HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

Maryland Medicaid Managed Care Organization

2016 Annual Technical Report

Health Choice

Delmarva Foundation

A Quality Health Strategies Company

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Executive Summary

Introduction

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

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

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

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

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

As of December 31, 2015, the HealthChoice program served over 990,487 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 (KPMAS) – entered HealthChoice June 2014
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- Riverside Health of Maryland (RHMD)
- UnitedHealthcare (UHC)

Kaiser began participating in the HealthChoice program in June 2014. The EQRO's evaluation of Kaiser for calendar year (CY) 2015 included all EQRO activities with the exception of Performance Improvement Projects and the Consumer Report Card because the MCO did not have sufficient data. Their full participation in all EQRO activities will begin in CY 2017.

Pursuant to 42 CFR 438.364, the 2015 Annual Technical Report describes the findings from Delmarva Foundation's External Quality Review activities for years 2014–2015 which took place in CY 2016. The report includes each review activity conducted by Delmarva Foundation, the methods used to aggregate and analyze information from the review activities, and conclusions drawn regarding the quality, access, and timeliness of healthcare services provided by the HealthChoice MCOs.

HACA Quality Strategy

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

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

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

EQRO Program Assessment Activities

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

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

Delmarva Foundation also conducted an optional activity: validation of encounter data reported by the MCOs. As the EQRO, Delmarva Foundation conducted each of the mandatory activities and the optional activities in a manner consistent with the CMS protocols during CY 2016.

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

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

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

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

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

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

General Overview of Findings

Assessment of Quality, Access, and Timeliness

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

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

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

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

Annual Review Activities that Assess Quality, Access, and Timeliness			
Systems Performance Review	**Quality**	**Access**	**Timeliness**
Standard 1 – Systematic Process of Quality Assessment and Improvement	√		
Standard 2 – Accountability to the Governing Body	√		
Standard 3 – Oversight of Delegated Entities	√		
Standard 4 – Credentialing and Recredentialing	√	√	√
Standard 5 – Enrollee Rights	√	√	√
Standard 6 – Availability and Accessibility		√	√

Annual Review Activities that Assess Quality, Access, and Timeliness			
Standard 7 – Utilization Review	√	√	√
Standard 8 – Continuity of Care	√	√	√
Standard 9 – Health Education Plan	√	√	
Standard 10 – Outreach Plan	√	√	
Standard 11 – Fraud and Abuse	√		√
Value Based Purchasing	**Quality**	**Access**	**Timeliness**
Adolescent Well-Care	√	√	√
Adult BMI Assessment	√		
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 Project	**Quality**	**Access**	**Timeliness**
Adolescent Well-Care PIP	√	√	√
High Blood Pressure PIP	√	√	√
EPSDT Medical Record Review	**Quality**	**Access**	**Timeliness**
Health and Developmental History	√		√
Comprehensive Physical Examination	√		√
Laboratory Tests/At-Risk Screenings		√	√
Immunizations	√		√
Health Education and Anticipatory Guidance	√		√
Encounter Data Validation	**Quality**	**Access**	**Timeliness**
Inpatient, Outpatient, Office Visit Medical Record Review	√		
HEDIS®	**Quality**	**Access**	**Timeliness**
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	√		

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

Annual Review Activities that Assess Quality, Access, and Timeliness			
Diabetes Monitoring for People with Diabetes and Schizophrenia	√	√	
Antidepressant Medication Management	√		
Follow–Up Care after Hospitalization for Mental Illness	√	√	√
Follow–Up Care for Children Prescribed ADHD Medication	√	√	√
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	√		
Frequency of Selected Procedures		√	
Inpatient Utilization – General Hospital/Acute Care	√	√	
Mental Health Utilization	√	√	
Antibiotic Utilization	√	√	
Board Certification	√		
Enrollment by Product Line		√	
Enrollment by State		√	
Language Diversity of Membership		√	
Race/Ethnicity Diversity of Membership		√	
Weeks of Pregnancy at Time of Enrollment			√
Total Membership		√	
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 New	√		
Statin Therapy for Patients with Cardiovascular Disease New	√		
CAHPS®	Quality	Access	Timeliness
Getting Needed Care		√	
Getting Care Quickly			√
How Well Doctors Communicate	√		
Customer Service	√	√	
Shared Decision Making	√		
Health Promotion and Education	√		
Coordination of Care	√		
Access to Prescription 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

Delmarva Foundation performed an independent annual review of services in order to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice Program. COMAR 10.09.65 requires that all HealthChoice MCOs comply with the Systems Performance Review (SPR) standards and all applicable federal and state laws and regulations. This section describes the findings from the SPR for CY 2015, conducted in January and February of 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 (KPMAS)*
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- Riverside Health of Maryland (RHMD)
- UnitedHealthcare (UHC)

*Joined HealthChoice in July of 2014. This is the MCO's second SPR.

Purpose and Process

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

The SPRs were conducted at the MCO's corporate offices and performed by a team of health care professionals. The onsite component provides the MCOs with an opportunity to demonstrate the efficacy of their health care system. Policies, committee minutes, work plans, reports, and other written procedures were presented to the reviewers that demonstrate the continuous quality improvement efforts undertaken by the MCOs. Key staff interfaced with the team to further define their organization's operational protocols. In addition, the team evaluated the effectiveness of any Corrective Action Plans (CAPs) initiated as a result of the prior year's review.

The CY 2015 SPR was the last comprehensive onsite review conducted on an annual basis. Going forward, the Department will require the EQRO to conduct comprehensive onsite SPRs every three years with exemption reviews in the interim years. CAPs will continue to be reviewed on an annual basis.

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General and Insurance 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 2015 review before application.

The review team that performed the annual SPRs consists of health 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. The team completed the reviews and provided feedback to the DHQA and each MCO with the goal of improving the care provided to HealthChoice enrollees.

Methodology

For CY 2015, COMAR 10.09.65.03 required that all HealthChoice MCOs comply with the SPR standards established by the Department and all applicable federal and state laws and regulations. In September 2015, Delmarva Foundation provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2015 and invited the MCOs to direct any questions or issues requiring clarification to Delmarva Foundation and DHQA. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2015 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- CY 2015 Systems Performance Review Standards and Guidelines, including specific changes

Prior to the onsite 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, continuity of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Delmarva Foundation prior to the onsite visit.

During the onsite reviews in January and February of 2016, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion, exit conferences were held with the MCOs. The purpose of the conferences was to provide the MCOs with preliminary findings, based on interviews and all documentation reviewed. Notification was also provided during the exit conferences that the MCOs would receive a follow-up letter describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from

receipt of the follow-up letter to submit any additional information to Delmarva Foundation; documents received were subsequently reviewed against the standard(s) to which they related.

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

Met	100%
Partially Met	50%
Unmet	0%

Each element or component of a standard was of equal weight. Elements/Components that were reviewed as baseline were not scored. A CAP was required for each performance standard that did not meet the minimum required compliance score, as defined for the CY 2015 review.

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

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

The following eleven performance standards were included in the CY 2015 review cycle:

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

For all standards, MCOs are expected to meet the compliance score of 100%. When new MCOs join the HealthChoice Program, they must meet an 80% compliance score for its first year of operation, 90% for its second year of operation, and 100% for all future reviews.

For CY 2015, all MCOs, except for KPMAS, were expected to meet the compliance score of 100% for all standards. The KPMAS compliance score was set at 90% for its second SPR. The MCOs were required to submit a CAP for any standard that did not meet the minimum compliance score.

Preliminary results of the SPR were compiled and submitted to DHMH for review. Upon the Department's approval, the MCOs received a report containing individual review findings. After receiving the preliminary reports, the MCOs were given 45 calendar days to respond to Delmarva Foundation 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 DHMH and Delmarva Foundation to clarify issues or ask for assistance in preparing a CAP.

Corrective Action Plan Process

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

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

In the event that a CAP is deemed unacceptable, Delmarva Foundation will provide technical assistance to the MCO until an acceptable CAP is submitted. Five MCOs were required to submit CAPs for the CY 2015 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

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

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2016 will determine whether the CAPs from the CY 2015 review were implemented and effective. In order to make this determination, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

Findings

The HealthChoice MCO annual SPR consists of 11 standards. The compliance threshold established by DHMH for all standards for CY 2015 is 100% for all MCOs, except for KPMAS for which the compliance threshold is set at 90% for its second SPR.

All eight HealthChoice MCOs participated in the SPR. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. If the MCO's score was below the minimum threshold, a CAP was required. Three MCOs (JMS, MPC, and MSFC) received perfect scores in all standards. Five MCOs (ACC, KPMAS, PPMCO, RHMD, and UHC) were required to submit CAPs for CY 2015.

Table 2 provides for a comparison of SPR results across MCOs and the MD MCO Compliance for the CY 2015 review. The three highlighted plans, JMS, MPC, and MSFC received compliance scores of 100% in each standard reviewed.

Table 2. CY 2015 MCO Compliance Score

	Standard	Elements Reviewed	MD MCO Compliance Score	ACC	JMS	KPMAS[1]	MPC	MSFC	PPMCO	RHMD	UHC
1	Systematic Process	36	100%	100%	100%	100%	100%	100%	100%	100%	100%
2	Governing Body	12	99%*	100%	100%	100%	100%	100%	100%	96%*	100%
3	Oversight of Delegated Entities	7	93%*	100%	100%	100%	100%	100%	90%*	60%*	100%
4	Credentialing	42	99%*	99%*	100%	100%	100%	100%	100%	96%*	99%*
5	Enrollee Rights	25	99%*	100%	100%	94%	100%	100%	98%*	100%	100%
6	Availability and Access	10	98%*	100%	100%	80%*	100%	100%	100%	100%	100%
7	Utilization Review	24	94%*	84%*	100%	98%	100%	100%	89%*	91%*	93%*
8	Continuity of Care	6	100%	100%	100%	100%	100%	100%	100%	100%	100%
9	Health Education Plan	12	95%*	100%	100%	100%	100%	100%	92%*	92%*	79%*
10	Outreach Plan	14	96%*	100%	100%	71%*	100%	100%	100%	100%	100%
11	Fraud and Abuse	19	98%*	100%	100%	94%	100%	100%	100%	89%*	100%
	Composite Score		98%↑	98%↑	100%	95%↑	100%	100%	98%↑	95%↓	98%↑

*Denotes that the minimum compliance score of 100% was unmet.
[1]KPMAS's minimum compliance threshold is set at 90%, as this was the MCO's second SPR.

For each standard assessed for CY 2015, the following section describes the requirements reviewed; the results, including the MD MCO compliance score; the overall MCO findings; the individual MCO opportunities for improvement and CAP requirements, if applicable; and follow up, if required.

STANDARD 1: Systematic Process of Quality Assessment/Improvement

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

Results:

- All MCOs received compliance ratings of 100%.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 90%.

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

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 2: Accountability to the Governing Body

Requirements: The governing body of the MCO is the Board of Directors or, where the Board's participation with the quality improvement issues is not direct, a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care. There must be documentation that the governing body has oversight of the QAP. The governing body must approve the overall QAP and an annual QAP. The governing body formally designates an accountable entity or entities within the organization to provide oversight of quality assurance, or has formally decided to provide oversight as a committee. The governing body must routinely receive written reports on the QAP that describe actions taken, progress in meeting quality objectives, and improvements made. The governing body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review of findings and issues of concern within the MCO. The governing body is active in credentialing, recredentialing, and utilization review activities.

Results:

- The overall MD MCO Compliance Score for CY 2015 was 99% which was an increase over the CY 2014 Compliance Score of 96%.
- ACC, JMS, KPMAS, MPC, MSFC, PPMCO, and UHC met the minimum compliance threshold for this standard.
- RHMD received a compliance score of 96%, and was required to submit a CAP.
- KPMAS received a compliance score of 100%, which was above the minimum compliance threshold of 90%.

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

MCO Opportunity/CAP Required

RHMD Opportunities/CAPs:

Component 2.7a - The governing body is active in UM activities. The governing body meeting minutes reflect ongoing reporting of UM activities and findings.

RHMD received a finding of partially met because according to the Health Services Management Program Description, the Quality Improvement Committee oversees all Health Services activities, including review and approval of the Health Services Program Description. The Program Description outlines all UM activities. The Health Services Program Description was reviewed and approved by the BOD on October 26, 2015; however, the Quality Improvement Committee did not approve the Health Services Program Description.

There is evidence that Health Services Reports specific to UM activities were provided to the Quality Improvement Committee quarterly. For example, at the June 16, 2015 Quality Improvement Committee meeting, the Vice President of Health Services presented the Health Services quarterly report. It was noted that inpatient metrics are trending down for admits/1,000 members; average length of service; and days of care. The Medical Director pointed out that RHMD has enough historical data to establish a benchmark for admits/1,000 members, which will enable the Quality Improvement Committee to more effectively evaluate UM progress. The Chief Medical Officer

commented that the average length of stay for skilled nursing facilities is 17 days, which is too high; he recommended that this number be below 14 days. The reporting of various case management performance metrics also was evidenced at this Quality Improvement Committee meeting. For example, Case Management staff have not been notifying members of their right to opt out of Case Management, and this is an area needing improvement.

At the direction of the Quality Improvement Committee, a UM Committee was developed in July 2015. The committee has met monthly to address UM reporting needs and areas of under utilization of services.

In order to receive a finding of met in the next SPR, RHMD must ensure that the Quality Improvement Committee reviews and approves the Health Services Program Description within the first quarter of the year.

Follow-up:

- RHMD was required to submit a CAP for the above component. Delmarva Foundation reviewed and approved the submission.
- Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

STANDARD 3: Oversight of Delegated Entities

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

Results:

- The overall MD MCO Compliance Score was 93% for CY 2015 which was an increase over the CY 2014 Compliance Score of 90%.
- ACC, JMS, KPMAS, MPC, MSFC, and UHC met the minimum compliance threshold for this standard.
- PPMCO received a compliance score of 90%, and was required to submit a CAP.
- RHMD received a compliance score of 60%, and was required to submit a CAP.
- KPMAS received a compliance score of 100%, which was above the minimum compliance threshold of 90%.

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

PPMCO Opportunities/CAPs:

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

PPMCO received a finding of partially met because although there was evidence of quarterly review of Superior Vision complaint and grievance reports, there was inconsistent documentation of Process Management Team approval of these reports. Superior Vision reports were presented to the Process Management Team on April 9, 2015 (fourth quarter 2014); July 9, 2015 (first quarter 2015); October 8, 2015 (second quarter 2015); and December 10, 2015 (third quarter 2015). Only the April and October minutes document formal acceptance/approval of the report.

Subsequent to the review, PPMCO provided the Medical Policy Committee with Executive Summaries that included a summary of Process Management Team minutes from specified meetings. The Medical Policy Committee Executive Summary from September 4, 2015, summarized minutes from the July Process Management Team meeting and noted that required delegation reports were accepted with no identified deficiencies. The specific delegate, delegated activity, and report time frame were not identified. This documentation is inadequate in demonstrating formal approval of quarterly delegate reports. The finding, therefore, remained partially met.

In order to receive a finding of met in the next SPR, PPMCO must document in the appropriate committee meeting minutes, formal quarterly review and approval of quarterly complaint, grievance, and appeal reports from all applicable delegates.

RHMD Opportunities/CAPs:

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

RHMD received a finding of unmet for this component. In response to the CY 2014 SPR findings, RHMD was required to develop a CAP to provide evidence of formal review and approval of delegate quarterly complaint, grievance, and appeal reports on a quarterly basis by the appropriate committee designated in the MCO's policy for each of the four quarters (fourth quarter of 2014 and first, second, and third quarters of 2015.) As indicated below, the CAP was not fully implemented and a continuing opportunity for improvement exists.

There was evidence of the Quality Improvement Committee's quarterly review and approval of Superior Vision reports for each quarter; however, neither the minutes nor the attached Delegated Oversight Committee report consistently reflect the specific delegated activity included in the report. Minutes are generally limited to a notation that all standards were met.

In order to receive a finding of met in the next SPR, RHMD must demonstrate evidence in the appropriate committee(s) meeting minutes of the review and approval of each delegate's complaint, grievance, and appeals report noting the specific delegated activity(ies) included in the report.

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

RHMD received a finding of unmet for this component. In response to the CY 2014 SPR findings, RHMD was required to develop a CAP to provide evidence of formal review and approval of each delegate's annual UMP and UM criteria by the appropriate committee designated in the MCO's policy. As indicated below, the CAP was not implemented and a continuing opportunity for improvement exists.

According to the Vice President of Provider Relations, Caremark's UMP was received too late for the Delegated Oversite Committee and Quality Improvement Committee to complete its review in 2015. The plan is to bring this document to the Quality Improvement Committee in the first quarter of 2016. A copy of Caremark's UMP was provided with an effective date of May 2015 through May 2016.

In order to receive a finding of met in the next SPR, RHMD must demonstrate evidence of annual approval by the appropriate committee(s) of any delegated entity's UMP and criteria if UM is delegated.

Follow-up:

- PPMCO and RHMD were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

STANDARD 4: Credentialing and Recredentialing

Requirements: The QAP must contain all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services. The MCO must have written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. The MCO may delegate credentialing/recredentialing activities with a written description of the delegated activities, a description of the delegate's accountability for designated activities, and evidence that the delegate accomplished the credentialing activities. The credentialing process must be ongoing and current. There must be evidence that the MCO requests information from recognized monitoring organizations about the practitioner. The credentialing application must include information regarding the use of illegal drugs, a history of loss of license and loss or limitation of privileges or disciplinary activity, and an attestation to the correctness and completeness of the application. There must be evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the 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:

- The overall MD MCO Compliance Score was 99% for CY 2015 which was consistent with CY 2014.
- JMS, KPMAS, MPC, MSFC, and PPMCO met the minimum compliance threshold for this standard.
- ACC received a compliance score of 99%, and was required to submit a CAP.
- RHMD received a compliance score of 96%, and was required to submit a CAP.
- UHC received a compliance score of 99%, and was required to submit a CAP.
- KPMAS received a compliance score of 100%, which was above its minimum compliance threshold of 90%.

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

MCO Opportunity/CAP Required

ACC Opportunities/CAPs:

Component 4.8e - There is evidence that recredentialing is performed at least every three years and meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements.

ACC received a finding of partially met for this component because ACC's credentialing plan and policies appropriately indicate that recredentialing is to be performed at least every 36 months; however, in a review of 10

recredentialing records, all but 1 met the 36-month time frame for a decision date. The non-compliant record was approved for recredentialing 3 weeks after the 36-month time frame. According to credentialing staff, this particular record fell out of compliance while staff were waiting for a provider to complete his disclosure of ownership and control paperwork.

As a follow-up to the SPR, ACC provided Delmarva with a spreadsheet used for tracking the status of recredentialing time frames. In 2015, a total of 641 Maryland providers were recredentialed by the ACC Credentialing Committee. Of these 641, 27 provider records did not meet the 36-month turnaround time for recredentialing, for a total compliance rate of 95.79%. Of the 27 records, 19 were recredentialed within 37 months, 5 within 38 months, and one each at 39, 40, and 42 months, respectively. Based on this data, the one record found non-compliant during the onsite SPR was not an outlier.

In order for this standard to be considered met during the next SPR, the sample selected for recredentialing must meet 100% compliance with the 36-month recredentialing turnaround time.

RHMD Opportunities/CAPs:

Component 4.8b - There is evidence that recredentialing is performed at least every three years and that it includes a review of available performance data.

RHMD received a finding of partially met because the recredentialing records reviewed included a review of quality of care issues but did not include a review of complaint data prior to a recredentialing decision.

In order for this component to be met during the next SPR, RHMD must incorporate both quality of care and quality of service/complaint data as part of recredentialing.

Component 4.9a - There is evidence that the recredentialing process includes a review of enrollee complaints.

RHMD received a finding of unmet for this component because in a review of recredentialing records, there was no indication that quality of service data, such as enrollee grievances against a practitioner, were considered in making the recredentialing determination. According to QI staff, all grievance data against practitioners is collected centrally by the Appeal and Grievance Department and reviewed by QI monthly for quality of care issues. While quality of care issues are considered at the time of credentialing, the process for also incorporating quality of service/grievance data is not in place.

In order for this component to receive a finding of met during the next SPR, RHMD must develop a process for reviewing enrollee grievances data prior to recredentialing practitioners/providers and incorporate this process into the Credentialing Plan and Policy.

UHC Opportunities/CAPs:

Component 4.8e - There is evidence that recredentialing is performed at least every three years and meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements.

UHC received a finding of partially met for this component because of the nine records reviewed, there were two that did not meet the time frames set forth in the MCO's policies regarding recredentialing within 36 months of the last approval.

In order for this component to be met in the next SPR, UHC must demonstrate that all recredentialing records meet the time frame for recredentialing within 36 months of the prior credentialing approval date.

Follow-up:

- ACC, RHMD, and UHC were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

STANDARD 5: Enrollee Rights

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

Results:

- The overall MD MCO Compliance Score was 99% for CY 2015 which was an increase over the CY 2014 Compliance Score of 96%.
- ACC, JMS, KPMAS, MPC, MSFC, RHMD, and UHC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 94%, which exceeded its minimum compliance threshold of 90%.
- PPMCO received a compliance score of 98%, and is required to submit a CAP.

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

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

MCO Opportunity/CAP Required

PPMCO Opportunities/CAPs:

Component 5.1g - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR and the MCO adheres to the time frames set forth in its policies and procedures for resolving grievances.

PPMCO received a finding of partially met for this component because 1 of 30 grievance records reviewed did not adhere to the time frames set forth in its policies and procedures for resolving complaints and grievances. The grievance record reviewed that fell out of compliance was regarding a member inquiring about a billing issue and was considered an administrative grievance. Although the MCO had 30 days to resolve, the grievance was not resolved within the regulatory time frame.

Subsequent to the review, PPMCO provided policies and procedures to support the grievance process, but 1 of the 30 records remained out of compliance with the time frames set forth in the MCO's policies and procedures. In order to receive a finding of met in the next SPR, PPMCO must adhere to the time frames set forth in its policies and procedures for resolving all grievances.
Follow-up: ➢ PPMCO was required to submit a CAP for the above component. Delmarva Foundation reviewed and approved the submission. ➢ Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

STANDARD 6: Availability and Accessibility

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

Results:

- The overall MD MCO Compliance Score was 98% for CY 2015 which was a decrease from the CY 2014 Compliance Score of 99%.
- ACC, JMS, MPC, MSFC, PPMCO, RHMD, and UHC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 80%, and was required to submit a CAP.

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

MCO Opportunity/CAP Required

KPMAS Opportunities/CAPs:

Component 6.1c - 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 has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance.

KPMAS received a finding of unmet for this component. In the CY 2014 SPR, KPMAS cited the following telephone performance standards:

- ASA: < 30 seconds
- Call abandonment rate: < 3%
- Service level (% of calls answered within 30 seconds): > 80%

The Appointment Access Policy outlined two of three KPMAS telephone performance standards noted above. The policy also stated that statistics were reviewed daily and shared with call center supervision to address service levels not meeting goals.

This policy did not include a detailed methodology for specific monitoring, measures, and committees responsible for oversight of the performance standards.

In order to receive a finding of met in the next SPR, KPMAS must establish policies and procedures for the operation of its customer/enrollee services and have standards/indicators to monitor, measure, and report on its performance.

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

KPMAS received a finding of unmet for this component because Customer Call Center reports, including call center performance for each standard, are provided to the Senior Director of Medicaid Operations. It was recommended in the CY 2014 SPR that Customer Call Center standards be included in the QMP. Upon interview, KPMAS stated that the call metrics were included in the Quality Work Plan Evaluation for 2015. In the MCO response, KPMAS stated that the metrics were cited in the work plan; however, there were no call center performance metrics in the Medicaid Work Plan document provided. Also, documentation of review of the call center performance metrics is needed through the quality committees.

In order to receive a finding of met in the next SPR, KPMAS must provide documentation of the review of enrollee services call center performance.

Follow-up:

- KPMAS was required to submit a CAP for the above components. Delmarva Foundation reviewed and approved the submissions.
- Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

STANDARD 7: Utilization Review

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

Results:

- The overall MD MCO Compliance Score was 94% for CY 2015 which was an increase over the CY 2014 Compliance Score of 92%.
- JAI, KPMAS, MPC, and MSFC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 98%, which exceeded its minimum compliance threshold of 90%.
- ACC, PPMCO, RHMD, and UHC received compliance scores of 84%, 89%, 91%, and 93%, respectively. These MCOs were required to submit CAPs.

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

MCO Opportunity/CAP Required

ACC Opportunities/CAPs:

Component 7.3a - The written UR Plan has mechanisms in place to detect over utilization and under utilization of services. Services provided must be reviewed for over and under utilization.

ACC received a finding of unmet for this component. In response to the CY 2014 SPR findings, ACC was required to develop a CAP to demonstrate that the MCO reports utilization and evaluates opportunities for improvement in

meeting minutes of the designated committee(s) consistent with its UMP, work plan, and policies. As indicated below, an opportunity continues to exist in documenting review of services for over and under utilization.

As noted in prior reviews, the UMP Description includes as one of its goals to minimize and/or eliminate over and under utilization of medical and behavioral health services. The UM Work Plan for 2015 includes monitoring performance against the following indicators and indicator thresholds and evaluating quarterly for trends and identifying opportunities for improvement:

- Days per 1,000
- Average length of stay
- Admits per 1,000
- Readmission rate
- Emergency room visits per 1,000

The Over/Under-Utilization of Services Policy outlines the procedures for monitoring of over and under utilization of services, using aggregated data or nonidentifiable utilization reports produced on at least a quarterly basis. The results of reviews are to be reported to the Medical Advisory Committee and the Quality Management Committee. The results are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and to identify fraud and abuse. Specific focus areas identified include:

- Acute/chronic care – readmissions, pharmaceuticals, specialty referrals, emergency room utilization, and home health and durable medical equipment utilization relative to diagnostic entity
- Preventive care – well-child/adult primary care provider visits, age-appropriate immunizations, mammograms, and blood lead level testing

According to the above policy, providers identified as having significant aberrant patterns of utilization are to be reviewed by the Medical Director and provider relations staff to determine actual utilization of services. An action plan for the provider and the health plan is to be developed by provider relations in collaboration with the Medical Director and discussed with the provider, as appropriate. Intervention strategies targeted at enhancing appropriate utilization practices are to be reviewed by Health Care Management Services and Quality Management Staff with the Medical Director. Member intervention for cases of member over utilization and under utilization is to be addressed through case management/care management and/or Health Education and outreach.

In reviewing Medical Advisory Committee minutes from seven meetings in 2015, only two meetings (March 16 and December 12) were found to have documented a review of UM metrics (IP only), which were reported by Temporary Assistance to Needy Families, Supplemental Security Income, and FAMCARE categories with notation of any trends as applicable.

In the Quality Management Committee minutes of November 4, 2015, it was reported that month-over-month emergency room visits identified as non-emergent have been monitored at the corporate level as well as locally via the emergency room work group. The Preventable Emergency Room Diagnosis list was noted as driving the data analysis. It was reported that 52% of all emergency room visits with diagnoses that met criteria did not need to be treated by the emergency room. Of these visits, 75% could have been managed by a primary care physician and 74% could have been treated at an urgent care center (overlapping denominators). The emergency room work group was assigned the task of further analysis of opportunities and reporting back to the Quality Management Committee.

In order to receive a finding of met in the next SPR, ACC must demonstrate that it reports utilization and evaluates opportunities for improvement in meeting minutes of the designated committee(s) consistent with its UMP, work plan, and policies.

Component 7.3b - The written UR Plan has mechanisms in place to detect over utilization and under utilization of services. UR reports must provide the ability to identify problems and take the appropriate corrective action.

ACC received a finding of partially met for this component. In response to the CY 2014 SPR findings, ACC was required to develop a CAP to demonstrate that the designated committee(s) consistent with its UMP, UM Work Plan, and policies addresses both over and under utilization issues and takes appropriate action to address identified opportunities for improvement based upon an analysis of those issues. As indicated below, an opportunity continues to exist to identify over and under utilization problems and take appropriate corrective action.

There was no evidence that ACC identified utilization problems and implemented corrective action in any of the seven Medical Advisory Committee meeting minutes reviewed for 2015. The Director of UM confirmed that there was no such documentation in Medical Advisory Committee meeting minutes.

In the November 4, 2015, Quality Management Committee meeting, there was evidence of discussion of a number of potential/actual areas of over and under utilization. For example, in relation to outpatient sleep studies it was noted that some research studies suggest that sleep disorders are more prevalent for adults, more prevalent in adults as they become overweight, and more prevalent in the African-American population. Based on this research, it was reported that the prevalence for the ACC population should be about 20% rather than the current 2%. It was suggested that ACC providers may be underutilizing sleep studies, but due to other issues impacting a large number of MCO members, sleep study utilization was not being prioritized at that time. In the interim, planned interventions included:

- Exploring provider education opportunities.
- Encouraging home and freestanding sleep study facilities.
- Monitoring for trends, opportunities for improvement, and over and under utilization.

Foot and back orthotics were also discussed in the above meeting, noting that these services were being provided for diagnoses not consistent with medical necessity criteria based on an analysis of claims data for the third quarter. In response, ACC reported that it had engaged corporate partners to discuss a pre-certification requirement for these services in 2016.

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

Component 7.3c - The written UR Plan has mechanisms in place to detect over utilization and under utilization of services. Corrective measures implemented must be monitored.

ACC received a finding of partially met for this component. In response to the CY 2014 SPR findings, ACC was required to develop a CAP to demonstrate that the designated committee(s), consistent with its UMP, UM Work

Plan, and policies, routinely monitors corrective measures that have been implemented in response to both over and under utilization issues. As indicated below, an opportunity continues to exist to demonstrate that monitoring of corrective measures is occurring as documented in meeting minutes of the appropriate committees.

There was no evidence that the MCO monitored corrective measures to address areas of over and/or under utilization based on review of Medical Advisory Committee minutes from seven meetings held in 2015. The Director of UM confirmed that there was no such documentation in Medical Advisory Committee meeting minutes.

In the Quality Management Committee minutes of March 4, 2015, an update was provided on the Readmission Reduction Initiative. This initiative analyzes Chesapeake Regional Information System for Patients data to identify Group 2 members admitted to participating hospitals. These members receive social worker or Case Management intervention for 30 days post discharge in an effort to decrease readmission. A year to date decrease in the readmission rate for three of the six participating hospitals was reported. It was determined that the increase at the remaining three hospitals was due to readmission needs for complex conditions, chemotherapy, and transplants. It was further reported that this initiative would be monitored for trend and an analysis of the rates of all participating hospitals. In the Quality Management Committee minutes of June 3, 2015, it was reported that the readmission rate for the stabilization team for all of 2014 was 10.8%. ACC reached out to 471 members in 2014; 249 were enrolled into the program and 185 graduated. Only 20 were readmitted, with most readmissions to University of Maryland Medical System, Sinai, and St. Agnes facilities.

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

Component 7.4d - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that there are well publicized and readily available appeal mechanisms for both providers and enrollees.

ACC received a finding of partially met for this component. ACC continues to use an easily understandable and comprehensive two-page question-and-answer form entitled Amerigroup Appeal Process to accompany all adverse determination letters. It details the types of reviews, provides instructions for requesting each type of review, and explains the appeal process available through the HealthChoice Enrollee Help Line.

These procedures are detailed in the Member/Provider Action Appeal Process – MD Policy that also outlines the information on the appeal process to be included in the member handbook.

Detailed, easily understandable information on appeals, including an explanation of the difference between a grievance and an appeal and time frames for resolution, was found in the most recent version (2015) of the member handbook. Similar information was included in the 2015 provider manual.

As noted in the CY 2014 review, there are some inconsistencies among the documents reviewed. For expedited appeals, the member handbook identifies a time frame of three calendar days for resolution, whereas the provider manual notes three business days and the Member/Provider Action Appeal Process – MD Policy states 72 hours.

Moreover, both the member handbook and the Member/Provider Action Appeal Process – MD Policy include a filing time frame of 90 business days while the provider manual states the filing time frame as 90 days.

In order to receive a finding of met in the next SPR, ACC must resolve the inconsistencies in the time frames for appeal filing and resolution of expedited appeals in all policies and member and provider materials.

Component 7.6c - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. The MCO acts upon identified issues as a result of the review of the data.

ACC received a finding of unmet for this component. In response to the 2014 review findings, ACC was required to develop a CAP to demonstrate in the appropriate committee minutes the actions ACC has taken in response to UM-related results from the CAHPS® and Provider Satisfaction surveys. Additionally, ACC was required to demonstrate routine monitoring of these actions. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

In the Quality Management Committee minutes of February 4, 2015, provider satisfaction with the UM process was reviewed. Although ACC noted that satisfaction goals were met, the MCO conducted a barrier analysis to identify additional opportunities for improvement. In response to identified barriers, ACC noted current and ongoing initiatives to improve timeliness of authorization process completion to include:

- Close monitoring of transitions during technology and system integration for identification of "glitches" or system disruptions.
- Actively participating in change management operational meetings and work groups.
- Defining reporting needs for ongoing workload re-balance and calibration.
- Defining and implementing monitoring of reports for state-mandated and NCQA-required determination and notification.

In analyzing opportunities to improve member satisfaction with UM processes, ACC focused on results from the Child CAHPS® survey since children represent nearly 64% of the membership. Opportunities to improve satisfaction were identified in response to the following survey items:

- Easy to get an appointment for child with specialist
- Easy to get care believed necessary for child

Identified barriers included:

- Specialty network limitations exist in certain geographic areas.
- High-demand participating specialists have limited schedule openings.
- Approval of non-contracted providers requires multiple hand-offs, needing process improvement.
- Health plan initiatives may have unintended impact on member's perception of satisfaction.

Actions to improve satisfaction included:

- Identifying geographic specialty provider gaps and collaborating with provider relations to address.
- Ongoing recruitment and retention of skilled associates.
- Reassessing and rebalancing workloads and training as needed to assure best practices.

- Defining reporting needs for ongoing monitoring of workload and staff recalibration to meet turnaround times.
- Maintaining ongoing process and technology improvement.
- Closely monitoring technologic integration/upgrades to identify potential disruptions to timeliness.
- Utilizing multi-disciplinary, cross-functional work groups to evaluate potential impact of programs and initiatives on members.
- Monitoring and reporting results of actions taken to improve member and provider satisfaction with UM.

A review of subsequent Quality Management Committee meeting minutes from 2015 found no evidence of quarterly reporting to the Quality Management Committee on the status of the interventions identified above. This is not consistent with the MCO's policy.

In order to receive a finding of met in the next SPR, ACC must demonstrate quarterly reporting to the Quality Management Committee on the status of interventions implemented to improve member and provider satisfaction with UM processes consistent with the MCO's policy.

PPMCO Opportunities/CAPs:

Component 7.4c - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that the reasons for decisions are clearly documented and available to the enrollee in easy to understand language.

PPMCO received a finding of partially met for this component. In response to the CY 2014 SPR findings, PPMCO was required to develop a CAP to demonstrate that reasons for review determinations are documented in language that is clearly understandable to the member in all adverse determination letters. As indicated below, the CAP was successfully implemented; however, an opportunity exists for improvement in accurate and clear documentation of the reasons for decisions and criteria utilized in adverse determination letters.

The Clinical and Administrative Denial Notification Policy outlines the content for denial letters to include the principal reason for the determination to deny in easily understood language and a statement of the specific criteria, guideline, or benefit provision used in rendering the decision.

A review of 10 member adverse determination letters demonstrated reasons for decisions were documented in easily understandable language. One of the letters, however, identified the Summary Plan Description as the guideline used for denial of a request for an electric wheelchair when the patient record documented the rationale for the denial was based on InterQual criteria. A second letter was unclear as to the reason for the adverse determination in response to a request for genetic testing for Pompe Disease and a test for Voltage-Gated Calcium Channel Antibody. The reason for the denial was based on lack of clinical review criteria, causing the tests to be considered experimental. However, statements such as "the Medical Director must be able to access appropriate relevant resources to assist them in making their decision" could potentially be confusing to the member.

In order to receive a finding of met in the next SPR, PPMCO must demonstrate that it identifies the correct criteria or guidelines utilized in making a review determination and that the rationale for the determination is clearly stated.

Component 7.4 e - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

PPMCO received a finding of unmet for this component. In response to the CY 2014 SPR findings, PPMCO was required to develop a CAP to demonstrate consistent compliance with preauthorization determination and adverse determination notification time frames specified by the State at the 95% threshold. This includes both medical and pharmacy authorization requests. Additionally, all policies that included time frames for preauthorization determinations and adverse determination notifications were to be revised to be consistent with COMAR requirements. Tracking of compliance was also required to demonstrate COMAR time frame requirements. As documented below, inconsistent compliance with required time frames indicates that the CAP was not fully implemented. PPMCO has not fully met this component for at least the last eight review cycles, with the exception of 2011, which was scored as baseline.

Two policies were reviewed that included determination and notification time frames: the Utilization Management Determination and Notification Timeframes Policy and the Step Therapy, Prior Authorization and Quantity Limits Policy. Both have been revised to ensure consistency with COMAR requirements.

The UM Turnaround Time for Pre-certification for Inpatient, Outpatient, and Pharmacy document reported compliance with determination and notification time frames by month throughout 2015. Compliance with decision time frames varied in 2015, with a high of 68% in January and December and a low of 47% in November. According to the new Senior Director of UM, who assumed this position in late 2015, several process changes have been implemented in addition to cross training, which is demonstrating improved compliance in 2016. Compliance with notification time frames consistently exceeded the 95% threshold in 2015.

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

Component 7.4 f - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that appeal decisions are made in a timely manner as required by the exigencies of the situation.

PPMCO received a finding of unmet for this component. In response to the CY 2014 SPR findings, PPMCO was required to develop a CAP to demonstrate consistent compliance with State-required time frames for appeal resolution. This component had not been met since the CY 2012 review. As indicated below, inconsistent compliance with required time frames indicates that the CAP was not fully implemented.

PPMCO has elected to develop time frames for appeal resolution that are more stringent than required by COMAR 10.09.71.05. The Member Appeal Policy requires expedited/urgent care appeals to be resolved within 36 hours of receipt at both first and second levels rather than the 3 business days specified by regulation. Whereas COMAR specifies a time frame for resolution of non-expedited appeals within 30 days, PPMCO has established a time frame of 15 calendar days for both first- and second-level routine pre-service appeals and 30 calendar days for first- and second-level post-service appeals. The policy also provides for a 14-calendar-day extension to allow the member to submit all applicable documentation for consideration in the appeal review. In response to recommendations from the CY 2014 review, PPMCO has revised the policy to explicitly state that appeal rights are also available for adverse determinations for initial pre-service requests. It has also revised the standard time frame for processing an appeal that does not meet criteria for an expedited appeal to 15 days rather than the 30 days incorrectly cited in the previous version. The current version of this policy no longer describes the process for

monitoring compliance with resolution time frames or the process and time frame for reporting compliance to the appropriate oversight committee.

The Priority Partners Member Appeals - Compliance document identifies compliance with resolution time frames for non-urgent pre-service, expedited pre-service, and post-service by month throughout 2015. Compliance for non-urgent pre-service appeals showed steady improvement from a low of 79% in January to 100% in December. Compliance for expedited pre-service appeals was reported at 100% for four months, including the last three months of 2015. According to the new Manager of Appeals, this improvement was achieved through new hires, cross training, and outsourcing emergency room appeals.

A review of a sample of 10 appeal records from CY 2015 revealed 100% compliance for six standard appeals and 0% compliance for expedited appeals.

It is recommended that PPMCO revise the Member Appeal Policy to describe the process for monitoring compliance with the appeal resolution time frames and the time frame for reporting compliance to the appropriate oversight committee.

In order to receive a finding of met in the next SPR, PPMCO must demonstrate consistent compliance with State-required time frames for appeal resolution.

RHMD Opportunities/CAPs:

Component 7.2e - The UR Plan specifies criteria for UR/UM decisions. There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM standards.

RHMD received a finding of unmet for this component because there was no evidence that UM staff receive annual training on the interpretation and application of Milliman Care Guidelines. According to the Vice President of Health Services, annual updates to Milliman Care Guidelines are circulated to the team and discussed at stand-up meetings. There was no documentation of this requirement in the Health Services Management Program Description or in any policy.

It is recommended that RHMD develop a policy or include in the Health Services Management Program Description the requirement for annual training of UM staff on the interpretation and application of medical necessity criteria.

In order to receive a finding of met in the next SPR, RHMD must demonstrate that UM staff receive annual training on the interpretation and application of medical necessity criteria.

Component 7.4e - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

RHMD received a finding of partially met for this component. In response to the CY 2014 SPR findings, RHMD was required to develop a CAP 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. As indicated below, an opportunity continues to exist to demonstrate compliance with regulatory time frames for preservice determinations and adverse determination notifications, a documented methodology, and plan documents consistent with COMAR time frames.

The UM Program Structure and Processes Policy, effective September 1, 2015, includes a table documenting the time frames for UM decisions and notifications. The time frame for written notification to members for non-urgent preservice requests is documented as within 24 hours of the decision and no later than within 15 days of the request. Written notification for urgent preservice requests is to occur within 24 hours of the decision and no later than within 72 hours of receipt of the request. These time frames continue to be inconsistent with COMAR 10.09.71.04, which requires preservice determinations within two business days of receipt of clinical information but not later than seven calendar days from the date of the initial request. Written notification of an adverse determination is to be provided to the enrollee within 24 hours for emergency, medically related requests and within 72 hours for non-emergency, medically related requests. The Health Services Management Program Description has been revised to reflect notification of an adverse determination consistent with regulatory time frames.

The Denial of Services Policy outlines the procedures for communicating an adverse determination to a member. The policy includes the requirement for providing a member with written notice of an adverse determination of a previously authorized service at least 10 days prior to termination, suspension, or reduction of the service.

The Health Services Management Program Description states that the Timeliness of Authorization of Services Report is reviewed at the Provider Advisory Committee. It further reports that the MCO adheres to the State-specified threshold for all prior authorization review decisions of 95%. A sample of prior authorization reviews is to be completed quarterly, using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.

As evidence of tracking compliance, the MCO provided an audit spreadsheet for 2015. According to the Vice President of Health Services, all adverse preservice determinations were audited in 2015 for compliance with required turnaround times. Preservice determinations resulting in an approval were not included in this audit, so compliance with decision turnaround times could not be determined. Compliance with adverse determination notification time frames met or exceeded the 95% threshold for the first three quarters of 2015 but fell below at 93% for the fourth quarter.

Subsequent to the onsite review, RHMD provided the Case Audits Desktop Procedure, which requires that all adverse determinations be audited on a monthly basis. For purposes of compliance this is inadequate. Compliance with preservice determination time frames needs to be monitored and reported for approvals as well as adverse determinations. Additionally, the desktop procedure should clearly identify the separate time frames that are monitored, such as preservice requests with and without sufficient clinical information and notification of adverse determinations for expedited versus routine requests. If a sample is to be utilized, it must reflect use of the sample size calculator approved by DHMH.

In order to receive a finding of met in the next SPR, RHMD must demonstrate compliance with regulatory time frames for all preservice determinations, including both approvals and denials, and adverse determination notifications. The methodology for determining compliance must be clearly documented to provide necessary guidance to audit staff. Additionally, all applicable plan documents must reflect determination and notification time frames consistent with COMAR.

UHC Opportunities/CAPs:

Component 7.4e - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

UHC received a finding of unmet for this component. In response to the CY 2014 SPR, UHC was required to develop a CAP to address ongoing opportunities for improvement in demonstrating consistent tracking and compliance with State-required time frames for determinations and notifications for medical and pharmacy services prior authorization requests. Although UHC has demonstrated considerable improvement in complying with State-required time frames, the CAP was not fully implemented and continuing opportunities for improvement exist as noted below.

The Initial Review Timeframes Policy includes state-specific time frames at the end of the policy. Determination and adverse determination notification time frames are identified and consistent with regulation. The policy also specifies that the MCO will give an enrollee written notice of any action, except for denials of payment which do not require notice to the enrollee, within 10 days before the action for termination, suspension, or reduction of a previously authorized covered service.

UHC provided separate tracking of compliance with determination and notification time frames for medical and pharmacy services, by month, throughout 2015. Results are detailed for each area below.

In reviewing the prior authorization medical turnaround time Compliance Report for 2015, compliance was reported as follows:

- Expedited determinations – 11 out of 12 months met or exceeded the 95% compliance threshold; the outlier month was at 92%. (Of note, 8 months were at 100%.)
- Routine determinations within 2 business days – all 12 months met or exceeded the 95% threshold.
- Routine determinations within 7 calendar days – 11 out of 12 months met or exceeded the 95% compliance threshold. The outlier month fell slightly below the threshold at 94%.
- Written notification within 24 hours – 9 out of 12 months were at 100% compliance; outlier months ranged from 67% to 83%.
- Written notification within 72 hours – 10 out of 12 months met or exceeded the 95% compliance threshold; outlier months were at 78% and 94%.

In reviewing the prior authorization pharmacy turnaround time Compliance Report for 2015, compliance was reported as follows:

- Expedited determinations – 5 out of 12 months met or exceeded the 95% compliance threshold; outlier months ranged from 75% to 94%. (Of note, the last 4 months of 2015 exceeded the threshold.)
- Routine determinations within 2 business days – 5 out of 12 months met or exceeded the 95% compliance

threshold; outlier months ranged from 63% to 93%. (Of note, the last 4 months of 2015 exceeded the threshold.)

- There were no requests that required additional clinical information, so no compliance percentages were reported for the seven calendar day time frame.
- Compliance with time frames for notification of adverse determinations was consistently reported at 100%.

In order to receive a finding of met in the next SPR, UHC must consistently demonstrate compliance with State-required time frames for medical and pharmacy prior authorization determinations and adverse determination notifications.

Component 7.6c - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. The MCO acts upon identified issues as a result of the review of the data.

UHC received a finding of partially met for this component. During the onsite review, there was no evidence that UHC acted upon identified issues as a result of review of member and provider satisfaction with UM processes as documented in the appropriate oversight committee meeting minutes consistent with its policy.

Subsequent to the onsite review, UHC provided additional information to demonstrate compliance with this component. However, this component remains partially met because no new initiatives were implemented as of the end of October 2015. Additionally, continuing initiatives did not appear to be based on quantifiable data or a root cause analysis, such as a Geo Access analysis that reflects the need for specific specialists within certain geographic areas.

The CAHPS® Work Plan, updated October 30, 2015, included three UM-related measures with an identified owner, strategies, tasks, and status. The status for each of these measures was listed as “not yet started.” An example of a UM-related measure was “Got an appointment for your child to see a specialist as soon as you needed.” A strategy was identified to outreach and provide onsite education for providers concerning appointment scheduling and access and availability standards. The task was listed as “provider outreach brochure and provider and member outreach script updates to review and educate on standards.”

The undated CAHPS® UM document identified continuing initiatives to address UM-related opportunities. For example, in response to results related to the child survey item “Got an appointment with a specialist as soon as needed” actions included continuing to perform GeoAccess mapping to ensure a sufficient number of specialists are available.

As evidence that the status of interventions is monitored, UHC submitted Service Quality Improvement Subcommittee meeting minutes from October 29, 2015, as a sample. No specific UM interventions were discussed; however, it was noted that a copy of the updated CAHPS® Work Plan would be distributed for review and e-vote after the meeting.

It is recommended that UHC provide a work plan specifically related to identified UM opportunities rather than scatter different initiatives over multiple documents.

In order to receive a finding of met in the next SPR, UHC must demonstrate that it acts upon and monitors identified issues in a timely manner as a result of review of both member and provider satisfaction with UM processes as documented in the appropriate oversight committee meeting minutes consistent with its policy.

Follow-up:

- ACC, PPMCO, RHMD and UHC were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

STANDARD 8: Continuity of Care

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

Results:

- The overall MD MCO Compliance Score was 100% for CY 2015 which is consistent with CY 2014.
- All MCOs met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 90%.

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

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 9: Health Education Plan Review

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

Results:

- The overall MD MCO Compliance Score was 95% for CY 2015 which was an increase of the CY 2014 Compliance Score of 82%.
- ACC, JMS, KPMAS, MPC, and MSFC receive a compliance score of 100%.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 90%.
- PPMCO, RHMD, and UHC received compliance scores of 92%, 92%, and 79% respectively. These MCOs were required to submit CAPs.

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

MCO Opportunity/CAP Required

PPMCO Opportunities/CAPs:

Element 9.4 - The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.

PPMCO received a finding of unmet for this element. According to the Manager of Health Promotion and Wellness, Health Educators are made aware of members in special need of educational efforts through their routine interaction with practice sites. However, no documentation was provided to support this process or evidence that mechanisms are in place and functioning to identify members in special need of educational efforts.

Subsequent to the review, PPMCO provided evidence that members in special need of educational efforts are referred for health education. For example, two referrals for members of the same family were submitted by the primary care physician for nutritionist services and weight-loss coaching. Additional documents submitted included the Population Assessment, which focused on special needs populations not the broader population in special need of educational efforts, and a listing of community presentations on health education topics.

In order to receive a finding of met in the next SPR, PPMCO must provide documentation of the process for identifying enrollees in special need of educational efforts, including evidence that mechanisms are in place and functioning.

RHMD Opportunities/CAPs:

Component 9.3a - The MCO's Health Education Plan must have a written methodology for an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.

RHMD received a finding of unmet for this component. In the CY 2014 SPR, it was noted that in order for RHMD to receive a finding of met in the CY 2015 SPR, it must provide evidence of a formal annual evaluation of the impact of the Health Education Plan on process and/or outcome measures. As noted below, the CAP was not implemented and a continuing opportunity for improvement exists.

The Health Education Plan states that RHMD evaluates its Health Education Plan annually through the QA Evaluation. It further states that recommendations to improve the education plan are presented to the Quality Improvement Committee and Provider Advisory Committee. The Health Education Plan documents several mechanisms used to assess the impact of the MCO's educational activities through analysis of data, including:

- EPSDT compliance, well-care visits
- HEDIS® results
- Appointment compliance and adherence
- Pharmacy compliance and adherence
- Readmission reports
- Educational tracking system reports
- Member profiles for high-risk membership

The 2015 Health Education Evaluation, 4th Quarter 2015, was submitted to demonstrate evidence of the evaluation of the implementation of health education activities and their impact on health outcomes. The overview consisted of a general description of wellness and preventive services; health education/disease management targeting of certain chronic conditions; pregnancy-related resources; and notifications sent to members diagnosed with asthma, diabetes, and hypertension who have not been prescribed the correct medication or who have not filled/refilled their prescription. Additionally, it was reported that in 2015 RHMD offered six webinars to its providers to educate them on the 2015 updates to the American Diabetes Association's Standards of Medical Care in Diabetes.

In the Results section of the evaluation the MCO reported that the program is evaluated using clinical data and satisfaction surveys, including:

- Recommendations from the Provider Advisory Committee on improving health education options for patients
- Consumer Advisory Board feedback
- Member evaluations
- CAHPS® results
- HEDIS® data

Qualitative feedback from the above stakeholders was included in the evaluation; however, there was no evidence of the impact of the Health Education Plan on process and/or outcome measures as required by this component. It was noted in the evaluation that HEDIS® data has been collected monthly for CY 2015, but RHMD did not yet have final HEDIS® rates available to identify trends in the effectiveness of its Health Education Plan.

In order to receive a finding of met in the next SPR, RHMD must demonstrate evidence of an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency department utilization, avoidable admissions, utilization of preventive health services, and clinical measures.

UHC Opportunities/CAPs:

Component 9.3a - The MCO's HEP must have a written methodology for an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.

UHC received a finding of unmet for this component. According to the Health Education Plan, UHC measures program outcomes in clinical, financial, and operational categories.

Clinical Outcomes:
- Adherence to disease-specific, evidence-based guidelines for all chronic conditions, as well as preventive and curative care measures
- Clinical markers and HEDIS®, such as lead, obesity, preventive health services, and body mass index falling within normal ranges
- Member and provider satisfaction survey

Financial Outcomes:
- Improved access to care
- Reduced emergency room encounters report
- Improved use of formulary and generic drugs

Operational Outcomes:
- Consistent improved results on member satisfaction surveys – CAHPS® 5.0H
- Engagement rate by Health Educator

Subsequent to the onsite review UHC provided additional documentation to demonstrate compliance; however, this component remains unmet. Documentation submitted comprised minutes from the December 10, 2015, Provider Advisory Committee meeting minutes demonstrating review/approval of the Health Education Plan; a summary of member attendance at four health education-related events held in December 2015; and examples of member evaluations of a Diabetes Education Program.

In order to receive a finding of met in the next SPR, UHC must demonstrate implementation of its written methodology for an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.

Element 9.4 - The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.

UHC received a finding of partially met for this element. The Health Education Plan states that early identification of the MCO's special needs populations is achieved via State and HEDIS® missed opportunity reports, primary care providers and self-referrals using the Customer Service or Care/Disease Management Departments, practitioner referrals, Health Risk Assessments (at the time of enrollment), Inpatient Case Management, state flags, pharmacy data, and retrospective claims analyses. These mechanisms identify not only special needs populations but also members in special need of educational efforts.

UHC's Universal Tracking Device software compiles information from multiple sources, including claims, laboratory, and pharmacy data, to predict the future risk of members' intensity and utilization of services. A member who has been identified as needing a service receives an auto or live voice message and then is mailed health education materials related to the identified condition.

The Health Education Plan also suggests a number of tactics to use in the event that a member is not complying with the treatment plan, such as:

- Continuing to invite member to community events
- Sending outbound reminder notifications
- Sending auto-callers
- Working to identify and understand the member's barriers to success
- Problem solving for alternative solutions
- Reporting noncompliance to the treating provider/specialist, offering potential solutions and integrating provider feedback

No documentation was provided to support that these mechanisms are in place and functioning.

In order to receive a finding of met in the next SPR, UHC must provide documentation to support mechanisms are in place and functioning to identify enrollees in special need of educational efforts.

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

UHC received a finding of unmet for this component. According to the Health Education Plan providers are given the opportunity to evaluate health education programs during the Provider Advisory Committee meetings and provider onsite visits. This information is to be included in the annual QI Program evaluation. The HEP further states that UHC network providers annually review the Health Education Plan to ensure enrollee educational sessions are appropriate for the targeted population.

As evidence of compliance the MCO submitted Provider Advisory Committee meeting minutes from December 10, 2015, that reported approval of the 2015–2016 Health Education Plan via e-vote. This is insufficient in demonstrating that providers evaluated the MCO's Health Education Plan.

The MCO also submitted a completed provider evaluation form relating to an outreach scheduling appointment initiative that did not appear to address health education. In order to receive a finding of met in the next SPR, UHC must demonstrate that providers are given the opportunity to evaluate member educational sessions and the overall Health Education Plan.
Follow-up: ➢ PPMCO, RHMD, and UHC were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions. ➢ Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

STANDARD 10: Outreach Plan Review

Requirements: The MCO must have developed a comprehensive written Outreach Plan to assist participants in overcoming barriers in accessing health care services. The Outreach Plan must adequately describe the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the Outreach Plan, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.

Results:
- The overall MD MCO Compliance Score was 96% for CY 2015 which was an increase over the CY 2014 Compliance Score of 89%.
- ACC, JMS, MPC, MSFC, PPMCO, RHMD, and UHC receive a compliance score of 100%.
- KPMAS received a compliance score of 71%, which was below the minimum compliance threshold of 90%, and was required to submit a CAP.

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

MCO Opportunity/CAP Required

KPMAS Opportunities/CAPs:

Component 10.1a - The MCO has developed a written Outreach Plan that describes populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership.

KPMAS received a finding of unmet for this component. KPMAS provided no evidence to support compliance with this component.

In order to receive a finding of met in the next SPR, KPMAS must describe the membership demographics including, but not limited to:
- Where the largest portion of the members reside
- Adult versus child populations
- Breakdown of the identified special needs populations as cited in COMAR (a chart by county describing this information is not sufficient)
- The most common health conditions among its Maryland HealthChoice membership
- The barriers to health care for its Maryland HealthChoice members

Component 10.1b - The MCO has developed a written Outreach Plan that describes MCO's organizational capacity to provide both broad-based and enrollee-specific outreach.

KPMAS received a finding of unmet for this component. KPMAS outreach is primarily conducted through the Medicaid Office, the centralized onboarding unit, provider health care teams, and the Case Management team. These teams and units were partially described; however, each team/unit did not have complete descriptions including number of positions, position descriptions, and educational requirements.

In order to receive a finding a met in the next review, KPMAS must:

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

Component 10.1e - The MCO has developed a written Outreach Plan that describes Role of the MCO's provider network in performing outreach.

KPMAS received a finding of unmet for this component. KPMAS provided no evidence to support compliance with this component.

In order to receive a finding of met in the next SPR, KPMAS must have a written policy on the provider's role in performing outreach. KPMAS must have a mechanism in place to deliver these policies to the providers.

Component 10.1f - The MCO has developed a written Outreach Plan that describes MCO's relationship with each of the LHDs and ACCUs.

KPMAS received a finding of unmet for this component. KPMAS provided no evidence to support compliance with this component.

In order to receive a finding of met in the next SPR, KPMAS must have a relationship with each of the LHDs/ACCUs in each county of operation. KPMAS must have policies and procedures regarding referrals for outreach to members and those referrals should be tracked by the MCO.

Follow-up:

- KPMAS was required to submit a CAP for the above components. Delmarva Foundation reviewed and approved the submission.
- Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

STANDARD 11: Fraud and Abuse

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

Results:

- The overall MD MCO Compliance Score was 98% for CY 2015 which was consistent with CY 2014.
- ACC, JMS, KPMAS, MPC, MSFC, PPMCO, and UHC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 94%, which exceeded its minimum compliance threshold of 90%.
- RHMD received a compliance score of 89%, and was required to submit a CAP.

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

MCO Opportunity/CAP Required

RHMD Opportunities/CAPs:

Component 11.4c - The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with.

RHMD received a finding of unmet for this component. The CRC approved the administrative and management procedures (Compliance Plan) for RHMD. However, there was no evidence of review and approval of the delegated vendors' fraud and abuse plans by the designated committees (Delegated Oversight Committee and Quality Improvement Committee).

In order to receive a finding of met in the CY 2015 SPR, RHMD must determine which committee is responsible for review and approval of the vendors' fraud and abuse plans and clearly document such review and approval in the meeting minutes.

Component 11.4d - The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.

RHMD received a finding of unmet for this component. It is reported by the Director of Compliance that the delegate's fraud and abuse reports are to be reviewed by either the Delegated Oversight Committee or the Quality Improvement Committee. On review of both the Delegated Oversight Committee and the Quality Improvement Committee meeting minutes for 2015, it was determined that neither committee had noted review of these reports in the minutes.

In order to receive a finding of met in the next SPR, RHMD must provide evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities.

Follow-up:

- RHMD was required to submit a CAP for the above components. Delmarva Foundation reviewed and approved the submission.
- Results of the activities outlined in the approved CAP will be reviewed in the next SPR.

Figure 1 shows the HealthChoice Aggregate compliance rates from CY 2013 through CY 2015.

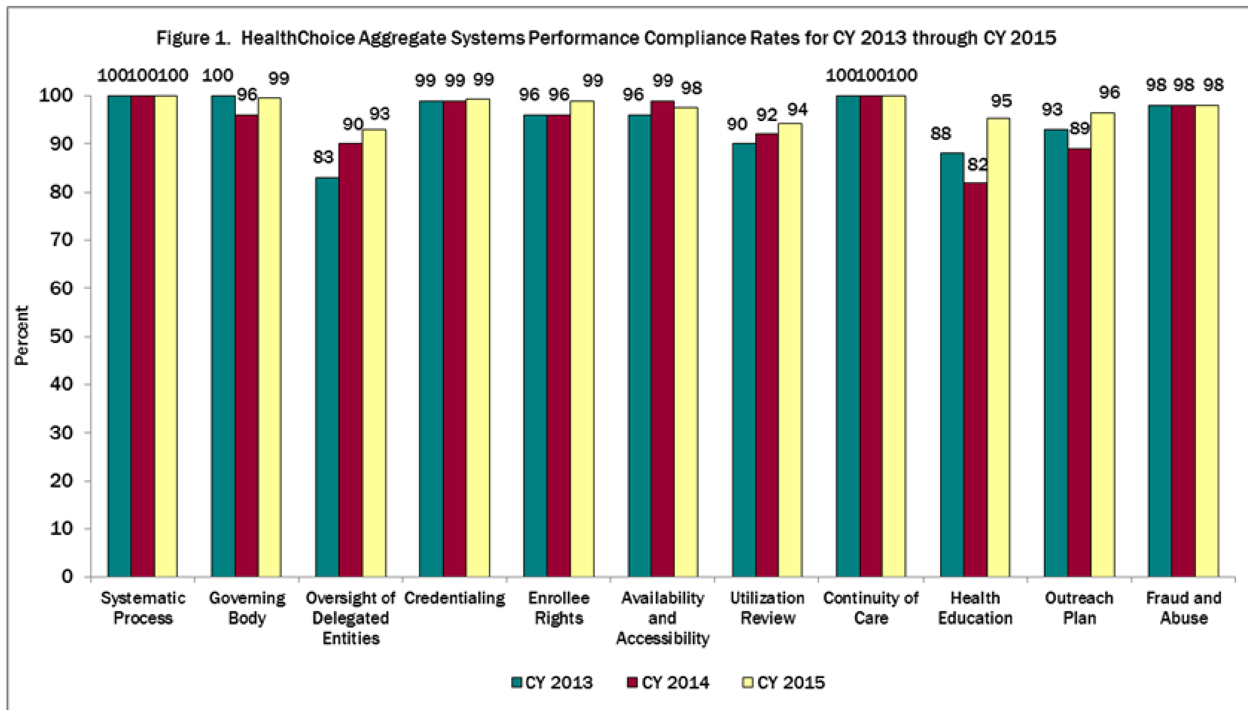

Figure 1. HealthChoice Aggregate Systems Performance Compliance Rates for CY 2013 through CY 2015

Between CY 2014 and CY 2015, the MD MCO compliance score increased for six standards (Governing Body, Oversight of Delegated Entities, Enrollee Rights, Utilization Review, Health Education, and Outreach Plan), remained unchanged for four standards (Systematic Process, Credentialing, Continuity of Care, and Fraud and Abuse), and decreased for one standard (Availability and Accessibility).

The overall MD MCO Composite Score increased to 98% in CY 2015 from 97% in both CY 2013 and CY 2014. It should be noted that KPMAS entered HealthChoice in mid-CY 2014, thus undergoing its second review during CY 2015.

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

- ACC offers very comprehensive reporting of health plan initiatives, barriers to accomplishing these activities, and recommended actions for improvement in its Quality Management Committee meeting minutes. Status updates of work plan activities are reported at each meeting.

- ACC has an effective structure for monitoring and oversight of delegate activities and demonstrates timely resolution of any corrective action plans required of delegates related to performance deficiencies.
- ACC evidences extremely clear language in member letters stating the reasons for adverse determinations that are easily understandable and noting what is needed for criteria to be met.
- ACC has an extremely comprehensive Case Management Program Descripiton which defines all facets of the program, from member identification and engagement to assessment of Case Management effectiveness. The Case Management Program Description also outlines the training Case Management staff are required to attend. ACC continues to do an excellent job of using members' demographic, culturally specific, and epidemiological data to drive decisions around Case Management strategies.
- ACC displays initiative and creativity on the part of the Health Education staff who applied and were awarded two grants to fund shared medical appointments for diabetes and hypertension. Although minimal improvement was demonstrated in select measures the team identified key learnings which will strengthen future initiatives in these areas.

Jai Medical Systems

- JMS has a very comprehensive Quality Assurance Program Description which is updated annually to reflect the changing needs of the HealthChoice enrollee population. Studies are appropriately developed to monitor these changes and assess the effectiveness of care delivery.
- JMS continues to have an excellent program for communicating with providers about issues that affect Quality of Care. Providers are sent HEDIS® measures at each season and are expected to review the new measures and sign a statement that they read and understand the requirements. Quarterly Provider Report Cards are sent to providers on pharmacy, utilization management, and encounter data.
- JMS has a stable utilizatition management program that demonstrates extremely active management of patients on an individual and group basis and timely, personal outreach to PCPs to discuss identified opportunities for improvement.
- JMS continues to have a robust Health Education Program as evidenced by the number and diversity of health education offerings and the high number of PCP referrals of JMS members for educational interventions. Classes/programs reflect the needs of the population based on data analysis and provider recommendations. Of particular note are the Hepatitis C classes that were initiated in 2015 which are delivered by a pharmaceutical company at one of the JMS medical sites.
- JMS surveys all PCPs annually requesting feedback on the MCO's health education programs. These surveys not only provide invaluable recommendations but also serve to educate providers on the availability of a wide variety of offerings available through the MCO.

Kaiser Permanente of the Mid–Atlantic States, Inc.

- KPMAS approaches quality improvement from a systemic as well as an individual practitioner and medical center level. Committees, policies and procedures, and clearly defined standards of care establish a strong infrastructure from which actual and potential quality of care and quality of service issues can be

addressed. The PowerPoint Presentation on the quality improvement process provides the documentation to support a best practice in the approach used and the process cycle for quality improvement.

- KPMAS offers a best practice in their approach to monitoring quality of care and quality of service issues. Performance expectations and possible variations are clearly defined. Quality of service issues are screened by clinicians to ensure that clinical quality is not compromised.
- KPMAS uses easy to understand language in appeal letters and acknowledge the MCO's regret that it cannot provide a more favorable response to the request made by the member. This is among the best appeal letters this reviewer has seen demonstrating sensitivity to the member's needs.
- KPMAS uses health equity data to establish priorities for HEDIS® interventions which supports targeting members based upon unique needs of these member subgroups.
- KPMAS includes in the evaluation of the InSTEP Diabetes Program multiple clinical outcome and process measures for both participant and non-participant groups. Although the small number of program participants presents a challenge for determining program effectiveness the established methodology serves as a good foundation for ongoing measurement, particularly as the participants increase.

Maryland Physicians Care

- MPC demonstrates utilization of health care equity data to inform interventions addressing improvement opportunities in its postpartum visit rate.
- MPC consistently exceeds the performance threshold for compliance with preauthorization determination and adverse determination notification time frames.
- MPC includes a statement in all adverse determination letters that "your appeal will not affect your ability to receive other services through MPC". This statement is helpful in overcoming any potential fears members may experience regarding the impact of filing an appeal on receipt of other health care services through the MCO.
- MPC evidences a best practice as demonstrated by its CORE Report and predictive modeling approach used for identifying and stratifying members into Case Management/Disease Management. This enables Case Management to work with the most complex members to target specific interventions that help to reduce inpatient and emergency department stays and decrease readmission rates.
- MPC offers an excellent example of the methods it uses to coordinate with community based organizations and to monitor continuity and coordination of member's care through its Coordination of Member Care Policy. Coordination of care study designs are comprehensive and allow MPC to gauge the effectiveness of Case Management interventions.

MedStar Family Choice, Inc.

- MSFC demonstrates a continuing strength within its operating structure resulting from its cross-departmental and community-based communication and collaboration which are directed at improving

member care and services. Multidisciplinary teams are used routinely to address barriers to care and to develop strategies for performance improvement.

- MSFC continues to develop and present an Annual Oversight Summary of each delegate to the Quality Improvement/Utilization Management Committee and Executive Operations Team. As noted in the past, these summaries are extremely comprehensive and provide a snapshot of the delegate's performance throughout the year and any identified opportunities for improvement.
- MSFC consistently meets appeal time frames and exceeds the threshold for compliance with pre-service determination and notification time frames for standard and urgent requests.
- MSFC includes a statement in all adverse determination letters that the member's appeal will not affect their ability to receive other services through MSFC thereby removing any perceived barrier to the member filing an appeal.
- MSFC demonstrates substantial reductions in inpatient and emergency room visits as a result of Disease Management services provided to members with either asthma or diabetes. Education on self-management of these diseases is a key component of Disease Management related interventions.

Priority Partners

- PPMCO uses a risk checklist for all applications to the provider network. This ensures a thorough review of all potential risks to the organization.
- PPMCO has implemented an ambulatory intensive care pilot program based on an evidence based practice. Preliminary results demonstrate increased PCP encounters, decreased ER and hospital utilization, and decreased costs.
- PPMCO demonstrates ongoing effectiveness of its Case Management/Disease Management programs and pilot programs such as the Emergency Room Diversion program through reductions in costs and in emergency room and inpatient utilization.
- PPMCO has implemented new initiatives in 2015 in response to low member participation in health education activities offered by the MCO which have demonstrated some success in improving the rate. These include program redesign, member incentives, and employing a health educator on the eastern shore in recognition of cultural differences from the western shore.
- PPMCO evidences the development of a close working relationship by the health educators with the practice sites. These relationships can be leveraged to gain increased member participation in health education activities through provider referrals.

Riverside Health of Maryland

- RHMD evidences delegation agreements and accompanying amendments that are extremely comprehensive in scope in outlining the responsibilities of the delegate and the MCO, delegate performance requirements, and remedies for nonperformance.

- RHMD has a large number of network providers participating on the Provider Advisory Committee representing a broad range of specialties. This facilities discussion and recommendations that reflect a thorough consideration of relevant issues.
- RHMD demonstrates extremely well organized appeal case files and for the third year in a row has achieved 100% compliance with appeals resolution time frames. Additionally, the appeal letter is easy to understand and includes a closing statement expressing care about the member and appreciation for helping RHMD to do its best to serve the member.
- RHMD actively employs text messaging as a component of its Health Education Plan which not only includes preventive health reminders but also provides a quick link to more detailed information. The texts also include a link if the member would like the information provided in Spanish.
- RHMD has expanded its outreach efforts through contracting with a vendor that provides physician support services for direct patient care and transitional care to qualifying patients in their home. RHMD has implemented this to target the hard to reach member and members who have difficulty obtaining healthcare in a traditional office.

UnitedHealthcare

- UHC manages quality of care issues through a Regional and National Peer Review Committee structure. This model is intended to create a wider breadth of provider oversight with a focus on timely and comprehensive review of participating network providers across all lines of business and state jurisdictions. By expanding the scope of quality of care issue review, there is a greater opportunity to look for trends across a provider's entire practice area rather than by just one state jurisdiction.
- UHC continues to set the standard for comprehensive and easy to understand language in all of its member adverse determination letters. Of particular note is the clear, understandable reason(s) for the determination which specify what criteria were not met.
- UHC demonstrates through its Health Education Plan a particular strength in its focus on social determinants of behavior and a related strategy to bring health education to members through use of community venues, such as the YMCA, shopping malls, etc.
- UHC evidences implementation of the Person Centered Care Model for ensuring that holistic member needs, including medical, behavioral and social/environmental needs, are addressed through the engagement of hospitals and physicians. The primary goal is to ensure the person receives the right care from the right providers in the right place and at the right time. At a member level, this Care Model ultimately leads to the development of Person - Centered Care which leverages interdisciplinary teams and combines the resources of UnitedHealth Group with medical homes and other integrated care organizations to reduce costs and improve outcomes.
- UHC clearly identifies through its Government Programs Anti-Fraud, Waste, and Abuse Program its commitment to providing members with access to high-quality medical care while complying with all state, federal, and local laws and regulations.

Conclusions

Maryland has set high standards for MCO quality assurance systems. In general, 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. For example, JMS, MPC, and MSFC received scores of 100% on the annual SPR in CYs 2013-2015.

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. The CY 2015 review provided evidence of the continuing progression of the HealthChoice MCOs to ensure the delivery of quality health care for their enrollees. Two new MCOs (RHMD and KPMAS) entered the HealthChoice recently and promptly demonstrated a commitment to quality with SPR scores at 88% (RHMD) and 91% (KPMAS) in their first year reviews. A collaborative quality improvement relationship between the MCO, the Department, and the EQRO increased the scores of RHMD during their second year's review to 97% and KPMAS to 95% on the second review.

The EQRO will conduct its next comprehensive onsite SPR in CY 2019. To promote continuous quality improvement, the Department and the EQRO will identify areas annually for focused review.

SECTION II
Value Based Purchasing

Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) began working with the Center for Health Care Strategies in 1999 to develop a Value Based Purchasing Initiative (VBPI) for HealthChoice, Maryland's Medicaid managed care program. VBP improves quality by awarding 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).

DHMH contracted with Delmarva Foundation and HealthcareData Company, LLC (HDC), a NCQA–Licensed Organization, to perform a validation of the CY 2015 VBP measurement data. Validation is the process by which an independent entity evaluates the accuracy of reported performance measure data and determines the extent to which specific performance measure calculations followed established specifications. A validation (or audit) determination is assigned to each measure, indicating whether the result is fully compliant, substantially compliant, or not valid. HDC performed the validation of the HEDIS®–based VBP measurement data for all ten of the HealthChoice MCOs using the NCQA's HEDIS® Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures. Delmarva Foundation validated the measures developed by the Department and calculated by The Hilltop Institute of University of Maryland Baltimore County (Hilltop).

Performance Measure Selection Process

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

DHMH selects measures that are:

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

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

Value-Based Purchasing Validation

Several sources of measures (Table 3) are included in the CY 2015 VBP program. They are chosen from NCQA's HEDIS® data set, encounter data, and data supplied by the HealthChoice MCOs, and subsequently validated by Delmarva Foundation. The measure type and the presence of an existing audit or validation process determined the validation activities undertaken.

Table 3. CY 2015 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	DHMH
Ambulatory Care Services for SSI Children	Access to Care	Encounter Data	DHMH
Breast Cancer Screening	Effectiveness of Care	HEDIS®	MCO
Childhood Immunization Status (Combo 3)	Effectiveness of Care	HEDIS®	MCO
Comprehensive Diabetes Care – 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	DHMH
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 2015 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, HDC holds annual auditor conference calls with all MCOs to address any NCQA changes or updates to the audit guidelines and provide technical assistance.

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

The post onsite and reporting phase of the HEDIS® Compliance Audit includes the issuance of a follow-up letter to the MCO that lists any items the auditors still require to complete the audit; a list of corrective actions for problems found in the Roadmap or onsite, as well as the necessary completion dates; and preliminary audit findings specifically indicating the measures at risk for a *Not 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, DHMH used ten of the HEDIS® audit measure determinations as VBP measure determinations. The HEDIS® measures in the VBP program are:

- Adolescent Well Care
- Adult BMI Assessment
- Breast Cancer Screening
- Childhood Immunization Status (Combo 3)
- Comprehensive Diabetes Care – HbA1c Testing
- Controlling High Blood Pressure
- Immunizations for Adolescents (Combo 1)
- Medication Management for People with Asthma – Medication Compliance 75%
- Postpartum Care
- Well Child Visits for Children Ages 3–6

EQRO Measures Validation

Three CY 2015 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

Delmarva Foundation validated the measurement data for each of the above VBP measures, including the specifications for each encounter data-based measure, source code to determine algorithmic compliance with the measure specifications, information regarding the encounter data processing system, and analysis of the

encounter data process. Clarifications and corrections to source code were conducted to ensure algorithmic compliance with VBP measure specifications.

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

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

Validation Determination	Definition
Fully Compliant (FC)	Measure was fully compliant with State specifications and reportable.
Substantially Compliant (SC)	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid (NV)	Measure deviated from state specifications such that the reported rate was significantly biased. This designation is also assigned to measures where no rate was reported, although reporting of the rate was required.
Not Applicable (NA)	Measure was not reported because the entity did not have any Medicaid 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 HDC 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 HDC were determined to be reportable for all MCOs with the exception of the Medication Management for People with Asthma measure for KPMAS.

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 Delmarva Foundation, no issues were identified that could have introduced bias to the resulting statistics.

Table 6. EQRO VBP Measure Validation Determinations

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

CY 2015 Incentive/Disincentive Target Setting Methodology

The following target setting methodology has been developed for the CY 2015 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 2015 Incentive/Disincentive Targets

Table 7 shows the CY 2015 VBP measures and their targets.

Table 7. CY 2015 VBP Measures and Targets

Performance Measure	Data Source	2015 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: ≥ 81% Neutral: 77%–80% Disincentive: ≤ 76%
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: ≥ 66% Neutral: 59%–65% Disincentive: ≤ 58%
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: ≥ 85% Neutral: 82%–84% Disincentive: ≤ 81%
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: ≥ 62% Neutral: 54%–61% Disincentive: ≤ 53%
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: ≥ 76% Neutral: 71%–75% Disincentive: ≤ 70%
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: ≥ 68% Neutral: 62%–67% Disincentive: ≤ 61%
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: ≥ 43% Neutral: 31%–42% Disincentive: ≤ 30%
Postpartum Care: % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	HEDIS®	Incentive: ≥ 78% Neutral: 74%–77% Disincentive: ≤ 73%
Well-Child Visits for Children Ages 3 – 6 Years: % of children ages 3–6 (enrolled 320 or more days) receiving at least one well-child visit during the measurement year, consistent with American Academy of Pediatrics & EPSDT recommended number of visits	HEDIS®	Incentive: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%

2015 Performance Measure Results

The CY 2015 performance results presented in Table 6 were validated by Delmarva Foundation and DHMH's contracted HEDIS® Compliance Audit™ firm, HDC. The contractors determined the validity and the accuracy of the performance measure results. All measures were calculated in a manner that did not introduce bias, allowing the results to be used for public reporting and the VBP program. In CY 2015, all eight HealthChoice MCOs qualified to participate in the initiative:

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

Table 8 represents the CY 2015 VBP results for each of the MCOs.

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Table 8. MCO CY 2015 VBP Performance Summary

Performance Measure	CY 2015 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	RHMD	UHC
		Incentive (I); Neutral (N); Disincentive (D)							
Adolescent Well Care	Incentive: ≥ 73% Neutral: 68%–72% Disincentive: ≤ 67%	68% (N)	83% (I)	57% (D)	73% (I)	64% (D)	73% (I)	43% (D)	65% (D)
Adult BMI Assessment	Incentive: ≥ 81% Neutral: 77%–80% Disincentive: ≤ 76%	85% (I)	97% (I)	100% (I)	82% (I)	90% (I)	86% (I)	85% (I)	93% (I)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	83% (D)	89% (I)	60% (D)	84% (N)	82% (D)	85% (N)	74% (D)	81% (D)
Ambulatory Care Services for SSI Children	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%	83% (N)	88% (I)	53% (D)	83% (N)	81% (D)	85% (N)	59% (D)	80% (D)
Breast Cancer Screening	Incentive: ≥ 66% Neutral: 59%–65% Disincentive: ≤ 58%	66% (I)	73% (I)	89% (I)	72% (I)	66% (I)	68% (I)	64% (N)	62% (N)
Childhood Immunization Status (Combo 3)	Incentive: ≥ 82% Neutral: 79%–81% Disincentive: ≤ 78%	82% (I)	87% (I)	78% (D)	82% (I)	83% (I)	83% (I)	80% (N)	81% (N)
Comprehensive Diabetes Care – HbA1c Testing	Incentive: ≥ 85% Neutral: 82%–84% Disincentive: ≤ 81%	87% (I)	94% (I)	95% (I)	86% (I)	88% (I)	89% (I)	88% (I)	83% (N)
Controlling High Blood Pressure	Incentive: ≥ 62% Neutral: 54%–61% Disincentive: ≤ 53%	54% (N)	76% (I)	86% (I)	56% (N)	71% (I)	60% (N)	48% (D)	57% (N)
Immunizations for Adolescents (Combo 1)	Incentive: ≥ 76% Neutral: 71%–75% Disincentive: ≤ 70%	87% (I)	82% (I)	83% (I)	85% (I)	80% (I)	89% (I)	83% (I)	85% (I)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 68% Neutral: 62%–67% Disincentive: ≤ 61%	64% (N)	74% (I)	51% (D)	57% (D)	60% (D)	64% (N)	44% (D)	57% (D)
Medication Management for People with Asthma – Medication Compliance 75%	Incentive: ≥ 43% Neutral: 31%–42% Disincentive: ≤ 30%	25% (D)	51% (I)	N/A*	36% (N)	26% (D)	24% (D)	48% (I)	29% (D)
Postpartum Care	Incentive: ≥ 78% Neutral: 74%–77% Disincentive: ≤ 73%	74% (N)	88% (I)	84% (I)	69% (D)	69% (D)	74% (N)	62% (D)	66% (D)
Well Child Visits for Children Ages 3–6	Incentive: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%	86% (N)	91% (I)	83% (D)	89% (I)	86% (N)	85% (N)	62% (D)	81% (D)

*This measure is not applicable due to insufficient eligible population (e.g. <30 members).

2015 VBP Financial Incentive/Disincentive Methodology

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

Table 9 represents the incentive and/or disincentive amounts provided to each MCO for each performance measure and the total incentive/disincentive amount for the CY 2015 VBP Program.

Table 9. MCO CY 2015 VBP Incentive/Disincentive Amounts

Performance Measure	MCO							
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	RHMD	UHC
Adolescent Well Care	$0	$137,817	($74,598)	$654,603	($224,485)	$791,486	($95,558)	($650,160)
Adult BMI Assessment	$727,733	$137,817	$74,598	$654,603	$224,485	$791,486	$95,558	$650,160
Ambulatory Care Services for SSI Adults	($727,733)	$137,817	($74,598)	$0	($224,485)	$0	($95,558)	($650,160)
Ambulatory Care Services for SSI Children	$0	$137,817	($74,598)	$0	($224,485)	$0	($95,558)	($650,160)
Breast Cancer Screening	$727,733	$137,817	$74,598	$654,603	$224,485	$791,486	$0	$0
Childhood Immunization Status (Combo 3)	$727,733	$137,817	($74,598)	$654,603	$224,485	$791,486	$0	$0
Comprehensive Diabetes Care – HbA1c Testing	$727,733	$137,817	$74,598	$654,603	$224,485	$791,486	$95,558	$0
Controlling High Blood Pressure	$0	$137,817	$74,598	$0	$224,485	$0	($95,558)	$0
Immunizations for Adolescents (Combo 1)	$727,733	$137,817	$74,598	$654,603	$224,485	$791,486	$95,558	$650,160
Lead Screenings for Children Ages 12–23 Months	$0	$137,817	($74,598)	($654,603)	($224,485)	$0	($95,558)	($650,160)
Medication Management for People with Asthma – Medication Compliance 75%	($727,733)	$137,817	N/A*	$0	($224,485)	($791,486)	$95,558	($650,160)
Postpartum Care	$0	$137,817	$74,598	($654,603)	($224,485)	$0	($95,558)	($650,160)
Well Child Visits for Children Ages 3–6	$0	$137,817	($74,598)	$654,603	$0	$0	($95,558)	($650,160)
Total Incentive/ Disincentive Amount	$2,183,199	$1,791,621	$0	$3,273,015	$0	$3,957,430	($286,674)	($3,250,800)

*This measure is not applicable due to insufficient eligible population (e.g. <30 members).

SECTION III
Performance Improvement Projects

Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is responsible for the evaluation of the quality of care provided to Medical Assistance recipients in the HealthChoice program. DHMH contracts with the Delmarva Foundation to serve as the External Quality Review Organization (EQRO). As the EQRO, Delmarva Foundation 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 DHMH, the MCOs continued the Adolescent Well Care PIPs and the Controlling High Blood Pressure PIPs. This report summarizes the findings from the validation of both PIPs. The MCOs who conducted PIPs in 2016 were:

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

*RHMD completed its first full year of operation in CY 2014 and was able to begin providing data and participating in the Controlling High Blood Pressure PIP in CY 2015.

PIP Purpose and Methodology

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

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

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

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

Table 10. 10–Step Validation Methodology to PIP Validation

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

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

Table 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.

Adolescent Well Care PIPs

All Adolescent Well Care PIPs focused on increasing the number of adolescents ages 12–21 who receive at least one comprehensive well–care visit with a PCP or an OB/GYN practitioner during the measurement year, according to HEDIS® technical specifications. For MCOs in Maryland, this is a measure that is incorporated into the Value Based Purchasing, Consumer Report Card, and EPSDT Medical Record Review activities. Therefore, the AWC rate impacts results in several areas of the MCO's quality review.

Riverside Health of Maryland and Kaiser Permanente of the Mid-Atlantic States, Inc. entered the HealthChoice system in 2013 and 2014. Therefore, they were not able to provide data and not required to participate in the AWC PIP.

Table 12 represents the PIP Validation Results for all Adolescent Well Care PIPs for CY 2016 for the remaining six MCOs.

Table 12. Adolescent Well Care PIP Validation Results for CY 2016

Step/Description	Adolescent Well Care CY 2016 PIP Review Determinations					
	ACC	JMS	MPC	MSFC	PPMCO	UHC
1. Assess the Study Methodology	Met	Met	Met	Met	Met	Met
2. Review the Study Question(s)	Met	Met	Met	Met	Met	Met
3. Review the Selected Study Indicator(s)	Met	Met	Met	Met	Met	Met
4. Review the Identified Study Population	Met	Met	Met	Met	Met	Met

Step/Description	Adolescent Well Care CY 2016 PIP Review Determinations					
	ACC	JMS	MPC	MSFC	PPMCO	UHC
5. Review Sampling Methods	Met	Met	Met	Met	Met	Met
6. Review Data Collection Procedures	Met	Met	Met	Met	Met	Met
7. Assess Improvement Strategies	Partially Met	Met	Met	Met	Met	Met
8. Review Data Analysis & Interpretation of Study Results	Partially Met	Met	Met	Met	Met	Met
9. Assess Whether Improvement is Real Improvement	Met	Met	Met	Met	Met	Met
10. Assess Sustained Improvement	Met	Met	Met	Unmet	Met	Met

ACC received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies) and Step 8 (Review Data Analysis & Interpretation of Study Results). Under Step 7, ACC did not list any new interventions for 2015 including planned interventions from the 2014 qualitative analysis. Step 8 listed an inaccurate increase from the prior period; evidenced a limited analysis of results including a lack of MCO barriers; and did not identify any planned follow-up activities for the coming year.

MSFC received a rating of "Unmet" for Step 10 as sustained improvement was not demonstrated through repeated remeasurements over comparable time periods.

Adolescent Well Care 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 Adolescent Well Care PIP:

- Member: Knowledge deficits.
- Member: Lack of transportation to PCP appointments.
- Member: Many adolescents have concerns regarding privacy at clinic visits.
- Member: Lack of incentive to schedule and/or keep scheduled appointment.
- Member: Difficulty scheduling appointments that work for the teen, parent, and PCP.
- Provider: Lack of infrastructure to identify members in need of a preventive care visit.
- Provider: Lack of staff and materials to provide member education and outreach.
- Provider: Challenges associated with the high number of members that fail to keep a scheduled appointment.
- Provider: Knowledge deficits relating to optimal billing for comprehensive services and missed opportunities when completing a sports physical or sick visit.

- MCO: Member outreach given that reaching members via phone or mail may be difficult due to inaccurate member demographic information.
- MCO: Lack of ability to capture all AWC visits received outside of the assigned primary care provider site.
- MCO: No provider incentives for providing routine care for adolescents.
- MCO: Members who fall in and out of eligibility within the review period are difficult to track.

Adolescent Well Care Interventions Implemented

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

- Member education and outreach.
- Member and provider incentives.
- Onsite and remote appointment scheduling.
- Free transportation for members needing a well care visit.
- Provider opportunity report listings sent regularly and/or posted on MCO provider portal.
- Year round provider HEDIS® education and chart reviews.
- Home Visits targeting adolescents that have never been seen in past two years.
- Ongoing initiatives to improve accuracy of member demographic information.
- Availability of a pediatrician with office hours every Saturday.
- Use of School Based Well Clinics for well-care visits if attempts at assigned provider office are not successful.
- Member appointment reminders sent to help decrease No Shows.

Adolescent Well Care Indicator Results

This is the third remeasurement year for the Adolescent Well Care PIP. Table 13 represents the indicator rates for all MCOs for the PIP.

Table 13. CY 2015 Adolescent Well Care PIP Indicator Rates

Measurement Year	Indicator 1: Adolescent Well Care					
	ACC	JMS	MPC	MSFC	PPMCO	UHC
Baseline Year 1/1/12–12/31/12	68.06%	76.85%	60.20%	69.40%	67.59%	59.71%
Measurement Year 1 1/1/13–12/31/13	67.93%	76.72%	68.75%	67.80%	61.57%	60.80%
Remeasurement Year 2 1/1/14–12/31/14	64.68%	80.27%	68.29%	61.20%	68.75%	58.48%
Remeasurement Year 3 1/1/15–12/31/15	67.92%	82.59%	73.15%	64.03%	72.79%	64.80%

Each MCO targeted the current HEDIS® 90th percentile as a goal each year for the AWC PIP. The HEDIS® 90th percentile, as described in the Standards and Guidelines for the Accreditation of Health Plans, is calculated by NCQA using specified HEDIS® measures reported by organizations annually; NCQA determines the HEDIS® measure portion of the score by comparing organization results with a national benchmark (the 90th percentile of national results) and with regional and national thresholds (the 75th, 50th and 25th percentiles). NCQA uses the higher of two scores: the result based on comparison with the average of the regional and national thresholds, or the result based on comparison with national thresholds.

ACC, JMS, MPC, and PPMCO performed above the 90th percentile for measurement year 2015, and the remaining two MCOs performed below the 90th percentile. Four MCOs' (JMS, MPC, PPMCO, and UHC) indicator rates increased over baseline measurement. Those increases ranged from 5.09 percentage points to 12.96 percentage points. Specifically, the improvements in performance rates over baseline measurements were:

- JMS' rate increased by 5.74 percentage points
- MPC's rate increased by 12.96 percentage points
- PPMCO's rate increased by 5.2 percentage points
- UHC's rate increased by 5.09 percentage points

ACC and MSFC indicator rates for measurement year 2015 decreased over baseline measurement. Specifically:

- ACC's rate decreased by 0.14 percentage points
- MSFC's rate decreased by 5.37 percentage points

Controlling High Blood Pressure PIPs

All Controlling High Blood Pressure PIPs focused on increasing the percentage of members 18–85 years of age who had a diagnosis of hypertension and 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.

Riverside Health of Maryland completed its first full year of operation in CY 2014 and was able to begin providing data and participating in the Controlling High Blood Pressure PIP. Kaiser Permanente of the Mid-Atlantic States, Inc. entered the HealthChoice system in June 2014 and therefore was not able to provide data and not required to participate in this PIP in CY 2015.

Table 14 represents the PIP Validation Results for all Controlling High Blood Pressure PIPs for CY 2015.

Table 14. Controlling High Blood Pressure PIP Validation Results for CY 2016

Step/Description	Controlling High Blood Pressure CY 2016 PIP Review Determinations						
	ACC	JMS	MPC	MSFC	PPMCO	RHMD	UHC
1. Assess the Study Methodology	Met	Met	Met	Met	Met	Met	Met
2. Review the Study Question(s)	Met	Met	Met	Met	Met	Met	Met
3. Review the Selected Study Indicator(s)	Met	Met	Met	Met	Met	Met	Met
4. Review the Identified Study Population	Met	Met	Met	Met	Met	Met	Met
5. Review Sampling Methods	Met	Met	Met	Met	Met	Met	Met
6. Review Data Collection Procedures	Met	Met	Met	Met	Met	Partially Met	Met
7. Assess Improvement Strategies	Partially Met	Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
8. Review Data Analysis & Interpretation of Study Results	Met	Met	Met	Met	Met	Met	Partially Met
9. Assess Whether Improvement Is Real Improvement	Partially Met	Met	Partially Met	Met	Met	Met	Met
10. Assess Sustained Improvement	Met	Met	Met	Met	Met	N/A	Met

RHMD 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.

ACC, MPC, MSFC, PPMCO, RHMD, and UHC received a rating of "Partially Met" for Step 7 (Assess Improvement Strategies). ACC, MPC, MSFC, RHMD, and UHC failed to address either the linguistic and/or cultural needs of their membership in the design and implementation of interventions. PPMCO failed to implement interventions that were expected to improve processes or outcomes.

UHC received a rating of "Partially Met" for Step 8 (Review Data Analysis & Interpretation of Study Results) because the analysis of findings was incomplete based upon the data analysis plan. It did not include analysis of results or interpretation of the success of the PIP.

ACC and MPC 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.

RHMD received a rating of "Not Applicable" for Step 10 (Assess Sustained Improvement) because this was the first remeasurement year, and sustained improvement cannot be assessed until two remeasurements have occurred.

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: Noncompliance with diet, exercise, and medication regime.
- Member: Noncompliance with follow–up care.
- Member: Lack of transportation for PCP appointments.
- Member: African Americans face more health disparities than Whites for high blood pressure.
- Provider: Lack of continuity and coordination of care between ER, Specialist and PCP.
- Providers: Knowledge deficit of missed appointments by their patient population.
- Provider: Lack of awareness of current treatment guidelines.
- Provider: Lack of awareness of the MCO resources available to assist in member compliance (i.e. member outreach initiatives, available benefits, health education opportunities).
- Provider: Variation in staffing and skill set at practices for taking blood pressure readings.
- MCO: Insufficient or inaccurate member contact and demographic data.
- MCO: Limited line of sight into actual blood pressure readings.
- MCO: 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 ER encounters to ensure appointments with PCP.
- Member and provider education.
- Transportation for member PCP appointments.
- Medical record reviews to ensure documentation of blood pressure readings.
- Member outreach and incentives.
- Shared medical appointments for members with hypertension and/or diabetes funded by a DHMH grant.

Controlling High Blood Pressure Indicator Results

This is the second remeasurement year of data collection for the Controlling High Blood Pressure PIP. Table 15 represents the Controlling High Blood Pressure PIP indicator rates for all MCOs for the PIP.

Table 15. CY 2016 Controlling High Blood Pressure PIP Indicator Rates

Measurement Year	Indicator 1: Controlling High Blood Pressure						
	ACC	JMS	MPC	MSFC	PPMCO	RHMD	UHC
Baseline Year 1/1/13 – 12/31/13	49.00%	56.20%	46.78%	65.52%	56.97%	N/A	42.34%
Measurement Year 1 1/1/14 – 12/31/14	63.87%	69.34%	61.38%	69.15%	59.52%	32.13%	50.85%
Remeasurement Year 2 1/1/15 – 12/31/15	54.10%	76.40%	55.85%	71.19%	60.18%	48.18%	56.93%
Remeasurement Year 3 1/1/16 – 12/31/16	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Each MCO targeted the current HEDIS® 90th percentile as a goal each year for the CBP PIP. There is wide variation among the MCOs in their performance relative to the 2016 HEDIS® Medicaid goal. Both JMS and MSFC are performing above the 90th percentile. PPMCO is approaching the 75th percentile, MPC and UHC are slightly above the 50th percentile, ACC is approaching the 50th percentile, and RHMD is slightly above the 25th percentile for this measure.

All seven MCOs made improvements in performance rates over their baseline measurements:

- ACC's rate increased by 5.1 percentage points.
- JMS' rate increased by 20.2 percentage points.
- MPC's rate increased by 9.07 percentage points.
- MSFC's rate increased by 5.67 percentage points.
- PPMCO's rate increased by 3.21 percentage points.
- RHMD's rate increased by 16.05 percentage points.
- UHC's rate increased by 14.59 percentage points.

Recommendations

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

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

Section IV
Encounter Data Validation

Introduction

The Medicaid Managed Care Provisions of the 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, Maryland's Department of Health and Mental Hygiene (DHMH) has contracted with Delmarva Foundation to serve as the EQRO for the HealthChoice Program. Among the functions the Delmarva Foundation performs is the medical record review component for encounter data validation (EDV). This report presents the findings for the calendar year (CY) 2015 EDV medical record review.

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.
- Review of medical records for additional confirmation of findings.

The EDV protocol also makes the following assumptions:

- An encounter refers to the electronic record of a service provided to 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 2015 encounter data by June 2016.
- Encounter data completeness and accuracy requires continued monitoring and improvement. States need to develop encounter data standards and monitor for accuracy and completeness. Ultimately, it is the State that establishes standards for encounter data accuracy and completeness.

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

The EDV protocol consists of five sequential activities:

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

Medical Record Review Procedure

Medical Record Validation

Medical record documentation for services provided from January 2015 through December 2015 was compared to the encounter data for the same time period. The medical record was validated as the correct medical record requested by verifying the patient name, date of birth, and gender.

Encounter Data Validation

After completing medical record reviewer training and achieving an inter-rater reliability agreement score of 93%, reviewers entered data from the medical record reviews into the Delmarva Foundation EDV Tool/Database. The medical record was reviewed by either a certified coder or a nurse with coding experience to determine if the submitted encounter data (diagnosis, procedure, or revenue codes) could be validated against the findings in the medical record (see Table 16 for definition of terms). Where the diagnosis, procedure, and revenue codes could be substantiated by the medical record, the review decision was "yes" or "a match." Conversely, if the medical record could not support the encounter data, the review decision was "no" or "no match." For inpatient encounters, the medical record reviewers also matched the principal diagnosis code to the primary sequenced diagnosis. The review included validation of a maximum of 9 diagnosis codes, 6 procedure codes, and 23 revenue codes per record.

Table 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.

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

- As directed by the CMS Protocol, medical record reviewers could not infer a diagnosis from the medical record documentation. Reviewers were required to use the diagnosis listed by the provider. For example, if the provider recorded "fever and chills" in the medical record, and the diagnosis in the encounter data

was "upper respiratory infection," the record did not match for diagnosis even if the medical record documentation would support the use of that diagnosis.

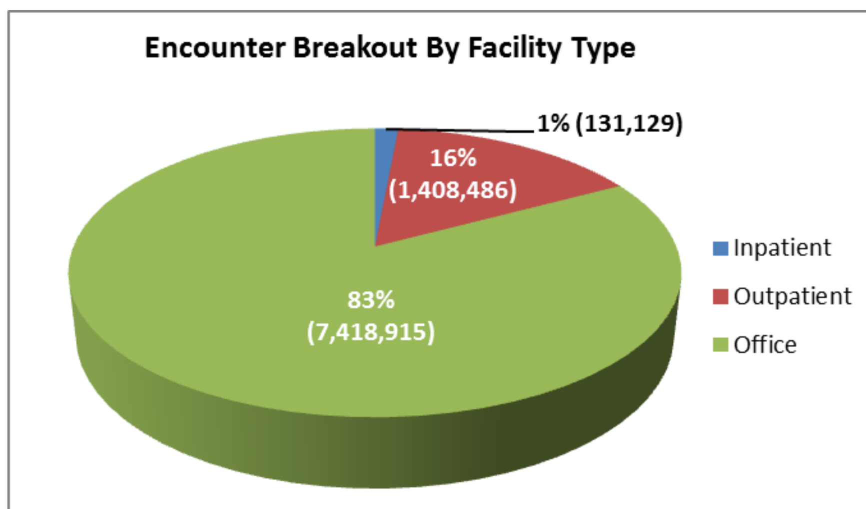
- For inpatient encounters with multiple diagnoses listed, the medical record reviewers were instructed to match the first listed diagnosis (as the principal diagnosis) with the primary diagnosis in the encounter data.
- Procedure data was matched to the medical record regardless of sequencing.

Medical Record Sampling

Delmarva Foundation received a random sample of HealthChoice encounter data for hospital inpatient, outpatient and physician office services that occurred in CY 2015 from The Hilltop Institute of University of Maryland Baltimore County (Hilltop). The sample size, determined to achieve a 95% confidence interval, was 384 medical records (Table 2). Oversampling for CY 2015 continued in order to ensure adequate numbers of medical records were received to meet the required sample size. The hospital inpatient encounter types were oversampled by 500%, while the hospital outpatient and office visit encounter types were oversampled by 200%.

The 2015 EDV encounters by facility type are demonstrated in Figure 2.

Figure 2. Maryland EDV Encounters by Facility Type



The majority of the CY 2015 sample was made up of office visit encounters at 83% (7,418,915 encounters). Outpatient encounters represented 16% (1,408,486 encounters) of the sample and inpatient encounters represent 1% (131,129 encounters) of the sample. Similar trends for the random sample by encounter type were seen for each year from CY 2013 through CY 2015. Please refer to Table 17 below for an encounter type sample size from CY 2013 to CY 2015.

Table 17. Maryland EDV Sample Size by Encounter Type, CY 2013 – CY 2015

	CY 2013			CY 2014			CY 2015		
Encounter Type	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size
Inpatient	114,236	1.5%	6	137,754	1.4%	5	131,129	1.5%	6
Outpatient	1,143,752	15.1%	58	1,550,736	16.0%	61	1,408,486	15.7%	60
Office Visit	6,340,051	83.4%	320	7,994,529	82.6%	317	7,418,915	82.8%	318
Total	7,598,039	100.0%	384	9,683,019	100.0%	383	8,958,540	100.0%	384

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

- Inpatient encounters decreased by 0.1 percentage points from 1.5% in CY 2013 to 1.4% in CY 2014, and then increased by 0.1 percentage points to 1.5% in CY 2015.
- Outpatient encounters increased by 0.9 percentage points from CY 2013 to 16.0% in CY 2014, and then decreased by 0.3 percentage points to 15.7% in CY 2015.
- Office visits encounters decreased by 0.8 percentage points from 83.4% in CY 2013 to 82.6% in CY 2014, and then increased by 0.2 percentage points to 82.8% in CY 2015.

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

- Office visit encounters make up the majority of the random sample of encounter data in all three years.
- Inpatient encounters comprise a very small part of the random sample, less than two percent in all three years.
- The percentage of office visit encounters in the random sample decreased from CY 2013 to CY 2014, and then increased slightly in CY 2015. A similar trend was observed for outpatient encounters.
- The percentage of inpatient encounters declined from CY 2013 to CY 2014 and then increased slightly from CY 2014 to CY 2015.

With the approval of DHMH, Delmarva Foundation mailed requests for medical records to the providers of service. Non-responders were contacted by telephone and fax. Response rates by encounter type are outlined in Table 18.

Table 18. CY 2013-CY 2015 Maryland EDV Medical Record Review Response Rates by Encounter Type

Encounter Type	CY 2013		CY 2014		CY 2015	
	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	7	Yes	6	Yes	7	Yes
Outpatient	61	Yes	63	Yes	60	Yes
Office Visit	324	Yes	318	Yes	318	Yes
Total	392		387		385	Yes

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

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 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.

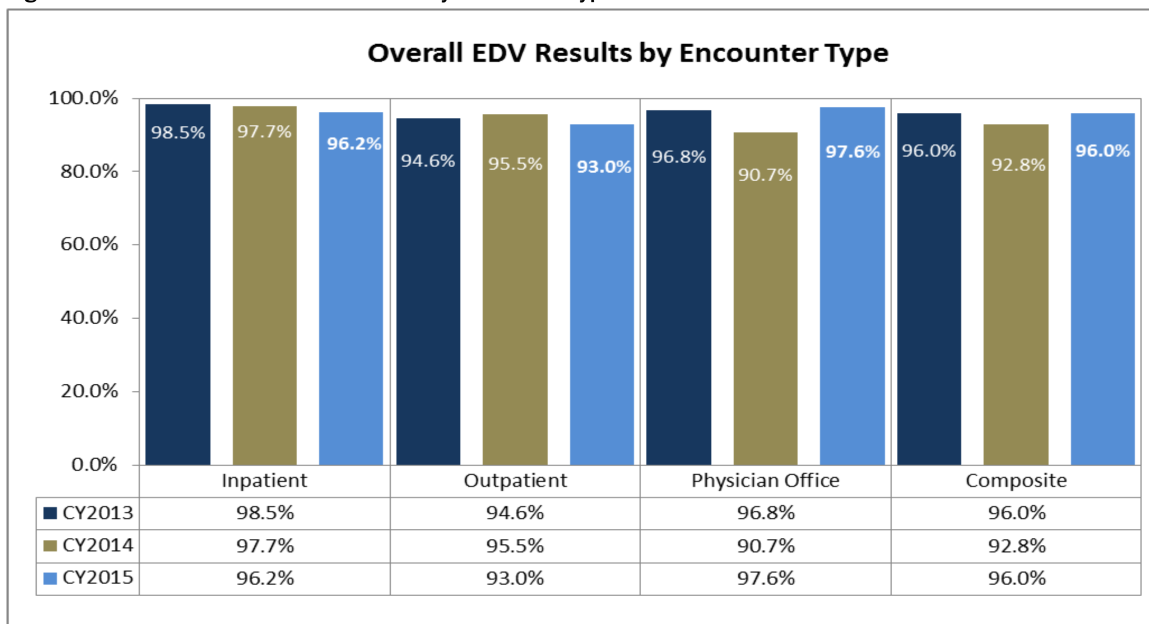
Exclusion Criteria

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 385 medical records were reviewed. The overall results for CY 2013 through CY 2015 EDV by encounter type are displayed in Figure 3.

Figure 3. CY 2013-CY 2015 EDV Results by Encounter Type



	Inpatient	Outpatient	Physician Office	Composite
CY2013	98.5%	94.6%	96.8%	96.0%
CY2014	97.7%	95.5%	90.7%	92.8%
CY2015	96.2%	93.0%	97.6%	96.0%

The overall element match rate increased by 3.2 percentage points for CY 2015 as compared to CY 2014, and was consistent with the CY 2013 match rate of 96.0%. The results for CY 2013 - CY 2015 EDV are displayed in Tables 19 through 22 below and the findings are discussed in the following section.

Table 19. Maryland EDV Results by Encounter Type, CY 2013 – CY 2015

Encounter Type	Records Received & Reviewed			Total Elements Possible*			Total Matched Elements			Percentage of Matched Elements		
	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015
Inpatient	7	6	7	65	88	130	64	86	125	98.5%	97.7%	96.2%
Outpatient	61	63	60	666	601	560	630	574	521	94.6%	95.5%	93.0%
Office Visit	324	318	318	1,014	1,004	1067	982	911	1041	96.8%	90.7%	97.6%
TOTAL	392	387	385	1,745	1,693	1757	1,676	1,571	1687	96.0%	92.8%	96.0%

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

The inpatient encounter match rate declined for the third consecutive year to a rate of 96.2% for CY 2015 which was a decrease of 1.5 percentage points from CY 2014. The rate fell by 0.8 percentage points from 98.5% in CY 2013 to 97.7% in CY 2014.

The outpatient encounter data match rate decreased by 2.5 percentage points in CY 2015 to 93.0% compared to CY 2014 (95.5%) falling below the CY 2013 rate of 94.6%.

Office visit encounters increased considerably (6.9 percentage points) in CY 2015 to a rate of 97.6% over the CY 2014 rate of 90.7%. This rate is only 1.3 percentage points under the highest match rate for this encounter which was in CY 2011.

The overall match rate (medical record review supporting the encounter data submitted) in CY 2015 was 96.0%, which represents a 3.2 percentage point increase from CY 2014, consistent with the match rate of 96.0% achieved in CY 2013.

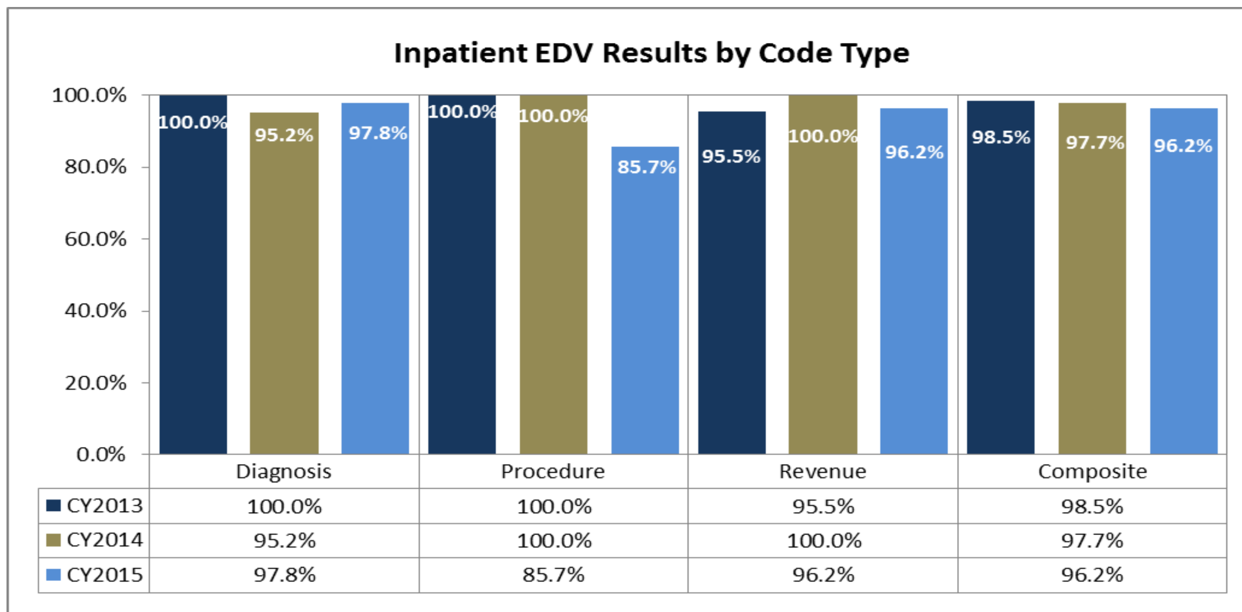
Results by Review Element

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 2013 through CY 2015 are displayed in Figure 4.

Figure 4. CY 2013-CY 2015 Inpatient EDV Results by Code Type



Overall, the total match rate for inpatient encounters across all code types declined by 1.5 percentage points from 97.7% in CY 2014 to 96.2% in CY 2015. Match rates declined for the second year from 98.5% in CY 2013 reflecting underlying declines in procedures and revenue codes. Tables 5 through 7 illustrate EDV results by review element by code type from CY 2013 through CY 2015.

Table 20. Maryland EDV Results by Code by Inpatient Encounter Type, CY 2013 – CY 2015

Inpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015
Match	39	40	44	4	3	6	21	43	75	64	86	125
No Match	0	2	1	0	0	1	1	0	3	1	2	5
Total Elements	39	42	45	4	3	7	22	43	78	65	88	130
Match Percent	100%	95.2%	97.8%	100%	100%	85.7%	95.5%	100%	96.2%	98.5%	97.7%	96.2%

In CY 2015, inpatient diagnosis codes were matched at 97.8% when compared to the content of the inpatient medical record. This is an increase of 2.6 percentage points compared to CY 2014.

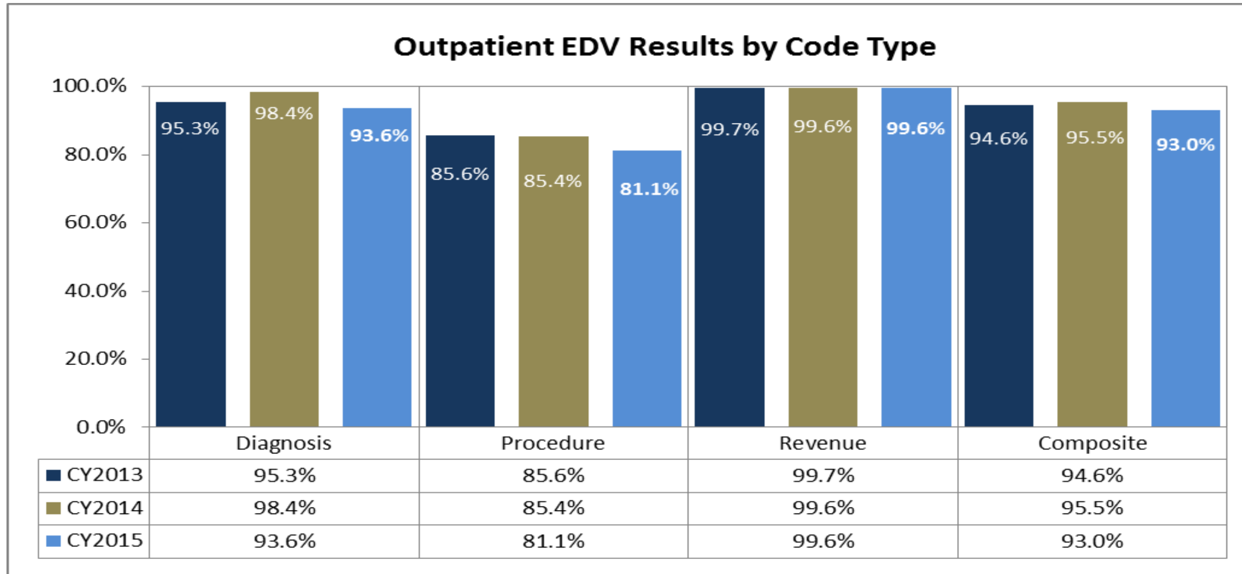
The match rate for inpatient procedure codes decreased by 14.3 percentage points to a rate of 85.7% in CY 2015 compared to a rate of 100.0% for both CY 2013 and CY 2014.

In CY 2015, inpatient revenue codes decreased by 3.8 percentage points to a match rate of 96.2% compared to the CY 2014 match rate of 100%, however remained slightly above the CY 2013 match rate of 95.5%.

Outpatient Encounters

The outpatient EDV results by code type for CY 2013 through CY 2015 are displayed in Figure 5.

Figure 5. CY 2013-CY 2015 Outpatient EDV Results by Code Type



Overall, the total match rate for outpatient encounters across all of the code types decreased by 2.5 percentage points from 95.5% in CY 2014 to 93.0% in CY 2015.

Table 21. Maryland EDV Results by Code by Outpatient Encounter Type, CY 2013 – CY 2015

Outpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015
Match	182	182	161	154	134	116	294	258	244	630	574	521
No Match	9	3	11	26	23	27	1	1	1	36	27	39
Elements	191	185	172	180	157	143	295	259	245	666	601	560
Match Percent	95.3%	98.4%	93.6%	85.6%	85.4%	81.1%	99.7%	99.6%	99.6%	94.6%	95.5%	93.0%

In CY 2015, the outpatient diagnosis code match rate decreased by 4.8 percentage points to 93.6%, compared to 98.4% in CY 2014.

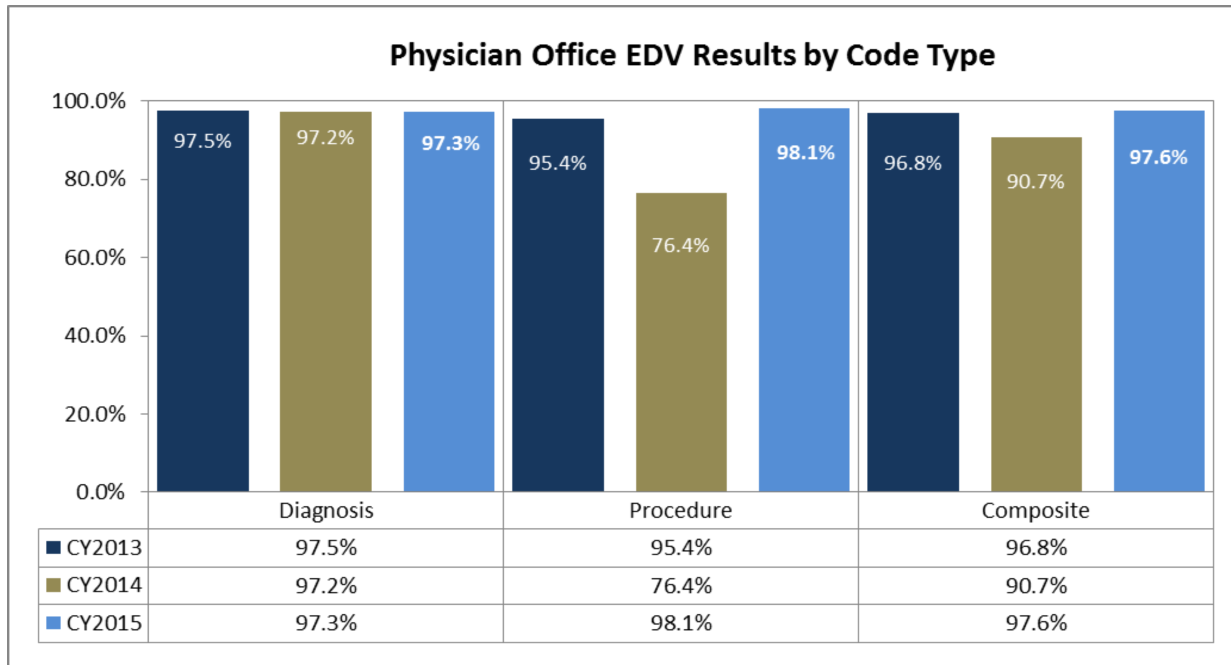
Consistent with findings for outpatient encounters in CY 2014, the procedure code had the lowest match rate of all elements reviewed in CY 2015 at 81.1%. The procedure code match rate has decreased for three consecutive years: 4.3 percentage points from the match rate of 85.4% in CY 2014; 0.2 percentage points from the match rate of 85.6% in CY 2013; and 10.5 percentage points from the match rate of 96.1% in CY 2012.

In CY 2015 the match rate for outpatient revenue codes remained the same at 99.6% slightly below the CY 2013 rate of 99.7%.

Office Visit Encounters

The office visit EDV results by code type for CY 2013 through CY 2015 are displayed in Figure 6.

Figure 6. CY 2013-CY 2015 Office Visit EDV Results by Code Type



Overall, the office visit match rate increased 6.9 percentage points to 97.6% in CY 2015 from 90.7% in CY 2014, rising above the CY 2013 rate of 96.8%.

Table 22. Maryland EDV Results by Code by Office Visit Encounter Type, CY 2013 – CY 2015

Office Visit Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015
Match	673	671	729	309	240	312	NA	NA	NA	982	911	1041
No Match	17	19	20	15	74	6	NA	NA	NA	32	93	26
Total Elements	690	690	749	324	314	318	NA	NA	NA	1,014	1,004	1067
Match Percent	97.5%	97.2%	97.3%	95.4%	76.4%	98.1%	NA	NA	NA	96.8%	90.7%	97.6%

In CY 2015, the diagnosis code match increased by 0.1 percentage points to 97.3% compared to CY 2014, and remained below the CY 2013 rate of 97.5%.

The procedure code match rates increased 21.7 percentage points from 76.4% in CY 2014 to 98.1% in CY 2015, which is above the CY 2013 match rate of 95.4%.

Revenue codes are not applicable for office visit encounters.

"No Match" Results by Element and Reason

Diagnosis Code Element Review

Tables 23 through 25 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 23. Maryland EDV "No Match" Results for Diagnosis Code Element CY 2013-2015

"No Match" for Diagnosis Code Element									
Encounter Type	Total Elements			Lack of Medical Record Documentation			Incorrect Principal Diagnosis (Inpatient) or Incorrect Diagnosis Codes		
	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015
Inpatient	0	2	1	0	2	1	0	0	0
% of Total				0%	100%	100%	0%	0%	0%
Outpatient	9	3	11	2	0	0	7	3	11
% of Total				22.2%	0%	0%	77.8%	100%	100%
Office Visit	17	19	20	3	3	11	14	16	9
% of Total				17.6%	15.8%	55.0%	82.4%	84.2%	45.0%

There was one "no match" for the inpatient diagnosis code element in CY 2015. This "no match" was due to a lack of medical documentation. In CY 2014, there were two "no match" inpatient diagnosis code elements due to a lack of medical record documentation. All inpatient diagnosis codes elements matched in CY 2013.

Of the 11 "no match" outpatient diagnosis code elements in CY 2015, 100% resulted from incorrect diagnosis codes. Similarly, 100% of "no match" outpatient diagnosis code elements in CY 2014 were attributed to incorrect diagnosis codes. However in CY 2013, 77.8% of the "no match" outpatient diagnosis code elements resulted from incorrect diagnosis codes and 22.2% resulted from a lack of medical record documentation.

For office visit encounters, 55% of the "no match" diagnosis code elements in CY 2015 resulted from a lack of medical record documentation. By contrast, in CY 2014 the majority (84.2%) of "no match" office visit

diagnosis code elements were due to incorrect diagnosis codes. Similarly in CY 2013, 82.4% "no match" office visit diagnosis code elements were the result of 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 procedure codes

Table 24. Maryland EDV "No Match" Results for Procedure Code Element CY 2013-2015

"No Match" for Procedure Code Element									
Encounter Type	Total Elements			Lack of Medical Record Documentation			Incorrect Principal Diagnosis (Inpatient) or Incorrect Diagnosis Codes		
	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015
Inpatient	0	0	3	0	0	3	0	0	0
% of Total				0%	0%	100%	0%	0%	0%
Outpatient	26	23	1	1	3	1	25	20	0
% of Total				3.8%	13.0%	100%	96.2%	87.0%	0
Office Visit	15	74	6	0	2	0	15	72	6
% of Total				0%	2.7%	0%	100%	97.3%	100%

For CY 2015, the three "no match" inpatient procedure code elements were due to a lack of medical record documentation. In CY 2013 and CY 2014 there were no errors for inpatient procedure code elements reviewed.

There was one "no match" outpatient procedure code element for CY 2015 which was due to a lack of medical record documentation. In CY 2013 and CY 2014, the majority of the "no match" outpatient procedure code elements (96.2% and 87.0% respectively) were due to incorrect diagnosis codes with only a small percentage (3.8% and 13% respectively) due to a lack of medical record documentation.

In CY 2015, 100% of the six "no match" procedure code errors for office visit procedure code elements were the result of incorrect diagnosis codes, compared to 97.3% in CY 2014, and 100% in CY 2013.

Revenue Code Element Review

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

- Lack of medical record documentation
- Incorrect revenue codes

Table 25. Maryland EDV "No Match" Results for Revenue Code Element CY 2013-2015

"No Match" for Revenue Code Element *									
Encounter Type *	Total Elements			Lack of Medical Record Documentation			Incorrect Revenue Code		
	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015	CY 2013	CY 2014	CY 2015
Inpatient	1	0	3	0	0	3	1	0	0
% of Total				0%	0%	100%	100%	0%	0%
Outpatient	1	1	1	1	1	1	0	0	0
% of Total				100%	100%	100%	0%	0%	0%

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

There were three "no match" inpatient revenue code elements in CY 2015. All "no match" codes were due to a lack of medical record documentation. There were no revenue code element issues for CY 2014, and one "no match" inpatient revenue code element for CY 2013 that was due to an incorrect revenue code.

The one revenue code element "no match" error for outpatient encounters in CY 2015 was due to a lack of medical record documentation, similar to both CY 2014 and CY 2013.

Conclusions and Recommendations

For CY 2015, overall encounters matched the medical records 96.0% of the time. This match rate exceeds Delmarva Foundation's recommended standard of 90% for accuracy of match rates between encounter data and medical records. Therefore, the encounter data submitted for CY 2015 can be considered reliable for reporting purposes. The overall match rate for CY 2015 (96.0%) was 3.2 percentage points above the CY 2014 rate of 92.8% and consistent with the match rate for CY 2013.

The office visit encounter type had the highest match rate at 97.6%, followed by the inpatient encounter type match rate at 96.2%. The outpatient encounter type match rate had the lowest match rate at 93.0%.

Amongst all encounters, the procedure code element had the lowest match rate at 92.7%, compared to the highest match rate at 98.8% for revenue codes.

Delmarva Foundation concluded that the primary reason for diagnosis code errors were incorrect diagnosis codes for the outpatient encounters. The reasons for errors were almost equally split (55% and 45%) between the lack of medical record documentation and incorrect diagnosis codes for the office visit encounters. For inpatient encounter types, there was only one "no match" error which was due to a lack of medical record documentation.

In regards to the procedure code element review, office visit encounter type "no match" errors were due solely to incorrect diagnosis codes whereas for both inpatient and outpatient encounter type "no match" errors were due to a lack of medical record documentation.

The revenue code element review resulted in four "no match" errors. Three were from the inpatient encounter type and one from the outpatient encounter type. All errors were due to a lack of medical record documentation.

Delmarva Foundation recommends the following based on the CY 2015 EDV:

- The majority of the "no match" rates in outpatient and office visit encounters were due to incorrect codes. Conversely all seven inpatient "no match" codes across all elements were due to 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.
- 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, including the patient's date of birth, should be continued in order to mitigate the impact of lack of documentation on meeting the minimum sample.

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

Introduction

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

This report summarizes the findings from the EPSDT medical record review for CY 2015. Approximately 558,376 children were enrolled in the HealthChoice Program during this period. The eight Managed Care Organizations (MCOs) evaluated for CY 2015 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)
- Riverside Health of Maryland (RHMD)
- UnitedHealthcare (UHC)

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 includes documentation of:

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

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

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

Laboratory tests/at-risk screenings require documentation of:

- Hereditary/metabolic screening test results at birth and again by 1 month* of age.
- Age-appropriate risk assessment results for tuberculosis, cholesterol, and sexually transmitted diseases.
- Counseling and/or laboratory test results for at-risk recipients.
- Anemia tests at 12** and 24*** months of age.
- Lead risk assessment beginning at 6 months through 6 years of age.
- Referral to the lab for lead testing at appropriate ages.
- Blood lead tests results at 12** and 24*** months of age.
- Baseline blood lead test results for ages 3 through 5 when not done at 12 or 24 months of age.
- Children with a blood level greater than 5 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 DHMH Immunization Schedule is being implemented in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
- Age-appropriate vaccines are not postponed for inappropriate reasons.
- Children and/or adolescents who are delayed in their immunizations are brought current with the DHMH Immunization Schedule.

Health education and anticipatory guidance requires documentation of:

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

CY 2015 EPSDT Review Process

Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during CY 2015 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 V20 or V70. (For children less than 2 years of age who may have had 4-6 preventive visits within a 12-month period, only one date of service was selected.)
- Sample includes recipients when visits with CPT 99381-85 or 99391-95 were provided by primary care providers and clinics with the following specialties: pediatrics, family practice, internal medicine, nurse practitioner, general practice, or a Federally Qualified Health Center (FQHC).

Scoring Methodology

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

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

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

Score	Finding
2	Complete
1	Incomplete
0	Missing

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

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

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 Delmarva Foundation for review. In total, 3,016 medical records were reviewed for CY 2015.

The review criteria used by Delmarva Foundation's review nurses was the same as those developed and used by the Department. Delmarva Foundation 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 91% prior to the beginning of the CY 2015 EPSDT Medical Record Review and completed a second IRR testing with a score of 96% mid-way through the review.

EPSDT Review Results

EPSDT review indicators are based on current pediatric preventive care guidelines and DHMH identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance 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. Two of the eight MCOs met the minimum compliance score of 80% in each of the five component areas for the CY 2015 review. CAPs for the Laboratory Tests/At Risk Screenings component were required from six MCOs (ACC, KPMAS, MPC, PPMCO, RHMD, and UHC).

Findings for the CY 2015 EPSDT review by component area are described in Table 26.

Table 26. CY 2015 EPSDT Component Results by MCO

Component	CY 2015 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	RHMD	UHC	CY 2013	CY 2014	CY 2015
Health & Developmental History	88%	99%	95%	89%	93%	91%	90%	88%	89%	88%	92%
Comprehensive Physical Examination	91%	97%	99%	91%	94%	92%	93%	91%	91%	93%	93%
Laboratory Tests/At Risk Screenings	79%	98%	62%	77%	81%	79%	74%	73%	77%	76%	78%
Immunizations	85%	88%	80%	84%	82%	87%	83%	83%	84%	83%	84%

Component	CY 2015 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	RHMD	UHC	CY 2013	CY 2014	CY 2015
Health Education/ Anticipatory Guidance	89%	98%	99%	90%	93%	93%	92%	88 %	89%	91%	92%

Underlined scores denote that the minimum compliance score of 75% was unmet for CY 2013 and CY 2014, and the 80% minimum compliance score was unmet for CY 2015.

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

Health and Developmental History

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

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

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

Table 27. CY 2015 Health and Developmental History Element Scores

Health and Development History Elements	ACC CY 2015	JMS CY 2015	KPMAS CY 2015	MPC CY 2015	MSFC CY 2015	PPMCO CY 2015	RHMD CY 2015	UHC CY 2015
Substance Abuse Assessment	79%	100%	94%	79%	91%	92%	79%	79%
Psychosocial History	91%	100%	96%	91%	94%	92%	95%	90%
Mental Health Assessment	86%	100%	99%	91%	95%	90%	91%	88%
Family History	85%	99%	90%	86%	89%	85%	87%	82%
Peri-natal History	87%	98%	73%	92%	96%	82%	94%	87%

Health and Development History Elements	ACC CY 2015	JMS CY 2015	KPMAS CY 2015	MPC CY 2015	MSFC CY 2015	PPMCO CY 2015	RHMD CY 2015	UHC CY 2015
Health History	94%	100%	99%	93%	97%	95%	94%	94%
Developmental Assessment/History/ Surveillance (0–5 years)	93%	95%	100%	94%	95%	95%	94%	91%
Developmental Assessment/History/ Surveillance (6–20 years)	92%	97%	99%	91%	96%	96%	90%	91%
Developmental Screening Using Standardized Tool at 9, 18, 24–30 Month Visits	63%	92%	99%	73%	65%	80%	70%	72%
Recorded Autism Screening using Standardized Tool*	50%	100%	100%	59%	62%	78%	73%	55%
MCO Aggregate Element Score	88%	99%	95%	89%	93%	91%	90%	88%

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

Health and Developmental History Results

- All MCO's scores exceeded the minimum compliance score of 80% for this component for CY 2015.
- The HealthChoice Aggregate score decreased by 1 percentage point from CY 2013 to CY 2014 and increased by 4 percentage points from CY 2014 to CY 2015 to a score of 92%.

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 28. CY 2015 Comprehensive Physical Examination Element Scores

Comprehensive Physical Exam Elements	ACC CY 2015	JMS CY 2015	KPMAS CY 2015	MPC CY 2015	MSFC CY 2015	PPMCO CY 2015	RHMD CY 2015	UHC CY 2015
Graphed Height	92%	99%	99%	93%	91%	91%	92%	90%
Measured Height	99%	100%	100%	99%	100%	100%	99%	99%
Graphed Weight	93%	99%	99%	93%	91%	91%	93%	90%
Measured Weight	100%	100%	100%	99%	100%	100%	99%	99%
Graphed Head Circumference	81%	96%	94%	81%	84%	<u>73%</u>	86%	80%
Measured Head Circumference	84%	98%	97%	88%	89%	83%	92%	88%
Measured Blood Pressure	96%	100%	98%	98%	98%	97%	99%	98%
Documentation Of Minimum 5 Systems	92%	84%	100%	96%	97%	97%	96%	95%
Assessed Hearing	89%	99%	100%	86%	94%	90%	93%	88%
Assessed Vision	91%	98%	100%	90%	94%	92%	95%	92%
Assessed Nutritional Status	80%	85%	99%	<u>77%</u>	90%	83%	87%	82%
Conducted Oral Screening	93%	100%	99%	96%	98%	98%	95%	92%
Calculated BMI (2yrs and older)	82%	100%	98%	<u>79%</u>	93%	90%	89%	84%
Graphed BMI (2yrs and older)	85%	100%	98%	86%	87%	88%	86%	83%
MCO Aggregate Element Score	91%	97%	99%	91%	94%	92%	93%	91%

Underlined scores denote that the 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 2015.
- Calculation and graphing of BMI was included in the scoring of this component for the first time in CY 2015.
- The HealthChoice Aggregate score increased by 2 percentage points from CY 2013 to CY 2014 and remained the same from CY 2014 to CY 2015 at a score of 93%.

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 29. CY 2015 Laboratory Test/At–Risk Screenings Element Scores

Laboratory Test/At–Risk Screenings Elements	ACC CY 2015	JMS CY 2015	KPMAS CY 2015	MPC CY 2015	MSFC CY 2015	PPMCO CY 2015	RHMD CY 2015	UHC CY 2015
Cholesterol Risk Assessment per Schedule	74%	99%	60%	74%	77%	71%	62%	68%
STI/HIV Risk Assessment per Schedule	78%	99%	89%	82%	86%	87%	76%	84%
Referred for Lead Test	87%	96%	67%	80%	90%	84%	89%	80%
12 Month Lead Test Result per Schedule	81%	94%	62%	60%	95%	71%	77%	60%
24 Month Lead Test Result per Schedule	71%	85%	53%	59%	83%	70%	61%	74%
Lead Risk Assessment	86%	100%	72%	91%	93%	93%	91%	85%
Anemia Screening per Schedule	91%	95%	67%	79%	91%	81%	78%	80%
Conducted Second Hereditary/Metabolic Screening by 2–4 wks	72%	100%	40%	85%	88%	70%	73%	84%
Baseline Lead Testing Completed	90%	98%	52%	82%	91%	76%	70%	79%
Tb Risk Assessment (1 month–20years)	72%	99%	52%	74%	70%	77%	67%	67%
MCO Aggregate Element Score	79%	98%	62%	77%	81%	79%	74%	73%

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

Laboratory/ At Risk Screening Results

- Two of the eight MCOs (Jai Medical Systems, Inc. and MedStar Family Choice, Inc.) exceeded the minimum compliance score of 80% for this component for CY 2015.
- Six of the eight MCOs (AMERIGROUP Community Care, Kaiser Permanente of the Mid-Atlantic States, Inc., Maryland Primary Care, Priority Partners, Riverside Health of Maryland, and UnitedHealthcare) scored below the minimum compliance score of 80% and were required to submit CAPs for the Laboratory/At Risk Screening component.
- The HealthChoice Aggregate score decreased by 1 percentage point from CY 2013 to CY 2014 and increased by 2 percentage points from CY 2014 to CY 2015 to a rate of 78%.

Immunizations

Rationale: Children on Medical Assistance must be immunized according to the current Maryland DHMH Recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland

State Medical Society and is based on the current recommendations of the U.S. Public Health Service's Advisory Committee of Immunization Practices (ACIP) and the American Academy of Pediatrics. Primary care providers who see Medicaid recipients through 18 years of age must participate in the Department's Vaccines for Children (VFC) Program.

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

Table 30. CY 2015 Immunizations Element Scores

Immunizations Elements	ACC CY 2015	JMS CY 2015	KPMAS CY 2015	MPC CY 2015	MSFC CY 2015	PPMCO CY 2015	RHMD CY 2015	UHC CY 2015
TD Vaccine(s) per Schedule	88%	96%	77%	85%	89%	93%	74%	85%
Hepatitis B Vaccine(s) per Schedule	91%	97%	87%	92%	90%	94%	88%	91%
MMR Vaccine(s) per Schedule	96%	100%	96%	97%	97%	98%	97%	97%
Polio Vaccine(s) per Schedule	95%	99%	89%	95%	93%	97%	95%	95%
Hib Vaccine(s) per Schedule	77%	78%	76%	77%	80%	80%	88%	80%
DTP/DTaP (DT) Vaccine(s) per Schedule	94%	96%	87%	94%	88%	95%	91%	91%
Hepatitis A Vaccine(s) per Schedule (2 dose requirement)	92%	95%	93%	88%	94%	90%	96%	93%
Influenza Vaccine(s) (Beginning at 6 months of age per schedule)	62%	66%	64%	58%	56%	64%	57%	57%
Meningococcal (MCV4) Vaccine(s) per Schedule	88%	98%	75%	85%	92%	94%	72%	87%
Varicella Vaccine(s) per Schedule (2 dose requirement)	90%	97%	83%	91%	86%	93%	84%	88%
Rotavirus Vaccine(s) per Schedule	87%	94%	54%	79%	82%	100%	87%	86%
Assessed if Immunizations are Up to Date	77%	76%	74%	79%	75%	78%	81%	77%
PCV-13 Vaccine(s) per Schedule	96%	95%	89%	92%	91%	95%	93%	94%
Human Papillomavirus Vaccine(s)*	71%	88%	70%	70%	73%	76%	58%	72%
MCO Aggregate Element Score	85%	88%	80%	84%	82%	87%	83%	83%

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

* This immunization data was collected for informational purposes only and was not used in the calculation of the overall component score.

Immunizations Results

- All MCO's scores exceeded the minimum compliance scores of 80% for this component for CY 2015.
- The HealthChoice Aggregate score for this component decreased by 1 percentage point from CY 2013 to CY 2014 and increased by 1 percentage point from CY 2014 to CY 2015 to a score of 84%.

Health Education/Anticipatory Guidance

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

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

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

Table 31. CY 2015 Health Education/Anticipatory Guidance Element Scores

Health Education/ Anticipatory Guidance Elements	ACC CY 2015	JMS CY 2015	KPMAS CY 2015	MPC CY 2015	MSFC CY 2015	PPMCO CY 2015	RHMD CY 2015	UHC CY 2015
Provided Education and Referral to Dentist	<u>78%</u>	98%	94%	<u>79%</u>	87%	88%	83%	<u>79%</u>
Provided Age Appropriate Guidance	92%	100%	100%	92%	96%	95%	93%	92%
Specified Requirements for Return Visit	86%	92%	100%	89%	88%	89%	90%	82%
Provided Ed/Referral for Identified Problems/Tests	98%	100%	100%	97%	99%	99%	99%	98%
MCO Aggregate Element Score	89%	98%	99%	90%	93%	93%	92%	88%

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

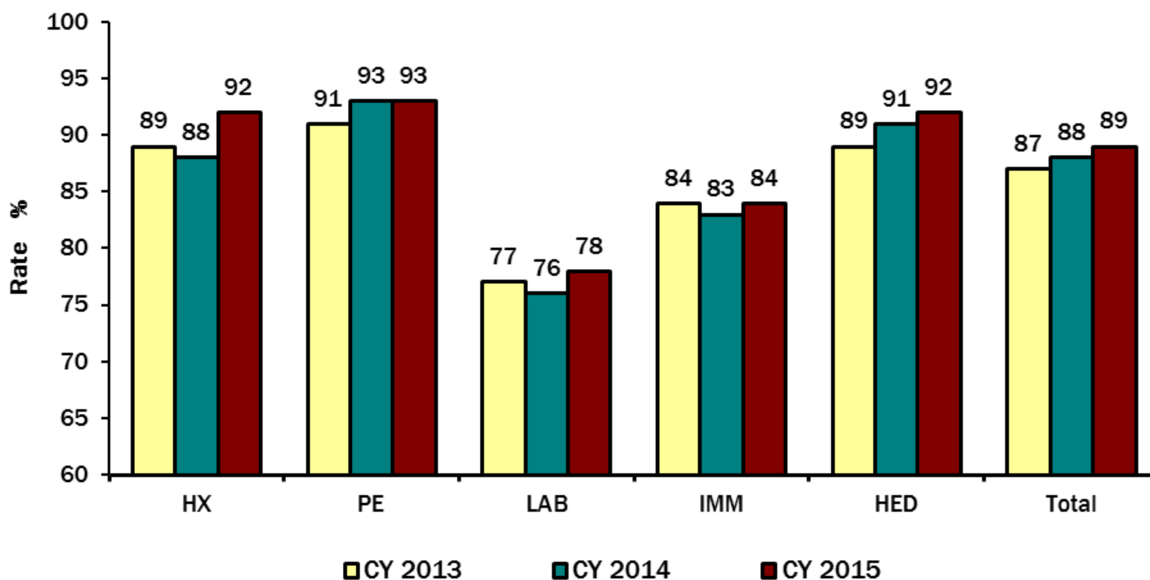
Health Education/Anticipatory Guidance Results

- All MCO's scores exceeded the minimum compliance score of 80% for this component for CY 2015.
- The HealthChoice Aggregate score for this component increased by 2 percentage points from CY 2013 to CY 2014 and increased by 1 percentage point from CY 2014 to CY 2015 to a score of 92%.

Trending of Aggregate Compliance Scores

Figure 7 compares the HealthChoice Aggregate Scores from CY 2013 to CY 2015.

Figure 7. HealthChoice Aggregate Scores for EPSDT
Program Review Components for CY 2013 through CY 2015



From CY 2013 to CY 2014, the HealthChoice Aggregate Scores increased for two components (Comprehensive Physical Examination and Health Education/Anticipatory Guidance) and decreased for three (Health and Developmental History, Laboratory Tests/At Risk Screenings, and Immunization) components. These changes resulted in a one percentage point increase for the Total score in CY 2014.

From CY 2014 to CY 2015 the HealthChoice Aggregate Scores increased for four components (Health and Developmental History, Laboratory Tests/At Risk Screenings, Immunizations, and Health Education/Anticipatory Guidance) and remained the same for one component (Comprehensive Physical Examination). This resulted in a one percentage point increase to the Total score for CY 2015.

Corrective Action Plan Process

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

Required Contents of EPSDT CAPs

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

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

EPSDT CAP Evaluation 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, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

Conclusions

Two of the eight MCOs (Jai Medical Systems, Inc. and MedStar Family Choice, Inc.) met the minimum compliance score of 80% for all five components. Six MCOs (AMERIGROUP Community Care, Kaiser Permanente of the Mid-Atlantic States, Inc., Maryland Physicians Care, Priority Partners, Riverside Health of Maryland, and UnitedHealthcare) scored below the 80% minimum compliance score for the Laboratory Tests/At–Risk Screenings component and were required to submit CAPs.

The CAPs were evaluated by Delmarva Foundation and determined acceptable for the specific area where deficiencies occurred for CY 2015.

The MCO results of the EPSDT review demonstrated strong compliance with the timely screening and preventive care requirements of the Healthy Kids/EPSDT Program. Aggregate scores for four of the five

components were above the 80% minimum threshold for compliance. The aggregate score for Laboratory Tests/At-Risk Screenings was 78% which is slightly below the 80% minimum threshold for compliance.

After increasing by 2 percentage points for CY 2015, the Laboratory Tests/At Risk Screenings component still falls slightly below the HealthChoice Aggregate of 80%. Historically, the Laboratory Tests/At Risk Screenings component score has represented an area in most need of improvement. MCO specific recommendations for quality improvement continue to be shared with MCOs annually.

The CY 2015 Total Composite Score of 89% was a slight one percentage point increase from the CY 2014 Total Composite Score of 88%. 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.

The result of the EPSDT review demonstrates strong compliance with the timely screening and preventive care requirements of the HealthChoice/ EPSDT Program. Scores for all five components increased or remained unchanged from CY 2014 to CY 2015.

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

Introduction

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

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

Within DHMH, the HACA is responsible for the quality oversight of the HealthChoice programs. DHMH measures HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS® reporting. Performance is measured at both the managed care organization level and on a statewide basis. All eight HealthChoice MCOs submitted CY 2015 data for HEDIS® 2016.

Measures Designated for Reporting

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

Measures Selected by DHMH for HealthChoice Performance Reporting

DHMH required HealthChoice managed care organizations to report all HEDIS® measures applicable to a Medicaid line of business except where the measure is exempted by the Department or carved out. This was a total of 48 HEDIS® measures including two Experience of Care measures which are not within the scope of this report; Flu Vaccinations for Adults Ages 18-64 (FVA) & Medical Assistance with Smoking and Tobacco

Use Cessation (MSC). The required set reflected two first-year HEDIS® measures, however, the results will not be publicly reported until HEDIS® 2017. The two new measures are as follows:

- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Statin Therapy for Patients with Diabetes (SPD).

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

Effectiveness of Care (EOC) Domain: 27 measures

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC), all indicators except HbA1c good control (<7.0%)
- Statin Therapy for Patients with Diabetes (SPD) **New**
- 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) **New**
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Lead Screening in Children (LSC)
- Human Papillomavirus Vaccine for Female Adolescents (HPV)
- Non–Recommended Cervical Cancer Screening in Adolescent Females (NCS)
- Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
- Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

Access/Availability of Care (AAC) Domain: 4 measures

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

Utilization and Relative Resource Use (URR) Domain: 8 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
- Frequency of Selected Procedures (FSP)
- Inpatient Utilization – General Hospital/ Acute Care (IPU), Report Only "a" Level of Measure
- Antibiotic Utilization (ABX), Report Only "a" Level of Measure

Health Plan Descriptive Information: 7 measures

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

No Benefit (NB) Measure Designations: 12 measures

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

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
- Antidepressant Medication Management (AMM)
- Follow–Up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Follow–Up Care after Hospitalization for Mental Illness (FUH)
- Mental Health Utilization (MPT)

- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Annual Dental Visit (ADV)
- Use of First–Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Identification of Alcohol and Other Drug Services (IAD)

HEDIS® Measures Reporting History

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

Table 32. HEDIS® Measures Reporting History

NCQA Domain	Measure Name	HealthChoice Reporting History
EOC	Adult BMI Assessment (ABA)	2013
EOC	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	2012
EOC	Childhood Immunization Status (CIS)	< 2005
EOC	Immunizations for Adolescents (IMA)	2010
URR	Well-Child Visits in the First 15 Months of Life (W15)	< 2005
URR	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	< 2005
URR	Adolescent Well-Care Visits (AWC)	< 2005
EOC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	2014
EOC	Appropriate Testing for Children with Pharyngitis (CWP)	2007
EOC	Lead Screening in Children (LSC)	2015
EOC	Human Papillomavirus Vaccine for Female Adolescents (HPV)	2015
EOC	Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	2015
EOC	Use of Appropriate Medications for People with Asthma (ASM)	2006
EOC	Medication Management for People With Asthma (MMA)	2013
EOC	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	2007
EOC	Asthma Medication Ratio (AMR)	2014
EOC	Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	2014
EOC	Pharmacotherapy Management of COPD Exacerbation (PCE)	2014
AAC	Children and Adolescents' Access to Primary Care Practitioners (CAP)	2007
AAC	Adults' Access to Preventive/Ambulatory Health Services (AAP)	2007
EOC	Breast Cancer Screening (BCS)	2007
EOC	Cervical Cancer Screening (CCS)	2007
EOC	Chlamydia Screening in Women (CHL)	2007
AAC	Prenatal and Postpartum Care (PPC)	< 2005
URR	Frequency of Ongoing Prenatal Care (FPC)	< 2005
EOC	Controlling High Blood Pressure (CBP)	2013

NCQA Domain	Measure Name	HealthChoice Reporting History
EOC	Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	2014
EOC	Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	2015
EOC	Statin Therapy for Patients with Cardiovascular Disease (SPC)	2016
EOC	Comprehensive Diabetes Care (CDC)	< 2005
EOC	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	2015
EOC	Statin Therapy for Patients with Diabetes (SPD)	2016
EOC	Use of Imaging Studies for Low Back Pain (LBP)	2012
EOC	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	2013
EOC	Annual Monitoring for Patients on Persistent Medications(MPM)	2013
AAC	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	2009
URR	Identification of Alcohol and Other Drug Services (IAD)	2009
URR	Ambulatory Care (AMB)	2007
URR	Frequency of Selected Procedures (FSP)	2015
URR	Inpatient Utilization - General Hospital/Acute Care (IPU)	2015
URR	Antibiotic Utilization (ABX)	2015
HPDI	Board Certification (BCR)	2015
HPDI	Enrollment by Product Line (ENP)	2015
HPDI	Enrollment by State (EBS)	2015
HPDI	Language Diversity of Membership (LDM)	2015
HPDI	Race/Ethnicity Diversity of Membership (RDM)	2015
HPDI	Weeks of Pregnancy at Time of Enrollment (WOP)	2015
HPDI	Total Membership (TLM)	2015
AAC	Call Answer Timeliness (CAT)	2006

HEDIS® Methodology

The HEDIS®–reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS® 2016 Volume 2: Technical Specifications.*

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

- **Administrative data:** Data from transaction systems (claims, encounters, enrollment, and practitioner) provide the majority of administrative data. Organizations may receive encounter files from pharmacy, laboratory, vision, and behavioral health vendors.
- **Supplemental data:** NCQA defines supplemental data as atypical administrative data, i.e., not claims or encounters. Sources include immunization registry files, laboratory results files, case management databases, and medical record–derived databases.

- **Medical record data:** Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA–defined hybrid method. HEDIS® specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records needs to be chased. NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by DHMH for HEDIS® reporting. Use of the hybrid method is optional. NCQA maintains that no one approach to measure calculation or data collection is considered superior to another. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across–the–board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

The following table shows actual HEDIS® 2016 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 33. MCO Use of Administrative or Hybrid Method

Measure List	ACC	JMS	KPMAS	MPC	MSFC	PP	RHP	UHC
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
HPV – Human Papillomavirus Vaccine for Female Adolescents	H	H	A	H	H	A	H	H
IMA – Immunization 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
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.

- **Conference Call**: 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 (January 29th in 2016). The auditor reviews the HEDIS® Roadmap prior to the onsite audit in order to make preliminary assessments regarding Information Systems (IS) compliance and to identify areas requiring follow–up at the onsite audit.
- **Information Systems (IS) standards compliance**: The onsite portion of the HEDIS® Audit expands upon information gleaned from the HEDIS® Roadmap to enable the auditor to make conclusions about the organization's compliance with IS standards. IS standards, describing the minimum requirements for information systems and processes used in HEDIS® data collection, are the foundation on which the auditor assesses the organization's ability to report HEDIS® data accurately and reliably. The auditor reviews data collection and management processes, including the monitoring of vendors, and makes a determination regarding the soundness and completeness of data to be used for HEDIS® reporting.
- **HEDIS® Measure Determination (HD) standards compliance**: The auditor uses both onsite and offsite activities to determine compliance with HD standards and to assess the organization's adherence to HEDIS® Technical Specifications and report–production protocols. The auditor confirms the use of NCQA–certified software. The auditor reviews the organization's sampling protocols for the hybrid method. Later in the audit season, the auditor reviews HEDIS® results for algorithmic compliance and performs benchmarking against NCQA–published means and percentiles.
- **Medical Record Review Validation (MRRV)**: The HEDIS® audit includes a protocol to validate the integrity of data obtained from medical record review (MRR) for any measures calculated using the hybrid method. The audit team compares its medical record findings to the organization's abstraction forms for a sample of positive numerator events. Part one of the validation may also include review of a convenience sample of medical records for the purpose of finding procedural errors early in the medical record abstraction process so that timely corrective action can be made. This is optional based on NCQA standards and auditor opinion. MRRV is an important component of the HEDIS® Compliance Audit. It ensures that medical records reviews performed by the organization, or by its contracted vendor, meet audit standards for sound processes and that abstracted medical data are accurate. In part two of the MRRV, the auditor selects hybrid measures from like–measure groupings for measure validation. MRRV tests medical records and appropriate application of the HEDIS® hybrid specifications (i.e., the member is a numerator positive or an exclusion for the measure). NCQA uses an acceptable quality level of 2.5 percent for the sampling process, which translates to a sample of 16 medical records for each selected measure.

- **Audit designations:** The auditor approves the rate/result calculated by the HealthChoice organization for each measure included in the HEDIS® report, as shown in the following table of audit results, excerpted from *Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures*. These changes include the addition of new audit designations Not Required, Biased Rate, and Un-Audited as described in the table.

Table 34. Audit Designations

Rate/Result	Comment
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 DHMH.)
NQ	Not Required. The organization was not required to report the measure.
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 DHMH has contracted with outside vendors for coverage of certain services. HDC 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 juxtaposed 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® 2016 Volume 2: Technical Specifications.*
- Rationale – For all measures, except Call Answer Timeliness (CAT) the source of the information is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of 2016. These citations appear under the *Brief Abstract* on the Web site of the National Quality Measures Clearinghouse, http://www.qualitymeasures.ahrq.gov/. For CAT the rationale was adapted from *HEDIS® 2004 Vol. 2: Technical Specifications.*
- Summary of Changes for HEDIS® 2016 – The source of the text, is the *HEDIS® 2016 Volume 2: Technical Specifications*, incorporating additional changes published in the *HEDIS® 2016 Volume 2: "October" Technical Update.*

Year-to-Year Changes

Table 35 shows the numbers of organizations that experienced a lower or higher change in HEDIS® rates from 2014 to 2015. The change in the MARR (2016 rate minus 2015 rate) and the change in the NHM (2015 rate minus 2014 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® 2016 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 35. Changes in HEDIS® Rates from 2015 to 2016

HEDIS® Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Adult BMI Assessment (ABA)	3	4	0.9%	4%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	3	3	-0.1%	2%
Childhood Immunization Status (CIS) – Combination 2	1	6	7.3%	-0.2%
Childhood Immunization Status (CIS) – Combination 3	1	5	8.6%	-0.5%
Childhood Immunization Status (CIS) – Combination 4	0	7	8.9%	1.3%
Childhood Immunization Status (CIS) – Combination 5	0	7	6.2%	0.8%
Childhood Immunization Status (CIS) – Combination 6	3	4	2.1%	1.4%
Childhood Immunization Status (CIS) – Combination 7	1	6	6.1%	1.3%
Childhood Immunization Status (CIS) – Combination 8	2	5	2.5%	1.8%
Childhood Immunization Status (CIS) – Combination 9	3	4	1.7%	1.2%
Childhood Immunization Status (CIS) – Combination 10	3	4	1.8%	1.4%
Immunizations for Adolescents (IMA) – Combination 1	0	7	12.3%	1.2%
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*	4	2	-0.1%	-0.5%
Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or Six-or-more visits rates**	1	6	2.3%	-1.1%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	3	5	0.7%	0.4%
Adolescent Well-Care Visits (AWC)	1	7	3.5%	0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – BMI Percentile– Total Rate	7	1	-2.7%	7.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Nutrition – Total Rate	3	4	-2%	1.4%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Counseling for Physical Activity – Total Rate	5	2	-2%	+3%
Appropriate Testing for Children with Pharyngitis (CWP)	0	7	5.6%	3%
Lead Screening in Children (LSC)	1	6	2.5%	0.3%
Human Papillomavirus Vaccine for Female Adolescents (HPV)	1	5	5.1%	2.4%
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*	8	0	-1.4%	-1.8%

HEDIS® Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Medication Management for People With Asthma (MMA) – Total 50% of treatment period	2	4	5.4%	-0.1%
Medication Management for People With Asthma (MMA) – Total 75% of treatment period	0	6	7.1%	-0.8%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	1	6	3%	1.8%
Asthma Medication Ratio (AMR)	1	5	0.5%	-6.1%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	0	6	3.6%	0%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Systemic Corticosteroid Rate	4	3	-0.3%	-0.4%
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate	3	4	-0.6%	-1.9%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	3	5	-1.7%	-0.6%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	1	7	0.8%	-0.5%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	2	5	-1.7%	1%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–19 years	1	6	-1.1%	0.8%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20–44 years	4	4	-0.6%	-1.3%
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	1	6	0.2%	-0.7%
Breast Cancer Screening (BCS)	1	6	2.1%	0.9%
Cervical Cancer Screening (CCS)	5	3	-0.7%	-2.4%
Chlamydia Screening in Women (CHL) – Age 16–20 years	7	0	-3.9%	-0.1%
Chlamydia Screening in Women (CHL) – Age 21–24 years	3	5	1.6%	-1.6%
Chlamydia Screening in Women (CHL) – Total (16–24) years	6	2	-0.9%	-0.3%
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	2	6	1.6%	0.5%
Prenatal and Postpartum Care (PPC) – Postpartum Care	2	6	4.2%	0.5%
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*	8	0	-2.1%	-0.2%
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	1	6	3%	-0.4%
Controlling High Blood Pressures (CBP)	3	5	1.8%	0.6%
Persistence of Beta–Blocker Treatment after a Heart Attack (PBH)	3	1	-8.4%	-0.9%
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	5	2	-0.2%	2.5%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*	4	2	-4.6%	-2%
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)	3	5	4.3%	1%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	5	3	-1.3%	0.8%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	1	7	8.2%	2%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	5	3	-1%	1.5%
Use of Imaging Studies for Low Back Pain (LBP)	3	4	0.2%	-0.4%
Disease–Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	1	4	4.9%	-0.9%
Annual Monitoring for Patients on Persistent Medications (MPM) – members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	2	5	0.3%	-0.6%
Annual Monitoring for Patients on Persistent Medications (MPM) – members on digoxin	3	1	0	-37.2%**

HEDIS® Measure	MCOs Performing Lower	MCO Performing Higher	MARR Change	NHM Change
Annual Monitoring for Patients on Persistent Medications (MPM) – members on diuretics	3	4	0	-1%
Annual Monitoring for Patients on Persistent Medications (MPM) – Total rate	3	5	0	0.7%
Ambulatory Care (AMB) – Outpatient visits per 1,000 member months	3	5	6.8	-8.6
Ambulatory Care (AMB) – Emergency department (ED) visits per 1,000 member months	5	3	1.8	-0.8
Call Answer Timeliness (CAT)	0	8	8.3%	-4%

* A lower rate indicates better performance.

** Attributable to a change in the specification.

Table 36 shows organizations that demonstrated incremental increases in performance scores over the past three years (2016 less 2014) for those MCOs that reported all three years.) The analysis only shows a trend toward improvement. It does not indicate superior performance. For a comparison of one organization against another, please refer to the measure–specific tables in this report. For measures where a lower rate indicates better performance (single asterisk), the table shows organizations having a decrease in performance score over the past three years.

Table 36. HEDIS® Measures Incremental Increases in Performance

HEDIS® Measure	ACC	JMS	MPC	MSFC	PP	RHMD[1]	UHC
Adult BMI Assessment (ABA)	X	X	X	X	X		X
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	X			X			X
Childhood Immunization Status (CIS) – Combination 2	X	X	X		X	X	X
Childhood Immunization Status (CIS) – Combination 3	X	X	X		X	X	X
Childhood Immunization Status (CIS) – Combination 4	X	X	X		X	X	X
Childhood Immunization Status (CIS) – Combination 5	X	X	X		X	X	X
Childhood Immunization Status (CIS) – Combination 6	X		X		X	X	
Childhood Immunization Status (CIS) – Combination 7	X	X	X		X	X	X
Childhood Immunization Status (CIS) – Combination 8	X		X		X	X	
Childhood Immunization Status (CIS) – Combination 9	X	X	X		X	X	
Childhood Immunization Status (CIS) – Combination 10	X	X	X		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	
Well–Child Visits in the First 15 months of Life (W15) – DHMH Five or Six–or–more visits rates**			X			X	
Well–Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	X	X		X	X	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		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

HEDIS® Measure	ACC	JMS	MPC	MSFC	PP	RHMD[1]	UHC
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
Asthma Medication Ratio (AMR)		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		X		
Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator Rate		X	X			X	
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12–24 months	X		X		X		X
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months–6 years	X	X	X	X	X	X	X
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7–11 years	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		X		X	X	
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45–64 years	X	X	X		X	X	X
Breast Cancer Screening (BCS)	X	X	X	X	X		X
Cervical Cancer Screening (CCS)						X	
Chlamydia Screening in Women (CHL) – Age 16–20 years		X					
Chlamydia Screening in Women (CHL) – Age 21–24 years		X	X			X	X
Chlamydia Screening in Women (CHL) – Total (16–24) years							
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care		X				X	
Prenatal and Postpartum Care (PPC) – Postpartum Care	X	X				X	X
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*	X			X			X
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits				X		X	X
Controlling High Blood Pressures (CBP)	X	X	X	X	X	X	X
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)							
Comprehensive Diabetes (CDC) – Hemoglobin A1c (HbA1c) Testing	X	X	X	X	X	X	X
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%)*		X	X	X	X	X	X
Comprehensive Diabetes (CDC) – HbA1c Control (< 8.0%)			X	X	X	X	X
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed							
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	X	X	X	X	X	X	X
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	X	X					
Use of Imaging Studies for Low Back Pain (LBP)		X			X		
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	X				X		X
Annual Monitoring for Patients on Persistent Medications (MPM) - members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).	X	X	X	X	X		X
Annual Monitoring for Patients on Persistent Medications (MPM) - members on digoxin							
Annual Monitoring for Patients on Persistent Medications (MPM) - members on diuretics.	X	X	X		X		X
Annual Monitoring for Patients on Persistent Medications (MPM) - Total rate	X	X	X	X	X		X
Call Answer Timeliness (CAT)		X				X	X
Totals	39	40	39	18	39	30	38

* A lower rate indicates better performance.

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

[1]RHMD 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® 2016.

Highlights

- The MARR for Childhood Immunization Status (CIS) Combinations 2,3,4,5, & 7 all increased by greater than five percentage points while Immunizations for Adolescents Combination One increased by 12.3 points from HEDIS® 2015 to 2016. MARR increases were primarily due to improved scores by MPC and RHMD.
- All HealthChoice MCOs improved their Appropriate Testing for Children with Pharyngitis Score resulting in an increase of over five percentage points to the MARR. MARR increases were primarily due to improved scores from all HealthChoice plans, but particularly RHMD.
- The MARR improved by more than five percentage points for the Human Papillomavirus Vaccine for Female Adolescents measure. MARR increases were primarily due to improved scores by JMS, PP, and UHC. Note: This measure will be restructured for 2017 and combined with IMA.
- The MARR improved by greater than 5 percentage points for both indicators (50% Total & 75% Total) of the Medication Management for People with Asthma measure.
- There was a significant increase (>8%) to Comprehensive Diabetes Care – Medical Attention for Nephropathy rate which may be partially attributable to a specification change allowing positive or negative results as long as a qualifying test was performed.
- The MARR experienced a significant decrease to the rate for Persistence of Beta-Blocker Treatment after a Heart Attack from 2015 to 2016 without any changes to the specification. Plans decreasing the most were MSFC, ACC, MPC and UHC.

Measures with the greatest percentage improvement all belonged to the Effectiveness of Care (EOC) Domain with notable gains to the Prevention and Screening and Respiratory Conditions categories. Measures with the greatest degree of improvement include: Immunizations for both Adolescents and Children, Appropriate Testing for Children with Pharyngitis, Medication Management for People with Asthma - Total 50% of Treatment Period and Total 75% of Treatment Period, and Comprehensive Diabetes Care - Medical Attention for Nephropathy. Call Answer Timeliness also experienced a significant rate increase in 2016, but was not included here since it was not audited in all cases as per changing NCQA requirements.

Measures with the greatest percentage decline were primarily Effectiveness of Care measures, but also included one Access/Availability of Care measure. Measures with the greatest rate decreases follow in declining order of degree: Persistence of Beta-Blocker Treatment after a Heart Attack, Chlamydia Screening in Women - Age 16-20 Years, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile Total Rate, Counseling for Nutrition Total Rate, and Counseling for Physical Activity Total Rate, Children and Adolescents Access to Primary Care Practitioners - Age 12-24 months, and Age 7-11 years.

The seven plans that reported in each of the last three years had an average improvement rate of nearly 61% meaning that, on average, each plan improved on 35 of 57 measures from 2014 to 2016.

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

Introduction

COMAR 10.09.65.03(C)(4) requires that all HealthChoice MCOs participate in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. DHMH has contracted with WBA Market Research (WBA), an NCQA–certified survey vendor, since 2008 to conduct its survey. WBA administers this survey to a random sample of eligible adult and child members enrolled in HealthChoice via mixed methodology (mail with telephone follow–up), per NCQA protocol. Eight MCOs participated in the HealthChoice CAHPS® 2016 survey based on services provided in CY 2015:

- AMERIGROUP Community Care (ACC)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic, Inc. (KPMAS) - First-year HealthChoice MCO
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- Riverside Health of Maryland (RHMD)
- UnitedHealthcare (UHC)

2016 CAHPS® 5.0H Medicaid Survey Overview

In 2016, 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 2015. The survey measures those aspects of care for which members are the best and/or the only source of information. From this survey, members' ratings of and experiences with the medical care they receive can be determined. Based on members' health care experiences, potential opportunities for improvement can be identified. Specifically, the results obtained from this consumer survey will allow DHMH to:

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

Results from the CAHPS® 5.0H survey summarize member satisfaction with their health care through ratings, 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 2015

In 2016, NCQA made several revisions to the CAHPS® Adult and Child Medicaid Satisfaction Survey protocol, as outlined below:

- Revised the sampling methodology. Instead of a random sample, survey vendors must use a systematic sample to ensure a reproducible and auditable sample that is representative of the eligible population. In addition, disenrolled members may not be removed from the sample.
- Removed the restriction on over-sampling rates and over-sampling in increments of 5% is no longer required.
- Revised the telephone phase of the mixed methodology protocol by limiting telephone attempts to six.
- Revised the definition of a "complete and valid survey" so that not only must responses indicate the member meets the eligible population criteria, but three of the following five questions must be answered appropriately:
  - In the last 6 months, did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?
  - Do you (Does your child) have a personal doctor?
  - In the last 6 months, did you make any appointments (for your child) to see a specialist?
  - In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works? (Adult) In the last 6 months, did you get information or help from customer service at your child's health plan? (Child)
  - Using a number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your (child's) health plan?

- Added the following dispositions: non-response: incomplete; ineligible: removed from sample during deduplication—duplicate household of sampled adult member; and ineligible: removed from sample during deduplication—duplicate household of sampled child member.
- In 2016, DHMH made one revision to the CAHPS® 5.0H Adult and Child Medicaid Survey reporting so all percentages are now shown unrounded, to one decimal place.

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, DHMH 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, 2015).

Between February and May 2016, WBA collected 4,552 valid surveys from the eligible Medicaid adult population (70 of which were conducted in Spanish) and 4,966 valid surveys from the eligible Medicaid child population (412 of which were completed in Spanish). Of the responses, 2,795 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 were marked as a duplicate record during the systematic sampling process) or had a language barrier (non-English or Spanish). In addition, adult members who were mentally or physically incapacitated and unable to complete the survey themselves were also considered ineligible. Non-respondents included those who had refused to participate, could not be reached due to a bad address or telephone number, did not complete the survey 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 37 shows the total number of adult and child members in the sample that fell into each disposition category.

Table 37. Sample Dispositions

Disposition Group	Disposition Category	Adult	Child (General Population/Sample A)
Ineligible	Removed from sample during deduplication	69	1,040
	Deceased	15	1
	Does not meet eligibility criteria	292	195
	Language barrier	106	105
	Mentally/Physically incapacitated	29	N/A
	Total Ineligible	**511**	**1,341**
Non–Response	Bad address/phone	1,025	1,264
	Incomplete	280	381
	Refusal	702	1,451

Disposition Group	Disposition Category	Adult	Child (General Population/Sample A)
	Maximum attempts made	6,970	7,757
	Total Non–Response	**8,977**	**10,853**

Table 38 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 38. Adult Surveys Mailed

HealthChoice MCO	Systematic Sample	Surveys Mailed (after deduplication)	Mail and Phone Completes*	Response Rate
AMERIGROUP Community Care	1,755	1,750	514	30%
Jai Medical Systems	1,755	1,739	601	36%
Kaiser Permanente[1]	1,755	1,741	522	31%
Maryland Physicians Care	1,755	1,753	576	34%
MedStar Family Choice	1,755	1,751	600	35%
Priority Partners	1,755	1,753	624	37%
Riverside Health	1,755	1,734	485	29%
UnitedHealthcare	1,755	1,750	630	37%
Total HealthChoice MCOs	**14,040**	**13,971**	**4,552**	**34%**

*During the telephone follow–up, members had the option to complete the survey in either English or Spanish.
[1]First-year HealthChoice MCO

Table 39 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 39. Child Surveys Mailed

HealthChoice MCO	Sample A Systematic Sample	CCC Systematic Sample[2]	Total Systematic Sample	General Population Mailed (Sample A)	CCC Oversample Mailed (Sample B)	Total Surveys Mailed	General Population Mail and Phone Completes *	CCC Respondents	General Population Response Rate
AMERIGROUP Community Care	2,145	1,840	3,985	2,131	1,797	3,928	723	379	34%
Jai Medical Systems	2,145	634	2,779	1,733	400	2,133	448	186	26%
Kaiser Permanente[1]	2,145	419	2,564	1,874	269	2,143	544	133	30%
Maryland Physicians Care	2,145	1,840	3,985	2,126	1,785	3,911	680	507	32%
MedStar Family Choice	2,145	1,840	3,985	2,083	1,613	3,696	676	467	33%
Priority Partners	2,145	1,840	3,985	2,124	1,780	3,904	717	488	34%
Riverside Health	2,145	785	2,930	1,929	564	2,493	503	162	27%
UnitedHealthcare	2,145	1,840	3,985	2,120	1,780	3,900	675	473	33%
Total HealthChoice MCOs	**17,160**	**11,038**	**28,198**	**16,120**	**9,988**	**26,108**	**4,966**	**2,795**	**31%**

*During the telephone follow–up, members had the option to complete the survey in either English or Spanish.
[1]First-year HealthChoice MCO
[2] 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.

Findings

Key Findings from the 2016 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 40 shows each of the four Overall Rating questions and the Summary Rate for these questions from CAHPS® 2014, 2015, and 2016. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

Table 40. CAHPS® Adult Summary Rates of Overall Ratings Questions for 2014-2016

Overall Ratings	2016 (Summary Rate - *8,9,10*)	2015 (Summary Rate - *8,9,10*)	2014 (Summary Rate - *8,9,10*)
Specialist Seen Most Often	79.2%	79.3%	77.1%
Personal Doctor	79.2%↑	75.7%	77.0%
Health Care	74.8%↑	68.9%	69.9%
Health Plan	74.1%↑	69.0%	72.2%

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

HealthChoice members give their highest satisfaction ratings to their Specialist (79.2% giving a rating of 8, 9 or 10) and/or their Personal Doctor (79.2%, up from 75.7% in 2015). Somewhat fewer HealthChoice members give positive satisfaction ratings to their Health Care (74.8%, up from 68.9% in 2015) and/or Health Plan (74.1%, up from 69.0% in 2015) overall.

Overall Ratings

The following table 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 41. CAHPS® 2016 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	**79.2%**	**79.2%**	**74.8%**	**74.1%**
AMERIGROUP Community Care	76.1%	78.7%	72.7%	72.6%
Jai Medical Systems	78.5%	79.0%	69.9%	69.8%
Kaiser Permanente[1]	**83.9%***	82.2%	**80.8%***	**78.9%***
Maryland Physicians Care	76.7%	74.9%	76.3%	75.2%
MedStar Family Choice	81.5%	**83.8%***	79.8%	79.8%
Priority Partners	81.7%	80.3%	73.2%	77.7%
Riverside Health	74.7%	75.3%	73.0%	73.2%
UnitedHealthcare	79.9%	78.8%	73.4%	66.5%

*HealthChoice MCO with the highest Summary Rate
[1]First-year HealthChoice MCO

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.

The following table show composite measure comparisons for Adult Summary Rates from CAHPS® 2014 to 2016.

Table 42. CAHPS® Adult 2014-2016 Summary Rates for Composite Measure Results

Composite Measure	2016 (Summary Rate – *Always/Usually or Yes*)	2015 (Summary Rate – *Always/Usually or Yes*)	2014 (Summary Rate – *Always/Usually or Yes*)
How Well Doctors Communicate	90.8%	89.6%	89.2%
Customer Service	87.1%	84.8%	85.2%
Getting Needed Care	81.3%	79.6%	80.1%
Getting Care Quickly	80.5%h	77.9%	79.4%
Coordination of Care	79.9%	78.5%	78.7%
Shared Decision-Making[1]	79.3%	77.6%	52%
Health Promotion and Education	76.7%	74.5%	73.7%

[1]Shared Decision-Making composite measure revised in 2015. Response choices altered. Trending impacted.

HealthChoice MCOs receive the highest ratings among their members on the "How Well Doctors Communicate" (90.8% Summary Rate – Always/Usually) and "Customer Service" (87.1% 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 (76.7% Summary Rate – Yes). Notably, positive ratings for the "Getting Care Quickly" composite measure increased from 2015 to 2016 (up from 77.9% to 80.5% Summary Rate – Always/Usually).

The following table 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 43. CAHPS® 2016 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	**90.8%**	**87.1%**	**81.3%**	**80.5%**	**79.9%**	**79.3%**	**76.7%**
AMERIGROUP Community Care	89.7%	82.1%	**82.9%***	79.4%	73.5%	77.9%	73.0%
Jai Medical Systems	90.2%	**90.8%***	80.6%	78.9%	82.2%	79.2%	**82.6%***
Kaiser Permanente[1]	90.8%	87.3%	82.0%	80.3%	83.6%	75.6%	75.5%
Maryland Physicians Care	89.2%	87.2%	79.8%	81.8%	81.7%	**82.3%***	79.0%
MedStar Family Choice	92.5%	90.4%	82.2%	81.0%	77.1%	79.9%	80.4%
Priority Partners	90.6%	83.0%	81.1%	**82.8%**	79.6%	79.0%	75.2%
Riverside Health	90.8%	86.5%	79.4%	75.9%	75.4%	80.7%	72.5%
UnitedHealthcare	**92.7%***	87.2%	82.1%	82.0%	**84.6%***	78.4%	74.0%

*HealthChoice MCO with the highest Summary Rate
[1]First-year HealthChoice MCO

Key Findings from the 2016 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 44 and 45. The summary rate represents the percentage of members who rated the question an 8, 9, or 10. Rates are provided for 2014, 2015 and 2016.

Table 44. CAHPS® Child – General Population Summary Rates of Overall Rating Questions for 2014-2016

Overall Ratings	2016 (Summary Rate - *8,9,10*)	2015 (Summary Rate - *8,9,10*)	2014 (Summary Rate - *8,9,10*)
Personal Doctor	90.1%	89.1%	88.6%
Health Care	87.6%	86.4%	86.1%
Health Plan	85.3%	84.5%	85.1%
Specialist	82.2%	83.1%	80.3%

HealthChoice MCOs continue to receive high satisfaction ratings from parents/guardians regarding their child's Personal Doctor (90.1%), Health Care overall (87.6%), Health Plan overall (85.3%) and Specialist (82.2%).

Table 45. CAHPS® Child – CCC Population Summary Rates of Overall Rating Questions for 2014-2016

Overall Ratings	2016 (Summary Rate - *8,9,10*)	2015 (Summary Rate - *8,9,10*)	2014 (Summary Rate - *8,9,10*)
Personal Doctor	88.2%	88.2%	87.1%
Health Care	85.7%	84.2%	83.1%
Specialist	84.1%	82.9%	81.9%
Health Plan	82.2%	82.0%	82.5%

HealthChoice MCOs continue to receive high satisfaction ratings from parents/guardians of children with chronic conditions regarding their child's Personal Doctor (88.2%), Health Care overall (85.7%), Specialist (84.1%) and Health Plan overall (82.2%).

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 46. CAHPS® 2016 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	**90.1%**	**87.6%**	**85.3%**	**82.2%**
AMERIGROUP Community Care	91.3%	88.4%	88.1%	84.3%
Jai Medical Systems	**94.8%***	**93.2%***	84.6%	**85.2%***
Kaiser Permanente[1]	86.4%	82.5%	81.2%	84.8%
Maryland Physicians Care	89.1%	85.7%	86.6%	79.6%
MedStar Family Choice	89.1%	85.7%	87.2%	83.3%
Priority Partners	92.2%	90.6%	**89.2%***	80.8%
Riverside Health	88.5%	85.6%	77.6%	75.0%
UnitedHealthcare	89.6%	88.7%	84.3%	84.5%

*HealthChoice MCO with the highest Summary Rate
[1]First-year HealthChoice MCO

Table 47. CAHPS® 2016 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	**88.2%**	**85.7%**	**84.1%**	**82.2%**
AMERIGROUP Community Care	88.4%	84.7%	80.4%	84.5%
Jai Medical Systems	**93.7%***	**91.8%***	78.9%	**89.6%***
Kaiser Permanente[1]	83.6%	79.8%	83.7%	79.5%
Maryland Physicians Care	87.4%	85.3%	85.2%	82.2%
MedStar Family Choice	87.2%	84.8%	85.3%	84.6%
Priority Partners	90.6%	89.3%	84.2%	85.0%

	Overall Ratings (Summary Rate - *8,9,10*)			
	Personal Doctor	Health Care	Specialist	Health Plan
Riverside Health	87.0%	83.2%	77.6%	78.9%
UnitedHealthcare	87.1%	84.0%	88.0%*	74.1%

*HealthChoice MCO with the highest Summary Rate
[1]First-year HealthChoice MCO

Composite Measures

Tables 48, 49, and 50 show the child composite measure results from CAHPS® 2014, 2015, and 2016.

Table 48. CAHPS® Child – General Population 2014-2016 Summary Rates for Composite Measure Results

Composite Measures	2016 (Summary Rate - *Always/Usually or Yes*)	2015 (Summary Rate - *Always/Usually or Yes*)	2014 (Summary Rate - *Always/Usually or Yes*)
How Well Doctors Communicate	94.2%	93.9%	93.8%
Getting Care Quickly	88.9%	88.4%	89.7%
Customer Service	86.6%	86.3%	87.2%
Getting Needed Care	83.1%	83.4%	84.4%
Coordination of Care	81.3%	81.1%	82.2%
Shared Decision-Making[1]	79.0%	78.6%	57%
Health Promotion and Education	73.8%	74.5%	74.8%

[1]Shared Decision-Making composite measure revised in 2015. Response choices altered. Trending impacted.

In 2016, HealthChoice MCOs received the highest ratings among their child members on the following composite measures:

- How Well Doctors Communicate (94.2% Summary Rate – Always/Usually);
- Getting Care Quickly (88.9% Summary Rate – Always/Usually); and
- Customer Service (86.6% Summary Rate – Always/Usually).

Somewhat lower proportions of child members gave HealthChoice MCOs positive ratings for the "Shared Decision-Making" (79.0% Summary Rate – Yes) and "Health Promotion and Education" (73.8% Summary Rate – Yes) composite measures.

Table 49. CAHPS® Child – CCC Population 2014-2016 Summary Rates for Composite Measure Results

Composite Measures	2016 (Summary Rate - *Always/Usually or Yes*)	2015 (Summary Rate - *Always/Usually or Yes*)	2014 (Summary Rate - *Always/Usually or Yes*)
How Well Doctors Communicate	94.5%	94.8%	94.2%
Getting Care Quickly	91.7%	92.4%	92.2%
Customer Service	88.4%	87.4%	86.3%
Getting Needed Care	85.4%	85.6%	84.7%
Coordination of Care	83.9%	82.5%	80.6%
Shared Decision-Making[1]	83.1%	83.6%	
Health Promotion and Education	79.3%	79.8%	80.4%

[1]Shared Decision-Making composite measure revised in 2015. Response choices altered. Trending impacted.

In 2016, HealthChoice MCOs received the highest ratings among their child members with chronic conditions on the following composite measures:

- How Well Doctors Communicate (94.5% Summary Rate – Always/Usually); and
- Getting Care Quickly (91.7% Summary Rate – Always/Usually).

Somewhat lower proportions of child members with chronic conditions gave HealthChoice MCOs positive ratings for the following composite measures:

- Coordination of Care (83.9% Summary Rate – Always/Usually);
- Shared Decision-Making (83.1% Summary Rate – Yes); and
- Health Promotion and Education (79.3% Summary Rate – Yes).

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 50. CAHPS® Child – CCC Population 2014-2016 Summary Rates for Additional Composite Measure Results

Additional CCC Composite Measures	2016 (Summary Rate - *Always/Usually or Yes*)	2015 (Summary Rate - *Always/Usually or Yes*)	2014 (Summary Rate - *Always/Usually or Yes*)
Family Centered Care: Personal Doctor Who Knows Child	91.2%	91.3%	90.1%
Family Centered Care: Getting Needed Information	90.9%↓	92.5%	90.5%

Additional CCC Composite Measures	2016 (Summary Rate - *Always/Usually or Yes*)	2015 (Summary Rate - *Always/Usually or Yes*)	2014 (Summary Rate - *Always/Usually or Yes*)
Access to Prescription Medicine	89.4%	90.6%	90.5%
Coordination of Care for Children with Chronic Conditions	76.1%	73.0%	74.7%
Access to Specialized Services	75.3%	77.5%	78.6%

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

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 51. CAHPS® 2016 MCO Child – General Population Summary Rates for Composite Measure Results

	Composite Measures (Summary Rate - *Always/Usually or Yes*)						
	How Well Doctors Communicate	Getting Care Quickly	Customer Service	Getting Needed Care	Coordination of Care	Shared Decision Making	Health Promotion and Education
HealthChoice Aggregate	**94.2%**	**88.9%**	**86.6%**	**83.1%**	**81.3%**	**79.0%**	**73.8%**
AMERIGROUP Community Care	92.7%	86.4%	85.3%	79.9%	79.4%	76.3%	71.5%
Jai Medical Systems	**97.5%***	**95.5%***	89.4%	**86.9%***	**88.8%***	**83.5%***	**83.7%***
Kaiser Permanente[1]	92.1%	86.1%	88.4%	81.3%	77.9%	75.0%	75.6%
Maryland Physicians Care	94.4%	90.4%	**89.5%***	84.9%	81.2%	75.9%	73.3%
MedStar Family Choice	94.9%	90.4%	88.5%	85.2%	83.2%	77.8%	76.5%
Priority Partners	94.1%	89.8%	86.7%	82.7%	82.3%	82.5%	71.3%
Riverside Health	93.4%	85.9%	81.7%	82.2%	82.3%	79.9%	68.1%
UnitedHealthcare	94.7%	87.6%	83.0%	82.1%	78.4%	80.6%	72.3%

*HealthChoice MCO with the highest Summary Rate
[1]First-year HealthChoice MCO

Table 52. CAHPS® 2016 MCO Child – CCC Population Summary Rates for Composite Measure Results

	Composite Measures (Summary Rate - *Always/Usually or Yes*)						
	How Well Doctors Communicate	Getting Care Quickly	Customer Service	Getting Needed Care	Coordination of Care	Shared Decision Making	Health Promotion and Education
HealthChoice Aggregate	**94.5%**	**91.7%**	**88.4%**	**85.4%**	**83.9%**	**83.1%**	**79.3%**
AMERIGROUP Community Care	93.8%	88.6%	88.7%	83.4%	84.3%	83.8%	82.5%
Jai Medical Systems	**97.3%***	**96.6%***	**91.0%***	88.6%	**92.5%***	**88.5%***	**86.7%***
Kaiser Permanente[1]	90.3%	89.3%	83.3%	80.6%	77.8%	75.1%	84.8%
Maryland Physicians Care	94.6%	92.3%	**91.0%***	87.6%	85.8%	82.4%	78.8%
MedStar Family Choice	95.5%	91.1%	89.1%	88.2%	85.1%	82.8%	80.1%
Priority Partners	93.8%	93.0%	89.9%	85.3%	82.1%	83.8%	75.1%
Riverside Health	93.0%	91.5%	81.1%	**88.8%***	80.0%	85.6%	77.9%
UnitedHealthcare	94.9%	91.9%	87.3%	81.8%	83.0%	81.7%	77.3%

*HealthChoice MCO with the highest Summary Rate
[1]First-year HealthChoice MCO

Table 53. 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	**91.2%**	**90.9%**	**89.4%**	**76.1%**	**75.3%**
AMERIGROUP Community Care	91.7%	91.7%	85.3%	74.2%	**79.8%***
Jai Medical Systems	**92.2%***	**94.3%***	**95.8%***	79.2%	73.1%
Kaiser Permanente[1]	82.6%	87.6%	94.3%	**81.4%***	63.7%
Maryland Physicians Care	90.7%	91.0%	89.2%	74.9%	78.9%
MedStar Family Choice	91.3%	90.2%	94.7%	77.9%	79.4%
Priority Partners	91.9%	91.4%	90.8%	75.7%	71.5%
Riverside Health	91.4%	90.5%	90.4%	73.6%	71.9%
UnitedHealthcare	91.6%	89.9%	82.0%	76.5%	72.8%

*HealthChoice MCO with the highest Summary Rate
[1]First-year HealthChoice MCO

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 2016 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,

[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%).

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 2016 findings, the "Getting Needed Care" and "How Well Doctors Communicate" composite measures have the most significant impact on adult members' overall rating of their Health Care. 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 "Doctor spent enough time with you" 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 listened carefully to you
- Doctor explained things in a way that was easy to understand
- Doctor showed respect for what you had to say

Child Medicaid Members – Key Drivers of Satisfaction with Health Plan

Based on the 2016 findings, the "Customer Service" composite measure has the most significant impact on child members' overall rating of their Health Plan. There were no attributes identified as unmet needs that should be considered priority areas for improving child members' overall rating of their Health Plan. However, the attribute "Received information or help needed from child's health plan's Customer Service" is an area that is of high importance to child members where HealthChoice MCOs perform at a moderate level. Improvement in this area could have a positive impact on child members' overall rating of their Health Plan.

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).

The attributes listed below are identified as driving strengths and performance in these areas should be maintained. If performance on these attributes is decreased, it could have a negative impact on child members' overall rating of their Health Plan.

- Treated with courtesy and respect by child's health plan's Customer Service
- Got the care, tests or treatment your child needed

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

Based on the 2016 findings, the "Getting Needed Care" composite measure is 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 attribute "Got an appointment for your child to see a specialist as soon as you needed" is a moderate driver of satisfaction where child members perceive HealthChoice MCOs to be performing at a lower level. Improvement in this area 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.

- Got the care, tests or treatment your child needed
- Child's doctor listened carefully to you

Section VIII
Consumer Report Card

Introduction

As a part of its External Quality Review contract with the State of Maryland Department of Health and Mental Hygiene (DHMH), Delmarva Foundation (Delmarva) is responsible for developing a Medicaid Consumer Report Card. Delmarva contracted with the National Committee for Quality Assurance (NCQA) to assist in the Report Card development and production.

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 DHMH Value Based Purchasing (VBP) initiative.

Information Reporting Strategy

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

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

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

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

The 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

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

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

- **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?

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
  - No changes
- Taking Care of Women
  - Add the Cervical Cancer Screening measure.
- Care for Adults With Chronic Illness
  - Remove Diabetes LDL-C Screening and Control; the measures have been retired.

Format

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

- *Space:* Maximize the amount to display data and explanatory text.

- *Message:* Communicate health plan quality in positive terms to build trust in the information presented.
- *Instructions:* Be concrete about how consumers should use the information.
- *Text:* Relate the utility of the Report Card to the audience's situation (e.g., new participants choosing a plan 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 plan) and reading level.
- *Narrative:* Emphasize *why* what is being measured in each reporting category is important, rather than giving a detailed explanation of *what* is being measured. For example, "making sure that kids get all of their shots protects them against serious childhood diseases" instead of "the percentage of children who received the following antigens …"
- *Design:* Use color and layouts to facilitate navigation and align the star ratings to be left justified consistent with the key.

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

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

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

Rating Scale

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

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 plans that are available to them. This methodology

differs from similar methodologies that compare plan performance to ideal targets or national percentiles. This approach is more useful in an environment where consumers must choose from a group of plans.

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

Analytic Methodology

NCQA and Delmarva Foundation recommend that the Report Card compare each plan's actual score to the unweighted, statewide plan average for a particular reporting category. An icon or symbol would denote whether a plan performed "above," "the same as," or "below" the statewide Medicaid plan average.[4]

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 plans. Information should allow consumers to easily detect substantial differences in plan performance. The index of differences should compare plan-to-plan quality performance directly, and the differences between plans should be statistically reliable.

Handling Missing Values

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

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

The third issue is that the method used to replace missing values should not provide an incentive for 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 plans that perform below the mean would be higher if they fail to report.

Replacing missing Medicaid plan data with commercial plan data is inappropriate because the characteristics of Medicaid populations differ from those of commercial populations. This restricts the potential group to

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

national Medicaid plans, regional Medicaid plans, or Maryland HealthChoice plans. Analyses conducted by NCQA for the annual *State of Health Care Quality Report* have consistently shown substantial regional differences in performance of commercial managed care plans. Assuming that regional differences generalize to Medicaid plans, it would be inappropriate to use the entire group of national Medicaid plans to replace missing values for Maryland HealthChoice plans.

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

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

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

- If fewer than 50 percent of the plans report a measure, the measure is dropped from the Report Card category.
- If a plan has reported at least 50 percent of the measures in a reporting category, the missing values are replaced with the mean or minimum values, based on the reasons for the missing value.
- Plans 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 plans.

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

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

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

CY 2016 Report Card Results

HealthChoice MCOs	Performance Area					
	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
ACC	★★	★★	★★★	★	★★★	★★
JMS	★★★	★★	★★★	★★	★★★	★★★
KPMAS*	N/A	N/A	N/A	N/A	N/A	N/A
MPC	★★★	★★	★★	★★	★★	★★
MSFC	★	★★★	★★★	★★	★★	★★
PPMCO	★★★	★★	★★★	★★	★★★	★★
RHMD	★	★★	★	N/A	★	★
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.
*KPMAS became a HealthChoice MCOs in 2014, therefore ratings were not applicable.

Section IX
Review of Compliance with Quality Strategy

Table 54 below describes HACA's progress against the Quality Strategy's goal.

Table 54. Quality Strategy Evaluation

Department's Quality Strategy Goal	Performance Against Goal	Met
Ensure compliance with changes in Federal/State law and regulation	The Department consistently reviews all new Federal and State laws and regulations. Any new laws and regulations are immediately put into the standards and guidelines for review and communicated to the MCOs.	√
Improve performance over time	The Department continually strives to improve performance, which is evident through the high standards it sets for the MCOs in the Annual Systems Performance Review, Value Based Purchasing Initiative, Performance Improvement Projects, and other review activities. It continually monitors the progress of MCO performance in multiple areas as demonstrated throughout this report.	√
Allow comparisons to national and state benchmarks	In almost every area of review, comparisons to national and state benchmarks can be found to mark progress and delineate performance against goals.	√
Reduce unnecessary administrative burden on MCOs	The Department has attempted to reduce unnecessary administrative burden to the MCOs in any way possible. Delmarva Foundation has assisted with this goal in streamlining the Annual Systems Review Process so that documentation can be submitted electronically. Additionally, since NCQA accreditation is required for all HealthChoice MCOs, the Department allowed deeming for eligible standards for the CY 2015 review. The Department will also be moving the comprehensive Systems Review Process from an annual to a triennial 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 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 Asthma Medication Ratio for participants identified as having persistent asthma.	√

√ – 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 2015 activities, Delmarva Foundation has developed several recommendations for all MCOs which are identified within each section of the Annual Technical Report.

EQRO Recommendations for HACA

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

- 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 areas 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 will be published and many revisions to the standards will be implemented in 2017 and 2018.
- Hold focus groups with consumer advisory boards to receive feedback on the revision of the Consumer Report Card to ensure its continued relevance to the enrollee population.
- Expand upon the current Encounter Data Validation (EDV) task to include all CMS protocol activities, and align the task approach with the most current EDV protocol which includes five sequential activities to access the validity of MCO-reported data.

Conclusion

This report is a representation of all EQRO, HEDIS®, and CAHPS® activities that took place in calendar years 2015–2016 for the Maryland HealthChoice program. Opportunities for improvement and best practices of the MCOs are noted in the executive summary and within each individual review activity.

The Department sets high standards for MCO QA systems. As a result, the HealthChoice MCOs have quality systems and procedures in place to promote high quality care with well–organized approaches to quality improvement. The CY 2016 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care for Maryland managed care participants.

Acronym List

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

Acronym List

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
HCMS	Health Care Management Services
HD	HEDIS® Measure Determination
HDC	HealthcareData Company, LLC
HED	Health Education/Anticipatory Guidance
HEDIS	Healthcare Effectiveness Data and Information Set
HEP	Health Education Plan
HILLTOP	The Hilltop Institute of University of Maryland Baltimore County
HIV	Human Immunodeficiency Virus
HCQIS	Healthcare Quality Improvement System for Medicaid Managed Care
HQUMC	Healthcare Quality and Utilization Management Committee
HRA	Health Risk Assessment
HS	Health Services
HX	Health and Developmental History
IDSS	Interactive Data Submission System
IMM	Immunizations
IPU	Inpatient Utilization-General Hospital/Acute Care
IRR	Inter-rater Reliability
IS	Information Systems
JMS	Jai Medical Systems
KPMS	Kaiser Permanente of the Mid-Atlantic States
LAB	Laboratory Tests/At-Risk Screenings
LDM	Language Diversity of Membership
LHDs	Local Health Departments
MAC	Medical Advisory Committee
MARR	Maryland Average Reportable Rate
MCG	Milliman Care Guidelines
MCO	Managed Care Organization
MD	Maryland
MPC	Maryland Physicians Care

Acronym List

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
PAC	Provider Advisory Committee
PCP	Primary Care Physician
PE	Comprehensive Physical Exam
PIP	Performance Improvement Project
PMT	Process Management Team
PPMCO	Priority Partners
PT	Physical Therapy
QA	Quality Assurance
QAP	Quality Assurance Program
QIC	Quality Improvement Committee
QIO	Quality Improvement Organization
QMC	Quality Management Committee
QMP	Quality Management Program
QOC	Quality of Care
RDM	Race/Ethnicity Diversity of Membership
RHMD	Riverside Health of Maryland
ROADMAP	Record of Administration, Data Management and Processes
RQIC	Regional Quality Improvement Committee
RUMC	Regional Utilization Management Committee
SA	Substance Abuse
SC	Substantially Compliant
SPR	Systems Performance Review
SSI	Supplemental Security Income

Acronym List

STI/HIV	Sexually Transmitted Infection/Human Immunodeficiency Virus
TAT	Turn Around Time
TLM	Total Membership
UBH	United Behavioral Health
UHC	UnitedHealthcare
UM	Utilization Management
UMP	Utilization Management Program
UR	Utilization Review
URI	Upper Respiratory Infection
URR	Utilization and Relative Resource Use
VBP	Value Based Purchasing
VBPI	Value Based Purchasing Initiative
VFC	Vaccine for Children
VIS	Vaccine Information Statement
WBA	WBA Market Research

Adolescent Well-Care Visits (AWC)

SUMMARY OF CHANGES TO HEDIS 2016

Added "Numerator events by supplemental data" to the Data Elements for Reporting table to capture the number of members who met numerator criteria using supplemental data.

Description

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

Note

This measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.

Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.

Eligible Population

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

Administrative Specification

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

Hybrid Specification

Denominator

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

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

Numerator

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

Administrative

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

Medical record

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

A health history.

A physical developmental history.

A mental developmental history.

A physical exam.

Health education/anticipatory guidance.

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

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

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

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

Note

Refer to Appendix 3 for the definition of PCP *and* OB/GYN and other prenatal care practitioners.

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

Data Elements for Reporting

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

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

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

Controlling High Blood Pressure (CBP)

SUMMARY OF CHANGES TO HEDIS 2016

- Revised a value set used to identify the event/diagnosis.
  - Added HCPCS codes to identify outpatient visits.
  - Renamed the Outpatient CPT Value Set to Outpatient Without UBREV Value Set.
- Clarified how to assign the diabetes flag.
- Removed the criteria for polycystic ovaries when assigning a flag of “not diabetic” in the event/diagnosis.
- Clarified the denominator section of the Hybrid Specification to state that if the hypertension diagnosis is not confirmed, the member is excluded and replaced by a member from the oversample.
- Added a method and value sets to identify nonacute inpatient admissions for optional exclusions.
- Added a *Note* to clarify when organizations may change the diabetes flag that was assigned based on administrative data.

Description

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Note: *Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.*

Definitions

Adequate control Adequate control is defined as meeting any of the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg.
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Representative BP The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages 18–85 years as of December 31 of the measurement year.

Continuous enrollment The measurement year.

Allowable gap No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis Members are identified as hypertensive if there is at least one outpatient visit (Outpatient Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) during the first six months of the measurement year.

Diabetes Flag for Numerator Assessment After the Eligible Population is identified, assign each member either a ***diabetic*** or ***not diabetic*** flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for members with diabetes is different than the threshold for members without diabetes).

Step 1 Assign a flag of ***diabetic*** to members identified as diabetic using claim/encounter data or pharmacy data. The organization must use both methods to assign the diabetes flag, but a member only needs to be identified by one method. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).

Step 2 From the members identified in Step 1, assign a flag of ***not diabetic*** to members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Note*: Members classified as diabetic in step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are re-classified as* ***not diabetic*** in this step.

Step 3 For members who were not assigned a flag in step 1 or step 2, assign a flag of ***not diabetic***.

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Hybrid Specification

Denominator

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

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

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

It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis that is not part of the office visit note; see ***Note*** at the end of this section).
- Office note.
- Subjective, Objective, Assessment, Plan (SOAP) note.
- Encounter form.
- Diagnostic report.
- Hospital discharge summary.

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

If the diagnosis of hypertension cannot be confirmed, the member is excluded and replaced by the next member from the oversample.

Identifying the medical record

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

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

Step 1 Identify the member's PCP.

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

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

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

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

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

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

Numerator The number of members in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

To determine if the member's BP is adequately controlled, the representative BP must be identified.

Administrative None.

Medical record Follow the steps below to determine representative BP.

Step 1 Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed.

Do not include BP readings:

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

If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

Step 2 Determine numerator compliance based on the following criteria:

- Members 18-59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.
- Members 60-85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Members 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

The member is not compliant if the BP reading does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Step 3 A single rate is reported for all three groups. Sum the numerator events from Step 2 to obtain the rate.

Exclusions *(optional)*

- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
- Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the discharge date for the stay.

Note

- *Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator. If a problem list is found in an office visit note then it would be considered a dated problem list and the date of the visit must be used.*
- *Organizations generally require an oversample of 10 percent–15 percent to meet the MRSS for confirmed cases of hypertension.*
- *Only administrative data should be used to assign the diabetes flag. The intent of the flag is to determine the appropriate BP threshold to use for the member during numerator assessment. The only exception is if the member is flagged as a diabetic but medical record evidence contains information that classifies the member as a valid data error. To meet criteria as a valid data error, the medical record must contain no evidence of diabetes and include a notation that refutes the diagnosis, as described in Substituting Medical Records in the Guidelines for Calculations and Sampling. In this case, the diabetes flag may be changed to "not diabetic," but the member may not be removed from the sample.*

Data Elements for Reporting

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

Table CBP-1/2/3: Data Elements for Controlling High Blood Pressure

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

HEDIS 2016 Results, page one of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016	HEDIS 2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR	NHM
Prevention and Screening - Adult																										
Adult BMI Assessment **(ABA)**	72.0%	82.4%	**85.2%**	80.2%	98.5%	**96.6%**		98.4%	**100.0%**	70.2%	84.9%	**82.4%**	82.6%	86.4%	**90.3%**	82.9%	89.6%	**86.1%**	NA[1]	NA[1]	**85.4%**	68.9%	81.9%	**92.7%**	89.8%	79.9%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis **(AAB)**	23.88%	24.5%	**25.9%**	35.2%	34.1%	**33.0%**		NA[1]	**NA[1]**	22.0%	21.9%	**19.5%**	15.2%	19.9%	**22.8%**	23.94%	24.4%	**22.2%**	NA[1]	NA[1]	**23.1%**	20.8%	23.7%	**26.0%**	24.6%	28.5%
Childhood Immunization Status **(CIS)** – Combination 2 (DTaP, IPV, MMR, HiB, Hep B, VZV)	81.3%	83.8%	**83.1%**	86.5%	88.4%	**88.7%**		NA[1]	**79.5%**	73.7%	70.8%	**84.7%**	88.1%	81.8%	**85.9%**	83.1%	83.6%	**84.5%**	NA[1]	50.0%	**80.9%**	73.0%	77.4%	**83.5%**	83.5%	73.8%
Childhood Immunization Status **(CIS)** – Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	78.2%	81.9%	**81.9%**	86.1%	87.6%	**87.3%**		NA[1]	**78.2%**	72.1%	68.2%	**82.1%**	85.9%	79.3%	**83.2%**	80.8%	80.1%	**83.0%**	NA[1]	43.8%	**80.2%**	71.3%	73.7%	**80.5%**	82.1%	70.4%
Childhood Immunization Status **(CIS)** – Combination 4 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A)	73.6%	77.6%	**78.9%**	84.8%	85.2%	**86.8%**		NA[1]	**78.2%**	62.8%	64.7%	**78.0%**	81.3%	76.6%	**80.5%**	69.4%	78.5%	**79.7%**	NA[1]	43.8%	**78.2%**	66.2%	67.9%	**75.7%**	79.5%	66.2%
Childhood Immunization Status **(CIS)** – Combination 5 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV)	63.9%	63.7%	**68.3%**	71.7%	68.0%	**76.4%**		NA[1]	**68.0%**	47.0%	57.1%	**59.9%**	70.1%	64.5%	**67.9%**	54.6%	68.5%	**69.0%**	NA[1]	37.5%	**58.0%**	56.9%	60.1%	**61.6%**	66.1%	57.2%
Childhood Immunization Status **(CIS)** – Combination 6 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	49.3%	53.0%	**52.6%**	47.8%	46.8%	**47.6%**		NA[1]	**52.6%**	37.7%	40.6%	**41.8%**	59.4%	51.6%	**47.9%**	49.5%	54.2%	**59.7%**	NA[1]	28.1%	**41.0%**	44.3%	48.4%	**42.6%**	48.2%	43.6%
Childhood Immunization Status **(CIS)** – Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	60.7%	61.3%	**65.7%**	71.3%	67.2%	**76.4%**		NA[1]	**68.0%**	44.0%	55.0%	**57.8%**	66.7%	62.5%	**65.7%**	50.7%	68.5%	**67.3%**	NA[1]	37.5%	**56.7%**	54.7%	57.4%	**58.9%**	64.6%	54.7%
Childhood Immunization Status **(CIS)** – Combination 8 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	47.9%	50.9%	**51.4%**	47.4%	45.6%	**47.2%**		NA[1]	**52.6%**	34.9%	38.5%	**40.1%**	56.2%	49.4%	**47.2%**	44.4%	53.5%	**57.5%**	NA[1]	28.1%	**40.3%**	41.4%	46.2%	**40.9%**	47.1%	42.1%
Childhood Immunization Status **(CIS)** – Combination 9 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	42.4%	43.5%	**46.8%**	40.9%	36.4%	**42.5%**		NA[1]	**46.2%**	28.4%	34.3%	**32.5%**	49.9%	44.3%	**40.2%**	36.3%	48.4%	**51.1%**	NA[1]	23.4%	**30.0%**	37.0%	41.4%	**35.0%**	40.5%	37.1%
Childhood Immunization Status **(CIS)** – Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	41.2%	42.1%	**45.6%**	40.9%	36.0%	**42.5%**		NA[1]	**46.2%**	27.7%	33.0%	**31.6%**	47.0%	42.8%	**39.4%**	34.3%	48.4%	**50.0%**	NA[1]	23.4%	**29.4%**	35.3%	40.2%	**33.8%**	39.8%	36.1%
Immunizations for Adolescents **(IMA)** – Combination 1 (Meningococcal, Tdap/Td)	69.4%	74.8%	**86.8%**	75.5%	76.7%	**82.1%**		NA[1]	**82.7%**	62.7%	74.07%	**85.4%**	70.7%	72.4%	**80.0%**	74.5%	74.07%	**89.2%**	NA[1]	64.7%	**82.7%**	63.4%	66.2%	**84.8%**	84.2%	71.4%
Well-Child Visits in the First 15 months of Life **(W15)** – No well-child visits [2]	1.0%	2.1%	**0.9%**	3.1%	1.9%	**4.4%**		NA[1]	**2.0%**	0.5%	1.56%	**1.2%**	1.2%	3.5%	**3.5%**	1.1%	1.59%	**1.5%**	NA[1]	10.9%	**8.5%**	1.9%	0.9%	**2.5%**	3.1%	2.2%
Well-Child Visits in the First 15 months of Life **(W15)** – DHMH Five or more visits (constructed by combining HEDIS rates for five and six-or-more visits)	88.9%	85.1%	**88.9%**	84.4%	81.6%	**82.4%**		NA[1]	**78.2%**	83.6%	84.9%	**85.9%**	86.0%	82.8%	**82.7%**	83.7%	81.9%	**82.2%**	NA[1]	56.6%	**67.0%**	87.4%	83.6%	**87.2%**	81.8%	76.5%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life **(W34)**	83.9%	83.7%	**85.8%**	88.9%	90.6%	**90.9%**		84.6%	**82.6%**	88.8%	87.0%	**88.7%**	83.5%	86.7%	**85.5%**	83.8%	86.8%	**85.2%**	NA[1]	57.4%	**62.3%**	75.0%	79.2%	**80.7%**	82.7%	71.9%
Adolescent Well-Care Visits **(AWC)**	67.9%	64.7%	**67.9%**	76.7%	80.3%	**82.6%**		63.5%	**57.1%**	68.8%	68.3%	**73.2%**	67.8%	61.2%	**64.0%**	61.6%	68.8%	**72.8%**	NA[1]	31.8%	**42.6%**	60.8%	58.5%	**64.8%**	65.6%	50.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – BMI Percentile- Total Rate	49.5%	60.9%	**56.4%**	92.2%	94.7%	**92.7%**		99.0%	**98.6%**	46.5%	58.3%	**56.7%**	59.8%	67.3%	**62.4%**	52.1%	72.5%	**70.1%**	NA[1]	41.5%	**32.1%**	45.5%	57.9%	**61.0%**	66.3%	64.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – Counseling for Nutrition – Total Rate	59.0%	71.5%	**66.0%**	94.4%	97.6%	**97.6%**		98.1%	**94.5%**	54.4%	66.4%	**66.7%**	74.1%	72.9%	**73.5%**	54.2%	73.6%	**74.3%**	NA[1]	50.8%	**36.7%**	67.6%	64.5%	**69.5%**	72.4%	60.5%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents **(WCC)** – Counseling for Physical Activity – Total Rate	51.4%	61.3%	**58.1%**	89.8%	91.2%	**93.4%**		98.1%	**94.5%**	58.8%	60.0%	**63.9%**	72.9%	67.8%	**65.5%**	44.7%	70.1%	**70.1%**	NA[1]	43.1%	**30.4%**	60.6%	63.0%	**62.8%**	67.3%	53.5%
Appropriate Testing for Children with Pharyngitis **(CWP)**	78.36%	79.8%	**82.4%**	70.8%	80.2%	**85.6%**		NA[1]	**98.3%**	78.42%	82.9%	**86.3%**	86.9%	90.5%	**94.5%**	80.5%	83.1%	**85.9%**	NA[1]	76.4%	**87.1%**	83.1%	86.0%	**86.6%**	88.3%	69.5%
Lead Screening in Children **(LSC)**	[5]	77.1%	**79.4%**	[5]	87.2%	**92.1%**	[5]	NA[1]	**64.5%**	[5]	70.0%	**73.8%**	[5]	88.6%	**82.6%**	[5]	71.9%	**75.7%**	[5]	53.1%	**67.7%**	[5]	68.6%	**74.9%**	76.3%	66.8%
Human Papillomavirus Vaccine for Female Adolescents **(HPV)**	[5]	23.7%	**30.9%**	[5]	33.9%	**46.2%**	[5]	NA[1]	**NA[1]**	[5]	21.8%	**26.6%**	[5]	24.3%	**23.1%**	[5]	17.7%	**28.0%**	[5]	NA[1]	**14.1%**	[5]	15.1%	**26.3%**	27.9%	22.2%
Non-Recommended Cervical Cancer Screening in Adolescent Females **(NCS)** [2]	[5]	5.3%	**3.9%**	[5]	2.1%	**1.9%**	[5]	1.9%	**0.6%**	[5]	4.2%	**2.0%**	[5]	2.9%	**1.9%**	[5]	3.7%	**2.4%**	[5]	5.2%	**4.0%**	[5]	5.8%	**3.2%**	2.5%	3.8%

[1] When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.
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[3] HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013-2015, this rate is being calculated by HDC.
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Table A – HealthChoice Organizations HEDIS 2016 Results

HEDIS 2016 Results, page two of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016	HEDIS 2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR	NHM
Respiratory Conditions - Adult and Child																										
Use of Appropriate Medications for People with Asthma **(ASM)**** – Total Ages 5–11	90.3%	90.0%	**	93.59%	91.4%	**		NA[1]	**	91.4%	92.5%	**	93.62%	93.5%	**	91.6%	92.0%	**	NA[1]	NA[1]	**	91.9%	90.8%	**	**	90.6%
Use of Appropriate Medications for People with Asthma **(ASM)**** – Total Ages 12–18	87.8%	87.1%	**	86.0%	86.3%	**		NA[1]	**	90.4%	91.5%	**	94.2%	91.6%	**	88.5%	89.5%	**	NA[1]	NA[1]	**	88.0%	88.6%	**	**	86.4%
Use of Appropriate Medications for People with Asthma **(ASM)**** – Total Ages 19–50	73.7%	73.1%	**	81.3%	89.4%	**		NA[1]	**	80.1%	77.9%	**	75.2%	77.6%	**	76.8%	74.9%	**	NA[1]	NA[1]	**	72.9%	73.7%	**	**	74.0%
Use of Appropriate Medications for People with Asthma **(ASM)**** – Total Ages 51–64	68.6%	79.0%	**	71.4%	83.8%	**		NA[1]	**	76.3%	80.9%	**	NA	NA	**	73.0%	77.6%	**	NA[1]	NA[1]	**	79.0%	72.8%	**	**	70.9%
Use of Appropriate Medications for People with Asthma **(ASM)**** – Total Ages 5–64	86.29%	86.3%	**	83.6%	87.9%	**		NA[1]	**	86.97%	87.3%	**	90.1%	89.0%	**	87.02%	87.1%	**	NA[1]	NA[1]	**	86.28%	84.11%	**	**	83.9%
Use of Appropriate Medications for People with Asthma **(ASM)**** – Total Ages 5–50 [3]	86.8%	83.4%	**	86.4%	89.0%	**		NA[1]	**	87.53%	87.3%	**	90.1%	87.6%	**	87.6%	85.4%	**	NA[1]	NA[1]	**	86.6%	84.3%	**	**	83.7%
Medication Management for People With Asthma **(MMA)** – Total 50% of treatment period	45.8%	48.8%	**48.5%**	49.4%	59.6%	**73.9%**		NA[1]	**NA[1]**	57.9%	57.9%	**61.5%**	51.9%	49.9%	**48.8%**	43.3%	44.5%	**46.8%**	NA[1]	NA[1]	**64.5%**	49.9%	48.4%	**54.0%**	56.9%	54.2%
Medication Management for People With Asthma **(MMA)** – Total 75% of treatment period	22.9%	23.2%	**25.1%**	24.5%	34.8%	**51.4%**		NA[1]	**NA[1]**	32.9%	34.0%	**35.6%**	26.6%	24.1%	**25.8%**	20.0%	20.5%	**23.7%**	NA[1]	NA[1]	**48.4%**	27.8%	25.2%	**28.5%**	34.1%	30.5%
Appropriate Treatment for Children with Upper Respiratory Infection **(URI)**	86.5%	88.03%	**89.4%**	83.0%	92.4%	**97.1%**		NA[1]	**97.5%**	86.6%	85.6%	**88.7%**	84.3%	89.5%	**90.0%**	86.0%	89.0%	**90.6%**	NA[1]	86.4%	**85.5%**	82.0%	85.2%	**88.8%**	91.0%	87.0%
Asthma Medication Ratio **(AMR)**	68.6%	56.54%	**63.0%**	60.5%	56.50%	**61.9%**		NA[1]	**NA[1]**	69.1%	65.0%	**64.0%**	73.7%	68.1%	**69.3%**	69.6%	63.8%	**64.7%**	NA[1]	NA[1]	**52.4%**	69.8%	63.4%	**64.0%**	62.7%	59.4%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD **(SPR)**	25.8%	23.6%	**30.0%**	26.3%	32.6%	**34.9%**		NA[1]	**NA[1]**	21.1%	20.8%	**25.5%**	34.5%	29.2%	**30.8%**	23.7%	27.2%	**28.0%**	NA[1]	NA[1]	**NA[1]**	25.6%	25.6%	**31.2%**	30.1%	31.0%
Pharmacotherapy Management of COPD Exacerbation **(PCE)** – Systemic Corticosteroid Rate	73.6%	69.0%	**70.3%**	69.2%	73.6%	**73.3%**		NA[1]	**NA[1]**	72.6%	72.1%	**74.4%**	76.3%	72.2%	**71.0%**	69.7%	69.7%	**75.7%**	NA[1]	78.1%	**70.3%**	78.2%	73.0%	**70.2%**	72.2%	65.4%
Pharmacotherapy Management of COPD Exacerbation **(PCE)** – Bronchodilator Rate	87.5%	84.8%	**84.9%**	82.5%	85.4%	**88.6%**		NA[1]	**NA[1]**	84.9%	85.1%	**87.4%**	90.3%	92.4%	**84.5%**	84.0%	85.0%	**83.7%**	NA[1]	81.3%	**86.1%**	84.9%	86.3%	**80.8%**	85.1%	79.0%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 12–24 months	97.8%	97.7%	**97.9%**	94.7%	96.2%	**91.5%**		100.0%	**91.3%**	96.5%	96.9%	**97.2%**	96.4%	93.9%	**95.3%**	89.8%	97.6%	**97.8%**	NA[1]	87.8%	**84.9%**	96.3%	96.6%	**97.0%**	94.1%	95.5%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 25 months–6 years	92.8%	93.1%	**94.1%**	88.7%	91.8%	**93.0%**		98.0%	**89.1%**	90.0%	90.3%	**91.6%**	89.8%	88.4%	**90.0%**	93.5%	93.3%	**94.2%**	NA[1]	69.4%	**77.5%**	91.1%	91.3%	**92.6%**	90.3%	87.8%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 7–11 years	94.3%	95.3%	**96.1%**	93.8%	92.7%	**93.8%**		98.4%	**98.1%**	92.1%	92.61%	**93.5%**	93.5%	92.58%	**92.0%**	92.7%	94.4%	**95.3%**	NA[1]	NA[1]	**76.8%**	93.1%	93.6%	**94.4%**	92.5%	91.0%
Children and Adolescents' Access to Primary Care Practitioners **(CAP)** – Age 12–19 years	90.5%	91.9%	**93.0%**	90.8%	92.9%	**94.2%**		94.2%	**96.6%**	88.5%	89.7%	**91.6%**	92.7%	91.7%	**90.6%**	91.9%	92.5%	**93.7%**	NA[1]	NA[1]	**75.2%**	90.1%	90.9%	**92.1%**	90.9%	89.3%
Adults' Access to Preventive/Ambulatory Health Services **(AAP)** – Age 20–44 years	79.4%	79.4%	**79.7%**	72.9%	71.0%	**69.3%**		92.9%	**82.7%**	81.1%	80.9%	**82.8%**	79.7%	76.3%	**75.8%**	81.7%	82.3%	**82.6%**	NA[1]	63.6%	**69.3%**	80.4%	80.0%	**79.0%**	77.7%	79.4%
Adults' Access to Preventive/Ambulatory Health Services **(AAP)** – Age 45–64 years	87.2%	86.7%	**88.2%**	86.6%	86.75%	**87.8%**		95.7%	**87.0%**	87.80%	87.4%	**89.4%**	86.9%	85.1%	**85.7%**	0.0%	89.0%	**90.0%**	NA[1]	75.9%	**79.6%**	87.80%	88.0%	**88.0%**	87.0%	86.6%
Breast Cancer Screening **(BCS)**	58.1%	66.0%	**65.9%**	69.4%	72.1%	**72.6%**		87.2%	**88.5%**	48.5%	65.9%	**72.1%**	64.4%	63.4%	**66.0%**	57.0%	62.5%	**68.3%**	NA[1]	NA[1]	**63.8%**	52.7%	58.1%	**62.3%**	70.0%	58.8%
Cervical Cancer Screening **(CCS)**	79.64%	67.8%	**67.5%**	79.5%	66.8%	**77.3%**		90.8%	**79.2%**	79.58%	65.75%	**65.2%**	74.0%	66.2%	**61.5%**	75.9%	74.4%	**69.3%**	NA[1]	35.5%	**41.1%**	62.8%	58.8%	**60.1%**	65.1%	60.2%
Chlamydia Screening in Women **(CHL)** – Age 16–20 years	62.4%	61.4%	**61.0%**	86.7%	87.6%	**87.6%**		76.9%	**69.2%**	58.2%	58.9%	**56.8%**	54.8%	57.2%	**52.2%**	61.5%	59.2%	**57.5%**	NA[1]	61.1%	**49.5%**	55.4%	55.2%	**52.1%**	60.8%	51.2%
Chlamydia Screening in Women **(CHL)** – Age 21–24 years	71.9%	71.7%	**68.6%**	72.3%	65.0%	**72.8%**		80.8%	**84.7%**	67.1%	67.3%	**68.7%**	68.4%	66.5%	**65.3%**	69.9%	68.0%	**67.5%**	NA[1]	58.7%	**61.2%**	64.8%	63.2%	**65.4%**	69.3%	60.1%
Chlamydia Screening in Women **(CHL)** – Total (16–24) years	66.0%	66.0%	**64.2%**	81.2%	77.3%	**80.3%**		79.5%	**79.6%**	62.0%	62.6%	**62.0%**	60.1%	61.3%	**58.6%**	64.8%	62.7%	**61.5%**	NA[1]	59.7%	**56.3%**	59.0%	58.8%	**57.9%**	65.1%	54.6%

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Table A – HealthChoice Organizations HEDIS 2016 Results

HEDIS 2016 Results, page three of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016	HEDIS 2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR	NHM
Prenatal and Postpartum Care																										
Prenatal and Postpartum Care **(PPC)** – Timeliness of Prenatal Care	84.2%	85.7%	**83.9%**	85.8%	83.2%	**87.2%**		88.0%	**92.9%**	84.9%	80.3%	**81.5%**	85.4%	79.2%	**84.5%**	90.9%	88.2%	**90.3%**	52.2%	73.3%	**74.5%**	87.1%	84.1%	**80.7%**	84.4%	82.4%
Prenatal and Postpartum Care **(PPC)** – Postpartum Care	71.6%	66.0%	**73.7%**	78.5%	83.6%	**88.0%**		86.0%	**83.8%**	71.9%	65.0%	**68.9%**	72.0%	71.1%	**69.2%**	75.6%	70.7%	**73.7%**	43.5%	47.4%	**62.3%**	63.8%	62.5%	**66.2%**	73.2%	61.8%
Frequency of Ongoing Prenatal Care **(FPC)** – Less than 21% of expected visits [2]	8.2%	5.9%	**5.2%**	2.2%	4.5%	**3.5%**		7.7%	**5.8%**	5.6%	6.9%	**5.6%**	4.4%	7.6%	**3.2%**	4.4%	9.3%	**8.5%**	37.0%	17.4%	**12.2%**	5.8%	6.8%	**5.2%**	6.1%	14.2%
Frequency of Ongoing Prenatal Care **(FPC)** – Greater than or equal to 81% of expected visits	75.5%	72.6%	**73.4%**	70.8%	64.0%	**66.7%**		56.9%	**72.4%**	70.6%	69.8%	**65.3%**	71.3%	64.6%	**71.8%**	78.8%	61.7%	**62.7%**	21.7%	55.0%	**55.0%**	73.2%	74.5%	**75.8%**	67.9%	55.2%
Controlling High Blood Pressure **(CBP)**	49.0%	63.9%	**54.1%**	56.2%	69.3%	**76.4%**		87.8%	**86.0%**	46.8%	61.4%	**55.9%**	65.5%	69.2%	**71.2%**	57.0%	59.5%	**60.2%**	NA[1]	32.1%	**48.2%**	42.3%	50.9%	**56.9%**	63.6%	57.1%
Persistence of Beta-Blocker Treatment After a Heart Attack **(PBH)**	NA[1]	91.5%	**84.9%**	NA[1]	NA[1]	**NA[1]**		NA[1]	**NA[1]**	87.5%	90.2%	**84.3%**	NA[1]	NA[1]	**67.7%**	86.1%	84.6%	**85.7%**	NA[1]	NA[1]	**NA[1]**	82.9%	87.8%	**77.9%**	80.1%	83.3%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia **(SMC)**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**NA[1]**	[6]	76.2%
Comprehensive Diabetes **(CDC)** – Hemoglobin A1c (HbA1c) Testing	83.4%	88.7%	**87.4%**	89.1%	90.7%	**94.3%**		96.4%	**94.5%**	79.5%	87.9%	**85.9%**	84.7%	88.0%	**87.8%**	78.1%	89.4%	**89.4%**	NA[1]	84.6%	**88.3%**	79.1%	85.9%	**82.5%**	88.8%	86.3%
Comprehensive Diabetes **(CDC)** – HbA1c Poor Control (>9.0%) [2]	38.8%	38.5%	**42.2%**	31.0%	37.2%	**26.6%**		21.8%	**28.2%**	48.6%	40.8%	**40.8%**	37.2%	44.5%	**31.6%**	48.1%	35.6%	**35.6%**	NA[1]	60.8%	**39.2%**	45.5%	41.1%	**39.7%**	35.5%	43.6%
Comprehensive Diabetes **(CDC)** – HbA1c Control (< 8.0%)	51.4%	51.4%	**49.2%**	61.5%	52.4%	**60.4%**		60.0%	**57.6%**	43.3%	50.8%	**49.7%**	54.0%	43.5%	**59.9%**	44.3%	54.3%	**55.1%**	NA[1]	38.8%	**48.2%**	46.5%	46.2%	**51.6%**	54.0%	46.5%
Comprehensive Diabetes **(CDC)** – Eye Exam (Retinal) Performed	65.4%	48.6%	**53.9%**	79.6%	64.1%	**71.9%**		87.3%	**84.7%**	72.0%	65.7%	**65.8%**	71.1%	54.0%	**52.6%**	71.0%	69.0%	**62.9%**	NA[1]	44.8%	**35.0%**	56.9%	58.6%	**55.2%**	60.2%	54.4%
Comprehensive Diabetes **(CDC)** – Medical Attention for Nephropathy	75.7%	80.3%	**90.7%**	93.1%	93.4%	**96.9%**		100.0%	**95.3%**	75.3%	75.9%	**89.9%**	82.7%	80.9%	**91.0%**	73.8%	82.5%	**89.4%**	NA[1]	74.8%	**90.8%**	75.9%	81.5%	**91.2%**	91.9%	81.0%
Comprehensive Diabetes **(CDC)** – Blood Pressure Control (<140/90 mm Hg)	55.6%	65.3%	**60.0%**	60.4%	69.7%	**76.8%**		83.6%	**87.1%**	55.4%	56.4%	**55.2%**	70.1%	69.0%	**67.6%**	64.2%	60.7%	**62.6%**	NA[1]	39.9%	**36.5%**	51.6%	55.2%	**46.0%**	61.5%	61.9%
Diabetes Monitoring for People with Diabetes and Schizophrenia **(SMD)**	[5]	76.7%	**68.9%**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**NA[1]**	[5]	NA[1]	**65.5%**	[5]	NA[1]	**NA[1]**	[5]	68.7%	**68.7%**	[5]	NA[1]	**NA[1]**	[5]	74.6%	**72.2%**	68.8%	69.4%
Use of Imaging Studies for Low Back Pain **(LBP)**	76.7%	74.2%	**74.6%**	77.2%	69.2%	**77.7%**		NA[1]	**71.5%**	76.6%	76.7%	**75.5%**	73.3%	71.8%	**72.7%**	75.2%	75.0%	**76.0%**	NA[1]	78.1%	**74.2%**	73.4%	74.3%	**73.2%**	74.4%	75.1%
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis **(ART)**	60.0%	62.8%	**78.0%**	NA[1]	NA[1]	**NA[1]**		NA[1]	**NA[1]**	73.8%	65.8%	**67.5%**	NA	89.2%	**77.4%**	67.6%	72.5%	**83.1%**	NA[1]	NA[1]	**NA[1]**	67.7%	61.5%	**69.8%**	75.2%	69.5%
Annual Monitoring for Patients on Persistent Medications **(MPM)–** Members on angiotensin converting enzyme **(ACE)** inhibitors or angiotensin receptor blockers **(ARB)**	89.0%	89.4%	**90.5%**	95.1%	94.4%	**96.5%**		95.0%	**92.8%**	87.0%	88.4%	**89.0%**	90.2%	90.0%	**90.3%**	88.1%	88.1%	**89.0%**	NA[1]	86.1%	**86.1%**	88.6%	89.2%	**88.7%**	90.4%	87.3%
Annual Monitoring for Patients on Persistent Medications **(MPM)** – Members on digoxin	95.7%	59.5%	**58.3%**	NA2	NA[1]	**NA[1]**		NA[1]	**NA[1]**	92.2%	54.9%	**47.5%**	NA2	NA[1]	**NA[1]**	88.9%	44.9%	**58.1%**	NA[1]	NA[1]	**NA[1]**	86.4%	57.7%	**52.9%**	54.2%	54.0%
Annual Monitoring for Patients on Persistent Medications **(MPM)** – Members on diuretics	86.9%	88.42%	**89.6%**	94.1%	93.9%	**95.6%**		NA[1]	**90.8%**	86.2%	86.5%	**88.5%**	88.5%	89.0%	**88.32%**	87.4%	87.9%	**88.30%**	NA[1]	90.5%	**84.4%**	87.5%	88.40%	**87.8%**	89.2%	86.9%
Annual Monitoring for Patients on Persistent Medications **(MPM)** – Total rate	85.4%	88.9%	**89.9%**	94.1%	94.0%	**95.9%**		94.2%	**91.8%**	86.3%	87.2%	**88.6%**	86.6%	89.3%	**89.4%**	87.3%	87.8%	**88.5%**	NA[1]	87.9%	**85.2%**	87.7%	88.7%	**88.1%**	89.7%	86.8%

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[3] HEDIS specifications changed in 2012, and this age range is no longer reported. For 2013-2015, this rate is being calculated by HDC.
[4] New measure for HEDIS 2014.
[5] New measure for HEDIS 2015.
[6] There is no reportable average for this measure as all MCOs reported NA for denominator of <30.
* Sub-measure retired by NCQA for HEDIS 2015.

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Table A – HealthChoice Organizations HEDIS 2016 Results

HEDIS 2016 Results, page four of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016	HEDIS 2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR	NHM
Ambulatory Care **(AMB)** – Outpatient visits per 1,000 member months	365.1	356.01	**372.6**	340.8	315.5	**345.1**		404.4	**324.9**	365.3	365.02	**406.4**	344.5	360.0	**358.6**	386.6	390.7	**406.5**	269.8	296.8	**332.6**	373.3	381.6	**378.1**	365.6	357.2
Ambulatory Care **(AMB)** – Emergency department (ED) visits per 1,000 member months 3	56.2	58.2	**55.1**	90.1	96.4	**94.0**		23.2	**24.9**	74.6	70.9	**71.0**	62.66	57.4	**56.1**	62.70	62.0	**60.1**	66.0	64.9	**89.8**	62.1	63.1	**59.5**	63.8	62.4
Frequency of Selected Procedures **(FSP)** – Bariatric weight loss surgery /1000 MM 45-64 F	[5]	0.05	**0.05**	[5]	0.02	**0.00**	[5]	0.00	**0.00**	[5]	0.056	**0.068**	[5]	0.07	**0.10**	[5]	0.055	**0.06**	[5]	0.038	**0.12**	[5]	0.043	**0.04**	0.074	0.08
Frequency of Selected Procedures **(FSP)** – Bariatric weight loss surgery /1000 MM 45-64 M	[5]	0.00	**0.0074**	[5]	0.016	**0.00**	[5]	0.00	**0.00**	[5]	0.00	**0.015**	[5]	0.00	**0.015**	[5]	0.01	**0.03**	[5]	0.04	**0.00**	[5]	0.018	**0.010**	0.015	0.02
Frequency of Selected Procedures **(FSP)** – Tonsillectomy /1000 MM 0-9 T	[5]	0.42	**0.48**	[5]	0.18	**0.13**	[5]	0.13	**0.00**	[5]	0.47	**0.55**	[5]	0.39	**0.45**	[5]	0.60	**0.64**	[5]	0.21	**0.31**	[5]	0.43	**0.51**	0.44	0.63
Frequency of Selected Procedures **(FSP)** – Tonsillectomy /1000 MM 10-19 T	[5]	0.16	**0.186**	[5]	0.05	**0.18**	[5]	0.20	**0.00**	[5]	0.21	**0.26**	[5]	0.17	**0.19**	[5]	0.24	**0.25**	[5]	0.09	**0.16**	[5]	0.19	**0.194**	0.20	0.28
Frequency of Selected Procedures **(FSP)** – Hysterectomy, abdominal /1000 MM 45-64 F	[5]	0.46	**0.31**	[5]	0.44	**0.36**	[5]	0.01	**0.00**	[5]	0.50	**0.32**	[5]	0.53	**0.47**	[5]	0.35	**0.45**	[5]	0.45	**0.23**	[5]	0.47	**0.28**	0.35	0.35
Frequency of Selected Procedures **(FSP)** – Hysterectomy, vaginal /1000 MM 45-64 F	[5]	0.188	**0.1510**	[5]	0.02	**0.00**	[5]	0.00	**0.00**	[5]	0.16	**0.24**	[5]	0.17	**0.22**	[5]	0.20	**0.31**	[5]	0.11	**0.17**	[5]	0.191	**0.1506**	0.21	0.25
Frequency of Selected Procedures **(FSP)** – Cholecystectomy, open /1000 MM 30-64 M	[5]	0.047	**0.022**	[5]	0.03	**0.0569**	[5]	0.00	**0.00**	[5]	0.08	**0.04**	[5]	0.06	**0.0574**	[5]	0.055	**0.03**	[5]	0.00	**0.00**	[5]	0.04	**0.018**	0.039	0.03
Frequency of Selected Procedures **(FSP)** – Cholecystectomy, open /1000 MM 45-64 F	[5]	0.07	**0.010**	[5]	0.063	**0.045**	[5]	0.00	**0.00**	[5]	0.037	**0.05**	[5]	0.056	**0.012**	[5]	0.061	**0.06**	[5]	0.00	**0.00**	[5]	0.040	**0.02**	0.03	0.04
Frequency of Selected Procedures **(FSP)** – Laparoscopic/1000 MM 30-64 M	[5]	0.21	**0.20**	[5]	0.11	**0.05**	[5]	0.172	**0.00**	[5]	0.34	**0.31**	[5]	0.172	**0.24**	[5]	0.193	**0.29**	[5]	0.12	**0.21**	[5]	0.191	**0.26**	0.22	0.32
Frequency of Selected Procedures **(FSP)** – Laparoscopic/1000 MM 45-64 F	[5]	0.49	**0.36**	[5]	0.19	**0.29**	[5]	0.00	**0.00**	[5]	0.67	**0.62**	[5]	0.69	**0.40**	[5]	0.65	**0.69**	[5]	0.34	**0.43**	[5]	0.60	**0.44**	0.46	0.66
Frequency of Selected Procedures **(FSV)** – Back Surgery /1000 MM 45-64 F	[5]	0.41	**0.46**	[5]	0.58	**0.56**	[5]	0.00	**0.00**	[5]	0.66	**0.81**	[5]	0.56	**0.67**	[5]	0.78	**0.74**	[5]	0.30	**0.43**	[5]	0.55	**0.60**	0.61	0.55
Frequency of Selected Procedures **(FSP)** – Back Surgery /1000 MM 45-64 M	[5]	0.43	**0.58**	[5]	0.42	**0.41**	[5]	0.00	**0.00**	[5]	0.65	**0.85**	[5]	0.52	**0.69**	[5]	0.66	**0.80**	[5]	0.39	**0.47**	[5]	0.62	**0.83**	0.66	0.63
Frequency of Selected Procedures **(FSP)** – Mastectomy /1000 MM 15-44 F	[5]	0.022	**0.0226**	[5]	0.030	**0.050**	[5]	0.00	**0.00**	[5]	0.026	**0.045**	[5]	0.016	**0.01**	[5]	0.036	**0.03**	[5]	0.00	**0.051**	[5]	0.041	**0.0233**	0.034	0.03
Frequency of Selected Procedures **(FSP)** – Mastectomy /1000 MM 45-64 F	[5]	0.16	**0.13**	[5]	0.04	**0.07**	[5]	0.00	**0.00**	[5]	0.14	**0.12**	[5]	0.11	**0.10**	[5]	0.21	**0.23**	[5]	0.19	**0.173**	[5]	0.20	**0.171**	0.14	0.17
Frequency of Selected Procedures **(FSP)** – Lumpectomy /1000 MM 15-44 F	[5]	0.15	**0.113**	[5]	0.00	**0.07**	[5]	0.00	**0.00**	[5]	0.14	**0.106**	[5]	0.18	**0.20**	[5]	0.16	**0.14**	[5]	0.11	**0.05**	[5]	0.13	**0.107**	0.111	0.13
Frequency of Selected Procedures **(FSP)** – Lumpectomy /1000 MM 45-64 F	[5]	0.365	**0.27**	[5]	0.21	**0.25**	[5]	0.01	**0.00**	[5]	0.29	**0.28**	[5]	0.41	**0.52**	[5]	0.49	**0.42**	[5]	0.27	**0.14**	[5]	0.372	**0.38**	0.32	0.40

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Table A – HealthChoice Organizations HEDIS 2016 Results

HEDIS 2016 Results, page five of five	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2014	2015	2016	2016	HEDIS 2015
HealthChoice Organizations	ACC			JMS			KPMAS			MPC			MSFC			PP			RHMD			UHC			MARR	NHM
Ambulatory Care (Utilization) (continued)																										
Inpatient Utilization - General Hospital Acute Care **(IPU)** – Total Inpatient: Total Discharges /1000 MM	[5]	5.95	**5.83**	[5]	9.89	**10.06**	[5]	6.40	**5.49**	[5]	6.47	**6.84**	[5]	7.01	**6.67**	[5]	6.61	**6.75**	[5]	6.73	**8.59**	[5]	7.17	**6.60**	7.10	7.97
Inpatient Utilization - General Hospital Acute Care **(IPU)** – Total Inpatient: Total Average Length of Stay	[5]	3.96	**4.14**	[5]	4.12	**4.81**	[5]	4.59	**3.34**	[5]	3.66	**3.75**	[5]	4.03	**4.22**	[5]	3.85	**4.06**	[5]	3.72	**3.47**	[5]	4.12	**4.23**	4.00	4.01
Antibiotic Utilization **(ABX)** – Average Scrips PMPY for Antibiotics (aaattot)	[5]	0.87	**0.85**	[5]	0.88	**0.87**	[5]	0.68	**0.67**	[5]	1.03	**1.10**	[5]	0.86	**0.88**	[5]	0.97	**0.97**	[5]	0.77	**0.85**	[5]	0.98	**0.92**	0.89	0.98
Antibiotic Utilization **(ABX)** – Average Days Supplied per Antibiotic Script (acattot)	[5]	9.29	**9.35**	[5]	8.983	**9.00**	[5]	8.977	**9.46**	[5]	9.40	**9.32**	[5]	9.23	**9.10**	[5]	9.39	**9.42**	[5]	9.21	**9.28**	[5]	9.26	**9.35**	9.28	9.30
Antibiotic Utilization **(ABX)** – Average Scrips PMPY for Antibiotics of Concern (adattot)	[5]	0.35	**0.35**	[5]	0.29	**0.29**	[5]	0.27	**0.25**	[5]	0.41	**0.45**	[5]	0.34	**0.35**	[5]	0.39	**0.39**	[5]	0.32	**0.38**	[5]	0.43	**0.41**	0.36	0.41
Antibiotic Utilization **(ABX)** – Percentage of Antibiotics of Concern of all Antibiotics (apttot)	[5]	40.4%	**40.8%**	[5]	33.0%	**33.7%**	[5]	40.5%	**37.8%**	[5]	39.8%	**40.8%**	[5]	40.2%	**40.1%**	[5]	40.4%	**40.7%**	[5]	42.1%	**44.6%**	[5]	43.2%	**44.3%**	40.3%	41.4%
Call Answer Timeliness **(CAT)**	89.7%	82.9%	**86.6%**	93.4%	92.7%	**97.9%**		69.6%	**84.2%**	89.2%	86.7%	**88.2%**	91.3%	77.3%	**91.0%**	71.0%	43.5%	**58.0%**	NA[1]	80.4%	**87.9%**	89.4%	84.3%	**90.2%**	85.5%	80.9%

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Table A1 – Health Plan Descriptive Information

	ACC	JMS	KPMAS	MPC	MSFC	PP	RHMD	UHC
Board Certification **(BCR)** – Family Medicine: Number of Physicians	570	49	177	655	286	613	551	761
Board Certification **(BCR)** – Family Medicine: Number Board Certified	403	42	172	346	136	578	362	561
Board Certification **(BCR)** – Family Medicine: Percent Board Certified	70.70%	85.71%	97.18%	52.82%	47.55%	94.29%	65.70%	73.72%
Board Certification **(BCR)** – Internal Medicine: Number of Physicians	2,024	557	380	1,319	473	943	668	2,307
Board Certification **(BCR)** – Internal Medicine: Number Board Certified	1,464	519	369	928	298	887	412	1,756
Board Certification **(BCR)** – Internal Medicine: Percent Board Certified	72.33%	93.18%	97.11%	70.36%	63.00%	94.06%	61.68%	76.12%
Board Certification **(BCR)** – OB/GYN: Number of Physicians	584	113	171	714	360	758	515	836
Board Certification **(BCR)** – OB/GYN: Number Board Certified	448	95	150	310	139	723	266	720
Board Certification **(BCR)** – OB/GYN: Percent Board Certified	76.71%	84.07%	87.72%	43.42%	38.61%	95.38%	51.65%	86.12%
Board Certification **(BCR)** – Pediatrician: Number of Physicians	1,106	158	105	973	167	851	537	1,212
Board Certification **(BCR)** – Pediatrician: Number Board Certified	845	146	105	715	48	808	325	1,017
Board Certification **(BCR)** – Pediatrician: Percent Board Certified	76.40%	92.41%	100.00%	73.48%	28.74%	94.95%	60.52%	83.91%
Board Certification **(BCR)** – Geriatricians: Number of Physicians	84	37	2	49	15	40	32	88
Board Certification **(BCR)** – Geriatricians: Number Board Certified	53	34	2	33	5	38	23	57
Board Certification **(BCR)** – Geriatricians: Percent Board Certified	63.10%	91.89%	100.00%	67.35%	33.33%	95.00%	71.88%	64.77%
Board Certification **(BCR)** – Other Specialists: Number of Physicians	5,068	1,938	871	5,424	2,230	11,493	3,073	5,764
Board Certification **(BCR)** – Other Specialists: Number Board Certified	3,732	1,758	847	3,572	1,207	10,770	1,465	4,615
Board Certification **(BCR)** – Other Specialists: Percent Board Certified	73.64%	90.71%	97.24%	65.86%	54.13%	93.71%	47.67%	80.07%
Enrollment by Product Line **(ENP)** – Shows only total member months for Female	1,674,894	132,883	121,660	1,179,962	424,716	1,586,242	153,309	1,270,877
Enrollment by Product Line **(ENP)** – Shows only total member months for Male	1,405,128	145,122	101,136	904,595	341,526	1,253,413	151,157	1,062,926
Enrollment by Product Line **(ENP)** – Shows only total member months Total	3,080,022	278,005	222,796	2,084,557	766,242	2,839,655	304,466	2,333,803
Enrollment by State **(EBS)** – Maryland Only	253,373	21,969	29,598	178,113	66,346	241,869	26,456	170,806

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	ACC	JMS	KPMAS	MPC	MSFC	PP	RHMD	UHC
Language Diversity **(LDM)** – Spoken - English Number	10	32,808	30,858	0	0	0	0	4
Language Diversity **(LDM)** – Spoken - English Percent	0.00%	99.76%	81.82%	0.00%	0.00%	0.00%	0.00%	0.00%
Language Diversity **(LDM)** – Spoken - Non-English Number	5,338	79	3,777	0	0	0	0	2,382
Language Diversity **(LDM)** – Spoken - Non-English Percent	1.60%	0.24%	10.01%	0.00%	0.00%	0.00%	0.00%	0.91%
Language Diversity **(LDM)** – Spoken - Unknown Number	327,965	0	3,058	236,314	97,250	311,467	45,494	260,034
Language Diversity **(LDM)** – Spoken - Unknown Percent	98.40%	0.00%	8.11%	100.00%	100.00%	100.00%	100.00%	99.09%
Language Diversity **(LDM)** – Spoken - Declined Number	0	0	21	0	0	0	0	0
Language Diversity **(LDM)** – Spoken - Declined Percent	0.00%	0.00%	0.06%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity **(RDM)** – White / Total	63,072	3,806	7,220	82,652	0	107,710	15,327	92,373
Race/Ethnicity Diversity **(RDM)** – White / Percent	18.92%	11.57%	19.14%	34.98%	0.00%	34.58%	33.69%	35.20%
Race/Ethnicity Diversity **(RDM)** – Black / Total	141,924	16,625	19,118	104,253	0	123,299	17,152	113,988
Race/Ethnicity Diversity **(RDM)** – Black / Percent	42.58%	50.55%	50.69%	44.12%	0.00%	39.59%	37.70%	43.44%
Race/Ethnicity Diversity **(RDM)** – American Indian & Alaska Native / Total	0	93	90	13	0	4	0	0
Race/Ethnicity Diversity **(RDM)** – American Indian & Alaska Native / Percent	0.00%	0.28%	0.24%	0.01%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity **(RDM)** – Asian / Total	13,950	629	2,444	8,311	5,075	10,917	2,160	14,447
Race/Ethnicity Diversity **(RDM)** – Asian / Percent	4.19%	1.91%	6.48%	3.52%	5.22%	3.51%	4.75%	5.51%
Race/Ethnicity Diversity **(RDM)** – Native Hawaiian - Pacific Islander / Total	335	27	32	12	0	0	64	296
Race/Ethnicity Diversity **(RDM)** – Native Hawaiian - Pacific Islander / Percent	0.10%	0.08%	0.08%	0.01%	0.00%	0.00%	0.14%	0.11%
Race/Ethnicity Diversity **(RDM)** – Other / Total	0	0	649	0	0	0	0	0
Race/Ethnicity Diversity **(RDM)** – Other / Percent	0.00%	0.00%	1.72%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity **(RDM)** – 2+ Races / Total	0	0	5	0	0	0	0	0
Race/Ethnicity Diversity **(RDM)** – 2+ Races / Percent	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%
Race/Ethnicity Diversity **(RDM)** – Unknown / Total	114,032	11,707	8,058	41,073	92,175	69,537	1,486	41,316
Race/Ethnicity Diversity **(RDM)** – Unknown / Percent	34.21%	35.60%	21.37%	17.38%	94.78%	22.33%	3.27%	15.74%
Race/Ethnicity Diversity **(RDM)** – Declined / Total	0	0	98	0	0	0	9,305	0
Race/Ethnicity Diversity **(RDM)** – Declined / Percent	0.00%	0.00%	0.26%	0.00%	0.00%	0.00%	20.45%	0.00%
Week of Pregnancy at Time of Enrollment **(WOP)** – 13-27 weeks	28.96%	18.12%	36.54%	24.01%	32.12%	29.01%	28.29%	26.76%
Week of Pregnancy at Time of Enrollment **(WOP)** – 28+ weeks	17.49%	16.72%	18.95%	16.24%	20.68%	19.35%	18.97%	16.01%
Week of Pregnancy at Time of Enrollment **(WOP)** – Unknown	4.78%	0.00%	5.11%	4.14%	0.00%	3.71%	15.64%	3.80%
Total Membership – Total membership numbers for each plan	253,373	21,993	38,584	178,253	116,374	242,133	26,494	170,957

A Performance Report Card

for Consumers

2016

HealthChoice
MARYLAND'S MEDICAID HEALTH PLAN PROGRAM

Printed 3/2016

Looking at Health Plan Performance

All health plans in HealthChoice received high satisfaction ratings from the majority of their members.

This Report Card shows how the health plans in HealthChoice compare to each other in key areas. You should use this Report Card along with other items in the enrollment packet to help you choose a health plan.

To choose a health plan, call 1-800-977-7388. If you are hearing impaired, you can call the TDD line 1-800-977-7389.

Key
- ★★★ Above HealthChoice Average
- ★★ HealthChoice Average
- ★ Below HealthChoice Average

Performance Areas

Health Plans (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	N/A	N/A	N/A	N/A	N/A
MARYLAND PHYSICIANS CARE	★★★	★★	★★	★★	★★	★★
MEDSTAR FAMILY CHOICE	★	★★★	★★★	★★	★★	★★
PRIORITY PARTNERS	★★★	★★	★★★	★★	★★★	★★
RIVERSIDE HEALTH OF MARYLAND	★	★★	★	N/A	★	★
UNITEDHEALTHCARE	★★★	★★	★	★★	★	★

This information was collected from health plans and their members and is the most current performance data available. The information was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member composition.
NOTE: N/A means that ratings are not applicable and does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan.
**Kaiser Permanente became a HealthChoice MCO in 2014, therefore ratings are not applicable.*

Performance Area Descriptions

Access to Care
- Appointments are scheduled without a long wait
- The health plan has good customer service
- Everyone sees a doctor at least once a year
- The health plan answers member calls quickly

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

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

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

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

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

If you are having trouble getting health care from your health plan or your doctor, try calling the health plan for customer service. Then, call the Enrollee Help Line if you still have a problem at 1-800-284-4510.

Services Covered by Each Health Plan

- Visits to the doctor, including regular check-ups
- Immunizations (shots) for kids under 21
- Care while pregnant
- Family planning and birth control
- Prescription drugs
- X-ray and lab services
- Hospital services
- Home health services
- Hospice services
- Emergency services
- OB/GYN care for women
- Eye exams for adults and children
- Primary mental health services through your primary care doctor (other mental health services through the Specialty Mental Health System 1-800-888-1965)
- Transportation services
- Vision care including exams and glasses each year for kids under 21

Every HealthChoice health plan offers some additional services.

Do You Want to Ask the Health Plans Questions?

Health Plan	Phone
AMERIGROUP COMMUNITY CARE	1-800-600-4441
JAI MEDICAL SYSTEMS	1-888-524-1999
KAISER PERMANENTE	1-855-249-5019
MARYLAND PHYSICIANS CARE	1-800-953-8854
MEDSTAR FAMILY CHOICE	1-888-404-3549
PRIORITY PARTNERS	1-800-654-9728
RIVERSIDE HEALTH OF MARYLAND	1-800-730-8530
UNITEDHEALTHCARE	1-800-318-8821

For more information visit the HealthChoice website
www.dhmh.maryland.gov

INFORME CALIFICATIVO SOBRE DESEMPEÑO

para Consumidores

2016

HealthChoice

PROGRAMA DEL PLAN DE SALUD MEDICAID DE MARYLAND

Impresión
3/2016

EVALUACION DEL DESEMPENO DEL PLAN DE SALUD

Todos los planes de salud de HealthChoice recibieron altas calificaciones de satisfacción de parte la mayoría de sus miembros.

Este informe calificativo muestra el lugar que ocupan los planes de salud de HealthChoice en ciertas áreas clave. Usted puede valerse de este informe y de los demás materiales del paquete de inscripción como ayuda para decidirse por un plan de salud.

Para elegir un plan de salud, llame al 1-800-977-7388. Si tiene problemas de audición, puede llamar a la línea TDD, al número 1-800-977-7389.

Clave

- ★★★ Por encima del promedio de HealthChoice
- ★★ Promedio de HealthChoice
- ★ Por debajo del promedio de HealthChoice

ÁREAS DEL FUNCIONAMIENTO

PLANES DE SALUD (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	N/A	N/A	N/A	N/A	N/A
MARYLAND PHYSICIANS CARE	★★★	★★	★★	★★	★★	★★
MEDSTAR FAMILY CHOICE	★	★★★	★★★	★★	★★	★★
PRIORITY PARTNERS	★★★	★★	★★★	★★	★★★	★★
RIVERSIDE HEALTH OF MARYLAND	★	★★	★	N/A	★	★
UNITEDHEALTHCARE	★★★	★★	★	★★	★	★

Esta información se recogió de los planes de salud y de sus miembros y son los datos de rendimiento más actuales disponibles. La información fue revisada para su exactitud por organizaciones independientes. Las puntuaciones de rendimiento del plan de salud no se han ajustado a las diferencias en las regiones de servicio o la composición miembro. NOTA: N/A significa que las calificaciones no son aplicables y no se describe el rendimiento o la calidad de la atención prestada por el plan de salud. No debería afectar su opción de plan de salud.

**Kaiser Permanente se convirtió en un MCO HealthChoice en 2014, por lo tanto, clasificaciones no son aplicables.*

Descripción de las Áreas de Desempeño

Acceso a la Atención

- Se otorgan citas sin demoras prolongadas
- El plan de salud tiene buena atención al cliente
- Todos ven al doctor por lo menos una vez por año
- El plan de salud responde a los miembros de las llamadas rápidamente

Comunicación con el Médico y sus Servicios

- Los doctores explican las cosas con claridad y responden las preguntas
- El personal del consultorio del doctor es servicial
- Los doctores brindan buena atención

Si usted tiene problemas para recibir atención médica de su plan de salud o de su doctor, llame al plan de salud y pida que lo comuniquen con el servicio de atención al cliente. Luego, si todavía tiene problemas, llame a la línea para afiliados de HealthChoice, Enrollee Help Line, al número 1-800-284-4510.

Mantenimiento de la Salud de los Niños

- Los niños son vacunados para protegerlos de enfermedades graves
- Los niños ven al doctor y al dentista periódicamente
- Los niños son sometidos a análisis para detectar intoxicación por plomo

Atención de Niños con Enfermedades Crónicas

- Los doctores les brindan atención individual
- Los niños reciben los medicamentos que necesitan
- El doctor o la enfermera conocen las necesidades del niño
- Los doctores hacen participar a los padres en la toma de decisiones

Atención de la Mujer

- Las mujeres se someten a estudios de detección de cáncer de mama y de cáncer de cuello de útero
- Se cuida de la mujer durante el embarazo y después del parto

Atención de Adultos con Enfermedades Crónicas

- Se observan y controlan los niveles de azúcar en sangre
- Se analizan y controlan los niveles de colesterol
- Se examinan los ojos para ver si hay pérdida de la visión
- Los riñones están saludables y en buen funcionamiento
- El uso apropiado de antibióticos
- El tratamiento adecuado para el dolor lumbar

Servicios Cubiertos por Cada Plan de Salud

- Visitas al médico, incluso los chequeos periódicos
- Inmunizaciones (vacunas) para menores de 21 años
- Atención durante el embarazo
- Planificación familiar y control de la natalidad
- Medicamentos recetados
- Servicios radiológicos y de laboratorio
- Servicios de hospital
- Servicios de salud en el hogar
- Servicios para enfermos terminales
- Servicios de emergencia
- Atención ginecológica y de obstetricia para mujeres
- Exámenes de los ojos para adultos y niños
- Servicios primarios de salud mental a través de su primarios doctor (otros servicios de salud mental a través de Specialty Mental Health System 1-800-888-1965)
- Servicios de transporte
- Atención de la vista, incluso exámenes y anteojos cada año para menores de 21 años

Cada plan de salud HealthChoice ofrece algunos servicios adicionales.

¿TIENE PREGUNTAS PARA LOS PLANES DE SALUD?

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
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Para obtener mayor información visite el sitio web de HealthChoice, *www.dhmh.maryland.gov*