**	**Yes**	**1,695**	**1653**	**No**

*MPC did not submit a sufficient number of medical records to meet the minimum samples required for the office visit setting.

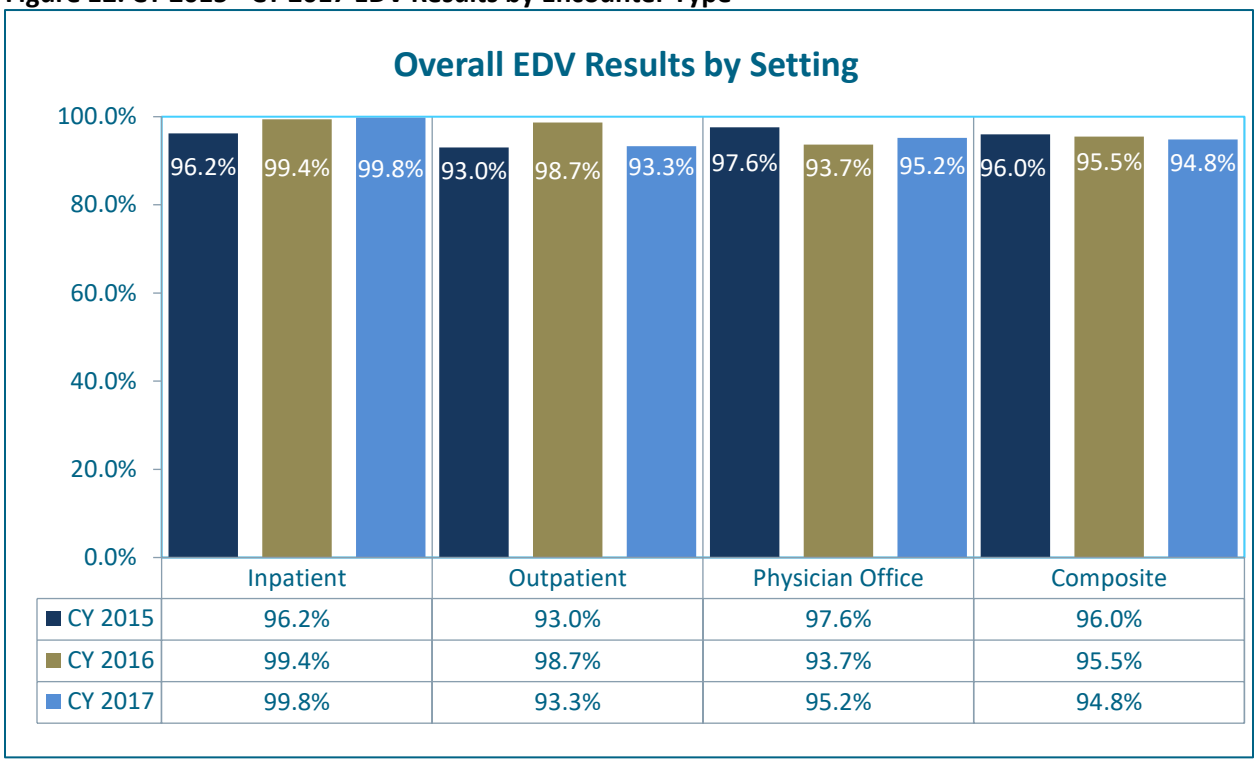
All MCOs submitted a sufficient number of medical records to meet the minimum samples required for each setting type of the encounter data review except for MPC, which did not submit the required number of office visit records. Overall, there were more records reviewed than were required for outpatient and office visit settings.

Analysis Methodology. Data from the database were used to analyze the consistency between submitted encounter data and corresponding medical records. Results were analyzed and presented separately by encounter type and review element. Match rates (medical record review supporting the encounter data submitted) and reasons for "no match" errors for diagnosis code, procedure code, and revenue code elements are presented for inpatient, outpatient, and office visit encounter types in the results below.

Exclusion Criteria. Cases where a match between the medical record and encounter data could not be verified because it was not legible or the date of birth, date of service, gender, or name were missing or incorrect were excluded from the review and determined invalid. Nearly 10% (231) of the total records were determined to be invalid. Of those records, 97% (224) were for physician office visits and the remaining 3% were outpatient records. No inpatient records were invalid.

Results. The analysis of the data was organized by review elements including diagnosis, procedure, and revenue codes. A total of 2,210 medical records were reviewed. The overall EDV results for CY 2015 through CY 2017 by encounter type are displayed in Figure 12.

Figure 12. CY 2015 - CY 2017 EDV Results by Encounter Type



The CY 2017 overall match rate was 94.8%, which represents a 0.7 percentage point decline from CY 2016. Match rates for both inpatient and physician office settings increased, while outpatient match rates declined 5.4%. The decline in the outpatient rate is the reason for the slight decrease in the overall match rate.

Table 26 provides trending of the EDV records for CY 2015 through CY 2017 by encounter type.

Table 26. CY 2015 – CY 2017 EDV Results by Encounter Type

Encounter Type	Records Reviewed			Total Possible Elements*			Total Matched Elements			Percentage of Matched Elements		
	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017
Inpatient	7	54	48	130	1,117	1,005	125	1,110	1,003	96.2%	99.4%	99.8%
Outpatient	60	473	474	560	4,448	5,479	521	4,389	5,113	93.0%	98.7%	93.3%
Office Visit	318	2,584	1,695	1,067	9,778	7,269	1,041	9,160	6,921	97.6%	93.7%	95.2%
TOTAL	**385**	**3,111**	**2,217**	**1,757**	**15,343**	**13,753**	**1,687**	**14,659**	**13,037**	**96.0%**	**95.5%**	**94.8%**

*Possible elements include diagnosis, procedure, and revenue codes.

The overall element match rate declined by 0.7 percentage points from 95.5% in CY 2016 to 94.8% in CY 2017 and remains 1.2 percentage points below the CY 2015 match rate of 96.0%.

The inpatient encounter match rate increased 0.4 percentage points from 99.4% in CY 2016 to 99.8% in CY 2017 and is 3.6 percentage points above the CY 2015 score of 96.2%.

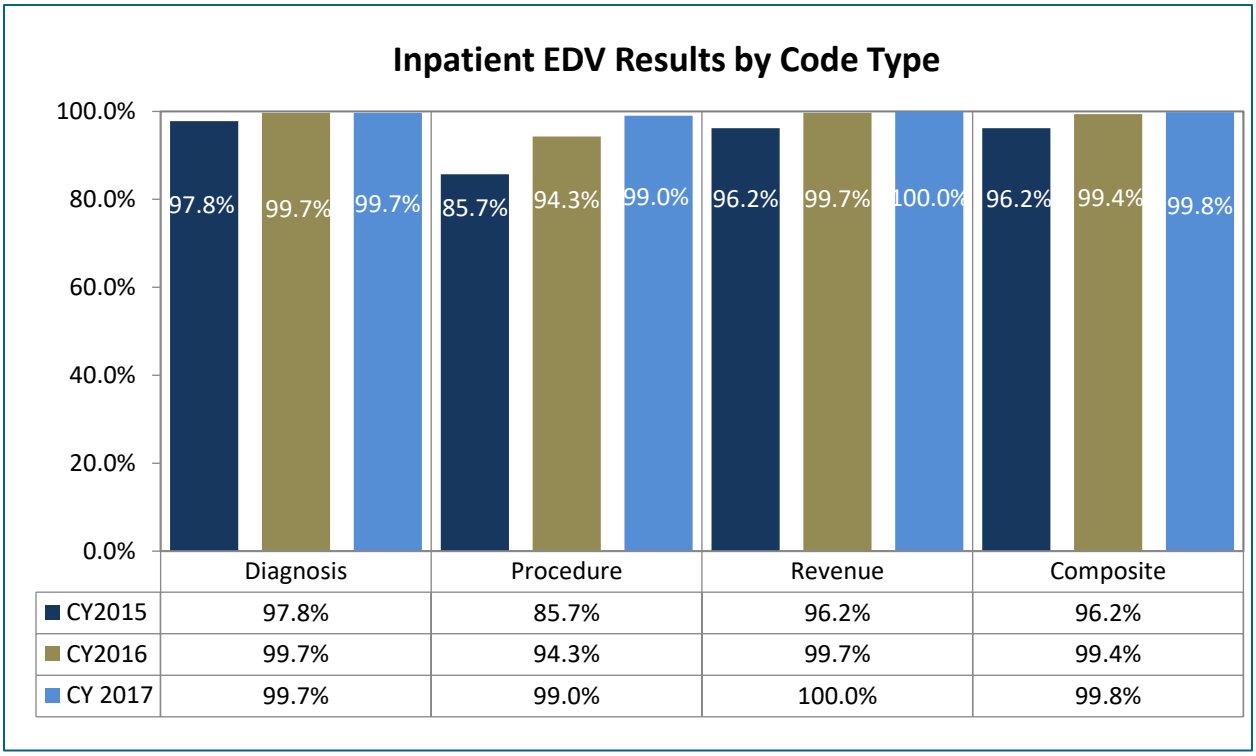
The outpatient encounter match rate decreased by 5.4 percentage points from 98.7% in CY 2016 to 93.3% in CY 2017, after an increase of 5.7 percentage points from 93.0% in CY 2015 to 98.7% in CY 2016. The office visit encounter match rate increased 1.5 percentage points from 93.7% in CY 2016 to 95.2% in CY 2017, but remains 2.4 percentage points below CY 2015.

Results by Review Element

The EDV review element match rates were analyzed by code type including diagnosis, procedure, and revenue codes. The following section outlines those results.

Inpatient Encounters. The inpatient EDV results by code type for CY 2015 through CY 2017 are displayed in Figure 13.

Figure 13. CY 2015 - CY 2017 Inpatient EDV Results by Code Type



	Diagnosis	Procedure	Revenue	Composite
CY2015	97.8%	85.7%	96.2%	96.2%
CY2016	99.7%	94.3%	99.7%	99.4%
CY 2017	99.7%	99.0%	100.0%	99.8%

Overall, the total match rate for inpatient encounters across all code types remained fairly stable, increasing by 0.4 percentage points from 99.4% in CY 2016 to 99.8% in CY 2017, and continues the upward trend from 96.2% in CY 2015.

Table 27 provides trending of EDV inpatient encounter type results by code from CY 2015 through CY 2017.

Table 27. CY 2015 – CY 2017 EDV Inpatient Encounter Type Results by Code

Inpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017
Match	44	367	328	6	66	103	75	677	572	125	1,110	1003
No Match	1	1	1	1	4	1	3	2	0	5	7	2
Total Elements	45	368	329	7	70	104	78	679	572	130	1,117	1005
Match Percent	**97.8%**	**99.7%**	**99.7%**	**85.7%**	**94.3%**	**99.0%**	**96.2%**	**99.7%**	**100%**	**96.2%**	**99.4%**	**99.8%**

The inpatient diagnosis code match rate remained unchanged in CY 2017 at 99.7%, after an increase of 1.9 percentage points from CY 2015 to CY 2016.

The inpatient procedure code match rate continued to improve, increasing 4.7 percentage points from 94.3% in CY 2016 to 99.0% for CY 2017. This was a substantial increase from the CY 2015 rate of 85.7%.

The CY 2017 inpatient revenue code match rate increased slightly to 100%, 0.3 percentage points above the CY 2016 rate of 99.7%. This is 3.8 percentage points above the low of 96.2% in CY 2015.

The CY 2017 MCO-specific inpatient results by code type are shown in Table 28.

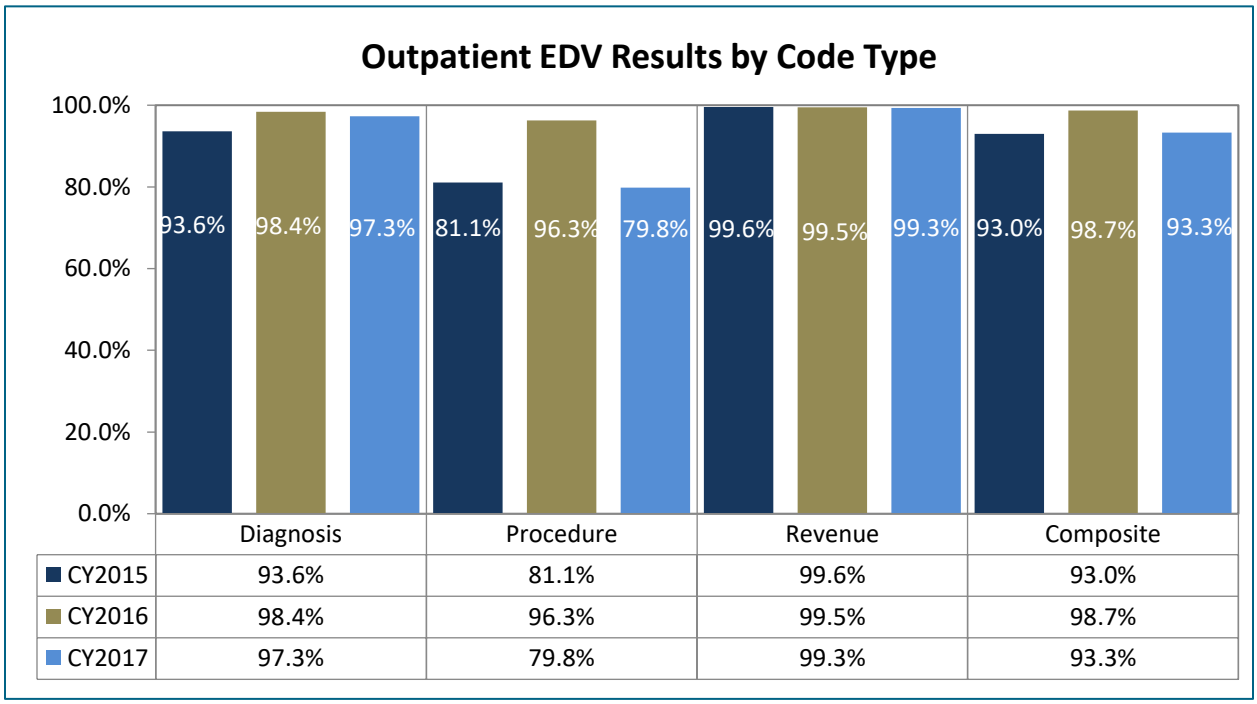
Table 28. MCO Inpatient Results by Code Type

MCO	# of Reviews	Diagnosis Codes			Procedures Codes			Revenue Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ACC	5	26	27	96%	5	5	100%	50	50	100%	81	82	99%
JMS	7	57	57	100%	24	25	96%	113	113	100%	194	195	99%
KPMAS	5	32	32	100%	13	13	100%	74	74	100%	119	119	100%
MPC	6	31	31	100%	4	4	100%	50	50	100%	85	85	100%
MSFC	5	28	28	100%	41	41	100%	41	41	100%	110	110	100%
PPMCO	6	49	49	100%	11	11	100%	95	95	100%	155	155	100%
UHC	7	56	56	100%	NA	NA	NA	78	78	100%	134	134	100%
UMHP	7	49	49	100%	5	5	100%	71	71	100%	125	125	100%

Six of the eight MCOs (KPMAS, MPC, MSFC, PPMCO, UHC and UMHP) achieved a match rate of 100.0% for inpatient encounters across all code types. The two remaining MCOs, ACC and JMS, received an overall rate of 99%.

Outpatient Encounters. The outpatient EDV results by code type for CY 2015 through CY 2017 are displayed in Figure 14.

Figure 14. CY 2015 - CY 2017 Outpatient EDV Results by Code Type



	Diagnosis	Procedure	Revenue	Composite
CY2015	93.6%	81.1%	99.6%	93.0%
CY2016	98.4%	96.3%	99.5%	98.7%
CY2017	97.3%	79.8%	99.3%	93.3%

Overall, the total match rate for outpatient encounters across all code types decreased substantially, dropping 5.4 percentage points from 98.7% in CY 2016 to 93.3% in CY 2017, similar to the overall rate of 93.0% in CY 2015. The decrease was primarily due to the large decrease in match rate for procedure codes, which dropped 16.5 percentage points from a rate of 96.3% in CY 2016. A decline of 1.1 percentage points in diagnosis codes from 98.4% in CY 2016 to 97.3% in CY 2017 also contributed to the overall decline. Table 29 provides trending of EDV outpatient encounter type results by code from CY 2015 through CY 2017.

Table 29. CY 2015 – CY 2017 EDV Outpatient Encounter Type Results by Code

Outpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017
Match	161	1,436	1597	116	626	1206	244	2,327	2310	521	4,389	5113
No Match	11	24	44	27	24	305	1	11	17	39	59	366
Elements	172	1,460	1641	143	650	1511	245	2,338	2327	560	4,448	5479
Match Percent	**93.6%**	**98.4%**	**97.3%**	**81.1%**	**96.3%**	**79.8%**	**99.6%**	**99.5%**	**99.3%**	**93.0%**	**98.7%**	**93.3%**

The CY 2017 outpatient diagnosis code match rate decreased by 1.1 percentage points to 97.3% from the CY 2016 rate of 98.4%, but remains above the CY 2015 rate of 93.6%.

Although the outpatient procedure code match rate has consistently had the lowest match rate of all code types, the rate had a substantial decline of 16.5 percentage points from 96.3% in CY 2016 to 79.8%

in CY 2017. This is 1.3 percentage points below the CY 2015 rate of 81.1%, making it the lowest rate in the 3-year period.

Outpatient revenue codes have remained relatively stable for the 3-year period with only a slight decline from 99.5% in CY 2016 to 99.3% in CY 2017.

The CY 2017 MCO-specific outpatient results by code type are shown in Table 30.

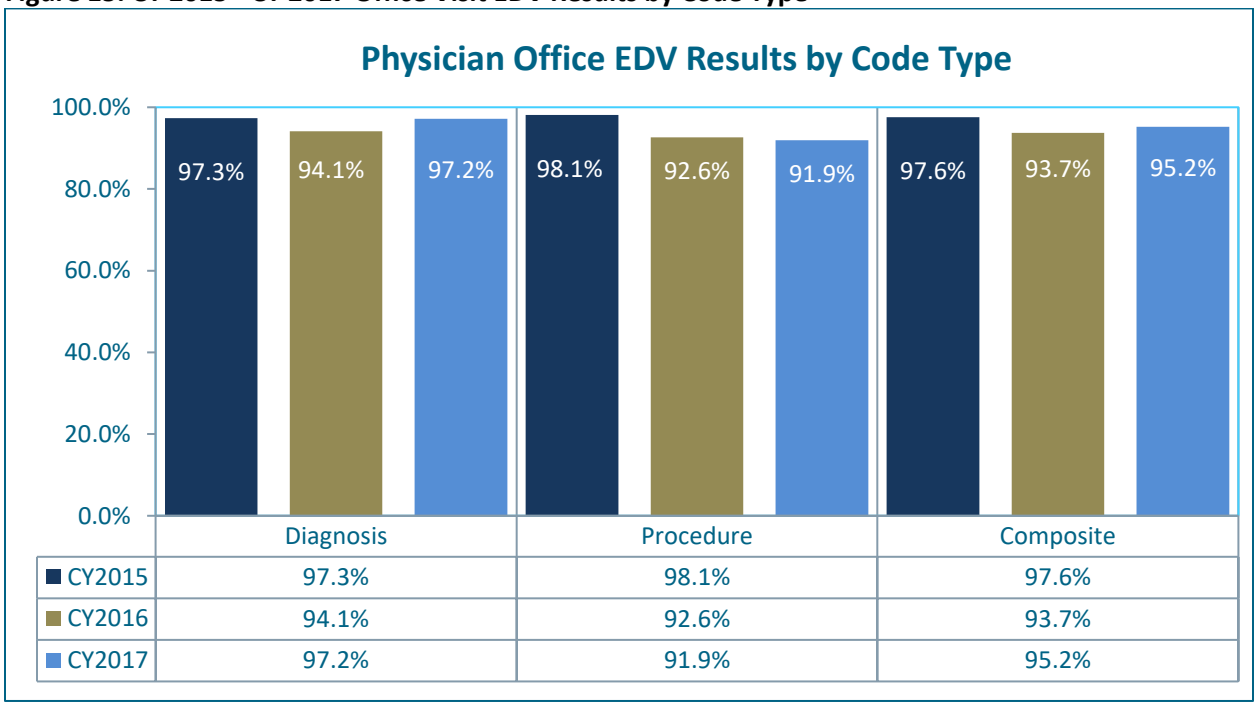
Table 30. MCO Outpatient Results by Code Type

MCO	# of Reviews	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ACC	55	174	176	98.9%	113	161	70.2%	232	232	100.0%	519	569	91.2%
JMS	94	373	384	97.1%	255	295	86.4%	437	444	98.4%	1065	1123	94.8%
KPMAS	19	65	66	98.5%	55	73	75.3%	122	122	100.0%	242	261	92.7%
MPC	66	222	232	95.7%	157	199	78.9%	314	316	99.4%	693	747	92.8%
MSFC	48	149	150	99.3%	110	148	74.3%	249	249	100.0%	508	547	92.9%
PPMCO	69	224	230	97.4%	136	167	81.4%	232	233	99.6%	592	630	94.0%
UHC	59	189	198	95.5%	174	214	81.3%	348	355	98.0%	711	767	92.7%
UMHP	64	201	205	98.0%	206	254	81.1%	376	376	100.0%	783	835	93.8%

MCO-specific results by code type ranged from 91.2% (ACC) to 94.8% (JMS). Overall, outpatient revenue codes were the highest scoring elements. Four of the eight MCOs (ACC, KPMAS, MSFC and UMHP) achieved a match rate of 100.0% for this element. The lowest scoring element was procedure codes with MCO scores ranging from a low of 70.2% (ACC) to a high of 86.4% (JMS).

Office Visit Encounters. The office visit EDV results by code type for CY 2015 through CY 2017 are displayed in Figure 15.

Figure 15. CY 2015 - CY 2017 Office Visit EDV Results by Code Type



Overall, the office visit match rate increased 1.5 percentage points to 95.2% in CY 2017 from 93.7% in CY 2016, remaining below the CY 2015 rate of 97.6%. Table 31 provides trending of EDV office visit encounter type results by code from CY 2015 through CY 2017.

Table 31. CY 2015 – CY 2017 EDV Office Visit Encounter Type Results by Code

Office Visit Encounter Type	Diagnosis Codes			Procedure Codes			Total		
	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017	CY 2015	CY 2016	CY 2017
Match	729	6,740	4,405	312	2,420	2,516	1,041	9,160	6,921
No Match	20	425	123	6	193	223	26	618	348
Total Elements	749	7,165	4,530	318	2,613	2,739	1,067	9,778	7,269
Match Percent	**97.3%**	**94.1%**	**97.2%**	**98.1%**	**92.6%**	**91.9%**	**97.6%**	**93.7%**	**95.2%**

Revenue codes are not applicable for office visit encounters.

The diagnosis code match rate increased by 3.1 percentage points from 94.1% in CY 2016 to 97.2% in CY 2017, which is slightly lower than the CY 2015 rate of 97.3%.

The procedure code match rate dropped 0.7 percentage points from CY 2016, and remains below the CY 2015 rate of 98.1%.

The CY 2017 MCO specific office visit match rates by code type are shown in Table 32.

Table 32. MCO Office Visit Results by Code Type

MCO	# of Reviews	Diagnosis Codes			Procedure Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%
ACC	217	493	515	95.7%	325	361	90.0%	818	876	93.4%
JMS	185	576	595	96.8%	226	248	91.1%	802	843	95.1%
KPMAS	246	635	641	99.1%	344	387	88.9%	979	1028	95.2%
MPC	199	503	530	94.9%	313	341	91.8%	816	871	93.7%
MSFC	227	561	576	97.4%	305	351	86.9%	866	927	93.4%
PPMCO	207	518	530	97.7%	347	362	95.9%	865	892	97.0%
UHC	210	542	558	97.1%	342	358	95.5%	884	916	96.5%
UMHP	204	577	585	98.6%	314	331	94.9%	891	916	97.3%

Revenue codes are not applicable for office visit encounters.

Overall, diagnosis codes yielded the highest match rates, ranging from 95.7% (ACC) to 99.1% (KPMAS). The lowest scoring element was procedure codes, ranging from 86.9% (MSFC) to 95.9% (PPMCO).

"No Match" Results by Element and Reason

Table 33 illustrates the reasons for "no match" errors. The reasons for determining a "no match" error for the diagnosis, procedure, and revenue code elements were:

- Lack of medical record documentation.
- Incorrect principal diagnosis (inpatient encounters) or incorrect diagnosis codes.

Table 33. CY 2015-CY 2017 Reasons for "No Match" by Encounter Type

Encounter Type		CY 2015					CY 2016					CY 2017				
		Incorrect Codes		Lack of Documentation		Total Elements	Incorrect Codes		Lack of Documentation		Total Elements	Incorrect Codes		Lack of Documentation		Total Elements
		#	%	#	%	#	#	%	#	%	#	#	%	#	%	#
Diagnosis	IP	0	0%	1	100%	**1**	1	100%	0	0%	**1**	1	100%	0	0%	**1**
	OP	11	100%	0	0%	**11**	13	54%	11	46%	**24**	44	100%	0	0%	**44**
	OV	9	45%	11	55%	**20**	208	49%	217	51%	**425**	123	98%	2	2%	**125**
Procedure	IP	0	0%	3	100%	**3**	4	100%	0	0%	**4**	1	100%	0	0%	**1**
	OP	0	0%	1	100%	**1**	23	96%	1	4%	**24**	305	100%	0	0%	**305**
	OV	6	100%	0	0%	**6**	151	78%	42	22%	**193**	179	80%	44	20%	**223**
Revenue	IP	0	0%	3	100%	**3**	0	0%	2	100%	**2**	0	0%	0	0%	**0**
	OP	0	0%	1	100%	**1**	6	55%	5	45%	**11**	16	94%	1	6%	**17**

IP-Inpatient; OP-Outpatient; OV-Office Visit

Incorrect coding accounted for the majority of all diagnosis, procedure, and revenue code mismatches in CY 2017. This is a substantial change from CY 2016, when non-compliant codes were consistently split between lack of medical record documentation and incorrect codes.

Activity 5: EDV Findings

After completion of Steps 1, 2, and 4, Qlarant created data tables that display summary statistics for the information obtained from these activities for each MCO. Summarizing the information in tables makes it easier to evaluate by highlighting patterns in the accuracy and completeness of encounter data. Qlarant also provided a narrative accompanying these tables, highlighting individual MCO issues and providing recommendations to each MCO and DQA about improving the quality of the encounter data.

Results of Activity 5: EDV Findings

The HealthChoice MCOs were found to have information systems in place that produce accurate and complete encounter data. The MCOs use standard forms and coding schemes that allow for capturing appropriate data elements for claims processing. MDH has a comprehensive 837 process, which instructs the MCOs on the collection and submission of encounter data.

The encounter data submitted by the HealthChoice MCOs for CY 2017 can be considered reliable for reporting purposes as the EDV overall match rate was 94.8%. This rate exceeded the recommended match rate standard of 90% for EDV set by Qlarant. The CY 2017 overall match rate was a slight 0.7 percentage point decrease from the CY 2016 rate of 95.5% and one percentage point below the CY 2015 rate of 96%.

While the inpatient and office visit match rates increased in CY 2017, these were offset by the significant 5.4 percentage point decrease in the outpatient rate. This resulted in the 0.7 percentage point decline in the overall match rate.

In CY 2017, 100% of mismatched diagnosis codes for inpatient and outpatient encounters and 98.4% of the mismatched office visit diagnosis codes were due to incorrect code selection. The remaining 1.6% of the office visit diagnosis code mismatches was due to a lack of supporting documentation in the medical record.

Similarly, the majority of mismatched procedure code elements for inpatient, outpatient, and office visit encounters contributed to incorrect code selection for CY 2017.

There were no inpatient revenue code mismatches in CY 2017. The majority of all outpatient revenue code mismatches were due to incorrect code selection.

MCO-specific results are outlined below.

AMERIGROUP Community Care

- ACC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
  - 99% for all inpatient codes reviewed; a decrease from 100% in CY 2016.
  - 91.2% for all outpatient codes reviewed; a 6.9 percentage point decrease from 98.1% in CY 2016.
  - 93.4% for all office visit codes reviewed; an increase from 92.7% in CY 2016.

Jai Medical Systems, Inc.

- JMS achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
  - 99% for all inpatient codes reviewed; an increase from 98% in CY 2016.
  - 94.8% for all outpatient codes reviewed; a decrease of 4.4 percentage points from the CY 2016 rate of 99.2%.
  - 95.1% for all office visit codes reviewed; an increase of 2 percentage points from the CY 2016 rate of 93.1%.

Kaiser Permanente of the Mid-Atlantic States, Inc.:

- KPMAS achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
  - 100% for all inpatient codes reviewed; consistent with the CY 2016 rate.
  - 92.7% for all outpatient codes reviewed; a 5 percentage point decrease from the CY 2016 rate of 97.7%.
  - 95.2% for all office visit codes reviewed; a decrease of 1.4 percentage points from the CY 2016 rate of 96.6%.

Maryland Physicians Care:

- MPC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
  - 100% for all inpatient codes reviewed; consistent with CY 2016 rate.

  - 92.8% for all outpatient codes reviewed; a decrease of 5.3 percentage points below the CY 2016 rate.
  - 93.7% for all office visit codes reviewed; an increase of 2.1 percentage points over the CY 2016 rate.
- It should be noted that the MPC providers did not submit the sufficient number of office visit records to meet the minimum sample required for the review. Therefore, the remaining number of records required to meet the minimum sample (seven) received a finding of no match for all elements reviewed. Entering a no match for the remaining seven records significantly impacted the MPC's rate as the office visit results were at 97.6% prior to the results of the seven records being entered.

MedStar Family Choice, Inc.:

- MSFC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
  - 100% for all inpatient codes reviewed; an improvement of 1 percentage point over the CY 2016 rate of 99%.
  - 92.9% for all outpatient codes reviewed; dropping 4.4 percentage points from the CY 2016 rate of 97.3%.
  - 93.4% for all office visit codes reviewed; a 1.1 percentage point improvement over the CY 2016 rate of 92.3%.

Priority Partners:

- PPMCO achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
  - 100% for all inpatient codes reviewed; consistent with the CY 2016 rate.
  - 94% for all outpatient codes reviewed; a decrease of 5.5 percentage points from the CY 2016 rate of 99.5%.
  - 97% for all office visit codes reviewed; an increase of 1.9 percentage point from the CY 2016 rate of 95.1%.

UnitedHealthcare Community Plan:

- UHC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
  - 100% for all inpatient codes reviewed; consistent with the CY 2016 rate.
  - 92.7% for all outpatient codes reviewed; a decline of 6.2 percentage points from the CY 2016 rate of 98.9%.
  - 96.5% for all office visit codes reviewed; an increase of 2.5 percentage points over the CY 2016 rate of 94%.

University of Maryland Health Partners:

- UMHP achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
  - 100% for inpatient codes reviewed; a 1 percentage point increase over the CY 2016 rate of 99%.
  - 93.8% for all outpatient codes reviewed; a decrease of 5.7 percentage points from the CY 2016 rate of 99.5%.

- 97.3% for all office visit codes reviewed; an increase of 3.7 percentage points over the CY 2016 rate of 93.6%.

Corrective Action Plans

For the CY 2017 EDV, all HealthChoice MCOs achieved match rates above the 90% standard; therefore no corrective action plans are required.

Recommendations

Qlarant and Hilltop recommend the following to MDH based on the CY 2017 EDV:

- Monitor 8ER reports to identify trends and encourage improvement of encounter data quality, especially for MCOs with higher rates of rejection. As noted in Activity 3, Step 1, 8ER error reports as a result of the EDI process were reviewed. Out of approximately 40 million overall encounters, over 1.8 million encounters (approximately 4.6%) were rejected through the EDI process in CY 2017. While all MCOs had rejections, KPMAS accounted for 16.4% of rejected encounters but only 4.7% of accepted encounters.
- Work with the MCOs to encourage accurate population of the prescribing physician data field. This data field was reviewed and found that it was invalid in over 92% of encounters. Encounters by claim type were also reviewed and the distribution was relatively similar across MCOs. MDH should review this information to determine if the data are as expected and whether follow-up discussions are required.
- Monitor monthly submissions to ensure that the MCOs submit data in a timely manner. A comparison of the end date of service to the encounter submission date was completed and it was found that most encounters are submitted to MDH within one month of the date of service. A spike in submissions is noted in April, likely due to the rate-setting encounter data submission deadline. As noted, JMS submits most of its encounters more than one month after the date of service, and UMHP submitted nearly 4% of encounters one year after the date of service.
- Monitor PCP visits by MCO in future encounter data validations. This report determined the percentage of enrollees with a PCP visit by MCO to establish a baseline for analysis. Because the rates varied only slightly among MCOs, the data did not indicate any errors or outliers.
- Review the baseline data provided for volume of inpatient visits, ED visits, and observation stays by MCO, and compare trends in future annual encounter data validations. Trends across MCOs were relatively similar. Reasonable assumptions for future data include small numbers of inpatient hospitalizations, observation stays, and ED visits compared to the total CY 2017 encounter data. The percentages of each service type should also remain consistent between MCOs.
- Review and audit the participant level reports provided by Hilltop for pregnancy, dementia, and over 65/missing age outlier data. MCOs submitting the encounter outliers should be notified and demographic information should be updated as needed.
- Instruct MCOs to caution providers on the use of appropriate codes that reflect what is documented in the medical record. The mismatch in rates is due to either incorrect codes or a lack of medical record documentation.
- Revision of the current rate of oversampling to reflect a reduction in the oversample of IP and OP, with a slight increase in the oversampling of physician visits, to ensure adequate numbers of medical records are received to meet the required sample size.

- Communicate with provider offices to reinforce the requirement to supply all supporting medical record documentation for the encounter data review so that all minimum samples can be met.

Conclusion

HealthChoice is a mature managed care program, and overall, analysis of the electronic encounter data indicates that the data are complete, accurate, and valid. The MCOs have similar distributions of rejections, types of encounters, and outliers, except where specifically noted above. This analysis did identify minor outliers that merit further monitoring and investigation by MDH. Continuing to work with each MCO to address any identified discrepancies will increase MDH's ability to assess the efficiency and effectiveness of the Medicaid program.

Based on the Medicaid and CHIP Managed Care Final Rule and federal guidance, MDH modified its regulations and managed care contracts to establish minimum elements for encounter data to improve the accuracy and completeness of submissions. In the reporting requirements section of the CY 2019 managed care contract, MCOs now must ensure they transmit the following encounter information at a minimum: Enrollee and provider identifying information; service, procedure, and diagnoses codes; allowed, paid, enrollee responsibility, and third-party liability amounts; and service, claims submission, adjudication, and payment dates (Section II.I.5, pg. 11). This requirement is echoed in Maryland regulation at COMAR 10.09.65.15B (3).

The HealthChoice MCOs were found to have information systems in place that produce accurate and complete encounter data. The MCOs use standard forms and coding schemes that allow for capturing appropriate data elements for claims processing. The encounter data submitted by the HealthChoice MCOs for CY 2017 can be considered reliable for reporting purposes, as the EDV overall match rate was 94.8%. This rate exceeded the recommended match rate standard of 90% for EDV set by Qlarant. The CY 2017 overall match rate was a 0.7 percentage point decrease from the CY 2016 rate of 95.5%, and one percentage point below the CY 2015 rate of 96%. While the inpatient and office visit match rates increased in CY 2017, these were offset by the 5.4 percentage point decrease in the outpatient rate. HealthChoice MCOs inpatient, outpatient, and office visit rates demonstrated little variation from CY 2015 to CY 2017, with no MCOs requiring CAPs.

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

Introduction

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the federally mandated Medicaid program for screening, prevention, diagnosis, and treatment of physical and mental health conditions in children and adolescents 0 through 20 years of age (as defined by Omnibus Budget Reconciliation Act [OBRA] 1989). Each State determines its own periodicity schedule for services, including periodic physical and mental health screening, vision, dental, and hearing services.

The Program's philosophy is to provide quality health care that is patient focused, prevention oriented, coordinated, accessible, and cost effective. The foundation of this philosophy is based on providing a "medical home" for each enrollee, by connecting each enrollee with a primary care provider (PCP) who is responsible for providing preventive and primary care services, managing referrals, and coordinating all necessary preventive care for the enrollee. The Program emphasizes health promotion and disease prevention, and requires that participants be provided health education and outreach services.

As the Maryland Department of Health's (MDH's) contracted External Quality Review Organization (EQRO), Qlarant annually completes an EPSDT medical record review. The medical record review findings assist MDH in evaluating the degree to which HealthChoice children and adolescents 0 through 20 years of age are receiving timely screening and preventive care in accordance with the Maryland Preventive Health Schedule.

This report summarizes the findings from the EPSDT medical record review for Calendar Year (CY) 2017. Approximately 628,954 children were enrolled in the HealthChoice Program during this period. The eight Managed Care Organizations (MCOs) evaluated for CY 2017 were:

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

Program Objectives

The Maryland EPSDT Program's mission is to promote access to and assure availability of quality health care for Medical Assistance children and adolescents through 20 years of age. In support of the program's mission, the primary objective of the EPSDT medical record review is to collect and analyze data to assess the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. The review includes an assessment of MCO performance for the following EPSDT components 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.
- Developmental history/surveillance through 20 years of age.
- Mental health assessment beginning at 3 years of age.
- Substance abuse screening beginning at 11 years of age, younger if indicated.
- Developmental screening using a 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, unclothed, 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.
- 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.
- Age-appropriate tuberculosis and cholesterol risk assessment results 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.
- Anemia test results at 1, 2, and 3-5 years of age.
- Lead risk assessment beginning at 6 months through 6 years of age.
- Referral to the lab for blood lead testing or follow up at appropriate ages.
- Blood lead test results at 1 and 2 years of age.
- Baseline blood lead test results at 3 to 5 years of age when not done at 24 months of age.
- STI/HIV risk assessment beginning at 11 years of age, or younger if indicated.

Immunizations require assessment of need and documentation that:

- The MDH Immunization Schedule is being followed in accordance with the Advisory Committee on Immunization Practices (ACIP) 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 and 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.

CY 2017 EPSDT Review Process

Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during calendar year 2017 for children from birth through 20 years of age. The sampling methodology includes the following criteria:

- A random sample is drawn from preventive care encounters per MCO, including a 10% over sample.
- Sample size per MCO provides a 90% confidence level and 5% margin of error.
- Sample includes only recipients through 20 years of age as of the last day of the measurement year.
- Sample includes EPSDT recipients enrolled on last day of measurement year, and for at least 320 days in the same MCO.
  Exception – If the recipient's age on the last day of selected period is less than 365 days, the criteria is modified to read same MCO for 180 days, with no break in eligibility.
- Sample includes recipients 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 preventive visits within a 12-month period, only one date of service was selected.
- Sample includes recipients when visits with CPT 99381-85 or 99391-95 were provided by primary care providers and clinics with the following specialties: pediatrics, family practice, internal medicine, nurse practitioner, or general practice.

Scoring Methodology

Data from the medical record reviews were entered into Qlarant's EPSDT Evaluation Tool. The analysis of the data was organized by the following age groupings:

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

The following scores were provided to the specific elements within each age group based on medical record documentation:

Score	Finding
2	Complete
1	Incomplete
0	Missing

Exception – When an element is not applicable to a child, such as a vision assessment for a blind child or a documented refusal for a flu vaccine by a parent, a score of two was given.

Elements, each weighted equally, within a component were scored and added together to derive the final component score. Similarly, the composite score (or overall score) follows the same methodology.

Scoring reflects the percentage of possible points obtained in each component, for each age group, and for each MCO. The minimum compliance score is 80% for each component. If the minimum compliance score is not met, a Corrective Action Plan (CAP) will be required.

New elements and elements with revised criteria are scored as baseline.

The following should be considered when assessing results based on the random sampling methodology:

- Randomized record sampling does not assure that 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-certified providers. Providers who have not been certified by the program may not be familiar with the preventive care requirements. However, MCOs are still required by regulation to assure that preventive services are rendered to Medicaid recipients 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.

Medical Record Review Process

Medical records were randomly selected in order to assess compliance with the program standards. Nurse reviewers conducted all medical record reviews in the provider offices, with the exception of providers with only one child in the sample. These providers were given the option to mail or fax a complete copy of the medical record to Qlarant for review. A total of 2,350 medical records were reviewed in CY 2017.

The review criteria used by Qlarant's review nurses were the same as those developed and used by MDH's Healthy Kids Program nurse consultants. The review nurses successfully completed annual training and conducted inter-rater reliability (IRR) prior to the EPSDT review.

EPSDT Review Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance score of 80% for each of the five components. If an MCO did not achieve the minimum compliance score, the MCO was required to submit a CAP. Each MCO met the minimum compliance score of 80% for all five component areas in CY 2017 (Table 34).

Table 34. CY 2017 EPSDT Component Results by MCO

Component	CY 2017 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2015	CY 2016	CY 2017
Health & Developmental History	94%	99%	98%	91%	93%	94%	92%	92%	92%	92%	92%
Comprehensive Physical Examination	96%	99%	97%	93%	96%	96%	92%	93%	93%	96%	96%
Laboratory Tests/At Risk Screenings	81%	99%	92%	82%	82%	81%	80%	81%	78%	85%	82%
Immunizations	89%	95%	96%	86%	93%	89%	87%	87%	84%	85%	90%
Health Education/ Anticipatory Guidance	93%	99%	97%	91%	93%	94%	90%	92%	92%	95%	94%
Total Score	**91%**	**98%**	**96%**	**88%**	**92%**	**92%**	**88%**	**89%**	**89%**	**91%**	**92%**

The following section provides a description of each component along with a summary of each HealthChoice MCOs' 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.

Components. Medical history includes personal, family, perinatal, psychosocial, developmental, and mental health information. Psychosocial history assesses support systems and exposure to family and/or community violence, which may adversely affect the child's mental health. Developmental, autism, and depression screenings determine the need for referral and/or follow-up services. The mental health assessment provides an overall view of the child's personality, behaviors, social interactions, affect, and temperament. The substance abuse assessment identifies children who should be referred for counselling and/or treatment.

Documentation. Annual updates for personal, family, and psychosocial histories are required to ensure the most current information is available. The 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. While the CRAFFT assessment tool and those used for developmental and autism screening are suggested, the PHQ-9 or HEAD screen is mandatory for the depression screening.

Table 35. CY 2017 Health and Developmental History Element Results

CY 2017 Health and Development History Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Recorded Medical history	97%	100%	98%	96%	98%	99%	96%	96%
Recorded Family History	91%	99%	94%	88%	84%	92%	88%	88%
Recorded Perinatal History	92%	100%	94%	79%	86%	86%	80%	83%
Recorded Psychosocial History	95%	100%	97%	94%	94%	94%	94%	93%
Recorded Developmental Surveillance/History (0-5 years of age)	96%	98%	100%	94%	98%	97%	96%	97%
Recorded Developmental Surveillance/History (6-20 years of age)	95%	98%	100%	89%	95%	96%	91%	94%
Recorded Developmental Screening Tool	83%	100%	100%	81%	84%	86%	88%	88%
Recorded Autism Screening Tool	85%	100%	100%	67%	74%	68%	65%	83%
Recorded Mental/Behavioral Health Assessment	95%	100%	99%	94%	95%	94%	94%	92%
Recorded Substance Abuse Assessment[1]	80%	99%	99%	81%	87%	87%	83%	81%
Depression Screening[2]	48%	69%	92%	67%	58%	72%	59%	56%
MCO Component Score	**94%**	**99%**	**98%**	**91%**	**93%**	**94%**	**92%**	**92%**

Underlined scores denote scores below the 80% minimum compliance requirement.
[1]Baseline score for CY 2017; element criteria revised.
[2]Baseline score for CY 2017; new element.

Health and Developmental History Results:

- All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.
- The HealthChoice Aggregate score remains stable at 92% since CY 2014.

Comprehensive Physical Examination

Rationale. The comprehensive physical exam uses a systems review method that requires documentation of a minimum of five systems (example - heart, lungs, eyes, ears, nose, throat, abdominal, genitals, skeletal-muscular, neurological, skin, head, and face) to meet EPSDT standards.

Components & 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 Body Mass Index (BMI) beginning at 2 years of age.

Table 36. CY 2017 Comprehensive Physical Examination Element Results

CY 2017 Comprehensive Physical Exam Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Documentation of Minimum 5 Systems Examined	100%	99%	100%	97%	99%	99%	97%	97%
Vision Assessment	93%	100%	89%	92%	95%	93%	91%	94%
Hearing Assessment	90%	100%	91%	91%	92%	92%	87%	93%
Nutritional Assessment	96%	100%	100%	94%	97%	97%	93%	96%
Conducted Oral Assessment	98%	99%	99%	94%	95%	98%	93%	95%
Measured Height	99%	100%	100%	97%	99%	99%	97%	97%
Graphed Height	95%	99%	99%	90%	95%	96%	91%	89%
Measured Weight	99%	100%	100%	97%	99%	99%	97%	97%
Graphed Weight	95%	99%	99%	91%	96%	96%	90%	90%
BMI Percentile	94%	99%	100%	89%	93%	96%	90%	87%
BMI Graphing	94%	99%	99%	88%	93%	96%	89%	87%
Measured Head Circumference	100%	100%	97%	95%	86%	95%	91%	97%
Graphed Head Circumference	87%	94%	97%	91%	83%	95%	82%	92%
Measured Blood Pressure	97%	100%	97%	96%	99%	97%	95%	96%
MCO Component Score	**96%**	**99%**	**97%**	**93%**	**96%**	**96%**	**92%**	**93%**

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

Comprehensive Physical Examination Results:

- All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.
- The HealthChoice Aggregate score remains consistent at 96% in CY 2017 after an increase of 3 percentage points in CY 2016.

Laboratory Tests/At-Risk Screenings

Rationale. The Healthy Kids Program requires assessments of risk factors associated with heart disease, tuberculosis, lead exposure, and sexually transmitted infection/human immunodeficiency virus (STI/HIV).

Components. Assessment of risk factors includes:

- A second newborn metabolic screen (lab test) by 8 weeks of age.
- Tuberculosis risk assessment annually beginning at 1 month of age.
- Cholesterol risk assessment annually beginning at 2 years of age.
- 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 6 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 annually beginning at 11 years of age.
- Anemia test results at 1, 2, and 3-5 years of age.
- STI/HIV risk assessment annually beginning at 11 years of age.

Table 37. CY 2017 Laboratory Test/At–Risk Screenings Element Results

CY 2017 Laboratory Test/At-Risk Screenings Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Newborn Metabolic Screen	100%	88%	100%	100%	NA	100%	100%	75%
Recorded TB Risk Assessment	82%	99%	95%	81%	80%	82%	80%	75%
Recorded Cholesterol Risk Assessment	85%	100%	85%	83%	78%	80%	81%	79%
Dyslipidemia Lab Test[1]	59%	79%	55%	35%	44%	54%	48%	50%
Conducted Lead Risk Assessment	87%	100%	97%	92%	91%	89%	92%	92%
12 Month Blood Lead Test	64%	100%	97%	80%	92%	64%	75%	98%
24 Month Blood Lead Test	80%	100%	100%	82%	64%	93%	79%	79%
3 – 5 Year (Baseline) Blood Lead Test	70%	96%	88%	76%	85%	75%	71%	77%
Referral to Lab for Blood Lead Test	76%	97%	90%	77%	85%	75%	71%	85%
Conducted Anemia Risk Assessment[1]	72%	96%	55%	52%	62%	77%	65%	73%
Anemia Test[2]	71%	94%	84%	74%	77%	72%	74%	82%
Recorded STI/HIV Risk Assessment[1]	83%	99%	96%	78%	95%	84%	88%	85%
MCO Component Score	**81%**	**99%**	**92%**	**82%**	**82%**	**81%**	**80%**	**81%**

Underlined scores denote scores below the 80% minimum compliance requirement.
[1]Baseline score for CY 2017; element criteria revised.
[2]Baseline score for CY 2017; new element.
NA – Not applicable as there were no records included in the sample requiring a review of this element.

Laboratory/At-Risk Screening Results. All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017. After a significant seven percentage point increase from 78% in CY 2015 to 85% in CY 2016, the HealthChoice Aggregate score decreased by three percentage points to 82% in CY 2017.

Immunizations

Rationale. Children on 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 (ACIP) and the American Academy of Pediatrics. Primary care providers who see Medicaid recipients through 18 years of age must participate in the Department'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 date, dosage, site of administration, manufacturer, lot number, publication date of Vaccine Information Statement (VIS), and name/location of provider. Immunization components are listed in the table below.

Table 38. CY 2017 Immunizations Element Results

CY 2017 Immunization Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Hepatitis B	90%	98%	97%	88%	95%	91%	88%	86%
Diphtheria/tetanus/acellular pertussis (DTaP)	92%	99%	100%	91%	94%	93%	91%	92%
Haemophilus influenza type B (HIB)	91%	99%	99%	91%	96%	91%	92%	90%
Pneumococcal (PCV-7 or PCV-13 [Prevnar])	93%	99%	98%	91%	94%	91%	92%	91%
Polio (IPV)	92%	97%	97%	88%	95%	91%	89%	88%
Measles/Mumps/Rubella (MMR)	92%	98%	97%	88%	95%	90%	89%	88%
Varicella (VAR)	91%	98%	97%	87%	93%	91%	91%	88%
Tetanus/diphtheria/acellular pertussis (TDAP)	88%	99%	95%	84%	96%	89%	88%	86%
Influenza (Flu)	82%	88%	98%	75%	85%	86%	78%	84%
Meningococcal (MCV4)	93%	98%	95%	88%	97%	87%	82%	83%
Hepatitis A	89%	94%	94%	84%	93%	86%	87%	83%
Rotavirus	82%	92%	100%	100%	100%	100%	85%	87%
Human Papillomavirus (HPV)[1]*	84%	97%	95%	78%	92%	82%	83%	71%
Assessed Immunizations Up-to-Date	88%	89%	91%	84%	88%	90%	82%	87%
MCO Component Score	**89%**	**95%**	**96%**	**86%**	**93%**	**89%**	**87%**	**87%**

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

[1]Element criteria revised.

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

Immunizations Results

- All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.
- The HealthChoice Aggregate score for this component continues to improve. After an increase of one percentage point in CY 2016, the Immunization component aggregate score continued to rise another five percentage points in CY 2017 to 90%.

Health Education/Anticipatory Guidance

Rationale. Health education enables the patient and family to make informed health care 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.

Components: A minimum of three topics must be discussed 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 2 years 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 the 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."

Documentation. The primary care provider must specifically document whenever 2-year intervals for preventive care are the usual and customary schedule of the practice instead of annual visits.

Table 39. CY 2017 Health Education/Anticipatory Guidance Element Results

CY 2017 Health Education/Anticipatory Guidance Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Documented Age Appropriate Anticipatory Guidance	97%	100%	100%	96%	96%	98%	94%	97%
Documented Health Education/ Referral for Identified Problems/ Tests	98%	100%	99%	97%	99%	98%	96%	96%
Documented Referral to Dentist	84%	99%	88%	79%	88%	87%	81%	82%
Specified Requirements for Return Visit	92%	98%	100%	90%	89%	93%	89%	90%
MCO Component Score	**93%**	**99%**	**97%**	**91%**	**93%**	**94%**	**90%**	**92%**

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

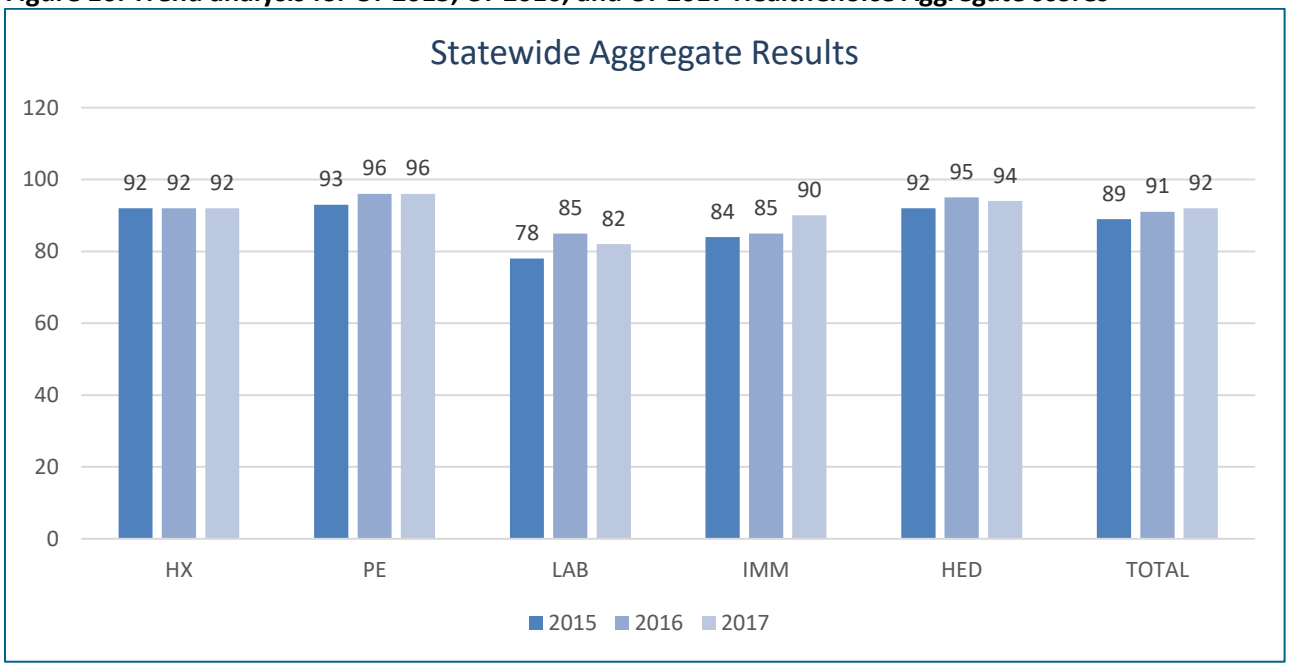
Health Education/Anticipatory Guidance Results

- All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.
- The HealthChoice Aggregate score for this component decreased slightly by one percentage point in CY 2017 to 94% after the three percentage point increase demonstrated in CY 2016.

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 CY 2015 through CY 2017 can be interpreted as reflecting differences in quality of care. Potential effects of demographic factors or changes in case mix must also be considered. One must evaluate both the magnitude and pattern of the change in terms of potential clinical impact in order to determine whether the results reflect a change in the quality of care being delivered to enrollees. The HealthChoice Aggregate scores from CY 2015 to CY 2017 are presented in Figure 16.

Figure 16. Trend analysis for CY 2015, CY 2016, and CY 2017 HealthChoice Aggregate scores



The total HealthChoice Aggregate scores demonstrate continuous improvement with increases in the total score by two percentage points (89% to 91%) from CY 2015 to CY 2016, and one percentage point (91% to 92%) from CY 2016 to CY 2017.

In CY 2017, the IMM – Immunizations component score demonstrated a significant improvement of five percentage points. Two component scores (HX – Health and Developmental History and PE – Comprehensive Physical Exam) remained the same and two component scores (LAB – Laboratory Tests/At Risk Screenings and HED – Health Education/Anticipatory Guidance) decreased. The total score increased by one percentage point and all Statewide Aggregate Component scores continued to remain above the 80% minimum compliance threshold in CY 2017.

Corrective Action Plan Process

MDH sets high performance standards for the Healthy Kids/EPSDT Program. In the event the minimum compliance score is not met, MCOs are required to submit a CAP. The CAPs are evaluated by Qlarant to determine whether the plans 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 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 are 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. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH may take further action.

Each MCO met the minimum compliance score of 80% for all five components; therefore, no CAPs are required for CY 2017.

Conclusions

HealthChoice Aggregate scores for each of the five components were above the 80% minimum threshold for compliance. After a significant seven percentage point increase from 78% in CY 2015 to 85% in CY 2016, the Laboratory Test/At-Risk Screenings Component demonstrated a three percentage point decrease to 82% in CY 2017. It is recommended that MCOs continue their concerted efforts in this area so that the component scores do not drop below the minimum compliance score of 80% in CY 2018. Scores for each component area except for the Laboratory Test/At-Risk Screenings Component increased or remained unchanged from CY 2016 to CY 2017. This resulted in an increase of one percentage point in the CY 2017 HealthChoice Aggregate Total Composite Score from 91% to 92%.

Although there were no CAPs required for CY 2017, the scores for the Laboratory Test/At-Risk Screenings Component for six out of the eight MCOs are within two percentage points of the minimum compliance score. MCOs should continue to monitor the elements of this component closely.

The MCO results of the EPSDT review demonstrate strong compliance with the timely screening and preventive care requirements of the Healthy Kids/EPSDT Program. Overall scores indicate that the

MCOs, in collaboration with PCPs, are committed to the Department's goals to provide care that is patient focused, prevention oriented, and follows the Maryland Schedule of Preventive Health Care.

Section VI
Consumer Report Card

Introduction

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

The Report Card is meant to help Medicaid participants select a HealthChoice MCO. Information in the Report Card includes performance results from the Healthcare Effectiveness Data and Information Set (HEDIS®) measures, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey questions and the MDH encounter data measures.

Information Reporting Strategy

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

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

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

Organizing Information

Relevant information is grouped in a minimal number of reporting categories and in single-level summary scores to enhance comprehension and interpretation of quality measurement information provided for a Medicaid audience. The Qlarant team will design the Report Card to include six categories, with one level of summary scores (measure roll-ups) per MCO, for each reporting category.

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

Measures are grouped into reporting categories that are meaningful to consumers. Based on a review of the potential measures available for the Report Card (HEDIS®, CAHPS®, and the MDH's VBP initiative), the team recommends the following reporting categories:

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

Rationale. The recommended categories are based on measures reported by HealthChoice MCOs in 2017 and are designed to focus on clearly identifiable areas of interest. Consumers will be directed to focus on MCO performance in the areas most important to them and their families. The first two categories are relevant to all participants; the remaining categories are relevant to specific Maryland HealthChoice participants: children, children with chronic illness, women, and adults with chronic illness. Reporting measures individually (in addition to the reporting categories listed above) is not recommended. Comparing the performance of a category composed of many measures with the performance of individual measures may give undue weight to the individual measures.

Measure Selection

Measures are selected that apply to project goals. The measures that the project team considered for inclusion in the Report Card are derived from those that MDH requires MCOs to report, which include HEDIS® measures; the CAHPS® results from both the Adult Questionnaire and the Child Questionnaire; and MDH's VBP measures. Each year, the team has created measure selection criteria that has a consistent and logical framework for determining which quality of care measures are to be included in each composite.

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

HEDIS® 2017 Measure Changes
NCQA retired the *Call Answer Timeliness* measure.

There were updates made to several HEDIS® measures, however, these modifications do not affect the Report Card methodology. For detailed changes, refer to *HEDIS® 2017, Volume 2: Technical Specifications for Health Plans.*

CAHPS® 2017 Measure Changes
No modifications were made to the CAHPS® Survey for CY 2017, however, the following reporting category changes were made:

- Access to Care
  - Remove *Call Answer Timeliness* as the measure has been retired.
  - Move the Access to Care – SSI Children (ages 0-20)* measure into the Access to Care Category from the Care for Kids with Chronic Illness Category.
- Doctor Communication and Service – No Changes
- Keeping Kids Healthy – No Changes

- Care for Kids with Chronic Illness
  - Remove the Access to Care – SSI Children (ages 0-20)* measure from the Care for Kids with Chronic Illness Category and into the Access to Care Category.
  - Add the 12-18 year age group to the Medication Management for People With Asthma measure.
- Taking Care of Women – No Changes
- Care for Adults With Chronic Illness – No Changes

Format

It is important to display information in a format that is easy to read and understand by the member. The following principles are important when designing Report Cards:

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

A 24 x 9.75-inch pamphlet folded in thirds, with English on one side and Spanish on the opposite side is used to display the report card. Pamphlets allow one-page presentation of all information. Measure explanations can be integrated on the same page as performance results, helping readers match the explanation to the data.

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

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

Rating Scale

MCOs are rated on a tri-level rating scale. The report card compares each MCO's performance with the average of all MCOs potentially available to the target audience; in this case, the average of all HealthChoice MCOs ("the Maryland HealthChoice MCO average"). Use stars or circles to represent performance that is "above," "the same as," or "below" the Maryland HealthChoice MCO average.

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

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

Methodology

Analytic Method

Qlarant compares each MCO's actual score with the unweighted statewide MCO average for a particular reporting category. An icon or symbol would denote whether an MCO performed "above," "the same as" or "below" the statewide Medicaid MCO average.

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

Handling Missing Values

Replacing missing values can create three issues. First is deciding which pool of observed (non-missing) MCOs should be used to derive replacement values for missing data. The second issue is how imputed values will be chosen. Alternatives are fixed values (such as "zero" or "the 25th percentile for all MCOs in the nation"), calculated values (such as means or regression estimates), or probable selected values (such as multiplying imputed values). The third issue is that the method used to replace missing values should not provide an incentive for poorly performing plans to intentionally fail to report data. For example, if missing values are replaced with the mean of non-missing cases, scores for MCOs that perform below the mean would be higher if they fail to report.

Replacing missing Medicaid MCO data with commercial plan data is inappropriate because the characteristics of Medicaid populations differ from those of commercial populations. This restricts the potential group to national Medicaid plans, regional Medicaid MCOs, or Maryland HealthChoice MCOs. Analyses conducted by NCQA for the annual *State of Health Care Quality Report* have consistently

shown substantial regional differences in performance of commercial managed care plans. Assuming that regional differences generalize to Medicaid MCOs, it would be inappropriate to use the entire group of national Medicaid MCOs to replace missing values for Maryland HealthChoice MCOs.

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

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

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

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

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

- If fewer than 50 percent of the MCOs report a measure, the measure is dropped from the Report Card category.
- If an MCO has reported at least 50 percent of the measures in a reporting category, the missing values are replaced with the mean or minimum values, based on the reasons for the missing value.
- MCOs missing more than 50 percent of the measures composing a reporting category are given a designation of “Insufficient Data” for the measurement category.

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

Handling New MCOs

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

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

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

Case-Mix Adjustment of CAHPS® Data

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

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

Statistical Methodology

The statistical methodology includes the following steps:

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

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

Quality Control

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

CY 2018 Report Card Results

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

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

Section VII
Focused Reviews of Grievances, Appeals, and Denials

Introduction

Maryland's HealthChoice Program (HealthChoice) is a managed care program based upon a comprehensive system of continuous quality improvement that includes problem identification, analysis, corrective action, and reevaluation. The objective is to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding the care and services received by HealthChoice enrollees.

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care (QOC) provided to Maryland Medical Assistance enrollees in HealthChoice Managed Care Organizations (MCOs). MDH, pursuant to 42 CFR 438.204 and Code of Maryland Regulations (COMAR) 10.09.65, is responsible for monitoring the QOC provided to MCO enrollees when delivered. Under Federal law [Section 1932(c)(2)(A)(i) of the Social Security Act], MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract to ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program. MDH contracts with Qlarant to serve as the EQRO.

Qlarant conducts quality studies focused on determining MCO compliance with federal and state laws and regulations pertaining to the handling of grievances and appeals, and the appropriateness of denials of service. These studies consist of quarterly evaluations of grievance, appeal, and pre-service denial results submitted by each MCO, along with an annual record review. This is the second annual focused review conducted for MDH.

Assessment of MCO compliance was completed by applying the performance standards defined for Calendar Year (CY) 2017. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2017, and the first and second quarters of 2018. The annual record review encompassed member grievances, appeals, and pre-service denials that occurred during CY 2017. The nine MCOs evaluated during these time frames were:

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

ABH joined the HealthChoice Program in October 2017; therefore quarterly reports were submitted for the fourth quarter of 2017 and thereafter. Additionally, an annual record review for CY 2017 was not completed for ABH, as the MCO was in operation for just over two months of the calendar year.

Purpose and Objectives

The purpose of this review was to:

1. Assess MCO compliance with federal and state regulations governing member and provider grievances, member appeals, pre-service authorization requests, and adverse determinations; and
2. Facilitate increased compliance within these areas by illustrating trends and opportunities for improvement.

Review objectives addressed the following:

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

Methodology

MDH requires all HealthChoice MCOs to submit quarterly Grievance, Appeal, and Pre-Service Denial Reports within 30 days of the close of the quarter in an approved form to Qlarant. A review tool for each reporting category was developed by Qlarant, submitted, and approved by MDH for use in validating/evaluating quarterly MCO reports. The review tools (templates) for Grievances, Appeal, and Pre-Service Denials are found in Appendices A, B, and C. Following validation of the data submitted by the MCOs, these review tools allowed Qlarant to enter data from the MCO reports and to identify areas of non-compliance. Results from MCOs also were aggregated to allow MCO peer group comparisons. MCO-specific trends were identified after three quarters of data was available. Quarterly reports to MDH included an analysis of MCO data and recommendations, as appropriate. MCOs were provided a separate report of quarterly reviews which included areas for follow-up when data issues, ongoing non-compliance, or negative trends were identified.

In addition to quarterly reviews of MCO submitted reports, Qlarant conducted an annual record review of a sample of CY 2017 grievance, appeal, and pre-service denial records. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for CY 2017. Qlarant selected 35 cases from each listing using a random sampling approach and requested that each MCO upload the selected case records to the Qlarant portal. Using the 10/30 rule, an initial sample of 10 grievance, appeal, and denial records were reviewed. If an area of non-compliance was discovered, an additional 20 records were reviewed for the non-compliant component. Results of this record review, including strengths, best practices, and opportunities for improvement, were provided to MDH. MCOs were also provided with the results from each of the record reviews. Both reports included peer comparisons for each of the review components.

Limitations

Review of quarterly MCO grievance, appeal, and denial reports has identified only minor improvements in the validity of report data over the prior annual report period. Appeal reporting, in particular, includes ongoing formula errors that calculate totals in the quarterly reporting forms and a failure by several of the MCOs (ABH, KPMAS, and MPC) to comply with required reporting elements. Provider administrative appeals were still being included in reports by three MCOs (ACC, KPMAS, and PPMCO) in this review period. Additionally, one MCO (MSFC) has been excluding provider-submitted appeals on behalf of members. Reporting of pre-service denials has had similar issues. Two MCOs (ACC and UHC) were not including denials from at least one of their delegated entities. One MCO (UHC) included inpatient concurrent review denials in its reports. As a result of these continuing opportunities for improvement, caution must be exercised in reviewing the results contained in this report.

Results

This section provides MCO-specific review results of select grievance, appeal, and pre-service denial measures in table format. Graphical representation is also displayed, where applicable. Such presentation of data facilitates comparisons of MCO performance over time and in relation to peers based on quarterly reports and annual record review results.

The percentage of compliance demonstrated for various components is represented by a review determination of met, partially met, or unmet, as follows:

Met	Compliance consistently demonstrated
Partially Met	Compliance inconsistently demonstrated
Unmet	No evidence of compliance

Grievance Results

A grievance is an expression of dissatisfaction about any matter other than an action and is defined in COMAR 10.09.62.01B(58-1). COMAR 10.09.71.02C(1) describes three categories of grievances:

Category 1: Emergency medically related grievances
Example: Emergency prescription or incorrect prescription provided

Category 2: Non-emergency medically related grievances
Example: DME/DMS-related complaints about repairs, upgrades, vendor issues, etc.

Category 3: Administrative grievances
Example: Difficulty finding a network PCP or specialist

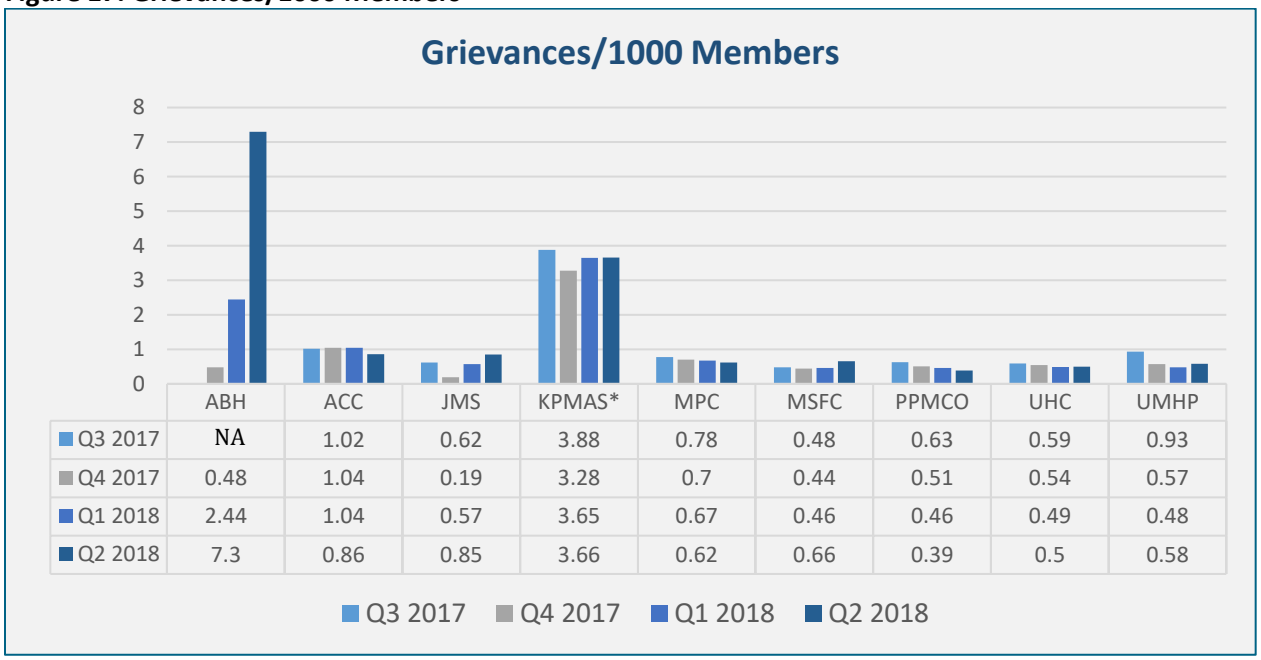
The MCO grievance review encompassed a review of comparative statistics and an assessment of compliance with the following requirements with federal and state laws and regulations:

- Comparative Statistics
  - Grievances filed per 1000 members

  - Grievances filed per 1000 providers
- Resolution Time Frames (based upon 100% compliance)
  - Emergency medically related grievances resolved within 24 hours
  - Non-emergency medically related grievances resolved within 5 days
  - Administrative grievances resolved within 30 days
- Grievance Definitions
  - Must meet the definition of an expression of dissatisfaction about any matter other than an action.
  - May include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.
- Grievance Documentation: Grievance issue must be fully described in the enrollee record.
- Grievance Determination:
  - Grievance determination must be documented in the enrollee record, appropriately address the grievance issue, and identify the steps taken to resolve the issue.
  - Written determination must be forwarded to:
    - Enrollee who filed the grievance;
    - Individuals and entities required to be notified of the grievance; and
    - The Department's complaint unit (for complaints referred to the MCO by the Department's complaint unit).

Figure 17 displays a comparison of MCO grievances per 1000 members for four quarters.

Figure 17. Grievances/1000 Members



	ABH	ACC	JMS	KPMAS*	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	1.02	0.62	3.88	0.78	0.48	0.63	0.59	0.93
Q4 2017	0.48	1.04	0.19	3.28	0.7	0.44	0.51	0.54	0.57
Q1 2018	2.44	1.04	0.57	3.65	0.67	0.46	0.46	0.49	0.48
Q2 2018	7.3	0.86	0.85	3.66	0.62	0.66	0.39	0.5	0.58

NA – Not Applicable
*Major outlier in comparison to other MCOs

KPMAS was a major outlier in grievances per 1000 members for all four quarters with attitude/service-related categories representing the majority of issues. ABH began reporting in Q4 of 2017. Grievances

per 1000 members have been trending upward, however, performance fluctuations are expected from newer MCOs. Grievances per 1000 members for the remaining MCOs fall within a fairly narrow range.

Table 40 offers a comparison of MCO reported grievances per 1000 providers for four quarters.

Table 40. MCO Reported Grievances/1000 Providers

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	0.00	0.00	0.56	0.22	0.00	0.03	0.00	4.94*
Q4 2017	0.00	0.00	0.00	0.00	0.47	0.00	0.14	0.00	0.87
Q1 2018	0.00	0.00	0.19	0.00	0.29	0.00	1.10*	0.07	0.09
Q2 2018	1.08	0.00	0.00	0.00	0.31	0.38	0.00	0.07	0.00

NA-Not Applicable
*Major outlier in comparison to other MCOs

MCO Reported Grievances per 1000 providers consistently remain low for the majority of MCOs. For third quarter of 2017, UMHP was a major outlier for this measure in comparison to all other MCOs; however, the MCO has demonstrated a downward trend since then. For the first quarter of 2018, PPMCO was a major outlier. For the second quarter of 2018, ABH grievances per 1000 providers exceeded all other MCOs; however, performance fluctuations are expected from newer MCOs.

Comparisons of MCO reported compliance with resolution time frames for member grievances based on MCO quarterly submissions are displayed in Table 41 for four quarters.

Table 41. MCO Reported Compliance with Member Grievance Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	Met	Met	PM	Met	PM	Met	PM	Met
Q4 2017	Met	Met	Met	PM	Met	PM	Met	Met	PM
Q1 2018	Met	Met	Met	PM	Met	PM	PM	PM	Met
Q2 2018	Met	Met	Met	Unmet	Met	Met	PM	Met	Met

NA-Not Applicable; PM-Partially Met

Four MCOs (ABH, ACC, JMS, and MPC) met the resolution time frames for member grievances in all four quarters. UMHP demonstrated full compliance for three of the four quarters. MSFC only met the required time frames in one of the four quarters. KPMAS did not meet the resolution time frames in any of the four quarters.

Comparisons of MCO reported compliance with resolution time frames for provider grievances based on MCO quarterly submissions are displayed in Table 42.

Table 42. MCO Reported Compliance with Provider Grievance Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	NA	NA	Met	Met	NA	Met	NA	Met
Q4 2017	NA	NA	NA	NA	Met	NA	Met	NA	Met
Q1 2018	NA	NA	Met	NA	Met	NA	Met	NA	Met
Q2 2018	Met	NA	NA	NA	Met	Met	NA	Met	NA

NA-Not applicable as the MCO did not receive any provider grievances during the reporting period.

All MCOs, as applicable, met the resolution time frames for provider grievances throughout the four quarters. MCOs that did not receive any provider grievances for the quarter were reported as NA for compliance for that quarter.

Table 43 presents a comparison of the annual grievance record review results across MCOs. Results are based upon a random selection of grievance records during CY 2017. Reviews were conducted utilizing the 10/30 rule.

Table 43. CY 2017 MCO Annual Grievance Record Review Results

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

PM - Partially Met

One MCO (ACC) received a finding of partially met for “Appropriate Classification” as they did not correctly identify the category of the grievance upon receipt. All MCO records reviewed demonstrated full explanation of the grievance issue. Resolution timeliness was met by all MCOs with the exception of MSFC and PPMCO. Two MCOs (JMS and KPMAS) demonstrated an opportunity for improving the appropriateness of the resolution.

Four of the MCOs (ACC, PPMCO, UHC, and UMHP) received a finding of met for the resolution letter component. The remaining five MCOs received a partially met or unmet score due to inconsistent or missing resolution letters within the records reviewed.

Appeal Results

An appeal is a request for a review of an action as stated in COMAR 10.09.62.01B(12-1). The regulation provides the following definitions of an action:

- Action 1: Denial or limited authorization of a requested service, including the type or level of service

- Action 2: Reduction, suspension, or termination of a previously authorized service
- Action 3: Denial, in whole or part, of payment for a service
- Action 4: Failure to provide services in a timely manner
  (i.e., if the MCO fails to provide services within the timeframes defined by the State in COMAR 10.09.66.07)
- Action 5: Failure of an MCO to act within the required appeal time frames set in COMAR (i.e., COMAR 10.09.71.05)

In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. As a result, MDH communicated to the MCOs new regulatory requirements for appeal processing with an effective date of January 1, 2018. This date was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementation of the new requirements. Updates to COMAR 10.09.71.05 as they relate to MCO reported appeal results addressed in this report include the following:

- MCOs may only have one level of enrollee appeal, and enrollees must first appeal to the MCO before requesting a State fair hearing.
- Except for expedited appeals, MCOs shall resolve each appeal and provide notice of resolution, as expeditiously as the enrollee's health condition requires within 30 days from the date the MCO receives the appeal unless an extension is requested.
- Expedited appeals shall be resolved as expeditiously as the enrollee's health condition requires but no later than 72 hours after the MCO receives the appeal.

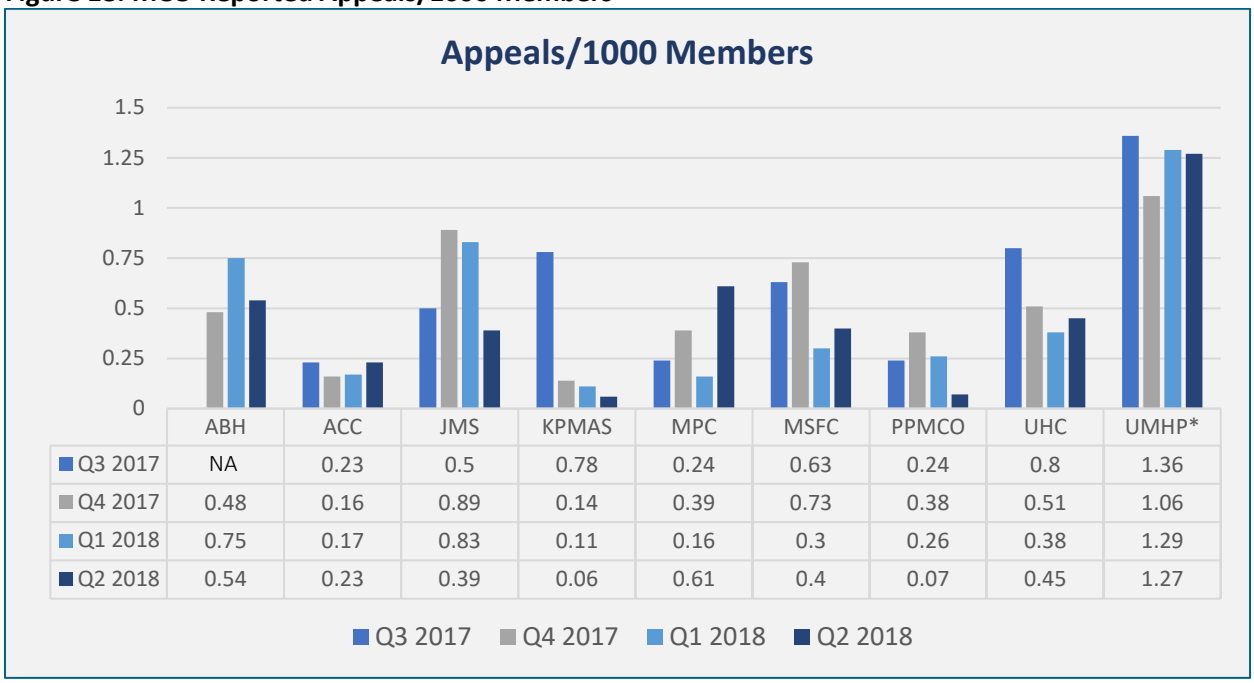
Providers can file appeals on a member's behalf. Maryland's regulations previously did not require the provider to seek written authorization before filing an appeal on the member's behalf.

The MCO appeal review encompassed the following comparative statistics and an assessment of compliance with federal and state laws and regulations:

- Comparative Statistics: Appeals Filed Per 1000 Members
- Resolution Time Frames (based upon 100% compliance)
  - Expedited appeals are required to be completed within three business days.
  - Non-emergency appeals are required to be completed within 30 days, unless an extension is requested.
- Appeal Processing: Appeals are to be processed as expeditiously as the enrollee's health requires.
- Notifications of Denial of an Expedited Request
- Appeal Documentation: Appeal decisions are to be documented fully in the enrollee record.
- Decision Made by Health Care Professional with Appropriate Expertise
- Written Notification: The appeal resolution is to be provided to the enrollee in a written letter and must include results in easy to understand language by the member.

Figure 18 provides a comparison of MCO reported appeals per 1000 members based on MCO quarterly submissions.

Figure 18. MCO Reported Appeals/1000 Members



	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP*
Q3 2017	NA	0.23	0.5	0.78	0.24	0.63	0.24	0.8	1.36
Q4 2017	0.48	0.16	0.89	0.14	0.39	0.73	0.38	0.51	1.06
Q1 2018	0.75	0.17	0.83	0.11	0.16	0.3	0.26	0.38	1.29
Q2 2018	0.54	0.23	0.39	0.06	0.61	0.4	0.07	0.45	1.27

NA – Not Applicable
*Outlier in comparison to other MCOs

UMHP has consistently been at the top of the range in reported appeals per 1000 members in comparison to all other MCOs during all four quarters. MCO-specific trending and comparisons between MCOs, however, is not feasible at this time since several MCOs (ACC, KPMAS, MSFC, and PPMCO) were either including provider administrative appeals or omitting provider appeals on behalf of members in this measure during this time frame. Also, because of these issues it is difficult to assess the impact of moving to one level of appeal beginning February 1, 2018, for those MCOs that previously provided a two-level appeal process.

Comparisons of MCO reported compliance with resolution time frames for member appeals are displayed in Table 44 based on MCO quarterly submissions.

Table 44. MCO Reported Compliance with Member Appeal Resolution Time Frames

Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	Met	Met	PM	Met	PM	PM	PM	Met
Q4 2017	Met	Met	Met	PM	Met	PM	Met	Met	Met
Q1 2018	Met	Met	Met	PM	Met	Met	PM	PM	Met
Q2 2018	Met	Met	Met	Met	Met	Met	Unmet	PM	Met

NA-Not Applicable; PM-Partially Met

Five MCOs (ABH, ACC, JMS, MPC, and UMHP) consistently met appeal resolution time frames for the four quarters reviewed. MSFC demonstrated compliance for two quarters. KPMAS, PPMCO, and UHC demonstrated compliance for one quarter. It does not appear that the change in the resolution time

frame for expedited appeals from three business days to 72 hours effective February 1, 2018, had an impact on MCO compliance results.

Table 45 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2017. Reviews were conducted utilizing the 10/30 rule.

Table 45. CY 2017 MCO Appeal Record Review Results

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

NA-Not Applicable; PM – Partially Met

All but one MCO demonstrated compliance with each review component. KPMAS received a score of partially met for the requirement to provide the appeal decision to the enrollee in easy to understand language.

Pre-Service Denial Results

Actions and decisions regarding services to enrollees that require preauthorization by the MCO are defined in COMAR 10.09.71.04. The regulation states that the MCO shall make a determination in a timely manner so as not to adversely affect the health of the enrollee and within 2 business days of receipt of necessary clinical information, but no later than 7 calendar days from the date of the initial request. It further details that:

- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested:
  - Shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
  - May not be arbitrarily based solely on diagnosis, type of illness, or condition.

- Notices of a decision to deny an authorization shall be provided to the enrollee and the regulation provider within the following time frames:
  - 24 hours from the date of determination for emergency, medically related requests; and
  - 72 hours from the date of determination for nonemergency, medically related requests.
- An MCO shall give an enrollee written notice of any action, except for denials of payment which do not require notice to the enrollee, within the following time frames:
  - At least 10 days before the action for termination, suspension, or reduction of a previously authorized covered service.
- A notice of adverse action shall be in writing and:
  - Be translated for enrollees who speak prevalent non-English languages;
  - Include language clarifying that oral interpretation is available for all languages and how to access it;
  - Be written in an easily understood language and format that takes into consideration enrollees with special needs;
  - Be available in alternative formats; and
  - Inform enrollees that information is available in alternative formats and how to access those formats.

In April 2016, CMS issued final regulations that revised existing Medicaid managed care rules for contract periods beginning on or after July 1, 2017. As a result, MDH communicated to the MCOs new regulatory requirements for certain services that require preauthorization with an effective date of January 1, 2018. This date was subsequently revised to dates of services requested on or after February 1, 2018, to allow the MCOs additional time for implementation of the new requirements. Updates to COMAR 10.09.71.04 as they relate to MCO reported preauthorization determination time frame results addressed in this report include the following:

- For standard authorization decisions, the MCO shall make a determination within 2 business days of receipt of necessary clinical information, but not later than 14 calendar days
- For expedited authorization decisions, the MCO shall make a determination and provide notice no later than 72 hours after receipt of the request for services
- For all covered outpatient drug authorization decisions, the MCO shall provide notice by telephone or other telecommunication device within 24 hours of a preauthorization request; and within 24 hours, by phone, for covered outpatient drug decisions.

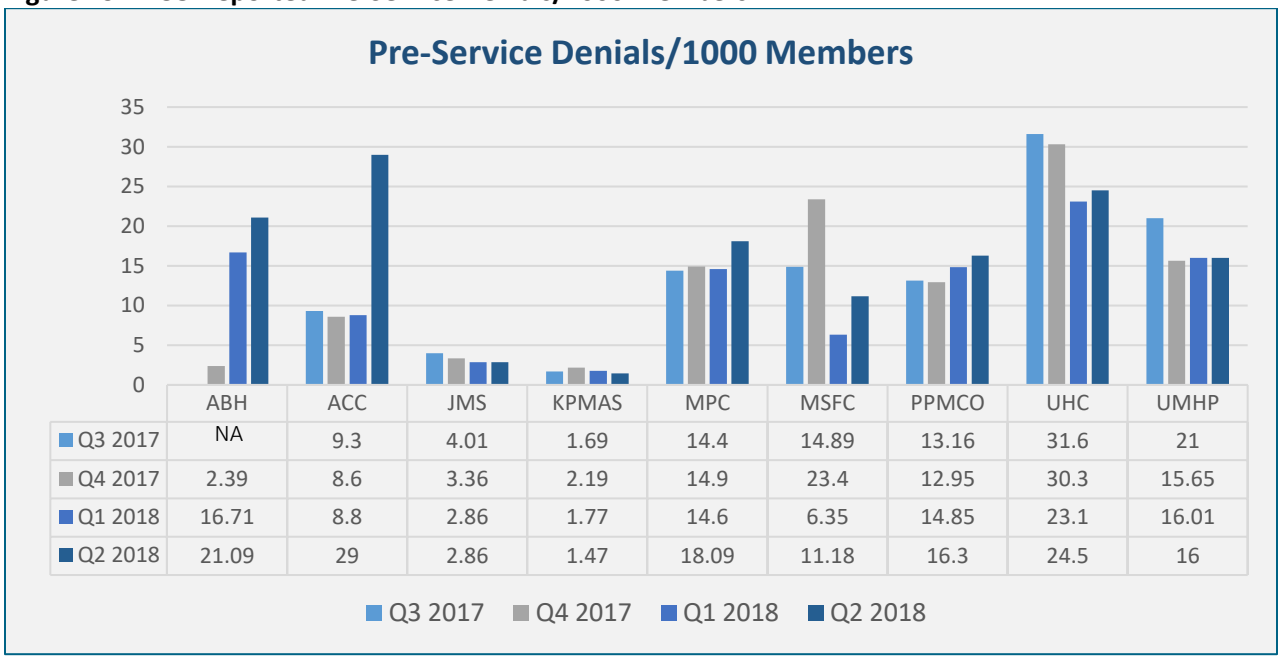
The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics: Pre-service Denials Rendered Per 1000 Members
  - Preauthorization Time Frames: Determinations provided within 2 business days of receipt of necessary clinical information but no later than 7 calendar days from date of initial request based on a compliance threshold of 95%
  - Notice of Decision to Deny Time Frames: Initial services provided to enrollee within 24 hours for emergency, medically related requests and not more than 72 hours for non-emergency, medically related requests based upon a compliance threshold of 95%
  - Notification Time Frames: For any previously authorized service written notice to enrollee is provided at least 10 days prior to reducing, suspending, or terminating a covered service based upon a compliance threshold of 95%.

- Adverse Determinations
  - Must be based upon medical necessity criteria and clinical policies.
  - Must be rendered by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Adverse Determination Letters: Must include all 16 required regulatory components.

Figure 19 provides a comparison of MCO reported pre-service denials per 1000 members based on MCO quarterly submissions.

Figure 19. MCO Reported Pre-Service Denials/1000 Members



	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017	NA	9.3	4.01	1.69	14.4	14.89	13.16	31.6	21
Q4 2017	2.39	8.6	3.36	2.19	14.9	23.4	12.95	30.3	15.65
Q1 2018	16.71	8.8	2.86	1.77	14.6	6.35	14.85	23.1	16.01
Q2 2018	21.09	29	2.86	1.47	18.09	11.18	16.3	24.5	16

NA – Not Applicable

Overall, pre-service denials have been trending upward for most MCOs. Primarily, pharmacy service requests appear to be driving the increase. MCO-specific trending and comparisons between MCOs, however, are not feasible at this time since delegate denials have not been submitted consistently by all MCOs throughout the review period. Limitations preventing MCO comparisons include:

- ACC omitted pharmacy denials until the second quarter of 2018.
- UHC included inpatient concurrent review denials in its count. It is currently working on the ability to submit denials from their dental vendor.
- MSFC changed its dental vendor, who initially reported denials by request rather than by tooth/procedure.

Despite these issues, the consistently low number of denials for JMS and KPMAS is believed to be related to their clinic-based plan models.

Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based upon self-report through MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Table 46 represents results of the MCO's reported compliance with pre-service determination time frames.

Table 46. MCO Reported Compliance with Pre-Service Determination Time Frames (Quarterly Reports)

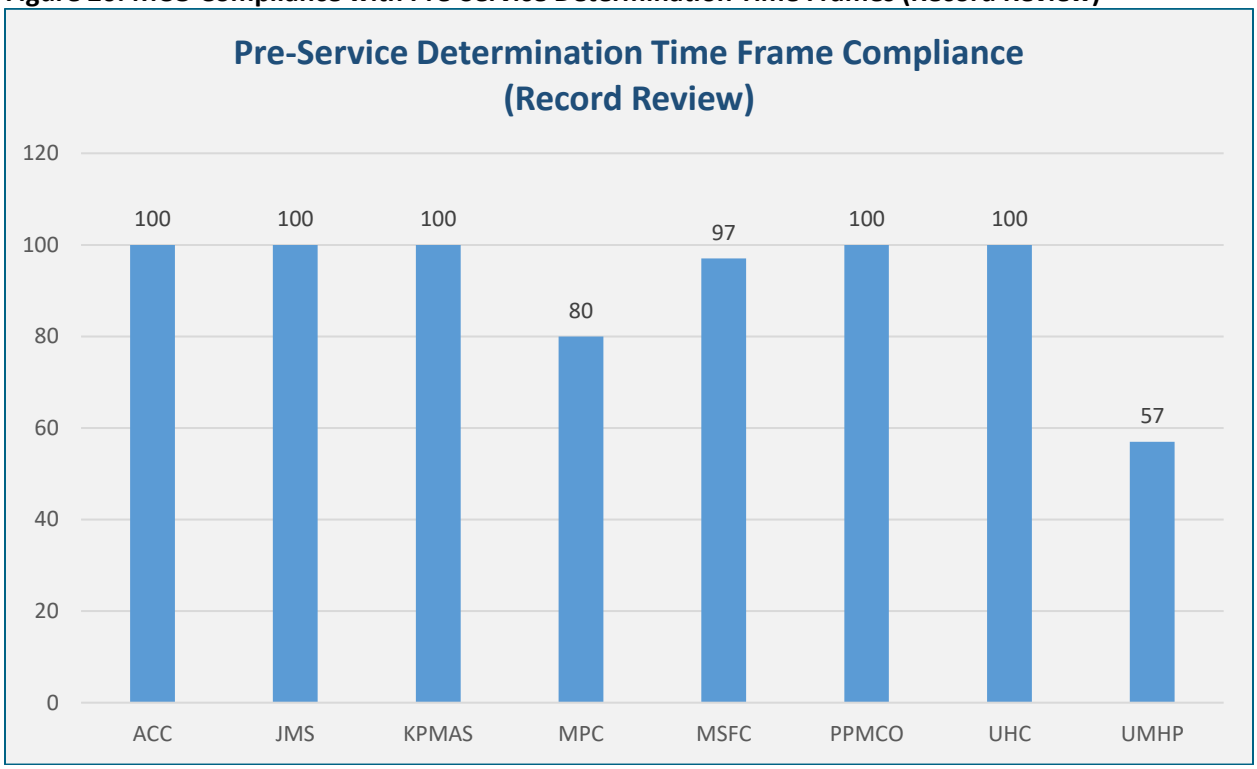
Report Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017 Emergency	N/A	N/A	100%	100%	73%	100%	92%	70%	95%
Q4 2017 Emergency	N/A	N/A	100%	88%	97%	100%	95%	64%	95%
Q1 2018 Emergency	100%	N/A	100%	83%	95%	84%	97%	100%	99%
Q2 2018 Emergency	100%	N/A	100%	100%	98%	96%	98%	98%	100%
Q3 2017 Non-Emergency	N/A	97%	99%	94%	85%	100%	99%	97%	99%
Q4 2017 Non-Emergency	100%	99%	100%	84%	91%	100%	90%	87%	99%
Q1 2018 Non-Emergency	100%	99%	100%	93%	96%	100%	42%	99%	99%
Q2 2018 Non-Emergency	100%	99%	96%	95%	95%	100%	98%	100%	100%

Four of the MCOs (ABH, ACC, JMS, and UMHP) met or exceeded the 95% threshold based upon a review of MCO quarterly reports. Overall compliance results ranged from 42% to 94% for the remaining five MCOs (KPMAS, MPC, MSFC, PPMCO, and UHC). ABH did not begin reporting until Q4 for which they did not have emergency requests. ACC did not have emergent requests for any of the quarters reviewed.

Effective February 1, 2018, MDH extended the time frame for non-emergency pre-service determinations from 7 to 14 calendar days and required the MCO to make a determination and provide notice no later than 72 hours after receipt of an expedited request for services to be consistent with federal regulations. While extension of the time frame for standard authorization requests did not have a noticeable impact on overall compliance in the first quarter of 2018, all MCOs exceeded the 95% compliance threshold for the second quarter. This is the best result for the four quarters. Not only does this change allow more time for the MCOs to obtain additional clinical information from the requesting provider but it also may have a positive impact on the volume of appeals. Frequently adverse determinations are overturned on appeal as a result of the provider submitting additional clinical information not provided with the initial pre-service request.

Record reviews were also conducted to assess compliance with COMAR requirement for timeliness of pre-service determinations. The record review was based upon the 10/30 rule. Results are highlighted in Figure 20.

Figure 20. MCO Compliance with Pre-Service Determination Time Frames (Record Review)



All but two of the MCOs (MPC and UMHP) met or exceeded the 95% threshold based upon the annual review of the MCO's records. MPC had a compliance rate of 80% while UMHP had a rate of 57%.

Compliance with COMAR requirements for the timeliness of adverse determination notifications was assessed based upon MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Record reviews were conducted based upon the 10/30 rule. Table 47 displays the number of records reviewed and the issues identified.

Table 47. MCO Adverse Determination Records Reviewed

MCO	Records Reviewed	Issues Identified
ACC	10	None
JMS	10	None
KPMAS	10	None
MPC	30	Turn Around Times & Letter Components
MSFC	30	Turn Around Times & Letter Components
PPMCO	30	Letter Compliance
UHC	30	Letter Compliance
UMHP	30	Turn Around Times & Letter Components

Results of MCO reported compliance with adverse determination notification time frames based on the quarterly reports are highlighted in Table 48.

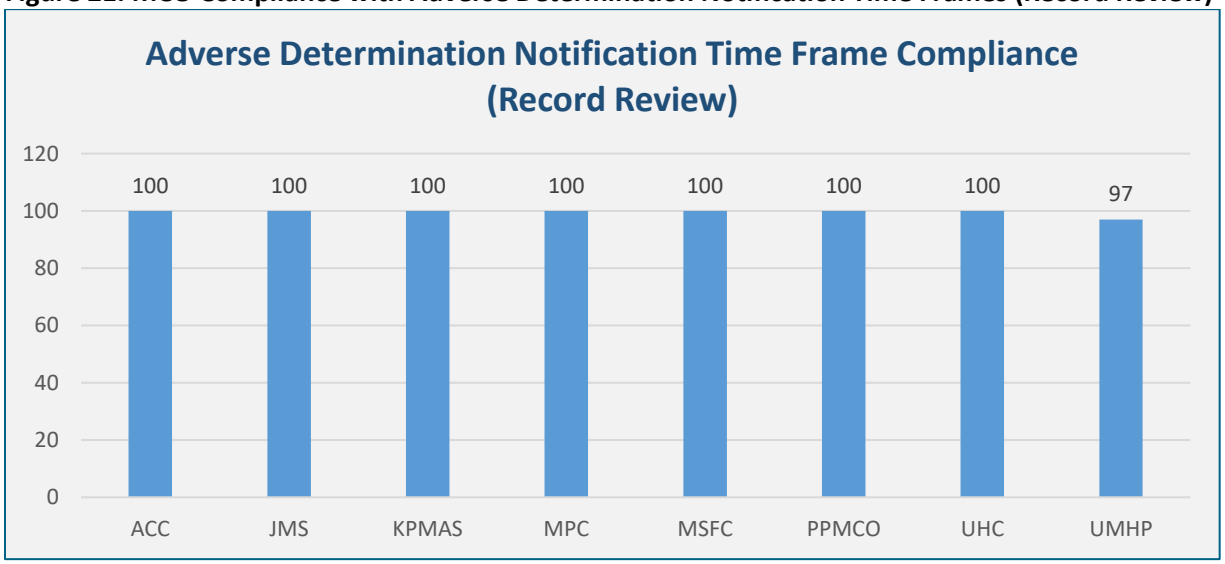
Table 48. MCO Reported Compliance with Adverse Determination Notification Time Frames (Quarterly Reports)

Report Quarter	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Q3 2017 Emergency	N/A	N/A	100%	100%	100%	100%	98%	98%	100%
Q4 2017 Emergency	N/A	N/A	100%	100%	99%	100%	95%	98%	99%
Q1 2018 Emergency	100%	N/A	100%	83%	100%	95%	96%	100%	100%
Q2 2018 Emergency	100%	N/A	100%	100%	100%	96%	98%	99%	100%
Q3 2017 Non-Emergency	N/A	99%	100%	100%	96%	100%	96%	98%	100%
Q4 2017 Non-Emergency	100%	96%	100%	100%	93%	100%	98%	88%	96%
Q1 2018 Non-Emergency	100%	99%	97%	99%	98%	100%	35%	100%	99%
Q2 2018 Non-Emergency	94%	99%	100%	99%	98%	98%	96%	100%	100%

Four of the MCOs (ACC, JMS, MSFC and UMHP) met or exceeded the 95% threshold based upon a review of MCO quarterly reports. Overall MCO reported compliance results ranged from 35% to 94% for the remaining five MCOs (ABH, KPMAS, MPC, PPMCO, and UHC). ABH did not begin reporting until Q4, for which they did not have emergency requests. ACC did not report any emergent requests for any of the quarters reviewed.

Results of compliance with adverse determination notification time frames based on the annual record review of CY 2017 records are highlighted in Figure 21.

Figure 21. MCO Compliance with Adverse Determination Notification Time Frames (Record Review)



All eight MCOs met or exceeded the 95% threshold based upon an annual review of the MCO's records. Seven of the eight demonstrated 100% compliance.

Table 49 provides a comparison of denial record review results across MCOs for CY 2017. Results are based upon a random selection of denial records. Reviews were conducted utilizing the 10/30 rule.

Table 49. Results of CY 2017 Denial Record Reviews

Requirement	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Appropriateness of Adverse Determinations	Met	Met	Met	Met	Met	Met	Met	Met
Compliance with Pre-Service Determination Time Frames	Met	Met	Met	PM	Met	Met	Met	PM
Compliance with Adverse Determination Notification Time Frames	Met	Met	Met	Met	Met	Met	Met	Met
Required Letter Components	Met	Met	Met	PM	Met	PM	PM	PM

PM-Partially Met

All MCOs demonstrated compliance with the appropriateness of adverse determinations supported by medical necessity criteria and MCO-specific clinical policies. All but two MCOs (MPC and UMHP) met or exceeded the pre-service determination time frame threshold of 95% and all MCOs were compliant with the adverse determination notification time frames. Only half of the MCOs included all 16 required components in member adverse determination letters. The most frequent missing component was the Notice of Nondiscrimination which became a requirement in the fourth quarter of 2016.

Recommendations

Overall, the MCOs demonstrated fairly strong and consistent results in meeting regulations relating to grievances, appeals, and pre-service denials. This may be attributed to comprehensive MCO oversight by MDH and its effective use of Qlarant as the contracted EQRO. Compliance with regulatory time frames continues to be the greatest challenge as evidenced by MCO results in the majority of categories. Corrective action plans (CAPs) through the Systems Performance Review process are in place to address MCOs that have had ongoing issues in demonstrating compliance. As necessary, MDH has also instituted a quarterly review to assess progress in CAP implementation and related performance measures.

As a result of opportunities identified following the 2017 focused review, MDH:

- Developed and implemented managed care model notices for denials, appeals, and grievances in February 2018.
- Released a written clarification of what constitutes a grievance as defined in COMAR which has resulted in MCOs improving classification of grievances and inquiries.
- Approved new System Performance Review standards for CY 2018 relating to the following:
  - Written notification of grievance determinations, even when a case is closed, because of inability to contact the member.

- Documentation of reasonable efforts to provide the member with prompt verbal notice of the denial of an expedited appeal resolution and evidence of a written notice within two calendar days.
- Evidence that appeal decisions are made by health care professionals who have appropriate clinical expertise in treating the member's condition or disease consistent with the MCO's policies and procedures.

The following recommendations are offered in response to new and/or continuing opportunities for improvement:

- In view of ongoing issues with the validity of the data reported by the MCOs, it is recommended that MDH consider pursuing appropriate action through its Performance Monitoring Policies, including the use of sanctions, if an MCO fails to demonstrate improvement. In the absence of valid data assessment of full compliance, identification of MCO-specific trends and comparisons of individual MCO results with MCO ranges is limited.
- For outpatient drug adverse determinations, require MCOs to report compliance with the 72-hour written notice requirement separately from the 72-hour time frame for standard authorization requests. This will ensure consistency in reporting delegated pharmacy denials among the MCOs and provide additional detail to better identify opportunities for improvement relating to medical and/or pharmacy compliance with written notification requirements.

MCO-Specific Summaries

The MCO-specific results from quarterly assessments and CY 2017 record reviews are highlighted in the following grievance, appeal, and pre-service denial summaries. Each MCO summary includes the following, as applicable:

- ✓ MCO-specific trends
- ✓ Comparison with Other MCOs
- ✓ Compliance
- ✓ Strengths
- ✓ Best Practices
- ✓ Opportunities
- ✓ Recommendations

Aetna Better Health of Maryland	
Trends	✓ Member and provider grievances per 1000 demonstrate an upward trend quarter over quarter reflecting the maturation process of this new MCO. No negative trends identified for grievances. ✓ Appeal results are fairly consistent over three quarters. No negative trends identified for appeals. ✓ Denials per 1000 members demonstrate an upward trend quarter over quarter, reflecting the maturation process of this new MCO. No negative trends identified for pre-service denials.

Aetna Better Health of Maryland	
Comparison to Other MCOs	✓ Results are generally consistent with all other MCOs taking into consideration the recent entry into the HealthChoice system.
Compliance	✓ Grievance resolution time frames were met for all three quarters. ✓ Appeal resolution time frames were consistently met for all three quarters. ✓ Pre-Service determination and notification time frames met or exceeded the 95% threshold for all three quarters with one exception. ✓ Compliance with the pre-service determination notification time frame for non-emergent denials fell to 94% in the second quarter.
Strengths	✓ 100% compliance with appeal resolution time frames for all three quarters.
Opportunities	✓ Continuing formula errors that calculate totals in the quarterly reporting forms in appeal reports.
Notes	✓ ABH commenced operations on October 23, 2017. ✓ Record review results for grievances, appeals, and pre-service denials are not included in view of the limited number available during CY 2017. ✓ Quarterly results need to be viewed with caution due to the small numbers.
Recommendations	✓ ABH must correct ongoing formula errors and improve its oversight of report accuracy.
AMERIGROUP Community Care	
Trends	✓ Grievance results are fairly consistent over four quarters. No negative trends identified. ✓ Appeal results are fairly consistent, although there has been a slight upward trend in the last three quarters. No negative trends identified. ✓ Pre-service Denial results are fairly consistent over four quarters. No negative trends identified.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs. ✓ Appeal results are generally consistent with all other MCOs; however, the appeal rate per 1000 members remains slightly below all other MCOs. ✓ Pre-service denial results are generally consistent with all other MCOs; however, it is the only MCO that has never reported any emergent denials.
Compliance	✓ Member Grievance resolution time frames were met for all four quarters. No provider grievances were received during the review time frame. ✓ Appeal resolution time frames were consistently met for all four quarters. MCO included provider administrative appeals in reports throughout the review period. ✓ Pre-service determination and notification time frames met or exceeded the 95% threshold for all four quarters. ACC only began including pharmacy denials in second quarter.

AMERIGROUP Community Care	
Strengths	✓ Grievances and their resolutions were well documented. Grievance resolutions were appropriate. Compliance with time frames was consistently met in all four quarters. ✓ 100% compliance with appeal resolution time frames for all four quarters.
Best Practices	✓ Resolution letters are in plain language and describe well the grievance and the resolution. ✓ Appeal resolution letters are written in plain language and for medical necessity appeals the title and specialization of the Medical Director/designee is included. ACC includes a Maryland Medicaid Appeal Form in all resolution letters when the first level appeal results in an uphold decision. ✓ Excellent use of plain language in all adverse determination letters. Availability of ACC case manager to help member explore other options, like services within their community that may be free or of little cost if services requested exceed benefit limits, included in all letters with contact number provided. Detailed attachment to all letters on ACC appeal process.
Opportunities	✓ Appropriate classification of grievances. ✓ Inappropriate inclusion of provider administrative appeals in quarterly reports. ✓ Adverse determination letters need to be updated to replace Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Ensure auditing process incorporates guidance from MDH relating to the definition of a grievance. ✓ Eliminate reporting of provider administrative appeals in quarterly appeal reports before a reliable analysis can be performed to compare to other MCOs. ✓ Update adverse determination letters to replace Enrollee Help Line with HealthChoice Help Line. MCO requested to investigate lack of reported emergent denials. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.
Jai Medical Systems, Inc.	
Trends	✓ Grievance results are fairly consistent over four quarters, however, there has been a slight uptick in member grievances per 1000 the last three quarters. All member grievances relate to access or attitude/service issues. ✓ Appeal results are fairly consistent over four quarters with a downward trend in appeals per 1000 members the last three quarters. No negative trends identified. ✓ Pre-service denial results are fairly consistent over four quarters. No negative trends identified.

Jai Medical Systems, Inc.	
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs. However, its compliance with the requirement for resolution letters was at the low end of the range. ✓ Appeal results are generally consistent with all other MCOs. ✓ Pre-service denial results are generally consistent with all other MCOs; however, the MCO is at the low end of the MCO range in denials per 1000 members.
Compliance	✓ Resolution time frames for member and provider grievances were met for all four quarters. ✓ Appeal resolution time frames were consistently met for all four quarters. ✓ Pre-service determination and notification time frames met or exceeded the 95% threshold for all four quarters.
Strengths	✓ Grievances are appropriately classified, fully described in case notes, and 100% compliant with resolution time frames. ✓ 100% compliance with appeal resolution time frames for all four quarters. ✓ Compliance is demonstrated in all areas for pre-service denials.
Best Practices	✓ All appeal resolution letters are in plain language and include the board certification and specialty of the physician who reviewed the appeal.
Opportunities	✓ Consistency in sending resolution or case closure letters to any member who filed a grievance and others, as appropriate. ✓ Complete and appropriate resolution of all grievances. ✓ Access and attitude/service grievances. ✓ Adverse determination letters need to be updated to replace Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Ensure policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members whom the MCO was unable to contact by phone and as a result closed the case. ✓ Consider implementing a process for auditing a sample of grievance records to ensure resolutions are appropriate and a resolution letter has been sent to any member who has filed a grievance. ✓ Consider conducting a root cause analysis of access and attitude/service related member grievances to identify opportunities for improvement. ✓ Update adverse determination letters to replace Enrollee Help Line with HealthChoice Help Line.

Kaiser Permanente of the Mid-Atlantic States, Inc.	
Trends	✓ Grievance results are fairly consistent over four quarters; however, member grievances relating to attitude/service have represented the highest number of grievances over the four quarters reviewed. ✓ Appeal results are fairly consistent over four quarters, however, there has been a downward trend in appeals per 1000 members the last three quarters after KPMAS discontinued including provider administrative appeals in error. No negative trends identified. ✓ Pre-service denial results are fairly consistent over three quarters. Reporting errors identified in the third and fourth quarters have been resolved. No negative trends identified.
Comparison with Other MCOs	✓ KPMAS has remained at the top of the range all four quarters for participant member grievances among the established MCOs. Additionally, resolution appropriateness was a major outlier based upon results of the annual record review as 6 of the 20 grievance records reviewed demonstrated incomplete or inappropriate resolutions. Case notes reflected an apology from the member but no evidence was provided that the MCO communicated what action it would take to resolve the grievance. Compliance with the requirement for resolution letters also was at the low end of the range. ✓ Appeal results are generally consistent with all other MCOs, except for resolution letter compliance. The majority of resolution letters reviewed were either incomplete, inaccurate, and/or did not provide a denial reason but rather only a code. ✓ Pre-service denial results are generally consistent with all other MCOs. Pre-service denials per 1000 members are below the range of the other MCOs, possibly due to the MCO's model.
Compliance	✓ Resolution time frames have not been met for member grievances for the four quarters reviewed. Compliance with the resolution time frame for provider grievances was met in the only quarter they were received. ✓ Compliance with the resolution time frame for non-emergency appeals was not met in three of the four quarters resulting in a Systems Performance Review CAP. ✓ KPMAS demonstrated compliance with pre-service denial determination time frames only in the second quarter. Compliance with notification time frames was met in all quarters except the first.
Strengths	✓ Grievances are well-documented.
Best Practices	✓ Well documented appeal records include detailed arguments on behalf of the members for the coverage.

Kaiser Permanente of the Mid-Atlantic States, Inc.	
Opportunities	✓ Consistency in sending resolution or case closure letters to any member who filed a grievance and others, as appropriate. Complete and appropriate resolution of all grievances. Consistent compliance with member resolution time frames. Attitude/service related grievances. ✓ Member appeal resolution letters need to be complete, accurate, and provide a clear explanation of the reason for the decision in easy to understand language. Continuing formula errors that calculate totals in the quarterly reporting forms occur. ✓ Pre-service denial adverse determination letters need to be updated to replace Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Ensure policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members whom the MCO was unable to contact by phone and as a result closed the case. Consider implementing a process for auditing a sample of grievance records to ensure resolutions are appropriate and a resolution letter has been sent to any member who has filed a grievance. ✓ Increase oversight to ensure that it consistently meets member grievance resolution time frames. Consider conducting a root cause analysis of service/attitude-related member grievances to identify opportunities for improvement. ✓ Develop a process for auditing appeal resolution letters before they are mailed and provide necessary staff training, as indicated, to ensure that letters are complete, accurate, and written in plain language. KPMAS must correct ongoing formula errors and improve its oversight of report accuracy. ✓ Increase oversight of medical necessity review process to ensure compliance with pre-service denial determination time frames. Update adverse determination letters to replace Enrollee Help Line with HealthChoice Help Line. Will continue to monitor performance individually and against MCO ranges to assess potential opportunities for improvement.
Maryland Physicians Care	
Trends	✓ Grievance results are fairly consistent over four quarters, although there has been a slight downward trend in grievances received quarter over quarter. Access-related issues represent the majority of grievances over the four quarters under review. ✓ Appeal results are fairly consistent; however, there has been a slight upward trend in appeals per 1000 members quarter over quarter. ✓ Pre-service denial results are fairly consistent over four quarters; however, there was a slight uptick in denials per 1000 members reported for the second quarter. No negative trends were identified.

Maryland Physicians Care	
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs with one major exception. MPC demonstrated no evidence of compliance with the requirement for resolution letters. ✓ Appeal results are generally consistent with all other MCOs. ✓ Pre-service denial results are generally consistent with all other MCOs. Based upon the annual record review, MPC is at the low end of the range for required letter components.
Compliance	✓ Resolution time frames consistently met for member and provider grievances. ✓ Appeal resolution time frames were consistently met for all four quarters. ✓ Pre-service denial determination and notification time frames met or exceeded the 95% threshold for the first and second quarters of 2018. Notifications demonstrated compliance in the third quarter.
Strengths	✓ Grievances and their resolutions are well documented and resolutions are appropriate. 100% compliance with resolution time frames. ✓ 100% compliance with appeal resolution time frames for all four quarters.
Opportunities	✓ Compliance with requirement for sending a resolution letter to any member who has filed a grievance. ✓ Access related member grievances. ✓ Continuing formula errors that calculate totals in the quarterly reporting forms occur. ✓ Compliance with all 16 required letter components for pre-service denials. ✓ Consistent use of HealthChoice Help Line, which has replaced the Enrollee Help Line, in all letters. ✓ Consistent compliance with pre-service denial determination time frames.
Recommendations	✓ Ensure its policies and procedures document the COMAR requirement for sending resolution letters to any member who filed a grievance and others, as appropriate. This includes members whom the MCO was unable to contact by phone and as a result closed the case. ✓ Consider implementing a process for auditing a sample of grievance records to ensure a resolution letter has been sent to any member who has filed a grievance. ✓ Consider conducting a root cause analysis of access-related member grievances to identify opportunities for improvement. ✓ Correct ongoing formula errors and improve its oversight of report accuracy. ✓ Implement or review audit process to ensure all adverse determination letters include all required components and updated language. ✓ Increase oversight of medical necessity review process to ensure continued compliance with determination time frames.

MedStar Family Choice, Inc.	
Trends	✓ Grievance results are fairly consistent over four quarters, however, member grievances per 1000 have been trending upward over the last three quarters. ✓ Appeal results are fairly consistent over four quarters. No negative trends were identified. ✓ Pre-service denial results are fairly consistent over four quarters; however, the total pre-service denials per 1000 members demonstrates considerable fluctuations due to an MCO reported transcription error in the fourth quarter and the new dental vendor reporting denials per request rather than by tooth/procedure in the first quarter.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs with two exceptions. It is a major outlier for resolution timeliness and is at the low end of the range for demonstrating compliance with the requirement for a resolution letter. ✓ Appeal results are generally consistent with all other MCOs. ✓ Pre-service denial results are generally consistent with all other MCOs.
Compliance	✓ Compliance with resolution time frames for member non-emergency medically-related grievances has not been met for the third and fourth quarters and for the first three quarters for administrative grievances. The resolution time frame has been met for the only two provider grievances received during the four quarters under review. ✓ Appeal resolution time frames were met in two of the four quarters. MCO acknowledged that it had not been including provider submitted appeals on behalf of members until the second quarter. ✓ Pre-service denial determination and notification time frames met or exceeded the 95% threshold in all but the first quarter when the emergent determination time frame was not met.
Strengths	✓ Grievances and their resolutions are well-documented. Resolutions are appropriate. Three attempts are made to contact a member who filed a grievance before the case is closed.
Best Practices	✓ All resolution letters are in plain language and include the board certification and specialty of the physician who reviewed the appeal.
Opportunities	✓ Consistent mailing of resolution letters to any member who filed a grievance and others, as appropriate. Consistent compliance with resolution time frames for member grievances. Documentation of correct date of grievance receipt. ✓ Compliance with appeal resolution time frames. Improved oversight of appeal reporting.

Priority Partners	
Trends	✓ Grievance results are fairly consistent over four quarters with the exception of a downward trend in member grievances quarter over quarter. No negative trends identified. ✓ Appeal results are fairly consistent over four quarters, although appeals per 1000 members has trended downward over the last three quarters. Compliance with resolution time frames has been trending downward the last two quarters. ✓ Pre-service denial results are fairly consistent over four quarters. Pre-service denials per 1000 members have been trending up the last three quarters although still within the range of the other MCOs. Additionally, the percentage of emergent denials has increased considerably in the first two quarters of 2018.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs with member grievances at the low end of the range. ✓ Appeal results are generally consistent with all other MCOs, although its appeals per 1000 members are at the low end of the range. ✓ Pre-service denial results are generally consistent with all other MCOs, although it is well above all the other MCOs in its percentage of emergent denials. Based upon the annual record review, PPMCO is at the low end of the range for required letter components.
Compliance	✓ Compliance with resolution time frames for member grievances was not fully met in the first two quarters of 2018. All provider grievances met the resolution time frames. ✓ Full compliance with resolution time frames has been demonstrated only in the fourth quarter 2017. MCO acknowledged it has been including provider administrative appeals in reports throughout the review period. ✓ Consistent compliance with the 95% threshold was only demonstrated in the second quarter of 2018 for both emergent and non-emergent denials. Compliance with notification time frames has been met in three of the four quarters for both emergent and non-emergent denials.
Strengths	✓ Grievances and their resolution are well documented and resolutions are appropriate.
Best Practices	✓ Resolution letters are in plain language and provided in both English and Spanish. ✓ Appeal resolution letters are in plain language with a detailed explanation as to the reason for the decision for both upheld and overturned determinations, the criteria used, the documentation considered in reviewing the case, and the qualifications of the physician who made the determination.

Priority Partners	
Opportunities	✓ Consistent compliance with resolution time frames for member grievances. ✓ Consistent compliance with appeal resolution time frames. Resolution time frame identified in appeal acknowledgment letters. Inappropriate inclusion of provider administrative appeals in quarterly reports. ✓ Consistent compliance with pre-service denial determination and notification time frames. Compliance with all 16 required letter components and consistent replacement of Enrollee Help Line with HealthChoice Help Line.
Recommendations	✓ Increase MCO oversight to ensure that member grievance resolution time frames are consistently met. ✓ A quarterly Systems Performance Review CAP is currently in place to address non-compliance with appeal resolution time frames. Revise appeal acknowledgment letters to identify resolution time frames applicable to the specific appeal. MCO must eliminate reporting of provider administrative appeals in quarterly appeal reports. ✓ A Systems Performance Review CAP is currently in place to address non-compliance with pre-service denial determination and notification time frames. Implement or review audit process to ensure all adverse determination letters include all required components and updated language.
UnitedHealthcare Community Plan	
Trends	✓ Grievance results are fairly consistent over four quarters. ✓ Appeal results are fairly consistent over the last three quarters, having stabilized after a fairly large decrease in the appeals per 1000 members rate in third quarter. No negative trends were identified. ✓ Pre-service denial results are fairly consistent over four quarters with one exception. Emergent denials decreased considerably in the second quarter of 2018 after the MCO discovered that it was including inpatient concurrent review denials in its count. No negative trends identified.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs with member and provider grievances per 1000 at the low end of the MCO range. ✓ Appeal results are generally consistent with all other MCOs; however, expedited requests remain above the high end of the MCO range. ✓ Pre-service denial results are generally consistent with all other MCOs; however, emergent requests have been at the top of the range of other MCOs based upon the error identified above. Based upon the annual record review, UHC is at the low end of the range for required letter components.

UnitedHealthcare Community Plan	
Compliance	✓ Compliance with resolution time frames for member grievances was met in two of four quarters. Two quarters fell slightly below the 100% threshold for administrative grievances at 98% and 99%. Compliance with the resolution time frame for provider grievances was met in the one applicable quarter. ✓ Appeal resolution time frames were not met consistently for three of the four quarters. ✓ Consistent compliance with pre-service denial determination and notification time frames has been demonstrated for the first and second quarters of 2018. UHC has not been including denials from its dental vendor in its count.
Strengths	✓ Grievances and their resolution are well documented and resolutions are appropriate.
Best Practices	✓ Resolution letters are in plain language and are very detailed in describing the grievance and the resolution. UHC also provides a written acknowledgement of each grievance, only one of two MCOs to do so. ✓ All appeal resolution letters are in plain language and include the board certification and specialty of the reviewer.
Opportunities	✓ Consistent compliance with the resolution time frame for member administrative grievances. ✓ Consistent compliance with appeal resolution time frames. ✓ Consistent compliance with pre-service denial determination and notification time frames. Compliance with all 16 required letter components and consistent replacement of Enrollee Help Line with HealthChoice Help Line. Inclusion of dental vendor denials in its count.
Recommendations	✓ Increase oversight of compliance with the resolution time frame for member administrative grievances. ✓ Improve oversight of appeal resolution time frames to ensure compliance with time frames is consistently met. ✓ Implement or review audit process to ensure all adverse determination letters include all required components and updated language. Include denials from dental vendor in its count. Increase oversight of medical necessity review process to ensure continued compliance with time frames.

University of Maryland Health Partners	
Trends	✓ Member grievances have been trending upward the past three quarters. Grievances relating to attitude/service issues, in particular, have been trending up the last four quarters and now represent 60% of all grievances. Provider grievances have demonstrated a downward trend quarter over quarter. ✓ Appeal results are fairly consistent over four quarters, although there has been a slight downward trend in appeals per 1000 members the last three quarters. This decrease possibly is the result of UMHP changing its appeal per 1000 members rate calculation to be consistent with the other MCOs. No negative trends identified. ✓ Pre-service denial results are fairly consistent over four quarters. Denials per 1000 members has remained relatively stable after UMHP implemented a correction to its formula for calculating the measure prior to the fourth quarter report.
Comparison with Other MCOs	✓ Grievance results are generally consistent with all other MCOs. ✓ Appeal results are generally consistent with all other MCOs with one major outlier. Appeals per 1000 members remain above the top of the MCO range. ✓ Pre-service denial results are generally consistent with all other MCOs; however, it is outside of the range of other MCOs for required letter components based upon the annual record review.
Compliance	✓ Compliance with grievance resolution time frames was met for three of the four quarters. The time frame was not met for member grievances in the fourth quarter. ✓ Appeal resolution time frames were consistently met for all four quarters. ✓ Compliance with pre-service denial determination and notification time frames are met consistently for both non-emergent and emergent denials.
Strengths	✓ Grievances and their resolution are well documented and resolutions are appropriate. ✓ 100% compliance with appeal resolution time frames for all four quarters.
Best Practices	✓ All members submitting a grievance receive both an acknowledgement letter describing the grievance and the time frame for resolution and a resolution letter. All letters are written in plain language. ✓ All denials upheld on appeal include a comprehensive three-page document, Appeal Rights Description, with the appeal resolution letter. All letters are in plain language.
Opportunities	✓ Quality of grievance resolution letters. Attitude/service related grievances. ✓ Specialty of appeal reviewer not included in all resolution letters. ✓ Compliance with all 16 required letter components and consistent replacement of Enrollee Help Line with HealthChoice Help Line.

University of Maryland Health Partners	
Recommendations	✓ Consider routinely auditing a sample of grievance resolution letters to ensure use of proper grammar and complete sentences. Consider conducting a root cause analysis of service/attitude related member grievances to identify opportunities for improvement. ✓ Consider including the specialty of the physician reviewer in all clinical appeal resolution letters. ✓ Implement or review audit process to ensure all adverse determination letters include all required components and updated language.

Conclusions

This second year report includes studies of MCO grievance, appeal, and denial quarterly reports from the third quarter of 2017 through the second quarter of 2018. Additionally, a sample of grievance, appeal, and denial records were reviewed for CY 2017. Based upon the outcomes of these studies, supplemented by the annual record reviews, most MCOs demonstrated strong and consistent results in meeting the majority of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice members is timely and accessible. Below are strengths identified in specific review components where all, or a majority, of the MCOs were in compliance:

- Appropriately classified and resolved grievances
- Fully documented grievance issues
- Processed appeals based upon level of urgency
- Documented appeal decisions well and resolved appeals timely
- Made appeal decisions by health care professional with appropriate expertise
- Made appeal decisions available to the enrollee in easy to understand language
- Appropriately provided adverse determinations

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

- Member grievance resolution time frames
- Grievance resolution letters
- Pre-service determination time frames
- Adverse determination notification time frames
- Required components in adverse determination letters

As noted in the Limitations section, the validity of the data submitted by the MCOs continues to be a challenge after two years, despite detailed instructions and ongoing technical assistance. Consequently, assessment results documented in this report need to be considered with some caution. Subsequent reporting will yield a greater level of confidence in the review outcomes for annual reporting.

Section VIII
Network Adequacy Validation

Introduction

Maryland's HealthChoice Program (HealthChoice) is a statewide mandatory managed care program that provides health care to most Medicaid participants. Eligible Medicaid participants enroll in the Managed Care Organization (MCO) of their choice and select a primary care provider (PCP) to oversee their medical care. The HealthChoice Program is based upon a comprehensive system of continuous quality improvement that includes problem identification, analysis, corrective action, and ongoing evaluation. The objective of quality improvement efforts is to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding care received by HealthChoice enrollees.

HealthChoice's philosophy is to provide quality health care that is coordinated, accessible, cost effective, patient focused, and prevention oriented. The program's foundation hinges on providing a "medical home" for each enrollee by connecting each enrollee with a PCP responsible for providing preventive and primary care services, managing referrals, and coordinating all necessary care for the enrollee. HealthChoice emphasizes health promotion and disease prevention, and requires that enrollees be provided health education and outreach services.

The Maryland Department of Health (MDH) engages in a broad range of activities to monitor network adequacy and access. These areas have been subject to greater oversight since the Centers for Medicare and Medicaid Services (CMS) issued the Final Rule CMS-2390-F, the first major overhaul to Medicaid managed care regulations in more than a decade. The Final Rule requires states to adopt time and distance standards for certain network provider types during contract periods beginning on or after July 1, 2018. States must also publicize provider directories and network adequacy standards for each MCO.

As the contracted External Quality Review Organization (EQRO) for the HealthChoice Program, Qlarant annually evaluates the quality assurance program and activities of each managed care organization (MCO). To ensure MCOs have the ability to provide enrollees with timely access to a sufficient number of in-network providers, and members have access to needed care within a reasonable time frame, Qlarant evaluated the network adequacy of the HealthChoice Program MCOs.

Qlarant completed primary care provider (PCP) surveys in calendar year (CY) 2018 to assess the accuracy of MCOs' online provider directories as a first step of the network adequacy evaluation. Surveys evaluated all nine HealthChoice MCOs active between **January 1, 2018 and December 31, 2018:**

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

Background

Hilltop Network Adequacy Assessments (2015 – 2017)

MDH contracted with the Hilltop Institute, University of Baltimore County (Hilltop) to assess network adequacy for MCOs in two phases.

Phase 1. In October – December 2015, Hilltop completed Phase 1, a pilot test of a new network adequacy validation (NAV) survey instrument that tested the validity of its capability to assess HealthChoice network adequacy. The target population included HealthChoice PCPs defined as primary care, adult medicine, internal medicine, general practice, family medicine, or pediatric specialty types. The list also included nurse practitioners and physician assistants who worked with one of these primary care specialty types.

Using examples from the literature, Hilltop's methodology included a partial secret shopper survey that masked surveyors' identity and affiliation with the surveying institution. In Phase 1, Hilltop identified a sample size of 259 with surveyors completing 127 successful calls for a response rate of 62.9%. Reported reasons for not reaching a provider in the first phase included the provider not practicing at the practice location listed in the online directory, incorrect telephone numbers, inability to complete the survey, and refusal to participate.

Phase 2. Hilltop completed Phase 2, another pilot test of the NAV survey instrument, from January 24, 2017 through February 24, 2017. MDH had revised the Code of Maryland Regulations (COMAR) requirements in 2016 to require online directory fields to state whether the provider's panel was open to specific age groups. The survey instrument was streamlined for an automated information recording, which limited time between call transactions. Increased training and monitoring of survey calls were added to ensure protocol adherence.

Sampling the PCP population was problematic as Hilltop found data available on the MCO's online provider directories to be unreliable when they generated the pool of eligible PCPs. From a total of 24,394 providers statewide, Hilltop determined there were 4,095 unique PCP locations. Surveyors completed 1,029 calls to 1,041 PCP offices. They reported a successful call rate of 34.7% (361) with more completed on the first attempt. Hilltop findings from Phase 2 revealed more issues with the address accuracy and telephone number comparable to Phase 1.

Qlarant Network Adequacy Assessments

Beginning in CY 2017, MDH transitioned the survey administration from Hilltop to its EQRO, Qlarant. Surveys were conducted in June and July 2017 to validate the MCO's online provider directories and assess compliance with State access and availability requirements. Qlarant adopted a methodology similar to Hilltop and conducted calls to a statistically significant sample of PCPs within each MCO.

Surveys were conducted to a total of 1,319 PCPs with successful contact made to 870 PCPs, yielding a response rate of 66%. This was an increase of 53% over Hilltop's Phase 2 response rate of 35%. In CY 2017, Qlarant's surveyors verified:

- Accuracy of online provider directories, including telephone number and address
- Whether the provider accepts the MCO listed in the provider directory

- Whether the provider practice accepts new patients
- What age range the provider serves
- The first available routine appointment
- The first available urgent care appointment

Results of the CY 2017 surveys demonstrated the following:

- Correctness of the provider telephone number and/or address continued to be an area of weakness across HealthChoice MCOs.
- The majority of PCPs surveyed (94%) stated that they accepted the MCO listed in the provider directory.
- The majority of PCPs surveyed (87%) stated that they accepted new patients. This was an increase from the Phase 2 results at 71.7%.
- Similar to Phase 2, 76% of PCPs surveyed accepted all ages versus specific ages.
- The majority of PCPs surveyed (89%) were compliant with the first available routine appointment requirement.
- An opportunity for improvement was noted regarding compliance with the first available urgent care appointment requirement in which results for PCPs surveyed were 67%.

Beginning with the Qlarant Network Adequacy Assessment in CY 2017, MDH set an 80% minimum compliance score for the network adequacy assessment. MCOs that did not meet the minimum compliance score in the areas of provider directory accuracy or compliance with routine and urgent care appointment time frames were required to submit corrective action plans (CAPs) to Qlarant. Following the CY 2017 activities, CAPs were submitted by all MCOs and approved by Qlarant.

CY 2018 Network Adequacy Validation Activities

MDH has set the following goals for the CY 2018 Network Adequacy Validation Activities:

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

Table 50 defines the State's directory requirements and access and availability requirements outlined in COMAR.

Table 50. Provider Directory and Access and Availability Requirements

COMAR	Standard
Accuracy of Provider Directory *COMAR 10.09.66.02C(1)(d)*	MCOs shall maintain a provider directory listing individual practitioners who are the MCO's primary and specialty care providers, additionally indicating the PCP name, address, practice location(s), telephone number(s), website URL as appropriate, group affiliation, cultural and linguistic capabilities, whether the provider has completed cultural competence training, practice accommodations for physical disabilities, whether the provider is accepting new patients, age range of patients accepted or no age limit.

COMAR	Standard
30-Day Non-Urgent Care Appointment *COMAR 10.09.66.07A(3)(b)(iv)*	Requests for routine and preventative primary care appointments shall be scheduled to be performed within 30 days of the request
48-Hour Urgent Care Appointment *COMAR 10.09.66.07A(3)(b)(iii)*	Individuals requesting urgent care shall be scheduled to be seen within 48 hours of the request

Several process improvements were implemented in response to CY 2017 report recommendations and comments from stakeholders after the conclusion of the survey process. Table 51 notes the CY 2017 recommendation and the CY 2018 process improvement implemented.

Table 51. CY 2018 Process Improvements Implemented

CY 2017 Recommendation	CY 2018 Process Improvement
Survey Tool and Data Sample Improvements	
Improve survey tool to 1) capture options for respondents who were unable to or refused to answer survey questions and 2) add dropdown boxes to provide surveyors more options and limit free text options.	The survey tool was improved adding the noted items. These changes allowed for more uniform data collection and comparisons.
Explore how to survey those MCOs with clinic-based staffing models so that a statistically significant sample of providers at unique provider locations can be surveyed and comparisons can be made across all HealthChoice MCOs.	Each MCO provided a listing of contracted PCPs. The total of PCPs contracted determined the statistically significant sample drawn for each MCO. After the sample was drawn, the lists were merged and PCPs were unduplicated so that no PCP was surveyed at the same location.
Explore with MDH expanding the surveys beyond PCPs to include assessment of compliance with access standards for obstetric, pediatric, and specialist providers.	MDH made the decision to limit the scope of the review to PCPs including providers specializing in primary care, adult medicine, internal medicine, general practice, family medicine, or pediatrics.
MCO-Specific Improvements	
Submit complete provider directory in comma separated value (CSV) format to ensure timely sampling and uploading to survey tool.	MCOs provided a listing of contracted PCPs a month prior to the survey in an excel format. Listings included all PCP information.
MDH-Specific Improvements	
Develop and enforce regulations requiring the MCOs to provide current provider directories in comma separated value (CSV) format.	MDH required the MCOs to submit the MCO information to Qlarant.

In addition to the above process improvements, Qlarant implemented the following activities as a result of our continual quality improvement process:

- Offered alternatives for meeting the urgent care appointment time frame in response to MCO comments. For example, if the PCP was unable to see the patient within a 48-hour time frame and another PCP in the practice was able to see the patient within 48 hours, this was found to be compliant with the requirement.
- Divided the survey into two parts, a telephone survey and directory validation survey. This reduced the time on the phone with PCP offices.
- Requested and received from the MCOs a URL/link to the online provider directories in order to complete the validation portion of the survey.

Survey Methodology

Surveyor Training and Quality Assurance

Qlarant's subcontractor, Cambridge Federal, conducted the telephonic surveys to each PCP office. Four of the six surveyors returned from CY 2017 survey activities, providing consistency in survey administration. Orientation and training were enhanced for the subcontractor in CY 2018 to include an in-depth instruction on the revised survey tool and guidance of its use; mock scenarios of survey calls and data entry; post-test/inter-rater reliability; and follow-up education. Qlarant performed weekly status reports with the Cambridge Federal Lead Surveyor including review of weekly call completion and quality assurance activities, surveyor assignments, and correction of data collection issues, as applicable.

Data Sources

Qlarant requested and received from each MCO a listing of contracted primary care providers (PCPs). The PCPs were defined as providers specializing in primary care, adult medicine, internal medicine, general practice, family medicine, or pediatrics. The MCOs were provided an Excel spreadsheet template to submit information on each PCP, including:

- Last and First Name
- Credentials
- Provider Type (MCO confirmed PCP status)
- Provider Specialty
- Practice Location (Address, Suite, City, Town, State, Zip)
- Telephone Number

Qlarant assessed the MCO's PCP listings for completeness. Issues were identified regarding incomplete data, non-PCPs included in the listings, and incorrect telephone numbers. MCOs were requested to make the appropriate corrections and resubmit the PCP listings. Additionally, MCOs were requested to validate the list of PCPs contracted in contiguous states (PA, WV, VA, DE and DC) to ensure that PCPs met the distance standards noted in COMAR 10.09.64. If the PCP met these requirements, they could be included in the listing. Included in the listings were 156 PCPs from the following contiguous states: DC – 145; Delaware – 8; Virginia – 3.

Qlarant requested additional information from the MCOs regarding how members access the MCO online provider directory. MCOs provided a URL link to the directory. The MCOs were given the

individual PCP information components that would be included in the validation activity, to which many MCOs submitted detailed descriptions of how this information was displayed and located.

Sampling

A total of 17,934 contracted PCPs were submitted by the 9 MCOs. The survey sample selected for each MCO was determined using the number of PCPs submitted by each MCO. A statistically significant sample size based on a 90% confidence level (CL) and 5% error rate was determined based on each MCOs total number of contracted PCPs. Table 52 shows the total number of PCPs submitted by each MCO including the statistically significant sample size using the 90% confidence level.

Table 52. CY 2018 MCO Contracted PCPs and Sample Size

MCO	Number of Contracted PCPs	Sample Size 90% CL with 5% Error
ABH	953	210
ACC	2,738	245
JMS	489	174
KPMAS	430	167
MPC	1,616	231
MSFC	2,451	243
PPMCO	5,060	256
UHC	2,509	244
UMHP	1,688	233
TOTAL	**17,934**	**2003**

Qlarant randomly selected the sample from each MCO's PCP listing and merged all MCO sample PCPs in an Excel spreadsheet. If a PCP was repeated at the same address on the spreadsheet, it was replaced with a different PCP on the spreadsheet. The purpose of replacing duplicate PCPs was to increase the number of unique PCPs in the sample for each MCO.

Survey Validation Tool

After validating the list of un-duplicated PCPs, Qlarant loaded the list into the electronic survey instrument.

To minimize provider burden, the CY 2018 surveys were separated into two parts, a telephone survey and a validation survey, as depicted in Figure 22.

Figure 22. CY 2018 Surveys

The telephone survey solicited responses to verify PCP information, including:

- The name and address of the PCP
- Whether the PCP accepts the listed MCO and new Medicaid patients
- Routine and urgent care appointment availability

Qlarant added the validation survey to verify the following information using the MCOs' online directory:

- Ages served by the PCP
- Languages spoken by the PCP
- Cultural competency training of the PCP
- Whether the practice had accommodations for disabled patients

Data Collection

Surveyors made at least three call attempts. If the first call attempt resulted in no contact with a live respondent, surveyors attempted to call again on another day and time. They made up to three attempts for each call unless they reached a wrong number or the office was permanently closed. Surveyors confirmed wrong PCP telephone numbers by calling the telephone number twice. If the call resulted in a wrong number or the office was permanently closed, the survey ended. Surveyors ended the call on the third attempt if they were prompted to leave a message, were on hold for more than 5 minutes, or had no answer. Other reasons for a surveyor ending the call were:

- Respondent refused to participate
- Listed provider was not a practicing PCP
- PCP listed was not with the practice or did not practice at that location
- PCP listed was not with the identified MCO

Surveys were considered successful if the surveyor was able to reach the listed PCP and complete the survey. Successful telephone surveys with completed data entries were then validated against the details noted in the MCO's online directory. However, if the PCP was not found in the online provider directory, the validation survey ended.

Surveys were conducted during normal business hours from 9:00 am – 5:00 pm, except for the hours from 12:00 pm – 1:00 pm, which was consistent with the CY 2017 approach. The responses to the survey questions were documented in the survey tool and stored electronically on Qlarant's secure web-based portal.

HealthChoice Results

This section details the results of the telephonic and validation surveys in the following categories:

- Successful Contacts
- Unsuccessful Contacts
- Accuracy of PCP Information
  - PCP Information
  - PCP Affiliation & Open Access

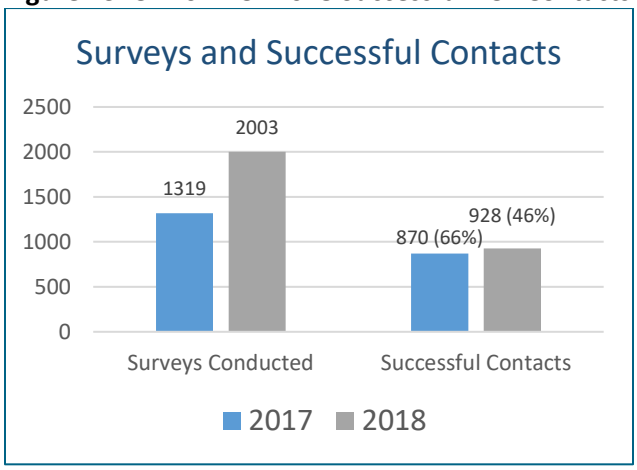
- Validation of MCO Online Provider Directories
- Compliance with Routine Appointment Requirements
- Compliance with Urgent Care Appointment Requirements

Successful Contacts

Surveys were conducted to a statistically significant sample of 2,003 PCPs in June and July 2018. A contact was considered successful if the surveyor reached the PCP and completed the telephonic survey.

Figure 23 illustrates the total number of calls attempted and successful contacts for CY 2017 and CY 2018.

Figure 23. CY 2017-CY 2018 Successful PCP Contacts

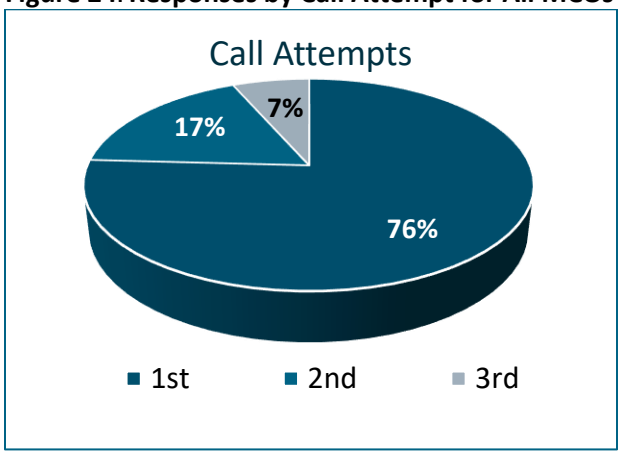


Successful PCP Contacts

- PCP surveys conducted substantially increased by 52% (684) in CY 2018 over CY 2017.
- Successful PCP contacts substantially decreased from 66% in CY 2017 to 46% in CY 2018.

Figure 24 illustrates the total percentages of successful PCP contacts by call attempt for all MCOs.

Figure 24. Responses by Call Attempt for All MCOs



Successful Call Attempts

- Attempts were made to contact 2,003 PCPs in CY 2018.
- Successful surveys were completed to 928 PCPs, yielding a response rate of 46%.
- The majority of the surveys (704/76%) were completed on the first contact.

Of the 2,003 PCP surveys attempted in CY 2018, there were 928 successful PCP surveys completed, thus yielding a response rate of 46%. The low percentage of successful PCP contacts can be an indication of a significant network issue considering members would be unable to reach over 50% of the PCPs identified by the MCOs. The majority of successful surveys (704 - 76%) were completed upon the first

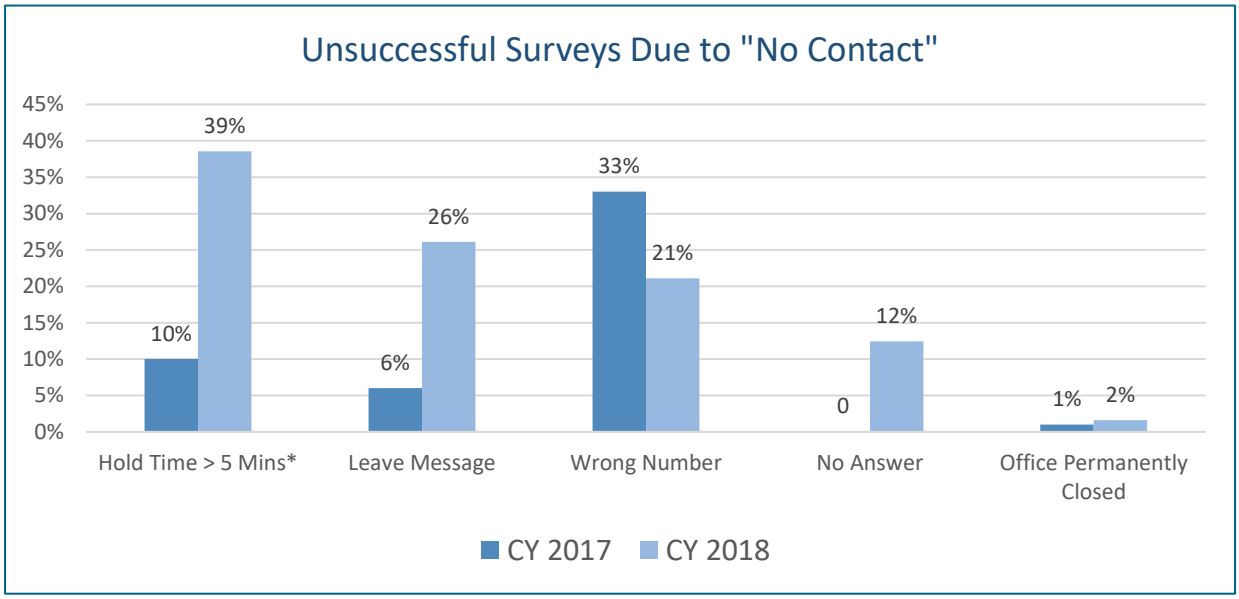
contact to the PCP. The remaining 24% were completed on the 2nd and 3rd attempts. Results demonstrate that the response rate was significantly lower than the CY 2017 rate of 66%.

Unsuccessful Contacts

From the 2,003 PCP surveys attempted in CY 2018, a total of 1,057 PCP surveys were unsuccessful. The reasons for unsuccessful surveys were divided into two categories, "No Contact" or "PCP Response". Unsuccessful surveys categorized as "No Contact" were calls in which the surveyor was unable to reach the PCP, such as a "wrong number" or "no answer". Unsuccessful surveys categorized as "PCP Response" were calls that ended after initial contact with a live respondent. In these circumstances, the respondent may have refused to participate or noted that the provider was not a PCP.

A total of 498 (46%) telephonic surveys were unsuccessful due to "No Contact". Reasons for unsuccessful contact with the PCP along with process descriptions are noted in Figure 25:

Figure 25. Unsuccessful Surveys Due to No Contact



If surveyors waited on hold for more than five minutes, the call was ended. Surveyors attempted to call back twice on various days and times to complete the survey. However, after the third contact, the survey was deemed unsuccessful. Hold times increased from 10% in CY 2017 to 39% in CY 2018. This change in rate could be attributed to the fact that the hold time changed from 10 minutes in CY 2017 to 5 minutes in CY 2018 to adhere to industry standards. However, being put on hold for more than 5 minutes is a barrier for members reaching their PCP office.

If the surveyor was asked to leave a message without being able to get through to a live attendant, the call was ended after the third attempt without leaving a message. PCP offices that required the surveyor to leave a message substantially increased from 6% in CY 2017 to 26% in CY 2018. It was noted by surveyors that the use of automated messaging systems did not allow surveyors to get through to a live respondent at many of the PCP offices and required the surveyor to either call back or leave a message each time.

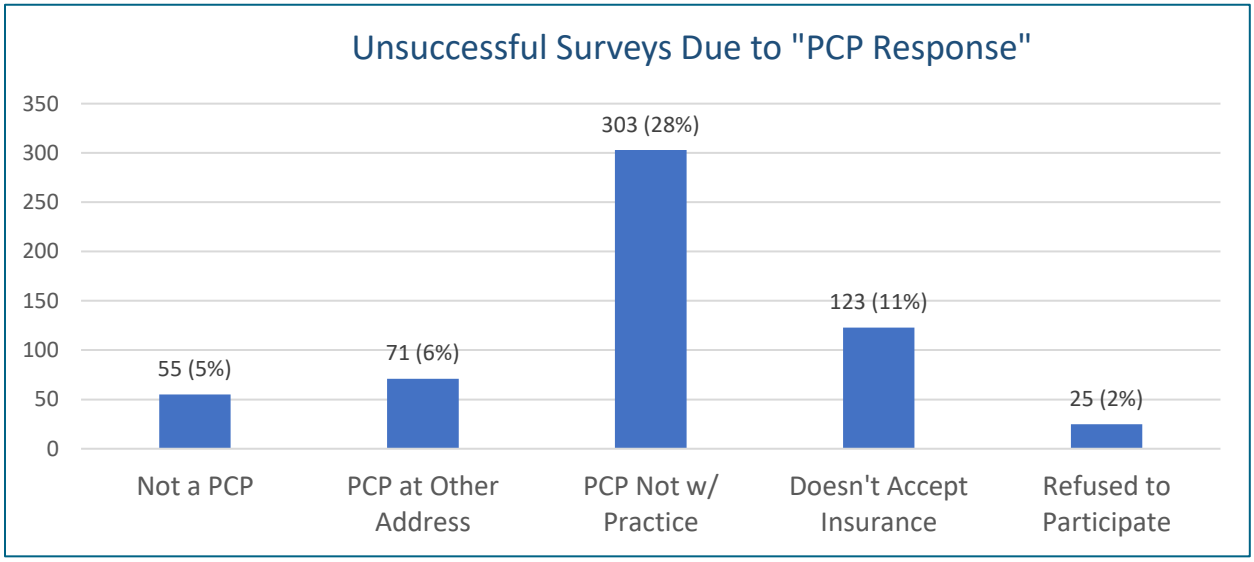
If the telephone number was wrong, the surveyor dialed the number again to ensure that the number was dialed correctly. The number of PCPs with wrong numbers decreased to 21% in CY 2018, a noticeable improvement from 33% in CY 2017. This category made up 12% of the unsuccessful calls for CY 2018. Since there was not a separate data category for "no answer" in CY 2017, the result for "wrong number" was higher at 33%.

The number of PCP offices that reported to be permanently closed doubled from 1% in CY 2017 to 2% in CY 2018.

A total of 577 telephonic surveys were unsuccessful due to "PCP Response". The PCP telephonic survey ended if any of the following criteria was met and are illustrated in Figure 26.

- The provider identified for the survey was not a PCP.
- The PCP did not practice at the listed address.
- The PCP was not with the practice listed.
- The PCP did not accept the listed insurance.
- The respondent refused to participate in the survey.

Figure 26. Unsuccessful Surveys Due to "PCP Response"



The survey scenarios mimic real barriers to members attempting to contact their PCP to obtain primary care services, except for the respondents who refused to participate. Data regarding unsuccessful surveys due to "PCP Response" was not collected in CY 2017, apart from respondents' refusal to participate. In CY 2017, there were 15 PCP offices that refused to participate. This number increased to 25 in CY 2018.

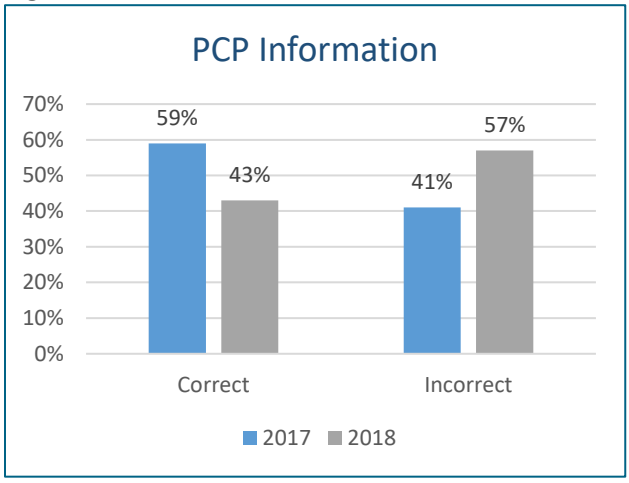
The largest category for unsuccessful surveys was the PCP was not with the identified practice. This misinformation may create a significant challenge for members attempting to contact PCPs listed at a specific practice or office, or when a new member is trying to contact a PCP. It could also be a network adequacy issue, considering the State relies on accurate location data when ensuring appropriate PCP coverage. These barriers can result in members seeking care from urgent care facilities or emergency

services, or delaying annual preventative care visits, if unable to find a PCP or contact their PCP to obtain an appointment.

Accuracy of PCP Information

In order to assess the MCOs' online directories, Qlarant conducted telephonic surveys from June to July 2018 based on the PCP information provided by the MCOs. Telephonic surveys verified the accuracy of the PCP information used to populate each MCO's online provider directory. Results of the telephonic survey for all HealthChoice MCOs are presented in Figure 27.

Figure 27. PCP Information



PCP Information

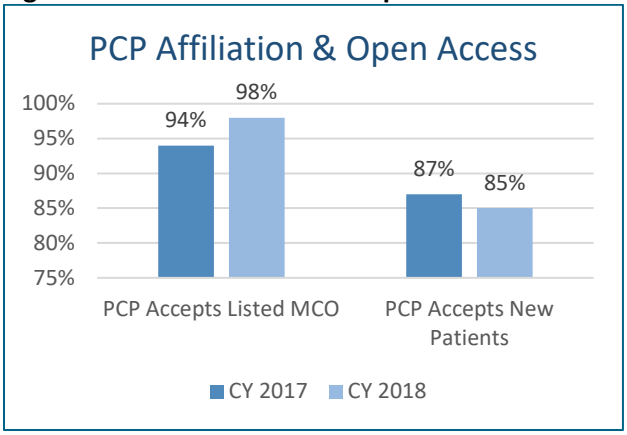
- Correct PCP telephone numbers and addresses were found in 867 (43%) of the 2,003 attempted surveys.
- A total of 1,136 (57%) PCPs had incorrect contact information or details (phone number or address).
- The accuracy of PCP information decreased by 16 percentage points in CY 2018.

Although the sample data was provided by the MCOs and a larger sample of PCPs was surveyed in CY 2018, inaccurate contact information remains a barrier to network access. In fact, the accuracy of the PCP information decreased in CY 2018 by 16 percentage points. In CY 2017, 59% of the PCP addresses and phone numbers were accurate; whereas in CY 2018, the accuracy of PCP information was only 43%. In both survey years, surveyors attempted to obtain corrected information from the PCP offices, and in some cases, these attempts led to successful contacts.

CY 2017 survey results demonstrated that from the 1,319 providers surveyed, 197 (15%) had incorrect telephone numbers, 87 (7%) had incorrect addresses, and 213 (16%) providers were no longer with the facility or at the location noted in the directory. The CY 2018 survey results demonstrate that from 2,003 PCPs surveyed, 105 (5%) of PCPs had incorrect telephone numbers, 61 (3%) PCPs had incorrect addresses, and 374 (19%) of PCPs were no longer with the practice or at the location noted in the directory. Members who cannot contact their PCPs due to changes in practice designations and/or locations is an access issue and continuity of care concern for both MDH and the MCOs. This warrants a need for the MCOs to measure and monitor the accuracy of PCP information more closely.

The CY 2018 telephonic surveys validated that PCPs accepted the listed MCO and new Medicaid patients, as illustrated in Figure 28.

Figure 28. PCP Affiliation and Open Access



PCP Affiliation & Open Access

- Almost all PCPs surveyed (98%) confirmed that they accepted the listed MCO in CY 2018.
- The majority of PCPs surveyed (85%) report accepting new patients in CY 2018.

Survey results demonstrated that the almost all PCPs surveyed in both CY 2017 (94%) and 2018 (98%) stated that they were affiliated with the listed MCO. Additionally, the majority of PCPs surveyed in CY 2017 (87%) and CY 2018 (85%) stated that they accepted new patients. The number of PCPs accepting new patients decreased 2 percentage points from the CY 2017 survey results. It should be noted that the CY 2018 surveyors specifically asked if the PCP accepted "new Medicaid patients," whereas in past years surveys simply asked if the PCP accepted "new patients." It is unknown if the change in wording contributed to the decline in results.

Although the rate of 85% of PCPs accepting new patients seems satisfactory, note only 46% of the PCPs were successfully contacted by surveyors, due to inaccurate information provided by the MCOs. Therefore, further analysis into open panels may warrant further MCO oversight.

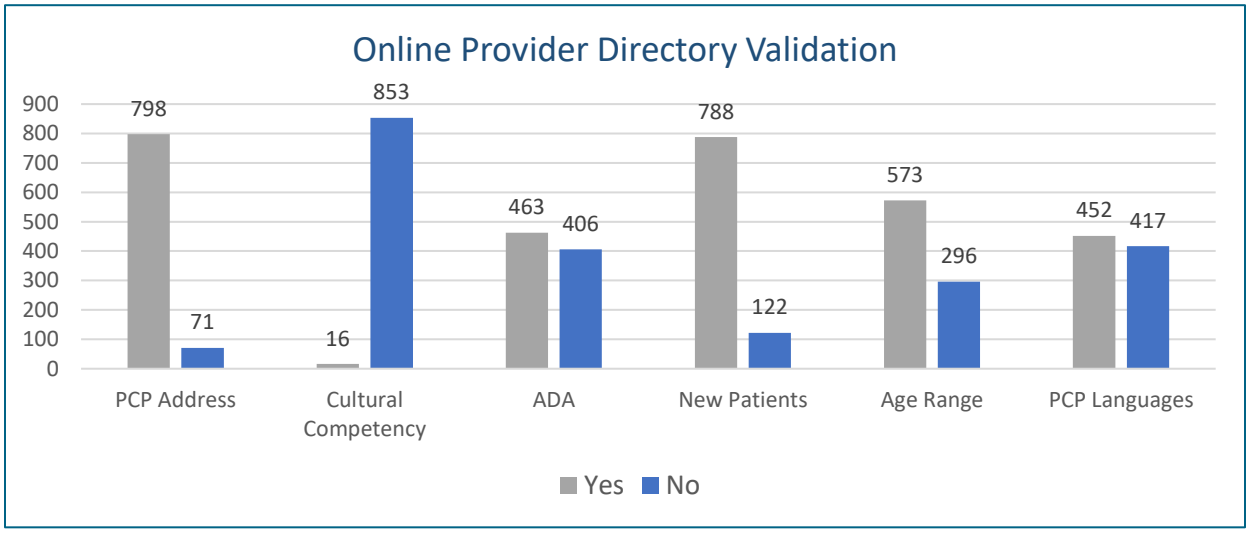
Validation of MCO Online Provider Directories

Qlarant validated the information in the MCO's online provider directory for each PCP that completed the telephone survey. The online directory was reviewed for the following information:

- **PCP Address:** Accuracy of the information presented in the online directory such as the PCP's name, address, practice location(s), and telephone number(s).
- **Cultural Competency:** An indication in the online directory for the PCP as to whether the PCP has completed cultural competency training.
- **ADA (Practice Accommodations for Physical Disabilities):** An indication in the online directory for the PCP as to whether the practice location has accommodations for individuals with disabilities.
- **New Patients:** An indication in the online directory for the PCP as to whether the PCP is accepting new patients.
- **Age Range:** An indication in the online directory for the PCP as to what ages the PCP serves.
- **PCP Languages:** An indication in the online directory of the languages spoken by the PCP.

Results of the online provider directory survey validation are presented in Figure 29.

Figure 29. Online Provider Directory Survey Validation Results



A total of 928 PCPs reported that they were active with an MCO; however, 58 PCPs were not found in the MCO's online provider directory. Therefore, 870 PCPs were validated against the MCO's online provider directories for compliance with the regulations. Online provider directory results indicate that:

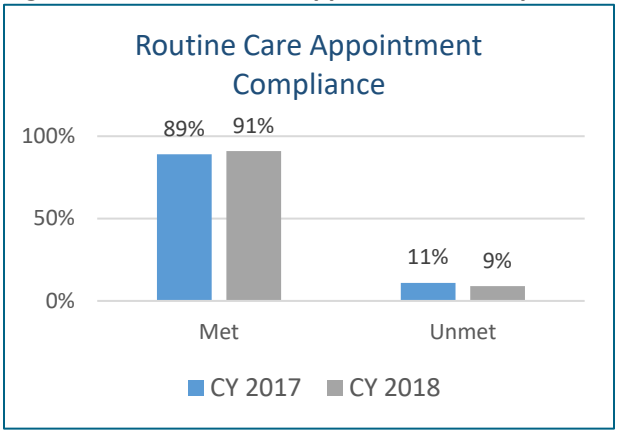
- Almost all PCP directories validated (798 or 92%) matched the address and responses provided in the telephone surveys.
- The majority of PCP directories (788 or 87%) validated that PCPs accepted new Medicaid patients compared to responses during the telephone survey.
- Over half of PCP directories (573 or 66%) listed age ranges of patients served. However, a significant number of PCP directories (296 or 34%) did not specify age ranges or had placeholders. Members, especially parents of children or adolescents, rely on this information when searching for PCPs.
- Almost half of the PCP directories (452 or 52%) specified the languages spoken by the PCP. The remaining directories did not specify languages spoken. There was a wide variety in what, where, and how this information was presented in the online directories.
    - Some MCO directories placed an overall statement in another section of the directory that instructed members to assume the PCP spoke English unless otherwise noted, while other directories listed English and other languages.
    - Some MCO directories had placeholders for languages spoken and some did not. If there were placeholders, some contained information, some were left blank, and some noted "not specified".

  Without a standard to support a consistent method and appropriate content that clearly communicates the required information, it presents a challenge for members in finding a PCP to meet their language or cultural needs.
- Almost half of PCP directories (463 or 53%) specified practice accommodations for patients with disabilities. Since all PCP offices are required to be ADA accessible, MCOs should update the online directories with this information in a manner that is easily accessible to members.
- Almost none (16 or 2%) of the PCP directories included information regarding whether the PCP received cultural competency training. Several MCOs were in the process of implementing changes to their online directories and placeholders were noted on the PCP sites, but no specific information was able to be validated.

Compliance with Routine Appointment Requirements

Survey results of PCP compliance with routine appointment requirements are presented in Figure 30.

Figure 30. Routine Care Appointment Compliance



Routine Care Appointment Compliance

- Of the 928 PCPs successfully surveyed, 99% provided routine care appointment availability.
- The majority of PCPs surveyed (829/91%) met compliance with the 30-day appointment time frame.
- CY 2018 results demonstrated an increase over the CY 2017 results.

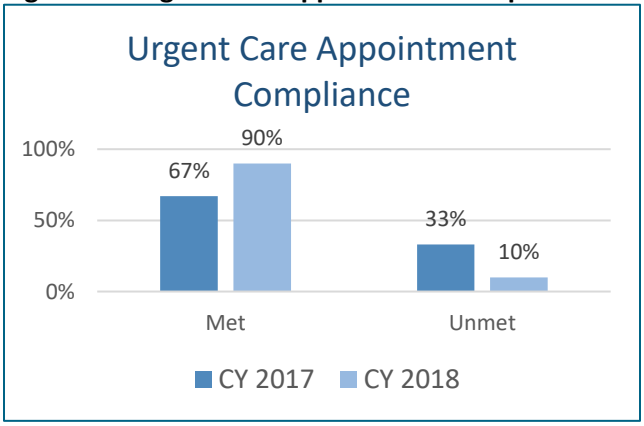
The number of PCPs that provided routine care appointment availability increased from 85% in CY 2017 to 99% in CY 2018. Results demonstrate a slight increase of 2 percentage points over CY 2017 of PCPs that met compliance with the 30-day appointment time frame from 89% in CY 2017 to 91% in CY 2018.

There was a change in methodology in which surveyors were instructed to ask respondents if they could schedule appointments. As we learned in previous surveys, some PCP offices and MCOs utilize separate staff or scheduling centers to provide support in booking appointments for PCPs. If the respondent stated that there was a separate number to contact in order to schedule appointments, the surveyor requested to be transferred or hung up and contacted the new number to obtain appointment availability.

Compliance with Urgent Care Appointment Requirements

Survey results for PCP compliance with urgent care appointments are presented in Figure 31.

Figure 31. Urgent Care Appointment Compliance



Urgent Care Appointment Compliance

- Of the 928 PCPs surveyed, 99% provided urgent care appointment availability.
- The majority of PCPs surveyed (920/90%) met compliance with the 48-hour appointment time frame.
- Results for CY 2018 were significantly higher than CY 2017.

Results for Urgent Care Appointment Compliance increased significantly compared to CY 2017, due to a substantial change in methodology. Based on feedback received from MCOs last year, surveyors asked if the practice could provide an appointment with another provider in the same practice location as an alternative when the surveyed PCP was unable to see a patient within the urgent care time frame. Additionally, data was collected on alternative options offered by the practice, such as referring the member to urgent care services, referring the member to the emergency room, or to another option.

An increase was demonstrated in the number of PCPs that provided urgent care appointment availability from CY 2017 at 84% to CY 2018 at 90%. The majority of PCPs (90%) surveyed met compliance with the 48-hour appointment time frame, a significant increase of 23 percentage points over the CY 2017 rate of 67%. A review of the results demonstrated that 69% of PCPs offered an urgent care appointment within the required 48 hours; an additional 21% of PCPs offered an appointment within the required time frame with another provider in the same practice. The option of directing the enrollee to an urgent care clinic offered by 10% of the PCPs surveyed appears to be a standard practice among PCPs when an urgent care appointment cannot be made upon request. Investigation of member complaints or grievances may provide MDH further insight into whether enrollees are accessing urgent care services because of PCP referrals to urgent care centers.

MCO-Specific Results for Successful Contacts

MCO-specific results of successful calls are presented in Table 53, including the total number of PCP calls attempted, the total number of calls successfully completed, the call attempt on which the call was successfully completed, and the percentage of successfully completed calls.

Table 53. CY 2018 MCO Results of Successful Contacts

CY 2018 MCO Successful Contacts						
MCO	**Number of Call Attempts**	**1st Call Attempt**	**2nd Call Attempt**	**3rd Call Attempt**	**Total**	**Percent of Successfully Completed Calls**
ABH	210	81 (80%)	15 (15%)	5 (5%)	101	48%
ACC	245	110 (77%)	24 (17%)	9 (6%)	143	58%
JMS	174	69 (78%)	18 (20%)	2 (2%)	89	51%
KPMAS	167	23 (79%)	0 (0%)	6 (21%)	29	17%
MPC	231	66 (71%)	18 (19%)	9 (10%)	93	40%
MSFC	243	82 (77%)	14 (13%)	11 (10%)	107	44%
PPMCO	256	104 (75%)	28 (20%)	7 (5%)	139	54%
UHC	244	92 (74%)	26 (21%)	7 (6%)	125	51%
UMHP	233	77 (75%)	20 (20%)	5 (5%)	102	44%
TOTAL	**2003**	**703 (76%)**	**163 (18%)**	**61 (7%)**	**928**	**46%**

Of the 2,003 PCP surveys attempted in CY 2018, there were 928 successful PCP surveys completed, thus yielding a response rate of 46%. MCO-specific results demonstrated that ACC had the highest percent of successful calls with 58% and KPMAS had the lowest with 17%. The majority of all calls, both statewide and by MCO, were completed on the 1st call attempt.

MCO-Specific Results of Unsuccessful Contacts

MCO-specific results of unsuccessful contacts due to "No Contact" are presented in Table 54.

Table 54. CY 2018 MCO Result of Unsuccessful Contacts Due to "No Contact"

CY 2018 MCO Unsuccessful Contacts Due to "No Contact"							
MCO	**Leave Message**	**Hold Time > 5 Minutes**	**No Answer**	**Office Closed Permanently**	**Other**	**Wrong Number**	**MCO Total**
ABH	11	5	1	1	0	20	**38 (8%)**
ACC	8	7	10	1	1	22	**49 (10%)**
JMS	21	37	3	0	0	3	**64 (13%)**
KPMAS	32	60	18	0	0	1	**111 (22%)**
MPC	15	12	6	1	0	26	**60 (12%)**
MSFC	14	48	3	3	0	7	**75 (15%)**
PPMCO	4	7	8	1	0	12	**32 (6%)**
UHC	17	8	5	1	0	5	**36 (7%)**
UMHP	8	8	8	0	0	9	**33 (7%)**
Total by Reason	**130 (26%)**	**192 (39%)**	**62 (12%)**	**8 (2%)**	**1 (0%)**	**105 (21%)**	**498**

MCO results demonstrate that hold times (192 or 39%), leaving messages (130 or 26%), and wrong numbers (105 or 21%) contributed to the majority of unsuccessful contacts due to "No Contact". KPMAS had the highest number of unsuccessful calls (60) due to hold times, followed by MSFC (48) and JMS (37). KPMAS also had the highest number of calls requiring the surveyor to leave a message (32), followed by JMS (21) and UHC (17). MPC had the highest number of wrong numbers (26), followed by ACC (22) and ABH (20).

MCO-specific results of unsuccessful contacts due to "PCP Response" are presented in Table 55.

Table 55. CY 2018 MCO Result of Unsuccessful Contacts Due to "PCP Response"

CY 2018 MCO Unsuccessful Contacts Due to "PCP Response"						
MCO	**Not a PCP**	**Refused to Participate**	**PCP Not w/ Practice**	**PCP at Another Address**	**Doesn't Accept MCO**	**MCO Total**
ABH	2	0	34	5	30	**71 (12%)**
ACC	3	4	30	1	15	**53 (9%)**
JMS	2	1	9	3	6	**21 (4%)**
KPMAS	1	0	7	0	19	**27 (5%)**
MPC	6	0	64	5	3	**78 (14%)**
MSFC	10	1	30	14	6	**61 (11%)**
PPMCO	10	2	40	14	19	**85 (15%)**
UHC	12	10	39	7	15	**83 (14%)**
UMHP	9	7	50	22	10	**98 (17%)**
Total by Reason	**55 (10%)**	**25 (4%)**	**303 (53%)**	**71 (12%)**	**123 (21%)**	**577**

MCO results demonstrate that the majority (303 or 53%) of unsuccessful contacts due to "PCP Response" were because the PCP was not with the practice. An additional 123 contacts or 21% of the unsuccessful contacts were because the PCP did not accept the identified MCO. MPC had the highest number of unsuccessful calls (64) due to PCPs not with the practice, followed by UMHP (50) and PPMCO (40). ABH had the highest number of PCPs stating that they did not accept the identified MCO (30), followed by both KPMAS (19) and PPMCO (19).

MCO-Specific Results for Accuracy of PCP Information

MCO-specific results from the successful contacts for the accuracy of PCP information are presented in Table 56.

Table 56. CY 2018 MCO Results from Successful Contacts for Accuracy of PCP Information

MCO	Successful Contacts	Correct PCP Information Provided	Accepts Listed MCO	Accepts New Patients
ABH	101	97 (96%)	97 (96%)	88 (87%)
ACC	143	131 (92%)	143 (100%)	129 (90%)
JMS	89	85 (96%)	88 (99%)	80 (90%)
KPMAS	29	29 (100%)	29 (100%)	21 (72%)
MPC	93	84 (90%)	93 (100%)	83 (89%)
MSFC	107	99 (93%)	103 (96%)	90 (84%)
PPMCO	139	127 (91%)	135 (97%)	110 (79%)
UHC	125	120 (96%)	124 (99%)	101 (81%)
UMHP	102	95 (93%)	102 (100%)	86 (84%)
TOTAL	**928**	**867 (93%)**	**914 (98%)**	**788 (85%)**

Results demonstrated that the accuracy of PCP information, such as name, address, and phone numbers for successful contacts ranged between 90% and 100%. One MCO (KPMAS) had an accuracy rate of 100% and three MCOs (ABH, JMS, and UHC) had rates of 96%. PCPs reporting that they accepted the listed MCO ranged from 96% to 100%, with four MCOs (ACC, KPMAS, MPC, and UMHP) with results at 100%. PCPs that reported that they were accepting new patients ranged from 72% (KPMAS) to 90% (ACC and JMS).

MCO-Specific Results for Compliance with Appointment Requirements

MCO-specific results for compliance with routine and urgent care appointment time frame requirements are presented in Table 57.

Table 57. CY 2018 MCO Results for Compliance with Appointment Requirements

Compliance	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
Compliance with Routine Care Appointment Time Frame (within 30 Days)										
Compliant with Time Frame	95%	87%	89%	79%	92%	92%	86%	90%	87%	89%
# of Wait Days (Average)	8	11	9	19	11	10	12	10	12	9
# of Wait Days (Range)	0-133	0-204	0-71	0-97	0-144	0-117	0-112	0-99	0-78	0-204
Compliance with Urgent Care Appointment Time Frame (within 48 Hours)										
Compliant with Time Frame	73%	70%	73%	7%	80%	60%	76%	60%	75%	69%
Appointment Available w/ Another PCP At Same Location w/48 hours	16%	15%	25%	72%	14%	26%	19%	26%	20%	21%
COMPLIANCE WITH URGENT CARE APPOINTMENT	**89%**	**85%**	**98%**	**79%**	**94%**	**86%**	**95%**	**86%**	**95%**	**90%**

*Underline denotes that the minimum compliance score is unmet.

Results for compliance with routine care appointments within 30 days ranged from 79% (KPMAS) to 95% (ABH). The average wait time for a routine care appointment ranged from 8 (ABH) to 19 (KPMAS) days.

Results for compliance with urgent care appointments within 48 hours with the PCP surveyed or another PCP at the same location ranged from 79% (KPMAS) to 98% (JMS). KPMAS' compliance score for urgent care appointment time frames at 79% was 11 percentage points lower than the HealthChoice Aggregate and below the minimum compliance score set by MDH at 80%. A corrective action plan (CAP) is required to improve compliance with urgent care appointment time frames.

Results for PCPs that provided an alternative option when urgent care appointments were not available with the PCP surveyed or another PCP at the same location ranged from 2% (JMS) to 21% (KPMAS). Three MCOs (MSFC, PPMCO, and UHC) had PCPs that did not provide any options when urgent care appointments were unavailable.

MCO-Specific Results for Validation of Online Provider Directories

MCO-specific results for the validation of Online Provider Directories are presented in Table 58.

Table 58. CY 2018 MCO Results for Validation of Online Provider Directories

Requirement	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	HealthChoice Aggregate
PCP Listed in Online Directory	96%	93%	100%	97%	96%	96%	92%	85%	96%	**95%**
PCP's Practice Location Matched Survey Response	95%	90%	97%	97%	96%	96%	91%	83%	96%	**93%**
PCP's Practice Telephone Number Matched Survey Response	95%	91%	97%	97%	86%	96%	91%	80%	92%	**92%**
Online Directory Specifies that PCP Accepts New Medicaid Patients and Matches Survey Response	86%	80%	90%	52%	86%	83%	58%	70%	75%	**76%**
Online Directory Specifies Age Specifications of Patient Seen	96%	88%	61%	83%	89%	64%	4%	85%	8%	**64%**
Online Directory Specifies Languages Spoken By PCP	96%	92%	99%	21%	2%	32%	28%	26%	21%	**46%**
Online Directory Specifies Practice Accommodations for Patients with Disabilities	14%	92%	1%	0%	96%	95%	14%	83%	3%	**44%**
Online Directory Specifies Cultural Competency Training Completed by PCP	0%	7%	1%	0%	0%	2%	0%	2%	0%	**1%**

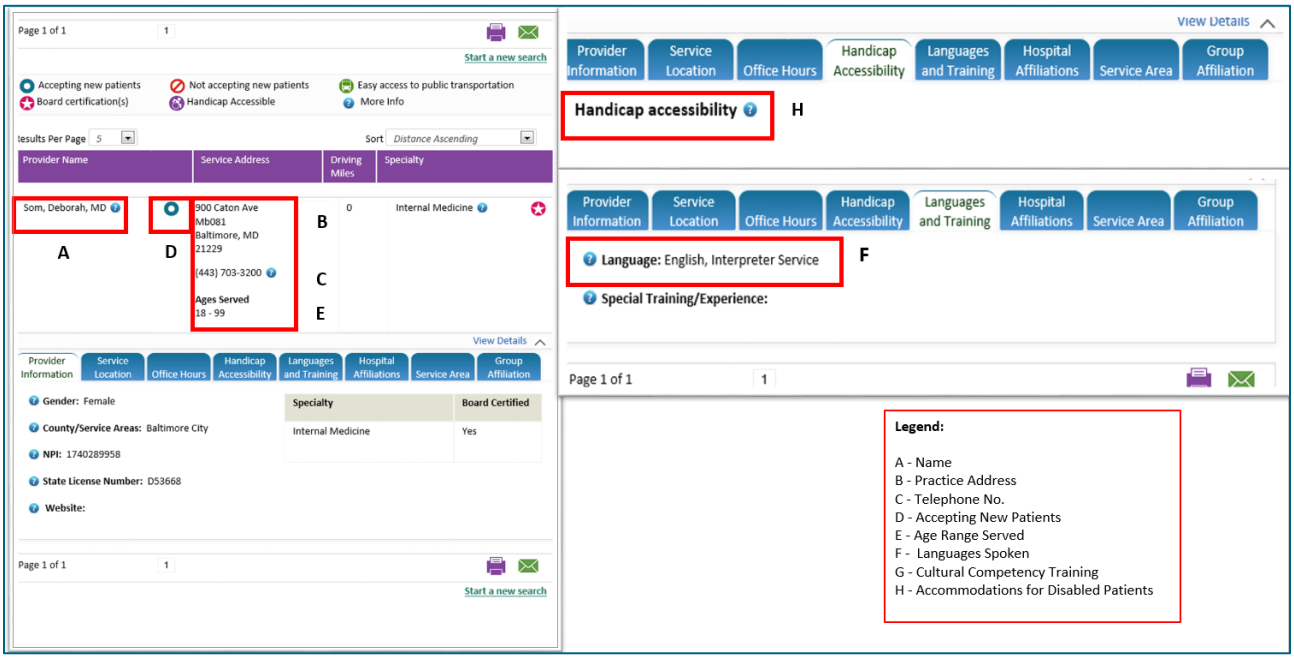
*Underline denotes that the minimum compliance score is unmet.

Validation of the MCO online provider directories demonstrate that MCO rates for the:

- PCP being listed in the online provider directory ranged from 85% (UHC) to 100% (JMS).
- PCP's practice location matching the survey response ranged from 83% (UHC) to 97% (JMS and KPMAS).
- PCP's telephone number matching the survey response ranged from 80% (UHC) to 97% (JMS and KPMAS).
- PCP accepts new Medicaid patients ranged from 52% (KPMAS) to 90% (JMS).
- Directory specifies the ages that the PCP accepts ranged from 4% (PPMCO) to 96% (ABH).
- Directory specifies the languages spoken by the PCP ranged from 2% (MPC) to 99% (JMS).
- Directory specifies the practice has accommodations for patients with disabilities ranged from 0% (KPMAS) to 96% (MPC).
- Directory specifies the PCP completed cultural competency training ranged from 0% to 7% (ACC).

The minimum compliance score is 80% for the validation of online directories. Based on the CY 2018 results, all nine MCOs are required to submit CAPs to Qlarant to correct PCP details noted in the online provider directory. Snapshots of MCO Online Provider Directories follow with recommendations for improvements necessary to become compliant with current requirements.

ABH Online Provider Directory



ABH's online provider directory is easy to review and complete with designated placeholders for each of the components required by regulation. ABH provides icons with a colored legend specifying language spoken, provider training, and handicap accessibility. Placeholders that do not have information are left blank. Information icons with a question mark inform the enrollee when accessed that the self-reported information is "updated with changes in the provider's professional standing or every three years".

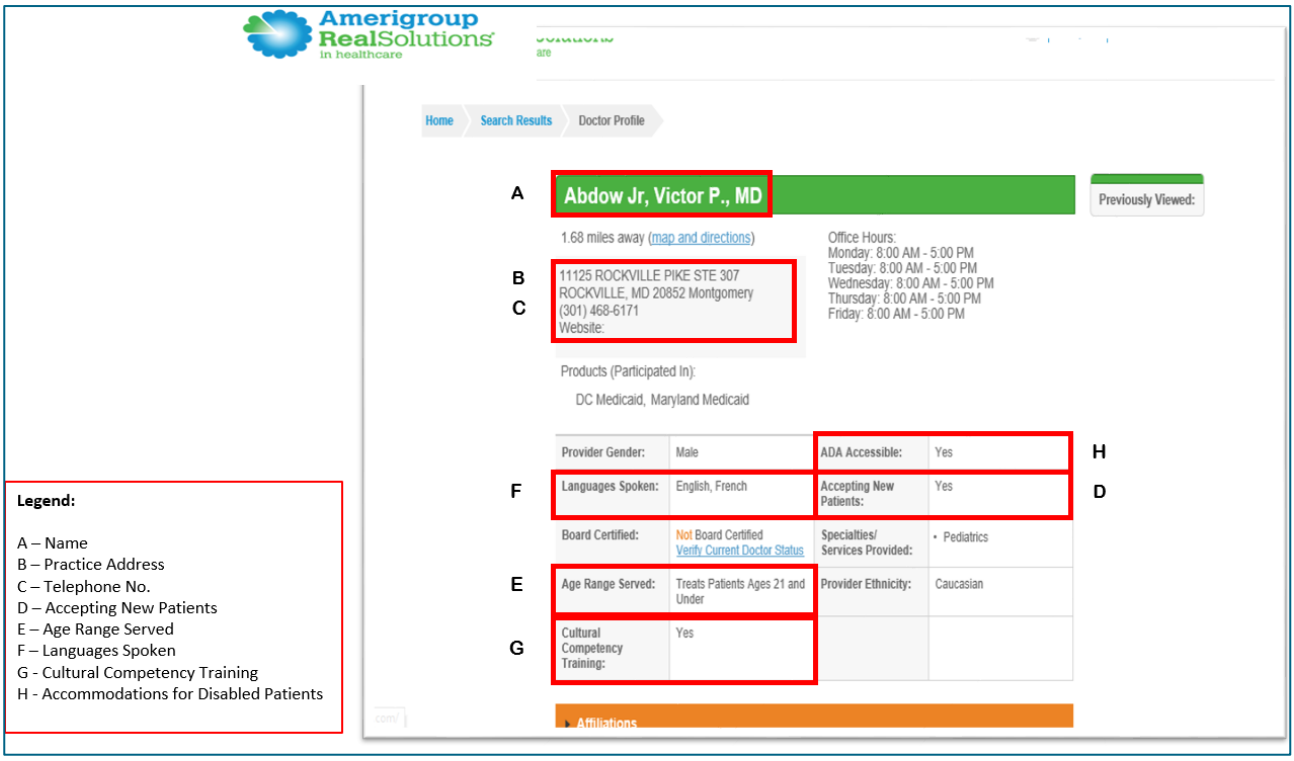
In order to be compliant in the CY 2019 validations, ABH must submit a CAP addressing the following:

- Online provider directories must specify whether the office practice has ADA accommodations. If "Handicap Accessibility" means that the office is handicap accessible, it would be clearer to the member to state "Handicap Accessible" or "Handicap Accessibility: Yes".
- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must specify whether the provider has completed cultural competency training.

Qlarant makes the following recommendations for ABH:

- Provide a clear response for placeholders that do not specify information; use "none specified" instead of leaving a blank.

ACC Online Provider Directory



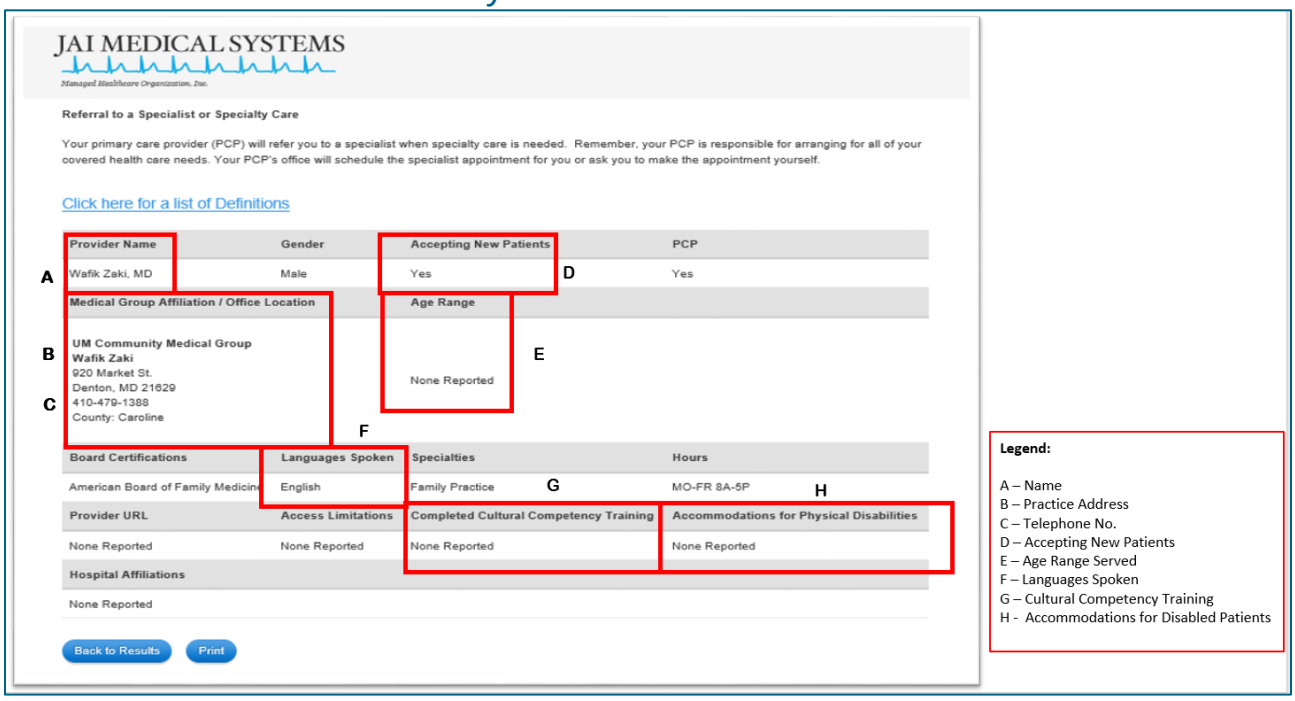
ACC's online provider directory is easy to read, available on one page, and includes placeholders for each of the components required by regulation. The directory also includes a feature that allows an enrollee to select and review up to three providers side by side.

ACC provides a statement in the glossary for members indicating that the provider information is updated on a daily basis and may change. ACC encourages members to ask if the provider is still with Amerigroup and accepting new patients when they contact them. The ACC member services contact number is also noted in the glossary.

In order to be compliant in the CY 2019 validations, ACC must submit a CAP addressing the following:

- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must consistently include placeholders and responses that specify whether the provider has completed cultural competency training.

JMS Online Provider Directory



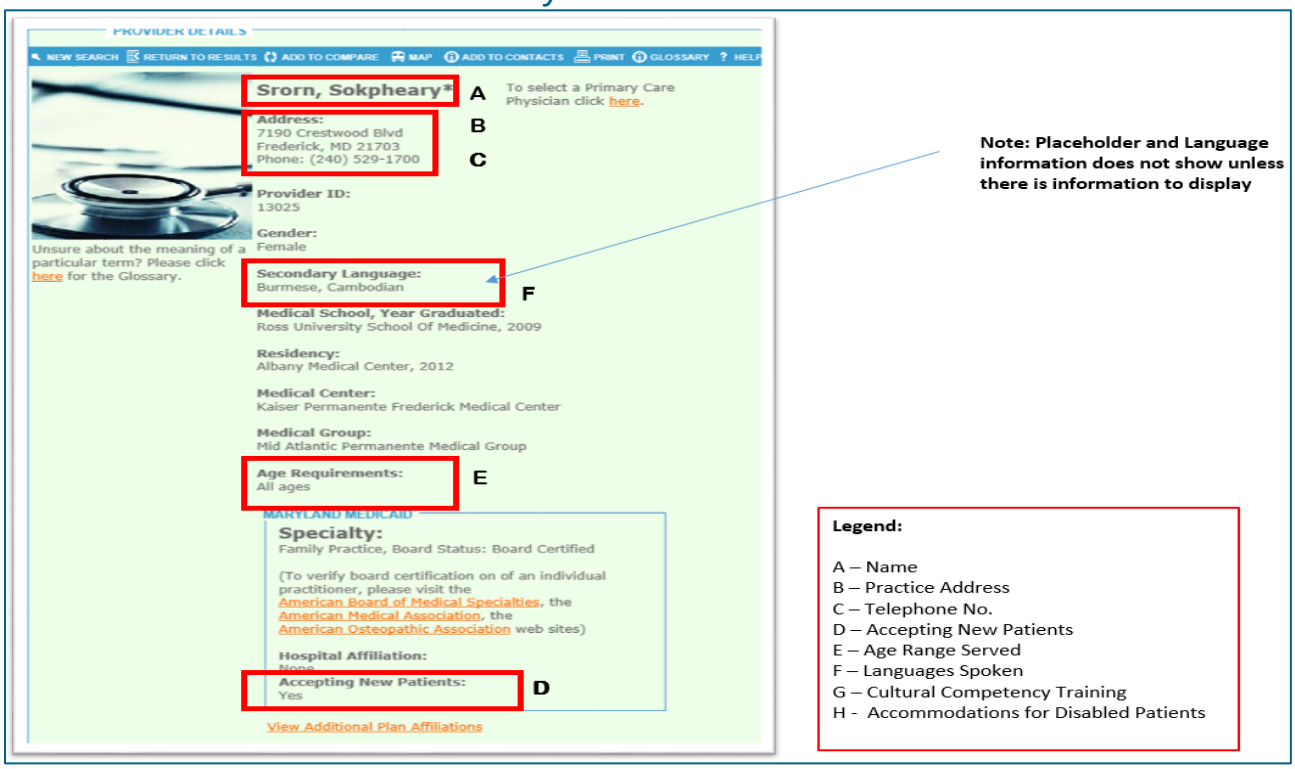
JMS's online provider directory is easy to read, available on one page, and includes placeholders and responses for each of the components required by regulation. If there is no information for a component, the response is not left blank; it is noted as "None Reported".

JMS provides in the glossary the customer service department telephone number, clear directions for navigation of the online provider directory, and a description of the information update process through an active hyperlink. JMS states the directory information is "reported and validated by the participating provider at least annually".

In order to be compliant in the CY 2019 validations, JMS must submit a CAP addressing the following:

- Online provider directories must indicate what ages the provider serves.
- Online provider directories must indicate that the office practice has Accommodations for Physical Disabilities.
- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must indicate whether the provider has completed cultural competency training.

KPMAS Online Provider Directory



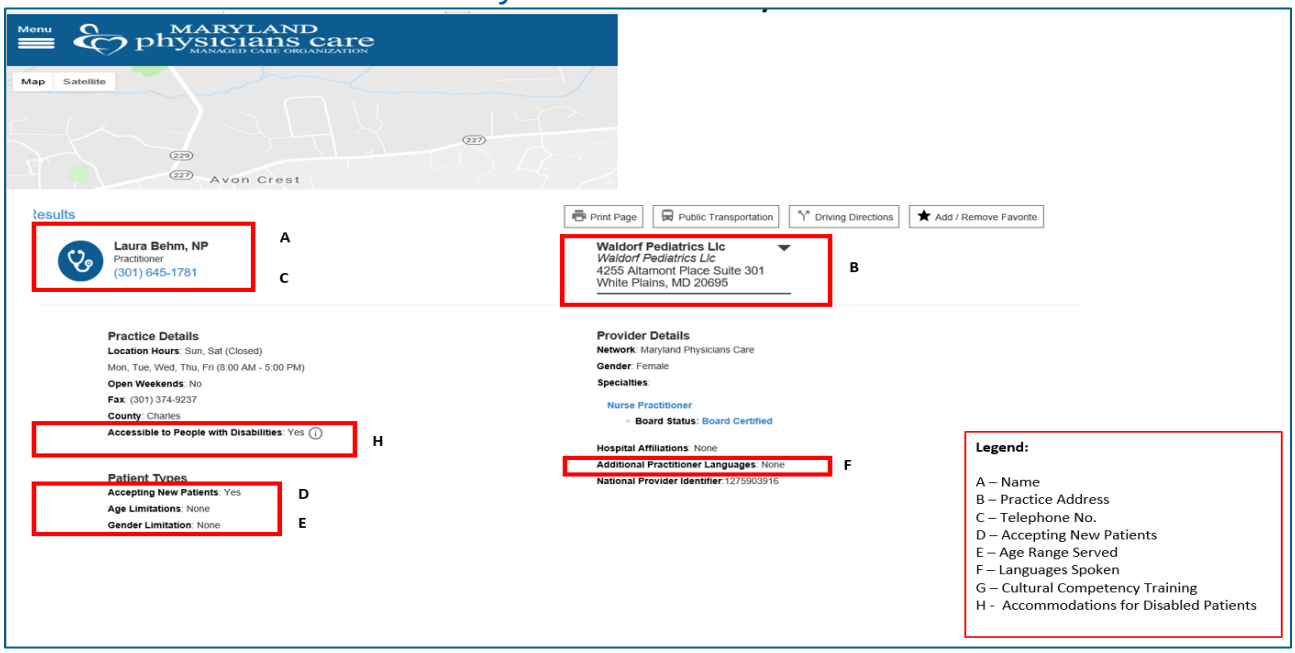
KPMAS's online provider directory is easy to read and includes placeholders and responses, but does not include all of the components required by regulation. The glossary contains general information on the status of cultural competency training and practice accommodations for disabled patients for all providers.

KPMAS provides a "secondary language" placeholder to specify other languages than English spoken by the provider and staff. This placeholder is left blank if no other language is spoken other than English.

In order to be compliant in the CY 2019 validations, KPMAS must submit a CAP addressing the following:

- Online provider directories must indicate other languages spoken by the provider. If there are no other languages, the placeholder should clearly specify "None" and not be left blank.
- Online provider directories must specify whether each office practice has ADA Accommodations.
- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must specify whether each provider has completed cultural competency training.

MPC Online Provider Directory



MPC's online provider directory is easy to read, available on one page, and includes placeholders for all of the components required by regulation except for one (whether the provider has completed cultural competency training). The placeholder for ADA accessibility provides a response including an icon for more information. When the icon is accessed, a table appears with an accessibility legend listing accommodations available at the provider site such as Braille signage, accessible exam rooms, ramps, and equipment. It was found during the validation process that when accessing the icon placed next to a "yes" response for some PCPs, the table appeared, but information pertaining to the specific accessibility accommodations of the practice location was not included.

The response to the placeholder for age limitations specified for some providers is "none". This could be interpreted as the provider has no age limitations or that there is no information for this placeholder.

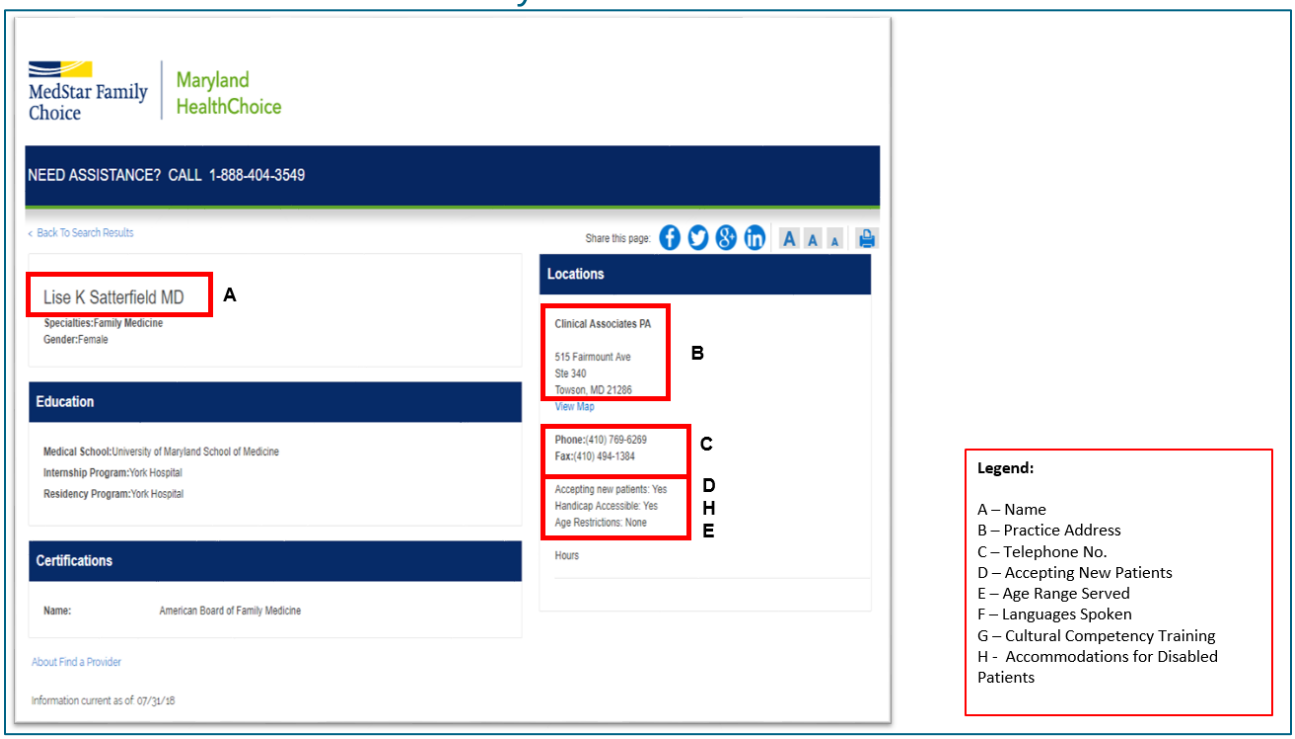
In order to be compliant in the CY 2019 validations, MPC must submit a CAP addressing the following:

- Online provider directories must consistently include responses for languages spoken by the PCP.
- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must specify whether each provider has completed cultural competency training.

Qlarant recommends MPC complete the following:

- Ensure the icon next to the accessibility response includes specifics and is not left blank. If the provider does not have ADA accommodations, the icon should be deleted.
- Clarify responses to the age limitation placeholder, for example "serves all ages" or "no limitations". Clarification could be made to the placeholder so that a shorter response can be provided, for example: "Ages Served: All" or "Ages Served: 18+".

MSFC Online Provider Directory



MSFC's online provider directory is easy to read, available on one page, and includes placeholders and responses for all of the components required by regulation except for languages spoken and cultural competency training. The response to the placeholder for age restrictions specified "none". This could be interpreted as the provider has no age limitations or that there is no information for this placeholder.

Best practices found on the MSFC's online directory:

- MSFC shares how current the provider information is with a date at the bottom of the page.

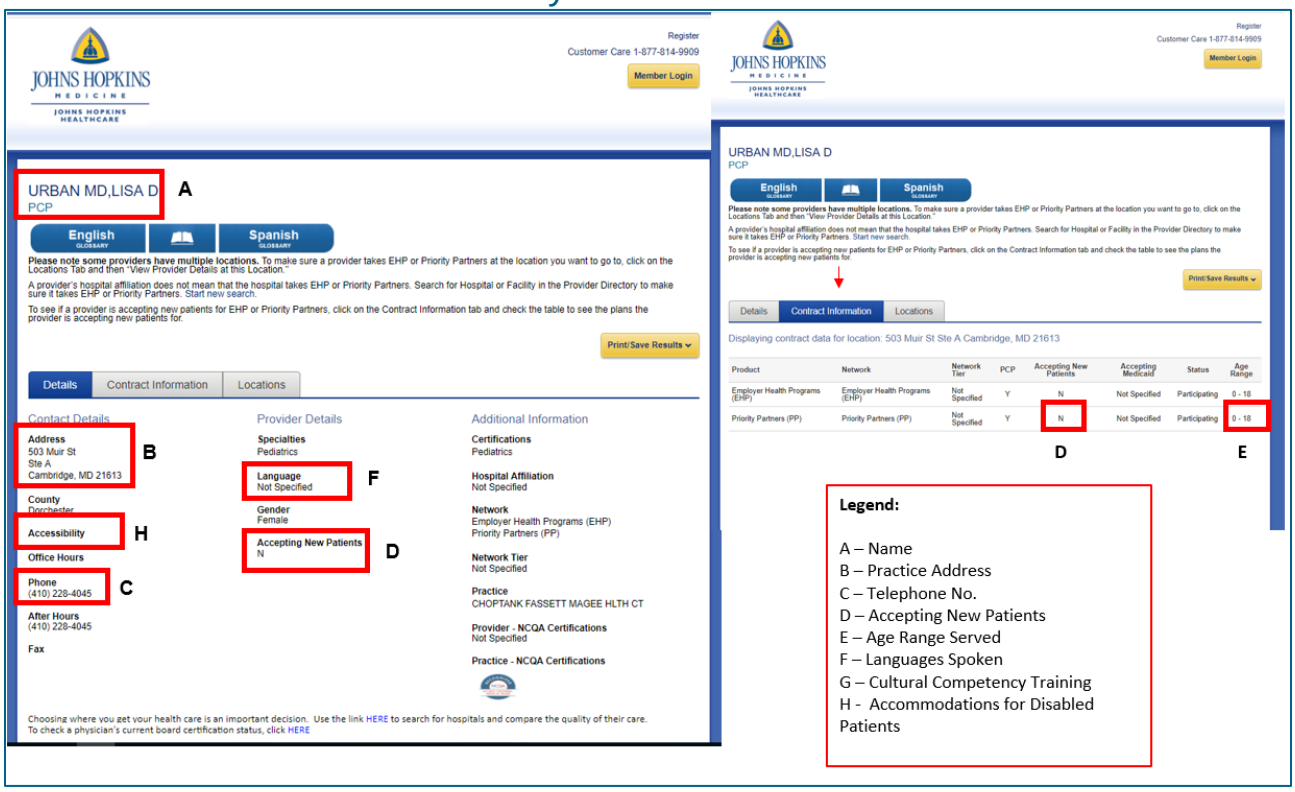
In order to be compliant in the CY 2019 validations, MSFC must submit a CAP to address the following:

- Online provider directories must include the age ranges served by the PCP.
- Online provider directories must specify other languages spoken by the provider. If there are no other languages, the placeholder should clearly specify "None" and not be left blank.
- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must specify whether each provider has completed cultural competency training.

Qlarant recommend that MSFC complete the following:

- Clarify response to the age restrictions placeholder, for example "serves all ages" or "no restrictions". Alternatively, revise the placeholder so that a shorter response can be provided, for example: "Ages Served: All" or "Ages Served: 18+".

PPMCO Online Provider Directory

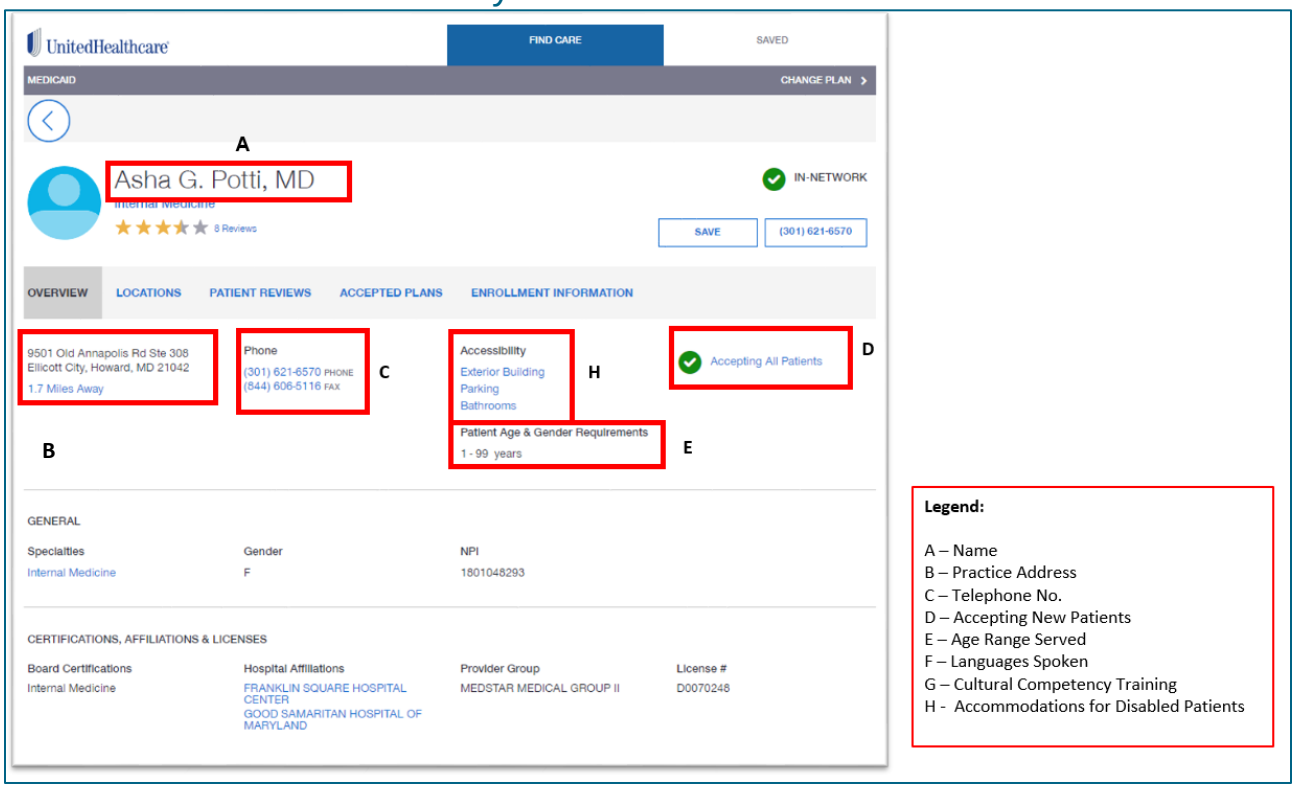


PPMCO's online provider directory takes several clicks to access and the provider information is on two pages named "details" and "contact information". The directory is complete with designated placeholders for all of the components required by regulation except for cultural competency training. Additionally, although there is a placeholder for Accessibility, it was left blank. Other responses communicate that the information is "not specified" when information is not available.

In order to be compliant in the CY 2019 validations, PPMCO must submit a CAP to address the following:

- Online provider directories must specify other languages spoken by the provider. If there are no other languages, the placeholder should clearly specify "None". This information should be collected, and the response should not be left blank or state "not specified".
- Online provider directories must specify ADA accessibility responses for the provider.
- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must specify whether each provider has completed cultural competency training.

UHC Online Provider Directory



UHC's online provider directory is easy to read and includes placeholders and responses for all of the components required by regulation except for cultural competency training. After clicking on the locations tab, the member can see the languages spoken by staff. However, validators found that many responses to the languages spoken placeholder were left blank. The site includes a feature at the bottom of the individual providers' directory page entitled "report incorrect information" encouraging members to notify UHC of incorrect information.

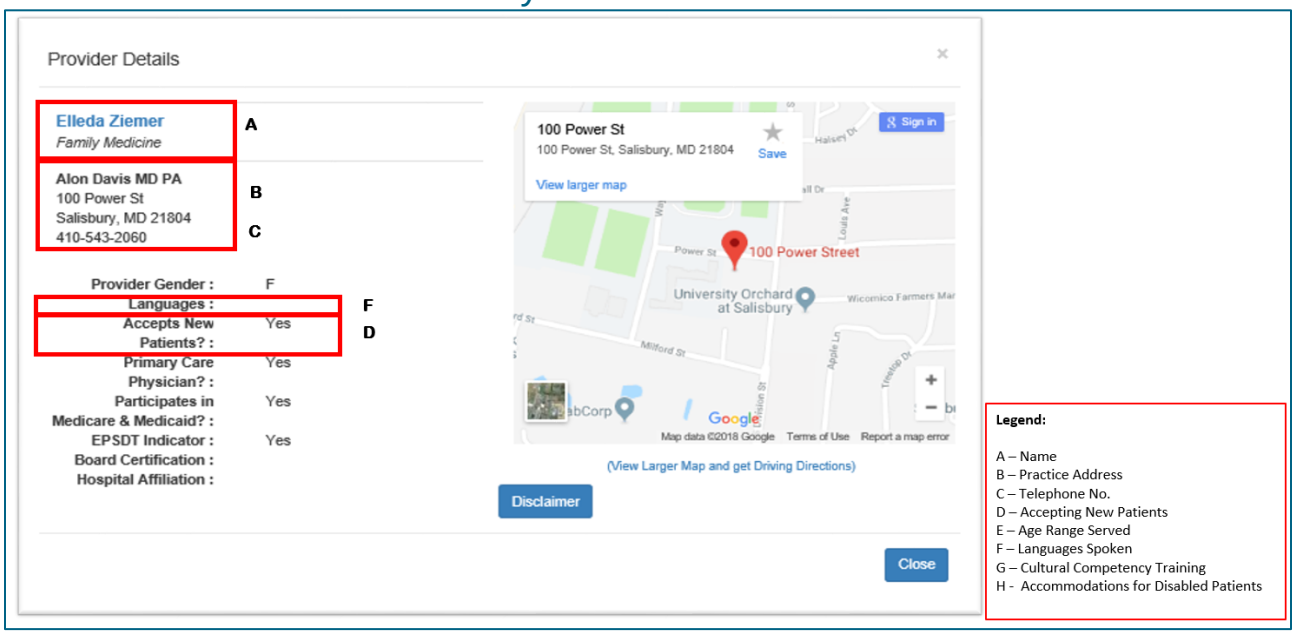
Best practices found on the UHC's online directory:

- The Accessibility placeholder specifies what accommodations are available at the providers' practice location.
- There is a link to "contact us" at the bottom of the page which directs the member to call the member services number located on the back of their member ID card to report inaccurate information.

In order to be compliant in the CY 2019 validations, UHC must submit a CAP to address the following:

- Online provider directories must include a response to the languages spoken placeholder.
- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must specify whether each provider has completed cultural competency training.

UMHP Online Provider Directory



UMHP's online provider directory contains five of the eight components required by regulation. The directory is missing placeholders and/or responses for age ranges served, languages spoken, cultural competency training, and accommodations for disabled patients. UMHP leaves placeholders blank if information is not received by the providers. The online provider directory includes a disclaimer that when accessed states that UMHP receives, validates, and updates directories using self-reported information every three years during the credentialing process. Enrollees are directed to call the provider directly or UMHP for the most up-to-date information.

In order to be compliant in the CY 2019 validations, UMHP must submit a CAP to address the following:

- Online provider directories must specify ages served by the provider.
- Online provider directories must specify ADA accessibility responses for the provider.
- Online provider directories must include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.
- Online provider directories must specify whether each provider has completed cultural competency training.

Conclusions

Significant improvements were made to the CY 2018 survey process that enhanced the data sample submission and collection process, including the survey tool itself. These changes improved the network adequacy validation by allowing MCOs to verify PCP data and reducing burden on the providers.

Despite the improvements in the process, the overall response rate for the CY 2018 surveys was 46%, a decrease of 20 percentage points compared to the CY 2017 response rate of 66%. Even though the sample data was provided directly from the MCOs, a trend of inaccurate information continues. In CY 2017, 59% of the PCP addresses and phone numbers were accurate, and in CY 2018, the accuracy of PCP information fell 16 percentage points to 43%.

The majority of PCPs surveyed in 2018 (98%) for open access demonstrated that they accepted the MCO, which is a 4 percentage point increase from the CY 2017 results (94%). Additionally, the majority of PCPs stated in CY 2018 (85%) that they accepted new patients, which is a decrease of 2 percentage points from the CY 2017 survey results (87%).

Overall, rates increased for both routine and urgent care appointment compliance. An increase of 2 percentage points was reflected in routine care appointment compliance from 89% in CY 2017 to 91% in CY 2018. However, a statistically significant increase of 23 percentage points was seen in urgent care appointment compliance rates from 67% in CY 2017 to 90% in CY 2018. This was likely due to the change in the survey methodology that allowed practices to schedule an appointment with another provider in the same practice location as an alternative when the surveyed PCP was unable to see a patient within the required urgent care time frame.

Several barriers to network adequacy have been identified through conducting the surveys. Primarily, the inaccuracy of PCP contact information does not allow for members to easily access PCPs. Once a PCP is identified, it is difficult for members to obtain PCP appointments. Considering the State relies on accurate data from the MCOs to ensure appropriate PCP coverage statewide, these barriers warrant further investigation to determine if they impact network adequacy determinations. Such barriers may cause members who are unable to contact their PCP to seek care from urgent care facilities or emergency services. Furthermore, members may delay annual preventative care visits for themselves or their children if they are unable to contact a PCP and/or obtain an appointment.

MDH set a minimum compliance score of 80% for the Network Adequacy Assessment. Based on the CY 2018 results, all nine MCOs are required to submit CAPs to Qlarant to correct PCP details noted in the online provider directory. Additionally, KPMAS is required to complete a CAP to improve compliance with urgent care appointment time frames.

Recommendations

The following recommendations are resultant of the CY 2018 surveys.

Survey Tool and Data Sample Recommendations

- **Develop a web-based data collection tool** that involves skip logic and other enhancements that will provide for easier surveying, data collection, quality monitoring, and data analysis.

- **Request National Provider Information (NPI) numbers** in the MCO PCP information listings to identify unique PCP samples. This will also provide MDH with an accurate representation of the number of individual PCPs statewide.

MCO Recommendations

- **Provide complete and accurate PCP information** and current URLs to online provider directories.
- **Notify PCPs of the MD NAV survey time frame** and promote participation one month before the surveys begin.
- **Refrain from completing any MCO-specific provider surveys** within the same time frame as the MD NAV surveys to optimize PCP participation.
- **Ensure that MCO's online provider directory specifies** the following information for each PCP:
  - Whether they accept new Medicaid patients
  - The ages of patients served
  - All languages spoken by the PCP
  - That the practice location has accommodations for patients with disabilities, including offices, exam room(s), and equipment.
- **Indicate PCPs that have completed cultural competency training** on each PCP's online provider directory entry.*
- **Clearly indicate appointment call center telephone numbers** in online directory webpages so members know what number to contact to schedule appointments for those MCOs with centralized scheduling processes.
- **Add the customer service department's telephone number** on the bottom of each directory page for member reference.
- **Share how current the information is in the online directory** by adding a date at the bottom of each page.

*CMS proposed in the November 14, 2018 Federal Register that §438.410(h)(1)(vii) be amended to eliminate the indication of cultural competency training of the PCP requirement in the online directory. Therefore, MDH is not making this recommendation a mandatory requirement.

MDH Recommendations

- **Promote standards/best practices** for MCOs' online provider directory information, including:
  - Use of consistent lexicon for provider detail information
  - Use of placeholders with consistent descriptions for provider details that are missing, such as "none" or "none specified" rather than blanks
  - List all languages spoken by providers
  - Require all directories to state the date the information was last updated for easy monitoring
- **Continue to monitor MCO complaints** regarding the use of urgent care services and review utilization trending to ensure members are not accessing these services due to an inability to identify or access PCPs.
- **Review and revise COMAR 10.09.66.07(A)(3)(iii)** to specify which provider types are required to schedule patients within 48 hours of an appointment request.

Section IX
Healthcare Effectiveness Data and Information Set (HEDIS®)

Introduction

In accordance with COMAR 10.09.65.03B(2)(a), the HealthChoice MCOs are required to collect HEDIS® measures each year based on relevancy to the HealthChoice population. HEDIS® is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and result-calculation in order to promote a high degree of standardization of HEDIS® measures. Reporting entities are required to register with NCQA and undergo an annual NCQA HEDIS® Compliance Audit™.

To ensure audit consistency, only NCQA-licensed organizations using NCQA certified auditors may conduct a HEDIS® Compliance Audit. The audit conveys sufficient integrity to HEDIS® data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance.

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

Within MDH, the HealthChoice & Acute Care Administration (HACA) is responsible for the quality oversight of the HealthChoice program. MDH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS® reporting. Performance is measured at both the managed care organization level and on a statewide basis. HEDIS® results are incorporated annually into a HealthChoice Health Plan Performance Report Card developed to assist HealthChoice enrollees to make comparisons when selecting a health plan.

For HEDIS® 2018, MDH required HealthChoice managed care organizations to report the complete HEDIS® measure set for services rendered in CY 2017 to HealthChoice enrollees. These measures provide meaningful managed care organization comparative information and they measure performance relative to MDH's priorities and goals.

Accreditation

All HealthChoice MCOs are required by MCH to be NCQA accredited per COMAR §10.09.65.02. In addition, according to COMAR §10.09.64.08, any HealthChoice organizations that joined the HealthChoice program after January 1, 2013, are required to be NCQA accredited within two years of their effective date. Accreditation is based on a combination of adherence to accreditation standards and a comprehensive evaluation/analysis of clinical performance and consumer experience. A total of 100 points is possible with 50 points based on standards and 50 points on performance and consumer experience. The accreditation levels are used to rate the quality of care provided by health plans to their members. Based on the total number of points achieved, NCQA assigns a level of accreditation. Current accreditation status for all HealthChoice MCOs is listed in Table 59.

Table 59. HealthChoice MCO NCQA Accreditation Status

HealthChoice MCO	Accreditation Status
AMERIGROUP Community Care (ACC)	Commendable
Jai Medical Systems, Inc. (JMS)	Excellent
Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)	Excellent
Maryland Physicians Care (MPC)	Commendable
MedStar Family Choice, Inc. (MSFC)	Commendable
Priority Partners (PPMCO)	Commendable
UnitedHealthcare Community Plan (UHC)	Commendable
University of Maryland Health Partners (UMHP)	Accredited

NCQA Accreditation Levels are described in Table 60.

Table 60. NCQA Accreditation Levels

Level	Description
Excellent	NCQA awards its highest status of Excellent to organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS®/CAHPS® results are in the highest range of national performance.
Commendable	NCQA awards a status of Commendable to organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement. Organizations with this status may not have had their HEDIS®/CAHPS® results evaluated. If HEDIS®/CAHPS® results were evaluated, organizations must take further action to achieve higher accreditation status.
Accredited	NCQA awards a status of Accredited to organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations with this status may not have had their HEDIS®/CAHPS® results evaluated. If HEDIS®/CAHPS® results were evaluated, organizations must take further action to achieve higher accreditation status.
Provisional	NCQA awards a status of Provisional to organizations with programs for service and clinical quality that meet some, but not all, basic requirements for consumer protection and quality improvement. Organizations awarded this status need to improve their processes as well as clinical and service quality to achieve a higher accreditation status.
Interim	NCQA awards a status of Interim to organizations with basic structure and processes in place to meet expectations for consumer protection and quality improvement. Organizations awarded this status will need to undergo a Full Survey within 18 months to demonstrate they have executed those processes effectively.
Denied	NCQA awards a status of Denied Accreditation to organizations whose programs for service and clinical quality do not meet NCQA requirements.

* Source: NCQA (2017). *What Accreditation Levels Can a Plan Achieve?* Retrieved from: http://www.ncqa.org/Programs/Accreditation/health-plan-hp/Accreditation-Levels

Measures Designated for Reporting

Annually, MDH determines the set of measures required for HEDIS® reporting. MDH selects these measures because they provide meaningful MCO comparative information and measure performance pertinent to MDH's priorities and goals.

Measures Selected by MDH for HealthChoice Reporting

MDH required HealthChoice managed care organizations to report 45 HEDIS® measures for services rendered in CY 2017. The required set reflected two first-year HEDIS® measures (Use of Opioids at High Dosage and Use of Opioids from Multiple Providers). The reportable measures within the four NCQA domain categories include:

Effectiveness of Care (EOC) - 28 measures:

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC), all indicators except HbA1c Control (<7.0%)
- Statin Therapy for Patients with Diabetes (SPD)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Appropriate Testing for Children with Pharyngitis (CWP)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- Chlamydia Screening in Women (CHL)
- Use of Imaging Studies for Low Back Pain (LBP)
- Annual Monitoring for Patients on Persistent Medications (MPM)
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Medication Management for People with Asthma (MMA)
- Controlling High Blood Pressure (CBP)
- Adult Body Mass Index (BMI) Assessment (ABA)
- Asthma Medication Ratio (AMR)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy Management of COPD Exacerbation (PCE)
- Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Lead Screening in Children (LSC)
- Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
- Use of Opioids at High Dosage (UOD)*
- Use of Opioids From Multiple Providers (UOP)*

**First Year Measures*

Access/Availability of Care (AAC) - 3 measures:

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Prenatal and Postpartum Care (PPC)

Utilization and Risk Adjusted Utilization (URR) - 8 measures:

- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Ambulatory Care: Total (AMB)
- Frequency of Selected Procedures (FSP)
- Standardized Healthcare-Associated Infection Ratio (HAI)
- Inpatient Utilization: Total (IPUA)
- Antibiotic Utilization: Total (ABX)

Health Plan Descriptive Information - 6 measures:

- Board Certification (BCR)
- Enrollment by Product Line: Total (ENPA)
- Enrollment by State (EBS)
- Language Diversity of Membership (LDM)
- Race/ Ethnicity Diversity of Membership (RDM)
- Total Membership (TLM)

Measures Collected From the Adult CAHPS® Survey - 2 measures:

- Flu Vaccinations for Adults Ages 18-64 (FVA)
- Medical Assistance with Smoking and Tobacco Use Cessation (MSC) (advising Smokers and Tobacco Users to Quit Rate Only)

No Benefit (NB) Measure Designations - 14 Measures:

The NB designation is utilized for measures where MDH has contracted with outside vendors for coverage of certain services. MetaStar and MCOs do not have access to the data. So that MCOs are not penalized, NCQA allows the MCOs to report these measures with a NB designation. The following 14 measures are reported with an NB designation and do not appear in the measure specific findings of this report.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
- Antidepressant Medication Management (AMM)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Follow-Up Care after Hospitalization for Mental Illness (FUH)
- Follow-Up After Emergency Department (ED) Visit for Metal Illness (FUM)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

- Mental Health Utilization (MPT)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Annual Dental Visit (ADV)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Identification of Alcohol and Other Drug Services (IAD)

Measures Not Reported by MDH for HealthChoice

MDH does not report categories of measures in HealthChoice Reporting if they are exempt, suspended, or retired by NCQA. Below are the included HEDIS® 2018 measures that fall into those categories.

Measures Exempt from Reporting

- Comprehensive Diabetes Care
  - HbA1c Control (<7.0%)
- Ambulatory Care
  - Dual Eligibles (AMBB)
  - Disabled (AMBC)
  - Other (AMBD)
- Inpatient Utilization
  - General Hospital/Acute Care: Dual Eligibles (IPUB)
  - General Hospital/Acute Care: Disabled (IPUC)
  - General Hospital/Acute Care: Other (IPUD)
- Identification of Alcohol and Other Drug Services
  - Dual Eligibles (IADB)
  - Disabled (IADC)
  - Other (IADD)
- Antibiotic Utilization
  - Dual Eligibles (ABXB)
  - Disabled (ABXC)
  - Other (ABXD)
- Enrollment by Product Line
  - Dual Eligibles (ENPB)
  - Disabled (ENPC)
  - Other (ENPD)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF)
- Utilization of the PHQ-9 to Monitor Depression Systems for Adolescents and Adults (DMS)
- Depression Remission or Response for Adolescents and Adults (DRR)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF)
- Pneumococcal Vaccination Coverage for Older Adults (PVC)

NCQA Suspended Measures for HEDIS® 2018

- Relative Resource Use for People with Diabetes (RDI)
- Relative Resource Use for People with Cardiovascular Conditions (RCA)
- Relative Resource Use for People with Hypertension (RHY)

- Relative Resource Use for People with COPD (RCO)
- Relative Resource Use for People with Asthma (RAS)

Measures Retired for HEDIS® 2018:

- Frequency of Prenatal Care (FPC)

HEDIS® Methodology

MetaStar follows guidelines for data collection and specifications for measure calculation described in *HEDIS® 2018 Volume 2: Technical Specifications.*

Data Collection: The health plan pulls together all data sources to include administrative data, supplemental data, and medical record data, typically into a data warehouse, against which HEDIS® software programs are applied to calculate measures. The three approaches that may be utilized are defined below:

Administrative Data. Refers to data that is collected, processed, and stored in automated information systems. Administrative data includes enrollment or eligibility information, claims information, and managed care encounters. Examples of claims and encounters include hospital and other facility services, professional services, prescription drug services, and laboratory services. Administrative data are readily available, are inexpensive to acquire, are computer readable, and typically encompass large populations.

Supplemental Data. NCQA defines supplemental data as atypical administrative data, (i.e., not claims or encounters). Sources include immunization registry files, laboratory results files, case management databases, and electronic health record databases. There are two distinct categories of supplemental data with varying requirements for proof-of-service. The most stable form is Standard Supplemental Data which is from a database with a constant form that does not change over time. Non-standard Supplemental Data is in a less stable form and may be manipulated by human intervention and interaction. Non-standard Supplemental Data must be substantiated by proof-of-service documentation and is subject to primary source verification yearly.

Medical Record Data. Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA-defined hybrid methodology. HEDIS® specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records need to be chased. NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by MDH for HEDIS® reporting. Use of the hybrid method is optional. NCQA maintains that no one approach to measure calculation or data collection is considered superior to another. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across-the-board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

Table 61 shows the HEDIS® 2018 measures collected by use of the administrative or hybrid method. The HealthChoice organization chooses the administrative versus hybrid method based on available resources, as the hybrid method takes significant resources to perform.

Table 61. MCO Use of Administrative or Hybrid Method

Measure List	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
ABA – Adult BMI Assessment	H	H	H	H	H	H	H	H
AWC – Adolescent Well-Care Visits	H	H	H	H	H	H	H	H
CBP – Controlling High Blood Pressure	H	H	H	H	H	H	H	H
CCS – Cervical Cancer Screening	H	H	H	H	H	H	H	H
CDC – Comprehensive Diabetes Care	H	H	H	H	H	H	H	H
CIS – Childhood Immunization Status	H	H	H	H	H	H	H	H
IMA– Immunizations for Adolescents	H	H	H	H	H	H	H	H
LSC – Lead Screening in Children	A	H	H	H	H	A	H	H
PPC – Prenatal and Postpartum Care	H	H	H	H	H	H	H	H
W15 – Well-Child Visits in the First 15 Months of Life	H	H	H	H	H	A	H	H
W34 – Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	H	A	H	H	H	H	H	H
WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	H	H	H	H	H	H	H	H

H – Hybrid; A – Administrative

HEDIS® Audit Protocol

The HEDIS® auditor follows NCQA's *Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures*. The main components of the audit are:

Pre-Onsite Teleconference: A conference call is held two to four weeks prior to onsite visit to introduce key personnel, review the onsite agenda, identify session participants, and determine a plan to audit data sources used for HEDIS®.

HEDIS® Roadmap Review. The HEDIS® "Roadmap" is an acronym representing the HEDIS® Record of Administration, Data Management, and Processes. The Roadmap is a comprehensive instrument designed by NCQA to collect information from each HealthChoice plan regarding structure, data collection and processing, and HEDIS® reporting procedures. The health plan completes and submits the Roadmap to the auditing organization by January 31st of each reporting year. The auditor reviews the HEDIS® Roadmap prior to the onsite audit in order to make preliminary assessments regarding Information Systems (IS) compliance and to identify areas requiring follow–up at the onsite audit.

Information Systems (IS) Standards Compliance. The onsite portion of the HEDIS® Audit expands upon information gleaned from the HEDIS® Roadmap to enable the auditor to make conclusions about the organization's compliance with IS standards. IS standards measure how the organization collects, stores, analyzes and reports medical, customer service, member, practitioner, and vendor data. IS standards describe the minimum requirements for information systems and processes used in HEDIS data collection and provides the foundation on which the auditor assesses the organization's ability to report HEDIS data accurately, completely, and reliably. The auditor reviews data collection and management processes, including the monitoring of vendors, and makes a determination regarding the soundness and completeness of data to be used for HEDIS® reporting.

HEDIS® Measure Determination (HD) Standards Compliance. The auditor uses both onsite and offsite activities to determine compliance with HD standards and to assess the organization's adherence to HEDIS® Technical Specifications and report–production protocols. The auditor confirms the use of NCQA–certified software. The auditor reviews the organization's sampling protocols for the hybrid method. Later in the audit season, the auditor reviews HEDIS® results for algorithmic compliance and performs benchmarking against NCQA–published means and percentiles.

Medical Record Review Validation (MRRV). The HEDIS® audit includes a protocol to validate the integrity of data obtained from medical record review (MRR) for any measures calculated using the hybrid method. The audit team compares its medical record findings to the organization's abstraction forms for a sample of positive numerator events. Part one of the validation may also include review of a convenience sample of medical records for the purpose of finding procedural errors early in the medical record abstraction process so that timely corrective action can be made. This is optional based on NCQA standards and auditor opinion. MRRV is an important component of the HEDIS® Audit. It ensures that medical record reviews performed by the organization, or by its contracted vendor, meet audit standards for sound processes and that abstracted medical data are accurate. In part two of the MRRV, the auditor selects hybrid measures from like–measure groupings for measure validation. MRRV tests medical records and appropriate application of the HEDIS® hybrid specifications (i.e., the member is a numerator positive or an exclusion for the measure). NCQA uses an acceptable quality level of 2.5 percent for the sampling process, which translates to a sample of 16 medical records for each selected measure.

Audit Designations: An NCQA audit results in audited rates or calculations at the measure or indicator level and indicates whether the measures can be publicly reported. All measures selected for reporting must have a final audited result. A measure selected for reporting or required by a state or federal program can receive an audit designation of BR if the auditor determines it is not reportable. The auditor approves the rate/result calculated by the HealthChoice organization for each measure included in the HEDIS® report. Table 62 shows the audit designations of audit results, excerpted from *Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures.*

Table 62. HEDIS® Audit Designations

Designation	Description
R	Reportable. A reportable rate was submitted for the measure.
NA	Small Denominator. The organization followed the specifications but the denominator was too small (<30) to report a valid rate.
NB	Benefit Not Offered. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reported. The organization chose not to report the measure. (An organization may exercise this option only for those measures not included in the measurement set required by MDH.)
NQ	Not Required. The organization was not required to report the measure.
BR	Biased Rate. The calculated was materially biased.
UN	Un-Audited. The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g. measured collected using electronic clinical data systems).

Note: The NB designation is utilized for measures where MDH has contracted with outside vendors for coverage of certain services. Metastar and HealthChoice Organizations do not have access to the data. NCQA allows the MCOs to report these measures with a NB designation so that they are not penalized.

Bias Determination. If the auditor determines that a measure is biased, the organization cannot report a rate for that measure and the auditor assigns the designation of BR. Bias is based on the degree of error or data completeness for the data collection method used. NCQA defines four bias determination rules, applied to specific measures. These are explained in Appendix 9 of *Volume 5: HEDIS® Compliance Audit™: Standards, Policies and Procedures*.

Final Audit Opinion. At the close of the audit, the auditor renders the Final Audit Opinion, containing a Final Audit Statement along with measure–specific rates/results and comments housed in the Audit Review Table.

Measure Specific Findings Explanation

Three metrics are calculated to accompany the MCO–specific scores:

Maryland Average Reportable Rate (MARR): The MARR is an average of HealthChoice MCOs' rates as reported to NCQA. In most cases, all eight MCOs contributed a rate to the average. Where one or more organizations reported *NA* instead of a rate, the average consisted of fewer than eight component rates.

National HEDIS® Mean (NHM) and NCQA Benchmarks: The NHM and Benchmarks are taken from NCQA's HEDIS® Audit Means, Percentiles and Ratios – Medicaid, released each year to each reporting organization along with a data use license that outlines how this data can be used. The NCQA data set gives prior-year rates for each measure displayed as the mean rate and the benchmarked rate at the 5th, 10th, 25th, 50th, 75th, 90th and 95th percentiles. NCQA averages the rates of all organizations submitting HEDIS® results, regardless of the method of calculation (administrative or hybrid). NCQA's method is the same as that used for the MARR, but on a larger scale.

Year–to–year trending is possible when specifications remain consistent from year to year. (Expected updates to industry–wide coding systems are not considered specification changes.) For each measure, the tables display up to five years of results, where available.

Prior year results are retained in the trending tables, regardless of specification changes. Text in italics notes when prior–year results fall under different specifications. Performance trends at the organization level are compared with the trends for the MARR and the NHM for the same measurement year. Rates are rounded to one decimal point from the rate/ratio reported to NCQA. This rounding corresponds to the rounding used by NCQA for the NHM. Where any two or more rates are identical at this level of detail, an additional decimal place of detail is provided.

According to NCQA reporting protocols, *NA* may replace a rate.

Sources of Accompanying Information

Description. The source of the information is NCQA's *HEDIS® 2018 Volume 2: Technical Specifications.*

Rationale. For all measures, the source of the information is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of 2017. These citations appear under the *Brief Abstract* on the Web site of the National Quality Measures Clearinghouse, http://www.qualitymeasures.ahrq.gov/.

Summary of Changes for HEDIS® 2018. The source of the text, is the *HEDIS® 2018 Volume 2: Technical Specifications*, incorporating additional changes published in the *HEDIS ®2018 Volume 2: "October" Technical Update.*

Year-To-Year Changes

Table 63 shows the number of MCOs that experienced a lower or higher change in HEDIS rates from service year 2016 to 2017. The change in the MARR (2018 rate minus 2017 rate) and the change in the NHM (2017 rate minus 2016 rate) place Maryland HealthChoice organization trends in perspective. It should be considered when reviewing these figures that the NHM is retrospective while the MARR is for the current season. A comparison of change in the MARR vs. change in the NHM may be indicative of a specification change or reflect other lability considerations. For measures where a lower rate indicates better performance (single asterisk), the number of lower performing organizations appears in the higher column and the number of higher performing organizations appear in the lower column. New measures or indicators with no trendable history are not included in this analysis of change. HEDIS® 2018 results of *NA* are not included in these results. Rates that stayed the same from last year and did not increase or decrease are not included in this table.

Table 63. Changes in HEDIS® Rates from 2017 to 2018

HEDIS® Measure	Lower	Higher	MARR Change	NHM Change
Adult BMI Assessment (ABA)	1	7	1.9	**-0.1**
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	0	8	6.9	2.3
Childhood Immunization Status (CIS) – Combination 2	7	1	**-4.2**	0.5

HEDIS® Measure	Lower	Higher	MARR Change	NHM Change
Childhood Immunization Status (CIS) – Combination 3	6	2	**-4.2**	0.7
Childhood Immunization Status (CIS) – Combination 4	5	2	**-3.8**	1.1
Childhood Immunization Status (CIS) – Combination 5	6	1	**-1.6**	1.1
Childhood Immunization Status (CIS) – Combination 6	3	5	2.2	**-0.1**
Childhood Immunization Status (CIS) – Combination 7	6	2	**-1.4**	1.3
Childhood Immunization Status (CIS) – Combination 8	3	5	2.4	0.0
Childhood Immunization Status (CIS) – Combination 9	3	5	2.8	**-0.1**
Childhood Immunization Status (CIS) – Combination 10	3	5	3.0	0.1
Immunizations for Adolescents (IMA) – Combination 1	2	6	1.4	2.4
Immunizations for Adolescents (IMA) – Combination 2	0	8	15.8	NA
Well-Child Visits in the First 15 months of Life (W15) – No Well-Child Visits*	5	3	1.1	0.1
Well-Child Visits in the First 15 months of Life (W15) – MDH Five or Six-or-More Visits Rates**	1	7	2.5	NA
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	4	4	**-0.2**	0.9
Adolescent Well-Care Visits (AWC)	2	6	**-0.4**	1.7
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI Percentile - Total Rate	2	5	2.9	4.7
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	2	6	2.7	5.1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	3	4	2.0	4.2
Appropriate Testing for Children with Pharyngitis (CWP)	3	5	1.4	3.0
Lead Screening in Children (LSC)	3	4	0.7	1.1
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*	0	7	**-0.4**	**-0.7**
Medication Management for People With Asthma (MMA) – Total 50% of Treatment Period	2	6	2.4	2.4
Medication Management for People With Asthma (MMA) – Total 75% of Treatment Period	2	6	1.8	2.1
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	3	5	0.4	0.8
Asthma Medication Ratio (AMR)	5	3	0.9	1.4
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	3	5	2.7	0.6
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	3	5	2.9	**-1.2**
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	4	4	1.0	0.6
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–24 Months	4	4	0.6	0.1
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 25 Months to 6 Years	7	1	**-1.1**	**-0.1**

HEDIS® Measure	Lower	Higher	MARR Change	NHM Change
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 7–11 Years	5	2	**-1.0**	**-0.3**
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–19 Years	8	0	**-1.6**	**-0.1**
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 Years	7	1	**-2.3**	**-0.6**
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 Years	7	1	**-1.3**	**-0.6**
Breast Cancer Screening (BCS)	4	4	**-0.1**	0.4
Cervical Cancer Screening (CCS)	5	2	**-2.5**	2.2
Chlamydia Screening in Women (CHL) – Age 16–20 years	1	7	1.8	2.4
Chlamydia Screening in Women (CHL) – Age 21–24 years	3	4	0.6	1.6
Chlamydia Screening in Women (CHL) – Total (16–24) years	3	5	1.2	2.1
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	7	1	**-2.7**	1.7
Prenatal and Postpartum Care (PPC) – Postpartum Care	3	5	0.4	**-9.5**
Controlling High Blood Pressures (CBP)	3	3	**-5.4**	1.8
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)	7	1	**-6.3**	**-0.6**
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	2	4	8.2	**-0.2**
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Received Statin Therapy – Total	3	5	0.9	4.1
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Statin Adherence 80% - Total	3	5	2.6	**-9.0**
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	7	1	**-1.0**	0.7
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*	6	2	3.1	**-2.1**
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	5	3	**-1.5**	1.6
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	3	5	0.8	2.2
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	5	3	**-1.5**	**-0.1**
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	3	5	2.8	0.7
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	3	4	**-8.3**	1.5
Statin Therapy for Patients With Diabetes (SPD) – Received Statin Therapy	2	6	0.8	2.1
Statin Therapy for Patients With Diabetes (SPD) – Statin Adherence 80%	6	1	**-2.2**	1.6
Use of Imaging Studies for Low Back Pain (LBP)	1	6	2.8	**-3.1**
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	5	3	**-2.8**	1.4
Annual Monitoring for Patients on Persistent Medications (MPM) - Members on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB)	7	1	**-0.9**	0.6
Annual Monitoring for Patients on Persistent Medications (MPM) - Members on Diuretics	6	2	**-1.0**	0.4

HEDIS® Measure	Lower	Higher	MARR Change	NHM Change
Annual Monitoring for Patients on Persistent Medications (MPM) - Total Rate	6	2	**-0.8**	0.4
Ambulatory Care (AMB) – Outpatient Visits per 1,000 Member Months	6	1	2.7	7.8
Ambulatory Care (AMB) – Emergency Department (ED) Visits per 1,000 Member Months	6	1	**-7.2**	0.6
Standardized Healthcare-Associated Infection Ratio (HAI)* – Central Line – Associated Blood Stream Infection (CLABSI) – Plan Weighted SIR	7	1	**-0.1**	**-0.3**
Standardized Healthcare-Associated Infection Ratio (HAI)* – Catheter – Associated Urinary Tract Infection (CAUTI) – Plan Weighted SIR	4	4	0.1	**-0.2**
Standardized Healthcare-Associated Infection Ratio (HAI)* – MRSA Bloodstream Infection (MRSA) – Plan Weighted SIR	4	4	0.1	**-0.3**
Standardized Healthcare-Associated Infection Ratio (HAI)* – Clostridium Difficile Intestinal Infection (CDIFF) – Plan Weighted SIR	6	2	**-0.1**	**-0.1**
Use of Opioids at High Dosage	0	8	0.1	-
Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers	0	8	0.3	-
Use of Opioids From Multiple Providers (UOP) - Multiple Pharmacies	0	7	0.1	-
Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers and Multiple Pharmacies	0	7	0.1	-

* A lower rate indicates better performance.
** Not a HEDIS sub-measure; MetaStar is calculating for MDH trending purposes.

Three Year Trending

Table 64 shows MCOs that demonstrated incremental increases in performance scores over the past three years (2018 less 2016 for those plans that reported all three years). The analysis only shows a trend toward improvement. It does not indicate superior performance. For a comparison of one organization against another, please refer to the measure-specific tables in this report. For measures where a lower rate indicates better performance (single asterisk), the table shows organizations having a decrease in performance score over the past three years.

Table 64. HEDIS® Measures Incremental Increases in Performance

HEDIS® Measure	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP[1]
Adult BMI Assessment (ABA)	X	X		X	X	X	X	X
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	X	X		X	X	X	X	X
Childhood Immunization Status (CIS) – Combination 2	X							
Childhood Immunization Status (CIS) – Combination 3	X							
Childhood Immunization Status (CIS) – Combination 4	X				X			
Childhood Immunization Status (CIS) – Combination 5	X							X
Childhood Immunization Status (CIS) – Combination 6		X	X					X
Childhood Immunization Status (CIS) – Combination 7	X				X	X		X

HEDIS® Measure	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP[1]
Childhood Immunization Status (CIS) – Combination 8		X	X		X			X
Childhood Immunization Status (CIS) – Combination 9		X	X		X		X	X
Childhood Immunization Status (CIS) – Combination 10		X	X		X		X	X
Immunizations for Adolescents (IMA) – Combination 1	X	X	X		X		X	X
Immunizations for Adolescents (IMA) – Combination 2								
Well-Child Visits in the First 15 months of Life (W15) – No Well-Child Visits*	X	X			X		X	X
Well-Child Visits in the First 15 months of Life (W15) – MDH Five or Six-or-More Visits Rates**		X	X		X		X	X
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	X	X				X	X	X
Adolescent Well-Care Visits (AWC)	X		X					X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI Percentile - Total Rate	X	X	X		X	X	X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	X		X		X		X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	X	X	X		X		X	X
Appropriate Testing for Children with Pharyngitis (CWP)		X		X		X	X	
Lead Screening in Children (LSC)	X		X	X	X	X		X
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*	X		X	X	X	X	X	X
Medication Management for People With Asthma (MMA) – Total 50% of Treatment Period	X	X			X	X	X	
Medication Management for People With Asthma (MMA) – Total 75% of Treatment Period					X	X	X	
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	X	X	X		X	X	X	X
Asthma Medication Ratio (AMR)	X	X						X
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	X	X		X	X	X	X	
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate					X			X
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate					X			X
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–24 Months		X	X		X			X
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 25 Months–6 Years								X

HEDIS® Measure	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP[1]
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 7–11 Years		X						X
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–19 Years	X							X
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 Years								
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 Years								
Breast Cancer Screening (BCS)	X	X			X	X		X
Cervical Cancer Screening (CCS)			X					X
Chlamydia Screening in Women (CHL) – Age 16–20 Years	X	X	X		X	X	X	X
Chlamydia Screening in Women (CHL) – Age 21–24 Years	X	X			X	X	X	X
Chlamydia Screening in Women (CHL) – Total (16–24) Years	X	X			X	X	X	X
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	X		X	X			X	X
Prenatal and Postpartum Care (PPC) – Postpartum Care			X	X	X		X	X
Controlling High Blood Pressures (CBP)	X				X		X	X
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)					X			
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)								
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Received Statin Therapy – Total	X	X		X	X	X	X	
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Statin Adherence 80% - Total							X	
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	X	X			X		X	
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*	X		X		X		X	
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	X	X	X				X	
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	X	X			X		X	X
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy								
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	X				X		X	X
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)							X	
Statin Therapy for Patients With Diabetes (SPD) – Received Statin Therapy	X	X			X	X	X	X
Statin Therapy for Patients With Diabetes (SPD) – Statin Adherence 80%							X	

HEDIS® Measure	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP[1]
Use of Imaging Studies for Low Back Pain (LBP)	X	X				X	X	
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)				X	X		X	
Annual Monitoring for Patients on Persistent Medications (MPM) - Members on Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARB).							X	
Annual Monitoring for Patients on Persistent Medications (MPM) - Members on Diuretics.							X	X
Annual Monitoring for Patients on Persistent Medications (MPM) - Total Rate							X	
Ambulatory Care (AMB) – Outpatient Visits per 1,000 Member Months								
Ambulatory Care (AMB) – Emergency Department (ED) Visits per 1,000 Member Months 3								
Standardized Healthcare-Associated Infection Ratio (HAI)* – Central Line – Associated Blood Stream Infection (CLABSI) – Plan Weighted SIR								
Standardized Healthcare-Associated Infection Ratio (HAI)* – Catheter – Associated Urinary Tract Infection (CAUTI) – Plan Weighted SIR								
Standardized Healthcare-Associated Infection Ratio (HAI)* – MRSA bloodstream infection (MRSA) – Plan Weighted SIR								
Standardized Healthcare-Associated Infection Ratio (HAI)* – Clostridium Difficile Intestinal Infection (CDIFF) – Plan Weighted SIR								
Use of Opioids at High Dosage (UOD)								
Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers								
Use of Opioids From Multiple Providers (UOP) - Multiple Pharmacies								
Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers and Multiple Pharmacies								
Totals	**35**	**29**	**20**	**10**	**36**	**19**	**38**	**38**

**Custom measure made up of 5 visits and 6 or more visits combined

* A lower rate indicates better performance.

[1] UMHP reported NA for most measures in their first year of reporting. They will be given credit for improvement in any measure where they improved from their first reported rate to the rate for HEDIS 2018.

HEDIS® Year 2018 Highlights

- The MARR for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) increased by 6.9% from the prior year due to improved performance amongst all MCOs. Six out of eight MCOs experienced significant improvement of greater than 5% from the prior year.

- All MCOs, with the exception of MedStar Family Care and Kaiser experienced a decline in the reported rate for Childhood Immunizations Status- Combination 3 (CIS). The most significant declines were seen by UnitedHealthcare who had a 7.1% decline in rate from the prior year, and Maryland Physician Care whose performance declined 14% from the prior year.
- Immunizations for Adolescents-Combination 2 (IMA) saw improvement amongst all MCOs in 2017. There was a significant change made to the measure specification numerator criteria in 2017 that likely attributed to the improvement in performance. The updated specifications allow for two HPV vaccines, where prior specifications required three doses of the HPV vaccine.
- Persistence of Beta-Blocker Treatment after a Heart Attack (PBH) all MCOs except MedStar Family Care saw a decline in performance from the prior year. This decline in reported rates from the majority of MCOs caused the MARR to drop 6.3% for the 2017 measurement year. It should be noted, that while the eligible population for each MCO exceeded 30 members, the minimum number of members to report the measure, the eligible populations are still relatively small for each MCO, which can result in volatility of the reported rate year-to-year.
- Overall, utilization slightly increased for Inpatient and Outpatient settings, while Emergency Department utilization experienced a significant decline.
    - Inpatient Utilization – General Hospital/Acute Care (IPU) total discharges/1000 members months was stable in 2017 for seven of the eight MCOs experiencing only minor changes in reported rates from the prior year. UnitedHealthcare, experienced a significant change in the utilization rate. The United HealthCare reported rate increased by approximately 10% from the prior year.
    - Ambulatory Care (AMB) experienced a decrease in Emergency Department Visits for all MCOs except Kaiser Permanente. Jai Medical and University of Maryland experienced the most significant declines, each experiencing a greater than 10% change in the reported rate from the prior year. The decline in Emergency Department utilization amongst the MCOs resulted in an approximately 11% decrease to the MARR for this measure.
    - Ambulatory Care (AMB) Outpatient visits declined amongst all MCOs with the exception of University of Maryland Health Partners who experienced 34% increase in the number of outpatient visits per 1000 months.

Section X
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

Introduction

COMAR 10.09.65.03(C)(4) requires that all HealthChoice MCOs participate in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. The Maryland Department of Health (MDH) began contracting with the Center for the Study of Services (CSS), an NCQA–certified survey vendor, in 2017 to conduct its survey. CSS administers this survey to a random sample of eligible adult and child members enrolled in HealthChoice via mixed methodology (mail with telephone follow–up), per NCQA protocol. Eight MCOs participated in the HealthChoice CAHPS® 2018 survey based on services provided in CY 2017 as listed below.

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

2017 CAHPS® 5.0H Medicaid Survey Overview

In 2018, the 5.0H version of the CAHPS® Adult and Child Medicaid Satisfaction Surveys was used to survey the HealthChoice population about services provided in CY 2017. The survey measures those aspects of care for which members are the best and/or the only source of information. From this survey, members' ratings of and experiences with the medical care they receive can be determined. Based on members' health care experiences, potential opportunities for improvement can be identified. Specifically, the results obtained from this consumer survey will allow MDH to:

- Determine how well participating HealthChoice MCOs are meeting their members' expectations
- Provide feedback to the HealthChoice MCOs to improve quality of care
- Encourage HealthChoice MCO accountability
- Develop a HealthChoice MCO action plan to improve members' quality of care

Results from the CAHPS® 5.0H survey summarize member satisfaction with their health care through ratings, composite measures, and question summary rates. In general, summary rates represent the percentage of respondents who chose the most positive response categories as specified by NCQA. Ratings and composite measures in the CAHPS® 5.0H Adult and Child Medicaid Survey include:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision–Making

Five additional composite measures are calculated for the Children with Chronic Conditions (CCC) population:

- Access to Prescription Medicine
- Access to Specialized Services
- Family Centered Care: Getting Needed Information
- Family Centered Care: Personal Doctor Who Knows Child
- Coordination of Care for CCC

Survey Methodology

CSS administered the 2018 Health Plan CAHPS® Survey in accordance with the NCQA methodology detailed in *HEDIS® 2018, Volume 3: Specifications for Survey Measures* and *Quality Assurance Plan for HEDIS® 2018 Survey Measures.* The NCQA-prescribed sample size consisted of 3,490 members for the Child Medicaid with CCC Measure version of the survey and 1,350 members for the Adult Medicaid version. Sample-eligible members were members who were 18 years of age or older (for the Adult version) or 17 years of age or younger (for the Child Medicaid with CCC Measure version) as of December 31, 2017; were currently enrolled; had been continuously enrolled for six months (with no more than one enrollment break of 45 days or less); and whose primary coverage was through Medicaid. The sample frame for the Child with CCC Measure survey included a pre-screen status code to identify children that were likely to have a chronic condition (CCC) based on claim and encounter records. Using this code, a second sample was drawn from the child Medicaid CCC population, in addition to those members from the general child Medicaid population included in the initial sample.

Prior to sampling, CSS carefully inspected the member files and informed the MDH of any errors or irregularities found (such as missing address elements or subscriber numbers). Once the quality assurance process had been completed, CSS processed member addresses through the USPS National Change of Address service to ensure that the mailing addresses were up-to-date. The final sample was generated following the NCQA-specified methodology, with no more than one member per household selected to receive the survey. CSS assigned each sampled member a unique identification number, which was used to track their progress throughout the data collection process.

The appropriate health plan name and logo appeared on the materials that were sent to members. The outer envelope used for survey mailings was marked “RESPONSE NEEDED” or “FINAL REMINDER – PLEASE RESPOND,” depending on the mailing wave. Each survey package included a postage-paid return envelope. In addition to English, members had the option to complete the survey in Spanish using a telephone request line. All of the elements of the survey package were approved by NCQA prior to the initial mailing.

The MDH elected to use NCQA’s mixed survey administration methodology, which involved two survey mailings with telephone follow-up. Data collection closed on May 15, 2018. Survey results were submitted to NCQA on May 30, 2018.

Member Dispositions and Response Rates

A detailed breakdown of sample member dispositions is provided in Table 65 below. Table 66 and 67 provide response rate information on each surveyed MCO by population type.

Table 65. Sample Dispositions Among Adult and Child Members

Disposition Group	Disposition Category	Adult	Child General Population
Ineligible	Deceased	6	10
	Does not meet eligibility criteria (1)	108	149
	Language barrier (3)	46	55
	Mentally/Physically incapacitated (4)	8	N/A
	Total Ineligible	**168**	**214**
Non–Response	Incomplete but eligible	219	339
	Refusal	184	764
	Maximum attempts made	7,845	8,362
	Added to Do Not Call (DNC) List (8)	76	60
	Total Non–Response	**8,324**	**9,525**

*Maximum attempts made include two survey mailings and a maximum of six call attempts

Table 66. Adult Survey Completes and Response Rate

HealthChoice MCO	Sample Size	Completes*	Response Rate
ACC	1,350	273	20.7%
JMS	1,350	313	23.4%
KPMAS	1,350	266	20.0%
MPC	1,350	278	20.9%
MSFC	1,350	290	21.8%
PPMCO	1,350	330	24.9%
UHC	1,350	311	23.4%
UMHP	1,350	247	18.6%
Total HealthChoice MCOs	**10,800**	**2,308**	**21.7%**

*During the telephone follow–up, members had the option to complete the survey in either English or Spanish.

Table 67. Child Survey Completes and Response Rate

MCO	General Population	CCC Population	Sample Size Total	General Population Completes	CCC Population Completes	General Population Response Rate
ACC	1,650	1,840	3,490	474	338	29.2%
JMS	1,650	791	2,441	336	164	20.7%
KPMAS	1,650	1,840	3,490	419	220	25.9%
MPC	1,650	1,840	3,490	457	404	28.1%
MSFC	1,650	1,840	3,490	412	322	25.3%
PPMCO	1,650	1,840	3,490	517	389	31.6%
UHC	1,650	1,840	3,490	464	394	28.6%
UMHP	1,650	1,840	3,490	382	249	23.8%
Total	**13,200**	**13,671**	**26,871**	**3,461**	**2,480**	**26.7%**

*During the telephone follow-up, members had the option to complete the survey in either English or Spanish.

Survey Measures

Ratings

The CAHPS® survey includes four global ***rating questions*** that ask respondents to rate the following items on a *0* to *10* scale:

- ***Rating of Personal Doctor*** (*0* = worst personal doctor possible; *10* = best personal doctor possible).
- ***Rating of Specialist Seen Most Often*** (*0* = worst specialist possible; *10* = best specialist possible)
- ***Rating of All Health Care*** (*0* = worst health care possible; *10* = best health care possible)
- ***Rating of Health Plan*** (*0* = worst health plan possible; *10* = best health plan possible)

Rating question results are reported as the proportion of members selecting one of the top three responses (*8*, *9*, or *10*).

Composites

Composite measures combine results from related survey questions into a single measure to summarize performance in specific areas. ***Composite Global Proportions*** express the proportion of respondents selecting the desired response option(s) from a given group of questions on the survey. A global proportion is calculated by first determining the proportion of respondents selecting the response(s) of interest on each survey question contributing to the composite and subsequently averaging these proportions across all items in the composite.

The following composites are reported for the Adult and General Child Medicaid populations:

- ***Getting Needed Care*** combines responses to two survey questions that address member access to care. Results are reported as the proportion of members responding *Always* or *Usually*.

- ***Getting Care Quickly*** combines responses to two survey questions that address timely availability of urgent and routine care. Results are reported as the proportion of members responding *Always* or *Usually*.
- ***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*.
- ***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*.
- ***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*.

The following composite measures are calculated and reported for the Child CCC population:

- ***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*.
- ***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*.
- ***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*.
- ***Getting Needed Information*** (single item). Results are reported as the proportion of members responding *Always* or *Usually*.
- ***Access to Prescription Medicines*** (single item). Results are reported as the proportion of members responding *Always* or *Usually*.

HealthChoice MCO Performance on CAHPS® Survey Measures

The tables that follow show how the HealthChoice Aggregate and each of the individual MCOs performed over time. For each measure, the best performing plan is identified by an asterisk.

Overall Ratings – Adult Population

There were four Overall Ratings questions asked in the CAHPS® 5.0H Adult Medicaid Survey that used a scale of "0 to 10," where a "0" represented the worst possible and a "10" represented the best possible. Table 68 shows each of the four Overall Rating questions and the Summary Rate for these questions from CAHPS® 2016, 2017, and 2018. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

Table 68. CAHPS® Adult Population – Aggregate Rates of Overall Ratings Questions for 2016-2018

Overall Ratings	2018 (Summary Rate – *8,9,10*)	2017 (Summary Rate – *8,9,10*)	2016 (Summary Rate – *8,9,10*)
Specialist Seen Most Often	80.4%	81.3%	79.2%
Personal Doctor	79.0%	79.8%	79.2%
Health Care	74.3%	73.6%	74.8%
Health Plan	75.9%	74.0%	74.1%

HealthChoice members give their highest satisfaction ratings to their Specialist (80.4% , down from 81.3% in 2017) and/or their Personal Doctor (79.0%, down from 79.8% in 2017). Somewhat fewer HealthChoice members gave positive satisfaction ratings to their Health Care (74.3%, up from 73.6% in 2017) and/or Health Plan (75.9%, up from 74.0% in 2017) overall.

Table 69 shows health plan comparisons of the eight participating HealthChoice MCOs for the four Overall Ratings questions asked in the CAHPS® 5.0H Adult Medicaid Survey. The HealthChoice MCO with the highest Summary Rate for a particular overall rating is identified by an asterisk. Additionally, it indicates the HealthChoice Aggregate for each question.

Table 69. CAHPS® 2018 MCO Adult Population –- Summary Rates of Overall Rating Questions

MCOs	Overall Ratings (Summary Rate – *8,9,10*)			
	Specialist Seen Most Often	Personal Doctor	Health Care	Health Plan
HealthChoice Aggregate	**80.4%**	**79.0%**	**74.3%**	**75.9%**
ACC	74.7%	74.9%	71.1%	71.3%
JMS	78.3%	**82.5%***	75.1%	77.2%
KPMAS	83.7%	80.8%	76.7%	77.5%
MPC	82.0%	77.0%	76.3%	76.0%
MSFC	80.6%	77.5%	71.2%	76.7%
PPMCO	83.3%	82.0%	**79.5%***	**79.9%***
UHC	76.1%	75.7%	71.1%	72.07%
UMHP	**84.1%***	82.5%	73.3%	75.69%

*HealthChoice MCO with the highest Summary Rate

Composite Measure Results – Adult Population

Composite measures assess results for main issues/areas of concern. These composite measures were derived by combining survey results of similar questions (note: two of the composite measures are comprised of only one question). Specifically, it's the average of each response category of the attributes that comprise a particular service area or composite.

Table 70 shows the composite measure comparisons for Adult Summary Rates from CAHPS® 2016 to 2018.

Table 70. CAHPS® Adult Population – 2016-2018 Summary Rates for Composite Measure Results

Composite Measure	2018 (Summary Rate – *Always/Usually or Yes*)	2017 (Summary Rate – *Always/Usually or Yes*)	2016 (Summary Rate – *Always/Usually or Yes*)
Getting Needed Care	82.2%	82.2%	81.3%
Getting Care Quickly	81.6%	81.4%	80.5%
How Well Doctors Communicate	91.7%	91.7%	90.8%
Customer Service	88.4%	89.1%	87.1%
Shared Decision-Making	79.3%	81.0%	79.3%

HealthChoice MCOs receive the highest ratings among their members on the "How Well Doctors Communicate" (91.7% Summary Rate – Always/Usually) and "Customer Service" (88.4% Summary Rate – Always/Usually) composite measures. On the other hand, the research shows that HealthChoice MCOs receive the lowest ratings among their members on the "Shared Decision-Making" composite measure (79.3% Summary Rate – Yes). The composite measures "Getting Care Quickly" increased slightly from 2017 to 2018 (up from 81.4% to 81.6% Summary Rate – Always/Usually). The composite measure "Getting Needed Care" rating remained consistent with 2017 at 82.2% (Summary Rate – Always/Usually).

Table 71 shows health plan comparisons of Adult Summary Rates for composite measures for the eight participating HealthChoice MCOs. The HealthChoice MCO with the highest Summary Rate for a particular composite measure is identified by an asterisk. Additionally, it indicates the HealthChoice Aggregate for each question.

Table 71. CAHPS® 2018 MCO Adult Population –- Summary Rates for Composite Measure Results

MCOs	Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision-Making
HealthChoice Aggregate	**82.2%**	**81.6%**	**91.7%**	**88.4%**	**79.3%**
ACC	77.9%	81.2%	90.8%	89.7%	**82.2%***
JMS	80.6%	82.0%	93.8%	87.2%	77.9%
KPMAS	85.0%	79.3%	90.2%	86.5%	75.1%
MPC	83.8%	**84.9%***	91.7%	84.6%	78.2%
MSFC	79.5%	77.5%	90.0%	88.4%	80.3%
PPMCO	83.4%	83.6%	**93.9%***	**96.2%***	80.2%
UHC	**86.2%***	81.7%	89.9%	89.2%	80.4%
UMHP	80.5%	82.6%	92.5%	85.7%	79.6%

*HealthChoice MCO with the highest Summary Rate

Overall Ratings – Child Population

The results from the four Overall Ratings questions asked in the CAHPS® 5.0H Child Medicaid Survey are represented in Tables 72 and 73. The summary rate represents the percentage of members who rated the question an 8, 9, or 10. Rates are provided for 2016, 2017, and 2018.

Table 72. CAHPS® Child Population – Summary Rates of Overall Rating Questions for 2016-2018

Overall Ratings	2018 (Summary Rate – *8,9,10*)	2017 (Summary Rate – *8,9,10*)	2016 (Summary Rate – *8,9,10*)
Personal Doctor	91.1%	90.3%	90.1%
Health Care	89.0%	88.0%	87.6%
Health Plan	86.8%	86.7%	85.3%
Specialist	85.3%	85.4%	82.2%

HealthChoice MCOs continue to receive high satisfaction ratings from parents/guardians regarding their child's Personal Doctor (91.1%), Health Care overall (89.0%), Health Plan overall (86.8%) and Specialist (85.3%). Results for Overall Rating questions for 2018 exceeded results for each of the prior two years for three of the four questions. Although the satisfaction rating for Specialist decreased very slightly in 2018 it has increased over three percentage points since 2016.

The following table shows plan comparisons of Child Summary Ratings of the four Overall Rating questions for the eight participating HealthChoice MCOs. The HealthChoice MCO with the highest Summary Rate for a particular overall rating question is identified by an asterisk. Additionally, the table indicates the HealthChoice Aggregate for each question.

Table 73. CAHPS® 2018 MCO Child Population – Summary Rates of Overall Rating Questions

MCOs	Overall Ratings (Summary Rate – *8,9,10*)			
	Personal Doctor	Specialist	Health Care	Health Plan
HealthChoice Aggregate	**91.1%**	**85.3%**	**89.0%**	**86.8%**
ACC	92.2%	81.9%	86.5%	86.3%
JMS	**95.0%***	84.0%	91.3%	85.9%
KPMAS	92.0%	81.8%	91.6%	87.3%
MPC	89.4%	85.9%	84.7%	83.8%
MSFC	87.2%	**88.9%***	87.6%	86.8%
PPMCO	92.3%	86.1%	91.5%	**90.2%***
UHC	92.7%	88.7%	**92.4%***	88.2%
UMHP	88.0%	82.7%	86.4%	84.6%

*HealthChoice MCO with the highest Summary Rate

Composite Measures Results – Child Population

Tables 74 and 75 show the child composite measure results from CAHPS® 2016, 2017, and 2018.

Table 74. CAHPS® Child Population – 2016-2018 Summary Rates for Composite Measure Results

Composite Measures	2018 (Summary Rate – *Always/Usually or Yes*)	2017 (Summary Rate – *Always/Usually or Yes*)	2016 (Summary Rate – *Always/Usually or Yes*)
Getting Needed Care	83.5%	83.0%	83.1%
Getting Care Quickly	88.7%	88.1%	88.9%
How Well Doctors Communicate	94.0%	94.0%	94.2%
Customer Service	88.5%	88.4%	86.6%
Shared Decision-Making	80.3%	77.0%	79.0%

In 2018, HealthChoice MCOs received the highest ratings among their child members on the following composite measures:

- How Well Doctors Communicate (94.0% Summary Rate – Always/Usually);
- Getting Care Quickly (88.7% Summary Rate – Always/Usually);.

- Customer Service (88.5% Summary Rate – Always/Usually).

Somewhat lower proportions of child members gave HealthChoice MCOs positive ratings for the "Getting Needed Care" (83.5% Summary Rate – Yes) and "Shared Decision-Making" (80.3% Summary Rate – Yes) composite measures.

In addition to the aforementioned standard CAHPS® composite measures, five additional composite measures are calculated with regard to the CCC population. These results are listed in the table below.

Table 75. CAHPS® Child – CCC Population – 2016-2018 Summary Rates for Additional Composite Measure Results

Additional CCC Composite Measures	2018 (Summary Rate – *Always/Usually or Yes*)	2017 (Summary Rate – *Always/Usually or Yes*)	2016 (Summary Rate – *Always/Usually or Yes*)
Access to Prescription Medicine	91.0%	90.8%	89.4%
Access to Specialized Services	78.7%	77.0%	75.3%
Family Centered Care: Getting Needed Information	92.7%	91.4%	90.9%
Family Centered Care: Personal Doctor Who Knows Child	92.1%	90.1%	91.2%
Coordination of Care for Children with Chronic Conditions	73.1%	73.6%	76.1%

Table 76 and 77 show health plan comparisons of the eight participating HealthChoice MCOs among the Child Population. The HealthChoice MCO with the highest Summary Rate for a particular composite measure is identified by an asterisk. Additionally, it indicates the HealthChoice Aggregate for each question.

Table 76. CAHPS® 2018 MCO Child Population – Summary Rates for Composite Measure Results

MCOs	Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
HealthChoice Aggregate	**83.5%**	**88.7%**	**94.0%**	**88.5%**	**80.3%**
ACC	80.3%	84.4%	93.1%	84.0%	79.5%
JMS	87.2%	**94.1%***	**97.4%***	**95.2%***	**82.8%***

MCOs	Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
HealthChoice Aggregate	**83.5%**	**88.7%**	**94.0%**	**88.5%**	**80.3%**
KPMAS	80.8%	87.9%	94.0%	88.9%	77.1%
MPC	81.4%	86.9%	92.6%	86.0%	80.9%
MSFC	87.1%	89.1%	95.1%	87.8%	82.8%
PPMCO	**87.5%***	91.6%	94.2%	89.0%	81.3%
UHC	82.0%	90.3%	95.2%	90.9%	77.1%
UMHP	79.7%	86.0%	91.1%	86.6%	80.7%

*HealthChoice MCO with the highest Summary Rate

Table 77. CAHPS® 2018 MCO Child – CCC Population Summary Rates for Additional Composite Measure Results

MCOs	Additional CCC Composite Measures (Summary Rate – *Always/Usually or Yes*)				
	Access to Prescription Medicine	Access to Specialized Services	Getting Needed Information	Personal Doctor Who Knows Child	Coordination of Care for Children with Chronic Conditions
HealthChoice Aggregate	**91.0%**	**78.7%**	**92.7%**	**92.1%**	**73.1%**
ACC	83.6%	75.4%	89.9%	89.9%	77.0%
JMS	93.3%	73.4%	**95.6%***	**94.6%***	69.7%
KPMAS	91.4%	74.1%	91.6%	88.5%	**78.6%***
MPC	90.0%	78.0%	93.3%	92.6%	69.6%
MSFC	93.0%	79.9%	93.1%	93.3%	76.2%
PPMCO	**94.9%***	82.1%	91.3%	92.2%	77.3%
UHC	92.8%	**82.3%***	94.0%	93.3%	68.8%
UMHP	89.2%	76.1%	94.1%	90.7%	65.8%

*HealthChoice MCO with the highest Summary Rate

Key Driver Analysis

Key Driver Analysis identifies those areas of health plan performance and aspects of member experience that shape members' overall assessment of their health plan. To the extent that these areas or experiences can be improved, the overall rating of the plan will reflect these gains. For each member population type, five priorities for quality improvement with the greatest potential to affect the overall *Rating of Health Plan* score are identified below.

Key Drivers of Member Experience – Adult Medicaid

Ratings of the plan are strongly related to members' ability to get the care they need when they need it (Q14). Making appointments for routine care at a doctor's office or clinic (Q5) may also be viewed as an indirect measure of access and availability of care. *Rating of Personal Doctor* may reflect the quality of the health plan's network and its ability to contract with better providers.

Priority	Key Driver	Interpretation	Recommended Action
1	Q14. Ease of getting needed care, tests, or treatment (percent *Always* or *Usually*)	The higher the proportion of plan members reporting that the necessary care, tests, or treatment were easy to get, the higher the overall plan score	Improve member access to care (ease of getting needed care, tests, or treatment)
2	Q29. Written materials or the Internet provided needed information (percent *Always* or *Usually*)	The higher the proportion of members reporting that they found the information they needed in the plan's written materials or the Internet, the higher the overall plan score	Improve saliency, availability, and clarity of information about how the health plan works in written materials or on the Internet
3	Q5. Made appointments for routine care at a doctor's office or clinic (percent *Yes*)	The higher the proportion of members who made appointments for check-up or routine care at a doctor's office or clinic during the past 6 months, the higher the overall plan score	Improve member access to care (scheduling appointments for routine care)
4	Q31. Health plan customer service provided needed information or help (percent *Always* or *Usually*)	The higher the proportion of members who were able to get the information or help they needed from customer service, the higher the overall plan score	Improve the ability of the health plan customer service to provide members with necessary information or help
5	Q23. Rating of Personal Doctor (percent *8*, *9*, or *10*)	The higher the proportion of members rating their personal doctor as *8*, 9, or *10*, the higher the overall plan score	Improve the quality of physicians in health plan network (personal doctors)

Key Drivers of Member Experience – Child Medicaid

Ratings of the plan are strongly related to members' ability to get the care they need as soon as they need it (Q15, Q46, and Q6). *Rating of Personal Doctor* (Q41) may reflect the quality of the health plan's network and its ability to contract with better providers.

Priority	Key Driver	Interpretation	Recommended Action
1	Q15. Ease of getting needed care, tests, or treatment (percent *Always* or *Usually*)	The higher the proportion of respondents reporting that the necessary care, tests, or treatment were easy to get, the higher the overall plan score	Improve member access to care (ease of getting needed care, tests, or treatment)
2	Q41. Rating of Personal Doctor (percent *8*, *9*, or *10*)	The higher the proportion of members rating their child's personal doctor as *8*, *9*, or *10*, the higher the overall plan score	Improve the quality of physicians in the plan's network (personal doctors)
3	Q46. Got specialist appointment as soon as needed (percent *Always* or *Usually*)	The higher the proportion of respondents who were able to get a specialist appointment when they needed it, the higher the overall plan score	Improve member access to care (getting an appointment to see a specialist)
4	Q50. Customer service provided needed information or help (percent *Always* or *Usually*)	The higher the proportion of respondents who got the information or help they needed when they called customer service, the higher the overall plan score	Improve the ability of the health plan customer service to provide members with necessary information or help
5	Q6. Got an appointment for a check-up or routine care as soon as needed (percent *Always* or *Usually*)	The higher the proportion of respondents who made checkup/routine care appointments for their child at a doctor's office or clinic during the past 6 months, the higher the overall plan score	Improving member access to care (getting a checkup or routine care as soon as needed

Section XI
Review of Compliance with Quality Strategy

Quality Strategy Evaluation

Table 78 describes HACA's progress against the Quality Strategy's goal.

Table 78. Quality Strategy Evaluation

Department's Quality Strategy Goal	Performance Against Goal	Met
Ensure compliance with changes in Federal/State law and regulation.	The Department consistently reviews all new Federal and State laws and regulations. Any new laws and regulations are immediately put into the standards and guidelines for review and communicated to the MCOs.	√
Improve performance over time.	The Department continually strives to improve performance, which is evident through the high standards it sets for the MCOs in the Annual Systems Performance Review, Value Based Purchasing Initiative, Performance Improvement Projects, and other review activities. It continually monitors the progress of MCO performance in multiple areas as demonstrated throughout this report, and holds annual one-on-one Quality Meetings with each MCO to review results and discuss quality initiatives.	√
Allow comparisons to national and state benchmarks.	In almost every area of review, comparisons to national and state benchmarks can be found to mark progress and delineate performance against goals.	√
Reduce unnecessary administrative burden on MCOs.	The Department has attempted to reduce unnecessary administrative burden to the MCOs in any way possible. MDH has moved from an annual to a triennial Systems Review Process with desktop reviews occurring in the intervening years. Based on feedback from the MCOs, the period for commenting on revised SPR standards and guidelines was shortened from 90 days to 60 days to allow for more pre-site preparation time. Additionally, sample sizes were reduced for the EPSDT and EDV record reviews which reduced the administrative burden on the MCOs while continuing to ensure valid and reliable results. Furthermore, the Department drafted Model Notices for Grievances, Appeals, and Preservice Denials for MCO use to assist them in complying with new regulations.	√

Department's Quality Strategy Goal	Performance Against Goal	Met
Assist the Department with setting priorities and responding to identified areas of concern such as children, pregnant women, children with special healthcare needs, adults with a disability, and adults with chronic conditions.	The HealthChoice and Acute Care Administration assisted the Department by: • Requiring NCQA accreditation and adding HEDIS® performance measures to monitor compliance with quality of care and access standards for participants. • Volunteering to report Medicaid Adult and Child CORE Measures which will assist CMS to better understand the quality of health care that adults and children enrolled in Medicaid receive. • Revising the Value Based Purchasing Initiative to incentivize measures that include adults with disabilities and adults and children with chronic conditions. • Designing supplemental CAHPS® survey questions to address pregnant women and children to provide data input for the Deputy Secretary of Health Care Financing – Medical Care Programs Administration's annual Managing for Results report that includes key goals, objectives, and performance measure results for each calendar year. • Developing and implementing a performance monitoring policy coupled with intermediate sanctions to hold MCOs accountable for quality improvement. • Raising the minimum compliance score for EPSDT Medical Record Reviews to 80% for all components. • Requiring a new Performance Improvement Project addressing the Lead Screening. • Implementing the Medicaid and CHIP Managed Care Final Rule which set new operational standards for MCOs.	√

√ – Goal Met

EQRO Recommendations for MCOs

Each MCO is committed to delivering high quality care and services to its participants. However, opportunities exist for continued performance improvement. Based upon the evaluation of CY 2017 activities, Qlarant has developed several recommendations for all MCOs which are identified within each section of the Annual Technical Report.

EQRO Recommendations for HACA

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

- Complete implementation of CMS' Final Rule provisions which will be effective January 1, 2019, since Maryland's managed care contracts operate on a calendar year basis.

- Review the current MCO Performance Monitoring Policy to ensure that it is meeting its established goals and revise as indicated.
- Explore opportunities to further revise MCO requirements to better align with NCQA to decrease the administrative burden on the MCOs.
- Explore the NCQA accreditation review timelines compared to the onsite SPR timelines for each of the MCOs to see if there is any way to adjust time frames for audits to reduce the administrative burden so that the MCOs do not undergo both comprehensive audits in the same calendar year.

Conclusion

This report is a representation of all EQRO, HEDIS®, and CAHPS® activities that took place in calendar years 2017–2018 for the Maryland HealthChoice program. Opportunities for improvement and best practices of the MCOs are noted in the executive summary and within each individual review activity.

Overall strengths for the HealthChoice program in the areas of quality, access, and timeliness of care and services are outlined in Table 79.

Table 79. HealthChoice Program Strengths for Quality, Access, and Timeliness

HealthChoice Program Strength	Q	A	T
Encounter Data Validation: Encounter data submitted by the HealthChoice MCOs for CY 2017 is considered accurate and reliable with an overall match rate of 94.8%.	√		
EPSDT Medical Record Reviews: HealthChoice total scores continue to increase; scores increased by two percentage points (89% to 91%) from CY 2015 to CY 2016, and one percentage point (91% to 92%) from CY 2016 to CY 2017.	√	√	√
Quarterly Grievances, Appeals, and Pre-Service Denials: MCOs demonstrated fairly strong and consistent results in meeting regulatory requirements for grievances, appeals, and preservice denials.	√		√
Performance Improvement Projects: Validation of Asthma Medication Ratio and Lead Screening PIPs, determined levels of confidence or high levels of confidence for all eight participating MCOs with only one exception.	√	√	√

The Department sets high standards for MCO QA systems. As a result, the HealthChoice MCOs have quality systems and procedures in place to promote high quality care with well–organized approaches to quality improvement. The CY 2017 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care for Maryland managed care participants.

Additionally, the HealthChoice MCOs have further demonstrated their commitment to quality by obtaining NCQA accreditation. NCQA awards accreditation to health plans with strong consumer protections and a commitment to quality by completing a comprehensive evaluation that bases its results on clinical performance (i.e., HEDIS® measures) and consumer experience (i.e., CAHPS® measures). Recent accreditation reviews resulted in two of the HealthChoice MCOs (JMS and KPMAS) receiving NCQA's highest accreditation rating of excellent, and five of the MCOs (ACC, MPC, MSFC, PPMCO, and UHC) receiving the second highest rating of commendable. JMS is also the highest ranking Medicaid plan nationwide for NCQA accreditation.

Acronym List

Acronym	Definition
ABH	Aetna Better Health of Maryland
ACC	AMERIGROUP Community Care
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act of 1990
ADV	Annual Dental Visit
AHRQ	Agency for Healthcare Research and Quality
AWC	Adolescent Well Care
BBA	Balanced Budget Act of 1997
BCR	Board Certification
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBP	Controlling High Blood Pressure
CCC	Children with Chronic Conditions
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COMAR	Code of Maryland Regulations
CPT	Current Procedural Terminology
CY	Calendar Year
CSS	Center for the Study of Services
DHQA	Division of HealthChoice Quality Assurance
DOC	Delegate Oversight Committee
EBS	Enrollment by State
ED	Emergency Department
EDV	Encounter Data Validation
ENP	Enrollment by Product Line
EOC	Effectiveness of Care
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
FC	Fully Compliant
FQHC	Federally Qualified Health Center
FSP	Frequency of Selected Procedures
HACA	HealthChoice and Acute Care Administration

Acronym	Definition
HD	HEDIS® Measure Determination
HED	Health Education/Anticipatory Guidance
HEDIS®	Healthcare Effectiveness Data and Information Set
HEP	Health Education Plan
HILLTOP	The Hilltop Institute of University of Maryland Baltimore County
HIV	Human Immunodeficiency Virus
HCQIS	Healthcare Quality Improvement System for Medicaid Managed Care
HX	Health and Developmental History
IDSS	Interactive Data Submission System
IMM	Immunizations
IPU	Inpatient Utilization-General Hospital/Acute Care
IRR	Inter-rater Reliability
IS	Information Systems
ISCA	Information Systems Capability Assessment
JMS	Jai Medical Systems, Inc.
KPMAS	Kaiser Permanente of the Mid-Atlantic States, Inc.
LAB	Laboratory Tests/At-Risk Screenings
LDM	Language Diversity of Membership
MMAC	Maryland Medical Advisory Committee
MARR	Maryland Average Reportable Rate
MCG	Milliman Care Guidelines
MCO	Managed Care Organization
MD	Maryland
MDH	Maryland Department of Health
MPC	Maryland Physicians Care
MRR	Medical Record Review
MRRV	Medical Record Review Validation
MSFC	MedStar Family Choice, Inc.
NA	Not Applicable
NB	No Benefit
NCC	National Call Center
NCQA	National Committee for Quality Assurance
NHM	National HEDIS® Mean
NR	Not Reportable
NV	Not Valid
OB/GYN	Obstetrician/Gynecology

Acronym	Definition
PA	Preauthorization
PCP	Primary Care Physician
PE	Comprehensive Physical Exam
PIP	Performance Improvement Project
PPMCO	Priority Partners
PT	Physical Therapy
QA	Quality Assurance
QAP	Quality Assurance Program
QIC	Quality Improvement Committee
QIO	Quality Improvement Organization
QMC	Quality Management Committee
QMP	Quality Management Program
QOC	Quality of Care
RDM	Race/Ethnicity Diversity of Membership
ROADMAP	Record of Administration, Data Management and Processes
RQIC	Regional Quality Improvement Committee
SC	Substantially Compliant
SPR	Systems Performance Review
SSI	Supplemental Security Income
STI/HIV	Sexually Transmitted Infection/Human Immunodeficiency Virus
TAT	Turn Around Time
TLM	Total Membership
UHC	UnitedHealthcare Community Plan
UM	Utilization Management
UMHP	University of Maryland Health Partners
UR	Utilization Review
URI	Upper Respiratory Infection
URR	Utilization and Relative Resource Use
VBP	Value Based Purchasing
VBPI	Value Based Purchasing Initiative
VFC	Vaccine for Children
VIS	Vaccine Information Statement

HEDIS® Results Tables

TABLE A2-1. HealthChoice Organizations HEDIS 2018 Results

HEDIS 2018 Results, (Page 1 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Prevention and Screening – Adult																									
Adult BMI Assessment **(ABA)**	85.2%	91.0%	92.0%	96.6%	98.0%	98.5%	100.0%	98.0%	98.1%	82.4%	89.3%	87.8%	90.3%	90.6%	96.2%	86.1%	89.6%	91.2%	92.7%	90.3%	93.7%	85.4%	88.6%	92.9%	93.8%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis **(AAB)**	25.9%	30.0%	31.8%	33.0%	37.0%	43.6%	NA[1]	57.1%	71.2%	19.5%	21.3%	26.5%	22.8%	20.7%	30.0%	22.2%	25.5%	30.0%	26.0%	25.9%	31.2%	23.1%	25.0%	33.2%	37.2%
Childhood Immunization Status **(CIS)** – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	83.1%	85.0%	85.2%	88.7%	91.0%	85.4%	79.5%	73.1%	72.5%	84.7%	79.9%	66.2%	85.9%	84.4%	84.2%	84.5%	83.5%	79.8%	83.5%	79.8%	74.5%	80.9%	80.8%	76.6%	78.0%
Childhood Immunization Status **(CIS)** – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	81.9%	83.0%	82.5%	87.3%	88.0%	83.7%	78.2%	70.0%	70.3%	82.1%	78.5%	64.5%	83.2%	81.8%	82.7%	83.0%	82.6%	77.9%	80.5%	77.9%	70.8%	80.2%	79.3%	75.2%	75.9%
Childhood Immunization Status **(CIS)** – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	78.9%	80.0%	80.1%	86.8%	88.0%	83.3%	78.2%	69.5%	70.1%	78.0%	75.7%	62.5%	80.5%	79.3%	81.3%	79.7%	80.9%	76.4%	75.7%	74.7%	67.4%	78.2%	76.6%	73.7%	74.3%
Childhood Immunization Status **(CIS)** – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	68.3%	70.0%	69.8%	76.4%	73.0%	71.2%	68.0%	55.0%	62.3%	59.9%	59.5%	52.6%	67.9%	67.9%	67.9%	69.0%	69.5%	68.1%	61.6%	65.2%	57.4%	58.0%	60.6%	58.6%	63.5%
Childhood Immunization Status **(CIS)** – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	52.6%	42.0%	48.7%	47.6%	57.0%	64.4%	52.6%	46.3%	55.7%	41.8%	42.4%	34.1%	47.9%	49.6%	47.7%	59.7%	48.8%	50.9%	42.6%	44.8%	41.6%	41.0%	41.4%	46.7%	48.7%
Childhood Immunization Status **(CIS)** – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	65.7%	68.0%	67.9%	76.4%	73.0%	71.2%	68.0%	55.0%	62.0%	57.8%	57.9%	51.3%	65.7%	66.2%	67.2%	67.3%	68.4%	67.4%	58.9%	63.5%	55.5%	56.7%	59.6%	57.9%	62.5%
Childhood Immunization Status **(CIS)** – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	51.4%	42.0%	47.7%	47.2%	57.0%	64.4%	52.6%	46.0%	55.7%	40.1%	41.4%	33.1%	47.2%	48.2%	47.5%	57.5%	48.4%	50.9%	40.9%	43.1%	40.4%	40.3%	40.6%	45.7%	48.2%
Childhood Immunization Status **(CIS)** – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	46.8%	37.0%	44.3%	42.5%	49.0%	55.8%	46.2%	37.5%	49.9%	32.5%	32.9%	27.7%	40.2%	43.8%	41.1%	51.1%	42.6%	46.5%	35.0%	39.7%	36.7%	30.0%	34.1%	37.2%	42.4%
Childhood Immunization Status **(CIS)** – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	45.6%	36.0%	43.3%	42.5%	49.0%	55.8%	46.2%	37.5%	49.9%	31.6%	32.2%	27.0%	39.4%	42.3%	40.9%	50.0%	42.3%	46.5%	33.8%	38.7%	35.8%	29.4%	38.8%	36.7%	42.0%
Immunizations for Adolescents **(IMA)** – Combination 1 (Meningococcal, Tdap/Td)	86.8%	88.0%	89.1%	82.1%	89.0%	89.7%	82.7%	80.5%	83.7%	85.4%	88.2%	84.7%	80.0%	84.2%	88.6%	89.2%	89.1%	87.1%	84.8%	86.7%	87.4%	82.7%	80.5%	87.5%	87.2%
Immunizations for Adolescents **(IMA)** Combination 2 (Meningococcal, Tdap, HPV)	N/A	28.94%	48.9%	N/A	52.69%	72.2%	N/A	26.69%	47.5%	N/A	21.30%	37.7%	N/A	24.09%	35.5%	N/A	26.85%	38.4%	N/A	22.87%	36.5%	N/A	17.37%	30.4%	43.4%
Well-Child Visits in the First 15 months of Life **(W15)** – No well-child visits [2]	0.9%	1.0%	0.5%	4.4%	5.0%	0.5%	2.0%	3.6%	2.0%	1.2%	1.4%	2.0%	3.5%	3.2%	2.0%	1.5%	1.5%	5.0%	2.5%	0.3%	2.4%	8.5%	8.5%	2.0%	2.0%
Well-Child Visits in the First 15 months of Life **(W15)** – MDH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)	88.9%	88.7%	88.8%	82.4%	80.7%	85.9%	78.2%	78.4%	86.9%	85.9%	83.6%	84.2%	82.7%	82.7%	86.5%	82.2%	82.0%	76.5%	87.2%	87.1%	87.6%	67.0%	74.2%	81.0%	84.7%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life **(W34)**	85.8%	88.0%	88.8%	90.9%	90.0%	91.3%	82.6%	79.6%	77.6%	88.7%	79.9%	76.6%	85.5%	79.5%	77.1%	85.2%	81.0%	85.6%	80.7%	82.6%	81.5%	62.3%	69.8%	70.3%	81.1%
Adolescent Well-Care Visits **(AWC)**	67.9%	69.0%	73.0%	82.6%	84.0%	80.7%	57.1%	56.0%	59.1%	73.2%	72.7%	54.7%	64.0%	55.8%	59.7%	72.8%	64.4%	65.7%	64.8%	62.6%	63.8%	42.6%	52.6%	56.7%	64.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – BMI Percentile- Total Rate	56.4%	73.0%	73.2%	92.7%	92.0%	95.9%	98.6%	100.0%	100.0%	56.7%	60.8%	53.0%	62.4%	74.7%	81.1%	70.1%	68.5%	76.4%	61.0%	76.5%	75.7%	32.1%	54.5%	68.1%	77.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – Counseling for Nutrition – Total Rate	66.0%	79.0%	75.7%	97.6%	95.0%	97.6%	94.5%	94.3%	100.0%	66.7%	64.0%	62.3%	73.5%	71.9%	85.3%	74.3%	73.4%	73.7%	69.5%	76.0%	77.1%	36.7%	63.8%	67.6%	79.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – Counseling for Physical Activity – Total Rate	58.1%	72.0%	68.1%	93.4%	91.0%	96.6%	94.5%	100.0%	100.0%	63.9%	56.8%	53.0%	65.5%	69.9%	80.2%	70.1%	67.4%	66.2%	62.8%	70.9%	71.8%	30.4%	53.8%	62.0%	74.7%
Appropriate Testing for Children with Pharyngitis **(CWP)**	82.4%	81.0%	79.6%	85.6%	83.0%	92.2%	98.3%	93.4%	91.9%	86.3%	88.3%	87.7%	94.5%	92.2%	93.7%	85.9%	86.0%	86.2%	86.6%	87.8%	89.3%	87.1%	84.0%	86.7%	88.4%
Lead Screening in Children **(LSC)**	79.4%	80.0%	80.0%	92.1%	91.0%	88.6%	64.5%	66.1%	68.5%	73.8%	72.2%	74.7%	82.6%	84.8%	83.0%	75.7%	78.6%	80.1%	74.9%	73.0%	72.0%	67.7%	70.6%	74.5%	77.7%
Non-Recommended Cervical Cancer Screening in Adolescent Females **(NCS)** [2]	3.9%	3.0%	2.1%	1.9%	2.0%	2.0%	0.6%	0.1%	0.0%	2.0%	1.8%	1.4%	1.9%	1.3%	1.1%	2.4%	2.0%	1.4%	3.2%	3.0%	2.5%	4.0%	1.9%	1.3%	1.5%
Medication Management for People With Asthma **(MMA)** – Total 50% of treatment period	48.5%	47.0%	50.0%	73.9%	77.0%	75.0%	NA[1]	50.5%	61.5%	61.5%	64.4%	60.5%	48.8%	50.1%	53.7%	46.8%	48.1%	49.6%	54.0%	53.6%	55.7%	64.5%	55.9%	59.9%	58.2%
Medication Management for People With Asthma **(MMA)** – Total 75% of treatment period	25.1%	21.0%	23.8%	51.4%	52.0%	51.0%	NA[1]	28.4%	33.3%	35.6%	38.3%	34.1%	25.8%	25.2%	29.4%	23.7%	24.5%	25.2%	28.5%	28.4%	31.5%	48.4%	31.2%	34.8%	32.9%
Appropriate Treatment for Children with Upper Respiratory Infection **(URI)**	89.4%	91.0%	92.0%	97.1%	97.0%	98.0%	97.5%	97.25	98.1%	88.7%	88.7%	88.6%	90.0%	92.2%	91.5%	90.6%	90.8%	92.0%	88.8%	89.6%	90.1%	85.5%	88.0%	87.7%	92.2%
Asthma Medication Ratio **(AMR)**	63.0%	67.0%	63.2%	61.9%	70.0%	70.7%	NA[1]	72.6%	77.9%	64.0%	63.6%	63.1%	69.3%	67.9%	64.6%	64.7%	62.2%	58.9%	64.0%	63.6%	62.7%	52.4%	47.3%	60.1%	65.2%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.

ACC: AMERIGROUP Community Care
JMS: Jai Medical Systems
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MPC: Maryland Physicians Care
MSFC: MedStar Family Choice
PPMCO: Priority Partners
UHC: UnitedHealthcare
UMHP: University of Maryland Health Partners
MARR: Maryland Average Reportable Rate

HEDIS 2018 Results, (Page 2 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD **(SPR)**	30.0%	30.0%	30.5%	34.9%	32.0%	40.7%	NA[1]	50.0%	NA	25.5%	31.5%	32.0%	30.8%	40.7%	38.9%	28.0%	29.9%	31.1%	31.2%	32.9%	32.2%	NA[1]	37.5%	36.9%	34.6%
Pharmacotherapy Management of COPD Exacerbation **(PCE)** – Systemic Corticosteroid Rate	70.3%	68.0%	68.2%	73.3%	65.0%	68.4%	NA[1]	55.2%	78.6%	74.4%	73.9%	70.8%	71.0%	71.6%	74.8%	75.7%	66.7%	61.8%	70.2%	65.0%	69.0%	70.3%	80.7%	78.2%	71.2%
Pharmacotherapy Management of COPD Exacerbation **(PCE)** – Bronchodilator Rate	84.9%	81.0%	82.3%	88.6%	86.0%	87.9%	NA[1]	75.9%	83.3%	87.4%	86.9%	85.8%	84.5%	87.3%	88.7%	83.7%	81.5%	80.9%	80.8%	81.5%	80.4%	86.1%	89.3%	88.7%	84.7%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 12–24 months	97.9%	98.0%	97.5%	91.5%	93.0%	92.5%	91.3%	92.5%	95.7%	97.2%	96.4%	96.1%	95.3%	94.3%	95.5%	97.8%	97.0%	93.6%	97.0%	96.2%	96.8%	84.9%	89.2%	94.0%	95.2%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 25 months–6 years	94.1%	93.0%	93.5%	93.0%	92.0%	91.8%	89.1%	87.5%	86.3%	91.6%	90.8%	88.7%	90.0%	87.6%	86.9%	94.2%	93.1%	89.5%	92.6%	92.0%	90.5%	77.5%	83.5%	83.4%	88.8%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 7–11 years	96.1%	96.0%	96.0%	93.8%	94.0%	94.3%	98.1%	92.5%	91.7%	93.5%	94.0%	92.4%	92.0%	92.8%	91.9%	95.3%	95.4%	90.9%	94.4%	94.8%	93.9%	76.8%	83.5%	84.3%	91.9%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 12–19 years	93.0%	94.0%	93.6%	94.2%	95.0%	93.8%	96.6%	91.5%	90.4%	91.6%	91.8%	89.9%	90.6%	90.7%	89.2%	93.7%	94.1%	89.6%	92.1%	93.4%	92.1%	75.2%	85.0%	83.5%	90.3%
Adults' Access to Preventive/Ambulatory Health Services **(AAP)** – Age 20–44 years	79.7%	76.0%	74.3%	69.3%	68.0%	64.4%	82.7%	75.3%	73.7%	82.8%	79.9%	75.7%	75.8%	72.5%	71.1%	82.6%	80.4%	76.5%	79.0%	76.7%	75.1%	69.3%	65.4%	65.6%	72.0%
Adults' Access to Preventive/Ambulatory Health Services **(AAP)** – Age 45–64 years	88.2%	86.0%	84.6%	87.8%	86.0%	83.7%	87.0%	82.1%	81.5%	89.4%	87.3%	85.1%	85.7%	83.2%	81.9%	90.0%	88.4%	86.0%	88.0%	86.7%	86.1%	79.6%	77.5%	77.9%	83.3%
Breast Cancer Screening **(BCS)**	65.9%	66.0%	69.2%	72.6%	74.0%	77.5%	88.5%	87.9%	81.5%	72.1%	68.2%	59.2%	66.0%	65.5%	67.1%	68.3%	69.2%	68.5%	62.3%	60.2%	59.9%	63.8%	67.3%	74.9%	69.7%
Cervical Cancer Screening **(CCS)**	67.5%	66.0%	62.5%	77.3%	73.0%	76.8%	79.2%	79.2%	80.4%	65.2%	66.3%	56.7%	61.5%	55.9%	54.3%	69.3%	64.7%	64.0%	60.1%	68.6%	59.6%	41.1%	45.3%	45.3%	62.4%
Chlamydia Screening in Women **(CHL)** – Age 16–20 years	61.0%	62.0%	63.9%	87.6%	89.0%	91.0%	69.2%	69.8%	71.3%	56.8%	57.6%	56.4%	52.2%	56.0%	59.1%	57.5%	60.0%	60.7%	52.1%	56.0%	57.4%	49.5%	50.1%	55.1%	64.4%
Chlamydia Screening in Women **(CHL)** – Age 21–24 years	68.6%	70.0%	71.8%	72.8%	85.0%	81.7%	84.7%	82.1%	80.2%	68.7%	68.7%	66.0%	65.3%	66.3%	68.2%	67.5%	68.0%	68.0%	65.4%	65.4%	67.2%	61.2%	60.4%	67.6%	71.3%
Chlamydia Screening in Women **(CHL)** – Total (16–24) years	64.2%	66.0%	67.4%	80.3%	87.0%	86.6%	79.6%	77.5%	77.0%	62.0%	62.8%	61.1%	58.6%	61.3%	64.0%	61.5%	63.6%	64.0%	57.9%	60.0%	61.6%	56.3%	56.3%	62.5%	68.0%
Prenatal and Postpartum Care **(PPC)** – Timeliness of Prenatal Care	83.9%	89.0%	87.4%	87.2%	79.0%	78.3%	92.9%	96.7%	93.7%	81.5%	89.5%	82.7%	84.5%	83.6%	78.%	90.3%	89.3%	84.4%	80.7%	87.6%	85.2%	74.5%	86.4%	88.3%	84.9%
Prenatal and Postpartum Care **(PPC)** – Postpartum Care	73.7%	73.7%	72.0%	88.0%	81.3%	83.6%	83.8%	84.1%	85.2%	68.9%	67.1%	69.1%	69.2%	71.2%	74.0%	73.7%	71.3%	69.1%	66.2%	70.6%	66.4%	62.3%	71.0%	74.0%	74.2%
Controlling High Blood Pressure **(CBP)**	54.1%	63.0%	62.0%	76.4%	72.0%	74.9%	86.0%	84.4%	85.2%	55.9%	68.7%	46.2%	71.2%	72.8%	72.8%	60.2%	51.1%	53.3%	56.9%	64.9%	64.7%	48.2%	NA	52.3%	62.7%
Persistence of Beta-Blocker Treatment After a Heart Attack **(PBH)**	84.9%	71.0%	65.2%	NA[1]	87.0%	68.8%	NA[1]	90.5%	81.8%	84.3%	83.2%	81.6%	67.7%	80.5%	80.8%	85.7%	75.0%	72.3%	77.9%	81.0%	77.6%	NA[1]	81.0%	70.0%	74.8%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia **(SMC)**	NA[1]	77.0%	NA	NA[1]	NA	NA	NA[1]	53.9%	NA	NA[1]	76.9%	NA	NA[1]	75.0%	NA	NA[1]	57.1%	66.7%	NA[1]	70.8%	NA	NA[1]	NA	NA	66.7%
Statin Therapy for Patients With Cardiovascular Disease (**SPC**) – Received Statin Therapy – Total	66.0%	70.1%	68.3%	78.4%	80.8%	82.1%	N/A	89.5%	93.0%	72.2%	75.4%	75.1%	77.5%	80.2%	78.6%	72.1%	72.1%	75.7%	71.0%	73.5%	73.8%	N/A	71.9%	74.5%	77.6%
Statin Therapy for Patients With Cardiovascular Disease (**SPC**) – Statin Adherence 80% - Total	76.5%	48.7%	53.6%	56.7%	54.6%	53.7%	NA	44.1%	46.3%	66.8%	64.6%	64.3%	55%	44.4%	50.0%	74.7%	50.2%	52.6%	45.1%	48.0%	55.4%	NA	56.5%	55.9%	54.0%
Comprehensive Diabetes **(CDC)** – Hemoglobin A1c (HbA1c) Testing	87.4%	85.0%	90.5%	94.3%	95.0%	94.9%	94.5%	92.7%	91.6%	85.9%	88.7%	80.8%	87.8%	91.7%	90.0%	89.4%	89.3%	88.1%	82.5%	86.1%	85.9%	88.3%	82.5%	81.8%	87.9%
Comprehensive Diabetes **(CDC)** – HbA1c Poor Control (>9.0%) [2]	42.2%	40.0%	34.1%	26.6%	27.0%	29.9%	28.2%	27.8%	28.0%	40.8%	34.4%	47.9%	31.6%	29.5%	31.4%	35.6%	34.0%	38.9%	39.7%	35.55%	35.5%	39.2%	42.1%	49.2%	36.9%
Comprehensive Diabetes **(CDC)** – HbA1c Control (< 8.0%)	49.2%	52.0%	59.4%	60.4%	63.0%	61.1%	57.6%	60.0%	60.9%	49.7%	56.5%	46.0%	59.9%	58.1%	56.7%	55.1%	53.5%	49.6%	51.6%	51.1%	54.5%	48.2%	48.7%	42.6%	53.8%
Comprehensive Diabetes **(CDC)** – Eye Exam (Retinal) Performed	53.9%	49.9%	55.7%	71.9%	74.0%	75.7%	84.7%	87.8%	84.5%	65.8%	51.9%	42.8%	52.6%	49.8%	63.7%	62.9%	55.7%	38.4%	55.2%	56.9%	62.3%	35.0%	31.2%	39.2%	57.8%
Comprehensive Diabetes **(CDC)** – Medical Attention for Nephropathy	90.7%	87.0%	90.5%	96.9%	94.0%	94.2%	95.3%	94.2%	92.2%	89.9%	87.9%	86.4%	91.0%	92.4%	91.0%	89.4%	99.8%	86.9%	91.2%	90.3%	89.8%	90.8%	85.6%	88.1%	89.9%
Comprehensive Diabetes **(CDC)** – Blood Pressure Control (<140/90 mm Hg)	60.0%	64.0%	64.7%	76.8%	78.0%	76.5%	87.1%	84.5%	82.3%	55.2%	55.6%	49.9%	67.6%	62.9%	69.8%	62.6%	55.5%	56.7%	46.0%	59.9%	65.2%	36.5%	41.6%	58.6%	65.5%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.

ACC: AMERIGROUP Community Care
JMS: Jai Medical Systems
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MPC: Maryland Physicians Care
MSFC: MedStar Family Choice
PPMCO: Priority Partners
UHC: UnitedHealthcare
UMHP: University of Maryland Health Partners
MARR: Maryland Average Reportable Rate

HEDIS 2018 Results, (Page 3 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations		**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Diabetes Monitoring for People with Diabetes and Schizophrenia **(SMD)**	68.9%	74.0%	66.7%	NA[1]	77.0%	82.9%	NA[1]	NA	NA	65.5%	62.7%	60.1%	NA[1]	58.6%	66.0%	68.7%	70.2%	65.0%	72.2%	75.4%	76.3%	NA[1]	57.7%	59.5%	59.5%
Statin Therapy for Patients With Diabetes (**SPD**) – Received Statin Therapy	58.3%	59.4%	60.0%	59.4%	63.3%	65.3%	79.1%	84.4%	78.9%	59.3%	59.2%	59.1%	58.8%	59.5%	62.9%	57.6%	58.6%	59.2%	59.0%	58.2%	60.3%	50.5%	53.8%	57.8%	62.9%
Statin Therapy for Patients With Diabetes (**SPD**) – Statin Adherence 80%	54.1%	49.2%	44.9%	49.5%	50.7%	43.7%	55.9%	50.3%	52.1%	60.0%	59.7%	58.6%	54.3%	48.8%	47.4%	50.6%	48.9%	46.1%	48.6%	48.7%	48.7%	58.3%	57.9%	55.7%	49.6%
Use of Imaging Studies for Low Back Pain **(LBP)**	74.6%	76.0%	76.7%	77.7%	69.0%	79.9%	71.5%	76.9%	77.1%	75.5%	72.7%	75.0%	72.7%	66.1%	72.7%	76.0%	77.8%	77.7%	73.2%	73.3%	75.4%	74.2%	70.4%	70.4%	75.6%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis **(ART)**	78.0%	80.0%	74.7%	NA[1]	73.0%	69.7%	NA[1]	93.6%	87.8%	67.5%	69.3%	70.1%	77.4%	78.9%	82.5%	83.1%	77.6%	78.3%	69.8%	72.1%	69.9%	NA[1]	73.5%	62.8%	74.5%
Annual Monitoring for Patients on Persistent Medications **(MPM)**– Members on angiotensin converting enzyme **(ACE)** inhibitors or angiotensin receptor blockers **(ARB)**	90.5%	90.0%	88.9%	96.5%	97.0%	94.7%	92.8%	92.0%	90.3%	89.0%	88.5%	86.2%	90.3%	89.3%	90.0%	89.0%	88.4%	88.1%	88.7%	89.4%	89.3%	86.1%	85.6%	85.2%	89.1%
Annual Monitoring for Patients on Persistent Medications **(MPM)** – Members on diuretics	89.6%	89.0%	88.0%	95.6%	95.0%	93.7%	90.8%	90.5%	88.6%	88.5%	88.0%	86.0%	88.32%	87.5%	88.3%	88.30%	88.2%	88.3%	87.8%	88.8%	88.0%	84.4%	86.6%	84.9%	88.2%
Annual Monitoring for Patients on Persistent Medications **(MPM)** – Total rate	89.9%	89.9%	88.5%	95.9%	96.0%	94.2%	91.8%	91.4%	89.6%	88.6%	88.1%	86.1%	89.4%	88.4%	89.3%	88.5%	88.1%	88.2%	88.1%	88.9%	88.7%	85.2%	85.9%	85.1%	88.7%
Ambulatory Care **(AMB)** – Outpatient visits per 1,000 member months	372.6	366.86	354.3	345.1	350.64	328.7	324.9	336.59	315.9	406.4	420.4	397.5	358.6	359.78	356.2	406.5	NA	390.3	378.1	367.49	345.1	332.6	247.26	332.2	352.5
Ambulatory Care **(AMB)** – Emergency department (ED) visits per 1,000 member months 3	55.1	53.43	50.6	94.0	93.62	83.0	24.9	26.28	26.6	71.0	68.5	61.9	56.1	55.64	53.5	60.1	NA	58.0	59.5	56.84	51.7	89.8	86.43	60.7	55.7
Frequency of Selected Procedures **(FSP)** – Bariatric weight loss surgery /1000 MM 45-64 F	0.05	0.05	0.1	0.00	0.59	0.0	0.00	0.05	0.1	0.068	0.04	0.0	0.10	0.07	0.1	0.06	0.03	0.0	0.04	0.05	0.0	0.12	0.07	0.0	0.0
Frequency of Selected Procedures **(FSP)** – Bariatric weight loss surgery /1000 MM 45-64 M	0.0074	0.01	0.0	0.00	0.50	0.0	0.00	NA	0.0	0.015	0.01	0.0	0.015	0.01	0.0	0.03	NA	0.0	0.010	0.01	0.0	0.00	NA	0.0	0.0
Frequency of Selected Procedures **(FSP)** – Tonsillectomy /1000 MM 0-9 T	0.48	0.48	0.5	0.13	0.21	0.1	0.00	0.23	0.3	0.55	0.62	0.6	0.45	0.48	0.5	0.64	0.58	0.6	0.51	0.51	0.5	0.31	0.37	0.4	0.4
Frequency of Selected Procedures **(FSP)** – Tonsillectomy /1000 MM 10-19 T	0.186	0.14	0.2	0.18	0.17	0.1	0.00	0.20	0.1	0.26	0.26	0.2	0.19	0.24	0.2	0.25	0.24	0.2	0.194	0.20	0.2	0.16	0.34	0.2	0.2
Frequency of Selected Procedures **(FSP)** – Hysterectomy, abdominal /1000 MM 45-64 F	0.31	0.27	0.3	0.36	0.31	0.2	0.00	0.26	0.3	0.32	0.27	0.2	0.47	0.30	0.3	0.45	0.26	0.3	0.28	0.28	0.2	0.23	0.32	0.4	0.3
Frequency of Selected Procedures **(FSP)** – Hysterectomy, vaginal /1000 MM 45-64 F	0.1510	0.15	0.1	0.00	0.02	0.0	0.00	0.20	0.2	0.24	0.19	0.1	0.22	0.27	0.2	0.31	0.17	0.2	0.1506	0.17	0.1	0.17	0.17	0.1	0.1
Frequency of Selected Procedures **(FSP)** – Cholecystectomy, open /1000 MM 30-64 M	0.022	0.04	0.0	0.0569	0.02	0.1	0.00	0.03	0.0	0.04	0.07	0.0	0.0574	0.06	0.0	0.03	0.04	0.0	0.018	0.04	0.0	0.00	0.05	0.0	0.0
Frequency of Selected Procedures **(FSP)** – Cholecystectomy, open /1000 MM 45-64 F	0.010	0.51	0.0	0.045	0.05	0.0	0.00	0.02	0.0	0.05	0.08	0.0	0.012	0.04	0.0	0.06	0.03	0.0	0.02	0.04	0.0	0.00	0.05	0.1	0.0
Frequency of Selected Procedures **(FSP)** – Laparoscopic/1000 MM 30-64 M	0.20	0.19	0.2	0.05	0.06	0.0	0.00	0.12	0.1	0.31	0.29	0.2	0.24	0.15	0.1	0.29	0.23	0.2	0.26	0.22	0.2	0.21	0.18	0.2	0.2
Frequency of Selected Procedures **(FSP)** – Laparoscopic/1000 MM 45-64 F	0.36	0.51	0.5	0.29	0.19	0.3	0.00	0.24	0.4	0.62	0.55	0.5	0.40	0.56	0.3	0.69	0.51	0.5	0.44	0.42	0.4	0.43	0.32	0.6	0.4
Frequency of Selected Procedures **(FSP)** – Back Surgery /1000 MM 45-64 F	0.46	0.53	0.5	0.56	0.59	0.3	0.00	0.14	0.1	0.81	0.86	0.7	0.67	0.58	0.5	0.74	0.62	0.7	0.60	0.54	0.6	0.43	0.39	0.5	0.5
Frequency of Selected Procedures **(FSP)** – Back Surgery /1000 MM 45-64 M	0.58	0.42	0.5	0.41	0.50	0.6	0.00	0.16	0.2	0.85	0.84	0.7	0.69	0.68	0.7	0.80	0.82	0.8	0.83	0.70	0.6	0.47	0.39	0.5	0.6
Frequency of Selected Procedures **(FSP)** – Mastectomy /1000 MM 15-44 F	0.0226	0.03	0.0	0.050	0.00	0.0	0.00	0.00	0.0	0.045	0.02	0.0	0.01	0.04	0.1	0.03	0.02	0.0	0.0233	0.03	0.0	0.051	0.04	0.0	0.0
Frequency of Selected Procedures **(FSP)** – Mastectomy /1000 MM 45-64 F	0.13	0.18	0.1	0.07	0.02	0.0	0.00	0.15	0.1	0.12	0.08	0.1	0.10	0.06	0.1	0.23	0.11	0.1	0.171	0.13	0.1	0.173	0.07	0.1	0.1
Frequency of Selected Procedures **(FSP)** – Lumpectomy /1000 MM 15-44 F	0.113	0.09	0.1	0.07	0.05	0.1	0.00	0.6	0.0	0.106	0.12	0.1	0.20	0.12	0.1	0.14	0.12	0.1	0.107	0.11	0.1	0.05	0.08	0.1	0.1
Frequency of Selected Procedures **(FSP)** – Lumpectomy /1000 MM 45-64 F	0.27	0.33	0.3	0.25	0.19	0.1	0.00	0.41	0.3	0.28	0.37	0.3	0.52	0.36	0.4	0.42	0.32	0.3	0.38	0.29	0.3	0.14	0.37	0.3	0.3
Standardized Healthcare-Associated Infection Ratio **(HAI)*** – Central line – associated blood stream infection (CLABSI) – Plan Weighted SIR	N/A	1.05	0.9	N/A	0.93	0.6	N/A	1.37	1.0	N/A	0.15	1.0	N/A	0.98	0.7	N/A	0.01	0.0	N/A	1.04	0.9	N/A	1.25	1.0	0.8
Standardized Healthcare-Associated Infection Ratio **(HAI)*** – Catheter – Associated Urinary Tract Infection (CAUTI) – Plan Weighted SIR	N/A	0.79	0.9	N/A	0.78	0.7	N/A	0.80	0.6	N/A	0.18	1.0	N/A	1.04	1.1	N/A	0.01	0.0	N/A	1.04	1.0	N/A	1.08	0.9	0.8
Standardized Healthcare-Associated Infection Ratio **(HAI)*** – MRSA bloodstream infection (MRSA) – Plan Weighted SIR	N/A	0.83	0.8	N/A	1.23	0.9	N/A	0.77	0.5	N/A	0.28	1.1	N/A	1.03	1.1	N/A	0.01	0.0	N/A	0.62	1.0	N/A	0.97	0.9	0.8
Standardized Healthcare-Associated Infection Ratio **(HAI)*** – Clostridium Difficile Intestinal Infection (CDIFF) – Plan Weighted SIR	N/A	1.03	0.9	N/A	0.89	0.6	N/A	1.44	1.2	N/A	0.42	1.0	N/A	0.98	0.9	N/A	0.01	0.0	N/A	1.38	0.9	N/A	1.21	0.9	0.8

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.

ACC: AMERIGROUP Community Care
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UMHP: University of Maryland Health Partners
MARR: Maryland Average Reportable Rate

HEDIS 2018 Results, (Page 4 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	**ACC**			**JMS**			**KPMAS**			**MPC**			**MSFC**			**PPMCO**			**UHC**			**UMHP**			**MARR**
Inpatient Utilization - General Hospital Acute Care **(IPU)** – Total Inpatient: Total Discharges /1000 MM	5.83	5.23	5.1	10.06	9.53	9.2	5.49	5.33	5.6	6.84	6.58	6.5	6.67	6.83	6.6	6.75	6.49	6.8	6.60	4.91	5.6	8.59	6.91	7.2	6.6
Inpatient Utilization - General Hospital Acute Care **(IPU)** – Total Inpatient: Total Average Length of Stay	4.14	4.17	4.2	4.81	4.47	4.6	3.34	3.36	3.4	3.75	3.87	2.5	4.22	4.18	4.8	4.06	4.09	4.4	4.23	4.40	4.4	3.47	3.51	3.5	4.0
Antibiotic Utilization **(ABX)** – Average Scrips PMPY for Antibiotics (aaattot)	0.85	0.84	0.8	0.87	0.79	0.8	0.67	0.58	0.6	1.10	1.09	1.0	0.88	0.90	0.9	0.97	0.98	0.9	0.92	0.91	0.8	0.85	0.86	0.8	0.8
Antibiotic Utilization **(ABX)** – Average Days Supplied per Antibiotic Script (acattot)	9.35	9.28	9.3	9.00	8.67	7.7	9.46	9.29	9.3	9.32	9.30	9.2	9.10	8.94	8.9	9.42	9.32	9.3	9.35	9.09	9.3	9.28	9.32	9.2	9.0
Antibiotic Utilization (**ABX**) – Average Scrips PMPY for Antibiotics of Concern (adattot)	0.35	0.34	0.3	0.29	0.26	0.3	0.25	0.22	0.2	0.45	0.45	0.4	0.35	0.36	0.3	0.39	0.40	0.4	0.41	0.40	0.4	0.38	0.38	0.3	0.3
Antibiotic Utilization (**ABX**) – Percentage of Antibiotics of Concern of all Antibiotics (apttot)	40.8%	40.35%	38.8%	33.7%	33.08%	32.5%	37.8%	38.16%	35.9%	40.8%	41.26%	40.4%	40.1%	40.49%	39.0%	40.7%	41.51%	39.3%	44.3%	43.74%	41.6%	44.6%	44.32%	42.2%	38.7%
Use of Opioids at High Dosage (**UOD**)*			76.0			38.6			22.4			119.9			76.2			105.1			72.2			135.3	80.7
Use of Opioids From Multiple Providers (**UOP**) - Multiple Prescribers*			313.3			267.5			262.8			195.7			387.5			329.4			250.0			321.1	290.9
Use of Opioids From Multiple Providers (**UOP**) - Multiple Pharmacies*			109.1			126.8			69.6			0.0			105.9			129.3			62.3			124.7	91.0
Use of Opioids From Multiple Providers (**UOP**) - Multiple Prescribers and Multiple Pharmacies*			69.4			93.9			39.0			0.0			80.0			88.4			35.4			89.4	61.9

*New measures reported for HEDIS 2018

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Table A2-2. Health Plan Descriptive Information

Health Plan Descriptive Information, (Page 1 of 2)	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Board Certification **(BCR)** – Family Medicine: Number of Physicians	798	78	208	623	290	656	791	704
Board Certification **(BCR)** – Family Medicine: Number Board Certified	472	63	192	396	203	622	565	565
Board Certification **(BCR)** – Family Medicine: Percent Board Certified	59.15%	80.77%	92.31%	63.56%	70.00%	94.82%	71.43%	80.26%
Board Certification **(BCR)** – Internal Medicine: Number of Physicians	3083	597	454	1294	477	1012	2442	853
Board Certification **(BCR)** – Internal Medicine: Number Board Certified	2229	533	436	979	325	955	1873	672
Board Certification **(BCR)** – Internal Medicine: Percent Board Certified	72.30%	89.28%	96.04%	75.66%	68.13%	94.37%	76.70%	78.78%
Board Certification **(BCR)** – OB/GYN: Number of Physicians	697	208	183	814	152	846	800	638
Board Certification **(BCR)** – OB/GYN: Number Board Certified	527	170	156	436	85	797	673	431
Board Certification **(BCR)** – OB/GYN: Percent Board Certified	75.61%	81.73%	85.25%	53.56%	55.92%	94.21%	84.13%	67.55%
Board Certification **(BCR)** – Pediatrician: Number of Physicians	1588	194	110	1021	311	882	1507	628
Board Certification **(BCR)** – Pediatrician: Number Board Certified	1243	176	101	792	194	849	1213	485
Board Certification **(BCR)** – Pediatrician: Percent Board Certified	78.27%	90.72%	91.82%	77.57%	62.38%	96.26%	80.49%	77.23%
Board Certification **(BCR)** – Geriatricians: Number of Physicians	133	37	5	19	8	50	91	36
Board Certification **(BCR)** – Geriatricians: Number Board Certified	81	34	5	15	7	49	56	26
Board Certification **(BCR)** – Geriatricians: Percent Board Certified	60.90%	91.89%	100%	78.95%	87.50%	98.00%	61.54%	72.22%
Board Certification **(BCR)** – Other Specialists: Number of Physicians	5271	2477	1112	4759	1924	12803	5870	4147
Board Certification **(BCR)** – Other Specialists: Number Board Certified	4080	2119	1063	3363	1267	11934	4568	2354
Board Certification **(BCR)** – Other Specialists: Percent Board Certified	77.40%	85.55%	95.59%	70.67%	65.85%	93.21%	77.82%	56.76%
Enrollment by Product Line **(ENP)** – Shows only total member months for Female	1787702	143292	373694	1412334	556051	1914988	985663	231236
Enrollment by Product Line **(ENP)** – Shows only total member months for Male	1517147	163317	321102	1146162	466059	1542521	858840	241940
Enrollment by Product Line **(ENP)** – Shows only total member months Total	3304849	306609	694796	2558496	1022110	3457509	1844503	473176
Enrollment by State **(EBS)** – Maryland Only	275302	26342	64778	216647	89923	298740	151443	43709

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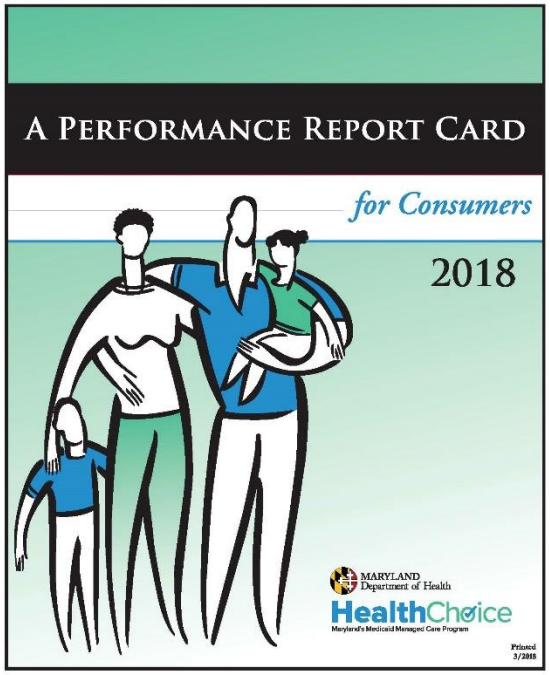
MARR: Maryland Average Reportable Rate
NHM: National HEDIS Mean

Health Plan Descriptive Information, (Page 2 of 2)	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Language Diversity **(LDM)** – Spoken - English Number	10	21658	66554	248957	0	0	10703	0
Language Diversity **(LDM)** – Spoken - English Percent	0.0%	67.2%	88.2%	96.3%	0.0%	0.0%	5.7%	0.0%
Language Diversity **(LDM)** – Spoken - Non-English Number	13260	0	8693	2363	0	0	3991	0
Language Diversity **(LDM)** – Spoken - Non-English Percent	4.1%	0.0%	11.5%	0.9%	0.0%	0.0%	2.1%	0.0%
Language Diversity **(LDM)** – Spoken - Unknown Number	311616	10578	186	7161	111000	347187	172769	55575
Language Diversity **(LDM)** – Spoken - Unknown Percent	96%	33%	0.25%	2.77%	100%	100%	92%	100.00%
Language Diversity **(LDM)** – Spoken - Declined Number	0	0	32	0	0	0	0	0
Language Diversity **(LDM)** – Spoken - Declined Percent	0%	0%	0%	0%	0%	0%	0%	0%
Race/Ethnicity Diversity **(RDM)** – White / Total	57491	4103	14397	84767	29346	105277	61302	16300
Race/Ethnicity Diversity **(RDM)** – White / Percent	17.70%	12.73%	19.08%	32.79%	26.44%	30.32%	32.70%	29.33%
Race/Ethnicity Diversity **(RDM)** – Black / Total	123759	19349	42260	93905	0	122749	78956	19152
Race/Ethnicity Diversity **(RDM)** – Black / Percent	38.09%	60.02%	56.00%	36.33%	0%	35.36%	42.12%	34.46%
Race/Ethnicity Diversity **(RDM)** – American Indian & Alaska Native / Total	0	137	159	0	0	2	0	0
Race/Ethnicity Diversity **(RDM)** – American Indian & Alaska Native / Percent	0%	0.42%	0.21%	0.00%	0%	0%	0%	0%
Race/Ethnicity Diversity **(RDM)** – Asian / Total	14050	962	5674	9136	5802	0	11135	2486
Race/Ethnicity Diversity **(RDM)** – Asian / Percent	4.32%	2.98%	7.52%	3.53%	5.23%	0%	5.94%	4.47%
Race/Ethnicity Diversity **(RDM)** – Native Hawaiian - Pacific Islander / Total	409	44	49	327	0	13327	281	98
Race/Ethnicity Diversity **(RDM)** – Native Hawaiian - Pacific Islander / Percent	0.13%	0.14%	0.06%	0.13%	0%	3.84%	0.15%	0.18%
Race/Ethnicity Diversity **(RDM)** – Other / Total	0	0	1678	744	881	0	0	0
Race/Ethnicity Diversity **(RDM)** – Other / Percent	0%	0%	2.22%	0%	0.79%	0%	0%	0%
Race/Ethnicity Diversity **(RDM)** – 2+ Races / Total	0	0	366	0	0	0	0	0
Race/Ethnicity Diversity **(RDM)** – 2+ Races / Percent	0%	0%	0.48%	0%	0%	0%	0%	0%
Race/Ethnicity Diversity **(RDM)** – Unknown / Total	129177	7641	10643	69602	74469	2390	35789	472
Race/Ethnicity Diversity **(RDM)** – Unknown / Percent	40%	24%	14%	27%	67%	1%	19%	1%
Race/Ethnicity Diversity **(RDM)** – Declined / Total	0	0	239	0	502	103442	0	17067
Race/Ethnicity Diversity **(RDM)** – Declined / Percent	0%	0%	0.32%	0%	0%	30%	0%	30.71%
Total Membership – Total membership numbers for each plan	324886	32236	75465	258481	111000	347187	187463	55575

CY 2018 MD HealthChoice Performance Report Card

English Version



Looking at Health Plan Performance

All health plans in HealthChoice received high satisfaction ratings from the majority of their members.

This Report Card shows how the health plans in HealthChoice compare to each other in key areas. You should use this Report Card along with other items in the enrollment packet to help you choose a health plan.

To choose a health plan, call 1-855-642-8572. If you are hearing impaired, you can call the TDD line 1-855-642-8573.

Key
★★★ Above HealthChoice Average
★★ HealthChoice Average
★ Below HealthChoice Average

Performance Areas

Health Plans	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
AETNA BETTER HEALTH	N/A	N/A	N/A	N/A	N/A	N/A
AMERIGROUP COMMUNITY CARE	★★	★★	★★★	★★	★★	★
JAI MEDICAL SYSTEMS	★★★	★★★	★★★	★★★	★★	★★★
KAISER PERMANENTE	★★	★★	★	★★	★★★	★★★
MARYLAND PHYSICIANS CARE	★★	★★	★★	★★	★	★★
MEDSTAR FAMILY CHOICE	★	★★	★★	★★★	★	★★
PRIORITY PARTNERS	★★★	★★	★★	★★	★	★★
UNITEDHEALTHCARE	★★	★★	★★	★★	★	★
UNIVERSITY OF MARYLAND HEALTH PARTNERS	★	★★	★	★★	★	★

*This information was collected from health plans and their members and is the most current performance data available. The information was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member composition. NOTE: N/A means that the rating is not applicable and does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan. *Aetna Better Health became a HealthChoice MCO in 2017, therefore ratings are not applicable.*

Performance Area Descriptions

Access to Care
- Appointments are scheduled without a long wait
- The health plan has good customer service
- Everyone sees a doctor at least once a year
- The health plan answers member calls quickly

Doctor Communication and Service
- Doctors explain things clearly and answer questions
- The doctor's office staff is helpful
- Doctors provide good care

Keeping Kids Healthy
- Kids get shots to protect them from serious illness
- Kids see a doctor and dentist regularly
- Kids get tested for lead

Care for Kids with Chronic Illness
- Doctors give personal attention
- Kids get the medicine they need
- A doctor or nurse knows the child's needs
- Doctors involve parents in decision making

Taking Care of Women
- Women are tested for breast cancer and cervical cancer
- Moms are taken care of when they are pregnant and after they have their baby

Care for Adults with Chronic Illness
- Blood sugar levels are monitored and controlled
- Cholesterol levels are tested and controlled
- Eyes are examined for loss of vision
- Kidneys are healthy and working properly
- Appropriate use of antibiotics
- Appropriate treatment for lower back pain

If you are having trouble getting health care from your health plan or your doctor, try calling the health plan for customer service. Then, call the Enrollee Help Line if you still have a problem at 1-800-284-4510.

Services Covered by Each Health Plan
- Visits to the doctor, including regular check-ups
- Immunizations
- Care while pregnant
- Family planning and birth control
- Prescription drugs
- X-ray and lab services
- Hospital services
- Home health services
- Hospice services
- Emergency services
- OB/GYN care for women
- Eye exams for adults and children
- Eye glasses for children under 21
- Primary mental health services through your primary care doctor (other mental health and substance use services through the Specialty Mental Health System 1-800-888-1965)
- Transportation services (call your local Health Department)

Every HealthChoice health plan offers some additional services.

MDH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability in its health programs and activities.

Help is available in your language: 1-855-642-8572 (TTY: 1-855-642-8573). These services are available for free.

Hay ayuda disponible en su idioma: 1-855-642-8572 (TTY: 1-855-642-8573). Estos servicios están disponibles gratis.

您若需要免费中文帮助，请拨打这个电话号码：1-855-642-8572 (TDD: 1-855-642-8573)

DO YOU WANT TO ASK THE HEALTH PLANS QUESTIONS?

AETNA BETTER HEALTH	1-866-827-2710
AMERIGROUP COMMUNITY CARE	1-800-600-4441
JAI MEDICAL SYSTEMS	1-888-524-1999
KAISER PERMANENTE	1-855-249-5019
MARYLAND PHYSICIANS CARE	1-800-953-8854
MEDSTAR FAMILY CHOICE	1-888-404-3549
PRIORITY PARTNERS	1-800-654-9728
UNITEDHEALTHCARE	1-800-318-8821
UNIVERSITY OF MARYLAND HEALTH PARTNERS	1-800-730-8530

For more information visit the HealthChoice website *www.health.maryland.gov*

CY 2018 MD HealthChoice Performance Report Card

Spanish Version

EVALUACION DEL DESEMPENO DEL PLAN DE SALUD

Todos los planes de salud de HealthChoice recibieron altas calificaciones de satisfacción de parte la mayoría de sus miembros.

Este informe calificativo muestra el lugar que ocupan los planes de salud de HealthChoice en ciertas áreas clave. Usted puede valerse de este informe y de los demás materiales del paquete de inscripción como ayuda para decidirse por un plan de salud.

Para elegir un plan de salud, llame al 1-855-642-8572. Si tiene problemas de audición, puede llamar a la línea TDD, al número 1-855-642-8573.

Clave
- ★★★ Por encima del promedio de HealthChoice
- ★★ Promedio de HealthChoice
- ★ Por debajo del promedio de HealthChoice

ÁREAS DEL FUNCIONAMIENTO

PLANES DE SALUD

MARYLAND Department of Health HealthChoice Maryland's Medicaid Managed Care Program	Acceso a la Atención	Comunicación con el Médico y sus Servicios	Mantenimiento de la Salud de los Niños	Atención de Niños con Enfermedades Crónicas	Atención de la Mujer	Atención de Adultos con Enfermedades Crónicas
AETNA BETTER HEALTH*	N/A	N/A	N/A	N/A	N/A	N/A
AMERIGROUP COMMUNITY CARE	★★	★★	★★★	★★	★★	★
JAI MEDICAL SYSTEMS	★★★	★★★	★★★	★★★	★★	★★★
KAISER PERMANENTE	★★	★★	★	★★	★★★	★★★
MARYLAND PHYSICIANS CARE	★★	★★	★★	★★	★	★★
MEDSTAR FAMILY CHOICE	★	★★	★★	★★★	★	★★
PRIORITY PARTNERS	★★★	★★	★★	★★	★	★★
UNITEDHEALTHCARE	★★	★★	★★	★★	★	★
UNIVERSITY OF MARYLAND HEALTH PARTNERS	★	★★	★	★★	★	★

*Esta información se recogió de los planes de salud y de sus miembros y con los datos de rendimiento más actuales disponibles. La información fue revisada para su exactitud por organizaciones independientes. Las puntuaciones de rendimiento del plan de salud no se han ajustado a las diferencias en las regiones de servicio o la composición miembro. NOTA: N/A significa que la calificación no es aplicable y no describe el desempeño o la calidad de la atención proporcionada por el plan de salud. No debería afectar su opción de plan de salud. *Aetna Better Health se convirtió en un MCO HealthChoice en 2017, por lo tanto, clasificaciones no son aplicables.*

Descripción de las Áreas de Desempeño

Acceso a la Atención
- Se otorgan citas sin demoras prolongadas
- El plan de salud tiene buena atención al cliente
- Todos ven al doctor por lo menos una vez por año
- El plan de salud responde a los miembros de las llamadas rápidamente

Comunicación con el Médico y sus Servicios
- Los doctores explican las cosas con claridad y responden las preguntas
- El personal del consultorio del doctor es servicial
- Los doctores brindan buena atención

Si usted tiene problemas para recibir atención médica de su plan de salud o de su doctor, llame al plan de salud y pida que lo comuniquen con el servicio de atención al cliente. Luego, si todavía tiene problemas, llame a la línea para afiliados de HealthChoice, Estrella Help Line, al número 1-800-284-4510.

Mantenimiento de la Salud de los Niños
- Los niños son vacunados para protegerlos de enfermedades graves
- Los niños ven al doctor y al dentista periódicamente
- Los niños son sometidos a análisis para detectar intoxicación por plomo

Atención de Niños con Enfermedades Crónicas
- Los doctores les brindan atención individual
- Los niños reciben los medicamentos que necesitan
- El doctor o la enfermera conocen las necesidades del niño
- Los doctores hacen participar a los padres en la toma de decisiones

Atención de la Mujer
- Las mujeres se someten a estudios de detección de cáncer de mama y de cáncer de cuello de útero
- Se cuida de la mujer durante el embarazo y después del parto

Atención de Adultos con Enfermedades Crónicas
- Se observan y controlan los niveles de azúcar en sangre
- Se analizan y controlan los niveles de colesterol
- Se examinan los ojos para ver si hay pérdida de la visión
- Los riñones están saludables y en buen funcionamiento
- El uso apropiado de antibióticos
- El tratamiento adecuado para el dolor lumbar

Servicios Cubiertos por Cada Plan de Salud
- Visitas al médico, incluso los chequeos periódicos
- Inmunizaciones
- Atención durante el embarazo
- Planificación familiar y control de la natalidad
- Medicamentos recetados
- Servicios radiológicos y de laboratorio
- Servicios de hospital
- Servicios de salud en el hogar
- Servicios para enfermos terminales
- Servicios de emergencia
- Atención ginecológica y de obstetricia para mujeres
- Exámenes de los ojos para adultos y niños
- Gafas para niños menores de 21 años
- Servicios primarios de salud mental a través de su primarios doctor (otros servicios de salud mental y uso de sustancias a través del Sistema de Salud Mental Especializado 1-800-888-1965)
- Servicios de transporte (llame a su departamento de salud local)

Cada plan de salud HealthChoice ofrece algunos servicios adicionales.

MDH cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a raza, color, origen nacional, edad, discapacidad en sus programas y actividades de salud.

Help is available in your language: 1-855-642-8572 (TTY: 1-855-642-8573). These services are available for free.

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¿TIENE PREGUNTAS PARA LOS PLANES DE SALUD?

AETNA BETTER HEALTH	1-866-827-2710
AMERIGROUP COMMUNITY CARE	1-800-600-4441
JAI MEDICAL SYSTEMS	1-888-524-1999
KAISER PERMANENTE	1-855-249-5019
MARYLAND PHYSICIANS CARE	1-800-953-8854
MEDSTAR FAMILY CHOICE	1-888-404-3549
PRIORITY PARTNERS	1-800-654-9728
UNITEDHEALTHCARE	1-800-318-8821
UNIVERSITY OF MARYLAND HEALTH PARTNERS	1-800-730-8530

Para obtener mayor información visite el sitio web de HealthChoice, *www.health.maryland.gov*