HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

MARYLAND Department of Health

HealthChoice
Maryland's Medicaid Managed Care Program

Qlarant

Medicaid Managed Care Organization

CY 2017 Annual Technical Report

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Executive Summary

Introduction

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible participants in contracted Managed Care Organizations (MCOs) through the Maryland Medicaid Managed Care Program, known as HealthChoice. HealthChoice has been operational since June 1997 and 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 to provide quality health care that is patient focused, prevention oriented, coordinated, accessible, and cost effective.

MDH's HealthChoice and Acute Care Administration (HACA) is responsible for 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.

MDH 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], MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided by each contracted MCO to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice Program. For this purpose, MDH contracts with Qlarant Quality Solutions, Inc. (formerly Delmarva Foundation for Medical Care, Inc.) to serve as the EQRO.

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

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

As of December 31, 2016, the HealthChoice program served over 1,133,369 participants. The Department contracted with eight MCOs during this evaluation period. The eight MCOs evaluated during this period were:

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

*Formerly Riverside Health of Maryland (RHMD)

KPMAS began participating in the HealthChoice program in June 2014. The EQRO's evaluation of KPMAS for calendar year (CY) 2016 included all EQRO activities with the exception of the Controlling High Blood Pressure Performance Improvement Project which was in its final year. KPMAS' full participation in all EQRO activities will begin in CY 2017.

Pursuant to 42 CFR 438.364, the 2016 Annual Technical Report describes the findings from Qlarant's External Quality Review activities for years 2015–2016 which took place in CY 2017. The report includes each review activity conducted by Qlarant, the methods used to aggregate and analyze information from the review activities, and conclusions drawn regarding the quality, access, and timeliness of healthcare services provided by the HealthChoice MCOs.

HACA Quality Strategy

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

- Ensure compliance with changes in Federal/State laws and regulations affecting the Medicaid program;
- Improve quality and health care performance continually using evidence–based methodologies for evaluation;
- Compare Maryland's results to national and state performance benchmarks to identify areas of success and improvement;

- Reduce administrative burden on MCOs and the program overall; and,
- Assist the Department with setting priorities and responding to identified areas of concern within the HealthChoice participant population.

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

EQRO Program Assessment Activities

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

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

Qlarant also conducted an optional activity, validation of encounter data reported by the MCOs. As the EQRO, Qlarant conducted each of the mandatory activities and the optional activity in a manner consistent with the CMS protocols during CY 2017.

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

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

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

- Systems Performance Review

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

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

General Overview of Findings

Assessment of Quality, Access, and Timeliness

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

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

of timeliness given in the Institute of Medicine National Health Care Quality Report refers to "obtaining needed care and minimizing unnecessary delays in getting that care." *(Envisioning the National Health Care Quality Report, 2001)*.

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

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

Systems Performance Review	Q	A	T
Standard 1 – Systematic Process of Quality Assessment and Improvement	√		
Standard 2 – Accountability to the Governing Body	√		
Standard 3 – Oversight of Delegated Entities	√		
Standard 4 – Credentialing and Recredentialing	√	√	√
Standard 5 – Enrollee Rights	√	√	√
Standard 6 – Availability and Accessibility		√	√
Standard 7 – Utilization Review	√	√	√
Standard 8 – Continuity of Care	√	√	√
Standard 9 – Health Education Plan	√	√	
Standard 10 – Outreach Plan	√	√	
Standard 11 – Fraud and Abuse	√		√
Value Based Purchasing	**Q**	**A**	**T**
Adolescent Well–Care	√	√	√
Adult BMI Assessment	√		
Ambulatory Care Services for SSI Adults Ages 21–64 Years	√	√	
Ambulatory Care Services for SSI Children Ages 0–20 Years	√	√	
Breast Cancer Screening	√	√	√
Childhood Immunization Status (Combo 3)	√	√	√
Comprehensive Diabetes Care – HbA1c Testing	√	√	√
Controlling High Blood Pressure	√		√
Immunizations for Adolescents	√		√
Lead Screenings for Children Ages 12–23 Months	√		√
Medication Management for People with Asthma	√	√	√
Postpartum Care	√	√	√
Well–Child Visits for Children Ages 3–6 Years	√	√	√
Performance Improvement Projects	**Q**	**A**	**T**
Asthma Medication Ratio PIP	√		
High Blood Pressure PIP	√	√	√
Encounter Data Validation	**Q**	**A**	**T**
Inpatient, Outpatient, Office Visit Medical Record Review	√		
EPSDT Medical Record Review	**Q**	**A**	**T**
Health and Developmental History	√		√
Comprehensive Physical Examination	√		√
Laboratory Tests/At–Risk Screenings		√	√
Immunizations	√		√
Health Education and Anticipatory Guidance	√		√

Focused Review of Grievances, Appeals, & Denials	Q	A	T
Grievances	√		√
Appeals	√		√
Denials	√		√
Network Adequacy	**Q**	**A**	**T**
Correctness of Provider Directories	√		
Compliance with Routine Care Appointment Requirements		√	√
Compliance with Urgent Care Appointment Requirements		√	√
HEDIS®	**Q**	**A**	**T**
Weight Assessment and Counseling for Nutrition and Physical activity for Children/Adolescent	√	√	√
Childhood Immunization Status	√		√
Immunizations for Adolescents	√		√
Appropriate Treatment for Children with Upper Respiratory Infection	√		
Appropriate Testing for Children with Pharyngitis	√		
Breast Cancer Screening	√		√
Cervical Cancer Screening	√		√
Chlamydia Screening in Women	√		√
Comprehensive Diabetes Care	√		√
Standardized Healthcare-Associated Infection Ratio - *New*	√		
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	√	√	√
Depression Remission or Response for Adolescents and Adults - *New*	√		
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	√	√	
Non–Recommended Cervical Cancer Screening in Adolescent Females	√	√	

HEDIS®	Q	A	T
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	√	√	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	√	√	
Diabetes Monitoring for People with Diabetes and Schizophrenia	√	√	
Antidepressant Medication Management	√		
Follow-Up After Emergency Department Visit for Mental Illness - *New*	√	√	√
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence - *New*	√	√	√
Follow–Up Care after Hospitalization for Mental Illness	√	√	√
Follow–Up Care for Children Prescribed ADHD Medication	√	√	√
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	√		
Inpatient Utilization – General Hospital/Acute Care	√	√	
Frequency of Selected Procedures		√	
Mental Health Utilization	√	√	
Antibiotic Utilization	√	√	
Board Certification	√		
Enrollment by Product Line		√	
Enrollment by State		√	
Language Diversity of Membership		√	
Race/Ethnicity Diversity of Membership		√	
Total Membership		√	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	√		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	√		
Annual Dental Visit	√	√	√
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	√		
Statin Therapy for Patients with Diabetes	√		
Statin Therapy for Patients with Cardiovascular Disease	√		
CAHPS®	**Q**	**A**	**T**
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 Medicine*		√	
Access to Specialized Services*		√	
Family Centered Care: Personal Doctor Who Knows Your Child*	√		
Family Centered Care: Getting Needed Information*	√		
Coordination of Care for Children with Chronic Conditions*	√		

*Additional Composite Measures for Children with Chronic Conditions

Section I
Systems Performance Review

Introduction

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care (QOC) provided by Managed Care Organizations (MCOs) to HealthChoice enrollees. Qlarant, as the contracted External Quality Review Organization (EQRO), performs an independent annual review of MCO services provided to participants in order to ensure that they meet the standards set forth in the regulations governing the HealthChoice Program. COMAR 10.09.65 requires that all HealthChoice MCOs comply with the Systems Performance Review (SPR) standards and all applicable federal and state laws and regulations. This section describes the findings from the SPR for Calendar Year (CY) 2016. All eight MCOs were evaluated during this review period:

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

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Purpose and Process

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

In view of the decision by MDH to move to triennial rather than annual onsite reviews, the assessment for CY 2016 was conducted as an Interim Desktop Review. This assessment was completed by applying the systems performance standards defined for CY 2016 in the Code of Maryland Regulations (COMAR) 10.09.65.03B(1). The focus of the review was primarily on three areas: standards that were not fully met in the CY 2015 review, standards that were scored as baseline in the CY 2015 review, and new standards introduced during CY 2016. Additionally, a review of a sample of credentialing and recredentialing records was conducted to assess compliance with applicable standards.

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; Code of Maryland

Regulations (COMAR); the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care;" Public Health Code of Federal Regulations; and Department requirements. The HealthChoice and Acute Care Administration leadership and the Division of HealthChoice Quality Assurance (DHQA) approved the MCO performance standards used in the CY 2016 review before application.

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

Methodology

In October 2016, Qlarant provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2016 and invited the MCOs to direct any questions or issues requiring clarification to Qlarant and DHQA. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2016 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- CY 2016 Systems Performance Review Standards and Guidelines, including specific changes

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

During the desktop reviews conducted in January of 2017, the team reviewed all relevant documentation needed to assess the standards. A follow-up letter was provided to each MCO describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Qlarant; documents received were subsequently reviewed against the standard(s) to which they related.

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

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

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

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

The CY 2016 SPR Interim Desktop Review included:

- All MCO CAPs from the CY 2015 SPR for any of the following areas:
  - Systematic Process of Quality Assessment
  - Accountability to the Governing Body
  - Oversight of Delegated Entities
  - Credentialing and Recredentialing
  - Enrollee Rights
  - Availability and Accessibility
  - Utilization Review
  - Coordination of Care
  - Health Education
  - Outreach
  - Fraud and Abuse
- Standards that were reviewed as baseline in CY 2015, were reviewed and scored in the CY 2016 review:
  - 1.10
  - 3.3c and 3.3e (if 3.3e was deemed for an MCO in CY 2015, it was deemed in CY 2016)
  - 5.6d
  - 7.7
  - 8.6
- New standards introduced by the Department for CY 2016. These standards were scored as baseline:
  - 5.8
  - 7.5
  - 11.1f
- A focused review of Credentialing and Recredentialing records included the following elements/components of Standard 4: 4.4, 4.5, 4.6, 4.7, 4.8, and 4.9.

For CY 2016, each MCO was expected to receive a finding of "Met" for all elements/components reviewed. The MCOs were required to submit a CAP for any element/component that did not receive a finding of "Met".

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

Corrective Action Plan Process

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

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

In the event that a CAP is deemed unacceptable, Qlarant provides technical assistance to the MCO until an acceptable CAP is submitted. Six MCOs were required to submit CAPs for the CY 2016 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2017 will determine whether the CAPs from the CY 2016 review were implemented and effective. In order to make this determination, Qlarant will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH will be notified for further action.

Following the CY 2016 SPR, MDH implemented its Quality Monitoring Policy whereby an MCO that had a CAP for two or more consecutive years in the same element/component would require quarterly monitoring by the EQRO. Therefore, five MCOs (ACC, KPMAS, PPMCO, RHMD and UHC) were required to submit quarterly updates of their CAPs to Qlarant. Progress will be reported quarterly to MDH.

Findings

If the MCO's did not receive a finding of "Met", a CAP was required. Two MCOs (JMS and MPC) received findings of "Met" in all standards reviewed. Six MCOs (ACC, KPMAS, MSFC, PPMCO, RHMD, and UHC) were required to submit CAPs for CY 2016. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

Table 2 provides for a comparison of SPR results across MCOs and the MD MCO Compliance for the CY 2016 review.

Table 2. CY 2016 MCO Review Results

Standard	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
3 - Oversight of Delegated Entities	**3.3 c**		**3.3c**		**3.3 c**	**3.3 b** **3.3 c**	**3.3 c**	**3.3 b** **3.3 c** **3.3 e**
4 - Credentialing							**4.4 i**	**4.8 e**
5 - Enrollee Rights	**5.6 d**							
6 - Availability and Access			**6.1 d**					
7 - Utilization Review	**7.4 d** **7.7**					**7.4 e** **7.4 f**	**7.4 e** **7.7**	**7.4 e** **7.6 c** **7.7**
CAPs Required	**3**	**0**	**2**	**0**	**1**	**2**	**3**	**3**

For each standard assessed for CY 2016, the following section describes:

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

STANDARD 3: Oversight of Delegated Entities

REQUIREMENTS:

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

RESULTS:

For Component 3.3b, quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable, the following two MCOs had opportunities for improvement and required CAPs:

- PPMCO – Partially Met
- UMHP – Unmet

For Component 3.3c, review and approval of claims payment activities at least semi-annually, where applicable, the following six MCOs had opportunities for improvement and required CAPs:

- ACC - Unmet
- KPMAS – Unmet
- MSFC – Partially Met
- PPMCO – Unmet
- UHC – Partially Met
- UMHP - Unmet

For Component 3.3e, review and approval of over and under utilization reports, at least semi-annually, where applicable, the following MCO had an opportunity for improvement and required a CAP: UMHP - Unmet.

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:

ACC Opportunities/CAPs: For Component 3.3c, ACC did not provide evidence of QMC review and approval of claims payment activities reports from Superior Vision and ESI for the fourth quarter of 2015, and the first three quarters of 2016.

Subsequent to the initial submission, ACC provided additional documentation. Review of QMC minutes from February 3, 2016, demonstrated approval of fourth quarter 2015, claims activities reports from Superior Vision and ESI. There was no evidence of approval of first, second, and third quarter 2016, claims activities reports from Superior Vision or ESI based upon review of the remainder of QMC meeting minutes submitted from 2016.

In order to receive a finding of met in the CY 2017 review, ACC must demonstrate QMC review and approval of claims activities reports from all applicable delegated entities at least on a semi-annual basis or more frequently based upon MCO policy. Documentation must specify the report being approved and the time frame such as fourth quarter 2016 Superior Vision claims activities reports.

KPMAS Opportunities/CAPs: For Component 3.3c, in response to the CY 2015 SPR findings, KPMAS was required to demonstrate that the appropriate committee reviewed and approved all delegate claims activities reports at least semi-annually in order to receive a finding of met in the CY 2016. Continued opportunities for improvement existed.

There was no evidence of RQIC review and approval of EMI claims activities reports for the fourth quarter 2015, and the second quarter, 2016. RQIC approval for first quarter reports was documented in the minutes of May 25, 2016, and third quarter in the minutes of October 19, 2016. Additionally, no evidence was submitted to support RQIC review and approval of MedImpact's claims activities on a semi-annual basis or more frequently based upon MCO policy.

Subsequent to the initial submission, KPMAS submitted additional documentation for review. RQIC minutes from February 17, 2016, demonstrated review and approval of third and fourth quarters 2015, claims activities reports from EMI. An RQIC Executive Summary was submitted dated July 29, 2016, displaying results for second quarter 2016; however, there were no RQIC minutes documenting review and approval of the second quarter EMI report.

Minutes submitted from the RQIC meeting of March 16, 2016, demonstrated review and approval of MedImpact's fourth quarter 2015, claims activities report. Second quarter 2016, claims activities reports from MedImpact were approved in the RQIC meeting of September 21, 2016. RQIC minutes from June 15, 2016, and December 21, 2016, documented approval of the consent agenda report, however, there

was no documentation in the meeting minutes that MedImpact's claims activities reports were reviewed and approved.

In order to receive a finding of met in the CY 2017 review, KPMAS must demonstrate that the RQIC reviews and approves claims activities reports from all delegated entities at least on a semi-annual basis or more frequently based upon MCO policy. Minutes must reflect the specific report being approved and the associated time frame, such as EMI claims activities reports from second quarter 2016.

MSFC Opportunities/CAPs: For Component 3.3c, the QI/UMC and EOT are responsible for the review and approval of claims activities reports from all delegated entities except Vestica. Vestica's claims payment activities reports are reviewed and approved exclusively by the EOT.

There was evidence of review and approval of quarterly claims activities reports from Superior Vision by the QI/UMC on March 17, 2016, (fourth quarter 2015). In the July 21, 2016, meeting minutes it was reported that review and approval of first and second quarter 2016 reports would occur at the September 15, 2016, meeting. No additional QI/UMC meeting minutes were submitted to evidence review and approval of first, second, and third quarter 2016 reports. No EOT meeting minutes were submitted to demonstrate review and approval of claims activities reports from Superior Vision on at least a semi-annual basis consistent with the MCO's policy.

There was evidence of review and approval of semi-annual claims activities reports from Caremark by the QI/UMC on May 19, 2016, (July through December 2015.) In the July 21, 2016, meeting minutes it was reported that review and approval of first and second quarter 2016, reports would occur at the September 15, 2016, meeting. No additional QI/UMC meeting minutes were submitted. No EOT meeting minutes were submitted to demonstrate review and approval of claims activities reports from Caremark on at least a semi-annual basis consistent with the MCO's policy. There was no evidence of at least semi-annual review and approval of claims activities reports from Vestica as no EOT meeting minutes were submitted.

Subsequent to its initial submission MSFC provided additional documentation. QI/UMC minutes from December 15, 2016, demonstrated review and approval of first and second quarter Caremark claims activities reports. EOT minutes from December 15, 2016, demonstrated review and approval of Caremark claims activities reports for third and fourth quarters 2015, and first and second quarters 2016.

In the QI/UMC minutes from December 15, 2016, there was evidence of review and approval of claims activities reports from Superior Vision for first, second, and third quarters, 2016. EOT minutes

demonstrated review and approval of Superior Vision claims activities reports from fourth quarter 2015, (April 14, 2016), and first, second, and third quarters 2016, (December 15, 2016).
EOT meeting minutes evidenced approval of Vestica claims activities reports for fourth quarter 2015, (February 18, 2016), first quarter 2016, (May 17, 2016), second quarter 2016 (August 18, 2016), and third quarter 2016 (December 15, 2016).

In order to receive a finding of met in the CY 2017 review, MSFC must demonstrate that claims activities reports from all applicable vendors are reviewed and approved on at least a semi-annual basis by the specific committee(s) identified in its policies.

PPMCO Opportunities/CAPs: For Component 3.3b, in the CY 2015 SPR, PPMCO was required to develop a CAP to demonstrate formal appropriate committee quarterly review and approval of quarterly complaint, grievance, and appeal reports from all applicable delegates. As indicated below, continuing opportunities for improvement exist in demonstrating compliance.

Complaints and grievances are delegated to Superior Vision. In 2016 PPMCO created the IPAD Committee which includes among its responsibilities review and approval of delegate reports.
There was evidence of IPAD Committee review and approval of Superior Vision quarterly complaint and grievance reports in the meetings of May 2, 2016, (fourth quarter 2015), and July 14, 2016 (first quarter 2016). In the draft October 2016, minutes it was reported that all goals were met but did not specify the delegated activity report that was approved. There was no evidence of third quarter IPAD Committee approval of complaint and grievance reports.

Subsequent to the initial submission, PPMCO provided additional documentation to demonstrate compliance. The finalized IPAD Committee minutes from October 13, 2016, did not specify the activity report that was approved as noted above following review of the draft minutes. The IPAD Committee minutes from the December 8, 2016, meeting demonstrated review and approval of Superior Vision's complaint and grievance report for the third quarter, 2016.

In order to receive a finding of met in the CY 2017 review, PPMCO must demonstrate in the appropriate committee meeting minutes formal quarterly review and approval of quarterly complaint, grievance, and appeal reports from all applicable delegates. Documentation must specify the report being approved and the time frame, such as third quarter 2016 Superior Vision complaint and grievance reports.

For Component 3.3c, in the 2015 SPR, findings noted that in order to receive a met in the 2016 SPR, PPMCO was required to demonstrate review and approval of delegated claims activities reports from all

applicable delegates no less than semi-annually in the appropriate committee meeting minutes. As indicated below, this requirement was partially met and continued opportunities for improvement exist.

Claims payment activities are delegated to both Caremark and Superior Vision. In 2016 PPMCO created the IPAD Committee which includes among its responsibilities review and approval of delegate reports.

There was evidence of IPAD Committee review and approval of Superior Vision claims activities reports in the meetings of May 2, 2016 (fourth quarter 2015), and July 14, 2016 (first quarter 2016). In the draft October 2016, minutes it was reported that all goals were met but did not specify the delegated activity report that was approved. There was no evidence of third quarter IPAD Committee approval of claims activities reports.

In the March 18, 2016, IPAD Committee meeting minutes it was reported that all Caremark delegate reports were approved but the specific delegated activity reports were not documented. First and second quarter 2016 claims activities reports were approved in the September 8, 2016, IPAD Committee meeting.

Subsequent to the initial submission, PPMCO provided additional documentation to demonstrate compliance. IPAD Committee minutes were provided for October 13, 2016; however, there was no evidence of approval of Caremark claims activities reports. IPAD Committee minutes were also submitted for the February 9, 2017, meeting which is outside of the review time frame.

The finalized IPAD Committee minutes from October 13, 2016, did not specify the activity report that was approved as noted above following review of the draft minutes. The IPAD Committee minutes from the December 8, 2016, meeting demonstrated review and approval of Superior Vision's claims activities report for the third quarter, 2016.

In order to receive a finding of met in the CY 2017 review, PPMCO must demonstrate in the appropriate committee meeting minutes specific review and approval of delegated claims activities reports from all applicable delegates no less than semi-annually or more frequently based upon the MCO's policies. Documentation must specify the report approved and time frame, such as Superior Vision's third quarter 2016 claims activities report.

UHC Opportunities/CAPs: For Component 3.3c, UHC did not provide documentation to demonstrate compliance with appropriate committee (SQIS) review and approval of delegated entities' (March Vision) claims payment activities reports at least semi-annually for the CY 2016 review. The MCO incorrectly reported in its UHC Standard 3 Narrative that this component was deemed based on CY 2015 SPR.

Subsequent to the initial submission, UHC provided additional documentation to demonstrate compliance. Review of SQIS minutes throughout 2016 documented the following:

- February 25, 2016 meeting - Review of November and December 2015, March Vision claims volume only. Approval of scorecard (monthly service levels) documented.
- April 27, 2016 meeting - Review of first quarter 2016, March Vision claims processing activities. Approval of scorecard (monthly service levels) documented.
- August 31, 2016 meeting - Review of second quarter 2016, monthly service levels, however, no specific documentation of claims activities. Approval of scorecard (monthly service levels) documented.
- December 7, 2016 - Review of third quarter 2016, March Vision claims processing activities. Approval of scorecard (monthly service levels) documented.

In order to receive a finding of met in the CY 2017 review, UHC must demonstrate that all delegates' claims activities reports are specifically reviewed and approved by the appropriate committee at least semi-annually or more frequently as required by the MCO's policies. Approvals should consistently document specific reports and time frames reviewed, such as review and approval of the third quarter 2016 March Vision claims activities report.

UMHP Opportunities/CAPs: For Component 3.3b, the CY 2015 SPR findings noted that in order to receive a finding of met UMHP was required to develop a CAP to demonstrate formal review and approval of delegate quarterly complaint, grievance, and appeal reports on a quarterly basis by the appropriate committee (QIC) designated in the MCO's policy for each of the four quarters (fourth quarter of 2015 and first, second, and third quarters of 2016). QIC meeting minutes must reflect the specific delegated activity included in each delegate's report being approved. The CAP was not fully implemented and a continuing opportunity for improvement existed.

Superior Vision is the only known vendor delegated complaints, grievances, and appeals.

QIC meeting minutes from March 24, 2016, documented review and approval of the DOC report. It did not specify the delegated entity, the quarter being reviewed, or the specific delegated activity report approved as required. The QIC minutes of June 21, 2016, documented review and approval of the DOC report. Minutes reflected the review of first quarter reports and identified each vendor, but did not specify the reports reviewed/approved, only noting where standards were not met. In the draft QIC meeting minutes of September 20, 2016, the delegated entities were identified with a note that all standards were met. There was no mention of the quarter being reviewed or the specific delegated activity report reviewed. Additionally, there was no documentation of approval of any delegate reports.

There was no evidence submitted of QIC review and approval of third quarter 2016 complaint, grievance, and appeals reports.

In order to receive a finding of met in the CY 2017 review, UMHP must demonstrate evidence in the QIC meeting minutes of review and approval of each delegate's quarterly complaint, grievance, and appeal reports on a quarterly basis noting the specific delegated activity(ies) and quarter included in the report being approved.

For Component 3.3c, in the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, UMHP was required to demonstrate QIC review and approval of each delegate's claims activities reports at least semi-annually noting the specific delegated activity being approved in the minutes. UMHP did not meet these requirements and continuing opportunities for improvement exist.

Superior Vision and CVS Health are the only known vendors delegated claims payment activities. QIC meeting minutes from March 24, 2016, documented review and approval of the DOC report. It did not specify the delegated entity, the quarter being reviewed or the specific delegated activity report approved as required. The QIC minutes of June 21, 2016, documented review and approval of the DOC report. Minutes reflected the review of first quarter reports and identified each vendor, but did not s meeting minutes of September 20, 2016, the delegated entities were identified with a note that all specify the reports reviewed/approved, only noting where standards were not met. In the draft QIC meeting minutes of September 20, 2016, the delegated entities were identified with a note that all standards were met. There was no mention of the quarter being reviewed or the specific delegated activity report reviewed. Additionally, there was no documentation of approval of any delegate reports. There was no evidence submitted of QIC review and approval of third quarter 2016, claims payment activities reports.

In order to receive a finding of met in the CY 2017 review, UMHP must demonstrate evidence in the QIC meeting minutes of review and approval of each delegate's claims activities reports at least semi-annually noting the specific delegated activity(ies) and time frame included in the report being approved.

For Component 3.3e, in the CY 2015 SPR, findings noted that in order to receive a met UMHP was required to demonstrate QIC review and approval of each delegate's over and under utilization reports at least semi-annually, noting the specific delegated activity being approved in the minutes. A continuing opportunity for improvement existed.

CVS Health is the only known UM delegated entity.

QIC meeting minutes from March 24, 2016, documented review and approval of the DOC report. It did not specify the delegated entity, the quarter being reviewed or the specific delegated activity report approved as required. The QIC minutes of June 21, 2016, documented review and approval of the DOC report. Minutes reflected the review of first quarter reports and identified each vendor, but did not specify the reports reviewed/approved only noting where standards were not met. In the draft QIC meeting minutes of September 20, 2016, the delegated entities were identified with a note that all standards were met. There was no mention of the quarter being reviewed or the specific delegated activity report reviewed. Additionally, there was no documentation of approval of any delegate reports. There was no evidence submitted of QIC review and approval of third quarter 2016, over and under utilization reports.

In order to receive a finding of met in the CY 2017 review, UMHP must demonstrate evidence in the QIC meeting minutes of review and approval of each delegate's over and under utilization reports at least semi-annually, noting the specific delegated activity(ies) and time frame included in the report being approved.

FOLLOW-UP:

- ACC, KPMAS, MSFC, PPMCO, UHC, and UMHP were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- PPMCO and UMHP will provide quarterly updates on the CAP for component 3.3b to Qlarant in adherence with MDH's Quarterly Monitoring Policy.
- The approved CAPs will be reviewed in CY 2017.

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 American's with Disabilities Act 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 Americans with Disabilities Act of 1990 (ADA) standards, if applicable.

RESULTS:
For Component 4.4i, adherence to the time frames set forth in the MCO's policies regarding credentialing date requirements, one MCO had an opportunity for improvement and required a CAP: UHC – Partially Met

For Component 4.8e, meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements, one MCO had an opportunity for improvement and required a CAP: UMHP – Partially Met

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 was one minor issue identified with the recredentialing process within this review; however, the MCOs evidence strong oversight in credentialing and recredentialing processes.

MCO OPPORTUNITY/CAP REQUIRED
UHC Opportunities/CAPs: For Component 4.4i, one of ten records reviewed did not meet compliance with the time frames for processing provider applications which is required within 120 days from the date the 30-day notification letter was sent to the provider. For this record, the application was processed 138 days from the date of the 30-day notice.

An additional 20 initial credentialing records were reviewed to assess compliance with credentialing time frame requirements. Of these additional records, one did not meet the 120-day processing requirement; instead it took 134 days to credential the provider.

Follow-up documentation and interviews with UHC credentialing and compliance staff indicate that the NCC experienced a high inventory of providers requiring credentialing in late 2015 to early 2016. This inventory was greater than the capacity available to process the volume. As a result, the timeliness of

some of the initial credentialing files fell outside of the standard timeliness requirement to process an application. In order to respond to the 2015 CAP, UHC enhanced internal credentialing monitoring processes by hiring new staff and conducting real-time tracking of all initial credentialing against required turnaround times.

Data provided by the NCC in the document, Maryland Provider Credentialing 2016 Avg Days TAT, reveals that the high inventory was addressed; all provider applications for initial credentialing, from February 2016 through December 2016, were completed within 120 days. The trends show that TAT has gone from over 120 days for nine percent of applications in January 2016 (the remaining 91% at 72 days) to an average TAT of 14 days with 100% compliance for all records.

In order to receive a finding of met in the CY 2017 review, UHC must continue tracking the timeliness of the initial credentialing application process to ensure that 100% of applications are processed within 120 days from the date the 30-day notification is sent to the provider.

UMHP Opportunities/CAPs: For Component 4.8e, in a review of 10 recredentialing records, there were two that did not meet the required 36-month time frame for a decision date. The first record had a prior credentialing date of July 24, 2013, and the most recent recredentialing approval was August 17, 2016. The second record had a prior credentialing date of January 24, 2013, and March 30, 2016, for the recredentialing cycle.

An additional 20 recredentialing records were requested specifically for the review of compliance with the 36-month decision date requirement. Of these 20, all were processed within 36 months of the prior credentialing date.

In order to receive a finding of met in the CY 2017 review, UMHP must implement a process for monitoring timeliness of recredentialing to ensure that all required time frames are met.

FOLLOW-UP:

- UHC and UMHP were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- UMHP will provide quarterly updates on the CAP for component 4.8e to Qlarant in adherence with MDH's Quarterly Monitoring Policy.
- The approved CAPs will be reviewed in CY 2017.

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:

For Component 5.6d, the MCO includes the Continuity of Health Care Notice in the new enrollee packet, one MCO had an opportunity for improvement and required a CAP: ACC – Unmet

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.

MCO OPPORTUNITY/CAP REQUIRED:

ACC Opportunities/CAPs: For Component 5.6d, ACC provided a draft of the member handbook that was pending MDH approval for review; however, it was not clear whether the Continuity of Healthcare Notice was provided to enrollees.

In order to receive a finding of met in the CY 2017 review, ACC must provide a Continuity of Healthcare Notice in the new member packet.

FOLLOW-UP:

- ACC was required to submit a CAP for the above component. Qlarant reviewed and approved the submission.
- The approved CAP will be reviewed in CY 2017.

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:

For Component 6.1d, the MCO has documented review of the Enrollee Services Call Center performance, one MCO had an opportunity for improvement and required a CAP: KPMAS – Unmet

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. Each MCO has an effective system in place for notifying members of wellness services.

MCO OPPORTUNITY/CAP REQUIRED:

KPMAS Opportunities/CAPs: For Component 6.1d, in the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 review, KPMAS was required to develop a CAP to demonstrate review of Enrollee Services Call Center performance. The CAP implemented as a result of the CY 2015 SPR was not fully implemented and a continued opportunity for improvement existed.

Customer Call Center reports, including call center performance for each standard, are provided to the Senior Director of Medicaid Operations. Customer Call Center standards were included in the QMP. There was documentation that the review of call center performance metrics went through the quality committees, however, the policy states that they have an abandonment rate of 3% or less and the RQIC agenda and minutes state that they have an abandonment rate of 4% or less.

In order to receive a finding of met in the CY 2017 review, KPMAS must demonstrate consistency in the standard for abandonment rate percentage in all applicable policies, reports, and committee agendas and minutes.

FOLLOW-UP:

- KPMAS was required to submit a CAP for the above component. Qlarant reviewed and approved the submission.
- KPMAS will provide quarterly updates on the CAP for component 6.1d to Qlarant in adherence with MDH's Quarterly Monitoring Policy.

- The approved CAP will be reviewed in CY 2017.

STANDARD 7: Utilization Review

REQUIREMENTS:

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

RESULTS:

For Component 7.4d, there are well publicized and readily available appeal mechanisms for both providers and enrollees, one MCO had an opportunity for improvement and was required to submit a CAP: ACC – Unmet

For Component 7.4e, preauthorization and concurrent review decisions are made in a timely manner as specified by the State, the following three MCOs had opportunities for improvement and were required to submit CAPs:

- PPMCO - Unmet
- UHC - Unmet
- UMHP - Unmet

For Component 7.4f, appeal decisions are made in a timely manner as required by the exigencies of the situation, one MCO had an opportunity for improvement and was required to submit a CAP: PPMCO – Unmet

For Component 7.6c, the MCO acts upon identified issues as a result of the review of the data, one MCO had an opportunity for improvement and was required to submit a CAP: UMHP – Unmet

For Element 7.7, the MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department. The following three MCOs had opportunities for improvement and were required to submit CAPs:

- ACC – Partially Met
- UHC – Partially Met
- UMHP – Partially Met

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 UR decisions.

MCO OPPORTUNITY/CAP REQRUIRED:

ACC Opportunities/CAPs: For Component 7.3 d, in the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, ACC was required to demonstrate that it has resolved all inconsistencies in appeal time frames for filing and resolution of expedited appeals in its policies, member handbook, and provider manual. There was no evidence that the CAP was implemented in CY 2016, therefore, continued opportunities for improvement existed.

The Member Appeals - MD Policy, last revised on November 9, 2016, states that members have 90 calendar days for filing an appeal from the date of Notice of Action. Preservice (non-emergency) appeals are to be resolved within 30 calendar days of receipt of the appeal and expedited appeals as

expeditiously as the medical condition requires but no later than three business days from receipt of the request. Neither the provider manual nor the member handbook that were in place during CY 2016 was submitted for review to determine if the identified inconsistencies were resolved as planned. Subsequent to the initial submission, ACC submitted additional documentation to demonstrate compliance. The draft 2016 provider manual included time frames for filing an appeal and resolving an expedited appeal that was consistent with the Member Appeals - MD Policy. The member handbook, revised October 2016, specified three business days for resolution of expedited appeals consistent with the above policy and draft provider manual, however, the time frame for filing an appeal was stated as 90 business days.

In order to receive a finding of met in the CY 2017 review, ACC must resolve the inconsistency in the time frame for filing an appeal which currently states 90 calendar days in the Member Appeals- MD Policy and the draft 2016 Provider Manual consistent with regulatory requirements and 90 business days in the 2016 member handbook.

For Component 7.7, the Provider Payment Appeal Process Policy was updated to incorporate the IRO process available to providers who exhaust the MCO's internal appeal process. The IRO external review process outlined in this policy is consistent with all regulatory requirements with one exception. Following the stated requirement for the MCO to reimburse the provider for claims determined to be medically necessary by the IRO, including any interest, the policy further states that the MCO acknowledges that MDH (MDH) will deduct the amount from its future Medicaid payments plus the liquidated damage(s) and remit payment to the IRO. This language appears to suggest that provider payment will be deducted by MDH from the MCO's future Medicaid payments rather than the fixed case fee in the event of non-payment by the MCO within the required time frame. In a later section the policy does include the correct requirements for MCO payment of the IRO invoice, time frame, and consequences including liquidated damages if payment is not made within the required time frame. This issue also was identified in the CY 2015 SPR.

As evidence of the establishment of an online account with the IRO and successful uploading capabilities, ACC submitted an email from the IRO requesting upload of case documentation and a final determination letter from the IRO relating to the case.

In order to receive a finding of met in the CY 2017 review, ACC must revise the Provider Payment Appeal Process Policy to eliminate language relating to provider payment that appears to imply that MDH (MDH) will deduct the amount from the MCO's future Medicaid payments in the event the IRO overturns the MCO's determination.

PPMCO Opportunities/CAPs: For Component 7.4 e, in the CY 2015 SPR, findings noted that in order to receive a finding of met in the CY 2016 SPR PPMCO was required to demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations. There was no evidence that the CAP was successfully implemented and continued opportunities for improvement existed.

No reports were submitted documenting determination and notification compliance results throughout CY 2016. The only documentation submitted was an updated CAP through September 2016.

Subsequent to the initial submission, PPMCO provided additional documentation of compliance results. Aggregate results were provided for CY 2016, which does not meet the requirement for no less than quarterly reporting of results. Additionally, results for this time frame did not meet the 95% compliance threshold. Compliance with determination time frames for urgent pre-service was reported as 46.03%, and 20.23% for non-urgent pre-service. Timeliness of notifications was reported as 100% for urgent pre-service and 99.69% for non-urgent pre-service.

In order to receive a finding of met in the CY 2017 review, PPMCO must demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations. Compliance results must be reported on at least a quarterly basis.

For Component 7.4 f, in the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, PPMCO was required to demonstrate compliance with State required time frames for appeal resolution or MCO time frames if more stringent. The CAP was partially implemented and continued opportunities for improvement existed.

The September Quarterly Update to the CAP for this component reported YTD compliance with appeal resolution time frames. Compliance with the resolution time frame for non-urgent appeals was documented as 98.2%. Compliance with expedited time frames was documented as 86.0%.

Subsequent to the initial submission, PPMCO provided additional documentation to demonstrate compliance. The Appeals Monthly Reporting Master document reported compliance with PPMCO's standard of 15 calendar days for non-urgent pre-service appeals at 98.1% overall with monthly results ranging from 95.4% to 99.5%. Compliance with PPMCO's standard of 36 hours (1 calendar day) for expedited pre-service appeals was reported as 86.7% overall with monthly results ranging from 71.4% to 100%.

In order to receive a finding of met in the CY 2017 review, PPMCO must demonstrate compliance with time frames for non-urgent and expedited appeals consistent with regulatory requirements or the time frames specified in their internal policies if more stringent.

UHC Opportunities/CAPs: For Component 7.4 e, in the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, UHC was required to consistently demonstrate compliance with regulatory time frames for medical and pharmacy preservice determination and notifications. The CAP that was developed was only partially implemented and continued opportunities for improvement existed.

UHC provided separate tracking of compliance with determination and notification time frames for medical and pharmacy, by month, from January through October 2016. There were no requests which required additional clinical information; therefore compliance percentages were not reported for the seven calendar day time frame. Results are detailed for each area below.

In reviewing the PA medical TAT Compliance Report for 2016, compliance was reported as follows:

- Expedited determinations – 8 out of 10 months exceeded the 95% compliance threshold.
- Routine determinations within 2 business days – 9 out of 10 months met or exceeded the 95% threshold.
- Routine determinations within 7 calendar days – all 10 months exceeded the 95% compliance threshold.
- Written notification within 24 hours – 5 out of 10 months exceeded the 95% threshold and were at 100%; outlier months ranged from 67% to 75%.
- Written notification within 72 hours – 3 out of 10 months met or exceeded the 95% compliance threshold; outlier months ranged from 84% to 94%.

In reviewing the PA pharmacy TAT Compliance Report for 2016, compliance was reported as follows:

- Expedited determinations – all 10 months demonstrated 100% compliance.
- Routine determinations within 2 business days – all 10 months exceeded the 95% compliance threshold.
- Written notification within 24 hours – all 10 months exceeded the 95% compliance threshold (8 months at 100%).
- Written notification within 72 hours – all 10 months demonstrated 100% compliance.

UHC provided a CAP to address missed TAT compliance for letters which included actions and time frames for remediation.

Subsequent to the initial submission, UHC provided additional documentation; however, it did not provide any additional support to demonstrate compliance with regulatory time frames during CY 2016.

In order to receive a finding of met in the CY 2017 review, UHC must consistently demonstrate compliance with regulatory time frames for medical and pharmacy preservice determination and notifications at the 95% threshold.

For Component 7.7, in the CY 2015 SPR, findings noted that in order to receive a finding of met in the CY 2016 SPR, UHC was required to demonstrate that the Independent Review Organization Policy includes all required components. Continued opportunities exist for demonstrating compliance with the requirements of this element.

As evidence of compliance with this element, the MCO submitted the Independent Review Organization Policy, revised December 1, 2015. As noted in the CY 2015 SPR, missing content includes the following MCO responsibilities:

- The requirement to establish an online account with the IRO and provide all required information through this account
- Upload the complete case record for each medical case review request within five business days of receipt of the request from the IRO
- Upload any additional case-related documentation requested by the IRO within two business days of receipt of notification of a request for additional information from the IRO
- Agree to pay the fixed case fee should the IRO rule against the MCO
- Acknowledge that MDH will deduct the fixed case rate amount from the MCO's future Medicaid payments plus liquidated damaged according to the published schedule in the event the MCO does not pay the Contractor within 60 days of the release of the invoice
- Acknowledge that if the MCO receives an adverse decision from the Contractor it may file an appeal in accordance with COMAR 10.09.72.06.

As evidence of an executed agreement and compliance with IRO requirements UHC submitted a screenshot of the Active UHC Account on the IRO site showing the status and decision of specific UHC cases.

Subsequent to the initial submission, UHC submitted the MD Independent Review Organization Standard Operating Procedure which includes the time frames for submission of the case record and response to any additional documentation requests from the IRO. UHC also resubmitted the

Independent Review Organization Policy with the same revision date as initially submitted and the same missing requirements.

In order to receive a finding of met in the CY 2017 review, UHC must demonstrate that it has a policy that includes all required components for supporting the IRO complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO.

UMHP Opportunities/CAPs: For Component 7.4 e, in the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, UMHP was required to demonstrate 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, MCO documents needed to be revised to reflect the regulatory time frames. Opportunities continue to exist to demonstrate compliance with regulatory time frames for pre-service determinations and adverse determination notifications and correct documentation of COMAR requirements within the MCO's policy.

The Turnaround Time Report Desktop Procedure outlines the process for monitoring compliance with determination and notification time frames through the Turnaround Time Report, the report fields, the compliance threshold, committee reporting, and the process for addressing opportunities for improvements. The MCO provided a sample Turnaround Time Report from October 2016, which demonstrated 93.37% compliance with the determination time frame, which is below the 95% threshold, and 97.65% compliance with notification time frames. The MCO did not submit the UM Program Structure and Processes Policy which was required to be revised to reflect notification time frames consistent with COMAR.

Subsequent to the initial submission UMHP provided additional documentation to demonstrate compliance. The UM Program Structure Policy includes a table specifying time frames for UM determinations and notifications. For non-urgent pre-service requests determination and notification time frames are consistent with regulatory requirements. For urgent pre-service requests the policy states that a notification is mailed to a member within 24 hours of the decision...and no later than 72 hours of receipt of the request. This is inconsistent with the regulatory requirement of 24 hours from the determination.

Consistent with the CAP requirements, compliance results were reported for fourth quarter 2016. The Turnaround Time Report for Q4 2016 Determinations included an overall compliance rate for the months of October, November, and December. Additional detail was provided reflecting inclusion of urgent concurrent and post service compliance results which are outside of the scope of this review. Non-urgent pre-service addressed the two business day requirement. Compliance results for the two

business day requirement ranged from 83% to 92%. No results were identified for non-urgent pre-service requests which required additional clinical information. Compliance results for urgent pre-service requests ranged from 36% to 50%.

The Turnaround Time Report Q4 2016 Notifications included overall compliance results for the quarter and a breakdown which included urgent concurrent and post-service requests which are outside of the scope of this review. Compliance results for urgent pre-service was reported as 100% within two business days for the quarter. This time frame is inconsistent with the regulatory requirement of 24 hours from the determination. Compliance with non-urgent pre-service notification requirements was reported as 99.89% within two business days however, this is inconsistent with the regulatory requirement of 72 hours.

In order to receive a finding of met in the CY 2017 review, UMHP must demonstrate that it meets the 95% compliance threshold for determination and adverse determination notification time frames consistent with regulatory requirements on at least a quarterly basis. Additionally, the UM Program Structure and Processes Policy must be revised to demonstrate that the incorrect urgent pre-service notification time frame has been corrected to be in compliance with COMAR requirements.

For Component 7.6 c, in the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, UMHP was required to demonstrate that the MCO acts upon UM related issues as a result of review of CAHPS® and Provider Satisfaction Survey results. As indicated below, the CAP was partially implemented.

According to the approved CAP submitted by UMHP in response to the CY 2015 findings, the CAHPS® Workgroup presented its proposed UM process interventions to the QIC on June 21, 2016, the QIC approved the interventions, and was to monitor progress at future meetings including September 20, 2016, and December 20, 2016. In reviewing the QIC minutes from the June 21, 2016, QIC meeting, it was noted that development and implementation of UM related interventions to address CAHPS®/Provider Satisfaction scores was deferred to the third quarter QIC meeting. In reviewing the draft minutes from that meeting held on September 20, 2016, and a slide from the Third Quarter Quality QIC Presentation, UM related interventions included a planned provider newsletter to include an article about what is required when submitting a formulary exception request and implementation of provider portal improvements. The minutes also mentioned a UM Satisfaction QIA. This March 2016 document included practitioner and member-related interventions with completion dates. There was no evidence that this QIA was presented to the QIC prior to the September 20, 2016, meeting.

In order to receive a finding of met in the CY 2017 review, UMHP must demonstrate that quarterly updates to the QIC are provided on the status of UM related interventions consistent with the approved

CAP. Interventions should be implemented timely to have an impact on the scores in the next round of CAHPS® and Provider Satisfaction surveys.

For Component 7.7, The Provider Appeals - IRO Request Policy was submitted which documents all required elements including establishment of an online account with the IRO, time frames for uploading requested case records, time frames for reimbursing the provider in the event of an overturn by the IRO, and the consequences in the event the MCO does not pay the fixed case fee if the IRO rules against the MCO. The policy also acknowledges the MCO's right to file an appeal in the event it receives an adverse decision from the IRO.

As evidence of compliance with IRO requests for case records, the MCO submitted an IRO online account screenshot that included requested date and received file date for several cases and the status of review.

In order to receive a finding of met in the CY 2017 review, UMHP must correct the apparent typo in its Provider Appeals-IRO Request Policy which states that any additional case-related documentation requested will be uploaded by the IRO rather than the MCO.

FOLLOW-UP:

- ACC, PPMCO, UHC, and UMHP were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- ACC (7.4d), PPMCO (7.4e and 7.4f), UHC (7.4e), and UMHP (7.4e and 7.6c) will provide quarterly updates on the CAPs for Standard 7 to Qlarant in adherence with MDH's Quarterly Monitoring Policy.
- The approved CAPs will be reviewed in CY 2017.

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

- All member letters were written in plain language and easily understandable. A best practice is the inclusion of information on the availability of an ACC case manager to help the member explore other options like services in the community that may be free or of little cost to the member if the services they requested exceeded the benefit limits.

Jai Medical Systems

- All member letters were written in plain language to facilitate member understanding. Additional information required for reconsideration was very clear in all letters reviewed.

Kaiser Permanente of the Mid–Atlantic States, Inc.

- All member letters were written in plain language to facilitate member understanding. Additional information required for reconsideration was very clear in all letters reviewed.
- KPMAS has included within the Maryland Medicaid Provider Appeals Procedure Policy a process for identifying improvement opportunities relating to provider appeals and committees and workgroups responsible for tracking and review.

Maryland Physicians Care

- In all 10 records reviewed, MPC notifies the provider of the intent to process the recredentialing application within the same day it is received.

MedStar Family Choice, Inc.

- All member letters were written in plain language to facilitate member understanding. Additional information required for reconsideration was very clear in all letters reviewed.

Priority Partners

- All member letters were written in plain language making them easily understandable for the member.

UnitedHealthcare

- All adverse determination letters were written in plain language and easily understandable for the member.

University of Maryland Health Partners

- UMHP's Health Education Evaluation is comprehensive in scope and provides comparative data such as HealthChoice Aggregate HEDIS® rates and the MCO's prior and current year rates to evaluate the effectiveness of its HEP.

Conclusions

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

This is evident in the comparison of annual SPR results demonstrated throughout the history of HealthChoice.

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. The CY 2016 review provided evidence of the continuing progression of the HealthChoice MCOs to ensure the delivery of quality health care for their enrollees. For example, JMS, MPC, and MSFC received scores of 100% on the annual SPR in CYs 2013-2015 and JMS and MPC continued with perfect scores in the CY 2016 Interim Desktop SPR. Although numerical scores were not provided during this review, vast improvement was seen for each MCO compared to last year's performance scores in the areas of assessment where the MCOs had implemented corrective action as a result of identified opportunities for improvement.

Beginning in CY 2016, MDH now requires that, according to its Quality Monitoring Policy, any MCO that has had a CAP for two or more consecutive years in the same element/component will be required to provide quarterly monitoring reports to Qlarant. Therefore, five MCOs (ACC, KPMAS, PPMCO, UHC and UMHP) are required to submit quarterly updates of their CAPs to Qlarant. Additionally, all CAPs will be reviewed on an annual basis.

Qlarant will conduct an Interim Desktop SPR in CY 2018 and its next comprehensive onsite SPR in CY 2019. To promote continuous quality improvement, MDH and the EQRO may identify areas for focused review.

SECTION II
Value Based Purchasing

Introduction

The Maryland Department of Health (MDH) 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 business and incentives to contractors based on their performance along a range of dimensions. The goal of Maryland's purchasing strategy is to achieve better enrollee health through improved 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).

MDH contracted with Qlarant and MetaStar, Inc. (MetaStar), a NCQA–Licensed Organization, to perform a validation of the CY 2016 VBP measurement data. Validation is the process by which an independent entity evaluates the accuracy of reported performance measure data and determines the extent to which specific performance measure calculations followed established specifications. A validation (or audit) determination is assigned to each measure, indicating whether the result is fully compliant, substantially compliant, or not valid. MetaStar performed the validation of the HEDIS®–based VBP measurement data for all ten of the HealthChoice MCOs using the NCQA's HEDIS® Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures. Qlarant validated the measures developed by MDH and calculated by The Hilltop Institute of University of Maryland Baltimore County (Hilltop).

Performance Measure Selection Process

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

MDH selects measures that are:

1. Relevant to the core populations served by HealthChoice, including children, pregnant women, special needs children, adults with disabilities, and adults with chronic conditions;
2. Prevention–oriented and associated with improved outcomes;
3. Measurable with available data;
4. Comparable to national performance measures for benchmarking;

5. Consistent with how CMS is developing a national set of performance measures for Medicaid MCOs; and
6. Possible for MCOs to affect change.

Value-Based Purchasing Validation

Several sources of measures (Table 3) are included in the CY 2016 VBP program. They are chosen from NCQA's HEDIS® data set, encounter data, and data supplied by the HealthChoice MCOs, and subsequently validated by Qlarant. The measure type and the presence of an existing audit or validation process determined the validation activities undertaken.

Table 3. CY 2016 VBP Measures

Performance Measure	Domain	Measure	Reporting Entity
Adolescent Well Care	Use of Services	HEDIS®	MCO
Adult BMI Assessment	Effectiveness of Care	HEDIS®	MCO
Ambulatory Care Services for SSI Adults	Access to Care	Encounter Data	MDH
Ambulatory Care Services for SSI Children	Access to Care	Encounter Data	MDH
Breast Cancer Screening	Effectiveness of Care	HEDIS®	MCO
Childhood Immunization Status (Combo 3)	Effectiveness of Care	HEDIS®	MCO
Comprehensive Diabetes Care – HbA1 Testing	Effectiveness of Care	HEDIS®	MCO
Controlling High Blood Pressure	Effectiveness of Care	HEDIS®	MCO
Immunizations for Adolescents (Combo 1)	Effectiveness of Care	HEDIS®	MCO
Lead Screenings for Children Ages 12–23 Months	Effectiveness of Care	Encounter, Lead Registry, & Fee For Service Data	MDH
Medication Management for People with Asthma – Medication Compliance 75%	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® Measures Validation

HealthChoice MCOs are required to produce and report audited HEDIS® data under COMAR 10.09.65.03B(2). Ten of the CY 2016 VBP measures are HEDIS® measures and are validated under the HEDIS® Compliance Audit. The goal of the HEDIS® audit is to ensure accurate, reliable, and publicly reportable data.

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

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

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

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

Table 4. HEDIS® Compliance Audit Designations

Audit Findings	Description	Rate/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 was not required to report the measure.	Not Reportable	NR

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

- Adolescent Well Care
- Adult BMI Assessment
- 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 – Medication Compliance 75%
- Postpartum Care
- Well Child Visits for Children Ages 3–6

EQRO Measures Validation

Three CY 2016 VBP measures were calculated by The Hilltop Institute of University of Maryland Baltimore County (Hilltop), using encounter data submitted by the MCOs, Maryland Department of the Environment's Lead Registry data, and Fee-for-Service data. The measures are:

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

Qlarant validated the measurement data for each of the above VBP measures, including the specifications for each encounter data-based measure, source code to determine algorithmic

compliance with the measure specifications, information regarding the encounter data processing system, and analysis of the encounter data process. Clarifications and corrections to source code were conducted to ensure algorithmic compliance with VBP measure specifications.

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

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

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

Validation Results

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

All of the VBP measures audited by MetaStar were determined to be reportable for all MCOs with the exception of the Controlling High Blood Pressure Medication measure for UMHP.

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

Table 6. EQRO VBP Measure Validation Determinations

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

CY 2016 Incentive/Disincentive Target Setting Methodology

The following target setting methodology has been developed for the CY 2016 VBP measures:

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

CY 2016 Incentive/Disincentive Targets

Table 7 shows the CY 2016 VBP measures and their targets.

Table 7. CY 2016 VBP Measures and Targets

Performance Measure	Data Source	2016 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: ≥ 73% Neutral: 68%–72% 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: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%
Ambulatory Care Services for SSI Adults Ages 21–64 Years: % of SSI adults (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year	Encounter Data	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%
Ambulatory Care Services for SSI Children Ages 0–20 Years: % of SSI children (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year	Encounter Data	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%
Breast Cancer Screening: % of women 50–74 years of age who had a mammogram to screen for breast cancer	HEDIS®	Incentive: ≥ 71% Neutral: 66%–70% Disincentive: ≤ 65%
Childhood Immunization Status (Combo 3): % of children who turned 2 years of age during the measurement year who were continuously enrolled for 12 months immediately preceding their second birthday and who had 4 DTaP, 3 IPV, 1 MMR, 2 H influenza type B, 3 hepatitis B, 1 chicken pox vaccine (VZV), and pneumococcal conjugate by the time period specified and by the child's 2nd birthday	HEDIS®	Incentive: ≥ 82% Neutral: 79%–81% 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: ≥ 92% Neutral: 89%–91% Disincentive: ≤ 88%
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: ≥ 69% Neutral: 63%–68% Disincentive: ≤ 62%
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: ≥ 79% Neutral: 75%–78% Disincentive: ≤ 74%
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: ≥ 69% Neutral: 64%–68% Disincentive: ≤ 63%
Medication Management for People with Asthma – Medication Compliance 75%: % 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: ≥ 42% Neutral: 31%–41% Disincentive: ≤ 30%
Postpartum Care: % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS®	Incentive: ≥ 74% Neutral: 70%–73% Disincentive: ≤ 69%
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: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%

2016 Performance Measure Results

The CY 2016 performance results presented in Table 8 were validated by Qlarant and MDH's contracted HEDIS® Compliance Audit™ firm, MetaStar. The contractors determined the validity and the accuracy of the performance measure results. All measures were calculated in a manner that did not introduce bias, allowing the results to be used for public reporting and the VBP program. In CY 2016, all eight HealthChoice MCOs qualified to participate in the initiative:

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

*Formerly Riverside Health of Maryland (RHMD)

Table 8 represents the CY 2016 VBP results for each of the MCOs.

Table 8. MCO CY 2016 VBP Performance Summary

Performance Measure	CY 2015 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
		Incentive (I); Neutral (N); Disincentive (D)							
Adolescent Well Care	Incentive: ≥ 73% Neutral: 68%–72% Disincentive: ≤ 67%	69% (N)	84% (I)	56% (D)	73% (I)	56% (D)	64% (D)	63% (D)	53% (D)
Adult BMI Assessment	Incentive: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%	91% (I)	98% (I)	98% (I)	89% (I)	91% (I)	90% (I)	90% (I)	89% (I)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	82% (D)	90% (I)	68% (D)	84% (N)	81% (D)	85% (N)	79% (D)	78% (D)
Ambulatory Care Services for SSI Children	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%	83% (N)	91% (I)	77% (D)	81% (D)	78% (D)	84% (N)	79% (D)	71% (D)
Breast Cancer Screening	Incentive: ≥ 71% Neutral: 66%–70% Disincentive: ≤ 65%	66% (N)	74% (I)	88% (I)	68% (N)	66% (N)	69% (N)	60% (D)	67% (N)
Childhood Immunization Status (Combo 3)	Incentive: ≥ 82% Neutral: 79%–81% Disincentive: ≤ 78%	83% (I)	88% (I)	70% (D)	79% (N)	82% (I)	83% (I)	78% (D)	79% (N)
Comprehensive Diabetes Care – HbA1c Testing	Incentive: ≥ 92% Neutral: 89%–91% Disincentive: ≤ 88%	85% (D)	95% (I)	93% (I)	89% (N)	92% (I)	89% (N)	86% (D)	83% (D)
Controlling High Blood Pressure	Incentive: ≥ 69% Neutral: 63%–68% Disincentive: ≤ 62%	63% (N)	72% (I)	84% (I)	69% (I)	73% (I)	51% (D)	65% (N)	BR (D)
Immunizations for Adolescents (Combo 1)	Incentive: ≥ 79% Neutral: 75%–78% Disincentive: ≤ 74%	88% (I)	89% (I)	81% (I)	88% (I)	84% (I)	89% (I)	87% (I)	81% (I)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 69% Neutral: 64%–68% Disincentive: ≤ 63%	64% (N)	78% (I)	48% (D)	59% (D)	58% (D)	63% (D)	58% (D)	51% (D)
Medication Management for People with Asthma – Medication Compliance 75%	Incentive: ≥ 42% Neutral: 31%–41% Disincentive: ≤ 30%	21% (D)	52% (I)	28% (D)	38% (N)	25% (D)	25% (D)	28% (D)	31% (N)
Postpartum Care	Incentive: ≥ 74% Neutral: 70%–73% Disincentive: ≤ 69%	74% (I)	81% (I)	84% (I)	67% (D)	71% (N)	71% (N)	71% (N)	71% (N)
Well Child Visits for Children Ages 3–6	Incentive: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%	88% (I)	90% (I)	80% (D)	80% (D)	80% (D)	81% (D)	83% (D)	70% (D)

BR – Biased Rate as reported by the HEDIS vendor.

2016 VBP Financial Incentive/Disincentive Methodology

As described in the Code of Maryland Regulations 10.09.65.03, MDH uses financial incentives and disincentives to promote performance improvement. There are three levels of performance for all measures: incentive, neutral, and disincentive. Financial incentives are earned when performance meets or exceeds the incentive target for a measure. Conversely, disincentives are assessed when performance is at or below the 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 MDH 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 2016 VBP Program.

Table 9. MCO CY 2016 VBP Incentive/Disincentive Amounts

Performance Measure	MCO							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Adolescent Well Care	$0	$151,384.26	($153,603.15)	806,400.09	($284,526.30)	(994,323.72)	($594,996.30)	($134,303.46)
Adult BMI Assessment	837,019.53	$151,384.26	$153,603.15	$806,400.09	$284,526.30	$994,323.72	$594,996.30	$134,303.46
Ambulatory Care Services for SSI Adults	($837,019.53)	$151,384.26	($153,603.15)	$0	($284,526.30)	$0	($594,996.30)	($134,303.46)
Ambulatory Care Services for SSI Children	$0	$151,384.26	($153,603.15)	($806,400.09)	($284,526.30)	$0	($594,996.30)	($134,303.46)
Breast Cancer Screening	$0	$151,384.26	$153,603.15	$0	$0	$0	($594,996.30)	$0
Childhood Immunization Status (Combo 3)	$837,019.53	$151,384.26	($153,603.15)	$0	$284,526.30	$994,323.72	($594,996.30)	$0
Comprehensive Diabetes Care – HbA1c Testing	($837,019.53)	$151,384.26	$153,603.15	$0	$284,526.30	$0	($594,996.30)	($134,303.46)
Controlling High Blood Pressure	$0	$151,384.26	$153,603.15	$806,400.09	$284,526.30	($994,323.72)	$0	($134,303.46)
Immunizations for Adolescents (Combo 1)	$837,019.53	$151,384.26	$153,603.15	$806,400.09	$284,526.30	$994,323.72	$594,996.30	$134,303.46
Lead Screenings for Children Ages 12–23 Months	$0	$151,384.26	($153,603.15)	($806,400.09)	($284,526.30)	($994,323.72)	($594,996.30)	($134,303.46)
Medication Management for People with Asthma – Medication Compliance 75%	($837,019.53)	$151,384.26	($153,603.15)	$0	($284,526.30)	($994,323.72)	($594,996.30)	$0
Postpartum Care	$837,019.53	$151,384.26	$153,603.15	($806,400.09)	$0	$0	$0	$0
Well Child Visits for Children Ages 3–6	$837,019.53	$151,384.26	($153,603.15)	($806,400.09)	($284,526.30)	($994,323.72)	($594,996.30)	($134,303.46)
Total Incentive/ Disincentive Amount	$1,674,039.07	$1,967,995.36	($153,603.15)	$0	($284,526.30)	($1,988,647.44)	($4,164,974.07)	($671,517.29)

SECTION III
Performance Improvement Projects

Introduction

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

HealthChoice MCOs conduct two PIPs annually. As designated by MDH, the MCOs continued the Controlling High Blood Pressure PIP. The Asthma Medication Ratio PIP replaced the Adolescent Well Care PIP in 2017. This report summarizes the findings from the validation of both PIPs. The MCOs who conducted PIPs in 2017 were:

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

*KPMAS completed its first full year of operation in CY 2015 and was able to begin providing data and participating in the Asthma Medication Ratio PIP in CY 2017 (MY 2016).

**Formerly Riverside Health of Maryland (RHMD)

PIP Purpose and Objectives

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

intervention development are transferable to other projects that can lead to improvement in other health areas.

Topics Selected

MDH initiated the Asthma Medication Ratio PIP in February 2017 using HEDIS® 2017 measurement rates as the baseline measurement for MCOs in developing interventions due September 30, 2017. The measure seeks to increase the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Asthma is a chronic lung disease that affects Marylanders regardless of age, sex, race, or ethnicity. Although the exact cause of asthma is unknown and it cannot be cured, it can be controlled with self-management, education, appropriate medical care, and avoiding exposure to environmental triggers. In Maryland, asthma results in millions of dollars in health care costs — costs that are largely preventable through an evidence-based, public health approach to asthma control. Maryland's Asthma Control Program and its partners have demonstrated success through an evidence-based, public health approach to asthma control by focusing on communities with the greatest needs.

MDH initiated the 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 artery 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 diseases.

Validation Process

The guidelines utilized for PIP review activities were CMS' *External Quality Review Protocol 3: Validating Performance Improvement Projects.* The tool assists in evaluating whether 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. Annual PIP submissions were required by September 30th. The annual submissions included results of measurement activities, a status report of intervention implementations, analysis of the measurement results using the defined data analysis plan, as well as information concerning any modifications to (or removal of) intervention strategies that may not be yielding anticipated improvement. If an MCO

decided to modify other portions of the project, updates to the submissions were permitted in consultation with Qlarant and the Department.

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

Table 10. 10–Step Validation Methodology to PIP Validation

Validation Steps	Qlarant's Validation Process
Step 1. The **study topic** selected must be appropriate and relevant to the MCO's population.	Review the study topic/project rationale and look for demographic characteristics, prevalence of disease, and potential consequences (risks) of disease. MCO–specific data should support the study topic.
Step 2. The **study question(s)** must be clear, simple, and answerable.	Identify a study question that addresses the topic and relates to the indicators.
Step 3. The **study indicator(s)** must be meaningful, clearly defined, and measurable.	Examine each project indicator to ensure appropriateness to the activity. Numerators/denominators and project goals should be clearly defined.
Step 4. The **study population** must reflect all individuals to whom the study questions and indicators are relevant.	Examine the study population (targeted population) relevancy, which is provided in the project rationale and indicator statements.
Step 5. The **sampling method** must be valid and protect against bias.	Assess the techniques used to provide valid and reliable information.
Step 6. The **data collection procedures** must use a systematic method of collecting valid and reliable data representing the entire study population.	Review the project data sources and collection methodologies, which should capture the entire study population.
Step 7. The **improvement strategies**, or interventions, must be reasonable and address barriers on a system level.	Assess each intervention to ensure project barriers are addressed. Interventions are expected to be multi–faceted and induce permanent change. Interventions should demonstrate consideration of cultural and linguistic differences within the targeted population.

Validation Steps	Qlarant's Validation Process
Step 8. The **study findings**, or results, must 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 must be assessed as **real improvement**.	Assess performance improvement to ensure the same methodology is repeated. Improvement should be linked to interventions, as opposed to an unrelated occurrence. Review statistical testing results.
Step 10. Sustained improvement must be demonstrated through repeated measurements.	Review the results after the second re–measurement to determine consistent and sustained improvement when compared to baseline.

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

Table 11. Rating Scale for PIP Validation

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

Results

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

Asthma Medication Ratio PIPs

All Asthma Medication Ratio PIPs focused on increasing the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total

asthma medications of 0.50 or greater during the measurement year, according to HEDIS® technical specifications.

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

Table 12. Asthma Medication Ratio PIP Validation Results for CY 2017

Step/Description	Asthma Medication Ratio CY 2017 PIP Review Determinations							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1. Assess the Study Methodology	M	M	M	M	M	M	M	M
2. Review the Study Question(s)	M	M	M	M	M	M	M	M
3. Review the Selected Study Indicator(s)	M	M	M	M	M	M	M	M
4. Review the Identified Study Population	M	M	M	M	M	M	M	M
5. Review Sampling Methods	NA	NA	NA	NA	NA	NA	NA	NA
6. Review Data Collection Procedures	M	M	M	M	M	M	M	M
7. Assess Improvement Strategies	M	M	M	M	M	PM	M	PM
8. Review Data Analysis & Interpretation of Study Results	PM	M	M	M	PM	M	M	M
9. Assess Whether Improvement is Real Improvement	NA	NA	NA	NA	NA	NA	NA	NA
10. Assess Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA

M-Met; PM-Partially Met; U-Unmet; NA-Not Applicable

All MCOs received a rating of "Not Applicable" for Step 5 (Review Sampling Methods) because the entire study population was included.

Two MCOs (PPMCO and UMHP) received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies) because member interventions did not address cultural differences. Additionally, PPMCO's barrier analysis was limited primarily to a literature review and interventions were not robust enough and not always linked to an identified barrier. UMHP's member interventions were too narrowly focused.

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

All MCOs received a rating of "Not Applicable" for Step 9 (Assess Whether Improvement is Real Improvement) because CY 2016 was the baseline measurement year; indicator improvement will be assessed in subsequent years.

All MCOs received a rating of "Not Applicable" for Step 10 (Assess Sustained Improvement) because two remeasurements are required before sustained improvement can be determined.

Asthma Medication Ratio PIP Identified Barriers

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

Member Barriers:

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

Provider Barriers:

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

MCO Barriers:

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

Asthma Medication Ratio Interventions Implemented

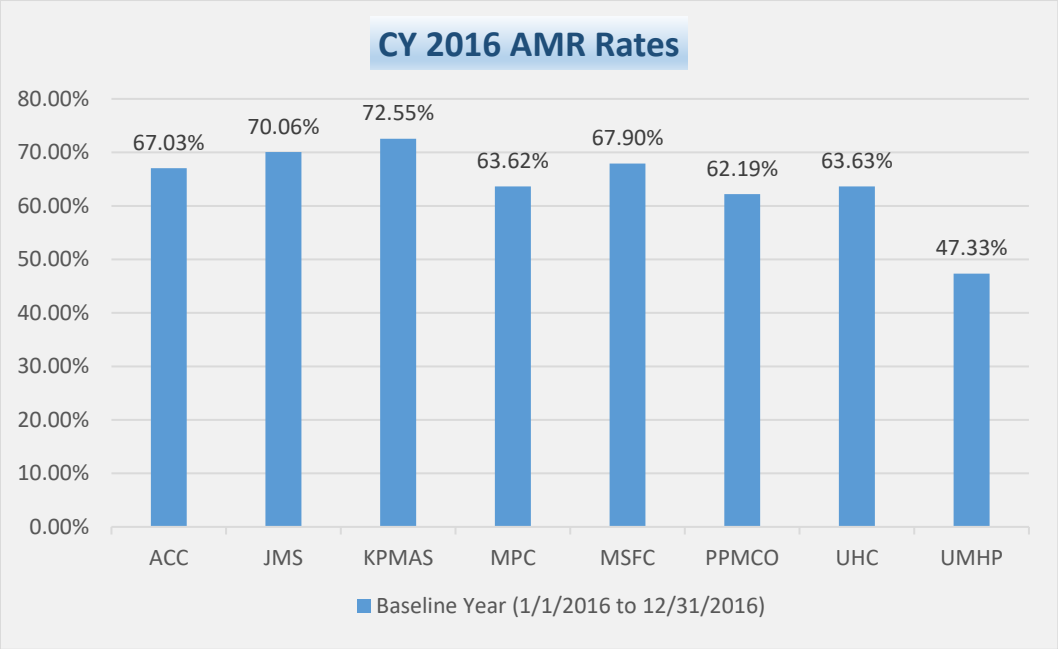
The following are examples of interventions which are being implemented by the HealthChoice MCOs for the Asthma Medication Ratio PIPs:

- Member education and outreach including targeting members who meet specific criteria.
- Use of CRISP data (Chesapeake Regional Information System) by MCOs and providers to identify and target members with emergency department usage.
- Disease/case management.
- Provider education.
- Provider care opportunity reports.
- Electronic medical record supplemental data from high volume provider sites.
- Transportation for office appointments and prescription needs; pharmacy delivery of prescriptions.
- Transitional care coordination to facilitate PCP follow-up after emergency department visit.
- Required review of member demographics upon each member contact.
- Asthma Adherence Monitoring Program through retail pharmacists.
- Onsite appointment scheduling.
- Chart review/patient assessment/recommended interventions by allergist of pediatric patients discharged from emergency department or hospital for asthma.
- Creation of an electronic medical record tool to require decision-making/chart review before refilling rescue medications.

Asthma Medication Ratio Indicator Results

This is the baseline measurement year for the Asthma Medication Ratio PIP. Figure 1 represents the indicator rates for all MCOs for the PIP.

Figure 1. Asthma Medication Ratio PIP Indicator Rates



There is wide variation among the MCOs in the baseline rates relative to the 2017 HEDIS® Medicaid benchmark at the 90th percentile. One MCO (KPMAS) exceeds this benchmark for the AMR rate. Three MCOs (ACC, JMS and MSFC) are performing close to or above the 75th percentile for this measure. Baseline rates for MPC, PPMCO, and UHC are at or above the 50th percentile. UMHP is performing below the 25th percentile.

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 whose blood pressure was adequately controlled during the measurement year. Although the HEDIS measure accounts for ages 18–85 years of age, Maryland HealthChoice covers adults through age 64.

Table 13 represents the CY 2017 Validation Results for all Controlling High Blood Pressure PIPs.

Table 13. Controlling High Blood Pressure PIP Validation Results for CY 2017

Step/Description	Controlling High Blood Pressure CY 2017 PIP Review Determinations						
	ACC	JMS	MPC	MSFC	PPMCO	UHC	UMHP
1. Assess the Study Methodology	M	M	M	M	M	M	M
2. Review the Study Question(s)	M	M	M	M	M	M	M

Step/Description	Controlling High Blood Pressure CY 2017 PIP Review Determinations						
	ACC	JMS	MPC	MSFC	PPMCO	UHC	UMHP
3. Review the Selected Study Indicator(s)	M	M	M	M	M	M	M
4. Review the Identified Study Population	M	M	M	M	M	M	PM
5. Review Sampling Methods	M	M	M	M	M	M	PM
6. Review Data Collection Procedures	M	M	M	M	M	M	PM
7. Assess Improvement Strategies	PM	M	M	M	PM	M	PM
8. Review Data Analysis & Interpretation of Study Results	M	M	M	M	PM	M	PM
9. Assess Whether Improvement Is Real Improvement	M	PM	M	M	PM	M	M
10. Assess Sustained Improvement	M	M	M	M	U	M	NA

M-Met; PM-Partially Met; U-Unmet; NA-Not Applicable

One MCO (UMHP) received a rating of "Partially Met" for Step 4 (Review the Identified Study Population) because its data collection approach included another line of business that was not applicable to the study question.

One MCO (UMHP) received a rating of "Partially Met" for Step 5 (Review Sampling Methods) because of a sampling error that resulted in a biased rate.

One MCO (UMHP) received a rating of "Partially Met" for Step 6 (Review Data Collection Procedures) because it failed again this measurement year to provide information on the staff and personnel collecting the data. Additionally, due to a sampling error, there was an insufficient number of enrollees included in the medical record review.

Three MCOs (ACC, PPMCO, and UMHP) received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies). Two MCOs (PPMCO and UMHP) did not evidence sufficient interventions to improve outcomes in a meaningful way. Additionally, PPMCO did not implement any new interventions in CY 2016. Two MCOs (ACC and UMHP) had broad-based interventions that did not appear to address cultural differences among population subgroups.

Two MCOs (PPMCO and UMHP) received a rating of "Partially Met" for Step 8 (Review Data Analysis & Interpretation of Study Results). Both MCOs' analysis of findings was incomplete based upon their data analysis plan. Most notably, an assessment of the impact or effectiveness of interventions was missing.

Two MCOs (JMS and PPMCO) received a rating of "Partially Met" for Step 9 (Assess Whether Improvement is Real Improvement) because there was no documented quantitative improvement in the rate from the previous measurement year.

One MCO (PPMCO) received a rating of "Unmet" for Step 10 (Assess Sustained Improvement) because it's MY 2016 rate fell below the baseline rate. UMHP received a rating of "Not Applicable" for Step 10 because improvement over baseline could not be determined due to the biased rating received for the HEDIS® measure.

Controlling High Blood Pressure PIP Identified Barriers

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

Member Barriers:

- Noncompliance with diet, exercise, and medication regime.
- Noncompliance with follow–up care.
- Lack of transportation for PCP appointments.
- African Americans face more health disparities than Whites for high blood pressure.

Provider Barriers:

- Knowledge deficit of missed opportunities within their patient population (members in need of blood pressure monitoring visits, members with uncontrolled hypertension, members not adhering to prescribed medications).
- Lack of resources for patient follow-up.
- Lack of awareness of current treatment guidelines.
- Lack of awareness of the MCO resources available to assist with member compliance (i.e. member outreach initiatives, available benefits, health education opportunities).

MCO Barriers:

- Insufficient or inaccurate member contact and demographic data.
- Limited line of sight into actual blood pressure readings.
- Controlling Blood Pressure measure has a unique structure that makes it difficult to follow members' progress/needs year-round.

Controlling High Blood Pressure PIP Interventions Implemented

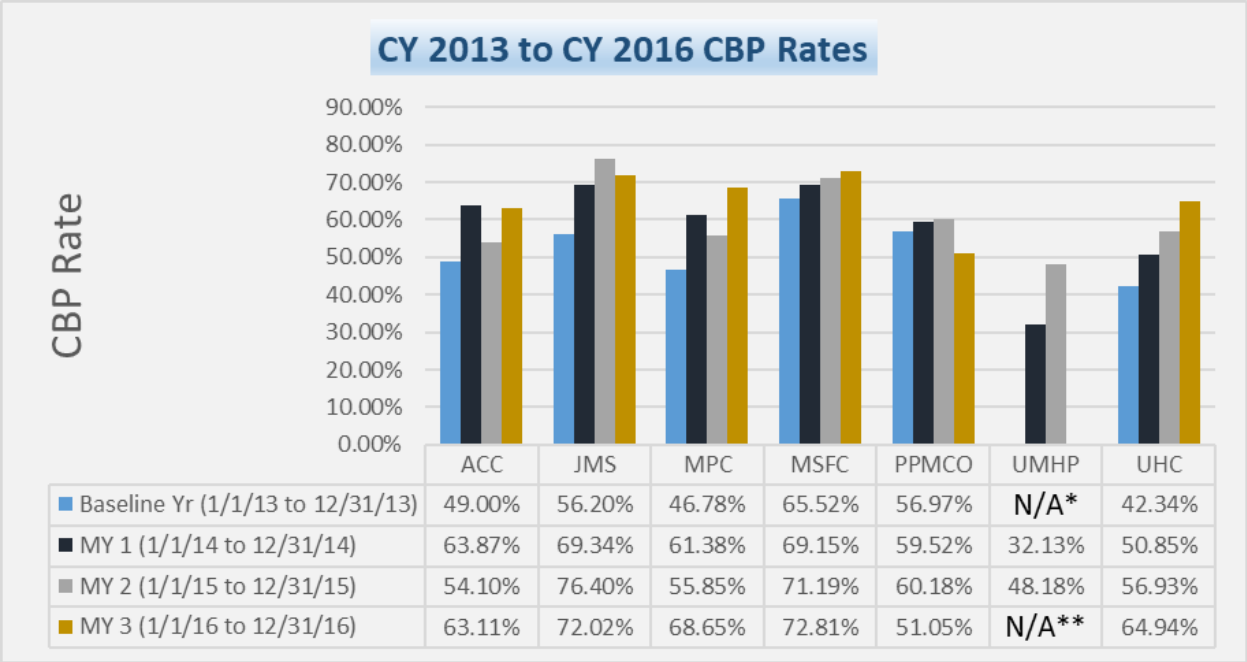
The following are examples of interventions that were implemented by the HealthChoice MCOs for the Controlling High Blood Pressure PIPs:

- Disease Management Programs addressing management of hypertension.
- Onsite appointment scheduling.
- Medication adherence and gaps in therapy reports/letters to PCPs and members.
- Access to blood pressure readings at high volume provider sites.
- Quarterly newsletters to African Americans with high blood pressure.
- Follow up on emergency room encounters to ensure appointments with PCP.
- Member and provider education (i.e. printed materials, individual contact, social media, MCO website).
- Transportation for member PCP appointments.
- Case management.
- Provider incentives for submitting individual member's blood pressure readings.
- PCP home visits.
- Updates to member demographic databased upon review of multiple databases.
- Participation in Health Fairs.
- Member outreach and incentives.
- 90-day medication supply allowance for certain antihypertensive medications.
- Pharmacy Counseling Program.

Controlling High Blood Pressure Indicator Results

This is the third remeasurement year of data collection for the Controlling High Blood Pressure PIP. Figure 2 represents the Controlling High Blood Pressure PIP indicator rates for all MCOs for the PIP.

Figure 2. Controlling High Blood Pressure PIP Indicator Rates



	ACC	JMS	MPC	MSFC	PPMCO	UMHP	UHC
Baseline Yr (1/1/13 to 12/31/13)	49.00%	56.20%	46.78%	65.52%	56.97%	N/A*	42.34%
MY 1 (1/1/14 to 12/31/14)	63.87%	69.34%	61.38%	69.15%	59.52%	32.13%	50.85%
MY 2 (1/1/15 to 12/31/15)	54.10%	76.40%	55.85%	71.19%	60.18%	48.18%	56.93%
MY 3 (1/1/16 to 12/31/16)	63.11%	72.02%	68.65%	72.81%	51.05%	N/A**	64.94%

N/A* UMHP did not begin collecting data until CY 2014 for this measure.
N/A** In CY 2016 UMHP received a biased rate and was therefore unable to report a valid rate.

There is wide variation among the MCOs in their performance relative to the 2017 HEDIS® Medicaid benchmark at the 90th percentile. Both JMS and MSFC are performing above the 90th percentile. MPC and UHC are performing slightly above the 75th percentile. ACC is performing near the 75th percentile and PPMCO has dropped below the 50th percentile for this measure.

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

- ACC's rate increased by 14.11 percentage points.
- JMS' rate increased by 15.82 percentage points.
- MPC's rate increased by 21.87 percentage points.
- MSFC's rate increased by 7.29 percentage points.
- UHC's rate increased by 22.6 percentage points.

PPMCO experienced a decline of 5.92 percentage points over its baseline measurement. UMHP's performance relative to its baseline measurement could not be determined, because of the biased rate received in CY 2016 for the HEDIS® measure.

Recommendations

Qlarant recommends that the MCOs concentrate efforts on:

- Completing an in-depth annual barrier analysis to identify root causes of suboptimal performance, 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. In particular, increased attention to identifying administrative barriers is recommended.
- Ensuring that interventions address differences among population subgroups, such as differences in health care attitudes and beliefs among various racial/ethnic groups within the MCO's membership.
- Assessing interventions for their effectiveness, and making adjustments where outcomes are unsatisfactory. Consideration should be given to small tests of change to assess intervention effectiveness before implementing across the board.
- Ensuring that data analysis, both quantitative and qualitative, is consistent with the data analysis plan.

Conclusions

All MCOs are required to conduct two PIPs annually. The Controlling High Blood Pressure PIP continued in CY 2017 with CY 2016 results representing the third remeasurement. Seven of the eight MCOs participated in this PIP. KPMAS was not required to participate since its first full year of operation was completed in CY 2015. All eight MCOs are participating in the Asthma Medication Ratio PIP that was initiated in CY 2017. Baseline results were submitted for CY 2016. A separate HEDIS® audit of all PIP indicator results was conducted by an independent NCQA certified organization.

An assessment of the validity and reliability of the PIP study design and results reflects a detailed review of each MCO's PIPs and audited HEDIS® findings and conclusions for the selected indicators. Tables 14 and 15 identify the level of confidence Qlarant has assigned to each MCO's Asthma Medication Ratio and Controlling High Blood Pressure PIPs for CY 2017.

Table 14. CY 2017 Asthma Medication Ratio PIP Results Level of Confidence

Level of Confidence in Reported Results	Indicator 1: Asthma Medication Ratio							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
High Confidence	X	X	X	X	X		X	
Confidence								X
Low Confidence						X		
Reported PIP Results Not Credible								

A low confidence level was assigned to PPMCO's Asthma Medication Ratio PIP as the barriers they identified were limited to a literature review and their interventions were not robust enough, not always linked to an identified barrier, and primarily directed at members. A level of confidence was assigned to UMHP's PIP due to the narrow focus of its member interventions.

Table 15. CY 2017 Controlling High Blood Pressure PIP Results Level of Confidence

Level of Confidence in Reported Results	Indicator 1: Controlling High Blood Pressure						
	ACC	JMS	MPC	MSFC	PPMCO	UHC	UMHP
High Confidence	X	X	X	X		X	
Confidence							
Low Confidence					X		
Reported PIP Results Not Credible							X

The Controlling High Blood Pressure PIP submitted by PPMCO in CY 2017 was assigned a low level of confidence because it did not evidence sufficient interventions to improve outcomes in a meaningful way. Reported results for UMHP's PIP were not credible because HEDIS® audit findings determined the indicator rate to be biased based upon a sampling error and an inadequate sample size.

Section IV
Encounter Data Validation

Introduction

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

Qlarant conducted EDV for the Calendar Year (CY) 2016, which encompassed January 1, 2016 through December 31, 2016. The CY 2016 EDV included the full scope of review included in the CMS EDV protocol, *Validation of Encounter Data Reported by the MCO, Protocol 4, Version 2.0, September 2012.*

Purpose

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

Encounter Data Validation Process

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

- Assessment of health plan information system (IS).
- Analysis of health plan electronic encounter data for 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

- Review of medical records for additional confirmation of findings.

The EDV protocol makes the following assumptions:

- An encounter refers to the electronic record of a service provided to a health plan enrollee by both institutional and non-institutional providers.
- The State specifies the types of encounters (e.g., physician, hospital, dental, vision, laboratory, etc.) for which encounter data are to be provided. In addition, the type of data selected for review (inpatient, outpatient, etc.) is directly proportionate to the total percent of encounter types per calendar year.
- Encounter data is considered "complete" when the data can be used to describe the majority of services that have been provided to Medicaid beneficiaries who are health plan enrollees. HealthChoice required managed care organizations (MCOs) to submit CY 2016 encounter data by June 2017.
- 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.

Encounter Data Validation Review Activities

Qlarant completed the following EDV activities:

Activity 1: Review of State requirements for collection and submission of encounter data.
Activity 2: Review of health plan's capability to produce accurate and complete encounter data.
Activity 3: Analysis of health plan's electronic encounter data for accuracy and completeness.*
Activity 4: Review of medical records for additional confirmation of findings.
Activity 5: Analysis and submission of findings.

* MDH elected not to complete Activity 3 during the CY 2016 EDV activities.

Summary of Findings

Activity 1: Review of State Requirements

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

- DQA's requirements for collection and submission of encounter data by MCOs (specifications in the contracts between the State and the MCO)

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

Results of Activity 1: Review of State Requirements

Qlarant determined the following results regarding Activity 1:

MDH uses an 837 process for the collection and submission of encounter data by MCOs. MDH submitted for review 837 Companion Guides for Dental, Institutional, and Professional Encounters. The 837 Companion Guides include data submission format requirements for MCO use.

MDH does not have a formal "data dictionary" with requirements regarding the types of encounters that must be validated. It is recommended that a document of this type be formally developed by MDH and include a description of the information flow from the MCO to the State, including the role of contractors, if any.

It is also recommended that MDH develop standards for encounter data completeness and accuracy. These standards would include a list and description of edit checks that are built into MDH's MMIS that identify how the system handles data that fail edit checks and the requirements for data submissions.

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

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

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

Review of the ISCA. Qlarant reviewed the MCO's ISCA to determine where the MCO's information systems may be vulnerable to incomplete or inaccurate data capture, integration, storage, or reporting. An MCO may have undergone an assessment of its information systems, (e.g., via the HEDIS® Roadmap as part of a HEDIS® Compliance Audit). Qlarant requested a copy of the most recent Roadmap/ISCA completed as part of the HEDIS audit. Qlarant reviewed the ISCA findings for the following:

1. Information Systems: Data Processing and Procedures
   a. Data Base Management System (DBMS) Type
   b. Programming language
   c. Process for updating the program to meet changes in State requirements
2. Claims/Encounter Processing
   a. Overview of the processing of encounter data submissions
   b. Completeness of the data submitted
   c. Policies/procedures for audits and edits
3. Claims/Encounter System Demonstration
   a. Processes for merging and/or transfer of data
   b. Processes for encounter data handling, logging and processes for adjudication
   c. Audits performed to assure the quality and accuracy of the information and timeliness of processing
   d. Maintenance and updating of provider data
4. Enrollment Data
   a. Verification of claims/encounter data
   b. Frequency of information updates
   c. Management of enrollment/disenrollment information

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

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

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

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

- All MCOs appear to have well managed systems and processes.
- All MCOs use only standard forms and coding schemes.
- All MCOs are capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service.
- All MCOs appear to have information systems and processes capable of producing accurate and complete encounter data.
- Five MCOs (ACC, KPMAS, PPMCO, UHC, and UMHP) process claims and encounters with in-house systems and three MCOs (JMS, MSFC, and MPC) contract with Third Party Administrators for processing claims and encounters.

MCO-specific results pertaining to the ISCA Assessment were provided to the MCOs under separate attachments.

Activity 3: Analysis of MCO's Electronic Encounter Data

MDH elected not to complete Activity 3 for CY 2016 based on requirements set forth in CFR §438.602 specifying that periodic independent audits of the accuracy, truthfulness, and completeness of the encounter data submitted by the MCOs being conducted once every three years. MDH elected to postpone this activity until the CY 2017 or CY 2018 Encounter Data Review.

Activity 4: Medical Record Validation

Medical Record Sampling. Qlarant received a random sample of HealthChoice encounter data for hospital inpatient, outpatient, and physician office (office visit) services that occurred for the review year from The Hilltop Institute of University of Maryland Baltimore County (Hilltop). The sample size used was determined to achieve a 95% confidence interval. Oversampling was used in order to ensure adequate numbers of medical records are received to meet the required sample size. The hospital inpatient and outpatient encounter types were oversampled by 500%, while the office visit encounter types were oversampled by 200% for each MCO.

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

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

Where the diagnosis, procedure, and revenue codes can be substantiated by the medical record, a determination of "yes" or "match" is provided. Conversely, if the medical record cannot support the encounter data, a determination of "no" or "no match" is provided. For inpatient encounters, the medical record reviewers also match the principal diagnosis code to the primary sequenced diagnosis. A maximum of 9 diagnosis codes, 6 procedure codes, and 23 revenue codes were validated per record for the EDV. A definition of EDV terms are provided in Table 16.

Table 16. EDV Definition of Terms

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

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

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

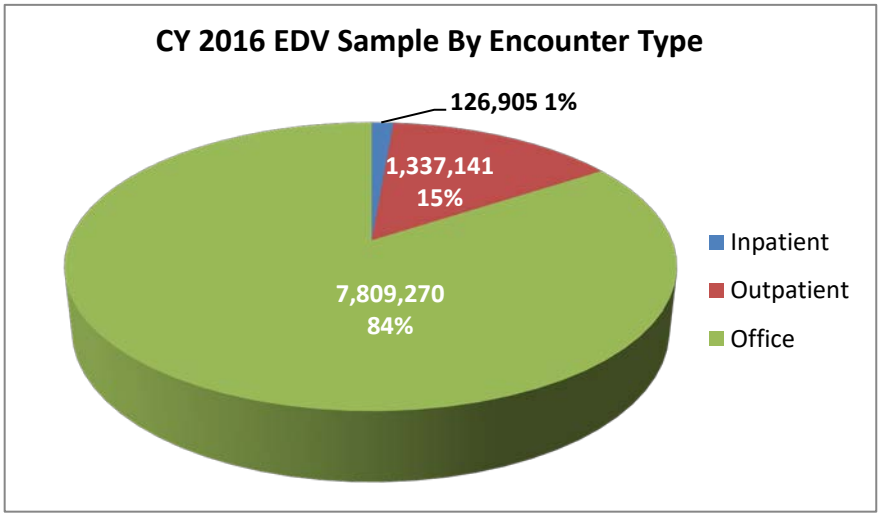
Results of Activity 4: Medical Record Validation

Medical Record Sampling. Qlarant requested and received the CY 2016 random sample of HealthChoice encounter data from The Hilltop Institute of University of Maryland Baltimore County (Hilltop). The samples were drawn by MCO from hospital inpatient, outpatient, and physician office services that

occurred in CY 2016 and were determined to achieve a 95% confidence interval with a 5% margin of error. Oversampling continued in order to ensure adequate numbers of medical records were received to meet the required sample size. The hospital inpatient encounter services were oversampled by 500%, while the hospital outpatient and office visit encounter services were oversampled by 200% per MCO.

A representation of the overall CY 2016 EDV sample by encounter type is demonstrated in Figure 3.

Figure 3. Overall CY 2016 EDV Sample by Encounter Type



The majority of the overall CY 2016 sample was comprised of office visit encounters at 84% (7,809,270 encounters). Outpatient encounters represented almost 15% (1,337,141 encounters) of the sample and inpatient encounters represented 1% (126,905 encounters) of the sample. Similar trends for the random sample by encounter type were seen each year from CY 2014 through CY 2016. Please refer to Table 17 for the distribution of the EDV sample by encounter type from CY 2014 to CY 2016.

Table 17. CY 2014 - CY 2016 EDV Sample by Encounter Type

Encounter Type	CY 2014			CY 2015			CY 2016		
	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size
Inpatient	137,754	1.4%	5	131,129	1.5%	6	126,905	1.4%	42
Outpatient	1,550,736	16.0%	61	1,408,486	15.7%	60	1,337,141	14.4%	458
Office Visit	7,994,529	82.6%	317	7,418,915	82.8%	318	7,809,270	84.2%	2,572
Total	**9,683,019**	**100.0%**	**383**	**8,958,540**	**100.0%**	**384**	**9,273,316**	**100.0%**	**3,072**

The following trends occurred in encounter types in the random sample:

- Inpatient encounters increased by 0.1 percentage point from 1.4% in CY 2014 to 1.5% in CY 2015, and subsequently declined by 0.1 percentage point to 1.4% in CY 2016.

- Outpatient encounters decreased by 0.3 percentage points from 16.0% in CY 2014 to 15.7% in CY 2015, and continued to decline by 1.3 percentage points to a rate of 14.4% for CY 2016.
- Office visits encounters increased slightly by 0.2 percentage points from 82.6% in CY 2014 to 82.8% in CY 2015, and further increased by 1.4 percentage points to a rate of 84.2% in CY 2016.

The following conclusions can be drawn from both the proportionate random sample of encounters and the total population for CY 2016:

- It is the baseline year for collecting data and representing results at an MCO level.
- Samples sizes for all settings increased dramatically and the overall sample was almost ten times larger than the sample drawn in CY 2015 representing all settings proportionately, and to assure reliability.
- Office visit encounters make up the majority of the random sample of encounter data; similar for all three trend years reported.
- Inpatient encounters comprise a very small part of the random sample; similar for all three trend years reported.
- The percentage of inpatient encounters increased slightly by 0.2 percentage points from CY 2014 to CY 2015, and then declined slightly by 0.1 percentage points from CY 2015 to CY 2016.
- The percentage of outpatient encounters decreased slightly by 0.3 percentage points from 2014 to CY 2015, and then declined again by 1.3 percentage points in 2016.
- The percentage of office visit encounters increased slightly by 0.2 percentage points from CY 2014 to CY 2015. Due to sampling at an MCO level, the percentage of office visit encounters was 84.2%, a slight increase of 1.4 percentage points from CY 2015.

Qlarant faxed requests for medical records to the providers of service. Non-responders were contacted by the MCOs to submit the medical records. Minimum samples for all MCOs were reached for the CY 2016 review. Response rates by encounter type are outlined in Table 18.

Table 18. CY 2014 - CY 2016 EDV Medical Record Review Response Rates by Encounter Type

Encounter Type	CY 2014		CY 2015		CY 2016	
	Total Records Received and Reviewed	Sample Size Achieved?	Total Records Received and Reviewed	Sample Size Achieved?	Total Records Received and Reviewed	Sample Size Achieved?
Inpatient	6	Yes	7	Yes	54	Yes
Outpatient	63	Yes	60	Yes	473	Yes
Office Visit	318	Yes	318	Yes	2,584	Yes
Total	**387**		**385**		**3,111**	

Review sample sizes were achieved for each encounter type for all three calendar years. MCO-specific response rates by encounter type are outlined in Table 19.

Table 19. CY 2016 MCO EDV Medical Record Review Response Rates by Encounter Type

MCO	CY 2016								
	Inpatient Records Received and Reviewed	Minimum Reviews Required	Sample Size Achieved?	Outpatient Records Received and Reviewed	Minimum Reviews Required	Sample Size Achieved?	Office Visit Records Received and Reviewed	Minimum Reviews Required	Sample Size Achieved?
ACC	8	4	Yes	50	49	Yes	334	331	Yes
JMS	10	8	Yes	111	110	Yes	270	266	Yes
KPMAS	5	4	Yes	18	18	Yes	362	362	Yes
MPC	7	5	Yes	67	65	Yes	315	314	Yes
MSFC	5	4	Yes	46	44	Yes	337	336	Yes
PPMCO	7	5	Yes	67	62	Yes	318	317	Yes
UHC	6	6	Yes	53	53	Yes	325	325	Yes
UMHP	6	6	Yes	61	57	Yes	323	321	Yes
Total	**54**	**42**	**Yes**	**473**	**458**	**Yes**	**2,584**	**2,572**	**Yes**

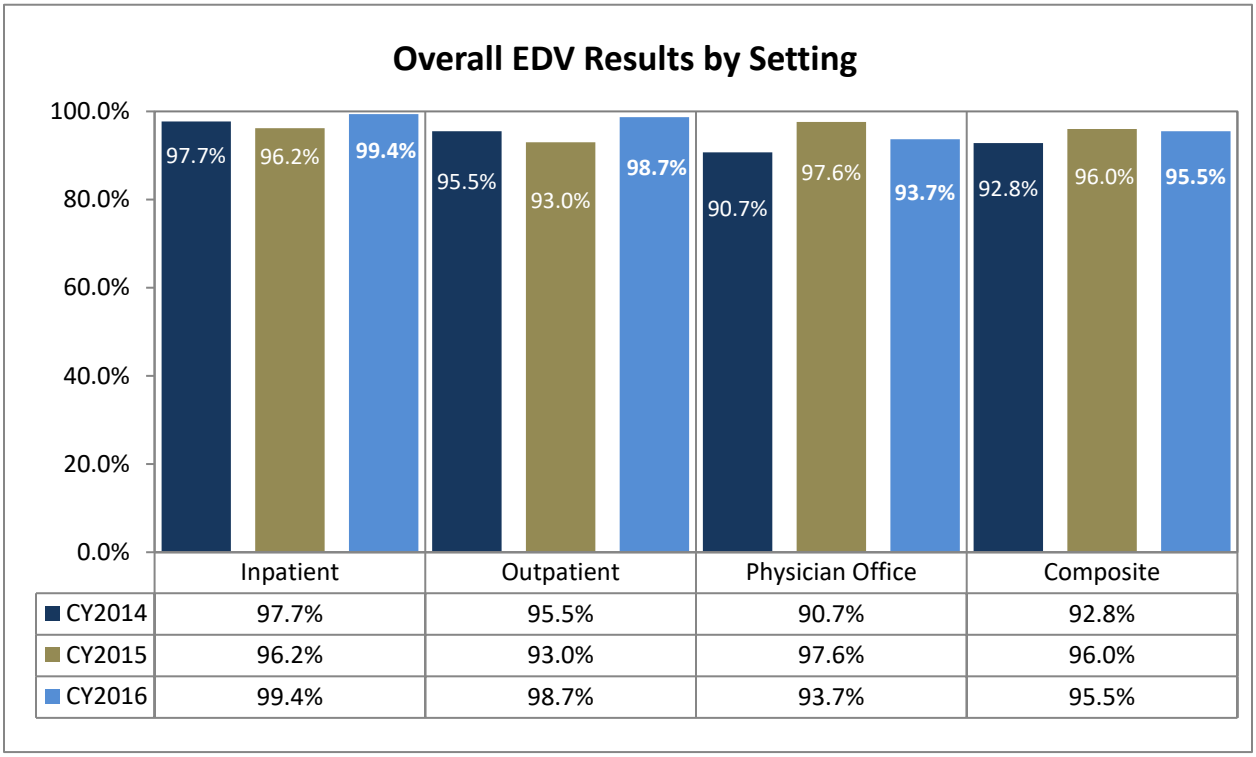
Review sample sizes were achieved for each encounter type for CY 2016 for all MCOs.

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

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

Results. The analysis of the data was organized by review elements including diagnosis, procedure, and revenue codes. A total of 3,111 medical records were reviewed. The overall EDV results for CY 2014 through CY 2016 by encounter type are displayed in Figure 4.

Figure 4. CY 2014 - CY 2016 EDV Results by Encounter Type



The CY 2016 overall match rate was 95.5%, which represents a 0.5 percentage point decline from CY 2015, but remained 2.7 percentage points above the CY 2014 rate of 92.8%. Match rates for both inpatient and outpatient settings increased. The slight decrease in the overall match rate was driven by the decline in the physician office visit rate, representing the majority of reviews completed.

Table 20 provides trending of the EDV records for CY 2014 through CY 2016 by encounter type.

Table 20. CY 2014 – CY 2016 EDV Results by Encounter Type

Encounter Type	Records Received & Reviewed			Total Elements Possible*			Total Matched Elements			Percentage of Matched Elements		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
Inpatient	6	7	54	88	130	1,117	86	125	1,110	97.7%	96.2%	99.4%
Outpatient	63	60	473	601	560	4,448	574	521	4,389	95.5%	93.0%	98.7%
Office Visit	318	318	2,584	1,004	1,067	9,778	911	1,041	9,160	90.7%	97.6%	93.7%
TOTAL	**387**	**385**	**3,111**	**1,693**	**1,757**	**15,343**	**1,571**	**1,687**	**14,659**	**92.8%**	**96.0%**	**95.5%**

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

The overall element match rate declined by 0.5 percentage points from 95.5% in CY 2016 to 96.0% CY 2015, but remains 2.7 percentage points above the CY 2014 match rate of 92.8%.

The inpatient encounter match rate increased by 3.2 percentage points from 96.2% in CY 2015 to 99.4% in CY 2016, after a decline of 1.5 percentage points from 97.7% in CY 2014 to 96.2% in CY 2015.

The outpatient encounter match rate increased by 5.7 percentage points from 93.0% in CY 2015 to 98.7% in CY 2016, after a decline of 2.5 percentage points from 95.5% in CY 2014 to 93.0% in CY 2015.

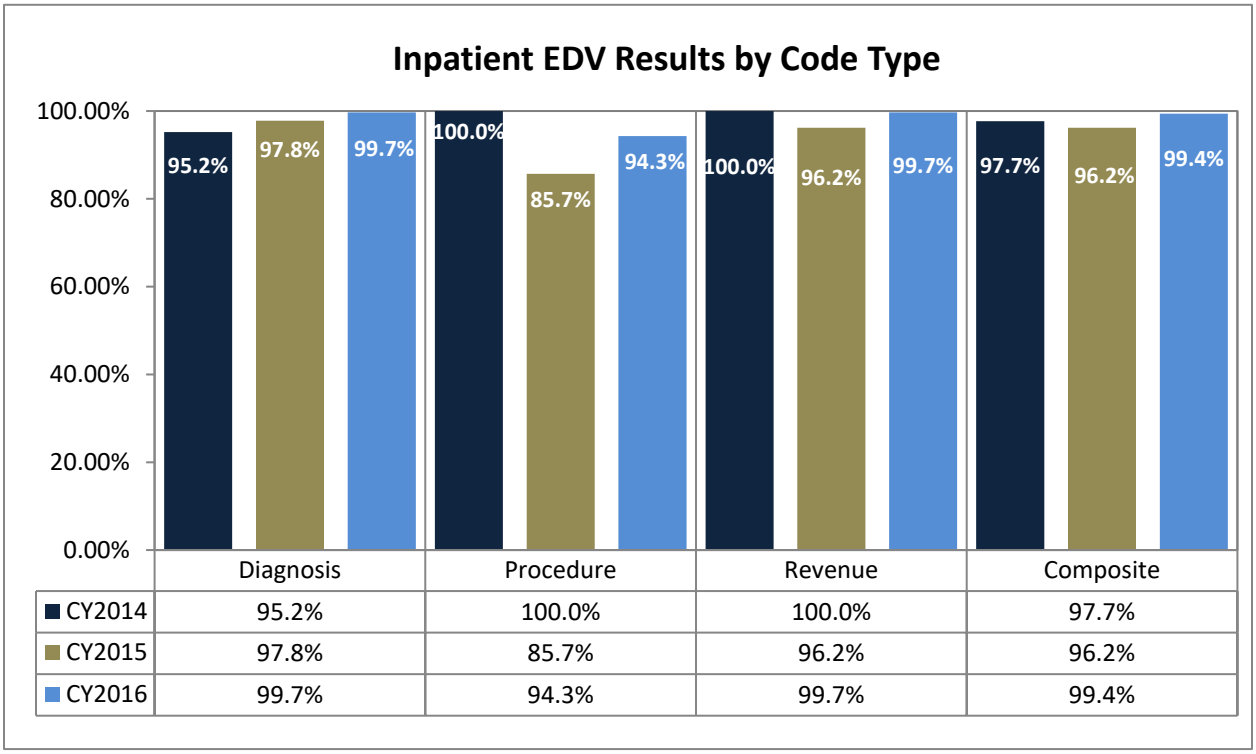
The office visit encounter match rate declined 3.9 percentage points from 97.6% in CY 2015 to 93.7% in CY 2016, but remains 3.0 percentage points above the CY 2014 match rate of 90.7%.

Results by Review Element

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

Inpatient Encounters. The inpatient EDV results by code type for CY 2014 through CY 2016 are displayed in Figure 5.

Figure 5. CY 2014 - CY 2016 Inpatient EDV Results by Code Type



	Diagnosis	Procedure	Revenue	Composite
CY2014	95.2%	100.0%	100.0%	97.7%
CY2015	97.8%	85.7%	96.2%	96.2%
CY2016	99.7%	94.3%	99.7%	99.4%

Overall, the total match rate for inpatient encounters across all code types increased by 3.2 percentage points from 96.2% in CY 2015 to 99.4% in CY 2016. This followed a slight decline in match rates of 1.5 percentage points from CY 2014 to CY 2015, which reflected underlying declines in procedure and

revenue codes. Table 21 provides trending of EDV inpatient encounter type results by code from CY 2014 through CY 2016.

Table 21. CY 2014 – CY 2016 EDV Inpatient Encounter Type Results by Code

Inpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
Match	40	44	367	3	6	66	43	75	677	86	125	1,110
No Match	2	1	1	0	1	4	0	3	2	2	5	7
Total Elements	42	45	368	3	7	70	43	78	679	88	130	1,117
Match Percent	**95.2%**	**97.8%**	**99.7%**	**100%**	**85.7%**	**94.3%**	**100%**	**96.2%**	**99.7%**	**97.7%**	**96.2%**	**99.4%**

The inpatient diagnosis code match rate increased by 1.9 percentage points to 99.7% for CY 2016 after an increase of 2.6 percentage points in CY 2015.

The inpatient procedure code match rate increased by a significant 8.6 percentage points to 94.3% in CY 2016 from the CY 2015 rate of 85.7%. However, the rate still does not meet the peak rate of 100% seen in CY 2014.

The inpatient revenue code match rate increased by 3.5 percentage points to 99.7% in CY 2016 from the CY 2015 rate of 96.2%, almost reaching the rate of 100% attained in CY 2014.

The CY 2016 MCO-specific inpatient results by code type are shown in Table 22.

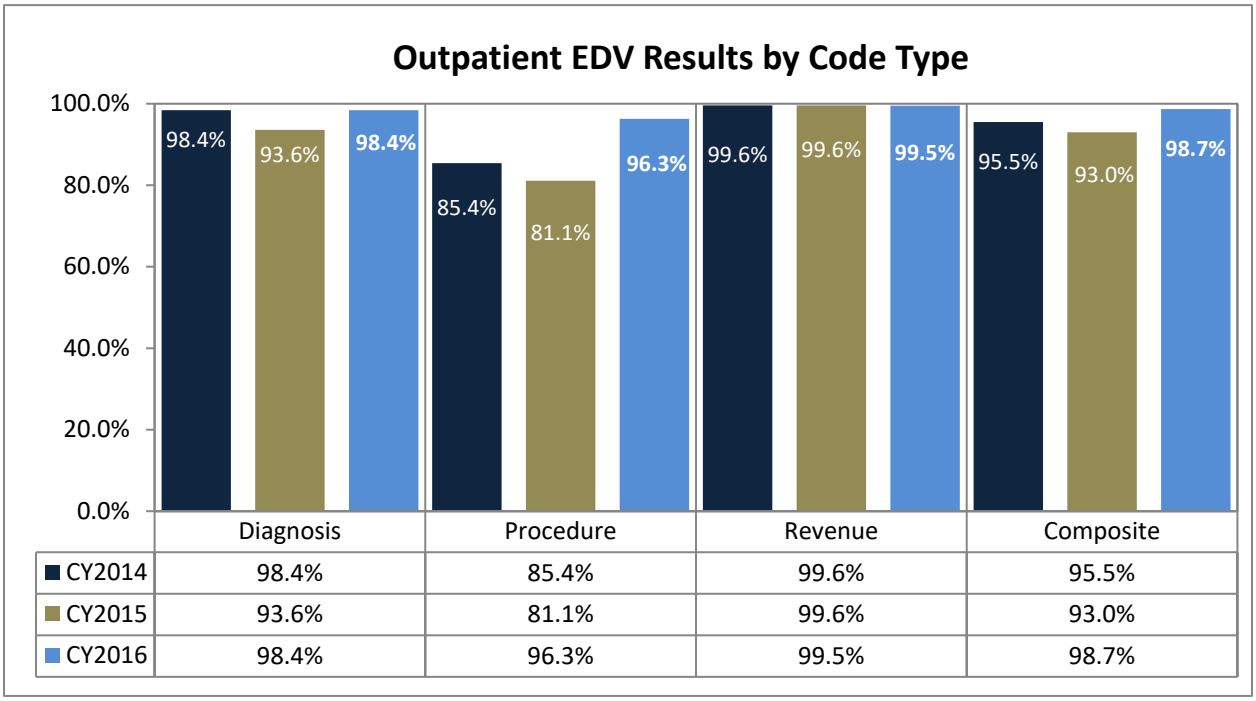
Table 22. MCO Inpatient Results by Code Type

MCO	Reviews Completed	Diagnosis Codes			Procedures Codes			Revenue Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ACC	8	58	58	100%	8	8	100%	113	113	100%	179	179	100%
JMS	10	68	69	99%	11	15	73%	125	125	100%	204	209	98%
KPMAS	5	37	37	100%	7	7	100%	75	75	100%	119	119	100%
MPC	7	50	50	100%	15	15	100%	85	85	100%	150	150	100%
MSFC	5	32	32	100%	6	6	100%	48	49	98%	86	87	99%
PPMCO	7	43	43	100%	8	8	100%	93	93	100	144	144	100%
UHC	6	43	43	100%	NA	NA	NA	84	84	100%	127	127	100%
UMHP	6	36	36	100%	11	11	100%	54	55	98%	101	102	99%

Five out of eight MCOs (ACC, KPMAS, MPC, PPMCO, and UHC) achieved a match rate of 100.0% for inpatient encounters across all code types. Three MCOs (JMS, MSFC, and UMHP) received rates of 98% and above.

Outpatient Encounters. The outpatient EDV results by code type for CY 2014 through CY 2016 are displayed in Figure 6.

Figure 6. CY 2014 - CY 2016 Outpatient EDV Results by Code Type



Overall, the total match rate for outpatient encounters across all code types increased substantially by 5.7 percentage points from 93% in CY 2015 to 98.7% in CY 2016, driven by increases in both diagnosis and procedures code match rates. Table 23 provides trending of EDV outpatient encounter type results by code from CY 2014 through CY 2016.

Table 23. CY 2014 – CY 2016 EDV Outpatient Encounter Type Results by Code

Outpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
Match	182	161	1,436	134	116	626	258	244	2,327	574	521	4,389
No Match	3	11	24	23	27	24	1	1	11	27	39	59
Elements	185	172	1,460	157	143	650	259	245	2,338	601	560	4,448
Match Percent	**98.4%**	**93.6%**	**98.4%**	**85.4%**	**81.1%**	**96.3%**	**99.6%**	**99.6%**	**99.5%**	**95.5%**	**93.0%**	**98.7%**

The CY 2016 outpatient diagnosis code match rate increased by 4.8 percentage points to 98.4% from the CY 2015 rate of 93.6%, bringing it back up to the CY 2014 rate.

Although the outpatient procedure code match rate has consistently had the lowest match rate of all code types for this element, the rate increased substantially by 15.2 percentage points from 81.1% in CY 2015 to 96.3% in CY 2016.

The CY 2016 match rate for outpatient revenue codes decreased 0.1 percentage point to 99.5% in CY 2016 from the CY 2015 and CY 2016 rate of 99.6% in both years.

The CY 2016 MCO-specific outpatient results by code type are shown in Table 24.

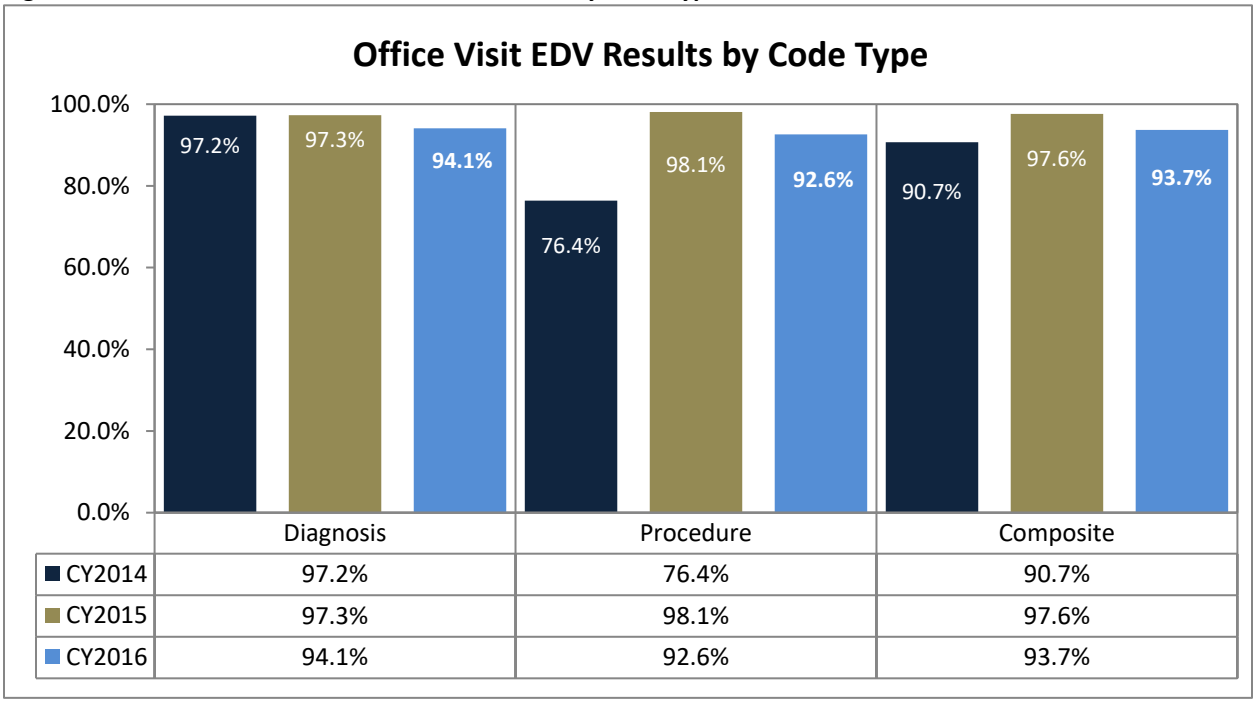
Table 24. MCO Outpatient Results by Code Type

MCO	Reviews Conducted	Diagnosis Codes			Procedures Codes			Revenue Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ACC	50	148	150	98.7%	144	147	98.0%	212	217	97.7%	504	514	98.1%
JMS	111	390	392	99.5%	30	32	93.8%	550	554	99.3%	970	978	99.2%
KPMAS	18	69	69	100%	28	33	84.8%	111	111	100%	208	213	97.7%
MPC	67	146	147	99.3%	194	205	94.6%	319	320	99.7%	659	672	98.1%
MSFC	46	158	169	93.5%	3	4	75.0%	271	271	100%	432	444	97.3%
PPMCO	67	181	182	99.5%	3	3	100%	247	248	99.6%	431	433	99.5%
UHC	53	166	170	97.6%	70	72	97.2%	298	298	100%	534	540	98.9%
UMHP	61	178	181	98.3%	154	154	100%	319	319	100%	651	654	99.5%

MCO-specific total results ranged from 97.3% (MSFC) to 99.5% (PPMCO). Overall, outpatient revenue codes were the highest scoring element with 4 out of 8 MCOs achieving a match rate of 100.0% for this element. The lowest scoring element was procedures codes. Scores ranged from a low of 75% (MSFC) to 100% (PPMCO and UMHP).

Office Visit Encounters. The office visit EDV results by code type for CY 2014 through CY 2016 are displayed in Figure 7.

Figure 7. CY 2014 - CY 2016 Office Visit EDV Results by Code Type



Overall, the office visit match rate decreased 3.9 percentage points to 93.7% in CY 2016 from 97.6% in CY 2015, remaining above the CY 2014 rate of 90.7%. Table 25 provides trending of EDV office visit encounter type results by code from CY 2014 through CY 2016.

Table 25. CY 2014 – CY 2016 EDV Office Visit Encounter Type Results by Code

Office Visit Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
Match	671	729	6,740	240	312	2,420	NA	NA	NA	911	1,041	9,160
No Match	19	20	425	74	6	193	NA	NA	NA	93	26	618
Total Elements	690	749	7,165	314	318	2,613	NA	NA	NA	1,004	1,067	9,778
Match Percent	**97.2%**	**97.3%**	**94.1%**	**76.4%**	**98.1%**	**92.6%**	**NA**	**NA**	**NA**	**90.7%**	**97.6%**	**93.7%**

The diagnosis code match rate declined by 3.2 percentage points from 97.3% in CY 2015 to 94.1% in 2016, falling below the CY 2014 rate of 97.2%.

The procedure code match rate decreased by 5.5 percentage points from 98.1% in CY 2015 to 92.6% in CY 2016, but remaining above the CY 2014 match rate of 76.4%.

Revenue codes are not applicable for office visit encounters.

The CY 2016 MCO-specific office visit rates by code type are shown in Table 26.

Table 26. MCO Office Visit Results by Code Type

MCO	Reviews	Diagnosis Codes			Procedures Codes			Revenue Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ACC	334	793	850	93.3%	308	338	91.1%	NA	NA	NA	1,101	1,188	92.7%
JMS	270	800	855	93.6%	246	268	91.8%	NA	NA	NA	1,046	1,123	93.1%
KPMAS	362	1,001	1,039	96.3%	352	362	97.2%	NA	NA	NA	1,353	1,401	96.6%
MPC	315	781	850	91.9%	289	318	90.9%	NA	NA	NA	1,070	1,168	91.6%
MSFC	337	838	920	91.1%	320	335	95.5%	NA	NA	NA	1,158	1,255	92.3%
PPMCO	318	810	839	96.5%	297	325	91.4%	NA	NA	NA	1,107	1,164	95.1%
UHC	325	852	902	94.5%	306	330	92.7%	NA	NA	NA	1,158	1,232	94.0%
UMHP	323	865	910	95.1%	302	337	89.6%	NA	NA	NA	1,167	1,247	93.6%

MCO-specific results ranged from 91.6% (MPC) to 96.6% (KPMAS). Overall, diagnosis codes yielded the highest scores, ranging from 91.1% (MSFC) to 96.5% (PPMCO). Overall, the lowest scoring element was procedures codes ranging from 89.6% (UMHP) to 97.2% (KPMAS).

"No Match" Results by Element and Reason

Diagnosis Code Element Review. Tables 27 through 29 illustrate the principle reasons for "no match" errors. The reasons for determining a "no match" error for the diagnosis code element were:

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

Table 27. CY 2014 – CY 2016 EDV "No Match" Results for Diagnosis Code Element

"No Match" for Diagnosis Code Element									
Encounter Type	Total Elements			Lack of Medical Record Documentation			Incorrect Principal Diagnosis (Inpatient) or Incorrect Diagnosis Codes		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
Inpatient	2	1	1	2	1	0	0	0	1
% of Total				**100%**	**100%**	**0%**	**0%**	**0%**	**100%**
Outpatient	3	11	24	0	0	11	3	11	13
% of Total				**0%**	**0%**	**45.8%**	**100%**	**100%**	**54.2%**
Office Visit	19	20	425	3	11	217	16	9	208
% of Total				**15.8%**	**55.0%**	**51.1%**	**84.2%**	**45.0%**	**48.9%**

There was one unmatched code for the inpatient diagnosis code element in CY 2016 that was due to an incorrect diagnosis code. In CY 2015, there was one unmatched inpatient diagnosis code element due to a lack of medical record documentation. In CY 2014 there were two unmatched diagnosis codes due to lack of medical record documentation.

There were 24 unmatched outpatient diagnosis code elements in CY 2016. Of those unmatched codes, 11 (45.8%) resulted from a lack of medical record documentation and 13 (54.2%) resulted from incorrect diagnosis codes. For both CY 2015 and CY 2014, all unmatched diagnosis code elements were attributed to incorrect diagnosis codes.

There were 425 unmatched office visit diagnosis code elements in CY 2016. Of those unmatched codes, 217 (51.1%) resulted from a lack of medical record documentation and 208 (48.9%) resulted from incorrect diagnosis codes. In CY 2015, 55% of the unmatched diagnosis code elements were due to a lack of medical record documentation. By contrast, in CY 2014, the majority, 84.2% of unmatched codes resulted from incorrect diagnosis codes.

Procedure Code Element Review. The reasons for determining a "no match" error for the procedure code element were:

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

Table 28. CY 2014 – CY 2016 EDV "No Match" Results for Procedure Code Element

"No Match" for Procedure Code Element									
Encounter Type	Total Elements			Lack of Medical Record Documentation			Incorrect Principal Procedures (Inpatient) or Incorrect Procedures Codes		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
Inpatient	0	3	4	0	3	0	0	0	4
% of Total				**0%**	**100%**	**0%**	**0%**	**0%**	**100%**
Outpatient	23	1	24	3	1	1	20	0	23
% of Total				**13.0%**	**100%**	**4.2%**	**87.0%**	**0**	**95.8%**
Office Visit	74	6	193	2	0	42	72	6	151
% of Total				**2.7%**	**0%**	**21.8%**	**97.3%**	**100%**	**78.2%**

In CY 2016, the four unmatched inpatient procedure code elements were due to incorrect procedure codes. By contrast, for CY 2015 all "no matches" were due to a lack of medical record documentation. There were no errors for inpatient procedures codes in CY 2014.

There was one unmatched outpatient procedure code element for CY 2016 due to a lack of medical record documentation. In CY 2015, 23 of the 24 unmatched outpatient procedure codes resulted from incorrect procedures codes. The majority (87%) of unmatched outpatient procedures codes in CY 2014 were due to incorrect procedures codes.

A trend appears to be shown in the unmatched office visit procedure code element as the majority of office visit errors from CY 2014 to CY 2016 are due to incorrect procedure codes. In CY 2016, the majority (78.2%) of unmatched office visit procedure code errors were the result of incorrect procedures codes. A lack of medical record documentation produced 42 (21.8%) unmatched office visit procedure code errors. In CY 2015, all unmatched office visit procedures codes resulted from incorrect procedures codes. Again in CY 2014, the majority (97.3%) of unmatched office procedure codes resulted from incorrect procedures codes.

Revenue Code Element Review. The reasons for determining a "no match" error for the revenue code element were:

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

Table 29. CY 2014 – CY 2016 EDV "No Match" Results for Revenue Code Element

"No Match" for Revenue Code Element *									
Encounter Type *	Total Elements			Lack of Medical Record Documentation			Incorrect Revenue Code		
	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016	CY 2014	CY 2015	CY 2016
Inpatient	0	3	2	0	3	2	0	0	0
% of Total				**0%**	**100%**	**100%**	**0%**	**0%**	**0%**
Outpatient	1	1	11	1	1	5	0	0	6
% of Total				**100%**	**100%**	**45.5%**	**0%**	**0%**	**54.5%**

***Note – Revenue Codes do not apply to office visit encounters**

In CY 2015 and CY 2016, all unmatched inpatient revenue code elements resulted from a lack of medical record documentation.

In CY 2016, there were 5 (45.5%) unmatched outpatient revenue codes that resulted from a lack of medical record documentation and 6 (54.5%) that resulted from incorrect revenue codes. For both CY 2015 and CY 2014, all unmatched revenue codes were due to a lack of medical record documentation.

Encounter Data Validation Activity 5: EDV Findings

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

Results of Activity 5: EDV Findings

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

The encounter data submitted by the HealthChoice MCOs for CY 2016 can be considered reliable for reporting purposes as the EDV overall match rate was 95.5%. This rate exceeded the recommended match rate standard of 90%, for EDV set by Qlarant. The CY 2016 overall match rate (95.5%) was a slight 0.5 percentage point decrease from the CY 2015 rate of 96%, but remains 2.7 percentage points higher than the CY 2014 match rate.

Although there were significant increases in the overall match rates in CY 2016 for both inpatient and outpatient encounter types, the office visit counter type decreased resulting in a 0.5 percentage point decline in the overall match rate.

In CY 2016, the lack of medical record documentation and incorrect diagnosis codes both contributed to the unmatched diagnosis codes for outpatient and office visit encounters. However, incorrect diagnosis codes alone contributed to the one unmatched diagnosis code for the inpatient encounters.

The majority of unmatched procedure code elements in inpatient, outpatient, and office visit encounters are contributed to incorrect procedure codes for CY 2016.

The majority of unmatched revenue code elements in inpatient encounter types resulted from a lack of medical record documentation in CY 2016. However, for outpatient encounter types, there were both issues with medical record documentation and revenue codes.

MCO-Specific results are outlined below:

AMERIGROUP Community Care

- ACC has information systems in place that produce accurate and complete encounter data.
- ACC uses standard forms and coding schemes that allow for capturing appropriate data elements for claims processing.
- ACC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 100% for all inpatient codes reviewed.
    - 98.1% for all outpatient codes reviewed.
    - 92.7% for all office visit codes reviewed.

Jai Medical Systems, Inc.

- JMS has information systems in place that produce accurate and complete encounter data.
- JMS uses standard forms and coding schemes that allow for capturing appropriate data elements for claims processing.
- JMS achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 98% for all inpatient codes reviewed.
    - 99.2% for all outpatient codes reviewed.
    - 93.1% for all office visit codes reviewed.

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

- KPMAS has information systems in place that produce accurate and complete encounter data.
- KPMAS uses standard forms and coding schemes that allow for capturing appropriate data elements for claims processing.
- KPMAS achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 100% for all inpatient codes reviewed.
    - 97.7% for all outpatient codes reviewed.
    - 96.6% for all office visit codes reviewed.

Maryland Physicians Care:

- MPC has information systems in place that produce accurate and complete encounter data.
- MPC uses standard forms and coding schemes that allow for capturing appropriate data elements for claims processing.
- MPC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 100% for all inpatient codes reviewed.
    - 98.1% for all outpatient codes reviewed.
    - 91.6% for all office visit codes reviewed.

MedStar Family Choice, Inc.:

- MSFC has information systems in place that produce accurate and complete encounter data.
- MSFC uses standard forms and coding schemes that allow for capturing appropriate data elements for claims processing.

- MSFC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 99% for all inpatient codes reviewed.
    - 97.3% for all outpatient codes reviewed.
    - 92.3% for all office visit codes reviewed.

Priority Partners:

- PPMCO has information systems in place that produce accurate and complete encounter data.
- PPMCO uses standard forms and coding schemes that allow for capturing appropriate data elements for claims processing.
- PPMCO achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 100% for all inpatient codes reviewed.
    - 99.5% for all outpatient codes reviewed.
    - 95.1% for all office visit codes reviewed.

UnitedHealthcare Community Plan:

- UHC has information systems in place that produce accurate and complete encounter data.
- UHC uses standard forms and coding schemes that allow for capturing appropriate data elements for claims processing.
- UHC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 100% for all inpatient codes reviewed.
    - 98.9% for all outpatient codes reviewed.
    - 94% for all office visit codes reviewed.

University of Maryland Health Partners:

- UMHP has information systems in place that produce accurate and complete encounter data.
- UMHP uses standard forms and coding schemes that allow for capturing appropriate data elements for claims processing.
- UMHP achieved match rates above the standard of 90% recommended by Qlarant in all areas of review:
    - 99% for inpatient codes reviewed.
    - 99.5% for all outpatient codes reviewed.
    - 93.6% for all office visit codes reviewed.

Corrective Action Plans

For the CY 2016 EDV, there are no corrective action plans required of the HealthChoice MCOs.

Recommendations

Qlarant recommends the following based on the CY 2016 EDV:

- Unmatched rates are due to either incorrect codes or a lack of medical record documentation. The Department, in conjunction with MCOs, may want to caution providers on the use of appropriate codes that reflect what is documented in the medical record.
- MDH should develop a formal "data dictionary" with requirements regarding the types of encounters that must be validated. The data dictionary should include a description of the information flow from the MCO to the State, including the role of contractors, if any.
- MDH should develop standards for encounter data completeness and accuracy. These standards would include a list and description of edit checks that are built into MDH's MMIS that identify how the system handles data that fail edit checks and the requirements for data submissions.
- Given that the results were vastly similar when conducting the EDV statewide in CY 2015 and by MCO in CY 2016, and in an attempt to be consistent with CMS' goals of reducing the burden on both providers and MCOs, the sample should be reduced per MCO to reflect a 90% confidence level with a 5% margin of error. This will continue to ensure valid results.
- 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.
- Communication with provider offices reinforcing the requirement to supply all supporting medical record documentation for the encounter data 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 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the federally mandated Medicaid program for screening, prevention, diagnosis, and treatment of physical and mental health conditions in children and adolescents 0 through 20 years of age (as defined by Omnibus Budget Reconciliation Act [OBRA] 1989). Each State determines its own periodicity schedule for services, including periodic physical and mental health screening, vision, dental, and hearing services.

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

As the Maryland Department of Health's (MDH's) contracted External Quality Review Organization (EQRO), Qlarant Quality Solutions, Inc. (Qlarant) 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 report summarizes the findings from the EPSDT medical record review for Calendar Year (CY) 2016. Approximately 614,356 children were enrolled in the HealthChoice Program during this period. The eight Managed Care Organizations (MCOs) evaluated for CY 2016 were:

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

*Formerly Riverside Health of Maryland (RHMD)

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 a Managed Care Organization (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 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 mg/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 MDH 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 MDH 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 2016 EPSDT Review Process

Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during CY 2016 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 percent confidence level and 5 percent 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 Z00.129 or Z00.00. (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).

Scoring Methodology

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

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

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

Score	Finding
2	Complete
1	Incomplete
0	Missing

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

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

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

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

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

Medical Record Review Process

Medical records were randomly selected in order to assess compliance with the program standards. Nurse reviewers conducted all medical record reviews in the provider offices with the exception of providers with only one child in the sample. These providers were given the option to mail or fax a complete copy of the medical record to Qlarant for review. In total, 3,004 medical records were reviewed for CY 2016.

The review criteria used by Qlarant's review nurses was the same as those developed and used by the Department. Qlarant completed annual training and conducted inter-rater reliability (IRR). HealthChoice nurses participated in the annual training and were consulted during the review. The review nurses achieved an IRR score of 90% prior to the beginning of the CY 2016 EPSDT Medical Record Review and completed a second IRR testing with a score of 90% mid-way through the review.

EPSDT Review Results

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

MCOs met the minimum compliance score of 80% in each of the five component areas for the CY 2016 review. A CAP for the Laboratory Tests/At Risk Screening component was required from one MCO, UHC.

Findings for the CY 2016 EPSDT review by component area are described in Table 30.

Table 30. CY 2016 EPSDT Component Results by MCO

Component	CY 2016 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2014	CY 2015	CY 2016
Health & Developmental History	90%	99%	99%	89%	91%	88%	90%	88%	88%	92%	92%
Comprehensive Physical Examination	95%	99%	99%	93%	97%	94%	94%	94%	93%	93%	96%
Laboratory Tests/At Risk Screenings	85%	99%	93%	82%	82%	82%	78%	82%	76%	78%	85%
Immunizations	85%	88%	85%	84%	86%	88%	82%	85%	83%	84%	85%
Health Education/ Anticipatory Guidance	94%	100%	100%	92%	94%	95%	92%	93%	91%	92%	95%

Underlined scores denote that the minimum compliance score of 75% was unmet for CY 2014, and the 80% minimum compliance score was unmet for CY 2015 and CY 2016.

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, perinatal, 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 31. CY 2016 Health and Developmental History Element Scores

CY 2016 Health and Development History Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Substance Abuse Assessment	93%	100%	100%	88%	86%	79%	80%	82%
Psychosocial History	94%	100%	97%	94%	96%	93%	96%	95%
Mental Health Assessment	94%	100%	100%	95%	94%	92%	93%	95%
Family History	93%	100%	100%	86%	88%	88%	90%	89%
Perinatal History	91%	100%	82%	85%	93%	85%	82%	93%
Health History	97%	100%	100%	96%	98%	97%	98%	98%
Developmental Assessment/History/ Surveillance (0–5 years)	96%	96%	100%	97%	97%	94%	99%	98%
Developmental Assessment/History/ Surveillance (6–20 years)	96%	98%	100%	96%	95%	93%	97%	93%
Developmental Screening Using Standardized Tool at 9, 18, 24–30 Month Visits	79%	100%	97%	84%	86%	75%	88%	84%
Recorded Autism Screening using Standardized Tool	56%	89%	100%	60%	76%	61%	80%	64%
Standardized History Form	86%	100%	100%	84%	94%	89%	90%	77%
Completed CRAFFT Tool-Recommended*	31%	89%	100%	37%	39%	27%	20%	34%
MCO Component Score	**90%**	**99%**	**99%**	**89%**	**91%**	**88%**	**90%**	**88%**

Underlined scores denote that element score is below 80%, which may impact the minimum level compliance score for the component.
*Baseline score for CY 2016.

Health and Developmental History Results

- All MCO scores exceeded the minimum compliance score of 80% for this component for CY 2016.

- The HealthChoice Aggregate score remained at 92% from CY 2015 to CY 2016 after an increase of 4 percentage points from CY 2014 to CY 2015.

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 32. CY 2016 Comprehensive Physical Examination Element Results

CY 2016 Comprehensive Physical Exam Element Results								
Element	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Graphed Height	93%	100%	100%	92%	98%	95%	89%	93%
Measured Height	100%	100%	100%	100%	100%	100%	100%	100%
Graphed Weight	93%	100%	100%	92%	98%	95%	90%	94%
Measured Weight	100%	100%	100%	100%	100%	100%	100%	100%
Graphed Head Circumference	86%	95%	95%	84%	89%	90%	77%	91%
Measured Head Circumference	91%	98%	98%	92%	92%	93%	90%	93%
Measured Blood Pressure	97%	99%	97%	97%	97%	98%	98%	98%
Documentation Of Minimum 5 Systems	99%	96%	100%	98%	99%	98%	98%	96%
Assessed Hearing	94%	99%	100%	94%	96%	93%	94%	93%
Assessed Vision	96%	99%	100%	94%	95%	93%	95%	94%
Assessed Nutritional Status	85%	94%	97%	78%	88%	80%	85%	80%
Conducted Oral Screening	97%	99%	100%	97%	97%	98%	96%	96%
Calculated BMI (2yrs and older)	94%	100%	100%	95%	99%	96%	97%	96%

CY 2016 Comprehensive Physical Exam Element Results								
Element	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Graphed BMI (2yrs and older)	91%	99%	100%	86%	97%	91%	88%	90%
MCO Component Score	**95%**	**99%**	**99%**	**93%**	**97%**	**94%**	**94%**	**94%**

Underlined scores denote that element score is below 80%, which may impact the minimum level compliance score for the component.

Comprehensive Physical Examination Results

- All MCO's scores exceeded the minimum compliance score of 80% for this component for CY 2016.
- The HealthChoice Aggregate score increased by 3 percentage points from CY 2015 to CY 2016 to a rate of 96% after remaining at 93% during CY 2014 and CY 2015.

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 33. CY 2016 Laboratory Test/At–Risk Screenings Element Results

CY 2016 Laboratory Test/At-Risk Screenings Element Results								
Element	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Cholesterol Risk Assessment per Schedule	81%	99%	98%	81%	83%	80%	79%	79%
STI/HIV Risk Assessment per Schedule	93%	100%	99%	87%	83%	85%	86%	86%
Referred for Lead Test	91%	96%	90%	90%	90%	82%	76%	81%
12 Month Lead Test Result per Schedule	73%	93%	75%	70%	91%	77%	79%	80%
24 Month Lead Test Result per Schedule	94%	100%	73%	68%	73%	81%	75%	78%
Lead Risk Assessment	93%	100%	98%	92%	93%	90%	83%	89%
Anemia Screening per Schedule	90%	96%	79%	78%	86%	82%	74%	80%
Conducted Second Hereditary/Metabolic Screening by 2–4 wks.	90%	100%	77%	63%	85%	80%	69%	88%
Baseline Lead Testing Completed	94%	96%	80%	86%	83%	85%	76%	77%
Tb Risk Assessment (1 month–20 years)	80%	99%	99%	79%	71%	79%	74%	80%
MCO Component Score	**85%**	**99%**	**93%**	**82%**	**82%**	**82%**	**78%**	**82%**

Underlined scores denote that element score is below 80%, which may impact the minimum level compliance score for the component.

Laboratory/ At Risk Screening Results

- Seven of the eight MCOs (ACC, JMS, MPC, MSFC, PPMCO, and UMHP) exceeded the minimum compliance score of 80% for this component in CY 2016.
- One of the eight MCOs (UHC) scored below the minimum compliance score of 80% and was required to submit a CAP for the Laboratory/At Risk Screening component.
- The HealthChoice Aggregate score increased by 7 percentage points from 78% in CY 2015 to 85% in CY 2016. There was a 2 percentage point increase demonstrated from CY 2014 to CY 2015.

Immunizations

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

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

Table 34. CY 2016 Immunizations Element Results

CY 2016 Immunization Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
TD Vaccine(s) per Schedule	91%	97%	86%	91%	89%	97%	87%	90%
Hepatitis B Vaccine(s) per Schedule	91%	96%	90%	92%	91%	95%	88%	91%
MMR Vaccine(s) per Schedule	95%	99%	98%	93%	98%	96%	94%	95%
Polio Vaccine(s) per Schedule	89%	93%	88%	84%	95%	92%	85%	89%
Hib Vaccine(s) per Schedule	88%	93%	74%	89%	93%	93%	86%	89%
DTP/DTaP (DT) Vaccine(s) per Schedule	86%	91%	84%	87%	89%	90%	83%	85%
Hepatitis A Vaccine(s) per Schedule (2 dose requirement)	91%	97%	71%	88%	95%	88%	90%	84%
Influenza Vaccine(s) (Beginning at 6 months of age per schedule)	63%	68%	77%	59%	70%	65%	59%	59%
Meningococcal (MCV4) Vaccine(s) per Schedule	88%	97%	81%	90%	89%	93%	86%	89%
Varicella Vaccine(s) per Schedule (2 dose requirement)	92%	95%	86%	91%	89%	95%	89%	89%
Rotavirus Vaccine(s) per Schedule	92%	88%	69%	81%	88%	86%	70%	78%
Assessed if Immunizations are Up to Date	90%	84%	93%	91%	84%	93%	88%	92%
PCV–13 Vaccine(s) per Schedule	93%	95%	92%	92%	94%	95%	89%	92%
Human Papillomavirus Vaccine(s)*	70%	87%	67%	66%	77%	69%	69%	70%
MCO Component Score	**85%**	**88%**	**85%**	**84%**	**86%**	**88%**	**82%**	**85%**

*This immunization data was collected for informational purposes only and was not used in the calculation of the overall component score.
Underlined scores denote that element score is below 80%, which may impact the minimum level compliance score for the component.

Immunizations Results

- All MCO's scores exceeded the minimum compliance score of 80% for this component in CY 2016.
- The HealthChoice Aggregate score for this component increased by one percentage point from 84% in CY 2015 to 85% in CY 2016. There was a one percentage point increase demonstrated from CY 2014 to CY 2015.

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 two 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 35. CY 2016 Health Education/Anticipatory Guidance Element Results

CY 2016 Health Education/Anticipatory Guidance Element Results								
Element	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Provided Education and Referral to Dentist	84%	100%	99%	82%	86%	85%	81%	81%
Provided Age Appropriate Guidance	97%	100%	100%	94%	94%	98%	96%	95%
Specified Requirements for Return Visit	93%	99%	100%	91%	94%	96%	93%	93%
Provided Ed/Referral for Identified Problems/Tests	100%	100%	100%	98%	99%	100%	99%	99%
MCO Component Score	**94%**	**100%**	**100%**	**92%**	**94%**	**95%**	**92%**	**93%**

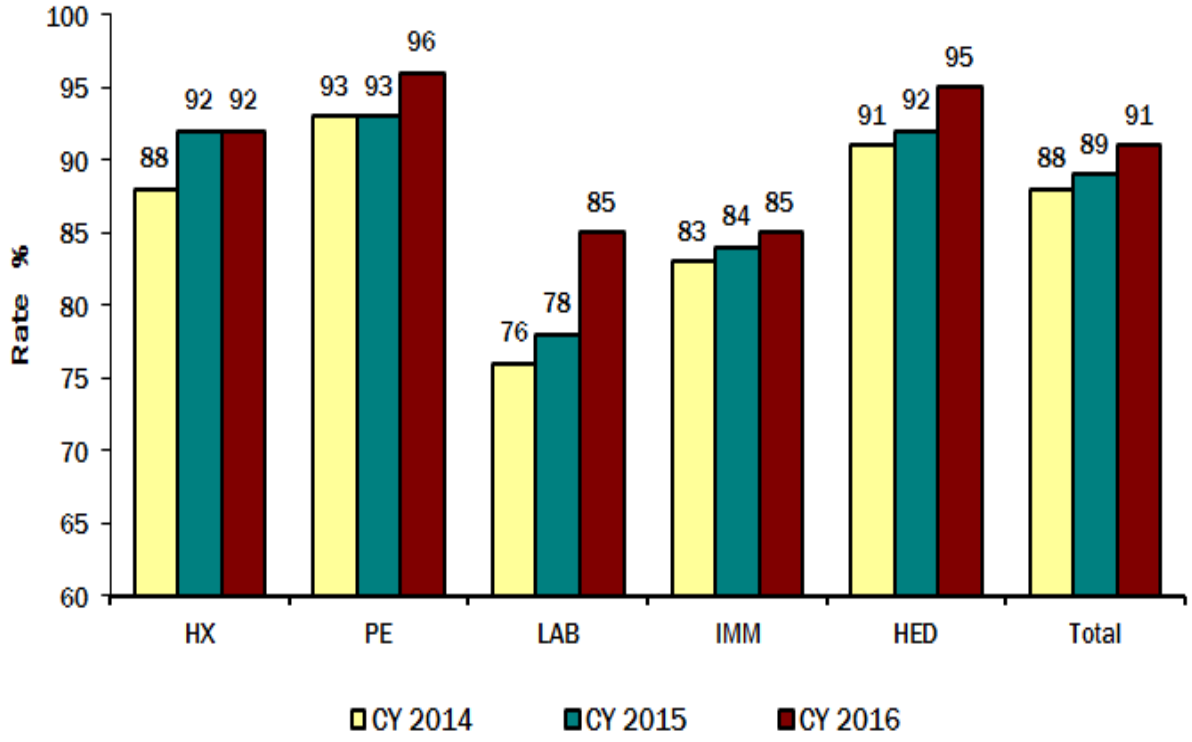
Health Education/Anticipatory Guidance Results

- All MCO's scores exceeded the minimum compliance score of 80% for this component in CY 2016.
- The HealthChoice Aggregate score for this component increased by three percentage points from 92% in CY 2015 to 95% in CY 2016. There was a one percentage point increase demonstrated from CY 2014 to CY 2015.

Trending of Aggregate Compliance Scores

The bar graph in Figure 8 below depicts the trend analysis of CY 2014, CY 2015 and CY 2016 Health Choice Aggregate component scores for Healthy Kids/EPSDT Program.

Figure 8. Trend analysis for CY 2014, CY 2015, and CY 2016 HealthChoice Aggregate component scores.



The HealthChoice Aggregate Total scores have shown very little variation from CY 2014 to CY 2016. Total scores increased by one percentage point (88% to 89%) from CY 2014 to CY 2015, and increased by two percentage points (89% to 91%) from CY 2015 to CY 2016.

The component scores from CY 2014 to CY 2016 have likewise shown little variation. The CY 2014 to CY 2015 component scores remained the same in one area (PE – Comprehensive Physical Exam), and increased in four areas (HX – Health and Developmental History, LAB – Laboratory Tests/At Risk Screenings, IMM – Immunizations, and HED – Health Education/Anticipatory Guidance. The CY 2015 to CY 2016 component scores remained the same in one area (HX – Health and Developmental History), and increased in all other areas of review.

All component scores remained above the 75% minimum threshold for compliance for CY 2014. In 2015, the minimum compliance score moved to 80%. All component scores except for LAB – Laboratory Tests/At-risk Screenings remained above the 80% minimum threshold for compliance for CY 2015. In 2016, all HealthChoice Aggregate component scores remained above the 80% minimum threshold for compliance.

Corrective Action Plan Process

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

Required Contents of EPSDT CAPs

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 Process

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, Qlarant will evaluate all data collected or trended by the MCO through the monitoring mechanism

established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH will be notified for further action.

Conclusions

HealthChoice Aggregate scores for each of the five components were above the 80% minimum threshold for compliance. The Laboratory Test/At Risk Screenings Component demonstrated a notable increase of seven percentage points. This is likely due to the MCO's concerted efforts and corrective action plans implemented in CY 2015 for this component.

Scores for all five components increased or remained unchanged from CY 2015 to CY 2016. The CY 2016 Total Composite Score of 91% increased by two percentage points over the CY 2015 Total Composite Score of 89%.

Seven of the eight MCOs (ACC, JMS, KPMAS, MPC, MSFC, PPMCO and UMHP) met the minimum compliance score of 80% for all five components. One MCO, UHC, scored below the 80% minimum compliance score for the Laboratory Tests/At–Risk Screenings component and was required to submit a CAP. The CAP was evaluated by Qlarant and determined acceptable for the specific area where deficiencies occurred for CY 2016.

The MCO results of the EPSDT review demonstrated strong compliance with the timely screening and preventive care requirements of the Healthy Kids/EPSDT Program. Overall scores indicate that the MCOs, in collaboration with PCPs, are committed to the Department's goals to provide care that is patient focused and prevention oriented, and follows the Maryland Schedule of Preventive Health Care.

Section VI
Consumer Report Card

Introduction

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

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

Information Reporting Strategy

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

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

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

Organizing Information

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

Rationale. Research has shown that people have difficulty comparing MCO performance when information is presented in too many topic areas. To include a comprehensive set of performance measures in an effective consumer-information product (one that does not present more information

than is appropriate for an audience of Medicaid participants), measures must be combined into a limited number of reporting categories that are meaningful to the target audience.

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

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

Rationale. The recommended categories are based on measures reported by HealthChoice MCOs in 2016 and are designed to focus on clearly identifiable areas of interest. Consumers will be directed to focus on MCO performance in the areas most important to them and their families. The first two categories are relevant to all participants; the remaining categories are relevant to specific Maryland HealthChoice participants: children, children with chronic illness, women, and adults with chronic illness. Reporting measures individually (in addition to the reporting categories listed above) is not recommended. Comparing the performance of a category composed of many measures with the performance of individual measures may give undue weight to the individual measures.

Measure Selection

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

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

HEDIS® 2016 Measure Changes. Updates were made to several HEDIS® 2016 measures, however, these modifications do not affect the Report Card methodology. NCQA also retired the HEDIS® measure

rotation policy. For detailed changes, refer to *HEDIS® 2016, Volume 2: Technical Specifications for Health Plans.* Additionally, the *Use of Appropriate Medications for People With Asthma* measure was retired. The following recommendations are proposed for replacement of this measure:

- In the Keeping Kids Healthy, the measure could be replaced with *Asthma Medication Ratio*.
- In the Care for Adults with Chronic Illness, the measure could be replaced with the *Asthma Medication Ratio*

Updates for HEDIS® 2017. The *Immunizations for Adolescents* and *Human Papillomavirus Vaccine for Female Adolescents* measures are combined and report receipt of all recommended vaccines (meningococcal, Tdap and HPV) for female and male adolescents by their 13th birthday.

CAHPS® Measure Reporting Category Changes

- Access to Care - No changes
- Doctor Communication and Service - No changes
- Keeping Kids Healthy - No changes
- Care for Kids with Chronic Illness
  - Remove Use of Appropriate Medications for People With Asthma (5-11 years) as the measure has been retired.
- Taking Care of Women
  - Add the Cervical Cancer Screening measure.
- Care for Adults With Chronic Illness
  - Remove Use of Appropriate Medications for People With Asthma [19-64 (combine 19-50 and 51-64)] as the measure has been retired.

Format

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

- **Space.** Maximize the amount to display data and explanatory text.
- **Message.** Communicate MCO quality in positive terms to build trust in the information presented.
- **Instructions.** Be concrete about how consumers should use the information.
- **Text.** Relate the utility of the Report Card to the audience's situation (e.g., new participants choosing an MCO for the first time, participants receiving the Annual Right to Change Notice and prioritizing their current health care needs, current participants learning more about their MCO) and reading level.

- **Narrative.** Emphasize why what is being measured in each reporting category is important, rather than giving a detailed explanation of what is being measured. For example, "making sure that kids get all of their shots protects them against serious childhood diseases" instead of "the percentage of children who received the following antigens…"
- **Design.** Use color and layout to facilitate navigation and align the star ratings to be left justified ("ragged right" margin), consistent with the key.

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

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

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

Rating Scale

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

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

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

Analytic Methodology

Qlarant recommends that the Report Card compare each MCO's actual score with the unweighted statewide MCO average for a particular reporting category. An icon or symbol would denote whether an MCO performed "above," "the same as" or "below" the statewide Medicaid MCO average.[3]

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

Handling Missing Values

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

Replacing missing Medicaid MCO data with commercial plan data is inappropriate because the characteristics of Medicaid populations differ from those of commercial populations. This restricts the potential group to national Medicaid plans, regional Medicaid MCOs, or Maryland HealthChoice MCOs. Analyses conducted by NCQA for the annual State of Health Care Quality Report have consistently shown substantial regional differences in performance of commercial managed care plans. Assuming that regional differences generalize to Medicaid MCOs, it would be inappropriate to use the entire group of national Medicaid MCOs to replace missing values for Maryland HealthChoice MCOs.

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

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

MCOs are sometimes unable to provide suitable data (for example, if too few of their members meet the eligibility criteria for a measure), despite their willingness to do so. These missing data are classified as "Not Applicable" (NA). If the NCQA HEDIS Compliance Audit™ finds a measure to be materially biased, the HEDIS measure is assigned a " Biased Rate" (BR) and the CAHPS survey is assigned "Not Reportable" (NR).

For Report Card purposes, missing values for MCOs will be handled in this order:

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

Calculations in each category are based on the remaining reportable measures versus reportable MCOs.

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

Handling New MCOs

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

Members Who Switch Products/Product Lines

Per HEDIS® guidelines, members who are enrolled in different products or product lines in the time specified for continuous enrollment for a measure are continuously enrolled and are included in the

product and product-line specific HEDIS® report in which they were enrolled as of the end of the continuous enrollment period. For example, a member enrolled in the Medicaid product line who switches to the commercial product line during the continuous enrollment period is reported in the commercial HEDIS® report.

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

Case–Mix Adjustment of CAHPS® Data

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

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

Statistical Methodology

The statistical methodology includes the following steps:

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

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

Quality Control

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

CY 2017 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	★★★	★★★
MPC	★★★	★★	★★	★★	★	★
MSFC	★★	★★★	★★	★★	★	★★
PPMCO	★★	★★	★★★	★★	★★	★★
UMHP	★	★★	★	★★	★	★
UHC	★★	★★	★★	★★	★	★

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

Section VII
Focused Reviews of Grievances, Appeals, and Denials

Introduction

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to Maryland Medical Assistance recipients enrolled in HealthChoice Managed Care Organizations (MCOs). Qlarant, as the contracted External Quality Review Organization (EQRO), conducts quality studies focused on determining MCO compliance with federal and state laws and regulations pertaining to the handling of grievances and appeals, and the appropriateness of denials of service. These studies consist of quarterly evaluations of grievance, appeal, and pre-service denial results submitted by each MCO and an annual record review. This is the first focus review conducted for the MDH.

Assessment of MCO compliance was completed by applying the systems performance standards defined for Calendar Year (CY) 2016 in the Code of Maryland Regulations (COMAR) 10.09.65. Quarterly studies of grievances, appeals, and pre-service denials were conducted for the third and fourth quarters of 2016, and the first and second quarters of 2017. The annual record review encompassed member grievances, appeals, and pre-service denials that occurred during calendar year 2016. Using the 10/30 rule, an initial sample of 10 grievance, appeal, and denial records were reviewed. If an area of non-compliance was discovered an additional 20 records were reviewed for the non-compliant component. The eight MCOs evaluated during these time frames were:

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

*Formerly Riverside Health of Maryland (RHMD)

The following section will provide MCO specific review results of select grievance, appeal, and pre-service denial measures in table format. This facilitates comparisons of MCO performance over time and in relation to its peers based on quarterly reports and annual record review results. Data from the third quarter of 2016, was omitted as a result of reporting inconsistencies discovered among the MCOs.

For the purpose of this Executive Summary, the percentage of compliance demonstrated for various components is represented by a review determination of met, partially met, or unmet, as follows:

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

Findings

The following sections include findings for Grievances, Appeals and Pre-Service Denials.

Grievance Findings

A grievance is an expression of dissatisfaction about any matter other than an action and is defined in COMAR 10.09.62.01[58-1]. The regulation describes three categories of grievances:

- Category 1: Emergency medically related grievances (24 hours)
  Example: Emergency prescription or incorrect prescription provided
- Category 2: Non-emergency medically related grievances (5 calendar days)
  Example: DME/DMS related complaints about repairs, upgrades, vendor issues, etc.
- Category 3: Administrative grievances (30 calendar days)
  Example: Difficulty finding a network PCP or specialist

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

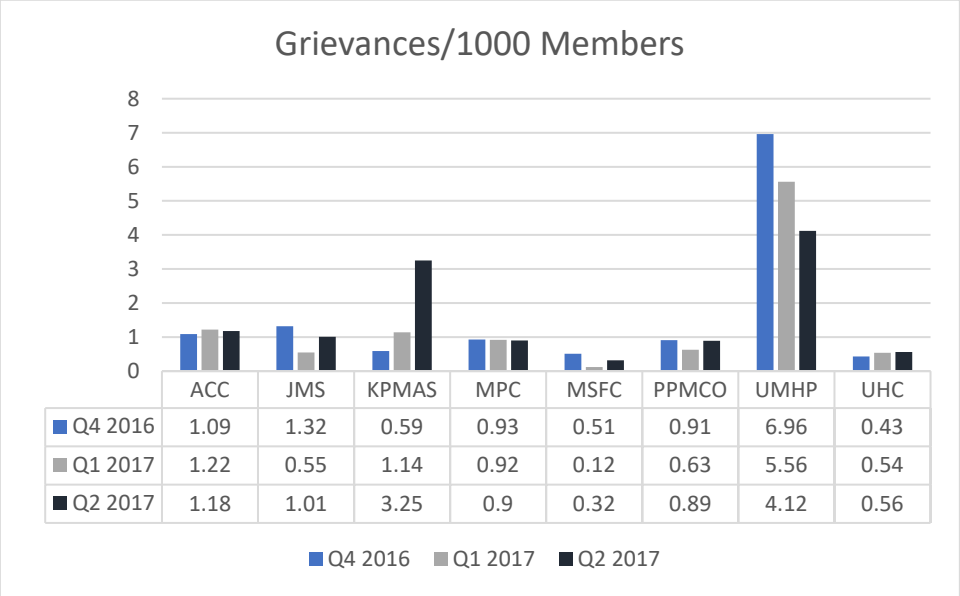
- Comparative Statistics
  - Grievances filed per 1000 members
  - Grievances filed per 1000 providers
- Resolution Time Frames (based upon 100% compliance)
  - Emergency medically related grievances within 24 hours
  - Non-emergency medically related grievances within 5 days
  - Administrative grievances within 30 days
- Grievance Definitions
  - Must meet the definition of an expression of dissatisfaction about any matter other than an adverse benefit determination.

- May include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested.

- Grievance Documentation: Grievance issue must be fully described in the enrollee record
- Grievance Determination:
  - Grievance determination must be documented in the enrollee record, appropriately address the grievance issue, and identify the steps taken to resolve the issue.
  - Written Determination must be forwarded to:
    1. Enrollee who filed the grievance
    2. Individuals and entities required to be notified of the grievance
    3. The Department's complaint unit for complaints referred to the MCO by the Department's complaint unit or ombudsman program

Figure 9 provides a comparison of MCO grievances per 1000 members for three quarters.

Figure 9. Grievances/1000 Members



	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	1.09	1.32	0.59	0.93	0.51	0.91	6.96	0.43
Q1 2017	1.22	0.55	1.14	0.92	0.12	0.63	5.56	0.54
Q2 2017	1.18	1.01	3.25	0.9	0.32	0.89	4.12	0.56

UMHP was a major outlier in grievances per 1000 members for all three quarters however, this measure has been trending downward since the fourth quarter of 2016. Both KPMAS and UHC demonstrate an upward trend in grievances per 1000 members since the fourth quarter of 2016. This measure falls within a fairly narrow range for the remaining MCOs.

Table 36 offers a comparison of MCO grievances per 1000 providers for three quarters.

Table 36. Grievances/1000 Providers

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP*	UHC
Q4 2016	0	0	0	0	0.81	0.13	0.71	0.1
Q1 2017	0	0.21	0.92	0	0	0.2	65.44*	0.1
Q2 2017	0	0.21	0.92	0	0.47	0.5	28.77*	0

*Major outliers in comparison to other MCOs

Grievances per 1000 providers remains low for the majority of MCOs. For first and second quarters of 2017, UMHP was a major outlier for this measure in comparison to all other MCOs. For Q1 2017, UMHP had 65.44, and Q2 28.77, grievances per 1000 providers compared to less than 1 grievance per 1000 providers on average for all other MCOs.

Comparisons of MCO compliance with resolution time frames for member grievances based on MCO quarterly submissions are displayed in Table 37 for three quarters.

Table 37. Compliance with Member Grievance Resolution Time Frames

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	M	M	PM	PM	PM	M	M	PM
Q1 2017	M	M	PM	M	PM	PM	M	PM
Q2 2017	M	M	PM	PM	PM	PM	M	PM

M-Met; PM-Partially Met

Three MCOs (ACC, JMS, and UMHP) met the resolution time frames for member grievances in all three quarters. KPMAS, MSFC, and UHC received a finding of partially met for all three quarters. MPC and PPMCO met the resolution time frames in one of the three quarters.

Comparisons of MCO compliance with resolution time frames for provider grievances based on MCO quarterly submissions are displayed in Table 38.

Table 38. Compliance with Provider Grievance Resolution Time Frames

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	NA	N/A	M	PM	M	M	M	NA
Q1 2017	NA	M	NA	M	NA	M	M	M
Q2 2017	NA	M	M	M	M	M	M	NA

M-Met; PM-Partially Met; NA-Not Applicable

All but one MCO met the resolution time frame for provider grievances. MPC received a finding of partially met for the fourth quarter 2016.

Table 39 presents a comparison of grievance record review results across MCOs. Results are based upon a random selection of grievance records reviewed for CY 2016. Reviews were conducted utilizing the 10/30 rule.

Table 39. CY 2016 MCO Grievance Record Review Results

Requirement	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Appropriately Classified as a Grievance	PM	M	PM	M	M	PM	M	M
Issue Is Fully Described	M	M	M	M	M	M	M	M
Resolution Timeliness	M	M	M	M	PM	M	PM	M
Resolution Appropriateness	M	PM	PM	M	PM	M	M	M
Resolution Letter	M	U	PM	U	PM	M	M	M

M-Met; PM-Partially Met; U-Unmet; NA-Not Applicable

All MCO records reviewed demonstrated full explanation of the grievance issue. Three MCOs (ACC, KPMAS and PPMCO) received a finding of partially met for the component addressing appropriate classification of a grievance. Resolution timeliness was met by all MCOs with the exception of MSFC and UMHP. Three MCOs demonstrated an opportunity for improving the appropriateness of the resolution. Four of the MCOs (ACC, PPMCO, UMHP, and UHC) received a finding of met for the resolution letter component. The remainder of the MCOs received a partially met or unmet score due to inconsistent or missing resolution letters within the records reviewed.

Appeal Findings

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

- Action 1: Denial or limited authorization of a requested service, including the type or level of service
- Action 2: Reduction, suspension, or termination of a previously authorized service
- Action 3: Denial, in whole or part, of payment for a service
- Action 4: Failure to provide services in a timely manner
  - (i.e., if the MCO fails to provide services within the timeframes defined by the State in COMAR 10.09.66.07)
- Action 5: Failure of an MCO to act within the required appeal time frames set in COMAR

Providers can file appeals on a participant's behalf. Maryland's 1115 waiver has special terms and conditions that do not require the provider to seek written authorization before filing an appeal on the participant's behalf.

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

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

Table 40 provides a comparison of MCO appeals per 1000 members based on MCO quarterly submissions.

Table 40. MCO Appeals/1000 Members

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	0.27	0.32	1.1	0.63	0.67	1.89	14.59*	0.64
Q1 2017	0.04	0.16	0.69	0.51	1.01	0.87	5.44*	0.63
Q2 2017	0.04	0.31	1.02	0.39	0.69	0.06	5.13*	0.56

*Major outlier in comparison to other MCOs

UMHP has consistently been a major outlier in appeals per 1000 members in comparison to all other MCOs. This measure, however, has been trending downward for the past two quarters for the MCO. Appeals per 1000 members falls within a fairly narrow range for the remaining MCOs.

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

Table 41. MCO Compliance with Member Appeal Resolution Time Frames

Quarter	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	M	M	M	M	M	PM	M	PM
Q1 2017	M	M	PM	M	M	PM	M	PM
Q2 2017	M	M	PM	M	M	M	M	PM

M-Met; PM-Partially Met; U-Unmet; NA-Not Applicable

Five MCOs (ACC, JMS, MPC, MSFC, and UMHP) consistently met appeal resolution time frames for the three quarters reviewed. KPMAS and PPMCO demonstrated compliance for one quarter. UHC was scored as a partially met for all three quarters.

Table 42 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2016. Reviews were conducted utilizing the 10/30 rule.

Table 42. CY 2016 MCO Appeal Record Review Results

Requirement	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Processed Based Upon Level of Urgency	M	M	M	M	M	PM	M	M
Compliance with Resolution Time Frame for Expedited Appeal	M	M	M	NA	M	PM	M	M
Compliance with Notification Time Frame for Non-Emergency Appeal	M	M	M	M	M	PM	M	M
Appeal Decision Documented	M	M	M	M	M	M	M	M
Decision Available to Enrollee in Easy to Understand Language	M	M	M	M	M	M	M	M

M-Met; PM-Partially Met; U-Unmet; NA-Not Applicable

All but one MCO demonstrated compliance with each review component. PPMCO received a score of partially met for the following components: processed based upon level of urgency, compliance with resolution time frame for expedited appeal, and compliance with notification time frame for non-emergency appeals.

Pre-Service Denial Findings

Actions and decisions regarding services to enrollees that require preauthorization by the MCO are defined in COMAR 10.09.71.04. The regulation states that the MCO shall make a determination in a

timely manner so as not to adversely affect the health of the enrollee and within 2 business days of receipt of necessary clinical information, but no later than 7 calendar days from the date of the initial request. It further details that:

- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested:
  - Shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and
  - May not be arbitrarily based solely on diagnosis, type of illness, or condition.
- Notices of a decision to deny an authorization shall be provided to the enrollee and the regulation provider within the following time frames:
  - 24 hours from the date of determination for emergency, medically related requests; and
  - 72 hours from the date of determination for nonemergency, medically related requests.
- An MCO shall give an enrollee written notice of any action, except for denials of payment which do not require notice to the enrollee, within the following time frames:
  - At least 10 days before the action for termination, suspension, or reduction of a previously authorized covered service.
- A notice of adverse action shall be in writing and:
  - Be translated for enrollees who speak prevalent non-English languages;
  - Include language clarifying that oral interpretation is available for all languages and how to access it;
  - Be written in an easily understood language and format that takes into consideration enrollees with special needs;
  - Be available in alternative formats; and
  - Inform enrollees that information is available in alternative formats and how to access those formats.

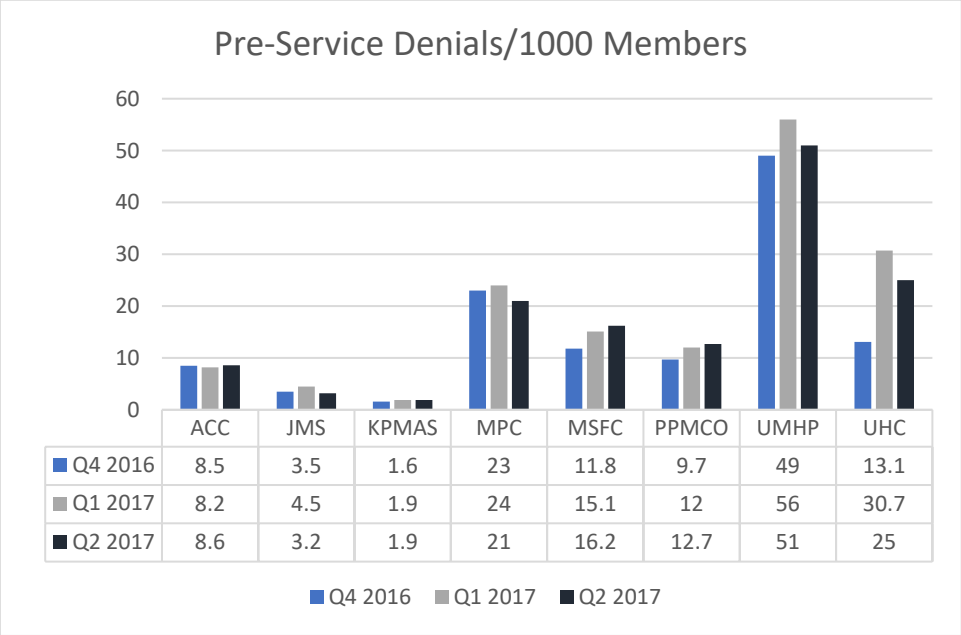
The MCO pre-service denial review encompassed the following comparative statistics and compliance with federal and state laws and regulations:

- Comparative Statistics: Pre-service Denials Rendered Per 1000 Members
- Preauthorization Time Frames: Determinations provided within 2 business days of receipt of necessary clinical information but no later than 7 calendar days from date of initial request based on a compliance threshold of 95%
- Notice of Decision to Deny Time Frames: Initial services provided to enrollee within 24 hours for emergency, medically related requests and not more than 72 hours for non-emergency, medically related requests based upon a compliance threshold of 95%

- Notification Time Frames: For any previously authorized service written notice to enrollee is provided at least 10 days prior to reducing, suspending, or terminating a covered service based upon a compliance threshold of 95%.
- Adverse Determinations
  - Must be based upon medical necessity criteria and clinical policies.
  - Must be rendered by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
- Adverse Determination Letters: Must include all 15 required regulatory components.

Figure 10 provides a comparison of MCO pre-service denials per 1000 members based on MCO quarterly submissions.

Figure 10. MCO Pre-Service Denials/1000 Members

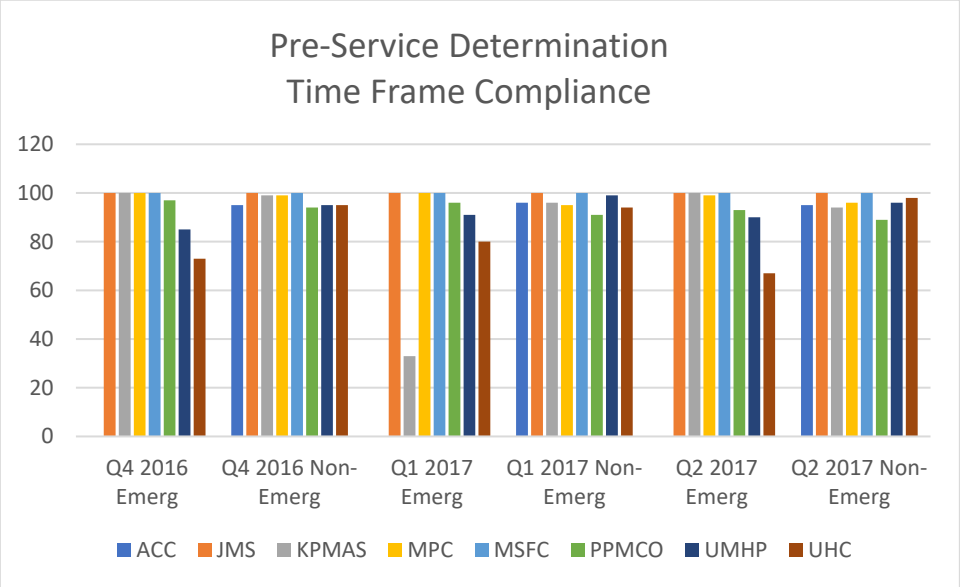


	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UMHP	UHC
Q4 2016	8.5	3.5	1.6	23	11.8	9.7	49	13.1
Q1 2017	8.2	4.5	1.9	24	15.1	12	56	30.7
Q2 2017	8.6	3.2	1.9	21	16.2	12.7	51	25

MPC and UMHP were major outliers in comparison to other MCOs' pre-service denials per 1000 members for all three quarters. UHC was an outlier in respect to this measure for the first two quarters of 2017.

Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based upon MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Figure 11 represents results of the MCO's compliance with pre-service determination time frames.

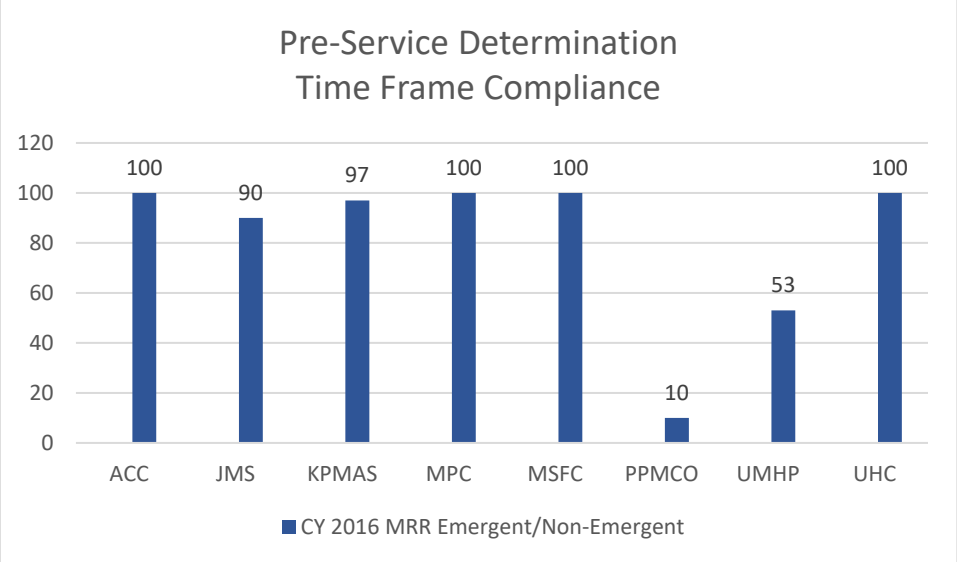
Figure 11. MCO Compliance with Pre-Service Determination Time Frames



Four of the MCOs (ACC, JMS, MPC, and MSFC) met or exceeded the 95% threshold based upon a review of MCO quarterly reports. Overall compliance results for the remaining four MCOs (KPMAS, PPMCO, UMHP, and UHC) ranged from 33% to 94%. ACC did not have any emergent requests for the quarters reviewed.

Record reviews were also conducted to assess compliance with COMAR requirement for timeliness of pre-service determinations. The record review was based upon the 10/30 rule. Results are highlighted in Figure 12.

Figure 12. MCO Compliance with Pre-Service Determination Time Frames

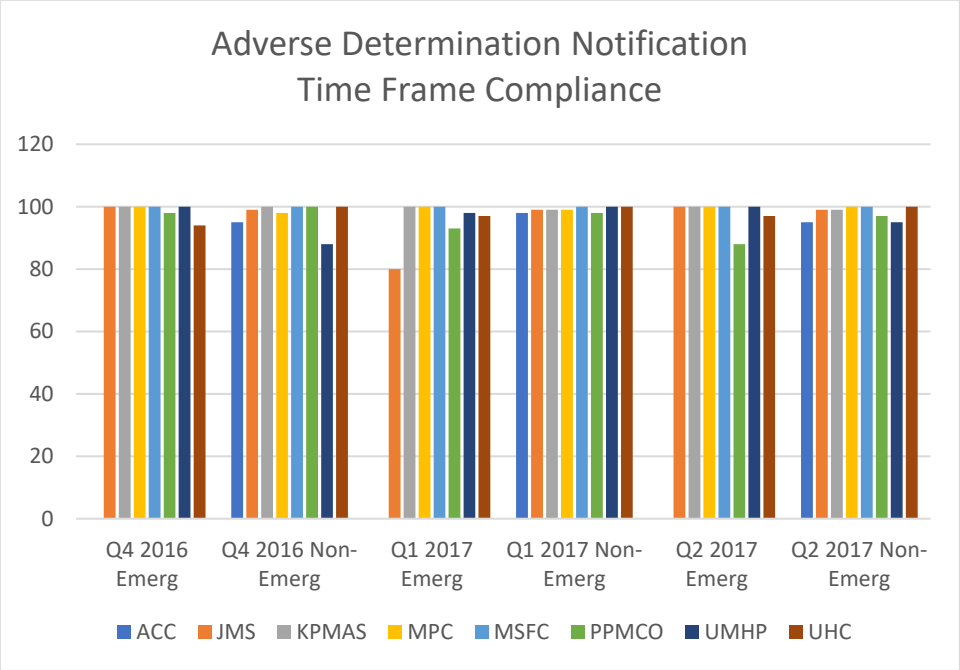


Five of the MCOs (ACC, KPMAS, MPC, MSFC, and UHC) met or exceeded the 95% threshold based upon the annual review of the MCO's records. Overall compliance results for the remaining three MCOs (JMS, PPMCO, and UMHP) ranged from 10% to 90%.

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

Results of compliance with adverse determination notification time frames based on the quarterly reports are highlighted in Figure 13.

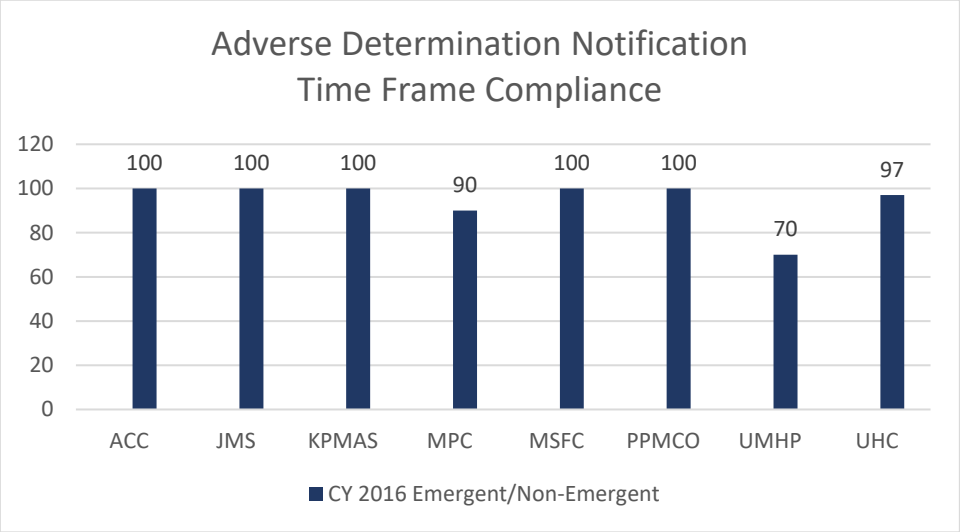
Figure 13. MCO Compliance with Adverse Determination Notification Time Frames



Four of the MCOs (ACC, KPMAS, MPC, and MSFC) met or exceeded the 95% threshold based upon a review of MCO quarterly reports. Overall compliance results for the remaining four MCOs (JMS, PPMCO, UMHP, and UHC) ranged from 80% to 94%. ACC did not have any emergent requests for the quarters reviewed.

Results of compliance with adverse determination notification time frames based on the annual record review of CY 2016 records are highlighted in Figure 14.

Figure 14. MCO Compliance with Adverse Determination Notification Time Frames



Six of the MCOs (ACC, JMS, KPMAS, MSFC, PPMCO, and UHC) met or exceeded the 95% threshold based upon an annual review of the MCO's records. UMHP and MPC results were 70% and 90% respectively.

Table 43 provides a comparison of denial record review results across MCOs for CY 2016. Results are based upon a random selection of denial records. Reviews were conducted utilizing the 10/30 rule.

Table 43. CY 2016 MCO Denial Record Review Results

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

M-Met; PM-Partially Met; U-Unmet; NA-Not Applicable

All MCOs demonstrated compliance with the appropriateness of adverse determinations supported by medical necessity criteria and MCO specific clinical policies. Additionally, all MCOs were found to have included all required components in adverse determination letters. Four of the MCOs (ACC, KPMAS, MSFC, and UHC) met or exceeded the 95% threshold for pre-service determinations and adverse determination notifications based on review of a sample of records.

Recommendations

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

Grievance and appeal record reviews surfaced additional opportunities for improvement. As a result, it is recommended that MDH approve new System Performance Review standards relating to the following:

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

Section VIII
Network Adequacy Validation

Executive Summary

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

HealthChoice's philosophy is to provide quality health care that is coordinated, accessible, cost effective, patient focused, and prevention oriented. The foundation of the program hinges 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 care for the enrollee. HealthChoice emphasizes health promotion and disease prevention, and requires that enrollees be provided health education and outreach services.

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

Beginning in 2015, MDH collaborated with The Hilltop Institute at University of Maryland, Baltimore County (Hilltop) to develop a validation method to test the accuracy of HealthChoice MCO's provider directories. This was conducted in two phases. In Phase 1, Hilltop conducted a pilot survey from October to December of 2015. For Phase 2, MDH and Hilltop streamlined the survey tool and surveyed a statistically significant sample of 361 primary care providers from the entire HealthChoice network by combining online provider directories from all MCOs. Surveys were conducted between January and February of 2017.

Phase 2 verified the accuracy of information in provider directories, such as name, address, phone number, whether the provider practices as a PCP, whether the provider was accepting new patients, and

patient age range. Phase 2 results found that while most directory information was accurate, discrepancies exist in key areas such as contact information and PCP status. Nearly 19% of all providers surveyed reported a telephone number different from the one provided in the directory. The percentage of group practices listed with an incorrect telephone number was 23.9%. In addition, approximately 13% of providers listed as PCPs in directories indicated that they do not provide primary care services. Further, over 22% of providers surveyed indicated that they were not accepting new patients, which contradicted information in MCO provider directories.

The Phase 2 Final Report indicates MDH would require MCOs to create a Network Directory Compliance Plan to demonstrate how they will correct provider directory issues identified within the report. Due to the timing of the start of Phase 3 survey collection, MDH did not implement this requirement. However, MDH shared information regarding inaccurate directory entries with MCOs to ensure follow up with the surveyed providers in order to correct their directories. MDH also distributed this report to stakeholder groups, such as the Maryland Medicaid Advisory Committee (MMAC).

In Phase 3, MDH transitioned the survey administration from Hilltop to its External Quality Review Organization (EQRO), Qlarant Quality Solutions, Inc. (Qlarant). Surveys were conducted in June and July of 2017 with the goal of validating the MCO's online provider directories and assessing compliance with State access and availability requirements. Qlarant adopted methodology similar to Hilltop's survey and conducted calls to a statistically significant sample of PCPs within each MCO.

Surveys were conducted to a total of 1,319 PCPs with successful contact made to 870 PCPs, yielding a response rate of 66%. This was an increase of 53% over Phase 2 response rate of 35%. In Phase 3, Qlarant surveyors verified:

- Accuracy of online provider directories, including telephone number and address
- Whether the provider accepts the MCO listed in the provider directory
- Whether the provider practices accepts new patients
- What age range the provider serves
- The first available routine appointment
- The first available urgent care appointment

Results demonstrated the following:

- The correctness of the provider telephone number and/or address continued to be an area of weakness across the HealthChoice MCOs.
- The majority of PCPs surveyed (94%) stated that they accepted the MCO listed in the provider directory.

- The majority of PCPs surveyed (87%) stated that they accepted new patients. This was an increase from the Phase 2 results at 71.7%.
- Similar to Phase 2, 76% of PCPs surveyed accepted all ages versus specific ages.
- The majority of the PCPs surveyed (89%) were compliant with the first available routine appointment requirement.
- An opportunity for improvement is noted regarding the compliance with the first available urgent care appointment requirement in which results for PCPs surveyed were 67%.

Beginning with the calendar year (CY) 2017 Phase 3 Assessment, MDH set an 80% minimum compliance score for the network adequacy assessment. MCOs that did not meet the minimum compliance score in the areas of provider directory accuracy or compliance with routine and urgent care appointment time frames are required to submit corrective action plans (CAPs) to Qlarant.

Introduction

Qlarant is contracted as the EQRO for the Division of Quality Assurance (DQA). As such, Qlarant annually evaluates the quality assurance program and activities of each MCO contracting with the State of Maryland to provide care to Medical Assistance enrollees in the HealthChoice Program. To ensure that MCOs have the ability to provide enrollees with timely access to a sufficient number of in-network providers and ensure that members have access to needed care within a reasonable time frame, MDH contracted with Qlarant to evaluate the network adequacy of the HealthChoice Program MCOs.

In October 2016, MDH contracted with Qlarant to conduct the Phase 3 assessment of MCO provider directories. In collaboration with MDH, the goals of the assessment were expanded to include an assessment of the network adequacy of the HealthChoice program as follows:

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

Qlarant completed PCP Surveys in Calendar Year (CY) 2017 to assess the accuracy of MCO's provider directories as a first step in the evaluation of the network adequacy evaluation. The PCP Surveys evaluated all eight HealthChoice MCOs active between **January 1, 2017 and December 31, 2017:**

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

- Maryland Physicians Care (MPC)
- University of Maryland Health Partners (UMHP)*

*Formerly Riverside Health of Maryland (RHMD)

To complete the validation of the MCO's online provider directories and assess compliance for access and availability requirements, Qlarant adopted methodology like Hilltop's and expanded it by adding the compliance assessment of appointment timeframe requirements. Similar to Phases 1 and 2, a partial secret shopper model was utilized to complete the surveys, which included the surveyor identifying themselves as calling on behalf of the Maryland Medicaid program and MDH. MCOs and providers were not notified of the calls or survey questions in advance.

Sampling Methodology (Phase 3)

The sample for each MCO was determined based on the number of unique provider offices identified in Phase 2 by Hilltop in January/February of 2017. Based on the population size of 4,095 unique provider offices, the minimum recommended sample size of 250 primary care providers (PCPs) per MCO were selected, providing a 90% confidence level and a 5% margin of error. The minimum sample of PCPs was selected from each MCO's online provider directory except for JMS and KPMAS.

Both JMS and KPMAS have clinic-based service models where multiple providers offer services at a limited number of locations. Therefore, we were unable to reach the minimum samples of PCPs at unique provider locations. Additionally, KPMAS does not have a traditional provider directory; only lists the provider's name and practice location. KPMAS members are instructed to call Member Services to schedule an appointment. This further complicates verification activities for this MCO. Based on the MCO models for JMS and KPMAS, it is foreseen that this issue will be presented going forward. For these reasons, results for these MCOs are provided for informational purposes only and cannot be compared to other MCO results.

The sample of PCPs was randomly selected from each MCO's online directory one week prior to the surveys. PCPs included primary care, internal medicine, and general medicine. The provider information was obtained from the directory and uploaded into a survey tool on the portal for the surveyor. Provider information included:

- Name of Provider
- Practice Name, if available
- Address
- Telephone
- MCO Affiliation

Copies of the survey tool used by the surveyors is in Addendum A6-1. The responses to the survey questions were documented in the survey tool and stored electronically on Qlarant's secure web-based portal. Surveys were conducted during normal business hours (9:00 am – 5:00 pm, except during the 12:00 pm – 1:00 pm lunch hour) which was consistent with the Hilltop survey.

Qlarant's subcontractor, Cambridge Federal, conducted the telephonic surveys to provider offices. Surveyors were trained by Qlarant on the purpose of the survey, the secure web-based portal, data collection tool, and survey instrument. Respondents of the surveys varied by practice; however, in general, they were individuals who have direct contact with patients and schedule appointments. Surveyors captured data in a data collection tool located on the portal while completing the interview with the providers. Qlarant monitored data submissions and progress daily.

Access and Availability Requirements (Phase 3)

To assess compliance with State access and availability requirements outlined in COMAR, the data gathered from the telephonic surveys were compared to the standards noted in Table 44:

Table 44. Access and Availability Requirements

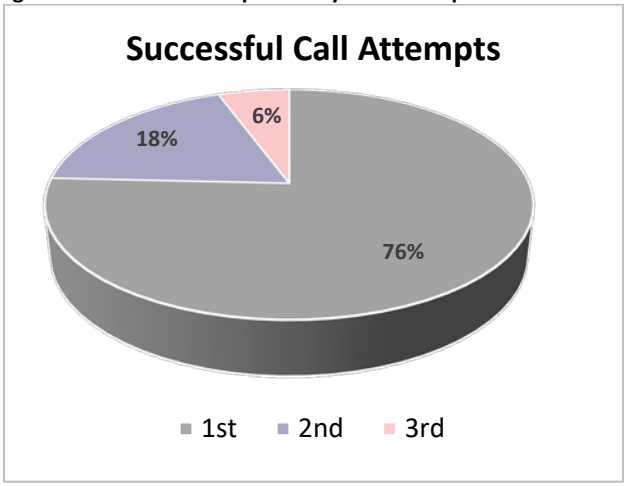
Access and Availability Requirement	Standard
Accuracy of Provider Directories *COMAR 10.09.66.02C(1)(d)*	MCOs shall maintain a provider directory listing individual practitioners who are the MCO's primary and specialty care providers, additionally indicating the PCP name, address, practice location(s), whether the provider is accepting new patients, ages served, and how access is limited.
30-Day Non-Urgent Care Appointment *COMAR 10.09.66.07A(3)(b)(iv)*	Routine and preventative care appointments shall be scheduled within 30 days.
48-Hour Urgent Care Appointment *COMAR 10.09.66.07A(3)(b)(iii)*	Urgent care appointments shall be scheduled within 48 hours of the request.

HealthChoice Aggregate Results (Phase 3)

Successful Contacts

Surveys were conducted with 1,319 PCPs in June and July of 2017. A contact was considered successful if the surveyor reached the PCP and complete the survey. Figure 15 illustrates the total percentages of successful contacts by call attempt for all MCOs.

Figure 15. Successful Responses by Call Attempt for All MCOs



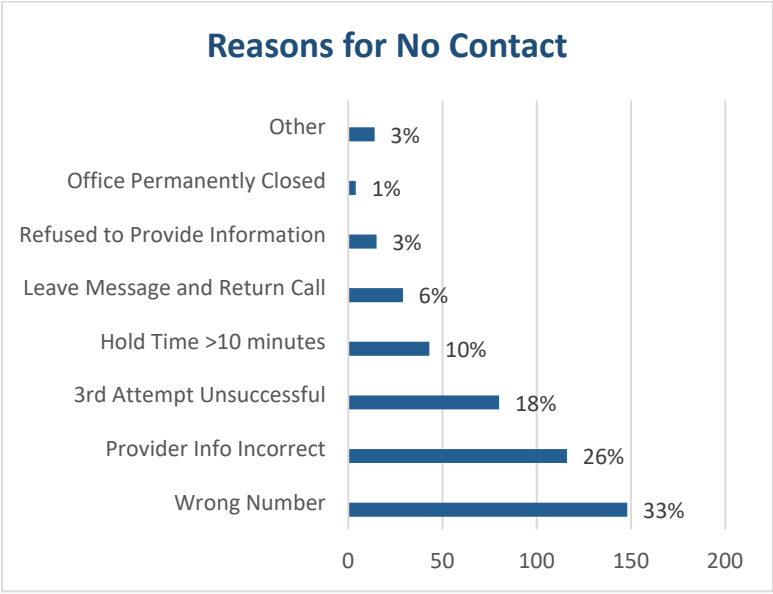
Successful contact was made to 870 PCPs, yielding a response rate of 66%. This was an increase of 53% over Phase 2 response rate of 35%.

Of the 870 successful contacts, 76% (659) of the surveys were completed on the first call, 18% (162) were completed on the second attempt, and 6% (49) were completed on the third attempt. All MCOs had similar percentages of successful contacts ranging from 14% to 18%.

Unsuccessful Contacts

If the surveyor was unable to reach a PCP to complete the survey after the third call, it was determined an unsuccessful contact. Reasons for the unsuccessful contacts to PCPs are captured in Figure 16.

Figure 16. Unsuccessful Reasons for No Contact

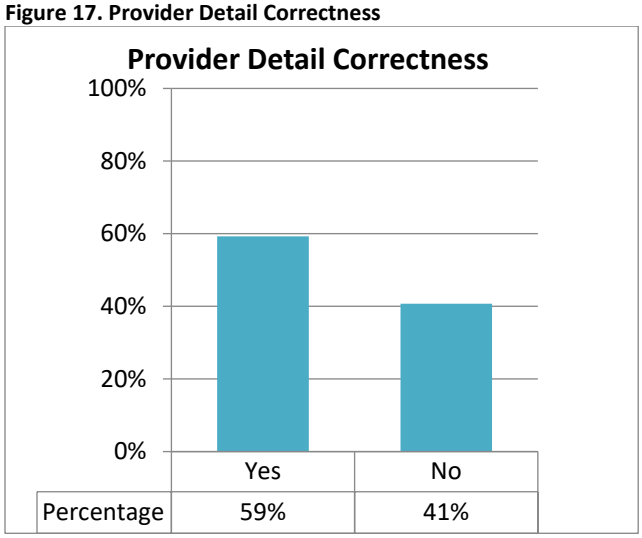


A total of 449 calls were unsuccessful. The majority of the unsuccessful contacts to PCPs (33%) resulted from an incorrect phone number followed by the second highest (26%) reason of incorrect provider information. Reasons for no contact also included responses such as the provider is no longer with the practice/facility, provider is retired, no provider by the listed name, or the provider practices at a different office than the one surveyed. An additional 18% of the calls were considered unsuccessful after the surveyor could not reach the PCP after the third.

Accuracy of MCO Online Directories

Compliance with COMAR 10.09.66.02C(1)(d) requires that MCOs maintain a provider directory listing individual practitioners who are the MCO's primary care providers. The directory must indicate the PCP name, address, and practice location(s). Qlarant surveyed providers to verify the accuracy of information provided in each MCO's online directory. Results of this review for all HealthChoice MCOs are presented in Figure 17.

Figure 17. Provider Detail Correctness



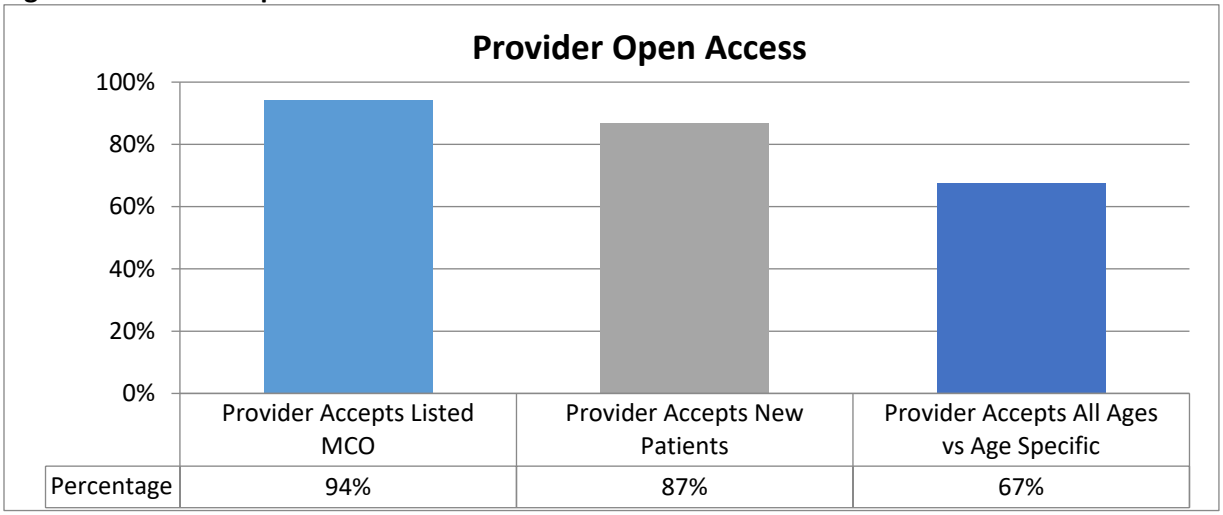
Of the 1,319 providers surveyed, 781 (59%) had correct addresses and telephone numbers. The remaining 538 (41%) providers had incorrect contact information. An attempt was made by the surveyors to obtain corrected information. In some cases, surveyors made successful contacts based on the updated information. This resulted in an increase in the total successful contacts (from 781 to 870).

The Phase 2 Survey completed separated incorrect phone number and address in their findings. They noted 18.8% of respondents had an incorrect telephone number and an incorrect component of the provider's address ranged from 8 to 14%. Phase 3 Survey results demonstrated that from the 1,319 providers surveyed, 197 (15%) had incorrect telephone numbers, 87 (7%) had incorrect addresses, and 213 (16%) providers were no longer with the facility or at the location noted in the directory.

Assessment of Open Access

Compliance with COMAR 10.09.66.02C(1)(d) requires that MCOs maintain a provider directory listing individual practitioners who are the MCO's PCPs. The provider directory must indicate whether the provider accepts new patients. The CY 2017 survey reviewed acceptance of new patients, acceptance of listed MCO, and the age of patients served by the provider, as illustrated in Figure 18. Due to the inconsistency of data available on the MCO's online provider directories, the only verifiable factor linking back to the provider directory was whether the PCP accepted the listed MCO.

Figure 18. Provider Open Access



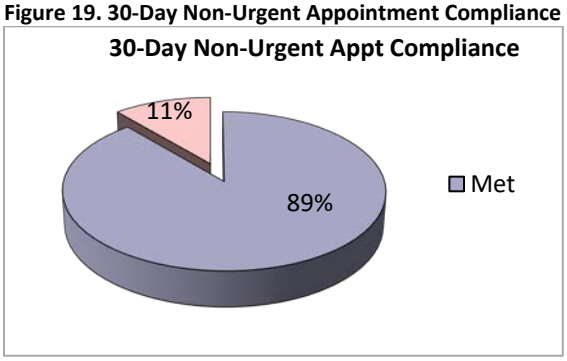
A summary of provider open access survey results follows:

- The majority of PCPs surveyed (94%) stated that they accepted the MCO listed in the provider directory.
- The majority of PCPs surveyed (87%) stated that they accepted new patients. This was an increase from the Phase 2 Survey at 71.7%.
- Sixty-seven percent of PCPs surveyed accepted all ages versus specific ages. This was a decrease from the Phase 2 Survey at 73.1%.

Compliance with Routine Appointment Requirements

Compliance with COMAR 10.09.66.07A(3)(b)(iv) requires routine and preventative care appointments to be scheduled within 30 days of the request. The results of the MCOs compliance with routine appointment requirements are presented in Figure 19.

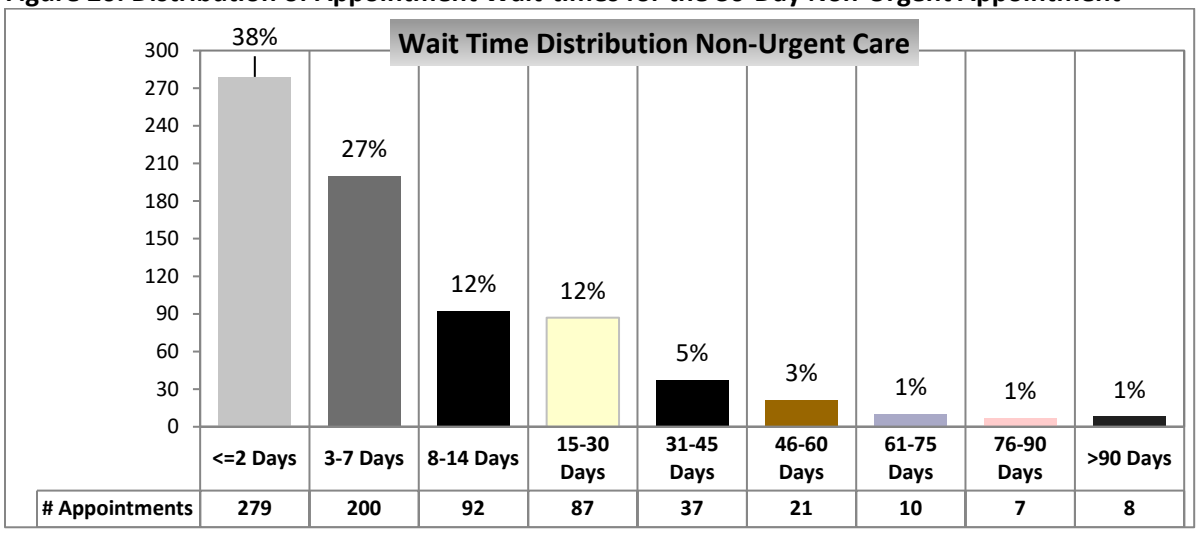
Figure 19. 30-Day Non-Urgent Appointment Compliance



Of the 870 PCPs successfully contacted, 741 (85%) provided appointment availability for non-urgent care appointments. Overall, 658 providers (89%) met compliance with the 30-day non-urgent care appointment requirement.

Further detail regarding the distribution of appointment times for the 30-day non-urgent appointment compliance is captured below in Figure 20.

Figure 20. Distribution of Appointment Wait-times for the 30-Day Non-Urgent Appointment

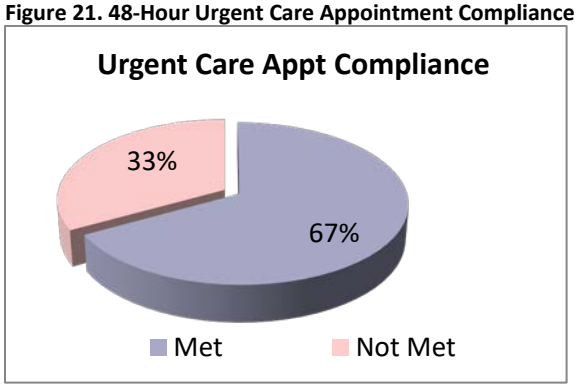


Of the 870 PCPs successfully contacted, a total of 741 non-urgent care appointments were scheduled. The majority of appointments (38%) were scheduled for the same or next day. Collectively, 77% of appointments were scheduled within the following 2-week timeframe. Of concern are the 83 (11%) appointments scheduled that did not meet compliance with the 30-day requirement. Thirty-seven of these appointments were scheduled within 31 to 45 days; 21 were scheduled within 46 to 60 days; 10 were scheduled within 61 to 75 days; 7 were scheduled within76 to 90 days; and 8 were scheduled after more than 90 days.

Compliance with Urgent Care Appointment Requirements

Compliance with COMAR 10.09.66.07A(3)(b)(iii) requires that urgent care appointments be scheduled within 48 hours of the request. The results of the MCOs compliance are presented in Figure 21.

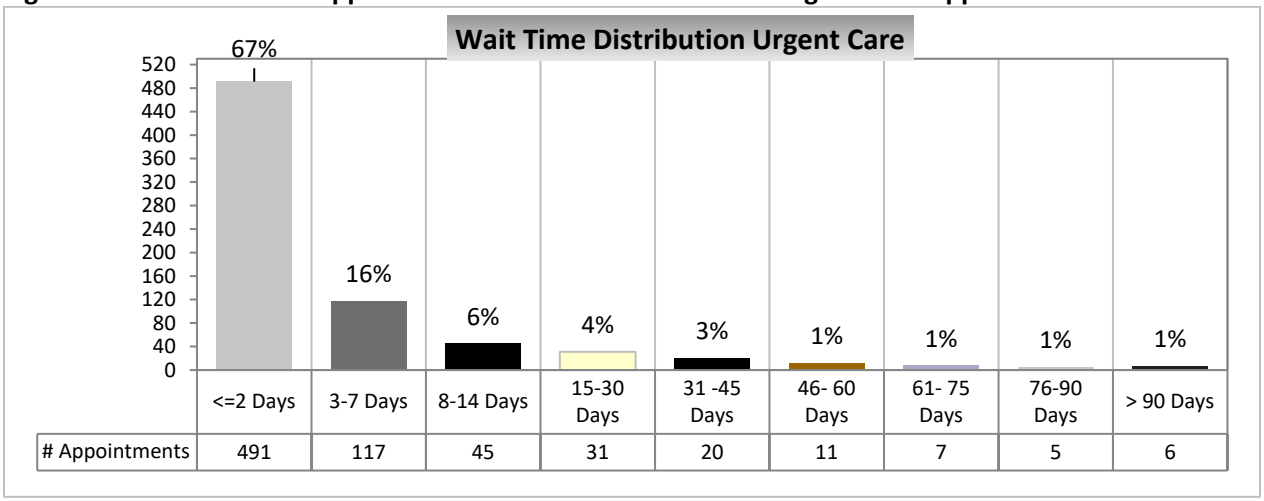
Figure 21. 48-Hour Urgent Care Appointment Compliance



Of the 870 PCPs that were successfully contacted, 733 provided information regarding the next available urgent care appointment. The overall 48-hour urgent care appointment compliance rate was 67%.

Further detail regarding the distribution of appointment times provided by PCPs for the 48-hour urgent care appointments is captured in Figure 22.

Figure 22. Distribution of Appointment Wait Times for 48-Hour Urgent Care Appointments



Survey results showed that 67% of appointments were scheduled within 48 hours of the request, which complied with the regulation. Of concern were 242 (33%) urgent care appointments scheduled outside of the required 48-hour time frame. There were 16% scheduled within the week; 6% were scheduled between 1 and 2 weeks; and the remaining 11% exceeded a 2-week wait time.

MCO-Specific Results (Phase 3)

Tables 45 through 52 provide an assessment of HealthChoice MCO-specific compliance with State access and availability requirements, and how they compare against against the CY 2017 HealthChoice MCO aggregate for Phase 3. The MCO-specific compliance results focus on the following:

- Successful contacts
- Unsuccessful contacts
- Accuracy of MCO Online Directories
- Compliance with Routine Care Appointsments (w/i 30-days)
- Compliance with Urgent Care Appointment (w/i 48 hours)

Table 45. Amerigroup Community Care Access and Availability Results

AMERIGROUP Community Care		
Standard	**Phase 3 CY 2017 ACC Rate**	**Phase 3 CY 2017 HealthChoice MCO Aggregate***
Successful Contacts	**63%**	**66%**
Unsuccessful Contacts	**37%**	**34%**
Accuracy of MCO Online Directories	**56%**	**59%**
Compliance with Routine Care Appointment (w/i 30-days)	**88%**	**89%**
Compliance with Urgent Care Appointment (w/i 48-hrs)	**76%**	**67%**

*JMS and KPMAS had fewer providers in the sample survey.
_Denotes that the MCO did not meet the minimum compliance score.

In the CY 2017 Phase 3, successful contact was made to 63% of ACC's PCPs. This was slightly lower (3 percentage points) than the HealthChoice Aggregate's total of 66%. The accuracy of ACC online directory was found to be 56% and again, slightly lower than the HealthChoice Aggregate of 59%. Compliance with routine care appointment time frames was 88% and only 1 percentage point lower than the HealthChoice Aggregate at 89%. Although ACC's compliance score for urgent care appointment time frames at 75% was 9 percentage points above the HealthChoice Aggregate, it did not reach the minimum compliance score set by MDH at 80%.

A corrective action plan (CAP) was required to correct provider details noted in the online provider directory and improve compliance with urgent care appointment time frames. ACC was provided a spreadsheet identifying providers surveyed that had incorrect provider directory information and were noncompliant with appointment time frames.

Table 46. Jai Medical Systems, Inc Access and Availability Results

Jai Medical Systems, Inc.		
Standard	**Phase 3 CY 2017 JMS Rate**	**Phase 3 CY 2017 HealthChoice MCO Aggregate***
Successful Contacts	**51%**	**66%**
Unsuccessful Contacts	**49%**	**34%**
Accuracy of MCO Online Directories	**27%**	**59%**
Compliance with Routine Care Appointment (w/i 30-days)	**88%**	**89%**
Compliance with Urgent Care Appointment (w/i 48-hrs)	**83%**	**67%**

*JMS and KPMAS had fewer providers in the sample survey.
_Denotes that the MCO did not meet the minimum compliance score.

In the CY 2017 Phase 3, successful contact was made to 51% of JMS's PCPs. This was 15 percentage points lower than the HealthChoice Aggregate's total of 66%. The accuracy of JMS' online directory was found to be 27%, significantly lower than the HealthChoice Aggregate at 59%. Compliance with routine care appointment time frames was 88% and only 1 percentage point lower than the HealthChoice Aggregate. JMS' compliance score for urgent care appointment time frames was 83% which was 16 percentage points above the HealthChoice Aggregate.

A corrective action plan (CAP) was required to correct provider details noted in the online provider directory. JMS was provided a spreadsheet attached to this report identifying providers surveyed that had incorrect provider directory information and were noncompliant with appointment time frames.

Table 47. Kaiser Permanente of MidAtlantic States, Inc Access and Availability Results

Kaiser Permanente of the Mid-Atlantic States, Inc.		
Standard	**Phase 3 CY 2017 KPMAS Rate**	**Phase 3 CY 2017 HealthChoice MCO Aggregate***
Successful Contacts	**76%**	**66%**
Unsuccessful Contacts	**24%**	**34%**
Accuracy of MCO Online Directories	**53%**	**59%**
Compliance with Routine Care Appointment (w/i 30-days)	**100%**	**89%**
Compliance with Urgent Care Appointment (w/i 48-hrs)	**60%**	**67%**

*JMS and KPMAS had fewer providers in the sample survey.
_Denotes that the MCO did not meet the minimum compliance score.

In the CY 2017 Phase 3, successful contact was made to 76% of KPMAS' PCPs. This was 10 percentage points higher than the HealthChoice Aggregate's total of 66%; however, KPMAS had significantly fewer providers surveyed. The accuracy of KPMAS' online directory was found to be 53%, what was 6 percentage points lower than the HealthChoice Aggregate at 59%. Compliance with routine care appointment time frames was 100%. However, KPMAS' compliance score for urgent care appointment time frames at 60% which was 7 percentage points lower than the HealthChoice Aggregate and below the minimum compliance score set by MDH at 80%.

A corrective action plan (CAP) was required to correct provider details noted in the online provider directory and improve compliance with urgent care appointment time frames. KPMAS was provided a spreadsheet attached to this report identifying providers surveyed that had incorrect provider directory information and were noncompliant with appointment time frames.

Table 48. Maryland Physicians Care Access and Availability Results

Maryland Physicians Care		
Standard	**Phase 3 CY 2017 MPC Rate**	**Phase 3 CY 2017 HealthChoice MCO Aggregate***
Successful Contacts	**65%**	**66%**
Unsuccessful Contacts	**35%**	**34%**
Accuracy of MCO Online Directories	**54%**	**59%**
Compliance with Routine Care Appointment (w/i 30-days)	**90%**	**89%**
Compliance with Urgent Care Appointment (w/i 48-hrs)	**75%**	**67%**

*JMS and KPMAS had fewer providers in the sample survey.
_Denotes that the MCO did not meet the minimum compliance score.

In the CY 2017 Phase 3, successful contact was made to 65% of MPC's PCPs. This was slightly lower (1 percentage point) than the HealthChoice Aggregate's total of 66%. The accuracy of MPC's online directory was found to be 54%, which was 5 percentage points below the HealthChoice Aggregate at 59%. Compliance with routine and urgent care appointment time frames were 90% and 75% respectively, both of which were higher than the HealthChoice Aggregates at 89% and 67% respectively. However, the urgent care appointment time frame did not reach the minimum compliance score set by MDH at 80%.

A corrective action plan (CAP) was required to correct provider details noted in the online provider directory and improve compliance with urgent care appointment time frames. MPC was provided a spreadsheet attached to this report identifying providers surveyed that had incorrect provider directory information and were noncompliant with appointment time frames.

Table 49. MedStar Family Choice, Inc. Access and Availability Results

MedStar Family Choice, Inc.		
Standard	**Phase 3 CY 2017 MSFC Rate**	**Phase 3 CY 2017 HealthChoice MCO Aggregate***
Successful Contacts	**68%**	**66%**
Unsuccessful Contacts	**32%**	**34%**
Accuracy of MCO Online Directories	**65%**	**59%**
Compliance with Routine Care Appointment (w/i 30-days)	**86%**	**89%**
Compliance with Urgent Care Appointment (w/i 48-hrs)	**45%**	**67%**

*JMS and KPMAS had fewer providers in the sample survey.
_Denotes that the MCO did not meet the minimum compliance score.

In the CY 2017 Phase 3, successful contact was made to 68% of MSFC's PCPs. This was slightly higher (2 percentage points) than the HealthChoice Aggregate's total of 66%. The accuracy of MSFC's online directory was found to be 65%; although 6 percentage points higher than the HealthChoice Aggregate at 59%, it does not reach the 80% minimum compliance score set by MDH. Compliance with routine care appointment time frames was 86%, only 3 percentage point lower than the HealthChoice Aggregate at 89%. MSFC's compliance score for urgent care appointment time frames was 45%, which is significantly lower than both the HealthChoice Aggregate at 67% and the minimum compliance score set by MDH at 80%.

A corrective action plan (CAP) was required to correct provider details noted in the online provider directory and improve compliance with urgent care appointment time frames. MSFC was provided a spreadsheet attached to this report identifying providers surveyed that had incorrect provider directory information and were noncompliant with appointment time frames.

Table 50. Priority Partners Access and Availability Results

Priority Partners		
Standard	**Phase 3 CY 2017 PPMCO Rate**	**Phase 3 CY 2017 HealthChoice MCO Aggregate***
Successful Contacts	**80%**	**66%**
Unsuccessful Contacts	**20%**	**34%**
Accuracy of MCO Online Directories	**77%**	**59%**
Compliance with Routine Care Appointment (w/i 30-days)	**91%**	**89%**
Compliance with Urgent Care Appointment (w/i 48-hrs)	**77%**	**67%**

*JMS and KPMAS had fewer providers in the sample survey.
_Denotes that the MCO did not meet the minimum compliance score.

In the CY 2017 Phase 3, successful contact was made to 80% of PPMCO's PCPs. This was significantly higher (14 percentage points) than the HealthChoice Aggregate's total of 66%. PPMCO exceeded the HealthChoice Aggregate significantly in each of area assessed. The accuracy of PPMCO's online directory was found to be 77%; although 18 percentage points higher than the HealthChoice Aggregate at 59%, it did not reach the minimum compliance score set at 80% by MDH. Compliance with routine care appointment time frames was 91%, which was 2 percentage points higher than the HealthChoice Aggregate at 89%. Compliance with urgent care appointment time frames at 77% was 10 percentage points higher than the HealthChoice Aggregate at 67%, but did not reach the minimum compliance score set at 80% by MDH.

A corrective action plan (CAP) was required to correct provider details noted in the online provider directory and improve compliance with urgent care appointment time frames. PPMCO was provided a spreadsheet attached to this report identifying providers surveyed that had incorrect provider directory information and were noncompliant with appointment time frames.

Table 51. UnitedHealthcare Community Plan Access and Availability Results

UnitedHealthcare Community Plan		
Standard	**Phase 3 CY 2017 UHC Rate**	**Phase 3 CY 2017 HealthChoice MCO Aggregate***
Successful Contacts	**60%**	**66%**
Unsuccessful Contacts	**40%**	**34%**
Accuracy of MCO Online Directories	**56%**	**59%**
Compliance with Routine Care Appointment (w/i 30-days)	**89%**	**89%**
Compliance with Urgent Care Appointment (w/i 48-hrs)	**68%**	**67%**

*JMS and KPMAS had fewer providers in the sample survey.
_Denotes that the MCO did not meet the minimum compliance score.

In the CY 2017 Phase 3, successful contact was made to 60% of UHC's PCPs. This was 6 percentage points lower than the HealthChoice Aggregate's total of 66%. The accuracy of UHC online directory was found to be 56%, which is 3 percentage points lower than the HealthChoice Aggregate at 59%. Compliance with routine care appointment time frames was equal to the HealthChoice Aggregate at 89%. Although UHC's compliance score for urgent care appointment time frames at 68% was 1 percentage point above the HealthChoice Aggregate at 67%, it did not reach the minimum compliance score set by MDH at 80%.

A corrective action plan (CAP) was required to correct provider details noted in the online provider directory and improve compliance with urgent care appointment time frames. UHC was provided a

spreadsheet attached to this report identifying providers surveyed that had incorrect provider directory information and were noncompliant with appointment time frames.

Table 52. University of Maryland Health Partners Access and Availability Results

University of Maryland Health Partners		
Standard	**Phase 3 CY 2017 UMHP Rate**	**Phase 3 CY 2017 HealthChoice MCO Aggregate***
Successful Contacts	**66%**	**66%**
Unsuccessful Contacts	**34%**	**34%**
Accuracy of MCO Online Directories	**64%**	**59%**
Compliance with Routine Care Appointment (w/i 30-days)	**88%**	**89%**
Compliance with Urgent Care Appointment (w/i 48-hrs)	**60%**	**67%**

*JMS and KPMAS had fewer providers in the sample survey.
_Denotes that the MCO did not meet the minimum compliance score.

In the CY 2017 Phase 3, successful contact was made to 66% of UMHP's PCPs. This was equal to the HealthChoice Aggregate's total at 66%. The accuracy of UMHP's online directory was found to be 64%; although higher than the HealthChoice Aggregate at 59%, it does not reach the minimum compliance rate set at 80% by MDH. Compliance with routine care appointment time frames was 88% and only 1 percentage point lower than the HealthChoice Aggregate. UMHP's compliance score for urgent care appointment time frames was 60%, which is 6 percentage points lower than the HealthChoice Aggregate at 67% and lower than the minimum compliance score set by MDH at 80%.

A corrective action plan (CAP) was required to correct provider details noted in the online provider directory and improve compliance with urgent care appointment time frames. UMHP was provided a spreadsheet attached to this report identifying providers surveyed that had incorrect provider directory information and were noncompliant with appointment time frames.

Conclusions and Recommendations

Overall, the process for collecting the desired data from the surveys were well organized and met established time frames. One of the greatest challenges for this task was obtaining the contact information from the MCO provider directories. A large portion of the information needed to be manually pulled from the MCO websites and entered into spreadsheets, which were later uploaded into the survey portal.

The overall response rate for Phase 3 was 66%. This was an increase of 53% over Phase 2 response rate of 35%. Surveys demonstrated an overall accuracy rate of the MCO online directories of 59% which was

similar to Phase 2. The MCO compliance with routine and urgent care appointment requirements 89% and 67% respectively.

MDH set a minimum compliance score of 80% for the CY 2017 Assessment. If the minimum compliance score is not met, MCOs are required to submit a corrective action plan to Qlarant. All MCOs required to provide CAPs to correct provider details noted in the online provider directory. Additionally, seven MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) are required to provide CAPs to improve compliance with urgent care appointment time frames.

Qlarant reviewed the data collected and entered by Cambridge Federal staff, focusing largely on the review of comments entered by the surveyors. The Phase 3 PCP surveys yielded the following observations and recommendations for the next phase of surveys:

Survey Tool and Data Sample Recommendations

- **Improve** the Survey Tool, Qlarant will 1) add options to the survey tool to capture options for respondents who were unable to or refused to answer survey questions and 2) add additional dropdown boxes to provide surveyors more options to limit the free text comments.
- **Explore** how to survey those MCOs with clinic-based staffing models so that a statistically significant sample of providers at unique provider locations can be surveyed and comparisons can be made across all HealthChoice MCOs.
- **Explore** with MDH expanding the surveys beyond PCPs to include assessment of compliance with access standards for obstetric, pediatric, and specialist providers.

MCO-Specific Recommendations

- **Submit** complete provider directory in comma separated value (CSV) format to ensure timely sampling and uploading to survey tool.
- **Ensure** provider online directories are up to date and accurate.
- **Ensure** provider directories include the ages and populations served by the provider.
- **Ensure** provider directories include information pertaining to open panels.
- **Instruct** provider offices to cooperate when they requested to complete a survey for MDH.
- **Educate** provider offices on COMAR regulations for provider access:
  - 30-day non-urgent care appointment wait time requirements.
  - 48-hour urgent care appointment wait time requirements.

MDH Specific Recommendations

- **Develop and enforce** regulations requiring the MCOs to provide current provider directories in comma separated value (CSV) format.
- **Review and revise** COMAR 10.09.66.07(A)(3)(iii) to specify which provider types are required to schedule patients within 48 hours of the request.

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

Introduction

In accordance with COMAR 10.09.65.03B(2)(a), the HealthChoice MCOs are required to collect HEDIS® measures each year based on relevancy to the HealthChoice population. HEDIS® is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and result-calculation in order to promote a high degree of standardization of HEDIS® measures. Reporting entities are required to register with NCQA and undergo an annual NCQA HEDIS® Compliance Audit™.

To ensure audit consistency, only NCQA-licensed organizations using NCQA certified auditors may conduct a HEDIS® Compliance Audit. The audit conveys sufficient integrity to HEDIS® data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance.

The Maryland Department of Health (MDH) contracted with MetaStar, Inc. (MetaStar), an NCQA-Licensed Organization, to conduct HEDIS® Compliance Audits of all HealthChoice organizations and to summarize the results.

Within MDH, the HealthChoice & Acute Care Administration (HACA) is responsible for the quality oversight of the HealthChoice program. MDH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS® reporting. Performance is measured at both the managed care organization level and on a statewide basis. HEDIS® results are incorporated annually into a HealthChoice Health Plan Performance Report Card developed to assist HealthChoice enrollees to make comparisons when selecting a health plan. All eight HealthChoice MCOs submitted CY 2016 data for HEDIS® 2017.

Measures Designated for Reporting

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

Measures Selected by MDH for HealthChoice Performance Reporting

MDH required HealthChoice managed care organizations to report 59 HEDIS® measures for services rendered in calendar year 2016. The required set reflected four first-year HEDIS® measures which will not be publicly reported for HEDIS® 2017. The four new measures are as follows:

- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence
- Standardized Healthcare-Associated Infection Ratio
- Depression Remission or Response for Adolescents and Adults

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

Effectiveness of Care (EOC) Domain: 26 measures

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)*
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC), all indicators except HbA1c Control (<7.0%)
- Statin Therapy for Patients with Diabetes (SPD)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Appropriate Testing for Children with Pharyngitis (CWP)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- Chlamydia Screening in Women (CHL)
- Use of Imaging Studies for Low Back Pain (LBP)
- Annual Monitoring for Patients on Persistent Medications (MPM)
- Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Medication Management for People with Asthma (MMA)
- Controlling High Blood Pressure (CBP)
- Adult BMI Assessment (ABA)
- Asthma Medication Ratio (AMR)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy Management of COPD Exacerbation (PCE)
- Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Lead Screening in Children (LSC)

- Non–Recommended Cervical Cancer Screening in Adolescent Females (NCS)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

*Measure contains a first-year numerator (Combination 2) that will not be publically reported for HEDIS 2017.

Access/Availability of Care (AAC) Domain: 3 measures

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Children and Adolescents' Access to Primary Care Practitioners (CAP)
- Prenatal and Postpartum Care (PPC)

Utilization and Relative Resource Use (URR) Domain: 9 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), Report Only "a" Level of Measure (Total)
- Frequency of Selected Procedures (FSP)
- Standardized Healthcare- Associated Infection Ratio (HAI) – *New*
- Inpatient Utilization – General Hospital/ Acute Care (IPU), Report Only "a" Level of Measure (Total)
- Antibiotic Utilization (ABX), Report Only "a" Level of Measure (Total)

Health Plan Descriptive Information: 6 measures

- Board Certification (BCR)
- Enrollment by Product Line (ENP), Report Only "a" Level of Measure (Total)
- Enrollment by State (EBS)
- Language Diversity of Membership (LDM)
- Race/ Ethnicity Diversity of Membership (RDM)
- Total Membership (TLM)

No Benefit (NB) Measure Designations: 14 measures

The NB designation is utilized for measures where MDH has contracted with outside vendors for coverage of certain services. MetaStar and HealthChoice Organizations do not have access to the data. So that plans are not penalized, NCQA allows health plans to report these measures with an NB

designation. The following 14 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)
- Follow-Up After Emergency Department Visit for Metal Illness (FUM) – *New*
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) - *New*
- Mental Health Utilization (MPT)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Annual Dental Visit (ADV)
- Use of First–Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Identification of Alcohol and Other Drug Services (IAD)

Not Required (NQ) Measure Designations: 1 Measure

The NQ designation is utilized for measures which are not required to be reported.

- Depression Remission or Response for Adolescents and Adults (DRR) – *New*

HEDIS® Measures Not Utilized by MDH for HealthChoice Reporting

There are two categories of measures that MDH does not utilize for HealthChoice Reporting. They include Measures Exempt from Reporting and Measures that have been retired by NCQA for HEDIS 2017.

Measures Exempt from Reporting

- Comprehensive Diabetes Care
  - HbA1c Control (<7.0%)
- Ambulatory Care
  - Dual Eligibles (AMBB)
  - Disabled (AMBC)

  - Other (AMBD)
- Inpatient Utilization
  - General Hospital / Acute Care: Dual Eligibles (IPUB)
  - General Hospital / Acute Care: Disabled (IPUC)
  - General Hospital / Acute Care: Other (IPUD)
- Identification of Alcohol and Other Drug Services
  - Dual Eligibles (IADB)
  - Disabled (IADC)
  - Other (IADD)
- Antibiotic Utilization
  - Dual Eligibles (ABXB)
  - Disabled (ABXC)
  - Other (ABXD)
- Relative Resource Use for People with Diabetes (RDI)
- Relative Resource Use for People with Cardiovascular Conditions (RCA)
- Relative Resource Use for People with Hypertension (RHY)
- Relative Resource Use for People with COPD (RCO)
- Relative Resource Use for People with Asthma (RAS)
- Enrollment by Product Line
  - Dual Eligibles (ENPB)
  - Disabled (ENPC)
  - Other (ENPD)
- Utilization of the PHQ-9 to Monitor Depression Systems for Adolescents and Adults (DMS)
- Depression Remission or Response for Adolescents and Adults (DRR)

Measures Retired for HEDIS 2017

- Call Answer Timeliness (CAT)
- Weeks of Pregnancy (WOP)

HEDIS® Methodology

The HEDIS®–reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS® 2017 Volume 2: Technical Specifications*.

Data collection: The organization pulls together all data sources to include administrative data, supplemental data, and medical record data, typically into a data warehouse, against which HEDIS® software programs are applied to calculate measures. The three approaches that may be utilized are defined below:

- **Administrative data: D**ata that is collected, processed, and stored in automated information systems includes enrollment or eligibility information, claims information, and managed care encounters. Examples of claims and encounters include hospital and other facility services, professional services, prescription drug services, and laboratory services.
- **Supplemental data:** NCQA defines supplemental data as atypical administrative data, i.e., not claims or encounters. Sources include immunization registry files, laboratory results files, case management databases, and electronic health record databases.
- **Medical record data:** Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA–defined hybrid methodology. HEDIS® specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records needs to be chased. NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by MDH for HEDIS® reporting. Use of the hybrid method is optional. NCQA maintains that no one approach to measure calculation or data collection is considered superior to another. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across–the–board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

Table 53 shows actual HEDIS® 2017 measures collected by use of the administrative or hybrid method. The HealthChoice organization chooses the administrative versus hybrid method based on available resources, as the hybrid method takes significant resources to perform.

Table 53. MCO Use of Administrative or Hybrid Method

Measure List	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
ABA – Adult BMI Assessment	H	H	H	H	H	H	H	H
AWC – Adolescent Well-Care Visits	H	H	A	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
IMA – Immunizations for Adolescents	H	H	H	H	H	H	H	H
LSC – Lead Screening in Children	A	H	H	A	H	A	H	H
PPC – Prenatal and Postpartum Care	H	H	H	H	H	H	H	H
W15 – Well-Child Visits in the First 15 Months of Life	H	H	H	H	H	A	H	H

Measure List	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
W34 – Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	H	H	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.

- **Pre-Onsite Teleconference**: A conference call is held two to four weeks prior to onsite visit to introduce key personnel, review the onsite agenda, identify session participants, and determine a plan to audit data sources used for HEDIS®.
- **HEDIS® Roadmap Review**: The HEDIS® "Roadmap" is an acronym representing the HEDIS® Record of Administration, Data Management, and Processes. The Roadmap is a comprehensive instrument designed by NCQA to collect information from each HealthChoice plan regarding structure, data collection and processing, and HEDIS® reporting procedures. The health plan completes and submits the Roadmap to the auditing organization by January 31st of each reporting year. The auditor reviews the HEDIS® Roadmap prior to the onsite audit in order to make preliminary assessments regarding Information Systems (IS) compliance and to identify areas requiring follow–up at the onsite audit.
- **Information Systems (IS) Standards Compliance:** The onsite portion of the HEDIS® Audit expands upon information gleaned from the HEDIS® Roadmap to enable the auditor to make conclusions about the organization's compliance with IS standards. IS standards measure how the organization collects, stores, analyzes and reports medical, customer service, member, practitioner, and vendor data. IS standards describe the minimum requirements for information systems and processes used in HEDIS® data collection and provides the foundation on which the auditor assesses the organization's ability to report HEDIS® data accurately, completely, and reliably. The auditor reviews data collection and management processes, including the monitoring of vendors, and makes a determination regarding the soundness and completeness of data to be used for HEDIS® reporting.
- **HEDIS® Measure Determination (HD) Standards Compliance**: The auditor uses both onsite and offsite activities to determine compliance with HD standards and to assess the organization's adherence to HEDIS® Technical Specifications and report–production protocols. The auditor confirms the use of NCQA–certified software. The auditor reviews the organization's sampling protocols for the hybrid method. Later in the audit season, the auditor reviews HEDIS® results

for algorithmic compliance and performs benchmarking against NCQA–published means and percentiles.

- **Medical Record Review Validation (MRRV)**: The HEDIS® audit includes a protocol to validate the integrity of data obtained from medical record review (MRR) for any measures calculated using the hybrid method. The audit team compares its medical record findings to the organization's abstraction forms for a sample of positive numerator events. Part one of the validation may also include review of a convenience sample of medical records for the purpose of finding procedural errors early in the medical record abstraction process so that timely corrective action can be made. This is optional based on NCQA standards and auditor opinion. MRRV is an important component of the HEDIS® Compliance Audit. It ensures that medical record reviews performed by the organization, or by its contracted vendor, meet audit standards for sound processes and that abstracted medical data are accurate. In part two of the MRRV, the auditor selects hybrid measures from like–measure groupings for measure validation. MRRV tests medical records and appropriate application of the HEDIS® hybrid specifications (i.e., the member is a numerator positive or an exclusion for the measure). NCQA uses an acceptable quality level of 2.5 percent for the sampling process, which translates to a sample of 16 medical records for each selected measure.
- **Audit Designations:** An NCQA audit results in audited rates or calculations at the measure or indicator level and indicates whether the measures can be publicly reported. All measures selected for reporting must have a final audited result. A measure selected for reporting or required by a state or federal program can receive an audit designation of BR if the auditor determines it is not reportable. The auditor approves the rate/result calculated by the HealthChoice organization for each measure included in the HEDIS® report. Table 54 shows the audit designations of audit results, excerpted from *Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures.*

Table 54. Audit Designations

Rate/Result	Description
R	Reportable. A reportable rate was submitted for the measure.
NA	Small Denominator. The organization followed the specifications but the denominator was too small (<30) to report a valid rate.
NB	Benefit Not Offered. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reported. The organization chose not to report the measure. (An organization may exercise this option only for those measures not included in the measurement set required by MDH.)
NQ	Not Required. The organization was not required to report the measure.

Rate/Result	Description
BR	Biased Rate. The calculated rate was materially biased.
UN	Un-Audited. The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g. measures collected using electronic clinical data systems).

Note. The NB designation is utilized for measures where MDH has contracted with outside vendors for coverage of certain services. Metastar and HealthChoice Organizations do not have access to the data. NCQA allows the health plans to report these measures with a NB designation so that plans are not penalized.

- **Bias Determination:** If the auditor determines that a measure is biased, the organization cannot report a rate for that measure and the auditor assigns the designation of BR. Bias is based on the degree of error or data completeness for the data collection method used. NCQA defines four bias determination rules, applied to specific measures. These are explained in Appendix 9 of *Volume 5: HEDIS® Compliance Audit™: Standards, Policies and Procedures*.
- **Final Audit Opinion:** At the close of the audit, the auditor renders the Final Audit Opinion, containing a Final Audit Statement along with measure–specific rates/results and comments housed in the Audit Review Table.

Measure Specific Findings Explanation

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

- **Maryland Average Reportable Rate (MARR):** The MARR is an average of HealthChoice MCOs' rates as reported to NCQA. In most cases, all eight MCOs contributed a rate to the average. Where one or more organizations reported *NA* instead of a rate, the average consisted of fewer than eight component rates.
- **National HEDIS® Mean (NHM) and NCQA Benchmarks:** The NHM and Benchmarks are taken from NCQA's HEDIS® Audit Means, Percentiles and Ratios – Medicaid, released each year to each reporting organization along with a data use license that outlines how this data can be used. The NCQA data set gives prior-year rates for each measure displayed as the mean rate and the benchmarked rate at the 5th, 10th, 25th, 50th, 75th, 90th and 95th percentiles. NCQA averages the rates of all organizations submitting HEDIS® results, regardless of the method of calculation (administrative or hybrid). NCQA's method is the same as that used for the MARR, but on a larger scale.

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

Prior year results are retained in the trending tables, regardless of specification changes. Text in italics

notes when prior–year results fall under different specifications. Performance trends at the organization level are compared with the trends for the MARR and the NHM for the same measurement year.

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

According to NCQA reporting protocols, *NA* may replace a rate.

Sources of accompanying information:

Description. The source of the information is NCQA's *HEDIS® 2017 Volume 2: Technical Specifications.*

Rationale. For all measures, the source of the information is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of 2017. These citations appear under the *Brief Abstract* on the Web site of the National Quality Measures Clearinghouse, http://www.qualitymeasures.ahrq.gov/. **Summary of Changes for HEDIS® 2017**. The source of the text, is the *HEDIS® 2017 Volume 2: Technical Specifications*, incorporating additional changes published in the *HEDIS® 2017 Volume 2: "October" Technical Update.*

Year–to–Year Changes

Table 55 shows the numbers of organizations that experienced a lower or higher change in HEDIS® rates from service year 2015 to 2016. The change in the MARR (2017 rate minus 2016 rate) and the change in the NHM (2016 rate minus 2015 rate) place Maryland HealthChoice organization trends in perspective.

It should be considered when reviewing these figures that the NHM is retrospective while the MARR is for the current season. A comparison of change in the MARR vs. change in the NHM may be indicative of a specification change or reflect other lability considerations. For measures where a lower rate indicates better performance (single asterisk), the number of lower performing organizations appears in the higher column and the number of higher performing organizations appear in the lower column. New measures or indicators with no trendable history are not included in this analysis of change. HEDIS® 2017 results of *NA* are not included in these results. Rates that stayed the same from last year and did not increase or decrease are not included in this table.

Table 55. Changes in HEDIS® Rates from 2016 to 2017

HEDIS® Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Adult BMI Assessment (ABA)	2	6	2.1	0.9

HEDIS® Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	2	5	5.7	-0.4
Childhood Immunization Status (CIS) – Combination 2	5	3	-1.6	-1.3
Childhood Immunization Status (CIS) – Combination 3	6	2	-2.0	-1.4
Childhood Immunization Status (CIS) – Combination 4	5	3	-1.4	-0.3
Childhood Immunization Status (CIS) – Combination 5	3	4	-1.0	0
Childhood Immunization Status (CIS) – Combination 6	3	5	-1.7	-4.6
Childhood Immunization Status (CIS) – Combination 7	2	6	-0.7	0.5
Childhood Immunization Status (CIS) – Combination 8	3	5	-1.3	-4.1
Childhood Immunization Status (CIS) – Combination 9	3	5	-0.9	-3.2
Childhood Immunization Status (CIS) – Combination 10	3	5	-0.8	-2.9
Immunizations for Adolescents (IMA) – Combination 1	3	5	1.6	1.3
Well–Child Visits in the First 15 months of Life (W15) – No well–child visits*	4	2	0	0.4
Well–Child Visits in the First 15 months of Life (W15) – MDH Five or Six–or–more visits rates**	5	2	.4	0
Well–Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	5	3	-1.4	-0.6
Adolescent Well–Care Visits (AWC)	5	3	-1.0	-1.1
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile– Total Rate	2	6	8.7	0.3
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	5	3	4.8	-0.3
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	3	5	5.4	-0.1
Appropriate Testing for Children with Pharyngitis (CWP)	5	3	-1.3	1.6
Lead Screening in Children (LSC)	3	5	0.7	-0.3
Non–Recommended Cervical Cancer Screening in Adolescent Females (NCS)*	1	7	-0.6	-1.1
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	3	4	-1.1	2.5
Medication Management for People With Asthma (MMA) – Total 75% of treatment period	4	3	-3.0	2.3
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	2	5	0.8	0.8
Asthma Medication Ratio (AMR)	5	2	1.6	0.3
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	1	4	2.7	0

HEDIS® Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	5	2	-2.1	1.7
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	4	3	-0.3	1.0
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	4	4	0.5	0.8
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	7	1	-0.4	-0.6
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	2	6	-0.4	-0.8
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	1	7	1.0	-0.7
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	8	0	-3.4	-2.1
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	8	0	-2.4	-1.0
Breast Cancer Screening (BCS)	4	4	-0.2	-0.3
Cervical Cancer Screening (CCS)	4	3	-0.2	-4.4
Chlamydia Screening in Women (CHL) – Age 16–20 years	0	8	1.8	0.3
Chlamydia Screening in Women (CHL) – Age 21–24 years	2	4	1.4	0.5
Chlamydia Screening in Women (CHL) – Total (16–24) years	1	6	1.7	0.6
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	3	5	3.2	-2.4
Prenatal and Postpartum Care (PPC) – Postpartum Care	3	4	.6	-0.9
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*	5	3	-1.1	-2.2
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	3	5	3.1	1.4
Controlling High Blood Pressures (CBP)	3	4	4.5	-2.4
Persistence of Beta–Blocker Treatment after a Heart Attack (PBH)	3	2	-2.0	-2.8
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	NA	NA	57.1	1.8
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Received Statin Therapy – Total	0	5	3.8	NA
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Statin Adherence 80% - Total	5	1	-11.1	NA
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	4	4	0.1	-0.3
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*	6	2	-1.7	1.8
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	3	5	1.3	-1.0
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	5	3	-3.2	-1.7

HEDIS® Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	6	2	-0.5	9.0
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	3	5	1.2	-2.9
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	1	3	3.0	-1.2
Statin Therapy for Patients With Diabetes (SPD) – Received Statin Therapy	2	6	1.8	NA
Statin Therapy for Patients With Diabetes (SPD) – Statin Adherence 80%	6	2	-2.1	NA
Use of Imaging Studies for Low Back Pain (LBP)	4	4	-1.6	-1.5
Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	1	4	2.1	2.2
Annual Monitoring for Patients on Persistent Medications (MPM) – members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	6	2	-0.4	0.2
Annual Monitoring for Patients on Persistent Medications (MPM) – members on digoxin	4	0	-9.3	0.1
Annual Monitoring for Patients on Persistent Medications (MPM) – members on diuretics	6	2	0	0.6
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate	5	3	-0.2	0.5
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	3	4	-15.74	1.68
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months	6	1	-0.84	2.2

* A lower rate indicates better performance.
** Not a HEDIS® sub-measure: MetaStar is calculating for MDH trending purposes.

Table 56 shows organizations that demonstrated incremental increases in performance scores over the past three years (2017 less 2015) for those MCOs that reported all three years.) The analysis only shows a trend toward improvement. It does not indicate superior performance. 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 56. HEDIS® Measures Incremental Increases in Performance

HEDIS® Measure	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP[1]
Adult BMI Assessment (ABA)	X			X	X		X	
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	X	X			X	X	X	

HEDIS® Measure	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP[1]
Childhood Immunization Status (CIS) – Combination 2	X	X		X	X		X	X
Childhood Immunization Status (CIS) – Combination 3	X	X		X	X	X	X	X
Childhood Immunization Status (CIS) – Combination 4	X	X		X	X	X	X	X
Childhood Immunization Status (CIS) – Combination 5	X	X		X	X	X	X	X
Childhood Immunization Status (CIS) – Combination 6		X		X				X
Childhood Immunization Status (CIS) – Combination 7	X	X		X	X		X	X
Childhood Immunization Status (CIS) – Combination 8		X		X				X
Childhood Immunization Status (CIS) – Combination 9		X						X
Childhood Immunization Status (CIS) – Combination 10		X						X
Immunizations for Adolescents (IMA) – Combination 1	X	X		X	X	X	X	X
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*	X			X	X	X	X	X
Well-Child Visits in the First 15 months of Life (W15) – MDH Five or Six-or-more visits rates**	X					X	X	X
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	X						X	X
Adolescent Well-Care Visits (AWC)	X	X		X			X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) - BMI Percentile- Total Rate	X		X	X	X		X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	X						X	X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	X		X		X		X	X
Appropriate Testing for Children with Pharyngitis (CWP)	X	X		X	X	X	X	X
Lead Screening in Children (LSC)	X	X		X		X	X	X
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*	X	X	X	X	X	X	X	X
Medication Management for People With Asthma (MMA) – Total 50% of treatment period		X		X	X	X	X	
Medication Management for People With Asthma (MMA) – Total 75% of treatment period		X		X	X	X	X	
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	X	X		X	X	X	X	X
Asthma Medication Ratio (AMR)	X	X					X	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	X			X	X	X	X	
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate				X				X
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate		X		X				X

HEDIS® Measure	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP[1]
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–24 months	X				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	X	X	X	
Children and Adolescents' Access to Primary Care Practitioners (CAP) - Age 12–19 years	X	X		X		X	X	
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years								X
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years								X

* A lower rate indicates better performance.
** Not a HEDIS sub-measure; MetaStar is calculating for MDH trending purposes.
[1] UMHP reported NA for most measures in their first year of reporting. They will be given credit for improvement in any measure where they improved from their first reported rate to the rate for HEDIS 2017

HEDIS® Year 2017 Highlights

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) saw marked increases in 2017. UMHP and ACG experienced the most significant increases for all three numerators (BMI Percentile; Counseling for Physical Activity; and Counseling for Nutrition) out of all eight MCOs. UHC and MSFC also showed significant increases for the BMI percentile numerator.
  - BMI percentile – Total rate of Maryland Average Reported Rate increased 19% in 2017 (UMHP +70%; ACC +29%; UHC +25%; and MSFC +20%)
  - Counseling for Physical Activity – Total Rate increased 14%. (UMHP +77% and ACC +24%).
  - Counseling for Nutrition – Total Rate increased 12% (UMHP +74% and ACC +20%)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) experienced an overall increase of 9%. MSFC (+32%) and MPC (24%) showed the most notable increases. Modest gains were experienced by PP and UHC as well.
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) experienced an overall increase of 7%. Most MCOs saw impressive increases in 2017 with the exception of MSFC and UHC.
- Comprehensive Diabetes Care (CDC) specifically focused on the Retinal Eye Exam numerator showed an overall decrease of 6%. MPC, PP, UMHP, and ACG all saw decreases of greater than 5%.

- Overall, utilization seems to have decreased for Inpatient, Emergency Department, and Outpatient settings.
  - Inpatient Utilization – General Hospital/Acute Care (IPU) showed decreased utilization overall across all MCOs with the exception of MSFC. Most notable decreases were seen by UHC (-26%) and UMHP (-20%).
  - Ambulatory Care (AMB) experienced an overall decrease in Emergency Department Visits of -14%. KPMAS was the only MCO to experience an increase for this numerator. A decrease of -15% was also seen for Outpatient visits, where the majority of MCOs experienced a decrease, KPMAS and MPC experienced increases.
- Statin Therapy for Patients with Cardiovascular Disease (SPC), specifically the Statin Adherence 80% numerator experienced a -15% decrease. UHC was the only MCO who experienced an increase for 2017. ACG (-36%), PP (-33%), and MSFC (-19%) experienced the greatest decreases for this numerator.
- Annual Monitoring for Patient on Persistent Medications (MPM), specifically the Digoxin numerator experienced an overall decrease of -21%, Most notable decreases were seen by ACG (-25%) and PP (-25%).
- Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS), experienced an overall decrease of -27%. All MCOs decreased with the exception of JMS. Most notable decreases include KPMAS (-82%), UMHP (-53%), MSFC (-32%), and ACG (-23%).

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

Introduction

COMAR 10.09.65.03(C)(4) requires that all HealthChoice MCOs participate in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. The Maryland Department of Health (MDH) has contracted with wbaRESEARCH (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. Eight MCOs participated in the HealthChoice CAHPS® 2017 survey based on services provided in CY 2016:

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

*Formerly Riverside Health of Maryland (RHMD)

2016 CAHPS® 5.0H Medicaid Survey Overview

In 2017, 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 2016. The survey measures those aspects of care for which members are the best and/or the only source of information. From this survey, members' ratings of and experiences with the medical care they receive can be determined. Based on members' health care experiences, potential opportunities for improvement can be identified. Specifically, the results obtained from this consumer survey will allow MDH to:

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

Results from the CAHPS® 5.0H survey summarize member satisfaction with their health care through ratings, composite measures, and question summary rates. In general, summary rates represent the

percentage of respondents who chose the most positive response categories as specified by NCQA. Ratings and composite measures in the CAHPS® 5.0H Adult and Child Medicaid Survey include:

- Overall Ratings of Personal Doctor, Health Care, Specialist, 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
- Access to Specialized Services
- Family Centered Care: Personal Doctor Who Knows Child
- Family Centered Care: Getting Needed Information
- Coordination of Care for CCC

Survey, Reporting and Methodology Changes in 2017

In 2017, NCQA made several revisions to the CAHPS® Adult Medicaid Satisfaction Survey protocol, as outlined below:

- Added a new deduplication method to be used before selecting the systematic sample and clarified that survey vendors use the subscriber ID and mailing address to identify household members.
- NCQA will not calculate results for the Rating of Overall Health and Rating of Overall Mental/Emotional Health questions in HEDIS 2017.
- Disposition codes were changed from the alphanumeric system signifying survey administration method and status of the member record (e.g., M21=Mail, Ineligible; T10=Phone, Complete) to a more simplified numeric system focusing on the status of the member record (0=Complete, 1=Does Not Meet Eligible Population Criteria, 2=Incomplete (but Eligible), 3=Language Barrier, 4=Physically or Mentally Incapacitated, 5=Deceased, 6=Refusal, 7=Non-Response After Maximum Attempts, 8=Added to Do Not Call List).

MDH made no revisions to the CAHPS® 5.0H Adult and Child Medicaid Survey tool in 2017.

Research Approach

Eligible adult and child members from each of the eight 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 eight HealthChoice MCOs with "Return Service Requested "and 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 adult Medicaid plans and 1,650 for child Medicaid plans (General Population). In addition to the required sample size, MDH elected to over-sample at a rate of 30%.

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). This is standard procedure when the CAHPS® 5.0H Child Medicaid Satisfaction 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.

In 2016, the sampling methodology was revised from a random sample selection to a systematic sample selection process, and disenrolled members were not to be removed from the sample. To qualify, adult Medicaid members had to be 18 years of age or older, while child Medicaid members had to be 17 years of age or younger. Furthermore, members of both populations 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, 2016).

Between February and May 2017, WBA collected 4,337 valid surveys from the eligible Medicaid adult population (59 of which were conducted in Spanish) and 5,079 valid surveys from the eligible Medicaid child population (542 of which were completed in Spanish). Of the responses, 2,903 of the 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). Non-respondents included those who had refused to participate, could not be reached due to a bad address or telephone number, did not complete the survey, were added to the Do Not Call list or were unable to be contacted during the survey time period. Ineligible surveys were subtracted from the sample size when computing the response rate.

Table 57 shows the total number of adult and child members in the sample that fell into each disposition category.

Table 57. Sample Dispositions Among Adult and Child Members

Disposition Group	Disposition Category	Adult	Child (General Population/Sample A)
Ineligible	Deceased (5)	18	2
	Does not meet eligibility criteria (1)	225	217
	Language barrier (3)	68	127
	Mentally/Physically incapacitated (4)	38	N/A
	Total Ineligible	**349**	**346**
Non–Response	Incomplete but eligible (2)	296	421
	Refusal (6)	1,156	1,395
	Maximum attempts made (7)*	7,901	9,914
	Added to Do Not Call (DNC) List (8)	1	5
	Total Non–Response	**9,354**	**11,735**

*Maximum attempts made include two survey mailings and a maximum of six call attempts

Table 58 below illustrates the number of adult surveys mailed, the number of completed surveys (mail and phone), and the response rate for each HealthChoice MCO.

Table 58. Adult Survey Completes and Response Rate

HealthChoice MCO	Surveys Mailed	Mail and Phone Completes*	Response Rate
ACC	1,755	542	32%
JMS	1,755	584	34%
KPMAS	1,755	472	28%
MPC	1,755	577	34%
MSFC	1,755	520	31%
PPMCO	1,755	585	34%
UHC	1,755	577	34%
UMHP	1,755	480	28%
Total HealthChoice MCOs	**14,040**	**4,337**	**32%**

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

Table 59 below illustrates the number of child surveys mailed, the number of completed surveys (mail and phone), and the response rate for each HealthChoice MCO.

Table 59. Child Survey Completes and Response Rate

MCO	General Population Mailed (Sample A)	CCC Oversample Mailed (Sample B)	Total Surveys Mailed	General Population Mail and Phone Completes*	CCC Respondents[1]	General Population Response Rate
ACC	2,145	1,840	3,985	758	390	36%
JMS	2,145	266	2,411	459	154	22%
KPMAS	2,145	927	3,072	603	191	29%
MPC	2,145	1,840	3,985	667	542	32%
MSFC	2,145	1,840	3,985	642	465	31%
PPMCO	2,145	1,840	3,985	742	542	35%
UHC	2,145	1,840	3,985	681	424	32%
UMHP	2,145	979	3,124	527	195	25%
Total	**17,160**	**11,372**	**28,532**	**5,079**	**2,903**	**30%**

[1]Note: In HealthChoice MCOs with fewer members than the required CCC sample size (1,840), the sample includes all members with a diagnosis indicative of a probable chronic condition who were not already selected for the general population sample.
*During the telephone follow-up, members had the option to complete the survey in either English or Spanish.

Findings

Key Findings from the 2017 CAHPS® 5.0h Adult Medicaid Survey

There were four Overall Ratings questions asked in the CAHPS® 5.0H Adult Medicaid Survey that used a scale of "0 to 10", where a "0" represented the worst possible and a "10" represented the best possible. Table 60 shows each of the four Overall Rating questions and the Summary Rate for these questions from CAHPS® 2015, 2016, and 2017. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

Table 60. CAHPS® Adult Summary Rates of Overall Ratings Questions for 2015-2017

Overall Ratings	2017 (Summary Rate - *8,9,10*)	2016 (Summary Rate - *8,9,10*)	2015 (Summary Rate - *8,9,10*)
Specialist Seen Most Often	81.3%	79.2%	79.3%
Personal Doctor	79.8%	79.2%	75.7%
Health Care	73.6%	74.8%	68.9%
Health Plan	74.0%	74.1%	69.0%

HealthChoice members give their highest satisfaction ratings to their Specialist (81.3% , up from 79.2% in 2016) and/or their Personal Doctor (79.8%, up from 79.2% in 2016). Somewhat fewer HealthChoice members give positive satisfaction ratings to their Health Care (73.6%, down from 74.8% in 2016) and/or Health Plan (74.0%, down from 74.1% in 2016) overall.

Overall Ratings

Table 61 shows health plan comparisons of the eight participating HealthChoice MCOs for the four Overall Ratings questions asked in the CAHPS® 5.0H Adult Medicaid Survey. The HealthChoice MCO with the highest Summary Rate for a particular overall rating is identified by an asterisk. Additionally, it indicates the HealthChoice Aggregate for each question.

Table 61. CAHPS® 2017 MCO Adult Summary Rates of Overall Rating Questions

	Overall Ratings (Summary Rate – *8,9,10*)			
	Specialist Seen Most Often	Personal Doctor	Health Care	Health Plan
HealthChoice Aggregate	**81.3%**	**79.8%**	**73.6%**	**74.0%**
ACC	77.0%	78.8%	70.1%	73.6%
JMS	82.0%	80.1%	69.1%	70.1%
KPMAS	78.8%	**83.0%***	**80.7%***	**78.7%***
MPC	81.5%	79.5%	75.7%	76.8%
MSFC	82.0%	81.3%	75.2%	76.0%
PPMCO	82.0%	80.9%	76.6%	75.5%
UHC	81.8%	75.4%	69.1%	68.7%
UMHP	**84.5%***	80.2%	73.3%	73.3%

***HealthChoice MCO with the highest Summary Rate

Composite Measures

Composite measures assess results for main issues/areas of concern. These composite measures were derived by combining survey results of similar questions (note: two of the composite measures are comprised of only one question). Specifically, it's the average of each response category of the attributes that comprise a particular service area or composite.

Table 62 shows the composite measure comparisons for Adult Summary Rates from CAHPS® 2015 to 2017.

Table 62. CAHPS® Adult 2015-2017 Summary Rates for Composite Measure Results

Composite Measure	2017 (Summary Rate – *Always/Usually or Yes*)	2016 (Summary Rate – *Always/Usually or Yes*)	2015 (Summary Rate – *Always/Usually or Yes*)
How Well Doctors Communicate	91.7%	90.8%	89.6%
Customer Service	89.1%	87.1%	84.8%
Getting Needed Care	82.2%	81.3%	79.6%

Composite Measure	2017 (Summary Rate – *Always/Usually or Yes*)	2016 (Summary Rate – *Always/Usually or Yes*)	2015 (Summary Rate – *Always/Usually or Yes*)
Getting Care Quickly	81.4%	80.5%	77.9%
Coordination of Care	83.6%	79.9%	78.5%
Shared Decision-Making	81.0%	79.3%	77.6%
Health Promotion and Education	76.9%	76.7%	74.5%

HealthChoice MCOs receive the highest ratings among their members on the "How Well Doctors Communicate" (91.7% Summary Rate – Always/Usually) and "Customer Service" (89.1% Summary Rate – Always/Usually) composite measures. On the other hand, the research shows that HealthChoice MCOs receive the lowest ratings among their members on the "Health Promotion and Education" composite measure (76.9% Summary Rate – Yes). Notably, positive ratings for the "Coordination of Care" composite measure increased from 2016 to 2017 (up from 79.9% to 83.6% Summary Rate – Always/Usually). Additionally, positive ratings increased from 2016 to 2017 for composite measures "Getting Needed Care" (up from 81.3% to 82.2% Summary Rate – Always/Usually) and "Getting Care Quickly" (up from 80.5% to 81.4% Summary Rate – Always/Usually).

Table 63 shows health plan comparisons of Adult Summary Rates for composite measures for the eight participating HealthChoice MCOs. The HealthChoice MCO with the highest Summary Rate for a particular composite measure is identified by an asterisk. Additionally, it indicates the HealthChoice Aggregate for each question.

Table 63. CAHPS® 2017 MCO Adult Summary Rates for Composite Measure Results

	Composite Measures (Summary Rate – *Always/Usually or Yes*)						
	How Well Doctors Communicate	Customer Service	Getting Needed Care	Getting Care Quickly	Coordination of Care	Shared Decision -Making	Health Promotion and Education
HealthChoice Aggregate	**91.7%**	**89.1%**	**82.2%**	**81.4%**	**83.6%**	**81.0%**	**76.9%**
ACC	92.3%	88.4%	80.7%	77.7%	82.6%	**82.4%***	77.4%
JMS	90.0%	88.4%	81.0%	80.7%	**88.3%***	80.1%	79.1%
KPMAS	91.6%	**94.3%***	82.5%	80.1%	80.9%	79.1%	72.2%

	Composite Measures (Summary Rate – *Always/Usually or Yes*)						
	How Well Doctors Communicate	Customer Service	Getting Needed Care	Getting Care Quickly	Coordination of Care	Shared Decision -Making	Health Promotion and Education
HealthChoice Aggregate	**91.7%**	**89.1%**	**82.2%**	**81.4%**	**83.6%**	**81.0%**	**76.9%**
MPC	91.2%	87.8%	**84.7%***	**84.3%***	84.1%	80.8%	76.2%
MSFC	90.1%	87.7%	78.9%	80.3%	84.8%	81.3%	**79.3%***
PPMCO	93.6%	92.6%	84.4%	83.8%	82.4%	80.4%	78.6%
UHC	91.6%	87.5%	81.9%	83.7%	84.1%	81.9%	78.0%
UMHP	**93.7%***	87.0%	82.7%	78.8%	79.7%	81.5%	72.9%

*HealthChoice MCO with the highest Summary Rate

Key Findings from the 2017 CAHPS® 5.0h Child Medicaid Survey (With CCC Measurement Set)

The results from the four Overall Ratings questions asked in the CAHPS® 5.0H Child Medicaid Survey are represented in Tables 64 and 65. The summary rate represents the percentage of members who rated the question an 8, 9, or 10. Rates are provided for 2015, 2016, and 2017.

Table 64. CAHPS® Child – General Population Summary Rates of Overall Rating Questions for 2015-2017

Overall Ratings	2017 (Summary Rate - *8,9,10*)	2016 (Summary Rate - *8,9,10*)	2015 (Summary Rate - *8,9,10*)
Personal Doctor	90.3%	90.1%	89.1%
Health Care	88.0%	87.6%	86.4%
Health Plan	86.7%	85.3%	84.5%
Specialist	85.4%	82.2%	83.1%

HealthChoice MCOs continue to receive high satisfaction ratings from parents/guardians regarding their child's Personal Doctor (90.3%), Health Care overall (88.0%), Health Plan overall (86.7%) and Specialist (85.4%). Results for Overall Rating questions for 2017 exceeded results for each of the prior two years.

Table 65. CAHPS® Child – CCC Population Summary Rates of Overall Rating Questions for 2015-2017

Overall Ratings	2017 (Summary Rate - *8,9,10*)	2016 (Summary Rate - *8,9,10*)	2015 (Summary Rate - *8,9,10*)
Personal Doctor	88.9%	88.2%	88.2%
Health Care	85.9%	85.7%	84.2%
Specialist	83.1%	82.2%	82.0%
Health Plan	82.6%	84.1%	82.9%

HealthChoice MCOs continue to receive high satisfaction ratings from parents/guardians of children with chronic conditions regarding their child's Personal Doctor (88.9%), Health Care overall (85.9%), Specialist (83.1%) and Health Plan overall (82.6%).

Overall Ratings

The following tables show plan comparisons of Child Summary Ratings of the four Overall Rating questions for the eight participating HealthChoice MCOs. The HealthChoice MCO with the highest Summary Rate for a particular overall rating question is identified by an asterisk. Additionally, they indicate the HealthChoice Aggregate for each question.

Table 66. CAHPS® 2017 MCO Child – General Population Summary Rates of Overall Rating Questions

	Overall Ratings (Summary Rate - *8,9,10*)			
	Personal Doctor	Health Care	Health Plan	Specialist
HealthChoice Aggregate	**90.3%**	**88.0%**	**86.7%**	**85.4%**
ACC	89.2%	88.7%	86.9%	89.3%
JMS	**93.9%***	**91.3%***	88.1%	85.7%
KPMAS	91.1%	88.4%	86.7%	**92.1%***
MPC	90.5%	85.4%	84.9%	83.3%
MSFC	89.6%	87.4%	88.7%	85.4%
PPMCO	92.3%	89.7%	**89.6%***	81.6%
UHC	90.3%	88.5%	85.0%	87.7%
UMHP	85.7%	85.1%	83.3%	78.7%

***HealthChoice MCO with the highest Summary Rate

Table 67. CAHPS® 2017 MCO Child – CCC Population Summary Rates of Overall Rating Questions

	Overall Ratings (Summary Rate - *8,9,10*)			
	Personal Doctor	Health Care	Specialist	Health Plan
HealthChoice Aggregate	**88.9%**	**85.9%**	**83.1%**	**82.6%**
ACC	86.5%	88.1%	81.6%	86.3%
JMS	**97.1%***	**93.5%***	**89.5%***	81.3%
KPMAS	87.9%	86.0%	83.2%	**88.9%***
MPC	87.8%	84.4%	83.0%	83.2%
MSFC	87.7%	85.3%	84.7%	82.6%
PPMCO	91.0%	87.6%	87.4%	80.8%
UHC	89.4%	83.4%	79.6%	78.8%
UMHP	86.9%	82.3%	72.6%	81.6%

*HealthChoice MCO with the highest Summary Rate

Composite Measures

Tables 68, 69, and 70 show the child composite measure results from CAHPS® 2015, 2016, and 2017.

Table 68. CAHPS® Child – General Population 2015-2017 Summary Rates for Composite Measure Results

Composite Measures	2017 (Summary Rate - *Always/Usually or Yes*)	2016 (Summary Rate - *Always/Usually or Yes*)	2015 (Summary Rate - *Always/Usually or Yes*)
How Well Doctors Communicate	94.0%	94.2%	93.9%
Customer Service	88.4%	86.6%	86.3%
Getting Care Quickly	88.1%	88.9%	88.4%
Getting Needed Care	83.0%	83.1%	83.4%
Coordination of Care	79.9%	81.3%	81.1%
Shared Decision-Making	77.0%	79.0%	78.6%
Health Promotion and Education	73.6%	73.8%	74.5%

In 2017, HealthChoice MCOs received the highest ratings among their child members on the following composite measures:

- How Well Doctors Communicate (94.0% Summary Rate – Always/Usually);
- Customer Service (88.4% Summary Rate – Always/Usually); and
- Getting Care Quickly (88.1% Summary Rate – Always/Usually);.

Somewhat lower proportions of child members gave HealthChoice MCOs positive ratings for the "Shared Decision-Making" (77.0% Summary Rate – Yes) and "Health Promotion and Education" (73.6% Summary Rate – Yes) composite measures.

Table 69. CAHPS® Child – CCC Population 2015-2017 Summary Rates for Composite Measure Results

Composite Measures	2017 (Summary Rate - *Always/Usually or Yes*)	2016 (Summary Rate - *Always/Usually or Yes*)	2015 (Summary Rate - *Always/Usually or Yes*)
How Well Doctors Communicate	94.4%	94.5%	94.8%
Customer Service	89.3%	88.4%	87.4%
Getting Care Quickly	91.6%	91.7%	92.4%
Getting Needed Care	84.7%	85.4%	85.6%
Coordination of Care	80.2%	83.9%	82.5%
Shared Decision-Making	82.6%	83.1%	83.6%
Health Promotion and Education	80.4%	79.3%	79.8%

In 2017, HealthChoice MCOs received the highest ratings among their child members with chronic conditions on the following composite measures:

- How Well Doctors Communicate (94.4% Summary Rate – Always/Usually);
- Getting Care Quickly (91.6% Summary Rate – Always/Usually); and
- Customer Service (89.3% Summary Rate – Always/Usually).

Somewhat lower proportions of child members with chronic conditions gave HealthChoice MCOs positive ratings for the following composite measures:

- Shared Decision-Making (82.6% Summary Rate – Yes);
- Health Promotion and Education (80.4% Summary Rate – Yes); and
- Coordination of Care (80.2% Summary Rate – Always/Usually).

In addition to the aforementioned standard CAHPS® composite measures, five additional composite measures are calculated with regard to the CCC population. These results are listed in the table below.

Table 70. CAHPS® Child – CCC Population 2015-2017 Summary Rates for Additional Composite Measure Results

Additional CCC Composite Measures	2017 (Summary Rate - *Always/Usually or Yes*)	2016 (Summary Rate - *Always/Usually or Yes*)	2015 (Summary Rate - *Always/Usually or Yes*)
Family Centered Care: Personal Doctor Who Knows Child	90.1%	91.2%	91.3%
Family Centered Care: Getting Needed Information	91.4%	90.9%	92.5%
Access to Prescription Medicine	90.8%	89.4%	90.6%
Coordination of Care for Children with Chronic Conditions	73.6%	76.1%	73.0%
Access to Specialized Services	77.0%	75.3%	77.5%

The following tables show health plan comparisons of the eight participating HealthChoice MCOs among the General Population and CCC Population. The HealthChoice MCO with the highest Summary Rate for a particular composite measure is identified by an asterisk. Additionally, they indicate the HealthChoice Aggregate for each question.

Table 71. CAHPS® 2017 MCO Child – General Population Summary Rates for Composite Measure Results

	Composite Measures (Summary Rate - *Always/Usually or Yes*)						
	How Well Doctors Communicate	Customer Service	Getting Care Quickly	Getting Needed Care	Coordination of Care	Shared Decision Making	Health Promotion and Education
HealthChoice Aggregate	**94.0%**	**88.4%**	**88.1%**	**83.0%**	**79.9%**	**77.0%**	**73.6%**
ACC	92.5%	86.0%	85.7%	79.1%	76.5%	76.1%	68.9%
JMS	**96.7%***	91.0%	**96.6%***	**90.3%***	**88.2%***	**84.3%***	**81.9%***
KPMAS	93.5%	**91.2%***	88.1%	85.7%	79.3%	74.4%	75.6%
MPC	94.3%	87.5%	90.4%	83.9%	80.2%	77.8%	74.7%

	Composite Measures (Summary Rate - *Always/Usually or Yes*)						
	How Well Doctors Communicate	Customer Service	Getting Care Quickly	Getting Needed Care	Coordination of Care	Shared Decision Making	Health Promotion and Education
HealthChoice Aggregate	**94.0%**	**88.4%**	**88.1%**	**83.0%**	**79.9%**	**77.0%**	**73.6%**
MSFC	95.0%	88.4%	89.7%	84.0%	81.8%	78.3%	75.3%
PPMCO	94.4%	88.6%	86.8%	85.2%	80.2%	77.2%	73.7%
UHC	94.0%	87.1%	85.9%	80.0%	81.4%	74.2%	71.1%
UMHP	91.8%	88.1%	83.5%	78.4%	74.0%	74.3%	70.9%

*HealthChoice MCO with the highest Summary Rate

Table 72. CAHPS® 2017 MCO Child – CCC Population Summary Rates for Composite Measure Results

	Composite Measures (Summary Rate - *Always/Usually or Yes*)						
	How Well Doctors Communicate	Customer Service	Getting Care Quickly	Getting Needed Care	Coordination of Care	Shared Decision Making	Health Promotion and Education
HealthChoice Aggregate	**94.4%**	**89.3%**	**91.6%**	**84.7%**	**80.2%**	**82.6%**	**80.4%**
ACC	92.2%	**91.6%***	88.7%	82.2%	82.9%	**84.8%***	78.4%
JMS	**96.3%***	88.5%	**97.2%***	**95.7%***	**93.6%***	83.6%	**93.5%***
KPMAS	94.9%	91.0%	91.9%	88.1%	65.6%	72.4%	80.0%
MPC	95.6%	91.5%	93.5%	85.8%	81.0%	82.9%	82.3%
MSFC	94.7%	90.9%	90.9%	83.0%	77.9%	82.9%	80.1%
PPMCO	94.1%	90.8%	91.1%	85.2%	83.2%	84.1%	78.6%
UHC	94.0%	85.4%	91.7%	83.6%	77.8%	82.1%	77.6%
UMHP	94.1%	80.3%	90.0%	82.9%	78.3%	79.4%	81.6%

*HealthChoice MCO with the highest Summary Rate

Table 73. CAHPS® 2016 MCO Child – CCC Population Summary Rates for Additional Composite Measure Results

	Additional CCC Composite Measures (Summary Rate - *Always/Usually or Yes*)				
	FCC: Personal Doctor Who Knows Child	FCC: Getting Needed Information	Access to Prescription Medicine	Coordination of Care for Children with Chronic Conditions	Access to Specialized Services
HealthChoice Aggregate	**90.1%**	**91.4%**	**90.8%**	**73.6%**	**77.0%**
ACC	90.7%	91.2%	86.6%	76.0%	72.3%
JMS	91.2%	**95.9%***	**94.2%***	75.2%	**90.4%***
KPMAS	84.4%	89.7%	91.0%	72.1%	72.6%
MPC	90.6%	91.8%	92.1%	69.4%	73.6%
MSFC	89.8%	92.9%	92.6%	75.0%	82.5%
PPMCO	90.9%	92.1%	92.9%	74.4%	78.8%
UHC	**91.7%***	88.1%	87.1%	73.8%	76.5%
UMHP	86.5%	91.1%	91.1%	**77.2%***	74.8%

*HealthChoice MCO with the highest Summary Rate

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 2017 findings, the "Customer Service" composite measure has the most significant impact on adult members' overall rating of their Health Plan. There were no attributes identified as *unmet*

needs[2] that should be considered priority areas for improving adult members' overall rating of their Health Plan. However, the attributes "Got the care, tests or treatment you needed" and "Received information or help needed from health plan's Customer Service" are identified as key drivers that are of high importance to members where they perceive HealthChoice MCOs to be performing at a moderate level. If performance on these attributes is improved, it could have a positive impact on adult members' overall rating of their Health Plan.

Treated with courtesy and respect by health plan's Customer Service is an attribute identified as a *driving strength*[3] and performance in this area should be maintained. If performance on this attribute is decreased, it could have a negative impact on adult members' overall rating of their Health Plan.

Adult Medicaid Members – Key Drivers of Satisfaction with Health Care

Based on the 2017 findings, the "How Well Doctors Communicate" composite measure has the most significant impact on adult members' overall rating of their Health Care. There were no attributes identified as *unmet needs* that should be considered priority areas for improving adult members' overall rating of their Health Care. However, the attributes "Got the care, tests or treatment you needed" and "Received the care needed as soon as you needed" are identified as key drivers that are of high importance to members where they perceive HealthChoice MCOs to be performing at a moderate level. If performance on these attributes is improved, it could have a positive impact on adult members' overall rating of their Health Care.

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.

- Doctor explained things in a way that was easy to understand
- Doctor spent enough time with you
- Doctor listened carefully to you
- Doctor showed respect for what you had to say

[2] ***Unmet needs*** are key drivers that are of high importance to members where they perceive HealthChoice MCOs to be performing at a lower level (Summary Rate is less than 80%).

3 ***Driving strengths*** are key drivers that are of high importance to members where they perceive HealthChoice MCOs to be performing at a higher level (Summary Rate is 90% or more).

Child Medicaid Members – Key Drivers of Satisfaction with Health Plan

Based on the 2017 findings, the "Getting Needed Care" and "How Well Doctors Communicate" composite measures are identified as having the most significant impact on child members' overall rating of their Health Care. 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" and "Got the care, tests or treatment your child needed" are areas that are of high importance to child members where HealthChoice MCOs perform at a moderate level. Improvement in these areas could have a positive impact on child members' overall rating of their Health Plan.

The attribute "Treated with courtesy and respect by child's health plan's Customer Service" is identified as a *driving strength* and performance in this area should be maintained. If performance on this attribute decreases, it could have a negative impact on child members' overall rating of their Health Plan.

Child Medicaid Members – Key Drivers of Satisfaction with Health Care

Based on the 2017 findings, the "Getting Needed Care" and "How Well Doctors Communicate" composite measures are identified as having the most significant impact on child members' overall rating of their Health Care. 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 attributes "Got the care, tests or treatment your child needed" and "Child's doctor spent enough time with your child" are key drivers of satisfaction where child members perceive HealthChoice MCOs to be performing at a moderate level. Improvement in these areas could have a positive impact on child members' overall rating of their Health Care.

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.

- Child's doctor listened carefully to you
- Child's doctor explained things about your child's health in a way that was easy to understand

Section XI
Review of Compliance with Quality Strategy

Table 74 below describes HACA's progress against the Quality Strategy's goal.

Table 74. 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. Qlarant has assisted with this goal in streamlining the Annual Systems Review Process so that documentation can be submitted electronically. Additionally, since NCQA accreditation is required for all HealthChoice MCOs, the Department allowed deeming for eligible standards beginning with the CY 2015 review. The Department also has moved the comprehensive Systems Review Process from an annual to a triennial review beginning with the CY 2016 review. Desktop reviews will occur in the intervening years based upon specific criteria.	√

Assist the Department with setting priorities and responding to identified areas of concern such as children, pregnant women, children with special healthcare needs, adults with a disability, and adults with chronic conditions.	The HealthChoice and Acute Care Administration assisted the Department by: ➢ Requiring NCQA accreditation and adding HEDIS® performance measures to monitor compliance with quality of care and access standards for participants. ➢ Volunteering to report Medicaid Adult and Child CORE Measures which will assist CMS to better understand the quality of health care that adults and children enrolled in Medicaid receive. ➢ Revising the Value Based Purchasing Initiative to incentivize measures that include adults with disabilities and adults and children with chronic conditions. ➢ Designing supplemental CAHPS® survey questions to address pregnant women and children to provide data input for the Deputy Secretary of Health Care Financing – Medical Care Programs Administration's annual Managing for Results report that includes key goals, objectives, and performance measure results for each calendar year. ➢ Developing and implementing a monitoring policy coupled with intermediate sanctions to hold MCOs accountable for quality improvement. ➢ Raising the minimum compliance score for EPSDT Medical Record Reviews to 80% for all components. ➢ Requiring a new Performance Improvement Project addressing the Lead Screening.	√

√ – 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 2016 activities, Qlarant has developed several recommendations for all MCOs which are identified within each section of the Annual Technical Report.

EQRO Recommendations for HACA

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

- Since the comprehensive Systems Performance Review has been changed to occur on a triennial rather than an annual basis, the Department may want to explore alternative ways to review the MCOs for quality, access, and timeliness of care. For example,
  - Provide an additional area of focus to the interim desktop reviews regarding quality, access or timeliness such as credentialing/recredentialing, timeliness of customer call center services, etc.
  - Implement a collaborative performance improvement project focusing on identified best practices.
- 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. Additionally, the CMS' Final Rule has been published and many revisions to the standards will be implemented in 2017 and 2018.
- Utilize consumer focus group findings and survey feedback in making revisions to the Consumer Report Card to ensure its continued relevance to the enrollee population.
- Decrease the sample size for EPSDT and EDV record reviews based upon a 90 percent confidence level rather than the current 95 percent with a 5 percent margin of error to reduce the administrative burden on the MCOs while continuing to ensure valid and reliable results.
- Shorten the comment period for MCOs to provide feedback following release of new/revised draft Standards and Guidelines from 90 to either 30 or 45 days. This will provide the MCOs with a longer time frame between finalization of the standards and uploading of their pre-site documents for review.

Conclusion

This report is a representation of all EQRO, HEDIS®, and CAHPS® activities that took place in calendar years 2016–2017 for the Maryland HealthChoice program. Opportunities for improvement and best practices of the MCOs are noted in the executive summary and within each individual review activity.

Overall strengths for the HealthChoice program are in the following areas:

- **Quality.** Encounter data submitted by the HealthChoice MCOs for CY 2016 is considered accurate and reliable with an overall match rate of 95.5%.
- **Quality, Access, and Timeliness.** EPSDT total scores continue to increase; HealthChoice total scores increased by one percentage point (88% to 89%) from CY 2014 to CY 2015, and increased by two percentage points (89% to 91%) from CY 2015 to CY 2016.
- **Quality and Timeliness.** MCOs demonstrated fairly strong and consistent results in meeting regulatory requirements for grievances, appeals, and preservice denials.

An identified opportunity for improvement for the HealthChoice program is in the area of Network Adequacy. PCP surveys conducted in first Network Adequacy Assessment in CY 2017 demonstrated an overall accuracy rate of 59% for the MCO online directories and compliance with routine and urgent care appointment requirements were 89% and 67% respectively. Although, baseline rates for the MCOs, these rates indicate possible issues with quality, access, and timeliness of the MCO's PCP networks.

The Department sets high standards for MCO QA systems. As a result, the HealthChoice MCOs have quality systems and procedures in place to promote high quality care with well–organized approaches to quality improvement. The CY 2017 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care for Maryland managed care participants.

Additionally, the HealthChoice MCOs have further demonstrated their commitment to quality by obtaining NCQA accreditation. NCQA awards accreditation to health plans with strong consumer protections and a commitment to quality by completing a comprehensive evaluation that bases its results on clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures). Recent accredition reviews resulted in two of the HealthChoice MCOs receiving NCQA's highest accreditation rating of excellent, and five of the MCOs receiving the second highest rating of commendable.

Acronym List

ACC	AMERIGROUP Community Care
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act of 1990
ADV	Annual Dental Visit
AHRQ	Agency for Healthcare Research and Quality
AWC	Adolescent Well Care
BBA	Balanced Budget Act of 1997
BCR	Board Certification
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBP	Controlling High Blood Pressure
CCC	Children with Chronic Conditions
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COMAR	Code of Maryland Regulations
CPT	Current Procedural Terminology
CY	Calendar Year
DHQA	Division of HealthChoice Quality Assurance
DOC	Delegate Oversight Committee
EBS	Enrollment by State
ED	Emergency Department
EDV	Encounter Data Validation
ENP	Enrollment by Product Line
EOC	Effectiveness of Care
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ER	Emergency Room
FC	Fully Compliant
FQHC	Federally Qualified Health Center
FSP	Frequency of Selected Procedures
HACA	HealthChoice and Acute Care Administration
HD	HEDIS® Measure Determination
HED	Health Education/Anticipatory Guidance
HEDIS®	Healthcare Effectiveness Data and Information Set

Acronym List

HEP	Health Education Plan
HILLTOP	The Hilltop Institute of University of Maryland Baltimore County
HIV	Human Immunodeficiency Virus
HCQIS	Healthcare Quality Improvement System for Medicaid Managed Care
HX	Health and Developmental History
IDSS	Interactive Data Submission System
IMM	Immunizations
IPU	Inpatient Utilization-General Hospital/Acute Care
IRR	Inter-rater Reliability
IS	Information Systems
JMS	Jai Medical Systems, Inc.
KPMAS	Kaiser Permanente of the Mid-Atlantic States, Inc.
LAB	Laboratory Tests/At-Risk Screenings
LDM	Language Diversity of Membership
MMAC	Maryland Medical Advisory Committee
MARR	Maryland Average Reportable Rate
MCG	Milliman Care Guidelines
MCO	Managed Care Organization
MD	Maryland
MDH	Maryland Department of Health
MPC	Maryland Physicians Care
MRR	Medical Record Review
MRRV	Medical Record Review Validation
MSFC	MedStar Family Choice, Inc.
NA	Not Applicable
NB	No Benefit
NCC	National Call Center
NCQA	National Committee for Quality Assurance
NHM	National HEDIS® Mean
NR	Not Reportable
NV	Not Valid
OB/GYN	Obstetrician/Gynecology
PA	Preauthorization
PCP	Primary Care Physician
PE	Comprehensive Physical Exam

Acronym List

PIP	Performance Improvement Project
PPMCO	Priority Partners
PT	Physical Therapy
QA	Quality Assurance
QAP	Quality Assurance Program
QIC	Quality Improvement Committee
QIO	Quality Improvement Organization
QMC	Quality Management Committee
QMP	Quality Management Program
QOC	Quality of Care
RDM	Race/Ethnicity Diversity of Membership
ROADMAP	Record of Administration, Data Management and Processes
RQIC	Regional Quality Improvement Committee
SC	Substantially Compliant
SPR	Systems Performance Review
SSI	Supplemental Security Income
STI/HIV	Sexually Transmitted Infection/Human Immunodeficiency Virus
TAT	Turn Around Time
TLM	Total Membership
UHC	UnitedHealthcare Community Plan
UM	Utilization Management
UMHP	University of Maryland Health Partners
UR	Utilization Review
URI	Upper Respiratory Infection
URR	Utilization and Relative Resource Use
VBP	Value Based Purchasing
VBPI	Value Based Purchasing Initiative
VFC	Vaccine for Children
VIS	Vaccine Information Statement
WBA	WBA Market Research

TABLE A – HealthChoice Organizations HEDIS 2018 Results

HEDIS 2018 Results, (Page 1 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PPMCO			UHC			UMHP			MARR
Adult BMI Assessment (ABA)	85.2%	91.0%	92.0%	96.6%	98.0%	98.5%	100.0%	98.0%	98.1%	82.4%	89.3%	87.8%	90.3%	90.6%	96.2%	86.1%	89.6%	91.2%	92.7%	90.3%	93.7%	85.4%	88.6%	92.9%	93.8%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	25.9%	30.0%	31.8%	33.0%	37.0%	43.6%	NA[1]	57.1%	71.2%	19.5%	21.3%	26.5%	22.8%	20.7%	30.0%	22.2%	25.5%	30.0%	26.0%	25.9%	31.2%	23.1%	25.0%	33.2%	37.2%
Childhood Immunization Status (CIS) – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	83.1%	85.0%	85.2%	88.7%	91.0%	85.4%	79.5%	73.1%	72.5%	84.7%	79.9%	66.2%	85.9%	84.4%	84.2%	84.5%	83.5%	79.8%	83.5%	79.8%	74.5%	80.9%	80.8%	76.6%	78.0%
Childhood Immunization Status (CIS) – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	81.9%	83.0%	82.5%	87.3%	88.0%	83.7%	78.2%	70.0%	70.3%	82.1%	78.5%	64.5%	83.2%	81.8%	82.7%	83.0%	82.6%	77.9%	80.5%	77.9%	70.8%	80.2%	79.3%	75.2%	75.9%
Childhood Immunization Status (CIS) – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	78.9%	80.0%	80.1%	86.8%	88.0%	83.3%	78.2%	69.5%	70.1%	78.0%	75.7%	62.5%	80.5%	79.3%	81.3%	79.7%	80.9%	76.4%	75.7%	74.7%	67.4%	78.2%	76.6%	73.7%	74.3%
Childhood Immunization Status (CIS) – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	68.3%	70.0%	69.8%	76.4%	73.0%	71.2%	68.0%	55.0%	62.3%	59.9%	59.5%	52.6%	67.9%	67.9%	67.9%	69.0%	69.5%	68.1%	61.6%	65.2%	57.4%	58.0%	60.6%	58.6%	63.5%
Childhood Immunization Status (CIS) – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	52.6%	42.0%	48.7%	47.6%	57.0%	64.4%	52.6%	46.3%	55.7%	41.8%	42.4%	34.1%	47.9%	49.6%	47.7%	59.7%	48.8%	50.9%	42.6%	44.8%	41.6%	41.0%	41.4%	46.7%	48.7%
Childhood Immunization Status (CIS) – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	65.7%	68.0%	67.9%	76.4%	73.0%	71.2%	68.0%	55.0%	62.0%	57.8%	57.9%	51.3%	65.7%	66.2%	67.2%	67.3%	68.4%	67.4%	58.9%	63.5%	55.5%	56.7%	59.6%	57.9%	62.5%
Childhood Immunization Status (CIS) – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	51.4%	42.0%	47.7%	47.2%	57.0%	64.4%	52.6%	46.0%	55.7%	40.1%	41.4%	33.1%	47.2%	48.2%	47.5%	57.5%	48.4%	50.9%	40.9%	43.1%	40.4%	40.3%	40.6%	45.7%	48.2%
Childhood Immunization Status (CIS) – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	46.8%	37.0%	44.3%	42.5%	49.0%	55.8%	46.2%	37.5%	49.9%	32.5%	32.9%	27.7%	40.2%	43.8%	41.1%	51.1%	42.6%	46.5%	35.0%	39.7%	36.7%	30.0%	34.1%	37.2%	42.4%
Childhood Immunization Status (CIS) – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	45.6%	36.0%	43.3%	42.5%	49.0%	55.8%	46.2%	37.5%	49.9%	31.6%	32.2%	27.0%	39.4%	42.3%	40.9%	50.0%	42.3%	46.5%	33.8%	38.7%	35.8%	29.4%	38.8%	36.7%	42.0%
Immunizations for Adolescents (IMA) – Combination 1 (Meningococcal, Tdap/Td)	86.8%	88.0%	89.1%	82.1%	89.0%	89.7%	82.7%	80.5%	83.7%	85.4%	88.2%	84.7%	80.0%	84.2%	88.6%	89.2%	89.1%	87.1%	84.8%	86.7%	87.4%	82.7%	80.5%	87.5%	87.2%
Immunizations for Adolescents (IMA) Combination 2 (Meningococcal, Tdap, HPV)	N/A	28.94%	48.9%	N/A	52.69%	72.2%	N/A	26.69%	47.5%	N/A	21.30%	37.7%	N/A	24.09%	35.5%	N/A	26.85%	38.4%	N/A	22.87%	36.5%	N/A	17.37%	30.4%	43.4%
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits [2]	0.9%	1.0%	0.5%	4.4%	5.0%	0.5%	2.0%	3.6%	2.0%	1.2%	1.4%	2.0%	3.5%	3.2%	2.0%	1.5%	1.5%	5.0%	2.5%	0.3%	2.4%	8.5%	8.5%	2.0%	2.0%
Well-Child Visits in the First 15 months of Life (W15) – MDH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)	88.9%	88.7%	88.8%	82.4%	80.7%	85.9%	78.2%	78.4%	86.9%	85.9%	83.6%	84.2%	82.7%	82.7%	86.5%	82.2%	82.0%	76.5%	87.2%	87.1%	87.6%	67.0%	74.2%	81.0%	84.7%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	85.8%	88.0%	88.8%	90.9%	90.0%	91.3%	82.6%	79.6%	77.6%	88.7%	79.9%	76.6%	85.5%	79.5%	77.1%	85.2%	81.0%	85.6%	80.7%	82.6%	81.5%	62.3%	69.8%	70.3%	81.1%
Adolescent Well-Care Visits (AWC)	67.9%	69.0%	73.0%	82.6%	84.0%	80.7%	57.1%	56.0%	59.1%	73.2%	72.7%	54.7%	64.0%	55.8%	59.7%	72.8%	64.4%	65.7%	64.8%	62.6%	63.8%	42.6%	52.6%	56.7%	64.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile- Total Rate	56.4%	73.0%	73.2%	92.7%	92.0%	95.9%	98.6%	100.0%	100.0%	56.7%	60.8%	53.0%	62.4%	74.7%	81.1%	70.1%	68.5%	76.4%	61.0%	76.5%	75.7%	32.1%	54.5%	68.1%	77.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	66.0%	79.0%	75.7%	97.6%	95.0%	97.6%	94.5%	94.3%	100.0%	66.7%	64.0%	62.3%	73.5%	71.9%	85.3%	74.3%	73.4%	73.7%	69.5%	76.0%	77.1%	36.7%	63.8%	67.6%	79.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	58.1%	72.0%	68.1%	93.4%	91.0%	96.6%	94.5%	100.0%	100.0%	63.9%	56.8%	53.0%	65.5%	69.9%	80.2%	70.1%	67.4%	66.2%	62.8%	70.9%	71.8%	30.4%	53.8%	62.0%	74.7%
Appropriate Testing for Children with Pharyngitis (CWP)	82.4%	81.0%	79.6%	85.6%	83.0%	92.2%	98.3%	93.4%	91.9%	86.3%	88.3%	87.7%	94.5%	92.2%	93.7%	85.9%	86.0%	86.2%	86.6%	87.8%	89.3%	87.1%	84.0%	86.7%	88.4%
Lead Screening in Children (LSC)	79.4%	80.0%	80.0%	92.1%	91.0%	88.6%	64.5%	66.1%	68.5%	73.8%	72.2%	74.7%	82.6%	84.8%	83.0%	75.7%	78.6%	80.1%	74.9%	73.0%	72.0%	67.7%	70.6%	74.5%	77.7%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) [2]	3.9%	3.0%	2.1%	1.9%	2.0%	2.0%	0.6%	0.1%	0.0%	2.0%	1.8%	1.4%	1.9%	1.3%	1.1%	2.4%	2.0%	1.4%	3.2%	3.0%	2.5%	4.0%	1.9%	1.3%	1.5%
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	48.5%	47.0%	50.0%	73.9%	77.0%	75.0%	NA[1]	50.5%	61.5%	61.5%	64.4%	60.5%	48.8%	50.1%	53.7%	46.8%	48.1%	49.6%	54.0%	53.6%	55.7%	64.5%	55.9%	59.9%	58.2%
Medication Management for People With Asthma (MMA) – Total 75% of treatment period	25.1%	21.0%	23.8%	51.4%	52.0%	51.0%	NA[1]	28.4%	33.3%	35.6%	38.3%	34.1%	25.8%	25.2%	29.4%	23.7%	24.5%	25.2%	28.5%	28.4%	31.5%	48.4%	31.2%	34.8%	32.9%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	89.4%	91.0%	92.0%	97.1%	97.0%	98.0%	97.5%	97.25	98.1%	88.7%	88.7%	88.6%	90.0%	92.2%	91.5%	90.6%	90.8%	92.0%	88.8%	89.6%	90.1%	85.5%	88.0%	87.7%	92.2%
Asthma Medication Ratio (AMR)	63.0%	67.0%	63.2%	61.9%	70.0%	70.7%	NA[1]	72.6%	77.9%	64.0%	63.6%	63.1%	69.3%	67.9%	64.6%	64.7%	62.2%	58.9%	64.0%	63.6%	62.7%	52.4%	47.3%	60.1%	65.2%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.

ACC: AMERIGROUP Community Care
JMS: Jai Medical Systems
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MPC: Maryland Physicians Care
MSFC: MedStar Family Choice
PPMCO: Priority Partners
UHC: UnitedHealthcare
UMHP: University of Maryland Health Partners
MARR: Maryland Average Reportable Rate

HEDIS 2018 Results, (Page 2 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PPMCO			UHC			UMHP			MARR
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.0%	30.0%	30.5%	34.9%	32.0%	40.7%	NA[1]	50.0%	NA	25.5%	31.5%	32.0%	30.8%	40.7%	38.9%	28.0%	29.9%	31.1%	31.2%	32.9%	32.2%	NA[1]	37.5%	36.9%	34.6%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	70.3%	68.0%	68.2%	73.3%	65.0%	68.4%	NA[1]	55.2%	78.6%	74.4%	73.9%	70.8%	71.0%	71.6%	74.8%	75.7%	66.7%	61.8%	70.2%	65.0%	69.0%	70.3%	80.7%	78.2%	71.2%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	84.9%	81.0%	82.3%	88.6%	86.0%	87.9%	NA[1]	75.9%	83.3%	87.4%	86.9%	85.8%	84.5%	87.3%	88.7%	83.7%	81.5%	80.9%	80.8%	81.5%	80.4%	86.1%	89.3%	88.7%	84.7%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	97.9%	98.0%	97.5%	91.5%	93.0%	92.5%	91.3%	92.5%	95.7%	97.2%	96.4%	96.1%	95.3%	94.3%	95.5%	97.8%	97.0%	93.6%	97.0%	96.2%	96.8%	84.9%	89.2%	94.0%	95.2%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	94.1%	93.0%	93.5%	93.0%	92.0%	91.8%	89.1%	87.5%	86.3%	91.6%	90.8%	88.7%	90.0%	87.6%	86.9%	94.2%	93.1%	89.5%	92.6%	92.0%	90.5%	77.5%	83.5%	83.4%	88.8%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	96.1%	96.0%	96.0%	93.8%	94.0%	94.3%	98.1%	92.5%	91.7%	93.5%	94.0%	92.4%	92.0%	92.8%	91.9%	95.3%	95.4%	90.9%	94.4%	94.8%	93.9%	76.8%	83.5%	84.3%	91.9%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	93.0%	94.0%	93.6%	94.2%	95.0%	93.8%	96.6%	91.5%	90.4%	91.6%	91.8%	89.9%	90.6%	90.7%	89.2%	93.7%	94.1%	89.6%	92.1%	93.4%	92.1%	75.2%	85.0%	83.5%	90.3%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	79.7%	76.0%	74.3%	69.3%	68.0%	64.4%	82.7%	75.3%	73.7%	82.8%	79.9%	75.7%	75.8%	72.5%	71.1%	82.6%	80.4%	76.5%	79.0%	76.7%	75.1%	69.3%	65.4%	65.6%	72.0%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	88.2%	86.0%	84.6%	87.8%	86.0%	83.7%	87.0%	82.1%	81.5%	89.4%	87.3%	85.1%	85.7%	83.2%	81.9%	90.0%	88.4%	86.0%	88.0%	86.7%	86.1%	79.6%	77.5%	77.9%	83.3%
Breast Cancer Screening (BCS)	65.9%	66.0%	69.2%	72.6%	74.0%	77.5%	88.5%	87.9%	81.5%	72.1%	68.2%	59.2%	66.0%	65.5%	67.1%	68.3%	69.2%	68.5%	62.3%	60.2%	59.9%	63.8%	67.3%	74.9%	69.7%
Cervical Cancer Screening (CCS)	67.5%	66.0%	62.5%	77.3%	73.0%	76.8%	79.2%	79.2%	80.4%	65.2%	66.3%	56.7%	61.5%	55.9%	54.3%	69.3%	64.7%	64.0%	60.1%	68.6%	59.6%	41.1%	45.3%	45.3%	62.4%
Chlamydia Screening in Women (CHL) – Age 16–20 years	61.0%	62.0%	63.9%	87.6%	89.0%	91.0%	69.2%	69.8%	71.3%	56.8%	57.6%	56.4%	52.2%	56.0%	59.1%	57.5%	60.0%	60.7%	52.1%	56.0%	57.4%	49.5%	50.1%	55.1%	64.4%
Chlamydia Screening in Women (CHL) – Age 21–24 years	68.6%	70.0%	71.8%	72.8%	85.0%	81.7%	84.7%	82.1%	80.2%	68.7%	68.7%	66.0%	65.3%	66.3%	68.2%	67.5%	68.0%	68.0%	65.4%	65.4%	67.2%	61.2%	60.4%	67.6%	71.3%
Chlamydia Screening in Women (CHL) – Total (16–24) years	64.2%	66.0%	67.4%	80.3%	87.0%	86.6%	79.6%	77.5%	77.0%	62.0%	62.8%	61.1%	58.6%	61.3%	64.0%	61.5%	63.6%	64.0%	57.9%	60.0%	61.6%	56.3%	56.3%	62.5%	68.0%
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	83.9%	89.0%	87.4%	87.2%	79.0%	78.3%	92.9%	96.7%	93.7%	81.5%	89.5%	82.7%	84.5%	83.6%	78.%	90.3%	89.3%	84.4%	80.7%	87.6%	85.2%	74.5%	86.4%	88.3%	84.9%
Prenatal and Postpartum Care (PPC) – Postpartum Care	73.7%	73.7%	72.0%	88.0%	81.3%	83.6%	83.8%	84.1%	85.2%	68.9%	67.1%	69.1%	69.2%	71.2%	74.0%	73.7%	71.3%	69.1%	66.2%	70.6%	66.4%	62.3%	71.0%	74.0%	74.2%
Controlling High Blood Pressure (CBP)	54.1%	63.0%	62.0%	76.4%	72.0%	74.9%	86.0%	84.4%	85.2%	55.9%	68.7%	46.2%	71.2%	72.8%	72.8%	60.2%	51.1%	53.3%	56.9%	64.9%	64.7%	48.2%	NA	52.3%	62.7%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	84.9%	71.0%	65.2%	NA[1]	87.0%	68.8%	NA[1]	90.5%	81.8%	84.3%	83.2%	81.6%	67.7%	80.5%	80.8%	85.7%	75.0%	72.3%	77.9%	81.0%	77.6%	NA[1]	81.0%	70.0%	74.8%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	NA[1]	77.0%	NA	NA[1]	NA	NA	NA[1]	53.9%	NA	NA[1]	76.9%	NA	NA[1]	75.0%	NA	NA[1]	57.1%	66.7%	NA[1]	70.8%	NA	NA[1]	NA	NA	66.7%
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Received Statin Therapy – Total	66.0%	70.1%	68.3%	78.4%	80.8%	82.1%	N/A	89.5%	93.0%	72.2%	75.4%	75.1%	77.5%	80.2%	78.6%	72.1%	72.1%	75.7%	71.0%	73.5%	73.8%	N/A	71.9%	74.5%	77.6%
Statin Therapy for Patients With Cardiovascular Disease (SPC) – Statin Adherence 80% - Total	76.5%	48.7%	53.6%	56.7%	54.6%	53.7%	NA	44.1%	46.3%	66.8%	64.6%	64.3%	55%	44.4%	50.0%	74.7%	50.2%	52.6%	45.1%	48.0%	55.4%	NA	56.5%	55.9%	54.0%
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	87.4%	85.0%	90.5%	94.3%	95.0%	94.9%	94.5%	92.7%	91.6%	85.9%	88.7%	80.8%	87.8%	91.7%	90.0%	89.4%	89.3%	88.1%	82.5%	86.1%	85.9%	88.3%	82.5%	81.8%	87.9%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) [2]	42.2%	40.0%	34.1%	26.6%	27.0%	29.9%	28.2%	27.8%	28.0%	40.8%	34.4%	47.9%	31.6%	29.5%	31.4%	35.6%	34.0%	38.9%	39.7%	35.55%	35.5%	39.2%	42.1%	49.2%	36.9%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	49.2%	52.0%	59.4%	60.4%	63.0%	61.1%	57.6%	60.0%	60.9%	49.7%	56.5%	46.0%	59.9%	58.1%	56.7%	55.1%	53.5%	49.6%	51.6%	51.1%	54.5%	48.2%	48.7%	42.6%	53.8%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	53.9%	49.9%	55.7%	71.9%	74.0%	75.7%	84.7%	87.8%	84.5%	65.8%	51.9%	42.8%	52.6%	49.8%	63.7%	62.9%	55.7%	38.4%	55.2%	56.9%	62.3%	35.0%	31.2%	39.2%	57.8%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	90.7%	87.0%	90.5%	96.9%	94.0%	94.2%	95.3%	94.2%	92.2%	89.9%	87.9%	86.4%	91.0%	92.4%	91.0%	89.4%	99.8%	86.9%	91.2%	90.3%	89.8%	90.8%	85.6%	88.1%	89.9%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	60.0%	64.0%	64.7%	76.8%	78.0%	76.5%	87.1%	84.5%	82.3%	55.2%	55.6%	49.9%	67.6%	62.9%	69.8%	62.6%	55.5%	56.7%	46.0%	59.9%	65.2%	36.5%	41.6%	58.6%	65.5%

HEDIS 2018 Results, (Page 3 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PPMCO			UHC			UMHP			MARR
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	68.9%	74.0%	66.7%	NA[1]	77.0%	82.9%	NA[1]	NA	NA	65.5%	62.7%	60.1%	NA[1]	58.6%	66.0%	68.7%	70.2%	65.0%	72.2%	75.4%	76.3%	NA[1]	57.7%	59.5%	59.5%
Statin Therapy for Patients With Diabetes (SPD) – Received Statin Therapy	58.3%	59.4%	60.0%	59.4%	63.3%	65.3%	79.1%	84.4%	78.9%	59.3%	59.2%	59.1%	58.8%	59.5%	62.9%	57.6%	58.6%	59.2%	59.0%	58.2%	60.3%	50.5%	53.8%	57.8%	62.9%
Statin Therapy for Patients With Diabetes (SPD) – Statin Adherence 80%	54.1%	49.2%	44.9%	49.5%	50.7%	43.7%	55.9%	50.3%	52.1%	60.0%	59.7%	58.6%	54.3%	48.8%	47.4%	50.6%	48.9%	46.1%	48.6%	48.7%	48.7%	58.3%	57.9%	55.7%	49.6%
Use of Imaging Studies for Low Back Pain (LBP)	74.6%	76.0%	76.7%	77.7%	69.0%	79.9%	71.5%	76.9%	77.1%	75.5%	72.7%	75.0%	72.7%	66.1%	72.7%	76.0%	77.8%	77.7%	73.2%	73.3%	75.4%	74.2%	70.4%	70.4%	75.6%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	78.0%	80.0%	74.7%	NA[1]	73.0%	69.7%	NA[1]	93.6%	87.8%	67.5%	69.3%	70.1%	77.4%	78.9%	82.5%	83.1%	77.6%	78.3%	69.8%	72.1%	69.9%	NA[1]	73.5%	62.8%	74.5%
Annual Monitoring for Patients on Persistent Medications (MPM)– Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	90.5%	90.0%	88.9%	96.5%	97.0%	94.7%	92.8%	92.0%	90.3%	89.0%	88.5%	86.2%	90.3%	89.3%	90.0%	89.0%	88.4%	88.1%	88.7%	89.4%	89.3%	86.1%	85.6%	85.2%	89.1%
Annual Monitoring for Patients on Persistent Medications (MPM) – Members on diuretics	89.6%	89.0%	88.0%	95.6%	95.0%	93.7%	90.8%	90.5%	88.6%	88.5%	88.0%	86.0%	88.32%	87.5%	88.3%	88.30%	88.2%	88.3%	87.8%	88.8%	88.0%	84.4%	86.6%	84.9%	88.2%
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate	89.9%	89.9%	88.5%	95.9%	96.0%	94.2%	91.8%	91.4%	89.6%	88.6%	88.1%	86.1%	89.4%	88.4%	89.3%	88.5%	88.1%	88.2%	88.1%	88.9%	88.7%	85.2%	85.9%	85.1%	88.7%
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	372.6	366.86	354.3	345.1	350.64	328.7	324.9	336.59	315.9	406.4	420.4	397.5	358.6	359.78	356.2	406.5	NA	390.3	378.1	367.49	345.1	332.6	247.26	332.2	352.5
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months 3	55.1	53.43	50.6	94.0	93.62	83.0	24.9	26.28	26.6	71.0	68.5	61.9	56.1	55.64	53.5	60.1	NA	58.0	59.5	56.84	51.7	89.8	86.43	60.7	55.7
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 F	0.05	0.05	0.1	0.00	0.59	0.0	0.00	0.05	0.1	0.068	0.04	0.0	0.10	0.07	0.1	0.06	0.03	0.0	0.04	0.05	0.0	0.12	0.07	0.0	0.0
Frequency of Selected Procedures (FSP) – Bariatric weight loss surgery /1000 MM 45-64 M	0.0074	0.01	0.0	0.00	0.50	0.0	0.00	NA	0.0	0.015	0.01	0.0	0.015	0.01	0.0	0.03	NA	0.0	0.010	0.01	0.0	0.00	NA	0.0	0.0
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 0-9 T	0.48	0.48	0.5	0.13	0.21	0.1	0.00	0.23	0.3	0.55	0.62	0.6	0.45	0.48	0.5	0.64	0.58	0.6	0.51	0.51	0.5	0.31	0.37	0.4	0.4
Frequency of Selected Procedures (FSP) – Tonsillectomy /1000 MM 10-19 T	0.186	0.14	0.2	0.18	0.17	0.1	0.00	0.20	0.1	0.26	0.26	0.2	0.19	0.24	0.2	0.25	0.24	0.2	0.194	0.20	0.2	0.16	0.34	0.2	0.2
Frequency of Selected Procedures (FSP) – Hysterectomy, abdominal /1000 MM 45-64 F	0.31	0.27	0.3	0.36	0.31	0.2	0.00	0.26	0.3	0.32	0.27	0.2	0.47	0.30	0.3	0.45	0.26	0.3	0.28	0.28	0.2	0.23	0.32	0.4	0.3
Frequency of Selected Procedures (FSP) – Hysterectomy, vaginal /1000 MM 45-64 F	0.1510	0.15	0.1	0.00	0.02	0.0	0.00	0.20	0.2	0.24	0.19	0.1	0.22	0.27	0.2	0.31	0.17	0.2	0.1506	0.17	0.1	0.17	0.17	0.1	0.1
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 30-64 M	0.022	0.04	0.0	0.0569	0.02	0.1	0.00	0.03	0.0	0.04	0.07	0.0	0.0574	0.06	0.0	0.03	0.04	0.0	0.018	0.04	0.0	0.00	0.05	0.0	0.0
Frequency of Selected Procedures (FSP) – Cholecystectomy, open /1000 MM 45-64 F	0.010	0.51	0.0	0.045	0.05	0.0	0.00	0.02	0.0	0.05	0.08	0.0	0.012	0.04	0.0	0.06	0.03	0.0	0.02	0.04	0.0	0.00	0.05	0.1	0.0
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 30-64 M	0.20	0.19	0.2	0.05	0.06	0.0	0.00	0.12	0.1	0.31	0.29	0.2	0.24	0.15	0.1	0.29	0.23	0.2	0.26	0.22	0.2	0.21	0.18	0.2	0.2
Frequency of Selected Procedures (FSP) – Laparoscopic/1000 MM 45-64 F	0.36	0.51	0.5	0.29	0.19	0.3	0.00	0.24	0.4	0.62	0.55	0.5	0.40	0.56	0.3	0.69	0.51	0.5	0.44	0.42	0.4	0.43	0.32	0.6	0.4
Frequency of Selected Procedures (FSP) – Back Surgery /1000 MM 45-64 F	0.46	0.53	0.5	0.56	0.59	0.3	0.00	0.14	0.1	0.81	0.86	0.7	0.67	0.58	0.5	0.74	0.62	0.7	0.60	0.54	0.6	0.43	0.39	0.5	0.5
Frequency of Selected Procedures (FSP) – Back Surgery /1000 MM 45-64 M	0.58	0.42	0.5	0.41	0.50	0.6	0.00	0.16	0.2	0.85	0.84	0.7	0.69	0.68	0.7	0.80	0.82	0.8	0.83	0.70	0.6	0.47	0.39	0.5	0.6
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 15-44 F	0.0226	0.03	0.0	0.050	0.00	0.0	0.00	0.00	0.0	0.045	0.02	0.0	0.01	0.04	0.1	0.03	0.02	0.0	0.0233	0.03	0.0	0.051	0.04	0.0	0.0
Frequency of Selected Procedures (FSP) – Mastectomy /1000 MM 45-64 F	0.13	0.18	0.1	0.07	0.02	0.0	0.00	0.15	0.1	0.12	0.08	0.1	0.10	0.06	0.1	0.23	0.11	0.1	0.171	0.13	0.1	0.173	0.07	0.1	0.1
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 15-44 F	0.113	0.09	0.1	0.07	0.05	0.1	0.00	0.6	0.0	0.106	0.12	0.1	0.20	0.12	0.1	0.14	0.12	0.1	0.107	0.11	0.1	0.05	0.08	0.1	0.1
Frequency of Selected Procedures (FSP) – Lumpectomy /1000 MM 45-64 F	0.27	0.33	0.3	0.25	0.19	0.1	0.00	0.41	0.3	0.28	0.37	0.3	0.52	0.36	0.4	0.42	0.32	0.3	0.38	0.29	0.3	0.14	0.37	0.3	0.3
Standardized Healthcare-Associated Infection Ratio (HAI)* – Central line – associated blood stream infection (CLABSI) – Plan Weighted SIR	N/A	1.05	0.9	N/A	0.93	0.6	N/A	1.37	1.0	N/A	0.15	1.0	N/A	0.98	0.7	N/A	0.01	0.0	N/A	1.04	0.9	N/A	1.25	1.0	0.8
Standardized Healthcare-Associated Infection Ratio (HAI)* – Catheter – Associated Urinary Tract Infection (CAUTI) – Plan Weighted SIR	N/A	0.79	0.9	N/A	0.78	0.7	N/A	0.80	0.6	N/A	0.18	1.0	N/A	1.04	1.1	N/A	0.01	0.0	N/A	1.04	1.0	N/A	1.08	0.9	0.8
Standardized Healthcare-Associated Infection Ratio (HAI)* – MRSA bloodstream infection (MRSA) – Plan Weighted SIR	N/A	0.83	0.8	N/A	1.23	0.9	N/A	0.77	0.5	N/A	0.28	1.1	N/A	1.03	1.1	N/A	0.01	0.0	N/A	0.62	1.0	N/A	0.97	0.9	0.8
Standardized Healthcare-Associated Infection Ratio (HAI)* – Clostridium Difficile Intestinal Infection (CDIFF) – Plan Weighted SIR	N/A	1.03	0.9	N/A	0.89	0.6	N/A	1.44	1.2	N/A	0.42	1.0	N/A	0.98	0.9	N/A	0.01	0.0	N/A	1.38	0.9	N/A	1.21	0.9	0.8

HEDIS 2018 Results, (Page 4 of 4)	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2018
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PPMCO			UHC			UMHP			MARR
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Discharges /1000 MM	5.83	5.23	5.1	10.06	9.53	9.2	5.49	5.33	5.6	6.84	6.58	6.5	6.67	6.83	6.6	6.75	6.49	6.8	6.60	4.91	5.6	8.59	6.91	7.2	6.6
Inpatient Utilization - General Hospital Acute Care (IPU) – Total Inpatient: Total Average Length of Stay	4.14	4.17	4.2	4.81	4.47	4.6	3.34	3.36	3.4	3.75	3.87	2.5	4.22	4.18	4.8	4.06	4.09	4.4	4.23	4.40	4.4	3.47	3.51	3.5	4.0
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics (aaattot)	0.85	0.84	0.8	0.87	0.79	0.8	0.67	0.58	0.6	1.10	1.09	1.0	0.88	0.90	0.9	0.97	0.98	0.9	0.92	0.91	0.8	0.85	0.86	0.8	0.8
Antibiotic Utilization (ABX) – Average Days Supplied per Antibiotic Script (acattot)	9.35	9.28	9.3	9.00	8.67	7.7	9.46	9.29	9.3	9.32	9.30	9.2	9.10	8.94	8.9	9.42	9.32	9.3	9.35	9.09	9.3	9.28	9.32	9.2	9.0
Antibiotic Utilization (ABX) – Average Scrips PMPY for Antibiotics of Concern (adattot)	0.35	0.34	0.3	0.29	0.26	0.3	0.25	0.22	0.2	0.45	0.45	0.4	0.35	0.36	0.3	0.39	0.40	0.4	0.41	0.40	0.4	0.38	0.38	0.3	0.3
Antibiotic Utilization (ABX) – Percentage of Antibiotics of Concern of all Antibiotics (apttot)	40.8%	40.35%	38.8%	33.7%	33.08%	32.5%	37.8%	38.16%	35.9%	40.8%	41.26%	40.4%	40.1%	40.49%	39.0%	40.7%	41.51%	39.3%	44.3%	43.74%	41.6%	44.6%	44.32%	42.2%	38.7%
Use of Opioids at High Dosage (UOD)*			76.0			38.6			22.4			119.9			76.2			105.1			72.2			135.3	80.7
Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers*			313.3			267.5			262.8			195.7			387.5			329.4			250.0			321.1	290.9
Use of Opioids From Multiple Providers (UOP) - Multiple Pharmacies*			109.1			126.8			69.6			0.0			105.9			129.3			62.3			124.7	91.0
Use of Opioids From Multiple Providers (UOP) - Multiple Prescribers and Multiple Pharmacies*			69.4			93.9			39.0			0.0			80.0			88.4			35.4			89.4	61.9

*New measures reported for HEDIS 2018

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.

ACC: AMERIGROUP Community Care
JMS: Jai Medical Systems
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MPC: Maryland Physicians Care
MSFC: MedStar Family Choice
PPMCO: Priority Partners
UHC: UnitedHealthcare
UMHP: University of Maryland Health Partners
MARR: Maryland Average Reportable Rate

Table A1 – Health Plan Descriptive Information

HEDIS 2017 Results (Page 1 of 2)	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Board Certification (BCR) – Family Medicine: Number of Physicians	798	78	208	623	290	656	791	704
Board Certification (BCR) – Family Medicine: Number Board Certified	472	63	192	396	203	622	565	565
Board Certification (BCR) – Family Medicine: Percent Board Certified	59.15%	80.77%	92.31%	63.56%	70.00%	94.82%	71.43%	80.26%
Board Certification (BCR) – Internal Medicine: Number of Physicians	3083	597	454	1294	477	1012	2442	853
Board Certification (BCR) – Internal Medicine: Number Board Certified	2229	533	436	979	325	955	1873	672
Board Certification (BCR) – Internal Medicine: Percent Board Certified	72.30%	89.28%	96.04%	75.66%	68.13%	94.37%	76.70%	78.78%
Board Certification (BCR) – OB/GYN: Number of Physicians	697	208	183	814	152	846	800	638
Board Certification (BCR) – OB/GYN: Number Board Certified	527	170	156	436	85	797	673	431
Board Certification (BCR) – OB/GYN: Percent Board Certified	75.61%	81.73%	85.25%	53.56%	55.92%	94.21%	84.13%	67.55%
Board Certification (BCR) – Pediatrician: Number of Physicians	1588	194	110	1021	311	882	1507	628
Board Certification (BCR) – Pediatrician: Number Board Certified	1243	176	101	792	194	849	1213	485
Board Certification (BCR) – Pediatrician: Percent Board Certified	78.27%	90.72%	91.82%	77.57%	62.38%	96.26%	80.49%	77.23%
Board Certification (BCR) – Geriatricians: Number of Physicians	133	37	5	19	8	50	91	36
Board Certification (BCR) – Geriatricians: Number Board Certified	81	34	5	15	7	49	56	26
Board Certification (BCR) – Geriatricians: Percent Board Certified	60.90%	91.89%	100%	78.95%	87.50%	98.00%	61.54%	72.22%
Board Certification (BCR) – Other Specialists: Number of Physicians	5271	2477	1112	4759	1924	12803	5870	4147
Board Certification (BCR) – Other Specialists: Number Board Certified	4080	2119	1063	3363	1267	11934	4568	2354
Board Certification (BCR) – Other Specialists: Percent Board Certified	77.40%	85.55%	95.59%	70.67%	65.85%	93.21%	77.82%	56.76%
Enrollment by Product Line (ENP) – Shows only total member months for Female	1787702	143292	373694	1412334	556051	1914988	985663	231236
Enrollment by Product Line (ENP) – Shows only total member months for Male	1517147	163317	321102	1146162	466059	1542521	858840	241940
Enrollment by Product Line (ENP) – Shows only total member months Total	3304849	306609	694796	2558496	1022110	3457509	1844503	473176
Enrollment by State (EBS) – Maryland Only	275302	26342	64778	216647	89923	298740	151443	43709

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
[2] A lower rate indicates better performance.

ACC: AMERIGROUP Community Care
JMS: Jai Medical Systems
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MPC: Maryland Physicians Care
MSFC: MedStar Family Choice
PPMCO: Priority Partners
UHC: UnitedHealthcare
UMHP: University of Maryland Health Partners
MARR: Maryland Average Reportable Rate

HEDIS 2017 Results (Page 2 of 2)	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Language Diversity (LDM) – Spoken - English Number	10	21658	66554	248957	0	0	10703	0
Language Diversity (LDM) – Spoken - English Percent	0.0%	67.2%	88.2%	96.3%	0.0%	0.0%	5.7%	0.0%
Language Diversity (LDM) – Spoken - Non-English Number	13260	0	8693	2363	0	0	3991	0
Language Diversity (LDM) – Spoken - Non-English Percent	4.1%	0.0%	11.5%	0.9%	0.0%	0.0%	2.1%	0.0%
Language Diversity (LDM) – Spoken - Unknown Number	311616	10578	186	7161	111000	347187	172769	55575
Language Diversity (LDM) – Spoken - Unknown Percent	96%	33%	0.25%	2.77%	100%	100%	92%	100.00%
Language Diversity (LDM) – Spoken - Declined Number	0	0	32	0	0	0	0	0
Language Diversity (LDM) – Spoken - Declined Percent	0%	0%	0%	0%	0%	0%	0%	0%
Race/Ethnicity Diversity (RDM) – White / Total	57491	4103	14397	84767	29346	105277	61302	16300
Race/Ethnicity Diversity (RDM) – White / Percent	17.70%	12.73%	19.08%	32.79%	26.44%	30.32%	32.70%	29.33%
Race/Ethnicity Diversity (RDM) – Black / Total	123759	19349	42260	93905	0	122749	78956	19152
Race/Ethnicity Diversity (RDM) – Black / Percent	38.09%	60.02%	56.00%	36.33%	0%	35.36%	42.12%	34.46%
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Total	0	137	159	0	0	2	0	0
Race/Ethnicity Diversity (RDM) – American Indian & Alaska Native / Percent	0%	0.42%	0.21%	0.00%	0%	0%	0%	0%
Race/Ethnicity Diversity (RDM) – Asian / Total	14050	962	5674	9136	5802	0	11135	2486
Race/Ethnicity Diversity (RDM) – Asian / Percent	4.32%	2.98%	7.52%	3.53%	5.23%	0%	5.94%	4.47%
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Total	409	44	49	327	0	13327	281	98
Race/Ethnicity Diversity (RDM) – Native Hawaiian - Pacific Islander / Percent	0.13%	0.14%	0.06%	0.13%	0%	3.84%	0.15%	0.18%
Race/Ethnicity Diversity (RDM) – Other / Total	0	0	1678	744	881	0	0	0
Race/Ethnicity Diversity (RDM) – Other / Percent	0%	0%	2.22%	0%	0.79%	0%	0%	0%
Race/Ethnicity Diversity (RDM) – 2+ Races / Total	0	0	366	0	0	0	0	0
Race/Ethnicity Diversity (RDM) – 2+ Races / Percent	0%	0%	0.48%	0%	0%	0%	0%	0%
Race/Ethnicity Diversity (RDM) – Unknown / Total	129177	7641	10643	69602	74469	2390	35789	472
Race/Ethnicity Diversity (RDM) – Unknown / Percent	40%	24%	14%	27%	67%	1%	19%	1%
Race/Ethnicity Diversity (RDM) – Declined / Total	0	0	239	0	502	103442	0	17067
Race/Ethnicity Diversity (RDM) – Declined / Percent	0%	0%	0.32%	0%	0%	30%	0%	30.71%
Total Membership – Total membership numbers for each plan	324886	32236	75465	258481	111000	347187	187463	55575

A Performance Report Card

for Consumers

2017

HealthChoice
MARYLAND'S MEDICAID HEALTH PLAN PROGRAM

Printed
3/2017

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

HealthChoice — Maryland's Medicaid Health Plan Program	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	★★★	★★★
MARYLAND PHYSICIANS CARE	★★★	★★	★★	★★	★	★
MEDSTAR FAMILY CHOICE	★★	★★★	★★	★★	★	★★
PRIORITY PARTNERS	★★	★★	★★★	★★	★★	★★
UNITEDHEALTHCARE	★★	★★	★★	★★	★	★
UNIVERSITY OF MARYLAND HEALTH PARTNERS	★	★★	★	★★	★	★

This information was collected from health plans and their members and is the most current performance data available. The information was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member composition.
NOTE: N/A means that the rating is not applicable and does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan.

Performance Area Descriptions

Access to Care
- Appointments are scheduled without a long wait
- The health plan has good customer service
- Everyone sees a doctor at least once a year
- The health plan answers member calls quickly

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

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

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

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

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

If you are having trouble getting health care from your health plan or your doctor, try calling the health plan for customer service. Then, call the Enrollee Help Line if you still have a problem at 1-800-284-4510.

Services Covered by Each Health Plan

- Visits to the doctor, including regular check-ups
- Immunizations
- Care while pregnant
- Family planning and birth control
- Prescription drugs
- X-ray and lab services
- Hospital services
- Home health services
- Hospice services
- Emergency services
- OB/GYN care for women
- Eye exams for adults and children
- Eye glasses for children under 21
- Primary mental health services through your primary care doctor (other mental health and substance use services through the Specialty Mental Health System 1-800-888-1965)
- Transportation services (call your local Health Department)

Every HealthChoice health plan offers some additional services.

DHMH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability in its health programs and activities.

Help is available in your language: 1-800-977-7388 (TTY: 1-800-977-7389). These services are available for free.

Hay ayuda disponible en su idioma: 1-800-977-7388 (TTY: 1-800-977-7389). Estos servicios están disponibles gratis.

您若需要免费中文帮助，请拨打这个电话号码：1-800-977-7388 (TDD: 1-800-977-7389)

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
UNITEDHEALTHCARE	1-800-318-8821
UNIVERSITY OF MARYLAND HEALTH PARTNERS	1-800-730-8530

For more information visit the HealthChoice website *www.dhmh.maryland.gov*

Informe Calificativo Sobre Desempeño

para Consumidores

2017

HealthChoice
PROGRAMA DEL PLAN DE SALUD MEDICAID DE MARYLAND

Impresión 3/2017

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 (HealthChoice Programa del Plan de Salud Medicaid de Maryland)	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	★★★	★★★
MARYLAND PHYSICIANS CARE	★★★	★★	★★	★★	★	★
MEDSTAR FAMILY CHOICE	★★	★★★	★★	★★	★	★★
PRIORITY PARTNERS	★★	★★	★★★	★★	★★	★★
UNITEDHEALTHCARE	★★	★★	★★	★★	★	★
UNIVERSITY OF MARYLAND HEALTH PARTNERS	★	★★	★	★★	★	★

Esta información se recogió de los planes de salud y de sus miembros y 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 la calificación no es aplicable y no describe el desempeño o la calidad de la atención proporcionada por el plan de salud. No debería afectar su opción de plan de salud.

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
- Atención durante el embarazo
- Planificación familiar y control de la natalidad
- Medicamentos recetados
- Servicios radiológicos y de laboratorio
- Servicios de hospital
- Servicios de salud en el hogar
- Servicios para enfermos terminales
- Servicios de emergencia
- Atención ginecológica y de obstetricia para mujeres
- Exámenes de los ojos para adultos y niños
- Gafas para niños menores de 21 años
- Servicios primarios de salud mental a través de su primarios doctor (otros servicios de salud mental y uso de sustancias a través del Sistema de Salud Mental Especializado 1-800-888-1965)
- Servicios de transporte (llame a su departamento de salud local)

Cada plan de salud HealthChoice ofrece algunos servicios adicionales.

DHMH cumple con las leyes federales de derechos civiles aplicables y no discrimina en base a raza, color, origen nacional, edad, discapacidad en sus programas y actividades de salud.

Help is available in your language: 1-800-977-7388 (TTY: 1-800-977-7389). These services are available for free.

Hay ayuda disponible en su idioma: 1-800-977-7388 (TTY: 1-800-977-7389). Estos servicios están disponibles gratis.

您若需要免费中文帮助，请拨打这个电话号码：1-800-977-7388 (TDD: 1-800-977-7389)

¿Tiene Preguntas para los Planes de Salud?

AMERIGROUP COMMUNITY CARE	1-800-600-4441
JAI MEDICAL SYSTEMS	1-888-524-1999
KAISER PERMANENTE	1-855-249-5019
MARYLAND PHYSICIANS CARE	1-800-953-8854
MEDSTAR FAMILY CHOICE	1-888-404-3549
PRIORITY PARTNERS	1-800-654-9728
UNITEDHEALTHCARE	1-800-318-8821
UNIVERSITY OF MARYLAND HEALTH PARTNERS	1-800-730-8530

Para obtener mayor información visite el sitio web de HealthChoice, *www.dhmh.maryland.gov*

Network Adequacy 2017 Survey Tool

Table 75: Urgent and Non-urgent Calls

FIELD	DESCRIPTION
Call Date and Time	Surveyor notes the MM/DD/YYYY and time 00:00 of call
Provider Name	This field will be prepopulated based on the data sample
Practice Name	This field will be prepopulated based on the data sample, if available
Provider's Address and Phone	This field will be prepopulated based on the data sample
MCO	This field will be prepopulated based on the data sample
Provider Type	This field will be prepopulated based on the data sample
Person contacted and title	Surveyor enters name and title of person contacted
Provider details correct? (Y/N)	Surveyor notes whether the provider contact information is correct
Participating MCO	Surveyor reviews all MCOs with provider and indicates which MCOs with provider is participating
Does provider accept the listed insurances? (Y/N)	Surveyor notes if the provider participates with the prepopulated MCO
If No, Explain:	Surveyor notes comments, if any, from respondent
Successful Contact (Y/N)	Surveyor notes whether they successfully reached a respondent at the provider office.
If No, Reason	If the surveyor was unable to reach the provider office, they select a reason from the following options in the drop down menu: • Wrong number • 3rd attempt unsuccessful • Hold time greater than 10 minutes • Leave a message and they will get back to you • Office permanently closed • Other
If Other, Explanation	If the surveyor selected other above, they will provide an explanation in this field
Date urgent appointment	If an urgent appointment was made, the surveyor inserts the date of the appointment When surveyor enters the appointment date, a formula is used to calculate the difference between the date surveyed and the date of the appointment to determine the appointment wait time and compliance with standards.
Date non-urgent/routine appointment	If non-urgent appointment was made, the surveyor inserts the date of the appointment When the appointment date is entered by surveyor, a formula is used to calculate the difference between the date surveyed and the date of the appointment to determine the appointment wait time
Are you accepting new patients? (Y/N)	The surveyor notes whether or not the provider is accepting new patients

What are the ages of patients accepted?	The surveyor choses from the following: • All ages • Age specific
If age specific, what ages?	The surveyor notes the ages specified by respondent
If needed, does your office provide assistance with transportation to and from the appointment? (Y/N)	The surveyor notes whether or not the provider offers transportation assistance
Review complete (Y/N)	The surveyor chooses “yes” once all attempts have been made and the survey has been completed