HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

Medicaid Managed Care Organization

2015 Annual Technical Report

Delmarva Foundation
A Quality Health Strategies Company

Submitted by:
Delmarva Foundation
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Executive Summary

Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is responsible for evaluating the quality of care provided to eligible participants in contracted Managed Care Organizations (MCOs) through the Maryland Medicaid Managed Care Program, known as HealthChoice. HealthChoice has been operational since June 1997, and its quality assurance program operates pursuant to Title 42 of the Code of Federal Regulations (CFR), Section 438.204 and the Code of Maryland Regulations (COMAR) 10.09.65. HealthChoice's philosophy is based on providing quality health care that is patient–focused, prevention–oriented, comprehensive, coordinated, accessible, and cost–effective.

DHMH's HealthChoice and Acute Care Administration (HACA) is responsible for coordination and oversight of the HealthChoice program. HACA ensures that the initiatives established in 42 CFR 438, Subpart D are adhered to and all MCOs that participate in the HealthChoice program apply these principles universally and appropriately. The functions and infrastructure of HACA support efforts to identify and address quality issues efficiently and effectively. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care process and help to ensure that health care is not compromised. The Division of HealthChoice Quality Assurance (DHQA) within HACA is primarily responsible for coordinating the quality activities involving external quality review and monitoring Centers for Medicare and Medicaid Services (CMS) quality improvement requirements for the HealthChoice program.

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

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

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

As of December 31, 2014, the HealthChoice program served over 1,059,088 participants. The Department contracted with eight MCOs during this evaluation period. The eight MCOs evaluated during this period were:

- AMERIGROUP Community Care (Amerigroup/ACC)
- Jai Medical Systems, Inc. (Jai/JMS)
- Kaiser Permanente of the Mid–Atlantic States (Kaiser/KPMAS) – entered HealthChoice June 2014
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MedStar/MSFC)
- Priority Partners (Priority/PPMCO)
- Riverside Health of Maryland (Riverside/RHMD) – entered HealthChoice February 2013
- UnitedHealthcare (United/UHC)

Kaiser began participating in the HealthChoice program in June 2014. The EQRO's evaluation of Kaiser for calendar year (CY) 2014 included only the Systems Performance Review and Value Based Purchasing because the MCO did not have a full year of participation in the HealthChoice system. Their full participation in all EQRO activities will begin in CY 2016.

Pursuant to 42 CFR 438.364, the 2015 Annual Technical Report describes the findings from Delmarva Foundation's External Quality Review activities for years 2013–2014 which took place in CY 2015. The report includes each review activity conducted by Delmarva Foundation, the methods used to aggregate and analyze information from the review activities, and conclusions drawn regarding the quality, access, and timeliness of healthcare services provided by the HealthChoice MCOs.

HACA Quality Strategy

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

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

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

EQRO Program Assessment Activities

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

1) Conduct a review of MCOs' operations to assess compliance with State and Federal standards for quality program operations;
2) Validate State required performance measures; and
3) Validate State required Performance Improvement Projects (PIPs) that were underway during the prior 12 months.

Delmarva Foundation also conducted an optional activity: validation of encounter data reported by the MCOs. As the EQRO, Delmarva Foundation conducted each of the mandatory activities and the optional activities in a manner consistent with the CMS protocols during CY 2015.

Additionally, the following two review activities were conducted by Delmarva Foundation:

1) Conduct the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews; and
2) Develop and produce an annual Consumer Report Card to assist participants in selecting an MCO.

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

- Systems Performance Review
- Value Based Purchasing
- Performance Improvement Projects
- Encounter Data Validation
- EPSDT Medical Record Review
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Consumer Report Card

Separate report sections address each review activity and describe the methodology and data sources used to draw conclusions for the particular area of focus. The final report section summarizes findings and

recommendations to HACA and the MCOs to further improve the quality of, timeliness of, and access to health care services for HealthChoice participants.

General Overview of Findings

Assessment of Quality, Access, and Timeliness

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

- **Quality**, as it pertains to external quality review, is defined as "the degree to which an MCO or Prepaid Inpatient Health Plan increases the likelihood of desired health outcomes of its participants (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge." ([CMS], *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et. al. Subpart D– Quality Assessment and Performance Improvement,* [June 2002]).
- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is "the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services." *(2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*).
- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care." (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." *(Envisioning the National Health Care Quality Report, 2001).*

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

Table 1. Review Activities that Assess Quality, Access, and Timeliness

Annual Review Activities that Assess Quality, Access, and Timeliness			
Systems Performance Review	**Quality**	**Access**	**Timeliness**
Standard 1 – Systematic Process of Quality Assessment and Improvement	√		
Standard 2 – Accountability to the Governing Body	√		
Standard 3 – Oversight of Delegated Entities	√		
Standard 4 – Credentialing and Recredentialing	√	√	√
Standard 5 – Enrollee Rights	√	√	√

Annual Review Activities that Assess Quality, Access, and Timeliness			
Standard 6 – Availability and Accessibility		√	√
Standard 7 – Utilization Review	√	√	√
Standard 8 – Continuity of Care	√	√	√
Standard 9 – Health Education Plan	√	√	
Standard 10 – Outreach Plan	√	√	
Standard 11 – Fraud and Abuse	√		√
Value Based Purchasing	**Quality**	**Access**	**Timeliness**
Adolescent Well–Care	√	√	√
Adult BMI Assessment (NEW)	√		
Ambulatory Care Services for SSI Adults Ages 21–64 Years	√	√	
Ambulatory Care Services for SSI Children Ages 0–20 Years	√	√	
Breast Cancer Screening (NEW)	√	√	√
Childhood Immunization Status (Combo 3)	√	√	√
Comprehensive Diabetes Care – HbA1c Testing (NEW)	√	√	√
Controlling High Blood Pressure (NEW)	√		√
Immunizations for Adolescents	√		√
Lead Screenings for Children Ages 12–23 Months	√		√
Medication Management for People with Asthma (NEW)	√	√	√
Postpartum Care	√	√	√
Well–Child Visits for Children Ages 3–6 Years	√	√	√
Performance Improvement Project	**Quality**	**Access**	**Timeliness**
Adolescent Well–Care PIP	√	√	√
High Blood Pressure PIP	√	√	√
EPSDT Medical Record Review	**Quality**	**Access**	**Timeliness**
Health and Developmental History	√		√
Comprehensive Physical Examination	√		√
Laboratory Tests/At–Risk Screenings		√	√
Immunizations	√		√
Health Education and Anticipatory Guidance	√		√
Encounter Data Validation	**Quality**	**Access**	**Timeliness**
Inpatient, Outpatient, Office Visit Medical Record Review	√		
HEDIS®	**Quality**	**Access**	**Timeliness**
Childhood Immunization Status	√		√
Immunizations for Adolescents	√		√
Appropriate Treatment for Children with Upper Respiratory Infection	√		
Appropriate Testing for Children with Pharyngitis	√		

Annual Review Activities that Assess Quality, Access, and Timeliness			
Breast Cancer Screening	√		√
Cervical Cancer Screening	√		√
Chlamydia Screening in Women	√		√
Comprehensive Diabetes Care	√		√
Use of Appropriate Medications for People with Asthma	√		
Use of Imaging Studies for Low Back Pain	√		
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	√		
Adult BMI Assessment	√		√
Controlling High Blood Pressure	√		√
Annual Monitoring for Patients on Persistent Medications	√		√
Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	√		
Medication Management for People with Asthma	√		
Adults' Access to Preventive/Ambulatory Health Services	√	√	√
Children and Adolescents' Access to Primary Care Practitioners	√	√	√
Prenatal and Postpartum Care	√	√	√
Call Answer Timeliness		√	√
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	√	√	√
Frequency of Ongoing Prenatal Care	√	√	√
Well–Child Visits in the First 15 Months of Life	√	√	√
Well–Child Visits in the 3rd, 4th, 5th and 6th Years of Life	√	√	√
Adolescent Well–Care Visits	√	√	√
Ambulatory Care		√	
Identification of Alcohol and Other Drug Services	√	√	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	√	√	√
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	√		√
Pharmacotherapy Management of COPD Exacerbation	√		√
Asthma Medication Ratio	√		
Persistence of Beta–Blocker Treatment After a Heart Attack	√		√
Lead Screening in Children	√	√	
Human Papillomavirus Vaccine for Female Adolescents	√		
Non–Recommended Cervical Cancer Screening in Adolescent Females	√	√	
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	√	√	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Atipsychotic Medications	√	√	

Annual Review Activities that Assess Quality, Access, and Timeliness			
Diabetes Monitoring for People with Diabetes and Schizophrenia	√	√	
Antidepressant Medication Management	√		
Follow–Up Care after Hospitalization for Mental Illness	√	√	√
Follow–Up Care for Children Prescribed ADHD Medication	√	√	√
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	√		
Frequency of Selected Procedures		√	
Inpatient Utilization – General Hospital/Acute Care	√	√	
Mental Health Utilization	√	√	
Antibiotic Utilization	√	√	
Board Certification	√		
Enrollment by Product Line		√	
Enrollment by State		√	
Language Diversity of Membership		√	
Race/Ethnicity Diversity of Membership		√	
Weeks of Pregnancy at Time of Enrollment			√
Total Membership		√	
CAHPS®	**Quality**	**Access**	**Timeliness**
Getting Needed Care		√	
Getting Care Quickly			√
How Well Doctors Communicate	√		
Customer Service	√	√	
Shared Decision Making	√		
Health Promotion and Education	√		
Coordination of Care	√		
Access to Prescription Medication*		√	
Access to Specialized Services*		√	
Family Centered Care: Personal Doctor Who Knows Your Child*	√		
Family Centered Care: Getting Needed Information*	√		
Coordination of Care for Children with Chronic Conditions*	√		

*Additional Composite Measures for Children with Chronic Conditions

Section I
Systems Performance Review

Introduction

Delmarva Foundation performed an independent annual review of services in order to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice Program. COMAR 10.09.65 requires that all HealthChoice MCOs comply with the Systems Performance Review (SPR) standards and all applicable federal and state laws and regulations. This section describes the findings from the SPR for CY 2014, conducted in January and February of 2015. All eight MCOs were evaluated during this review period:

- AMERIGROUP Community Care (Amerigroup/ACC)
- Jai Medical Systems, Inc. (Jai/JMS)
- Kaiser Permanente of the Mid–Atlantic States (Kaiser/KPMAS) – entered HealthChoice June 2014
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MedStar/MSFC)
- Priority Partners (Priority/PPMCO)
- Riverside Health of Maryland (Riverside/RHMD) – entered HealthChoice February 2013
- UnitedHealthcare (United/UHC)

The SPRs were conducted at the MCO's corporate offices and performed by a review team consisting of health professionals, a nurse practitioner, and two masters prepared reviewers. The team has combined experience of more than 45 years in managed care and quality improvement systems, 33 years of which are specific to the HealthChoice program.

Purpose

The purpose of the SPR is to provide an annual assessment of the structure, process, and outcome of each MCO's internal quality assurance programs. Through the systems review, the team is able to identify, validate, quantify, and monitor problem areas, as well as identify and promote best practices. The team completed the reviews and provided feedback to the Division of HealthChoice Quality Assurance (DHQA) and each MCO with the goal of improving the care provided to HealthChoice participants.

Methodology

For CY 2014, COMAR 10.09.65.03 required that all HealthChoice MCOs comply with the SPR standards established by the Department and all applicable federal and state laws and regulations.

The following eleven performance standards were included in the CY 2014 review cycle:

- Systematic Process of Quality Assessment*
- Accountability to the Governing Body
- Oversight of Delegated Entities
- Credentialing and Recredentialing
- Enrollee Rights
- Availability and Accessibility
- Utilization Review (UR)
- Continuity of Care
- Health Education*
- Outreach*
- Fraud and Abuse

*Note: These standards were exempt from the CY 2014 review cycle for all MCOs except for Kaiser and Riverside, as this was the MCO's first and second SPRs, respectively.

For CY 2014, all MCOs (except for Kaiser and Riverside) were expected to meet the compliance score of 100% for all standards. The Kaiser compliance score was set at 80% for its first SPR, and the Riverside compliance score was set at 90% for its second SPR. The MCOs were required to submit a CAP for any standard that did not meet the minimum compliance score.

In September 2014, Delmarva provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for Calendar Year 2014 and invited the MCOs to direct any questions or issues requiring clarification to specific Delmarva and DHQA staff. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2014 Review Timeline
- External Quality Review Contact Persons
- Pre–site Visit Overview and Survey
- Pre–site SPR Document List
- Systems Performance Review Standards and Guidelines, including CY 2014 changes

Prior to the on–site review, the MCOs were required to submit a completed pre–site survey form and provide documentation for various processes such as quality and UM, delegation, credentialing, enrollee rights, continuity of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Delmarva staff prior to the on–site visit.

During the on–site reviews in January and February of 2015, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion,

exit conferences were held with each MCO. The purpose of the conferences was to provide the MCOs with preliminary findings, based on interviews and all documentation reviewed. During the exit conferences, Delmarva stated the MCOs would receive a follow–up letter describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow–up letter to submit any additional information to Delmarva. Any documents sent to Delmarva were subsequently reviewed against the standard(s) to which they related.

After completing the on–site review, Delmarva documented its findings for each standard by element and component. The level of compliance for each element and component was rated with a review determination of met, partially met, or unmet, as follows:

Met	100%
Partially Met	50%
Unmet	0%

Each element or component of a standard was of equal weight. A CAP was required for each performance standard that did not meet the minimum required compliance rate, as defined for the CY 2014 review.

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

The Department had the discretion to change a review finding to "Unmet" based on the fact that it has been found "Partially Met" for more than one consecutive year.

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

Corrective Action Plan Process

Each year the CAP process is discussed during the annual review meeting. This process requires that each MCO must submit a CAP which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the preliminary report. CAPs are

reviewed by Delmarva and determined to be adequate only if they address the following required elements and components:

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

In the event that a CAP is deemed unacceptable, Delmarva Foundation will provide technical assistance to the MCO until an acceptable CAP is submitted. Three MCOs were required to submit CAPs for the CY 2014 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Delmarva reviewed any additional materials submitted by the MCO, made appropriate revisions to the MCO's final report, and submitted the report to the DHMH for review and approval. The Final MCO Annual System Performance Review Reports were mailed to the MCOs.

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2015 will determine whether the CAPs from the CY 2014 review were implemented and effective. In order to make this determination, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

Findings

The HealthChoice MCO annual SPR consists of 11 standards. The compliance threshold established by DHMH for all standards for CY 2014 is 100% for all MCOs, except for Kaiser for which the compliance threshold is set at 80% for its first SPR and Riverside for which the compliance threshold is set at 90% for its second SPR.

All eight HealthChoice MCOs participated in the SPR. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. If the MCO's score was below the minimum threshold, a CAP was required. Three MCOs (Jai, Maryland Physicians Care, and MedStar) received perfect scores in all standards. Five MCOs (Amerigroup, Kaiser, Priority, Riverside, and United) were required to submit CAPs for CY 2014.

Table 2 provides for a comparison of SPR results across MCOs and the MD MCO Compliance for the CY 2014 review.

Table 2. CY 2014 MCO Compliance Score

Standard	Elements Reviewed	MD MCO Compliance Score	ACC	JMS	KPMAS+	MPC	MSFC	PPMCO	RHMD**	UHC
1 Systematic Process	33	100%	Exempt	Exempt	100%	Exempt	Exempt	Exempt	100%	Exempt
2 Governing Body	14	**96%***	100%	100%	**56%***	100%	100%	100%	100%	100%
3 Oversight of Delegated Entities	**7**	**90%***	100%	100%	**75%***	100%	100%	100%	**50%***	**92%***
4 Credentialing	42	**99%***	**99%***	100%	100%	100%	100%	100%	100%	100%
5 Enrollee Rights	24	**96%***	**93%***	100%	94%	100%	100%	**98%***	**85%***	100%
6 Availability and Access	10	**99%***	100%	100%	100%	100%	100%	100%	95%	100%
7 Utilization Review	23	**92%***	**89%***	100%	83%	100%	100%	**87%***	**89%***	**87%***
8 Continuity of Care	4	100%	100%	100%	100%	100%	100%	100%	100%	100%
9 Health Education Plan	12	**82%***	Exempt	Exempt	100%	Exempt	Exempt	Exempt	**67%***	Exempt
10 Outreach Plan	14	**89%***	Exempt	Exempt	**79%***	Exempt	Exempt	Exempt	100%	Exempt
11 Fraud and Abuse	19	**98%***	100%	100%	89%	100%	100%	100%	92%	100%
Composite Score		**97%**	**96%**	**100%**	**91%**	**100%**	**100%**	**97%**	**97%**	**97%**

Bolded text and an asterisk denote that the minimum compliance score was unmet.
**RHMD's minimum compliance threshold is set at 90%, as this was the MCO's second SPR.
+ Kaiser's minimum compliance threshold is set at 80%, as this was the MCO's first SPR.

For each standard assessed for CY 2014, the following section describes the requirements reviewed; the results, including the MD MCO compliance score; the overall MCO findings; the individual MCO opportunities for improvement and CAP requirements, if applicable; and follow up, if required.

STANDARD 1: Systematic Process of Quality Assessment/Improvement

Requirements: The MCO's Quality Assurance Program (QAP) objectively and systematically monitors/evaluates the quality of care (QOC) and services to participants. Through QOC studies and related activities, the MCO pursues opportunities for improvement on an ongoing basis. The QAP studies monitor QOC against clinical practice guidelines which are based on reasonable evidence based practices. The QAP must have written guidelines for its QOC studies and related activities that require the analysis of clinical and related services. The QAP must include written procedures for taking appropriate corrective action whenever inappropriate or substandard services are furnished. The QAP must have written guidelines for the assessment of the corrective actions. The QAP incorporates written guidelines for evaluation of the continuity and effectiveness of the QAP. A comprehensive annual written report on the QAP must be completed, reviewed, and approved by the MCO governing body. The QAP must contain an organizational chart that includes all positions required to facilitate the QAP.

Results:

- All MCOs (except for Kaiser and Riverside) were exempt from this standard as each MCO received compliance ratings of 100% for the past three consecutive years.
- Kaiser received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- Riverside received a compliance score of 100%, which exceeded its minimum compliance threshold of 90% for its second review.

Findings: This was Kaiser and Riverside's first and second reviews of their QAP, respectively. The MCOs' QAPs were found to be comprehensive in scope and to appropriately monitor and evaluate the quality of care and service to members using meaningful and relevant performance measures. Clinical care standards and/or practice guidelines are in place which the MCOs monitor performance against annually, and clinicians monitor and evaluate quality through review of individual cases where there are questions about care. Additionally, there was evidence of development, implementation, and monitoring of corrective actions.

MCO Opportunity/CAP Required

No CAPs were required.

Follow–up: No follow–up is required.

STANDARD 2: Accountability to the Governing Body

Requirements: The governing body of the MCO is the Board of Directors or, where the Board's participation with the quality improvement 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. There must be documentation that the governing body has oversight of the QAP. The governing body must approve the overall QAP and an annual QAP. The governing body formally designates an accountable entity or entities within the organization to provide oversight of quality assurance, or has formally decided to provide oversight as a committee. The governing body must routinely receive written reports on the QAP that describe actions taken, progress in meeting quality objectives, and improvements made. The governing body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review of findings and issues of concern within the MCO. The governing body is active in credentialing, recredentialing, and utilization review activities.

Results:

- The overall MD MCO Compliance Score was 96% for CY 2014.
- Amerigroup, Jai, Maryland Physicians Care, MedStar, Priority, Riverside, and United met the minimum compliance threshold for this standard.
- Riverside received a compliance score of 100%, which exceeded its minimum compliance threshold of 90% for its second review.
- Kaiser received a compliance score of 56%, which was below the minimum compliance threshold of 80%, and was required to submit a CAP.

Findings: Overall, MCOs continue to have appropriate oversight by their governing boards. Evidence of oversight was provided by the governing body, along with ongoing feedback and direction of quality improvement activities and operational activities of the MCO.

MCO Opportunity/CAP Required

Kaiser Opportunities/CAPs:

Element 2.3 – The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.

Kaiser received a finding of unmet because after a review of Regional Quality Improvement Committee (RQIC) meeting minutes for October, November, and December 2014, there was evidence of reporting on these functional areas per the RQIC Reporting Schedule for 2014; however, it was unclear which reports applied to the HealthChoice population as most reports were in the aggregate, across the tri–state region, for each service area.

In order to receive a finding of met in the CY 2015 SPR, Kaiser must ensure that reports pertaining to the Quality Management Program (QMP) Work Plan activities clearly represent the MD Medicaid population in order for this population to be monitored.

Element 2.5 – The governing body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review of findings and issues of concern within the MCO.

STANDARD 2: Accountability to the Governing Body

Kaiser received a finding of unmet because this standard pertains to the RQIC's receiving regular written reports from the QAP delineating actions taken and improvements made. In the RQIC meeting minutes for October, November, and December 2014, there was evidence of reporting on functional areas as per the RQIC Reporting Schedule for 2014. However, it is unclear which reports apply to HealthChoice population as most reports were in the aggregate across the region, per service area.

In order to receive a finding of met in the CY 2015 SPR, Kaiser must document how the RQIC takes action and provides follow–up when appropriate, specifically in relation to HealthChoice initiatives. These activities should be documented in the minutes of the meetings in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to the QMP. It is unclear from a review of meeting minutes that Kaiser is addressing the full intent of this standard at this time.

Component 2.7 a – The governing body is active in UR activities. The governing body meeting minutes reflect ongoing reporting of UR activities.

Kaiser received a finding of partially met. The Regional Utilization Management Committee (RUMC) reviewed and approved the UMP by electronic vote between October 1 and October 5, 2014. Although the RQIC's role in oversight of UM activities was clearly documented in the QMP and the Utilization Management Program (UMP), it was unclear what UM reports specific to HealthChoice were provided to the RQIC.

In order to receive a finding of met in the CY 2015 SPR, Kaiser must clearly document the HealthChoice–specific UM reports in the RQIC meeting minutes.

Component 2.7 b – The governing body is active in UR activities. The governing body meeting minutes reflect ongoing reporting of UR findings.

Kaiser received a finding of unmet. In the RQIC meeting minutes for October to December 2014, review confirmed evidence of reporting of UM findings for some of the reports above, but it was unclear which findings were specific to HealthChoice.

In order to receive a finding of met in the CY 2015 SPR, Kaiser must clearly document the HealthChoice–specific UM findings in the RQIC meeting minutes.

Follow–up:

- Kaiser was required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed during the CY 2015 SPR.

STANDARD 3: Oversight of Delegated Entities

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

Results:

- The overall MD MCO Compliance Score was 90% for CY 2014.
- Amerigroup, Jai, Maryland Physicians Care, MedStar, and Priority met the minimum compliance threshold for this standard.
- Kaiser received a compliance score of 75%, which was below its minimum compliance threshold of 80%, and was required to submit a CAP.
- Riverside received a compliance score of 50%, which was below its minimum compliance threshold of 90%, and was required to submit a CAP.
- United received a compliance score of 92%, which was below its minimum compliance threshold of 100%, and was required to submit a CAP.

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

MCO Opportunity/CAP Required

Kaiser Opportunities/CAPs:

Component 3.3 c – There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of claims payment activities, where applicable.

Kaiser received a finding of unmet because the MCO began operations in mid–June 2014 and delegate claims activities reports would have been available only for the third quarter of 2014. Review of MCO policies and discussions with staff indicated that no committee had been assigned the responsibility for approval of delegate reports, including claims activities, in 2014.

In order to receive a finding of met in the CY 2015 SPR, Kaiser must provide evidence that the appropriate committee has reviewed and approved all delegate reports, including claims activities, at the stated frequency.

Riverside Opportunities/CAPs:

Component 3.3 a – There is evidence of continuous and ongoing evaluation of delegated activities, including 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.

Riverside received a finding of partially met. Routine monitoring and oversight of delegated entities occurs at multiple levels throughout the organization. Monthly meetings with each delegate occurred throughout 2014 and focused on review of vendor performance and operational updates. The Delegate Oversight Committee (DOC)

STANDARD 3: Oversight of Delegated Entities

meets quarterly to review delegate–submitted quarterly reports and presents a summary of its findings to the QIC for review/approval. The Delegation of Services Policy requires an annual evaluation of each delegate, including reviews of policies and procedures, Utilization Management (UM), credentialing, member complaints or complex Case Management (CM) records, as appropriate, and relevant program descriptions. If the entity is accredited or certified by NCQA, the MCO may choose to forgo the oversight functions, such as policy and record reviews. According to the Vice President of Provider Relations, no delegate audits were conducted in 2014 even though one of their vendors, Block Vision, is not NCQA accredited.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence that the MCO conducts annual audits of its delegates per its Delegation of Services Policy.

Component 3.3b – There is evidence of continuous and ongoing evaluation of delegated activities, including quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable.

Riverside received a finding of unmet. In response to the CY 2013 SPR findings, Riverside was required to develop a CAP to provide evidence of formal review and approval of delegate quarterly complaint, grievance, and appeal reports on a quarterly basis by the appropriate committee designated in the MCO's policy. The CAP was not fully implemented and a continuing opportunity for improvement exists.

There was evidence of Quality Improvement Committee (QIC) quarterly review and approval of Block Vision and ValueOptions complaint, grievance, and appeal reports for first, second, and third quarters of 2014. QIC meeting minutes from March 31, 2014, noted that delegate reports for fourth quarter 2013 were presented at the December 2013 QIC, even though it was not the end of the fourth quarter. This would have resulted in an incomplete QIC approval for the quarter.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence of formal review and approval of delegate quarterly complaint, grievance, and appeal reports on a quarterly basis by the appropriate committee designated in the MCO's policy for each of the four quarters (fourth quarter of 2014 and first, second, and third quarters of 2015).

Component 3.3c – There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of claims payment activities, where applicable.

Riverside received a partially met. In response to the CY 2013 SPR findings, Riverside was required to develop a CAP to provide evidence of formal review and approval of delegate claims activities reports by the appropriate committee designated in the MCO's policy and according to the stated frequency. The CAP was not fully implemented and a continuing opportunity for improvement exists.

There was evidence of QIC quarterly review and approval of Block Vision, CVS/Caremark, and ValueOptions claims activities reports for first, second, and third quarters of 2014. QIC meeting minutes from March 31, 2014,

STANDARD 3: Oversight of Delegated Entities

noted that delegate reports for fourth quarter 2013 were presented at the December 2013 QIC, even though it was not the end of the fourth quarter. This would have resulted in an incomplete QIC approval for the quarter.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence of formal review and approval of delegate claims activities reports by the appropriate committee designated in the MCO's policy and according to the stated frequency.

Component 3.3d – There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.

Riverside received a finding of unmet. In response to the CY 2013 SPR findings, Riverside was required to develop a CAP to provide evidence of formal review and approval of each delegate's annual utilization management plan (UMP) and UM criteria by the appropriate committee designated in the MCO's policy. The CAP was not implemented and a continuing opportunity for improvement exists.

There was no evidence of QIC review and approval of the annual UMP and UM criteria from CVS/Caremark and ValueOptions in 2014 meeting minutes.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence of formal review and approval of each delegate's annual UMP and UM criteria by the appropriate committee designated in the MCO's policy.

Component 3.3e – There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of over and underutilization reports, where applicable.

Riverside received a finding of unmet. In response to the CY 2013 SPR findings, Riverside was required to develop a CAP to provide evidence of formal review and approval of each delegate's over and under utilization reports by the appropriate committee designated in the MCO's policy and according to the stated frequency. The CAP was not implemented and a continuing opportunity for improvement exists.

There was no evidence of QIC review and approval of ValueOptions and CVS/Caremark over and under utilization reports in QIC meeting minutes from 2014.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence of formal review and approval of each delegate's over and under utilization reports by the appropriate committee designated in the MCO's policy and according to the stated frequency.

United Opportunities/CAPs:

Component 3.3d – There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.

STANDARD 3: Oversight of Delegated Entities

United received a finding of partially met. The 2014 Delegation Manual requires the UMP and criteria of any UM delegated entity to be reviewed and approved annually by the Healthcare Quality and Utilization Management Committee (HQUMC) and Provider Advisory Committee (PAC). Minutes from the HQUMC of September 16, 2014, included a notation that the Care Core National (CCN) UMP Description was sent out following the meeting and approved by e–vote. Minutes from the PAC meeting of October 16, 2014, documented presentation of the CCN UMP and criteria and a motion to approve, which was seconded. It was clear that the intent was to approve, but no final committee approval was documented in the meeting minutes.

In order to receive a finding of met in the CY 2015 SPR, United must clearly document formal approval of any delegate's UMP Description in the appropriate committee meeting minutes.

Follow–up:

- Kaiser, Riverside, and United were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed during the CY 2015 SPR.

STANDARD 4: Credentialing and Recredentialing

Requirements: The QAP must contain 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. The MCO must have written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. The MCO may delegate credentialing/recredentialing activities with a written description of the delegated activities, a description of the delegate's accountability for designated activities, and evidence that the delegate accomplished the credentialing activities. The credentialing process must be ongoing and current. There must be evidence that the MCO requests information from recognized monitoring organizations about the practitioner. The credentialing application must include information regarding the use of illegal drugs, a history of loss of license and loss or limitation of privileges or disciplinary activity, and an attestation to the correctness and completeness of the application. There must be 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 Americans with Disabilities Act of 1990 (ADA) and the MCO's standards.

There must be evidence that recredentialing is performed at least every three years and includes a review of enrollee complaints, results of quality reviews, hospital privileges, current licensure, and office site compliance with ADA standards, if applicable.

Results:

- The overall MD MCO Compliance Score was 99% for CY 2014.
- Jai, Kaiser, Maryland Physicians Care, MedStar, Priority, Riverside, and United met the minimum compliance threshold for this standard.
- Kaiser received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- Riverside received a compliance score of 100%, which exceeded its minimum compliance threshold of 90% for its second review.
- Amerigroup received a compliance score of 99%, which was below its minimum compliance threshold of 100%, and was required to submit a CAP.

Findings: Overall, MCOs have appropriate policies and procedures in place to determine whether physicians and other health care professionals, licensed by the State and under contract to the MCO, are qualified to perform their services. Evidence in credentialing and recredentialing records demonstrated that those policies and procedures are functioning effectively. There were issues identified with the recredentialing process over the past year which represented the slight decline in the overall MCO compliance score.

MCO Opportunity/CAP Required

Amerigroup Opportunities/CAPs:

Component 4.4i – The credentialing process must be ongoing and current. At a minimum, the credentialing process must include adherence to the time frames set forth in the MCO's policies regarding credentialing date requirements.

STANDARD 4: Credentialing and Recredentialing

Amerigroup received a finding of partially met because nine of the ten provider records demonstrated adherence to the time frames set forth in the MCO's policies regarding the completion of the credentialing application process within 120 days of the 30–day notification letter. One provider record was processed in over 200 days, exceeding the allowed time frame of 120 days. In discussions with credentialing staff, it was determined that this provider's record fell out of the workflow queue at Corporate, and, as soon as it was identified, the record was processed immediately. To determine if this was a pattern, aging reports were reviewed to assess the application processing time for a sample of 85 initial credentialing applications. This review demonstrated that no other records were out of compliance for processing time frames. It appears that this noncompliant record is an outlier and not customary practice.

Delmarva will assess compliance to application processing time frames in the next SPR. In the future, if Amerigroup credentialing staff discovers that a provider application has fallen out of the work queue, the provider should be notified immediately of this fact.

Follow–up:

- Amerigroup was required to submit a CAP for the above component. Delmarva Foundation reviewed and approved the submission.
- The approved CAP will be reviewed during the CY 2015 SPR.

STANDARD 5: Enrollee Rights

Requirements: The organization demonstrates a commitment to treating participants in a manner that acknowledges their rights and responsibilities. The MCO must have a system linked to the QAP for resolving participants' grievances. This system must meet all requirements in COMAR 10.09.71.02 and 10.09.71.04. Enrollee information must be written to be readable and easily understood. This information must be available in the prevalent non–English languages identified by the Department. The MCO must act to ensure that the confidentiality of specified patient information and records are protected. The MCO must have written policies regarding the appropriate treatment of minors. The MCO must, as a result of the enrollee satisfaction surveys, identify and investigate sources of enrollee dissatisfaction, implement steps to follow–up on the findings, inform practitioners and providers of assessment results, and reevaluate the effectiveness of the implementation steps at least quarterly. The MCO must have systems in place to assure that new participants receive required information within established time frames.

Results:

- The overall MD MCO Compliance Score was 96% for CY 2014.
- Jai, Kaiser, Maryland Physicians Care, MedStar, and United met the minimum compliance threshold for this standard.
- Kaiser received a compliance score of 96%, which exceeded its minimum compliance threshold of 80% for its first review.
- Riverside received a compliance score of 85%, which was below the minimum compliance threshold of 90%, and was required to submit a CAP.
- Amerigroup and Priority received compliance scores of 93% and 98%, respectively. These scores were below the compliance threshold of 100% and required CAPs.

Findings: Overall, MCOs have policies and procedures in place that demonstrate their commitment to treating members in a manner that acknowledges their rights and responsibilities. Evidence of enrollee information was reviewed and found to be easily understood and written in Spanish as required by the Department.

Additionally, all MCOs provided evidence of their complaint, grievance, and appeals processes. However, opportunities for improvement did exist regarding policies and procedures, complaints/grievances, and satisfaction surveys.

MCO Opportunity/CAP Required

Amerigroup Opportunities/CAPs:

Component 5.5c – As a result of the enrollee satisfaction surveys, the MCO informs practitioners and providers of assessment results.

Amerigroup received a finding of unmet as there was no evidence that Amerigroup informed practitioners of 2013 Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey results in 2014. Subsequent to the SPR, Amerigroup provided additional documentation to support this standard. Amerigroup stated that the third quarter 2014 provider newsletter provided a notice of Amerigroup's QI Program stating that CAHPS® surveys were completed and results were available to providers by contacting Provider Services. The MCO stated that this allowed practitioners to determine when they wish to receive content from the MCO and provided an opportunity

STANDARD 5: Enrollee Rights

to obtain information in addition to CAHPS® results. The newsletter was reviewed and included the following statement after a brief sentence about the CAHPS® surveys being sent to members over the past six months: "To review the current Quality Improvement program summary, call Provider Services at 1–800–454–3730 – we'll be glad to send you a copy."

After review of the additional documents provided by Amerigroup, it was found that the statement noted in the provider newsletter does not meet the intent of the standard, as the standard requires the MCO to inform practitioners of the assessment results.

In order to receive a finding of met in the CY 2015 SPR, Amerigroup must annually inform practitioners of CAHPS® survey results.

Component 5.5d – As a result of the enrollee satisfaction surveys, the MCO reevaluates the effects of 5.5b. (Implements steps to follow up on the findings) at least quarterly.

Amerigroup received a finding of partially met. The member satisfaction survey results, action plans, and communication reports are evaluated by the Quality Management Committee (QMC). Review of the meeting minutes revealed discussion of corrective action based on survey results. The QMC monitors at least quarterly the progress of the interventions and improvements noted in the Quality Management Program (QMP) Annual Evaluation. A review of the QMC meetings of 2014 provided evidence of interventions taking place to address member satisfaction. However, clear documentation that correlates with the noted interventions in the Annual Evaluations addressing areas of the CAHPS® survey was not provided on a quarterly basis throughout 2014.

In order to receive a finding of met in the CY 2015 SPR, Amerigroup must provide clear documentation of quarterly monitoring of the progress of the interventions implemented as a result of the CAHPS® survey.

Priority Opportunities/CAPs:

Component 5.1d – The grievance policy and procedure describes the process for aggregation 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.

Priority received a finding of partially met. The Member Complaint/Grievance Policy describes the process for aggregation and analysis of grievance data and the use of the data for QI. All Priority grievances are logged into an electronic database that tracks grievances by the type and resolution of the grievance. When trends are identified, the MCO acts to make improvements to meet the needs of its members and providers.

The policy states that grievances are reported in aggregate to the Process Management Team (PMT) and DHMH quarterly and to the Consumer Advisory Board (CAB) annually.

Review of meeting minutes found evidence of at least quarterly reporting of grievance data to the PMT. However, there is not sufficient documentation in the CAB meeting minutes for December 2014 that complaints/grievances were reported to that board.

STANDARD 5: Enrollee Rights

In order to receive a finding of met in the next SPR, Priority must provide evidence of reporting grievance data to the CAB on an annual basis, according to their policy.

Riverside Opportunities/CAPs:

Component 5.5c – As a result of the enrollee satisfaction surveys, the MCO informs practitioners and providers of assessment results.

Riverside received a finding of unmet because providers were not made aware of the CAHPS® survey results in 2014. It is recommended that the Satisfaction Surveys Policy be revised to include that Riverside annually inform providers of the assessment results.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence that it informed providers of satisfaction survey results.

Component 5.6a – Policies and procedures are in place that address the content of new enrollee packets of information and specify the time frames for sending such information to the enrollee.

Riverside received a finding of unmet. It is reported by the Enrollment Department that welcome packet fulfillment reports are reviewed daily. Daily reports were provided and reviewed as evidence of this activity. Health Risk Assessment and Welcome Call policies were developed and are used to confirm receipt of new enrollee packets.

However, it is required that the MCO have a policy and procedure that includes the content of new enrollee packets and the regulatory time frames for mailing such information to new enrollees.

In order to receive a finding of met in the CY 2015 SPR, Riverside must develop a policy and procedure that specifies the content of new enrollee packets and the regulatory time frames for mailing such information to new enrollees.

Component 5.6c – The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution.

Riverside received a finding of unmet because it does not currently have a documented process for tracking timeliness of newborn enrollment that has the ability to identify issues for resolution. In the past, Riverside has provided a workflow process entitled "The In–Patient Newborn Notification Workflow Process," which documented the tracking process for newborn enrollment along with the reconciliation of the DHMH 1184 form. The MCO was unable to produce this document for review this year.

In order to receive a finding of met in the CY 2015 SPR, Riverside must have a formal policy and procedure that documents its process for tracking the timeliness of newborn enrollment. The process must have the ability to identify issues for resolution. It is recommended that this policy incorporate the workflow process that was presented in the CY 2013 SPR.

STANDARD 5: Enrollee Rights

Follow–up:

- Amerigroup, Riverside, and Priority were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed for compliance during the CY 2015 SPR.

STANDARD 6: Availability and Accessibility

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

Results:

- The overall MD MCO Compliance Score was 99% for CY 2014.
- All MCOs met the minimum compliance threshold for this standard.
- Kaiser received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- Riverside received a compliance score of 95%, which exceeded its minimum compliance threshold 90% for its second review.

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

MCO Opportunity/CAP Required

No CAPs were required.

Follow–up: No follow up is required.

STANDARD 7: Utilization Review

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

Results:

- The overall MD MCO Compliance Score was 92% in CY 2014.
- Jai, Kaiser, Maryland Physicians Care, and MedStar met the minimum compliance threshold for this standard.
- Kaiser received a compliance score of 83%, which exceeded its minimum compliance threshold of 80% for its first review.
- Riverside received a compliance score of 89%, which was below the minimum compliance threshold of 90%, and was required to submit a CAP.
- Amerigroup, Priority, and United received compliance scores of 89%, 87%, and 87%, respectively. These scores were below the minimum compliance threshold of 100% and required CAPs.

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

MCO Opportunity/CAP Required

Amerigroup Opportunities/CAPs:

Component 7.3a – Services provided must be reviewed for over and under utilization.

STANDARD 7: Utilization Review

Amerigroup received a finding of partially met because after reviewing Medical Advisory Committee (MAC) minutes from eight meetings in 2014, only one meeting was found to have documented a review of UM metrics (IP only), which were displayed as directional changes in comparison to the two prior years. There was no evidence of inclusion of SA utilization metrics in this table. Reporting of UM metrics occurred more frequently in the Quality Management Committee (QMC) (three times in 2014) and often included a summary analysis. For example, in the QMC meeting of August 13, 2014, admits per 1,000 were reported by aid category (TANF, SSI, FAMCARE) and admit decreases noted as having been anticipated as the flu season ended. The top admitting diagnoses include sickle cell, diabetes, hypertension, and depression. Reported increases in days of care for FAMCARE were attributed to chronic health issues among these former Provider Advisory Committee (PAC) members. Average length of stay increased for all categories, but SSI with a plan to monitor for trend. Readmission rates were also reported.

In order to receive a finding of met in the CY 2015 SPR, there must be evidence that the MCO reports utilization and evaluates opportunities for improvement in meeting minutes of the designated committee(s), consistent with its UMP, work plan, and policies.

Component 7.3b – UR reports must provide the ability to identify problems and take the appropriate corrective action.

Amerigroup received a finding of partially met because Medical Advisory Committee (MAC) minutes focused primarily on interventions to improve HEDIS® and VBP measures, often including a detailed examination of barriers and opportunities, as well as recommendations from committee members. Provider barriers and opportunities also were discussed, with the observation that collaboration is important. Per the first data run of the year, the MCO reported it has tripled the controlling–HBP group and this is expected to rise. There were no interventions identified in MAC minutes to address over utilization issues; however, in the QMC minutes of July 2, 2014, there was a discussion of an Emergency Department (ED) Diversion initiative. The goal was to increase the ED Diversion rate for 2014.

Subsequent to the on–site SPR review, Amerigroup submitted additional evidence to support compliance with this component, noting that Amerigroup has assigned review of over and under utilization to the QMC. This is in conflict, however, with the UMP Description and the Over/Under Utilization of Services Policy, which require, at a minimum, quarterly evaluation of over/under utilization trends and opportunities for improvement with reporting to the MAC and QMC on a quarterly basis. Evidence of quarterly reporting was not consistently present in the MAC or QMC minutes, so the finding of partially met remains unchanged.

In order to receive a finding of met in the CY 2015 SPR, Amerigroup must offer evidence that the designated committee(s) consistent with its UMP, UM Work Plan, and policies address both over and under utilization issues and take appropriate action to address identified opportunities for improvement based upon an analysis of those issues.

Component 7.3c – Corrective measures implemented must be monitored.

STANDARD 7: Utilization Review

Amerigroup received a finding of partially met because there was limited evidence in review of meeting minutes that the MAC monitors corrective measures that have been implemented to address over and under utilization. MAC minutes reported almost exclusively on changes in VBP measures. There was no evidence of MAC reporting on the status of the Readmission Reduction Initiative, although there were updates provided in a number of QMC meetings. For example, in the QMC meeting of August 13, 2014, it was reported that the readmission rate from 2013 to 2014 YTD fell by an average of 4.71% for three of the six hospitals that are part of this initiative. The University of Maryland Medical System's and John Hopkins Hospital's higher readmission rates were acknowledged to be due to complex conditions, chemo, and transplants.

Subsequent to the on–site SPR review, Amerigroup submitted additional evidence to support compliance with this component, noting that Amerigroup has assigned review of over and under utilization to the QMC. This is in conflict, however, with the UMP Description and the Over/Under Utilization of Services Policy, which require, at a minimum, quarterly evaluation of over/under utilization trends and opportunities for improvement, with reporting to the MAC and QMC on a quarterly basis. Evidence of quarterly reporting was not consistently present in the MAC or QMC minutes, so the finding of partially met remains unchanged.

In order to receive a finding of met in the CY 2015 SPR, Amerigroup must offer evidence that the designated committee(s), consistent with its UMP, UM Work Plan, and policies, routinely monitor(s) corrective measures that have been implemented in response to both over and under utilization issues.

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

Amerigroup received a finding of partially met. The Utilization Management Quality Monitoring Audits – MD Policy includes the State–specified threshold for determinations using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%. The policy, however, identifies an audit of 100% of preauthorization decisions and notifications on a quarterly basis. The policy further requires analysis of a random sample of outlier cases to determine the root cause when decisions do not meet the stated time frames and CAPs for audit compliance scores below 95%. CAPs are to be logged into the UM Work Plan for monitoring and appropriate follow–up. Compliance reports are to be presented to the QMC on a quarterly basis.

Compliance with turnaround times (TATs) is reported on a quarterly basis to the QMC. The 95% threshold for compliance with pre–service determination time frames was not met throughout 2014. The 95% threshold for adverse determination notification time frames was met in the last two quarters of 2014. The decline in 2014 performance was attributed to an increase in month over month volumes. Specifically, analysis revealed an increase in physical therapy (PT) requests from former PAC members who previously did not have the benefit. Interventions to meet the compliance threshold for both measures were documented to include recruitment efforts to increase staff, more stringent management of workflow via daily reports, investigation of external vendors for select UM functions, and staff retraining and restructuring. Another barrier identified was a delay at the clinician level. Processes were updated accordingly. UM is also working with the National Call Center (NCC) to address any delays originating at that source.

STANDARD 7: Utilization Review

The Pharmacy Prior Authorization Policy requires that prior authorization coverage requests be processed within 24 hours of receipt. If the prescribing provider has not responded to the MCO's request for additional clinical information within 24 hours, the request will be forwarded to a pharmacist for review. Coverage denial letters are generated and mailed and faxed to the provider and member within 24 hours or one business day of the decision. As noted in the CY 2013 review, this latter time frame is inconsistent with state requirements for notification within 72 hours of a determination for non–emergency, medically related requests, as it could result in noncompliance as a result of a three–day holiday weekend.

Subsequent to the on–site review, Amerigroup submitted a revised Pharmacy Prior Authorization Policy noting that the time frames had been changed to be consistent with regulation. This policy will be reviewed as a component of the required CAP submission following the MCO's review of the draft SPR report.

In order to receive a finding of met in the CY 2015 SPR, compliance with pre–service determination and adverse determination notification time frames must be consistently met at the 95% threshold or above. Additionally, as noted in the CY 2013 review, the Pharmacy Prior Authorization Policy must be revised to include notification time frames that are consistent with regulation.

Component 7.6c – The MCO acts upon identified issues as a result of the review of the data (enrollee satisfaction, provider satisfaction, or other appropriate measures).

Amerigroup received a finding of partially met. According to the Director of Health Care Management Services (HCMS), interventions were implemented in response to UM–related results from the 2013 CAHPS® and Provider Satisfaction surveys. However, neither MAC nor QMC meeting minutes provided specific details of interventions to address UM opportunities or evidence of ongoing monitoring. The April 21, 2014, MAC meeting minutes noted an initiative to meet with providers and participate in member forums to understand and improve member and provider satisfaction with UM. The QMC meeting minutes of May 4, 2014, noted that Amerigroup met or exceeded all goals for 2013 for the member and provider satisfaction surveys. However, no action plans were identified.

Subsequent to the on–site SPR review, Amerigroup submitted additional documentation to support compliance with this component. The QMC minutes of February 4, 2015, are outside of the CY 2014 review period and will be reviewed as a component of the CY 2015 review. In future reviews, Amerigroup must clearly document corrective measures that have been implemented in response to specific opportunities for improvement in relation to analysis of results of member and provider satisfaction with the UM process.

In order to receive a finding of met in the CY 2015 SPR, there must be evidence in appropriate committee minutes of the actions the MCO has taken in response to UM–related results from the CAHPS® and Provider Satisfaction surveys. Additionally, there should be evidence of routine monitoring of these actions.

STANDARD 7: Utilization Review

Priority Opportunities/CAPs:

Component 7.4c – The reasons for decisions are clearly documented and available to the enrollee.

Priority received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate that reasons for review determinations are documented in a language that is clearly understandable to the member in all adverse determination letters. The CAP was not fully implemented, and an opportunity continues to exist to improve member comprehension of adverse determination letters.
Two of the initial selection of 10 letters provided the reason for the adverse determination in clearly understandable language. The majority of letters specifically quoted InterQual or medical policy guidelines as the rationale for the decision. The remaining 10 letters for this time period were reviewed as well. Only four of those 10 letters included reasons for the determination in clearly understandable language.

In order to receive a finding of met in the 2015 SPR review, the MCO must document reasons for decisions in language that is clearly understandable to the member.

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

Priority received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate consistent compliance with preauthorization determination and adverse determination notification time frames specified by the State at the 95% threshold. This included medical, substance abuse (SA), and pharmacy authorization requests. Continued inconsistent compliance with required time frames indicates that the CAP was not fully implemented. Priority has not fully met this component for at least the last seven review cycles, with the exception of 2011, which was scored as baseline.

Several MCO policies described below address required time frames for determinations and notifications, including some time frames that are inconsistent with COMAR.

The Prospective, Concurrent and Retrospective Review Decision Timeframes and Lack of Information Policy includes decision and notification time frames in a chart format. Chart A includes decision and notification time frames for prospective reviews when all necessary clinical information is present. The time frame for urgent requests is 72 hours from receipt, which includes 48 hours for the determination and 24 hours for the notification. Routine requests with sufficient clinical information are not to exceed a total of seven–calendar days, including the determination and the notification. A two–business–day time frame is required for the decision and three additional business days are required for written notification. The three–business–day time frame for written notification is inconsistent with the COMAR required time frame of 72 hours from receipt of the determination.

In the same policy, Chart B includes decision and notification time frames for prospective review requests submitted with insufficient clinical information. The time frame for urgent requests is not to exceed five calendar days, including the required written notification of 24 hours. The time frame for routine requests is not to exceed

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seven calendar–days including one business day to request information, two business days for receipt of additional information, one business day for decision, and three additional business days for written notification. The stated time frames equal a total of seven business days rather than the overall stated time frame of seven calendar days. Additionally, as noted above, the three business days is inconsistent with the COMAR required time frame of 72 hours from receipt of the determination. These same time frames were included in the UMP.

The Pharmacy MSR Letters Policy requires urgent preservice requests with sufficient clinical information to be completed within three calendar days (two calendar days for the decision and one calendar day for notification). For urgent requests with insufficient clinical information the required time frame is five calendar days (one calendar day to request, two calendar days to receive requested information, one calendar day for the decision, and one calendar day for notification). For routine preservice requests with complete information, the stated time frame is five business days, including two business days for the decision and three business days for notification. The three business–day notification is inconsistent with the 72 hours required by regulation. For routine preservice requests with insufficient clinical information, the policy specifies a time frame of seven business days including one business day to request information, two business days for receipt of requested information, one business day for decision, and three business days for notification. As stated above the three business day notification is inconsistent with the regulatory requirement of 72 hours.

The Step Therapy, Prior Authorization and Quantity Limits Policy includes time frames for prior authorization and notification. Urgent requests are to be reviewed and a decision made within two–calendar–days of receipt of the request. Member and requesting provider notification of the determination is to occur within one calendar day of the determination. The policy further states that if the request does not contain sufficient clinical information the requesting provider will be contacted within one calendar day of receipt of the request. The requesting provider will have two calendar days to provide additional information. For routine requests a decision will be made within two business days of receipt of the request. Once a decision is made, the requesting provider and member will be notified within 72 hours. If the request does not contain sufficient information for the clinical pharmacist to make a decision, the requesting provider will be contacted within one business day of receipt of the request. The requesting provider will have two business days to provide additional information.

Quarterly reports were provided documenting UM TAT for precertification for BH, IP, Outpatient, and Pharmacy throughout 2014. Time frames, inclusive of determination and notification, were defined as follows:

- Urgent (complete information) – three days from date of original request (two calendar days for determination plus one calendar day for notification)
- Urgent (requested additional information) – five days from date of original request (four calendar days for determination plus one calendar day for notification)
- Routine preservice (complete information) – five business days from date of original request (two business days for determination plus three business days for notification)
- Routine preservice (requested additional information) – seven business days from date of original request (four business days for determination plus three business days for notification)

Table 1 provides the results of compliance by quarter for CY 2014.

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Table 1. PPMCO 2014 Quarterly Compliance Results for Determinations and Notifications

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Determination	69.99%	66.45%	57.89%	69.75%
Notification*	99.12%	99.02%	98.96%	98.88%

* Includes both approvals and denials and incorrect time frame of business rather than calendar days for routine requests.

In order to receive a finding of met in the CY 2015 SPR, Priority must demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations. Additionally, all policies that include time frames for preauthorization determinations and adverse determination notifications must be consistent with COMAR requirements. Tracking of compliance must also demonstrate COMAR time frame requirements.

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

Priority received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate consistent compliance with State–required time frames for appeal resolution. Continued inconsistent compliance with required time frames indicates that the CAP was not fully implemented.

Priority has elected to develop time frames for appeal resolution that are more stringent than required by COMAR 10.09.71.05. The Member Appeal Policy requires expedited/urgent care appeals be resolved within 36 hours of receipt at both first and second levels rather than the three business days specified by regulation. Whereas COMAR specifies a time frame for resolution of non–expedited appeals within 30 days, the MCO has established a time frame of 15 calendar–days for both first– and second–level routine pre–service appeals and 30 calendar days for first– and second–level post–service appeals. The policy also provides for a 14–calendar–day extension to allow the member to submit all applicable documentation for consideration in the appeal review.

The policy further describes the process for monitoring compliance with the above time frames on both a weekly and monthly basis. Compliance with time frames is to be reported to the Process Management Team (PMT) on a quarterly basis.

Minutes of the PMT demonstrate routine monitoring of compliance with appeal resolution time frames throughout 2014. For expedited pre–service appeals, the MCO met its performance goal 3 out of 11 months (one month had no expedited appeals). Compliance with the MCO standard of 36 hours ranged from 5% to 67% in the remaining 8 months. Compliance with the MCO standard for non–urgent pre–service appeals was not met in any of the 12 months in 2014. Compliance ranged from 33% to 98%.

A review of a sample of 10 appeal records from CY 2014, all standard, revealed 70% compliance with resolution time frames.

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The Member Appeals Policy as written addresses appeals for claim denials and reduction, termination, or refusal to extend an approved course of treatment. Although this language would suggest that appeal rights are not available for adverse determinations for initial pre–service requests, that does not appear to be the intent of the policy. Therefore, it is recommended that Priority revise the language in the Member Appeal Policy to explicitly state this right as well. Additionally, the Member Appeals Policy states that, if an appeal does not meet criteria for an expedited appeal, the appeal will be transferred to the standard time frame of no longer than 30 days from the date of receipt of the appeal with a possible 14–day extension. This is inconsistent with the MCO's time frame of 15 calendar days for pre–service routine appeals. As such, this time frame should be revised to ensure consistency with the time frame for routine appeals.

In order to receive a finding of met in the CY 2015 SPR, Priority must demonstrate consistent compliance with State–required time frames for appeal resolution.

Riverside Opportunities/CAPs:

Component 7.4c – The reasons for decisions are clearly documented and available to the enrollee.

Riverside received a finding of partially met because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate that reasons for adverse determinations are communicated in writing to the member and provide a clear, full, and complete explanation for the decision in easily understandable language. An opportunity continues to exist to improve member understandability of the reason for the decision in adverse determination letters.

Although there is evidence that reasons for determinations are documented in member records, one of the initial sample of 10 adverse determination letters did not provide an adequate explanation for the reason for the adverse determination. The reason for the adverse determination was stated as "Request does not meet criteria. Clinical documentation does not support the request." An additional sample of 20 letters was reviewed for this component and no further deficiencies relating to this component were found.

In order to receive a finding of met in the CY 2015 SPR, Riverside must consistently demonstrate that adverse determination letters provide a clear, full and complete explanation of the reason for the decision in easily understandable language.

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

Riverside received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate that it has a documented methodology for determining compliance with PA determination and adverse determination notification time frames consistent with state requirements, including use of the sample size calculator to ensure a statistically valid sample size if the total population is not used. An opportunity continues to exist to demonstrate compliance with regulatory time frames for pre–service determinations and adverse determination notifications based on a documented methodology.

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The UM Program Structure and Processes Policy includes a table documenting the time frames for UM decisions and notifications. The time frame for written notification to members for non–urgent pre–service requests is documented as within 24 hours of the decision and no later than within 15 days of the request. Written notification for urgent pre–service requests is to occur within 24 hours of the decision and no later than 72 hours of receipt of the request. These time frames are inconsistent with COMAR 10.09.71.04, which requires written notification of adverse determinations within 72 hours for routine pre–service and 24 hours for urgent pre–service from the determination. The Health Services (HS) Program Description also includes notification time frames that are inconsistent with regulatory requirements.

As evidence of tracking compliance, the MCO provided a document entitled Case Audit UR CY 2014. The sample size calculator determined a need to review 370 records. Compliance results reported for CY 2014 were 88% for determinations and 84% for notifications. Based upon discussions with the VP of HS, it appears that the sample may have included concurrent as well as pre–service reviews for determinations and approvals, as well as adverse determinations for notifications.
In order to receive a finding of met in the CY 2015 review, there must be evidence of documentation of the methodology for determining compliance with determination and notification time frames, such as a desktop procedure, and evidence that the MCO meets the 95% compliance threshold for determinations and notifications on at least a quarterly basis. Additionally, all MCO documents need to be revised to reflect the regulatory time frames.

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

Riverside received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate that it has copied the member's PCP on all adverse determination letters that it describes the additional information needed for reconsideration. Moreover, the letters did not consistently provide an adequate explanation of the reason for the adverse determination. Continued opportunities for improvement exist as the CAP was not fully implemented.

The Denial of Services Policy includes 12 of the 13 required letter components. The requirement to copy the member's PCP on the adverse determination letter was missing from the list of components. Additionally, the policy incorrectly identified the MCO, rather than EHL staff, as responsible for investigating the MCO decision, resolving within 10 days, or providing information about how to request a fair hearing.

A sample of 10 adverse determination letters was initially reviewed for compliance. Ten of the 13 required components were consistently present in all the letters. None of the 10 member letters evidenced that the PCP was copied. The MCO confirmed that PCPs have not been receiving a copy of the adverse determination letter unless they were the requesting provider. The component that requires a clear, full, complete factual explanation for the reasons for denial, reduction, or termination in understandable language was not met in one of the 10 letters, as reported in component 7.4c. Additionally, description of any additional information the MCO needs for reconsideration was included in only one of the initial sample of 10 letters. Another 20 adverse determination

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letters were reviewed for these three components. None of these letters showed evidence of the PCP being copied or documentation of additional information needed for reconsideration. An adequate explanation of the reason for the adverse determination was included in this second sample.

It is recommended that the MCO revise the Denial of Services Policy to include the requirement for copying the member's PCP on all adverse determination letters. It is also recommended that this policy be revised to correctly identify EHL staff, rather than the MCO, as responsible for investigating the MCO decision, resolving within 10 days, or providing information about how to request a fair hearing.

In order to receive a finding of met in the CY 2015 SPR, Riverside must demonstrate that it includes all required components in its adverse determination letters.

United Opportunities/CAPs:

Component 7.2b – The UR Plan must describe the mechanism or process for the periodic updating of the criteria.

United received a finding of partially met. The Clinical Review Criteria Policy, last reviewed on December 1, 2013, requires the MCO and actively practicing physicians with knowledge relevant to the clinical review criteria to evaluate criteria at least annually. The UMP Medical Director or designee is assigned responsibility for criteria approval. This is somewhat inconsistent with the State UMP Addendum, which assigns responsibility for annual review and approval of medical necessity criteria to the PAC and HQUMC. Although the Chief Medical Officer (CMO) chairs both committees, the approval authority is shared by committee members. This inconsistency was also noted in the CY 2013 SPR and required to be resolved for the CY 2014 SPR. According to the Director of HS, a representative from the national policy management team reported that the submitted policy expires December 31, 2014, and the new policy will cover 2015 activity. Because this inconsistency remains for the CY 2014 review, this component will be scored as a "partially met."

Subsequent to the on–site review, the MCO submitted additional documentation in support of compliance with this component. Although acknowledging that the UMP Description assigns annual approval authority of medical necessity criteria to both the HQUMC and PAC and the Clinical Review Criteria Policy assigns approval responsibility to the Medical Director, the MCO reported that, per United standard practice, final accountability for adoption of clinical review criteria rests with the Medical Director after review and approval by HQUMC and PAC. United reported that they did not see this as a conflict but rather a confirmation of standard practice and final accountability. It added, however, that in recognition of reviewer recommendations the MCO will ensure that the 2015 UMP Addendum will align more clearly with language in the national policy. MCO documentation needs to clearly reflect consistent approval authority for annual review of medical necessity criteria.

In order to receive a finding of met in the CY 2015 SPR, United must resolve the continuing inconsistency in the annual approval authority of medical necessity criteria as documented in the 2014 State UMP Addendum and the Clinical Review Criteria Policy.

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Component 7.2d – There must be evidence that the criteria (for UR/UM desitions) are reviewed and updated according to MCO policies and procedures.

United received a partially met because there was evidence of review of the continued use of Milliman Care Guidelines (MCG) and American Society of Addiction Medicine (ASAM) criteria in the HQUMC minutes of June 17, 2014, but there was no evidence of approval. Although the PAC minutes of the October 16, 2014, meeting recorded a seconded motion to approve continued use of MCG and ASAM no final approval was documented.

It is recommended that the MCO clearly document appropriate committee review and approval of medical necessity criteria in meeting minutes. Seconding the motion to approve documents the intent to approve, but it is insufficient to demonstrate overall committee approval.

In order to receive a finding of met in the CY 2015 SPR, United must provide evidence of formal committee review and approval of medical necessity criteria consistent with the MCO's UMP Description.

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

United received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR review to demonstrate consistent tracking and compliance with State–required time frames for determinations and notifications for Preauthorization (PA) requests for medical, pharmacy, and SA services. The CAP was partially implemented and continued opportunities for improvement exist in demonstrating routine compliance with State–required time frames. This is the sixth year since the CY 2007 review that this component has not been met. (This component was scored as baseline for the CY 2011 review.)

The United Behavioral Health (UBH) UMP Description includes a table identifying PA determination and notification time frames by state. The written notification time frames are inconsistent with COMAR.

According to the Director of HS, medical PA requests are processed in the CareOne system but BH and pharmacy are processed in another system. In October United became aware of issues with the data reported off the CareOne system. As a result the MCO discovered that determination and notification time frames for medical PA requests were inconsistently observed and developed a CAP in response. Review of the CAP identified activities that included retraining and increased monitoring.

In reviewing the MD TAT Compliance Report for medical PA requests and adverse determination notifications, compliance was demonstrated as follows:

- Expedited determinations – 8 out of 12 months met the 95% compliance threshold; outlier months ranged from 76.5% to 92.9%.
- Routine determinations within two business days – 1 out of 12 months met the 95% threshold.
- Routine determinations within seven calendar days – all months met the 95% compliance threshold.
- Written notification within 24 hours – 3 out of 11 months met the 95% threshold; outlier months ranged from 50.0% to 90.9%.

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- Written notification within 72 hours – 7 out of 12 months met the 95% compliance threshold; outlier months ranged from 84.3% to 94.4%.

Compliance with regulatory time frames for PA requests and adverse determination notifications related to pharmacy were reported as follows:

- Expedited determinations – all months met or exceeded the 95% compliance threshold.
- Routine determinations within two business days – 7 out of 12 months met the 95% compliance threshold; outlier months ranged from 72.1% to 92.3% (There were no requests that required additional clinical information.)
- Written notification within 24 hours – all months were at 100%.
- Written notification within 72 hours – all months were at 100%.

The UBH Compliance Report through November 2014 demonstrated that all approved PA requests were processed within regulatory time frames. For requests that resulted in an adverse determination, UBH demonstrated the following compliance:

- Expedited determinations – 9 out of 10 months were compliant, with the one outlier month reported as 75%.
- Routine determinations – 6 out of 11 months were at 100%; outlier months ranged from 78.9% to 93.3%. (There were no requests that required additional clinical information.)

In order to receive a finding of met in the CY 2015 SPR, United must consistently demonstrate compliance with State–required time frames for medical and pharmacy PA determinations and adverse determination notifications.

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

United received a finding of unmet because the MCO was required to submit a CAP as a result of the CY 2011, CY 2012, and CY 2013 SPR findings to address compliance with regulatory time frames for appeal processing on a consistent basis. The CAPs were partially implemented and continued opportunities for improvement exist in demonstrating routine compliance with State–required time frames.

The Medicaid Member Grievances and Appeals Policy includes the required 30–day resolution time frame for standard appeals and a more stringent time frame of 72 hours of receipt of appeal rather than the three business days specified per regulation.

The UBH UMP Description includes a table of state requirements identifying time frames for urgent and standard member appeals. For urgent appeals, determinations, along with verbal and written notification, are to occur within 24 hours of receipt of the request. For first– and second–level standard pre service appeals, determination and notification are to occur within 15 calendar days of receipt of the request. According to the Director of HS, the UBH UMP Description stated the time frames in error. UBH time frames for member appeals are consistent with United time frames.

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Compliance with State–required time frames for resolving member expedited and standard appeals were reported by month throughout 2014 in a spreadsheet entitled United Member Appeals. Compliance was reported separately for medical and pharmacy–related appeals. UBH compliance for SA–related appeals was tracked in a separate spreadsheet. For expedited medical appeals, compliance with the resolution time frame was met throughout 2014. For standard medical appeals, compliance was met in 7 of the 12 months, with the remaining months ranging from 90.0% to 98.1%. For expedited pharmacy appeals, one month, July, was reported as noncompliant at 95.6%. For standard pharmacy appeals, 10 of 12 months were compliant with the resolution time frames, with the 2 outlier months reported as 90.0% and 95.0%.

CAPs were initiated in response to both medical and pharmacy noncompliance and reported on the United Member Appeals spreadsheet. For example, in response to expedited medically–related appeals not achieving 100% compliance in July, it was reported that three triage errors in assigning priority were identified; coaching was subsequently provided to individual data entry personnel and application of performance management steps completed. It was further reported that a triage SharePoint site had been set up for continuous feedback between teams and that the urgent scrub process was still in place, but it was being reviewed for effectiveness.

The Master UBH Template January through November 2014 identified no member appeals received during this time frame.

A review of a random sample of 10 medical and pharmacy member appeals, all standard, revealed 100% compliance with the regulatory time frame for resolution.
In order to receive a finding of met in the CY 2015 SPR, United must provide evidence of consistently meeting regulatory resolution time frames or MCO time frames, if more stringent, for all medical and pharmacy appeals.

Follow–up:

- Amerigroup, Priority, Riverside, and United were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed during the CY 2015 SPR.

STANDARD 8: Continuity of Care

Requirements: The MCO must put a basic system in place that promotes continuity of care and case management. Participants with special needs and/or those with complex health care needs must have access to case management according to established criteria and must receive the appropriate services. The MCO must have policies and procedures in place to coordinate care with other appropriate agencies or institutions (e.g., school health programs). The MCO must monitor continuity of care across all services and treatment modalities. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow–up of referrals). The MCO must ensure appropriate initiation of care based on the results of the Health Risk Assessment (HRA) data supplied to the MCO. This must include a process for gathering HRA data, an ongoing analysis, and a process that calls for appropriate follow–up on results of the analysis.

Results:

- The overall MD MCO Compliance Score was 100% for CY 2014.
- All MCOs met the minimum compliance threshold for this standard.
- Kaiser received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- Riverside received a compliance score of 100%, which exceeded its minimum compliance threshold of 90% for its second review.

Findings: Overall, the findings, conclusions, actions taken, and results of actions taken as a result of the MCO's quality assurance activities are documented and reported to appropriate individuals within the MCO's structure and through the established quality assurance channels. All MCOs have allocated resources, such as automated tracking methodologies, that facilitate communication between members, PCPs, other health care professionals, and the MCO's care coordinators.

MCO Opportunity/CAP Required

No CAPs were required.

Follow–up: No follow–up is required.

STANDARD 9: Health Education Plan Review

Requirements: 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. The Health Education Plan must incorporate activities that address needs identified through the analysis of enrollee data and have a written methodology for an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency room (ER) utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures. The Health Education Plan must provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the members. The Health Education Plan must contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for member referrals. The MCO must have mechanisms in place to identify participants in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning. The MCO must make the education program available to the enrollee population and demonstrate that participants have attended.

Results:

- All MCOs (except for Kaiser and Riverside) were exempt from this standard as each MCO received compliance ratings of 100% for the past three consecutive years.
- Kaiser received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- Riverside received a compliance score of 67%, which was below the minimum compliance threshold of 90%, and was required to submit a CAP.

Findings: This area of review was exempt for all MCOs except for Kaiser and Riverside. The Health Education Plans were found to be comprehensive and include policies and procedures for internal staff education, provider education and continuing education units, and enrollee health education. However, continued opportunities were identified regarding the health education programs.

MCO Opportunity/CAP Required

Riverside Opportunities/CAPs:

Component 9.3a – The MCO's Health Education Plan must 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.

Riverside received a finding of unmet because as noted in the CY 2013 SPR, the Health Education Plan (HEP) documents several mechanisms used to assess the impact of the MCO's educational activities through analysis of data. However, the MCO completed no formal evaluation of the impact of the HEP on process and/or outcome measures in CY 2014.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence of a formal annual evaluation of the impact of the HEP on process and/or outcome measures.

STANDARD 9: Health Education Plan Review

<u>Component 9.3c</u> – The MCO's Health Education Plan must contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for member referrals.

Riverside received a finding of unmet because it was noted in the CY 2013 SPR that in order for the MCO to receive a finding of met in the CY 2014 SPR, the MCO must provide evidence that it notifies its providers of the availability of and contact information for accessing a health educator and/or educational program for member referrals.

The HEP states that providers can access health education materials and information on CM programs by contacting an associate in the HS Department. However, it is unclear as to how providers are made aware of the HEP and to contact the CM program or the HS Department for health education materials or information.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence that the MCO notifies its providers of the availability of and contact information for accessing a health educator and/or educational program for member referrals. This could be accomplished through the provider manual and also could be included in a provider newsletter.

<u>Component 9.5 b</u> – The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide attendance records and session evaluations completed by enrollees.

Riverside received a finding of unmet because there was a lack of evidence of attendance records, sign–in sheets, and evidence of completion of evaluations by members participating in its health education programs.

The MCO provides education on health–related topics at its Consumer Advisory Board (CAB) meetings. As evidence of compliance with this component, the MCO submitted evaluations of CAB meetings completed by members in attendance. Five evaluations were submitted for the June 19, 2014, meeting, 10 from August 21, 2014, and two from October 16, 2014. Although there was evidence that educational topics were presented at two of these meetings, the meeting evaluation form did not include any questions for CAB members to specifically evaluate these presentations.

The MCO subsequently provided a sample of a member evaluation of a diabetes education program conducted by staff at Upper Chesapeake Health. The survey covered the following areas: scheduling/registration, diabetes education, endocrinologist, and overall assessment of the center. On a five–point scale (with five being "very good") all of the areas were scored as a five in this member's evaluation. One member's evaluation is insufficient for demonstrating compliance.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide attendance records or sign–in sheets and evidence of completion of evaluations by members participating in its health education programs.

STANDARD 9: Health Education Plan Review

<u>Component 9.5c</u> – The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide provider evaluations of health education programs.

Riverside received a finding of unmet because the MCO did not receive provider evaluations on health education programs within CY 2014.

A memo from the Manager of QI, dated December 17, 2014, was sent to all the PAC members with a request for review of the HEP Description and a brief survey that asked for a graded response to the following statements:

- The Riverside HEP is helpful and appropriate to the needs of my patients.
- The Riverside HEP is comprehensive and addresses the needs of special needs and other vulnerable populations served.
- Provider involvement in the Riverside HEP is appropriate and effective.

Two survey responses were received, but both were dated as received in February 2015, which is outside the CY 2014 SPR review period.

As recommended in the CY 2013 SPR, the MCO may want to consider developing a survey that would offer actionable opportunities for improvement, such as soliciting provider recommendations for health education programs and obtaining feedback on the impact of their patients' participation in MCO health education programs, among other inquiries. The MCO may also want to increase its pool of potential respondents by including the survey in the provider newsletter.

In order to receive a finding of met in the CY 2015 SPR, Riverside must provide evidence of provider evaluations of the MCO's HEP. The MCO may want to begin the process of surveying its PAC members on the HEP earlier in the year so that they can meet the requirements of this component and also include any findings in the annual QAP Evaluation.

Follow–up:

- Riverside was required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed during the CY 2015 SPR.

STANDARD 10: Outreach Plan Review

Requirements: The MCO must have developed a comprehensive written Outreach Plan to assist participants in overcoming barriers in accessing health care services. The Outreach Plan must adequately describe 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 Outreach Plan, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.

Results:

- All MCOs (except for Kaiser and Riverside) were exempt from this standard as each MCO received compliance ratings of 100% for the past three consecutive years.
- Riverside received a compliance score of 100%, which exceeded its minimum compliance threshold 90% for its second review.
- Kaiser received a compliance score of 79%, which was below the minimum compliance threshold of 80%, and was required to submit a CAP.

Findings: This area of review was exempt for all MCOs except for Kaiser and Riverside. Overall, the Outreach Plans were found to have adequately described the populations served, an assessment of common health problems, and barriers to outreach within the MCO's membership. The MCOs also described the organizational capacity to provide both broad–based and enrollee specific outreach in the plan. The unique features of the MCO's enrollee education initiatives, community partnerships, and the roles of the provider network and local health departments were also included in the Outreach Plan. Appropriate supporting evidence of the outreach activities was also provided. However, opportunities for improvement were identified.

MCO Opportunity/CAP Required

Kaiser Opportunities/CAPs:

Component 10.1a – The MCO has developed a written OP that describes the following: Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership.

Kaiser received a finding of unmet because the MCO's Outreach Plan was not specific regarding the populations the MCO serves and did not include an assessment of common health problems of the membership.

In order to receive a finding of met in the CY 2015 SPR, Kaiser must:

- Describe the membership demographics, including but not limited to where the largest portion of the members reside and the adult versus child populations.
- Provide a breakdown of the identified SNPs as cited in COMAR (a chart by county describing this information is not sufficient).
- Identify the most common health conditions among the HealthChoice membership.
- Identify the barriers to health care for HealthChoice members.

Component 10.1b – The MCO has developed a written OP that describes the following: MCO's organizational capacity to provide both broad–based and enrollee–specific outreach.

STANDARD 10: Outreach Plan Review

Kaiser received a finding of partially met because the Outreach Plan partially described the teams and units involved in outreach, however, a complete description that includes the number of positions, position descriptions and education requirements was not included.

In order to receive a finding a met in the CY 2015 SPR, Kaiser must:

- Describe each unit or team and how they work together to provide outreach.
- Identify the number of positions within each team or unit.
- Provide job descriptions or describe what education or qualifications are needed to hold the positions.
- Describe the data systems used to manage and monitor the outreach services to members.

Component 10.1e – The MCO has developed a written OP that describes the following: Role of the MCO's provider network in performing outreach.

Kaiser received a finding of unmet because in 2014 the MCO did not have a written policy on the provider's role in performing outreach. The Kaiser provider manual states that the MCO expects that providers will perform outreach to members and details how they should be involved in outreach efforts to members. This includes notifying members of appointments and due dates for services such as immunizations. Provider outreach also includes facilitating member referrals for specialty care, documenting outreach efforts in member medical records, notifying the Kaiser CM unit for assistance with outreach, and requesting assistance from Administrative Care Coordination Units (ACCUs) at Local Health Departments (LHDs) when members miss scheduled appointments.

Subsequently to the review, Kaiser developed a Network Provider – Outreach to Member Policy that will take effect on April 1, 2015.

In order to receive a finding of met in the CY 2015 SPR, Kaiser must implement the Network Provider – Outreach to Member Policy and ensure that there is a mechanism in place to deliver this policy to the providers.

Component 10.1f – The MCO has developed a written OP that describes the following: MCO's relationship with each of the LHDs and ACCUs.

Kaiser received a finding of partially met. Kaiser maintains collaborative relationships with the LHDs through memoranda of understanding with nine county health departments in the MCO's service area that enables Kaiser staff to work collaboratively with the LHD/ACCUs to perform outreach activities to members as needed. However, Kaiser does not have agreements with all LHDs in which the MCO has members.

The Kaiser MD Medicaid Outreach and Collaboration with Local Health Department Policy states that the MCO will refer members to ACCUs at LHDs for outreach when the MCO is unable to reach members and bring them into care. The policy indicates that Kaiser will request the assistance of a LHD after the MCO has made documented attempts to contact members. The policy is silent on the number of attempts the MCO will make before LHD assistance is requested and on how the MCO will track the referrals made and returned from the LHD.

STANDARD 10: Outreach Plan Review
In order to receive a finding of met in the CY 2015 SPR, Kaiser must revise the MD Medicaid Outreach and Collaboration with Local Health Department Policy to include the number of attempts the MCO will make before making a referral to the LHD and how the MCO will track referrals made and returned from the LHD. Also, Kaiser will need to establish memoranda of understanding with all LHDs in which the MCO has members.
Follow–up: ➢ Kaiser was required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions. ➢ The approved CAPs will be reviewed during the CY 2015 SPR.

STANDARD 11: Fraud and Abuse

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

Results:

- The overall MD MCO Compliance Score was 98% for CY 2014.
- All MCOs met the minimum compliance threshold for this standard.
- Kaiser received a compliance score of 89%, which exceeded its minimum compliance threshold of 80% for its first review.
- Riverside received a compliance score of 92%, which exceeded its minimum compliance threshold 90% for its second review.

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

MCO Opportunity/CAP Required

No CAPs were required.

Follow–up: No follow–up is required.

Best and Emerging Practice Strategies

The MCOs effectively addressed quality, timeliness, and access to care issues in their respective managed care populations. The MCOs implemented the following best practice strategies:

Amerigroup Community Care

- Amerigroup has an extremely comprehensive set of policies and procedures to support contracting, ongoing monitoring, and oversight of its delegated entities.
- Amerigroup demonstrates a very disciplined approach to monitoring of delegated entities CAPs as evidenced by monthly review of progress in multiple meetings and monthly file reviews, as appropriate, to assess for compliance.
- Amerigroup evidences a best practice in its documentation of the Member & Consumer Health Advisory Committee meetings, which includes consumer comments and questions with Amerigroup responses.
- Amerigroup demonstrates an effective approach to developing corrective measures to address under utilization issues based upon root cause analysis, opportunity identification, and soliciting committee input on recommended interventions.

Jai Medical Systems

- Jai provides oversight of its delegated entities through an effective infrastructure that includes multiple levels of review throughout the organization.
- Jai utilizes formal studies to routinely evaluate the effectiveness of interventions to address over and under utilization issues and develops interventions based upon identified opportunities for improvement.
- Jai demonstrates a consistently high level of compliance with regulatory time frames for preauthorization determinations, adverse determination notifications, and resolution of expedited and standard appeals.
- Jai details information required for reconsideration in all adverse determination letters facilitating the appeal process for the member and their provider.
- Jai has established a well–documented process for evaluating results from both internal and State administered member and provider satisfaction surveys, identifying opportunities for improvement based upon clearly articulated goals and developing and monitoring CAPs.

Kaiser Permanente of the Mid–Atlantic States, Inc.

- Kaiser identifies and develops action plans to address potential and actual quality of care concerns and sentinel events through use of its Root Cause Analysis tool kit.
- Kaiser has comprehensive agreements with its delegates that delineate the delegated activities, responsibilities of both the delegate and the plan, performance expectations, reporting requirements, and procedures for handling any performance deficiencies.

- Kaiser effectively leverages the expertise of its specialty chiefs and national specialty groups to review applicable criteria and provide feedback before the criteria is submitted to the Regional Utilization Management Committee for review and approval.
- Kaiser has very detailed disease management program descriptions and member stratification processes in place to identify members for disease management with diabetes, asthma, and COPD.

Maryland Physicians Care

- Maryland Physicians Care has a well–established committee structure that supports oversight and ongoing monitoring of delegates at multiple levels throughout the organization.
- Maryland Physicians Care continues to use the Delegated Auditing Packet which is sent to each delegate prior to the annual delegated credentialing audit. This gives the delegate a clear understanding of the contractual requirements for credentialing and recredentialing.
- Maryland Physicians Care provides delegated entities a summary of their strengths in the letter sent to the delegate upon completion of each audit.
- Maryland Physicians Care has written guidelines in place for how a practitioner office site visit should be performed which ensures consistency in the review process, given the difference between providers' offices and staff performing the reviews.
- Maryland Physicians Care has a very focused approach to addressing identified areas of over and under utilization. Committee minutes support ongoing monitoring of planned interventions and their impact on key utilization indicators.
- Maryland Physicians Care consistently exceeds the threshold for compliance with preservice determination and adverse determination notification time frames and consistently meets regulatory time frames for notification of appeal resolution, both expedited and routine.

MedStar Family Choice, Inc.

- MedStar conducts effective monitoring of delegated vendors' performance which provides an extremely comprehensive snapshot of each delegate's performance and identified opportunities for improvement.
- MedStar consistently exceeds the minimum threshold for compliance with preauthorization determination and adverse determination notification time frames, despite considerable enrollment growth.
- MedStar continues to conduct an extremely thorough qualitative and quantitative analyses of CAHPS and provider survey results relating to satisfaction with UM processes.
- MedStar demonstrates a commitment to striving to be "best in class" by targeting areas for improvement even where the MCO is performing above the HealthChoice and Quality Compass benchmarks.

Priority Partners

- Priority has a comprehensive, well documented process for delegate monitoring and oversight which includes routine meetings, review of report submissions, and annual audits which assess performance against established goals.
- Priority has an excellent policy on recruitment and retention of providers especially in documenting methods for reducing the administrative burden on providers.
- Priority effectively utilizes its participating providers to review and recommend changes to medical and pharmacy policies as well as medical necessity criteria.
- Priority provides extremely comprehensive and timely data to support identification of opportunities to address potential over and under utilization at the practice level through its Inpatient Admission Monthly Dashboards.

Riverside Health of Maryland

- Riverside has comprehensive documents that address the delegate's responsibilities, procedures for remediation required reports, and time frames and benchmark requirements.
- Riverside proactively drills down on its utilization data to support the development of targeted interventions to address identified opportunities for improvement.
- Riverside demonstrates 100% compliance with regulatory time frames for notification of resolution of expedited and standard appeals despite larger than anticipated increases in enrollment.
- Riverside has developed specific interventions to address each of its top 10 diagnoses.
- Riverside has created multiple educational flyers for members on health care topics that are attractive, easy to read, and informative. Many of which address comorbid conditions such as diabetes and depression.
- Riverside provides well–written, member–friendly acknowledgements of each complaint received.

UnitedHealthcare

- United uses a specific ADA assessment to ensure that oversight of provider offices is occurring which is unique among the MCOs.
- United has taken a very comprehensive approach to utilization management, targeting all key stakeholders, members, PCPs, facilities, and LHDs, and utilizing its vast reporting capabilities to drill down to identify the root cause of utilization outliers and to develop multi–pronged action plans to address identified opportunities.
- United effectively utilizes the utilization management work plan as a working document to provide a detailed snapshot of utilization goals, associated interventions and quarterly updates on performance as well as a summary of the status of interventions.
- United has developed member friendly, easy to understand rationales for adverse determinations which are routinely incorporated in its member adverse determination letters.

Conclusions

Maryland has set high standards for MCO QA systems. In general, HealthChoice MCOs continue to make improvements in their QA monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. This is evident in the comparison of annual SPR results demonstrated throughout the history of the HealthChoice Program. For example, four of the seven (Amerigroup, Jai, Maryland Physicians Care, and MedStar) MCOs in CY 2013 and three of the eight (Jai, Maryland Physicians Care, and MedStar) MCOs in CY 2014 received scores of 100% on the annual SPR.

All MCOs have demonstrated the ability to design and implement effective QA systems. The CY 2014 review provided evidence of the continuing progression of the HealthChoice MCOs as each MCO provided evidence of their ability to ensure the delivery of quality health care for their enrollees. As Riverside and Kaiser entered the HealthChoice system over the past two years, they promptly demonstrated a commitment to quality with SPR scores at 88% (Riverside) and 91% (Kaiser) within their first year reviews. A collaborative quality improvement relationship between the MCO, the Department, and the EQRO increased the scores of Riverside in the CY 2014 review from 88% to 97%.

SECTION II
Value Based Purchasing

Introduction

DHMH began working with the Center for Health Care Strategies in 1999 to develop a Value Based Purchasing Initiative (VBPI) for HealthChoice, Maryland's Medicaid managed care program. VBP improves quality by awarding incentives to contractors based on their performance along a range of dimensions. The goal of Maryland's purchasing strategy is to achieve better participant health through improved MCO performance. Appropriate service delivery is promoted by aligning MCO incentives with the provision of high–quality care, increased access, and administrative efficiency. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice. In addition, the state's strategy meets the requirements of the Balanced Budget Act of 1997 (BBA).

DHMH contracted with Delmarva Foundation and HealthcareData Company, LLC (HDC), a NCQA–Licensed Organization, to perform a validation of the CY 2014 VBP measurement data. Validation is the process by which an independent entity evaluates the accuracy of reported performance measure data and determines the extent to which specific performance measure calculations followed established specifications. A validation (or audit) determination is assigned to each measure, indicating whether the result is fully compliant, substantially compliant, or not valid. HDC performed the validation of the HEDIS®–based VBP measurement data for all seven of the HealthChoice MCOs using the NCQA's *HEDIS® Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures*. Delmarva Foundation validated the measures developed by the Department and calculated by The Hilltop Institute of University of Maryland Baltimore County (Hilltop).

Performance Measure Selection Process

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

DHMH selects measures that are:

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

Value Based Purchasing Validation

Several sources of measures (Table 3) are included in the CY 2014 VBP program. They are chosen from NCQA's HEDIS® data set, encounter data, and data supplied by the HealthChoice MCOs, and subsequently validated by Delmarva Foundation. The measure type and the presence of an existing audit or validation process determined the validation activities undertaken.

Table 3. CY 2014 VBP Measures

Performance Measure	HEDIS® Domain	Measure	Reporting Entity
Adolescent Well Care	Use of Services	HEDIS®	MCO
Adult BMI Assessment	Effectiveness of Care	HEDIS®	MCO
Ambulatory Care Services for SSI Adults Ages 21–64	Access to Care	Encounter Data	DHMH
Ambulatory Care Services for SSI Children Ages 0–20	Access to Care	Encounter Data	DHMH
Breast Cancer Screening	Effectiveness of Care	HEDIS®	MCO
Childhood Immunization Status (Combo 3)	Effectiveness of Care	HEDIS®	MCO
Comprehensive Diabetes Care – HbA1c Testing	Effectiveness of Care	HEDIS®	MCO
Controlling High Blood Pressure	Effectiveness of Care	HEDIS®	MCO
Immunizations for Adolescents (Combo 1)	Effectiveness of Care	HEDIS®	MCO
Lead Screenings for Children Ages 12–23 Months	Effectiveness of Care	Encounter Data, Lead Registry, & Fee For Service Data	DHMH
Medication Management for People with Asthma	Effectiveness of Care	HEDIS®	MCO
Postpartum Care	Access to Care	HEDIS®	MCO
Well Child Visits for Children Ages 3–6	Use of Services	HEDIS®	MCO

HEDIS® Measure Validation

HealthChoice MCOs are required to produce and report audited HEDIS® data under COMAR 10.09.65.03.B(2). Ten of the CY 2014 VBP measures are HEDIS® measures and are validated under the provisions of the HEDIS® Compliance Audit. The goal of the HEDIS® audit is to ensure accurate, reliable, and publicly reportable data.

The HEDIS® audits were completed in three phases: offsite, onsite, and post onsite (reporting). The offsite audit phase includes a review of each MCO's HEDIS® Record of Administration, Data Management and Processes (Roadmap). The Roadmap is used to supply information about an MCO's data systems and

HEDIS® data reporting structure and processes. Other activities of the offsite audit process include the selection of HEDIS® measures to audit in detail (results are then extrapolated to the rest of the HEDIS® measures), investigation of measure rotation strategies, and validation of the medical record review process by the certified audit firm.

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

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

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

Table 4. HEDIS® Compliance Audit Designations

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

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

- Adolescent Well Care
- Adult BMI Assessment
- Breast Cancer Screening

- Childhood Immunization Status (Combo 3)
- Comprehensive Diabetes Care – HbA1c Testing
- Controlling High Blood Pressure
- Immunizations for Adolescents (Combo 1)
- Medication Management for People with Asthma
- Postpartum Care
- Well Child Visits for Children Ages 3–6

EQRO's Data Measure Validation

Three CY 2014 VBP measures were calculated by Hilltop for DHMH, using encounter data submitted by the MCOs for January 1 – December 31, 2014, Maryland Department of the Environment's Lead Registry data, and Fee–for–Service data. The measures calculated utilizing encounter data are:

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

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

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

Table 5. Possible Validation Findings for EQRO–Validated Measures (encounter data)

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

Validation Results

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

Kaiser was not able to report the following HEDIS VBP measures:

- Childhood Immunization Status (Combo 3)
- Immunizations for Adolescents (Combo 1)
- Medication Management for People with Asthma

Additionally, Kaiser was not able to report the Department's encounter data measures for Ambulatory Care Services for SSI Adults or Children.

Riverside was not able to report the following HEDIS VBP measures:

- Adult BMI Assessment
- Breast Cancer Screening
- Medication Management for People with Asthma

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

Table 6. EQRO VBP Measure Validation Determinations

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

CY 2014 VBP Incentive/Disincentive Target Setting Methodology

The Hilltop Institute of University of Maryland Baltimore County (Hilltop) developed a target setting methodology at the request of DHMH for VBP.

The incentive target is calculated as follows:

- Determine the mean of the highest score for the measure in CY 2012 and the overall average of all MCOs
- Add 15 percent of the difference between the new mean determined above and 100 percent

The disincentive target is calculated as follows:

- Determine the mean of the highest score for the measure in CY 2012 and the overall average of all MCOs
- Subtract 15 percent of the difference between the new mean determined above and 100 percent

The neutral range includes all scores falling between the incentive and disincentive targets.

Table 7 shows the CY 2014 VBP measures and their targets.

Table 7. CY 2014 VBP Measures

Performance Measure	Data Source	2014 Target
Adolescent Well Care: % of adolescents ages 12–21 (enrolled 320 or more days) receiving at least one comprehensive well–care visit with a PCP or an OB/GYN practitioner during the measurement year	HEDIS®	Incentive: ≥ 75% Neutral: 68%–74% Disincentive: ≤ 67%
Adult BMI Assessment: % of enrollees ages 18 to 74 who had an outpatient visit and whose body mass index was documented during the measurement year or the year prior to the measurement year	HEDIS®	Incentive: ≥ 81% Neutral: 76%–80% Disincentive: ≤ 75%
Ambulatory Care Services for SSI Adults Ages 21–64 Years: % of SSI adults (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year	Encounter Data	Incentive: ≥ 86% Neutral: 82%–85% Disincentive: ≤ 81%
Ambulatory Care Services for SSI Children Ages 0–20 Years: % of SSI children (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year	Encounter Data	Incentive: ≥ 85% Neutral: 80%–84% Disincentive: ≤ 79%
Breast Cancer Screening: % of women 50–74 years of age who had a mammogram to screen for breast cancer	HEDIS®	Incentive: ≥ 62% Neutral: 50%–61% Disincentive: ≤ 49%
Childhood Immunization Status (Combo 3): % of children who turned 2 years old during the measurement year who were continuously enrolled for 12 months immediately preceding their second birthday and who had 4 DTaP, 3 IPV, 1 MMR, 2 H influenza type B, 3 hepatitis B, 1 chicken pox vaccine (VZV), and pneumococcal conjugate by the time period specified and by the child's second birthday	HEDIS®	Incentive: ≥ 84% Neutral: 79%–83% Disincentive: ≤ 78%
Comprehensive Diabetes Care – HbA1c Testing: % of enrollees 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) test	HEDIS®	Incentive: ≥ 88% Neutral: 84%–87% Disincentive: ≤ 83%
Controlling High Blood Pressure: % of enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year	HEDIS®	Incentive: ≥ 66% Neutral: 55%–65% Disincentive: ≤ 54%
Immunizations for Adolescents (Combo I): % of adolescents 13 years of age during the measurement year who had one dose of meningococcal vaccine and either one Tdap or Td vaccine by their 13th birthday	HEDIS®	Incentive: ≥ 72% Neutral: 63%–71% Disincentive: ≤ 62%
Lead Screenings for Children Ages 12–23 Months: % of children ages 12–23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year	Lead Registry, Encounter & Fee for Service Data	Incentive: ≥ 72% Neutral: 63%–71% Disincentive: ≤ 62%
Medication Management for People with Asthma: % of enrollees 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year	HEDIS®	Incentive: ≥ 38% Neutral: 17%–37% Disincentive: ≤ 16%
Postpartum Care: % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS®	Incentive: ≥ 80% Neutral: 74%–79% Disincentive: ≤ 73%
Well–Child Visits for Children Ages 3 – 6 Years: % of children ages 3–6 (enrolled 320 or more days) receiving at least one well–child visit during the measurement year, consistent with American Academy of Pediatrics & EPSDT recommended number of visits	HEDIS®	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%

2014 Value Based Purchasing Results

The CY 2014 performance results presented in Table 8 were validated by Delmarva Foundation and DHMH's contracted HEDIS® Compliance Audit™ firm, HDC. The contractors determined the validity and the accuracy of the performance measure results. All measures were calculated in a manner that did not introduce bias, allowing the results to be used for public reporting and the VBP program. In CY 2014, all eight HealthChoice MCOs qualified to participate in the iniatiative.

- AMERIGROUP Community Care (Amerigroup/ACC)
- Jai Medical Systems, Inc. (Jai/JMS)
- Kaiser Permanente of the Mid–Atlantic States (Kaiser/KPMAS) – entered HealthChoice June 2014
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MedStar/MSFC)
- Priority Partners (Priority/PPMCO)
- Riverside Health of Maryland (Riverside/RHMD) – entered HealthChoice February 2013
- UnitedHealthcare (United/UHC)

Table 8 represents the CY 2014 VBP results for each of the MCOs.

Table 8. MCO CY 2014 VBP Performance Summary

	CY 2014 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	RHMD	UHC
		Incentive (I); Neutral (N); Disincentive (D)							
Adolescent Well Care	Incentive: ≥ 75% Neutral: 68%–74% Disincentive: ≤ 67%	65% (D)	80% (I)	64% (D)	68% (N)	61% (D)	69% (N)	32% (D)	59% (D)
Adult BMI Assessment	Incentive: ≥ 81% Neutral: 76%–80% Disincentive: ≤ 75%	82% (I)	99% (I)	98% (I)	85% (I)	86% (I)	90% (I)	N/A	82% (I)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 86% Neutral: 82%–85% Disincentive: ≤ 81%	81% (D)	88% (I)	N/A	83% (N)	80% (D)	84% (N)	70% (D)	82% (N)
Ambulatory Care Services for SSI Children	Incentive: ≥ 85% Neutral: 80%–84% Disincentive: ≤ 79%	81% (N)	86% (I)	N/A	83% (N)	76% (D)	84% (N)	51% (D)	78% (D)
Breast Cancer Screening	Incentive: ≥ 62% Neutral: 50%–61% Disincentive: ≤ 49%	66% (I)	72% (I)	87% (I)	66% (I)	63% (I)	63% (I)	N/A	58% (N)
Childhood Immunization Status (Combo 3)	Incentive: ≥ 84% Neutral: 79%–83% Disincentive: ≤ 78%	82% (N)	88% (I)	N/A	68% (D)	79% (N)	80% (N)	44% (D)	68% (D)
Comprehensive Diabetes Care – HbA1 Testing	Incentive: ≥ 88% Neutral: 84%–87% Disincentive: ≤ 83%	89% (I)	91% (I)	96% (I)	88% (I)	88% (I)	89% (I)	85% (N)	86% (N)
Controlling High Blood Pressure	Incentive: ≥ 66% Neutral: 55%–65% Disincentive: ≤ 54%	64% (N)	69% (I)	88% (I)	61% (N)	69% (I)	60% (N)	32% (D)	51% (D)
Immunizations for Adolescents (Combo 1)	Incentive: ≥ 72% Neutral: 63%–71% Disincentive: ≤ 62%	75% (I)	77% (I)	N/A	74% (I)	72% (I)	74% (I)	65% (N)	66% (N)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 72% Neutral: 63%–71% Disincentive: ≤ 62%	63% (N)	78% (I)	56% (D)	59% (D)	58% (D)	62% (D)	43% (D)	55% (D)
Medication Management for People with Asthma	Incentive: ≥ 38% Neutral: 17%–37% Disincentive: ≤ 16%	23% (N)	35% (N)	N/A	34% (N)	24% (N)	21% (N)	N/A	25% (N)
Postpartum Care	Incentive: ≥ 80% Neutral: 74%–79% Disincentive: ≤ 73%	66% (D)	84% (I)	86% (I)	65% (D)	71% (D)	71% (D)	47% (D)	63% (D)
Well Child Visits for Children Ages 3–6	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	84% (N)	91% (I)	85% (N)	87% (I)	87% (I)	87% (I)	57% (D)	79% (D)

N/A – The MCO followed the specifications but the denominator was too small to report a valid rate.

2014 VBP Financial Incentive and Disincentive Methodology

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

Table 9 represents the incentive and/or disincentive amounts provided to each MCO for each performance measure and the total incentive/disincentive amount for the CY 2014 VBP Program.

Table 9. MCO CY 2014 VBP Incentive/Disincentive Amounts

Performance Measure	MCO							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	RHMD	UHC
Adolescent Well Care	($840,068.92)	$141,993.20	($8,440.81)	$0	($226,075.17)	$0	($87,108.76)	($851,526.53)
Adult BMI Assessment	$840,068.92	$141,993.20	$8,440.81	$688,498.74	$226,075.17	$842,903.97	$0	$851,526.53
Ambulatory Care Services for SSI Adults	($840,068.92)	$141,993.20	$0	$0	($226,075.17)	$0	($87,108.76)	$0
Ambulatory Care Services for SSI Children	$0	$141,993.20	$0	$0	($226,075.17)	$0	($87,108.76)	($851,526.53)
Breast Cancer Screening	$840,068.92	$141,993.20	$8,440.81	$688,498.74	$226,075.17	$842,903.97	$0	$0
Childhood Immunization Status (Combo 3)	$0	$141,993.20	$0	($688,498.74)	$0	$0	($87,108.76)	($851,526.53)
Comprehensive Diabetes Care – HbA1 Testing	$840,068.92	$141,993.20	$8,440.81	$688,498.74	$226,075.17	$842,903.97	$0	$0
Controlling High Blood Pressure	$0	$141,993.20	$8,440.81	$0	$226,075.17	$0	($87,108.76)	($851,526.53)
Immunizations for Adolescents (Combo 1)	$840,068.92	$141,993.20	$0	$688,498.74	$226,075.17	$842,903.97	$0	$0
Lead Screenings for Children Ages 12–23 Months	$0	$141,993.20	($8,440.81)	($688,498.74)	($226,075.17)	($842,903.97)	($87,108.76)	($851,526.53)
Medication Management for People with Asthma	$0	$0	$0	$0	$0	$0	$0	$0
Postpartum Care	($840,068.92)	$141,993.20	$8,440.81	($688,498.74)	($226,075.17)	($842,903.97)	($87,108.76)	($851,526.53)
Well Child Visits for Children Ages 3–6	$0	$141,993.20	$0	$688,498.74	$226,075.17	$842,903.97	($87,108.76)	($851,526.53)
Total Incentive/ Disincentive Amount	$840,068.92	$1,703,918.40	$25,322.43	$1,376,997.48	$226,075.17	$2,528,711.91	($696,870.08)	($5,109,159.18)

SECTION III
Performance Improvement Projects

Introduction

COMAR 10.09.65.03 requires that all HealthChoice MCOs conduct performance improvement projects (PIPs) that focus on clinical or nonclinical areas. As the EQRO, Delmarva Foundation is responsible for evaluating the two PIPs from each of the HealthChoice MCOs according to CMS' *External Quality Review Protocol 3: Validating Performance Improvement Projects*. The PIPs are designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care or non–clinical care areas that are expected to have a favorable effect on health outcomes. The PIPs include measurements of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement.

In addition to improving the quality, access, or timeliness of service delivery, the process of completing a PIP functions as a learning opportunity for the MCO. The processes and skills required in PIPs, such as indicator development, root cause analysis, and intervention development, are transferable to other projects that can lead to improvement in other health areas.

Topics Selected

DHMH initiated the Adolescent Well Care PIP in March 2012 using HEDIS® 2012 measurement rates as the baseline measurement for MCOs in developing interventions due in fall 2012. The measure seeks to increase the percentage of adolescents 12–21 years of age in receiving at least one comprehensive well–care visit with a PCP or OB/GYN practitioner during the measurement year. Maryland's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review program measures health and developmental history; comprehensive physical exam; laboratory tests/at–risk screening; immunizations; and health education and anticipatory guidance for children and adolescents through age 20. The EPSDT 12–20 year age group consistently scores lower than the other four age groups in each of these categories. In addition, the underutilization of an adolescent well–care visit yields missed opportunities for prevention, early detection, and treatment; therefore, increasing routine adolescent utilization is an important health care objective for the Department.

DHMH initiated the Controlling High Blood Pressure PIP in March 2014 using HEDIS® 2014 measurement rates as the baseline measurement for MCOs in developing interventions due in fall 2014. The measure seeks to increase the percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. High blood pressure is a serious condition that can lead to coronary heart disease, heart failure, stroke, kidney failure, and other health

problems. According to the Maryland Behavioral Risk Factor Surveillance System, an estimated 1.4 million adults in Maryland have HBP. Additionally, every 33 minutes, one person in Maryland dies from heart attack, stroke, or other cardiovascular disease.

Delmarva Foundation was responsible for providing technical assistance, validation of results, education, and oversight of the MCOs' PIPs. All PIP submissions were made using an approved project submission tool.

As designated by DHMH, seven MCOs conducted PIPs in CY 2014 for submission in 2015:

- AMERIGROUP Community Care (Amerigroup/ACC)
- Jai Medical Systems, Inc. (Jai/JMS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MedStar/MSFC)
- Priority Partners (Priority/PPMCO)
- Riverside Health of Maryland (Riverside/RHMD)
- UnitedHealthcare (United/UHC)

The Adolescent Well Care PIP and the Controlling High Blood Pressure PIP continued in CY 2014. All MCOs identified above except for Riverside participated and submitted Adolescent Well Care PIPs and all seven MCOs submitted Controlling High Blood Pressure PIPs in September 2015. These submissions included CY 2014 data and results. Since Riverside had completed its first full year of operation in CY 2014, they were able to begin providing data and participate in the Controlling High Blood Pressure PIP given this PIP is only in its first year of remeasurement for all MCOs. Since Kaiser did not enter the HealthChoice system until CY 2014, they are not required to participate in the PIPs.

Methodology

The guidelines utilized for PIP review activities were CMS' *External Quality Review Protocol 3: Validating Performance Improvement Projects (PIPs)*. The protocol assists in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

Each MCO was required to provide the study framework and project description for each PIP. This information was reviewed to ensure that each MCO was using relevant and valid study techniques. The MCOs were required to provide annual PIP submissions in September 2015. The submissions included results of measurement activities, a status report of intervention implementations, analysis of the measurement results using the defined data analysis plan, as well as information concerning any modifications to (or removal of) intervention strategies that may not be yielding anticipated improvement. If an MCO decided to modify other portions of the project, updates to the submissions were permitted in consultation with Delmarva Foundation and the Department.

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

Table 10. 10–Step Validation Methodology to PIP Validation

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

As Delmarva Foundation staff conducted the review, each of the components within a step was rated as "Yes", "No", or "N/A" (Not Applicable). Components were then aggregated to create a determination of "Met", "Partially Met", "Unmet", or "Not Applicable" for each of the 10 steps.

Table 10 describes the criteria for reaching a determination in the scoring methodology.

Table 10. Rating Scale for PIP Validation

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

Findings

This section presents an overview of the findings from the validation activities completed for each PIP submitted by the MCOs. Each MCO's PIP was reviewed against all components contained within the 10 steps.

Adolescent Well Care PIPs

All Adolescent Well Care PIPs focused on increasing the number of adolescents ages 12–21 who receive at least one comprehensive well–care visit with a PCP or an OB/GYN practitioner during the measurement year, according to HEDIS® technical specifications.

Table 11 represents the PIP Validation Results for all Adolescent Well Care PIPs for CY 2014.

Table 11. Adolescent Well Care PIP Validation Results for CY 2014

Step/Description	Adolescent Well Care PIP Review Determinations					
	ACC	JMS	MPC	MSFC	PPMCO	UHC
1. Assess the Study Methodology	Met	Met	Met	Met	Met	Met
2. Review the Study Question(s)	Met	Met	Met	Met	Met	Met
3. Review the Selected Study Indicator(s)	Met	Met	Met	Met	Met	Met
4. Review the Identified Study Population	Met	Met	Met	Met	Met	Met
5. Review Sampling Methods	Met	Met	Met	Met	Met	Met
6. Review Data Collection Procedures	Met	Met	Met	Met	Met	Met
7. Assess Improvement Strategies	Met	Met	Met	Met	Met	Met
8. Review Data Analysis & Interpretation of Study Results	Met	Met	Met	Met	Met	Met
9. Assess Whether Improvement is Real Improvement	Partially Met	Met	Partially Met	Partially Met	Met	Partially Met
10. Assess Sustained Improvement	Met	Met	Met	Unmet	Met	Unmet

Four MCOs (Amerigroup, Maryland Physicians Care, MedStar, and United) received a rating of "Partially Met" for Step 9 (Assess Whether Improvement is Real Improvement) because their HEDIS rates decreased for this measurement period (CY 2014).

Two MCOs (MedStar and United) received a rating of "Unmet" for Step 10 (Assess Sustained Improvement) as sustained improvement was not demonstrated through repeated remeasurements over comparable time periods.

MCO Barriers and Interventions

Annually, the HealthChoice MCOs perform a barrier analysis to identify root causes, barriers to optimal performance, and potential opportunities for improvement. Additionally, the MCOs are required to identify member, provider and MCO barriers. The following common barriers were identified among the MCOs for the Adolescent Well Care PIP:

- Member: Unaware of the importance of the well care visit
- Member: Unaware that a sports physical is different from a well care visit
- Member: Transportation
- Provider: Completing sports physicals which do not qualify as wellness exams
- Provider: Many busy practices do not have the personnel to conduct outreach phone calls or mailings

- Provider: Limited access to after–hour and weekend wellness services along with a high demand during non–school periods, particularly during summer vacation
- MCO: Low reimbursement for routine adolescent well–visit
- MCO: No provider incentives for providing routine care for adolescents
- MCO: More communication needed about the importance of wellness exam during sport physicals

The following are examples of interventions which were implemented by the HealthChoice MCOs for the Adolescent Well Care PIPs:

- Nurse Medical Record Reviews to confirm that well child visits did not occur for non–compliant members
- Provider visits to top 20 high volume PCPs to share non compliance member reports
- Home visits offered to Supplemental Security Income (SSI) population
- Home visits to adolescents that have not been seen in the past two years
- Onsite appointment scheduling
- Birthday card reminders sent to members
- Wellness letter sent to members
- Automated telephone call reminders to non–compliant members
- Member incentives (Gift cards, movie tickets, electronics)
- Provider pay for performance program/provider incentives (financial)
- School based clinic collaboration
- Back to school flyers sent to youth regarding the importance of yearly check up
- Hiring of outreach representative
- Piloting use of Facebook to communicate need for Adolescent Well Care (AWC) visits
- Offer pediatric health fairs, with entertainment, games, food, and gifts at pediatric offices
- Provider focus groups to engage in conversations about primary care

Adolescent Well Care Indicator Results

This is the second remeasurement year for the Adolescent Well Care PIP. Table 12 represents the indicator rates for all MCOs for the PIP.

Table 12. CY 2014 Adolescent Well Care PIP Indicator Rates

Measurement Year	Indicator 1: Adolescent Well Care					
	ACC	JMS	MPC	MSFC	PPMCO	UHC
Baseline Year 1/1/12–12/31/12	68.06%	76.85%	60.20%	69.40%	67.59%	59.71%
Measurement Year 1 1/1/13–12/31/13	67.93%	76.72%	68.75%	67.80%	61.57%	60.80%
Remeasurement Year 2 1/1/14–12/31/14	64.68%	80.27%	68.29%	61.20%	68.75%	58.48%
Remeasurement Year 3 1/1/15–12/31/15	N/A	N/A	N/A	N/A	N/A	N/A

Jai, Maryland Physicians Care and Priority performed above the 90th percentile for measurement year 2014, and the remaining three MCOs performed below the 90th percentile. Three MCOs (Jai, Maryland Physicians Care, and Priority) indicator rates increased over baseline measurement. Those increases ranged from 1.16 percentage points to 8.09 percentage points. Specifically, the improvements in performance rates over their baseline measurements were:

- Jai's CY 2014 rates increased by 3.42 percentage points.
- Maryland Physicians Care's CY 2014 rates increased by 8.09 percentage points.
- Priority's CY 2014 rates increased by 1.16 percentage points.

Three MCOs (Amerigroup, MedStar, and United) indicator rates decreased over baseline measurement. Those decreases ranged from 1.23 percentage points to 8.2 percentage points. Specifically, the decreases in performance rates were:

- Amerigroup's CY 2014 rates decreased by 3.38 percentage points.
- MedStar's CY 2014 rates decreased by 8.2 percentage points.
- United's CY 2014 rates decreased by 1.23 percentage points.

Controlling High Blood Pressure PIPs

All Controlling High Blood Pressure PIPs focused on increasing the percentage of members 18–85 years of age who had a diagnosis of hypertension and who blood pressure was adequately controlled during the measurement year. Although the HEDIS measure accounts for ages 18–35 years of age, Maryland HealthChoice covers adults through age 64.

Table 13 represents the PIP Validation Results for all Controlling High Blood Pressure PIPs for CY 2014.

Table 13. Controlling High Blood Pressure PIP Validation Results for CY 2014

Step/Description	Controlling High Blood Pressure PIP Review Determinations						
	ACC	JMS	MPC	MSFC	PPMCO	RHMD	UHC
1. Assess the Study Methodology	Met	Met	Met	Met	Met	Met	Met
2. Review the Study Question(s)	Met	Met	Met	Met	Met	Met	Met
3. Review the Selected Study Indicator(s)	Met	Met	Met	Met	Met	Met	Met
4. Review the Identified Study Population	Met	Met	Met	Met	Met	Met	Met
5. Review Sampling Methods	Met	Met	Met	Met	Met	Met	Met
6. Review Data Collection Procedures	Met	Met	Met	Met	Met	Partially Met	Met
7. Assess Improvement Strategies	Met	Met	Met	Met	Met	Met	Met
8. Review Data Analysis & Interpretation of Study Results	Met	Met	Met	Met	Met	Met	Met
9. Assess Whether Improvement Is Real Improvement	Met	Met	Met	Met	Met	N/A	Met
10. Assess Sustained Improvement	N/A	N/A	N/A	N/A	N/A	N/A	N/A

One MCO (Riverside) received a rating of "Partially Met" for Step 6 (Review Data Collection Procedures) because it failed to provide information on the staff and personnel collecting the data.

One MCO (Riverside) received a rating of "Not Applicable" for Step 9 (Assess Whether Improvement Is Real Improvement) because this was the MCO's baseline submission. The MCO was a year behind the other MCOs in the data collection process.

All Controlling High Blood Pressure PIPs received a rating of "Not Applicable" for Step 10 (Assess Sustained Improvement) because this was the baseline year of data collection, and sustained improvement could not be assessed.

MCO Barriers and Interventions

The following common barriers were identified among the HealthChoice MCOs for the Controlling High Blood Pressure PIP:

- Member: Noncompliance with diet, exercise, and medication regime
- Member: Noncompliance with follow–up care
- Member: Transportation
- Provider: Providers do not make multiple attempts to get members into care
- Provider: Providers may not be aware of current treatment guidelines
- Provider: Providers may not be aware of the MCO resources available to assist in member compliance (e.g. member outreach initiatives, available benefits, health education opportunities)
- MCO: Insufficient or inaccurate member contact and demographic data
- MCO: MCO did not provide 90 day or mail order refills
- MCO: MCO needs to develop provider support tools to assist with high blood pressure education

The following are examples of interventions that were implemented by the HealthChoice MCOs for the Controlling High Blood Pressure PIPs:

- Hypertension Disease Management Program
- Physician education dinner series
- Provider work groups
- Pharmacy reminder programs for providers
- Social media to education members
- Follow up on ER encounters to ensure appointments with PCP
- Education materials to members and providers
- Transportation for members
- Medical record reviews
- Annual health fairs
- Increase staff for outreach to members
- Member incentives

Controlling High Blood Pressure Indicator Results

This is the first remeasurement year of data collection for the Controlling High Blood Pressure PIP. Table 14 represents the Controlling High Blood Pressure PIP indicator rates for all MCOs for the PIP.

Table 14. CY 2014 Controlling High Blood Pressure PIP Indicator Rates

Measurement Year	Indicator 1: Controlling High Blood Pressure						
	ACC	JMS	MPC	MSFC	PPMCO	RHMD	UHC
Baseline Year 1/1/13 – 12/31/13	49.00%	56.20%	46.78%	65.52%	56.97%	N/A	42.34%
Measurement Year 1 1/1/14 – 12/31/14	63.87%	69.34%	61.38%	69.15%	59.52%	32.13%	50.85%
Remeasurement Year 2 1/1/15 – 12/31/15	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Remeasurement Year 3 1/1/16 – 12/31/16	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Jai and MedStar are performing above the 75th Percentile and close to approaching the 90th Percentile. Amerigroup, Maryland Physicians Care, and Priority are performing above the 50th percentile and Amerigroup is close to approaching the 75th Percentile. The remaining MCO's rates (Riverside and United) are close to performing at the 25th Percentile for this measure.

Six MCOs made improvements in performance rates over their baseline measurements:

- Amerigroup's CY 2014 rates increased by 14.87 percentage points.
- Jai's CY 2014 rates increased by 13.14 percentage points.
- Maryland Physicians Care's CY 2014 rates increased by 14.60 percentage points.
- MedStar's CY 2014 rates increased by 3.63 percentage points.
- Priority's CY 2014 rates increased by 2.23 percentage points.
- United's CY 2014 rates increased by 8.51 percentage points.

Recommendations

Delmarva Foundation recommends that the MCOs continue to concentrate on the following:

- Completing thorough and annual barrier analysis, which will direct where limited resources can be most effectively used to drive improvement.
- Developing system–level interventions, which include educational efforts, changes in policy, targeting of additional resources, or other organization–wide initiatives. Face–to–face contact is usually most effective. To improve outcomes, interventions should be systematic (affecting a wide range of members, providers and the MCO), timely, and effective.
- Assessing interventions for their effectiveness, and making adjustments where outcomes are unsatisfactory.
- Detailing the list of interventions (who, what, where, when, how many) to make the intervention understandable and so that there is enough information to determine if the intervention was effective.

Section IV
Encounter Data Validation

Introduction

The Medicaid Managed Care Provisions of the BBA directed the U.S. Department of Health and Human Services to develop protocols to serve as guidelines for conducting EQRO activities. In 1995, CMS began developing a series of tools to help State Medicaid agencies collect, validate, and use encounter data for managed care program management and oversight. Among the functions that Delmarva Foundation performs as EQRO for the Maryland HealthChoice Program is the medical record review component for encounter data validation (EDV). Delmarva Foundation completes encounter data validation according to *CMS' EQR Protocol 4: Validation of Encounter Data Reported by the MCO*. The Department required all HealthChoice MCOs to submit CY 2014 encounter data by June 2015.

Encounter Data Validation Process

The CMS approach to EDV[1] includes the following three core activities:

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

The EDV protocol also makes the following assumptions:

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

[1] Department of Health and Human Services, Centers for Medicare and Medicaid Services. Validation of Encounter Data Reported by the MCO, A Voluntary Protocol for External Quality Review (EQR), September 2012

The EDV protocol consists of five sequential activities:

- Review of State requirements for collection and submission of encounter data
- Review of MCO's capability to produce accurate and complete encounter data
- Analysis of MCO's electronic encounter data for accuracy and completeness
- Review of medical records for additional confirmation of findings
- Analysis and submission of findings

Although the CMS protocol consists of five sequential activities, the Department currently contracts with Delmarva Foundation to conduct one of the five activities: review of medical records for additional confirmation of findings.

Medical Record Review Procedure

Medical Record Validation

Medical record documentation for services provided from January 2014 through December 2014 was compared to the encounter data for the same time period. The medical record was validated as the correct medical record requested by verifying the patient name, date of birth (DOB), and gender.

Encounter Data Validation

Medical record reviewers complete training and inter–rater reliability (IRR) testing annually. A minimum IRR score of 90% is required. After completing medical record reviewer training and achieving an inter–rater reliability score of 92%, reviewers entered data from the medical record reviews into the Delmarva Foundation EDV Tool/Database. The medical record was reviewed by either a certified coder or a nurse with coding experience to determine if the submitted encounter data (diagnosis, procedure, or revenue codes) could be validated against the findings in the medical record (see Table 15 for definition of terms). Where the diagnosis, procedure, and revenue codes could be substantiated by the medical record, the review decision was "yes" or "a match." Conversely, if the medical record could not support the encounter data, the review decision was "no" or "no match." For inpatient encounters, the medical record reviewers also matched the principal diagnosis code to the primary sequenced diagnosis. The review included validation of a maximum of 9 diagnosis codes, 6 procedure codes, and 23 revenue codes per record.

Table 15. EDV Definition of Terms

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

The following reviewer guidelines were used to determine agreement or "match" between the encounter data and the medical record findings:

- As directed by the CMS Protocol, medical record reviewers could not infer a diagnosis from the medical record documentation. Reviewers were required to use the diagnosis listed by the provider. For example, if the provider recorded "fever and chills" in the medical record, and the diagnosis in the encounter data was "upper respiratory infection," the record did not match for diagnosis even if the medical record documentation would support the use of that diagnosis.
- For inpatient encounters with multiple diagnoses listed, the medical record reviewers were instructed to match the first listed diagnosis (as the principal diagnosis) with the primary diagnosis in the encounter data.
- Procedure data was matched to the medical record regardless of sequencing.

Analysis Methodology

Data from the EDV Tool/Database were used to analyze the consistency between submitted encounter data and corresponding medical records. Results were analyzed and presented separately by encounter type and review element. Match rates and reasons for "no match" errors for diagnosis code, procedure code, and revenue code elements are presented for Inpatient, Outpatient, and Office Visit encounter types in the results. Delmarva Foundation recommended that DHMH set the standard for accuracy of match rates between encounter data and medical records at 90%, based on rates obtained in previous years.

Exclusion Criteria

Cases where a match between the medical record and encounter data could not be verified by DOB, gender, and name were excluded from analyses. If information for DOB, gender, or name were missing, the record could not be validated and was excluded from analyses.

Medical Record Sampling

Delmarva Foundation received a random sample of HealthChoice encounter data for hospital inpatient, hospital outpatient, and physician office services that occurred in CY 2014 from Hilltop. The sample size, determined to achieve a 95% confidence interval, was 383 medical records (Table 16). Oversampling for CY 2014 continued in order to ensure adequate numbers of medical records were received to meet the required sample size. The hospital inpatient encounter types were oversampled by 500%, while the hospital outpatient and office visit encounter types were oversampled by 200%.

Table 16. Maryland EDV Sample Size by Encounter Type, CY 2012 – CY 2014

	CY 2012			CY 2013			CY 2014		
Encounter Type	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size
Inpatient	116,434	1.60%	6	114,236	1.50%	6	137,754	1.40%	5
Outpatient	1,117,949	15.30%	59	1,143,752	15.05%	58	1,550,736	16.00%	61
Office Visit	6,090,237	83.10%	319	6,340,051	83.44%	320	7,994,529	82.60%	317
Total	**7,324,620**	**100.00%**	**384**	**7,598,039**	**100.00%**	**384**	**9,683,019**	**100.0%**	**383**

The shift in the proportion of encounter types of the random sample as seen in Table 16:

- Inpatient declined by 0.1 percentage points from 1.6% in CY 2012 to 1.5% in CY 2013, and then declined by 0.1 percentage points to 1.4% in CY 2014.
- Outpatient declined by 0.2 percentage points from CY 2012 to 15.1% in CY 2013, and then increased by .9 percentage points to 16.0% in CY 2014.
- Office visits increased by 0.3 percentage points from 83.1% in CY 2012 to 83.4% in CY 2013, and then decreased by 0.8 percentage points to 82.6% in CY 2014.

From the information provided in Table 16, the following conclusions can be drawn:

- Office visit encounters make up the majority of the random sample of encounter data in all three years.
- Inpatient encounters comprise a very small part of the random sample, less than two percent in all three years.
- The percentage of office visit encounters in the sample increased from CY 2012 to CY 2013, and then decreased slightly in CY 2014.
- The percentage of inpatient encounters has declined consecutively since CY 2012.
- The decrease in percentage of office visit and inpatient encounters in the CY 2014 sample was offset by an increase in the percentage of outpatient encounters.

With the approval of DHMH, Delmarva Foundation mailed requests for medical records to the providers of service. Non–responders were contacted by telephone and fax. The efforts to obtain adequate records to meet the minimum sample in CY 2014 continues to be impacted by the issue with providers not responding to the original letter requesting records and outpatient and office visit requests being returned due to bad addresses.

Response rates by encounter type are outlined in Table 17.

Table 17. Maryland EDV Medical Record Response Rates by Encounter Type, CY 2012 – CY 2014

Encounter Type	CY 2012 Total Records Received and Reviewed	CY 2012 Sample Size Achieved? Yes/No	CY 2013 Total Records Received and Reviewed	CY 2013 Sample Size Achieved? Yes/No	CY 2014 Total Records Received and Reviewed	CY 2014 Sample Size Achieved? Yes/No
Inpatient	7	Yes	7	Yes	6	Yes
Outpatient	60	Yes	61	Yes	63	Yes
Office Visit	326	Yes	324	Yes	318	Yes
Total	393		392		387	

Review sample sizes were achieved for each encounter type for all three calendar years.

Results

The analysis of the data was organized by review elements including diagnosis, procedure, and revenue codes. A total of 387 medical records were reviewed. The overall element match rate decreased by 3.2 percentage points for CY 2014 as compared to CY 2013, and remained lower than the CY 2012 match rate. The results for CY 2012 – CY 2014 EDV are displayed in the following tables and the findings are discussed.

Table 18. Maryland EDV Results by Encounter Type, CY 2012 – CY 2014

Encounter Type	Records Received & Reviewed			Total Elements Possible*			Total Matched Elements			Percentage of Matched Elements		
	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014
Inpatient	7	7	6	152	65	88	147	64	86	96.7%	98.5%	97.7%
Outpatient	60	61	63	614	666	601	588	630	574	95.8%	94.6%	95.5%
Office Visit	326	324	318	1,084	1,014	1,004	1,018	982	911	93.9%	96.8%	90.7%
TOTAL	393	392	387	1,850	1,745	1,693	1,753	1,676	1,571	94.8%	96.0%	92.8%

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

The overall match rate (medical record review supporting the encounter data submitted) in CY 2014 was 92.8%, which represents a 3.2 percentage point decrease from CY 2013 and falls below the match rate of 94.8% achieved in CY 2012.

From CY 2013 to CY 2014, the inpatient encounter data match rate decreased by 0.8 percentage points from the CY 2013 rate of 98.5% to 97.7%, which remains slightly above the CY 2012 match rate of 96.7%.

The outpatient encounter data match rate was 95.5% for CY 2014, representing an increase of 0.9 percentage points compared to CY 2013 for this encounter type (94.6%), and approaching the 2012 rate of 95.8%.

Office visit encounters registered a rate of 90.7% in CY 2014, a decrease of 6.1 percentage points compared to CY 2013 (96.8%), and 3.2 percentage points below the CY 2012 match rate of 93.9%.

Results by Review Element

Tables 19 through 21 illustrate EDV results by review element for each encounter type. The elements reviewed were diagnosis codes, procedure codes, and revenue codes. (Note: Revenue codes are not applicable for office visit encounters.)

Inpatient Encounters

Table 19. Maryland EDV Results by Element by Inpatient Encounter Type, CY 2012 – CY 2014

Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014
Match	43	39	40	15	4	3	89	21	43	147	64	86
No Match	4	0	2	0	0	0	1	1	0	5	1	2
Total Elements	47	39	42	15	4	3	90	22	43	152	65	88
Match Percent	91.5%	100%	95.2%	100%	100%	100%	98.9%	95.5%	100%	96.7%	98.5%	97.7%

In CY 2014, inpatient diagnosis codes were matched at a 95.2% rate when compared to the content of the inpatient medical record, a decrease of 4.8 percentage points compared to 2013.

In CY 2014, inpatient procedure codes maintained a 100% match rate when compared to inpatient medical records. Inpatient procedure codes have maintained a 100% match rate in each measurement year.

In CY 2014, all inpatient revenue codes matched in the review resulting in a match rate of 100%, increasing 4.5 percentage points from the CY 2013 match rate.

Overall, the total match rate for inpatient encounters across all elements in CY 2014 declined by 0.8 percentage points from 98.5% in CY 2013 to register a rate of 97.7%, and remains slightly above the 96.7% match rate reported in CY 2012.

Outpatient Encounters

Table 20. Maryland EDV Results by Element by Outpatient Encounter Type, CY 2012 – CY 2014

Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014
Match	162	182	182	171	154	134	255	294	258	588	630	574
No Match	17	9	3	7	26	23	2	1	1	26	36	27
Elements	179	191	185	178	180	157	257	295	259	614	666	601
Match Percent	90.5%	95.3%	98.5%	96.1%	85.6%	85.4%	99.2%	99.7%	99.6%	95.8%	94.6%	95.5%

In CY 2014, the outpatient diagnosis code element match rate increased by 3.1 percentage points to 98.4%, compared to 95.3% in CY 2013.

Consistent with CY 2013 outpatient encounter comparisons, the procedure code element had the lowest match rate of all elements in CY 2014 at 85.4%. This represents a decrease of 0.2 percentage points from the CY 2013 match rate. In CY 2013, the procedure code element match rate declined 10.5 percentage points to 85.6% from a score of 96.1% in CY 2012.

In CY 2014, outpatient revenue codes showed a slight decrease of 0.1 percentage points in match rate, shifting from 99.7% in CY 2013 to 99.6%.

Overall, the total match rate for outpatient encounters across all of the element types increased slightly by 0.9 percentage points, from 94.6% in CY 2013 to 95.5% in CY 2014.

Office Visit Encounters

Table 21. Maryland EDV Results by Element by Office Visit Encounter Type, CY 2012 – CY 2014

Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014	CY 2012	CY 2013	CY 2014
Match	707	673	671	311	309	240	NA	NA	NA	1,018	982	911
No Match	29	17	19	37	15	74	NA	NA	NA	66	32	93
Total Elements	736	690	690	348	324	314	NA	NA	NA	1,084	1,014	1,004
Match Percent	96.1%	97.5%	97.2%	89.4%	95.4%	76.4%	NA	NA	NA	93.9%	96.8%	90.7%

The total office visit match rate decreased 6.1 percentage points to 90.7% in CY 2014 from 96.8% in CY 2013, falling below the CY 2012 rate of 93.9%.

Diagnosis code and procedure code match rates both fell from CY 2013 to CY 2014 decreasing by a significant 19 percentage points for procedure codes and slightly by 0.3 percentage points for diagnosis codes. The CY 2013 match rate for diagnosis codes rose to 97.5% from 96.1%. Similarly, procedure codes rose in CY 2013, increasing six percentage points from 89.4% in CY 2012 to 95.4% in CY 2013.

Revenue codes are not applicable for office visit encounters.

"No Match" Results by Element and Reason

Diagnosis Code Element Review

Tables 22 through 24 illustrate the principal reasons for "no match" errors. The reasons for determining a "no match" for the diagnosis code element were:

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

Table 22. Maryland EDV CY 2014 "No Match" Results for Diagnosis Code Element

CY 2014 "No Match" for Diagnosis Code Element			
Encounter Type	Total Elements	Lack of Medical Record Documentation	Incorrect Principal Diagnosis (Inpatient) or Incorrect Diagnosis Codes
Inpatient	2	2	0
% of Total		100%	0%
Outpatient	3	0	3
% of Total		0%	100%
Office Visit	19	3	16
% of Total		15.8%	84.2%

There were two inpatient diagnosis codes that did not match in CY 2014, both resulting from lack of medical documentation. In CY 2013, all inpatient diagnosis codes matched. In CY 2012, all inpatient diagnosis code "no match" errors were due to incorrect diagnosis codes.

Of the three "no match" errors for outpatient encounters in CY 2014, 100% resulted from incorrect diagnosis codes. Similarly, the majority of the nine "no matches" for CY 2013 outpatient encounters (77.8%) were due to incorrect diagnosis codes, and 88.2% of the diagnosis code "no match" errors for outpatient encounters in CY 2012 were also the result of incorrect diagnosis codes.

For office visit encounters, 84.2% of the 19 "no match" errors in CY 2014 resulted from incorrect diagnosis codes, compared to 82.4% of the "no match" errors in CY 2013. In CY 2012, 72.4% "no match" errors for office visit encounters were the result of incorrect diagnosis codes.

Procedure Code Element Review

The reasons for determining a "no match" for the procedure code element were:

- Lack of medical record documentation
- Incorrect procedure codes

Table 23. Maryland EDV CY 2014 "No Match" Results for Procedure Code Element

CY 2014 "No Match" for Procedure Code Element			
Encounter Type	Total Elements	Lack of Medical Record Documentation	Incorrect Procedure Code
Inpatient	0	0	0
% of Total		0%	0%
Outpatient	23	3	20
% of Total		13.0%	87.0%
Office Visit	74	2	72
% of Total		2.7%	97.3%

All inpatient procedure codes matched.

In CY 2014, 87.0% of "no match" errors for outpatient encounters were due to incorrect procedure codes, compared to 96.2% in CY 2013. In CY 2012, 100% of the procedure code "no match" errors for office visits were due to incorrect procedure codes.

In CY 2014, 97.3% of the 74 procedure code "no match" errors for office visit encounters were the result of incorrect procedure codes, compared to 100% in CY 2013. By contrast, incorrect procedure codes accounted for 43.2% of the 37 "no match" errors detected in CY 2012, whereas 56.8% were due to lack of medical documentation.

Revenue Code Element Review

The reasons for determining a "no match" for the revenue code element were:

- Lack of medical record documentation
- Incorrect revenue codes

Table 24. Maryland EDV CY 2014 "No Match" Results for Revenue Code Element

CY 2014 "No Match" for Revenue Code Element *			
Encounter Type*	Total Elements	Lack of Medical Record Documentation	Incorrect Revenue Code
Inpatient	0	0	0
% of Total		0%	0%
Outpatient	1	1	0
% of Total		100%	0%

*Note – Revenue Codes do not apply to Office Visit encounters.

There were no inpatient procedure codes that did not match in CY 2014. There was one procedure code that did not match for CY 2013 and CY 2012 respectively, in both cases due to incorrect revenue codes.

The one revenue code "no match" error for outpatient encounters in CY 2014 was due to a lack of medical record documentation, similar to CY 2013. Of the two "no match" errors observed in CY 2012, one arose from lack of medical record documentation, while the other resulted from an incorrect revenue code.

Conclusions and Recommendations

For CY 2014, overall encounters matched the medical records 92.8% of the time. This match rate exceeds Delmarva Foundation's recommended standard of 90% for accuracy of match rates between encounter data and medical records. Therefore, the encounter data submitted for CY 2014 can be considered reliable for reporting purposes. The overall match rate for CY 2014 registered a decline of 3.2 percentage points below the match rate for 2013 and 2 percentage points below the CY 2012 rate.

The match rates for inpatient encounters were 97.7% and outpatient encounters were 95.5%. Office visits had the lowest match rate of all encounter types at 90.7%. Amongst all encounters, the procedure code element had the lowest match rate of all elements at 79.5%, as compared to the highest match rate of all elements at 99.7% for revenue codes.

Based on the EDV, Delmarva Foundation concluded that the primary reason for "no match" results in the outpatient and office visit encounters for the diagnosis code element was due to incorrect diagnosis codes. Only three of the nineteen "no match" errors for office visit encounters for the diagnosis code element were due to a lack of medical record documentation. All three of the "no match" errors for outpatient visit encounters for the diagnosis code element were due to incorrect diagnosis codes. By contrast, the two "no match" errors for inpatient encounters were both due to lack of medical record documentation.

The primary reason for all the "no match" results in the outpatient encounter data for the procedure code element (20 out of 23 records) was due to incorrect procedure codes. Similarly, 97.3% (72 out of 74) of the office visit encounter "no match" errors were due to incorrect procedure codes. All inpatient encounter data procedure code elements were matched.

There was only one "no match" error in revenue codes for outpatient encounter data which was due to lack of medical record documentation. There were no match errors for revenue codes for inpatient encounters.

Delmarva Foundation recommends the following based on the CY 2014 EDV:

- The majority of the "no match" rates in outpatient and office visit encounters were due to incorrect procedure codes. The Department, in conjunction with MCOs, may want to advise providers to use procedure codes appropriately to reflect what is documented in the medical record.
- The current rate of oversampling should be continued in order to ensure adequate numbers of medical records are received to meet the required sample size, as outpatient and office visit requests being returned due to bad addresses continues to be an issue in obtaining adequate records to meet the minimum sample.
- Communication with provider offices reinforcing the requirement to supply all supporting medical record documentation for the encounter data, including the patient's date of birth, should be continued in order to mitigate the impact of lack of documentation on meeting the minimum sample.

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

Introduction

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

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

As the EQRO, Delmarva Foundation annually completes an EPSDT medical record review. The medical records review findings assist the Department in evaluating the degree to which HealthChoice children and adolescents 0 through 20 years of age are receiving timely screening and preventive care in accordance with the Maryland Preventive Health Schedule.

This section summarizes the findings from the EPSDT medical record review for CY 2014. Approximately 596,577 children were enrolled in the HealthChoice Program during this period.

The seven MCOs evaluated for CY 2014 were:

- AMERIGROUP Community Care (Amerigroup/ACC)
- Jai Medical Systems, Inc. (Jai/JMS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MedStar/MSFC)
- Priority Partners (Priority/PPMCO)
- Riverside Health of Maryland (Riverside/RHMD)
- UnitedHealthcare (United/UHC)

Since Kaiser entered the HealthChoice program in July 2014, they were not required to participate in the EPSDT medical record review.

Program Objectives

The Maryland EPSDT Program's mission is to promote access to and assure availability of quality health care for Medical Assistance children and adolescents through 20 years of age. In support of the program's mission, the primary objective of the EPSDT medical record review is to collect and analyze data to assess the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. The review includes an assessment of MCO performance for the following EPSDT components and their respective subcategories:

Health and developmental history requires a comprehensive evaluation and includes documentation of:

- Annual medical, immunization, family, and psychosocial histories with yearly updates.
- Peri–natal history up through 2 years of age.
- Developmental history/surveillance through 20 years of age.
- Mental health assessment beginning at 3 years of age.
- Substance abuse screening beginning at 12 years of age, younger if indicated.
- Development screening using a standardized screening tool at the 9, 18, and 24–30 month visits.

Comprehensive, unclothed, physical exam requires evaluation and includes documentation of:

- A complete assessment of no fewer than five body systems.
- Age–appropriate vision and hearing assessments at every visit.
- Nutritional assessment at every age.
- Oral assessment at all ages.
- Height and weight measurement with graphing through 20 years of age.
- Head circumference measurement and graphing through 2 years of age.
- BMI calculation and graphing for ages 2 through 20.
- Blood pressure measurement beginning at 3 years of age.

Laboratory tests/at–risk screenings require documentation of:

- Hereditary/metabolic screening test results at birth and again by 1 month* of age.
- Age–appropriate risk assessment results for tuberculosis, cholesterol, and sexually transmitted diseases.
- Counseling and/or laboratory test results for at–risk recipients.
- Anemia tests at 12** and 24*** months of age.
- Lead risk assessment beginning at 6 months through 6 years of age.
- Referral to the lab for lead testing at appropriate ages.
- Blood lead tests results at 12** and 24*** months of age.
- Baseline blood lead test results for ages 3 through 5 when not done at 12 or 24 months of age.
- Children with a blood level greater than 5 ug/dL must have a blood level drawn within 3 months of the initial test.

NOTES: *accepted until 8 weeks of age, **accepted from 9–23 months of age, ***accepted from 24–35 months of age

Immunizations require assessment of need and documented administration that:

- The DHMH Immunization Schedule is being implemented in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
- Age–appropriate vaccines are not postponed for inappropriate reasons.
- Children and/or adolescents who are delayed in their immunizations are brought current with the DHMH Immunization Schedule.

Health education and anticipatory guidance requires documentation of:

- Age–appropriate guidance, with a minimum of three anticipatory guidance items or two major topics documented per visit.
- Counseling and/or referrals for health issues identified by the parent(s) or provider during the visit.
- Oral health assessment following eruption of teeth, yearly dental education, and referrals are required beginning at 12 months of age.
- Educating recipient and/or parent regarding schedule of preventive care visits.
- Return appointment documents, according to Maryland Schedule of Preventive Health Care.

CY 2014 EPSDT Review Process

Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during calendar year 2014 for children from birth through 20 years of age. The sampling methodology includes the following criteria:

- A random sample is drawn from preventive care encounters per MCO, including a 10% over sample.
- Sample size per MCO provides a 95% confidence level and 5% margin of error.
- Sample includes only recipients through 20 years of age as of the last day of the measurement year.
- Sample includes EPSDT for recipients enrolled on last day of measurement year, and for at least 320 days in the same MCO.

  Exception – If the recipient's age on the last day of selected period is less than 365 days, the criteria is modified to read same MCO for 180 days, with no break in eligibility.
- Sample includes recipients who had a preventive care encounter (CPT 99381–85 or 99391–95) with a diagnostic code of V20 or V70. (For children less than 2 years of age who may have had 4–6 preventive visits within a 12–month period, only one date of service was selected.)
- Sample includes recipients when visits with CPT 99381–85 or 99391–95 were provided by primary care providers and clinics with the following specialties: pediatrics, family practice, internal medicine, nurse practitioner, general practice, or a Federally Qualified Health Center (FQHC).

Medical Record Review Process

Medical records were randomly selected in order to assess compliance with the program standards. Nurse reviewers conducted all medical record reviews in the provider offices, with the exception of providers with

only one or two children in the sample. These providers were given the option to mail or fax a complete copy of the medical record to Delmarva Foundation for review. In total, 2,576 medical records were reviewed for CY 2014.

The review criteria used by Delmarva Foundation's review nurses were the same as those developed and used by the Department's EPSDT review nurses. Delmarva Foundation review nurses completed annual training and conducted Inter–Rater Reliability. The review nurses achieved a score of 90% prior to the beginning of the CY 2014 EPSDT Medical Record Review.

Scoring Methodology

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

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

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

Score	Finding
2	Complete
1	Incomplete
0	Missing

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

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

The scoring methodology produced a result that reflected the percentage of possible points obtained in each component, for each age group, and for each MCO. The minimum per component compliance score is 75%. If the minimum compliance score is not met, a CAP is required.

Findings

EPSDT review indicators are based on current pediatric preventive care guidelines and DHMH–identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance rate of 75% for each of the five components. If an MCO did not achieve the minimum compliance rate, the MCO was required to submit a CAP. Three of the seven MCOs (Amerigroup, Jai, and Maryland Physicians Care) met the minimum compliance rate of 75% in each of the five component areas for the CY 2014 review. CAPs for the Laboratory Tests/At–Risk Screenings component were required from four MCOs (MedStar, PPMCO, Riverside, and United).

Findings for the CY 2014 EPSDT review by component area are described in Table 25.

Table 25. CY 2014 EPSDT Component Results by MCO

Component	Number of Elements Reviewed	ACC	JMS	MPC	MSFC	PPMCO	RHMD	UHC	HealthChoice Aggregate CY 2014
Health & Developmental History	10	85%	97%	86%	91%	88%	89%	83%	88%
Comprehensive Physical Examination	14	91%	94%	94%	94%	93%	92%	91%	93%
Laboratory Tests/At–Risk Screenings	10	75%	95%	75%	**73%***	**73%***	**74%***	**67%***	76%
Immunizations	13	82%	83%	81%	83%	85%	82%	82%	83%
Health Education/ Anticipatory Guidance	4	90%	96%	88%	92%	91%	93%	89%	91%

Bolded and underlined text with an asterisk denotes that the minimum compliance score of 75% was unmet and a CAP was required.

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

Health and Developmental History

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

Components: Medical history includes family, peri–natal, developmental, psychosocial, and mental health information, as well as the immunization record. Psychosocial history assesses support systems and exposure to family and/or community violence, which may adversely affect the child's mental health. Developmental, mental health, and substance abuse screenings determine the need for referral and/or follow–up services. The mental health assessment provides an overall view of the child's personality, behaviors, social interactions, affect, and temperament.

Documentation: Annual updates for personal, family, and psychosocial histories are required to ensure the most current information is available. The use of a standard age–appropriate history form (such as the Maryland Healthy Kids Program Medical/Family History) or a similarly comprehensive history form (such as the CRAFFT Assessment Tool from Children's Hospital Boston) is recommended.

Table 26. CY 2014 Health and Developmental History Element Scores

Maryland Schedule of Preventive Health Care Health and Development History Elements	ACC CY 2014	JMS CY 2014	MPC CY 2014	MSFC CY 2014	PPMCO CY 2014	RHMD CY 2014	UHC CY 2014
Substance Abuse Assessment	72%	94%	58%	86%	84%	81%	69%
Psychosocial History	90%	99%	93%	97%	96%	96%	89%
Mental Health Assessment	80%	98%	82%	91%	83%	83%	86%
Family History	77%	98%	80%	85%	84%	85%	74%
Peri–natal History	84%	98%	84%	88%	83%	94%	78%
Health History	90%	100%	93%	95%	94%	92%	87%
Developmental Assessment/ History/Surveillance (0–5 years)	92%	89%	94%	95%	89%	92%	91%
Developmental Assessment/ History/Surveillance (6–20 years)	95%	94%	95%	95%	93%	94%	93%
Developmental Screening Using Standardized Tool at 9, 18, 24–30 Month Visits	61%	83%	67%	64%	59%	70%	62%
Recorded Autism Screening using Standardized Tool*	50%	69%	55%	67%	49%	26%	54%
MCO Aggregate Element Rate	85%	97%	86%	91%	88%	89%	83%

Underlined scores denote that the element score is below 75%, which may impact the minimum level compliance score for the component.
*Baseline for CY 2012 and CY 2013

Findings

- All MCO aggregate scores exceeded the minimum compliance rate of 75% for the Health and Developmental History component in CY 2014.
- The CY 2014 HealthChoice Aggregate score for the Health and Developmental History component is 88%, which is a one percentage point decrease from the 89% Aggregate score in CY 2013.

Comprehensive Physical Examination

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

Components & Documentation: A comprehensive physical exam includes documentation of:

- Subjective or objective vision and hearing assessments at every well–child visit.
- Measuring and graphing head circumference through 2 years of age.
- Recording blood pressure annually for children 3 years of age and older.
- Oral assessment, including a visual exam of the mouth, gums, and teeth.
- Nutritional assessment, including typical diet, physical activity, and education provided with graphing of weight and height through 20 years of age on the growth chart.
- Calculating and graphing Body Mass Index (BMI) for 2 through 20 years of age.
- Appropriate referrals for nutrition services and/or counseling due to identified nutrition or growth problems.

Table 27. CY 2014 Comprehensive Physical Examination Element Scores

Maryland Schedule of Preventive Health Care Comprehensive Physical Examination	ACC CY 2014	JMS CY 2014	MPC CY 2014	MSFC CY 2014	PPMCO CY 2014	RHMD CY 2014	UHC CY 2014
Graphed Height	86%	99%	92%	93%	89%	84%	85%
Measured Height	100%	100%	99%	99%	100%	99%	99%
Graphed Weight	86%	99%	92%	94%	89%	85%	84%
Measured Weight	99%	100%	99%	100%	100%	99%	99%
Graphed Head Circumference	79%	98%	77%	85%	72%	84%	77%
Measured Head Circumference	91%	100%	89%	90%	85%	96%	90%
Measured Blood Pressure	95%	100%	98%	97%	96%	97%	97%
Documentation Of Minimum 5 Systems	91%	63%	95%	95%	95%	91%	91%
Assessed Hearing	91%	90%	92%	88%	92%	94%	90%
Assessed Vision	94%	91%	94%	89%	94%	94%	93%
Assessed Nutritional Status	95%	98%	96%	94%	95%	96%	93%
Conducted Oral Screening	92%	91%	96%	96%	96%	93%	95%
Calculated BMI (2yrs and older)	90%	99%	92%	96%	95%	96%	87%
Graphed BMI (2yrs and older)	76%	99%	83%	83%	82%	82%	75%
MCO Aggregate Element Rate	91%	94%	94%	94%	93%	92%	91%

Underlined scores denote that the element score is below 75%, which may impact the minimum level compliance score for the component.

Findings

- All MCO aggregate scores exceeded the minimum compliance rate of 75% for the Comprehensive Physical Exam component for CY 2014.
- The CY 2014 HealthChoice Aggregate score for the Comprehensive Physical Exam component is 93%, which represents a two percentage point increase from 91% in CY 2012.

Laboratory Tests/At–Risk Screenings

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

Components: Assessment of risk factors includes:

- Tuberculosis risk assessment beginning at 1 month of age beginning in CY 2012.
- Heart disease/cholesterol risk assessment beginning at 2 years of age.
- STI/HIV risk assessment beginning at 12 years of age.
- Lead risk assessment for 6 months through 6 years of age. (A positive lead risk assessment necessitates blood lead testing at any age. In addition, blood lead levels must be obtained at 12** and 24*** months of age.)
- Blood testing of hematocrit or hemoglobin at 12** and 24*** months of age, at the same time as the blood lead test. (On the initial visit for all children 2 through 5 years of age, unless previous test results are available, a hematocrit or hemoglobin test is required.)
- A second hereditary/metabolic screen (lab test) by 2 to 4 weeks* of age.

Notes: *accepted until 8 weeks of age; **accepted from 9–23 months of age; ***accepted from 24–35 months of age

Table 28. CY 2014 Laboratory Test/At–Risk Screenings Element Scores

Maryland Schedule of Preventive Health Care Laboratory Test/At–Risk Screenings	ACC CY 2014	JMS CY 2014	MPC CY 2014	MSFC CY 2014	PPMCO CY 2014	RHMD CY 2014	UHC CY 2014
Cholesterol Risk Assessment per Schedule	70%	98%	73%	72%	69%	67%	66%
STI/HIV Risk Assessment per Schedule	79%	92%	81%	85%	82%	81%	72%
Referred for Lead Test	79%	90%	81%	79%	73%	79%	71%
12 Month Lead Test Result per Schedule	69%	89%	64%	80%	71%	70%	63%
24 Month Lead Test Result per Schedule	70%	75%	54%	76%	50%	50%	47%
Lead Risk Assessment	89%	98%	83%	87%	86%	91%	79%
Anemia Screening per Schedule	81%	89%	76%	81%	70%	75%	71%
Conducted Second Hereditary/Metabolic Screening by 2–4 weeks	82%	100%	71%	68%	71%	76%	82%
Baseline Lead Testing Completed	80%	83%	76%	73%	71%	55%	67%
Tb Risk Assessment (1 month–20years)	71%	99%	71%	62%	72%	72%	60%
MCO Aggregate Element Rate	75%	95%	75%	73%*	73%*	74%*	67%*

Underlined scores denote that the element score is below 75%, which may impact the minimum level compliance score for the component.

Findings

- This component score historically represents an area in need of improvement. MCO specific recommendations for quality improvement focused at the element level are shared annually with each MCO in the EPSDT Medical Record Review Report.
- MedStar, Priority, Riverside, and United scored below the minimum compliance rate of 75%. Each of these MCOs were required to submit a CAP.
- The CY 2014 HealthChoice Aggregate score for the Laboratory Tests/At–Risk Screenings component is 76%, which represents a one percentage point decrease from 77% in CY 2013.

Immunizations

Rationale: Children on Medical Assistance must be immunized according to the current Maryland DHMH Recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland State Medical Society and is based on the current recommendations of the U.S. Public Health Service's Advisory Committee of Immunization Practices (ACIP) and the American Academy of Pediatrics. Primary care providers who see Medicaid recipients through 18 years of age must participate in the Department's Vaccines for Children (VFC) Program.

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

Table 29. CY 2014 Immunizations Element Scores

Maryland Schedule of Preventive Health Care Immunizations	ACC CY 2014	JMS CY 2014	MPC CY 2014	MSFC CY 2014	PPMCO CY 2014	RHMD CY 2014	UHC CY 2014
TD Vaccine(s) per Schedule	82%	90%	80%	81%	91%	70%	87%
Hepatitis B Vaccine(s) per Schedule	88%	92%	88%	91%	92%	86%	88%
MMR Vaccine(s) per Schedule	95%	98%	97%	97%	98%	93%	96%
Polio Vaccine(s) per Schedule	92%	96%	94%	93%	95%	89%	90%
Hib Vaccine(s) per Schedule	75%	76%	76%	77%	76%	88%	79%
DTP/DTaP (DT) Vaccine(s) per Schedule	91%	91%	91%	92%	94%	85%	90%
Hepatitis A Vaccine(s) per Schedule (2 dose requirement)	84%	88%	92%	89%	94%	93%	90%
Influenza Vaccine(s) (Beginning at 6 months of age per schedule)	58%	56%	55%	58%	59%	54%	55%
Meningococcal (MCV4) Vaccine(s) per Schedule	86%	91%	79%	84%	89%	67%	85%
Varicella Vaccine(s) per Schedule (2 dose requirement)	85%	91%	88%	89%	92%	77%	88%
Rotavirus Vaccine(s) per Schedule	67%	72%	86%	100%	94%	83%	84%
Assessed if Immunizations are Up to Date	79%	72%	76%	77%	77%	84%	77%
PCV–13 Vaccine(s) per Schedule	91%	96%	90%	91%	94%	92%	90%
Human Papillomavirus Vaccine(s)*	57%	74%	59%	56%	69%	34%	60%
MCO Aggregate Element Rate	82%	83%	81%	83%	85%	82%	82%

Underlined scores denote that the element score is below 75%, which may impact the minimum level compliance score for the component.
* This immunization data was collected for informational purposes only and was not used in the calculation of the overall component score.

Findings

- All MCO aggregate scores exceeded the minimum compliance rate of 75% for the Immunization component for CY 2014.
- The HealthChoice Aggregate score for this component decreased one percentage points in CY 2014, from 84% in CY 2013 to the current rate of 83%. MCOs were encouraged to continue efforts to improve administration immunizations according to the DHMH Recommended Childhood and Adolescent Immunization Schedule.

Health Education/Anticipatory Guidance

Rationale: Health education enables the patient and family to make informed health care decisions. Anticipatory guidance provides the family with information on what to expect in terms of the child's current and next developmental stage. Information should be provided about the benefits of healthy lifestyles and practices, as well as injury and disease prevention.

Components: A minimum of three topics must be discussed at each Healthy Kids Preventive Care visit. These topics may include, but are not limited to, social interactions, parenting, nutrition, health, play, communication, sexuality, and injury prevention. Beginning at 2 years of age, annual routine dental referrals are required for the purpose of educating the parents about appropriate dental care, providing a cursory view of the child's dental health, and familiarizing the child with the dental equipment. Educating the family about the preventive care schedule and scheduling the next preventive care visit increase the chances of having the child or adolescent return for future preventive care visits. Additionally, follow–up for missed appointments needs to occur as soon as possible when the well–child visit is missed to prevent the child or adolescent from becoming "lost to care."

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

Table 30. CY 2014 Health Education/Anticipatory Guidance Element Scores

Maryland Schedule of Preventive Health Care Health Education/ Anticipatory Guidance	ACC CY 2014	JMS CY 2014	MPC CY 2014	MSFC CY 2014	PPMCO CY 2014	RHMD CY 2014	UHC CY 2014
Provided Education and Referral to Dentist	78%	98%	73%	83%	78%	78%	74%
Provided Age Appropriate Guidance	95%	97%	95%	98%	96%	94%	94%
Specified Requirements for Return Visit	90%	91%	89%	89%	89%	93%	88%
Provided Ed/Referral for Identified Problems/Tests	98%	99%	92%	99%	99%	98%	98%
MCO Aggregate Element Rate	90%	96%	88%	92%	91%	93%	89%

Underlined scores denote that the element score is below 75%, which may impact the minimum level compliance score for the component.

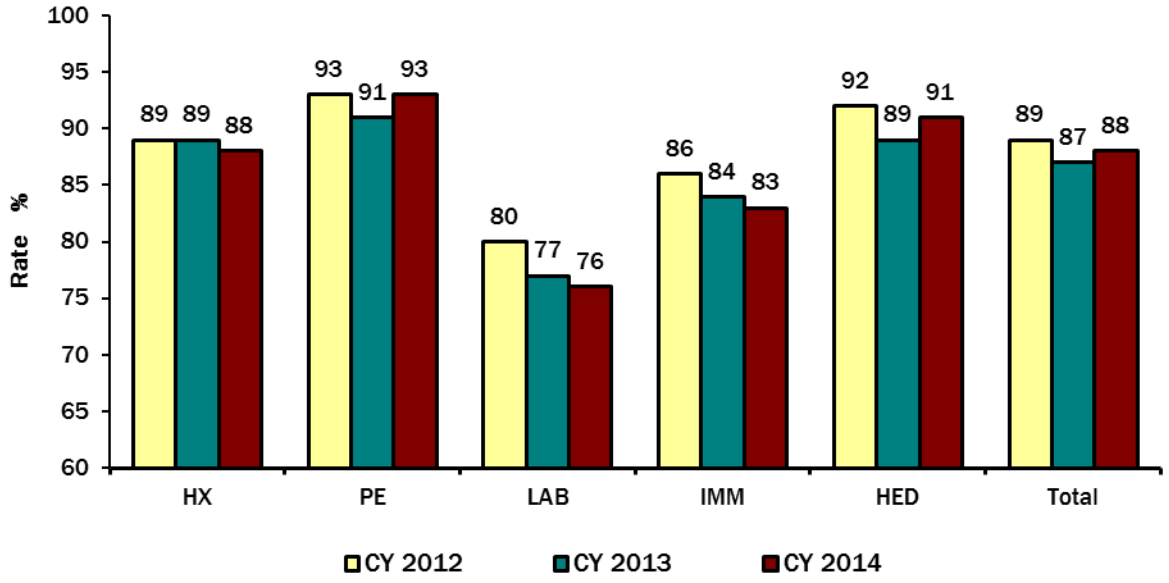
Findings

- All MCO's aggregate scores exceeded the minimum compliance rate for the Health Education/Anticipatory Guidance component for CY 2014.
- The CY 2014 HealthChoice Aggregate score for this component was 91%, which is a two percentage point increase from 89% in CY 2013.

Trending of Aggregate Compliance Scores

Figure 1 compares the HealthChoice Aggregate Rates for three reporting periods: January 1 – December 31, 2012 (CY 2012), January 1 – December 31, 2013 (CY 2013), and January 1 – December 31, 2014 (CY 2014).

Figure I–1. Trend analysis for CY 2012, CY 2013, and CY 2014 HealthChoice Aggregate component scores.



The HealthChoice Aggregate Total scores have shown little variation from CY 2012 to CY 2014. Total scores decreased by two percentage points (89% to 87%) from CY 2012 to CY 2013, and increased by one percentage point (87% to 88%) in CY 2014.

The component scores from CY 2012 to CY 2014 have likewise shown little variation. The CY 2013 to CY 2014 component scores increased in two areas (PE – Comprehensive Physical Exam and HED – Health and Developmental History) and decreased in three areas (HX – Health and Developmental History, LAB – Laboratory Tests/At–Risk Screenings, and IMM – Immunizations).

All component scores remained above the 75% minimum threshold for compliance from CY 2012 to CY 2014.

Corrective Action Plan Process

DHMH sets high performance standards for the Healthy Kids/EPSDT Program. In the event the minimum compliance score is not met, MCOs are required to submit a CAP. The CAPs are evaluated by Delmarva Foundation to determine whether the plans are acceptable. In the event that a CAP is deemed unacceptable, Delmarva Foundation provides recommendations to the MCOs until an acceptable CAP is submitted.

Required Contents of EPSDT CAPs

It is expected that each required CAP will include, at a minimum, the following components:

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

EPSDT CAP Evaluation

The review team will evaluate the effectiveness of any CAPs initiated as a result of the prior year's review. A review of all required EPSDT components are completed annually for each MCO. Since CAPs related to the review can be directly linked to specific components, the annual EPSDT review will determine whether the CAPs were implemented and effective. In order to make this determination, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

Conclusions

Three of the seven MCOs (Amerigroup, Jai, and Maryland Physicians Care) scored above the 75% minimum compliance score for all five components. MedStar, Priority, Riverside, and United scored below the 75% minimum compliance score for the Laboratory Tests/At–Risk Screenings component and were required to submit CAPs. The CAPs were evaluated by Delmarva Foundation to determine whether the plans were acceptable. Delmarva Foundation reviewed the CAPs and found them acceptable for the area where deficiencies occurred for CY 2014.

The result of the EPSDT review demonstrated strong compliance with the timely screening and preventive care requirements of the Healthy Kids/EPSDT Program. Aggregate scores for each of the five components remain above the 75% minimum threshold for compliance.

The CY 2014 Total Composite Score of 88% was a slight one percentage point increase from the CY 2013 Total Composite Score of 87%. Overall scores demonstrate that the MCOs, in collaboration with PCPs, are committed to the Department's goals to provide care that is patient focused and prevention oriented, and follows the Maryland Schedule of Preventive Health Care.

Section VI
Healthcare Effectiveness Data and Information Set (HEDIS®)

Introduction

In accordance with COMAR 10.09.65.03B(2)(a), the HealthChoice MCOs are required to collect HEDIS® measures each year based on relevancy to the HealthChoice population. HEDIS® is one of the most widely used sets of healthcare performance measures in the United States. The program is developed and maintained by NCQA. NCQA develops and publishes specifications for data collection and score calculation in order to promote a high degree of standardization of HEDIS® results. NCQA requires that the reporting entity register with NCQA and undergo a HEDIS® Compliance Audit™.

To ensure a standardized audit methodology, only NCQA–licensed organizations using NCQA–certified auditors may conduct a HEDIS® Compliance Audit. The audit conveys sufficient integrity to HEDIS® data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance across states and lines of business. DHMH contracted with HealthcareData Company, LLC (HDC), a NCQA–Licensed Organization, to conduct HEDIS® Compliance Audits of all HealthChoice organizations and to summarize the final results.

Within DHMH, the HACA is responsible for the quality oversight of the HealthChoice programs. DHMH measures HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS® reporting. Performance is measured at both the managed care organization level and on a statewide basis. All eight HealthChoice MCOs submitted CY 2014 data for HEDIS® 2015. Kaiser Permanente became a HealthChoice MCO in June 2014 and was required to report, however, the majority of the measures did not have enough eligible participants due to continuous enrollment requirements in some of the measures' specifications.

Measures Designated for Reporting

Annually, DHMH determines the set of measures required for HEDIS® reporting. DHMH selects these measures because they provide meaningful MCO comparative information and they measure performance pertinent to DHMH's priorities and goals.

Measures Selected by DHMH for HealthChoice Performance Reporting

DHMH required HealthChoice managed care organizations to report all HEDIS measures applicable to a Medicaid line of business except where the measure is exempted by the Department or carved out. This was a total of 53 HEDIS measures including 21 additional measures for services rendered in calendar year 2014. The 21 new measures are as follows:

- Lead Screening in Children (LSC)
- Human Papillomavirus Vaccine for Female Adolescents (HPV)
- Non–Recommended Cervical Cancer Screening in Adolescent Females (NCS)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
- Antidepressant Medication Management (AMM)
- Follow–Up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotics Medications for Individuals with Schizophrenia (SAA)
- Follow–Up Care after Hospitalization for Mental Illness (FUH)
- Frequency of Selected Procedures (FSP)
- Inpatient Utilization– General Hospital/Acute Care (IPU)
- Mental Health Utilization (MPT)
- Antibiotic Utilization (ABX)
- Board Certification (BCR)
- Enrollment by Product Line (ENP)
- Enrollment by State (EBS)
- Language Diversity of Membership (LDM)
- Race/ Ethnicity Diversity of Membership (RDM)
- Weeks of Pregnancy at Time of Enrollment (WOP)
- Total Membership (TLM)

The total reportable measures within the three NCQA domain categories are as follows:

Effectiveness of Care (EOC) Domain: 30 measures

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC), all indicators except HbA1c good control (<7.0%)
- Use of Appropriate Medications for People with Asthma (ASM)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)

- Appropriate Testing for Children with Pharyngitis (CWP)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- Chlamydia Screening in Women (CHL)
- Use of Imaging Studies for Low Back Pain (LBP)
- Annual Monitoring for Patients on Persistent Medications (MPM)
- Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Medication Management for People with Asthma (MMA)
- Controlling High Blood Pressure (CBP)
- Adult BMI Assessment (ABA)
- Asthma Medication Ratio (AMR)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy Management of COPD Exacerbation (PCE)
- Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Lead Screening in Children (LSC) **New**
- Human Papillomavirus Vaccine for Female Adolescents (HPV) **New**
- Non–Recommended Cervical Cancer Screening in Adolescent Females (NCS) **New**
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) **New**
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) **New**
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) **New**
- Antidepressant Medication Management (AMM) **New**
- Follow–Up Care for Children Prescribed ADHD Medication (ADD) **New**
- Adherence to Antipsychotics Medications for Individuals with Schizophrenia (SAA) **New**

Access/Availability of Care (AAC) Domain: 5 measures

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Prenatal and Postpartum Care (PPC)
- Call Answer Timeliness (CAT)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Utilization and Relative Resource Use (URR) Domain: 18 measures

- Frequency of Ongoing Prenatal Care (FPC)
- Well–Child Visits in the First 15 Months of Life (W15)
- Well–Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well–Care Visits (AWC)
- Ambulatory Care (AMB)

- Identification of Alcohol and Other Drug Services (IAD)
- Follow–Up Care after Hospitalization for Mental Illness (FUH) **New**
- Frequency of Selected Procedures (FSP) **New**
- Inpatient Utilization– General Hospital/ Acute Care (IPU) **New**
- Mental Health Utilization (MPT) **New**
- Antibiotic Utilization (ABX) **New**
- Board Certification (BCR) **New**
- Enrollment by Product Line (ENP) **New**
- Enrollment by State (EBS) **New**
- Language Diversity of Membership (LDM) **New**
- Race/ Ethnicity Diversity of Membership (RDM) **New**
- Weeks of Pregnancy at Time of Enrollment (WOP) **New**
- Total Membership (TLM) **New**

No Benefit (NB) Measure Designations

The NB designation is utilized for measures where DHMH has contracted with outside vendors for coverage of certain services. The vendor–generated claims/services are calculated outside of the IDSS (NCQA's Interactive Data Submission System), and HDC and the plans do not have access to the data. So that plans are not penalized, NCQA allows health plans to report these measures with a NB designation. The following ten measures are reported NB and do not appear in measure specific findings of this report.

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
- Antidepressant Medication Management (AMM)
- Follow–Up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Follow–Up Care after Hospitalization for Mental Illness (FUH)
- Mental Health Utilization (MPT)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Annual Dental Visit (ADV)
- Use of First–Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

HEDIS® Measures Reporting History

The following table shows the history of DHMH required reporting. A notation of ≤ 2005 indicates that DHMH chose to report the measure since at least 2005. The year refers to the HEDIS®–reporting year.

NCQA Domain	Measure Name	Indicators	HealthChoice Reporting History
EOC	Adult BMI Assessment (ABA)		2013
EOC	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)		2012
EOC	Childhood Immunization Status (CIS)	Combination 2[1]	≤ 2005
		Combination 3[1]	2006
		Combinations 4,5,6,7,8,9, and 10[1]	2010
EOC	Immunizations for Adolescents (IMA)	Combination 1[1]	2010
URR	Well–Child Visits in the First 15 Months of Life (W15)	No visits	≤ 2005
		DHMH non–HEDIS measure: Five and six–or–more visits	
URR	Well–Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)		≤ 2005
URR	Adolescent Well–Care Visits (AWC)		≤ 2005
EOC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	BMI Percentile – Total Rate	2014
		Counseling for Nutrition – Total Rate	
		Counseling for Physical Activity – Total Rate	
EOC	Appropriate Testing for Children with Pharyngitis (CWP)		2007
EOC	Lead Screening in Children (LSC)		2015
EOC	Human Papillomavirus Vaccine for Female Adolescents (HPV)		2015
EOC	Non–Recommended Cervical Cancer Screening in Adolescent Females (NCS)		2015
EOC	Use of Appropriate Medications for People with Asthma (ASM)	5–9 years of age; 10–17 years of age; 18–56 years of age; Total (5–56 years of age) (retired 2009)	2006–2009
		5–11 years of age; 12–50 years of age; Total (5–50 years of age) (retired 2010)	2010
		5–11 years of age; 12–18 years of age; 19–50 years of age; 51–64 years of age; Total (5–64 years of age); DHMH non–HEDIS measure: Total (5–50 years of age)	2012
EOC	Medication Management for People With Asthma (MMA)	Percentage of members who remained on an asthma controller medication for at least 50% of their treatment period	2013
		Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period	
EOC	Appropriate Treatment for Children with Upper Respiratory Infection (URI)		2007
EOC	Asthma Medication Ratio (AMR)		2014
EOC	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)		2014
EOC	Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid Rate	2014

[1] Descriptions of combinations can be found within applicable reporting sections.

NCQA Domain	Measure Name	Indicators	HealthChoice Reporting History
AAC	Children and Adolescents' Access to Primary Care Practitioners (CAP)	12–24 months of age	2007
		25 months–6 years of age	
		7–11 years of age	
		12–19 years of age	
AAC	Adults' Access to Preventive/Ambulatory Health Services (AAP)	20–44 years of age	2007
		45–65 years of age	
EOC	Breast Cancer Screening (BCS)		2007
EOC	Cervical Cancer Screening (CCS)		2007
EOC	Chlamydia Screening in Women (CHL)	Total (16–25 years of age) (retired in 2008)	2007–2008
		21–25 years of age (retired in 2009)	2007–2009
		16–20 years of age	2007
		21–24 years of age	2007
		Total (16–24 years of age)	2009
AAC	Prenatal and Postpartum Care (PPC)	Timeliness of prenatal care	≤ 2005
		Postpartum care	≤ 2005
URR	Frequency of Ongoing Prenatal Care (FPC)	<21 percent of expected visits	≤ 2005
		≥81 percent of expected visits	
EOC	Controlling High Blood Pressure (CBP)		2013
EOC	Persistence of Beta–Blocker Treatment After a Heart Attack (PBH)		2014
EOC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)		2015
EOC	Comprehensive Diabetes Care (CDC)	LDL–C screening (retired in 2015)	2007–2015
		HbA1c testing	≤ 2005
		HbA1c poor control (>9.0%)	≤ 2005
		HbA1c control (<8.0%)	2009
		Eye exam (retinal) performed	≤ 2005
		Medical attention for nephropathy	2007
		Blood pressure control (<140/90 mm Hg)	2007
EOC	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medication (SSD)		2015
EOC	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		2015
EOC	Use of Imaging Studies for Low Back Pain (LBP)		2012
EOC	Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)		2013
EOC	Annual Monitoring for Patients on Persistent Medications(MPM)	Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	2013
		Digoxin	
		Diuretics	
		Anticonvulsants	
		Total Rate	

NCQA Domain	Measure Name	Indicators	HealthChoice Reporting History
EOC	Antidepressant Medication Management (AMM)		2015
EOC	Follow–Up Care for Children Prescribed ADHD Medication (ADD)		2015
EOC	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)		2015
AAC	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Initiation: 13–17 years of age	2009
		Initiation: 18+ years of age	
		Initiation: Total ages 13–65	
		Engagement: 13–17 years of age	
		Engagement: 18+ years of age	
		Engagement: Total ages 13–65	
URR	Identification of Alcohol and Other Drug Services (IAD)	Any services	2009
URR	Ambulatory Care (AMB)	Ambulatory Surgery/Procedures (retired in 2011)	2007–2011
		Observation Room Stays (retired in 2011)	
		Outpatient visits	2007
		ED visits	
URR	Follow–Up After Hospitalization for Mental Illness (FUH)		2015
URR	Frequency of Selected Procedures (FSP)	Bariatric weight loss surgery / 1000 MM 45–64 F	2015
		Bariatric weight loss surgery / 1000 MM 45–64 M	
		Tonsillectomy / 1000 MM 0–9 Total	
		Tonsillectomy / 1000 MM 10–19 Total	
		Hysterectomy, abdominal / 1000 MM 45–64 F	
		Hysterectomy, vaginal / 1000 MM 45–64 F	
		Cholecystectomy, open / 1000 MM 30–64 M	
		Cholecystectomy, open / 1000 MM 45–64 F	
		Cholecystectomy, laparoscopic / 1000 MM 30–64 M	
		Cholecystectomy, laparoscopic / 1000 MM 45–64 F	
		Back Surgery / 1000 MM 45–64 F	
		Back Surgery / 1000 MM 45–64 M	
		Mastectomy / 1000 MM 15–44 F	
		Mastectomy / 1000 MM 45–64 F	
		Lumpectomy / 1000 MM 15–44 F	
		Lumpectomy / 1000 MM 45–64 F	
URR	Inpatient Utilization – General Hospital/Acute Care (IPU)	Total Inpatient Discharges / 1000 MM	2015
		Total Inpatient Average Length of Stay	
URR	Mental Health Utilization (MPT)		2015
URR	Antibiotic Utilization (ABX)		2015
URR	Board Certification (BCR)	All indicators	2015
URR	Enrollment by Product Line (ENP)		2015
URR	Enrollment by State (EBS)		2015
URR	Language Diversity of Membership (LDM)		2015

NCQA Domain	Measure Name	Indicators	HealthChoice Reporting History
URR	Race/Ethnicity Diversity of Membership (RDM)	All indicators	2015
URR	Weeks of Pregnancy at Time of Enrollment (WOP)	13–27 weeks	2015
		28+ weeks	
		Unknown	
URR	Total Membership (TLM)		2015
AAC	Call Answer Timeliness (CAT)		2006

HEDIS® Methodology

The HEDIS–reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS 2015 Volume 2: Technical Specifications*.

Data collection: The organization pulls together all data sources, typically into a data warehouse, against which HEDIS software programs are applied to calculate measures. Three approaches may be taken for data collection:

- **Administrative data:** Data from transaction systems (claims, encounters, enrollment, and practitioner) provide the majority of administrative data. Organizations may receive encounter files from pharmacy, laboratory, vision, and behavioral health vendors.
- **Supplemental data:** NCQA defines supplemental data as atypical administrative data, i.e., not claims or encounters. Sources include immunization registry files, laboratory results files, case management databases, and medical record–derived databases.
- **Medical record data:** Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA–defined hybrid method. HEDIS specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records needs to be chased. NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by DHMH for HEDIS reporting. Use of the hybrid method is optional. NCQA maintains that no one approach to measure calculation or data collection is considered superior to another. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across–the–board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

Use of the hybrid method is optional. NCQA maintains that no one approach to measure calculation or data collection is considered superior to another. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across–the–board statements about the need for, or positive impact of, one method versus another. In fact, an

organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

The following table shows actual HEDIS 2015 use of the administrative or hybrid method. The HealthChoice organization chooses the administrative versus hybrid method based on available resources, as the hybrid method takes significant resources to perform.

Measure List	ACC	JMS	KPMAS	MPC	MSFC	PP	RHP	UHC
ABA – Adult BMI Assessment	H	H	A	H	H	H	A	H
AWC – Adolescent Well–Care Visits	H	A	H	H	H	H	H	H
CBP – Controlling High Blood Pressure	H	H	H	H	H	H	H	H
CCS – Cervical Cancer Screening	H	H	H	H	H	H	H	H
CDC – Comprehensive Diabetes Care	H	H	H	H	H	H	H	H
CIS – Childhood Immunization Status	H	H	H	H	H	H	H	H
FPC – Frequency of Ongoing Prenatal Care	H	H	A	H	H	A	H	H
HPV – Human Papillomavirus Vaccine for Female Adolescents	H	H	A	H	H	A	A	A
IMA – Immunization for Adolescents	H	H	A	H	H	H	H	H
LSC – Lead Screening in Children	A	A	A	A	H	A	H	A
PPC – Prenatal and Postpartum Care	H	H	H	H	H	H	H	H
W15 – Well–Child Visits in the First 15 Months of Life	H	H	H	H	H	A	H	H
W34 – Well–Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	H	A	H	H	H	H	H	H
WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	H	H	H	H	H	H	H	H

H – Hybrid; A – Administrative

HEDIS® Audit Protocol

The HEDIS auditor follows NCQA's Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures. The main components of the audit are described below.

Offsite preparation for the onsite audit:

- **Conference call**: A conference call is held four to five weeks prior to on–site visit to introduce key personnel, review the onsite agenda, identify session participants, and determine a plan to audit data sources used for HEDIS.
- **HEDIS Roadmap review**: The HEDIS "Roadmap" is an acronym representing the HEDIS Record of Administration, Data Management and Processes. The Roadmap is a comprehensive instrument designed by NCQA to collect information from each HealthChoice plan regarding structure, data collection and processing, and HEDIS reporting procedures. The health plan completes and submits the Roadmap to the auditing organization by January 31st of each reporting year. The auditor reviews the HEDIS Roadmap prior to the onsite audit in order to make preliminary assessments regarding Information Systems (IS) compliance and to identify areas requiring follow–up at the onsite audit.

- **Information Systems (IS) standards compliance**: The onsite portion of the HEDIS Audit expands upon information gleaned from the HEDIS Roadmap to enable the auditor to make conclusions about the organization's compliance with IS standards. IS standards, describing the minimum requirements for information systems and processes used in HEDIS data collection, are the foundation on which the auditor assesses the organization's ability to report HEDIS data accurately and reliably. The auditor reviews data collection and management processes, including the monitoring of vendors, and makes a determination regarding the soundness and completeness of data to be used for HEDIS reporting.
- **HEDIS Measure Determination (HD) standards compliance**: The auditor uses both onsite and offsite activities to determine compliance with HD standards and to assess the organization's adherence to HEDIS Technical Specifications and report–production protocols. The auditor confirms the use of NCQA–certified software. The auditor reviews the organization's sampling protocols for the hybrid method. Later in the audit season, the auditor reviews HEDIS results for algorithmic compliance and performs benchmarking against NCQA–published means and percentiles.
- **Medical Record Review Validation (MRRV)**: The HEDIS audit includes a protocol to validate the integrity of data obtained from medical record review (MRR) for any measures calculated using the hybrid method. The audit team compares its medical record findings to the organization's abstraction forms for a sample of positive numerator events. Part one of the validation may also include review of a convenience sample of medical records for the purpose of finding procedural errors early in the medical record abstraction process so that timely corrective action can be made. This is optional based on NCQA standards and auditor opinion. MRRV is an important component of the HEDIS Compliance Audit. It ensures that medical records reviews performed by the organization, or by its contracted vendor, meet audit standards for sound processes and that abstracted medical data are accurate. In part two of the MRRV, the auditor selects hybrid measures from like–measure groupings for measure validation. MRRV tests medical records and appropriate application of the HEDIS hybrid specifications (i.e., the member is a numerator positive or an exclusion for the measure). NCQA uses an acceptable quality level of 2.5 percent for the sampling process, which translates to a sample of 16 medical records for each selected measure.

Audit designations: The auditor approves the rate/result calculated by the HealthChoice organization for each measure included in the HEDIS report, as shown in the following table of audit results, excerpted from *Volume 5: HEDIS Compliance Audit: Standards, Policies, and Procedures.*

Rate/Result	Comment
0–XXX	A rate or numeric result. The organization followed the specification and produced a reportable rate or result for the measure.
NA	Small Denominator. The organization followed the specifications but the denominator was too small (<30) to report a valid rate.

Rate/Result	Comment
NB	Benefit Not Offered. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reportable. ➢ The calculated rate was materially biased, or ➢ The organization chose not to report the measure, or ➢ The organization was not required to report the measure.

***** An organization may exercise this option only for those measures not included in the measurement set required by DHMH.

Bias Determination: If the auditor determines that a measure is biased, the organization cannot report a rate for that measure and the auditor assigns the designation of NR. Bias is based on the degree of error or data completeness for the data collection method used. NCQA defines four bias determination rules, applied to specific measures. These are explained in Appendix 10 of *Volume 5: HEDIS® Compliance Audit™: Standards, Policies and Procedures*.

Final Audit Opinion: At the close of the audit, the auditor renders the Final Audit Opinion, containing a Final Audit Statement along with measure–specific rates/results and comments housed in the Audit Review Table.

The organizations displayed commendable areas and progress from the previous audit:

- Kaiser was a new plan audited in 2015. The organization had no problem in reporting the required measures, the majority of which had no or very small eligible populations. Kaiser has a very qualified and experienced staff that was able to capitalize on their existing Medicare and Commercial reporting experiences. Existing software was appropriately modified for Medicaid reporting. HDC worked closely with the organization to explain reporting requirements. The plan's HEDIS project manager was formerly at UnitedHealthcare, so the learning curve was minimal.
- This was the first year that DHMH required all HEDIS measures to be reported, unless exempted or carved out. No organization had a problem with reporting the measures on time and completely.
- Organizations continued to increase the quality and quantity of ancillary vendor encounter files and supplemental administrative data. Particular emphasis was placed on capturing additional data on services rendered where this information is outside of the claims system. Organizations also implemented programs to encourage members to obtain the required services and notify primary care providers of members who are noncompliant for selected measures.
- All organizations implemented internal audit and oversight practices. The focus of the audits was on both data completeness and data accuracy. Some organizations established staff incentives for high performance and accuracy rates.
- Organizations have initiated provider profiling systems, linking results to provider incentive payments. Credentialing systems were able to report on the Board Certification (BCR) measure.

- The Value Based Purchasing program provided a strong incentive for health plans to improve their rates for the measures included in this program. Organizations focus more resources toward improvement of these measures versus others that are reported.

Measure–specific Findings – Explanation

Two metrics are calculated to accompany the MCO–specific scores:

- **Maryland Average Reportable Rate (MARR):** The MARR is an average of HealthChoice MCO's rates as reported to NCQA. In most cases, all eight MCOs contributed a rate to the average. Where one or more organizations reported *NA* or *NR* instead of a rate, the average consisted of fewer than seven component rates.
- **National HEDIS® Mean (NHM):** The mean value is taken from NCQA's *HEDIS® Audit Means, Percentiles and Ratios – Medicaid*, released each year to HEDIS® auditors and reporting organizations. The NCQA data set gives prior–year rates for each measure displayed as the mean rate and the rate at the 5th, 10th, 25th, 50th, 75th, 90th and 95th percentiles. *HEDIS® 2014 Means, Percentiles, and Ratios* pertinent to this report, as well as additional rates for measure components are reported to the Department. Any questions regarding such rates can be directed to the Department. NCQA averages the rates of all organizations submitting HEDIS® results, regardless of the method of calculation (administrative or hybrid). NCQA's method is the same as that used for the MARR, but on a larger scale.

Year–to–year trending: Year–to–year trending is possible when specifications remain consistent from year to year. (Expected updates to industry–wide coding systems are not considered specification changes.) For each measure, the tables display up to five years of results, where available.

Prior year results are retained in the trending tables, regardless of specification changes. Text in italics notes when prior–year results fall under different specifications. Performance trends at the organization level are juxtaposed with the trends for the MARR and the NHM for the same measurement year.

Rounding of figures: Rates are rounded to one decimal point from the rate/ratio reported to NCQA. This rounding corresponds to the rounding used by NCQA for the NHM. Where any two or more rates are identical at this level of detail, an additional decimal place of detail is provided.

Audit designation other than a rate/ratio: According to NCQA reporting protocols, *NA* or *NR* may replace a rate.

Sources of accompanying information:

- Description – The source of the information is NCQA's HEDIS® 2015 Volume 2: Technical Specifications.

- Rationale – For all measures, except Call Answer Timeliness (CAT) the source of the information is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of 2015. These citations appear under the *Brief Abstract* on the Web site of the National Quality Measures Clearinghouse, http://www.qualitymeasures.ahrq.gov/. For CAT the rationale was adapted from HEDIS® 2004 Vol. 2: Technical Specifications.
- Summary of Changes for HEDIS® 2015 – The source of the text, is the HEDIS® 2015 Volume 2: Technical Specifications, incorporating additional changes published in the HEDIS® 2015 Volume 2: "October" Technical Update.

Year–to–year Changes

Table 31 shows the numbers of organizations that experienced a lower or higher change in HEDIS® rates from 2013 to 2014. The change in the MARR (2015 rate minus 2014 rate) and the change in the NHM (2014 rate minus 2013 rate) place Maryland HealthChoice organization trends in perspective. For measures where a lower rate indicates better performance (single asterisk), the number of lower performing organizations appears in the higher column and the number of higher performing organizations appear in the lower column. New measures or indicators with no trendable history are not included in this analysis of change. HEDIS® 2015 results of *NA* are not included in tallies. Rates that stayed the same from last year and did not increase or decrease are not included in this table.

Table 31. Changes in HEDIS® Rates from 2014 to 2015

HEDIS Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Adult BMI Assessment (ABA)	0	6	12.8%	8.4%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	2	4	1.2%	2.3%
Childhood Immunization Status (CIS) – Combination 2	2	4	–4.4%	–1.7%
Childhood Immunization Status (CIS) – Combination 3	3	3	–5.6%	–1.2%
Childhood Immunization Status (CIS) – Combination 4	1	5	–2.4%	4.0%
Childhood Immunization Status (CIS) – Combination 5	3	3	–0.8%	1.1%
Childhood Immunization Status (CIS) – Combination 6	2	4	–1.9%	0.4%
Childhood Immunization Status (CIS) – Combination 7	2	4	0.5%	4.7%
Childhood Immunization Status (CIS) – Combination 8	2	4	–0.8%	3.0%
Childhood Immunization Status (CIS) – Combination 9	2	4	–0.3%	1.2%
Childhood Immunization Status (CIS) – Combination 10	2	4	0.3%	3.3%
Immunizations for Adolescents (IMA) – Combination 1	1	5	2.5%	3.0%
Well–Child Visits in the First 15 months of Life (W15) – No well–child visits*	2	4	1.7%	0.9%
Well–Child Visits in the First 15 months of Life (W15) – DHMH Five or Six–or–more visits rates**	5	1	–6.2%	–79.2%
Well–Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	2	4	–2.0%	–0.5%
Adolescent Well–Care Visits (AWC)	4	2	–5.2%	0.3%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile– Total Rate	0	6	11.4%	5.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	2	4	7.1%	3.7%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	1	5	6.3%	6.3%
Appropriate Testing for Children with Pharyngitis (CWP)	0	6	3.0%	–1.5%
Lead Screening in Children (LSC)			73.8%	66.5%
Human Papillomavirus Vaccine for Female Adolescents (HPV)			22.8%	19.8%
Non–Recommended Cervical Cancer Screening in Adolescent Females (NCS)			3.9%	5.6%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 5–11	4	2	–0.4%	0.5%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 12–18	2	4	0.0%	1.3%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 19–50	3	3	1.1%	0.5%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 51–64	1	4	5.1%	–1.1%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 5–64	2	4	0.3%	0.2%

* A lower rate indicates better performance.

** Not a HEDIS® sub–measure; HDC is calculating for DHMH trending purposes.

HEDIS Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–50**	4	2	–0.6%	--
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	3	3	1.8%	3.2%
Medication Management for People With Asthma (MMA) – Total 75% of treatment period	2	4	1.2%	2.4%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	1	5	3.3%	0.1%
Asthma Medication Ratio (AMR)	6	0	–6.3%	8.3%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	4	2	0.3%	–0.5%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	5	1	–0.8%	0.4%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	1	5	0.0%	–0.6%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	2	4	–0.8%	0.1%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	2	4	–1.4%	–0.1%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	2	4	0.7%	0.1%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	1	5	1.3%	0.1%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	5	1	–0.9%	0.3%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	3	3	–0.7%	0.8%
Breast Cancer Screening (BCS)	1	5	9.6%	6.0%
Cervical Cancer Screening (CCS)	6	0	–9.4%	–1.9%
Chlamydia Screening in Women (CHL) – Age 16–20 years	3	3	1.5%	–2.2%
Chlamydia Screening in Women (CHL) – Age 21–24 years	5	1	–1.4%	–2.0%
Chlamydia Screening in Women (CHL) – Total (16–24) years	4	2	0.5%	–2.2%
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	5	2	1.3%	–1.0%
Prenatal and Postpartum Care (PPC) – Postpartum Care	5	2	0.9%	–1.8%
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*	2	5	–1.5%	2.1%
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	5	2	–1.1%	–4.9%
Controlling High Blood Pressures (CBP)	0	6	9.0%	0.2%
Persistence of Beta–Blocker Treatment after a Heart Attack (PBH)	1	2	3.0%	2.2%
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	0	6	6.7%	0.8%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*	4	2	–1.4%	0.9%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	3	3	–0.5%	–1.1%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	5	1	–7.8%	0.3%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	1	5	4.3%	0.6%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	2	4	3.0%	1.5%
Use of Imaging Studies for Low Back Pain (LBP)	4	2	–1.2%	–0.1%
Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	2	2	3.0%	0.7%
Annual Monitoring for Patients on Persistent Medications (MPM) – members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	3	3	0.4%	1.6%
Annual Monitoring for Patients on Persistent Medications (MPM) – members on digoxin	4	0	–36.6%	1.0%
Annual Monitoring for Patients on Persistent Medications (MPM) – members on diuretics	1	5	0.8%	1.9%

* A lower rate indicates better performance.

** Not a HEDIS® sub–measure; HDC is calculating for DHMH trending purposes.

HEDIS Measure	MCOs Performing Lower	MCOs Performing Higher	MARR Change	NHM Change
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate	1	5	1.8%	1.6%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 13–17 Years	3	2	–1.4%	0.0%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 18+ Years	3	3	1.4%	–1.1%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation Overall Ages	3	3	1.2%	–1.2%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 13–17 Years	2	3	–1.0%	–0.5%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 18+ Years	3	3	1.7%	–0.1%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement Overall Ages	3	3	1.4%	–0.3%
Identification of Alcohol and Other Drug Services (IAD) – Any	1	6	1.2%	0.0%
Identification of Alcohol and Other Drug Services (IAD) – Inpatient	2	5	0.1%	–0.1%
Identification of Alcohol and Other Drug Services (IAD) – Intensive Outpatient/Partial Hospitalization	1	6	0.3%	–0.6%
Identification of Alcohol and Other Drug Services (IAD) – Outpatient/ED	1	6	1.6%	1.4%
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	3	4	9.46	(11.67)
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months	4	3	(5.77)	(2.70)
Call Answer Timeliness (CAT)	6	0	–10.1%	1.1%

* A lower rate indicates better performance.

** Not a HEDIS® sub–measure; HDC is calculating for DHMH trending purposes.

Three–year trends: Table 32 shows organizations that demonstrated incremental increases in performance scores over the past three years. The analysis only shows a trend toward improvement. It does not indicate superior performance. For a comparison of one organization against another, please refer to the measure–specific tables in this report. For measures where a lower rate indicates better performance (single asterisk), the table shows organizations having a decrease in performance score over the past three years.

Table 32. HEDIS® Measures Incremental Increases in Performance

HEDIS Measure	ACC	JMS	MPC	MSFC	PP	UHC
Adult BMI Assessment (ABA)	X	X	X	X	X	X
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	X		X	X	X	X
Childhood Immunization Status (CIS) – Combination 2		X				X
Childhood Immunization Status (CIS) – Combination 3		X				X
Childhood Immunization Status (CIS) – Combination 4	X	X			X	X
Childhood Immunization Status (CIS) – Combination 5	X	X	X	X	X	X
Childhood Immunization Status (CIS) – Combination 6	X	X			X	X
Childhood Immunization Status (CIS) – Combination 7	X	X	X	X	X	X
Childhood Immunization Status (CIS) – Combination 8	X	X			X	X
Childhood Immunization Status (CIS) – Combination 9	X	X	X	X	X	X
Childhood Immunization Status (CIS) – Combination 10	X	X	X	X	X	X
Immunizations for Adolescents (IMA) – Combination 1	X	X	X	X	X	X
Well–Child Visits in the First 15 months of Life (W15) – No well–child visits*		X				X
Well–Child Visits in the First 15 months of Life (W15) – DHMH Five or Six–or–more visits rates**			X			X
Well–Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	X	X		X	X	
Adolescent Well–Care Visits (AWC)		X	X		X	
Appropriate Testing for Children with Pharyngitis (CWP)	X	X	X	X	X	X
Use of Appropriate Medications for People With Asthma (ASM) – Ages 5–11	X		X			
Use of Appropriate Medications for People With Asthma (ASM) – Ages 12–18	X			X		
Use of Appropriate Medications for People With Asthma (ASM) – Ages 19–50				X		
Use of Appropriate Medications for People With Asthma (ASM) – Ages 51–64	X	X	X		X	
Use of Appropriate Medications for People With Asthma (ASM) – Ages 5–64						
Use of Appropriate Medications for People With Asthma (ASM) – Total combined ages 5–50**						
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	X	X	X		X	X
Medication Management for People With Asthma (MMA) – Total 75% of treatment period		X	X		X	
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	X	X		X	X	X
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months		X			X	
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	X	X	X		X	
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	X		X		X	
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	X	X	X			X
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years						
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years			X		X	X
Breast Cancer Screening (BCS)	X	X	X	X	X	X
Cervical Cancer Screening (CCS)						
Chlamydia Screening in Women (CHL) – Age 16–20 years		X	X			
Chlamydia Screening in Women (CHL) – Age 21–24 years		X				
Chlamydia Screening in Women (CHL) – Total (16–24) years		X	X			
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care						

* A lower rate indicates better performance.

** Not a HEDIS® sub–measure; HDC is calculating for DHMH trending purposes.

Note: RHMD and KPMAS were not included as they did not have three years of data.

Highlights

- The MARR for Well–Child Visits Ages 3–6 (W34) decreased by 2 percentage points from last year, and the MARR for Adolescent Well–Care Visits (AWC) decreased by 5 percentage points from last year.
- The MARR for all three categories of Weight Assessment and Counseling (WCC) improved significantly in 2015 over 2014, as did the Adult BMI Assessment (ABA).
- The MARR for Cervical Cancer Screening (CCS) decreased by nearly 10 percentage points from last year, while Breast Cancer Screening (BCS) increased by nearly 10 percentage points.
- The MARR for both categories of Prenatal and Postpartum Care (PPC) improved significantly in 2015 over 2014.
- The MARR for Ambulatory Care (AMB) for Outpatient Visits increased by 9 points, while ED Visits decreased by 5 points.

Measures with the greatest percentage improvement belonged to the Effectiveness of Care domain and include weight management for both adults and children, breast cancer screening, diabetes monitoring and treatment for respiratory illness.

Measures with the greatest percentage decline involved all three domains (Effectiveness of Care, Utilization, and Access). Those measures in significant decline include child and adolescent prevention and screening, eye exam for diabetes, cervical cancer screening, medical management for digoxin and call answer timeliness.

The six plans that reported in each of the last three years (Amerigroup, Jai, Maryland Physicians Care, MedStar, Priority, and United) had an average improvement rate of 51%, meaning that on average, each plan improved on 35 of 68 measures from 2013 to 2015.

Section VII
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

Introduction

COMAR 10.09.65.03(C)(4) requires that all HealthChoice MCOs participate in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. DHMH has contracted with WBA Market Research (WBA), an NCQA–certified survey vendor, since 2008 to conduct its survey. WBA administers this survey to a random sample of eligible adult and child members enrolled in HealthChoice via mixed methodology (mail with telephone follow–up), per NCQA protocol. Seven MCOs participated in the HealthChoice CAHPS® 2015 survey based on services provided in CY 2014:

- AMERIGROUP Community Care (Amerigroup/ACC)
- Jai Medical Systems (Jai/JMS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MedStar/MSFC)
- Priority Partners (Priority/PPMCO)
- Riverside Health of Maryland (Riverside/RHMD)
- UnitedHealthcare (United/UHC)

Kaiser did not participate in CAHPS® as they joined the HealthChoice system in July 2014.

2015 CAHPS® 5.0H Medicaid Survey Overview

In 2015, the 5.0H version of the CAHPS® Adult and Child Medicaid Satisfaction Surveys was used to survey the HealthChoice population about services provided in CY 2014. The survey measures those aspects of care for which members are the best and/or the only source of information. From this survey, members' ratings of and experiences with the medical care they receive can be determined. Based on members' health care experiences, potential opportunities for improvement can be identified. Specifically, the results obtained from this consumer survey will allow DHMH to:

- Determine how well participating HealthChoice MCOs are meeting their members' expectations
- Provide feedback to the HealthChoice MCOs to improve quality of care
- Encourage HealthChoice MCO accountability
- Develop a HealthChoice MCO action plan to improve members' quality of care

Results from the CAHPS® 5.0H survey summarize member satisfaction with their health care through ratings, composites, and question summary rates. In general, summary rates represent the percentage of respondents who chose the most positive response categories as specified by NCQA. Ratings and composite measures in the CAHPS® 5.0H Adult and Child Medicaid Survey include:

- Overall Ratings of Personal Doctor, Specialist, Health Care, and Health Plan
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision–Making
- Health Promotion and Education
- Coordination of Care

Five additional composite measures are calculated for the Children with Chronic Conditions (CCC) population:

- Access to Prescription Medicine
- Family Centered Care: Getting Needed Information
- Family Centered Care: Personal Doctor Who Knows Child
- Access to Specialized Services
- Coordination of Care for CCC

Survey, Reporting and Methodology Changes in 2015

In 2015, the National Committee for Quality Assurance (NCQA) made several revisions to the 5.0H version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Adult and Child Medicaid Satisfaction Surveys, including changes to the order and wording of survey questions.

- Revised Shared Decision–Making Composite Measure: significantly altered two of the three existing questions' response choices. Impact on trending is expected.
- Moved all supplemental questions to the end of the core survey instrument.
- At the request of NCQA, the Maryland Department of Health and Mental Hygiene (DHMH) made two revisions to the supplemental questions in the CAHPS® 5.0H Adult Medicaid Survey in 2015.
- Question 63 regarding the health plan's referral process was changed from a question rating the process to a question gauging experience. Impact on trending is expected.
- Question 64 regarding pharmacy coverage was changed from a question rating satisfaction to a question gauging ease of use. Impact on trending is expected.
- There were no survey changes made by DHMH to the CAHPS® 5.0H Child Medicaid Satisfaction Survey in 2015.

Research Approach

Eligible adult and child members from each of the seven HealthChoice MCOs that provide Medicaid services participated in this research. WBA administered a mixed methodology including mailing the CAHPS® survey along with a telephonic survey follow–up. Two questionnaire packages and follow–up reminder postcards were sent to random samples of eligible adult and child members from each of the seven HealthChoice

MCOs with "Return Service Requested" with WBA's toll–free number included. The mailed materials also included a toll–free number for Spanish–speaking members to complete the survey over the telephone. Those who did not respond by mail were contacted by phone to complete the survey. During the telephone follow–up, members had the option to complete the survey in either English or Spanish. The child surveys were conducted by proxy, that is, with the parent/guardian who knows the most about the sampled child's health care.

Sampling Methodology

The NCQA required sample size is 1,350 for each of the adult Medicaid plans. In addition to the required sample size, NCQA allows oversampling of up to 30%. DHMH elected to use this option. To qualify, adult Medicaid members had to be 18 years of age or older, as well as continuously enrolled in the HealthChoice MCO for five of the last six months as of the last day of the measurement year (December 31, 2014). Therefore, a total of 12,285 surveys were mailed for CAHPS® 2015.

A total of 3,962 valid surveys were completed between February and May 2015 for the adult HealthChoice population, 42 of which were completed in Spanish. The overall response rate from the eligible Medicaid adult population for CAHPS® 2014 was 33%.

The NCQA required sample size is 1,650 for child Medicaid plans (General Population/Sample A). In addition to the required sample size, NCQA allows over–sampling up to 30%. DHMH elected to use this option. To qualify, child Medicaid members had to be 17 years of age or younger. Furthermore, members had to be continuously enrolled in the HealthChoice MCO for five of the last six months as of the last day of the measurement year (December 31, 2014).

Among the child population, an additional over–sample of up to 1,840 child members with diagnoses indicative of a probable chronic condition was also pulled (CCC Over–sample/Sample B). This is standard procedure when the CAHPS® 5.0H Child Medicaid Survey (with CCC Measurement Set) is administered, to ensure the validity of the information collected.

The CCC population is identified based on child members' responses to the CCC survey–based screening tool (questions 60 to 73), which contains five questions representing five different health consequences; four are three–part questions and one is a two–part question. A child member is identified as having a chronic condition if all parts of the question for at least one of the specific health consequences are answered "Yes".

It is important to note that the General Population data set (Sample A) and CCC Over–sample data set (Sample B) are not mutually exclusive groups. For example, if a child member is randomly selected for the CAHPS® Child Survey sample (General Population/Sample A) and is identified as having a chronic condition

based on responses to the CCC survey–based screening tool, the member is included in both General and CCC Population results.

Between February and May 2015, WBA collected 4,612 valid surveys, 284 of which were completed in Spanish. The overall response rate from the eligible Medicaid child population was 31%. Of the responses, 2,617 child members across all HealthChoice MCOs qualified as being children with chronic conditions based on the parent's/guardian's responses to the CCC survey–based screening tool.

Ineligible adult and child members included those who were deceased, did not meet eligible population criteria (indicated non–membership in the specified health plan), or had a language barrier (non–English or Spanish). In addition, adult members who were mentally or physically incapacitated and unable to complete the survey themselves were also considered ineligible. Non–respondents included those who had refused to participate, could not be reached due to a bad address or telephone number, or were unable to be contacted during the survey time period. Ineligible surveys are subtracted from the sample size when computing a response rate.

Table 33 shows the total number of adult and child members in the sample that fell into each disposition category.

Table 33. Survey Dispositions

Disposition Group	Disposition Category	Adult Members	Child Members
Ineligible	Deceased	14	2
	Not members of specified health plan	312	173
	Language barrier	59	79
	Mentally/Physically incapacitated	14	N/A
	Total Ineligible	**399**	**254**
Non–Response	Bad address/phone	1,011	1,285
	Refusal	482	605
	Maximum contact attempts made	6,431	8,259
	Total Non–Response	**7,924**	**10,149**

Table 34 show the number of surveys mailed, the number of completed surveys (mail and phone), and the response rate for each HealthChoice MCO.

Table 34. MCO Response Rate

HealthChoice MCO	Surveys Mailed	Mail and Phone Completes*	Response Rate
AMERIGROUP Community Care	1,755	580	34%
Jai Medical Systems	1,755	645	37%
Maryland Physicians Care	1,755	559	33%
MedStar Family Choice, Inc.	1,755	576	34%
Priority Partners	1,755	544	32%
Riverside Health of Maryland	1,755	457	28%
UnitedHealthcare	1,755	601	35%
Total HealthChoice MCOs	**1,755**	**3,962**	**33%**

*During the telephone follow–up, members had the option to complete the survey in either English or Spanish.

Findings

Key Findings from the 2015 CAHPS® 5.0H Adult Medicaid Survey

There were four Overall Rating questions asked in the CAHPS® 5.0H Adult Medicaid Survey that used a scale of "0 to 10", where a "0" represented the worst possible rating and a "10" represented the best possible rating. Table 35 shows each of the four Overall Rating questions and the Summary Rate for these questions from CAHPS® 2014 and CAHPS® 2015. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

Table 35. CAHPS® 2014 and CAHPS® 2015 Adult Summary Rates for Overall Rating Questions

Overall Ratings	CAHPS 2014 (Summary Rate – 8,9,10)	CAHPS 2015 (Summary Rate – 8,9,10)
Health Care	70%	69%
Personal Doctor	77%	76%
Specialist Seen Most Often	77%	79%
Health Plan	72%↑	69%

Arrows (↓,↑) indicate that the particular measure is performing statistically better or worse than it did in the previous year.

Consistent with CAHPS® 2014, HealthChoice adult members give their highest satisfaction ratings (a rating of 8, 9, or 10) to their Specialist (79%) and/or their Personal Doctor (76%) in CAHPS® 2015. HealthChoice members continued to give slightly lower satisfaction ratings to their Health Plan (69%) and Health Care (69%) overall.

Overall Ratings

In order to assess how the HealthChoice MCOs overall ratings compared with other Medicaid adult and child plans nationwide, national benchmarks are provided. Specifically, the adult and child data are compared to the Quality Compass® benchmarks (Reporting Year 2014). Quality Compass® is a national database created by the NCQA to provide health plans with comparative information on the quality of the nation's managed care plans.

Table 36 shows a plan comparison of Adult Summary Ratings of the four Overall Rating questions for the seven participating HealthChoice MCOs. Additionally, it indicates the Quality Compass® and the HealthChoice Aggregate for each question.

Table 36. CAHPS® 2015 MCO Adult Summary Rates for Overall Rating Questions

CAHPS 2015 Adult Overall Ratings (Summary Rate – 8,9,10)				
	Health Care	Personal Doctor	Specialist Seen Most Often	Health Plan
AMERIGROUP Community Care	71%	78%	76%	68%
Jai Medical Systems	59%	73%	74%	64%
Maryland Physicians Care	69%	73%	84%*	71%
MedStar Family Choice, Inc.	73%*	80%*	81%	74%*
Priority Partners	71%	75%	79%	73%
Riverside Health of Maryland	71%	77%	81%	65%
UnitedHealthcare	70%	75%	80%	67%
HealthChoice Aggregate	69%	76%	79%	69%
Quality Compass®[1]	73%	80%	81%	75%

*MCO with the highest Summary Rate.
[1]Quality Compass® is a registered trademark of NCQA.

Composite measures assess results for main issues/areas of concern. The following composite measures were derived by combining survey results of similar CAHPS® questions:

- **How Well Doctors Communicate** – Measures how well personal doctor explains things, listens to them, shows respect for what they have to say and spends enough time with them.
- **Customer Service** – Measures members' experiences with getting the information needed and treatment by Customer Service staff.
- **Getting Care Quickly** – Measures members' experiences with receiving care and getting appointments as soon as they needed.
- **Getting Needed Care** – Measures members' experiences in the last six months when trying to get care from specialists and through health plan.
- **Coordination of Care** – Measures members' perception of whether their doctor is up–to–date about the care he/she received from other doctors or health providers.
- **Health Promotion and Education** – Measures members' experience with their doctor discussing specific things to do to prevent illness.
- **Shared Decision Making** – Measures members' experiences with doctors discussing the pros and cons of starting or stopping a prescription medicine and asking the member what they thought was best for them.

Table 37 shows the adult composite measure results from CAHPS® 2014 and CAHPS® 2015.

Table 37. CAHPS® 2014 and CAHPS® 2015 Adult Composite Measure Results

Composite Measure	CAHPS 2014 (Yes or A lot/ Some/Yes)	CAHPS 2015 (Yes or A lot/ Some/Yes)
How Well Doctors Communicate	89%	90%
Customer Service	85%↑	85%
Getting Care Quickly	79%	78%
Getting Needed Care	80%	80%
Coordination of Care	79%	79%
Health Promotion and Education	74%	75%
Shared Decision–Making*	N/A	78%

Arrows (↓,↑) indicate that the particular measure is performing statistically better or worse than it did in the previous year.
*Changes made to the 5.0 CAHPS Adult Medicaid Satisfaction Survey in 2015 impacted trending. Therefore, data prior to 2015 is not comparable.

Consistent with CAHPS® 2014, HealthChoice MCOs continued to receive the highest ratings among their members on the "How Well Doctors Communicate" composite in CAHPS® 2015 (90%). Research shows that HealthChoice MCOs receive the lowest ratings among their members on the following composite measure: Health Promotion and Education (745 Summary Rate – Yes).

Key Findings from the 2015 CAHPS® 5.0H Child Medicaid Survey

The results from the four Overall Ratings questions asked in the CAHPS® 5.0H Child Medicaid Survey are represented in Table 38. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

Table 38. CAHPS® 2014 and CAHPS® 2015 Child Summary Rates for Overall Rating Questions

Overall Ratings	CAHPS 2014 (Summary Rate – 8,9,10)		CAHPS 2015 (Summary Rate – 8,9,10)	
	General	CCC	General	CCC
Health Care	86%	83%	86%	84%
Personal Doctor	89%	87%	89%	88%
Specialist Seen Most Often	80%	82%	83%	83%
Health Plan	85%	83%	84%	82%

HealthChoice MCOs continued to receive high satisfaction ratings from both parents/guardians of the general children's population group and the parents/guardians of the children with chronic conditions population group for each overall rating question.

Table 39 shows a plan comparison of Child Summary Ratings of the four Overall Rating questions for the seven participating HealthChoice MCOs. Additionally, it indicates the Quality Compass® and HealthChoice Aggregate for each question.

Table 39. CAHPS® 2015 MCO Child Summary Rates for Overall Rating Questions

	2015 Child Overall Ratings (Summary Rate – 8,9,10)							
	Health Care		Personal Doctor		Specialist Seen Most Often		Health Plan	
	General	CCC	General	CCC	General	CCC	General	CCC
ACC	86%	85%	90%	88%	86%*	87%*	88%*	82%
JMS	87%	85%	92%*	90%	79%	81%	79%	79%
MPC	88%*	82%	86%	86%	82%	81%	86%	84%
MSFC	85%	84%	90%	86%	83%	83%	84%	84%
PPMCO	86%	86%*	90%	91%*	85%	82%	88%*	86%*
RHMD	83%	80%	86%	88%	76%	80%	76%	65%
UHC	87%	85%	89%	88%	85%	83%	85%	80%
Quality Compass®[1]	**85%**	**83%**	**88%**	**87%**	**85%**	**85%**	**84%**	**81%**
HC Aggregate	**86%**	**84%**	**89%**	**88%**	**83%**	**83%**	**84%**	**82%**

*MCO with the highest Summary Rate.
[1]Quality Compass® is a registered trademark of NCQA.

Table 40 shows the child composite measure results from CAHPS® 2014 and CAHPS® 2015.

Table 40. CAHPS® 2014 and CAHPS® 2015 Child Composite Measure Results

Composite Measure	CAHPS 2014 (Summary Rate– Always/Usually)		CAHPS 2015 (Yes or A lot/ Some/Yes)	
	General	CCC	General	CCC
How Well Doctors Communicate	94%	94%	94%	95%
Getting Care Quickly	91%↑	92%	88%	92%
Customer Service	87%↑	86%	86%	87%
Getting Needed Care	82%	85%	83%	86%
Coordination of Care	80%	81%	81%	83%
Shared Decision–Making*	N/A	62%	79%	84%
Health Promotion and Education[2]	73%	80%	75%	80%

Arrows (↓,↑) indicate that the particular measure is performing statistically better or worse than it did in the previous year.
*Changes made to the 5.0 CAHPS Adult Medicaid Satisfaction Survey in 2015 impacted trending. Therefore, data prior to 2015 is not comparable.

In CAHPS® 2015, HealthChoice MCOs continue to receive the highest ratings among both the general child population members and the child members with chronic conditions on the following composite measures:

- **How Well Doctors Communicate** – Measures how well personal doctor explains things, listens to them, shows respect for what they have to say and spends enough time with them.
- **Getting Care Quickly** – Measures member's experiences with receiving care and getting appointments as soon as they needed.

In addition, HealthChoice MCOs also received high ratings among the general population members for the following composite measure:

- **Customer Service** – Measures member's experiences with getting the information needed and treatment by Customer Service staff.

Research shows that for both the general population and child members with chronic conditions, HealthChoice MCOs received the lowest ratings on the "Health Promotion and Education" and "Shared Decision–Making" composites. HealthChoice MCOs also received a lower rating among the CCC population for the "Coordination of Care" composite measure.

Key Drivers of Satisfaction

In an effort to identify the underlying components of adult and child members' ratings of their Health Plan and Health Care, advanced statistical techniques were employed.

- Regression analysis is a statistical technique used to determine which influences or "independent variables" (composite measures) have the greatest impact on an overall attribute or "dependent variable" (overall rating of Health Plan or Health Care).
- In addition, correlation analyses were conducted between each composite measure attribute and overall rating of Health Plan and Health Care in order to ascertain which attributes have the greatest impact.

Adult Medicaid Members – Key Drivers of Satisfaction with **Health Plan**

Based on the 2015 findings, the "Customer Service" and "Getting Needed Care" composite measures have the most significant impact on adult members' overall rating of their Health Plan.

- The attribute listed below is identified as an "*unmet need*" and should be considered a priority area for the HealthChoice MCOs. If performance on this attribute is improved, it could have a positive impact on adult members' overall rating of their Health Plan.
  - Received information or help needed from health plan's Customer Service
- The following attributes are identified as "*driving strengths*" and performance in these areas should be maintained. If performance on these attributes is decreased, it could have a negative impact on adult members' overall rating of their Health Plan.
  - Treated with courtesy and respect by health plan's Customer Service
  - Doctor listened carefully to you
  - Doctor showed respect for what you had to say
  - Received the care needed as soon as you needed

Adult Medicaid Members – Key Drivers of Satisfaction with **Health Care**

Based on the 2015 findings, the "Getting Needed Care" and "How Well Doctors Communicate" composite measures have the most significant impact on adult members' overall rating of their Health Care.

- The attribute listed below is identified as an "*unmet need*" and should be considered a priority area for the HealthChoice MCOs. If performance on this attribute is improved, it could have a positive impact on adult members' overall rating of their Health Care.
  - Received an appointment for a check–up or routine care as soon as you needed

- The following attributes are identified as "*driving strengths*" and performance in these areas should be maintained. If performance on these attributes is decreased, it could have a negative impact on adult members' overall rating of their Health Care.
  - Got the care, tests or treatment you needed
  - Doctor spent enough time with you
  - Doctor explained things in a way that was easy to understand
  - Received the care needed as soon as you needed

Child Medicaid Members – Key Drivers of Satisfaction with **Health Plan**

Based on the 2015 findings, the "Customer Service" composite measure has the most significant impact on child members' overall rating of their Health Plan.

- There were no attributes identified as "*unmet needs"* that should be considered priority areas for improving child members' overall rating of their Health Plan.
  - However, the attribute "Received information or help needed from child's health plan's Customer Service" is an area that is of high importance to child members where HealthChoice MCOs perform at a moderate level. Improvement in this area could have a positive impact on child members' overall rating of their Health Plan.
- The attributes listed below are identified as *"driving strengths"* and performance in these areas should be maintained. If performance on these attributes is decreased, it could have a negative impact on child members' overall rating of their Health Plan.
  - Treated with courtesy and respect by child's health plan's Customer Service
  - Got the care, tests or treatment your child needed

Child Medicaid Members – Key Drivers of Satisfaction with **Health Care**

Based on the 2015 findings, the "Getting Needed Care" composite measure is identified as having the most significant impact on child members' overall rating of their Health Care.

- Given some of the high ratings received, there were no attributes identified as "*unmet needs"* that should be considered priority areas for improving child members' overall rating of their Health Care.
  - However, the attribute "Child's doctor spent enough time with your child" is an area that is of high importance to child members where HealthChoice MCOs perform at a moderate level. Improvement in this area could have a positive impact on child members' overall rating of their Health Care.
- Instead, the attributes listed below are identified as "*driving strengths"* and performance in these areas should be maintained. If performance on these attributes is decreased, it could have a negative impact on child members' overall rating of their Health Care.
  - Got the care, tests or treatment your child needed.
  - Child's doctor listened carefully to you.
  - Child's doctor showed respect for what you had to say.
  - Child's doctor explained things about your child's health in a way that was easy to understand.

Section VIII
Consumer Report Card

Introduction

DHMH contracted with Delmarva Foundation to develop a Medicaid Consumer Report Card (Report Card). Delmarva Foundation collaborated with the NCQA to assist in the Report Card development and production.

The Report Card assists Medicaid beneficiaries in selecting one of the participating HealthChoice MCOs. Information in the Report Card includes performance measures from HEDIS®, the CAHPS® survey, and DHMH's Value Based Purchasing Initiative.

Information Report Strategy

The reporting strategy incorporates methods and recommendations based on experience and research about presenting quality information to consumers. The most formidable challenge facing all consumer information projects is how to communicate a large amount of complex information in an understandable and meaningful manner while fairly and accurately representing the data.

To enhance comprehension and interpretation of quality measurement information provided for a Medicaid audience, the NCQA and Delmarva Foundation team designed the Report Card to include six categories, with one level of summary scores (measure roll–ups), per plan, for each reporting category. Research has shown that people have difficulty comparing plan performance when information is presented in too many topic areas. To include a comprehensive set of performance measures in an effective consumer information product (one that does not present more information than is appropriate for the audience), measures must be combined into a limited number of reporting categories that are meaningful to the target audience, Medicaid participants.

Based on a review of the measures available for the Report Card (HEDIS®, CAHPS® and DHMH's VBPI), the team recommended the following reporting categories and their descriptions:

- Access to Care
  - Appointments are scheduled without a long wait
  - The MCO has good customer service

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
CAHPS® is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

- Everyone sees a doctor at least once a year
- The MCO answers member calls quickly

➢ Doctor Communication and Service
- Doctors explain things clearly and answer questions
- The doctor's office staff is helpful
- Doctors provide good care

➢ Keeping Kids Healthy
- Kids get shots to protect them from serious illness
- Kids see a doctor and dentist regularly
- Kids get tested for lead

➢ Care for Kids With Chronic Illness
- Doctors give personal attention
- Kids get the medicine they need
- A doctor or nurse knows the child's needs
- Doctors involve parents in decision making

➢ Taking Care of Women
- Women are tested for breast cancer and cervical cancer
- Moms are taken care of when they are pregnant and after they have their baby

➢ Care for Adults with Chronic Illness
- Blood sugar levels are monitored and controlled
- Cholesterol levels are tested and controlled
- Eyes are examined for loss of vision
- Kidneys are healthy and working properly
- Appropriate use of antibiotics
- Appropriate treatment for lower back pain

The first two categories are relevant to all beneficiaries. The remaining categories are focused on more specific populations that are relevant to Maryland HealthChoice beneficiaries: children, children with chronic illness, women, and adults with chronic illness.

In accordance with its research, NCQA did not recommend reporting specific measures individually, in addition to the above reporting categories. Consumers comparing the performance of a category composed of many measures to individual measures may give undue weight to the performance on the individual measures.

Measure Selection

The measures that the project team considered for inclusion in the Report Card are derived from those that DHMH requires MCOs to report, which include HEDIS® measures, the CAHPS® survey results from both the Adult Questionnaire and the Child Questionnaire, and DHMH's VBP measures.

NCQA created measure selection criteria that included a consistent and logical framework for determining which quality of care measures are to be included in each composite each year.

Recent revisions to the CAHPS® survey and re–evaluations of HEDIS® measures influence NCQA's recommendations for the 2015 reporting strategy.

Reporting Category Changes:

Care for Kids with Chronic Illness

- Added *Medication Management for People With Asthma* (5–11 years; 75% indicator) HEDIS measure

Taking Care of Women

- Removed the *Cervical Cancer Screening* HEDIS measure due to the significant changes made to the measure

Care for Adults with Chronic Illness

- Add the following HEDIS measures:
  - *Use of Appropriate Medications for People With Asthma* [19–64 (combine 19–50 and 51–64)]
  - *Medication Management for People With Asthma* [19–64 (combine 19–50 and 51–64); use 75% indicator]
  - *Controlling High Blood Pressure*

Format

In addition to displaying information in a format that is easy to read and understand by member, the following principles are important when designing report cards:

- *Space:* Maximize the amount to display data and explanatory text
- *Message:* Communicate health plan 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 beneficiaries choosing a plan for the first time, beneficiaries receiving the Annual Right to Change Notice and prioritizing their current health care needs, current beneficiaries learning more about their plan) and reading level
- *Narrative:* Emphasize *why* what is being measured in each reporting category is important, rather than giving a detailed explanation of *what* is being measured. For example, "making sure that kids get all of their shots protects them against serious childhood diseases" instead of "the percentage of children who received the following antigens …"

- *Design:* Use color and layouts to facilitate navigation and align the star ratings to be left justified consistent with the key.

The Report Card was printed as a 24 x 9.75 inch pamphlet folded in thirds, with English on one side and Spanish on the opposite side. Pamphlets allow one–page presentation of all performance information. Additionally, measure explanations can be integrated on the same page as the performance results, facilitating a reader's ability to match the explanation to actual data.

Pamphlet contents were drafted to present the information at a sixth–grade reading level, with short, direct sentences intended to relate to the audience's particular concerns. Terms and concepts unfamiliar to the general public were avoided. Explanations of performance ratings, measure descriptions, and how to use the Report Card were straightforward and action–oriented. Contents were translated into Spanish by an experienced translation vendor.

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

Rating Scale

Performance is rated by comparing each MCO's performance to the average of all MCOs potentially available to the target audience; in this case, the average of all HealthChoice MCOs (a.k.a., the Maryland HealthChoice MCO average). Stars are used to represent performance that is "above," "the same as," or "below" the Maryland HealthChoice MCO average.

A tri–level rating scale in a matrix that displays performance across a select number of salient performance categories provides beneficiaries with an easy–to–read "picture" of quality performance across plans and presents data in a manner that emphasizes meaningful differences between plans that are available to them. This methodology differs from similar methodologies that compare plan performance to ideal targets or national percentiles. The team's recommended approach is more useful in an environment where consumers must choose from a group of available plans.

At this time, the team does not recommend developing an overall rating for each MCO. The proposed strategy allows the Report Card users to decide which performance areas are most important to them when selecting a plan.

Analytic Methodology

NCQA and Delmarva Foundation recommend that the Report Card compare each MCO's actual score to the unweighted, statewide plan average for a particular reporting category. An icon or symbol would denote whether a plan performed "above," "the same as," or "below" the statewide Medicaid plan average.[2]

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

Handling Missing Values

Three issues involve the replacement of missing values in this analysis. The first issue is deciding which pool of observed (non–missing) plans should be used to derive replacement values for missing data.

The second issue concerns how imputed values will be chosen. Alternatives are fixed values (such as zero or the 25th percentile for all plans in the nation), calculated values (such as means or regression estimates) or probable selected values (such as multiplying imputed values).

The third issue is that the method used to replace missing values should not provide an incentive for plans that perform poorly to purposefully fail to report data. For example, if missing values are replaced with the mean of non–missing cases, scores for plans that perform below the mean would be increased if they fail to report.

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

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

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

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

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

Plans are sometimes unable to provide suitable data (for example, if too few of their members meet the eligibility criteria for a measure), despite their willingness to do so. These missing data are classified as "not applicable" (N/A). If the NCQA HEDIS® Compliance Audit™ finds the measure to be materially biased, the measure is assigned a "Not Reportable" designation (NR).

For Report Card purposes, missing values will be replaced where a plan has reported data for at least 50 percent of the indicators in a reporting category. A plan that is missing more than 50 percent of the indicators that compose a reporting category will be given a designation of "insufficient data" for that measurement category. If fewer than 50 percent of the plans report a measure, the measure is dropped from the report card category. Therefore, the calculations in that category are based upon the remaining reportable measures. "N/A" and "NR" designations will be treated differently where values are missing. This procedure minimizes any disadvantage to plans that are willing but unable to report data.

Case–Mix Adjustment of CAHPS® Data

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

It is believed that respondents in poor health receive more intensive health care services, and their CAHPS®' survey 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® survey data used in this analysis.

Statistical Methodology

The statistical methodology includes the following steps:

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

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

CY 2015 Report Card Results

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

★ Below HealthChoice Average
★★ HealthChoice Average
★★★ Above HealthChoice Average
N/A – RHMD and KPMAS became HealthChoice MCOs in 2013 and 2014 and ratings are not applicable.

Section IX
Review of Compliance with Quality Strategy

Table 41 below describes HACA's progress against the Quality Strategy's goal.

Table 41. Quality Strategy Evaluation

Department's Quality Strategy Goal	Performance Against Goal	Met
Ensure compliance with changes in Federal/State law and regulation	The Department consistently reviews all new Federal and State laws and regulations. Any new laws and regulations are immediately put into the standards and guidelines for review and communicated to the MCOs.	√
Improve performance over time	The Department continually strives to improve performance, which is evident through the high standards it sets for the MCOs in the Annual Systems Performance Review, Value Based Purchasing Initiative, Performance Improvement Projects, and other review activities. It continually monitors the progress of MCO performance in multiple areas as demonstrated throughout this report.	√
Allow comparisons to national and state benchmarks	In almost every area of review, comparisons to national and state benchmarks can be found to mark progress and delineate performance against goals.	√
Reduce unnecessary administrative burden on MCOs	The Department has attempted to reduce unnecessary administrative burden to the MCOs in any way possible. Delmarva Foundation has assisted with this goal in streamlining the Annual Systems Review Process so that documentation can be submitted electronically.	√
Assist the Department with setting priorities and responding to identified areas of concern such as children, pregnant women, children with special healthcare needs, adults with a disability, and adults with chronic conditions.	The HealthChoice and Acute Care Administration has assisted the Department by: ➢ Requiring NCQA accreditation and adding HEDIS performance measures to monitor compliance with quality of care and access standards for participants. ➢ Volunteering to report Medicaid Adult and Child CORE Measures which will assist CMS to better understand the quality of health care that adults and children enrolled in Medicaid receive. ➢ Revising the Value Based Purchasing Initiative to incentivize measures that include adults with disabilities and adults and children with chronic conditions. ➢ Designing supplemental CAHPS® survey questions to address pregnant women and children to provide data input for the Deputy Secretary of Health Care Financing –Medical Care Programs Administration's annual Managing for Results report that includes key goals, objectives, and performance measure results for each calendar year. ➢ Developing a monitoring policy coupled with intermediate sanctions to hold MCOs accountable for quality improvement. ➢ Raising the minimum compliance score for EPSDT Medical Record Reviews to 80% for all components. ➢ Extending the Adolescent Well–Care performance improvement project for an additional year.	√

√ – Goal Met

EQRO Recommendations for MCOs

Each MCO is committed to delivering high quality care and services to its participants. However, opportunities exist for continued performance improvement. Based upon the evaluation of CY 2014 activities, Delmarva Foundation has developed several recommendations for all MCOs which are identified within each section of the Annual Technical Report.

EQRO Recommendations for HACA

Considering the results for measures of quality, access, and timeliness of care for the contracted MCOs, Delmarva Foundation developed the following recommendations for HACA:

- Considering Health Care Reform activities began in 2014 and Maryland Medicaid enrollment increased significantly, the Department should consider revising the layout of the MD Consumer Report Card. The Information Reporting Strategy may continue to be relevant, but the format of the report card may need to be revised, including different information displayed in a different manner. This update would include funding for consumer focus groups to test the understanding/ease of language and layout.
- Maryland MCOs are required by DHMH to be NCQA accredited. All but the new MCOs have obtained their full accreditation. The Department should look at alternative ways to review the MCOs for quality, access, and timeliness of care. Many of the MCOs have achieved the maximum compliance threshold of 100% in all standards of the systems performance review. The Department may want to concentrate their quality efforts in other areas such as focused quality studies or collaborative performance improvement projects to reduce the burden of the annual reviews on the MCOs.
- The SPR Standards and Guidelines should be reviewed and revised considering many were based on HCQIS (A Healthcare Quality Improvement System for Medicaid Managed Care) which was written in 1993.
- As the Adolescent Well Care PIP closes out, the Department should think about the use of a collaborative PIP where the MCOs, the Department, and the EQRO work together on the next selected PIP topic. This collaborative approach may spark new ideas and foster a productive learning environment where MCOs can transfer this knowledge to other projects they may be working on independently.

Conclusion

This report is a representation of all EQRO, HEDIS®, and CAHPS® activities that took place in calendar years 2014–2015 for the Maryland HealthChoice program. Opportunities for improvement and best practices of the MCOs are noted in the executive summary and within each individual review activity.

The Department sets high standards for MCO QA systems. As a result, the HealthChoice MCOs have quality systems and procedures in place to promote high quality care with well–organized approaches to quality

improvement. The CY 2015 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care for Maryland managed care participants.

Acronym List

ACC	AMERIGROUP Community Care
ACCUs	Administrative Care Coordination Units
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act of 1990
ADV	Annual Dental Visit
AHRQ	Agency for Healthcare Research and Quality
ASAM	American Society of Addictions Medicine
AWC	Adolescent Well Care
BBA	Balanced Budget Act of 1997
BCR	Board Certification
CAB	Consumer Advisory Board
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBP	Controlling High Blood Pressure
CCC	Children with Chronic Conditions
CCN	Care Core National
CFR	Code of Federal Regulations
CI	Confidence Interval
CM	Case Management
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
COMAR	Code of Maryland Regulations
CPT	Current Procedural Terminology
CY	Calendar Year
DHMH	Department of Health and Mental Hygiene
DHQA	Division of HealthChoice Quality Assurance
DOB	Date of Birth
DOC	Delegate Oversight Committee
EBS	Enrollment by State
ED	Emergency Department
EDV	Encounter Data Validation
ENP	Enrollment by Product Line
EOC	Effectiveness of Care
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room

Acronym List

FC	Fully Compliant
FQHC	Federally Qualified Health Center
FSP	Frequency of Selected Procedures
HACA	HealthChoice and Acute Care Administration
HCMS	Health Care Management Services
HD	HEDIS® Measure Determination
HDC	HealthcareData Company, LLC
HED	Health Education/Anticipatory Guidance
HEDIS	Healthcare Effectiveness Data and Information Set
HEP	Health Education Plan
HILLTOP	The Hilltop Institute of University of Maryland Baltimore County
HIV	Human Immunodeficiency Virus
HCQIS	Healthcare Quality Improvement System for Medicaid Managed Care
HQUMC	Healthcare Quality and Utilization Management Committee
HRA	Health Risk Assessment
HS	Health Services
HX	Health and Developmental History
IDSS	Interactive Data Submission System
IMM	Immunizations
IPU	Inpatient Utilization-General Hospital/Acute Care
IRR	Inter-rater Reliability
IS	Information Systems
JMS	Jai Medical Systems
KPMS	Kaiser Permanente of the Mid-Atlantic States
LAB	Laboratory Tests/At-Risk Screenings
LDM	Language Diversity of Membership
LHDs	Local Health Departments
MAC	Medical Advisory Committee
MARR	Maryland Average Reportable Rate
MCG	Milliman Care Guidelines
MCO	Managed Care Organization
MD	Maryland
MPC	Maryland Physicians Care
MRR	Medical Record Review
MRRV	Medical Record Review Validation
MSFC	MedStar Family Choice, Inc.
NA	Not Applicable

Acronym List

NB	No Benefit
NCC	National Call Center
NCQA	National Committee for Quality Assurance
NHM	National HEDIS® Mean
NR	Not Reportable
NV	Not Valid
OB/GYN	Obstetrician/Gynecology
PA	Preauthorization
PAC	Provider Advisory Committee
PCP	Primary Care Physician
PE	Comprehensive Physical Exam
PIP	Performance Improvement Project
PMT	Process Management Team
PPMCO	Priority Partners
PT	Physical Therapy
QA	Quality Assurance
QAP	Quality Assurance Program
QIC	Quality Improvement Committee
QIO	Quality Improvement Organization
QMC	Quality Management Committee
QMP	Quality Management Program
QOC	Quality of Care
RDM	Race/Ethnicity Diversity of Membership
RHMD	Riverside Health of Maryland
ROADMAP	Record of Administration, Data Management and Processes
RQIC	Regional Quality Improvement Committee
RUMC	Regional Utilization Management Committee
SA	Substance Abuse
SC	Substantially Compliant
SPR	Systems Performance Review
SSI	Supplemental Security Income
STI/HIV	Sexually Transmitted Infection/Human Immunodeficiency Virus
TAT	Turn Around Time
TLM	Total Membership
UBH	United Behavioral Health
UHC	UnitedHealthcare
UM	Utilization Management

Acronym List

UMP	Utilization Management Program
UR	Utilization Review
URI	Upper Respiratory Infection
URR	Utilization and Relative Resource Use
VBP	Value Based Purchasing
VBPI	Value Based Purchasing Initiative
VFC	Vaccine for Children
VIS	Vaccine Information Statement
WBA	WBA Market Research

Adolescent Well-Care Visits (AWC)

SUMMARY OF CHANGES TO HEDIS 2015

- Removed coding tables and replaced all coding table references with value set references.

Description

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Note: *This measure has the same structure as measures in the Effectiveness of Care domain. Organizations should follow the* Guidelines for Effectiveness of Care Measures *when calculating this measure. Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.*

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	12–21 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	At least one comprehensive well-care visit (Well-Care Value Set) with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the member.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for the Medicaid product line. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate.

Refer to *Guidelines for Calculations and Sampling* for information on reducing sample size.

Numerator

At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review. The PCP does not have to be assigned to the member.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.

Medical record

Documentation in the medical record must include a note indicating a visit to a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of *all* of the following:

- A health and developmental history (physical and mental).
- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation that a well-care exam occurred is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

Note

- *Refer to Appendix 3 for the definition of* PCP *and* OB/GYN and other prenatal care practitioners.
- *This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more information about well-care visits.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AWC-1/2: Data Elements for Adolescent Well-Care Visits

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS 2015

Removed coding tables and replaced all coding table references with value set references.

Removed "Telephone call record" as an acceptable method for confirming the hypertension diagnosis.

Clarified step 2 of the numerator to state when a BP reading is not compliant.

Revised the Optional Exclusion criteria to allow exclusion of all members who had a nonacute inpatient encounter during the measurement year (previously the exclusion was limited to nonacute inpatient *admissions*).

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.

Definitions

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP <90 mm Hg (BP in the normal or high-normal range).
Representative BP	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension was made). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled."

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–85 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/ diagnosis

Members are identified as hypertensive if there is at least one outpatient visit (Outpatient CPT Value Set) with a diagnosis of hypertension (Hypertension Value Set) during the first six months of the measurement year.

Note: *In order to increase the specificity of the eligible population, only CPT codes are used to identify outpatient visits.*

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population for each product line whose diagnosis of hypertension is confirmed by chart review. The organization may reduce the sample size using the prior years audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

To confirm the diagnosis of hypertension, the organization must find notation of one of the following in the medical record on or before June 30 of the measurement year:

- HTN.
- High BP (HBP).
- Elevated BP (↑BP).
- Borderline HTN.
- Intermittent HTN.
- History of HTN.
- Hypertensive vascular disease (HVD).
- Hyperpiesia.
- Hyperpiesis.

The notation of hypertension may appear on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis; see ***Note*** at the end of this section).
- Office note.
- Subjective, Objective, Assessment, Plan (SOAP) note.
- Encounter form.
- Diagnostic report.
- Hospital discharge summary.

Statements such as “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm the diagnosis if such statements are the *only* notations of hypertension in the medical record.

Identifying the medical record

Use one medical record for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the record must be considered. If an organization cannot find the medical record, the member remains in the measure denominator and is considered noncompliant for the numerator.

Use the following steps to find the appropriate medical record to review.

Step 1 Identify the member's PCP.

If the member had more than one PCP for the time period, identify the PCP who most recently provided care to the member.

If the member did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the member.

If a practitioner other than the member's PCP manages the hypertension, the organization may use the medical record of that practitioner.

Step 2 Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the organization may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.

If a member sees one PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of hypertension and the BP reading may be identified through two different medical records.

If a member has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the member's hypertension after June 30, the organization may use the PCP's chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the organization may use this chart for the most recent BP reading. If the member did not have any visit with the specialist prior to June 30 of the measurement year, the organization must go to another medical record to confirm the diagnosis.

Numerator The number of members in the denominator whose most recent BP is adequately controlled during the measurement year. For a member's BP to be controlled, *both* the systolic and diastolic BP *must be* <140/90 (adequate control). To determine if a member's BP is adequately controlled, the representative BP must be identified.

Administrative None.

Medical record Follow the steps below to determine representative BP.

Step 1 Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed. Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the member.

Step 2 Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

The member is not compliant if the BP reading is ≥140/90 or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Exclusions *(optional)*

Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.

Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

Exclude from the eligible population all members who had a nonacute inpatient encounter (Nonacute Care Value Set) during the measurement year.

Note

Organizations may use an undated notation of hypertension on problem lists. Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator.

Organizations generally require an oversample of 10 percent–15 percent to meet the MRSS for confirmed cases of hypertension.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table CBP-1/2/3: Data Elements for Controlling High Blood Pressure

	Hybrid
Measurement year	✓
Data collection methodology (Hybrid)	✓
Eligible population	✓
Number of numerator events by administrative data in eligible population (before exclusions)	✓
Current year's administrative rate (before exclusions)	✓
Minimum required sample size (MRSS) or other sample size	✓
Oversampling rate	✓
Final sample size (FSS)	✓
Number of numerator events by administrative data in FSS	✓
Administrative rate on FSS	✓
Number of original sample records excluded because of valid data errors	✓
Number of records excluded because of false-positive diagnoses	✓
Number of administrative data records excluded	✓
Number of medical record data records excluded	✓
Number of employee/dependent medical records excluded	✓
Records added from the oversample list	✓
Denominator	✓
Numerator events by administrative data	✓
Numerator events by medical records	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Table A – HealthChoice Organizations HEDIS 2015 Results

Appendix A4

HEDIS 2014 Results, page one of five	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Adult BMI Assessment (ABA)	61.3%	72.0%	82.4%	90.7%	80.2%	98.5%			98.4%	48.7%	70.2%	84.9%	76.4%	82.6%	86.4%	59.9%	82.9%	89.6%		NA[1]	NA[1]	49.1%	68.9%	81.9%	88.9%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	20.6%	23.88%	24.5%	35.5%	35.2%	34.1%			NA[1]	19.9%	22.0%	21.9%	14.1%	15.2%	19.9%	18.9%	23.94%	24.4%		NA[1]	NA[1]	16.0%	20.8%	23.7%	24.7%
Childhood Immunization Status (CIS) – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	84.7%	81.3%	83.8%	86.1%	86.5%	88.4%			NA[1]	76.9%	73.7%	70.8%	85.4%	88.1%	81.8%	86.8%	83.1%	83.6%		NA[1]	50.0%	70.3%	73.0%	77.4%	76.5%
Childhood Immunization Status (CIS) – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	83.5%	78.2%	81.9%	83.70%	86.1%	87.6%			NA[1]	74.3%	72.1%	68.2%	83.70%	85.9%	79.3%	83.8%	80.8%	80.1%		NA[1]	43.8%	66.7%	71.3%	73.7%	73.5%
Childhood Immunization Status (CIS) – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	75.9%	73.6%	77.6%	80.9%	84.8%	85.2%			NA[1]	67.4%	62.8%	64.7%	80.3%	81.3%	76.6%	73.8%	69.4%	78.5%		NA[1]	43.8%	58.9%	66.2%	67.9%	70.6%
Childhood Immunization Status (CIS) – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	61.3%	63.9%	63.7%	59.4%	71.7%	68.0%			NA[1]	55.3%	47.0%	57.1%	56.0%	70.1%	64.5%	59.6%	54.6%	68.5%		NA[1]	37.5%	52.0%	56.9%	60.1%	59.9%
Childhood Immunization Status (CIS) – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	49.7%	49.3%	53.0%	39.0%	47.8%	46.8%			NA[1]	42.4%	37.7%	40.6%	55.2%	59.4%	51.6%	51.5%	49.5%	54.2%		NA[1]	28.1%	38.2%	44.3%	48.4%	46.1%
Childhood Immunization Status (CIS) – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	57.8%	60.7%	61.3%	59.0%	71.3%	67.2%			NA[1]	51.4%	44.0%	55.0%	54.3%	66.7%	62.5%	56.2%	50.7%	68.5%		NA[1]	37.5%	47.2%	54.7%	57.4%	58.5%
Childhood Immunization Status (CIS) – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	47.3%	47.9%	50.9%	39.0%	47.4%	45.6%			NA[1]	38.7%	34.9%	38.5%	53.5%	56.2%	49.4%	48.3%	44.4%	53.5%		NA[1]	28.1%	35.3%	41.4%	46.2%	44.6%
Childhood Immunization Status (CIS) – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	38.5%	42.4%	43.5%	29.5%	40.9%	36.4%			NA[1]	33.8%	28.4%	34.3%	38.7%	49.9%	44.3%	41.1%	36.3%	48.4%		NA[1]	23.4%	31.6%	37.0%	41.4%	38.8%
Childhood Immunization Status (CIS) – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	37.1%	41.2%	42.1%	29.5%	40.9%	36.0%			NA[1]	31.0%	27.7%	33.0%	37.7%	47.0%	42.8%	39.7%	34.3%	48.4%		NA[1]	23.4%	29.2%	35.3%	40.2%	38.0%
Immunizations for Adolescents (IMA) – Combination 1 (Meningococcal, Tdap/Td)	65.0%	69.4%	74.8%	70.66%	75.5%	76.7%			NA[1]	57.6%	62.7%	74.07%	70.69%	70.7%	72.4%	67.4%	74.5%	74.07%		NA[1]	64.7%	56.4%	63.4%	66.2%	71.9%
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits [2]	1.00%	1.0%	2.1%	2.7%	3.1%	1.9%			NA[1]	1.11%	0.5%	1.56%	1.01%	1.2%	3.5%	1.14%	1.1%	1.59%		NA[1]	10.9%	2.2%	1.9%	0.9%	3.2%
Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)	86.1%	88.9%	85.1%	85.9%	84.4%	81.6%			NA[1]	77.8%	83.6%	84.9%	89.2%	86.0%	82.8%	84.3%	83.7%	81.9%		NA[1]	56.6%	82.1%	87.4%	83.6%	79.5%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	83.6%	83.9%	83.7%	87.7%	88.9%	90.6%			84.6%	87.5%	88.8%	87.0%	79.6%	83.5%	86.7%	80.7%	83.8%	86.8%		NA[1]	57.4%	83.8%	75.0%	79.2%	82.0%
Adolescent Well-Care Visits (AWC)	68.1%	67.9%	64.7%	76.9%	76.7%	80.3%			63.5%	60.2%	68.8%	68.3%	69.4%	67.8%	61.2%	67.6%	61.6%	68.8%		NA[1]	31.8%	59.7%	60.8%	58.5%	62.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile- Total Rate	[4]	49.5%	60.9%	[4]	92.2%	94.7%			99.0%	[4]	46.5%	58.3%	[4]	59.8%	67.3%	[4]	52.1%	72.5%	[4]	NA[1]	41.5%	[4]	45.5%	57.9%	69.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	[4]	59.0%	71.5%	[4]	94.4%	97.6%			98.1%	[4]	54.4%	66.4%	[4]	74.1%	72.9%	[4]	54.2%	73.6%	[4]	NA[1]	50.8%	[4]	67.6%	64.5%	74.4%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	[4]	51.4%	61.3%	[4]	89.8%	91.2%			98.1%	[4]	58.8%	60.0%	[4]	72.9%	67.8%	[4]	44.7%	70.1%	[4]	NA[1]	43.1%	[4]	60.6%	63.0%	69.3%
Appropriate Testing for Children with Pharyngitis (CWP)	75.9%	78.36%	79.8%	75.3%	70.8%	80.2%			NA[1]	77.4%	78.42%	82.9%	85.2%	86.9%	90.5%	78.2%	80.5%	83.1%		NA[1]	76.4%	79.8%	83.1%	86.0%	82.7%
Lead Screening in Children (LSC)		[5]	77.1%		[5]	87.2%		[5]	NA[1]		[5]	70.0%		[5]	88.6%		[5]	71.9%		[5]	53.1%		[5]	68.6%	73.8%
Human Papillomavirus Vaccine for Female Adolescents (HPV)		[5]	23.7%		[5]	33.9%		[5]	NA[1]		[5]	21.8%		[5]	24.3%		[5]	17.7%		[5]	NA[1]		[5]	15.1%	22.8%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) [2]		[5]	5.3%		[5]	2.1%		[5]	1.9%		[5]	4.2%		[5]	2.9%		[5]	3.7%		[5]	5.2%		[5]	5.8%	3.9%

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Table A – HealthChoice Organizations HEDIS 2015 Results

HEDIS 2014 Results, page two of five	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–11	88.7%	90.3%	90.0%	91.4%	93.59%	91.4%			NA[1]	92.30%	91.4%	92.5%	93.7%	93.62%	93.5%	92.30%	91.6%	92.0%		NA[1]	NA[1]	96.1%	91.9%	90.8%	91.7%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 12–18	86.2%	87.8%	87.1%	92.9%	86.0%	86.3%			NA[1]	92.3%	90.4%	91.5%	90.2%	94.2%	91.6%	89.6%	88.5%	89.5%		NA[1]	NA[1]	93.4%	88.0%	88.6%	89.1%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 19–50	79.5%	73.7%	73.1%	93.3%	81.3%	89.4%			NA[1]	81.8%	80.1%	77.9%	76.8%	75.2%	77.6%	80.7%	76.8%	74.9%		NA[1]	NA[1]	88.0%	72.9%	73.7%	77.8%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 51–64	77.7%	68.6%	79.0%	82.0%	71.4%	83.8%			NA[1]	78.5%	76.3%	80.9%	77.1%	NA	NA	77.0%	73.0%	77.6%		NA[1]	NA[1]	94.1%	79.0%	72.8%	78.8%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–64	86.5%	86.29%	86.3%	90.7%	83.6%	87.9%			NA[1]	88.7%	86.97%	87.3%	88.8%	90.1%	89.0%	88.9%	87.02%	87.1%		NA[1]	NA[1]	94.0%	86.28%	84.11%	87.0%
Use of Appropriate Medications for People with Asthma (ASM) – Total Ages 5–50 [3]	86.7%	86.8%	83.4%	92.5%	86.4%	89.0%			NA[1]	89.2%	87.53%	87.3%	89.4%	90.1%	87.6%	89.3%	87.6%	85.4%		NA[1]	NA[1]	94.0%	86.6%	84.3%	87.51%
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	44.8%	45.8%	48.8%	53.2%	49.4%	59.6%			NA[1]	49.4%	57.9%	57.9%	52.4%	51.9%	49.9%	40.3%	43.3%	44.5%		NA[1]	NA[1]	47.3%	49.9%	48.4%	51.5%
Medication Management for People With Asthma (MMA) – Total 75% of treatment period	24.1%	22.9%	23.2%	28.9%	24.5%	34.8%			NA[1]	26.6%	32.9%	34.0%	28.7%	26.6%	24.1%	19.7%	20.0%	20.5%		NA[1]	NA[1]	26.7%	27.8%	25.2%	27.0%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	85.1%	86.5%	88.03%	85.2%	83.0%	92.4%			NA[1]	86.1%	86.6%	85.6%	86.1%	84.3%	89.5%	85.0%	86.0%	89.0%		NA[1]	86.4%	80.1%	82.0%	85.2%	88.00%
Asthma Medication Ratio (AMR)	[4]	68.6%	56.54%	[4]	60.5%	56.50%			NA[1]	[4]	69.1%	65.0%	[4]	73.7%	68.1%	[4]	69.6%	63.8%	[4]	NA[1]	NA[1]	[4]	69.8%	63.4%	62.2%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	[4]	25.8%	23.6%	[4]	26.3%	32.6%			NA[1]	[4]	21.1%	20.8%	[4]	34.5%	29.2%	[4]	23.7%	27.2%	[4]	NA[1]	NA[1]	[4]	25.6%	25.6%	26.5%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	[4]	73.6%	69.0%	[4]	69.2%	73.6%			NA[1]	[4]	72.6%	72.1%	[4]	76.3%	72.2%	[4]	69.7%	69.7%	[4]	NA[1]	78.1%	[4]	78.2%	73.0%	72.5%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	[4]	87.5%	84.8%	[4]	82.5%	85.4%			NA[1]	[4]	84.9%	85.1%	[4]	90.3%	92.4%	[4]	84.0%	85.0%	[4]	NA[1]	81.3%	[4]	84.9%	86.3%	85.7%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	97.5%	97.8%	97.7%	91.1%	94.7%	96.2%			100.0%	97.1%	96.5%	96.9%	96.6%	96.4%	93.9%	90.3%	89.8%	97.6%		NA[1]	87.8%	96.7%	96.3%	96.6%	95.8%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	92.6%	92.8%	93.1%	90.4%	88.7%	91.8%			98.0%	89.0%	90.0%	90.3%	90.3%	89.8%	88.4%	92.5%	93.5%	93.3%		NA[1]	69.4%	91.1%	91.1%	91.3%	89.5%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	93.9%	94.3%	95.3%	93.30%	93.8%	92.7%			98.4%	91.5%	92.1%	92.61%	92.50%	93.5%	92.58%	92.50%	92.7%	94.4%		NA[1]	NA[1]	93.30%	93.1%	93.6%	94.2%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	89.5%	90.5%	91.9%	91.7%	90.8%	92.9%			94.2%	87.7%	88.5%	89.7%	92.5%	92.7%	91.7%	92.0%	91.9%	92.5%		NA[1]	NA[1]	89.2%	90.1%	90.9%	92.0%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	79.7%	79.4%	79.4%	74.8%	72.9%	71.0%			92.9%	81.4%	81.1%	80.9%	79.9%	79.7%	76.3%	83.5%	81.7%	82.3%		NA[1]	63.6%	80.2%	80.4%	80.0%	78.3%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	86.4%	87.2%	86.7%	87.8%	86.6%	86.75%			95.7%	86.8%	87.80%	87.4%	86.2%	86.9%	85.1%	0.0%	0.0%	89.0%		NA[1]	75.9%	87.5%	87.80%	88.0%	86.82%
Breast Cancer Screening (BCS)	49.1%	58.1%	66.0%	60.8%	69.4%	72.1%			87.2%	43.9%	48.5%	65.9%	56.8%	64.4%	63.4%	51.5%	57.0%	62.5%		NA[1]	NA[1]	48.4%	52.7%	58.1%	67.9%
Cervical Cancer Screening (CCS)	73.6%	79.64%	67.8%	80.9%	79.5%	66.8%			90.8%	74.0%	79.58%	65.75%	70.9%	74.0%	66.2%	75.0%	75.9%	74.4%		NA[1]	35.5%	69.8%	62.8%	58.8%	65.76%
Chlamydia Screening in Women (CHL) – Age 16–20 years	62.6%	62.4%	61.4%	81.1%	86.7%	87.6%			76.9%	58.1%	58.2%	58.9%	59.6%	54.8%	57.2%	61.8%	61.5%	59.2%		NA[1]	61.1%	56.9%	55.4%	55.2%	64.7%
Chlamydia Screening in Women (CHL) – Age 21–24 years	72.5%	71.9%	71.7%	63.9%	72.3%	65.0%			80.8%	67.6%	67.1%	67.3%	74.0%	68.4%	66.5%	68.9%	69.9%	68.0%		NA[1]	58.7%	63.7%	64.8%	63.2%	67.7%
Chlamydia Screening in Women (CHL) – Total (16–24) years	65.97%	66.0%	66.0%	74.2%	81.2%	77.3%			79.5%	62.3%	62.0%	62.6%	65.0%	60.1%	61.3%	64.6%	64.8%	62.7%		NA[1]	59.7%	59.5%	59.0%	58.8%	65.97%

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HEDIS 2014 Results, page three of five	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	87.8%	84.2%	85.7%	82.9%	85.8%	83.2%			88.0%	86.28%	84.9%	80.3%	86.28%	85.4%	79.2%	89.3%	90.9%	88.2%		52.2%	73.3%	84.7%	87.1%	84.1%	82.8%
Prenatal and Postpartum Care (PPC) – Postpartum Care	71.5%	71.6%	66.0%	83.7%	78.5%	83.6%			86.0%	68.4%	71.9%	65.0%	74.4%	72.0%	71.1%	72.5%	75.6%	70.7%		43.5%	47.4%	60.3%	63.8%	62.5%	69.0%
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits [2]	4.2%	8.2%	5.9%	3.6%	2.2%	4.5%			7.7%	10.6%	5.6%	6.9%	2.7%	4.4%	7.6%	4.4%	4.4%	9.3%		37.0%	17.4%	12.1%	5.8%	6.8%	8.2%
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	72.2%	75.5%	72.6%	75.8%	70.8%	64.0%			56.9%	60.1%	70.6%	69.8%	79.3%	71.3%	64.6%	78.8%	78.8%	61.7%		21.7%	55.0%	70.8%	73.2%	74.5%	64.9%
Controlling High Blood Pressure (CBP)	47.0%	49.0%	63.9%	52.3%	56.2%	69.3%			87.8%	23.9%	46.8%	61.4%	70.5%	65.5%	69.2%	59.1%	57.0%	59.5%		NA[1]	32.1%	43.1%	42.3%	50.9%	61.8%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	[4]	NA[1]	91.5%	[4]	NA[1]	NA[1]			NA[1]	[4]	87.5%	90.2%	[4]	NA[1]	NA[1]	[4]	86.1%	84.6%	[4]	NA[1]	NA[1]	[4]	82.9%	87.8%	88.5%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)		[5]	NA[1]		[5]	NA[1]		[5]	NA[1]		[5]	NA[1]		[5]	NA[1]		[5]	NA[1]		[5]	NA[1]		[5]	NA[1]	NA[1]
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	81.1%	83.4%	88.7%	89.8%	89.1%	90.7%			96.4%	76.0%	79.5%	87.9%	83.5%	84.7%	88.0%	82.4%	78.1%	89.4%		NA[1]	84.6%	78.1%	79.1%	85.9%	89.0%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) [2]	44.0%	38.8%	38.5%	35.4%	31.0%	37.2%			21.8%	52.6%	48.6%	40.8%	35.3%	37.2%	44.5%	41.7%	48.1%	35.6%		NA[1]	60.8%	54.3%	45.5%	41.1%	40.1%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	47.1%	51.4%	51.4%	54.7%	61.5%	52.4%			60.0%	39.9%	43.3%	50.8%	58.9%	54.0%	43.5%	49.1%	44.3%	54.3%		NA[1]	38.8%	38.9%	46.5%	46.2%	49.7%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	69.3%	65.4%	48.6%	80.1%	79.6%	64.1%			87.3%	64.6%	72.0%	65.7%	72.8%	71.1%	54.0%	78.1%	71.0%	69.0%		NA[1]	44.8%	57.7%	56.9%	58.6%	61.5%
Comprehensive Diabetes (CDC) – LDL-C Screening	76.0%	76.9%	*	88.5%	87.8%	*			*	69.2%	72.9%	*	77.4%	78.4%	*	73.1%	70.1%	*		NA[1]	*	74.2%	77.4%	*	*
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	73.6%	75.7%	80.3%	93.6%	93.1%	93.4%			100.0%	74.4%	75.3%	75.9%	78.8%	82.7%	80.9%	77.6%	73.8%	82.5%		NA[1]	74.8%	74.2%	75.9%	81.5%	83.7%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	48.4%	55.6%	65.3%	59.1%	60.4%	69.7%			83.6%	47.1%	55.4%	56.4%	73.7%	70.1%	69.0%	63.3%	64.2%	60.7%		NA[1]	39.9%	47.0%	51.6%	55.2%	62.5%
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		[5]	76.7%		[5]	NA[1]		[5]	NA[1]		[5]	NA[1]		[5]	NA[1]		[5]	68.7%		[5]	NA[1]		[5]	74.6%	73.4%
Use of Imaging Studies for Low Back Pain (LBP)	77.8%	76.7%	74.2%	70.9%	77.2%	69.2%			NA	75.2%	76.6%	76.7%	73.1%	73.3%	71.8%	75.0%	75.2%	75.0%		NA[1]	78.1%	74.8%	73.4%	74.3%	74.2%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	61.8%	60.0%	62.8%	NA	NA	NA			NA	71.9%	73.8%	65.8%	NA	NA	89.2%	69.5%	67.6%	72.5%		NA[1]	NA[1]	73.3%	67.7%	61.5%	70.3%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	90.1%	89.0%	89.4%	95.8%	95.1%	94.4%			95.0%	88.9%	87.0%	88.4%	87.6%	90.2%	90.0%	88.22%	88.1%	88.1%		NA[1]	86.1%	88.22%	88.6%	89.2%	90.1%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on digoxin	95.8%	95.7%	59.5%	NA2	NA2	NA[1]			NA[1]	91.4%	92.2%	54.9%	NA2	NA2	NA[1]	91.5%	88.9%	44.9%		NA[1]	NA[1]	93.4%	86.4%	57.7%	54.2%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on diuretics	88.2%	86.9%	88.42%	94.3%	94.1%	93.9%			NA[1]	88.04%	86.2%	86.5%	88.02%	88.5%	89.0%	87.2%	87.4%	87.9%		NA[1]	90.5%	87.8%	87.5%	88.40%	89.2%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on anticonvulsants	66.0%	66.3%	*	64.8%	75.6%	*			*	69.9%	70.4%	*	58.1%	67.1%	*	73.3%	68.3%	*		NA[1]	*	72.4%	75.0%	*	*
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate	86.2%	85.4%	88.9%	93.1%	94.1%	94.0%			94.2%	88.0%	86.3%	87.2%	84.1%	86.6%	89.3%	87.3%	87.3%	87.8%		NA[1]	87.9%	87.5%	87.7%	88.7%	89.7%

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HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 13–17 Years	42.0%	37.7%	43.72%	NA2	NA2	NA[1]			NA[1]	42.3%	38.9%	35.4%	5.0%	30.9%	31.0%	38.4%	41.8%	33.0%		NA[1]	NA[1]	42.9%	44.3%	43.67%	37.3%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 18+ Years	41.9%	38.8%	53.9%	37.1%	45.4%	47.2%			NA[1]	43.1%	37.3%	34.9%	29.2%	43.2%	35.3%	38.5%	37.0%	34.2%		NA[1]	44.0%	47.9%	45.7%	48.4%	42.6%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation Overall Ages	41.9%	38.6%	52.7%	36.8%	45.2%	47.2%			NA[1]	43.0%	37.5%	34.9%	27.4%	41.7%	35.1%	38.5%	37.5%	34.1%		NA[1]	43.4%	47.3%	45.5%	48.2%	42.2%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 13–17 Years	27.7%	24.1%	24.7%	NA2	NA2	NA[1]			NA[1]	26.5%	22.1%	24.8%	2.5%	19.8%	20.2%	22.6%	27.6%	20.9%		NA[1]	NA[1]	24.0%	30.3%	28.6%	23.8%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 18+ Years	18.2%	17.9%	21.0%	15.4%	17.0%	22.5%			NA[1]	20.5%	19.8%	19.6%	5.5%	21.6%	18.0%	17.0%	17.2%	16.3%		NA[1]	22.0%	17.8%	20.8%	26.1%	20.8%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement Overall Ages	19.7%	18.8%	21.4%	15.4%	16.9%	22.4%			NA[1]	21.0%	20.0%	20.0%	5.3%	21.4%	18.1%	17.6%	18.4%	16.6%		NA[1]	21.8%	18.5%	21.6%	26.2%	20.9%
Identification of Alcohol and Other Drug Services (IAD) – Any	2.6%	2.7%	5.7%	15.8%	16.9%	25.1%			3.7%	6.3%	6.0%	7.0%	3.1%	4.3%	5.6%	5.2%	5.0%	6.3%		14.9%	10.4%	3.6%	4.7%	9.1%	9.1%
Identification of Alcohol and Other Drug Services (IAD) – Inpatient	0.6%	0.5%	1.1%	3.8%	4.0%	4.5%			0.8%	1.3%	0.95%	0.9%	0.90%	0.8%	0.97%	0.94%	0.9%	0.95%		1.6%	0.99%	0.94%	1.03%	1.6%	1.5%
Identification of Alcohol and Other Drug Services (IAD) - Intensive Outpatient/Partial Hospitalization	0.3%	0.3%	0.97%	2.5%	2.5%	4.6%			0.3%	0.8%	0.7%	1.00%	0.18%	0.5%	0.6%	0.7%	0.6%	0.8%		1.3%	1.2%	0.22%	0.0%	1.26%	1.34%
Identification of Alcohol and Other Drug Services (IAD) - Outpatient/ED	2.4%	2.5%	5.4%	14.5%	15.6%	23.7%			3.2%	5.8%	5.6%	6.6%	2.5%	3.9%	5.0%	4.9%	4.6%	5.9%		11.9%	9.6%	3.0%	4.2%	8.46%	8.49%
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	363.6	365.1	356.01	373.9	340.8	315.5			404.4	385.3	365.3	365.02	361.6	344.5	360.0	407.8	386.6	390.7		269.8	296.8	374.2	373.3	381.6	358.8
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months 3	59.8	56.2	58.2	93.4	90.1	96.4			23.2	79.3	74.6	70.9	70.8	62.66	57.4	66.0	62.70	62.0		66.0	64.9	65.2	62.1	63.1	62.0
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 F		[5]	0.05		[5]	0.02		[5]	0.00		[5]	0.056		[5]	0.07		[5]	0.055		[5]	0.038		[5]	0.043	0.05
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 M		[5]	0.00		[5]	0.016		[5]	0.00		[5]	0.00		[5]	0.00		[5]	0.01		[5]	0.04		[5]	0.018	0.02
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 0-9 T		[5]	0.42		[5]	0.18		[5]	0.13		[5]	0.47		[5]	0.39		[5]	0.60		[5]	0.21		[5]	0.43	0.35
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 10-19 T		[5]	0.16		[5]	0.05		[5]	0.20		[5]	0.21		[5]	0.17		[5]	0.24		[5]	0.09		[5]	0.19	0.17
Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal /1000 MM 45-64 F		[5]	0.46		[5]	0.44		[5]	0.01		[5]	0.50		[5]	0.53		[5]	0.35		[5]	0.45		[5]	0.47	0.53
Frequency of Selected Procedures (FSP) – Hysterectomy, vaginal /1000 MM 45-64 F		[5]	0.188		[5]	0.02		[5]	0.00		[5]	0.16		[5]	0.17		[5]	0.20		[5]	0.11		[5]	0.191	0.15
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 30-64 M		[5]	0.047		[5]	0.03		[5]	0.00		[5]	0.08		[5]	0.06		[5]	0.055		[5]	0.00		[5]	0.04	0.05
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 45-64 F		[5]	0.07		[5]	0.063		[5]	0.00		[5]	0.037		[5]	0.056		[5]	0.061		[5]	0.00		[5]	0.040	0.05
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 30-64 M		[5]	0.21		[5]	0.11		[5]	0.172		[5]	0.34		[5]	0.172		[5]	0.193		[5]	0.12		[5]	0.191	0.19
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 45-64 F		[5]	0.49		[5]	0.19		[5]	0.00		[5]	0.67		[5]	0.69		[5]	0.65		[5]	0.34		[5]	0.60	0.52
Frequency of Selected Procedures (FSV) – Back Surgery /1000 MM 45-64 F		[5]	0.41		[5]	0.58		[5]	0.00		[5]	0.66		[5]	0.56		[5]	0.78		[5]	0.30		[5]	0.55	0.55
Frequency of Selected Procedures (FSP) – Back Surgery /1000 MM 45-64 M		[5]	0.43		[5]	0.42		[5]	0.00		[5]	0.65		[5]	0.52		[5]	0.66		[5]	0.39		[5]	0.62	0.53
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 15-44 F		[5]	0.022		[5]	0.030		[5]	0.00		[5]	0.026		[5]	0.016		[5]	0.036		[5]	0.00		[5]	0.041	0.03
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 45-64 F		[5]	0.16		[5]	0.04		[5]	0.00		[5]	0.14		[5]	0.11		[5]	0.21		[5]	0.19		[5]	0.20	0.15
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 15-44 F		[5]	0.15		[5]	0.00		[5]	0.00		[5]	0.14		[5]	0.18		[5]	0.16		[5]	0.11		[5]	0.13	0.14
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 45-64 F		[5]	0.365		[5]	0.21		[5]	0.01		[5]	0.29		[5]	0.41		[5]	0.49		[5]	0.27		[5]	0.372	0.43

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[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
* Sub-measure retired by NCQA for HEDIS 2015.

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JMS: Jai Medical Systems
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Table A – HealthChoice Organizations HEDIS 2015 Results

HEDIS 2014 Results, page five of five	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2013	2014	2015	2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Discharges /1000 MM		[5]	5.95		[5]	9.89		[5]	6.40		[5]	6.47		[5]	7.01		[5]	6.61		[5]	6.73		[5]	7.17	7.03
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Average Length of Stay		[5]	3.96		[5]	4.12		[5]	4.59		[5]	3.66		[5]	4.03		[5]	3.85		[5]	3.72		[5]	4.12	4.01
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics (aaattot)		[5]	0.87		[5]	0.88		[5]	0.68		[5]	1.03		[5]	0.86		[5]	0.97		[5]	0.77		[5]	0.98	0.88
Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script (acattot)		[5]	9.29		[5]	8.983		[5]	8.977		[5]	9.40		[5]	9.23		[5]	9.39		[5]	9.21		[5]	9.26	9.22
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics of Concern (adattot)		[5]	0.35		[5]	0.29		[5]	0.27		[5]	0.41		[5]	0.34		[5]	0.39		[5]	0.32		[5]	0.43	0.35
Antibiotic Utilization (ABX) – Percentage of Antibiotics of Concern of all Antibiotics (apttot)		[5]	40.4%		[5]	33.0%		[5]	40.5%		[5]	39.8%		[5]	40.2%		[5]	40.4%		[5]	42.1%		[5]	43.2%	39.9%
Call Answer Timeliness (CAT)	81.9%	89.7%	82.9%	95.0%	93.4%	92.7%			69.6%	87.7%	89.2%	86.7%	89.4%	91.3%	77.3%	84.9%	71.0%	43.5%		NA[1]	80.4%	92.4%	89.4%	84.3%	77.2%

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Table A1 – Health Plan Descriptive Information (New measures for 2015)

	ACC	JMS	KPMAS	MPC	MSFC	PP	RHMD	UHC
Board Certification (BCR) – Family Medicine: Number of Physicians	616	47	170	595	262	569	468	780
Board Certification (BCR) – Family Medicine: Number Board Certified	449	44	162	243	150	533	290	598
Board Certification (BCR) – Family Medicine: Percent Board Certified	72.9%	93.6%	95.3%	40.8%	57.3%	93.7%	62.0%	76.7%
Board Certification (BCR) – Internal Medicine: Number of Physicians	2288	558	385	1239	441	846	762	2370
Board Certification (BCR) – Internal Medicine: Number Board Certified	1698	526	364	740	293	792	448	1866
Board Certification (BCR) – Internal Medicine: Percent Board Certified	74.2%	94.3%	94.6%	59.7%	66.4%	93.6%	58.8%	78.7%
Board Certification (BCR) – Pediatrician: Number of Physicians	1295	161	94	930	164	845	734	1249
Board Certification (BCR) – Pediatrician: Number Board Certified	1054	143	92	631	66	806	450	1073
Board Certification (BCR) – Pediatrician: Percent Board Certified	81.4%	88.8%	97.9%	67.9%	40.2%	95.4%	61.3%	85.9%
Board Certification (BCR) – OB/GYN: Number of Physicians	668	100	156	568	309	666	393	822
Board Certification (BCR) – OB/GYN: Number Board Certified	512	83	140	143	130	636	242	721
Board Certification (BCR) – OB/GYN: Percent Board Certified	76.7%	83.0%	89.7%	25.2%	42.1%	95.5%	61.6%	87.7%
Board Certification (BCR) – Geriatricians: Number of Physicians	86	33	0	42	10	38	21	86
Board Certification (BCR) – Geriatricians: Number Board Certified	51	23	0	16	4	36	12	59
Board Certification (BCR) – Geriatricians: Percent Board Certified	59.3%	69.7%	0.0%	38.1%	40.0%	94.7%	57.1%	68.6%
Board Certification (BCR) – Other Specialists: Number of Physicians	5344	1691	810	4723	2121	10040	2627	6139
Board Certification (BCR) – Other Specialists: Number Board Certified	3997	1362	757	2819	1210	9474	1408	4973
Board Certification (BCR) – Other Specialists: Percent Board Certified	74.8%	80.5%	93.5%	59.7%	57.1%	94.4%	53.6%	81.0%
Enrollment by Product Line (ENP) – Shows only total member months for Female	1742194	145745	19019	1301131	392920	1592290	121547	1437400
Enrollment by Product Line (ENP) – Shows only total member months for Male	1474078	162349	15183	963862	305301	1245933	116604	1216858
Enrollment by Product Line (ENP) – Shows only total member months Total	3216272	308094	34202	2264993	698221	2838223	238151	2654258
Enrollment by State (EBS) – Maryland Only	266373	25252	10326	194943	65967	242549	26881	223438

	ACC	JMS	KPMAS	MPC	MSFC	PP	RHMD	UHC
Language Diversity (LDM) – Spoken - Non-English Number	4268	68	816	0	0	0	0	2186
Language Diversity (LDM) – Spoken - Non-English Percent	1.3%	0.2%	7.5%	0.0%	0.0%	0.0%	0.0%	0.8%
Language Diversity (LDM) – Spoken - Unknown Number	322935	0	387	236460	83128	289174	37399	282513
Language Diversity (LDM) – Spoken - Unknown Percent	98.7%	0.0%	3.5%	100.0%	100.0%	100.0%	100.0%	99.2%
Language Diversity (LDM) – Spoken - Declined Number	0	0	7	0	0	0	0	0
Language Diversity (LDM) – Spoken - Declined Percent	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Race/Ethnicity Diversity (RDM) – White / Total	63296	5117	2513	81776	26341	118701	12821	99723
Race/Ethnicity Diversity (RDM) – White / Percent	19.3%	14.7%	23.0%	34.6%	31.7%	41.1%	34.3%	35.0%
Race/Ethnicity Diversity (RDM) – Black / Total	156434	26066	5968	107872	38268	125657	15030	123919
Race/Ethnicity Diversity (RDM) – Black / Percent	47.8%	75.0%	54.5%	45.6%	46.0%	43.45%	40.2%	43.53%
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Total	0	117	11	0	0	8	0	0
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Percent	0.0%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
Race/Ethnicity Diversity (RDM) – Asian / Total	14210	749	526	7947	4280	9954	1867	14044
Race/Ethnicity Diversity (RDM) – Asian / Percent	4.3%	2.2%	4.8%	3.36%	5.2%	3.44%	5.0%	4.9%
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Total	259	34	7	0	0	0	48	257
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Percent	0.08%	0.10%	0.06%	0.0%	0.0%	0.0%	0.13%	0.09%
Race/Ethnicity Diversity (RDM) – Other / Total	0	0	149	0	0	0	0	0
Race/Ethnicity Diversity (RDM) – Other / Percent	0.0%	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Race/Ethnicity Diversity (RDM) – 2+ Races / Total	0	0	4	0	0	0	0	0
Race/Ethnicity Diversity (RDM) – 2+ Races / Percent	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Race/Ethnicity Diversity (RDM) – Unknown / Total	93013	2652	1737	38865	14239	34854	2425	46759
Race/Ethnicity Diversity (RDM) – Unknown / Percent	28.4%	7.6%	15.9%	16.4%	17.1%	12.1%	6.5%	16.4%
Race/Ethnicity Diversity (RDM) – Declined / Total	0	0	33	0	0	0	5208	0
Race/Ethnicity Diversity (RDM) – Declined / Percent	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	13.9%	0.0%
Week of Pregnancy at Time of Enrollment (WOP) – 13-27 weeks	29.6%	20.5%	NR	25.6%	30.9%	28.0%	37.5%	32.6%
Week of Pregnancy at Time of Enrollment (WOP) – 28+ weeks	13.3%	11.8%	NR	11.3%	17.7%	13.1%	23.8%	14.5%
Week of Pregnancy at Time of Enrollment (WOP) – Unknown	4.7%	0.0%	NR	4.2%	4.9%	4.6%	16.6%	4.8%
Total Membership – Total membership numbers for each plan	266363	25263	16040	195088	66532	242828	26926	223613

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A Performance Report Card

for Consumers

2016

HealthChoice
MARYLAND'S MEDICAID HEALTH PLAN PROGRAM

Printed
3/2016

Looking at Health Plan Performance

All health plans in HealthChoice received high satisfaction ratings from the majority of their members.

This Report Card shows how the health plans in HealthChoice compare to each other in key areas. You should use this Report Card along with other items in the enrollment packet to help you choose a health plan.

To choose a health plan, call 1-800-977-7388. If you are hearing impaired, you can call the TDD line 1-800-977-7389.

Key
- ★★★ Above HealthChoice Average
- ★★ HealthChoice Average
- ★ Below HealthChoice Average

Performance Areas

Health Plans	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
AMERIGROUP COMMUNITY CARE	★★	★★	★★★	★	★★★	★★
JAI MEDICAL SYSTEMS	★★★	★★	★★★	★★	★★★	★★★
KAISER PERMANENTE*	N/A	N/A	N/A	N/A	N/A	N/A
MARYLAND PHYSICIANS CARE	★★★	★★	★★	★★	★★	★★
MEDSTAR FAMILY CHOICE	★	★★★	★★★	★★	★★	★★
PRIORITY PARTNERS	★★★	★★	★★★	★★	★★★	★★
RIVERSIDE HEALTH OF MARYLAND	★	★★	★	N/A	★	★
UNITEDHEALTHCARE	★★★	★★	★	★★	★	★

This information was collected from health plans and their members and is the most current performance data available. The information was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member composition.
NOTE: N/A means that ratings are not applicable and does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan.
**Kaiser Permanente became a HealthChoice MCO in 2014, therefore ratings are not applicable.*

Performance Area Descriptions

Access to Care
- Appointments are scheduled without a long wait
- The health plan has good customer service
- Everyone sees a doctor at least once a year
- The health plan answers member calls quickly

Doctor Communication and Service
- Doctors explain things clearly and answer questions
- The doctor's office staff is helpful
- Doctors provide good care

Keeping Kids Healthy
- Kids get shots to protect them from serious illness
- Kids see a doctor and dentist regularly
- Kids get tested for lead

Care for Kids with Chronic Illness
- Doctors give personal attention
- Kids get the medicine they need
- A doctor or nurse knows the child's needs
- Doctors involve parents in decision making

Taking Care of Women
- Women are tested for breast cancer and cervical cancer
- Moms are taken care of when they are pregnant and after they have their baby

Care for Adults with Chronic Illness
- Blood sugar levels are monitored and controlled
- Cholesterol levels are tested and controlled
- Eyes are examined for loss of vision
- Kidneys are healthy and working properly
- Appropriate use of antibiotics
- Appropriate treatment for lower back pain

If you are having trouble getting health care from your health plan or your doctor, try calling the health plan for customer service.
Then, call the Enrollee Help Line if you still have a problem at 1-800-284-4510.

Services Covered by Each Health Plan

- Visits to the doctor, including regular check-ups
- Immunizations (shots) for kids under 21
- Care while pregnant
- Family planning and birth control
- Prescription drugs
- X-ray and lab services
- Hospital services
- Home health services
- Hospice services
- Emergency services
- OB/GYN care for women
- Eye exams for adults and children
- Primary mental health services through your primary care doctor (other mental health services through the Specialty Mental Health System 1-800-888-1965)
- Transportation services
- Vision care including exams and glasses each year for kids under 21

Every HealthChoice health plan offers some additional services.

Do you want to ask the health plans questions?

AMERIGROUP COMMUNITY CARE	1-800-600-4441
JAI MEDICAL SYSTEMS	1-888-524-1999
KAISER PERMANENTE	1-855-249-5019
MARYLAND PHYSICIANS CARE	1-800-953-8854
MEDSTAR FAMILY CHOICE	1-888-404-3549
PRIORITY PARTNERS	1-800-654-9728
RIVERSIDE HEALTH OF MARYLAND.	1-800-730-8530
UNITEDHEALTHCARE	1-800-318-8821

For more information visit the HealthChoice website *www.dhmh.maryland.gov*

Informe Calificativo Sobre Desempeño

para Consumidores

2016

HealthChoice
PROGRAMA DEL PLAN DE SALUD MEDICAID DE MARYLAND

Impresión
3/2016

Evaluacion del Desempeno del Plan de Salud

Todos los planes de salud de HealthChoice recibieron altas calificaciones de satisfacción de parte la mayoría de sus miembros.

Este informe calificativo muestra el lugar que ocupan los planes de salud de HealthChoice en ciertas áreas clave. Usted puede valerse de este informe y de los demás materiales del paquete de inscripción como ayuda para decidirse por un plan de salud.

Para elegir un plan de salud, llame al 1-800-977-7388. Si tiene problemas de audición, puede llamar a la línea TDD, al número 1-800-977-7389.

Clave
- ★★★ Por encima del promedio de HealthChoice
- ★★ Promedio de HealthChoice
- ★ Por debajo del promedio de HealthChoice

Áreas del Funcionamiento

Planes de Salud	Acceso a la Atención	Comunicación con el Médico y sus Servicios	Mantenimiento de la Salud de los Niños	Atención de Niños con Enfermedades Crónicas	Atención de la Mujer	Atención de Adultos con Enfermedades Crónicas
AMERIGROUP COMMUNITY CARE	★★	★★	★★★	★	★★★	★★
JAI MEDICAL SYSTEMS	★★★	★★	★★★	★★	★★★	★★★
KAISER PERMANENTE*	N/A	N/A	N/A	N/A	N/A	N/A
MARYLAND PHYSICIANS CARE	★★★	★★	★★	★★	★★	★★
MEDSTAR FAMILY CHOICE	★	★★★	★★★	★★	★★	★★
PRIORITY PARTNERS	★★★	★★	★★★	★★	★★★	★★
RIVERSIDE HEALTH OF MARYLAND	★	★★	★	N/A	★	★
UNITEDHEALTHCARE	★★★	★★	★	★★	★	★

Esta información se recogió de los planes de salud y de sus miembros y son los datos de rendimiento más actuales disponibles. La información fue revisada para su exactitud por organizaciones independientes. Las puntuaciones de rendimiento del plan de salud no se han ajustado a las diferencias en las regiones de servicio o la composición miembro. NOTA: N/A significa que las calificaciones no son aplicables y no se describe el rendimiento o la calidad de la atención prestada por el plan de salud. No debería afectar su opción de plan de salud.
**Kaiser Permanente se convirtió en un MCO HealthChoice en 2014, por lo tanto, clasificaciones no son aplicables.*

Descripción de las Áreas de Desempeño

Acceso a la Atención
- Se otorgan citas sin demoras prolongadas
- El plan de salud tiene buena atención al cliente
- Todos ven al doctor por lo menos una vez por año
- El plan de salud responde a los miembros de las llamadas rápidamente

Comunicación con el Médico y sus Servicios
- Los doctores explican las cosas con claridad y responden las preguntas
- El personal del consultorio del doctor es servicial
- Los doctores brindan buena atención

Si usted tiene problemas para recibir atención médica de su plan de salud o de su doctor, llame al plan de salud y pida que lo comuniquen con el servicio de atención al cliente. Luego, si todavía tiene problemas, llame a la línea para afiliados de HealthChoice, Enrollee Help Line, al número 1-800-284-4510.

Mantenimiento de la Salud de los Niños
- Los niños son vacunados para protegerlos de enfermedades graves
- Los niños ven al doctor y al dentista periódicamente
- Los niños son sometidos a análisis para detectar intoxicación por plomo

Atención de Niños con Enfermedades Crónicas
- Los doctores les brindan atención individual
- Los niños reciben los medicamentos que necesitan
- El doctor o la enfermera conocen las necesidades del niño
- Los doctores hacen participar a los padres en la toma de decisiones

Atención de la Mujer
- Las mujeres se someten a estudios de detección de cáncer de mama y de cáncer de cuello de útero
- Se cuida de la mujer durante el embarazo y después del parto

Atención de Adultos con Enfermedades Crónicas
- Se observan y controlan los niveles de azúcar en sangre
- Se analizan y controlan los niveles de colesterol
- Se examinan los ojos para ver si hay pérdida de la visión
- Los riñones están saludables y en buen funcionamiento
- El uso apropiado de antibióticos
- El tratamiento adecuado para el dolor lumbar

Servicios Cubiertos por Cada Plan de Salud

- Visitas al médico, incluso los chequeos periódicos
- Inmunizaciones (vacunas) para menores de 21 años
- Atención durante el embarazo
- Planificación familiar y control de la natalidad
- Medicamentos recetados
- Servicios radiológicos y de laboratorio
- Servicios de hospital
- Servicios de salud en el hogar
- Servicios para enfermos terminales
- Servicios de emergencia
- Atención ginecológica y de obstetricia para mujeres
- Exámenes de los ojos para adultos y niños
- Servicios primarios de salud mental a través de su primarios doctor (otros servicios de salud mental a través de Specialty Mental Health System 1-800-888-1965)
- Servicios de transporte
- Atención de la vista, incluso exámenes y anteojos cada año para menores de 21 años

Cada plan de salud HealthChoice ofrece algunos servicios adicionales.

¿Tiene preguntas para los planes de salud?

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