Qlarant

Maryland HealthChoice Program

Annual Technical Report

Calendar Year 2022

Maryland
DEPARTMENT OF HEALTH

Submitted April 2023

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Executive Summary

Background

As of December 31, 2021, the Maryland HealthChoice Program (HealthChoice) enrolled 1,446,237 participants. The Maryland Department of Health (MDH) contracted with nine managed care organization (MCOs) during this evaluation period.

Table 1 displays MCO profiles and quality characteristics for those MCOs evaluated during this period were:

Table 1. MY 2021 MCO Profiles

MCOs	Contracted Since	MY 2021 Enrollment***	NCQA Accreditation Status****
Aetna Better Health of Maryland (ABH)	2019	42,701	Accredited
AMERIGROUP Community Care (ACC)*	1999	298,779	Accredited
CareFirst BlueCross BlueShield Community Health Plan (CFCHP)**	2013	52,067	Accredited
Jai Medical Systems, Inc. (JMS)	1997	28,703	Accredited
Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)	2014	90,639	Accredited
Maryland Physicians Care (MPC)	1997	226,358	Accredited
MedStar Family Choice, Inc. (MSFC)	1997	98,679	Accredited
Priority Partners (PPMCO)	1995	322,078	Accredited
UnitedHealthcare Community Plan (UHC)	1997	156,362	Accredited

*ACC's name changed to Wellpoint Maryland, effective January 1, 2023 and will be reflected in MY 2023's report.
** Formerly University of Maryland Health Partners
*** Source: Maryland Department of Health, MCO enrollment as of 12/31/2021.
**** Source: MetaStar (2022, August). Statewide Executive Summary Report HealthChoice Participating Organization HEDIS®[1] MY 2021 Results. Madison, WI.

[1] The MD MCO accreditation is based on an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires states contracting with MCOs to conduct annual, independent reviews of the managed care program. To meet these requirements, MDH contracts with Qlarant, an independent external quality review organization (EQRO). Qlarant evaluates the quality, accessibility, and timeliness of health care services furnished by the MCOs through various mandatory activities following Centers for Medicare and Medicaid Services (CMS)-developed external quality review (EQR) protocols.[2] Qlarant completed the following EQR activities in calendar years (CYs) 2021 to 2022 to evaluate MCO performance for measurement year (MY) 2021:

- Systems Performance Review (SPR)
- Performance Improvement Project Validations (PIPs)
- Performance Measure Validation (PMV)
- Network Adequacy Validation (NAV)

Qlarant conducted optional activities that include:

- Encounter Data Validation (EDV)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews
- Development and production of an annual Consumer Report Card (CRC)
- Quarterly focused reviews of MCO grievances, appeals, and denials (GAD)

In addition to these EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing how data from all activities conducted were aggregated and analyzed, and how conclusions were drawn regarding the quality, accessibility, and timeliness of care furnished by the MCOs. This Annual Technical Report (ATR) serves as Qlarant's report to MDH on the assessment of MY 2021 MCO performance, describes EQR methodologies for completing activities, provides compliance results, and analyzes performance. Additionally, included are an overview of the quality, access, and timeliness of health care services provided to Maryland's HealthChoice enrollees; and recommendations for improvement, which if implemented, may positively impact enrollee outcomes.

Key Findings

In MY 2021, the COVID-19 public health emergency created unique barriers which affected both data collection and performance in numerous EQR tasks. The performance trends for each task that highlight these challenges are outlined in the following sections.

[2] The EQR Protocols are available at www.cms.gov.

Systems Performance Review (SPR)

MCOs are expected to be fully compliant with federal and contractual requirements. SPRs evaluate MCO compliance with structural and operational standards. For the MY 2021 SPR, Qlarant conducted a comprehensive onsite review.

Corrective action plans (CAPs) were required to address areas of noncompliance for eight of the nine MCOs (ABH, ACC, CFCHP, KPMAS, MPC, MSFC, PPMCO, and UHC), which should improve compliance rates if successfully implemented. Table 2 displays the number of CAPs required by each MCO and the number reviewed and successfully closed.

Table 2. MY 2021 Total Corrective Action Plans per MCO

MCO CAP Requirements	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Total Corrective Action Plans Required	3	2	5	0	4	3	1	3	3
Total Corrective Action Plans Closed	2	1	1	0	2	0	0	1	0

Performance Improvement Projects (PIPs)

All nine MCOs conducted two PIPs. The Asthma Medication Ratio (AMR) PIP assessed quality of care, while the Lead Screening PIP assessed quality, timeliness, and accessibility of care. The HEDIS AMR measure was selected for the AMR PIP. Two measures were chosen for the Lead Screening PIP: HEDIS Lead Screening and Maryland Encounter Data (for VBP lead screening rates). Table 3 displays the percentage change in indicator results from MY 2020 to MY 2021 for each MCO.

Table 3. Percentage Change in PIP Results from MYs 2020 to 2021

Indicator	ABH*	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Asthma Medication Ratio PIP Percentage Change									
Asthma Medication Ratio Screening	NA	1 ↓	9.9 ↑	2.2 ↓	9.7↑	1.1 ↑	1.3↑	0.5↓	5.7↓
Lead Screening PIP Percentage Change									
HEDIS Lead Screening	NA	6.4↓	5.6 ↓	8.2↓	5.2↓	23.1↓	1↑	5↓	1.3↓
VBP Lead Screening Rates	NA	1.2↓	12.5↓	1.4↓	7.9↑	10.6↑	0.9↓	0.9↓	1.4↓

Green = ↑ Improvement from MY 2020; Pink = ↓ Decline from MY 2020; NA = Not Applicable
*MY 2021 is a baseline study for ABH (ABH was not required to report previous year information)

Encounter Data Validation (EDV)

Validation of encounter data provides MDH with a level of confidence in the completeness and accuracy of encounter data submitted by the MCOs. MDH uses information from encounter data to determine the HealthChoice population's acuity, which then impacts the calculation of MCO capitation payments.

Overall, validation findings indicate data is complete and accurate. Most MCOs achieved a match rate of 96% or higher for each encounter type, meaning 96% or higher of claims[3] submitted were supported by medical record documentation, as shown in Table 4. There are no corrective action plans required as a result of the MY 2021 review due to all of the HealthChoice MCOs achieving match rates that are equal to or above the 90% compliance standard.

Table 4. MY 2021 MCO and HealthChoice Results by Encounter Type

MCO	Inpatient	Outpatient	Office Visits
ABH	100%	98%	99%
ACC	100%	99%	98%
CFCHP	100%	100%	99%
JMS	96%	99%	99%
KPMAS	100%	100%	100%
MPC	100%	99%	100%
MSFC	100%	100%	100%
PPMCO	98%	99%	99%
UHC	98%	100%	99%
HealthChoice	**99%**	**99%**	**99%**

Performance Measure Validation (PMV)

The Value-Based Purchasing (VBP) activity uses financial incentives and disincentives to promote performance improvement. MY 2021 VBP rates were drawn from HEDIS and encounter data rates reported by the MCOs and/or the Maryland Department of the Environment. For each of the seven selected measures, MDH calculates incentive, neutral, and disincentive ranges. These ranges are then used to determine if the MCOs' quality improvement efforts successfully resulted in improved health outcomes and if incentives or disincentives should be assessed.

[3] Encounter data consists of claims; therefore, these two terms, encounter and claims, are used interchangeably.

Table 5 displays whether the MCO will receive an overall incentive or will be required to pay a disincentive, based on calculated incentive, neutral, or disincentive amounts for each of the seven measures. In accordance with 42 CFR 438.4, MDH did not collect net disincentive amounts for MY 2021 VBP, based on the determination that collecting the net disincentives would impact the actuarial soundness of MY 2021 capitation rates.

Table 5. Overall VBP Net Outcomes by MCO

	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Net Outcomes	**D**	**D**	**D**	**I**	**I**	**D**	**D**	**D**	**D**

I = incentive threshold; D = disincentive threshold. Disincentives were not collected for MY 2021.

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

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical record review assesses the quality, timeliness, and accessibility of care. Over 2,400 medical records were reviewed for this activity. MY 2021 review indicators were based on current pediatric preventive care guidelines and MDH-identified priority areas. Compliance thresholds for all five components were set at 80%. For MY 2021, the medical record review process included onsite reviews. Continued closure of provider offices, due to the COVID-19 public health emergency, impacted the scheduling of onsite reviews. Due to methodology discrepancies, the MY 2021 EPSDT medical record review is still in development and finalized scoring is in progress. Upon conclusion of this task, revisions to the EPSDT portion of the ATR will be completed.

Consumer Report Card (CRC)

The CRC assists Medicaid participants when selecting a HealthChoice MCO. Information in the CRC includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Maryland's encounter data measures.

Tables 6 and 7 display the MY 2022 Consumer Report Card results and the overall star rating changes from MY 2021 to MY 2022.

Table 6. MY 2022 Consumer Report Card Results

Performance Areas	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Access to Care	★★	★★	★★	★★	★★	★★	★★	★★	★★
Doctor Communication and Service	★	★★	★★	★★★	★★	★★	★★	★★★	★★
Keeping Kids Healthy	★	★★★	★★	★★★	★★★	★	★★★	★	★★★
Care for Kids with Chronic Illness	★★	★★	★	NA	★★	★★★	★★	★★★	★
Taking Care of Women	★	★★★	★★	★★★	★★★	★	★	★	★
Care for Adults with Chronic Illness	★★	★	★	★★★	★★★	★	★★	★	★

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

Table 7. CRC Star Rating Changes from MY 2021 to MY 2022

Categories of Care	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Access to Care	↑	⊖	⊖	⊖	⊖	⊖	↓	⊖	⊖
Doctor Communication and Service	⊖	↑	↑	⊖	↓	↓	⊖	⊖	⊖
Keeping Kids Healthy	⊖	⊖	⊖	⊖	⊖	↓	↑	↓	↑
Care for Kids with Chronic Illness	NA	↑	⊖	NA	NA	↑	⊖	⊖	↓
Taking Care of Women	↓	↑	⊖	⊖	⊖	⊖	⊖	⊖	⊖
Care for Adults with Chronic Illness	↑	⊖	⊖	⊖	⊖	↓	↑	⊖	⊖

Light Green = ↑ improvement from MY 2021; Pink = ↓ decline from MY 2021; White = ⊖ no change from MY 2021;
Gray = NA reported as Not Applicable for MY 2021 and/or MY 2022

Focused Review of Grievances, Appeals, and Denials

Qlarant's MY 2022 study reviewed grievances, appeals, and denials to assess MCO compliance with federal and state laws and regulations pertaining to the appropriateness of denials of service and the handling of grievances and appeals. This activity consisted of reviewing quarterly MCO grievance, appeal, and denial reports from the final two quarters in MY 2021 and the first two quarters in MY 2022, along with a MY 2021 annual record review.

Table 8 displays overall MCO compliance scores from quarterly report submissions, based on MDH-established thresholds.

Table 8. MCO Overall Compliance with Regulatory Timeframes

Categories	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Member Grievances	M	M	M	M	PM	M	M	PM	M
Provider Grievances	PM	M	PM	M	NA	M	M	M	M
Enrollee Appeals	PM	PM	M	M	PM	PM	PM	M	PM
Adverse Determinations	PM	PM	PM	M	M	M	M	M	M
Adverse Notifications	M	M	M	M	M	M	M	M	M

Light Green = M (Met), Yellow = PM (Partially Met), Pink = UM (Unmet), Gray = NA (Not Applicable)

The annual record review of grievances, appeals, and denials assessed MCO compliance with processing requirements, timeliness of enrollee notifications, and required content and ease of understanding enrollee letters.

Table 9 displays MCO overall compliance with the above components, based on the annual record review.

Table 9. MCO Overall Compliance with Record Review Components

Categories	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Member Grievances	PM	PM	PM	M	PM	M	M	M	PM
Enrollee Appeals	PM	M	PM	NA	PM	PM	M	PM	PM
Adverse Determinations	M	PM	M	M	M	M	M	M	M
Adverse Notifications	M	M	M	M	M	M	M	M	M

Light Green = M (Met), Yellow = PM (Partially Met), Pink = UM (Unmet), Gray = NA (Not Applicable)

Network Adequacy Validation (NAV)

Qlarant's MY 2022 NAV assessed network adequacy for all nine MCOs to ensure each MCO has the ability to provide enrollees with timely access to needed care. This activity focused on two components: a survey of providers to assess compliance with state access and availability requirements and validation of MCO online provider directories.

In the aggregate, survey results of primary care provider (PCP) compliance with routine and urgent care appointment requirements were above the minimum compliance threshold of 80%, as displayed in Table 10.

Table 10. PCP Compliance with Routine and Urgent Care Appointments

MY 2022 NAV	Appointment Compliance	
	Routine Care	Urgent Care
Appointment Availability	87.6%	90.0%
Appointment Timeframes	93.0%	85.2%

Based on MY 2022 results, seven MCOs are required to submit CAPs to Qlarant to improve online provider directory accuracy (ACC, CFCHP, JMS, KPMAS, MPC, PPMCO, and UHC), one MCO is required to submit a CAP to improve compliance with routine care timeframes (MSFC), and one MCO is required to submit a CAP to improve compliance with urgent care timeframes (KPMAS).

Healthcare Effectiveness Data and Information Set (HEDIS)

MDH contracted with MetaStar, Inc. (MetaStar), a National Committee for Quality Assurance (NCQA) Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice managed care organizations and to summarize the results. For HEDIS MY 2021, MDH required HealthChoice MCOs to report the complete HEDIS measure set for services rendered in MY 2021 to HealthChoice enrollees. These measures provide meaningful MCO comparative information, and they evaluate performance relative to MDH's priorities and goals.

Maryland MCOs had high overall performance in their HEDIS rates prior to the COVID-19 pandemic. COVID is likely to have a continuing impact on healthcare delivery and measure performance for the foreseeable future. For additional findings and comprehensive details associated with the HEDIS MY 2021 results, see the full report linked in **Appendix D**.

Consumer Assessment of Healthcare Providers and Systems

MDH contracted with the Center for the Study of Services (CSS), an NCQA-certified survey vendor, to administer and report the results of the CAHPS 5.0H Member Experience Survey. The overall goal of the survey is to provide performance feedback that is actionable, and that will aid health plans in improving overall member experience.

CSS administered the Adult Medicaid version of the CAHPS Health Plan Survey for the Maryland Department of Health on behalf of the HealthChoice MCOs between February 17 and May 13, 2021. For additional findings and comprehensive details associated with the 2021 CAHPS results, see the full report linked in **Appendix D**.

Conclusion

The MCOs provided evidence of meeting most federal and contract requirements for compliance and quality-related reporting. Overall, the MCOs are performing well. MCOs developed CAPs for each deficiency identified.

MDH continues to encourage an environment of compliance and quality improvement and sets high standards to promote access to quality care. The MY 2021 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care and services for Maryland Medicaid managed care enrollees.

Maryland HealthChoice Program

2022 Annual Technical Report

Measurement Year 2021

Introduction

Background

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible participants by contracted managed care organizations (MCOs) through the Maryland Medicaid Managed Care Program, known as HealthChoice. HealthChoice has been operational since June 1997 under the authority of an 1115 waiver of the Social Security Act. HealthChoice's guiding principle is to provide quality health care that is patient-focused, prevention-oriented, coordinated, accessible, and cost-effective.

MDH's Medical Benefits Management Administration (MBMA) is responsible for oversight of the HealthChoice program. MBMA ensures the MCOs comply with initiatives established in 42 CFR §438, Subpart D. The Division of HealthChoice Quality Assurance (DHQA) within MBMA is primarily responsible for monitoring the quality activities involving external quality review (EQR) and Centers for Medicare and Medicaid Services (CMS) quality improvement requirements for the HealthChoice program. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care oversight process.

The 2022 Annual Technical Report (ATR) is a compilation of quality assurance activity reports for services and activities conducted during measurement years (MYs) 2021 and 2022. The ATR describes EQR methodologies for completing activities; provides MCO performance measure results; summarizes compliance results; and includes an overview of the quality, timeliness, and accessibility of health care services provided by the contracted MCOs. The COVID-19 public health emergency presented unique challenges for MCOs in MYs 2020 and 2021, which is reflected in performance assessed in the 2022 ATR.

As of December 31, 2021, HealthChoice enrolled 1,446,237 participants. MDH contracted with nine MCOs during this evaluation period. The MCOs evaluated during this period were:

- Aetna Better Health of Maryland (ABH)

- AMERIGROUP Community Care (ACC)[4]
- CareFirst Community Health Plan (CFCHP)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)

MBMA's Quality Strategy

Overall goals of MBMA's Quality Strategy are to:

- Ensure compliance with changes in federal and state laws and regulations affecting the HealthChoice program,
- Use evidence-based methodologies for evaluation to continuously improve quality and health care performance,
- Compare Maryland's results to national and state performance benchmarks to identify areas of success and improvement,
- Reduce administrative burden on MCOs and the HealthChoice program, and
- Assist MDH with setting priorities and responding to identified areas of concern within the HealthChoice participant population.

EQRO Program Assessment Activities

MDH is required annually to evaluate the quality of care provided by contracted MCOs, in accordance with federal law[5]. MDH contracts with Qlarant, an EQRO, to perform an independent annual review of services provided by each contracted MCO to ensure the services provided to participants meet standards set forth in the regulations governing HealthChoice.

Federal regulations require the EQRO to perform four mandatory activities, using methods consistent with CMS protocols:

- Triennial review of MCOs' operations to assess compliance with state and federal standards for quality program operations;
- Validation of state-required performance improvement projects (PIPs) underway during the prior 12 months;
- Validation of state-required performance measures; and

[4] Effective January 1, 2023, ACC's name changed to Wellpoint Maryland.
[5] Section 1932(c)(2)(A)(i) of the Social Security Act

- Validation of network adequacy for member access and timeliness to care.

Federal regulations also permit MDH to contract with an EQRO to validate encounter data submitted by the MCOs. Qlarant performed this activity on behalf of MDH, in collaboration with The Hilltop Institute at the University of Maryland Baltimore County (Hilltop).

Additionally, Qlarant completed the following four review activities:

- Review of medical records to ensure compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements;
- Development and production of an annual Consumer Report Card (CRC) to assist participants in selecting an MCO; and
- Quarterly focused reviews of MCO grievances, appeals, and denials (GAD).

Separate report sections address each review activity and describe the methodology and data sources used to assess MCO compliance and performance. The remaining sections of this report summarize overall MCO strengths, opportunities, and recommendations; and assess the status of previous findings and recommendations to MBMA and the MCOs to further improve the quality of, timeliness of, and access to health care services for HealthChoice participants.

Systems Performance Review

Objectives

Conducting a SPR provides an annual assessment of the structures, processes, and outcomes of each MCO's quality assurance program. Through the compliance, or systems review, Qlarant's review team identifies, validates, quantifies, and monitors problem areas, as well as distinguishes and promotes best practices.

Methodology

Qlarant conducted MY 2021's assessment as a comprehensive onsite review in response to MDH's decision to move to comprehensive triennial, rather than annual, onsite reviews. Due to the COVID-19 public health emergency, virtual onsite reviews were offered to each MCO. Reviewers completed the comprehensive assessment by applying systems performance standards. Performance standards used to assess each MCO's operational systems were developed through review of the Code of Maryland Regulations (COMAR) 10.67.04.03B(1); federal regulations, such as 42 CFR Part 438, Subpart D and Quality Assurance and Performance Improvement (QAPI) standards; and guidelines from other quality assurance accrediting bodies, such as the NCQA. **Appendix B** provides a crosswalk of COMAR regulations and SPR standards reviewed for MY 2021's

comprehensive onsite review. A sample review of the appeal, grievance, and adverse determination records was also conducted to assess compliance with applicable standards.

Prior to individual onsite or virtual reviews, each MCO received a draft of the standards in advance for review and comment within 45 days from receipt. All comments were taken into consideration prior to finalizing standards. SPR standards were finalized after review and approval by the DHQA.

During the onsite or virtual onsite reviews conducted in January through March of 2022, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation submitted by the MCOs to assess the standards. Reviews were conducted by a team of qualified healthcare professionals with over 50 years of combined EQR experience.

Data Collection and Review. Prior to the annual assessment, the MCO was required to submit a completed pre-audit survey form and provide documentation for various processes, such as quality and utilization management, delegation, credentialing, enrollee rights, continuity of care, outreach, and fraud and abuse policies. Documents provided included policies and procedures; meeting minutes; program descriptions; annual evaluations; work plans; tracking and monitoring reports; focused studies; delegate reports; population assessments; HEDIS and CAHPS results; enrollee handbooks and materials; provider manuals, directories, and newsletters; operational performance reports; and grievance, appeal, and adverse determination records. MCOs identified as requiring corrective action submitted a CAP, with proposed detailed actions, to correct any identified deficiencies from the review process.

After completing the review, Qlarant documented its findings and level of compliance for each standard by element and component. Levels of compliance for each element and component received a review determination of *Met*, *Met with Opportunity*, *Partially Met*, or *Unmet*, as defined in Table 11. MDH 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.

Table 11. SPR Validation Review Determinations

Review Determination	Criteria
Met (M)	Compliant with requirements
Met with Opportunity (MwO)	Compliant with requirements, but with an opportunity to improve; CAP is not required
Partially Met (PM)	CAP required
Unmet (UM)	CAP required
Not Applicable (NA)	Not Applicable

Exit letters provided to each MCO after the onsite or virtual onsite review described potential issues that could be addressed by supplemental documentation, if available. The MCOs were given ten 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 were related.

Final reports captured any appropriate revisions from additional documentation sent from the MCOs. After receiving the final report, the MCO is given 45 calendar days to respond to Qlarant with the required CAPs. The MCO could have also responded to any other issues contained in the report, at its discretion, within this same timeframe, and/or requested a consultation with DHQA and Qlarant to clarify issues or ask for assistance in preparing a CAP. Qlarant evaluates and determines the adequacy of compliance for all CAPs. A CAP is determined adequate only if it addresses all required elements and components (such as timelines, action steps, and documented evidence).

Non-duplication Deeming: CMS permits states the opportunity to use information from a private accreditation review, such as a NCQA audit, to meet comparable federal regulations. Using results from a comparable audit allows an opportunity for non-duplication deeming.

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

To qualify for deeming, MDH established the following criteria:

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

Using this information and the NCQA *Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards*[6] (Effective July 1, 2020 – June 30, 2021), Qlarant evaluated whether the MCO qualified for deeming of federal regulations. Appendix B provides a crosswalk of the SPR standards in which MDH permitted deeming for MY 2021's comprehensive onsite review.

[6] National Committee for Quality Assurance. (2020). Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards. Retrieved from https://store.ncqa.org/2020-medicaid-managed-care-toolkit.html

Results

Qlarant conducted the MY 2021 SPR as a comprehensive onsite/virtual onsite review. All MCOs demonstrated the ability to design and implement effective quality assurance systems. MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of healthcare services to managed care enrollees. Table 12 displays an aggregate review, at a glance, of the last three comprehensive SPR reviews for MYs 2015, 2018, and 2021. Standard 2 for Accountability to Governing Body and Standard 9 for Health Education Plan will be comprehensively reviewed during the MY 2022 interim SPR.

Table 12. SPR Aggregate Scores At-A-Glance

Standard	MY 2015	MY 2018	MY 2021
1: Systematic Process of Quality Assessment and Improvement	100%	100%	100%
2: Accountability to the Governing Body*	99%	93%	-
3: Oversight of Delegated Entities	93%	88%	95%
4: Credentialing and Recredentialing	99%	99%	99%
5: Enrollee Rights	99%	91%	96%
6: Availability and Accessibility	96%	86%	99%
7: Utilization Review	94%	93%	94%
8: Continuity of Care	100%	100%	100%
9: Health Education Plan*	95%	100%	-
10: Outreach Plan	96%	100%	99%
11: Fraud and Abuse	96%	94%	98%
Composite Score	**98%**	**97%**	**98%**

*Standards 2 and 9 will be comprehensively reviewed in the MY 2022 SPR.

Maryland has set exemplary standards for MCO quality assurance systems. Any standard scoring less than 100% required a CAP. In areas where deficiencies were noted in their CAP submissions, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. One MCO (JMS) received compliance scores of 100% in all standards reviewed. Eight MCOs (ABH, ACC, CFCHP, KPMAS, MPC, MSFC, PPMCO, and UHC) were required to submit CAPs for MY 2021. As a result of the MY 2021 SPR, four MCOs (ABH, ACC, CFCHP, and KPMAS) have continued quarterly CAP monitoring for component 7.8c. Tables 13 through 20 display overall MCO results for standard requirements not receiving a *Met* finding and/or with remaining opportunities for improvement. Standards address Oversight of Delegated Entities, Credentialing and Recredentialing, Enrollee Rights, Availability and Accessibility, Utilization Review, Continuity of Care, Outreach Plan, and Fraud and Abuse. Standard 1 for Systematic Process of Quality Assessment and Improvement resulted in 100% compliance with no additional opportunities for improvement identified.

Standard 3: Oversight of Delegated Entities

Results and Findings. Two MCOs (CFCHP and PPMCO) have opportunities for improvement and are required to submit CAPs. Results are displayed in Table 13.

Table 13. MY 2021 Comprehensive Review Results for Standard 3: Oversight of Delegated Entities

Element/Component Reviewed	CHCHP	PPMCO
3.3a	PM	-
3.3b	PM	-
3.3c	PM	-
3.3d	UM	PM
3.3e	UM	-

Gray dash (-) indicates that MCO Met compliance threshold

Standard 4: Credentialing and Recredentialing

Results and Findings. Three MCOs (CFCHP, MPC, and MSFC) have opportunities for improvement and are required to submit CAPs. Results are displayed in Table 14.

Table 14. MY 2021 Comprehensive Review Results for Standard 4: Credentialing and Recredentialing

Element/Component Reviewed	CFCHP	MPC	MSFC
4.4h	-	PM	-
4.4i	-	PM	-
4.4j	PM	PM	PM

Gray dash (-) indicates that MCO Met compliance threshold

Standard 5: Enrollee Rights

Results and Findings. Seven MCOs (ABH, ACC, CFCHP, KPMAS, MPC, PPMCO, and UHC) have opportunities for improvement and are required to submit CAPs. Two MCOs (CFCHP and JMS) received a finding of *Met with Opportunity* to address for MY 2022's SPR. Results are displayed in Table 15.

Table 15. MY 2021 Comprehensive Review Results for Standard 5: Enrollee Rights

Element/Component Reviewed	ABH	ACC	CFCHP	JMS	KPMAS	MPC	PPMCO	UHC
5.1a	-	-	PM	MwO	-	-	-	-
5.1c	-	-	MwO	-	-	-	-	-
5.1d	-	-	-	-	PM	PM	PM	-
5.1f	PM	-	-	-	-	-	-	-
5.1g	PM	-	PM	-	PM	-	PM	PM
5.1i	PM	-	-	-	-	-	-	-
5.2	-	-	-	-	-	-	PM	-
5.3e	-	-	UM	-	-	-	-	-
5.5c	PM	UM	PM	-	-	-	-	-
5.6c	PM	-	-	-	-	-	-	-
5.7b	-	PM	-	-	-	-	-	-
5.7c	PM	-	-	-	-	-	-	-
5.9c	-	UM	-	-	-	-	-	-
5.11	PM	-	-	-	-	-	-	-

Gray dash (-) indicates that MCO Met compliance threshold

Standard 6: Availability and Accessibility

Results and Findings. UHC is the only MCO with an opportunity for improvement and is required to submit a CAP. Results are displayed in Table 16.

Table 16. MY 2021 Comprehensive Review Results for Standard 6: Availability and Accessibility

Element/Component Reviewed	UHC
6.1c	UM

Standard 7: Utilization Review

Results and Findings. Seven MCOs (ABH, ACC, CFCHP, KPMAS, MPC, PPMCO, and UHC) have opportunities for improvement and are required to submit CAPs. Eight MCOs (ABH, ACC, CFCHP, JMS, MPC, MSFC, PPMCO, and UHC) received a finding of *Met with Opportunity,* indicating compliance with requirements, but identifying opportunities to improve before MY 2022's SPR. Four MCOs (ABH, ACC, CFCHP, and KPMAS) have

continued opportunities from MY 2020's SPR and require continued quarterly CAP monitoring for component 7.8c. Results are displayed in Table 17.

Table 17. MY 2021 Comprehensive Review Results for Standard 7: Utilization Review

Element/Component Reviewed	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
7.2e	-	MwO	MwO	-	-	-	-	-	-
7.3a	-	-	PM	-	PM	-	-	PM	-
7.3b	-	-	UM	-	-	-	-	MwO	-
7.3c	-	-	UM	-	PM	-	-	-	MwO
7.6a	-	-	PM	-	PM	-	-	-	-
7.6b	-	PM	-	-	-	-	-	-	-
7.7a	-	-	PM	-	PM	-	-	-	-
7.7e	-	-	PM	-	-	PM	-	PM	-
7.7f	PM	-	-	-	-	-	-	-	-
7.8a	PM	-	-	-	-	-	-	-	MwO
7.8b	-	-	-	-	-	MwO	-	-	-
7.8c	UM	UM	UM	NA	UM	PM	-	MwO	-
7.9b	-	-	PM	-	-	-	-	-	-
7.9c	-	-	UM	-	UM	-	-	-	PM
7.10	MwO	PM	PM	MwO	-	-	MwO	MwO	PM

Red font indicates quarterly updates are required on the CAP per MDH's Performance Monitoring Policy.
Gray dash (-) indicates that MCO Met compliance threshold

Standard 8: Continuity of Care

Results and Findings. Two MCOs (ACC and CFCHP) received a finding of *Met with Opportunity*, indicating compliance with requirements, but identifying opportunities to improve before MY 2022's SPR. Results are displayed in Table 18.

Table 18. MY 2021 Comprehensive Review Results for Standard 8: Continuity of Care

Element/Component Reviewed	ACC	CFCHP
8.2	-	MwO
8.6	MwO	-

Gray dash (-) indicates that MCO Met compliance threshold

Standard 10: Outreach Plan

Results and Findings. KPMAS is the only MCO with an opportunity for improvement and is required to submit a CAP. Eight MCOs (ABH, CFCHP, JMS, KPMAS, MPC, MSFC, PPMCO, and UHC) received a finding of *Met with Opportunity*, indicating compliance with requirements, but identifying opportunities to improve before MY 2022's SPR. Results are displayed in Table 19.

Table 19. MY 2021 Comprehensive Review Results for Standard 10: Outreach Plan

Element/Component Reviewed	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
10.1a	-	-	MwO	-	-	-	MwO	-
10.1d	-	MwO	-	PM	-	-	-	-
10.1f	MwO	MwO	MwO	MwO	MwO	MwO	-	MwO

Gray dash (-) indicates that MCO Met compliance threshold

Standard 11: Fraud and Abuse

Results and Findings. Three MCOs (ABH, CFCHP, and KPMAS) have opportunities for improvement and require CAP submissions. Two MCOs (ABH and ACC) received a finding of *Met with Opportunity*, indicating compliance with requirements, but identifying opportunities to improve before MY 2022's SPR. Results are displayed in Table 20.

Table 20. MY 2021 Comprehensive Review Results for Standard 11: Fraud and Abuse

Element/Component Reviewed	ABH	ACC	CFCHP	KPMAS
11.1f	UM	MwO	-	PM
11.4a	PM	-	-	-
11.4c	-	-	UM	-
11.4d	PM	-	PM	-
11.5b	MwO	-	-	-

Gray dash (-) indicates that MCO Met compliance threshold

Conclusions

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

Maryland set the minimum compliance rate for each quality assurance standard at 100%.

One MCO (JMS) received compliance scores of 100% in all standards reviewed. If an MCO did not meet the minimum compliance score, then a CAP submission was required. Eight MCOs (ABH, ACC, CFCHP, KPMAS, MPC, MSFC, PPMCO, and UHC) were required to submit CAPs for MY 2021. As a result of the MY 2021 SPR, four MCOs (ABH, ACC, CFCHP, and KPMAS) have continued quarterly CAP monitoring for component 7.8c. In areas where deficiencies were noted in their CAP submissions, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

Standard 2, Accountability to the Governing Body; and Standard 9, Health Education Plan, were previously exempt from the interim triennial review due to MCOs attaining 100% compliance in previous SPRs. Standards 2 and 9 are scheduled for a full review during the MY 2022 Interim Review, as there are no longer any exempted standards.

For additional findings and comprehensive details associated with the MY 2021 SPR Report, please access the link to the SPR Executive Summary in **Appendix D**.

Performance Improvement Projects

Objectives

Performance improvement projects (PIPs) are designed to achieve significant improvement, sustained over time, in clinical care and non-clinical care areas. 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.

MCOs conduct two PIPs annually. As designated by MDH, the MCOs continued the Asthma Medication Ratio (AMR) and Lead Screening PIPs. MY 2021 is the final measurement year for both PIPs; AMR and Lead PIPs were continued from 2018 through 2021 due to low performance improvements and minimal effects on AMR and Lead Screening rates in repeat measurement years.

Methodology

Qlarant evaluates PIPs to assess the methodology used by MCOs in design, implementation, analysis, and reporting; and to determine if the MCOs achieved and sustained improvement. A successful PIP evaluation, one in which the PIP meets all or the majority of the nine 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 nine-step process.

Data Collection and Review. PIP validation activities conducted by the EQRO included a detailed review of completed MCO questionnaires submitted for each PIP. Each PIP-specific questionnaire was developed by the EQRO, based on the nine steps required by the CMS EQR PIP Validation Protocol. Since both PIPs were selected by MDH, Steps 1 through 5 were pre-populated in the questionnaire. Completion of all questions related to Steps 6 through 9 was required of each MCO.

Qlarant scores each component within a step as *Met (M), Partially Met (PM), Unmet (UM), or Not Applicable (NA)*, which results in an assigned review determination, as defined in Table 21 below. A final assessment is conducted for all nine steps, with numeric scores provided for each component and step of the validation process. Each component assessed within each step is of equal value. A description of the review determination and the associated score follows.

Table 21. PIP Validation Review Determinations

Review Determination	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	NA

Each component assessed within each step is of equal value. The total of all steps provides 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 MDH can have in reported results. Qlarant evaluates confidence levels based on the PIP validation scores, as follows in Table 22.

Table 22. Confidence Levels

MCO-Reported Results	PIP Validation Score
High Confidence (High)	**90% to 100%**
Confidence (C)	**75% to 89%**
Low Confidence (Low)	**60% to 74%**
No Confidence (NC)	**59% or lower**

Qlarant uses a Diamond Rating System to compare the MCOs' PIP performance to NCQA benchmarks, as follows in Table 23.

Table 23. Diamond Rating System Used to Compare MCO Performance to Benchmarks

Diamonds	MCO Performance Compared to Benchmarks
♦♦♦♦	MCO rate is equal to or exceeds the NCQA Quality Compass 90th Percentile.
♦♦♦	MCO rate is equal to or exceeds the NCQA Quality Compass 75th Percentile, but does not meet the 90th Percentile.
♦♦	MCO rate is equal to or exceeds the NCQA Quality Compass 50th Percentile, but does not meet the 75th Percentile.
♦	MCO rate is below the NCQA Quality Compass 50th Percentile.

Results

All AMR PIPs focused on increasing the percentage of enrollees 5 to 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 MY according to HEDIS technical specifications. Table 24 displays the 2022 validation results for all AMR PIPs, including a corresponding level of confidence and a comparison of indicator rates to NCQA benchmarks. MY 2021 is the final MY of data collection for the AMR PIP. ABH's participation was not previously required as the MCO did not initiate operations until October 2017. MY 2021 is considered a baseline study for ABH. Figure 1 represents the AMR PIP indicator rates for all MCOs.

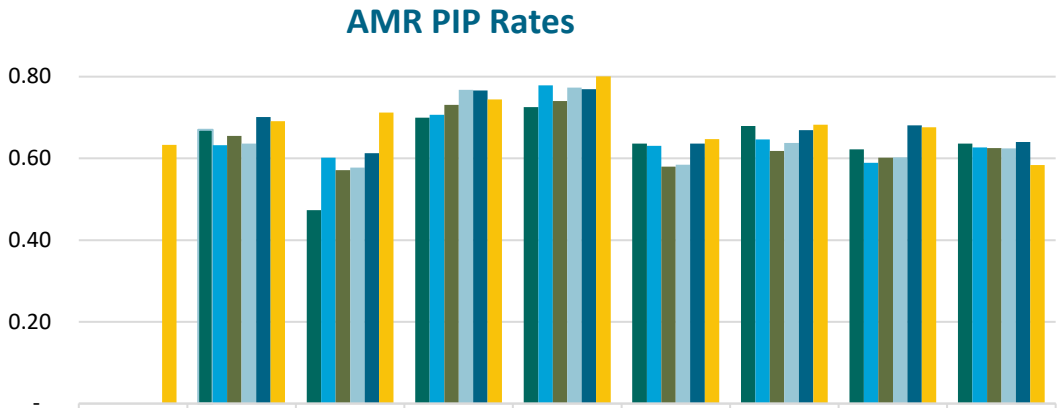
Table 24. 2022 AMR PIP Validation Results

2022 AMR PIP Validation Results									
Step/Description	**ABH**	**ACC**	**CFCHP**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**
Step 1. Topic	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 2. Aim Statement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Identified Population	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 4. Sampling Method	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 5. Performance Measures and Population	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 6. Data Collection Procedures	M	PM	M	M	M	M	M	M	M
Step 7. Data Analysis and Interpretation of Results	M	PM	M	M	PM	M	M	M	M
Step 8. Improvement Strategies (Interventions)	NA	PM	PM	M	PM	PM	PM	PM	PM
Step 9. Significant and Sustained Improvement	NA	PM	M	PM	M	PM	PM	PM	PM
PIP Numerical Score	**23**	**51**	**89**	**86**	**84**	**80**	**76**	**87**	**65**
PIP Total Available Points	**23**	**98**	**94**	**98**	**98**	**97**	**98**	**98**	**93**

2022 AMR PIP Validation Results									
Step/Description	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
PIP Validation Rating	100%	52.04%	94.68%	87.76%	85.71%	82.47%	77.55%	88.78%	69.89%
Confidence Level	High	NC	High	C	C	C	C	C	Low
MY 2021 Rate and Diamond Benchmark Comparison	63.3% ♦	69.1% ♦♦	71.2% ♦♦♦	74.4% ♦♦♦♦	86.6% ♦♦♦♦	64.7% ♦♦	68.2% ♦♦	67.6% ♦♦	58.3% ♦

MY 2021 is a baseline study for ABH.

Figure 1. MYs 2016 to 2021 AMR Rates



	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Baseline MY 2016	-	67.0%	47.3%	70.0%	72.6%	63.6%	67.9%	62.2%	63.6%
RMY 1 MY 2017	-	63.2%	60.1%	70.7%	77.9%	63.1%	64.6%	58.9%	62.7%
RMY 2 MY 2018	-	65.5%	57.1%	73.1%	74.0%	58.0%	61.8%	60.2%	62.5%
RMY 3 MY 2019	-	63.6%	57.8%	76.8%	77.3%	58.5%	63.8%	60.3%	62.4%
RMY 4 MY 2020	-	70.1%	61.3%	76.6%	76.9%	63.6%	66.9%	68.1%	64.0%
RMY 5 MY 2021	63.3%	69.1%	71.2%	74.4%	86.6%	64.7%	68.2%	67.6%	58.3%

MY 2021 is a baseline study for ABH (dash marker (-) indicates years ABH was not required to report).

All Lead Screening PIPs focused on increasing the percentage of children two years of age who had one or more capillary or venous blood tests for lead poisoning by their second birthday (HEDIS indicator) and the percentage of children ages 12 to 23 months (enrolled 90 or more days) who received a lead test during the current or prior calendar year (VBP indicator). MY 2021 is the final measurement year of data collection for the Lead Screening PIP. ABH's participation was not previously required as the MCO did not initiate operations until October 2017. MY 2021 is

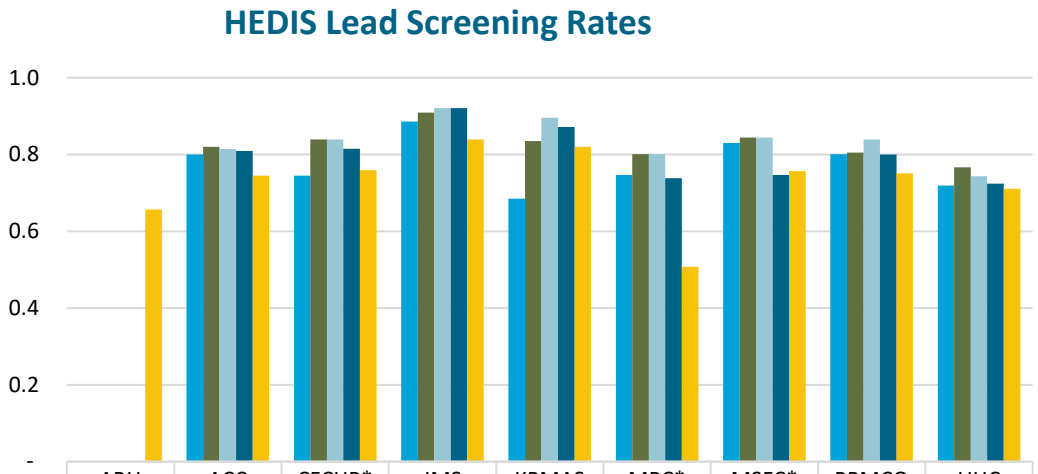
considered a baseline study for ABH. Table 25 displays the 2022 validation results for all Lead Screening PIPs, including a corresponding level of confidence and comparison of indicator rates to NCQA benchmarks. Figure 2 graphically displays the Lead Screening PIP indicator rates for all MCOs, while Figure 3 graphically displays the Maryland encounter data indicator rates.

Table 25. 2022 Lead Screening PIP Validation Results

2022 Lead Screening PIP Validation Results									
Step/Description	**ABH**	**ACC**	**CFCHP**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**
Step 1. Topic	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 2. Aim Statement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Identified Population	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 4. Sampling Method	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 5. Performance Measures and Population	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 6. Data Collection Procedures	M	PM	M	M	PM	M	M	M	M
Step 7. Data Analysis and Interpretation of Results	M	M	M	M	PM	M	M	M	M
Step 8. Improvement Strategies (Interventions)	NA	PM	PM	PM	PM	M	PM	PM	PM
Step 9. Significant and Sustained Improvement	NA	PM	PM	PM	M	PM	PM	PM	PM
PIP Numerical Score	**30**	**46**	**52**	**71**	**90**	**92**	**73**	**64**	**64**
PIP Total Available Points	**30**	**98**	**100**	**100**	**98**	**98**	**100**	**98**	**98**
PIP Validation Rating	**100%**	**46.94%**	**52%**	**71%**	**91.84%**	**93.88%**	**73%**	**65.31%**	**65.31%**
Confidence Level	**High**	**NC**	**NC**	**Low**	**High**	**High**	**Low**	**Low**	**Low**
MY 2021 Rate and Diamond Benchmark Comparison	**65.7%** ♦♦	**74.5%** ♦♦♦	**75.9%** ♦♦♦	**83.9%** ♦♦♦♦	**82%** ♦♦♦♦	**50.7%** ♦♦	**75.7%** ♦♦♦	**75%** ♦♦♦	**71.1%** ♦♦

MY 2021 is a baseline study for ABH.

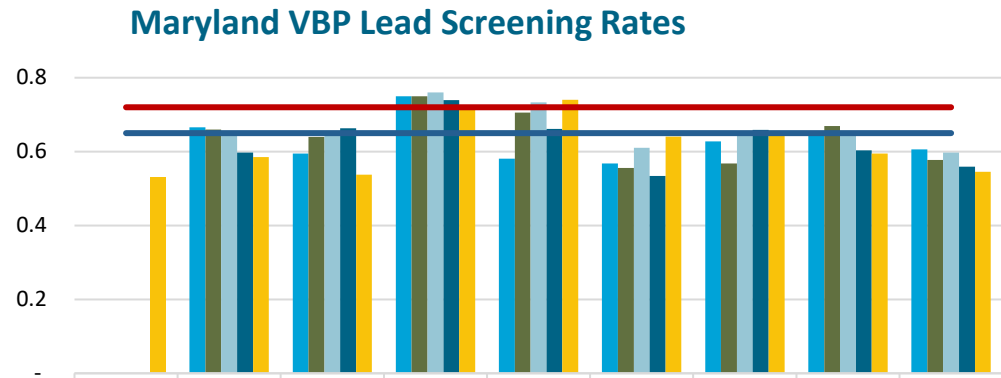
Figure 2. MYs 2017 to 2021 HEDIS Lead Screening Indicator Rates



	ABH	ACC	CFCHP*	JMS	KPMAS	MPC*	MSFC*	PPMCO	UHC
Baseline MY 2017	-	80.0%	74.5%	88.6%	68.5%	74.7%	83.0%	80.1%	72.0%
RMY 1 MY 2018	-	82.0%	83.9%	90.9%	83.5%	80.1%	84.4%	80.5%	76.7%
RMY 2 MY 2019	-	81.4%	83.9%	92.1%	89.6%	80.1%	84.4%	83.9%	74.4%
RMY 3 MY 2020	-	80.9%	81.5%	92.1%	87.2%	73.8%	74.7%	80.0%	72.4%
RMY 4 MY 2021	65.7%	74.5%	75.9%	83.9%	82.0%	50.7%	75.7%	75.0%	71.1%

*These MCOs elected to report HEDIS 2019 audited rates for HEDIS 2020 hybrid measures, based upon NCQA guidance in response to the impact of the COVID-19 public health emergency.
MY 2021 is a baseline study for ABH (dash marker (-) indicates years ABH was not required to report).

Figure 3. MYs 2017 to 2021 Maryland VBP Lead Screening Indicator Rates



	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Baseline MY 2017	-	66.6%	59.5%	75.0%	58.1%	56.8%	62.7%	64.6%	60.6%
RMY 1 MY 2018	-	66.0%	64.0%	75.0%	70.6%	55.6%	56.8%	66.9%	57.7%
RMY 2 MY 2019	-	65.2%	64.9%	76.0%	73.3%	61.0%	64.2%	64.5%	59.7%
RMY 3 MY 2020	-	59.7%	66.3%	73.9%	66.1%	53.4%	65.9%	60.3%	55.9%
RMY 4 MY 2021	53.0%	58.5%	53.8%	72.5%	74.0%	64.0%	65.0%	59.4%	54.5%
VBP Incentive	72%	72%	72%	72%	72%	72%	72%	72%	72%
VBP Disincentive	65%	65%	65%	65%	65%	65%	65%	65%	65%

MY 2021 is a baseline study for ABH.

Conclusions

Impact from the COVID-19 public health emergency continued for MY 2021. MCO modifications and recovery progress consistently focused on increased communication and education, such as text notifications, mailed literature, telehealth accessibility in provider offices, blog posts, 1:1 provider-to-member education in offices, outreach calls, and COVID-19 vaccine programs.

Overall, AMR and Lead Screening PIP performance results were mixed. Past results demonstrate an improvement in performance for the AMR PIP. Three MCOs (KPMAS, MPC, and MSFC) improved from *Low Confidence* in MY 2020 to *Confidence* in MY 2021. CFCHP's AMR improved from *Low Confidence* in MY 2020 to *High Confidence* in MY 2021. Past results for the Lead Screening PIP demonstrated a stronger performance overall. Three MCOs (CFCHP, JMS, and MSFC) declined in performance from *High Confidence* or *Confidence* in MY 2020 to *Low Confidence* or *Not Credible* in MY 2021. MY 2021 resulted in only three MCOs (ABH – baseline year, KPMAS, and MPC) receiving *High Confidence* ratings, while the

remaining six MCOs received *Low Confidence* or *Not Credible* ratings (ACC, CFCHP, JMS, MSFC, PPMCO, and UHC). As ABH did not initiate operations until October 2017, participation in MY 2021 is considered a baseline study.

For additional findings and comprehensive details associated with the 2022 Annual PIP Report, please access the link in **Appendix D**.

Encounter Data Validation

Objectives

States rely on valid and reliable encounter/claims[7] data submitted by MCOs to make key decisions, establish goals, assess and improve quality of care, monitor program integrity, and determine capitation payment rates. Collecting complete and accurate encounter data is critical to evolve with payment methodologies and value-based payment elements. Validation of encounter data provides MDH with a level of confidence in the completeness and accuracy of encounter data submitted by the MCOs.

Methodology

Data Collection and Review. Qlarant conducted EDV in accordance with the *CMS EQR Protocol 5 – Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*[8]. To assess the completeness and accuracy of encounter data, Qlarant completed Activities 1, 2, 4, and 5; and The Hilltop Institute, University of Maryland Baltimore County (Hilltop) completed Activity 3:

- **Activity 1.** Reviewed state requirements for collecting and submitting encounter data.
- **Activity 2.** Reviewed each MCO's capability to produce accurate and complete encounter data.
- **Activity 3.** Analyzed each MCO's electronic encounter data for accuracy and completeness. Summarized findings use data from Hilltop's report[9].
- **Activity 4.** Reviewed medical records for additional confirmation of findings.
- **Activity 5.** Conducted analysis and submitted findings to MDH.

[7] Encounter data consists of claims; therefore, these two terms, encounter and claims, are used interchangeably.
[8] CMS EQR protocols
[9] The Hilltop Institute. (December 2022). *EQR protocol 5, activity 3: Validation of encounter data, CY 2019 to CY 2021*. Baltimore, MD: UMBC.

Results

State Requirements for Collecting and Submitting Encounter Data. MDH establishes requirements for collecting and submitting encounter data. Section II.I.4 and 5 of the MY 2021 HealthChoice MCO Agreement and Appendix M of the contract specify encounter data requirements of the MCO and include all applicable COMAR provisions, including regulations concerning encounter data.

MCO's Capability to Produce Accurate and Complete Data. Qlarant assessed each MCO's capability for collecting accurate and complete encounter data. Information system processes and capabilities in capturing complete and accurate encounter data were assessed through a review of each MCO's Information Systems Capabilities Assessment (ISCA) and interviews with MCO personnel, as needed. No issues were identified. Results of the document review and interview process reveal:

- All MCOs are capable of capturing accurate encounter data.
- All MCOs are capturing appropriate data elements for claims processing.
- HealthChoice aggregate performance for processing clean claims in 30 days was 99%.

Analysis of MCO's Electronic Encounter Data for Accuracy and Completeness. Hilltop analyzed encounters failing initial electronic data interchange (EDI) edits (rejected encounters) and categorized rejected encounters as missing data (missing), participant not eligible for service (not eligible), value not valid for the field (not valid), inconsistent data (inconsistent), and duplicates (duplicate). Overall, the number of rejected encounters increased by 133.2% during MYs 2019 through 2021. MDH worked with the MCOs to resolve provider enrollment-related issues during MYs 2020 and 2021, which resulted in a decrease in the number of rejected encounters by 35%. Rejected encounters due to invalid data experienced the greatest increase (55.3 percentage points) between MY 2019 and MY 2021. Table 26 displays the distribution of rejected encounters submitted by all MCOs, by category, for MY 2019 through MY 2021.

Table 26. Distribution of Encounter Submissions Rejected by EDI Rejection Category, MY 2019 through MY 2021

Rejection Categories	MY 2019		MY 2020		MY 2021	
	Number of Rejected	Percent of Total	Number of Rejected	Percent of Total	Number of Rejected	Percent of Total
Missing	595,697	31.5%	1,053,540	15.5%	753,586	17.1%
Not Eligible	814,451	43%	450,374	6.6%	321,135	7.3%
Not Valid	334,314	17.7%	4,737,893	69.7%	3,224,258	73%
Inconsistent	46,438	2.5%	78,017	1.1%	40,961	0.9%
Duplicate	103,108	5.4%	480,007	7.1%	77, 347	1.8%
Total	**1,894,008**	**100%**	**6,799,831**	**100%**	**4,417,287**	**100%**

Source: The Hilltop Institute. (December 2022). *EQR protocol 5, activity 3: Validation of encounter data, CY 2019 to CY 2021*. Baltimore, MD: UMBC.

Effective analysis of the HealthChoice program requires complete, accurate, and timely processing of encounter data. Timeliness of encounter submissions remained relatively consistent across all months. An average of 45.9% of CY 2021 encounters were processed by MDH within 1 to 2 days of the end date of service, demonstrating a decrease from 46.1% in MY 2019, but an increase from 44.1% in MY 2020. Table 27 displays monthly processing times for submitted encounters for MYs 2019 through 2021.

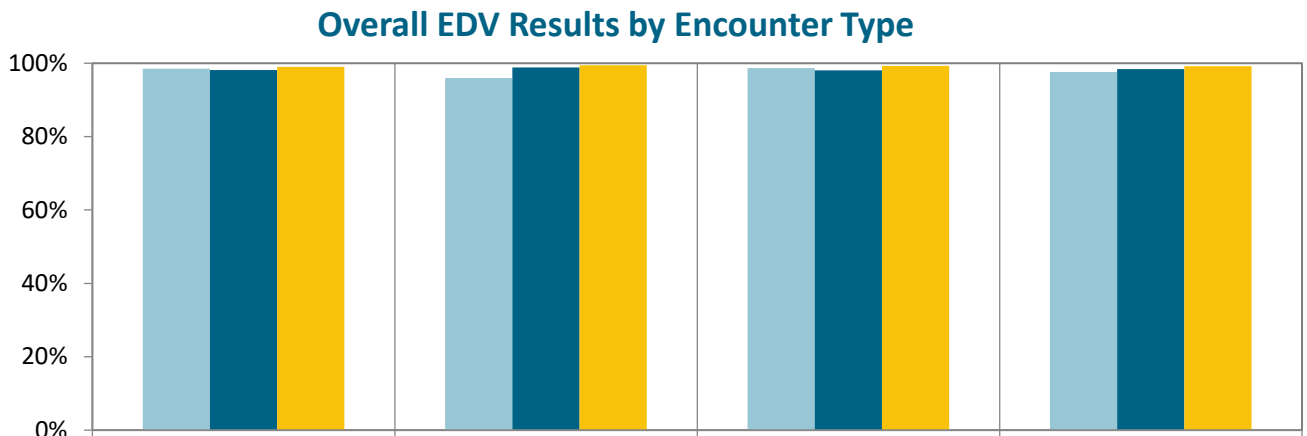
Table 27. Percentage of Accepted Encounters Submitted by Month and Processing Time, MY 2019 through MY 2021

Processing Time Range	Year	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Annual Total
1 – 2 Days	MY 2019	42.7%	44.8%	46.9%	48.7%	44.2%	45.5%	45%	47.7%	41.8%	48.6%	45.9%	51.7%	**46.1%**
	MY 2020	34%	35.2%	46.8%	48.8%	46.8%	51.4%	42.9%	47.4%	49.3%	45.3%	46.7%	43.6%	**44.1%**
	MY 2021	35.9%	41%	47.1%	41.9%	44.5%	51.4%	47.1%	50.9%	46.6%	45.5%	51.4%	45.6%	**45.9%**
3 – 7 Days	MY 2019	11.4%	13.6%	13.6%	10.3%	9.7%	14.3%	11.4%	10.5%	13.6%	11.4%	8.7%	8.4%	**11.4%**
	MY 2020	9.6%	9.6%	6.4%	12%	12.3%	10.5%	11.2%	12.2%	11.3%	10.2%	7.7%	7.8%	**9.9%**
	MY 2021	11.9%	15.1%	9.9%	11.7%	12.4%	10.7%	10.6%	10.2%	11.6%	12.9%	5.8%	10.2%	**11%**
8 – 31 Days	MY 2019	28.6%	24.2%	21.1%	25.1%	31%	24.9%	27.4%	24.8%	30.1%	26.1%	30.5%	25.7%	**26.6%**
	MY 2020	20.9%	23.4%	19.2%	18.9%	21%	19.6%	21.8%	21.6%	18.5%	24%	25.2%	25.9%	**21.8%**
	MY 2021	23.8%	22.3%	22%	24.8%	24.2%	19%	21.6%	19.7%	22.5%	22.2%	22%	23.9%	**22.3%**
1 - 2 Months	MY 2019	4.5%	4.5%	6.2%	5.2%	5.3%	5.2%	5.9%	6.7%	5.8%	5%	5.3%	4.3%	**5.3%**
	MY 2020	8.1%	5.2%	8.1%	5.2%	5.1%	4.2%	5.6%	4%	5.5%	6.8%	6.4%	8.4%	**6.2%**
	MY 2021	9.8%	6.1%	5.5%	6.4%	4.7%	6%	5%	5.1%	6.3%	5.9%	7.3%	6.5%	**6.2%**
2 - 6 Months	MY 2019	8.6%	8.7%	7.8%	6.7%	6%	6.3%	6.3%	6%	5.1%	6.4%	8.6%	9%	**7.1%**
	MY 2020	14%	14.6%	11%	6.8%	6.2%	8%	12.3%	9.3%	11.2%	10.1%	10.6%	13.1%	**11%**
	MY 2021	9.1%	7.5%	7.6%	7.5%	7%	5.5%	5.6%	6.9%	8.9%	9.7%	13%	13.3%	**8.5%**
6 – 7 Months	MY 2019	0.7%	0.6%	1.3%	0.5%	0.4%	0.4%	0.4%	0.4%	1.5%	1.7%	0.2%	0.4%	**0.7%**
	MY 2020	2%	1.6%	0.6%	0.7%	3%	0.9%	0.9%	1.6%	1.1%	1.1%	2.5%	0.4%	**1.4%**
	MY 2021	1.2%	1.2%	0.7%	0.5%	0.5%	0.5%	2.3%	1.7%	0.9%	3.3%	0.3%	0.5%	**1.1%**
7 – 12 Months	MY 2019	1.9%	1.7%	1.4%	2%	3%	3.1%	3.3%	3.8%	2.1%	0.9%	0.7%	0.5%	**2%**
	MY 2020	6.7%	5.7%	5.1%	6.1%	4.4%	5.1%	5%	3.6%	2.9%	2.5%	1%	0.8%	**4.1%**
	MY 2021	2.8%	3.1%	3.3%	4.1%	6.4%	6.9%	7.8%	5.5%	3.3%	0.5%	0.3%	0%	**3.6%**
More than 1 Year	MY 2019	1.8%	1.9%	1.7%	1.4%	0.4%	0.3%	0.2%	0.1%	0%	0%	0%	0%	**0.7%**
	MY 2020	4.8%	4.6%	2.8%	1.4%	1.3%	0.3%	0.2%	0.2%	0.1%	0%	0%	0%	**1.5%**
	MY 2021	5.5%	3.7%	3.8%	3%	0.3%	0.1%	0%	0%	0%	0%	0%	0%	**1.3%**
Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: The Hilltop Institute. (December 2022). *EQR protocol 5, activity 3: Validation of encounter data, CY 2019 to CY 2021*. Baltimore, MD: UMBC.

Analysis of Medical Records to Confirm Encounter Data Accuracy. Review of enrollees' medical records offers another method to examine the completeness and accuracy of encounter data. Analysis of sample data was organized by review elements, including diagnosis, procedure, and revenue codes (applicable only for inpatient and outpatient). Overall EDV results for MYs 2019 through 2021 are displayed by encounter type in Figure 4.

Figure 4. MY 2019 through MY 2021 EDV Results by Encounter Type



	Inpatient	Outpatient	Office Visit	Composite
MY 2019	99%	96%	99%	98%
MY 2020	98%	99%	98%	98%
MY 2021	99%	99%	99%	99%

The composite match rate across all encounter types showed improvement by one percentage point from MY 2020 (98%) to MY 2021 (99%). EDV results maintained consistency for outpatient encounters from MY 2020 to MY 2021 at 99%. Table 28 displays the trending of EDV records by encounter type, for MYs 2019 through MY 2021. An improvement of one percentage point occurred for inpatient and office visit encounter types from MY 2020 to MY 2021.

Table 28. MY 2019 through MY 2021 EDV Results by Encounter Type

Encounter Type	Records Reviewed			Total Possible Elements*			Total Matched Elements			Percentage of Matched Elements		
	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021	MY 2019	MY 2020	MY 2021
Inpatient	63	72	56	1,434	1,572	1,186	1,413	1,543	1,156	99%	98%	97%
Outpatient	538	492	514	7,288	6,149	6,812	7,000	6,078	6,774	96%	99%	99%
Office Visit	1,877	1,934	1,915	8,833	8,860	9,124	8,718	8,692	9,056	99%	98%	99%
Total	**2,478**	**2,498**	**2,485**	**17,555**	**16,581**	**17,122**	**17,131**	**16,313**	**16,986**	**98%**	**98%**	**99%**

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

MCO Encounter Data Validation Results. For MY 2021, all MCOs successfully achieved match rates equaling or scoring above the standard (90%) in all areas of review.

Table 29. MY 2019 through MY 2021 MCO and HealthChoice EDV Results by Encounter Type

Encounter Type by MY		ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice
Inpatient	MY 2019	99%	95%	95%	100%	100%	100%	99%	99%	100%	**99%**
	MY 2020	100%	99%	99%	92%	99%	100%	99%	99%	100%	**98%**
	MY 2021	100%	100%	100%	96%	100%	100%	100%	98%	98%	**99%**
Outpatient	MY 2019	96%	98%	99%	97%	99%	97%	90%	96%	95%	**96%**
	MY 2020	99%	97%	99%	100%	100%	100%	100%	99%	98%	**99%**
	MY 2021	98%	99%	100%	99%	100%	99%	100%	99%	100%	**99%**
Office Visits	MY 2019	99%	97%	99%	100%	99%	100%	99%	98%	98%	**99%**
	MY 2020	98%	97%	98%	100%	99%	97%	100%	99%	97%	**98%**
	MY 2021	99%	98%	99%	99%	100%	100%	100%	99%	99%	**99%**

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

Conclusions

Qlarant and Hilltop completed an EDV study for MDH assessing encounters paid during MY 2021. Qlarant conducted a medical record review on a sample of inpatient, outpatient, and office visit encounters (2,485) to confirm the accuracy of codes.

HealthChoice is a mature managed care program, and analysis of the electronic encounter data indicates data submitted by MCOs are valid (complete and accurate). Overall, MCOs achieved a match rate of 99%, meaning 99% of submitted claims were supported by medical record documentation. MCOs achieved a high match rate for each encounter setting: inpatient (99%), outpatient (99%), and office visit (99%).

For additional findings and comprehensive details associated with the MY 2021 EDV Report, please access the link in **Appendix D**.

Performance Measure Validation for Value-Based Purchasing

Objectives

MDH and the Center for Health Care Strategies developed a VBP initiative based on the goal to improve the health of core populations served by the HealthChoice program. In 1999, both agencies adopted the model of improving quality by awarding financial incentives to MCOs, based on their performance.

As the EQRO, Qlarant collaborates with MetaStar, Inc. (MetaStar), a NCQA-Licensed Organization, and Hilltop by validating the selected VBP measures for each MCO. This validation is completed by reviewing both data collection and processing systems and reviewing source code for each measure to determine compliance with MDH's measure specifications.

Methodology

MDH selects HEDIS and state-specific performance measures for the VBP program. Selected measures are calculated and validated per *HEDIS Volume 2: Technical Specifications for Health Plans* or MDH specifications before developing incentive, neutral, and disincentive ranges for each measure. These ranges are used to determine if the MCO's quality improvement efforts have successfully resulted in improved health outcomes and if incentives should be awarded. Table 30 displays the incentive, neutral, and disincentive criteria used for VBP activities.

Table 30. Financial Ranges for MCO's VBP Performance

Ranges	Review Criteria
Incentive	MCO performance meets or exceeds the incentive target for a measure. Financial incentive is applied.
Neutral	MCO performance falls between incentive and disincentive targets for a measure. No financial incentive or disincentive is applied.
Disincentive	MCO performance is at or below the disincentive target. Financial disincentive is applied.

Data Collection and Review. VBP encounter data measures were calculated by Hilltop. Hilltop used encounter data submitted by the MCOs and Lead Registry and Fee-for-Service data submitted by MDE, respectively, to calculate the below encounter data measures:

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

- Lead Screenings for Children - Ages 12 to 23 Months.

Qlarant validated the three measures by reviewing data collection, processing systems, and the source code for each measure to determine compliance with MDH's measure specifications.

For measures where MCOs do not meet minimum targets, a disincentive of 1/7 of 1 percent of the total capitation amount paid to the MCO during the MY shall be collected. For measures where MCOs meet or exceed incentive targets, the MCO is paid an incentive payment of 1/7 of 1 percent of the total capitation amount paid to the MCO during the MY. Amounts are calculated for each measure, and 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.

For MY 2021, based on where the MCO capitation rates were set, collection of VBP disincentive amounts would result in the capitation rates not being actuarilly sound in accordance with 42 CFR §438.4. Therefore, to maintain the actuarial soundness of the rates, MDH is not collecting net disincentives for MY 2021 VBP performance. Any net incentives earned by the MCO would be distributed based on available funding in the HealthChoice Performance Incentive Fund.

HEDIS

MDH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives such as HEDIS. Performance is measured at both the organizational level and on a statewide basis. HEDIS results are incorporated annually into a HealthChoice Consumer Report Card developed to assist HealthChoice enrollees in making comparisons when selecting a health plan. All nine HealthChoice organizations reported HEDIS in MY 2021. For HEDIS MY 2021, MDH required HealthChoice managed care organizations to report the complete HEDIS measure set for services rendered in MY 2021 to HealthChoice enrollees. These measures provide meaningful managed care organization comparative information, and they measure performance relative to MDH's priorities and goals.

Data collection and review. Each data source and process used by the MCOs to derive HEDIS measures was reviewed by MetaStar as a component of the HEDIS audit. For example, Medical Services Data (Claims), Enrollment Data, Practitioner Data, Medical Record Data (including data abstracted from medical records), Supplemental Data, as well as the processes used to transform and integrate the data for HEDIS reporting. The audit process includes systems demonstrations and reports/query reviews to instill confidence that the data used for measure production are complete, accurate, and that NCQA's HEDIS audit criteria/standards are met.

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 is needed. 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 the improvement of administrative data systems.

Results

According to MetaStar's annual report, *Statewide Executive Summary Report HealthChoice Participating Organization HEDIS 2021*, all VBP HEDIS measures achieved "Reportable" (R) designations for all MCOs. Qlarant's validation determined all VBP encounter data measure rates calculated by Hilltop were "Reportable" (R). Tables 31 and 32 display the MCOs' VBP performance summary; and incentive, disincentive, and neutral amounts for MY 2021. For MY 2021, disincentives were not collected due to actuarial soundness.

Table 31. MCO MY 2021 VBP Performance Summary

Performance Measure	MY 2021 Target	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Ambulatory Care Visits for SSI Adults	Incentive: ≥ 87% Neutral: 84% - 86% Disincentive: ≤ 83%	60%	80%	76%	90%	72%	84%	80%	84%	79%
Ambulatory Care Visits for SSI Children	Incentive: ≥ 87% Neutral: 84% - 86% Disincentive: ≤ 83%	46%	82%	64%	89%	76%	83%	76%	85%	79%
Asthma Medication Ratio (AMR)	Incentive: ≥ 71% Neutral: 66% - 70% Disincentive: ≤ 65%	63%	69%	71%	74%	87%	65%	68%	68%	58%
Breast Cancer Screening	Incentive: ≥ 75% Neutral: 71% - 74% Disincentive: ≤ 70%	44%	59%	67%	77%	74%	66%	70%	60%	57%
Comprehensive Diabetes Care - HbA1c Control	Incentive: ≥ 64% Neutral: 57% - 63% Disincentive: ≤ 56%	53%	56%	54%	60%	62%	57%	57%	55%	53%
Lead Screenings for Children - Ages 12 to 23 Months	Incentive: ≥ 72% Neutral: 67% - 71% Disincentive: ≤ 66%	53%	59%	54%	73%	74%	54%	65%	59%	55%
Prenatal and Postpartum Care – Postpartum Care	Incentive: ≥ 83% Neutral: 80% - 82% Disincentive: ≤ 79%	81%	83%	82%	88%	93%	84%	83%	84%	77%

Green – Incentive Threshold, Yellow – Neutral Threshold, Red – Disincentive Threshold

Table 32. MCO MY 2021 VBP Incentive/Disincentive Amounts

Performance Measure	MCO								
	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Ambulatory Care Visits for SSI Adults	$317,873.00	$1,788,077.00	$466,399.00	$323,766.00	$713,603.00	$0.00	$807,176.00	$0.00	$1,081,437.00
Ambulatory Care Visits for SSI Children	$317,873.00	$1,788,077.00	$466,399.00	$323,766.00	$713,603.00	$1,882,189.00	$807,176.00	$0.00	$1,081,437.00
Asthma Medication Ratio (AMR)	$317,873.00	$0.00	$466,399.00	$323,766.00	$713,603.00	$1,882,189.00	$0.00	$0.00	$1,081,437.00
Breast Cancer Screening	$317,873.00	$1,788,077.00	$466,399.00	$323,766.00	$0.00	$1,882,189.00	$807,176.00	$2,460,365.00	$1,081,437.00
Comprehensive Diabetes Care - HbA1c Control	$317,873.00	$1,788,077.00	$466,399.00	$0.00	$0.00	$0.00	$0.00	$2,460,365.00	$1,081,437.00
Lead Screenings for Children - Ages 12 to 23 Months	$317,873.00	$1,788,077.00	$466,399.00	$323,766.00	$713,603.00	$1,882,189.00	$807,176.00	$2,460,365.00	$1,081,437.00
Prenatal and Postpartum Care – Postpartum Care	$0.00	$1,788,077.00	$0.00	$323,766.00	$713,603.00	$1,882,189.00	$807,176.00	$2,460,365.00	$1,081,437.00

Disincentives were not collected due to actuarial soundness.
Green – Incentive Threshold, Yellow – Neutral Threshold, Red – Disincentive Threshold

For additional findings and comprehensive details associated with the MY 2021 Annual VBP Report, please access the link in **Appendix D**.

EPSDT Medical Record Review

Objectives

Maryland's EPSDT/Healthy Kids Program mission is to improve accessibility and ensure availability of quality health care for HealthChoice children and adolescents through 20 years of age. In support of the program's mission, the objective of the EPSDT medical record review is to assess timely delivery of EPSDT services to children and adolescents enrolled in an MCO. Qlarant's medical record review assesses MCO performance for the following EPSDT components:

- Health and Developmental History
- Comprehensive Physical Exam
- Laboratory Tests/At-Risk Screenings
- Immunizations
- Health Education/Anticipatory Guidance

Methodology

Sampling and Provider Outreach Methodology. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs from MY 2021 preventive care encounters for children and adolescents through 20 years of age. Sample size per MCO provided a 90% confidence level with a 5% margin of error.

NOTE: Due to methodology discrepancies, the MY 2021 EPSDT medical record review is still in development and finalized scoring is in progress. Upon conclusion of this task, revisions to the EPSDT portion of the ATR will be completed.

Medical Record Review and Scoring. Qlarant's medical record data reviewers are trained nurses and experienced MDH Healthy Kids Program nurse consultants. Abstracted data from the medical record reviews were organized and analyzed within five age groups. Within each age group, specific elements were scored based on medical record documentation, as shown in Table 33.

Table 33. EPSDT Validation Review Determinations

Review Determination	Criteria
Completed	2
Incomplete	1
Missing	0
Not Applicable*	NA

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

Elements within a component are weighted equally, scored, and added together to derive the final component score. Similarly, elements' composite (overall) score follows the same methodology. MDH established the minimum compliance score as 80% for each component. CAPs are required if the minimum compliance score is not met. New elements or elements with revised criteria are scored as baseline for MY 2021.

MY 2021's medical record review process was conducted onsite at providers' offices; therefore, results should be reviewed with caution due to the methodology change from previous reviews conducted as a desktop review.

Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. Guidelines and criteria are divided into five component areas. Tables 34 through 39 and Figure 5 display MCO results for the five EPSDT component areas evaluated for MY 2021 and HealthChoice aggregate results for MYs 2019, 2020, and 2021. Results will be updated upon the activity's completion.

Table 34. MY 2021 EPSDT Component Results by MCO

Table 34 Placeholder for Finalized Results

Table 35. MY 2021 Health and Developmental History Element Results

Table 35 Placeholder for Finalized Results

Table 36. MY 2021 Comprehensive Physical Examination Element Results

Table 36 Placeholder for Finalized Results

Table 37. MY 2021 Laboratory Test/At-Risk Screenings Element Results

Table 37 Placeholder for Finalized Results

Table 38. MY 2021 Immunization Element Results

Table 38 Placeholder for Finalized Results

Table 39. MY 2021 Health Education/Anticipatory Guidance Element Results

Table 39 Placeholder for Finalized Results

Figure 5. HealthChoice Aggregate Results by Component for MYs 2019 to 2021

Figure 5 Placeholder for Finalized Results

Conclusions

Due to methodology discrepancies, the MY 2021 EPSDT medical record review is still in development and finalized scoring is in progress. Upon conclusion of this task, revisions to the EPSDT portion of the ATR will be completed.

Consumer Report Card

Objectives

Developing a Medicaid Consumer Report Card assists Medicaid enrollees in selecting a MCO from available health plans in the HealthChoice program. Qlarant designs the report card to compare the quality of health care and to allow consumers to easily detect differences in MCO performance.

Measures are grouped into six reporting categories meaningful to enrollees. Based on a review of available measures (HEDIS, CAHPS, and MDH's encounter data measures), Qlarant recommended 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

HealthChoice enrollees are 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 enrollees (children, children with chronic illness, women, and adults with chronic illness).

Methodology

Each MCO's actual score on select performance measures is compared with the unweighted statewide MCO average for a particular reporting category. An icon or symbol denotes whether an MCO performed "*above*," "*the same as*," or "*below*" the statewide Medicaid MCO average.

Data Collection and Review. Performance measures are selected from HEDIS, CAHPS survey results from both the Adult Questionnaire and the Child Questionnaire, and MDH's encounter data measures. Recommended categories are based on measures reported by MCOs in 2021 and are designed to focus on clearly identifiable areas of interest.

Results

Tables 40 and 41 provide results of the MY 2022 Consumer Report Card and the overall Star Rating changes year over year.

Table 40. MY 2022 Consumer Report Card Results

Performance Areas	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Access to Care	★★	★★	★★	★★	★★	★★	★★	★★	★★
Doctor Communication and Service	★	★★	★★	★★★	★★	★★	★★	★★★	★★
Keeping Kids Healthy	★	★★★	★★	★★★	★★★	★	★★★	★	★★★
Care for Kids with Chronic Illness	★★	★★	★	NA	★★	★★★	★★	★★★	★
Taking Care of Women	★	★★★	★★	★★★	★★★	★	★	★	★
Care for Adults with Chronic Illness	★★	★	★	★★★	★★★	★	★★	★	★

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

Table 41. Star Rating Changes from MY 2021 to MY 2022

Performance Areas	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Access to Care	↑	⊖	⊖	⊖	⊖	⊖	↓	⊖	⊖
Doctor Communication and Service	⊖	↑	↑	⊖	↓	↓	⊖	⊖	⊖
Keeping Kids Healthy	⊖	⊖	⊖	⊖	⊖	↓	↑	↓	↑
Care for Kids with Chronic Illness	NA	↑	⊖	NA	NA	↑	⊖	⊖	↓
Taking Care of Women	↓	↑	⊖	⊖	⊖	⊖	⊖	⊖	⊖
Care for Adults with Chronic Illness	↑	⊖	⊖	⊖	⊖	↓	↑	⊖	⊖

Blue = ↑ improvement from MY 2021; Pink = ↓ decline from MY 2021; white = ⊖ no change; Gray = NA reported as Not Applicable for MY 2021 and/or MY 2022

For comprehensive details on the information reporting strategy and analytic methods associated with the production of the MY 2022 Consumer Report Card, please access the link to the Information Reporting Strategy and Analytic Methodology in **Appendix C**. English and Spanish versions of the 2022 Consumer Report Card are available in **Appendix D**.

Focused Review of Grievances, Appeals, and Denials

Objectives

Qlarant conducts quality studies focused on determining MCO compliance with federal and state laws and regulations, and evaluating appropriateness of denials of service and handling of grievances, appeals, and pre-service denials (GAD). These studies consist of quarterly evaluations of grievance, appeal, and pre-service denial reports submitted by each MCO, along with an annual record review. In support of review objectives, Qlarant:

- Validates data provided by MCOs in quarterly grievance, appeal, and pre-service denial reports.
- Compares individual performance among MCOs.
- Identifies MCO opportunities for improvement and provides recommendations.
- Requests corrective action when an MCO demonstrates consistent noncompliance with one or more review components.

Methodology

MCOs submit quarterly grievance, appeal, and pre-service denial reports within 30 days of the close of each quarter to Qlarant. Qlarant validates and evaluates quarterly MCO reports to identify areas of noncompliance. MCOs were provided quarterly reviews of their submissions, which identified required follow-up for data issues, ongoing noncompliance, or negative trends.

In addition to quarterly reviews of the reports submitted by MCOs, Qlarant conducted an annual record review. Annual record reviews utilize random sampling to assess MY 2021 grievance, appeal, and pre-service denial records. Results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, were provided to MDH as a component of each MCO's SPR report. Results of the record reviews were also shared with appropriate staff of each MCO. Technical assistance was provided as needed, to facilitate improved compliance.

Data Collection and Review. Assessment of MCO compliance applied performance standards defined for MY 2021 and aggregated MCO results to provide MCO comparisons. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2021 and the first and second quarters of 2022. The annual record review encompassed member grievances, appeals, and pre-service denials that occurred during MY 2021 and were gathered from November to December 2021.

Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for this time period. Qlarant selected 35 cases from each listing, using a random sampling approach, and requested each MCO to upload the selected case records to the Qlarant portal. Using the 10/30 rule, an initial sample of ten grievance, ten appeal, and ten denial records were reviewed. If an area of noncompliance was discovered, an additional 20 records were reviewed for the non-compliant component(s).

Results

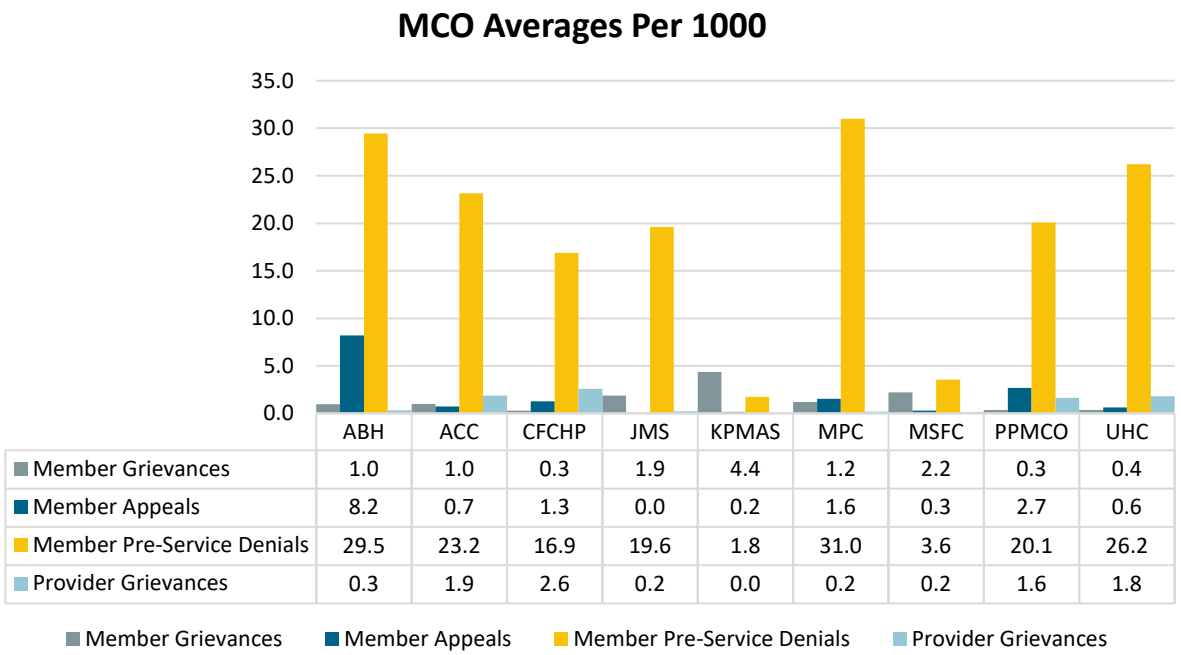
Compliance criteria for various components is represented by a review determination, as defined in Table 42. Annual record reviews and quarterly reports inform these results and provide comparisons of MCO performance over time and in relation to peers.

Table 42. GAD Validation Review Determinations

Review Determinations	Criteria
Met (M)	Compliance consistently demonstrated
Partially Met (PM)	Compliance inconsistently demonstrated
Unmet (UM)	No evidence of compliance
Not Applicable (NA)	Not Applicable/No data reported

Figure 6 displays a comparison of MCO averages of grievances, appeals, and pre-service denials per 1000 enrollees and grievances per 1000 providers for the review period spanning from the third quarter of 2021 through the second quarter of 2022.

Figure 6. Average Grievances, Appeals, and Pre-Service Denials/1000



	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Member Grievances	1.0	1.0	0.3	1.9	4.4	1.2	2.2	0.3	0.4
Member Appeals	8.2	0.7	1.3	0.0	0.2	1.6	0.3	2.7	0.6
Member Pre-Service Denials	29.5	23.2	16.9	19.6	1.8	31.0	3.6	20.1	26.2
Provider Grievances	0.3	1.9	2.6	0.2	0.0	0.2	0.2	1.6	1.8

Quarterly Compliance with Resolution Timeframes. Tables 43 through 45 display quarterly comparisons of MCO-reported compliance with resolution timeframes. Table 43 specifically displays MCO-reported compliance with resolution timeframes for member grievances. MDH relaxed the compliance threshold for grievance-resolution timeliness from 100% to 90% during the COVID-19 public health emergency, at the request of the Maryland Managed Care Organization Association. Maryland lifted the state of emergency effective July 1, 2021. MDH subsequently released new compliance thresholds that increased the relaxed threshold from 90% to 95%. The new compliance thresholds were put into effect as of October 1, 2021, which allowed for a 90-day transition period.

Table 43. Member Grievance Resolution Timeframes

MCO-Reported Compliance									
Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	M	M	M	M	M	M	M	M	M
Q4 2021	M	M	M	M	M	M	M	M	M
Q1 2022	M	M	M	M	M	M	M	PM	M
Q2 2022	M	M	M	M	PM	M	M	PM	M

Table 44. Provider Grievance Resolution Timeframes

MCO-Reported Compliance									
Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	UM	M	UM	M	NA	M	M	M	M
Q4 2021	M	M	M	M	NA	M	NA	M	M
Q1 2022	M	M	M	M	NA	M	M	M	M
Q2 2022	M	M	M	M	NA	M	M	M	M

NA (the MCO did not receive any provider grievances during the reporting period)

Table 45. Enrollee Appeal Resolution Timeframes

MCO-Reported Compliance									
Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2021	M	PM	M	NA	PM	UM	M	M	UM
Q4 2021	PM	PM	M	M	M	M	M	M	M
Q1 2022	M	PM	M	M	PM	PM	PM	M	PM
Q2 2022	M	PM	M	M	M	M	M	M	M

Quarterly Compliance with COMAR Requirements. Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based on self-report through MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample.

Tables 46 and 47 display results of MCO-reported compliance with determination notification timeframes, based on quarterly report submissions. Table 46 specifically displays results of the MCO's reported compliance with pre-service determination timeframes. As previously mentioned, during the COVID-19 public health emergency, the compliance threshold was lowered to 90%. Following the termination of the

public health emergency, the MCOs were provided a 90-day period to transition to the prior 95% threshold. The effective date of this change was October 1, 2021, the beginning of the fourth quarter of 2021.

Table 46. Pre-Service Determination Timeframes

MCO-Reported Compliance									
Quarter	ABH	ACC	CFCHP	JMS	KMPAS	MPC	MSFC	PPMCO	UHC
Compliance with Expedited Pre-Service Determination Timeframes for Medical Denials									
Q3 2021	100%	92%	100%	NA	100%	100%	100%	97%	100%
Q4 2021	100%	70%	100%	100%	100%	100%	NA	100%	100%
Q1 2022	100%	100%	100%	NA	100%	100%	100%	99%	100%
Q2 2022	92%	96%	100%	100%	100%	100%	100%	97%	100%
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials									
Q3 2021	98%	93%	29%	100%	100%	100%	99%	100%	98%
Q4 2021	98%	95%	79%	100%	98%	100%	99%	100%	98%
Q1 2022	97%	98%	99%	100%	96%	100%	99%	99%	100%
Q2 2022	97%	94%	100%	100%	96%	100%	99%	100%	100%
Compliance with Outpatient Pharmacy Pre-Service Determination Timeframes for Denials									
Q3 2021	100%	100%	100%	100%	NA	99%	99%	99%	100%
Q4 2021	100%	100%	99%	99%	100%	100%	100%	97%	100%
Q1 2022	100%	100%	100%	100%	NA	100%	96%	99%	100%
Q2 2022	100%	100%	99%	100%	100%	99%	97%	99%	100%

Results of MCO-reported compliance with adverse determination notification timeframes are displayed in Table 47. In addition to easing the compliance threshold for preauthorization determination timeliness during the COVID-19 public health emergency, MDH also reduced the threshold for adverse determination notification timeliness from 95% to 90%. Once the public health emergency was lifted, MCOs were provided with a 90-day transition period to return to the 95% threshold previously in place. October 1, 2021 was the effective date of this change.

Table 47. Adverse Determination Notification Timeframe

MCO-Reported Compliance									
Quarter	ABH	ACC	CFCHP	JMS	KMPAS	MPC	MSFC	PPMCO	UHC
Compliance with Expedited Medical Adverse Determination Notification Timeframes									
Q3 2021	97%	95%	100%	NA	100%	100%	100%	96%	100%
Q4 2021	100%	93%	100%	100%	100%	100%	NA	100%	97%
Q1 2022	100%	96%	100%	NA	100%	100%	100%	98%	100%
Q2 2022	100%	98%	100%	100%	100%	100%	100%	96%	100%
Compliance with Standard Medical Adverse Determination Notification Timeframes									
Q3 2021	100%	95%	100%	100%	100%	100%	100%	100%	96%
Q4 2021	99%	99%	100%	80%	99%	100%	100%	99%	96%
Q1 2022	98%	98%	100%	100%	91%	100%	99%	99%	100%
Q2 2022	99%	98%	100%	100%	97%	100%	100%	99%	100%
Compliance with Outpatient Pharmacy Adverse Determination Notification Timeframes									
Q3 2021	100%	100%	99%	100%	NA	100%	99%	100%	100%
Q4 2021	100%	100%	98%	100%	100%	100%	100%	100%	100%
Q1 2022	100%	100%	100%	100%	NA	100%	91%	100%	100%
Q2 2022	100%	100%	99%	99%	100%	100%	98%	100%	100%
Compliance with Prescriber Notification of Outcome within 24 Hours									
Q3 2021	100%	100%	99%	100%	100%	100%	100%	98%	100%
Q4 2021	100%	100%	98%	100%	100%	100%	100%	97%	100%
Q1 2022	100%	100%	100%	100%	100%	100%	96%	99%	100%
Q2 2022	100%	100%	100%	100%	100%	100%	98%	99%	100%

Record Review. Tables 48 through 49 and Figure 7 compare results from record reviews across MCOs. Table 48 specifically displays a comparison of the annual grievance record review results across MCOs. Results are based upon a random selection of grievance records during MY 2021. Reviews were conducted utilizing the 10/30 rule.

Table 48. MY 2021 MCO Annual Grievance Record Review Results

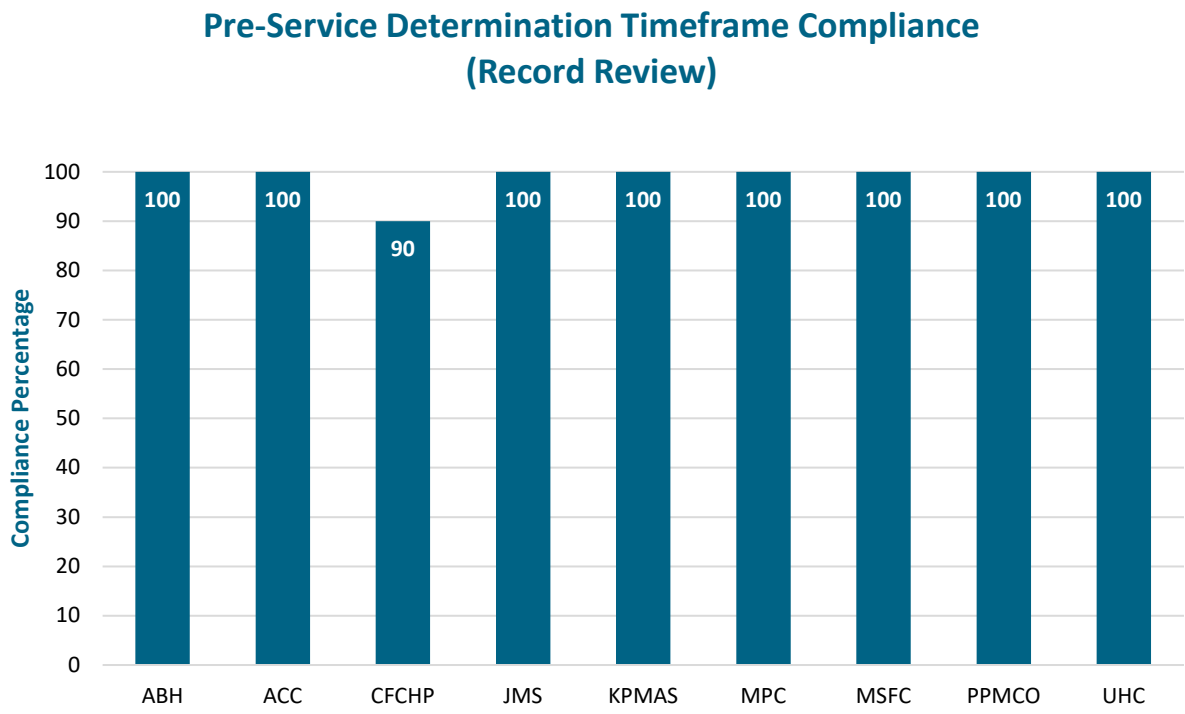
Requirement	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Appropriately Classified	M	PM	M	M	PM	M	M	M	PM
Acknowledgement Letter Timelines	PM	M	PM	M	M	M	M	M	PM
Issue is Fully Described	PM	M	M	M	M	M	M	M	M
Resolution Timeliness	M	M	M	M	PM	M	M	M	PM
Resolution Appropriateness	PM	M	M	M	M	M	M	M	M
Resolution Letter Timeliness	M	M	NA	M	PM	M	M	M	PM
Resolution Letter in Easy-to-Understand Language	M	M	M	M	M	M	M	M	M

Table 49. MY 2021 MCO Appeal Record Review Results

Requirement	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Processed Based Upon Level of Urgency	M	M	M	NA	M	M	M	M	M
Compliance with Timeframe for Written Appeal Acknowledgement Letter	M	M	PM	NA	PM	PM	M	M	PM
Compliance with Verbal Notification of Denial of an Expedited Request	M	M	UM	NA	M	M	NA	NA	NA
Compliance with Written Notification of Denial of an Expedited Request	M	M	UM	NA	M	M	NA	NA	NA
Compliance with 72-hour Timeframe for Expedited Appeal Resolution and Notification	PM	M	NA	NA	UM	M	M	PM	M
Compliance with Verbal Notification of Expedited Appeal Decision	PM	M	NA	NA	M	M	M	UM	M
Compliance with Written Notification Timeframe for Non-Emergency Appeal	M	M	M	NA	M	PM	M	M	PM
Appeal Decision Documented	M	M	M	NA	M	M	M	M	M
Decision Made by Health Care Professional with Appropriate Expertise	M	M	M	NA	M	M	M	M	M
Decision Available to Enrollee in Easy-to-Understand Language	PM	M	M	NA	M	M	M	M	M

Record Review – Compliance with COMAR Requirements. Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Results are based upon a random selection of pre-service adverse determination records from MY 2021. Results are illustrated in Figure 7.

Figure 7. MCO Compliance with Pre-Service Determination Timeframes (Record Review)



Tables 50 and 51, and Figure 8, respectively display a comparison of adverse determination record review results across MCOs. Results are based upon a random selection of adverse determination records reviewed for MY 2021.

Table 50. MCO Adverse Determination Record Review Issues

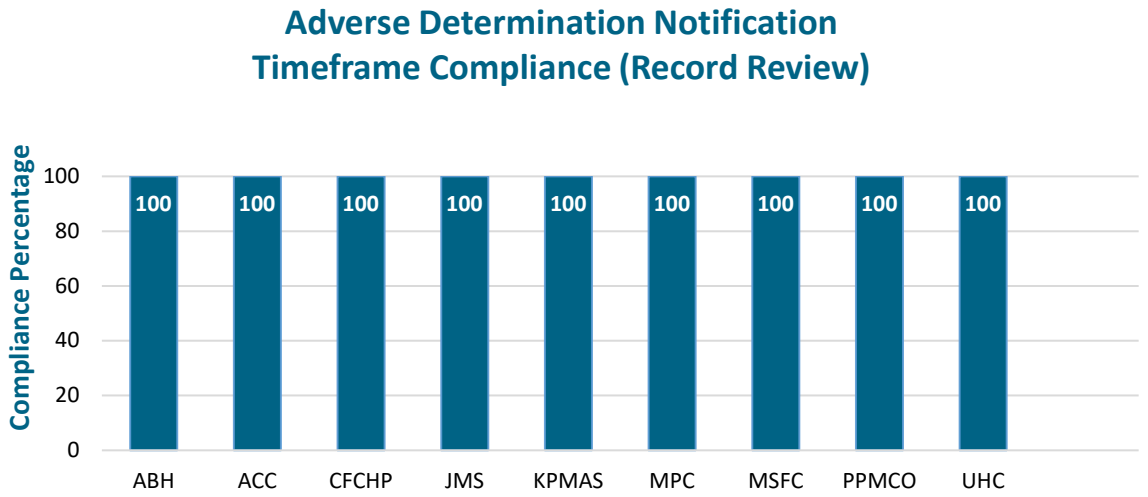
MCO	Issues Identified
ACC	Letter Components – Incorrect Timeframes and Use of Plain Language in Enrollee Letters

Note: No other issues were identified in the remaining eight MCOs.

Table 51. Results of MY 2021 Adverse Determination Record Reviews

Requirement	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Appropriateness of Adverse Determinations	M	M	M	M	M	M	M	M	M
Compliance with Pre-Service Determination Timeframes	M	M	M	M	M	M	M	M	M
Compliance with Adverse Determination Notification Timeframes	M	M	M	M	M	M	M	M	M
Required Letter Components	M	PM	M	M	M	M	M	M	M
Compliance with Prescriber Notification	M	M	M	M	NA	NA	M	M	M

Figure 8. MCO Compliance with Adverse Determination Notification Timeframes (Record Review)



Conclusions

Outcomes of the quarterly and annual studies demonstrated strong and consistent results from most MCOs in meeting most of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice enrollees is timely and accessible. Below are strengths identified in specific review components where all of the MCOs were in compliance:

- Grievance resolution letters written in easily understood language
- Timely pre-service determinations
- Timely pre-service adverse determination written notifications

- Appropriate adverse determinations, based upon MCO medical necessity criteria and policies

Validity of the data submitted by the MCOs, while much improved, continues to be a challenge, evidencing an ongoing absence of quality oversight. Consequently, assessment results should be considered with some caution. Recommendations were provided to both MDH and the MCOs for increasing validity in reporting, such as routine quality oversight of report submissions, and cross training of staff to ensure continuity in the event of staff turnover or absences. Subsequent reporting is anticipated to continue to yield a greater level of confidence in the review outcomes for annual reporting.

Additional findings and comprehensive details associated with the 2022 Annual Focused Study report are accessible at the link in **Appendix D**.

Network Adequacy Validation

Objectives

MDH engages in a broad range of activities to monitor adequacy and access. In 2015, MDH began conducting NAV activities by surveying MCOs and validating provider directories on an annual basis. This activity was transitioned to Qlarant in MY 2017. Qlarant has streamlined and developed a robust survey process to address inaccuracies in the MCOs' online provider directories to improve enrollees' timely access to care.

MDH established the following goals for MY 2022 NAV activities:

- Validate accuracy of MCOs' online provider directories; and
- Assess compliance with state access and availability requirements

Methodology

To complete the MY 2022 NAV task, Qlarant conducted two separate surveys, a telephone survey to a sample of provider offices and a validation survey to verify the accuracy of MCO online provider directories.

Data Collection and Review: A random sample for the telephone survey was selected from a listing of contracted PCPs obtained from each MCO. The telephone survey solicited responses to verify PCP information, including:

- Name and address of PCP,
- Provider acceptance of the listed MCO and new Medicaid enrollees, and

- Routine and urgent care appointment availability.

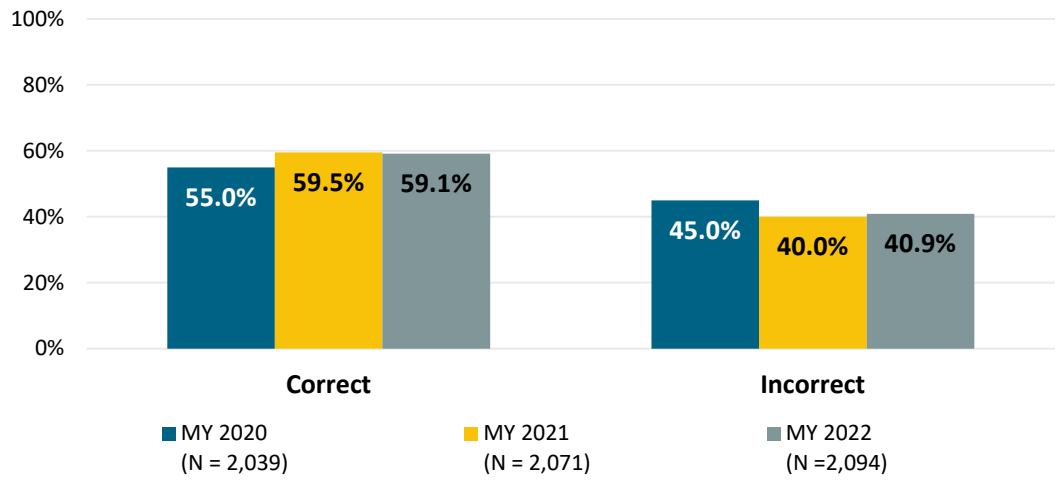
The validation survey verified the following information, using the MCOs' online provider directories:

- Correct address, as furnished by the MCO,
- Correct phone number, as furnished by the MCO,
- Correct status of accepting new Medicaid patients,
- Identified ages served by the PCP,
- Identified languages spoken by the PCP, and
- Identified available accommodations for disabled patients and specific Americans with Disabilities Act of 1990 (ADA)-accessible equipment.

Results

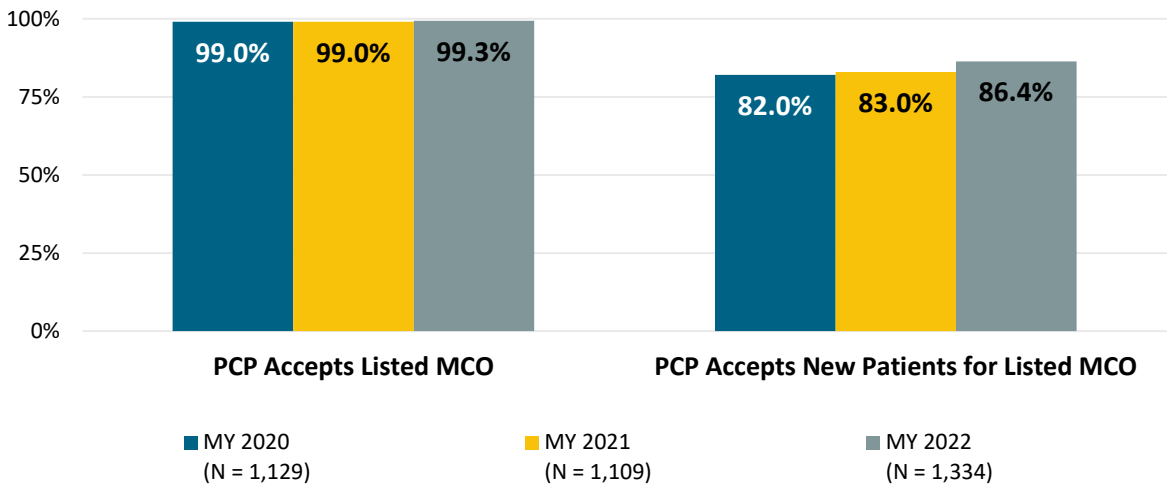
Accuracy of PCP information – Phone Numbers and Addresses. When contact is made with the PCP, the PCP's phone number and address provided by the MCO are verified. Results for the percentage of phone numbers and addresses that match the information provided by the MCOs are illustrated in Figure 9, trended by year. Each percentage is based on the total number of calls attempted. In MY 2022, 59.1% (1,238) of surveyed providers had accurate contact information, demonstrating a slight decline from MY 2021, where 59.5% (1,232) of surveyed providers had accurate information.

Figure 9. Accuracy of Provider's Contact Information (Phone Number and Address)



Accuracy of PCP Information – PCP Affiliation and Open Access. When contact is made with the PCP, verifications assess whether the PCP's affiliation with an MCO(s) is correct. Results for the acceptance of MCO and new patients are illustrated in Figure 10, trended by year.

Figure 10. PCP Affiliation & Open Access



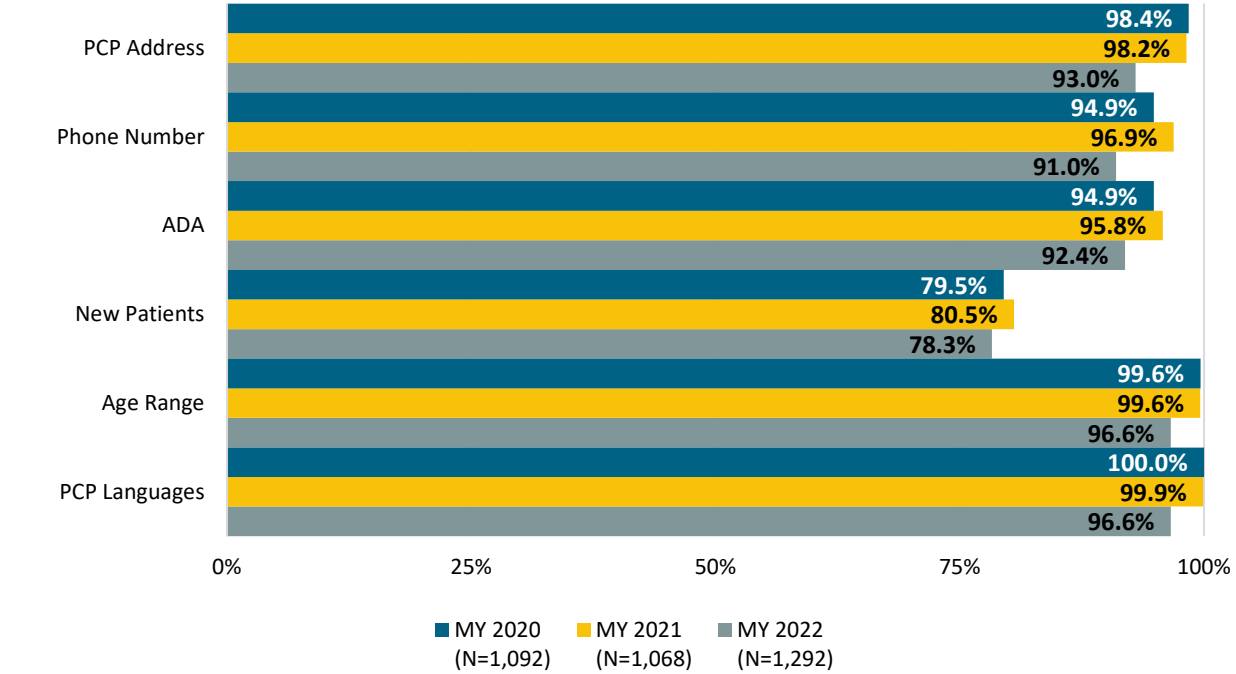
Similar to past MYs, about 99% (1,325) of PCPs accepted the listed MCO. Over 86% (1,152) of PCPs surveyed during MY 2022 indicated they were accepting new Medicaid patients – a 4.1 percentage point increase since MY 2020.

Validation of MCO Online Provider Directories. Qlarant validated the information provided in individual MCOs' online provider directory for each PCP that completed the telephonic survey. Figure 5 illustrates the proportion of telephone survey results matching the online provider directories. Based on previous best practice recommendations, most MCOs are currently using placeholders with consistent descriptions for provider details that are missing, such as "none" or "none specified" instead of 'blanks'. Figure 5 illustrates the proportion of telephone survey results matching the online provider directories.

Figure 11 shows the proportion of telephonic survey results matching the online provider directories by each of the review components listed above.[10] Since MY 2021, the proportion of telephone surveys matching the information within the online directory declined during MY 2022 across all review components. The largest declines were seen for the percentage of telephone surveys with matching addresses (down 5.2 percentage points) and matching phone numbers (down 5.9 percentage points). The area least likely to match the online provider directory across all three MYs regarded whether the PCP was accepting new patients – 78.3% in MY 2022. The area most likely to match the online provider directory across all three MYs concerned the PCP's age ranges and languages – 96.6% in MY 2022.

[10] Providers who were not listed in the online provider directory are not included in this measure.

Figure 11. Online Provider Directory Validation Results



Providers who were not listed in the online provider directory are not included in this measure.

HealthChoice aggregate results for the validation of online provider directories are displayed in Table 52.

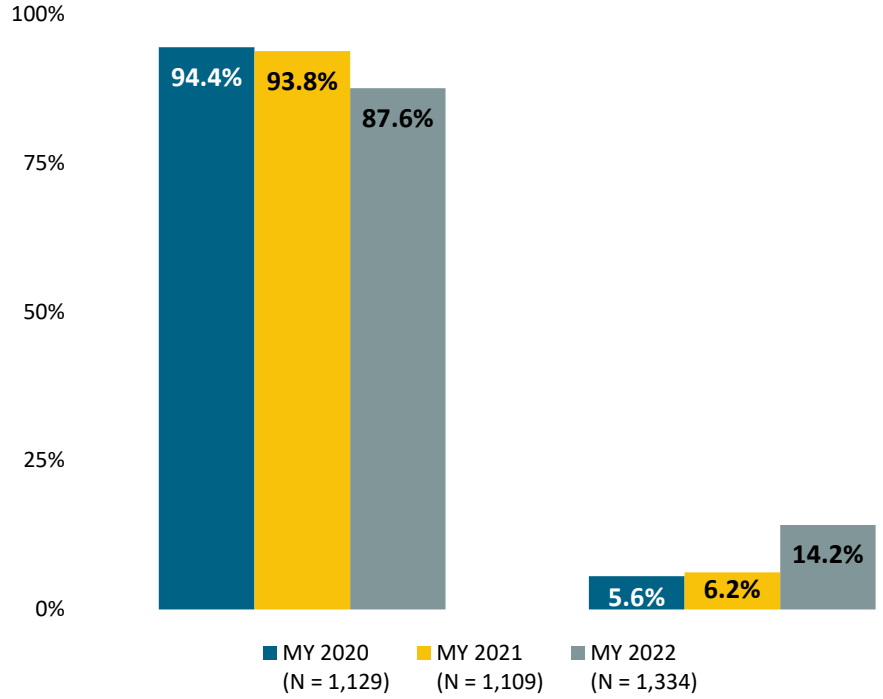
Table 52. MY 2022 HealthChoice Aggregate Results for Validation of Online Provider Directories

Requirement	HealthChoice Aggregate
PCP Listed in Online Directory	96.9% ↑
PCP's Practice Location Matched Survey Response	93.0% ↓
PCP's Practice Telephone Number Matched Survey Response	91.0% ↓
Specifies PCP Accepts New Medicaid Patients & Matches Survey Response	78.3% ↓
Specifies Age of Patients Seen	96.6% ↓
Specifies Languages Spoken by PCP	96.6% ↓
Practice has Accommodations for Patients with Disabilities	92.4% ↓
Minimum Compliance	**80%**
Total of Sampled Providers	**1,334**

Underline denotes that the 80% minimum compliance score is unmet.↑ Improvement from MY 2021; ↓ Decline from MY 2021

Compliance with Routine Care Appointment Requirements. To meet compliance, providers had to have an available appointment (in-person or telemedicine) within 30 days with the service provider or with an alternate provider. Survey results of PCP compliance with routine care appointment requirements are illustrated in Figure 12.

Figure 12. Percent of PCPs in Compliance with Routine Care Appointment Requirements

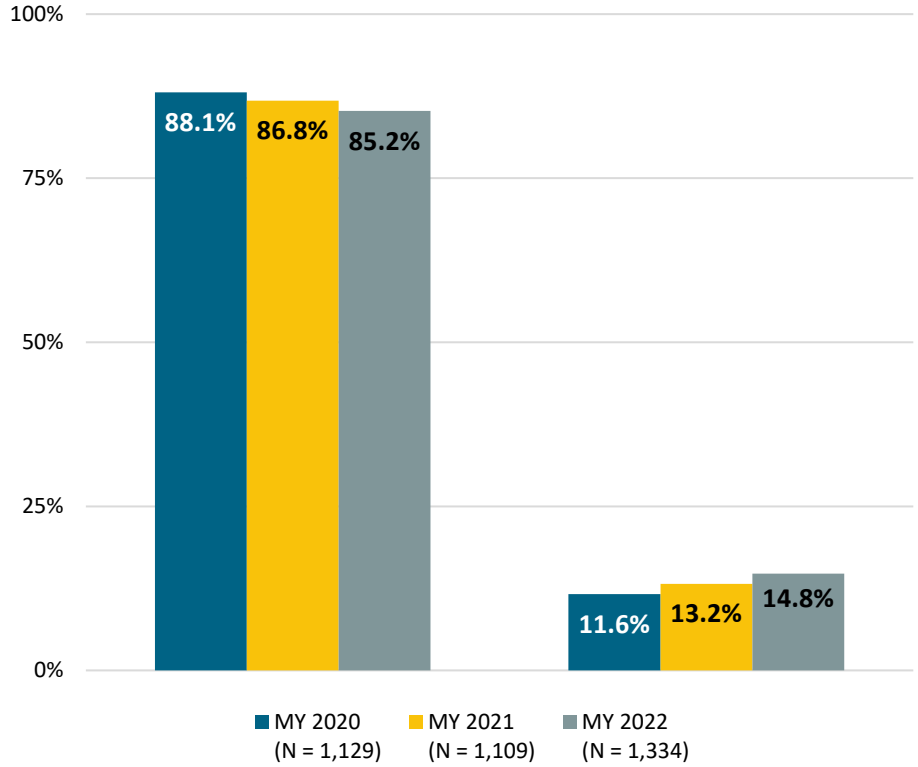


Routine Care Appointment Compliance

- Of the 1,334 PCPs successfully surveyed in MY 2022, 87.6% (1,168) provided routine care appointment availability within 30 days. This is 6.2 percentage points lower than the percent in MY 2021.
- Among the 1,168 providers in compliance,
  - 93% (1,088) had an appointment available with the requested service provider within 30 days.
  - 4% (52) had an appointment available with a different service provider within 30 days.
  - 2% (28) had a telemedicine appointment available with the requested provider, or an alternative provider, within 30 days.

Compliance with Urgent Care Appointment Requirements. To meet compliance, providers had to have an available urgent-care appointment (in-person or telemedicine) within 48 hours either at the service location or with an alternative provider. Survey results for PCP compliance with urgent care appointments requirements are illustrated in Figure 13.

Figure 13. Percent of PCPs in Compliance with Urgent Care Appointment Requirements



Urgent Care Appointment Compliance

- Of the 1,334 PCPs successfully surveyed in MY 2022, 85.2% (1,137) provided an urgent care appointment within 48 hours. This is 1.6 percentage points lower than MY 2021.
- Among the 1,137 providers in compliance,
  - 90% (1,024) had an appointment available at the service location with the requested provider within 48 hours.
  - 8% (95) had an appointment available at a different service provider within 48 hours.
  - 2% (18) had a telemedicine appointment available with the requested provider, or an alternative provider, within 48 hours.

HealthChoice Results for Compliance with Appointment Timeframe Requirements. Aggregated HealthChoice results for compliance with routine-care and urgent-care appointment timeframe requirements are displayed in Table 53.

Table 53. MY 2022 HealthChoice Results for Compliance with Appointment Requirements

Requirement	HealthChoice Aggregate
Compliance with Routine Care Appointment Timeframe (within 30 days)*	
Compliant with Timeframe	87.6%
# of Wait Days (Average)	10
# of Wait Days (Range)	0-30
Compliance with Urgent Care Appointment Timeframe (within 48 hours)*	
Compliance w/ Urgent Care Appointment	85.2%
Appointment Available w/ Requested PCP at Same Location (including telemedicine)	77.7%
Appointment Available w/ Another PCP at Same Location (including telemedicine)	7.5%
Minimum Compliance	**80%**

*Evaluated by determining compliance with appointment timeframe requirements out of successful contacts for each MCO.

Conclusions

The overall response rate for MY 2022 surveys was 63.7%, an increase of more than ten percentage points from MY 2021 (53.5%). Although the provider listings are offered directly by the MCOs, a fluctuating trend of inaccurate information remains an issue. For example, while the rate of accuracy with PCP addresses and phone numbers has improved since MY 2020 (55%), very little change was seen between MY 2021 (59.5%) and MY 2022 (59.1%).

In MY 2022, 99.8% of PCPs surveyed for open access demonstrated that they accepted the listed MCO; this is comparable to MY 2020 (99.1%) and MY 2021 (99.3%) results. Additionally, the majority of PCPs in MY 2022 (86.4%) accepted new patients for the listed MCO, which is a 3.1 percentage point increase compared to MY 2021 (83.3%).

MCO online provider directory validation results declined across all measures since MY 2021. Results show staff in provider offices and online provider directories are not accurately communicating or reflecting whether they are accepting new Medicaid patients, which prevents enrollees from scheduling appointments with their preferred PCP. MDH relies on accurate data from the MCOs to ensure appropriate PCP coverage statewide, therefore these barriers warrant further investigation to determine if they affect network adequacy determinations. Furthermore, enrollees may delay annual preventive care visits for themselves, or their children, if they are unable to contact a PCP and/or obtain an appointment, which could lead to adverse health care outcomes.

Overall, routine appointment compliance rates have declined since MY 2021. A total decline of 12 percentage points was reflected in routine care appointment compliance, dropping from 93.8% in MY 2021 to 87.6% in MY 2022. Urgent care appointment compliance rates continued to decrease to 85.2 percent in MY 2022 from 86.8% in MY 2021 and 88.1% in MY 2020.

Although several barriers to network adequacy have been identified through conducting the surveys, data should be evaluated with the continuing public health emergency in mind. While 1.4% of the surveys completed relayed COVID-19 public health emergency concerns, there is still the possibility that improvements or declines in evaluated areas could have been a result of accommodations put in place to address enrollee needs during this time. Additionally, increased telemedicine options are available when in-person appointments are unavailable.

MDH set a minimum compliance score of 80% for the network adequacy assessment. Based on MY 2022 results, seven MCOs (ACC, CFCHP, JMS, KPMAS, MPC, PPMCO, and UHC) are required to submit CAPs to Qlarant to improve online provider directory accuracy, and two MCOs are required to submit CAPs to improve compliance with timeframes for routine care and urgent care (MSFC and KPMAS, respectively).

For additional findings and comprehensive details associated with the MY 2022 NAV Report, please access the link in **Appendix D**.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS®) is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the NCQA. NCQA develops and publishes specifications for data collection and result calculation 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 potential enrollees with a means of comparing healthcare organization performance.

MDH contracted with MetaStar, Inc. (MetaStar), a NCQA Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice managed care organizations and to summarize the results.

For more details, see the report link in **Appendix D**.

Consumer Assessment of Health Providers and Systems

Introduced by the Agency for Healthcare Research and Quality (AHRQ) in the mid-1990s, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program encompasses the full range of standardized surveys that ask enrollees to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to enrollees, such as accessibility of services and provider communication skills.

The NCQA uses the Health Plan CAHPS survey in its Health Plan Accreditation Program as part of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures health plan performance on important dimensions of care and service and is designed to provide potential enrollees with the information they need to reliably compare the performance of health care plans. All HealthChoice MCOs are required to obtain NCQA Health Plan Accreditation.

The Health Plan CAHPS survey represents the enrollee experience component of the HEDIS measurement set. The survey measures enrollee experience of care and gives a general indication of how well the health plan meets enrollees' expectations. Surveyed enrollees are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months.

MDH contracted with CSS, an NCQA-certified survey vendor, to administer and report the results of the CAHPS® 5.0H Member Experience Survey. The overall goal of the survey is to provide performance feedback that is actionable and that will aid health plans in improving overall enrollee experience.

For more details, see the report link in **Appendix D**.

MCO Quality, Access, and Timeliness Assessment

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

- **Quality,** as it pertains to EQR, 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, through the provision of health services that are consistent with current professional knowledge, and interventions for performance improvement." *([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 it pertains to EQR, is defined as "the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined in 42 CFR 438.68 (Network adequacy standards) and 42 CFR 438.206 (Availability of services)." *([CMS], Final Rule: Medicaid Managed Care; 42 CFR Part 400, et al. Subpart D– Quality Assessment and Performance Improvement, [June 2002])).*
- **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 healthcare." *(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).*

MCO Aggregate Strengths, Improvements, and Recommendations

Tables 54 through 59 highlight strengths, improvements, opportunities, and recommendations summarizing aggregate performance across MCOs. Identified strengths, improvements, opportunities, and recommendations correspond to the quality, access, and/or timeliness of services delivered to MCO enrollees. Applicable domains for each strength or weakness are identified with a (↑) or (↓), indicating a positive or negative impact, as described below. Not all domains were impacted by each strength, improvement, opportunity, or recommendation. Where appropriate, recommendations include opportunities.

Table 54. MCO SPR Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	NA	**Systems Performance Review**
Strength: • 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. **Improvement:** • In the MY 2021 SPR, there was no change in MCO corrective action plans and overall improved compliance when compared to the last comprehensive review year (MY 2018). The number of overall CAPs remained at 25. The number of *Met with Opportunity* scores reduced from 26 in MY 2018 to 22 in MY 2021. **Recommendation:** • MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.			

Table 55. MCO PIP Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↓	↓	NA	**Performance Improvement Projects**

Improvements:

- Seven MCOs (ACC, CFCHP, JMS, KPMAS, MPC, MSFC, and PPMCO) demonstrated improvement in the AMR rate from baseline to MY 2021.
- Reported improvement was determined statistically significant for four MCOs (ACC, CFCHP, KPMAS, and PPMCO).
- CFCHP and KPMAS demonstrated sustained improvement from baseline. Two MCOs (CFCHP and KPMAS) demonstrated improvement in the HEDIS® Lead Screening rate from baseline to MY 2021.
- Reported improvement was determined statistically significant for one MCO (KPMAS). KPMAS also demonstrated sustained improvement from baseline.
- Three MCOs (KPMAS, MPC, and MSFC) demonstrated improvement in the VBP Lead Screening rate from baseline to MY 2021.
- Reported improvement was determined statistically significant for one MCO (KPMAS) and demonstrated sustained improvement from baseline.

Recommendations:

- Complete in-depth barrier analysis at least annually to identify root causes of suboptimal performance and to effectively drive improvement.
- Develop evidence-based, robust, system-level interventions in response to identified barriers.
- Implement timely interventions within the measurement year to have a meaningful impact on the measure rate.
- 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.
- Ensure that interventions are focused on the priority population for the lead screening PIP.
- Develop SMART objectives for all interventions to support evaluation of the effectiveness of interventions.
- Demonstrate consistent use of the Institute for Healthcare Improvement's rapid cycle PDSA approach to test the effectiveness of interventions and initiate adjustments where outcomes are unsatisfactory.
- Ensure that interventions address all system-wide barriers (member, provider, and MCO).
- Ensure that all PIP submissions include accurate final audited rates for each of the measures.
- Demonstrate a proactive approach to refining or developing new interventions when unforeseen challenges occur, such as the COVID-19 public health emergency.
- Ensure that a comprehensive analysis is completed to identify any factors that influenced comparability of initial and repeat measurements and any confounding variables that could have an obvious impact on outcomes when designing interventions.
- In designing interventions, determine the methodology for evaluating effectiveness in achieving the established goal.

Table 56. MCO EDV Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	NA	**Encounter Data Validation**

Strengths:

- 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.
- The HealthChoice MCO average rate for processing clean claims in 30 days was 95%, with MCO-specific rates ranging from 90% to 100%.
- All MCOs achieved office visit encounter match rates scored above 97% for three successive years.

Improvement:

- The composite match rate across all encounter types showed improvement from MY 2020 (98%) to MY 2021 (99%) by one percentage point.

Table 57. MCO EPSDT Strengths, Improvements, and Recommendations

Table 57 Placeholder for Finalized Results

Table 58. MCO GAD Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↓	↑	↑	**Focused Review of Grievances, Appeals, and Denials**

Strength:

- Most MCOs demonstrated strong and consistent results in meeting most of the grievance, appeal, and denial requirements.

Recommendations:

- Cross-train at least one additional staff member on the quarterly grievance, appeal, and denial reports to ensure continuity in the event of staff turnover or absence.
- Educate appeal staff to process appeals filed by a provider on behalf of an enrollee consistent with the MCO **Transmittal #137 *Processing Appeals Filed by Providers Representing HealthChoice Enrollees (PT 22-20)*** issued by MDH on March 16, 2020.
- MCOs need to establish a cross-functional workgroup to address the various points of entry and develop a process for aggregating all grievances to support accurate reporting. This is a carryover recommendation from the 2020 and 2021 Annual GAD Reports.
- Conduct a quarterly audit of a sample of enrollee calls to the Customer Service Department to ensure that all grievances are appropriately identified and documented in case notes and any applicable tracking systems.

Table 59. MCO NAV Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↓	↓	**Network Adequacy Validation**

Strengths:

- The percentage of providers surveyed with accurate contact information maintained similar performance to previous MYs, achieving about 59% in MY 2022.
- Responses matched the validation list during surveys regarding PCP acceptance of new Medicaid patients.

Improvements:

- The overall response rate for MY 2022 surveys was 63.7%, an increase of more than ten percentage points from MY 2021 (53.5%).
- Majority of PCPs in MY 2022 (86.4%) accepted new patients for the listed MCO, which is a 3.1 percentage point increase compared to MY 2021 (83.3%).

Recommendations:

- Provide complete and accurate PCP information for online provider directories.
- Notify PCPs of the Maryland NAV survey timeframe and promote participation one month before the surveys begin to minimize the pushback from the PCPs' staff to the surveyors.
- Refrain from completing any MCO-specific provider surveys within the same timeframe as the Maryland NAV surveys to optimize PCP participation.
- Frequently inspect online provider directories to ensure the status of accepting new Medicaid patients is accurate and communicate this information with provider office staff.
- Continue to ensure that MCO's online provider directory specifies ADA-specific information when the provider identifies as being handicap accessible.
- Clearly indicate appointment call center telephone numbers in online directory webpages so enrollees know what number to contact to schedule appointments for those MCOs with centralized scheduling processes.
- Continue adding the customer service department's telephone number or a scheduling assistance telephone number on the bottom of each directory page for member reference.
- Continue to share how current the information is in the online directory by adding a date stamp at the bottom of each page.
- Ensure the glossary is easily located.
- Use of placeholders with consistent descriptions for provider details that are missing, such as "none" or "none specified" rather than blanks.

↑ The MCO strength, improvement, and/or opportunity identified positively impacts quality, access, and/or timeliness.
↓ The MCO recommendation identified negatively impacts quality, access, and/or timeliness.

Assessment of Previous Recommendations

The following table identified recommendations made in the previous ATR (MY 2020) and the follow-up activities completed in 2021.

Table 60. 2021 Compliance with 2020 Recommendations

2021 Compliance with 2020 Recommendations	
2020 Recommendations	**2021 Compliance**
Encounter Data Validation	
The Department should continue to work with all MCOs to resolve rejected encounters. All MCOs experienced an increased incidence in provider-related rejections, although two MCOs also have non-provider related rejections.	This is a continued recommendation. MDH should work with the MCOs to instill best practices to improve their numbers of rejected encounters (The Hilltop Institute, 2022).
Continue to monitor monthly submissions to ensure that the MCOs submit data in a timely manner (The Hilltop Institute, 2020). MCOs that submit encounters more than 8 months after the date of service, which is the maximum time allotted for an encounter to be submitted to MDH, should be targeted for improvement (The Hilltop Institute, 2020).	This is a continued recommendation. MDH should continue to monitor monthly submissions to evaluate consistency and ensure that the MCOs submit data in a timely manner. MCOs that submit encounters more than eight months after the date of service—the maximum time allotted for an encounter to be submitted to MDH—should be flagged for improvement (The Hilltop Institute, 2022).
Continue to monitor PCP visits by MCO in future encounter data validations (The Hilltop Institute, 2020).	This is a continued recommendation. MDH should continue to monitor PCP visits by MCOs in future encounter data validations (The Hilltop Institute, 2022).
Continue to review these data and compare trends in future annual encounter data validations to look for consistency (The Hilltop Institute, 2020).	This is a continued recommendation. MDH should continue to review these data and compare trends in future annual encounter data validations to ensure consistency (The Hilltop Institute, 2022).
The Department should continue to review and audit the participant-level reports that Hilltop generated for delivery, dementia, and individuals over age 65, pediatric dental, as well as missing age outlier data. MCOs submitting the encounter outliers should be notified and demographic information should be updated, or adjustments should be made as needed.	This is a continued recommendation. MDH should continue to review and audit the participant-level, MCO-specific reports that Hilltop generated for delivery, dementia, individuals over age 65, pediatric dental, and missing age outlier data. MCOs that submit the encounter outliers should be notified, demographic information should be updated, and adjustments should be made, as needed (The Hilltop Institute, 2022).
Network Adequacy Validation	
Promote standards/best practices for MCOs' online provider directory information, including:	Recommendation continues to provide opportunities. Best practices were identified for most MCOs. Most MCOs currently use

2021 Compliance with 2020 Recommendations	
2020 Recommendations	**2021 Compliance**
• 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. • Require all directories to state the date the information was last updated, for easy monitoring.	placeholders with consistent descriptions for provider details that are missing - such as “none” or “none specified” instead of ‘blanks’.
Continue to monitor MCO complaints regarding the use of urgent care and emergency department services and review utilization trending to ensure members are not accessing these services due to an inability to identify or access PCPs.	Recommendation continues to provide opportunities.

State Recommendations

Considering the results for measures of quality, access, and timeliness of care for the contracted MCOs, Qlarant developed the following recommendations for MDH:

Performance Improvement Projects

- Continue to provide an enhanced review of MCOs’ PIPs to provide in-depth feedback on MCOs’ improvement strategies. With this more in-depth review, MCOs may be able to attain critical insight and increased intervention efficacy. Furthermore, providing a forum for MCOs to discuss barriers and share best practices also may be helpful in improving rates among all HealthChoice MCOs.

Encounter Data Validation

- Continue to work with the MCOs to resolve the provider data problems (The Hilltop Institute, 2022).
- Instruct MCOs to have their providers update and maintain accurate billing/claims address information to reduce returned mail and thus increase the number of records received for review. A total of 133 provider letters were returned to Qlarant for MY 2020, which contained requests for 336 patients.
- Communicate with provider offices and hospitals to reinforce the requirement to supply all supporting medical record documentation for the encounter data review so that all minimum samples can be achieved in a timely manner.

Focused Review of Grievances, Appeals, and Denials

- Require MCOs to implement routine quality oversight of all grievance, appeal, and denial quarterly report submissions.
- Explore options to support data quality of MCO quarterly grievance, appeal, and denial reports.
- Crosscheck MCO reported provider grievances with grievances submitted to MDH to ensure all grievances are counted in MCO reports.
- Consider conducting a focused record review of pharmacy-related denials and appeals to determine key drivers of the consistently high volume among MCOs.
- Consider including compliance with timeframes for sending written acknowledgment of grievance receipt, written resolution of grievance, and written acknowledgment of appeal receipt in the quarterly grievance and appeal reports submitted by the MCOs.

Network Adequacy Validation

- Continue allowing telemedicine appointments for routine or urgent appointments to accommodate enrollee preferences.

Conclusion

The MCOs provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, the MCOs are performing well. MCOs are actively working to address deficiencies identified during the review. The MCOs can trend performance to gauge where it meets and exceeds requirements and to identify opportunities for improvement. By implementing interventions and addressing these opportunities, the MCOs will improve in the areas of quality, access, and timeliness of care for the Maryland HealthChoice Program population.

MDH has effectively managed oversight and collaboratively worked with the MCOs and the EQRO to ensure successful program operations and monitoring of performance.

Appendices/Attachments

Introduction

MCO-Specific Summaries

MCO profiles and summary findings are based on the quality assurance activities that took place in MYs 2021 to 2022 for the Maryland HealthChoice program. Strengths, improvements, opportunities for improvement, and recommendations are noted for each MCO, as applicable, within each table serving as a profile summary for each MCO. Each table also presents whether strengths, improvements, opportunities for improvement, or recommendations are related to quality, access, and timeliness. Tables also identify positive or negative impacts on quality, access, and timeliness, carried over from the **MCO Quality, Access, and Timeliness Assessment** section.

SPR Standards and Guidelines

This appendix provides an in-depth listing and crosswalk of the SPR standards and guidelines to QAPI standards and 42 CFR Part 438, Subpart D.

2022 Final IRS and Methodology

This appendix explains the reporting strategy and analytic methods Qlarant used in developing the report card that MDH released in 2022, based on data reported from the MCOs in MY 2021. The information reporting strategy explains the criteria used to determine the most appropriate and effective methods of reporting quality information to Medicaid enrollees, the intended target audience. The analytic method provides a statistical basis and the analysis method used for reporting comparative MCO performance.

Appendix A: MCO-Specific Summaries

Table 61. ABH Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	ABH Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Systems Performance Review**
✓	✓	✓	**Strength:** • The Annual Analysis of Member Experience provided a comprehensive quantitative and qualitative analysis of the results of the CAHPS Adult and Child surveys, and barriers that impacted the overall rating of the plan. Based upon identified opportunities for improvement, an internal action plan was developed to address utilization management-related results, which included an improvement goal for each composite measure for 2021. A similar analysis of opportunities for improvement was completed, based on grievances and appeal data, with a separate analysis for access-related grievances related to network adequacy.
✓	✓	**NA**	**Improvement:** • ABH achieved a composite score of 97% in 2021, which increased by two percentage points over its 2018 result of 95%.
✓	✓	✓	**Recommendations:** • Add quarterly status update columns to the Internal Action Plan documents to document and track quarterly re-evaluation of the effects of steps taken to follow up on sources of enrollee dissatisfaction more clearly. • Revise the timeframe for obtaining additional clinical information for standard preauthorization (PA) requests specified in the Desktop: (UM) Clinical Request for Additional Information and Extension from 2 calendar days to 2 business days to better accommodate weekends and holidays. • Enhancing documentation of Special Investigations Unit (SIU) investigations within the Compliance Committee meeting minutes.
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	✓	**Strength:** • Various barriers were identified across member, provider, and MCO areas for both AMR and Lead Screening.
✓	**NA**	✓	**Recommendation:** • Consider the development and utilization of the PDSA cycle and SMART objectives during the initial stages of a new PIP cycle to ensure adequate information is provided for scoring and validation.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results

Quality	Access	Timeliness	ABH Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	**NA**	**NA**	**Strengths:** • Achieved match rates above the standard of 90% recommended by Qlarant in all areas of review: o 100% for all inpatient codes reviewed; maintained from MY 2020 and increased by one percentage point from MY 2019 (99%). o 98% for all outpatient codes reviewed; a one percentage point decrease from MY 2020 (99%) and a two-percentage point increase from MY 2019 (96%). o 99% for all office visit codes reviewed; a one percentage point increase from MY 2020 (98%) and consistent with the MY 2019 rate (99%).
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	✓	✓	**Strengths:** • Consistent compliance in meeting timeframes for resolution of enrollee grievances. • Consistent compliance in meeting the timeframes for adverse determination notifications. • All adverse determination letters were written in plain language and included a detailed explanation of the reason(s) for the determination and any additional information needed for reconsideration.
✓	✓	✓	**Improvements:** • Compliance with verbal and written enrollee notification requirements for denial of a request for an expedited appeal was successfully resolved and CAP was closed. • Compliance with required adverse determination letter components was successfully resolved and CAP was closed.
✓	✓	✓	**Recommendations:** • Retrain grievance staff on appropriate documentation requirements and grievance resolution. • Audit case notes on a routine basis to ensure compliance with documentation standards and appropriate grievance resolution. • Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for grievances acknowledgment letters, provider grievance resolutions, appeal resolution/notifications, and pre-service determinations. Increase the frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of appeal acknowledgment and resolution/notification letters, including those issued by delegated entities, to ensure the completeness and accuracy of content and ease of understanding.

Quality	Access	Timeliness	ABH Strengths, Improvements, and Recommendations
Quality	Access	Timeliness	Network Adequacy Validation
✓	✓	✓	**Strength:** • Scored above the 80% compliance threshold established by MDH in all online validation categories in the MY 2022 validation.
✓	✓	✓	**Recommendation:** • Urgent care compliance in MY 2022 was 80.1% – a 15 point decline since MY 2021 and just above the compliance threshold. ABH should address this area to ensure their compliance remains above 80%.

Table 62. ACC Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	ACC Strengths, Improvements, and Recommendations
Quality	Access	Timeliness	Systems Performance Review
✓	✓	NA	**Strengths:** • In its efforts to strengthen collaboration with community-based organizations (CBOs), ACC created an innovative strategy to meet enrollees where they are in the community. The program is called Live Share Health where ACC is working with a network of barbershops to use these points of service to engage enrollees in getting preventive health services, such as vaccines, or healthy food for a haircut. • ACC's 2021 Member Experience Report demonstrates the effective use of grievance data and established thresholds to support a more in-depth analysis of barriers and opportunities for improvement. In developing interventions, ACC takes a comprehensive approach by focusing on both enrollee and provider barriers. • All non-pharmacy adverse determination letters provided a detailed explanation of the reason for the determination and any additional information needed for reconsideration.
✓	✓	✓	**Recommendations:** • Establish a performance threshold for the provider site visit scoring tool. This will facilitate performance improvements, should an office not comply with the required performance level. • Revise the Member Grievances - MD Policy to explicitly address the requirement for documentation of the resolution of a grievance in the enrollee's case record. • Include in its report of grievances to the QMC compliance with grievance acknowledgment and grievance resolution letters, in addition to its reporting of grievance resolution. • Post notices and taglines, where appropriate, in conspicuous physical locations when ACC interacts with the public. • Update its policies to remove Maryland Market Watch, as ACC stated this no longer exists.

Quality	Access	Timeliness	ACC Strengths, Improvements, and Recommendations
			• Revise the Member Satisfaction Survey, and the Practitioner/Provider Satisfaction Survey, policies to clarify the process for analyzing and responding to opportunities for improvement from the MDH-coordinated surveys, including reporting of results, development of action plans, and ongoing monitoring of improvement initiatives and its frequency, by the appropriate department(s) and quality committee(s) at the health plan level. • Conduct a timelier review of CAHPS® and Provider Satisfaction Survey results, and development of action plans, to potentially impact subsequent years' results. • Include more recent data regarding the number of enrollees in each of the special populations in the Outreach Plan. • Include methods for provider referrals of potential FWA in provider newsletters, at least semi-annually. • Add an easy-to-access section on FWA to the provider website. • Add information on FWA to member newsletters at least semi-annually.
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	**NA**	**Strength:** • Reported improvement from baseline to MY 2021 was statistically significant for AMR.
✓	**NA**	✓	**Recommendation:** • Developing all future interventions to address barriers pertaining to members, providers, and the MCO. All interventions should clearly state the SMART objectives. Interventions should be assessed timely and should use the PDSA cycle to test interventions and make adjustments to interventions when needed.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	**NA**	**NA**	**Strength:** • Achieved match rates above the standard 90% recommended by Qlarant in all areas of review: o 100% for all inpatient codes reviewed; a one percentage point increase from MY 2020 (99%) and a five-percentage point increase from MY 2019 (95%). o 99% for all outpatient codes reviewed; a two-percentage point increase from MY 2020 (97%) and a one percentage point increase from MY 2019 (98%). o 98% for all office visit codes reviewed; a one percentage point increase from MY 2019 (97%) and MY 2020 (97%)

Quality	Access	Timeliness	ACC Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	✓	✓	**Strengths:** • Demonstrated consistent compliance in meeting timeframes for enrollee and provider grievance resolutions. • Demonstrated consistent compliance in meeting timeframes for sending enrollee acknowledgments of grievance and appeal receipt. • Enrollee grievances and steps to resolve were well described in case notes and resolution letters. • All non-pharmacy adverse determination letters provided a detailed explanation of the reason for the determination and any additional information needed for reconsideration.
✓	**NA**	✓	**Improvement:** • Consistent compliance with resolving provider grievances within regulatory timeframes.
✓	✓	✓	**Recommendations:** • Revise the Member Grievances - MD Policy to specify a timeframe for providing the enrollee with a written resolution of their grievance. • Retrain grievance staff on the appropriate categorization of grievances (emergency medically related, non-emergency medically related, and administrative). • Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for enrollee appeals, pre-service determinations, and adverse determination notifications. Increase the frequency and scope of monitoring until consistent compliance is demonstrated. • Work with the pharmacy vendor to ensure the use of the most recent adverse determination letter template and plain language in letters. Routinely audit a sample of adverse determination letters to ensure compliance. • Consider conducting a root cause analysis of billing/financial-related provider grievances to identify opportunities for improvement.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
✓	✓	**NA**	**Strength:** • Achieved 95% or more on five online validation categories.
✓	✓	**NA**	**Recommendation:** • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.

Table 63. CFCHP Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	CFCHP Strengths, Improvements, and Recommendations
Quality	Access	Timeliness	Systems Performance Review
✓	✓	NA	**Strengths:** • CFCHP encourages their enrollees to create vision boards and sends a survey to the enrollees after each Consumer Advisory Board meeting allowing them to provide feedback in response to the meeting they attended. Additionally, CFCHP has an open forum for enrollees to express concerns or bring up any issues they may have encountered with CFCHP or within CFCHP's network. • With the transition of ownership from University of Maryland Health Partners to CareFirst Community Health Plan Maryland in October 2020, the MCO experienced an increase in staff turnover in the early part of 2021. This occurred as HealthChoice enrollment grew from 52,000 at the beginning of 2021, to a total of 73,000 by year's end. As a result, the CFCHP leadership team increased the staffing complement by 100, with most staffing improvements made within the customer service and medical management departments. • Though not meeting established HEDIS benchmarks, CFCHP has shown noticeable improvements in year-over-year performance in both HEDIS and VBP measures.
✓	✓	NA	**Recommendations:** • Revise the section of the Disaster Recovery Plan at the end of the document, "Version Information & Changes," to reflect the need for an annual update of the plan. Also, it should be clarified in the Disaster Recovery Plan, which CFCHP committee is accountable for the review and approval of the document. • Place taglines on the Nondiscrimination Notice displayed at events when it interacts with the public. • Revise the Emergency Services Policy to state that coverage and payment provisions for emergency and post-stabilization services are communicated within their enrollee handbook and the provider manual. • Include in the Member Appeals Policy that no punitive action will be taken against a provider for supporting an enrollee's appeal or for requesting expedited resolution for an enrollee's appeal. • Include information about fraud detection and reporting in provider newsletters and new provider orientation and in subcontractor Business Associate Agreements if it is not included. • Use a consistent format for reporting delegate fraud, waste, and abuse activities. This may alleviate confusion and prevent underreporting. • Include information about fraud detection and reporting in enrollee newsletters.

Quality	Access	Timeliness	CFCHP Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	**NA**	**Strength:** • Demonstrated improvement in the HEDIS® Lead Screening rate from baseline to MY 2021.
✓	**NA**	**NA**	**Improvement:** • AMR improved from a Low Confidence level in MY 2020 to a High Confidence level for MY 2021.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	**NA**	**NA**	**Strength:** • Achieved match rates above the standard 90% recommended by Qlarant in all areas of review: o 100% for all inpatient codes reviewed; a one percentage point increase from MY 2020 (99%) and a five-percentage point increase from MY 2019. o 100% for all outpatient codes reviewed; a one percentage point increase from MY 2019 (99%) and MY 2020 (99%). o 99% for all office visit codes reviewed; a one percentage point increase from MY 2020 (98%) and consistent with the MY 2019 rate (99%).
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	**NA**	✓	**Strengths:** • Grievance resolution letters provided a full description of the grievance and the required steps to resolve. • Consistent compliance in meeting enrollee grievance resolution timeframes. • Consistent compliance in meeting enrollee appeal resolution/notification timeframes. • Consistent compliance with adverse determination notification timeframes.
✓	**NA**	**NA**	**Improvements:** • Grievance resolution letters are supported by case notes with full documentation of the grievance and required steps to resolve. • Adverse determination letters provide an explanation of the requested service in plain language.
✓	✓	✓	**Recommendations:** • Revise Member Grievances Policy to specify a timeframe for providing the enrollee a written resolution of their grievance. • Consider conducting a root cause analysis of billing/financial-related provider grievances to identify opportunities for improvement.

Quality	Access	Timeliness	CFCHP Strengths, Improvements, and Recommendations
			• Monitor timeliness of mailing of grievance and appeal acknowledgment letters on a routine basis. • Retrain appeal staff on the requirement for making a reasonable attempt to provide verbal notification of a denial of an expedited appeal request, and routinely audit a sample of cases to ensure compliance. • Ensure an effective process is in place for monitoring compliance with regulatory timeframes for provider grievances and pre-service determinations. • Increase the frequency and scope of monitoring until consistent compliance is demonstrated.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
✓	✓	**NA**	**Strength:** • Achieved 95% or more on five online validation categories.
✓	✓	**NA**	**Recommendation:** • Ensure staff responses regarding the PCP's phone number align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.

Table 64. JMS Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	JMS Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Systems Performance Review**
✓	✓	✓	**Strengths:** • Received compliance scores of 100% in all standards reviewed. • JMS has an effective process in place for trending and analyzing grievance data to identify opportunities for improvement and demonstrates that it acts upon any opportunities. • The Newborn Coordinator Operating Protocol outlines the duties of the Newborn Coordinator. The protocol included scenarios that may arise and how to address them. • JMS has established objective goals for questions related to the UM process for both internal and state-coordinated surveys, which are used to determine the need for corrective action if any goals are not met
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	**NA**	**Improvement:** • Reported improvement in performance in AMR PIP since the baseline MY appears to be the result of implementation of the planned interventions.

Quality	Access	Timeliness	JMS Strengths, Improvements, and Recommendations
✓	NA	NA	**Recommendation:** • Develop interventions using evidence-based literature that will provide sustainable results when repeated.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	NA	NA	**Strength:** • Achieved match rates above the standard 90% recommended by Qlarant in all areas of review: o 96% for all inpatient codes reviewed; a four-percentage point increase from MY 2020 (92%) and a decrease of four percentage points from MY 2019 (100%). o 99% for all outpatient codes reviewed; a one percentage point decrease from MY 2020 (100%) and a two-percentage point increase from MY 2019 (97%). o 99% for all office visit codes reviewed; a one percentage point decrease from MY 2020 (100%) and MY 2019 (100%).
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	✓	✓	**Strengths:** • Case notes provided a detailed description of the grievance, steps taken to resolve, and resolution. • All grievance resolution timeframes were consistently Met during the review period. • Grievance acknowledgment letters were evident in all records reviewed. • All enrollee grievance letters were written in plain language, with a full description of the grievance and an appropriate resolution. • All appeal resolution/notification timeframes were consistently Met. • All pre-service determination timeframes were consistently Met.
✓	✓	✓	**Improvement:** • Consistent compliance with pre-service determination timeframes.
✓	✓	✓	**Recommendations:** • Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for adverse determination notification timeframes. • Increase the frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of billing/financial-related enrollee grievances to identify opportunities for improvement.

Quality	Access	Timeliness	JMS Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
✓	✓	**NA**	**Recommendations:** • Ensure PCP office staff responses, regarding accepting new Medicaid patients for the assigned MCO, align with responses provided in the MCO online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. • Ensure MCO's online provider directory includes information regarding their providers' accommodations for patients with disabilities.

Table 65. KPMAS Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	KPMAS Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Systems Performance Review**
✓	✓	**NA**	**Strength:** • KPMAS has a detailed procedure outlining how they recruit enrollees to join the CAB. • Adverse determination letters provided a detailed explanation of the requested service and an explanation of the denial decision in plain language.
✓	✓	✓	**Recommendations:** • Retraining its grievance staff on the correct categorization of grievances and instituting regular audits to ensure grievances are being correctly categorized. • Outlining in writing and demonstrating how they track enrollee feedback from CAB meetings. • Including fraud, waste, and abuse (FWA) reporting in the member newsletter and investigating options for placing information in the clinic sites.
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	**NA**	**Strengths:** • Demonstrated sustained improvement in the HEDIS® Lead Screening rate from baseline to MY 2021. Reported improvement in HEDIS® Lead Screening rate was determined statistically significant. • Reported improvement was determined statistically significant for the VBP Lead Screening rate from baseline to MY 2021. • Demonstrated sustained improvement in the AMR rate from baseline to MY 2021.
✓	**NA**	**NA**	**Recommendations:** • Note issues, the root cause, and the solution as the lessons learned when analyzing interventions for the PDSA cycle and tests of change. Lessons learned could also be related to what may have led to success of an intervention that could be repeated.

Quality	Access	Timeliness	KPMAS Strengths, Improvements, and Recommendations
			• Clearly explain and justify the frequency of data collection in future PIP submissions. • Develop more robust culturally and linguistically appropriate interventions that will improve the overall PIP in at-risk subpopulations.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	**NA**	**NA**	**Strength:** • Achieved match rates above the standard 90% recommended by Qlarant for outpatient encounters and office visit encounters.
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	✓	✓	**Strengths:** • Enrollee grievance acknowledgment letters were evident in all records reviewed. • Records reviewed demonstrated thorough documentation of grievance, the required steps to resolve, and the resolution in all case notes. • Resolution letters provided a detailed description of the enrollee's grievance and are written in plain language. • Adverse determination letters provided a detailed explanation of the requested service and an explanation of the denial decision in plain language. • Demonstrated consistent compliance in meeting the timeframes for pre-service determinations.
✓	✓	✓	**Improvements:** • Consistent compliance with sending enrollees a grievance resolution letter. • MDH-approved appeal letter templates are consistently used. • Consistent compliance with verbal and written notification of denial of an expedited appeal request.
✓	✓	✓	**Recommendations:** • Consider conducting a root cause analysis of service/attitude-related enrollee grievances to identify opportunities for improvement. • Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for grievance resolutions, appeal acknowledgment letters, appeal resolutions/notifications, and adverse determination notifications. Increase the frequency and scope of monitoring until consistent compliance is demonstrated. • Retrain grievance staff on the assignment of enrollment grievances to the appropriate category (emergency medically related, non-emergency medically related, and administrative).

Quality	Access	Timeliness	KPMAS Strengths, Improvements, and Recommendations
Quality	Access	Timeliness	Network Adequacy Validation
✓	✓	NA	**Strength:** • Achieved 99% in four online validation categories.
✓	✓	NA	**Recommendation:** • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.

Table 66. MPC Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	MPC Strengths, Improvements, and Recommendations
Quality	Access	Timeliness	Systems Performance Review
✓	✓	✓	**Strengths:** • Adverse determination letters included a detailed explanation of the reason for the denial and identified what was needed for approval of the request in easily understood language. This is considered a best practice. • Appeal resolution letters included a very detailed description of the denied service being requested and an explanation of the decision in plain language. This is considered a best practice. • MPC has comprehensive action plans for responding to opportunities for improvement, based upon enrollee and provider satisfaction surveys, and consistently updates these plans on a quarterly basis. • MPC's Compliance Work Plan is a best practice in succinctly documenting the various types of fraud, waste, and abuse (FWA) audits; their purpose; and frequency.
✓	✓	✓	**Recommendations:** • Using the Key Indicator Report (KIR) for tracking and monitoring compliance with TATs for written grievance acknowledgment and resolution. • Revising the timeframes for sending a written resolution for urgent and routine administrative grievances, in the Member Grievance Process Policy, to clarify the timeframe is from the receipt of the grievance. Additionally, it is recommended that MPC consider the use of the KIR for tracking and monitoring compliance with timeframes established by the MCO for written grievance resolution. • Including the grievance resolution within the requirement for providing a description of the grievance in easily understood language in the Member Grievance Process Policy.

Quality	Access	Timeliness	MPC Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	**NA**	**Improvements:** • MPC reports an increase of over 50% of both the numerator and denominator in comparison to the baseline MY 2016 for AMR. There was also an AMR rate increase for MY 2021 in comparison to baseline MY 2016 by 1.07 percentage points. • The demonstrated improvement over the baseline VBP rate for Lead Screening appears to be the result of the planned quality improvement interventions.
✓	**NA**	**NA**	**Recommendations:** • Review all quantitative data to ensure reported accuracy. • Demonstrate sustained improvement over both HEDIS and VBP rates. • Continue to evaluate the effectiveness of its individual interventions over established goals.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	**NA**	**NA**	**Strength:** • Achieved match rates above the standard 90% recommended by Qlarant in all areas of review: o 100% for all inpatient codes reviewed; maintained from MY 2019 (100%) and MY 2020 (100%). o 99% for all outpatient codes reviewed; a one percentage point decrease from MY 2020 (100%) and a two percentage point increase from MY 2019. o 100% for all office visit codes reviewed; a three percentage point increase from MY 2020 (97%) and consistent with the MY 2019 rate (100%).
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	✓	✓	**Strengths:** • Consistent compliance in meeting timeframes for grievances, pre-service determinations, and adverse determination notifications was identified throughout the review period. • Case notes were very organized and provided a detailed description of the grievance, steps taken to resolve, and resolution. • Appeal resolution letters included a very detailed description of the denied service being requested and an explanation of the decision in plain language. • Adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial and what was needed for approval of the request in plain language.

Quality	Access	Timeliness	MPC Strengths, Improvements, and Recommendations
✓	NA	NA	**Improvement:** • Appeal resolution letters were written in plain language.
✓	✓	✓	**Recommendation:** • Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for written appeal acknowledgments and appeal resolution/notification. Increase frequency and scope of monitoring until consistent compliance is demonstrated.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
✓	✓	NA	**Strength:** • Achieved 100% in three online validation categories.
✓	✓	NA	**Recommendation:** • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.

Table 67. MSFC Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	MSFC Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Systems Performance Review**
✓	✓	NA	**Strengths:** • The cross-departmental community-based communication and collaboration to improve member care and services continues to be a strength of MSFC operations. • MSFC has an effective process in place for identifying opportunities for improvement based upon an analysis of member grievance data and implements interventions in response to its findings. • MSFC goes to great lengths to recruit enrollees to join the CAB. MSFC holds the CAB meetings virtually and in person. The Public Health Emergency did not negatively affect MSFC's enrollee participation. • Appeal resolution letters are written in plain language and include a description of the service being appealed and an explanation of the reasons for an overturned or upheld decision. • MSFC continues to have a robust process for ensuring that any entity that it contracts with, or employs is screened monthly for exclusion from participation in any federal and/or state program.
✓	NA	NA	**Recommendation:** • Update policies and procedures supporting compliance monitoring in order to reference the Corrective Action Policy for guidance.

Quality	Access	Timeliness	MSFC Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	**NA**	**Improvements:** • MSFC reported a slight improvement in the AMR rate by 0.31 percentage points in comparison to the baseline MY 2016. This has been the only RMY to show improvement over all five RMYs since the baseline MY 2016. • The reported improvement in the Lead Screening VBP measure from baseline to MY 2021 appears to be the result of MSFC interventions.
✓	**NA**	**NA**	**Recommendations:** • Institute a process for regularly assessing, testing, and adjusting PIP interventions as needed to improve PIP performance. • Develop sustainable evidenced-based interventions that directly address barriers in high-risk members that would positively impact the PIP rate.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	**NA**	**NA**	**Strength:** • Achieved match rates above the standard 90% recommended by Qlarant in all areas of review: o 100% for all inpatient codes reviewed; a one percentage point increase from MY 2019 (99%) and MY 2020 (99%). o 100% for all outpatient codes reviewed; maintained from MY 2020 (100%) and a significant improvement of ten percentage points from MY 2019 (90%). o 100% for all office visit codes reviewed; maintained from MY 2020 (100%) and a one percentage point increase from MY 2019 (99%).
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	✓	✓	**Strengths:** • Consistent compliance was demonstrated in meeting the resolution timeframes for enrollee and provider grievances in all applicable quarters. • Case notes were well organized and provided a detailed description of the grievance, steps taken to resolve, and resolution. • Acknowledgments of grievance and appeal receipt were sent to enrollees in all the records reviewed. • Detailed case notes provided descriptions of all appeal-related activities and outcomes. • All appeal resolution letters were written in plain language and provided a detailed explanation of the reason for the uphold or overturn the decision.

Quality	Access	Timeliness	MSFC Strengths, Improvements, and Recommendations
			• All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
✓	NA	✓	**Improvement:** • Appeal receipt date is not changed to reflect the date of enrollee consent.
✓	✓	✓	**Recommendation:** • Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with enrollee appeal resolution/notification timeframes and adverse determination notifications. Increase the frequency and scope of monitoring until consistent compliance is demonstrated.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
✓	✓	NA	**Strength:** • Demonstrated compliance with all of the requirements for validation of the online provider directories.
✓	✓	✓	**Recommendation:** • Ensure routine care appointments are made with the requested provider, or another provider, within the 30-day timeframe.

Table 68. PPMCO Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	PPMCO Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Systems Performance Review**
✓	✓	✓	**Strengths:** • PPMCO develops comprehensive and evidence-based scientific clinical and preventive guidelines using the most current scientific references. The rationale for developing these guidelines is very clear in supporting enrollee and provider education and UM decision-making. • PPMCO provides evidence of a very comprehensive oversight process of delegated vendors. The policy and procedure review and documentation of findings and recommendations for improvement is a best practice. • Case notes were very well organized, fully described the grievance, steps to resolve, and the resolution.
✓	✓	NA	**Recommendations:** • Update the COMAR reference for the definition of a specialty drug to 10.67.06.04 in the MDH Unified Corrective Managed Care Program Policy.

Quality	Access	Timeliness	PPMCO Strengths, Improvements, and Recommendations
			• Include information about the Screening, Brief Intervention, and Referral to Treatment process and Release of Information procedures in new provider orientation programs and in provider newsletters. • Review the method used for reporting on homeless individuals to ensure accuracy.
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	**NA**	**Strengths:** • The maintained improvement in performance since baseline appears to be the result of implementation of the planned interventions. • The improvement in the AMR rate from baseline to the MY 2021 rate was determined to be statistically significant.
✓	**NA**	**NA**	**Recommendations:** • Compare performance to the PIP long-term goal in addition to the other goals selected. • Review all quantitative data to ensure it is accurately presented. • Conduct small tests of change to assess intervention performance.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	**NA**	**NA**	**Strength:** • Achieved match rates above the standard 90% recommended by Qlarant in all areas of review: o 98% for all inpatient codes reviewed; a one percentage point decrease from MY 2019 (99%) and MY 2020 (99%). o 99% for all outpatient codes reviewed; maintained from MY 2020 (99%) and a three percentage point increase from MY 2019 (96%). o 99% for all office visit codes reviewed; maintained from MY 2020 (99%) and a one percentage point increase from MY 2019 (98%).
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	✓	✓	**Strengths:** • Case notes were well organized, and described the grievance, steps to resolve, and resolution. • Consistent compliance was demonstrated in meeting the resolution timeframe for provider grievances. • Acknowledgments of grievance and appeal receipt were sent to enrollees in all the records reviewed.

Quality	Access	Timeliness	PPMCO Strengths, Improvements, and Recommendations
			• Consistent compliance was demonstrated in meeting the resolution/notification timeframes for enrollee appeals. • Consistent compliance was demonstrated in meeting the timeframes for pre-service determinations and adverse determination notifications.
✓	✓	✓	**Improvements:** • Attitude/Service-related enrollee grievances have been steadily decreasing over the review period. • Consistent compliance with appeal resolution/notification timeframes. • Enrollee consent is documented in the case record when a provider is filing an appeal on behalf of the enrollee. • Appeal resolution letters reflect correct calculated dates, appeal receipt, and resolution dates. • Appeal and adverse determination letters were consistently written in plain language. • Consistent compliance with pre-service determination and adverse determination notification timeframes. • Additional clinical information, if required, was requested within two business days of receipt of a PA request.
✓	✓	✓	**Recommendations:** • Retain staff on the appropriate categorization of grievances. • Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with enrollee grievance resolution timeframes. • Retrain appeal staff and conduct routine audits on appeal case documentation requirements, including verbal notification of an expedited resolution.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
✓	✓	**NA**	**Strength:** • Achieved 100% in three online validation categories.
✓	✓	**NA**	**Recommendation:** • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online provider directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.

Table 69. UHC Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	UHC Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Systems Performance Review**
✓	**NA**	✓	**Strengths:** • UHC has a comprehensive process in place for the annual review of grievance data by category and subcategory, including three-year trending and comparison with established thresholds. A barrier analysis is conducted in response to any identified issues with action plans developed as indicated. • Documentation found in grievance case records was very detailed, demonstrating a thorough understanding of the enrollee's grievance, steps taken to resolve, and an appropriate resolution. • A sample review of ten adverse determination letters found that all included a very detailed explanation of the reason for the denial in plain language, including what is needed to demonstrate medical necessity. • UHC's enrollee appeal resolution letters include a very detailed explanation of the reason for both overturned and upheld decisions of an adverse determination in easy to understand language, and is considered a best practice.
✓	✓	**NA**	**Recommendation:** • Establish one IRO policy and procedure that addresses all aspects of the IRO process. This may eliminate the inconsistencies with having more than one policy and procedure.
Quality	**Access**	**Timeliness**	**Performance Improvement Projects**
✓	**NA**	**NA**	**Recommendations:** • Consistency with numbering interventions, as the same number was used after it was retired. • Develop evidence-based interventions and identify root causes for declines in performance, and make adjustments to interventions appropriately as needed. • Strengthen its lessons-learned response and identify a possible solution that can improve the performance of interventions. For example, UHC identified that the “repeat back” method of education may be a better way to confirm member understanding of inhaler use.
Quality	**Access**	**Timeliness**	**EPSDT Medical Record Review**
			Placeholder for Finalized Results
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
✓	**NA**	**NA**	**Strength:** • Achieved match rates above the standard 90% recommended by Qlarant in all areas of review: o 98% for all inpatient codes reviewed; a two percentage point decrease from MY 2019 (100%) and MY 2020 (100%).

Quality	Access	Timeliness	UHC Strengths, Improvements, and Recommendations
			o 100% for all outpatient codes reviewed; a two percentage point increase from MY 2020 (98%) and a five percentage point increase from MY 2019 (95%). o 99% for all office visit codes reviewed; a two percentage point increase from MY 2020 (97%) and a one percentage point increase from MY 2019 (98%).
Quality	**Access**	**Timeliness**	**Focused Review of Grievances, Appeals, and Denials**
✓	✓	✓	**Strengths:** • Consistent compliance with enrollee and provider grievance resolution timeframes was demonstrated in all four quarters. • Grievance case records provided a detailed description of the grievance, steps taken to resolve, and resolution. • All enrollee grievance resolution letters fully described the grievance and steps taken to resolve and are in plain language. • Appeal resolution letters provided a very detailed explanation of reasons for the overturn of a denial in addition to uphold decisions in easy to understand language. • Consistent compliance with pre-service determination and adverse determination notification timeframes was demonstrated in all four quarters. • Adverse determination letters included a very detailed explanation of the reason for the denial in plain language, including what is needed to demonstrate medical necessity.
✓	**NA**	✓	**Improvement:** • Consistent compliance with the resolution timeframes for enrollee and provider grievances.
✓	✓	✓	**Recommendations:** • Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with grievance acknowledgment letters, appeal acknowledgment letters, and appeal resolution/notification timeframes. Increase the frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of billing/financial-related enrollee and provider grievances to identify opportunities for improvement. • Consider including a more detailed description of the grievance in enrollee acknowledgment letters. • Educate appeal staff on dating appeal receipt as the date the provider filed on behalf of the enrollee.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
✓	✓	**NA**	**Strength:** • Met compliance with six out of seven requirements for validation of the online provider directories.

Quality	Access	Timeliness	UHC Strengths, Improvements, and Recommendations
✓	✓	NA	**Recommendation:** • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online provider directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.

Appendix B: MY 2021 SPR Standards and Guidelines

*Rows highlighted in blue identify NCQA deemable elements/components. Within the highlighted sections, italicized elements/components are eligible for deeming.

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
1.0	**Systematic Process of Quality Assessment and Improvement – The QAP objectively and systematically monitors and evaluates the QOC and services to enrollees, through QOC studies and related activities, and pursues opportunities for improvement on an ongoing basis.**			
1.1	The QAP ensures monitoring and evaluation of the enrolled population and areas of concern for the enrolled population. a. The monitoring and evaluation of care reflect the population served by the MCO in terms of age, disease categories, and special risk status. b. The QAP monitors and evaluates priority areas of concern selected by the State and any additional areas of concern identified by the MCO.	The MCO demonstrates the ability to capture and analyze data that describe the demographic, health status, and utilization patterns of the enrolled population. The MCO documents processes used to prioritize problems and develop a timeframe for QAP studies and projects.	• QA Plan • Policies & Procedures • Data Analysis • Population Assessment Data • Enrollee Profiles (demographic; medical; pharmacy; and utilization data) • QAC Meeting Minutes • QA Timeline/Work Plan • Outreach Plan	42 CFR §438.330 42 CFR §438.330(b)(4) COMAR 10.67.04.03A(3)(c)
1.2	The QAP's written guidelines for the MCO's QOC studies and related activities require the use of quality indicators.	QOC study designs or project plans contain indicators based on sound clinical evidence or guidelines. The methodology and frequency of data collection will be evaluated to determine if they are sufficient to detect change.	• QA Plan • Policies & Procedures • QOC Study Designs • QOC Project Plans	42 CFR §438.330 42 CFR §438.330(c) COMAR 10.67.04.03B(2)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience. b. Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.		• Quality Indicators, including HEDIS and CAHPS reports • Data Analysis	
1.3	The QAP has written guidelines for its QOC studies and related activities must include the use of clinical practice guidelines. *a.* Deleted in MY 2018. *b. Clinical practice guidelines are based on evidence-based practices or professional standards of practice and are developed or reviewed by MCO providers.* *c. The guidelines focus on the process and outcomes of health care delivery and access to care.*	There must be a comprehensive set of guidelines that address preventive care and the range of the populations enrolled in the MCO. Clinical practice guidelines provide the basis for QOC studies and related QA activities. There is evidence that these guidelines are based on reasonable evidence-based practice and have been developed or reviewed by plan providers. The guidelines in use allow for the assessment of the process and outcomes of care. The MCO must have a mechanism in place for reviewing the guidelines at least every two years and updating them as appropriate. There must be evidence that the MCO disseminated guidelines to providers and,	• QA Plan • Policies & Procedures • Practice Guidelines • Proof of Guidelines Disseminated to Providers • QA/QIC/MCO's Internal Provider/Medical Advisory Committee (MAC) Meeting Minutes • Clinical Care Standards • QOC Study Designs • QOC Study Tools • QOC Project Plans • Quality Indicators • Data Analysis	42 CFR §438.236 **NCQA :** **MED 2 Element A-C** **UM 2 Element C**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. A mechanism is in place for continuously updating the guidelines as appropriate. There is evidence that this occurs. *e. The guidelines are included in the provider manuals or disseminated to the providers (electronically or faxed) as they are adopted.* *f.* There are guidelines to address preventive health services for children and adults. *g. The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a.* *h. The MCO's clinical guidelines policies and procedures must reflect how the guidelines are used for UM decisions, enrollee education, and coverage of services.*	upon request, to enrollees and potential enrollees. Decisions for UM, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the clinical guidelines.	• Population Assessment Results	
1.4	The QAP has written guidelines for its Quality of Care studies	The QA Plan and/or related documents describe the methodology for monitoring	• QA Plan • Data Analysis	42 CFR §438.330b(3)-b(4)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	and related activities that require the analysis of clinical and related services. a. The QAP has written guidelines to evaluate the quality of care provided by the MCO's providers. b. Appropriate clinicians monitor and evaluate quality through review of individual cases and through studies analyzing patterns of clinical care. c. Multidisciplinary teams are used to analyze, identify, and address systems issues. d. Clinical and related service areas requiring improvements are identified through activities described in a. and b. above. e. Mechanisms to detect both over and underutilization of services.	the quality of care provided by the MCO's providers. This may be through study of clinical care and services through individual case reviews, provider utilization studies, and practice pattern analysis. The composition of the team is described in the QA Plan and/or related documents. There is evidence that through these activities those areas requiring improvement are identified and acted upon.	• Policies & Procedures • QA/QIC/MCO's internal Provider/Medical Advisory Committee (MAC) Meeting Minutes • QA/QIC/MAC Membership • QA/QIC/MAC Attendance Records	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	f. Mechanisms to assess the quality and appropriateness of the care provided to enrollees with special health care needs.			
1.5	The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The remedial/corrective action procedures specifically include: a. Performance thresholds to identify when actual or potential problems may exist that require remedial/corrective action. b. The individual(s) or department(s) responsible for making the final determinations regarding quality problems. c. The specific actions to be taken. d. The provision of feedback to the	The QA Plan specifies the process for identifying problems and taking appropriate corrective actions. Documentation must be provided to ensure that policies and procedures are in place that support the process and address all components of this element. This would include the identification, development, implementation, and monitoring of CAPs.	• QA Plan • Policies & Procedures • Data Analysis • Provider Feedback • CAPs	HCQIS II.E.1-7

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	appropriate health professionals, providers, and staff (as appropriate). e. The schedule and accountability for implementing corrective actions. f. The approach to modifying the corrective action if improvements do not occur. g. The procedures for terminating health professionals, providers, or staff (as appropriate).			
1.6 Deleted in MY 2017.				
1.7	The QA Plan incorporates written guidelines for evaluation of the status of QAP activities and the continuity and effectiveness of the QAP. a. The MCO reviews the status of QAP activities against the QA Work Plan on a quarterly basis. b. There is evidence that QA activities are assessed to determine if they have contributed	The QA Plan describes the method to be used to assure that the QAP is routinely reviewed to assess its scope and content. Documentation must be provided to substantiate that QA activities have resulted in improvements to care. And if not, what is being done to address areas of opportunity for improvement. QOC study data, analysis, reports and findings may support these improvements.	• QA Plan • Policies and Procedures • QAC Meeting Minutes • QOC Studies • QAP Annual Report	42 CFR §438.330(e)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	to improvements in the care and services delivered to enrollees.			
1.8	*A comprehensive annual written report on the QAP is completed. The annual report on the QAP must include:* *a. QA studies and other activities undertaken, results, and subsequent actions.* *b. Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results.* *c. Analysis of aggregate data on utilization and quality of services rendered.* *d. Demonstrated improvements in quality.* *e. Areas of deficiency.* *f. Recommendations for improvement to be included in the subsequent year's QA Work Plan.* *g. An evaluation of the overall effectiveness of the QAP.*	The annual report on the QAP must include all required components. **Note:** Element 2.1 requires this report to be reviewed and approved by the governing body to assess the QAP's continuity, effectiveness, and current acceptability.	• Annual QAP Evaluation Report • QAC Meeting Minutes • Governing Body Meeting Minutes	42 CFR §438.330(e) **NCQA: QI 1 Element C and D**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
1.9	The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.	The organizational chart must be comprehensive, indicating all appropriate positions and their relationships to one another.	• QAP Organizational Chart	42 CFR §438.330
1.10	The MCO must have a Disaster Recovery Plan that is updated on an annual basis.	The MCO and its subcontractor(s) shall have robust contingency and disaster recovery plans in place to ensure that the services provided will be maintained in the event of disruption to the MCO/subcontractor's operations (including, but not limited to, disruption to information technology systems), however caused.	• Disaster Recovery Plan • Evidence that subcontractor disaster recovery plans are in place.	COMAR 10.67.04.15(I)
2.0	**Accountability to the Governing Body – The governing body of the MCO is the BOD or, where the Board's participation with the QI issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care.**			
2.1	There is documentation that the governing body has oversight of the QAP and approves the annual QA Plan/Description and QA Work Plan.	The governing body is the BOD or the designated entity of senior management that has accountability and oversight of the operations of the MCO, including but not limited to the QAP. The QA Plan/Description must specify that the governing body has oversight of the QAP. The governing body meeting minutes must reflect review and approval of the annual QA Plan/Description and the annual QA Work Plan.	• QA Plan • MCO Organizational Chart • QA Organizational Chart • Governing Body Meeting Minutes	HCQIS III.A
2.2	The governing body formally designates an accountable	Documentation must be provided to indicate what committee or body the	• Governing Body Meeting Minutes	HCQIS III.B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	entity or entities within the organization to provide oversight of QA, or has formally decided to provide oversight as a committee.	governing body has designated as the entity accountable for oversight of QA activities. **Note:** When the BOD or the designated entity of senior management does not choose to provide direct oversight of the day-to-day operations of the QAP, it must formally designate in writing a committee or other entity to provide such oversight. For example, this may be the MCO's Quality Committee. However, the governing body must continue to perform all of the responsibilities noted in Standard 2.0.	• QA Plan • QAC Meeting Minutes • QA Organizational Chart	
2.3	The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.	There must be evidence that the governing body receives written reports from the QAC. Reporting to the governing body should occur according to the timeframes documented in the QA Plan (e.g., monthly, quarterly, etc.).	• Governing Body Meeting Minutes • QA Plan	HCQIS III.C
2.4	The governing body formally reviews, at least annually, a written report on the QAP Evaluation.	There must be evidence in the governing body meeting minutes that this document was reviewed and approved by the governing body.	• QAP Annual Evaluation Report • Governing Body Meeting Minutes	HCQIS III.D
2.5	The governing body takes action when appropriate and directs that the operational QAP be modified to accommodate review of findings and issues of concern within the MCO.	The governing body receives regular written reports from the QAP delineating actions taken and improvements made (Element 2.3). As a result, the governing body takes action and provides follow-up when appropriate. These activities are documented in the minutes of the	• QA Plan • Governing Body Meeting Minutes • QAC Meeting Minutes	HCQIS III.E

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		meetings in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to the QAP.		
2.6 Deleted in MY 2019.				
2.7	The governing body is active in UM activities. The governing body meeting minutes reflect ongoing reporting of: a. UM activities and findings, and b. Evaluation of UM progress.	The UM Plan provides a clear definition of the overall authority and responsibility of the governing body.	• Governing Body Meeting Minutes • UR Plan	HCQIS XIII
3.0	**Oversight of Delegated Entities and Subcontractors – The MCO remains accountable for all functions, even if certain functions are delegated to other entities.**			
3.1	The MCO must ensure that delegates have detailed agreements and are notified of the grievance and appeal system. a. The MCO must ensure that there is a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO.	Delegates are subcontractors that administer a critical benefit on behalf of the MCO that impacts enrollees directly (e.g., vision, claims, UM, pharmacy). Subcontractors are individuals or entities that have a contract with an MCO that relate directly or indirectly to the performance of the MOC's obligations under its contract with the state related to Medicaid (e.g., contractors providing outreach services, call center activities, or mobile laboratory vendors). Vendors are subcontractors that administer a function that does not	• Delegation Contract • Delegation Policies & Procedures	HCQIS VIIL A COMAR 10.67.04.17.A3

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. The MCO must provide evidence of informing delegates and subcontractors of the grievance and appeal system.	directly impact enrollees services or benefits (e.g. mail room, print services, and janitorial services). The contract for delegated activities contains all items listed in component a. The MCO must provide evidence that it has provided information about the grievance and appeal system to all delegates and subcontractors. For new delegates, evidence must be provided at the time that they entered into a contract with the MCO. For existing delegates, the MCO must provide evidence of an amendment to the agreement with the grievance and appeal system information or documentation it has shared with the delegate, and the delegate's acknowledgement of receipt. Since Adult dental is an optional service, do not include any dental vendors in reviewing any delegation standards. The only delegates required for standard 3 are those who are delegated UM, claims, and/or appeals and grievances for mandatory services, such as vision, drug, radiology, PT.		
3.2	The MCO has written procedures for monitoring and evaluating the implementation	The MCO has policies and procedures in place to monitor and evaluate the	• Delegation Contract • Delegation Policies & Procedures	HCQIS VIIL B COMAR 10.67.04.17.D

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	of the delegated functions and for verifying the quality of care being provided.	delegated functions and for verifying the care provided.	• Documentation of Monitoring Activities	
3.3	There is evidence of continuous and ongoing evaluation of delegated activities, including: a. Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc. b. Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. c. Review and approval of claims payment activities at least semi-annually, where applicable. d. Review and approval of the delegated entities' UM plan, which must include evidence of	There is evidence that an appropriate committee or body within the MCO makes process improvement decisions and acts upon the conclusions drawn from delegated entity monitoring according to the MCO's internal policies and procedures and/or the terms set forth in the delegate's contract. The MCO must provide evidence of items a. through e.	• Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities • Delegation Committee Meeting Minutes • Delegated Entities' Complaints, Grievances, and Appeals Reports, where applicable • Delegated Entities' Claims Payment Monitoring Reports, where applicable • Delegated Entities' Utilization Activity Reports, where applicable	HCQIS VI.C 42 CFR §438.230 (a & b) COMAR 10.67.04.17D COMAR 31.10.11 COMAR 31.10.23.01 Ins. Art. §15-1004 Ins. Art. §15-1005

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	review and approval of UM criteria by the delegated entity, where applicable. e. Review and approval of overutilization and underutilization reports, at least semi-annually, where applicable.			
3.4	The MCO has written policies and procedures for subcontractor termination that impacts the MCO's operations, services, or enrollees.	When the MCO terminates a subcontract, the MCO shall provide the Department with written notice regarding the termination that complies with the requirements of COMAR 10.67.04.17B(5).	• Subcontractor Policies and Procedures • Subcontractor Termination Notices	COMAR 10.67.04.65.17B(5)
4.0	**Credentialing and Recredentialing – The QAP contains all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services.** **NOTE**: As of 10/1/21, the compliance threshold changed from 100% to 95% for credentialing and recredentialing timeliness requirements.			
4.1	The MCO has written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. *a. The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial*	The MCO must have a comprehensive written Credentialing Plan and/or policies and procedures outlined in the QA Plan that describe the process for credentialing and recredentialing. The Credentialing Plan must designate the peer review body that has the authority to make recommendations regarding credentialing decisions and must identify the practitioners who fall under its authority.	• Credentialing Plan • Credentialing Process in QA Plan • Governing Body Meeting Minutes • Credentialing Policies & Procedures	HCQIS IX A-D Ins. Art. §15-112 (a)(4)(ii)(9) Ins. Art. §15-112 (d) COMAR 10.67.04.02M COMAR 10.67.04.17 **42 CFR §438.214** **NCQA:** **CR 1 Element A-B** **CR 2 Element A**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	credentialing and subsequent recredentialing process. b. *The Credentialing Plan designates a CC or other peer review body that makes recommendations regarding credentialing decisions.* c. *The Credentialing Plan must identify the practitioners who fall under its scope of authority and action.* d. The Credentialing Plan must include policies and procedures for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d).	Within 30 days of receipt of a completed application, the MCO shall send to the provider at the address listed in the application written notice of the MCO's: • Intent to continue to process the provider's application to obtain necessary credentialing information. • Rejection of the provider for participation in the MCO's provider panel. If the MCO provides notice to the provider of its intent to continue to process the provider's application, the MCO, within 120 days after the date the notice is provided, shall: • Accept or reject the provider for participation on the MCO's provider panel. • Send written notice of the acceptance or rejection to the provider at the address on the application. After the MCO receives the completed application, the MCO is subject to the aforementioned timeframes for completed application processing.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		When an "online credentialing system" is utilized by the MCO the following applies: • The MCO is required to track the date of the application i.e. query the online credentialing system so that dates of credentialing can be calculated. • The "10-Day Letter" is not applicable since the entire application must be completed prior to exiting the application. • The "30-Day Letter" still applies with the above mentioned timeframes. If an MCO does not accept applications through an "online credentialing system", notice shall be given to the provider at the address listed in the application within 10 days after the date the application is received that the application is complete.		
4.2	There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. Documentation includes: a. Written policies and procedures for the	There are policies and procedures in place for the suspension, reduction, or termination of practitioner privileges. There is evidence that these policies and procedures have been implemented. The policies and procedures must identify the mechanism for reporting serious quality deficiencies, resulting in	• Credentialing Plan • Recredentialing Plan • Credentialing Policies & Procedures • Provider Appeal Policy & Procedure • Provider Appeals Files	HCQIS IX H-J

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	suspension, reduction, or termination of practitioner privileges. b. A documented process for, and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner. c. Deleted in MY 2019.	suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place.	• Facility Site Reviews (completed forms/files)	
4.3	*If the MCO delegates credentialing/ recredentialing activities, the following must be present:* *a. A written description of the delegated activities.* *b. A description of the delegate's accountability for designated activities.* c. *Evidence that the delegate accomplished the credentialing activities.*	The contract for delegated services includes a description of the delegated activities and the delegate's accountability for designated activities. The delegate provides reports to the MCO according to the contract requirements.	• Delegation Contract • Delegate Progress Reports to the MCO • MCO Monitoring/ Auditing Documents	HCQIS IX G **42 CFR §438.214** **NCQA:** **CR 8 Element A-D**
4.4	The credentialing process must be ongoing and current. At a	The credentialing plan and policies and procedures require, at a minimum, that the MCO obtain the information required	• Credentialing Plan • Credentialing Policies & Procedures	HCQIS IX E.1-7 42 CFR §438.214 (c-e)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	minimum, the credentialing process must include: a. A review of a current valid license to practice. b. A review of a valid DEA or CDS certificate, if applicable. c. A review of graduation from medical/ancillary (NP, PT, OT, SLP etc.) school and completed residency or post-graduate training, as applicable. d. A review of work history. e. A review of a professional and liability claims history. f. A review of current adequate malpractice insurance according to the MCO's policy. g. Deleted as of the MY 2017 SPR. h. A review of EPSDT certification. i. Adherence to the timeframes set forth in the MCO's policies	in components a-k for the credentialing process. **Note:** (h) is applicable to those PCPs who deliver preventive health care services to enrollees less than 21 years of age. The reviewer will assess the MCO's methodology for verifying whether PCPs in the MCO's network that see patients under age 21 are EPSDT certified.	• Sample Credentialing Records • Written correspondence to providers • Screenshots from ePREP showing validation of provider enrollment in Medicaid • Provider agreement (for new contracts)	COMAR 10.67.04.02N Ins. Art. §15-112 (a)(4)(ii)(9) Ins. Art. §15-112 (d) MCO Transmittal PT 10-19

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	regarding credentialing date requirements. j. Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d). k. Verification that the provider is actively enrolled in Medicaid at the time of credentialing.			
4.5	*The MCO should request and review information from recognized monitoring organizations regarding practitioners. The evidence must include:* *a. Any revocation or suspension of a State license or a DEA/BNDD number.* *b. Any curtailment or suspension of medical staff privileges (other*	The credentialing plan and policies and procedures require that the MCO request information required in components a-d from recognized monitoring organizations.	• Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Credentialing Committee Meeting Minutes	HCQIS IX E.8-12 **42 CFR §438.214 (d)** **NCQA:** **CR 1 Element A** **CR 3 Element B** **CR 5 Element A**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	than for incomplete medical records). *c. Any sanctions imposed by Medicare and/or Medicaid.* d. *Information about the practitioner from the NPDB and the MBP.*			
4.6	*The credentialing application includes the following:* *a. The use of illegal drugs.* *b. Any history of loss of license.* *c. Any history of loss or limitation of privileges or disciplinary activity.* d. *Attestation to the correctness and completeness of the application.*	The credentialing plan and policies and procedures describe the application process. This process includes the requirement that the applicant must provide a statement that includes components a-d. There must be evidence in the credentialing files that this statement is completed. Type of credentialing application must be reviewed and in compliance with MIA regulatory requirements noted.	• Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Completed Application • Completed Uniform Credentialing Form	HCQIS IX E.13.a-e COMAR 31.10.26.03 **42 CFR §438.214** **NCQA:** **CR 3 Element C**
4.7	There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the ADA and the MCO's standards.	The credentialing plan and policies and procedures must require an initial visit to each potential primary care practitioner's office. There must be documentation that a review of the site includes both an evaluation of ADA compliance and medical record keeping, and that these practices are in conformance with the MCO's standards. Such standards should consider:	• Credentialing Plan • Credentialing Policies & Procedures • Site Visit Tool • Sample Completed Site Visit Tools • Sample Credentialing Records • Applicable Reports of On-site Visits	HCQIS IX E.14 COMAR 10.67.04.02 H (1) 28 CFR Chapter 1, Part 36

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Handicapped designated parking clearly marked and close to the entrance. • Ramps for wheelchair access. • Door openings to the practice and restroom and hallways should facilitate access for disabled individuals. • Elevator availability for practices above ground level.	• Credentialing Committee Meeting Minutes	
4.8	There is evidence that recredentialing is performed at least every three years and: *a. Includes a review of information from the NPDB.* b. Deleted in MY 2019. c. Includes all items contained in element 4.4 a–h, except 4.4 d (work history). *d. Includes all items contained in 4.6 a–d.* *e. Meets the timeframes set forth in the MCO's policies regarding recredentialing decision date requirements.* f. *Ensures the MCO is verifying that the provider is actively*	The credentialing plan and policies and procedures indicate that recredentialing is performed at least every three years. The recredentialing process requires a review of components contained in a-f. There is evidence in individual provider credentialing files that this has occurred. This information is used to decide whether or not to renew the participating physician agreement.	• Credentialing Plan • Recredentialing Policies & Procedures • Sample Credentialing Records • Credentialing Committee Meeting Minutes	HCQIS IX F.1-2 COMAR 10.67.04.02N Ins. Art. §15-112 (d) MCO Transmittal PT-10-19 **42 CFR §438.214** **NCQA:** **CR 1 Elements A - B** **CR 3 Elements A - C** **CR 4 Element A**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	enrolled in Medicaid at the time of recredentialing.			
4.9	There is evidence that the recredentialing process includes a review of the following: *a. Enrollee complaints/grievances.* *b. Results of quality reviews.* c. Deleted in MY 2018. d. Office site compliance with ADA standards, if applicable.	There is evidence in provider recredentialing records that complaints, grievances, and the results of quality reviews were reviewed prior to the MCO's recredentialing of providers. There is a process in place to re-assess provider site ADA compliance when: • Provider relocates to a site that has not previously been evaluated and approved as being ADA compliant, or • There is evidence of ADA non-compliance issues with a particular site of care delivery.	• Credentialing Plan • Recredentialing Policies & Procedures • Sample Recredentialing Records	HCQIS IX F.3 a – e **42 CFR §438.214** **NCQA:** **CR 5 Element A**
4.10	The MCO must have policies and procedures regarding the selection and retention of providers. a. The MCO must have written policies and procedures for selection and recruitment of providers in the HealthChoice Program. b. The MCO must have written policies and	Policies and procedures should be directed at ensuring that recipient choice is enhanced by providers participating in multiple MCOs. Also, ensuring that providers are retained within the Medicaid network.	• Credentialing Plan • Credentialing Policies and Procedures	42 CFR §438.214 42 CFR §438.207

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	procedures for the retention of providers in the HealthChoice Program.			
4.11	The MCO must ensure that enrollees' parents/guardians are notified if they have chosen for their child to be treated by a non-EPSDT certified PCP. a. The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired. b. The MCO must provide evidence of notification to parents/guardians that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a	The MCO must include in the notification: • An explanation of the EPSDT preventive screening services to which an enrollee is entitled according to the EPSDT periodicity schedule (only a summary is necessary if the periodicity schedule was included in the MCO's welcome packet); • Importance of accessing the EPSDT preventive screening services; and • Process for requesting a change to an EPSDT-certified PCP to obtain preventive screening services.	• Policies and Procedures • Letters to Parents/Guardians	COMAR 10.67.05.05

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	certified EPSDT PCP if desired.			
4.12	The MCO must have written policies and procedures for notifying the Department of provider terminations.	MCO must be compliant with the following COMAR 10.67.0410.67.04.17B(4) requirements for notifying and reporting provider terminations: a. When an MCO and provider terminate their contract the MCO shall provide the Department with a written notice regarding the termination. b. If the MCO is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided 90 days before the effective date of the termination. c. If the provider is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided within 15 days after the MCO receives the notice from the terminating provider. d. If 50 to 99 enrollees are affected, the notice shall contain the: i. Date of termination; ii. Name or names of providers or subcontractors terminating; iii. Number of enrollees affected; and	• Network Provider Termination Policies and Procedures • Network Provider Termination Notices to MDH • Examples of completed MDH required forms • Evidence of terminated provider notices to enrollees.	COMAR 10.67.04.17B 42 CFR § 438.10

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		iv. MCO's plan for transitioning enrollees to other providers. e. If more than 99 enrollees are affected, the MCO shall provide the Department with a Department-approved termination survey. f. In determining the number of enrollees affected under §B(4)(d) and (e) of this regulation, the MCO shall consider: i. For PCPs, the number of enrollees assigned to the PCP; and ii. For all other providers, the number of enrollees who are in active treatment or who have had an encounter with the provider in the previous 12 months. Additionally, per 42 CFR § 438.10, the MCO must make a good faith effort to give written notice of termination of contracted providers to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The MCO must provide notice to enrollees by the later of 30 calendar days prior to the effective		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		date of the termination, or 15 calendar days after receipt of issuance of the termination notice.		
5.0	**Enrollee Rights – The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.** **NOTE**: As of 10/1/21, the compliance threshold changed from 100% to 95% for grievance timeliness requirements.			
5.1	The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04. a. There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09. b. The system requires documentation of the substance of the grievances and steps taken. c. The system ensures that the resolution of a grievance is documented according to policy and procedure. d. The policy and procedure describes the process for aggregation	Timeframes for resolving grievances in the policy and procedure must be in accordance with the following: • Emergency medically related grievances not > 24 hours. • Non-emergency medically related grievances not > 5 days. • Administrative grievances not > 30 days. The policy and procedures must describe what types of information will be collected when grievances are recorded and processed. The MCO must have a grievance form. The policies and procedures must include the process stating how the form is used and how an enrollee can get assistance from the MCO in completing the form. The MCO must have a documented procedure for written notification of the MCO's determination:	• Grievance Policies & Procedures • Grievance Form • Grievance Logs • Grievance Reports • Grievances Files • QAC/QIC Meeting Minutes • CAB Meeting Minutes • Quarterly Complaints/Grievances • Appeal Reports • Sample Grievance Letters to Enrollees	HCQIS X.E.1-5 COMAR 10.67.09.02 COMAR 10.67.09.04 COMAR 10.67.09.05 42 CFR §438.402 (a & b) 42 CFR §438.406 (a & b) 42 CFR §438.408 (a-f)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning. e. Deleted in MY 2018. f. There is complete documentation of the substance of the grievance, steps taken to resolve, and the resolution in the case record. g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances. h. The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy.	• To the enrollee who filed the grievance • To those individuals and entities required to be notified of the grievance • To the Department's complaint unit for complaints referred to the MCO by the Department's complaint unit or ombudsman program If closing the grievance case due to not being able to contact the enrollee via phone, the MCO must notify the enrollee in writing that their grievance is being closed. The policies and procedures must describe the complete process from the registration through resolution of grievances. The policies and procedures must allow participation by the provider or an ombudsman, if appropriate, and must ensure the participation of individuals within the MCO who have authority to require corrective action. A sample of selected grievances is reviewed to assure that the process is complete and is being followed. The policies and procedures describe the		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	i. Written resolution letters describe the grievance and the resolution in easy to understand language.	process to be used for data collection and analysis. This must include timeframes for collection and reporting. (e.g., collected and analyzed quarterly, reported to the QAC quarterly). The policies and procedures must include the notification of results to the provider and the QACs as required by COMAR. If problems are identified, the reviewer will track the progress of problem resolution.		
5.2	*The MCO shall provide access to health care services and information in a manner consistent with the formatting and special access requirements of COMAR 10.67.05.01C.*	COMAR 10.67.05.01C states that all written materials must: • Use language and a format that is easily understood; • Be available in alternative formats and through the provision of auxiliary aids and services • Be available in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency. Enrollee information including, but not limited to, enrollee handbook, newsletters, and health education materials are written at the appropriate	• Enrollee Informational Materials	COMAR 10.67.04.02H COMAR 10.67.05.01 42 CFR §438.10 42 CFR §438.206 (c)(2) **NCQA: MED 12**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		reading comprehension level for the Medicaid population. The SMOG formula or the Flesch-Kincaid Grade Level Index will be applied to determine readability.		
5.3	The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO: a. *Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data.* b. Ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO. c. Must hold confidential all information obtained by its personnel about enrollees related to their care and shall not	The policies and procedures address all required components described in a-e. The MCO must provide evidence that these policies and procedures have been implemented. The MCO must provide documentation to demonstrate that it ensures patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information.	• Medical Records Policies & Procedures • Confidentiality Policies & Procedures • Sample Provider Contracts • Sample Provider Site Visit Evaluation Tool • Credentialing Policies & Procedures • Tools Related to Assessing Confidentiality of Patient Medical Records • Sample of MCO Employee Confidentiality Statement • Signed MCO Employee Confidentiality Statements • Sample Vendor Contracts	HCQIS X.1 42 CFR §438.100 (d) 42 CFR §438.224 HIPAA Health-General §§ 4-301 **NCQA: MED 4 Elements A - C**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	divulge it without the enrollee's authorization unless: (1) it is required by law, (2) it is necessary to coordinate the patient's care, or (3) it is necessary in compelling circumstances to protect the health or safety of an individual. d. Must ensure that the release of any information in response to a court order is reported to the patient in a timely manner. e. May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.4	The MCO has written policies regarding the appropriate treatment of minors.	The MCO has a written policy addressing the appropriate treatment of minors. This policy must address the minor's right to receive treatment without parental consent in cases of sexual abuse, rape, family planning, and sexually transmitted diseases.	• Treatment of Minors Policy	HCQIS X.J Health General 20-102
5.5	As a result of the enrollee satisfaction surveys, the MCO: a. Identifies and investigates sources of dissatisfaction. b. Implements steps to follow up on the findings. c. Informs practitioners and providers of assessment results. d. Reevaluates the effects of b. above at least quarterly.	There is a process in place for identifying sources of dissatisfaction. The MCO must have mechanisms in place to identify problems, develop plans to address problems, and provide follow-up. There must be documentation (e.g. meeting minutes, CAPs) to demonstrate that policies and procedures are in place and are being followed. There is a mechanism in place to provide survey information to providers as a group, and to an individual provider(s) if warranted.	• Patient Satisfaction Evaluation Policies and Procedures • Patient Satisfaction Evaluation Tool • Patient Satisfaction Survey Data Analysis • Corrective Action Plans • Appropriate Committee Meeting Minutes	HCQIS X.K.3 a-c HCQIS X.K.4 42 CFR §438.206 (c)
5.6	The MCO has systems in place to assure that new enrollees receive required information within established timeframes. a. Policies and procedures are in place that address the content of new enrollee packets of information and specify	Policies and procedures address the content of new enrollee information packets and timeframes for receipt of the packets. At a minimum, new enrollee information packets contain: • Enrollee ID card • Enrollee handbook • Provider Directory	• Enrollee Handbook • Enrollee Notices • Sample New Enrollee Information Packet • New Enrollee Policies & Procedures • Committee Meeting Minutes • ID Card Fulfillment Reports	COMAR 10.67.05.02 COMAR 10.67.04.02.G (3) COMAR 10.67.02.02 Ins. Art. §15-140 42 CFR 438.10

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	the time timeframes for sending such information to the enrollee. b. Policies and procedures are in place for newborn enrollments, including issuance of the MCO's ID card. c. The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution. d. The MCO includes the Continuity of Health Care Notice in the new enrollee packet. e. The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.	The MCO uses State-developed model enrollee handbooks and notices. New enrollee information packets are provided to new enrollees within 10 calendar days of MDH's notification to the MCO of enrollment. The packet includes the Continuity of Health Care Notice that is required by § 15-140(f) of the Insurance Article. The MCO has written procedures that track and monitor timeliness of receipt of ID cards (including newborns). Such monitoring is analyzed and if timelines are not met, there is evidence of corrective action and evaluation of progress. Performance is reported through a committee or the MCO's administrative structure. There is a documented process for newborn enrollment that includes timeframes. The MCO has a documented internal mechanism for processing and follow-up on the Daily MCO Newborn Enrollment Report from the Department.	• ID Card Fulfillment Tracking and Trending Analysis	
5.7	The MCO must have an active Consumer Advisory Board (CAB).	An MCO shall establish a CAB to facilitate the receipt of input from enrollees. The CAB membership shall consist of enrollees	• Policies and Procedures • Committee Charter	COMAR 10.67.04.12

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. The MCO's CAB membership must reflect the special needs population requirements. b. The CAB must meet at least six times a year. c. The MCO must have a mechanism for tracking enrollee feedback from the meetings.	and enrollees' family members, guardians, or caregivers. It is to be comprised of no less than 1/3 representation from the MCO's special needs populations, or their representatives. Pursuant to regulation, the CAB shall annually report its activities and recommendations to the MDH. The CAB Annual Report will, at a minimum, include the following information: • CAB Charter or P&P • Mission/Vision Statement for the CAB • Goals for the CAB • Structure of and member composition of the CAB • Dates, times, and locations for each CAB meeting • Summary of topics/issues discussed • Enrollee feedback/concerns • Accomplishments/Resolutions • Opportunities for Improvement/Follow-up	• CAB Meeting Minutes • CAB Annual Summary	
5.8	The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights. *a. Materials distributed by the MCO to the enrollee*	The MCO shall notify enrollees of the following services and make them available free of charge to the enrollee:	• Enrollee Handbook • Provider Directory • Enrollee Information/ Material • Screen Shot of the MCO Website	45 CFR §92.101 42 CFR §438.10 COMAR 10.67.05.01 **NCQA:**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	will include a nondiscrimination notice and a language accessibility statement in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency of Maryland. b. Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page. c. Notices and Taglines must be posted in significant communications and publications. d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public. e. MCO's electronic information provided to enrollees must meet	1. Written materials in the prevalent non-English languages identified by the State; 2. Written materials in alternative formats; 3. Oral interpretation services in all non-English languages; and 4. Auxiliary aids and services, such as: a. Teletypewriter/Telecommunication Device for the Deaf (TTY/TTD); and b. American Sign Language. The MCO shall include taglines with its written materials that: 1. Explain the availability of written translation or oral interpretation to understand the information provided; and 2. Provide the toll-free and TTY/TTD telephone number of the MCO's customer service unit. MCOs must take steps to notify enrollees and prospective enrollees about their rights under Section 1557 of the ACA. Specifically, MCOs must post a nondiscrimination Notice in English and in at least the top 15 non-English languages spoken by the individuals with limited	• Pictures of Notices and Taglines posted at enrollee events • Websites • Online Directories	**MED 12 Element D-H** **MED 13 Element B-C** **NET 5 Element J** **ME 7 A-B** **ME 2 Element A-B** **UM 3 Element A**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	requirements set forth in COMAR.	English proficiency of the relevant State or States. MCOs may combine the content of the Notice with other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Small-size material (trifold brochures) must have statements and taglines in at least the top 2 non-English languages. MCOs may use the Sample "Discrimination is Against the Law" statement to meet this requirement. The Notice and Taglines must be posted in a conspicuously-visible font size in a conspicuous location of covered entity websites accessible from the home page, in written materials critical to obtaining services, in significant communications and significant publications, and, where appropriate, in conspicuous physical locations where the entity interacts with the public. This applies to, but is not limited to: Marketing materials, enrollee communications related to health coverage, benefits, and prescription drug coverage, provider/pharmacy directories, formularies, enrollment forms, summary of benefits, and appeal and grievance notices.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		COMAR 10.67.05.01.D states that if the MCO provides enrollee information electronically (provider directory, EOB, enrollee handbook), the following requirements must be met: 1. The format is readily accessible; 2. The information is placed in a location on the MCO's website that is prominent and readily accessible; 3. The information is provided in an electronic form which can be electronically retained and printed; 4. The information is consistent with the content and language requirements of this section; 5. The enrollee is informed that the information is available in paper form without charge upon request; and 6. Should the enrollee request it, the MCO provides the information in paper form within 5 business days. MCOs should be prepared to provide evidence of materials referring enrollees to online information that advises them how to request printed material free of charge; evidence that the online information provided is downloadable and		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		printable; and information/reports that are uploaded to the MCO website should be 508c accessible.		
5.9	The MCO must maintain written policies and procedures for advance directives. a. The MCO must educate staff regarding advance directives policies and procedures. b. The MCO must provide adult enrollees with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618). c. The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.	The MCO must have written policies and procedures for advance directives. Advance directives are written instructions, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. MCOs must educate staff on advance directives. Staff should include clinical staff, case management, enrollee services, and outreach staff that would interact with enrollees and advance directives. Additionally, network management staff should be educated since they have contact with the provider network. MCO must provide examples of completed staff training such as signed attestations and rosters of staff showing dates of annual training completed.	• Policies and Procedures • Enrollee Handbook • Enrollee Notices • Staff Notices • Evidence of staff training	42 CFR §422.128 42 CFR §438.3(j)(1) 42 CFR §489.100 Hlth Gen Art §5-601-618 COMAR 10.67.04.02
5.10	MCO must comply with the marketing requirements of COMAR 10.67.04.23.	The MCO's marketing policies and procedures complies with the requirements of COMAR 10.67.04.23.	• Marketing Policies and Procedures	42 CFR §438.104 COMAR 10.67.04.23

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. An MCO may not have face-to-face contact with a recipient who is not an enrollee of the MCO unless contact is authorized by the Department or contact is initiated by the recipient. b. An MCO cannot engage in marketing activities without prior approval of the Department. c. Deleted in MY 2018.	An MCO may not have face-to-face or telephone contact with a recipient, or otherwise solicit a recipient who is not an enrollee of the MCO, unless authorized by the Department or the recipient initiates the contact. Subject to prior approval by the Department, an MCO may engage in marketing activities designed to make recipients aware of their availability, as well as any special services they offer. These marketing activities may involve campaigns using but not limited to: Television; Radio; Newspaper; Informational booths at public events; Billboards and other public displays; Addressee-blind informational mailings, but only when mailed to the MCO's entire service area; Magazines; Airborne marketing displays; or Public conveyances.	• Marketing Requests and Approvals from the Department	
5.11	The MCO has implemented policies and procedures to ensure that the MCO does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.	The MCO's has written policies and procedure to ensure: a. that it does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:	• Policies and Procedures • Provider manual • Enrollee handbook	42 CFR §438.102

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		i. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. ii. Any information the enrollee needs to decide among all relevant treatment options. iii. The risks, benefits, and consequences of treatment or non-treatment. iv. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. b. that if the MCO objects to providing, reimbursing for, or providing coverage of a counseling of referral service on moral or religious grounds for the requirements in 5.11, section a, then the MCO must furnish information about the services it		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		does not cover to MDH consistent with the requirements in § 438.102 (b)(1)(i)(A)(B) c. enrollees are informed how they can obtain information from the State to access the service(s) excluded in 5.11, section a.		
6.0	**Availability and Accessibility – The MCO has established measurable standards for access and availability.**			
6.1	The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services. *a. The MCO has developed and disseminated written access and availability standards.* b. The MCO has processes in place to monitor performance against its access and availability standards at least quarterly. c. The MCO has established policies and procedures for the operations of its customer/enrollee	The MCO has established access and availability standards that comply with HCQIS and COMAR requirements and demonstrates that these standards have been disseminated to providers. These standards must include: • routine appointments • urgent appointments • emergency care/services • telephone appointments • advice • enrollee service lines • outreach • clinical and pharmacy access The MCO must monitor against the above standards. The following should be included to ensure compliance with standards:	• Access and Availability Standards • Access and Availability Policies & Procedures • Provider Manual • Newsletters • Monitoring and Evaluation Processes • Committee Meeting Minutes • Monitoring Reports • Performance Trends • Evidence of Quarterly Monitoring of Access and Availability Standards	HCQIS XI COMAR 10.67.05.03-08 42 CFR §438.206(c)(1) 42 CFR §438.210 COMAR 10.67.05.07.B(2) 42 CFR §438.68(c)(1)(vii) 42 CFR §438.68(c)(1)(viii) 42 CFR §438.206(c)(2) 42 CFR §438.206(c)(3) CMS's Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	services and has developed standards/indicators to monitor, measure, and report on its performance. d. The MCO has documented a review of the Enrollee Services Call Center performance.	• Quarterly calls to be conducted to a sample of providers to ensure compliance with all access and availability standards including but not limited to the validation of provider directory information, compliance with appointment availability, and after hour requirements. • Quarterly survey results should be reviewed, reported, and trended by the MCO. • Providers failing the survey for not meeting access standards will be provided education and included in a survey within the next 6th months to ensure compliance. If the provider fails the following survey, they will be placed on a Corrective Action Plan by the MCO. The MCO has also established policies and procedures for the operations of its internal customer/enrollee services. Performance standards have been developed, such as telephone answering time, wait time, abandoned call rates, and timeframes for response to enrollees' inquiries. Such standards are measured for performance and identification of issues that affect enrollee services and are		Network Adequacy and Service Availability https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf **NCQA:** **NET 1 Element B-C**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		reported through established channels, such as committees.		
6.2	The MCO has a list of providers that are currently accepting new enrollees. a. The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population. b. At the time of enrollment, enrollees are provided with information about the MCO's providers. *c. The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities.* *d. The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.*	The MCO must conduct annual geo mapping to calculate average distance to ensure compliance with geographic access requirements. Specific network capacity and geographic access requirements are defined in COMAR 10.67.05.05.B and COMAR 10.67.05.06.B-D. Some of these are listed below: • Enrollee to physician ratio for local access area = 200:1 • Travel distance (urban) - 10 mile radius • Travel distance (suburban) – within 20 mile radius • Travel distance (rural) - within 30-mile radius. Annually compare percentages of network providers who communicate in non-English languages most common among enrollees. As defined in COMAR, the MCO must make available a listing of individual practitioners who are the MCO's primary and specialty care providers. Information must include:	• Provider Directory • Provider Manual • New Enrollee Packet • New Enrollee Orientation Materials • Availability & Access Standards • Access and Availability Policies & Procedures • Monitoring Methodology • Monitoring Reports • Committee Meeting Minutes • Top Ten Diagnoses for all Care Settings • Enrollee Complaint Reports • Documentation of any CAPs • Online Provider Directories • Provider Directory Machine Readable Format and File • Link to Online Provider Directory • Screenshots of Online Provider Directory	HCQIS XI COMAR 10.67.05.02C COMAR 10.67.05.05B COMAR 10.67.05.06B-D COMAR 10.67.05.01A (3) 42 CFR §438.10 (f) (2-6) 42 CFR §438.206 (b) 42 CFR §438.207 42 CFR §438.10 (h) (1) (i-viii) 42 CFR §438.236 **NCQA:** **NET 1 Elements A-C**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Name as well as any group affiliation • Street address • Telephone number • Website URL, as appropriate • Specialty, as appropriate • An indication of whether or not the provider is accepting new Medicaid patients • The provider's cultural and linguistic capabilities (including American Sign Language) • An indication of whether the provider has completed cultural competence training • An indication of whether or not access to the provider is otherwise limited (e.g. by age of patient or number of enrollees the provider will serve) • An indication of whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam rooms(s) and equipment The MCO must perform a quarterly review of the number of participating providers in the plan by type, geographic location, specialty, and acceptance of new patients.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		The directory must also include: ● A listing of the MCO's hospital providers, of both inpatient and outpatient services, in the enrollee's county with their addresses and services provided. Provider directories must be made available on the MCO's website in a machine-readable file and format. Hardcopy provider directory updates must be made quarterly if the MCO has a mobile-enabled electronic provider directory. Hardcopy provider directory updates must be made monthly if the MCO does not have a mobile-enabled electronic provider directory. Electronic provider directories must be updated no later than 30 calendar days after the MCO receives updated provider information. The MCO has a methodology in place to assess and monitor the network needs of its Medicaid population. The methodology substantiates how the MCO determines that it has sufficient numbers and the types of specialists, as well as PCPs, within its network to meet the care and service needs		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		of its population in all care settings. The methodology includes: ● A process of monitoring that has the ability to identify problem areas that are reported through the MCO's established structure. ● Follow-up activities and progress towards resolution that are evident. ● Direct access to specialists. Each MCO must have a mechanism in place to allow enrollees with special health care needs who have been determined to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the enrollee's condition and identified needs. This is determined through an assessment by appropriate health care professionals and can be provided for example, through a standing referral or an approved number of visits. "An MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its enrollees, including, but not limited to, the delivery of services and information to enrollees: In a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it."		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
6.3	The MCO has implemented policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services. a. Deleted in MY 2019. b. Deleted in MY 2019. c. Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	Policies and procedures must be in place and address trending and analysis of wellness services. The analysis must be included in the QAP with CAPs developed as appropriate. Documentation must be provided to substantiate that timeframes are adhered to and that tracking procedures are in place. The MCO has a written procedure/methodology that tracks and monitors timeliness of Initial Health Assessments (IHAs). Such monitoring is analyzed and if un-timeliness is identified, there is evidence of corrective action and evaluation of progress. Performance is reported through a committee or the MCO's administrative structure.	• Scheduling of IHA Policies & Procedures • IHA completion analysis • QAP	HCQIS XI COMAR 10.67.03.06 COMAR 10.67.05.03 COMAR 10.67.05.07
6.4	The MCO has implemented policies and procedures to ensure coverage and payment of emergency services and post-stabilization care services for enrollees.	Policies and procedures must be in place to ensure payment is not denied for emergency and post-stabilization treatment obtained under the following circumstances: a. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes	• Availability & Access Standards • Access and Availability Policies & Procedures • Claims Payment Policies & Procedures • ED Policies & Procedures • Enrollee handbook • Provider manual	42 CFR §438.114 10.67.05.08B 10.67.06.28 10.67.04.20B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		specified in §438.114(a)(b)(c)(1)(i)(ii). b. A representative of the MCO instructs the enrollee to seek emergency services. c. Emergency services obtained outside of the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services. d. Regardless of whether the servicing provider has a contract with the MCO. Documentation must be provided to indicate that the MCO does not: a. Limit what constitutes an emergency medical condition. b. Refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the enrollee's primary care provider or MCO of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. c. Hold liable an enrollee who has an emergency medical condition for		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. d. Bind the determination of the attending emergency physician, or the provider actually treating the enrollee, for who is responsible in determining when the enrollee is sufficiently stabilized for transfer or discharge as responsible for coverage and payment.		
7.0	**Utilization Review – The MCO has a comprehensive UM program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement.** **NOTE**: As of 10/1/21, the compliance threshold changed from 100% to 95% for preauthorization and appeal timeliness requirements.			
7.1	There is a comprehensive written UR Plan. *a. This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.* *b. The scope of the UR Plan includes a review of all*	The UR Plan is comprehensive and addresses components a-c. Component 7.1(c) requires that the MCO documentation reflect that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	• UR Plan • UR Meeting Minutes • Governing Body Meeting Minutes	HCQIS XIII A 42 CFR §438.236 **NCQA:** **UM 1 Element A** **UM 2 Element A**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	covered services in all settings, admissions in all settings, and collateral and ancillary services. c. There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.			
7.2	The UR Plan specifies criteria for UR/UM decisions. *a. The criteria used to make UR/UM decisions must be based on acceptable medical practice.* *b. The UR Plan must describe the mechanism or process for the periodic updating of the criteria.* *c. The UR Plan must describe the involvement of participating providers*	There is evidence that UR criteria are based on acceptable medical practice. The UR Plan must describe the process for reviewing and updating the criteria and for involving providers. There must be evidence that criteria are reviewed and updated per the policies and procedures. The MCO must use an appropriate mechanism to assess the consistency with which physician and non-physician reviewers apply medical necessity criteria.	• UR Plan • Documentation of review/approval of new medical necessity criteria/updates • Policies & Procedures for Criteria Review/Revision, annual IRR assessment, and annual training on UM criteria • UR Committee Meeting Minutes • Sign-in sheets, training logs, certificates of completion of annual	HCQIS XIII A COMAR 10.67.04.11 S 2 **42 CFR §438.210(a)** **NCQA:** **UM 1 Element A** **UM 2 Element A and C**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	in the review and updating of criteria. *d. There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures.* e. There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM criteria/guidelines. *f. There is evidence that the MCO evaluates the consistency with which all staff involved apply UR/UM criteria on at least an annual basis.*		training on UM criteria • Documentation of annual assessment of IRR among UM staff/physicians	
7.3	The written UR Plan has mechanisms in place to detect overutilization and underutilization of services. *a. Services provided must be reviewed for overutilization and underutilization.* b. UR reports must provide the ability to identify problems and take the	The UR Plan describes the process to be used for detecting overutilization and underutilization of services. UR reports and data analysis must be available and should demonstrate the ability to identify problems. There must be documentation to support that the MCO has developed, implemented, and provided follow-up of corrective actions for the identified issues.	• UR Plan • UR Policies & Procedures • Data Reports and Analysis • CAPs • UR Committee Meeting Minutes • Provider Profiles	HCQIS XIII 42 CFR §438.330 (b) **NCQA:** **MED 7 Element A**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	appropriate corrective action. c. Corrective measures implemented must be monitored.			
7.4	The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation. a. *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.* b. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate. c. Timeframes for preauthorization	MCO policies and procedures must be compliant with the requirements of COMAR 10.67.09.04. The MCO must demonstrate that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. For standard preauthorization requests, the MCO shall provide the preauthorization in a timely manner so as not to adversely affect the health of the enrollee and within 2 business days of receipt of necessary clinical information but not later than 14 calendar days from the date of the initial request. <u>If additional clinical information is required, it must be requested within 2 business days of receipt of the request.</u> For expedited authorization requests, the MCO shall make a preauthorization determination and provide notice in a	• UR Plan • UR Policies & Procedures • UR Organizational Charts • UM Position Descriptions • UM Staffing Plan • UR Committee Meeting Minutes • Delegate Reports to MCO • MCO Monitoring of Delegate Reports • TAT Compliance Reports	HCQIS XIII.C 1-7 COMAR 10.67.09.04 42 CFR §438.210 (c & d) 42 CFR §438.236 **<u>NCQA:</u>** **<u>UM 4 Element A-B, F</u>**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.	timely manner so as not to adversely affect the health of the enrollee and no later than 72 hours after receipt if the provider indicates or the MCO determines following the standard timeframe could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. For outpatient drug preauthorization decisions, the MCO shall approve, deny, or request additional information by telephone or other telecommunication device to the requesting provider within 24 hours of request. The enrollee, enrollee's representative, or the MCO may request an extension of the authorization timeframe of up to 14 calendar days. If the MCO extends the authorization timeframe, the MCO must provide evidence it notified enrollees in writing of the extension and the reason, as well as enrollees' right to file a grievance if they disagree with the MCO's decision. The state specified threshold for all preauthorization review decisions is 95%. A sample of preauthorization reviews must be reviewed for compliance with state specified timeliness by the MCO according to their policies (i.e., weekly,		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.5	Adverse determination letters include a description of how to file an appeal. a. All adverse determination letters are written in easy to understand language. b. Adverse determination letters include all required components.	There must be documented policies and procedures for appeals. Such policies and procedures must comply with the requirements stated in COMAR 10.67.09.04F. The required adverse determination letter components include: 1. Explanation of the requested care, treatment, or service. 2. Clear, full and complete factual explanation of the reasons for the denial, reduction or termination in understandable language. • Conclusive statements such as “services included under another procedure” and “not medically necessary” are not legally sufficient. 3. Use of the phrase “nationally recognized medical standards” is acceptable; however, the exact clinical guideline reference must be included. 4. Availability of a free copy of any guideline, code, or similar information MCO used to decide	• Enrollee Adverse Determination Letter Policies and Procedure • Sample Enrollee Adverse Determination Letters • Selected UR Cases	HCQIS XIII.C 1-7 COMAR 10.67.09.02 COMAR 10.67.09.04F 42 CFR §438.404 45 CFR §92.7 45 CFR §92.8 42 CFR §438.406

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		and the MCO contact number including TTY/TTD. 5. Description of any additional information MCO needs for reconsideration, if appropriate from enrollee and/or provider. 6. Statement of the availability and contact information of the MCO representative who made the decision if the enrollee's provider would like to contact him/her. 7. The enrollee's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO's action. This includes a copy of the enrollee's medical record, provided free of charge. 8. Direction to the enrollee to call the HealthChoice Help Line for assistance. 9. The enrollee may also appeal to the MCO directly by contacting the MCO (phone # or address) within 60 days from the date of the adverse determination notice. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals. 10. Explanation to the enrollee that if he/she is currently receiving		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		ongoing services that are being denied or reduced, he/she may be able to continue receiving these services during the appeal process by calling the MCO or the HealthChoice Help Line within 10 days from receipt of this letter. If the enrollee's appeal is denied, he/she may be required to pay for the cost of the services received during the appeal process. 11. Statement that the enrollee may represent self or use legal counsel, a relative, a friend, or other spokesperson. 12. There is evidence that the letter is copied to the requesting provider with copying the PCP optional. 13. A statement explaining the availability of the expedited review process, MCO phone number and timeframe for making a determination. 14. A statement that the enrollee or their representative may request an extension of the timeframe for appeals by up to 14 calendar days. 15. A statement of availability of the letter in other languages and alternate formats.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		16. Notice of Nondiscrimination and Appeals and Grievance Rights document.		
7.6	The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials. a. The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State. b. The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.	MCOs shall notify the enrollee and the provider in writing whenever the provider's request for preauthorization for a service is denied. Written notice of decision to deny initial services must be provided to the enrollee: • within 24 hours of the expedited authorization determination, **and** • within 72 hours of receipt of the request, **and** • within 72 hours for standard requests and outpatient drug decisions. For any previously authorized service, written notice to the enrollee must be provided at least 10 days prior to reducing, suspending, or terminating a covered service. The state specified threshold for all adverse determination notifications is 95%. A sample of adverse determination notifications must be reviewed for compliance with state specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This	• UR Plan • UR Policies & Procedures • UR Committee Meeting Minutes • Selected UR Cases • Enrollee Notices • TAT Compliance Reports	HCQIS XIII.C 1-7 COMAR 10.67.09.04 42 CFR §438.10 (f & g)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.7	The MCO must have written policies and procedures pertaining to enrollee appeals. a. The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05. *b. The MCO's appeals policies and procedures must include staffing safeguards to avoid conflicts of interest when reviewing appeals.* c. <u>The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes.</u> d. The MCO's appeal policies must include procedures for how the MCO will assist enrollees with the appeal process.	There is evidence that appeals are resolved and notification provided within the timeframes established by the State. Timeframes for resolving and providing notification of appeal decisions in the policy and procedure must be in accordance with the following: • Expedited Appeals **must be resolved and written notification of the decision provided within 72 hours of receipt. The MCO must also make reasonable efforts to provide oral notice of the decision.** • Standard Appeals **must be resolved and written notice provided within 30 days**, unless extended pursuant to 438.408 b & c. • Appeals may be extended up to 14 days. The MCO must ensure that decision makers on appeal were not involved in previous levels of review or decision making, were not subordinates of decision	• UR Organizational Charts • UM Position Descriptions • QM Committee Meeting Minutes • Enrollee Appeals Policies & Procedures • Contract • Appeals Forms & Logs • Appeals Reports including TAT compliance • Appeal Records • Enrollee Notices	HCQIS XIII.C 1-7 COMAR 10.67.09.02 COMAR 10.67.09.05 42 CFR §438.404 (b) 42 CFR §438.406 (a & b) 42 CFR §438.408 (a-f) <u>42 CFR §438.402 (c)(3)(ii)</u> **<u>NCQA:</u>** **<u>UM 8 Element A</u>** **<u>UM 9 Element A</u>** **<u>MED 10 Element A</u>**

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	e. Reasonable efforts are made to give the enrollee prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request. f. Written notifications to enrollees include appeal decisions that are documented in easy to understand language. *g. <u>The MCO's appeal policies and procedures must include oral inquiries seeking to appeal are treated as appeals.</u>*	makers involved in previous levels of decision making, and are health care professionals with clinical expertise in treating the enrollee's condition or disease. The method to collect information for review decisions is documented. A selected sample of enrollee appeals, or provider appeals submitted on behalf of the enrollee, will be reviewed to assure that the policies and procedures are being followed.		
7.8	The MCO must have written policies and procedures pertaining to provider appeals. a. The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03. b. The MCO's provider appeals policies and	Compliant with the requirements of COMAR 10.67.09.03, the MCO must have written policies and procedures for provider appeals. The state specified threshold for all provider appeal resolution is 95%. The MCO must provide evidence that it is monitoring compliance with written acknowledgment and written resolution timeframes through routine reports (i.e. weekly, monthly or quarterly) consistent with the MCO's policies that includes the compliance percentage for	• Provider Appeals Policies & Procedures • TAT Tracking logs for monitoring compliance with written acknowledgment and written resolution of provider appeals • TAT Compliance Reports for written	HCQIS XIII.C 1-7 COMAR 10.67.09.03 42 CFR §438.236

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	procedures must include a provider complaint and appeal process for resolving provider appeals timely. c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	each of the regulatory timeframes. The MCO can include either all provider appeals or a statistically valid sample in reporting compliance. If using a sample the MCO must use a statistically valid sample size with a confidence level of 95% and a sampling error of 5%. The MCO must include in its provider complaint process at least the following elements: An appeal process which: • Is available when the provider's appeal or grievance is not resolved to the provider's satisfaction; • Acknowledges receipt of provider appeals within 5 business days of receipt by the MCO; • Allows providers 90 business days from the date of a denial to file an initial appeal; • Allows providers at least 15 business days from the date of denial to file each subsequent level of appeal; • Resolves appeals, regardless of the number of appeal levels allowed by the MCO, within 90 business days of receipt of the initial appeal by the MCO;	acknowledgment and written resolution • Appeal Records	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Pays claim within 30 days of the appeal decision when a claim denial is overturned; • Provides at its final level an opportunity for the provider to be heard by the MCO's chief executive officer, or the chief executive officer's designee; • Provides timely written notice to the provider of the results of the internal appeal.		
7.9 (Formerly 7.6)	There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. a. The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures. b. The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other	The intent of this element is to provide a mechanism for enrollees and providers to offer opinions on the UR process in place at the MCO and assure that the MCO is reviewing and acting upon identified issues. There must be evidence these processes are in place and functioning. There must be evidence that these policies and procedures have been followed. The policies and procedures must describe the process to evaluate the effects of the program using data on enrollee and provider satisfaction and/or other appropriate measures. **If the MCO conducts any independent surveys, data sources must include both the MCO's independent survey results and MDH-**	• Enrollee & Provider Satisfaction Policies and Procedures Relating to UR Program • Enrollee and Provider Satisfaction Surveys Evaluating UR Program • Data Reports Evidencing Review • Trending Reports • Action Plans • Committee Meeting Minutes	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	appropriate data by the appropriate oversight committee. c. The MCO acts upon identified issues as a result of the review of the data.	**coordinated enrollee and provider satisfaction survey results.** It is expected that the MCO will review results of enrollee and provider satisfaction surveys and develop and implement action plans to address identified opportunities for improvement timely in order to have some impact on subsequent survey results.		
7.10 (Formerly 7.7)	The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.	"Independent review organization" means an entity that contracts with the Department to conduct independent review of managed care organizations' adverse decisions. The MCO's specific responsibilities under the Maryland Medicaid Managed Care Independent Review Services process are as follows and should be included in the policy and procedure: 1. Establish an online account with the IRO and provide all required information through this account. 2. Upload the complete case record for each medical case review request within five (5) business days of receipt of the request from the IRO. 3. Upload any additional, case-related documentation requested	• Complaint Resolution/IRO Policy and Procedure • MCO Independent Review Organization Agreement • Online Account • Sample Case Record • Logs documenting IRO invoices are paid within 60 days.	COMAR 10.67.13

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		by the IRO within two (2) business days of receipt of notification of a request for additional information from the IRO. 4. Agree to pay the fixed case fee should the IRO rule against the MCO and has a documented process to assure IRO invoices are paid within 60 days per COMAR 10.67.13.07C(2).		
7.11 (Formerly 7.8)	The MCO must have written policies and procedures for establishing a corrective managed care plan for enrollee abuse of medical assistance pharmacy benefits consistent with the Department's corrective managed care plan. a. The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation. b. The MCOs must provide evidence of implementation of the corrective managed care plan.	The MCO must have documented policies and procedures for a corrective managed care plan for abuse of pharmacy benefits consistent with COMAR 10.67.12. An MCO's corrective managed care plan shall cover enrollee abuse of medical assistance pharmacy benefits. For all pharmacy benefit abuse covered by an MCO's corrective managed care plan, the plan shall: • Use the criteria as described in Regulation .01B of this regulation to determine if enrollees have abused benefits; • Provide for a medical review of the alleged abuse consistent with §C of this regulation; • Provide that an enrollee found to have abused pharmacy benefits	• Corrective Managed Care Plan Policies and Procedures • Corrective Managed Care Plans • Notices to and Correspondence with Enrollees • Evidence of Record Reviews Completed by Licensed Medical Professionals	COMAR 10.67.12.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		will be enrolled in the program for 24 months; • Provide that an enrollee who has been enrolled in a 24-month plan and is subsequently found to have abused MCO pharmacy benefits shall be enrolled in the plan for an additional 36 months; • Provide for the MCO to select any participating pharmacy that meets the requirements of COMAR 10.67.12.02B(5) to serve as the enrollee's designated pharmacy provider for enrollees in corrective managed care; • Require an enrollee to obtain prescribed drugs only from a single designated pharmacy provider, which may be any pharmacy or any single branch of a pharmacy chain that participates in the MCO and meets the requirements of COMAR 10.67.05.06B and .07C(2) unless the prescription is: a) Pursuant to an emergency department visit; b) Pursuant to hospital inpatient treatment; or c) A specialty drug as defined in COMAR 10.67.06.04;		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Provide enrollees determined to have abused pharmacy benefits the ability to suggest pharmacy providers; • Require the MCO to accept the enrollee's suggestion referenced in §B(7) of this regulation unless the MCO determines that the recipient's choice of provider would not serve the enrollee's best interest in achieving appropriate use of the health care systems and benefits available through the MCO; • Provide an enrollee determined to have abused pharmacy benefits 20 days from the date of the notice to present additional documentation to explain the facts that serve as the basis for the MCO's determination of benefit abuse, consistent with §D of this regulation; • Provide for the designation of a new pharmacy provider if the enrollee moves out of the service area of the current pharmacy provider; • Provide for prompt reporting to the Department the name of any enrollee enrolled in the MCO's program, the duration of		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		enrollment, or any change in the duration of enrollment; and • Be submitted to the Department for review and approval: a) Within 60 days of the effective date of this regulation; and b) Before the implementation of any modification.		
7.12 Deleted in MY 2019.				
8.0	**Continuity of Care – The MCO has put a basic system in place that promotes continuity of care and case management.**			
8.1	Enrollees with special needs and/or those with complex health care needs must have access to CM according to established criteria and must receive the appropriate services.	The MCO must have policies and procedures in place to identify enrollees with special needs and/or complex health care needs, such as diabetes, severe asthma and high-risk pregnancy, and to enroll them into CM according to the MCOs established criteria. This system must allow the enrollee to access the appropriate services provided by the MCO. Per COMAR 10.67.04.04B, special needs populations are identified as: 1. Children with special health care needs. 2. Individuals with a physical disability. 3. Individuals with a developmental disability.	• CM Plan • CM Criteria/ • Standards • CM Policies & Procedures • CM Cases • Committee Meeting Minutes (e.g., QA/UR) • Job Descriptions • Reports and Analysis • Orientation/ • Training Materials	HCQIS XIV COMAR 10.67.03.06 COMAR 10.67.04.04-11 42 CFR §438.208(c)(1,2) MCO Agreement

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		4. Pregnant and postpartum women. 5. Individuals who are homeless. 6. Individuals with HIV/AIDS. 7. Children in State supervised care. Specifically, the MCO has documented evidence of the following: • CM Plan that describes the MCO's CM program and/or CM policies and procedures. • CM criteria and/or standards for the following: o Identification of children and adult enrollees with special needs o Assessments o Plans of care o Caseload • Committee reporting structure. • Minimum qualifications for case managers and case manager supervisors. • Orientation/Training for case managers. • Number of FTEs allocated for CM.		
8.2	The MCO must ensure appropriate initiation of care based on the results of HSNI data supplied to the MCO. This must include a process for gathering HSNI data, an ongoing	There is documented evidence of HSNI: • data collection methodology • data analysis activities, and	• HSNI Policies and Procedures • Reports and Analysis of TATs	COMAR 10.67.02.03 COMAR 10.67.05.07

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	analysis, and a process that calls for appropriate follow-up on results of the analysis.	• evidence that follow-up based on the results of the analysis is occurring in a timely manner. If MDH does not transmit HSNI for an enrollee to the MCO within 10 calendar days of enrollment, the MCO shall make at least two attempts to conduct an initial screening of the enrollee's needs, within 90 calendar days of the effective date of enrollment. At least one of these attempts shall be during non-working hours. If the MCO does not receive the HSNI within the 10-day window, the MCO should attempt to perform the screening. NOTE: The HSNI is completed at the time of enrollment into HealthChoice and this data is sent to the MCO from the state. The HSNI is NOT the Health Risk Assessment (HRA) performed by CM.		
8.3	The MCO must have policies and procedures in place to coordinate care with primary care, Local Health Departments (LHDs), school health programs, and other frequently involved community based organizations (CBOs).	The MCO must have policies and procedures in place to assure the coordination of services for its enrollees, including coordination of care/services with the enrollee's PCP, LHDs (ACCU/Ombudsman, and transportation), school based health centers, and other CBOs where coordination with the MCO is necessary to ensure enrollee services are coordinated. Other CBOs might include Chase Brexton for HIV/AIDS, homes and	• Continuity of Care Policies & Procedures	HCQIS XIV

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		domestic violence shelters, etc. Collaboration with other department activities such as quality and outreach.		
8.4	*The MCO must monitor continuity of care across all services and treatment modalities including discharges or admissions to inpatient setting to home. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).*	There is documented evidence of monitoring activities. This includes the collection and analysis of data.	• Continuity of Care Policies & Procedures (e.g. hospitalizations, prenatal care) • Data Analysis • QA & UR Committee Meeting Minutes	HCQIS XI **NCQA:** **QI 3 Element A**
8.5	The MCO must monitor the effectiveness of the CM Program.	• Methodology to evaluate the effectiveness of the CM program. • Methodology for monitoring the plans of care. • Methodology for evaluating plans of care.	• CM Evaluation Studies • Analysis and Reports • Computer Screen Shots of CM Software or Actual Demonstration of CM System • Case Records	HCQIS XIV COMAR 10.67.03.06 COMAR 10.67.04.04-11
8.6	The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.	The MCO has policies and procedures for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation through documentation of coordination in enrollee records. For enrollees with behavioral health conditions, coordination of care should include but not be limited to:	• Coordination with Behavioral Health and Substance Use Vendors Policy and Procedures • Enrollee Records • Provider Education Materials • Provider Newsletters	COMAR 10.67.04.14E

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		a. Cooperation with the Department's high utilizer pilot program, b. Assistance with the development and coordination of appropriate treatment plans for Enrollees c. Provider education and promotion for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process, d. Provider education about the substance use release of information (ROI) process under 42 CFR, Part 2, and e. Provider education for Enrollee identification and referrals to the ASO or core service agencies for behavioral health services.	• Screenshots of the MCO's website • Provider Manual	
8.7	The MCO must comply with providing the Continuity of Health Care Notice to enrollees and have policies and procedures in place to provide services in accordance with the MIA requirements when requested by enrollees.	The MCO has policies and procedures for complying with the Continuity of Health Care Notice and provides documentation of compliance. Evidence of compliance is not showing the Continuity of Health Care Notice in the Enrollee Handbook. Examples of evidence may be derived from care management notes, documentation of single case agreements with out-of-network providers, enrollee letters to show	• Policies and Procedures • Care management notes, single case agreements with out-of-network providers, enrollee letters	Ins. Art. §15-140(f)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		continued approval of a service received through an out-of-network provider, etc.		
9.0	**Health Education Plan – The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the enrollee population.** **This standard will be reviewed until the MCO attains 100% compliance.**			
9.1	The MCO has a comprehensive written Health Education Plan (HEP), which must include: a. The education plan's purpose and objectives. b. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events. c. A methodology for notifying enrollees and providers of available educational activities. d. A description of group and individual educational activities targeted at both providers and enrollees.	The MCO's HEP must contain all of the components listed in a-d. There must be an indication of how the objectives were established.	• HEP & Work Plan • Health Education Schedule of Events • Health Education Materials • Enrollee/Provider Notification Methodology	COMAR 10.67.04.03
9.2	The HEP incorporates activities that address needs identified	The MCO must provide evidence that enrollee data were analyzed to determine	• HEP • Enrollee Data Analysis	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	through the analysis of enrollee data.	the need for certain health education programs.	• Health Education Calendar of Events	
9.3	The MCO's HEP must: a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures. b. Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the enrollees. c. Contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for enrollee referrals.	The HEP must describe the qualifications of the staff that will conduct the educational sessions (e.g., certified diabetes instructor, registered dietician, or certified mental health provider). The education plan must describe how a provider can access a health educator/ educational program through the MCO (e.g., the MCO may designate a contact person to assist the provider in connecting the enrollee to a health educator or program).	• Data Analysis and Studies • HEP and Work Plan • Provider Manual • Impact Evaluation Methodology	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
9.4	The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.	Mechanisms to identify enrollees in special need of educational efforts may include CM, outreach, or PCP referral for one-on-one education of the enrollee with complex medical needs, the homebound enrollee, and the noncompliant enrollee with health issues.	• Special Educational Need Identification Mechanisms	COMAR 10.67.04.03
9.5	The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide: a. Samples of notifications, brochures, and mailings. b. Attendance records and session evaluations completed by enrollees. c. Provider evaluations of health education programs.	The MCO must demonstrate that enrollees are notified of educational programs and that they have been afforded the opportunity to evaluate these programs. The MCO must provide documentation in the form of notifications, attendance records and session evaluations. There must be evidence that providers are given the opportunity to evaluate enrollee educational sessions and the overall health education program.	• Enrollee Mailings • Attendance Records • Completed Session Evaluations • Program Evaluations • Completed Provider Evaluations	COMAR 10.67.04.03
10.0	**Outreach Plan – The MCO has developed a comprehensive written outreach services plan to assist enrollees in overcoming barriers in accessing health care services. The OP adequately describes the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.**			
10.1	The MCO has developed a written OP that describes the following:	Each of the MCOs participating in HealthChoice is unique in the manner in which it facilitates the outreach requirements. The OP must describe the	• Educational Materials • DM and CM Program Descriptions • MOUs	COMAR 10.67.04.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership. b. MCO's organizational capacity to provide both broad-based and enrollee-specific outreach. c. Unique features of the MCO's enrollee outreach initiatives. d. Community partnerships. e. Role of the MCO's provider network in performing outreach. f. MCO's relationship with each of the LHDs and ACCUs.	individual MCO's approach to providing outreach. This written plan must provide an overview of outreach activities that includes components 10.1a through 10.1f. Supporting policies and procedures must be in place to provide details regarding how these activities are carried out. The OP must include an overview of the populations to be served. At a minimum the populations must include: • Those in need of wellness/ preventive services. • Those children eligible for EPSDT services. • Those enrollees (both adults and children) who are difficult to reach or miss appointments. • Those enrollees comprising the following special populations defined in COMAR 10.67.04.04 B: 1) Children with special health care needs. 2) Individuals with a physical disability. 3) Individuals with a developmental disability. 4) Pregnant and postpartum women. 5) Individuals who are homeless.	• Community Event Calendars or Education Program Schedules • Provider Manual • Provider Contracts	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		6) Individuals with HIV/AIDS. 7) Children in State supervised care. • The OP must briefly describe common health problems within the MCO's membership (i.e., diabetes, HIV/AIDS, pediatric asthma) and any identified barriers or specific areas where outreach has been or is anticipated to be particularly challenging (i.e., rural population, non-English speaking populations). The OP must provide an overview of how the MCO's internal and external resources are organized to provide an effective outreach program. For example, the OP briefly describes the roles of various departments such as provider relations, enrollee services, CM, DM, health education and delegated entities in the performance of outreach activities. The OP must briefly describe data management systems to be utilized in performing outreach activities. This may include data systems or software used to identify, track, and report outreach activities.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		The OP briefly describes any unique educational activities related to the populations served, such as: • Languages in which materials are printed and availability of interpreter services. TTD/TTY services for those who are hearing impaired. • Any unique educational activities such as, CM or DM programs related to special populations (i.e., mother/baby programs, substance abuse programs for pregnant women, asthma management programs, etc.). • Any other unique services related to education. The OP briefly describes any community partners and their role in providing outreach activities to assist the MCO in bringing enrollees into care (i.e., church groups, YMCA, homeless shelters, community based school programs, parks and recreation programs, medical societies and/or associations such as the American Diabetes Assoc., etc.). The community partner may provide educational health fairs or screenings, educational materials, speakers, personnel who assist the enrollee in completing		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		necessary medical paperwork or who assist the enrollee in locating special services to facilitate bringing the enrollee into care, etc. (Do not include the role of the local health departments, since they are addressed in 10.1f) The OP must include a brief description of the role and responsibilities of providers for participating in outreach activities. The OP must demonstrate the MCO's relationship with the LHD/ACCU regarding collaborative efforts being undertaken (i.e. methods of referral). The description must include: • The LHD's responsibilities in outreach. • How results of the LHD's efforts are conveyed to the MCO.		
10.2	The MCO has implemented policies and procedures for: a. The provision of outreach services for new and existing enrollees for wellness/preventive health services. b. Deleted in MY 2019.	There must be evidence that the MCO has policies and procedures implemented for each of the activities in 10.2 a-d. The MCO identifies those enrollees in need of wellness/ preventive services and initiates activities to encourage utilization of these services. There is evidence that the MCO implements a system to track and monitor access to these services. For	• Data Reports • Outreach Logs • Enrollee Mailings • Educational Materials • LHD Reports	COMAR 10.67.05.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	c. The provision of outreach via telephone, written materials, and face-to-face contact. d. Monitoring of all outreach activities, including those delegated or subcontracted to other entities.	example, the MCO identifies and notifies enrollees of due dates for preventive services such as mammograms and cervical cancer screenings through reminder notices such as letters or postcards. The MCO must have policies and procedures in place to guide outreach staff in the outreach process. This guidance may be in the form of policies and procedures or process flow charts. There must be evidence that these processes are being followed. There must be evidence that the MCO utilizes a systematic process to provide outreach services that employs: • Telephone contact. • Written materials. • Face-to-face contact. There must be evidence that outreach activities are monitored. There must be evidence that the MCO monitors any delegated activities to assure that contracted or delegated activities are carried out. For example, if the MCO has an agreement with the LHD to perform specific outreach activities such as face-to-face contact with enrollees, the MCO must		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		have a mechanism for monitoring outcomes of these activities (i.e., number of enrollees referred for LHD outreach and number successfully reached).		
10.3	The MCO has implemented strategies: a. Deleted in MY 2019. b. Deleted in MY 2019. c. To promote the provision of EPSDT services and respond to no shows and non-compliant behavior related to children in need of EPSDT services. d. To bring enrollees into care who are difficult to reach or who miss appointments.	There must be evidence that the MCO has implemented strategies to provide outreach to the populations in 10.3 c and d. The MCO identifies and tracks children (up to 21 years of age) who are eligible for EPSDT services or treatment. The MCO identifies those enrollees due for services, enrollees who miss appointments, and non-compliant enrollees. There is evidence that the MCO provides outreach to schedule those children in need of EPSDT services and/or to bring those children who miss appointments into care.	• Outreach Work Plan • Data Reports • Tracking/Referral logs • Enrollee Mailings • Provider Mailings	COMAR 10.67.05.03
11.0	**Fraud and Abuse - The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.**			
11.1	The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and	The MCO demonstrates the ability to detect and identify inappropriate and unlawful conduct, fraudulent activities, and abusive patterns through detailed policies, procedures, education and training.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Compliance Officer Job Description and Qualifications	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include: a. Documentation that articulates the organization's commitment to comply with all applicable Federal and State laws, regulations, and standards. b. Designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and is responsible for ongoing monitoring of the MCO's mandatory compliance plan. c. Designation of a Compliance Officer to serve as the liaison between the MCO and the Department. d. A documented process for internal monitoring and auditing, both	The MCO demonstrates the ability to internally monitor and audit for potential fraud and abuse in such areas as encounter data, claims submission, claims processing, billing procedures, underutilization, customer service, enrollment and disenrollment, marketing, and provider/enrollee education materials. The MCO documents its processes used to detect and identify incidences of fraud and abuse. The MCO documents its processes used to ensure services were actually provided to the enrollee. There must be evidence of the process such as policies and procedures, reports, trending, meeting minutes, studies, call scripts, data results, etc.	• Compliance Committee Membership • Compliance Committee Meeting Minutes • Communication Between Compliance Officer & Compliance Committee • Routine and Random Audit Reports for Fraud and Abuse • Reports tracking the receipt and dispensation of all incidences of reported suspected fraud and abuse	Program for Medicaid Managed Care Organizations and Prepaid Health Plans"

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and abuse education of MCO staff, enrollees, and providers. e. A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation. f. A documented process to ensure that services billed to the MCO were			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	actually received by the enrollee.			
11.2	The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include: a. Education and training for the Compliance Officer and the MCO's employees on detection of fraud and abuse. b. A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO's employees. c. A documented process for enforcing standards	The MCO demonstrates clear and well-publicized communication of disciplinary guidelines to employees, subcontractors of the MCO, and enrollees to sanction fraud and abuse offenses. The MCO demonstrates its process exists, e.g. a hotline, which allows employees, subcontractors of the MCO, and enrollees to report suspected fraud and abuse without fear of reprisal. The MCO will also demonstrate its procedures for timely investigation, dispensation, and tracking of reported suspected incidences of fraud and abuse.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Staff orientation, education, and training protocols pertaining to fraud and abuse • Sign-in rosters for employee training sessions regarding fraud and abuse	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans"

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	by means of clear communication to employees, in well-publicized guidelines, to sanction incidents of fraud and abuse. d. A documented process for enforcement of standards through clear communication of well-publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse. e. A documented process for enforcement of standards through clear communication of well-publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse. f. A documented process for the reporting by employees of suspected fraud and abuse within the organization, without fear of reprisal. g. A documented process for reporting by subcontractors of the			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	MCO suspected fraud and abuse within the organization, without fear of reprisal. h. A documented process for reporting by enrollees of the MCO suspected fraud and abuse within the organization without fear of reprisal.			
11.3	The MCO maintains administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. It must include: a. A documented process for reporting all suspected cases of provider fraud and abuse to the MDH Office of the Inspector General and the Medicaid Fraud Control Unit within 30 calendar days of the initial report.	The MCO documents its processes for reporting and tracking suspected incidences of fraud and abuse to the appropriate State and Federal agencies within the appropriate timeframes and its cooperation with those agencies investigating those alleged incidents.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Documentation of reported incidences of fraud and abuse to State Medicaid Agency • Documentation of collaboration and cooperation with State Medicaid Fraud Control Unit	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans"

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. A documented process for cooperating with the MDH Office of the Inspector General and the State Medicaid Fraud Control Unit when suspected fraud and abuse is investigated.			
11.4	The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address: a. Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee. b. Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP. c. Evidence of the Compliance Committee's review and approval of	The MCO documents the mechanisms that evaluate the effectiveness of its fraud and abuse compliance plan through routine and random reports, CAPs and their implementation, administrative and management procedures. The MCO documents oversight of fraud and abuse activities for each delegate, including delegate compliance plans and fraud and abuse activity reports.	• Compliance Committee Minutes • Routine and Random Fraud and Abuse Reports • CAPs • CAP Implementation Reports • Delegate Fraud and Abuse Reports	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans"

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with. d. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.			
11.5 (Formerly 2.8)	An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies. a. An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals or entities debarred by Federal Agencies.	An MCO may not have a relationship with an individual or entities who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. An MCO may not have an affiliation with an individual or entities who have been debarred by Federal Agencies, as defined in the Federal Acquisition Regulation.	• Governance Policies and Procedures • Subcontracting and Employment Policies and Procedures • Evidence of database checks	42 CFR §438.610(a) 42 CFR §438.610(b) 42 CFR §438.610(c) COMAR 10.67.03.03 42 CFR §455.436 COMAR 10.67.07.03G

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO's equity. c. An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with an employment, consulting, or other arrangement with the MCO. d. An MCO must provide evidence of initial and monthly checks of the following databases as applicable: Social Security Death Master File; National Plan and Provider Enumeration System; List of Excluded Individuals/Entities;	Checks of all databases are required at the time of initial credentialing and recredentialing. Monthly checks of the following databases are required: List of Excluded Individuals/Entities and Excluded Parties List Systems/SAM.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	Excluded Parties List Systems/SAM. e. An MCO must have written policies and procedures for providing written disclosure of any prohibited affiliation and/or termination to MDH.			

MY 2021 Non-Duplication Deeming Standards Crosswalk

Standard 1 Systematic Process of Quality Assessment and Improvement	1.1 N	1.2 N	1.3 6/7	1.4 N	1.5 N	1.6 N/A	1.7 N	1.8 Y	1.9 N	1.10 N		
Standard 2 Accountability to the Governing Body	2.1 N	2.2 N	2.3 N	2.4 N	2.5 N	2.6 N/A	2.7 N					
Standard 3 Oversight of Delegated Entities and Subcontractors	3.1 N	3.2 N	3.3 N	3.4 N								
Standard 4 Credentialing and Recredentialing	4.1 3/4	4.2 N	4.3 Y	4.4 N	4.5 Y	4.6 Y	4.7 N	4.8 4/5	4.9 2/3	4.10 N	4.11 N	4.12 N
Standard 5 Enrollee Rights	5.1 N	5.2 Y	5.3 1/5	5.4 N	5.5 N	5.6 N	5.7 N	5.8 1/5	5.9 N	5.10 N	5.11 N	
Standard 6 Availability and Accessibility	6.1 1/4	6.2 2/4	6.3 N	6.4 N								
Standard 7 Utilization Review	7.1 2/3	7.2 5/6	7.3 1/3	7.4 1/3	7.5 N	7.6 N	7.7 2/7	7.8 N	7.9 N	7.10 N	7.11 N	7.12 N/A
Standard 8 Continuity of Care	8.1 N	8.2 N	8.3 N	8.4 Y	8.5 N	8.6 N	8.7 N					
Standard 9 Health Education Plan	9.1 N	9.2 N	9.3 N	9.4 N	9.5 N							
Standard 10 Outreach Plan	10.1 N	10.2 N	10.3 N									
Standard 11 Fraud and Abuse	11.1 N	11.2 N	11.3 N	11.4 N	11.5 N							

Green Y = Standard is deemable
Red N = Standard is not deemable
Yellow = Standard is partially deemable
Gray = Not applicable as standards have been deleted

MY 2021 MD SPR Standards to Part 438 Subpart D and QAPI Standards Crosswalk

Standards	Availability of Services	Assurances of Adequate Capability and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Provider Selection	Confidentiality	Grievance and Appeal Systems	Subcontractual Relationships and Delegation	Practice Guidelines	Health Information Systems	Quality Assessment and Performance Improvement Program
CFR Reference	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330
1: Systematic Process of Quality Assessment and Improvement	✓	✓	✓	✓	-	-	✓	✓	✓	✓	✓
2: Accountability to the Governing Body	-	-	-	✓	-	-	-	-	-	-	✓
3: Oversight of Delegated Entities and Subcontractors	-	-	-	-	-	-	✓	✓	-	-	✓
4: Credentialing and Recredentialing	✓	✓	✓	-	✓	-	✓	✓	-	-	✓
5: Enrollee Rights	✓	-	✓	-	✓	✓	✓	-	-	-	✓
6: Availability and Accessibility	✓	✓	✓	✓	-	-	-	-	-	-	✓
7: Utilization Review	✓	✓	✓	✓	-	-	✓	-	✓	✓	✓
8: Continuity of Care	✓	-	✓	-	-	-	-	-	-	✓	✓
9: Health Education Plan	✓	-	✓	-	-	-	-	-	-	-	✓
10: Outreach Plan	✓	✓	✓	-	-	-	-	-	-	-	✓
11: Fraud and Abuse	-	-	✓	✓	✓		✓	-	-	-	✓

Appendix C: 2022 Final IRS and Methodology

Information Reporting Strategy (IRS) and Analytic Methodology

2022 Maryland HealthChoice Consumer Report Card

Introduction

As a part of its external quality review contract with the Maryland Department of Health (MDH), Qlarant is responsible for developing a Medicaid Consumer Report Card.

The report card is meant to help Medicaid enrollees select a HealthChoice managed care organization (MCO). Information in the report card includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS®[11]), the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[12]) survey, and Maryland's encounter data measures.

This report explains the reporting strategy and analytic methods Qlarant will use in developing the report card MDH will release in 2022, based on data reported from the MCOs in MY 2021. This report is organized as follows:

- **The Information Reporting Strategy** explains the criteria used to determine the most appropriate and effective methods of reporting quality information to Medicaid enrollees, the intended target audience.
- **The Analytic Method** provides a statistical basis and the analysis method used for reporting comparative MCO performance.
- Appendices
    - Reporting Categories and Measures
    - Questions Comprising CAHPS Measures for the Medicaid Product Line

[11] HEDIS® is a registered trademark of NCQA.
[12] CAHPS® is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ)

Information Reporting Strategy

The most formidable challenge facing all consumer information projects is communicating a large amount of complex information in an understandable and meaningful manner while fairly and accurately representing the data. The reporting strategy presented incorporates methods and recommendations based on experience and research related to presenting quality information to consumers. Based on a review of the available HEDIS and CAHPS measures, Qlarant recommends the following reporting categories, outlined with associated measures in the tables that follow:

- 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

The recommended categories are based on measures reported by HealthChoice MCOs in 2021 and are designed to focus on clearly identifiable areas of interest. Consumers may focus on MCO performance in the areas most important to them and their families. The first two categories are relevant to all enrollees; the remaining categories are relevant to specific Maryland HealthChoice enrollees: 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

The measures considered for inclusion in the report card are derived from those required by MDH for MCOs to report. Those measures include HEDIS measures, the CAHPS results from both the Adult Questionnaire and the Child Questionnaire, and MDH's encounter data measures.

Appendix A includes the complete list of HEDIS, CAHPS, and Maryland encounter data measures recommended for inclusion in each reporting category.

HEDIS Measures

The following table identifies Measure Specification and HEDIS General Updates. For detailed changes, refer to *HEDIS Measurement Year 2020 & Measurement Year 2021, Volume 2: Technical Specifications for Health Plans.*

Table 1. Measure Specific Updates

Performance Measures	Changes for 2022 report card
Appropriate Testing for Children with Pharyngitis	Updated the instructions for excluding visits that result in an inpatient stay.
Appropriate Treatment Upper Respiratory Infection	Updated the instructions for excluding visits that result in an inpatient stay.
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	Updated the instructions for excluding visits that result in an inpatient stay.
Controlling High Blood Pressure	• In the Administrative Specification, added telephone visits, e-visits, and virtual check-ins as appropriate settings for BP readings. • Updated the Hybrid specification to indicate that sample size reduction is not allowed for MY 2020.
Comprehensive Diabetes Care	• Clarified the telehealth requirements. • Retired the "Medical Attention for Nephropathy" indicator and replaced it with BP Control <140/90 mm Hg.
Children and Adolescents' Access to Primary Care Practitioners	Measure retired.
Asthma Medication Ratio	Removed the restriction that only three of the four visits with an asthma diagnosis be an outpatient telehealth, telephone visit, e-visit, or virtual check-in when identifying the event/diagnosis.
Cervical Cancer Screening	Updated the Hybrid Specification to indicate that sample size reduction is allowed
Prenatal and Postpartum Visits	• Clarified that visits that occur prior to the enrollment start date (during the pregnancy) meet the criteria • Added telephone visits, e-visits, and virtual check-ins to the Timeliness of Prenatal Care rate • Updated the Hybrid specification to indicate that sample size reduction is allowed using only the current year's administrative rate for MY 2020
Well-Child Visits in the First 15 Months of Life -5+ Visit Rate	• Measure renamed Well-Child Visits in the First 30 Months of Life • A second indicator added, Well-Child Visits for Age 15 Months–30 Months • Data collected through administrative data only
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	• A new measure, Child and Adolescent Well-Care Visits, combined Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life and Adolescent Well-Care Measure with the following age ranges: 3-11, 12-17, 18-21, and Total • Data collected through administrative data only
Adolescent Well-Care Visits - 12-21 years	

Performance Measures	Changes for 2022 report card
Doctor Communication and Service	Shared Decision Making and Health Promotion for both child and adult have been added to this category.

CAHPS Patient Experience Survey Measures

Consistent with the 2021 Consumer Report Card, it is recommended that results of both the CAHPS Health Plan Survey 5.0H, Adult Version and the CAHPS Health Plan Survey 5.0H, Child Version with the Children with Chronic Conditions (CCC) measures be included.

The sampling protocol for the CAHPS 5.0H Child Questionnaire allows reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic illness. For each population, results include the same ratings, composites, and individual question summary rates. In addition, five CCC measures are reported for the population of children with chronic conditions.

Summary of CAHPS Measure Changes for the 2022 report card:

- The only change in the CAHPS measure specification is the addition of language to cover telehealth visits; some questions were revised to include phone and video visits.

Format

The following considerations are important when designing report cards:

Table 2. Formatting Elements

Format Element	Instructions
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 enrollees choosing an MCO for the first time, enrollees receiving the Annual Right to Change Notice and prioritizing their current health care needs, current enrollees learning more about their MCO) and reading level.
Narrative	Emphasize why what is being measured in each reporting category is important, rather than giving a detailed explanation of what is being measured. For example, "making sure that kids get all of their shots protects them against serious childhood diseases" instead of "the percentage of children who received the following antigens…"

Format Element	Instructions
Design	Use color and layout to facilitate navigation and align the star ratings to be left-justified ("ragged right" margin), consistent with the key.

Recommendation
Create an 11 x 18-inch, one-page document, with English on one side and Spanish on the opposite side. This one-page document allows for the 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 the document 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 enrollees had difficulty associating data in charts with explanations if they were presented elsewhere in the report card. Consumers prefer a format that groups related data on a single page. Given the number of MCOs whose information is being presented in Maryland's HealthChoice Consumer Report Card, a one-page document format will allow easy access to information.

Rating Scale

Rate MCOs on a tri-level rating scale.

Recommendation
Compare 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 as "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 enrollees 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 the Analytic Method section below.) 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 enrollees 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.

Analytic Method

The report card compares each MCO's actual score with the unweighted statewide MCO average for a particular reporting category. An icon or symbol denotes whether an MCO performed "above," "the same as," or "below" the statewide Medicaid MCO average.[13]

This analysis aims to generate reliable and useful information Medicaid enrollees can use to compare the quality of health care provided by Maryland's HealthChoice MCOs. A statistically reliable index of differences should compare MCO-to-MCO quality performance directly, allowing consumers to detect differences in MCO performance easily.

Handling Missing Values

Missing values are addressed in the following ways:

1. Analysts need to first decide which pool of observed (non-missing) MCOs should be used to derive replacement values for missing data and then decide how imputed values will be chosen. Imputed values may be fixed values (i.e., "zero," "25th percentile for all MCOs in the nation"), calculated values (i.e., means or regression estimates), or probable selected values (i.e., multiplying imputed values).

2. Analysts determine which method should be used to replace missing values, one that should not provide an incentive for poorly performing plans to intentionally fail to report data. For example, if missing values are replaced with the mean of non-missing cases, scores for MCOs that perform below the mean would be higher if they fail to report.

3. Commercial plan data is not an appropriate replacement for missing data because the characteristics of Medicaid populations differ from those of commercial populations. This restricts the potential group to national Medicaid plans, regional Medicaid MCOs, or Maryland HealthChoice MCOs. Analyses conducted by NCQA for the annual State of Health Care Quality Report have consistently shown substantial regional differences in the performance of commercial managed care plans. 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.

[13]For state performance reports directed at enrollees, NCQA believes it is most appropriate to compare an MCO's performance with the average of all MCOs serving the state. NCQA does not recommend comparing MCOs with a statewide average that has been weighted proportionally to the enrollment size of each MCO. A weighted average emphasizes MCOs with higher enrollments and is used to measure the overall statewide average. Report cards compare an MCO's performance relative to other MCOs, rather than presenting how well the state's Medicaid MCOs serve enrollees *overall*. In a report card, each MCO represents an equally valid option to the reader, regardless of enrollment size.

4. Further, utilizing regional MCOs to derive missing values is also inappropriate because of the substantial differences in Medicaid program administration across states. In other words, reporting of Medicaid data is skewed to a few large states with large Medicaid managed care enrollment.

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

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

- For HEDIS, health plans that followed the specifications but had too small a denominator (<30) to report a valid rate were assigned a result of NA.
- For CAHPS, MCOs who do not meet the minimum denominator of at least 100 responses are assigned a result of NA.

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

1. If fewer than 50% of the MCOs report a measure, the measure is dropped from the report card category.

2. If an MCO has reported at least 50% of the measures in a reporting category, the missing values are replaced with the mean or minimum values based on the reasons for the missing value.

3. MCOs missing more than 50% 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 when values are missing. "NA" values will be replaced with the mean of non-missing observations and "BR/NR" values will be replaced with the minimum value of non-missing observations. This minimizes any disadvantage to MCOs that are willing to report data but are unable to. Variances for replaced rates are calculated differently for CAHPS survey measures and for non-survey measures (HEDIS, Maryland encounter data). Refer to Appendix C for details.

Handling New MCOs

MCOs are eligible for inclusion in the report card when they are able to report more than half the required HEDIS and CAHPS measures used in the report card category.

Enrollees Who Switch Products/Product Lines

Per HEDIS guidelines, enrollees in different products or product lines during continuous enrollment for a measure are considered continuously enrolled and are included in the product and product-line specific HEDIS report in which they were enrolled as of the end of the continuous enrollment period. For example, enrollees in the Medicaid product line who switch to the commercial product line during the continuous enrollment period are reported in the commercial HEDIS report.

Case-Mix Adjustment of CAHPS Data

Several field tests indicate a tendency for CAHPS respondents in poor health to have lower satisfaction scores. It is not clear whether this is because enrollees 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

1. Create standardized versions (z-scores) of all measures for each MCO so that all component measures contributing to the summary scores for each reporting category are on the same scale. Standardized scores are determined by subtracting the overall mean for all MCOs from the mean value of individual MCOs and dividing by the standard deviation of all MCOs.

2. Combine the standardized measures into summary scores for each reporting category and MCO.

3. Calculate standard errors for individual MCO summary scores and for the mean summary scores for all MCOs.

4. Calculate difference scores for each reporting category by subtracting the mean summary score for all MCOs from the individual MCO summary score values.

5. Use the standard errors to calculate 95% confidence intervals (CI) for the difference scores.

6. Categorize MCOs into three categories on the basis of these CIs:

    - Above Average: 95% CI is in the positive range
    - Average: MCO's 95% CI includes zero
    - Below Average: 95% CI is in the negative range

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

Quality Control

Qlarant includes quality control processes 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.

Reporting Categories and Measures

Category: Access to Care	Data Source	Weight
Getting Needed Care (Summary Rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/12 1/12
Getting Care Quickly (Summary Rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/12 1/12
Customer Service (Summary Rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/12 1/12
Category: Access to Care	**Data Source**	**Weight**
Adults' Access to Preventive/Ambulatory Health Services - 20-44 years	HEDIS	1/6
Adults' Access to Preventive/Ambulatory Health Services - 45-64 years		
Access to Care - SSI Adult - 21 years or older*	MDH Encounter Data	1/6
Access to Care - SSI Children - ages 0-20*	MDH Encounter Data	1/6
Category: Doctor Communication & Service	**Data Source**	**Weight**
Rating of All Health Care (Rating Mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Rating of Personal Doctor (Rating Mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Rating of Specialist Seen Most Often (Rating Mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
How Well Doctors Communicate (Summary Rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Shared Decision Making ("Yes" Summary Rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Health Promotion and Education ("Yes" summary rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Coordination of Care ("Usually" & "Always" Question Summary Rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Category: Keeping Kids Healthy	**Data Source**	**Weight**
Childhood Immunization Status (Combo 3)*	HEDIS	1/8
Appropriate Treatment for Upper Respiratory Infections - 3 months - 18 years	HEDIS	1/8
Appropriate Testing for Pharyngitis - 2-18 years	HEDIS	1/8

Well-Child Visits in the First 30 Months of Life- Well-Child Visits in the First 15 Months	HEDIS	1/8
Category: Keeping Kids Healthy	**Data Source**	**Weight**
Child and Adolescent Well-Care Visits- Ages 3-11	HEDIS	1/8
Child and Adolescent Well-Care Visits- Ages 12-17 and Ages 18-21*	HEDIS	1/8
Lead Screening - 12-23 months*	MDH Encounter Data, MDE Lead Registry, FFS Data	1/8
Immunization for Adolescents (Combo 1)*	HEDIS	1/8
Category: Care for Kids with Chronic Illness	**Data Source**	**Weight**
Access to Prescription Medicines (Rating Mean)	CAHPS 5.0H MC	1/6
Category: Care for Kids with Chronic Illness	**Data Source**	**Weight**
Access to Specialized Services: Special Medical Equipment or Devices (Summary Rate)	CAHPS 5.0H MC	1/6
Family Centered Care: Personal Doctor or Nurse Who Knows Child ('Yes" Summary Rate)	CAHPS 5.0H MC	1/6
Family Centered Care: Getting Needed Information (Rating Mean)	CAHPS 5.0H MC	1/6
Coordination of Care for Children with Chronic Conditions ("Yes" Summary Rate)	CAHPS 5.0H MC	1/6
Asthma Medication Ratio - 5-11 years*	HEDIS	1/6
Asthma Medication Ratio - 12-18 years*		
Category: Taking Care of Women	**Data Source**	**Weight**
Breast Cancer Screening*	HEDIS	1/5
Cervical Cancer Screening	HEDIS	1/5
Chlamydia Screening - Total Rate: 16-24 years	HEDIS	1/5
Timeliness of Prenatal Care	HEDIS	1/5
Postpartum Care*	HEDIS	1/5
Category: Care for Adults with Chronic Illness	**Data Source**	**Weight**
CDC: Hemoglobin A1c (HbA1c) Testing*	HEDIS	1/8
CDC: HbA1c Poor Control (>9.0%)**	HEDIS	1/8
CDC: Eye Exam (Retinal) Performed	HEDIS	1/8
CDC: BP Control <140/90 mm Hg	HEDIS	1/8
Avoidance of Antibiotic Treatment Acute Bronchitis/Bronchiolitis- 18-64 years	HEDIS	1/8
Use of Imaging Studies for Low Back Pain	HEDIS	1/8
Asthma Medication Ratio - 19-50 years*	HEDIS	1/8
Asthma Medication Ratio - 51-64 years*		
Controlling High Blood Pressure*	HEDIS	1/8

*Maryland Value-Based Purchasing Measure

**Note: MCO rate used in the analysis is the inverse score in order to provide consistency with other measures (i.e., higher % is better).

CAHPS 5.0H Measures for the Medicaid Product Line

The table below displays the questions, response choices, and corresponding score values used to calculate results for the CAHPS 5.0H Adult Questionnaire and Child Questionnaire [With Children with Chronic Conditions measure (CCC)]. The sampling protocol for the Child Questionnaire allows for the reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic conditions.

Question	Getting Needed Care	Response Choices
Q20=MA Q41=MC	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	Never Sometimes Usually Always
Q9=MA Q10=MC	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	Never Sometimes Usually Always
Question	**Getting Care Quickly**	**Response Choices**
Q4=MA Q4=MC	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	Never Sometimes Usually Always
Q6=MA Q6=MC	In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	Never Sometimes Usually Always
Question	**How Well Doctors Communicate**	**Response Choices**
Q12=MA Q27=MC	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	Never Sometimes Usually Always

Question	How Well Doctors Communicate	Response Choices
Q13=MA Q28=MC	In the last 6 months, how often did your personal doctor listen carefully to you?	Never Sometimes Usually Always
Q14=MA Q29=MC	In the last 6 months, how often did your personal doctor show respect for what you had to say?	Never Sometimes Usually Always
Q15=MA Q32=MC	In the last 6 months, how often did your personal doctor spend enough time with you?	Never Sometimes Usually Always
Question	**Customer Service**	**Response Choices**
Q24=MA Q45=MC	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	Never Sometimes Usually Always
Q25=MA Q46=MC	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	Never Sometimes Usually Always
Question	**Coordination of Care**	**Response Choices**
Q17=MA Q35=MC	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	Never Sometimes Usually Always

Question	Rating of All Health Care	Response Choices
Q8=MA Q9=MC	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	1(worst) through 10(best)
Question	**Rating of Personal Doctor**	**Response Choices**
Q18=MA Q36=MC	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	1(worst) through 10(best)
Question	**Rating of Specialist Seen Most Often**	**Response Choices**
Q22=MA Q43=MC	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	1(worst) through 10(best)
Question	**Shared Decision Making**	**Response Choices**
Q43=MA Q79-MC	Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?	Yes No
Q44=MA Q80=MC	Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?	Yes No
Q45=MA Q81=MC	When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?	Yes No
Question	**Health Promotion and Education**	**Response Choices**
Q41=MA Q77=MC	In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?	Yes No

MA = CAHPS 5.0H Medicaid Adult Questionnaire MC = CAHPS 5.0H Medicaid Child Questionnaire (With CCC Measure)

CAHPS 5.0H Child Questionnaire Measures

The following questions from the CAHPS 5.0H Child Questionnaire provide information on parents' experience with their child's health plan for the population of children with chronic conditions. The five CCC measures summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions. The child is included in the CCC population calculations if one or more of the following survey-based screening criteria are true:

- Child currently needs/uses medicine prescribed by a doctor (other than vitamins) for a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child needs/uses more medical, mental health or educational services than is usual for most children the same age due to a medical, behavioral or other health condition lasting/ expected to last 12 months or more.
- Child is limited or prevented in any way in his or her ability to do the things most children of the same age can do because of a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child needs to get special therapy, such as physical, occupational or speech therapy for a medical, behavioral or other health condition lasting/expected to last 12 months or more.
- Child has any kind of emotional, developmental or behavioral problem lasting/expected to last 12 months or more for which he or she needs or gets treatment or counseling.

Question	Access to Prescription Medicines	Response Choices
Q51	In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?	Never Sometimes Usually Always
Question	**Access to Specialized Services**	**Response Choices**
Q15	In the last 6 months, how often was it easy to get special medical equipment or devices for your child?	Never Sometimes Usually Always

Question	Access to Specialized Services	Response Choices
Q18	In the last 6 months, how often was it easy to get this therapy for your child?	Never Sometimes Usually Always
Q21	In the last 6 months, how often was it easy to get this treatment or counseling for your child?	Never Sometimes Usually Always
Question	**Family-Centered Care: Personal Doctor Who Knows Child**	**Response Choices**
Q33	In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?	Yes No
Q38	Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	Yes No
Q39	Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?	Yes No
Question	**Family-Centered Care: Getting Needed Information**	**Response Choices**
Q8	In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?	Never Sometimes Usually Always
Question	**Coordination of Care for Children with Chronic Conditions**	**Response Choices**
Q13	In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	Yes No
Q24	In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	Yes No

Appendix D: Report Reference Page

Reports identified below can be found on MDH's Quality Assurance website.

Systems Performance Review

MY 2021 Statewide Executive Summary Report

Performance Improvement Projects

2022 Annual PIP Report

Encounter Data Validation

MY 2021 EDV Report

Value-Based Purchasing

MY 2021 VBP Report

Early and Periodic Screening, Diagnosis, and Treatment

Placeholder for MY 2021 EPSDT Statewide Executive Summary Report

Consumer Report Card

2022 Maryland Consumer Report Card English and Spanish

Focused Review of Grievances, Appeals, & Denials

2022 Annual Grievances, Appeals, & Denials Report

Network Adequacy Validation

MY 2022 Network Adequacy Report

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set Statewide Executive Summary Report HealthChoice Participating Organizations HEDIS 2021

Consumer Assessment of Healthcare Providers and Systems

State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations Adult and Child Populations 2021 CAHPS 5.0H Member Experience Survey