Qlarant

Maryland
DEPARTMENT OF HEALTH

HealthChoice
Maryland's Medicaid Managed Care Program

Medicaid Managed Care Organization

Performance Improvement Project Validation

2020 Maryland HealthChoice Annual Report

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Performance Improvement Project Validation

2020 Maryland HealthChoice Annual Report

Introduction and Overview

The Maryland Department of Health (MDH) is responsible for the evaluation of the quality of care provided to Medical Assistance enrollees in the HealthChoice program. To ensure the services provided meet acceptable standards for quality, access, and timeliness of care, MDH contracts with Qlarant to serve as the External Quality Review Organization (EQRO). As part of the external quality review, Qlarant completes an annual evaluation of Performance Improvement Projects (PIPs) conducted by the Managed Care Organizations (MCOs).

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

HealthChoice MCOs conduct two PIPs annually. As designated by MDH, the MCOs continued the Asthma Medication Ratio (AMR) PIP. The Lead Screening PIP replaced the Controlling High Blood Pressure PIP in 2018. This report summarizes the findings from the validation of both PIPs. The MCOs who conducted PIPs in 2020 are identified below. Aetna Better Health (ABH) did not conduct any PIPs for the CY 2019 measurement period since they joined the HealthChoice program in October 2017. Due to the COVID-19 public health emergency, MDH granted the MCOs an extension in submitting their annual reporting.

- 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 Validation Methodology

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

Table 1 describes the PIP review steps.

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[1] CMS EQRO Protocols

Table 1. 10–Step Review Process

Step 1. Study Topic	
The study topic selected must be appropriate and relevant to the MCO's population.	Qlarant reviews the study topic/project rationale and looks for demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO specific data must support the study topic and demonstrate the need for the PIP.
Step 2. Study Question	
The study question must be clear, simple, and answerable.	Qlarant reviews the study question which should reference the study population, activity, and expected outcome. The study question guides the PIP.
Step 3. Study Indicator(s)	
The study indicator(s) must be meaningful, clearly defined, and measurable.	Qlarant examines each project indicator to ensure appropriateness to the activity. Technical specifications described in the numerators/denominators must be clearly and accurately defined. Additionally, Qlarant ensures that project goals are appropriate as they serve to motivate process improvement.
Step 4. Study Population	
The study population must reflect all individuals to whom the study questions and indicators are relevant.	Qlarant examines the study population (population of interest) relevancy, which is provided in the project rationale and indicator statements. The PIP should describe the individuals who are eligible for and relevant to the topic.
Step 5. Sampling Method	
The sampling method must be valid and protect against bias.	Qlarant assesses the sampling technique and size used to provide valid and reliable information. When the MCO studies the entire population, this step is not necessary.
Step 6. Data Collection	
The data collection procedures must use a systematic method of collecting valid and reliable data.	Qlarant reviews the project data sources and collection methodologies to ensure the entire study population is appropriately captured. The project is meaningful only if data collection is both valid and reliable.
Step 7. Improvement Strategies	
The improvement strategies, or interventions, must be reasonable and address barriers on a system-level.	Qlarant assesses each intervention to ensure that barriers are addressed. Interventions are expected to be multi-faceted and induce permanent change. Effective interventions are tailored using specific, measurable, achievable, relevant, and time-oriented (SMART) objectives designed for the priority population. They use upstream approaches, such as policy reforms, workflow changes, and resource investments.

Step 8. Study Findings	
The study findings, or results, must be accurately and clearly stated.	Qlarant examines the project results, including the data analysis. There must be a comprehensive quantitative and qualitative analysis for each project indicator. In the quantitative analysis, we assess current performance compared to baseline and previous measurements. Performance should also be assessed against goals/benchmarks. The qualitative analysis should focus more on the project's level of success, identify barriers, and provide an assessment of interventions. Each intervention should undergo the continuous quality improvement process using Plan-Do-Study-Act (PDSA) analysis to determine whether or not the intervention is achieving the desired outcome. This analysis should be reflected in the study findings and include a description of the rationale to continue, discontinue, or alter the planned activity.
Step 9. Real Improvement	
Project results must demonstrate real improvement.	Qlarant assesses performance improvement and ensures the same methodology is repeated. Improvement should be linked to interventions and based on desired outcomes, as opposed to an unrelated occurrence or participation tally. This assessment is correlated to Step 7, Improvement Strategies. If interventions are assessed as reasonable and expected to improve outcomes, then the improvement is correlated to the project's interventions.
Step 10. Sustained Improvement	
Sustained improvement must be demonstrated through repeated measurements.	Qlarant assesses this step after the second remeasurement has been reported. Results are compared to baseline to confirm consistent and sustained improvement.

Rapid Cycle PIP Process

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 question. 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 enrollee, provider, and MCO barriers

5. **Develop sustainable improvement strategies** or interventions that address the identified barriers and includes key stakeholders
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 intervention outcomes to determine which interventions may be effective and which interventions may need to be modified, replaced, or eliminated. Ultimately, the MCO should be able to assess how the intervention impacts the study indicator(s)

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 modifications, 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 enrollee health outcomes.

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

PIP Scoring Methodology

Qlarant rates each component within a step as *Met (M)*, *Partially Met (PM)*, *Unmet (UM)*, or *Not Applicable (NA),* which result in an assigned score as defined in Table 2 below. A final assessment is made for each of the 10 steps with numeric scores provided for each component and step of the validation process. A description of the rating and the associated score follows:

Table 2. Rating Scale for PIP Validation

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

Each component assessed within each step is of equal value. The total of all steps provide the PIP validation score that is used to evaluate whether the PIP is designed, conducted, and reported in a sound manner and determine the degree of confidence a state agency can have in reported results. Qlarant evaluates confidence levels based on the PIP Validation scores as follows in Table 3.

Table 3. Confidence Levels

MCO Reported Results	PIP Validation Score
High Confidence	90%-100%
Confidence	75%-89%
Low Confidence	60%-74%
Not Credible	59% or lower

PIP Validation 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.

AMR PIPs

All AMR PIPs focused on increasing the percentage of enrollees 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®[2] technical specifications.

Table 4 represents the 2020 Validation Results for all AMR PIPs.

Table 4. AMR PIP Validation Results for 2020

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

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

All MCOs received a rating of "*NA*" for Step 1 (Assess the Study Methodology) and Step 2 (Review the Study Question) since MDH selected the study topic and question and Step 5 (Review Sampling Methods) because the entire study population was included.

All MCOs, with the exception of KPMAS received a rating of PM for Step 7 (Assess Improvement Strategies). KPMAS successfully implemented interventions to address member, provider, and MCO system-wide barriers they identified through data analysis and QI processes. Additionally, KPMAS

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provided asthma-related education to its members in both English and Spanish on its member portal including links to eight different videos in both languages.

Common issues across MCOs were for Step 7 (Assess Improvement Strategies):

- Lack of implemented interventions specific to priority populations.
- Lack of targeted interventions to address cultural differences.
- Inadequate planning to resolve unanticipated barriers.
- Inefficient timeliness in modifying interventions to have a measurable impact on rates.

UMHP did not implement any new interventions in 2019 although its rate has been lower the last two measurement years in comparison to its remeasurement 1 rate and UHC has not implemented any new interventions since January 2017 despite a steady decline in its rates since the baseline measurement.

Common themes identified across MCOs for Step 8 (Review Data Analysis & Interpretation of Study Results) revealed:

- Missing some or all of the required components of the defined data analysis plan in their data analysis.
- Lack of assessing the effectiveness of all or a majority of their interventions on the AMR rate.
- Not presenting all numerical results and findings accurately.

All MCOs, with the exception of JMS received a rating of PM for Step 9 (Assess Whether Improvement is Real Improvement) because there was either no documented quantitative improvement in the rate compared to the previous measurement year or there was no evidence that the improvement in the rate during this time frame was the result of the interventions or was statistically significant. UMHP, however, demonstrated statistically significant improvement from baseline to remeasurement year 3 as did JMS.

All MCOs, with the exception of JMS and UMHP, received a rating of UM for Step 10 (Assess Sustained Improvement) because sustained improvement was not demonstrated through repeated measurements. Although UMHP did not demonstrate sustained improvement from one remeasurement year to another, it has demonstrated sustained improvement from baseline over repeat measurement years and therefore received a rating of PM. JMS received a rating of met as it has demonstrated sustained improvement over baseline through repeated measurement years.

AMR PIP Interventions Implemented

Although there was an absence or limited analysis of the effectiveness of interventions, the MCOs determined the following interventions to be effective:

- Provider notification of members over-utilizing short-acting beta agonists with zero pharmacy claims for a longer acting controller medication
- Outreach to non-compliant members, their providers and pharmacies to coordinate controller medication refills
- Mail order program and 90-day prescription refills
- Outreach education from both pharmacists and technicians

- Video visits with an Allergist for members identified with unmanaged asthma

These are some examples of interventions determined by MCOs to be ineffective:

- Seasonal asthma mailings
- Health education classes
- Disease management program
- Asthma Action Plan outreach
- Provider lists of non-compliant members
- Pediatric-based reports embedded in the EMR

Below are examples of additional interventions implemented by the HealthChoice MCOs for the AMR PIPs:

- Health education and outreach, addressing enrollees who meet specific criteria
- Use of CRISP (Chesapeake Regional Information System for our Patients) data by MCOs and providers to identify and engage enrollees with ED usage
- 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 enrollee demographics upon each enrollee contact
- 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 Initiative for home assessment of asthma triggers
- Collaboration with school-based health centers
- Meetings with commonly used pharmacies to discuss auto refills of albuterol
- Clinical pharmacist outreach to members and providers
- Change from 30- to 90-day refills for selected medications
- Use of social media for asthma education

AMR 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 enrollees, providers, and the MCOs. Common barriers across all MCOs for the AMR PIP were identified as follows.

Enrollee 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 enrollee education and outreach
- Lack of awareness of medication usage
- Inconsistent application of clinical practice guidelines
- Knowledge deficit of MCO resources/initiatives to assist with enrollee compliance
- Knowledge deficits relating to appropriate asthma treatment
- Knowledge deficits relating to enrollee adherence

MCO Barriers:

- Inaccurate enrollee demographic information negatively impacting enrollee outreach
- Increased denials of medications at point of service due to frequent formulary changes
- Inaccuracy of pharmacy data provided
- Inability to evaluate impact of interventions in real time
- Inaccurate reporting
- Lack of knowledge regarding the health inequities affecting the disparate population

AMR PIP Indicator Results

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

Figure 1. CY 2016 - CY 2019 AMR Rates

AMR PIP Rates

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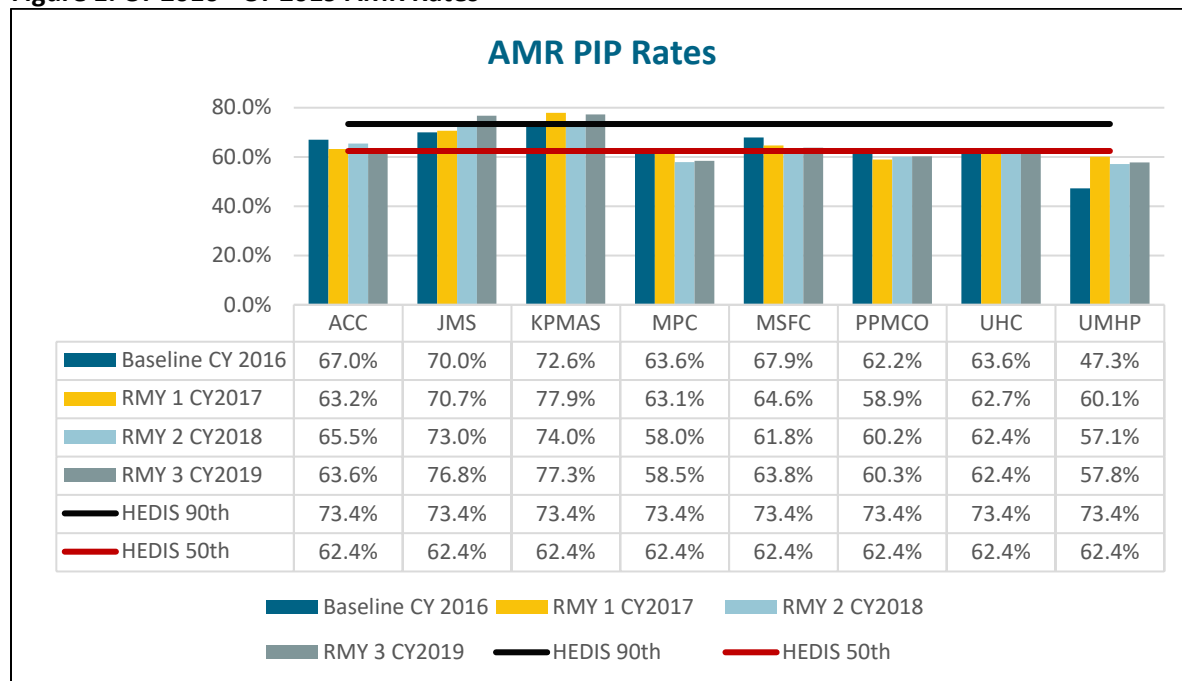
Note: Remeasurement Year (RMY)

There is wide variation among the MCOs in their performance relative to the HEDIS 2020 (MY 2019) Medicaid 90th Percentile benchmark. JMS and KPMAS are performing above the 90th percentile. Both MCOs have had multiple and ongoing systematic provider-based interventions since the initiation of this PIP. For example, JMS has provided education on the treatment of asthma to providers on an individual and small group basis; convened a group of PCPs treating a large number of members with asthma to discuss challenges and ideas for increasing compliance; and emails monthly reports to providers on members with double and consecutive refills of albuterol urging appropriate interventions. KPMAS has developed a decision support tool and an alert that highlights the member's AMR to guide treatment. Additionally, KPMAS has arranged video visits between an Allergist and individual members who demonstrate unmanaged asthma.

ACC's rate declined by 1.9 percentage points and UHC's rate remained unchanged. ACC's decline may be attributed to lack of interventions that are robust, timely, designed to increase engagement, and assessed for effectiveness throughout the measurement year and revised as needed. Many of the interventions UHC implemented were passive in nature and/or lacked focus on the AMR population. Additionally, some interventions had very low member participation.

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 (HEDIS indicator) and the percentage of children ages 12-23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year (value based purchasing [VBP] indicator).

Table 5 represents the 2020 Validation Results for all Lead Screening PIPs.

Table 5. Lead Screening PIP Validation Results for 2020

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

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

All MCOs received a rating of "*NA*" for Step 1 (Assess the Study Methodology) and Step 2 (Review the Study Question) since MDH selected the study topic and question.

Four MCOs' HEDIS sampling methodology met requirements and received a rating of M for Step 5 (Review Sampling Methods). The remaining MCOs received a rating of "*NA*" because the entire population was studied for both HEDIS and VBP indicators.

Similar to the AMR review, all MCOs, with the exception of KPMAS received a rating of PM for Step 7 (Assess Improvement Strategies). KPMAS successfully implemented interventions to address member, provider, and MCO system-wide barriers they identified through data analysis and QI processes. Additionally, KPMAS used the findings of its disparities analysis to revise existing interventions and inform new ones. For example, KPMAS provided a link to their multicultural MDH YouTube video on lead poisoning, available in English and Spanish, in electronic messages sent to members who self-identify as Hispanic.

Common issues across MCOs for Step 7 (Assess Improvement Strategies):

- Interventions implemented were either too passive, too generic, not adequately resourced, and/or not timely enough to have a measurable impact on the rate.
- Interventions implemented were not targeted to address disparities related to cultural, language or social determinants of health.
- Provider barriers were not identified or addressed.

UMHP had only three interventions in place in 2019 and no provider barriers were identified or addressed.

Common themes identified across MCOs for Step 8 (Review Data Analysis & Interpretation of Study Results) revealed:

- Quantitative and/or qualitative analysis that was fully consistent with its defined analysis plan was not provided.
- Errors reported within the numerical PIP results and/or findings.

Five MCOs received a rating of PM for Step 9 (Assess Whether Improvement is Real Improvement). ACC demonstrated a decline in both indicators from the prior measurement year. While JMS demonstrated improvement in both indicators, it was not statistically significant. PPMCO demonstrated improvement in only the HEDIS indicator and UHC in the VBP indicator. Only PPMCO demonstrated that the improvement was statistically significant, however, the improvement appeared only partially due to the result of interventions implemented in 2019. UMHP demonstrated improvement in its VBP measure from the prior measurement year and the improvement in performance from baseline to remeasurement 2 was determined to be statistically significant.

Only one MCO (KPMAS) received a rating of M for Step 10 (Assess Sustained Improvement). Five MCOs (ACC, JMS, PPMCO, UHC, and UMHP) received a rating of PM. ACC, JMS, and PPMCO demonstrated sustained improvement in their HEDIS indicator, and UHC and UMHP in their VBP indicator. MPC and MSFC received a rating of UM as there was no evidence of any sustained improvement.

Lead Screening PIP Interventions Implemented

Although there was an absence or limited analysis of the effectiveness of interventions, the MCOs determined the following interventions to be effective:

- Lead testing at community events with transportation provided
- In-home lead testing
- EMR alert reminders for lead testing
- Video link to MDH's You Tube lead video on member portal
- PCP outreach to non-JMC providers
- Targeted outreach in Anne Arundel County due to low testing rates
- Member gift cards for lead testing

These are some examples of interventions determined by MCOs to be ineffective:

- Outreach via letter and/or electronic message
- Social media platforms

- Interventions occurring too late to impact the VBP measures
- Growing Up lead-safe growth chart

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

- Enrollee education
- Clinic Days at provider sites with phlebotomy services
- Enrollee 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
- Enrollee 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
- EMR data share
- Provider feedback on lead screening performance
- MCO staff education on lead screening and available resources

Lead Screening PIP Identified Barriers

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

Enrollee 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
- Difficulty accessing labs as the labs are not close to provider offices

Provider Barriers:

- Knowledge deficit regarding different HEDIS and MDH requirements
- Lack of trust in Medtox results due to false positives

- Competing priorities during enrollee office visits
- Lack of point of care testing resources
- Lack of resources for patient follow-up
- Inability to coordinate care with the prioritized population
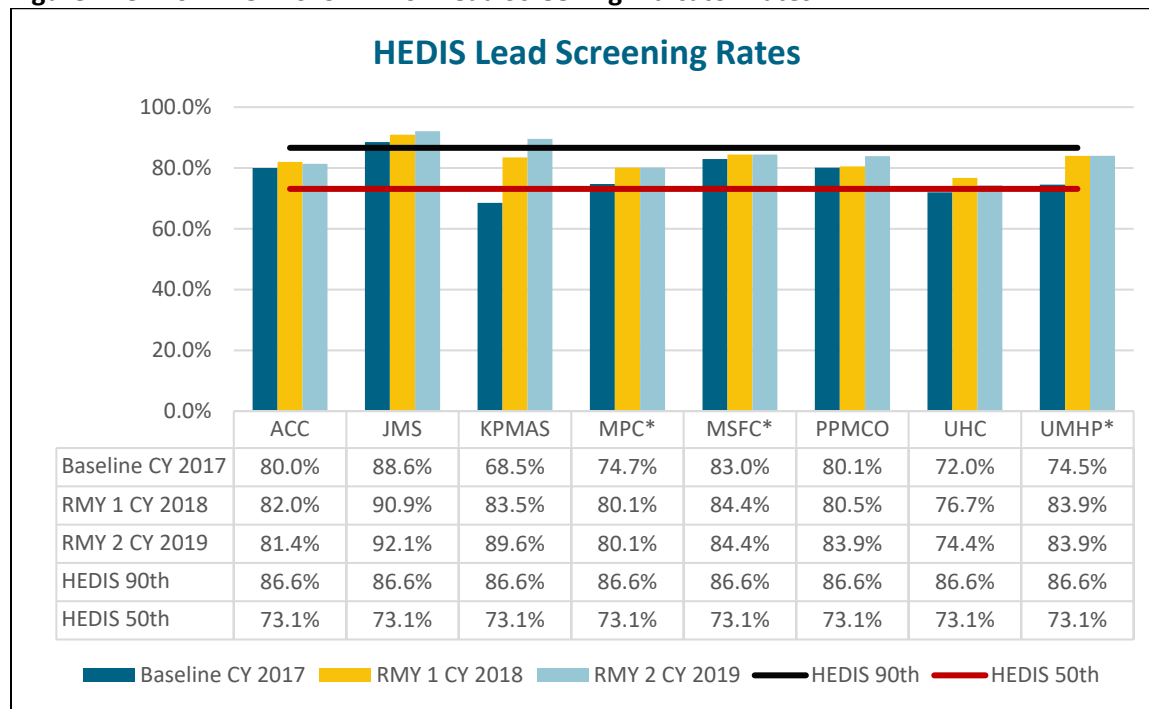
MCO Barriers:

- Home visit providers are not available in 12 counties
- Lack of data sharing across MCOs
- Insufficient or inaccurate enrollee contact and demographic data
- Inability to proactively identify lead care gaps
- Limited understanding of cultural and linguistic barriers
- Lack of resources to outreach enrollees with gaps in care, such as lead testing
- Staff lack of awareness of available programs and services and importance of screening/timing

Lead Screening PIP Indicator Results

CY 2019 is the second remeasurement year of data collection for the Lead Screening PIP. Figure 2 represents the HEDIS indicator rates for the eight MCOs participating in this PIP.

Figure 2. CY 2017 - CY 2019 HEDIS® Lead Screening Indicator Rates

HEDIS Lead Screening Rates

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

Legend: Baseline CY 2017 ■ RMY 1 CY 2018 ■ RMY 2 CY 2019 ── HEDIS 90th ── HEDIS 50th

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

Both JMS and KPMAS exceeded the 2020 HEDIS Medicaid 90th Percentile benchmark for the Lead Screening rate. The success of these two plans may be partially attributed to the common ownership of the health plan and the majority of PCP providers which allows for increased synergy and a shared

decision support system that alerts providers as to needed/overdue services, such as lead testing at the time of care. Four MCOs (ACC, MSFC, PPMCO, and UMHP) are performing above the 75th percentile (81.0%) for this measure. MPC and UHC are performing above the 50th percentile.
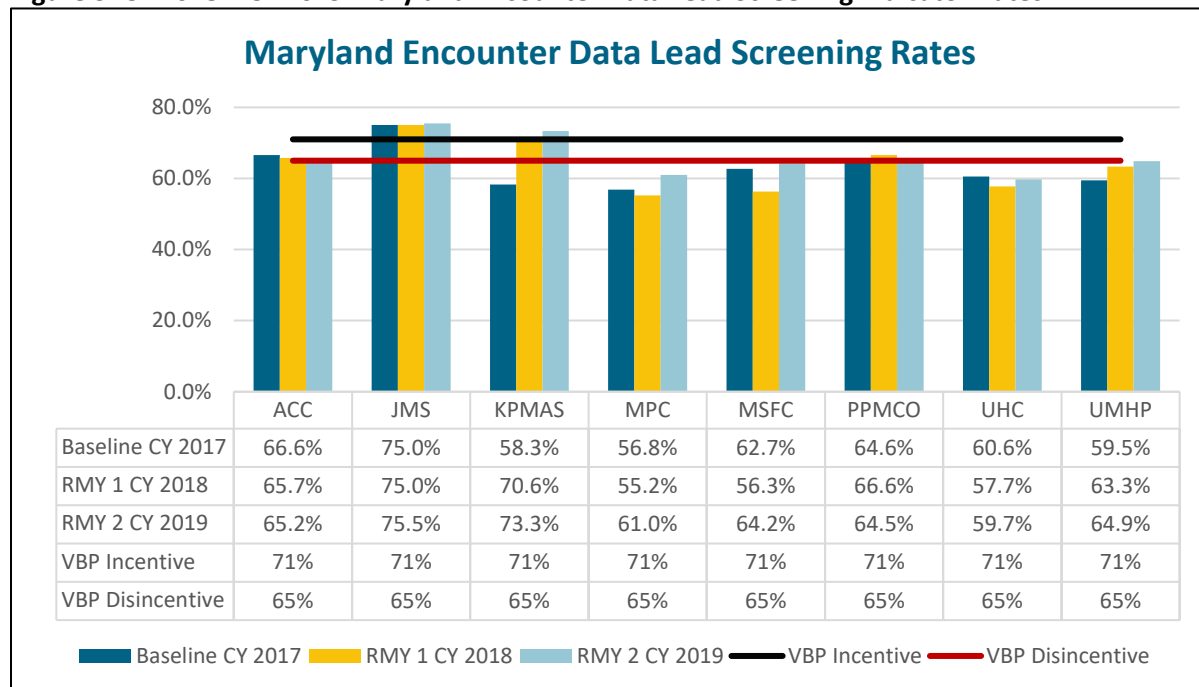
Two MCOs experienced a decline in performance over their remeasurement 1 rate:

- ACC's rate declined by 0.6 percentage points. ACC's decline may be attributed to lack of interventions that are robust, timely, designed to increase engagement, and assessed for effectiveness throughout the measurement year and revised as needed.
- UHC's rate declined by 2.3 percentage points. UHC's decline may be attributed to lack of robust, timely interventions.

NCQA allowed health plans to report HEDIS 2019 audited rates for HEDIS 2020 hybrid measures due to the impact of COVID-19. Three MCOs, (MPC, MSFC, and UMHP) elected this option, therefore, there is no change in their reported rate for MY 2020.

Figure 3 represents the Maryland encounter data indicator rates.

Figure 3. CY 2018 – CY 2019 Maryland Encounter Data Lead Screening Indicator Rates

Maryland Encounter Data Lead Screening Rates

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

Legend: ■ Baseline CY 2017 ■ RMY 1 CY 2018 ■ RMY 2 CY 2019 — VBP Incentive — VBP Disincentive

Note: Remeasurement Year (RMY)

JMS and KPMAS are the only MCOs with Maryland encounter data rates for lead screening that are in the incentive benchmark range of ≥ 71% for Maryland's Value Based Purchasing Initiative. ACC's rates fall in the neutral zone. The remaining five MCOs (MPC, MSFC, PPMCO, UHC, and UMHP) have rates within the VBP disincentive benchmark (≤ 65%).

Two MCOs experienced a decline in performance over their baseline rate:

- ACC's rate declined by 0.5 percentage points. ACC's decline may be attributed to lack of interventions that are robust, timely, designed to increase engagement, and assessed for effectiveness throughout the measurement year and revised as needed.
- PPMCO's rate declined by 2.1 percentage points, which was statistically significant. PPMCO's decline may be related to the delay in new interventions in the last four months of the year and the need for more targeted interventions to address specific barriers relating to the VBP measure.

AMR and Lead Screening PIPs Validity and Reliability Results

An assessment of the validity and reliability of the PIP study design and results reflects a detailed review of each MCO's PIPs and audited HEDIS and Maryland encounter data measure findings for the selected indicators. Tables 6 and 7 identify the level of confidence Qlarant has assigned to each MCO's AMR and Lead Screening PIPs for CY 2019 PIP performance.

Table 6. 2020 AMR 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					
Confidence					X			
Low Confidence	X			X		X	X	X
Reportable PIP Results Not Credible								

Both JMS and KPMAS were assigned a high confidence level as a result of the effectiveness of their interventions in increasing the AMR rate and their fidelity in adhering to all or most of the required steps in the PIP protocol.

MSFC's PIP was assigned a level of confidence due to the lack of targeted interventions in response to linguistic and cultural barriers; absence of statistically significant improvement; and lack of sustained improvement demonstrated through repeated measurements.

A low confidence level was assigned to five MCOs (ACC, MPC, PPMCO, UHC, and UMHP) for the AMR PIP, as their interventions were either not robust or timely enough, adequately resourced, or successfully implemented, and analysis of MCO data was not consistent with their defined data analysis plan. Additionally, ACC, MPC, PPMCO, UHC, and UMHP had no evidence of targeted interventions in response to linguistic and cultural barriers. ACC and UHC also demonstrated a decline in remeasurement 3 rates from the prior measurement year. Furthermore, ACC and PPMCO did not provide accurate numerical PIP results and findings.

Table 7. 2020 Lead Screening PIP Validation Results - Level of Confidence

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

 A level of high confidence was assigned to two MCOs (KPMAS, and MSFC) as a result of the effectiveness of their interventions in increasing the Lead Screening rate and their fidelity in adhering to most of the required steps in the PIP protocol.

A level of confidence was assigned to five MCOs (ACC, JMS, MPC, PPMCO, and UHC). ACC, PPMCO, and UHC did not demonstrate that their interventions were timely or robust enough to have a meaningful impact on their rates. Of these five, only JMS and UHC provided evidence of targeted interventions in response to linguistic and cultural barriers. MPC's analysis of its data was not consistent with its defined data analysis plan and PPMCO had a number of errors in its results and findings. ACC, PPMCO, and UHC also demonstrated a decline in at least one of the remeasurement 2 rates over the prior measurement year. No evidence of sustained improvement was demonstrated by MPC while ACC, PPMCO, and UHC demonstrated sustained improvement in only one of their indicators.

UMHP's reportable PIP results for its Lead Screening PIP was assigned a low confidence rating as its interventions were extremely limited, not robust or timely enough, and did not address all system components; no targeted interventions were implemented to address cultural and linguistic barriers; and its data analysis contained a number of errors and was not consistent with its defined data analysis plan.

PIP Conclusions and Recommendations

All MCOs are required to participate in two PIPs, AMR and Lead Screening. Due to the COVID-19 public health emergency, MDH granted the MCOs an extension in submitting their annual reporting. CY 2019 results for the AMR PIP were submitted in October 2020 and the Lead Screening results were submitted in November 2020, representing the third remeasurement year for the AMR PIP and the second remeasurement 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 MDH's subcontractor.

Overall, performance indicator results were mixed and opportunities for improvement remain. Confidence levels assigned to the AMR PIPs were lower than those assigned to the Lead PIPs. Over half of the MCO AMR PIPs were assigned a low confidence level while all Lead PIPs were assigned a level of confidence or high confidence except one MCO's PIP whose results were determined low confidence. This difference suggests that the implementation of a Rapid Cycle PIP methodology for Lead Screening has helped to facilitate more frequent assessments that lead to adjustments in interventions.

Qlarant recommendations remain fairly consistent from those offered in prior PIP Validations. This is the result of many MCOs continuing to submit PIPs that do not reflect the changes that were required or recommended following the last or, in many cases, the prior PIP validations. Qlarant recommends that the HealthChoice MCOs concentrate efforts on the areas described below.

- **Complete in-depth barrier analysis at least annually** to identify root causes of suboptimal performance and to effectively drive improvement. MCOs continue to conduct high-level barrier analyses, resulting in little or no improvement in indicator rates. For example, reports on provider gaps in care should be evaluated for their effectiveness in increasing the indicator rate.

A more in-depth root cause analysis should be conducted to address additional barriers related to providers whose performance does not improve to inform additional interventions. This is an iterative process and should be part of their PDSA activities and repeated until the MCO accomplishes its goal. A glaring omission in many PIP proposed interventions for the upcoming MY 2020 was the impact of COVID-19 related barriers.

- **Develop robust, system–level interventions** in response to identified barriers. Passive interventions, such as mass mailings, cold calls, and health fairs are generally seen as ineffective as they have minimal impact. Examples of effective interventions include educational efforts, changes in policy, targeting of additional resources, or other organization–wide initiatives. Face–to–face contact is usually most effective. For example, PCPs may be viewed as a trusted advisor by their patients so MCO efforts to leverage these relationships may be effective in influencing health-related behavior change. To improve outcomes, interventions should be systematic (affecting a wide range of enrollees, providers and the MCO), timely, and effective. MCOs should focus its efforts on implementing evidence-based strategies that are likely to lead to the desired improvement. Without effective interventions that affect change in procedures or operations, PIPs will struggle to improve performance and demonstrate limited success.
- **Implement timely interventions** within the measurement year to have a meaningful impact on the measure rate. Many MCOs are not implementing any new interventions until the latter half of the measurement year, most often in the last quarter.
- **Ensure that interventions address differences among population subgroups**, such as differences in health care attitudes and beliefs among various racial/ethnic groups within the MCO's membership. 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. Identifying a health disparity is only the first step. The next step is to understand why it exists. This requires in-depth analysis of possible contributing factors through review of available data, literature review, and collaboration with representatives of the subpopulation. For example, older women from a certain cultural background may believe in home remedies or have misperceptions about the adverse impact of certain recommended treatments. With this knowledge, interventions could be specifically targeted at addressing these misunderstandings or fears, such as aligning with an influential member of the community to outreach to these members or hosting a presentation at a relevant venue (such as a local church), led by a physician, preferably an older female, with the same cultural background. It should be noted, however, that a common barrier to understanding racial and cultural differences is the lack of critical demographic data for a large percentage of the MCOs' membership. MCOs need to explore approaches to increasing this data to better identify any health disparities. Inclusion of representatives from subpopulations with known disparities in the PIP process should help to drive effective improvement strategies.
- **Assess interventions for their effectiveness**, and initiate 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. Requiring MCOs to submit a plan for evaluating the effectiveness of each intervention as a component of its development may not only strengthen the evaluation methodology but also the design of the intervention.
- **Ensure that data analysis is consistent with the defined data analysis plan**, both quantitative and qualitative.

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- **Ensure that MCO reported rates are consistent in the number of decimal places** for all measurement periods and with audited rates. It was observed that a variance in reporting decimal places from one period to the next can have an impact on the percentage point changes and the results of statistical significance testing.

It appears that there is confusion among the MCOs in submitting the required content for reporting measurement year results for the Lead PIP due to quarterly submissions. Some MCOs analyzed the effectiveness of their interventions either across measurement years or year to date for CY 2020. This should be addressed in updates to the MCO Performance Improvement Project Reporting Tool based upon the revised Validation of Performance Improvement Projects Protocol released in October 2019.

MDH may want to consider how it might further incentivize MCOs to fully commit to demonstrating significant and sustainable improvement through implementation of robust, timely interventions. One MCO had no new interventions for the AMR PIP since January 2017 and another MCO had no new interventions for the AMR PIP in 2019 and only three interventions overall for the Lead PIP in 2019. Other MCOs often implemented interventions that lacked a laser focus on identified opportunities to improve performance on selected indicators.