Qlarant

Maryland
DEPARTMENT OF HEALTH

Maryland HealthChoice Program

Annual Technical Report

Calender Year 2024

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2024 Annual Technical Report

Executive Summary

Introduction

The Maryland Department of Health (MDH) contracts with Qlarant, an external quality review organization (EQRO), to evaluate Maryland's managed care program, known as HealthChoice. HealthChoice has served Marylanders on Medicaid since June 1997 under the authority of a Section 1115 waiver of the Social Security Act. Providing quality healthcare that is equitable, patient-focused, prevention-oriented, coordinated, accessible, and cost-effective are HealthChoice's guiding principles for the nine managed care organizations (MCOs) contracted to provide services:

- Aetna Better Health of Maryland (ABH)
- CareFirst BlueCross BlueShield Community Health Plan (CFCHP)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- Wellpoint Maryland (WPM)

As the Maryland EQRO, Qlarant evaluates MCO compliance with federal and state-specific requirements by conducting multiple external quality review (EQR) activities, including:

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review, also referenced as Systems Performance Review (SPR)
- Network Adequacy Validation (NAV)
- Network Adequacy Validation Focused Study (NAV FS)

- Encounter Data Validation (EDV)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews
- Development and production of an annual Consumer Report Card (CRC)
- Grievances, Appeals, and Denials (GAD) Focused Study

Qlarant conducted EQR activities throughout 2024 and evaluated MCO compliance and performance for measurement years (MYs) 2023 and 2024, as applicable. MDH is working towards minimizing disparities amongst the HealthChoice population by integrating health equity and a disparity lens into the HealthChoice framework. Comparisons between the Code of Maryland Regulations (COMAR) and the Code of Federal Regulations (42 CFR §438.350) set standards for compliance and performance are provided, as applicable. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities. This report summarizes results from all EQR activities and includes conclusions drawn regarding the quality, accessibility, and timeliness of care furnished by the MCOs. No MCOs were exempt from the EQR conducted for MYs 2023 and 2024. During 2024, Qlarant conducted the EQR activities identified below.

Table 1. EQR Activities Conducted During 2024

EQR Activity During 2024	MCO Performance Period*
PIP Validation	2023: January 1 – December 31
PMV	2023: January 1 – December 31
SPR	2023: January 1 – December 31
NAV	2023: January 1 – December 31
NAV FS	2024: June 1 – July 31
EDV	2023: January 1 – December 31
EPSDT Medical Record Reviews	2023: January 1 – December 31
CRC	2022: January 1 – December 31
GAD Focused Study	2023: January 1 – December 31

*MCO performance period is the timeframe that was evaluated during the EQR activity. Qlarant evaluates the most current MCO information, data, or results available for each EQR activity.

Key Findings

Performance Improvement Project Validation. PIPs are designed to achieve significant improvement, sustained over time, in clinical care and non-clinical care areas. Projects are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIPs must be designed, conducted, and reported in a methodologically sound manner. Through PIP validation, Qlarant assessed whether MCOs met state-specific requirements for incorporating national standards for Culturally and Linguistically Appropriate Services to prioritize health equity for HealthChoice enrollees.

HealthChoice MCOs conduct two PIPs annually. To align with statewide public health and Medicaid innovation initiatives specifically identified in the Statewide Integrated Health Improvement Strategy (SIHIS), MCOs completed perinatal PIPs related to the Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Prenatal Care PIP) and the Maternal Health and Infant/Toddler Care During the Postpartum Period (Postpartum Care-Related PIP) topics to reduce severe maternal morbidity and address preventive care services in early childhood. Healthcare Effectiveness Data and Information Set (HEDIS®)[1] performance measures were followed for each PIP.

Table 2. MY 2023 First Remeasurement Indicator Rate Percentages (PIP)

Indicator	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Prenatal Care PIP	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Prenatal and Postpartum Care: Prenatal Care (PPC-CH)	89.6%	93.3%	83.4%	94.4%	91.5%	85.0%	85.6%	86.6%	82.0%
Postpartum Care-Related PIP	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	83.3%	88.3%	86.6%	91.3%	85.4%	83.8%	78.1%	77.6%	83.2%
Well-Child Visits in the First 30 Months of Life (W30: 0-15 Months)	51.5%	52.8%	59.8%	72.7%	58.8%	54.3%	58.9%	59.5%	57.2%
Well-Child Visits in the First 30 Months of Life (W30: 15-30 Months)	68.6%	66.2%	73.1%	75.6%	68.6%	70.9%	71.2%	71.5%	75.3%
Childhood Immunization Status: Combo 3 (CIS-3)	66.4%	64.7%	65.0%	79.2%	65.9%	62.5%	72.0%	68.4%	75.4%

Performance Measure Validation. The Population Health Incentive Program (PHIP) is an incentive program designed to provide financial incentives to MCOs based on performance within certain measures. MY 2023 is the second implementation year of the two-round design for selected HEDIS measures and MDH-developed encounter measures. Qlarant completed PHIP activities in collaboration with MetaStar, Inc. (MetaStar) and The Hilltop Institute at the University of Maryland, Baltimore County (Hilltop). MDH elected to contract with MetaStar to validate measures and conduct the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audits™. Hilltop calculated the MDH-developed encounter data measures. Qlarant validated the three encounter data measures and analysis to determine financial incentives. Performance incentives rewarded MCO scores against benchmarks at or above the 50th percentile during the MY. Improvement incentives rewarded year-over-year improvement. Round 2 incentives rewarded MCOs earning above 80% of possible Round 1 incentives and performing sufficiently well on the HEDIS Performance Monitoring Policy requirements for MY 2023.

[1] Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

All nine MCOs received a financial reward for Round 1 – Tier 1 for performance, while seven of the nine MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, and WPM) received a Round 1 – Tier 2 incentive for improvement. No MCOs received a Round 2 incentive. The table below provides a summary of which MCOs received incentives for Round 1 tiers.

Table 3. Overall Net Outcomes by MCO for Round 1 (PHIP)

MCOs	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Tier 1 - Performance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tier 2 - Improvement	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes

Systems Performance Review. Qlarant evaluated MY 2023 MCO compliance with federal and contractual requirements as an interim desktop review. Interim desktop reviews reflect MDH's decision to move to triennial, rather than annual, onsite reviews to review standards that were scored as *Baseline* or *Met with Opportunities* or required a corrective action plan (CAP). The next comprehensive review will occur for MY 2024. MDH established the minimum compliance rate for each federal and contractual standard at 100%. SPRs evaluate MCO compliance with structural and operational standards.

CAPs were required to address areas of noncompliance for four of the nine MCOs (CFCHP, KPMAS, MPC, and WPM), which should improve compliance rates if successfully implemented. JMS continues to maintain compliance, without required CAPs, for multiple years. Qlarant calculates CAPs by standard, instead of by individual components or elements. MY 2023's CAP summary follows, including the number of MY 2023 CAPs required and reviewed for each MCO, compared to the number successfully closed and MY 2022's required CAPs.

Table 4. MY 2023 Total Corrective Action Plans per MCO (SPR)

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total CAPs Required	0	1	0	1	1	0	0	0	1
Total CAPs Closed	1	2	0	1	1	1	4	1	2
MY 2022 CAP Comparison	↓	↓	Ø	↓	↓	↓	↓	↓	↓

Light Green and ↓ = positive improvement from MY 2022 (decline in CAPs); **White** and Ø = no change from MY 2022

Network Adequacy Validation. In February 2023, CMS issued a new EQR protocol to assess MCO compliance with state and federal network adequacy standards: Protocol 4 – Validation of Network Adequacy. This new protocol states that MCOs must maintain provider networks that are sufficient to provide timely and accessible care to Medicaid enrollees across the continuum of care. Qlarant conducted the NAV task as a baseline study by validating the network adequacy for the review period of January 1, 2023 – December 31, 2023, or MY 2023. A validation rating for each MCO was assigned to individual indicators, ranging from *No Confidence* to *High Confidence*.

MCOs reported a different amount of distinct provider–to-enrollee ratios for provider types. Overall, there were 189 distinct provider-to-enrollee ratios that were identified across all MCO activities that could be validated based on COMAR, with 16 additional monitoring activities

MCOs conducted for additional provider specialties not listed. Of the 205 total potential ratios that could be reported, 128 were reported and reviewed. MCOs' calculations of their provider-to-enrollee ratios scored confidence levels of *Moderate Confidence* to *High Confidence*, with scores ranging from 68.8% to 100%.

Table 5. Validation Results for Provider-to-Enrollee Ratios (NAV)

MCO	Total Indicators Identified	High Confidence (90.0% -100%)	Moderate Confidence (51.0%-89.9%)	Low Confidence (10.0% -49.9%)	No Confidence (0.0%-9.9%)	Could Not Be Validated
ABH	23	23	0	0	0	0
CFCHP	23	12	2	0	0	9
JMS	23	23	0	0	0	0
KPMAS	21	2	0	0	0	19
MPC	23	13	10	0	0	0
MSFC	23	4	0	0	0	19
PPMCO	24	20	0	0	0	4
UHC	22	8	1	0	0	13
WPM	23	23	0	0	0	0

MCOs reported a different amount of monitoring activities for time and/or distance standards for each of the 25 provider types listed in COMAR across three geographical areas. Overall, Qlarant identified 650 different monitoring activities that could be conducted across all MCOs, 626 of which were reported. There were an additional 34 monitoring activities for additional specialties that were reported. MCOs' calculations for time and/or distance standards scored confidence levels of *Moderate Confidence* to *High Confidence*, with scores ranging from 70.6% to 100%.

Table 6. Validation Results for Time and Distance Standards (NAV)

MCO	Total Indicators Identified	High Confidence (90.0% - 100%)	Moderate Confidence (51.0% - 89.9%)	Low Confidence (10.0% - 49.9%)	No Confidence (0.0% - 9.9%)	Could Not Be Validated
ABH	78	78	0	0	0	0
CFCHP	81	60	21	0	0	0
JMS	54	48	0	0	0	6
KPMAS	75	75	0	0	0	0
MPC	72	42	30	0	0	3
MSFC	78	78	0	0	0	0
PPMCO	72	60	0	0	0	12

MCO	Total Indicators Identified	High Confidence (90.0% - 100%)	Moderate Confidence (51.0% - 89.9%)	Low Confidence (10.0% - 49.9%)	No Confidence (0.0% - 9.9%)	Could Not Be Validated
UHC	90	69	21	0	0	0
WPM	78	78	0	0	0	0

JMS was exempt from including time and distance NAV for rural areas due to the primary locations of its member/providers in urban and suburban areas.

Network Adequacy Validation Focused Review. Qlarant conducted telephonic surveys and provider directory validations to evaluate the network adequacy of HealthChoice MCOs to ensure timely access to necessary care and a sufficient number of in-network providers, determined by COMAR. MY 2024's survey sample included 2,026 primary care providers (PCPs) to monitor available coverage for current HealthChoice enrollees. Successful contact yielded a response rate of 55.8%, which represents 1,130 PCPs. Qlarant's surveyors verified:

- Accuracy of online provider directories, including telephone number and address;
- Provider acceptance of the MCO listed in the provider directory;
- Provider practice acceptance of new Medicaid patients;
- First availability for routine appointments; and
- First availability for urgent care appointments.

MDH established MY 2024's compliance threshold as 80% for each component reviewed. Two MCOs (MPC and MSFC) maintained compliance, without required CAPs, for multiple years. Required CAPs addressed areas of noncompliance and were calculated by individual requirements. Four of the nine MCOs (ABH, CFCHP, KPMAS, and WPM) should improve compliance rates with successfully implemented CAPs. The following table identifies the number of CAPs required by each MCO and contrasts the number of reviewed with those successfully closed.

Table 7. MY 2024 Total Corrective Action Plans per MCO (NAV FS)

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total CAPs Required	1	1	0	4	0	0	0	0	1
Total CAPs Closed	0	1	1	0	0	0	2	1	1
MY 2023 CAP Comparison	↑	Ø	↓	↑	Ø	Ø	↓	↓	Ø

Light green and ↓ = positive improvement (decline in CAPs); **Pink** and ↑ = negative increase in CAPs; **White** and Ø = no change in required CAPs

Encounter Data Validation. EDV ensures the overall validity and reliability of encounter data. Qlarant conducts a medical record review on a sample of inpatient, outpatient, and office visit encounters to confirm the accuracy of codes. MDH established MY 2023's compliance threshold as 90% for each encounter type reviewed. Validation of encounter data provides MDH with a level of confidence in the completeness and accuracy of encounter data submitted by the MCOs. All MCOs met the compliance threshold for all encounter types, and therefore, corrective action was not required.

Table 8. MY 2023 MCO and HealthChoice Results by Encounter Type (EDV)

Encounter Type	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
Inpatient	96%	99%	100%	99%	97%	98%	100%	99%	100%	**99%**
Outpatient	99%	98%	98%	100%	98%	99%	94%	99%	97%	**98%**
Office Visit	95%	95%	98%	97%	94%	95%	96%	95%	95%	**95%**

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews. The EPSDT medical record review assesses the quality, timeliness, and accessibility of care for children and adolescents through 20 years of age. Review indicators were based on current pediatric preventive care guidelines and MDH-identified priority areas. Nurse reviewers conducted all medical record reviews onsite at provider offices, except for providers with only one patient in the sample.

MDH established MY 2023's compliance threshold as 80% for each component reviewed. CAPs were required to address areas of noncompliance for seven MCOs in the *Laboratory Tests/At-Risk Screenings* component, which should improve compliance rates if successfully implemented. Qlarant calculated CAPs by component instead of individual elements. MY 2023's CAP summary follows for each MCO, identifying the number of total CAPs required and the number successfully closed after review.

Table 9. MY 2023 Total Corrective Action Plans per MCO (EPSDT)

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total CAPs Required	1	1	0	0	1	1	1	1	1
Total CAPs Closed	0	0	0	0	0	0	0	0	0
CAP Comparison to MY 2022	↑	↑	Ø	Ø	↑	↑	Ø	↑	↑

Pink and ↑ = negative increase in CAPs; **White** and Ø = no change in required CAPs

Consumer Report Card. The CRC assists Medicaid members in comparing and selecting a HealthChoice MCO. Information in the CRC includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Maryland's encounter data measures. Annually, Qlarant develops the CRC to reflect the data reported from MCOs during the previous measurement year. The 2024 CRC results and star rating comparison from the 2023 CRC follow.

Table 10. 2024 Results (CRC)

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

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

Table 11. Star Rating Changes from 2023 to 2024 (CRC)

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

Light green and ↑ = improvement from 2023; **Pink** and ↓ = decline from 2023; **White** and Ø = no change from 2023; **Gray** and NA = reported as Not Applicable for both 2023 and 2024

Grievances, Appeals, and Denials Focused Study. Qlarant assessed MCO compliance of grievances, appeals, and pre-service denials against performance standards established for MY 2023 and based on federal and state regulations pertaining to the appropriateness of denials of service and the handling of grievances and appeals. Quarterly submissions of MCO grievance, appeal, and pre-service denial reports were reviewed with the first through third quarters of MY 2023 data, while the fourth quarter reviewed annual MY 2023 data. An annual record review assessed member grievances, appeals, and pre-service denials submitted by members during MY 2023.

Conclusions drawn from analyzed data provide the MCOs with opportunities for improvement. The total number of opportunities for MY 2023 compared to MY 2022 is displayed in the following table.

Table 12. Comparison of Opportunities for Improvement from MY 2022 to MY 2023 (GAD)

Improvement Opportunities Comparison	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total # Opportunities MY 2022	2	11	0	7	2	0	4	1	8
Total # Opportunities MY 2023	1	2	2	1	3	1	5	6	3
MY 2022 to MY 2023 Comparison	↓	↓	↑	↓	↑	↑	↑	↑	↓

Light green and ↓ = positive decrease from MY 2022; **Pink** and ↑ = negative increase from MY 2022

Healthcare Effectiveness Data and Information Set

MDH contracted with MetaStar, a NCQA Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice managed care organizations and to summarize the results. For HEDIS MY 2023, MDH required HealthChoice MCOs to report the complete HEDIS measure set for services rendered in calendar year (CY) 2023 to HealthChoice enrollees. These measures provide meaningful MCO comparative information, and they evaluate performance relative to MDH's priorities and goals. For additional findings and comprehensive details associated with the HEDIS MY 2023 results, see the full report linked in **Appendix E.**

Consumer Assessment of Healthcare Providers and Systems

MDH contracted with the Center for the Study of Services, an NCQA-certified survey vendor, to administer and report the results of the CAHPS 5.1H Member Experience Survey. The overall goal of the survey is to provide actionable performance feedback that will aid health plans in improving overall member experience.

The Center for the Study of Services administered the Adult and Child Medicaid version of the CAHPS Health Plan Survey for the Maryland Department of Health on behalf of the HealthChoice MCOs between February 9 and May 10, with submission to NCQA on May 24, 2024. The Child survey included questions for children with chronic conditions. For additional findings and comprehensive details associated with the 2024 Adult and Child CAHPS results, see the full report linked in **Appendix E.**

Conclusion

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

MDH continues to encourage an environment of compliance and quality improvement and sets high standards to promote access to quality care. The MYs 2023 and 2024 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care and services for Maryland Medicaid managed care enrollees.

Maryland HealthChoice Program

External Quality Review

2024 Annual Technical Report

Introduction

Background

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

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

Quality characteristics of each MCO evaluated are included in profiles below; no MCO was exempt from the EQR for the measurement years (MYs) 2023 and 2024 included in this Annual Technical Report (ATR) for Maryland's managed care program, known as HealthChoice. MDH requires MCOs to attain and maintain National Committee for Quality Assurance (NCQA) accreditation.

Table 13. MY 2023 MCO Profiles

Profiles	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO*	UHC	WPM
Plan Type	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO	MCO
Populations Served	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid	Medicaid
Managed Care Authority	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]	Waiver Authority [Section 1115]
Contracted Since	2019	2013	1997	2014	1997	1997	1997	1997	1999
Enrollment	60,457	92,876	29,163	115,803	238,271	102,454	341,353	164,811	313,681
NCQA Accreditation Status	Accredited	Accredited	Accredited	Accredited	Accredited	Accredited	Accredited	Accredited	Accredited

Source: *HealthChoice Quality Strategy*
*PPMCO's NCQA status was provisional June 9, 2023 through August 22, 2024.

MDH strives to ensure the delivery of high quality, accessible care for managed care program members. The HealthChoice Quality Strategy identifies five broad managed care program goals.

- Improving access to health care for the Medicaid population
- Improving the quality of health services delivered
- Providing patient-focused, comprehensive, and coordinated care through the medical home
- Emphasizing health promotion and disease prevention
- Expanding coverage through resources generated through managed care efficiencies

To achieve these overarching goals, MDH has identified three specific goals and measurable objectives in the table below.

Table 14. HealthChoice Program Goals and Objectives

Goal	Objective
1. Improve HealthChoice aggregate performance on Medicaid Healthcare Effectiveness Data and Information Set (HEDIS®) measures by reaching or exceeding the pre-pandemic HealthChoice aggregate by MY 2024.	1. Increase the number of HEDIS measures that meet or exceed the HealthChoice aggregate achieved in MY 2018 or MY 2019, whichever is highest, by MY 2024. 2. Once Objective 1 is achieved, ensure HealthChoice aggregate meets or exceeds the NCQA National HEDIS Means by MY 2024.
2. Improve overall health outcomes for HealthChoice enrollees through expanding the network of available provider types, creating targeted quality and operational initiatives to enhance enrollee access to care, and promoting health service delivery innovation.	1. Increase the HealthChoice aggregate for the HEDIS Prenatal and Postpartum Care measures by three percentage points no later than MY 2024. 2. Improve the HealthChoice aggregate for measures tracking chronic health outcomes by MY 2024.
3. Ensure HealthChoice MCOs are complying with all state and federal requirements by meeting or exceeding the minimum compliance scores for all administrative quality assurance activities.	1. Increase the HealthChoice aggregate scores to 100% for all Systems Performance Review standards by MY 2024. 2. Increase the HealthChoice aggregate scores to at least 80% for all Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Healthy Kids Medical Record Review components by MY 2024. 3. Increase the HealthChoice aggregate scores to at least 85% for all network adequacy validation activities by MY 2024. 4. Increase the HealthChoice aggregate scores to at least 90% for encounter data validation by MY 2024. 5. Increase the HealthChoice aggregate to minimum compliance for each element of review for grievances, appeals, and pre-service determinations by MY 2024.

Purpose

Federal regulations require states contracting with MCOs to conduct annual, independent reviews of the managed care program. To meet these requirements, MDH contracts with Qlarant, an independent external quality review organization (EQRO). Qlarant evaluates the quality, accessibility, and timeliness of health care services furnished by the MCOs through various mandatory activities following CMS-developed EQR protocols. Qlarant completed the following EQR activities in CYs 2023 and 2024 to evaluate MCO performance for MY 2023:

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

- Network Adequacy Validation (NAV)

Qlarant conducted optional activities that include:

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

In addition to these EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing how data from all activities conducted were aggregated and analyzed, and how conclusions were drawn regarding the quality, accessibility, and timeliness of care furnished by the MCOs. This ATR serves as Qlarant's report to MDH on the assessment of MY 2023 MCO performance, describes EQR methodologies for completing activities, provides compliance results, and analyzes performance. Additionally, included are an overview of the quality, access, and timeliness of health care services provided to Maryland's HealthChoice enrollees and recommendations for improvement, which if implemented may positively impact enrollee outcomes.

Performance Improvement Project Validation

Objective

PIPs are designed to achieve and sustain improvement in clinical outcomes, administrative processes, or member satisfaction. PIPs use a systematic approach to quality improvement and can be effective tools to assist MCOs in identifying barriers and implementing targeted interventions. PIP review and validation assesses the level of improvement across MCOs and provides MDH and other stakeholders with a level of confidence in project results.

Methodology

Qlarant uses the *CMS EQR Protocol 1 – Validation of Performance Improvement Projects* as a guideline in PIP review activities and to verify that the MCOs used sound methodology in designing, implementing, analyzing, and reporting PIP activities. MDH required the MCOs to conduct two PIPs during MY 2023.

PIP Topics. To align with statewide public health and Medicaid innovation initiatives specifically identified in the Statewide Integrated Health Improvement Strategy (SIHIS), MCOs completed perinatal PIPs related to the Timeliness of Prenatal Care and Identification of High-Risk

Pregnancies (Prenatal Care PIP) and the Maternal Health and Infant/Toddler Care During the Postpartum Period (Postpartum Care-Related PIP) topics to reduce severe maternal morbidity and address preventive care services in early childhood. HEDIS® performance measures were selected for each PIP.

MDH provided a list of strategies for the MCOs to choose from for each PIP topic. MCOs were to select PIP strategies most appropriate for their enrollee populations and available resources. All strategies selected were required to include a health equity focus with a race/ethnicity lens to address health outcomes among the most disparate populations by conducting disparity analyses, including enrollee feedback, and examining resources. Prenatal Care PIPs consisted of one mandatory strategy, to improve completion and use of the Maryland Prenatal Risk Assessment (M-PRA), and two additional strategies. MCOs selected two strategies for Postpartum Care-Related PIPs.

Table 15. MY 2023 MDH-Selected Topics (PIP)

MY 2023 PIPs	Prenatal Care PIP	Postpartum Care-Related PIP
Topic	Timeliness of Prenatal Care and Identification of High-Risk Pregnancies	Maternal Health and Infant/Toddler Care During the Postpartum Period
Performance Measure(s)	• Prenatal and Postpartum Care: Prenatal Care (PPC-CH)	• Prenatal and Postpartum Care: Postpartum Care (PPC-AD) • Well-Child Visits in the First 30 Months of Life (W30: 0-15 Months) • Well-Child Visits in the First 30 Months of Life (W30: 15-30 Months) • Childhood Immunization Status: Combo 3 (CIS-3)
Aim	Will the implementation of targeted interventions focused on members, providers, and the MCO improve and sustain annual HEDIS performance rates in the area of Timeliness of Prenatal Care?	Will the implementation of targeted interventions focused on members, providers, and the MCO improve and sustain annual HEDIS performance rates in the area of Postpartum Care; Well-Child Visits in the First 30 Months of Life; and/or Childhood Immunization Status?
State-Specific Strategies	The prenatal care PIP topic consists of one mandatory strategy, *improve completion and use of the M-PRA*, and MCOs were to select two additional PIP strategies most appropriate to their member populations and available resources.	The postpartum care-related PIP topic focused on two strategies selected by the MCO. MCOs were to select PIP strategies most appropriate for their member populations and available resources.

Description of Data Obtained. During the MY 2023 remeasurement year, MCOs focused on addressing barriers to successful implementation, modifications to interventions, and studying outcomes.

Technical Methods of Data Collection and Analysis. Using the nine steps of the PIP protocol as a guideline, MCOs submitted PIP progress and updates on a quarterly basis for Qlarant and MDH to provide real-time feedback and guidance following the rapid cycle and Plan, Do, Study, Act (PDSA) processes.

1. **Review the selected PIP topic.** MDH selected the PIP topic.
2. **Review the PIP aim statement.** MDH provided the aim statement to align with statewide public health and Medicaid innovation initiatives. Strategies and process metrics were additionally provided to MCOs.
3. **Review the identified PIP population, selected PIP variables, and performance measures.** Qlarant executed this step according to the CMS EQR Protocol 1 and crosswalked our approach in this step:
    a. ***Population:*** Qlarant determined whether the MCO identified the PIP population in congruence with the aim statement.
    b. ***PIP Variables:*** Qlarant assessed whether the selected PIP variables were appropriate for measuring and tracking improvement.
    c. ***Performance Measures:*** Qlarant assessed whether performance measures were objective and measurable, clearly defined, based on current clinical knowledge or research, and focused on enrollee outcomes.
4. **Review the sampling method.** This step is required only when the MCO studies a sample of the entire population. Qlarant assessed the appropriateness of the MCO's sampling technique.
5. **Review the data analysis and interpretation of PIP results.** Qlarant evaluated the validity and reliability of MCO procedures used to collect the data displaying PIP measurements. Qlarant executed this step according to the CMS EQR Protocol 1.
6. **Review the data analysis and interpretation of PIP results.** Qlarant assessed the quality of data analysis and interpretation of PIP results. The review determines whether appropriate techniques were used and if the MCO's analysis and interpretation were accurate. A comprehensive quantitative and qualitative analysis is required for each project indicator. In the quantitative analysis, current performance compared to baseline and previous measurements are assessed. Performance is also evaluated against goals/benchmarks. The qualitative analysis focuses more on the project's level of success and identified barriers and provides an assessment of interventions. Each intervention utilizes the continuous quality improvement process using a PDSA analysis to determine whether the intervention is achieving the desired outcome. This analysis reflects the study findings and includes a description of the rationale for continuing, discontinuing, or altering the planned activity.
7. **Assess the improvement strategies (interventions).** Qlarant assessed the appropriateness of interventions for achieving improvement. Each intervention is assessed to ensure that barriers are addressed. Interventions must be multi-faceted and produce impactful and sustainable change. Effective interventions are tailored using specific, measurable, achievable, relevant, and time-oriented (SMART) objectives designed for the priority population. Interventions use upstream approaches, such as policy reforms, workflow changes, and resource investments.
8. **Assess the likelihood that significant and sustained improvement occurred.** Qlarant evaluated improvement by validating statistical significance testing results and evaluating improvement compared to baseline performance. Improvement should also be linked to interventions and based on desired outcomes, as opposed to an unrelated occurrence or solely a participation tally. This assessment is

correlated to Step 8, Improvement Strategies. If interventions are assessed as reasonable and expected to improve outcomes, then the improvement is correlated to the project's interventions. Sustained improvement is assessed after the second remeasurement has been reported. Results are compared to baseline to confirm consistent and sustained improvement. *It should be noted that MCOs are only scored on the improvement of the HEDIS measure rates that align with the MCO's selected strategies.

9. **State-Specific Strategies.** Qlarant evaluated evidence provided to determine if interventions were modified to improve the effectiveness of the strategy, based on process metric feedback. Improvement strategies must identify and prioritize enrollees specific to the selected strategies. This step has been added by MDH and Qlarant.

All PIPs use the Rapid Cycle PIP process to provide MCOs with a quality improvement method that identifies, implements, and measures changes over quarterly periods. This PIP process is continuous and aligns with the CMS EQR PIP Validation Protocol to allow the MCOs the opportunity to monitor their improvement efforts over shorter time periods. Frequent monitoring allows for quick modifications when necessary. The goal is for MCOs to improve performance efficiently and sustain improvement resulting in a long-term, positive impact on enrollee health outcomes.

Qlarant assists the MCOs in the Rapid Cycle PIP process by providing quarterly reporting templates and quarterly PIP assessments, making recommendations, providing quarterly technical assistance requested by MCOs, and breaking down the process into manageable steps based on the PIP development and implementation requirements:

1. Develop an appropriate project rationale based on supporting MCO data.
2. Identify performance measures that address the project rationale and reflect the study question/aim statement. Qlarant's team works to ensure MCOs have the appropriate performance measures and data collection methodologies in place to facilitate accurate and valid performance measure reporting.
3. Identify enrollee, provider, and MCO barriers.
4. Develop improvement processes and interventions that include key stakeholders and address the identified barriers. The interventions should support and apply the selected strategies in a strategic, systemic, and sustainable way.
5. Measure, assess, and analyze the impact of the interventions. MCOs must measure performance frequently (such as on a monthly or quarterly basis). It is critical to study intervention outcomes to determine which interventions may be effective and which interventions may need to be modified, replaced, or eliminated using performance measure results. Ultimately, the MCO should be able to assess how the intervention impacts the study indicator(s).

Qlarant rates each component within a step as *Met (M)*, *Partially Met (PM)*, *Unmet (UM)*, or *Not Applicable (NA)*, which results in an assigned score. A final assessment is made for all nine steps, with numeric scores provided for each component and step of the validation process. Each assessed component could result in varying total points due to the determination of components as *Not Applicable* for individual MCOs. A description of the rating and the associated score follow.

Table 16. MY 2023 Validation Review Determinations and Scoring (PIP)

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

Qlarant PIP reviewers evaluated the results of each step in the review process by answering a series of applicable questions, consistent with protocol requirements. Reviewers sought additional information and/or corrections from MCOs, when needed, during quarterly evaluations in preparation for the annual review.

The PIP validation score is the sum of all the step scores used to evaluate whether the PIP is designed, conducted, and reported in a sound manner and determines the degree of confidence a state agency can have in the reported results. Qlarant evaluates confidence levels based on the PIP validation scores.

Table 17. MY 2023 Validation Confidence Levels and Scoring (PIP)

MCO-Reported Confidence Levels and Criteria	Score
High Confidence (High) in MCO compliance	90% to 100%
Moderate Confidence (C) in MCO compliance	75% to 89%
Low Confidence (Low) in MCO compliance	60% to 74%
No Confidence (NC) in MCO compliance	59% or lower

Qlarant used a diamond rating system to compare the MCOs' PIP performance to NCQA benchmarks.

Table 18. MY 2023 Diamond Rating System Used to Compare MCO Performance to Benchmarks (PIP)

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

Timeline. Qlarant conducted MY 2023 PIP activities from January 2023 to December 2023.

Results

Validation results and findings for MY 2023's remeasurement performance are captured throughout the results section by PIP topic. Each MCO's PIPs were reviewed against all applicable components contained within the nine steps. Recommendations for each step that did not receive a *Met* rating follow each MCO's results in this report. Per NCQA, HEDIS trending between MY 2023 and previous MYs should be considered with caution due to clarifications for continuous enrollment requirements for the PPC-CH numerator[2].

Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Prenatal Care PIP)

Purpose. All Prenatal Care PIPs focused on the overarching goal of increasing the percentage of pregnant enrollees' engagement with timely prenatal care visits during MY 2023, according to the HEDIS PPC-CH measure specifications. The HEDIS PPC-CH measure assesses the access to prenatal care by the percentage of deliveries in which enrollees had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.

PIP Validation Step Results. This section represents data collection results for MY 2023 as the first remeasurement year for the Prenatal Care PIP. An assessment of the validity and reliability of the PIP study design and results reflects a detailed review of each MCO's PIPs and audited HEDIS measure findings for the selected indicators. The following table identifies the validation rating and the corresponding level of confidence Qlarant has assigned to each MCO's PIPs for MY 2023. MCOs' total available points for scoring varies due to the determination of components as *Not Applicable* for individual MCOs. All MCOs were given a rating of *NA* for Step 2 (Aim Statement) since MDH provided the aim statement. Seven of the nine MCOs' performances resulted in a confidence level of *High Confidence* for prenatal care PIP validations, ranging from 93.3% (PPMCO) to 100% (ABH). UHC's (77.3%) and WPM's (85.3%) performance resulted in a confidence level of *Confidence*.

[2] HEDIS MY 2023 Trending Memo

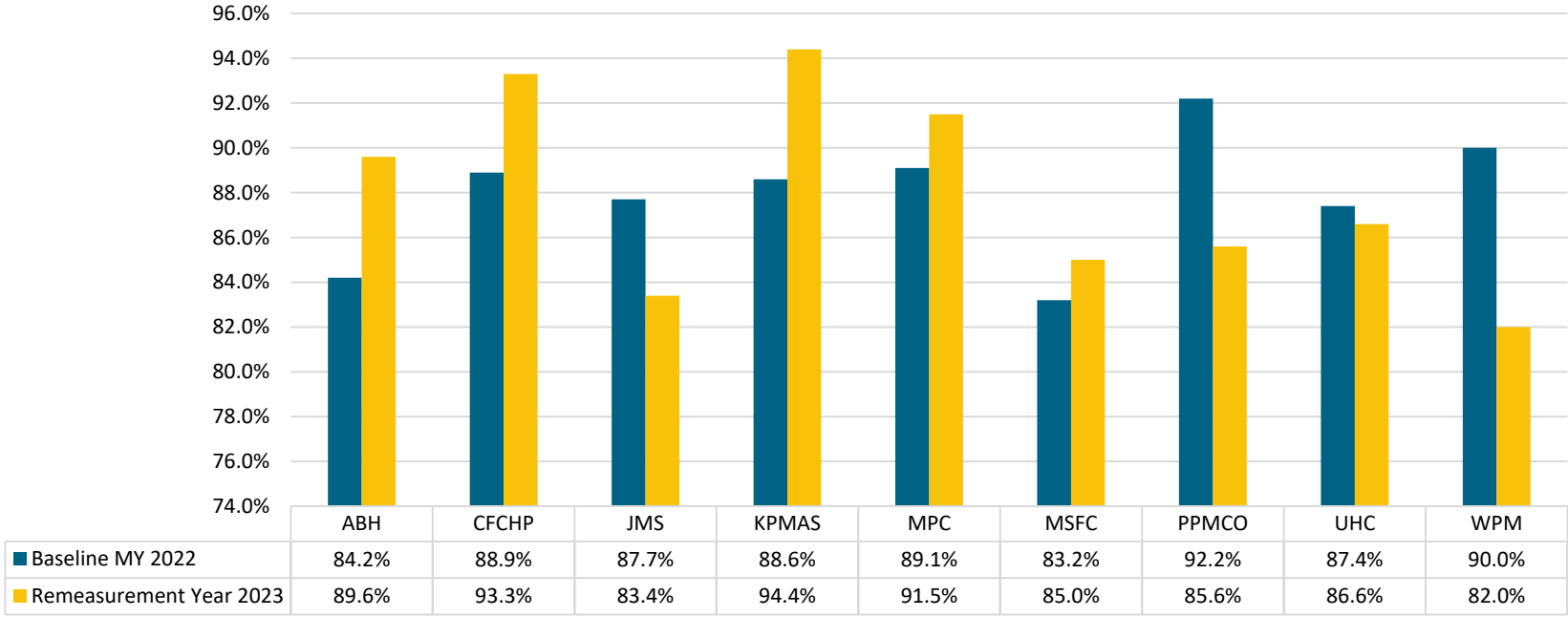
Table 19. MY 2023 Validation Rating and Confidence Levels (Prenatal Care PIP)

Step/Description	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Step 1. Topic	M	M	M	M	M	M	M	M	PM
Step 2. Aim Statement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Performance Measures and Population	M	M	M	PM	M	M	M	M	M
Step 4. Sampling Method	NA	M	NA	M	M	M	NA	NA	M
Step 5. Data Collection Procedures	M	M	M	M	M	M	M	PM	PM
Step 6. Data Analysis and Interpretation of Results	M	M	M	PM	M	M	M	M	M
Step 7. Improvement Strategies (Interventions)	M	M	M	M	M	M	M	PM	PM
Step 8. Significant and Sustained Improvement	M	PM	PM	M	PM	PM	PM	PM	PM
Step 9. State-Specific Strategies	M	M	M	PM	M	M	M	M	M
PIP Numerical Score	90	90	85	91	94	94	84	68	81
PIP Total Available Points	90	96	91	96	96	96	90	88	95
PIP Validation Rating	100%	93.8%	93.4%	94.8%	97.9%	97.9%	93.3%	77.3%	85.3%
Confidence Level	High	High	High	High	High	High	High	C	C

Validation Results: Light Green – M (*Met*); **Light Yellow** – PM (*Partially Met*); **Gray** – NA (*Not Applicable*)
Confidence Levels: Green – High (*High Confidence*); **Yellow** – C (*Confidence*)

Indicator Rate Performance – HealthChoice Performance. Figure(s) represent indicator rates for all MCOs, and table(s) compare indicator rates to the HEDIS 2023 NCQA Quality Compass Medicaid benchmarks. The MCOs' prenatal care rates for MY 2023 ranged from 82.0% (WPM) to 94.4% (KPMAS). ABH, CFCHP, KPMAS, MPC, and MSFC's performance rates increased in comparison to the baseline MY 2022. JMS, PPMCO, UHC, and WPM's performance rates decreased in comparison to the baseline MY 2022.

Figure 1. MY 2023 Indicator Rates (Prenatal Care PIP)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Baseline MY 2022	84.2%	88.9%	87.7%	88.6%	89.1%	83.2%	92.2%	87.4%	90.0%
Remeasurement Year 2023	89.6%	93.3%	83.4%	94.4%	91.5%	85.0%	85.6%	86.6%	82.0%

Indicator Rate Performance Compared to National Benchmarks. MCOs' performance rates for prenatal care varied in comparison to MY 2023 benchmarks, as shown in Table 20. CFHCP (93.3%) and KPMAS (94.4%) exceeded the 90th percentile. ABH (89.6%) and MPC (91.5%) exceeded the 75th percentile. MSFC (85.0%), PPMCO (85.6%), and UHC (86.6%) exceeded the 50th percentile. JMS (83.4%) and WPM (82.0%) fell below the 50th percentile.

Table 20. MY 2023 MCO Performance Comparison to NCQA's Quality Compass National Benchmarks (Prenatal Care PIP)

MY 2023 HealthChoice Performance	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Measure Rate	89.6%	93.3%	83.4%	94.4%	91.5%	85.0%	85.6%	86.6%	82.0%
Qlarant Diamond Rating	♦♦♦	♦♦♦♦	♦	♦♦♦♦	♦♦♦	♦♦	♦♦	♦♦	♦

♦♦♦♦ MCO rate equals or exceeds the 90th Percentile.
♦♦♦ MCO rate equals or exceeds the 75th Percentile but does not meet the 90th Percentile.
♦♦ MCO rate equals or exceeds the 50th Percentile but does not meet the 75th Percentile.
♦ MCO rate is below the 50th Percentile.

Maternal Health and Infant/Toddler Care During the Postpartum Period (Postpartum Care-Related PIP)

Purpose. Postpartum Care-Related PIPs focused on the improvement of specific postpartum care-related HEDIS measure rates that correlated with the individual MCO's selected strategies. The MCOs' selected strategies and correlating HEDIS measures are indicated in the table below.

Table 21. MY 2023 MCO-Selected Strategies and Correlating HEDIS Measure (Postpartum Care-Related PIP)

HEDIS Measure/Selected Strategy		ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
PPC-AD	Increase engagement throughout the 12-month coverage period	X	X	-	-	-	-	-	X	-
	Clinic-community linkages on behavioral health referrals and parenting supports	-	-	-	-	-	-	-	-	X
	Implement an electronic depression screening tool	-	-	-	X	-	-	X	-	-
W30	Promote WCV through engagement with doulas/HVS	X	-	X	-	X	-	-	-	X
	Value-added benefits for well-child care	-	-	-	X	-	X	-	-	-
CIS-3	Improve immunization rates	-	X	X	-	X	X	X	X	-

X – MCO selected strategy. Dash – MCO did not select strategy.

PIP Validation Step Results. An assessment of the validity and reliability of the PIP study design and results reflects a detailed review of each MCO's PIPs and audited HEDIS measure findings for the selected indicators. The following table identifies the validation rating and the corresponding level of confidence Qlarant has assigned to each MCO's PIPs for MY 2023. All MCOs were given a rating of *NA* for Step 2 (Aim Statement), since MDH provided the aim statement. Five of the nine MCOs' performances resulted in a confidence level of *High Confidence* for postpartum care PIP validations, ranging from 94.4% (PPMCO) to 100% (MSFC). Four of the nine MCOs' performances resulted in a confidence level of *Confidence*, ranging from 76.6% (CFCHP) to 88.7% (KPMAS).

Table 22. MY 2023 Validation Rating and Confidence Levels (Postpartum Care-Related PIP)

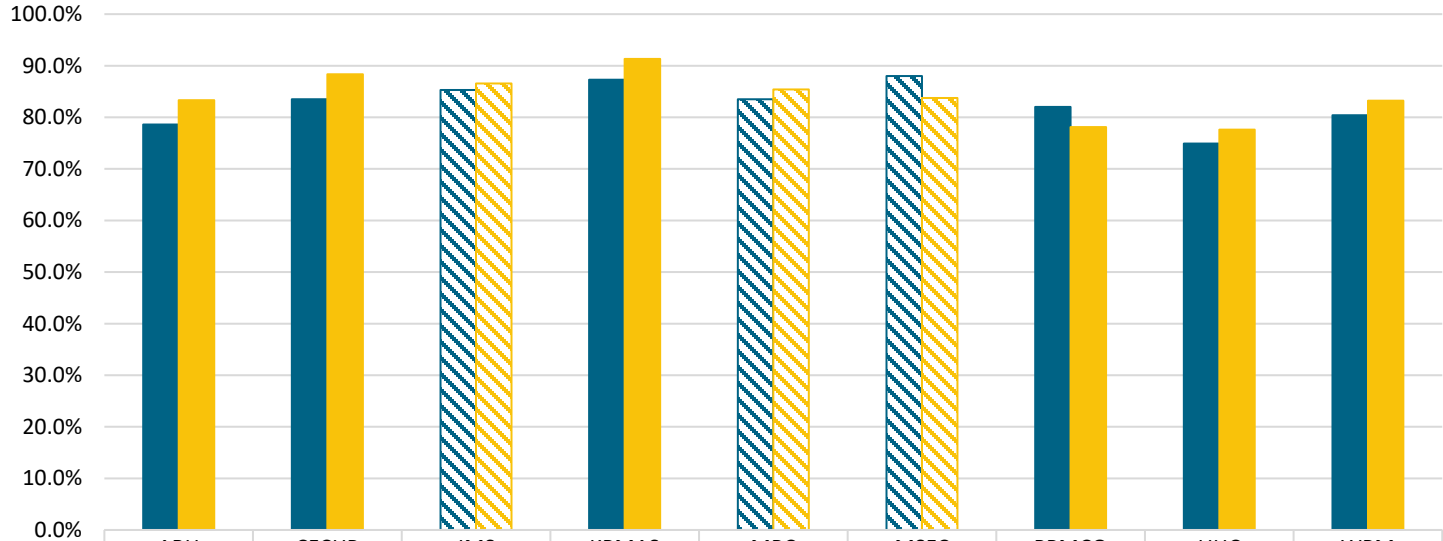
Step/Description	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Step 1. Topic	M	M	M	PM	M	M	M	M	PM
Step 2. Aim Statement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Performance Measures and Population	M	M	M	PM	M	M	M	PM	M
Step 4. Sampling Method	NA	M	M	M	M	M	NA	M	M
Step 5. Data Collection Procedures	M	M	M	M	M	M	M	M	M
Step 6. Data Analysis and Interpretation of Results	M	PM	M	PM	PM	M	PM	M	PM
Step 7. Improvement Strategies (Interventions)	M	PM	M	M	M	M	M	PM	PM
Step 8. Significant and Sustained Improvement	PM	PM	PM	PM	PM	M	PM	PM	PM
Step 9. State Specific Strategies	M	M	M	PM	M	M	M	M	M
PIP Numerical Score	85	72	93	86	92	95	85	77	81
PIP Total Available Points	87	94	97	97	97	95	90	91	95
PIP Validation Rating	97.7%	76.6%	95.9%	88.7%	94.9%	100%	94.4%	84.6%	85.3%
Confidence Level	High	C	High	C	High	High	High	C	C

Validation Results: Light Green – M (*Met*); Light Yellow – PM (*Partially Met*); **Gray** – NA (*Not Applicable*)
Confidence Levels: Green – High (*High Confidence)*; **Yellow** – C (*Confidence*)

Indicator Rate Performance – HealthChoice Performance. This section represents data collection results for MY 2023 as the first remeasurement year for the Postpartum Care-Related PIP. Figures represent indicator rates for all MCOs and table(s) compare indicator rates to the 2023 NCQA Quality Compass Medicaid HEDIS benchmarks.

Postpartum Care. The MCOs' postpartum care rates for MY 2023 ranged from 77.6% (UHC) to 91.3% (KPMAS). All but two MCOs (MSFC) and PPMCO) increased performance rates in comparison to the baseline in MY 2022.

Figure 2. MY 2023 Postpartum Care (PPC-AD) Indicator Rates (Postpartum Care-Related PIP)

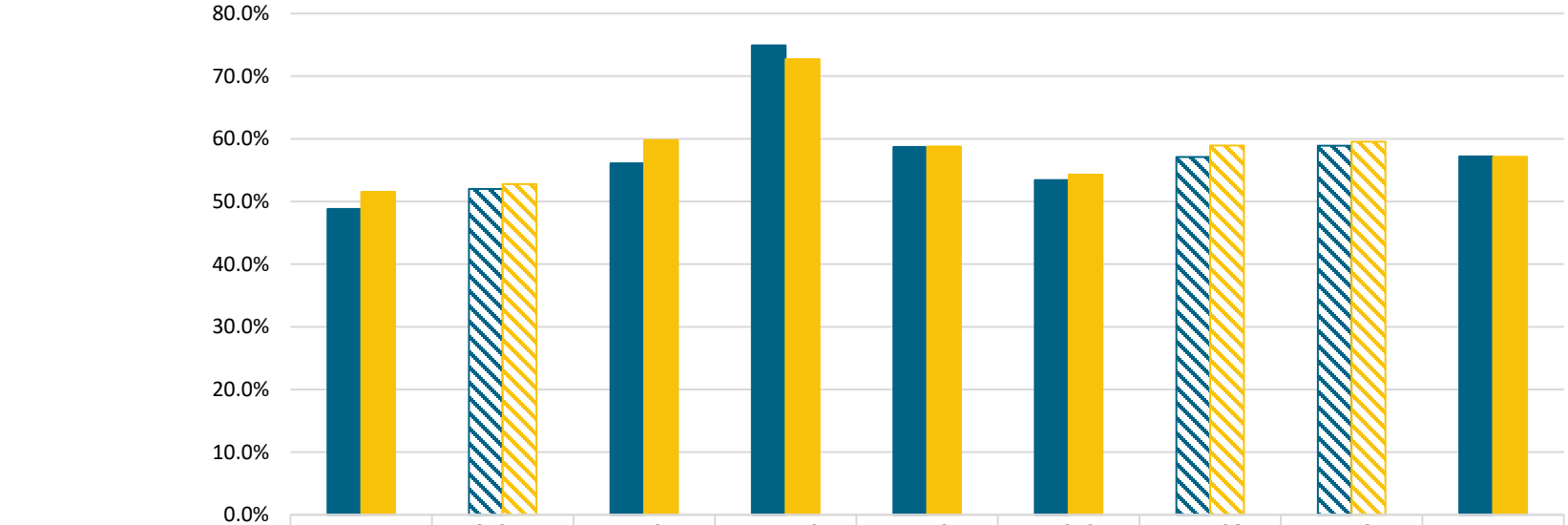


	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Baseline MY 2022	78.6%	83.5%	85.3%	87.3%	83.5%	88.0%	82.0%	74.9%	80.4%
Remeasurement Year 2023	83.3%	88.3%	86.6%	91.3%	85.4%	83.8%	78.1%	77.6%	83.2%

Solid bars represent MCOs that have selected a PPC-AD HEDIS rate strategy.
Striped bars represent MCOs that did not select a PPC-AD HEDIS rate strategy.

Well-Child Visits. The MCOs' W30 (0-15) rates for MY 2023 ranged from 51.5% (ABH) to 72.7% (KPMAS). All but two MCOs (KPMAS and WPM) increased performance rates compared to the baseline in MY 2022. The KPMAS performance rate decreased, and WPM's rate was sustained from baseline MY 2022 to MY 2023. The MCOs' W30 (15-30) rates for MY 2023 ranged from 66.2% (CFCHP) to 75.6% (KPMAS). ABH, JMS, KPMAS, MPC, and MSFC's performance rates increased in comparison to the baseline MY 2022. PPMCO, UHC, and WPM's performance rates decreased in comparison to the baseline MY 2022. CFCHP's rate was sustained from baseline MY 2022 to MY 2023.

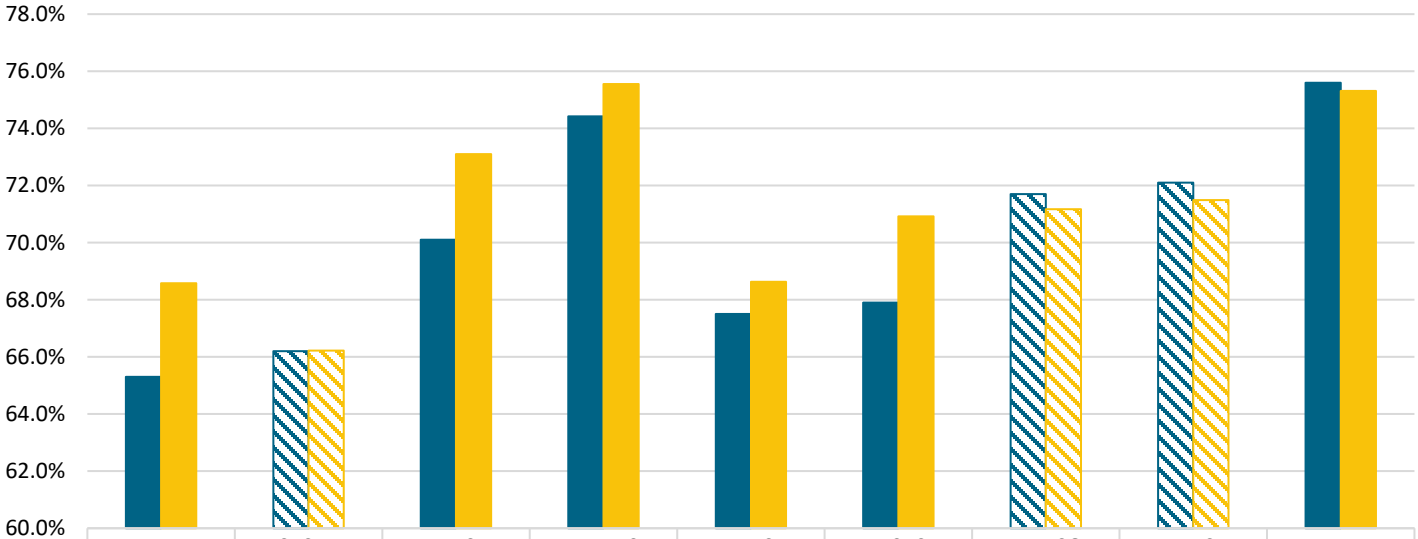
Figure 3. MY 2023 Well-Child Visits in the First 30 Months of Life (0-15 Months) Indicator Rates (Postpartum Care-Related PIP)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Baseline MY 2022	48.8%	52.0%	56.1%	74.9%	58.7%	53.4%	57.1%	58.9%	57.2%
Remeasurement Year 2023	51.5%	52.8%	59.8%	72.7%	58.8%	54.3%	58.9%	59.5%	57.2%

Solid bars represent MCOs that have selected a W30 HEDIS rate strategy.
Striped bars represent MCOs that did not select a W30 rate strategy.

Figure 4. MY 2023 Well-Child Visits in the First 30 Months of Life (15-30 Months) Indicator Rates (Postpartum Care-Related PIP)

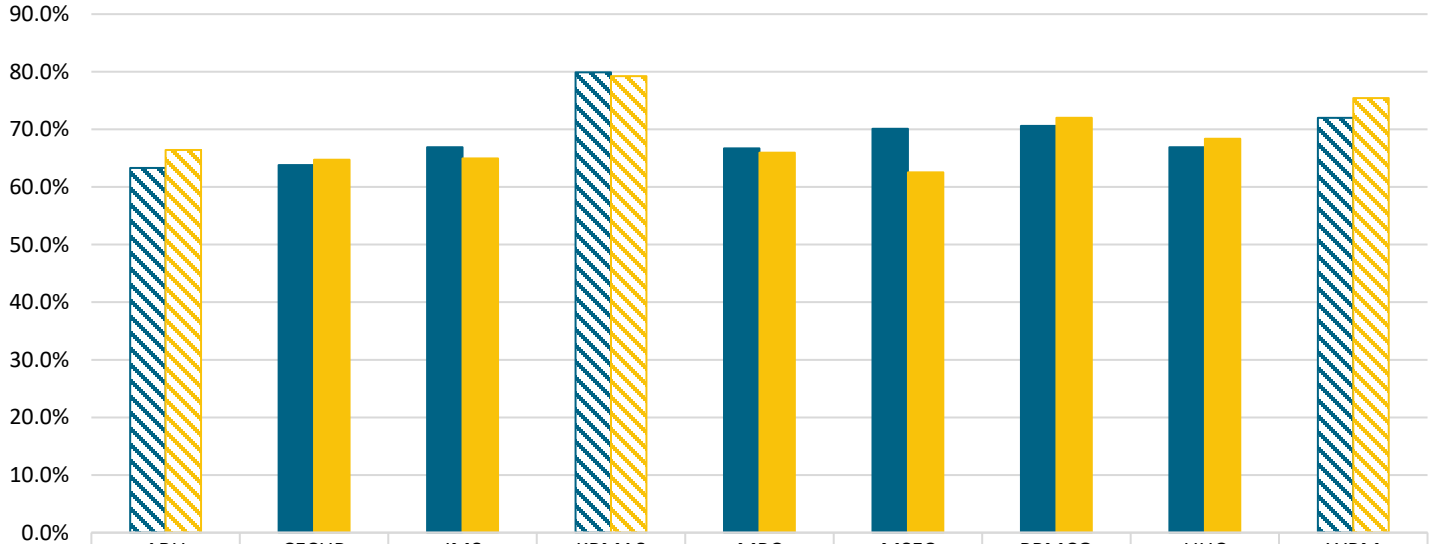


	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Baseline MY 2022	65.3%	66.2%	70.1%	74.4%	67.5%	67.9%	71.7%	72.1%	75.6%
Remeasurement Year 2023	68.6%	66.2%	73.1%	75.6%	68.6%	70.9%	71.2%	71.5%	75.3%

Solid bars represent MCOs that have selected a W30 HEDIS rate strategy.
Striped bars represent MCOs that did not select a W30 rate strategy.

Childhood Immunization Status. The MCOs' CIS-3 rates for MY 2023 ranged from 62.5% (MSFC) to 79.2% (KPMAS). ABH, CFCHP, PPMCO, UHC, and WPM's performance rates increased in comparison to the baseline MY 2022. JMS, KPMAS, MPC, and MSFC's performance rates decreased in comparison to the baseline MY 2022.

Figure 5. MY 2023 Childhood Immunization Status: Combo 3 Indicator Rates (Postpartum Care-Related PIP)



	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Baseline MY 2022	63.3%	63.8%	66.9%	79.9%	66.7%	70.1%	70.6%	66.9%	72.0%
Remeasurement Year 2023	66.4%	64.7%	65.0%	79.2%	65.9%	62.5%	72.0%	68.4%	75.4%

Solid bars represent MCOs that have selected a CIS-3 HEDIS rate strategy.
Striped bars represent MCOs that did not select a CIS-3 rate strategy.

Indicator Rate Performance Compared to National Benchmarks. For the MY 2023 PPC-AD measure, CFCHP (88.33%) and KPMAS (91.33%) performed within the 90th percentile. ABH (83.3%), JMS (86.6%), MPC (85.4%), and MSFC (83.8%) performed within the 75th percentile. WPM (83.2%) was the only MCO that performed within the 50th percentile. PPMCO (78.1%) and UHC (77.6%) were the only MCOs that performed below the 50th percentile.

For the MY 2023 W30 (0-15) measure, KPMAS (72.7%) was the only MCO that performed within the 90th percentile. All other MCOs performed below the 50th percentile, ranging from 51.5% (ABH) to 59.8% (JMS).

For the MY 2023 W30 (15-30) measure, JMS (73.1%), KPMAS (75.6%), and WPM (75.3%) performed within the 75th percentile. MSFC (70.9%), PPMCO (71.2%), and UHC (71.5%) performed within the 50th percentile. ABH (68.6%), CFCHP (66.2%), and MPC (68.6%) performed below the 50th percentile.

For the MY 2023 CIS-3 measure, KPMAS (79.2%) and WPM (75.4%) performed within the 90th percentile. PPMCO (72.0%) was the only MCO that performed within the 75th percentile. ABH (66.4%), CFCHP (64.7%), JMS (65.0%), MPC (65.9%), and UHC (68.4%) performed within the 50th percentile. MSFC (62.5%) was the only MCO that performed below the 50th percentile.

KPMAS had the highest performance across all four measures.

Table 23. MY 2023 MCO Performance Comparison to NCQA's Quality Compass (Postpartum Care-Related PIP)

MCO Rate Performance	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
PPC-AD Rate	83.3%	88.3%	86.6%	91.3%	85.4%	83.8%	78.1%	77.6%	83.2%
Diamond Rating	♦♦♦	♦♦♦♦	♦♦♦	♦♦♦♦	♦♦♦	♦♦♦	♦	♦	♦♦
W30 (0-15) Rate	51.5%	52.8%	59.8%	72.7%	58.8%	54.3%	58.9%	59.5%	57.2%
Diamond Rating	♦	♦	♦	♦♦♦♦	♦	♦	♦	♦	♦
W30 (15-30)	68.6%	66.2%	73.1%	75.6%	68.6%	70.9%	71.2%	71.5%	75.3%
Diamond Rating	♦	♦	♦♦♦	♦♦♦	♦	♦♦	♦♦	♦♦	♦♦♦
CIS-3 Rate	66.4%	64.7%	65.0%	79.2%	65.9%	62.5%	72.0%	68.4%	75.4%
Diamond Rating	♦♦	♦♦	♦♦	♦♦♦♦	♦♦	♦	♦♦♦	♦♦	♦♦♦♦

♦♦♦♦ MCO rate equals or exceeds the 90th Percentile.
♦♦♦ MCO rate equals or exceeds the 75th Percentile, but does not meet the 90th Percentile.
♦♦ MCO rate equals or exceeds the 50th Percentile, but does not meet the 75th Percentile.
♦ MCO rate is below the 50th Percentile.

Conclusion

HealthChoice is a mature managed care program, and analysis of PIP strategies and interventions submitted by MCOs enhances plans for quality assessment and performance improvement programs and HEDIS measure rates. During MY 2023, MCOs continued to implement and refine perinatal care interventions to improve health equity and the impact on SMART objectives and process metric goals. The PDSA cycle was used through the rapid cycle PIP process to assess small tests of evidence-based, systemic, and sustainable changes. Processes were implemented to modify interventions as needed when tests of change were not successful. All MCOs performed at levels of *Confidence* and *High Confidence* for both the prenatal care and postpartum care-related PIP topics during MY 2023. Five out of nine MCOs (ABH, JMS, MPC, MSFC, and PPMCO) performed at *High Confidence* levels for both PIP validations.

- **Quality** – MCOs must ensure that strategic, systemic, and impactful interventions are developed and implemented to improve the quality of care that enrollees receive in the areas of perinatal healthcare and preventative care for infants and toddlers. Interventions were required to have a health equity focus by overcoming barriers related to timely prenatal care, postpartum care, and/or

preventative care for infants and toddlers for disparate populations with the incorporation of each component of the Culturally and Linguistically Appropriate Services (CLAS) standards.

- **Access** – MCOs must ensure that interventions assess and reassess barriers and root causes related to timely prenatal care, postpartum care, and/or preventative care for infants and toddlers using the PDSA cycle. Interventions were required to address barriers to ensure adequate access to timely prenatal and postpartum care services for all enrollees, such as home visiting services, doula services, and enhanced case management for enrollees with substance use disorder.

- **Timeliness** – MCOs must ensure that interventions address barriers related to the timeliness of prenatal care, postpartum care, and/or preventative care for infants and toddlers. Following the PDSA cycle, MCOs modified interventions as needed to ensure enrollee engagement and follow through with prenatal and postpartum care, such as following the American College of Obstetricians and Gynecologists recommendations for timely postpartum care visits and the childhood immunization status schedule.

Overall PIP Performance. For MY 2023, all MCOs performed at confidence levels of *Confidence* and *High Confidence*. ABH, JMS, MPC, MSFC, and PPMCO performed at a confidence level of *High Confidence* for both PIP topics. UHC and WPM performed at a confidence level of C*onfidence* for both PIP topics. Validation ratings for the Prenatal Care PIP topic ranged from 77.3% (UHC) to 100% (ABH). Validation ratings for the Postpartum Care-Related PIP topics ranged from 76.6% (CFCHP) to 100% (MSFC). Although all MCOs performed at levels of *Confidence* and *High Confidence*, opportunities for improvement were identified and additional guidance was provided for each MCO during the rapid cycle PIP process.

Table 24. MY 2023 Remeasurement Overall Performance (PIP)

Performance Improvement Project		ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Prenatal Care PIP	Validation Rating	**100%**	**93.8%**	**93.4%**	**94.8%**	**97.9%**	**97.9%**	**93.3%**	**77.3%**	**85.3%**
	Confidence Level	**High**	**High**	**High**	**High**	**High**	**High**	**High**	**C**	**C**
	Any HEDIS Rate Improvement?	Yes	Yes	No	Yes	Yes	Yes	No	No	No
	Any Statistically Significant Improvement in HEDIS Rate?	Yes	No	No	Yes	No	No	No	No	No
	Any Sustained Improvement in HEDIS Rate?*	NA	NA	NA	NA	NA	NA	NA	NA	NA
Postpartum Care-Related PIP	Validation Rating	**97.7%**	**76.6%**	**95.9%**	**88.7%**	**94.9%**	**100%**	**94.4%**	**84.6%**	**85.3%**
	Confidence Level	**High**	**C**	**High**	**C**	**High**	**High**	**High**	**C**	**C**
	Any Postpartum Care HEDIS Rate Improvement?	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes
	Any Well-Child Visits in the First 30 Months of Life HEDIS Rate Improvement?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	Any Childhood Immunization Status HEDIS Rate Improvement?	Yes	Yes	No	No	No	No	Yes	Yes	Yes
	Any Statistically Significant Improvement in HEDIS Rate?	No	^NA	No	No	No	Yes	No	No	No
	Any Sustained Improvement in HEDIS Rate?*	NA	NA	NA	NA	NA	NA	NA	NA	NA

Confidence Levels: Green – High (*High Confidence*); **Yellow** – C (*Confidence*)
*At least two repeat measurements are required to evaluate the demonstration of sustained improvement.
^ CFCHP did not provide HEDIS sampling methodology numerators and denominators for MY 2022; therefore, statistical significance cannot be determined.

Quality Strategy Highlights

To achieve MDH's goal of delivering high-quality, accessible care to managed care enrollees, MDH developed a framework to focus on quality improvement efforts for the HealthChoice program. MDH set task goals of increasing the PPC-CH, PPC-AD, and CIS-3 measure rates for all MCOs

according to specific HealthChoice performance metrics, identified in the HealthChoice Quality Strategy for 2022-2024 in the table below. MCOs performing within the 90th percentile are expected to maintain performance within the 90th percentile. MCOs performing below the 90th percentile are expected to improve the baseline MY 2022 measure rates by five percent.

Table 25. MY 2023 HealthChoice Performance Against Quality Strategy Targets (PIP)

Performance Measure	Quality Strategy Targets MY 2024	HealthChoice Aggregate Performance Remeasurement MY 2023	Percentage Point Progress
Prenatal Care PIP	**%**	**%**	**# (↑, ↓, or NA)**
PPC-CH Performance	88.2%	87.94%	↓
Postpartum Care-Related PIP	**%**	**%**	**# (↑, ↓, or NA)**
PPC-AD Performance	81.3%	84.18%	↑
W30 (0-15) Performance	NA	58.40%	NA
W30 (15-30) Performance	NA	71.20%	NA
CIS-3 Performance	77.4%	68.80%	↓

NA (Not Applicable)
The MDH Quality Strategy did not identify quality strategy targets for the W30 measures because it was baseline at the time of issuance, so there is not a specific target for MY 2024.
Source: *HealthChoice Quality Strategy*

For additional findings and comprehensive details associated with the MY 2023 PIP validation, please access the link to the MY 2023 PIP Report in **Appendix E.** The **MCO Quality, Access, and Timeliness Assessment section** and **Appendix A** include informed conclusions from the PIP validation related to quality, access, and timeliness for the HealthChoice program.

Performance Measure Validation

Objective

Performance measures assist in monitoring the performance of individual MCOs at a point in time, tracking performance over time, and comparing performance among MCOs. The Performance Measure Validation (PMV) activity evaluates the accuracy and reliability of measures produced and reported by the MCO and determines the extent to which the MCO followed specifications for calculating and reporting the measures. Accuracy and reliability of the reported rates are essential to ascertain whether the MCO's quality improvement efforts have resulted in improved health outcomes. The validation process further allows MDH to have confidence in MCO measure results.

MDH utilizes Population Health Incentive Program (PHIP) activities as part of an incentive program designed to provide financial incentives to MCOs based on the performance of certain HEDIS and MDH-developed encounter measures. Analysis of select PHIP measures to determine

incentivized performance promotes the delivery of high-quality care within the HealthChoice managed care program and evaluates access to timely services to promote desired health outcomes.

Methodology

The PMV activity consists of validations and source material from several collaborative vendors, as identified below:

- MDH contracted with MetaStar to conduct HEDIS audits.
- MDH contracted with The Hilltop Institute at the University of Maryland, Baltimore County (Hilltop) to calculate PHIP encounter data measures.
- Qlarant validated the encounter data measures calculated by Hilltop and validated PHIP measures to determine financial incentives.

Healthcare Effectiveness Data and Information Set

More than 90% of American health plans utilize HEDIS performance measures. These HEDIS rates allow providers, employers, and consumers to compare the performance of health plans in the areas of quality, access, and enrollee satisfaction. State purchasers of health care utilize these aggregated HEDIS rates to evaluate an MCO's ability to demonstrate an improvement in preventive health outreach to its enrollees.

MDH incorporates six HEDIS measures in its PHIP activities, with the intent of the program to improve MCO performance with incentives. For additional findings and comprehensive details associated with HEDIS validations, please access MetaStar's S*tatewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2023 Results* in **Appendix E.**

Description of Data Obtained. Qlarant received information from the sources below to satisfy validation requirements.

- MDH provided all the MetaStar data, Hilltop data, and benchmark percentiles for each MCO.
- MetaStar provided HEDIS Final Audit Reports and reports summarizing results from the NCQA HEDIS Compliance Audits™[3].

Technical Methods of Data Collection and Analysis. MDH contracted with MetaStar to validate measures and conduct the NCQA HEDIS Compliance Audits. MetaStar validated six HEDIS measures and conducted the audits to ensure HEDIS data reported publicly by MCOs are

[3] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

accurate and reliable. The audit is conducted in three phases: a pre-site visit, a site visit, and a post-site visit (reporting), as displayed in the table below.

Timeline. MetaStar conducted MY 2023 PMV activities from January 2023 to December 2023.

Table 26. MetaStar's MY 2023 HEDIS Audit Phases and Activities (PMV)

Audit Phase	Activities
Pre-site Visit	• Perform a review of each MCO's HEDIS Record of Administration, Data Management, and Processes (Roadmap). The Roadmap captures self-reported information about an MCO's data systems and processes used for HEDIS data reporting. • Perform source code review and supplemental data validation; provide medical record review validation results; and select HEDIS measures to audit in further detail (results are then extrapolated to the rest of the HEDIS measures). • Conduct conference calls with each MCO to review any HEDIS guideline updates or measure specification changes and provide technical assistance.
Site Visit	• Investigate issues identified in the Roadmap, interview key staff, and review systems and processes used to collect data and produce HEDIS measures.
Post-site Visit	• Provide all MCOs with a list of follow-up items needed to complete the audit. • Require the MCO to implement corrective actions, which need to be completed with enough time to allow the auditor to assess the effect on measure results prior to final rate submission, if applicable. • Complete a final audit report and assign possible audit designations when the MCO has provided all requested documents and performed the recommended corrective actions. • Submit final HEDIS data to NCQA • Provide a final audit report to the MCO and NCQA.

Table 27. MetaStar's MY 2023 HEDIS Compliance Audit Designations (PMV)

HEDIS Designation	Description
R	Reportable. The MCO submitted a reportable rate for the measure.
NA	Small Denominator. The MCO followed the specifications, but the denominator was too small (e.g., <30) to report a valid rate.
NB	No Benefit. The MCO did not offer the health benefit required by the measure.
NR	Not Reported. The MCO chose not to report the measure.

HEDIS Measure Results – Comparing Previous Performance. The table below displays an analysis of change from comparisons of MY 2023's HEDIS measure results to MY 2022's results and indicates whether an MCO experienced a lower or higher change in HEDIS rates. Additional columns indicate changes in MARR (2023 rate minus 2022 rate) or NHM (2023 rate minus 2022 rate). MetaStar's *Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2023 Results* report provided the information in the following table and excludes

new measures or indicators with no trending history, HEDIS MY 2023 results which were reported as NA, or measures where the rates stayed the same from last year and did not increase or decrease.

Table 28. MY 2023 Summary of MetaStar's HEDIS Measure Results (PMV)

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change	NHM
Cervical Cancer Screening (CCS)	↑	↑	↓	↓	↓	↓	↓	↓	↓	7	2		-1.9%	↓	-0.5%	↓
Chlamydia Screening in Women (CHL), Total	↓	↓	↑	↑	↑	↓	↑	↓	↑	4	5		-0.3%	↓	0.7%	↑
Colorectal Cancer Screening (COL)	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		3.7%	↑	38.1%	↑
Appropriate Testing for Pharyngitis (CWP)	↑	↑	↑	↑	↑	↓	↑	↑	↓	2	7		4.6%	↑	6.9%	↑
Childhood Immunization Status (CIS), Combo 10	↓	↓	↑	↓	↓	↓	↓	↓	↓	8	1		-2.7%	↓	-2.8%	↓
Childhood Immunization Status (CIS), Combo 3	↑	↑	↓	↓	↓	↓	↑	↑	↑	4	5		0.0%	↓	0.7%	↑
Childhood Immunization Status (CIS), Combo 7	↑	↓	↓	↓	↑	↓	↑	↑	↑	4	5		0.2%	↑	0.3%	↑
Immunization for Adolescents (IMA), Combo 1	↑	↑	↓	↓	↓	↓	↓	↓	↓	7	2		-1.0%	↓	0.1%	↑
Immunization for Adolescents (IMA), Combo 2	↓	↑	↓	↓	↓	↓	↑	↓	↓	7	2		-2.0%	↓	0.3%	↑
Lead Screening in Children (LSC)	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		2.0%	↑	1.6%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI Percentile Documentation, Total	↑	↑	↓	↓	↑	↓	↓	↑	↑	4	5		-0.3%	↓	2.7%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change	NHM
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Nutrition, Total	↓	↑	↓	↓	↓	↓	↓	↑	↑	6	3		-1.6%	↓	1.1%	↑
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Physical Activity, Total	↑	↑	↓	↓	↑	↓	↓	↑	↑	4	5		-2.2%	↓	1.1%	↑
Appropriate Treatment for Upper Respiratory Infection (URI), Total	↓	↓	↓	↑	↓	↓	↓	↓	↓	8	1		-1.5%	↓	-1.6%	↓
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB), Total	↑	↓	↑	↑	↑	↓	↑	↑	↓	3	6		2.0%	↑	0.3%	↑
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	↓	↑		↑	↓	↑	↓	↓	↓	3	5	L	0.0%	↓	-0.1%	↓
Risk of Continued Opioid Use (COU), 15 Days, Total	↓	↓	↑	↓	↑	↑	↓	↑	↓	4	5	L	0.0%	↑	0.1%	↑
Risk of Continued Opioid Use (COU), 31 Days, Total	↓	↑	↑		↑	↑	↓	↑	↓	5	3	L	0.1%	↑	0.1%	↑
Use of Opioids at High Dosage (HDO)	↑	↑	↓	↓	↓	↓	↓	↑	↓	3	6	L	-0.4%	↓	0.2%	↑
Use of Opioids From Multiple Providers (UOP), Multiple Pharmacies	↑	↑	↓	↓	↑	↑	↑	↑	↓	6	3	L	0.3%	↑	1.0%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change	NHM
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers	↑	↓	↓	↑	↑	↓	↓	↑	↑	5	4	L	-0.2%	↓	0.1%	↑
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers and Multiple Pharmacies	↑	↑	↓	↑	↑	↑	↑	↑	↓	7	2	L	0.4%	↑	0.4%	↑
Asthma Medication Ratio (AMR), Total	↓	↑	↑	↑	↑	↓	↑	↓	↓	4	5		0.3%	↑	0.5%	↑
Pharmacotherapy Management of COPD Exacerbation (PCE), Bronchodilator	↑	↑	↑	↓	↑	↓	↑	↑	↑	2	7		1.6%	↑	-1.7%	↓
Pharmacotherapy Management of COPD Exacerbation (PCE), Systemic Corticosteroid	↑	↑	↑	↑	↑	↓	↑	↑	↓	2	7		4.8%	↑	-1.0%	↓
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	↓	↓	↓	↑	↑	↑	↑	↑	↓	4	5		2.4%	↑	0.8%	↑
Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 Years	↓	↓	↓	↑	↑	↓	↓	↓	↓	7	2		-0.8%	↓	1.4%	↑
Adults Access to Preventive/Ambulatory Health Services (AAP), 45-64 Years	↓	↓	↓	↑	↑	↓	↓	↓	↓	7	2		-0.6%	↓	0.7%	↑
Cardiac Rehabilitation – Achievement (CRE)	↑	↑	↓	↑	↑		↑	↓	↑	2	6		0.7%	↑	-0.1%	↓
Cardiac Rehabilitation – Engagement1 (CRE)	↑	↑	↓		↑		↓	↓	↑	3	4		0.8%	↑	0.4%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change	NHM
Cardiac Rehabilitation – Engagement2 (CRE)	↑	↑	↓	↑	↑		↑	↓	↑	2	6		1.6%	↑	0.4%	↑
Cardiac Rehabilitation – Initiation (CRE)		↑			↑	↓	↓	↓	↑	3	3		0.2%	↑	0.1%	↑
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)							↑			0	1		2.6%	↑	2.4%	↑
Controlling High Blood Pressure (CBP)	↓	↑	↑	↑	↑	↑	↓	↑	↑	2	7		3.2%	↑	3.0%	↑
Statin Therapy for Patients with Cardiovascular Disease (SPC), Received Statin Therapy, Total	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		2.8%	↑	0.6%	↑
Statin Therapy for Patients with Cardiovascular Disease (SPC), Statin Adherence 80%, Total	↑	↓	↑	↓	↑	↓	↑	↓	↓	5	4		-0.2%	↓	0.8%	↑
Prenatal and Postpartum Care (PPC) – Postpartum Care	↑	↑	↑	↑	↑	↓	↓	↑	↑	2	7		1.6%	↑	1.7%	↑
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	↑	↑	↓	↑	↑	↑	↓	↓	↓	4	5		0.0%	↑	0.2%	↑
Blood Pressure Control for Patients With Diabetes (BPD)	↑	↑	↑	↑	↑	↑		↑	↑	0	8		3.1%	↑	4.2%	↑
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		↑			↑	↓	↑	↓	↓	3	3		3.4%	↑	2.6%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change	NHM
Eye Exam for Patients with Diabetes (EED)	↑	↑	↓	↑	↑	↑	↓	↑	↑	2	7		2.5%	↑	1.3%	↑
Hemoglobin A1c Control for Patients with Diabetes (HBD), Control (<8.0%)	↑	↑	↓	↑	↑	↓	↓	↑	↑	3	6		1.7%	↑	4.5%	↑
Hemoglobin A1c Control for Patients with Diabetes (HBD), Poor Control (>9.0%)	↓	↓	↑	↓	↓	↑	↑	↓	↓	3	6	L	-2.0%	↓	-4.5%	↓
Kidney Health Evaluation for Patients with Diabetes (KED)	↑	↑	↓	↓	↑	↓	↑	↑	↑	3	6		0.2%	↑	3.1%	↑
Statin Therapy Evaluation for Patients with Diabetes (KED), Received Statin Therapy	↓	↓	↑	↓	↓	↓	↑	↑	↑	5	4		0.0%	↑	0.1%	↑
Stain Therapy for Patients with Diabetes (SPD), Statin Adherence 80%	↓	↓	↓	↑	↑	↓	↑	↑	↑	4	5		0.6%	↑	1.3%	↑
Antibiotic Utilization for Respiratory Conditions (AXR)	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		7.7%	↑	26.1%	↑
Child and Adolescent Well-Care Visits (WCV), 12-17 years	↑	↓	↓	↑	↑	↑	↑	↓	↑	3	6		1.3%	↑	2.9%	↑
Child and Adolescent Well-Care Visits(WCV), 18-21 years	↑	↓	↓	↑	↑	↓	↑	↑	↑	3	6		0.8%	↑	3.4%	↑
Child and Adolescent Well-Care Visits (WCV), 3-11 years	↑	↓	↓	↑	↑	↑	↑	↓	↑	3	6		1.4%	↑	3.0%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change	NHM
Child and Adolescent Well-Care Visits (WCV), Total	↑	↓	↓	↑	↑	↑	↑	↓	↑	3	6		1.6%	↑	3.5%	↑
Plan All-Cause Readmissions (PCR) – Observed	↑	↓	↓	↓	↑	↓	↓	↓	↓	7	2		-0.6%	↓	0.0%	↓
Plan All-Cause Readmissions (PCR) – Observed / Expected	↑	↓	↓	↓	↑	↓	↓	↓	↓	2	7	L	-0.04%	↓	-9.01	↓
Well-Child Visits in the First 30 Months of Life (W30), 15 Months	↑	↑	↑	↓	↑	↑	↑	↑	↓	2	7		0.9%	↑	2.2%	↑
Well-Child Visits in the First 30 Months of Life (W30), 15-30 Months	↑	↑	↑	↑	↑	↑	↓	↓	↓	3	6		1.2%	↑	2.5%	↑
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SSA)				↓			↑	↑		1	2		3.8%	↑	1.3%	↑
Antidepressant Medication Management (AMM), Acute Phase				↑			↓	↓	↓	3	1		0.7%	↑	1.7%	↑
Antidepressant Medication Management (AMM), Continuation Phase				↑			↓	↓	↓	3	1		-4.0%	↓	1.4%	↑
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				↑	↓		↑	↑	↓	2	3		3.8%	↑	2.4%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR Change	MARR	NHM Change	NHM
Diagnosed Mental Health Disorders (DMH), Total	↑	↑	↑	↓	↑	↓	↑	↑	↑	2	7		1.5%	↑	2.3%	↑
Diagnosed Substance Use Disorders (DSU), Total	↑	↓	↑	↓	↑	↓	↓	↓	↑	5	4		0.0%	↓	0.3%	↑
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Acute Phase		↓		↓	↑		↑	↓	↑	3	3		-1.7%	↓	1.7%	↑
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation Phase					↑		↓	↓	↑	2	2		2.8%	↑	-1.0%	↓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Blood Glucose and Cholesterol Total				↑			↑	↑		0	3		5.5%	↑	2.1%	↑
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Blood Glucose Total				↑			↑	↑		0	3		5.4%	↑	1.8%	↑
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Cholesterol Total				↑			↑	↑		0	3		4.7%	↑	1.9%	↑
Pharmacotherapy for Opioid Use Disorder (POD), Total					↑		↓	↓	↑	2	2		7.7%	↑	-2.5%	↓
Breast Cancer Screening (BCS-E)	↑	↓	↓				↓	↓		4	1		-0.4%	↓	0.9%	↑
Prenatal Immunization Status (PRS-E)	↓	↓	↑	↓	↑	↑	↑	↓	↑	4	5		1.8%	↑	-0.1%	↓

Source: *MetaStar's Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2023 Results*

Consumer Assessment of Healthcare Providers and Systems

The Agency for Healthcare Research and Quality (AHRQ) introduced the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program in the mid-1990s. Still used today, the CAHPS program utilizes standardized surveys to ask consumers and patients to evaluate their experiences with health care with topics important to consumers, such as accessibility of services and provider communication skills. NCQA uses HEDIS in the CAHPS survey process to assess MCO performance on dimensions of care and service and provide confidence to purchasers and consumers on MCO performance comparisons.

MDH contracted with the Center for the Study of Services (CSS) to administer the children with chronic conditions (CCC) version of the adult and child Health Plan CAHPS Survey.

Data Collection and Review. CSS followed the NCQA methodology detailed in *HEDIS 2024, Volume 3: Specifications for Survey Measures* and *Quality Assurance Plan for HEDIS 2024 Survey Measures*. Enrollee files received were carefully inspected to identify any errors, irregularities, or missing data elements such as addresses or subscriber numbers. The USPS National Change of Address service was used to process enrollee addresses and ensure updated information.

Timeline. CSS administered the CAHPS Health Plan Survey for the adult and child Medicaid populations between February 9 and May 10, 2024. MCO survey results were submitted to NCQA on May 24, 2024.

The tables below illustrate the summarized results of the CAHPS Health Plan Survey for the adult and child Medicaid populations.

Table 29. Summary of Trends in Performance on Key HealthChoice Adult Medicaid CAHPS Survey Measures (PMV)

Health Plan	Survey Year	2024 (MY 2023) NCQA Quality Compass National Average (All LOBs)	Health Choice Aggregate	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Getting Needed Care (% Usually or Always)	**2024**	**81.45%**	**79.70%**	**71.68% ⇊**	**80.41%**	**84.56%**	**75.09%**	**79.03% ⇊**	**85.82%**	**80.16%**	**76.56% ⇊**	**81.04%**
	2023		10th	<10th L	33rd	67th	<10th	10th	67th H	33rd	10th	33rd
	2022		78.19%	73.14%	81.70%	83.64%	73.49%	79.85%	77.12%	78.53%	76.86%	79.33%
			82.87%	77.38%	79.30%	84.93%	86.26% ✓	86.30%	83.04%	86.67%	80.68%	80.84%
Getting Care Quickly (% Usually or Always)	**2024**	**80.39%**	**78.82%**	**72.28% ⇊**	**81.44%**	**82.15%**	**73.26%**	**79.99%**	**83.09%**	**79.83%**	**79.90%**	**76.88%**
	2023		33rd	<10th L	33rd	33rd	<10th	33rd	67th H	33rd	33rd	10th
	2022		78.34%	73.94%	77.07%	85.27%	68.61%	81.41%	79.00%	79.32%	77.98%	83.28%
			80.83%	76.50%	78.58%	82.76%	82.07%	78.00%	81.97%	80.93%	82.26%	82.17%
Rating of Personal Doctor (% 9 or 10)	**2024**	**69.18%**	**66.20%**	**60.43%**	**67.76%**	**70.00% ⇊**	**64.71%**	**65.56%**	**69.89%**	**65.12%**	**67.14%**	**63.84%**
	2023		10th	<10th L	33rd	33rd H	10th	10th	33rd	10th	10th	10th
	2022		64.89%	63.41%	73.25%	70.27%	61.93%	62.50%	62.25%	67.10%	60.81%	62.14%
			65.25%	61.32%	64.41%	72.54%	62.75%	63.16%	68.53%	63.93%	63.04%	66.20%
Rating of Specialist Seen Most Often (% 9 or 10)	**2024**	**67.69%**	**65.34% ⇈**	**52.24%**	**63.01%**	**70.65%**	**69.86% ⇈**	**73.63%**	**67.59% ⇈**	**65.04%**	**62.14% ⇈**	**60.00% ⇊**
	2023		33rd	<10th ● L	10th	67th	67th	67th H	33rd	10th	<10th	<10th
	2022		61.79%	52.54%	66.25%	60.87%	67.50%	56.63% ✓	62.22%	64.29%	59.72%	63.01%
			61.60%	47.27%	60.00%	65.57%	66.67%	62.12%	58.44%	70.69%	59.38%	63.16%
Rating of All Health Care (% 9 or 10)	**2024**	**56.80%**	**54.46% ⇊**	**45.24%**	**55.91%**	**56.38%**	**58.57%**	**48.97% ⇊**	**55.84%**	**50.83%**	**63.25% ⇈**	**53.79%**
	2023		10th	<10th ● L	33rd	33rd	33rd	<10th	33rd	10th	67th ● H	10th
	2022		55.19%	50.49%	58.27%	43.81% ✓	52.48%	52.34%	58.97%	54.55%	61.06%	65.05%
			55.45%	45.24%	56.25%	58.59%	59.84%	58.41%	57.52%	48.08%	50.91% ✓	60.66%

<10th 10th 33rd 67th 90th Color shading represents 2024 plan performance compared to the 2024 (MY 2023) NCQA National Percentiles for All LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2024 plan rate indicates a statistically significant difference from the Aggregate rate at the 95% confidence level.

⇈⇊ next to the 2024 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2024 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

Source: State of Maryland Executive Summary Report HealthChoice 2024 CAHPS® 5.1H Member Experience Survey prepared by Center for the Study of Services

Table 30. Summary of Trends in Performance on Key HealthChoice Adult Medicaid CAHPS Survey Measures (Continued) (PMV)

Health Plan	Survey Year	2024 (MY 2023) NCQA Quality Compass National Average (All LOBs)	Health Choice Aggregate	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Rating of Health Plan (% 9 or 10)	**2024**	**61.47%**	**55.42% ⇊**	**49.47%**	**58.62% ⇈**	**57.08%**	**59.91%**	**47.93% ⇊**	**59.44%**	**48.44%**	**60.56% ⇈**	**56.44%**
	2023		10th	<10th	10th	10th	33rd	<10th ● L	10th	<10th ●	33rd H	10th
	2022		55.93%	48.00%	56.28%	47.64%	52.86%	53.01%	65.59%	61.81% ✓	59.22%	58.96%
			56.53%	51.80%	52.87%	56.80%	64.89%	53.85%	58.58%	60.63% ✓	50.28% ✓	57.46%
Coordination of Care (% Usually or Always)	**2024**	**85.64%**	**84.57%**	**77.78%**	**90.28%**	**80.00%**	**91.07%**	**88.89%**	**86.49%**	**84.21%**	**80.65%**	**82.89%**
	2023		33rd	<10th L	67th	<10th	90th H	67th	33rd	33rd	<10th	10th
	2022		82.55%	81.82%	95.65%	90.38%	75.71% ✓	79.73%	78.33%	78.26%	79.69%	85.19%
			84.85%	81.82%	77.78%	90.00%	84.38%	87.93%	85.71%	88.24%	86.15%	80.70%
Customer Service (% Usually or Always)	**2024**	**89.12%**	**88.65%**	**82.83%**	**89.57%**	**91.10% ⇊**	**88.55%**	**90.16%**	**91.76%**	**87.13%**	**89.10% ⇈**	**86.39% ⇊**
	2023		33rd	<10th L	33rd	67th	33rd	33rd	67th H	10th	33rd	<10th
	2022		88.60%	81.95%	90.89%	92.98%	90.70%	90.46%	86.61%	86.96%	87.21%	88.73%
			89.99%	87.27%	90.83%	93.15%	88.36%	87.07%	95.86%	91.25%	86.22%	89.86%
How Well Doctors Communicate (% Usually or Always)	**2024**	**92.95%**	**92.56%**	**91.42% ⇈**	**96.00%**	**92.19%**	**90.87%**	**94.33% ⇈**	**94.82%**	**92.47% ⇊**	**88.65%**	**92.69%**
	2023		33rd	10th	90th H	10th	10th	67th	67th	33rd	<10th L	33rd
	2022		91.78%	91.21%	96.58%	91.42%	87.14%	93.99%	93.25%	93.56%	86.41%	92.31%
			93.11%	90.64%	88.99%	93.90%	92.32%	93.90%	95.28%	96.06%	92.93%	92.90%
Shared Decision Making (% Yes)	**2024**	**Measure not supported by NCQA**	**79.86%**	**79.17%**	**83.23%**	**81.49%**	**78.44%**	**80.95%**	**76.56% ⇊**	**79.23%**	**76.91%**	**84.04% ⇈**
	2023		—	—	—	—	—	—	— L	—	—	— H
	2022		78.16%	70.39%	79.50%	80.26%	78.47%	82.59%	76.86%	77.83%	75.54%	78.95%
			80.17%	81.16%	83.95%	86.12%	71.08%	82.56%	79.12%	83.12%	84.71%	69.54%

<10th 10th 33rd 67th 90th Color shading represents 2024 plan performance compared to the 2024 (MY 2023) NCQA National Percentiles for All LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2024 plan rate indicates a statistically significant difference from the Aggregate rate at the 95% confidence level.

⇈⇊ next to the 2024 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2024 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

Source: State of Maryland Executive Summary Report HealthChoice 2024 CAHPS® 5.1H Member Experience Survey prepared by Center for the Study of Services

Table 31. Summary of Trends in Performance on Key HealthChoice Child Medicaid with CCC CAHPS Survey Measures (PMV)

Health Plan	Survey Year	2024 (MY 2023) NCQA Quality Compass National Average (All LOBs)	Health Choice Aggregate	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Getting Needed Care (% Usually or Always)	**2024**	**83.33%**	**79.92%**	**78.44%**	**80.56%** ⇈	**86.49%** ⇈	**74.92%**	**79.84%** ⇊	**76.77%** ⇊	**80.77%** ⇊	**82.19%**	**81.84%**
	2023		10th	10th	10th	67th H	<10th L	10th	<10th	10th	33rd	33rd
	2022		77.99%	70.45%	75.38%	85.91%	74.81%	81.26%	78.78%	83.19%	76.50%	78.01%
			80.24%	81.87%	74.71%	82.61%	74.94%	86.66%	79.44%	85.22%	76.86%	79.67%
Getting Care Quickly (% Usually or Always)	**2024**	**86.31%**	**82.51%**	**81.83%**	**85.10%**	**89.88%** ⇈	**67.57%**	**84.52%** ⇊	**83.52%** ⇈	**83.13%**	**84.12%**	**83.74%**
	2023		10th	10th	33rd	67th● H	<10th● L	10th	10th	10th	10th	10th
	2022		81.67%	80.49%	78.93%	86.10%	72.90%	84.86%	82.53%	85.83%	82.49%	81.85%
			82.08%	86.49%	79.58%	83.77%	72.15%	84.97%	76.37%	85.70%	84.08%	85.81%
Rating of Personal Doctor (% 9 or 10)	**2024**	**76.45%**	**75.42%**	**74.16%** ⇈	**74.22%**	**77.46%** ⇊	**77.37%**	**68.05%**	**75.33%**	**76.99%**	**75.39%**	**78.64%**
	2023		33rd	10th	10th	33rd	33rd	<10th● L	33rd	33rd	33rd	67th H
	2022		73.65%	72.53%	69.11%	78.66%	75.18%	75.09%	69.17%	78.22%	71.92%	73.42%
			74.83%	67.39%	71.82%	82.48%	76.32%	68.14%	74.86%	70.99%	81.55%	81.38%
Rating of Specialist Seen Most Often (% 9 or 10)	**2024**	**72.82%**	**70.78%**	**74.67%**	**71.43%**	**71.43%** ⇈	**69.49%**	**67.12%**	**67.27%**	**69.74%** ⇈	**67.14%**	**77.22%**
	2023		10th	67th	10th	10th	10th	10th L	10th	10th	10th	67th H
	2022		67.36%	65.96%	71.43%	70.00%	68.89%	75.44%	56.41%	63.79%	65.52%	67.27%
			68.09%	78.13%	67.44%	60.87%	77.50%	63.46%	66.67%	62.50%	70.97%	67.35%
Rating of All Health Care (% 9 or 10)	**2024**	**69.62%**	**70.58%**	**66.41%** ⇊	**68.44%** ⇈	**70.21%** ⇈	**71.32%**	**65.95%** ⇊	**69.43%**	**72.96%**	**73.58%**	**75.86%**
	2023		33rd	10th	33rd	33rd	33rd	10th L	33rd	67th	67th	67th H
	2022		67.84%	66.88%	62.30%	70.00%	64.39%	70.00%	63.64%	71.16%	71.07%	70.72%
			70.83%	68.70%	62.25%	68.18%	73.37%	70.07%	65.79%	72.19%	76.00%	76.97%

<10th 10th 33rd 67th 90th Color shading represents 2024 plan performance compared to the 2024 (MY 2023) NCQA National Percentiles for All LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2024 plan rate indicates a statistically significant difference from the Aggregate rate at the 95% confidence level.

⇈⇊ next to the 2024 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2024 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

Source: State of Maryland Executive Summary Report HealthChoice 2024 CAHPS® 5.1H Member Experience Survey prepared by Center for the Study of Services

Table 32. Summary of Trends in Performance on Key HealthChoice Child Medicaid with CCC CAHPS Survey Measures (Continued) (PMV)

Health Plan	Survey Year	2024 (MY 2023) NCQA Quality Compass National Average (All LOBs)	Health Choice Aggregate	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Rating of Health Plan (% 9 or 10)	**2024**	**71.31%**	**69.65%**	**67.10%** ↑↑	**73.09%**	**65.40%**	**66.14%** ↑↑	**68.07%** ↑↑	**66.67%**	**71.72%**	**67.23%**	**77.92%**
	2023		33rd	10th	33rd	10th L	10th	10th	10th	33rd	10th	67th● H
	2022		66.83% ✓ 68.42%	65.14% 60.96%	63.02% ✓ 67.28%	59.43% 71.20%	65.82% 63.96%	67.85% 66.80%	62.50% 65.14%	74.80% 69.86%	67.09% 71.95%	71.26% ✓ 77.46%
Coordination of Care (% Usually or Always)	**2024**	**83.50%**	**80.39%**	**77.14%**	**79.38%**	**87.88%**	**80.41%**	**80.56%**	**75.24%** ↓↓	**80.99%**	**82.42%**	**81.95%**
	2023		10th	10th	10th	67th H	10th	10th	<10th L	10th	33rd	10th
	2022		77.94% 81.34%	79.37% 77.78%	75.32% 90.91%	80.00% 92.00%	78.21% 83.05%	75.00% 79.37%	75.34% 80.43%	81.91% 78.87%	74.39% 78.95%	82.72% 76.79%
Customer Service (% Usually or Always)	**2024**	**88.29%**	**86.88%**	**81.03%**	**90.82%**	**93.02%**	**87.69%**	**81.17%** ↑↑	**85.71%**	**84.58%** ↓↓	**86.27%** ↑↑	**89.61%**
	2023		10th	<10th L	67th	90th H	33rd	<10th	10th	10th	10th	33rd
	2022		82.70% ✓ 89.01%	76.79% 90.45%	72.97% ✓ 93.86%	91.69% 92.20%	82.69% 88.75%	80.71% 80.48%	85.38% 90.76%	86.21% 93.55%	84.44% 79.84%	85.09% 88.56%
How Well Doctors Communicate (% Usually or Always)	**2024**	**93.83%**	**91.46%**	**90.01%**	**89.18%**	**94.02%**	**90.93%**	**91.83%**	**92.16%**	**93.72%** ↑↑	**90.30%**	**91.22%**
	2023		10th	<10th	<10th L	33rd H	10th	10th	10th	33rd	<10th	10th
	2022		90.77% 92.79%	89.59% 94.12%	88.93% 91.06%	93.22% 96.83%	89.12% 92.47%	92.91% 92.77%	91.25% 93.06%	92.84% 91.15%	89.81% 92.08%	89.84% 93.29%
Shared Decision Making (% Yes)	**2024**	**Measure not supported by NCQA**	**75.50%** ↓↓	**74.74%** ↓↓	**71.94%**	**87.62%**	**67.87%**	**68.47%** ↓↓	**79.75%**	**76.16%**	**84.57%**	**72.64%**
	2023		—	—	—	— H	— L	—	—	—	—	—
	2022		75.87% 78.62%	76.86% 81.52%	81.82% 76.19%	70.18% 84.49%	76.68% 70.85%	80.18% 81.04%	68.62% 78.41%	78.84% 78.79%	74.29% 82.03%	67.71% 74.51%

<10th 10th 33rd 67th 90th Color shading represents 2024 plan performance compared to the 2024 (MY 2023) NCQA National Percentiles for All LOBs.

H/L indicates the highest/lowest-performing plan on the measure.

● below the 2024 plan rate indicates a statistically significant difference from the Aggregate rate at the 95% confidence level.

↑↑↓↓ next to the 2024 plan rate indicates a directionally consistent (positive or negative), but not necessarily statistically significant, trend over two consecutive years.

✓ next to a prior-year rate indicates that the 2024 result represents a statistically significant improvement/decline from the prior-year rate at the 95% confidence level.

Source: State of Maryland Executive Summary Report HealthChoice 2024 CAHPS® 5.1H Member Experience Survey prepared by Center for the Study of Services

Population Health Incentive Program

MDH selected HEDIS and state-specific performance measures for the PHIP program.

Description of Data Obtained. In accordance with COMAR 10.67.04.03-2, financial incentives are allocated annually to HealthChoice MCOs that demonstrate high-quality care based on standardized measures of performance. MDH designed the PHIP to improve MCO performance by applying incentives to a set of performance measures. Qlarant collaborates with MetaStar, a NCQA-Licensed Organization; and Hilltop for completion of PHIP validation activities.

Technical Methods of Data Collection and Analysis. Selected HEDIS measures are calculated and validated per HEDIS Volume 2: Technical Specifications for Health Plans and then compared to the nationally calculated Quality Compass percentiles (see Table 35 for HEDIS validation results). These percentiles are used as incentive benchmarks to determine if the MCO's quality improvement efforts have successfully resulted in improved health outcomes. For state-specific performance measures, MDH and Hilltop calculate percentiles for comparison across HealthChoice MCOs once Qlarant's validation is complete (see Table 36 for Encounter Data validation results).

MDH selects incentivized performance measures with input from stakeholders, which include MCOs and the Maryland Medicaid Advisory Committee. Measure selection is based on legislative priorities, HealthChoice enrollee healthcare needs, and the below criteria:

- Whether the topic is relevant to the HealthChoice core populations, which include children, special needs children, pregnant women, adults with disabilities, and adults with chronic conditions;
- Whether the topic is prevention-oriented to promote optimum health;
- Whether the topic is measurable with data availability;
- Whether the topic is consistent with CMS Medicaid Core Set or HEDIS performance measures; and
- Whether the MCOs can achieve quality improvement and positive health outcomes in this topic.

MY 2023 PHIP rates were drawn from HEDIS and encounter data rates. The following table displays the selected PHIP measures for MY 2023.

Table 33. MY 2023 Measures (PHIP)

Performance Measure	Domain	Measure Source	Reporting Entity
Ambulatory Care Visits for Supplemental Security Income (SSI) Adults	Access to Care	Encounter Data	MCO
Ambulatory Care Visits for SSI Children	Access to Care	Encounter Data	MCO
Asthma Medication Ratio (AMR)	Effectiveness of Care	HEDIS	MCO

Performance Measure	Domain	Measure Source	Reporting Entity
Continued Opioid Use (COU): ≥31 days covered	Effectiveness of Care	HEDIS	MCO
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)	Effectiveness of Care	HEDIS	MCO
Lead Screening in Children (LSC)*	Effectiveness of Care	HEDIS	MCO
Prenatal and Postpartum Care (PPC-CH): Timeliness of Prenatal Care	Access and Availability to Care	HEDIS	MCO
Prenatal and Postpartum Care (PPC-AD): Postpartum Care	Access and Availability to Care	HEDIS	MCO

*For MY 2023, encounter-based lead data is excluded from the incentive calculations; the Lead Screening in Children (LSC) HEDIS measure is fully weighted.

Validation Methodology and Results

Encounter Data Measure Validation Methodology. PHIP encounter data measures were calculated by Hilltop. Hilltop used encounter data submitted by the MCOs and fee-for-service data to calculate the below encounter data measures:

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

Due to challenges with the Maryland Department of Environment (MDE) Childhood Lead Registry data, the encounter-based lead measure will not be used in the incentive calculations. Instead, the Lead Screening in Children (LSC) HEDIS measure will be worth a full measure (100%) for MY 2023.

Qlarant validated the encounter data measures by reviewing both data collection and processing systems and reviewing the source code for each measure to determine compliance with MDH's measure specifications. Validation designations were used to characterize the findings, as shown below.

Table 34. MY 2023 Validation Designation for Encounter Data Measures (PHIP)

Validation Designation	Description
R	Reportable; the measure was compliant with state specifications.
DNR	Do not report; the MCO rate was materially biased and should not be reported.
NA	Not applicable; the MCO was not required to report the measure.
NR	Not reportable; the measure was not reported because the MCO did not offer the required benefit.

Encounter Data Measure Validation Results. The table below displays MY 2023's encounter data measure validation results, validated by Qlarant.

Table 35. MY 2023 Encounter Data Measure Validation Results (PHIP)

Performance Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults	R	R	R	R	R	R	R	R	R
Ambulatory Care Visits for SSI Children	R	R	R	R	R	R	R	R	R

R = Reportable; the measure was compliant with state specifications.

Encounter Data Measure Validation Results. The table below displays MY 2023's HEDIS data measure validation results, validated by MetaStar.

Table 36. MetaStar's MY 2023 HEDIS Measure Validation Results (PHIP)

Performance Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Asthma Medication Ratio (AMR): Ages 5-64	R	R	R	R	R	R	R	R	R
Continued Opioid Use (COU): ≥ 31 days covered	R	R	R	R	R	R	R	R	R
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)	R	R	R	R	R	R	R	R	R
Lead Screening in Children (LSC)	R	R	R	R	R	R	R	R	R
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	R	R	R	R	R	R	R	R	R
Prenatal and Postpartum Care (PPC): Postpartum Care	R	R	R	R	R	R	R	R	R

R = Reportable; the MCO submitted a reportable rate for the measure.

Financial Incentive Methodology. The financial rewards to MCOs are based on performance and improvements of HEDIS and non-HEDIS quality measures against objective benchmarks. Available funds will be allocated through two rounds of incentive payments:

- In Round 1, payments to plans are made from the allocated incentive funding based on performance during the measurement year and improvement from the previous year. The maximum possible allocated incentive for each MCO will be up to 0.5% of total capitation payments during the measurement year (excluding supplemental payments). The amount will be determined by MDH budget allocations for the performance year under review.

- In Round 2, unallocated funds from Round 1 are redistributed among high-performing MCOs as additional incentives, up to a per-plan limit of 1% of the plan's measurement year capitation as total payment from Round 1 and Round 2.

Round 1 Incentives. Round 1 incentives consist of two types of incentives: performance incentives and improvement incentives:

- Tier 1: Performance incentives are intended to reward strong performance in the measurement year. Up to 100% of the Round 1 incentives can be earned through performance on quality measures during the measurement year.
- Tier 2: Improvement incentives are intended to reward year-over-year improvement. Up to one-third (1/3) of the Round 1 incentives can be earned through improvement for MCOs that do not earn full performance incentives.

The performance incentives are intended to reward MCOs for strong objective performance on each performance measure. This objective assessment will be made by comparing individual MCO performance on each measure to one of the following:

- For HEDIS measures, the distribution of national Medicaid health maintenance organization (HMO) scores for the measure during the measurement year using the HEDIS Quality Compass percentiles.
- For non-HEDIS measures, the distribution of Maryland MCO scores for the measure during the measurement year, as determined by Hilltop.

Each measure has a base value of one-eighth of the available incentive dollars per plan, which is a percentage of each plan's total capitation, not to exceed 1%, during the measurement year. Based on the measure score, MCOs will be assigned to one of the following four categories for each measure:

- **Superlative performance:** Measurement scores at or above the 90th percentile of Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS). For a score within this category, the MCO would receive 1/8 of 0.5 percent of capitation.
- **Very strong performance:** Measurement scores in the 75th to 89th percentiles (inclusive) of Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS). For a score within this category, the MCO would receive 2/3 of 1/8 of 0.5 percent of capitation.
- **Strong performance:** Measurement scores within the 50th to 74th percentiles (inclusive) of Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS). For a score within this category, the MCO would receive 1/3 of 1/8 of 0.5 percent of capitation.
- **None of the above:** Measurement scores below the 50th percentile of all Medicaid HMOs nationwide (HEDIS) or among Maryland MCOs (non-HEDIS). The MCO would not receive an incentive within this category.

The improvement incentives are intended to reward objectively strong improvement for MCOs that did not achieve superlative performance in the measurement year. For each measure, MCOs would receive 1/3 of the 1/8 of 0.5 percent of capitation if the following requirements are met:

- The MCO demonstrated improvement of at least 0.5 percentage points in the measure from the previous year, AND
- The MCO's current measurement year score is greater than or equal to the national 50th percentile.
- For any performance measures in which a lower score indicates stronger performance, year-over-year "improvement" is a reduction in the score for that measure.

Round 2 Incentives. In Round 2, unallocated program-wide funds from Round 1—that is, funds not disbursed from the total allocated to all MCOs in Round 1—would be redistributed among MCOs that meet the following qualifying criteria:

- The MCO earned above 80% of possible Round 1 incentives, AND
- The MCO performed sufficiently well on the HEDIS Performance Monitoring Policy requirements for the measurement year.

The incentive payments from Round 2 are not to exceed more than 1% of capitation in total across both rounds of incentives for any individual MCO. If the remaining funds from Round 1 are not sufficient to settle all qualifying MCOs up to 1% of capitation in Round 2, then the remaining funds will be disbursed proportionally among qualifying MCOs, based on the amount of funding needed to achieve 1% of total capitation. If there are additional funds remaining after settling qualifying MCOs up to 1% of capitation across both rounds, then MDH may, within its discretion, make additional payments to MCOs that are below 1% of capitation based on improvement or performance or place remaining funds into a non-lapsing pool.

Measurement Year. Hilltop conducted MY 2023 PHIP activities from January 2023 to December 2023.

Results

PHIP Model Parameters

The table below displays the total funding available for incentives for each MCO. Per MDH, there was 0.5% of capitation available for incentives, with an improvement buffer of 0.5%.

Table 37. Total Available Funds for PHIP

Capitation Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Available for Incentives (based on % cap approved by DBM)	$1,579,891	$2,652,542	$1,048,270	$2,937,379	$7,048,691	$2,951,871	$9,231,220	$4,267,480	$7,244,025

Capitation Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Max Payout for Each of the Measures (1/8th of available cap)	$197,486	$331,568	$131,034	$367,172	$881,086	$368,984	$1,153,902	$533,435	$905,503

PHIP Performance Measure Results

This section identifies Tier 1 and Tier 2 incentive results.

Table 38. Tier 1 Performance Incentives: MY 2023 Benchmark Percentiles (PHIP)

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	56.5%	73.4%	85.1%	69.3%	82.3%	79.0%	81.1%	75.7%	78.1%
Ambulatory Care Visits for SSI Children (MDH)	47.9%	69.0%	78.8%	69.7%	80.1%	71.2%	82.2%	75.8%	79.0%
Asthma Medication Ratio (AMR): Ages 5-64	56.0%	79.1%	77.3%	98.7%	74.6%	58.2%	76.7%	56.6%	52.1%
Continued Opioid Use (COU): ≥31 days covered^	2.9%	3.4%	4.3%	0.8%	4.0%	2.6%	3.6%	4.0%	2.3%
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)^	34.2%	29.0%	31.9%	29.1%	29.2%	31.4%	35.3%	34.6%	32.6%
Lead Screening in Children (LSC)	67.9%	69.6%	83.2%	86.5%	68.7%	77.3%	75.3%	67.6%	76.2%
Prenatal and Postpartum Care (PPC-CH): Timeliness of Prenatal Care	89.6%	93.3%	83.4%	94.4%	91.5%	85.0%	85.6%	86.6%	82.0%
Prenatal and Postpartum Care (PPC-AD): Postpartum Care	83.3%	88.3%	86.6%	91.3%	85.4%	83.8%	78.1%	77.6%	83.2%

Red = <50th percentile (no incentive); **Yellow** = 50-74th percentile (strong); **Light green** = 75-89th percentile (very strong); **Dark green** = 90th percentile (superlative)
^A lower rate indicates better performance.

Table 39. Tier 2 Improvement Incentives (PHIP)

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	No	No	No	No	No	No	No	No	No
Ambulatory Care Visits for SSI Children (MDH)	No	No	No	No	No	No	No	No	No
Asthma Medication Ratio (AMR): Ages 5-64	No	No	No	No	Yes	No	No	No	No
Continued Opioid Use (COU): ≥31 days covered^	Yes	No	No	No	No	No	No	No	No
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)^	No	Yes	No	Yes	Yes	No	No	No	Yes
Lead Screening in Children (LSC)	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes
Prenatal and Postpartum Care (PPC-CH): Timeliness of Prenatal Care	Yes	No	No	No	Yes	Yes	No	No	No
Prenatal and Postpartum Care (PPC-AD): Postpartum Care	Yes	No	No	No	Yes	No	No	No	Yes

Blue Yes = Improvement; **Gray** No = No Improvement
^ A lower rate indicates better performance.

PHIP Financial Incentive Results

Performance incentives aim to reward MCOs for strong objective performance on each performance measure. The tables below display the financial incentives for each MCO, based on specific performance measures.

Round 1. The following table identifies dollars awarded per MCO, based on Tier 1 performance incentives in MY 2023.

Table 40. MY 2023 Performance Incentive Dollars Awarded (PHIP Tier 1)

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	$0	$0	$87,356	$0	$587,391	$122,995	$384,634	$0	$301,834
Ambulatory Care Visits for SSI Children (MDH)	$0	$0	$43,678	$0	$293,695	$0	$769,268	$0	$301,834

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Asthma Medication Ratio (AMR): Ages 5-64	$0	$331,568	$131,034	$367,172	$587,391	$0	$1,153,902	$0	$0
Risk of Continued Opioid Use (COU): ≥31 days covered	$65,829	$110,523	$0	$367,172	$0	$122,995	$0	$0	$603,669
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9.0%)	$0	$221,045	$43,678	$244,782	$587,391	$122,995	$0	$0	$301,834
Lead Screening in Children (LSC)	$65,829	$110,523	$131,034	$367,172	$293,695	$245,989	$769,268	$177,812	$603,669
Prenatal and Postpartum Care (PPC-CH): Timeliness of Prenatal Care	$131,658	$331,568	$0	$367,172	$587,391	$122,995	$384,634	$177,812	$0
Prenatal and Postpartum Care (PPC-AD): Postpartum Care	$131,658	$331,568	$131,034	$367,172	$587,391	$245,989	$0	$0	$301,834
TOTAL	**$394,973**	**$1,436,793**	**$567,813**	**$2,080,644**	**$3,524,345**	**$983,957**	**$3,461,707**	**$355,623**	**$2,414,675**

Color coding correlates with Table 38. Tier 1 Performance Incentives: MY 2023 PHIP Benchmark Percentiles.

Table 41. MY 2023 Improvement Incentive Dollars Awarded (PHIP Tier 2)

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Ambulatory Care Visits for SSI Children (MDH)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Asthma Medication Ratio (AMR): Ages 5-64	$0	$0	$0	$0	$293,695	$0	$0	$0	$0
Continued Opioid Use (COU): ≥31 days covered	$65,829	$0	$0	$0	$0	$0	$0	$0	$0
Hemoglobin A1c Control for Patients with Diabetes (HBD):Poor HbA1c Control (>9.0%)	$0	$110,523	$0	$122,391	$293,695	$0	$0	$0	$301,834
Lead Screening in Children (LSC)	$65,829	$110,523	$0	$0	$293,695	$122,995	$384,634	$0	$301,834
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	$65,829	$0	$0	$0	$293,695	$122,995	$0	$0	$0
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	$65,829	$0	$0	$0	$293,695	$0	$0	$0	$301,834
TOTAL	**$263,315**	**$221,045**	**$0**	**$122,391**	**$1,468,477**	**$245,989**	**$384,634**	**$0**	**$905,503**

Color coding correlates with Table 39. Tier 2 Improvement Incentives.

Table 42. MY 2023 Round 1 Incentive Award Summary (PHIP Tier 1 & Tier 2)

Total Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	All MCOs
Tier 1- Performance Incentives	$394,973	$1,436,793	$567,813	$2,080,644	$3,524,345	$983,957	$3,461,707	$355,623	$2,414,675	$15,220,531
Tier 2 - Improvement Incentives	$263,315	$221,045	$0	$122,391	$1,468,477	$245,989	$384,634	$0	$905,503	$3,611,355
TOTAL INCENTIVES FOR ROUND 1	**$658,288**	**$1,657,839**	**$567,813**	**$2,203,034**	**$4,992,823**	**$1,229,946**	**$3,846,342**	**$355,623**	**$3,320,178**	**$18,831,886**
Maximum Possible Incentives from Round 1	$1,579,891	$2,652,542	$1,048,270	$2,937,379	$7,048,691	$2,951,871	$9,231,220	$4,267,480	$7,244,025	$38,961,369
Proportion of Potential Round 1 Incentives Earned	42%	63%	54%	75%	71%	42%	42%	8%	46%	48%

Round 2. No financial incentives were awarded to any of the MCOs for Round 2.

Summary. After Round 1 and Round 2 incentives were earned, $20,129,483 was left as unallocated funds from Round 2. MDH credited this remaining amount to a non-lapsing fund.

Table 43. MY 2023 Round 1 and Round 2 Incentives Awarded (PHIP Summary)

Total Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	All MCOs
Round 1 – Performance (Tier 1)	$394,973	$1,436,793	$567,813	$2,080,644	$3,524,345	$983,957	$3,461,707	$355,623	$2,414,675	**$15,220,531**
Round 1 – Improvement (Tier 2)	$263,315	$221,045	$0	$122,391	$1,468,477	$245,989	$384,634	$0	$905,503	**$3,611,355**
TOTAL INCENTIVES FOR ROUND 1	$658,288	$1,657,839	$567,813	$2,203,034	$4,992,823	$1,229,946	$3,846,342	$355,623	$3,320,178	**$18,831,886**
Round 2	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**

Total Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	All MCOs
Total Incentives (Round 1 and Round 2)	**$658,288**	**$1,657,839**	**$567,813**	**$2,203,034**	**$4,992,823**	**$1,229,946**	**$3,846,342**	**$355,623**	**$3,320,178**	**$18,831,886**
Percent of 2023 Capitation Earned as Incentives	0.21%	0.31%	0.27%	0.38%	0.35%	0.21%	0.21%	0.04%	0.23%	**0.24%**

Conclusion

PHIP is an incentive program designed to provide a financial reward to MCOs based on performance within certain measures, including both identified HEDIS measures and MDH-developed encounter measures. Round 1 is based on a two-tier review, looking at MCO performance and improvement within identified measures.

All nine MCOs received a financial reward for Round 1 Tier 1 for performance. Seven of the nine MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, and WPM) received a Round 1 Tier 2 improvement incentive. No MCO received a Round 2 incentive. The remaining funds have been credited to a non-lapsing fund.

Quality Strategy Highlights

MDH set task goals for the following HEDIS measures in the HealthChoice Quality Strategy for 2022-2024 based on pre-Covid public health emergency aggregate performance. Specific HealthChoice performance metrics and targets are displayed in the following table.

Table 44. MY 2023 Maryland Reportable Rate Against Quality Strategy Targets (PHIP)

Performance Measures	MDH Quality Strategy Targets for MY 2024	Maryland Average Reportable Rate for MY 2023
Asthma Medication Ratio (AMR): Ages 5-64	70.6%	69.9%
Continued Opioid Use (COU): ≥ 31 days covered^	1.9%	3.1%
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)^	36.9%	31.9%
Lead Screening in Children (LSC)	82.8%	74.7%
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	88.2%	87.9%

Performance Measures	MDH Quality Strategy Targets for MY 2024	Maryland Average Reportable Rate for MY 2023
Prenatal and Postpartum Care (PPC): Postpartum Care	81.3%	84.2%

Source: *HealthChoice Quality Strategy* and *MetaStar's Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2023 Results*
^ A lower rate indicates better performance.

For additional findings and comprehensive details associated with the MY 2023 PHIP validation, please access the link to the MY 2023 PHIP report in **Appendix E**. The **MCO Quality, Access, and Timeliness section** and **Appendix A** provide informed conclusions from the PHIP validation related to quality, access, and timeliness for the HealthChoice program.

Systems Performance Review

Objective

Conducting the SPR provides an annual assessment of the structures, processes, and outcomes of each MCO's quality assurance program. Qlarant's review team identifies, validates, quantifies, and monitors problem areas; and distinguishes and promotes best practices through compliance, or systems review. Assessment of MCO compliance with federal and state managed care program requirements, and structural and operational standards, may impact the quality, timeliness, or accessibility of healthcare services provided to managed care members. MDH receives an independent assessment of MCO capabilities through the SPR, which can be used to promote accountability and improve quality-related processes and monitoring.

Methodology

Qlarant conducted MY 2023's assessment as an interim desktop review in response to MDH's decision to move to triennial, rather than annual, onsite reviews. Reviewers completed the interim assessment by applying systems performance standards. Performance standards used to assess each MCO's operational systems were developed through the review of COMAR 10.67.04.03B(1); federal regulations, such as CFR, Subpart D and Quality Assurance and Performance Improvement (QAPI) standards; and guidelines from other quality assurance accrediting bodies, such as the NCQA. **Appendix B** provides a crosswalk of COMAR regulations and SPR standards reviewed for MY 2023's interim desktop review. Standards requiring a corrective action plan (CAP) or scored as *Baseline* in the MY 2022 interim desktop review were the focus of MY 2023's SPR. A sample review of appeal, grievance, and adverse determination records was also conducted to assess compliance with applicable standards.

MY 2023's interim desktop review phases included:

- **Pre-audit Overview and Survey.** Each MCO received a draft of the standards prior to individual desktop reviews for the opportunity to review and comment. Qlarant finalized SPR standards after review and approval by MDH. MCOs were required to submit a completed pre-audit survey form and provide documentation, written plans, and policies and procedures for various processes such as quality assurance and governance, delegation of activities, credentialing and recredentialing, enrollee rights, availability and accessibility, utilization review, continuity of care, health education, outreach, and fraud and abuse.
- **Individual Desktop Reviews.** The team reviewed all relevant documentation submitted by the MCOs to assess compliance with standards during the desktop reviews. Qualified healthcare professionals conducted the reviews, utilizing over 50 years of combined EQR experience and 40 years of HealthChoice experience.
- **Exit Letters.** Each MCO received exit letters after the interim desktop review that described potential issues that could be addressed by supplemental documentation, if available. After receiving the exit letter, the MCOs had the opportunity to submit any additional information to Qlarant, request a consultation to clarify issues, or ask for technical assistance in preparing a CAP. Documents received were subsequently reviewed against the standard(s) to which they related.
- **Final Reports.** After completing the review, Qlarant documented findings for each standard by element and component. Qlarant compiled and submitted draft results of the SPR to MDH for review. Upon MDH's approval, the MCOs received a final report containing individual review findings and any required CAPs.

Data Collection and Review. Documentation provided by the MCOs included policies and procedures; meeting minutes; program descriptions; annual evaluations; work plans; tracking and monitoring reports; focused studies; delegate reports; population assessments; HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results; operational performance reports; member handbooks and materials; provider manuals, directories, and newsletters; and grievance, appeal, and adverse determination records.

MCOs identified as requiring corrective action submitted a CAP with proposed detailed actions to correct any identified deficiencies from the review process. Qlarant evaluated and determined the adequacy of compliance for all CAPs. A CAP was determined adequate only if it addressed all required elements and components (such as timelines, actions steps, and documented evidence).

Each element and component received a review determination of *Met* or *Met with Opportunity* for compliance with performance standards, or *Partially Met* or *Unmet* for performance standards with required CAPs. MCOs were held accountable for standards in their policies and procedures that were more restrictive than what was required by MDH. MDH had the discretion to change a finding to *Unmet* if the element or component received a *Partially Met* finding for more than one consecutive year.

Table 45. MY 2023 Validation Review Determinations (SPR)

Determination Category	Review Determination and Criteria
Performance Evaluation Status	**Met (M).** MCO achieved compliance with all requirements and scored minimum compliance with performance standards relating to grievances, appeals, and denials (95%) or minimum compliance for all other performance standards (100%).
	Met with Opportunity (MwO). MCO achieved compliance with requirements but demonstrated an opportunity to improve; CAP is not required.
	Partially Met (PM). Qlarant required a CAP from MCO.
	Unmet (UM). Qlarant required a CAP from MCO.
Review Inclusion Status	**Baseline (B).** Qlarant reviewed but did not score the component, element, or standard.
	Deemed (D). Qlarant did not review the component, element, or standard as the MCO scored minimum compliance (100%) on the applicable NCQA standards.
	Not Applicable (NA). Qlarant did not review, as the component was not applicable.

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

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

To qualify for deeming, MDH established the following criteria:

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

Using this information and the NCQA Medicaid Managed Care Toolkit: Standards Crosswalk, *2020 Health Plan Standards* (Effective July 1, 2020 – June 30, 2021), Qlarant evaluated whether the MCO qualified for deeming federal regulations. **Appendix B** provides a crosswalk of the SPR standards in which MDH permitted deeming for MY 2023's interim desktop review. The State of Maryland is currently monitoring the Disenrollment standard. The upcoming comprehensive SPR will evaluate MCOs.

Timeline. MY 2023's SPR timeline started in July 2023 by providing MCOs an opportunity to review and comment on standards, laws, and regulations applying to the upcoming review. Any comments forwarded from MCOs during their 45-day comment period were considered before finalizing the "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" in September 2023. Interim desktop reviews occurred in January and February 2024. All relevant documentation was reviewed, including MCO submissions of previously requested pre-audit survey forms and documentation to support processes. After receiving exit letters at the conclusion of the virtual onsite reviews, MCOs had 10 business days to submit any additional information, clarify issues, ask for technical assistance in preparing a CAP, or request a consultation with Qlarant and MDH. After MDH's approval, MCOs received final reports. Any required CAPs were due within 45 days of receiving final reports. Continued technical assistance occurred if a CAP was unsuccessful until the MCO submitted an acceptable CAP.

Results

The following tables identify MCO performance resulting in opportunities for improvement and/or requiring corrective action before MY 2024's SPR across structural and operational standards.

Standard 5 Results and Findings for Enrollee Rights: All nine MCOs met minimum compliance (100%) for all elements and components reviewed for MY 2023 under Standard 5. Two MCOs (KPMAS and WPM) received a *Met with Opportunity* finding indicating compliance with requirements, but identifying opportunities to improve before MY 2024's SPR.

Table 46. MY 2023 MCO Opportunity Findings for Standard 5: Enrollee Rights (SPR)

MCO	PM	UM	MwO
KPMAS	NA	NA	5.1d
WPM	NA	NA	5.1h

NA – Not Applicable

Standard 7 Results and Findings for Utilization Review: Five MCOs (ABH, JMS, MSFC, PPMCO, and UHC) met minimum compliance (100%) for all elements and components reviewed for MY 2023 under Standard 7. Four MCOs (CFCHP, KPMAS, MPC, and WPM) have opportunities for improvement requiring quarterly CAP submissions. WPM is the only MCO receiving a *Met with Opportunity* finding, indicating compliance with requirements, but identifying opportunities to improve before MY 2024's SPR.

Table 47. MY 2023 MCO Opportunity Findings for Standard 7: Utilization Review (SPR)

MCO	PM	UM	MwO
CFCHP	NA	7.7c, 7.7e, and 7.8c	NA
KPMAS	NA	7.8c	NA
MPC	NA	7.7c	NA
WPM	NA	7.7c	7.10

Red font represents required quarterly updates for the CAP, per MDH's Performance Monitoring Policy
NA = Not Applicable

Standard 9 Results and Findings for Health Education Plan: All nine MCOs met minimum compliance (100%) for all elements and components reviewed for MY 2023 under Standard 9. Two MCOs (PPMCO and WPM) received a *Met with Opportunity* finding, indicating compliance with requirements, but identifying opportunities to improve before MY 2024's SPR.

Table 48. MY 2023 MCO Opportunity Findings for Standard 9: Health Education Plan (SPR)

MCO	PM	UM	MwO
PPMCO	NA	NA	9.3a and 9.5b
WPM	NA	NA	9.2 and 9.3a

NA = Not Applicable

Conclusion

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

Five MCOs (ABH, JMS, MSFC, PPMCO, and UHC) received a finding of *Met* and/or *Met with Opportunity* for all standards reviewed.

Continued Improvement Summary

If an MCO did not meet the required compliance rate, then a CAP submission was required to meet compliance during the next review. In areas where deficiencies were noted in CAP submissions, the MCOs received recommendations that, if implemented, should improve the MCO's performance for future reviews. Four MCOs (CFCHP, KPMAS, MPC, and WPM) were placed on quarterly CAP monitoring for MY 2023. CFCHP and KPMAS will require continued quarterly CAP monitoring for component 7.8c from MY 2022.

Table 49. MY 2023 Quarterly Corrective Action Plans per MCO (SPR)

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Quarterly CAPs Required	0	3	0	1	1	0	0	0	1
Total Quarterly CAPs Closed	0	3	0	3	2	0	0	0	3
Remaining Quarterly CAP Opportunities	0	1	0	1	1	0	0	0	0

For additional findings and comprehensive details associated with the MY 2023 SPR, please access the link to the MY 2023 SPR Statewide Executive Summary Report in **Appendix E**. The **MCO Quality, Access, and Timeliness section** and **Appendix A** provide informed conclusions from the SPR activity related to quality, access, and timeliness.

Network Adequacy Validation

Objective

In February 2023, CMS issued a new EQR protocol to assess MCO compliance with state and federal network adequacy standards: *Protocol 4 - Validation of Network Adequacy* . This new protocol states that MCOs must maintain provider networks that are sufficient to provide timely and accessible care to Medicaid enrollees across the continuum of care.

Methodology

Description of Data Obtained. To determine how each MCO measures these metrics, Qlarant sent a brief survey to each MCO to obtain detailed information, including MCO-source data and supporting documentation, regarding how the MCO conducts network adequacy and their NAV processes. Each MCO was requested to submit the following:

- Complete enrollment file from the measurement year containing demographic information for each enrollee, including date of birth, gender, and physical address.
  Complete provider file from the measurement year containing demographic information for each provider location, including Provider NPI, provider specialty, and each unique physical address where enrollees can access the providers. The provider file also contained information regarding status as a primary care physician (PCP), acceptance of new patients, and any age restrictions a provider implements.
- A data dictionary detailing the contents of the request files and possible values for each field.
- Documentation of provider-to-enrollee ratios for each provider the MCO (or affiliated contractor) monitors. The output could be from Excel or proprietary software, but it must contain counts for each provider type and counts for the number of enrollees.

- Documentation containing the number or percentage of enrollees whose physical address is within a set number of miles or minutes away from the nearest provider. The output could be from Excel or proprietary software, but it must contain counts for enrollees within the geographic region and the distance or time (e.g. average minutes, maximum minutes) to the nearest provider type.
- Any supporting documentation detailing standards and action plans related to network adequacy.

Qlarant evaluated the network adequacy validation processes conducted by MCOs for provider-to-enrollee ratios. Due to the variances in how MCOs conduct network adequacy by provider type for provider-to-enrollee ratios, Qlarant generated a list of 21 distinct provider types based on COMAR 10.67.05.05, to analyze MCOs' network adequacy processes for provider-to-enrollee ratios. Provider-to-enrollee ratio provider type indicators evaluated by Qlarant are listed below.

- PCP
- OB/GYN
- Core Specialties
- Major Specialties
- Pediatric Specialties

Qlarant evaluated the network adequacy processes conducted by MCOs for time and distance standards. Due to the variances in how MCOs conduct network adequacy by provider type for time and distance standards, Qlarant generated a list of 25 distinct provider types and 75 time and distance indicators to analyze MCOs' NAV processes for time and distance standards for geographic location (zip codes, rural, urban, and suburban). Time and distance standard indicators are identified in the table below.

Table 50. Time and Distance Standard Indicators (NAV)

Provider Type	Urban		Suburban		Rural	
	Max Time (min)	Max Distance (miles)	Max Time (min)	Max Distance (miles)	Max Time (min)	Max Distance (miles)
Primary Care	15	10	30	20	40	30
Primary Care – Pediatric	15	10	30	20	40	30
Pharmacy	15	10	30	20	40	30
Diagnostic Laboratory/X-Ray	15	10	30	20	40	30
Gynecology	15	10	30	20	40	30
Prenatal Care	15	10	30	20	90	75
Acute Inpatient Hospitals	20	10	45	30	75	60
Core Specialties	30	15	60	45	90	75

Provider Type	Urban		Suburban		Rural	
	Max Time (min)	Max Distance (miles)	Max Time (min)	Max Distance (miles)	Max Time (min)	Max Distance (miles)
(Cardiology, ENT, Gastroenterology, Neurology, Ophthalmology, Orthopedics, Surgery, Urology)						
Major Specialties (Allergy and Immunology, Dermatology, Endocrinology, Infectious Diseases, Nephrology, Pulmonology)	30	15	80	60	110	90
Pediatric Sub-Specialties (Cardiology, Gastroenterology, Neurology, Surgery)	30	15	80	60	250	200

Following the review of the submitted documentation, virtual site reviews were held with each MCO to resolve any outstanding questions. At the conclusion of the site reviews, Qlarant conducted a systematic review of the data sources to ensure all data variables needed for network adequacy monitoring were included. Qlarant reviewed each MCO's data collection, data processes, and data analyses to determine how well the health plan's work aligned with the state regulations. In order to determine if the MCO's results were valid, accurate, and reproducible, a random selection of one or two provider types was obtained for partial replication. Qlarant completed CMS *Protocol 4 Network Adequacy Validation* worksheet 4.6 to determine a validation score from 0% to 100% for each indicator. Finally, a validation rating was assigned to each MCO's individual indicators, ranging from *No Confidence* to *High Confidence*.

MCOs were scored according to the questionnaires in Appendix A. Each score is converted to a validation rating as identified in the table below.

Table 51. Validation Rating Determination (NAV)

Validation Score	Validation Rating
90.0% or greater	High Confidence
51.0% to 89.9%	Moderate Confidence
10.0% to 49.9%	Low Confidence
Less than 10%	No Confidence

Technical Methods of Data Collection and Analysis. States are required to set quantitative network adequacy standards to account for regional factors and the needs of the state's Medicaid populations. MDH has outlined quantitative network adequacy standards within the following COMAR regulations for MY 2023.

Table 52. MY 2023 Standards (NAV)

COMAR	Requirement
10.67.05.05A(5)	**PCP.** An MCO may include, as appropriate, any of the following practitioners to serve as the primary care provider for an enrollee: General practitioner, Family practitioner, Internist, Pediatrician, Obstetrics (OB)/Gynecology (GYN), Physician assistant, Certified nurse midwife, Nurse practitioner (certified in any of the following areas of specialization: Adult, Pediatric, Geriatric, OB/GYN, School nurse, and Family), and a physician practicing in a specialty area other than those enumerated in §A(5)(b)—(e) of this regulation.

10.67.05.05B(8)(c - d)	Adequacy of Provider Network
	• Capacity
	  ○ Unless the MCO can establish to the Department's satisfaction the adequacy of a higher ratio, the Department shall determine the MCO's capacity with respect to any local access area by assuming that in-plan individual practitioners, based on full-time equivalency, will be assigned no more than the number of enrollees that is consistent with a 200:1 ratio of enrollee to practitioner in the local access area.
	  ○ The Department may not approve an enrollee-to-PCP ratio that is higher than 2,000:1.

10.67.05.05-1A(2)(b)	The eight core specialties are: Cardiology, Otolaryngology (ENT), Gastroenterology, Neurology, Ophthalmology, Orthopedics, Surgery, and Urology.
10.67.05.05-1A(2)(c)	The six major specialties are: Allergy and immunology, Dermatology, Endocrinology, Infectious disease, Nephrology, and Pulmonology.
10.67.05.05-1A(2)(d)	The four pediatric subspecialties are: Cardiology, Gastroenterology, Neurology, and Surgery.

10.67.05.06A	Except as provided in §C of this regulation, an MCO shall develop and maintain a provider network that meets the following time and distance standards:
	• For adult and pediatric primary care, pharmacy, diagnostic laboratory and x-ray, and gynecology:
	  ○ In urban areas, within 15 minutes or ten miles
	  ○ In suburban areas, within 30 minutes or 20 miles
	  ○ In rural areas, within 40 minutes or 30 miles
	• For prenatal care, as defined in §B of this regulation:
	  ○ In urban areas, within 15 minutes or 10 miles
	  ○ In suburban areas, within 30 minutes or 20 miles
	  ○ In rural areas, within 90 minutes or 75 miles
	• For acute inpatient hospitals:

COMAR	Requirement
	○ In urban areas, within 20 minutes or 10 miles ○ In suburban areas, within 45 minutes or 30 miles ○ In rural areas, within 75 minutes or 60 miles • For core specialty types, as defined in Regulation .05-1A(2)(b) of this chapter: ○ In urban areas, within 30 minutes or 15 miles ○ In suburban areas, within 60 minutes or 45 miles ○ In rural areas, within 90 minutes or 75 miles • For major specialty types, as defined in Regulation .05-1A(2)(c) of this chapter: ○ In urban areas, within 30 minutes or 15 miles ○ In suburban areas, within 80 minutes or 60 miles ○ In rural areas, within 110 minutes or 90 miles • For pediatric subspecialty types, as defined in Regulation .05-1A(2)(d) of this chapter ○ In urban areas, within 30 minutes or 15 miles ○ In suburban areas, within 80 minutes or 60 miles ○ In rural areas, within 250 minutes or 200 miles
10.67.05.06 D-E	Geographical Access: Local Access Areas- refer to COMAR standard for chart. • For purposes of this regulation: ○ Urban enrollment area includes Baltimore City ○ Rural enrollment counties include: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, Saint Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester. ○ Suburban enrollment counties include: Baltimore County, Anne Arundel, Carroll, Harford, Howard, Montgomery, and Prince George's.

Following the review of the submitted documentation, virtual site reviews were held with each MCO to resolve any outstanding questions. At the conclusion of the site reviews, Qlarant conducted a systematic review of the data sources to ensure all data variables needed for network adequacy monitoring were included. Qlarant reviewed each MCO's data collection, data processes, and data analyses to determine how well the health plan's work aligned with the state regulations. In order to determine if the MCO's results were valid, accurate, and reproducible, a random selection of one or two provider types was obtained for partial replication. Qlarant completed CMS *Protocol 4 Network Adequacy Validation* worksheet 4.6 to determine a validation score from 0% to 100% for each indicator. Finally, a validation rating was assigned to each MCO's individual indicators, ranging from *No Confidence* to *High Confidence*.

Timeline. Qlarant conducted MY 2023 NAV activities from January 2023 to December 2023.

Results

The indicators validated were divided into two sections: Provider-to-Enrollee Ratios and Time and Distance Standards.

Provider-to-Enrollee Ratios

Purpose. COMAR requires MCOs to maintain a ratio of one provider per 200 enrollees, with a maximum limit of one provider per 2,000 enrollees. The table below summarizes the number of provider types MCOs included in their NAV for provider-to-enrollee ratios, how many provider types Qlarant was able to validate, and how many of the original 21 provider types were missing from validation.

Table 53. MY 2023 Provider-to-Enrollee Standards (NAV)

Requirement	COMAR
PCP. An MCO may include, as appropriate, any of the following practitioners to serve as the primary care provider for an enrollee: General practitioner, Family practitioner, Internist, Pediatrician, OB/GYN, Physician assistant, Certified nurse midwife, Nurse practitioner (certified in any of the following areas of specialization: Adult, Pediatric, Geriatric, OB/GYN, School nurse, and Family), and a physician practicing in a specialty area other than those enumerated in §A(5)(b)—(e) of this regulation.	10.67.05.05A(5)
The eight core specialties are: Cardiology, Otolaryngology (ENT), Gastroenterology, Neurology, Ophthalmology, Orthopedics, Surgery, and Urology.	10.67.05.05-1A(2)(b)
The six major specialties are: Allergy and immunology, Dermatology, Endocrinology, Infectious disease, Nephrology, and Pulmonology.	10.67.05.05-1A(2)(c)
The four pediatric subspecialties are: Cardiology, Gastroenterology, Neurology, and Surgery.	10.67.05.05-1A(2)(d)

Adequacy of Provider Network
• Capacity
  ○ Unless the MCO can establish to the Department's satisfaction the adequacy of a higher ratio, the Department shall determine the MCO's capacity with respect to any local access area by assuming that in-plan individual practitioners, based on full-time equivalency, will be assigned no more than the number of enrollees that is consistent with a 200:1 ratio of enrollee to practitioner in the local access area.
  ○ The Department may not approve an enrollee-to-PCP ratio that is higher than 2,000:1.
	10.67.05.05B(8)(c - d)

Monitoring Activities. The following tables summarize the provider-to-enrollee ratio indicators included in the NAV conducted by each MCO.

- ABH, JMS, MPC, and WPM included all 21 provider types in its NAV process for provider-to-enrollee ratios.

- CFCHP did not include nine of the 21 provider types in its NAV process for provider-to-enrollee ratios. CFCHP did not include Pediatric Specialty providers or Major Specialty providers, except for Nephrology. CFCHP included two additional provider types: Oncology and Pain Management providers.
- KPMAS and MSFC did not include 19 of the 21 provider types in its NAV process for provider-to-enrollee ratios. KPMAS only included PCP and Pediatric PCP provider types in its NAV process. MSFC submitted information for PCPs and two additional provider types classified as High Volume or High Impact: Prenatal providers and Oncology providers.
- PPMCO did include all 21 provider types in its NAV process for provider-to-enrollee ratios. However, PPMCO reported one consolidated result for all four pediatric subspecialities, instead of reporting them separately.
- UHC did not include 12 of the 21 provider types in its NAV process for provider-to-enrollee ratios. UHC included PCP, Pediatric PCP, and several major specialty provider types. UHC also included one additional provider type: Oncology. UHC included OB/GYN provider types; however, the NAV process for this provider type was categorized as *cannot be validated* as its methodology and implementation is different when compared to the other provider types.
- In addition to the 21 provider types, ABH included two additional provider types: Prenatal providers, Hematology/Oncology.
- In addition to the 21 provider types, JMS included two additional provider types: Hematology/Oncology and Podiatry.
- In addition to the 21 provider types, MPC included one additional provider type and additional ancillary provider type: Prenatal providers and Acute Inpatient Hospitals.
- In addition to the 21 provider types, PPMCO included one additional provider type: Hematology/Oncology. PPMCO also included two ancillary providers: Acute Inpatient Hospitals and Diagnostic Laboratories/X-Ray.
- In addition to the 21 provider types, WPM included two additional provider types: Prenatal providers and Hematology/Oncology.

Table 54. MY 2023 MCO Provider-to-Enrollee Ratios by Provider Type (NAV)

Provider Type Indicators	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Provider Types per COMAR									
Primary Care Physicians (PCP)									
PCP	✓*	✓*	✓*	✓	✓	✓*	✓*	✓*	✓*
Pediatric PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓
Women's Health									
OB/GYN	✓*	✓	✓		✓		✓	✓	✓
Core Specialists									
Cardiology	✓	✓	✓		✓		✓	✓	✓
ENT/Otolaryngology	✓	✓	✓		✓		✓	✓	✓
Gastroenterology	✓	✓	✓		✓		✓	✓	✓
Neurology	✓	✓	✓		✓		✓	✓	✓

Provider Type Indicators	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ophthalmology	✓	✓	✓		✓		✓	✓	✓
Orthopedics	✓	✓	✓		✓		✓		✓
Surgery	✓	✓	✓*		✓		✓	✓	✓
Urology	✓	✓	✓		✓		✓		✓
Major Specialists									
Allergy and Immunology	✓		✓		✓		✓		✓
Dermatology	✓		✓		✓		✓		✓
Endocrinology	✓		✓		✓		✓		✓
Infectious Diseases	✓		✓		✓		✓		✓
Nephrology	✓	✓	✓		✓		✓		✓
Pulmonology	✓		✓		✓		✓		✓
Pediatric Specialists									
Cardiology	✓		✓		✓		✓		✓
Gastroenterology	✓		✓		✓		✓		✓
Neurology	✓		✓		✓		✓		✓
Surgery	✓		✓		✓		✓		✓
Additional Provider Types									
Women's Health									
Prenatal Provider	✓				✓	✓			✓
Ancillary Providers									
Acute Inpatient Hospitals					✓		✓		
Diagnostic Laboratories/X-Ray							✓*		
Pharmacy									
Other Specialists									
Hematology/Oncology	✓	✓	✓			✓	✓	✓	✓
Pain Management		✓							
Podiatry			✓						

**MCO conducted NAV for additional subspecialties.*

Table 55. MY 2023 Number of Indicators Included of Provider-to-Enrollee Ratios (NAV)

MCO	Required Indicators Identified	Additional Indicators Identified	Number of Indicators Validated	Number of Required Indicators Missing
ABH	21	2	23	0
CFCHP	12	2	14	9
JMS	21	2	23	0
KPMAS	2	0	2	19
MPC	21	2	23	0
MSFC	2	2	4	19
PPMCO	21	3	20	4
UHC	8	1	9	13
WPM	21	2	23	0

Validation Results. The following table summarizes the validation results of NAV provider-to-enrollee ratios that were conducted by each MCO.

- **ABH:** All validated indicators achieved a confidence level of *High Confidence* score of 93.8%. ABH has set ratio standards of one provider for 2,500 enrollees, which exceed the maximum value reported in COMAR.
- **CFCHP:** Twelve of the 14 validated indicators achieved a confidence level of *High Confidence* score of 100%. Two indicators, Pediatric PCPs and OB/GYN providers, received a confidence level of *Moderate Confidence* score of 68.8%. Analysts identified that monitoring activities for these indicators looked at the entire enrollee population instead of the pediatric population and women's population, respectively. CFCHP did not include four Pediatric Specialty providers or five of the Major Specialty providers, except for Nephrology, so they could not be validated.
- **JMS:** All validated indicators achieved a confidence level of *High Confidence* score, ranging from 93.8% to 100%. The two indicators monitoring PCPs and Pediatric PCPs achieved a confidence level of *High Confidence* score of 100%, while the remaining 21 scored 93.8%. For these 21 indicators, JMS has set ratio standards of one provider for 7,000 enrollees, which exceed the maximum value reported in COMAR.
- **KPMAS:** All validated indicators achieved a confidence level of *High Confidence* score of 100%. KPMAS only included PCP and Pediatric PCP provider types in its NAV process, so the remaining 19 providers could not be validated.
- **MPC:** Thirteen of the 23 validated indicators achieved a confidence level of *High Confidence* score of 100%. The remaining 10 indicators received a confidence level of *Moderate Confidence* score of 68.8%. These indicators include major specialties and core specialties that do not have a pediatric counterpart. Analysts identified that the monitoring activities for these indicators only looked at the adult population and the pediatric population was not accounted for in another monitoring activity.
- **MSFC:** All validated indicators achieved a confidence level of *High Confidence* score of 100%. MSFC only submitted information for PCPs, Prenatal providers and Oncology providers, so the remaining 19 providers could not be validated

- **PPMCO:** All validated indicators achieved a confidence level of *High Confidence* score of 100%. PPMCO only reported one consolidated result for all four pediatric subspecialities, instead of reporting them separately, so those four could not be validated.
- **UHC:** Eight of the validated indicators achieved a confidence level of *High Confidence* score of 100%. One indicator, Pediatric PCP, received a confidence level of *Moderate Confidence* score of 68.8%. Analysts identified that the monitoring activity looked at the entire enrollee population instead of the pediatric population. UHC did not include 12 of the 21 provider types in its NAV process for provider-to-enrollee ratios, so it could not be validated. One provider, OB/GYN, was categorized as *could not be validated*, due to the different method implemented in calculating this indicator compared to the other monitoring activities.
- **WPM:** All validated indicators achieved a confidence level of *High Confidence* score of 100%.

Table 56. MY 2023 Validation Results for Provider-to-Enrollee Ratios (NAV)

MCO	Total Indicators Identified	High Confidence (90.0% -100%)	Moderate Confidence (51.0%-89.9%)	Low Confidence (10.0% -49.9%)	No Confidence (0.0%-9.9%)	Could Not Be Validated
ABH	23	23	0	0	0	0
CFCHP	23	12	2	0	0	9
JMS	23	23	0	0	0	0
KPMAS	21	2	0	0	0	19
MPC	23	13	10	0	0	0
MSFC	23	4	0	0	0	19
PPMCO	24	20	0	0	0	4
UHC	22	8	1	0	0	13
WPM	23	23	0	0	0	0

Time and Distance Standards

Purpose: COMAR requires MCOs to have a physical location accessible to enrollees that meets time or distance requirements. Time and distance standards are based on the geographical category of the enrollees' physical addresses (e.g. urban, suburban, and rural) and provider types. MCOs are permitted to conduct NAV for *either* time or distance standards, validating both is not required.

- ABH and WPM included time indicators for each of their provider types.
- JMS and PPMCO included distance indicators for each of their provider types.
- CFCHP, KPMAS, MPC, MSFC, and UHC included time *and* distance indicators for each of their provider types.

Table 57. MY 2023 Time and Distance Standards (NAV)

Requirement	COMAR
Except as provided in §C of this regulation, an MCO shall develop and maintain a provider network that meets the following time and distance standards: • For adult and pediatric primary care, pharmacy, diagnostic laboratory and x-ray, and gynecology: ○ In urban areas, within 15 minutes or ten miles ○ In suburban areas, within 30 minutes or 20 miles ○ In rural areas, within 40 minutes or 30 miles • For prenatal care, as defined in §B of this regulation: ○ In urban areas, within 15 minutes or 10 miles ○ In suburban areas, within 30 minutes or 20 miles ○ In rural areas, within 90 minutes or 75 miles • For acute inpatient hospitals: ○ In urban areas, within 20 minutes or 10 miles ○ In suburban areas, within 45 minutes or 30 miles ○ In rural areas, within 75 minutes or 60 miles • For core specialty types, as defined in Regulation .05-1A(2)(b) of this chapter: ○ In urban areas, within 30 minutes or 15 miles ○ In suburban areas, within 60 minutes or 45 miles ○ In rural areas, within 90 minutes or 75 miles • For major specialty types, as defined in Regulation .05-1A(2)(c) of this chapter: ○ In urban areas, within 30 minutes or 15 miles ○ In suburban areas, within 80 minutes or 60 miles ○ In rural areas, within 110 minutes or 90 miles • For pediatric subspecialty types, as defined in Regulation .05-1A(2)(d) of this chapter ○ In urban areas, within 30 minutes or 15 miles ○ In suburban areas, within 80 minutes or 60 miles In rural areas, within 250 minutes or 200 miles	10.67.05.06A
Geographical Access: Local Access Areas- refer to COMAR standard for chart. • For purposes of this regulation: ○ Urban enrollment area includes Baltimore City ○ Rural enrollment counties include: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, Saint Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester. ○ Suburban enrollment counties include: Baltimore County, Anne Arundel, Carroll, Harford, Howard, Montgomery, and Prince George's.	10.67.05.06 D-E

Monitoring Activities. The following tables summarize the time and distance standards indicators in the NAV conducted by each MCO.

- ABH, CFCHP, KPMAS, MPC, MSFC, UHC, and WPM included all 75 indicators in its NAV process for time and distance standards.
- JMS did not include six of the 50 indicators in its NAV process for time and distance standards.
- PPMCO did not include 12 of the 75 indicators in its NAV process for time and distance standards.
- In addition to the 25 provider types, ABH included one additional provider type: Hematology/Oncology.
- In addition to the 25 provider types, CFCHP included two additional provider types: Oncology and Pain Management.
- JMS included 21 of the 25 provider types and two additional provider types: Hematology/Oncology and Podiatry. JMS does not monitor network adequacy for ancillary providers (Acute Inpatient Hospitals, Pharmacy, and Diagnostic Lab and X-ray) as those monitoring efforts are accomplished by a separate division. Additionally, JMS is exempt from monitoring network adequacy for enrollees in designated rural areas, as the majority of its enrollees and service providers are located in designated urban and suburban areas.
- KPMAS included each provider type listed.
- MPC included 24 of the 25 provider types listed. MPC did not include one ancillary provider: Pharmacy.
- In addition to the 25 provider types, MSFC included one additional provider type: Hematology/Oncology.
- PPMCO included 20 of the 25 provider types listed and included one additional provider type: Hematology/Oncology. However, PPMCO did not include one ancillary provider: Pharmacy and reported one consolidated result for Pediatric Specialties instead of four individual providers.
- In addition to the 25 provider types, UHC included five additional provider types: Chiropractor, Occupational Therapy, Perinatology, Physical Therapy, and Speech Therapy.
- In addition to the 25 provider types, WPM included one additional provider type: Hematology/Oncology.

Table 58. MCO Time and Distance Standards by Provider Type (NAV)

Provider Type Indicators	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Provider Types per COMAR									
PCP									
PCP	✓*	✓*	✓*	✓	✓	✓*	✓*	✓	✓*
Pediatric PCP	✓	✓	✓	✓	✓	✓	✓	✓	✓
Women's Health									
OB/GYN	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prenatal Provider	✓	✓	✓	✓	✓	✓		✓	✓
Core Specialists									
Cardiology	✓	✓	✓	✓	✓	✓	✓	✓	✓
ENT/Otolaryngology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gastroenterology	✓	✓	✓	✓	✓	✓	✓	✓	✓

Provider Type Indicators	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Neurology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ophthalmology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Orthopedics	✓	✓	✓	✓	✓	✓	✓	✓	✓
Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓
Urology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Major Specialists									
Allergy and Immunology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dermatology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Endocrinology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Infectious Diseases	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nephrology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pulmonology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pediatric Specialists									
Cardiology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gastroenterology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neurology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ancillary Providers									
Acute Inpatient Hospitals	✓	✓		✓	✓	✓	✓	✓	✓
Diagnostic Laboratories/X-Ray	✓	✓		✓	✓*	✓	✓*	✓*	✓
Pharmacy	✓	✓		✓		✓		✓	✓
Additional Provider Types									
Other Specialists									
Hematology/Oncology	✓	✓	✓			✓	✓		✓
Pain Management		✓							
Podiatry			✓						
Chiropractor								✓	
Occupational Therapy								✓	
Perinatology								✓	
Physical Therapy								✓	
Speech Therapy								✓	

** MCO conducted NAV for additional subspecialties.*

Table 59. Number of Indicators Included for Time and Distance Standards (NAV)

MCO	Required Indicators Identified	Additional Indicators Identified	Number of Indicators Validated	Number of Required Indicators Missing
ABH	75	3	78	0
CFCHP	75	6	81	0
JMS	44	4	48	6
KPMAS	75	0	75	0
MPC	72	0	72	3
MSFC	75	3	78	0
PPMCO	60	3	60	15
UHC	75	15	90	0
WPM	75	3	78	0

JMS was exempt from including time and distance NAV for rural areas.

Validation Results. The following table summarizes the time and distance standards NAV that were conducted by each MCO.

- **ABH:** All validated indicators achieved a confidence level of *High Confidence* score of 100%.
- **CFCHP:** Sixty of the 81 validated indicators achieved a confidence level of *High Confidence* score of 100%. Monitoring regarding Pediatric PCPs, Pediatric Specialists, OB/GYN providers, and Prenatal providers received a confidence level of *Moderate Confidence* score of 70.6%. Analysts identified that monitoring activities for these indicators looked at the entire enrollee population instead of the pediatric population and women's population, respectively.
- **JMS:** All validated indicators achieved a confidence level of *High Confidence* score of 100%. As JMS does not monitor adequacy for ancillary providers, they could not be validated.
- **KPMAS:** All validated indicators achieved a confidence level of *High Confidence* score of 100%.
- **MPC:** Forty-two of the 72 validated indicators achieved a confidence level of *High Confidence* score of 100%. The remaining 30 indicators received a confidence level of *Moderate Confidence* score of 70.6%. These indicators include major specialties and core specialties that do not have a pediatric counterpart. Analysts identified that monitoring activities for these indicators only looked at the adult population and the pediatric population was not accounted for in another monitoring activity.
- **MSFC:** All validated indicators achieved a confidence level of *High Confidence* score of 100%. MPC did not include one ancillary provider: Pharmacy, so they could not be validated.
- **PPMCO:** All validated indicators achieved a confidence level of *High Confidence* score of 100%. PPMCO did not report any Pharmacy and reported one consolidated result for Pediatric Specialties instead of four individual providers, so these five provider types could not be validated in urban, suburban, and rural areas.

- **UHC:** Sixty-nine of the 90 validated indicators achieved a confidence level of *High Confidence* score of 100%. The remaining 21 indicators received a confidence level of *Moderate Confidence* score of 70.6%. These indicators include Pediatric PCPs, Pediatric subspecialties, OB/GYN, and Prenatal providers. Analysts identified that monitoring activities for these indicators looked at the entire enrollee population instead of the pediatric population and women's population, respectively.
- **WPM:** All validated indicators achieved a confidence level of *High Confidence* score of 100%.

Table 60. MY 2023 Validation Results for Time and Distance Standards (NAV)

MCO	Total Indicators Identified	High Confidence (90.0% - 100%)	Moderate Confidence (51.0% - 89.9%)	Low Confidence (10.0% - 49.9%)	No Confidence (0.0% - 9.9%)	Could not be validated
ABH	78	78	0	0	0	0
CFCHP	81	60	21	0	0	0
JMS	54	48	0	0	0	6
KPMAS	75	75	0	0	0	0
MPC	72	42	30	0	0	3
MSFC	78	78	0	0	0	0
PPMCO	72	60	0	0	0	12
UHC	90	69	21	0	0	0
WPM	78	78	0	0	0	0

JMS was exempt from including time and distance NAV for rural areas.

Conclusion

MCOs reported a different amount of distinct provider–to-enrollee ratios for provider types. Overall, there were 189 distinct provider-to-enrollee ratios that were identified across all MCO activities that could be validated based on COMAR, with 16 additional monitoring activities MCOs conducted for additional provider specialties not listed. Of the 205 total potential ratios that could be reported, 128 were reported and reviewed.

- Of the 21 provider types listed in COMAR, five MCOs reported ratios for every provider type: ABH, JMS, MPC, PPMCO, and WPM.
- All MCOs reported ratios for PCPs and Pediatric PCPs.
- Most MCOs reported ratios for OB/GYN providers; KPMAS and MSFC did not.
- ABH, MPC, MSFC, and WPM reported separate ratios for prenatal care.
- ABH, CFCHP, JMS, MPC, PPMCO, and WPM reported ratios for core specialties. UHC reported ratios for core specialties except for Orthopedics and Urology.

- ABH, JMS, MPC, PPMCO, and WPM reported ratios for major specialties. CFCHP only reported ratios for Nephrology.
- ABH, JMS, MPC, PPMCO, and WPM reported ratios for pediatric specialties.
- Most MCOs reported ratios for Oncology or Hematology/Oncology combined; KPMAS and MSFC did not.
- Two MCOs reported ratios for one or more ancillary providers: MPC and PPMCO.

MCOs' calculations of their provider-to-enrollee ratios scored confidence levels of *Moderate Confidence* to *High Confidence*, with scores ranging from 68.8% to 100%.

- All calculations for ABH, JMS, PPMCO, and WPM were scored with a confidence level of *High Confidence*.
- All calculations that could be validated for KPMAS and MSFC were scored with a confidence level of *High Confidence*; however, these scores were limited to PCPs and Women's Health. These MCOs did not report ratios for other providers.
- Calculations for CFCHP, MPC, and UHC scored with a confidence level of *Moderate Confidence* to *High Confidence*. Ratios that scored moderate confidence include specialties focused on the pediatric population or women's population.

MCOs reported a different amount of monitoring activities for time and/or distance standards for each of the 25 provider types listed in COMAR across three geographical areas. Overall, Qlarant identified 650 different monitoring activities that could be conducted across all MCOs, 626 of which were reported. There were an additional 34 monitoring activities for additional specialties that were reported.

- All MCOs, except for JMS, reported standards for urban, suburban, and rural populations. JMS was exempt from including rural areas in its NAV methodology due to the primary locations of its members/providers being in urban and suburban areas.
- All MCOs reported time and/or distance standards for PCPs, Pediatric PCPs, OB/GYN, Core Specialties, and Major Specialties.
- All MCOs, except for PPMCO, reported separate time and/or distance standards for prenatal care.

MCOs' calculations for time and/or distance standards scored confidence levels of *Moderate Confidence* to *High Confidence*, with scores ranging from 70.6% to 100%.

- All calculations for ABH, KPMAS, MSFC, and WPM were scored with a confidence level of *High Confidence*.
- All calculations that could be validated for JMS and PPMCO were scored with a confidence level of *High Confidence*. JMS did not report calculations for any ancillary providers. PPMCO also reported a consolidated rate for all pediatric subspecialties.
- CFCHP, MPC, and UHC scored a confidence level of *Moderate Confidence* to *High Confidence*. Standards that scored a confidence level of *Moderate Confidence* include specialties focused on the pediatric population or women's population.

Quality Strategy Highlights

MDH aims to deliver high quality, accessible care to managed care members. To achieve this goal, MDH developed a framework to focus quality improvement efforts for the HealthChoice Programs. Per the HealthChoice Quality Strategy[4], MDH has set a task goal of meeting network adequacy time and distance standards per COMAR regulation 10.67.05.06A. All MCOs scored confidence levels of *Moderate Confidence* and *High Confidence,* indicating the likelihood that their methodology for validating network adequacy time and distance standards will provide accurate results.

For additional findings and comprehensive details associated with the MY 2023 NAV, please access the link to the MY 2023 NAV report in **Appendix E**. The **MCO Quality, Access, and Timeliness section** and **Appendix A** provide informed conclusions from the NAV activity related to quality, access, and timeliness.

Network Adequacy Validation Focused Review

Objective

HealthChoice emphasizes health promotion and disease prevention, and the program requires health education and outreach services to be provided to enrollees. Utilization of a "medical home" connects each enrollee with a primary care provider (PCP) of their choice and identifies a PCP responsible for overseeing their medical care by providing preventive and primary care services, managing referrals, and coordinating all necessary care. MDH engages in a broad range of activities to monitor network adequacy and access to ensure efficient use and coverage for these services.

Qlarant evaluated the network adequacy of HealthChoice MCOs against COMAR standards through telephonic surveys and provider directory validations to ensure MCOs can provide enrollees with timely access to necessary care and to several in-network PCPs. No MCOs were exempt from this task.

Methodology

Description of Data Obtained. MDH established the following goals for MY 2024's focused study for network adequacy validation (NAV FS) activities:

- Assess compliance with MDH's access and availability requirements; and

[4] HealthChoice Quality Strategy 2022-2024

- Validate the accuracy of MCOs' online provider directories.

COMAR requirements for access and availability, and provider directories, which guided MY 2024 NAV FS activities, follow.

Table 61. Network Adequacy Requirements (NAV FS)

COMAR	Standard
Accuracy of Provider Directory *COMAR 10.67.05.02C(1)(d)*	MCOs shall maintain a provider directory listing individual practitioners who are the MCO's primary and specialty care providers in the enrollee's county, additionally indicating the PCP name, address, practice location(s), telephone number(s), website uniform resource locator (URL) as appropriate, group affiliation, cultural and linguistic capabilities, practices accommodations for physical disabilities, whether the provider is accepting new patients, and age range of patients accepted or no age limit.
30-Day Non-Urgent Care Appointment *COMAR 10.67.05.07A(3)(b)iv)*	Requests for routine and preventative primary care appointments shall be scheduled to be performed within 30 days of the request.
48-Hour Urgent Care Appointment *COMAR 10.67.05.07A(3)(b)(iii)*	Individuals requesting urgent care shall be scheduled to be seen within 48 hours of the request.

*CMS finalized in the November 13, 2020, Federal Register that §438.10(h) (1) (vii) eliminated the indication of cultural competency training of the PCP requirement in the online directory. Therefore, MDH does not require a review of this component.

Qlarant's subcontractor, Cambridge Federal, conducted MY 2024 survey activities for each PCP in the sample. MY 2024 orientation training for surveyors and validators included:

- In-depth instruction by subject matter experts on the survey tool;
- Mock scenarios of survey calls and data entry;
- Inter-rater reliability testing;
- Updates on online directory validation tools; and
- Follow-up education, as necessary.

To ensure quality survey and validation results, Qlarant performed quality checks and weekly oversight meetings with Cambridge Federal's lead surveyor and Qlarant's provider directory validators to review the following topics:

- Quality assurance activities;
- Progress reports;
- Surveyor/validator assignments; and
- Correction of data collection issues.

Qlarant requested and received a list of contracted PCPs from each MCO. Qualifying providers for MY 2024 NAV FS activities specialized in one of the following areas: primary care, adult medicine, internal medicine, general practice, family medicine, or pediatrics. Qlarant instructed MCOs to submit the following information for each PCP:

- National Provider Identifier (NPI)
- First and Last Name
- Credentials
- Provider Type (MCO confirmed PCP status)
- Provider Specialty
- Practice Location (Address, Suite, City, Town, State, Zip)
- Telephone Number

Qlarant assessed each MCO's submission for completeness. Corrections were requested if issues regarding incomplete data, non-PCPs included in the listings, or incomplete telephone numbers were identified. MCOs provided lists for PCPs contracted in contiguous states to Maryland (Delaware, District of Columbia, Pennsylvania, Virginia, and West Virginia). Listings included 158 PCPs from contiguous states:

- Delaware (21)
- District of Columbia (102)
- Pennsylvania (2)
- Virginia (20)
- West Virginia (13)

Qlarant also requested the URL link enrollees use to access each MCO's online provider directory.

Technical Methods of Data Collection and Analysis. The HealthChoice program network has 26,891 contracted PCPs across all nine MCOs. Each PCP can only be sampled once for each MCO; therefore, if a PCP of a different name but the same address was included in the MCO's sample, it was replaced with a different PCP when possible to still meet sample. This practice increased the number of unique PCPs in the sample for each MCO. PCPs with the same NPI number who are providing services at other practice locations (different addresses), as submitted by the MCOs, were not removed as duplicates from the sample. A total of 6,125 of the contracted PCPs across MCOs displayed a unique address.

A random sample, based on the number of contracted PCPs with unique addresses, was selected for each MCO using a 90% confidence level (CL) and a 5% margin of error. The table below shows the total number of contracted PCPs per MCO, total number of unique PCPs by address and the respective sample sizes. The final sample included 2,026 PCPs.

Table 62. MY 2024 Contracted PCPs and Sample Size by MCO (NAV FS)

PCP Sample	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Contracted PCPs (#)	1,658	6,619	1,081	381	3,179	1,996	7,309	874	3,794	**26,891**
Unique PCPs by Address (#)	805	908	228	371*	861	510	1,031	407	1,004	**6,125**
Sample Size (90% CL +/- 5%)	228	246	202	157	244	239	253	207	250	**2,026**

*Due to KPMAS' PCP model structure, unique addresses were selected when possible.

Responses to the telephonic survey questions were documented in the survey tool and stored electronically on Qlarant's secure web-based portal. The online provider directory validation portion of the NAV activity was completed in two steps. The table below highlights key elements of the NAV FS activity.

Table 63. MY 2024 Summary of Activities (NAV FS)

MY 2024 NAV FS Activity	Assessment
Telephone Survey	Telephone surveys solicited responses to verify PCP information, including: • Name and address of PCP • Provider acceptance of the listed MCO and new Medicaid enrollees • Routine and urgent care appointment availability
Validation of Network Adequacy Step 1	Verify information obtained during the ten-question telephone survey matched information provided by the MCO: • PCP address • PCP phone number
Validation of Network Adequacy Step 2	Verify the MCOs' online provider directories matched the following information for PCPs in the sample provided during the telephone surveys: • Status of accepting new Medicaid patients • Ages served by the PCP • Languages spoken by the PCP • Availability of accommodations for disabled patients and identified specific Americans with Disabilities Act of 1990 (ADA)-accessible equipment.

Telephone surveys were evaluated by two review determinations: *successful* and *unsuccessful*; their criteria follows.

Table 64. MY 2024 Review Determinations (NAV FS)

Review Determination	Criteria
Successful	• Surveyor reached the PCP within three call attempts and completed the survey. • Successful telephone surveys were validated against the details noted in the MCO's online directory. If the PCP was not in the MCO's online provider directory, the validation survey ended.
Unsuccessful	Reasons for unsuccessful surveys fall within two categories, "No Contact" and "PCP Response," with qualifying circumstances for each. **"No Contact"** unsuccessful surveys included calls in which the surveyor could not reach the PCP due to the number not reaching the intended provider (e.g., wrong number, office closed, or provider not with practice); no answer; reached voicemail; or hold time exceeded five minutes. **"PCP Response"** unsuccessful surveys included calls that ended after the initial communication with a respondent for wrong location listed for the provider (provider was not with the practice or did not practice at that location); provider not being a PCP; PCP not accepting the listed MCO; or practice refusing to participate.
Compliance Threshold	**MDH established the minimum compliance for MY 2024 as 80%.**

Surveyors conducted and documented at least three call attempts unless the surveyor reached a wrong number or if the office was found permanently closed. Surveyors confirmed wrong PCP telephone numbers by calling the telephone number twice; if the call resulted in a wrong number or the office was permanently closed, the survey ended. If the first call attempt resulted in no contact with a live respondent, surveyors attempted to call again on another day and time. Surveyors ended the call on the third attempt if they were prompted to leave a message, were on hold for more than five minutes, or had no answer.

Timeline. NAV FS activities occurred in June and July 2024 to assess MY 2024 compliance. Surveys were conducted on weekdays during normal business hours from 9:00 a.m. to 5:00 p.m. Eastern Standard Time.

Results

Results of the telephone and validation surveys are broken down into the following categories:

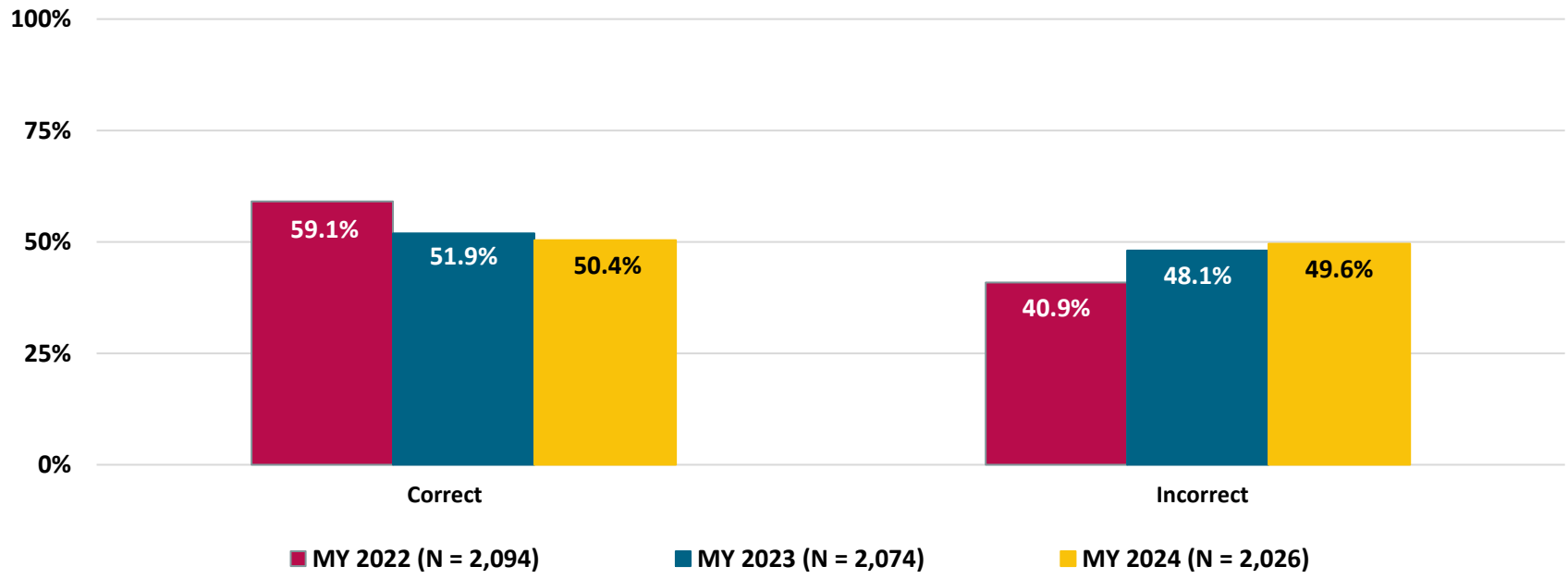
- Accuracy of PCP Information
  - PCP Information
  - PCP Affiliation & Open Access
- Successful Contacts

- Unsuccessful Contacts
- Compliance with Routine Appointment Requirements
- Compliance with Urgent Care Appointment Requirements
- Validation of MCO Online Provider Directories

Accuracy of PCP Information

Phone Numbers and Addresses. As previously noted, the Validation Tool is pre-populated by MCOs with information about the PCPs prior to the start of the survey. When contact is made with the PCP, the PCP's pre-populated phone number and address are verified. Results for the percentage of PCPs where the provided phone number and address match the information provided by the MCO are demonstrated in the figure below. MY 2024 demonstrated a decrease of 1.5 percentage points in the accuracy of provider contact information. There was an increase of 1.5 percentage points for incorrect provider information when compared to MY 2023 (48.1%). Incorrect provider information increased by 8.7 percentage points from MY 2022 (40.9%) to MY 2024 (49.6%).

Figure 6. MYs 2022 to 2024 Accuracy of Provider Contact Information (Phone Number and Address) (NAV FS)



Successful Contacts

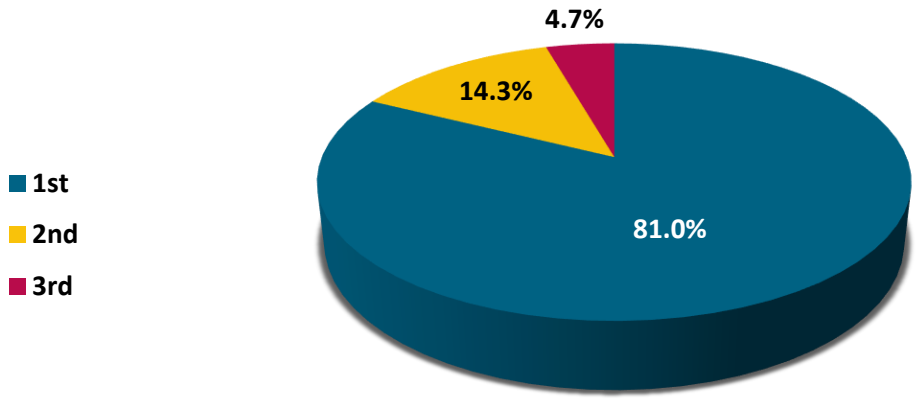
The number of attempted PCP surveys conducted decreased from 2,074 (MY 2023) to 2,026 (MY 2024). The percentage of successful contacts decreased by 3.9 percentage points from MY 2023 (59.3%) to MY 2024 (55.4%).

Table 65. MYs 2022 to 2024 Number of Surveys Conducted and Successful PCP Contacts (NAV FS)

Measurement Year	Total Surveys Conducted	Number of Successful Contacts	Percentage of Successful Contacts
2022	2,094	1,334	63.7%
2023	2,074	1,229	59.3%
2024	2,026	1,122	55.4%

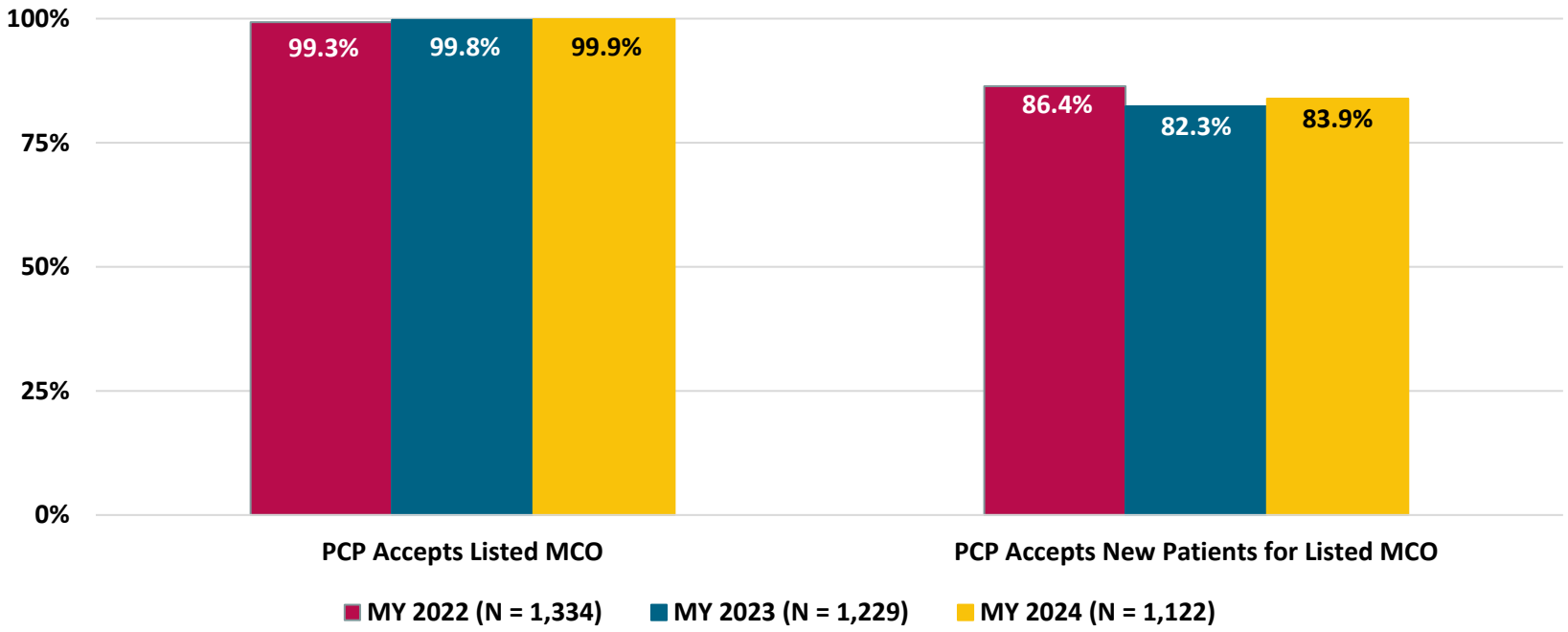
The figure below illustrates the number of call attempts surveyors used to reach PCPs before making contact and successfully completing the survey. Approximately 81.0% of providers were successfully contacted on the first call attempt, 14.3% on the second, and 4.7% on the third and final attempt.

Figure 7. MY 2024 Responses by Call Attempt for Successful Contacts (NAV FS)



PCP Affiliation and Open Access. The MY 2024 telephone surveys also validated whether PCPs accepted the listed MCO and new Medicaid patients. The figure below illustrates the results for these survey elements per MY. MY 2024 results displayed a consistent pattern when compared to MY 2022 and MY 2023. In MY 2024, performance improved from MY 2023, indicating 83.9% of PCPs accepted new patients for the listed MCO; which is a 1.6 increase in percentage points from MY 2023.

Figure 8. MYs 2022 to 2024 PCP Affiliation & Open Access (NAV FS)



MY 2024 Summary of Accuracy of PCP Information. Accuracy of PCP information for successful survey contacts for MY 2024 is displayed in the table below. Compared to all other MCOs, contact with PPMCO's and MPC's providers was least likely to be successful at 42.3% and 49.2%, respectively. PPMCO also had the lowest percentage of providers with accurate addresses (85%). All nine MCOs exceeded 99% for *Accepts Listed MCO*. WPM and KPMAS have the lowest percentages of PCP acceptance of new Medicaid patients at 73.5% and 73.9%, respectively.

Table 66. MY 2024 MCO Results from Successful Contacts for Accuracy of PCP Information (NAV FS)

MY 2024 Successful Calls	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Number of Calls	228	246	202	157	244	239	253	207	250	2,026
Successful Contacts (#)	143	127	104	111	120	137	107	141	132	1,122
%	**62.7%**	**51.6%**	**51.5%**	**70.7%**	**49.2%**	**57.3%**	**42.3%**	**68.1%**	**52.8%**	**55.4%**
Accurate PCP Address Provided (#)	139	123	100	111	117	129	91	133	120	1,063
%	**97.2%**	**96.9%**	**96.2%**	**100.0%**	**97.5%**	**94.2%**	**85.0%**	**94.3%**	**90.9%**	**94.7%**

MY 2024 Successful Calls	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Accepts Listed MCO (#)	143	127	104	111	120	137	107	141	131	1,121
%	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**99.2%**	**99.9%**
Accepts New Medicaid Patients Listed for MCO (#)	115	112	89	82	108	127	93	118	97	941
%	**80.4%**	**88.2%**	**85.6%**	**73.9%**	**90.0%**	**92.7%**	**86.9%**	**83.7%**	**73.5%**	**83.9%**

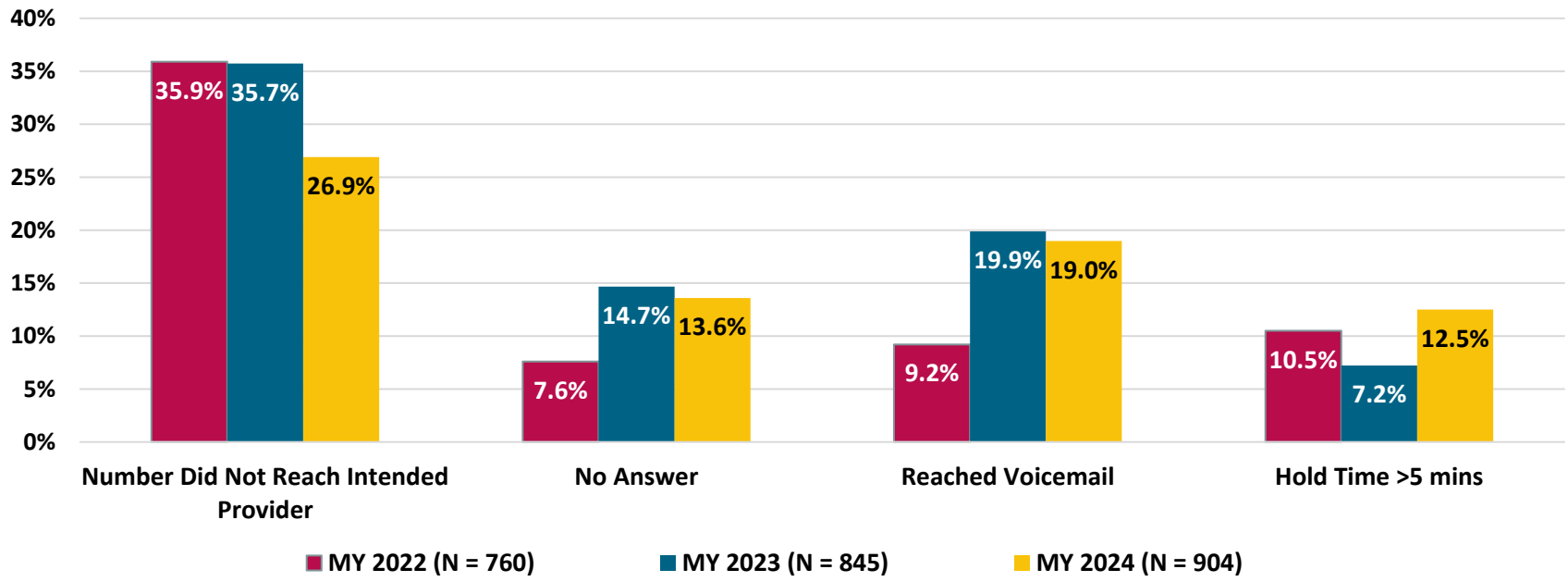
Unsuccessful Contacts

Of the 2,026 PCP surveys attempted in MY 2024, 904 PCP surveys (44.6%) were unsuccessful.

Unsuccessful Contacts within the "No Contact" Category. The most significant decrease in unsuccessful surveys due to "No Contact" was for *Number Did Not Reach Intended Provider* at 26.9%, 8.8 percentage points from MY 2023 (35.7%). However, it has been noted that MY 2024 demonstrates an increase of 5.3 percentage points for *Hold Times >5 mins*, compared to MY 2023 (7.2%). Results indicate the most common reason for unsuccessful calls for all MCOs was due to *Did Not Reach Intended Provider* (37.3%). Additional findings per MCO indicate the following:

- PPMCO had the highest percentage of survey calls that were unsuccessful due to *Did Not Reach Intended Provider* at 50.9%, followed by WPM at 45.1%.
- CFCHP and MPC providers were more likely than other MCOs not to answer survey calls at 30.3% and 21.7%, respectively.
- ABH and MSFC providers were more likely than other MCOs to send survey calls to voicemail at 33.3% and 34.7%, respectively.
- CFCHP was less likely than other MCOs to place the surveyor on hold for more than five minutes at 7.9%. KPMAS providers had the highest rate of placing the surveyor on hold for more than five minutes at 30.6%.

Figure 9. MYs 2022 to 2024 Unsuccessful Surveys due to "No Contact" (NAV FS)



*Denominator utilized all calls categorized as *Unsuccessful.*

Table 67. MY 2024 "No Contact" Categories by MCO (NAV FS)

MY 2024 "No Contact" Calls	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate* %/#
Did Not Reach Intended Provider	24.6%	37.1%	37.3%	41.7%	30.4%	28.0%	50.9%	34.0%	45.1%	**37.3% (243)**
No Answer	17.5%	30.3%	13.4%	11.1%	21.7%	18.7%	17.0%	14.9%	17.1%	**18.9% (123)**
Reached Voicemail	33.3%	24.7%	23.9%	16.7%	32.6%	34.7%	17.0%	29.8%	25.6%	**26.4% (172)**
Hold Time >5 Minutes	24.6%	7.9%	25.4%	30.6%	15.2%	18.7%	15.1%	21.3%	12.2%	**17.4% (113)**
Total Unsuccessful "No Contact" Call Counts	**57**	**89**	**67**	**36**	**92**	**75**	**106**	**47**	**82**	**651**

*Denominator utilized only unsuccessful calls categorized as *No Contact.*

Unsuccessful Contacts within the "PCP Response" Category. Three of the four categories for unsuccessful surveys declined from MY 2023 to MY 2024. The category of unsuccessful surveys due to *Wrong Location Listed for Provider* increased significantly from MY 2023 (2.6%) to MY 2024 (12.7%). The category of unsuccessful surveys due to *Not a PCP* decreased slightly from MY 2023 (5%) to MY 2024 (4.4%). The category of unsuccessful surveys due to *Does Not Accept Insurance* demonstrated a steady decline from MY 2022 (13.9%) to MY 2024 (9.2%). The decline continued for *Refused to Participate*, from 5.7% (MY 2022) to 1.7% (MY 2024).

Results indicate the most common unsuccessful survey reason for "PCP Response" for all MCOs was *Wrong Location Listed for Provider* (45.5%). Additional findings per MCO indicate the following:

- CFCHP, JMS, and MSFC were more likely than other MCOs to have the wrong location listed for the provider at 53.3%, 54.8% and, 51.9%, respectively.
- UHC was more likely than other MCOs to have a provider listed that was not a PCP at 47.4%, followed by MSFC at 33.3%.
- KPMAS was more likely than other MCOs to have PCPs not accept the MCO's insurance at 60.0%.
- UHC was more likely than other MCOs to have PCPs refuse to participate in the survey at 20.0%.

Figure 10. MYs 2022 to 2024 Unsuccessful Surveys due to "PCP Response" (NAV FS)

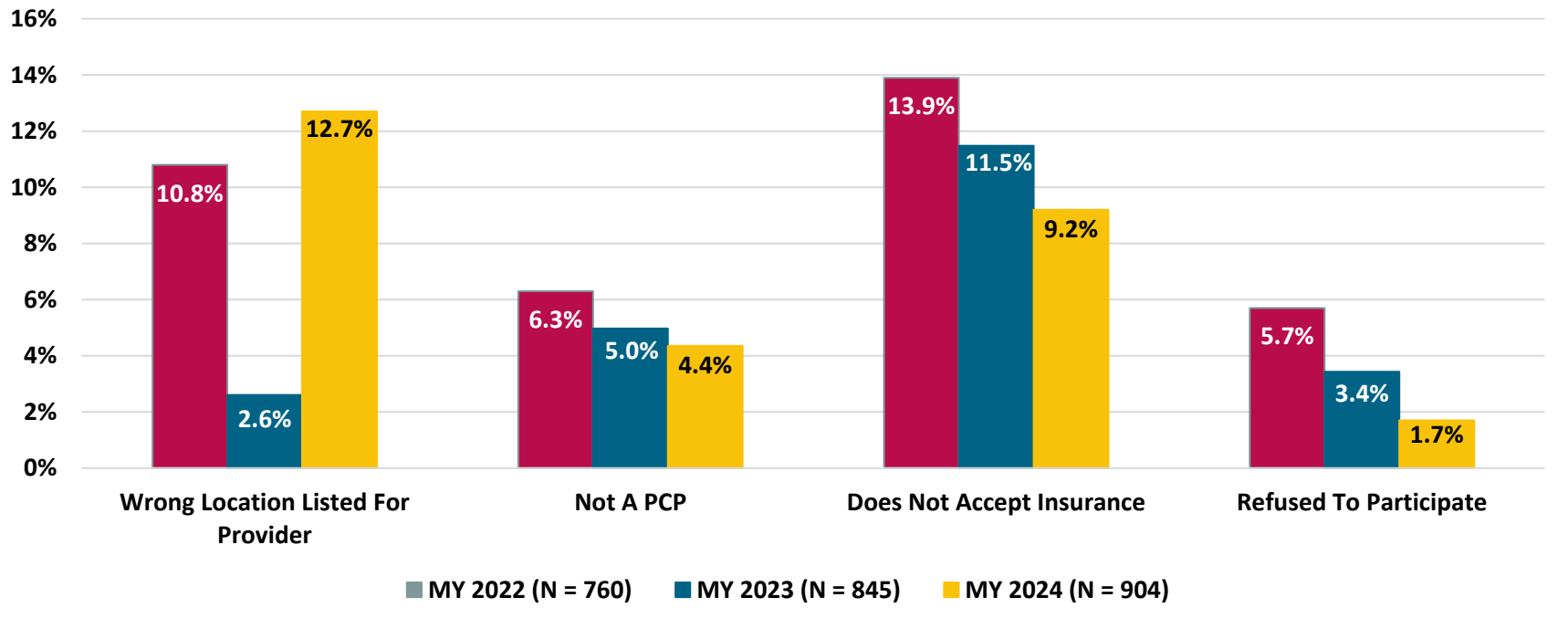


Table 68. MY 2024 "PCP Response" by MCO (NAV FS)

MY 2024 "PCP Response" Calls	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate* %/#
Wrong Location Listed for Provider	75.0%	53.3%	54.8%	10.0%	40.6%	51.9%	30.0%	26.3%	44.4%	**45.5% (115)**
Not a PCP	10.7%	10.0%	6.5%	10.0%	25.0%	33.3%	10.0%	47.4%	2.8%	**15.8% (40)**
Does Not Accept Insurance	10.7%	30.0%	35.5%	60.0%	28.1%	11.1%	55.0%	10.5%	50.0%	**32.8% (83)**
Refused to Participate	3.6%	6.7%	3.2%	20.0%	6.3%	3.7%	5.0%	15.8%	2.8%	**5.9% (15)**
Total Unsuccessful "PCP Response" Call Counts	**28**	**30**	**31**	**10**	**32**	**27**	**40**	**19**	**36**	**253**

* Denominator utilized only unsuccessful calls categorized as *PCP Response.*

Compliance with Appointment Standards

MCO-specific results for compliance with routine care and urgent care appointment timeframe requirements are displayed in the tables below.

Compliance with Routine Care Appointment Requirements. Survey results of PCP compliance with routine care appointment requirements follow. To meet compliance, providers had to have an appointment (in-person or telemedicine) available within 30 days of the survey call date with the service provider or with an alternative provider at the same location.

PCP compliance with routine care appointment requirements decreased by 2.1 percentage points from 90.5% (MY 2023) compared to 88.4% (MY 2024).

Results for compliance with routine care appointment availability within 30 days averaged 89.4% and ranged from 83.9% (ABH) to 94.2% (MPC). All MCOs met the MDH-required minimum compliance threshold (80%) for compliance with the routine care appointment timeframe. The average wait time for a routine care appointment was between eight days (CFCHP, KPMAS) and 12 days (ABH, JMS), with the average being ten days.

Figure 11. MYs 2022 to 2024 Percent of PCPs in Compliance with Routine Care Appointment Requirements (NAV FS)

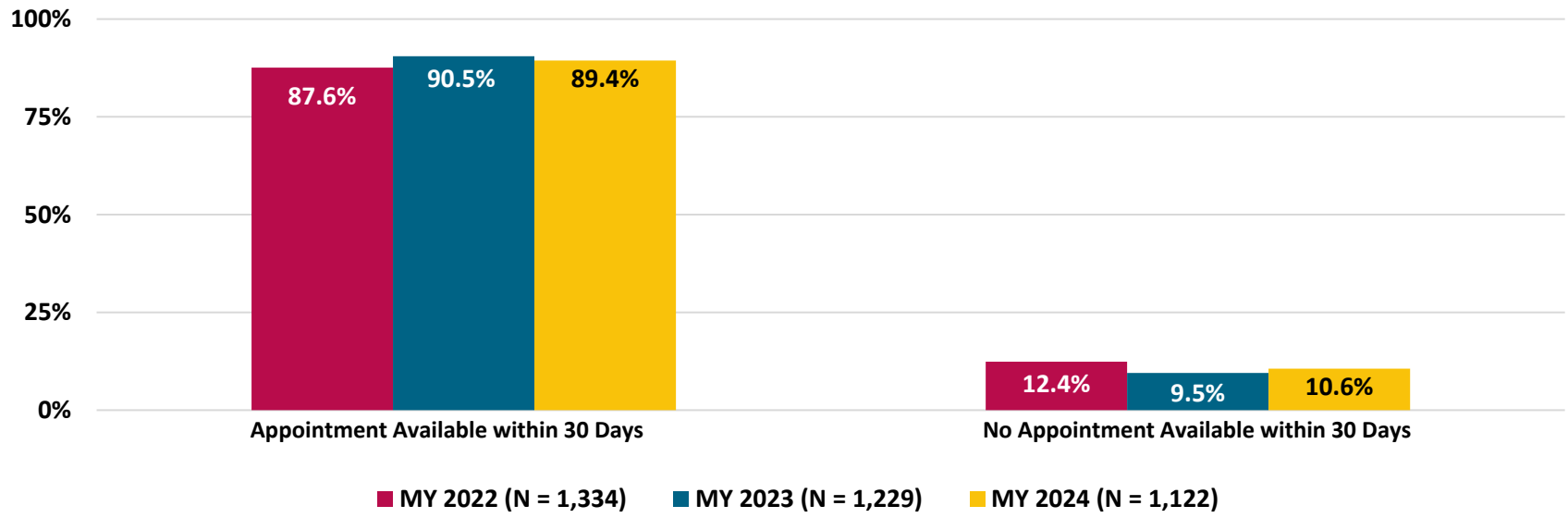


Table 69. MY 2024 MCO and HealthChoice Results for Compliance with Routine Care Appointment Timeframe (within 30 days) (NAV FS)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Compliance with Routine Care Appointment	**83.9%**	**93.7%**	**91.3%**	**84.7%**	**94.2%**	**92.7%**	**86.9%**	**87.2%**	**90.2%**	**89.4%**
# of Wait Days (Average)	12	8	12	8	11	9	11	9	9	10
# of Wait Days (Range)	0-32	0-32	0-42	0-29	0-35	0-34	0-36	0-56	0-32	0-56

Underline denotes that the 80% minimum compliance score is unmet. (*) denotes quarterly CAP requirement.

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

PCP compliance with urgent care appointment requirements for MY 2024 (91.0%) increased by 1.3 percentage points compared to MY 2023 (89.7%) and increased by 5.8 percentage points compared to MY 2022 (85.2%).

Results for compliance with urgent care appointments within 48 hours averaged 91% and ranged from 79.3% (KPMAS) to 96.9% (CFCHP). All MCOs, except for KPMAS, exceeded the MDH-required minimum compliance threshold (80%). KPMAS will be required to submit a quarterly CAP to improve compliance with the urgent care appointment timeframe.

Figure 12. MYs 2022 to 2024 Percent of PCPs in Compliance with Urgent Care Appointment Requirements (NAV FS)

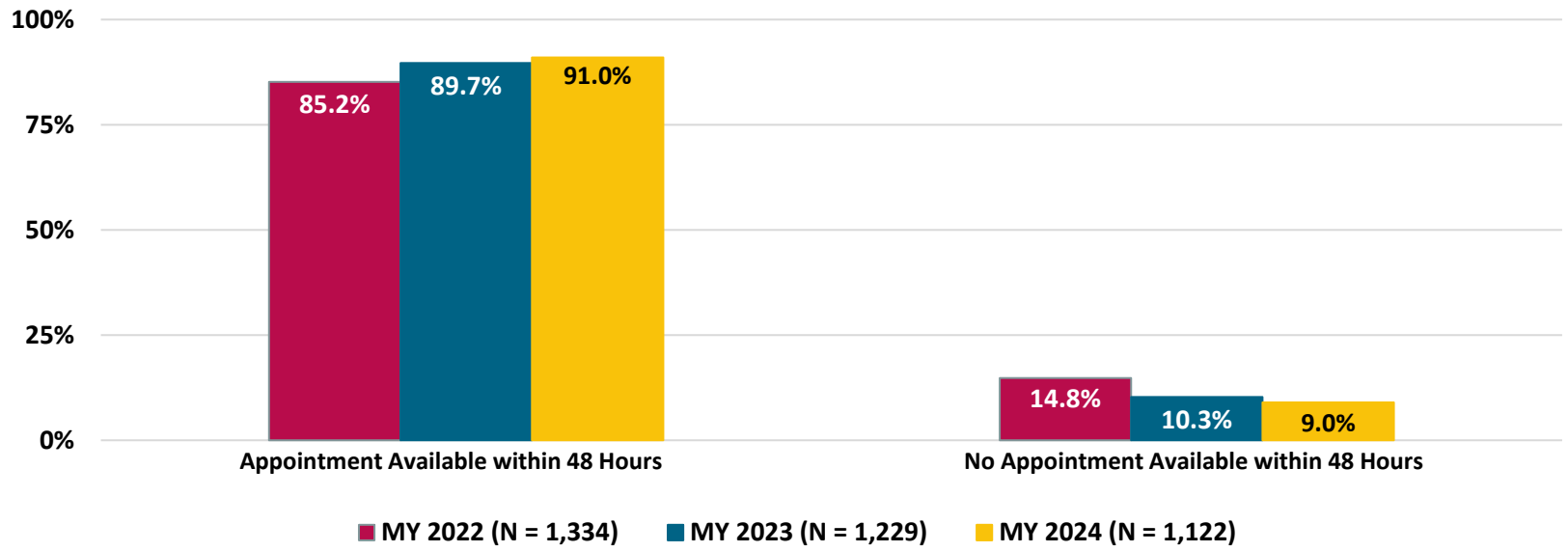


Table 70. MY 2024 MCO and HealthChoice Results for Compliance with Urgent Care Appointment Timeframe (within 48 hours) (NAV FS)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Compliance with Urgent Care Appointment	**91.6%**	**96.9%**	**92.3%**	**79.3%**	**93.3%**	**89.8%**	**92.5%**	**91.5%**	**90.9%**	**91.0%**
Appointment Available with Requested PCP at Same Location	76.2%	88.2%	83.7%	45.1%	89.2%	84.7%	81.3%	83.7%	76.5%	79.1%

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
within 48 hours (including telemedicine)										
Appointment Available with Another PCP at Same Location within 48 hours (including telemedicine)	15.4%	8.7%	8.7%	34.2%	4.2%	5.1%	11.2%	7.8%	14.4%	11.9%

Underline denotes that the 80% minimum compliance score is unmet. (*) denotes quarterly CAP requirement.

Validation of MCO Online Provider Directories

Qlarant validated the information in the MCOs' online provider directory for each PCP that completed the telephone survey. The online directories were reviewed for the following information:

- **PCP Address**: Accuracy of the information presented in the online directory, such as the PCP's name, address, and practice location(s).
- **PCP Phone Number**: Accuracy of the telephone number presented in the online directory.
- **ADA (Practice Accommodations for Physical Disabilities)**: Availability of specific accommodations for individuals with disabilities in the practice location, by indication in the online directory for the PCP.
- **New Patients**: Acceptance of new patients by the PCP, through indication in the online directory for the PCP.
- **Age Range**: Ages served by the PCP, through indication in the online directory for the PCP.
- **PCP Languages**: Languages spoken by the PCP, by indication in the online directory of the languages spoken by the PCP.

The MCOs' online provider directories demonstrated best practices, including:

- Using placeholders for provider details that are missing, such as "none" or "none specified," rather than leaving a blank field.
- The ability to filter by additional search criteria, such as provider specialty and location parameters.
- Continuing to share when provider information was last updated by adding a date stamp at the bottom of each page.

This section shows the proportion of telephone survey results matching the online provider directories by each of the review components listed above.[5]

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

The classification of successful telephone surveys matching the information within the online directory for MY 2024 is comparable to MY 2023 in all components. MY 2024 resulted in slight increases for accurate *PCP Address* (90.5% to 93.1%), *ADA* (94.7% to 94.8%), *New Patients* (77.8% to 80.7%), and *PCP Languages* (96.9% to 97.1%) compared to MY 2023.

Validation of the MCO online provider directories demonstrates the following:

- Rates for *PCPs Listed in Online Directory* ranged from 90.9% (WPM) to 100.0% (KPMAS).
- Rates for *PCP's Practice Location Matched Survey Response* ranged from 85.6% (WPM) to 98.4% (CFCHP).
- Four out of nine MCOs' scores failed to meet the minimum compliance in two key areas, *PCPs Practice Telephone Number Matched Survey Response* (CFCHP at 78.0%) and *Specifies if PCP Accepts New Medicaid Patients & Directory Matched Survey Response* (ABH at 75.5%, KPMAS at 69.4%, and WPM at 71.2%).

Figure 13. MYs 2022 to 2024 Online Provider Directory Validation Results (NAV FS)

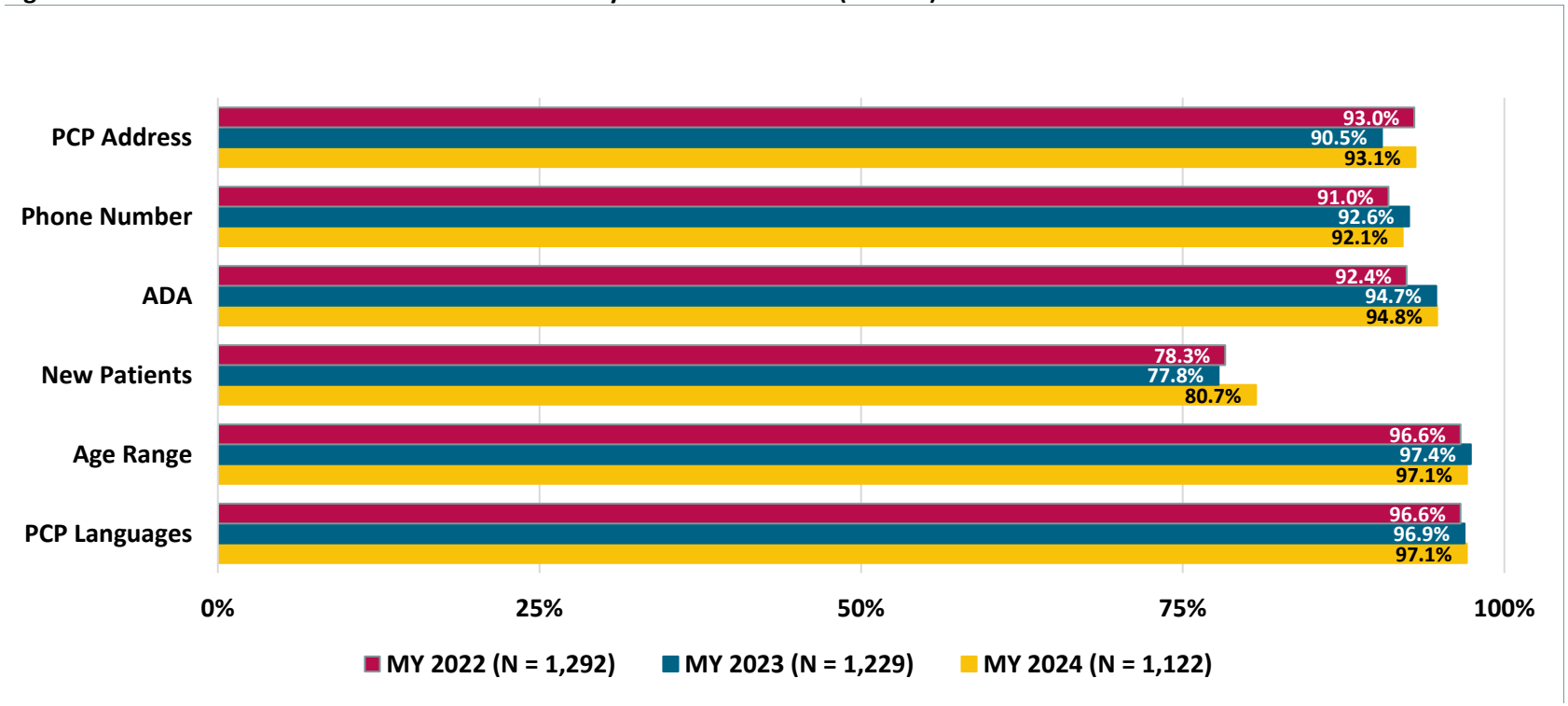


Table 71. MY 2024 MCO and HealthChoice Results for Validation of Online Provider Directories (NAV FS)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
PCP Listed in Online Directory	95.1% ↑	98.4% ↓	99.0% ↓	100.0% ↑	98.3% ↑	98.5% ↓	99.1% ↓	92.9% ↑	90.9% ↓	96.7% ↓
PCP's Practice Location Matched Survey Response	91.6% ↑	98.4% ↑	96.2% ↓	98.2% ↓	97.5% ↑	93.4% ↓	91.6% ↓	87.9% ↑	85.6% ↑	93.1% ↑
PCP's Practice Telephone Number Matched Survey Response	93.0% ↑	78.0% ↓	99.0% ↑	100.0% ↑	95.8% ↑	94.2% ↓	93.5% ↓	87.9% ↑	90.2% ↓	92.1% ↑
Specifies if PCP Accepts New Medicaid Patients & Directory Matched Survey Response	75.5% ↓	85.0% ↑	84.6% ↑	69.4% ↓	89.2% ↑	90.5% ↑	80.4% ↑	80.1% ↑	71.2% ↓	80.7% ↑
Specifies Ages of Patients Seen	94.4% ↓	98.4% ↓	99.0% ↓	100.0% ↑	98.3% ↑	98.5% ↓	100.0% =	92.9% ↑	93.9% ↓	97.1% ↓
Specifies Languages Spoken by PCP	95.1% ↑	98.4% ↓	99.0% ↓	99.1% ↑	98.3% ↑	98.5% ↑	100.0% ↑	92.9% ↑	93.9% ↓	97.1% ↑
Practice States if Accommodations for Patients with Disabilities are Available	92.3% ↓	98.4% ↓	99.0% ↓	100.0% ↑	98.3% ↑	97.8% ↓	88.8% ↑	92.9% ↑	87.1% ↓	94.8% ↑

Underline denotes that the 80% minimum compliance score is unmet. **Light green** and ↑ = Improvement from MY 2023, **Pink** and ↓= Decline from MY 2023

Conclusion

The overall response rate for MY 2024 was 55.4%, which is a 3.9 percentage point decrease from MY 2023 (59.3%). MY 2024 resulted in an increase in unsuccessful contacts made to provider offices due to *Hold Time >5 Minutes* (17.4%) compared to MY 2023 (7.2%); however, most unsuccessful contacts were related to *Did Not Reach Intended Provider* (37.3%). CFCHP and MPC had the greatest increases in unsuccessful contacts due to *No Answer* by 10.3 and 9.9 percentage points, respectively. There was a significant increase of 10.3 percentage points in unsuccessful contacts due to *Wrong Location Listed for Provider* from MY 2023 (2.6%) to MY 2024 (12.9%). All nine MCOs had significant increases in *Wrong Location Listed for Provider*; however, ABH had the most significant increase of 60 percentage points from MY 2023 (15.0%) to MY 2024 (75.0%). Seven of nine MCOs (CFCHP, JMS, MPC, MSFC, PPMCO, UHC, and WPM) had a decrease in successful contacts from MY 2023 to MY 2024, with MPC resulting in the most significant decrease of 16.2 percentage points (65.4% in MY 2023 to 49.2% in MY 2024).

Compliance with routine and urgent care appointment requirements is consistent from MY 2022 to MY 2024. All nine MCOs displayed compliance with routine care appointment requirements. One of nine MCOs (KPMAS) did not meet the 80% minimum compliance score for urgent care appointments (79.3%). Online provider directory validation results are consistent from MY 2022 to MY 2024. There was an increase

of 2.9 percentage points for *New Patients* from MY 2023 to MY 2024 (77.8% to 80.7%). Five of nine MCOs (JMS, MPC, MSFC, PPMCO, and UHC) met the 80% minimum compliance for all online provider directory validation categories.

- **Quality** - MCOs must ensure that PCPs are providing accurate information during member calls and when utilizing MCO online provider directories with an "easy to use" system to increase the likelihood that enrollees are able to access timely healthcare services to promote the desired health outcomes. Areas of impact during the MY 2024 NAV activity include:
  - An increase in the likelihood that enrollees will not reach the intended PCP due to hold times that are greater than five minutes or numbers not reaching the intended providers.
  - An increase in the likelihood that enrollees will not receive the accurate location for PCPs.
- **Access** - MCOs must ensure that the network of PCPs is adequately supporting members through "easy to use" systems to access accurate PCP information, the ability for enrollees to successfully contact PCP offices, schedule timely appointments, and providing PCPs within an adequate service area. Areas of impact during the MY 2024 NAV FS activity include:
  - Increased availability of network PCPs in neighboring states, such as Delaware, Pennsylvania, District of Columbia, Virginia, and West Virginia.
  - Increased accuracy of location information within online provider directories.
- **Timeliness** - MCOs must ensure that the network of PCPs is adequately supporting enrollees through the availability of routine and urgent care appointment times. Areas of impact during the MY 2024 NAV FS activity include:
  - An increase in the likelihood that enrollees will be able to schedule a routine care appointment within 30 days.
  - A decrease in the likelihood that enrollees will be able to schedule an urgent care appointment within 48 hours.

Quality Strategy Highlights

MDH set task goals for increasing all NAV requirements to 85% or above by MY 2024 in the HealthChoice Quality Strategy for 2022-2024, based on pre-Covid public health emergency aggregate performance. Specific HealthChoice performance metrics and targets are displayed in the table below.

In MY 2024, HealthChoice's aggregate performance exceeded the MDH-established minimum compliance threshold of 80% in each of the nine requirements. Eight of the nine requirements met or exceeded the MDH Quality Strategy goal of 85%, *Specifies if PCP Accepts New Medicaid Patients & Directory Matched Survey Response* falling short by four percentage points at 81%. Two of the nine requirements met or exceeded the specific MDH Quality Strategy Targets, *PCP Listed in Online Directory and Specifies PCP Accepts New Medicaid Patients* & *Matched Survey Response*.

Table 72. MY 2024 HealthChoice Aggregate Performance Against Quality Strategy Targets (NAV FS)

Requirement	HealthChoice Aggregate	MDH Quality Strategy Targets
Compliance with Appointment Timeframe Requirements	**Minimum Compliance (80%)**	**MY 2024: ≥85%**
Routine Care Appointment Timeframe	89%	100%
Urgent Care Appointment Timeframe	91%	93%
Compliance with Validation of Online Provider Directories	**Minimum Compliance (80%)**	**MY 2024: ≥85%**
PCP Listed in Online Directory	97%	97%
PCP's Practice Location Matched Survey Response	93%	98%
PCP's Practice Telephone Number Matched Survey Response	92%	96%
Specifies PCP Accepts New Medicaid Patients & Matches Survey Response	81%	80%
Specifies Age of Patient Seen	97%	100%
Specifies Languages Spoken by PCP	97%	100%
Practice has Accommodations for Patients with Disabilities	95%	100%

Source: *HealthChoice Quality Strategy*

For additional findings and comprehensive details associated with the MY 2024 NAV, please access the link to the MY 2024 NAV Report in **Appendix E**. The **MCO Quality, Access, and Timeliness section** and **Appendix A** provide informed conclusions from the NAV activity related to quality, access, and timeliness for the HealthChoice program.

Encounter Data Validation

Objective

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

Methodology

Description of Data Obtained. Qlarant conducted EDV for MY 2023, encompassing January 1, through December 31, 2023, for all nine MCOs. Qlarant obtained the following data to complete the EDV study:

- Electronic encounter data submitted by the MCOs

- Information Systems Capabilities Assessment (ISCA) documentation from the MCOs
- Medical records from providers

Technical Methods of Data Collection and Analysis. Qlarant conducted EDV in accordance with the *CMS External Quality Review (EQR) Protocol 5, Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*. To assess the completeness and accuracy of encounter data, Qlarant completed the following activities:

Activity 1. Reviewed state requirements for collecting and submitting encounter data. Qlarant reviewed MDH's contractual requirements for encounter data collection and submission to ensure the MCOs followed the specifications in file format and encounter types.

Activity 2. Reviewed the MCO's capability to produce accurate and complete encounter data. Qlarant completed an evaluation of the MCO's ISCA to determine whether the MCO's information system can collect and report high-quality encounter data.

Activity 3. Analyzed MCO electronic encounter data for accuracy and completeness. MDH elected to contract with Hilltop to analyze and evaluate the validity of encounter data to complete Activity 3. Hilltop performed an evaluation of all electronic encounter data submitted by the MCOs for MY 2021 through MY 2023 to determine the validity of the encounter data and ensure the data are complete, accurate, and of high quality.

Activity 4. Reviewed medical records for confirmation of findings of encounter data analysis. Qlarant's certified coders/nurse reviewers compared electronic encounter data to medical record documentation to confirm the accuracy of reported encounters. A random sample of encounters for inpatient, outpatient, and office visit claims were reviewed to evaluate if the electronic encounter was documented in the medical record and the level of documentation supported the billed service codes. Reviewers validate patient identifiers, diagnosis codes, procedure codes, and if applicable, revenue codes.

Activity 5. Submitted findings to MDH. Qlarant prepared a report for submission to MDH, which includes results, strengths, and recommendations.

Timeline. Qlarant conducted EDV for MY 2023, encompassing January 1, through December 31, 2023, for all nine HealthChoice MCOs.

Results

Activity 1: State Requirements for Collecting and Submitting Encounter Data

Purpose. Qlarant reviewed information regarding MDH's requirements for collecting and submitting encounter data. MDH provided Qlarant with:

- MDH's requirements for collecting and submitting encounter data by MCOs, including specifications in the contracts between the State and the MCO.
- Data submission format requirements for MCOs.
- Requirements specifying the types of encounters that must be validated.
- MDH's abridged data dictionary.
- A description of the information flow from the MCO to the State, including the role of any contractors or data intermediaries.
- MDH's standards for encounter data completeness and accuracy.
- A list and description of edit checks built into MDH's Medicaid Management Information System (MMIS) that identifies how the system treats data that fails edit checks.
- Requirements regarding timeframes for data submission.
- Prior year's EQR report on validating encounter data.
- Hilltop's report, *EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2021 to CY 2023*.
- Any other information relevant to encounter data validation.

Encounter Data Processes. MDH provided an abridged data dictionary and described the process of encounter data submission from the MCOs to the State. MCOs can submit encounter data through a web portal or through a file transfer protocol. Each MCO may contract with a vendor or use data intermediaries to prepare encounter data submissions.

The electronic data interchange (EDI) is an automated system that includes rules dictating the transfer of data from each MCO to MDH. MDH uses the Health Insurance Portability and Accountability Act (HIPAA) EDI transaction sets and standards for data submission of 820, 834, 835, and 837 files. The 837 file contains patient claim information, while the 835 file contains the payment and/or explanation of benefits for a claim. MDH processes encounters via the Electronic Data Interchange Translator Processing System for completeness and accuracy. All encounters are validated on two levels: first by performing Level 1 and Level 2 edit checks on 837 data, using HIPAA EDI implementation guidelines; and second, within MMIS's adjudication process. The system treats encounters that fail the MMIS edit checks in the following manner:

- All denied and rejected encounters appear with the MMIS Explanation of Benefit (EOB) code and description in the 8ER file, with one exception. EOB 101 is excluded from this report.
- All paid and denied encounters appear in the 835 file. Denied encounters use the HIPAA EDI Claim Adjustment Reason Codes and Remittance Advice Remark Codes to report back the denied reason. Encounters marked as suspended are not included in the 835.
- In addition, MMIS generates a summary report for each MCO.

Performance standards used to define requirements for encounters in MY 2023 are established by MDH in MY 2023 HealthChoice MCO Agreements and Appendix O of MCO contracts. MDH specifies the encounter data requirements for the collection and submission of encounter data by MCOs in Section II.I.4, and 5 of the MY 2023 HealthChoice MCO Agreement (p. 13). Appendix O of the contract includes all the COMAR provisions applicable to MCOs, including regulations concerning encounter data. Regulations applying to encounters in MY 2023 are noted in the table below.

Table 73. MY 2023 Encounter Data Requirements (EDV)

COMAR	Requirement

10.67.03.11A	A description of the applicant's management information system, including, but not limited to:
	• Capacities, including:
	  ○ The ability to generate and transmit electronic claims data consistent with the Medicaid Statistical Information System (MSIS) requirements or successor systems;
	  ○ The ability to collect and report data on enrollee and provider characteristics and on all services furnished to enrollees through an encounter data system;
	  ○ The ability to screen the data collected for completeness, logic, and consistency; and
	  ○ The ability to collect and report data from providers in standardized formats using secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts;
	• Software;
	• Characteristics; and
	• Ability to interface with other systems

10.67.03.11B	A description of the applicant's operational procedures for generating service-specific encounter data.
10.67.03.11C	Evidence of the applicant's ability to report, on a monthly basis, service-specific encounter data in UB04 or CMS1500 format.
10.67.07.03A(1)	MCOs shall submit to MDH the following: Encounter data in the form and manner described in COMAR 10.67.04.15B, 42 CFR §438.242(c), and 42 CFR §438.818.
10.67.07.03B	MCOs shall report to MDH any identified inaccuracies in the encounter data reported by the MCOs or its subcontractors within 30 days of the date discovered, regardless of the effect which the inaccuracy has upon MCOs reimbursement.
10.67.04.15B	Encounter Data: • MCOs shall submit encounter data reflecting 100% of provider-enrollee encounters in CMS1500 or UB04 format or an alternative format previously approved by MDH.

COMAR	Requirement

	• MCOs may use alternative formats, including:
	  ○ ASC X12N 837 and NCPDP formats; and
	  ○ ASC X12N 835 format, as appropriate.
	• MCOs shall submit encounter data that identifies the provider who delivers any items or services to enrollees at a frequency and level of detail to be specified by CMS and MDH, including, at a minimum:
	  ○ Enrollee and provider identifying information;
	  ○ Service, procedure, and diagnosis codes;
	  ○ Allowed, paid, enrollee responsibility, and third-party liability amounts; and
	  ○ Service, claims submissions, adjudication, and payment dates.
	• MCOs shall report encounter data within 60 calendar days after receipt of the claim from the provider.
	• MCOs shall submit encounter data utilizing a secure online data transfer system.

MDH sets forth requirements regarding timeframes for data submission in COMAR 10.67.04.15B, which specifies that MCOs must report encounter data within 60 calendar days after receipt of the claim from the provider. For daily data exchanges, the cutoff time is 3 p.m. for transmission of a single encounter data file for an MCO to receive an 835 the next day. Any encounters processed after the cutoff time will be picked up in the next adjudication cycle on the following business day.

Activity 2: MCO's Capability to Produce Accurate and Complete Encounter Data

Purpose. Qlarant assessed each MCO's capability for collecting accurate and complete encounter data. Each MCO's information systems process and capabilities in capturing complete and accurate encounter data will be assessed through the following steps:

1. Review of the MCO's ISCA.
2. Interview MCO personnel, as needed.

The purpose of the ISCA review is to assess the MCO's information systems capabilities to capture and assimilate information from multiple data sources. The documentation review also determines if the system may be vulnerable to incomplete or inaccurate data capture, integration, storage, or reporting. Documentation review findings are used to identify issues that may contribute to inaccurate or incomplete encounter data.

Results. After reviewing the findings from the ISCA, Qlarant conducted follow-up interviews with MCO personnel, as needed, to supplement the information and ensure an understanding of the MCO's information systems and processes. Results of the document review and interview process are summarized in the table below.

Table 74. MY 2023 ISCA Summary (EDV)

Information Systems Component Assessment	HealthChoice Aggregate
Captures Data Appropriately	**Yes/No**
Captures accurate encounter data	Yes for All
Captures all appropriate data elements for claims processing	Yes for All
Clean Claims Assessment	**%**
Clean Claims in 30 Days Timeliness Standard	96%
Clean Claims in 30 Days Timeliness Rate	99%
Electronic Claims Assessment	**%**
Percentage of electronic professional claims	96%
Percentage of electronic institutional/facility claims	87%

Activity 3: Analysis of MCO's Electronic Encounter Data for Accuracy and Completeness

Purpose. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Therefore, Hilltop completed Activity 3 of the EDV, which includes the following four steps for analyses:

1. Develop a data quality test plan based on data element validity requirements
2. Encounter data macro-analysis—verification of data integrity
3. Encounter data micro-analysis—generate and review analytic reports
4. Compare findings to state-identified benchmarks

Hilltop's report conclusions for MY 2023 Activity 3 are listed below.

Overall, analysis of the CY 2023 electronic encounter data submitted indicates improvements in provider enrollment-related denied encounters. Although the MCOs continue to struggle with the changes in encounter editing logic, the Department and the MCOs have continued to strengthen gains made in recent years.

In general, the MCOs have similar distributions of denials, types of encounters, types of visits, and outliers, except where specifically noted in the results. This analysis identified minor outliers that merit further monitoring and investigation, although the MCOs have made progress. Hilltop generated recipient-level reports for Department staff to discuss with the MCOs.

Hilltop found that the volume of accepted encounters was generally consistent with MCO enrollment. Although the time dimension analysis showed some variation among MCOs regarding the timeliness of encounter submissions, most encounters were submitted within the eight-month maximum time frame allotted by the Department. The decreases in encounters submitted within one to two days and three to seven days that were observed for CY 2023 are offset by the increase in the number of encounters submitted within eight to 31 days and one to two months.

Activity 4: Analysis of Medical Records to Confirm Encounter Data Accuracy

Purpose. A review of enrollees' medical records offers a method to examine the completeness and accuracy of encounter data. Using the encounter/claims data file prepared by Hilltop, Qlarant identified all enrollees with an inpatient, outpatient, and office visit service claim.

Medical Record Sample. The sample size was selected to ensure a 90% confidence interval with a +/-5% margin of error rate for sampling. Oversampling was used in order to ensure adequate numbers of medical records were received to meet the required sample size. Hospital inpatient and outpatient encounter types were oversampled by 300%, while office visit encounter types were oversampled by 400% for each MCO.

Records were requested directly from the billing providers. Qlarant mailed each sampled provider a letter with the specific record request, which included the patient's name, medical assistance identification number, date of birth, date(s) of service, claim number, and treating physician's NPI number. Targeted follow-up is addressed, as needed, to providers who did not respond to the initial request, including phone calls and fax requests. Providers were asked to securely submit medical record information to Qlarant with the following instructions:

- Identify documentation submitted for each patient using the patient's first and last name, medical assistance identification number, date of birth, age, gender, and provider name.
- Include all relevant medical record documentation to ensure receipt of adequate information for validating service codes (a list of recommended documentation was provided for reference).

The total number of EDV minimum samples required, classified by encounter type, is displayed in the table below. All MCOs, except for MSFC, met the minimum sample for each setting type of the encounter data review. MSFC submitted a sufficient number of records; however, a number of those records were deemed invalid. MSFC was notified and discovered the root cause, which has been corrected.

Table 75. MYs 2021 to 2023 Minimum Sample Required for Review by Encounter Type (EDV)

Sample Size by Encounter Type	MY 2021	MY 2022	MY 2023
Inpatient	55 (2%)	52 (2%)	52 (2%)
Outpatient	507 (21%)	497 (20%)	458 (19%)
Office Visit	1,892 (77%)	1,907 (78%)	1,944 (79%)
Total	**2,454**	**2,456**	**2,454**

Table 76. MY 2023 MCO Medical Record Review Response Rates by Encounter Type (EDV)

Response Rate by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Inpatient Records Reviewed (#)	**6**	**7**	**9**	**6**	**5**	**5**	**6**	**5**	**5**
Minimum Reviews Required (#)	6	7	8	5	5	5	6	5	5
Sample Size Achieved (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Outpatient Records Reviewed (#)	**51**	**51**	**78**	**19**	**56**	**48**	**66**	**53**	**45**
Minimum Reviews Required (#)	50	51	77	19	55	52	58	51	45
Sample Size Achieved (Yes/No)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Office Visit Records Reviewed (#)	**220**	**217**	**188**	**250**	**214**	**219**	**213**	**220**	**226**
Minimum Reviews Required (#)	215	215	187	249	213	216	209	217	223
Sample Size Achieved (Yes/No)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Match Rates. Medical records received were verified against the sample listing and enrollee demographic information from the data file to ensure consistency between submitted encounter data and corresponding medical records. Documentation was noted in the database as to whether the diagnosis, procedure, and if applicable, revenue codes were substantiated by the medical record. All diagnosis codes, procedure codes, and revenue codes included in the data were validated per record for the EDV. Qlarant defines findings of consistency in terms of *Match*, *No Match*, and *Invalid*, as shown in the table below.

Table 77. MY 2023 Review Determinations (EDV)

Review Determinations	Criteria
Match	Determinations were a *Match* when reviewers found documentation in the record.
No Match	Determinations were a *No Match* when there was a lack of documentation in the record, coding error(s), or upcoding.
Invalid	Determinations were *Invalid* when a medical record was not legible or could not be verified against the encounter data by patient name, account number, gender, date of birth, or date(s) of service. When this situation occurred, the reviewer ended the review process.

MY 2023's EDV review observed the following about match rates of HealthChoice performance across all three encounter types, shown in Table 78:

- The percentage of match rates remained above the standard compliance of 90% by five percentage points or above for all three encounter types and the composite rate.
- The composite match rate has steadily declined from MY 2021 (99%) to MY 2023 (96%) and decreased by two percentage points from MY 2022 (98%) to MY 2023 (96%).
- Inpatient match rates decreased by one percentage point from MY 2022 (100%) to MY 2023 (99%), matching MY 2021's rate.
- Outpatient match rates decreased by one percentage point from MY 2021 and 2022 (99%) to MY 2023 (98%).
- Office visit match rates have steadily declined from MY 2021 (99%) to MY 2023 (95%), decreasing by one percentage point from MY 2022 (96%).

Table 78. MYs 2021 to 2023 Results by Encounter Type (EDV)

Encounter Type	MY 2021	MY 2022	MY 2023
Inpatient	56	56	54
Outpatient	514	517	467
Office Visit	1,915	1,953	1,967
Total Records Reviewed	**2,485**	**2,526**	**2,488**
Inpatient	1,186	1,206	1,208
Outpatient	6,812	7,106	6,286
Office Visit	9,124	9,753	10,650
Total Possible Elements	**17,122**	**18,065**	**18,144**
Inpatient	1,173	1,203	1,195
Outpatient	6,774	7,033	6,144
Office Visit	9,056	9,409	10,157
Total Matched Elements	**17,003**	**17,645**	**17,496**
Inpatient	99%	100%	99%
Outpatient	99%	99%	98%
Office Visit	99%	96%	95%
Total Percentage of Matched Elements	**99%**	**98%**	**96%**

Inpatient Encounters. MY 2023's EDV review observed the following about match rates of HealthChoice performance for inpatient encounters, as shown in Table 79:

- The number of inpatient encounter types for *No Match* findings increased for diagnosis codes and procedure codes by eight and two encounters, respectively, from MY 2022 to MY 2023.
- The number of *No Match* findings for revenue codes maintained at two encounters for MY 2022 to MY 2023.
- The total *No Match* findings declined from MY 2021 (13) to MY 2022 (3); however, the total *No Match* findings increased for MY 2023 (13).

Table 79. MYs 2021 to 2023 Inpatient Encounter Type Results by Code (EDV)

Match Results by Code Type	MY 2021	MY 2022	MY 2023
Match	473	469	488
No Match	5	1	9
Total Elements	478	470	497
Diagnosis Match Percent	**99%**	**100%**	**98%**
Match	85	117	73
No Match	7	0	2
Total Elements	92	117	75
Procedure Match Percent	**92%**	**100%**	**97%**
Match	615	617	634
No Match	1	2	2
Total Elements	616	619	636
Revenue Match Percent	**99%**	**100%**	**100%**
Match	1,173	1,203	1,195
No Match	13	3	13
Total Elements	1,186	1,206	1,208
Total Match Percent	**99%**	**100%**	**99%**

MY 2023's EDV review observed the following about match rates of MCO performance by diagnosis, procedure, revenue, and total codes from inpatient encounters, as shown in Table 80:

- All MCOs achieved match rates above 93% for diagnosis codes, with CFCHP, JMS, PPMCO, and WPM scoring 100%.
- Total match rates for all codes ranged from 96% (ABH) to 100% (JMS, PPMCO, and WPM), exceeding the 90% compliance standard.
- JMS, PPMCO, and WPM had 100% match rates for inpatient encounters across all three code types.
- ABH and MPC were the only MCOs that fell below 100% for procedure code match rates at 90% and 88%, respectively.
- CFCHP and MSFC were the only MCOs that fell below 100% for revenue code match rates at 99% and 98%, respectively.

Table 80. MY 2023 MCO Inpatient Results by Code Type (EDV)

Code Types by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Diagnosis Codes Match (#)	**29**	**62**	**88**	**55**	**56**	**45**	**66**	**48**	**39**
Diagnosis Codes Total (#)	31	62	88	56	60	46	66	49	39
Diagnosis Codes Score (%)	94%	100%	100%	98%	93%	98%	100%	98%	100%
Procedure Codes Match (#)	**9**	**8**	**9**	**9**	**7**	**3**	**5**	**9**	**14**
Procedure Codes Total (#)	10	8	9	9	8	3	5	9	14
Procedure Codes Score (%)	90%	100%	100%	100%	88%	100%	100%	100%	100%
Revenue Codes Match (#)	**43**	**77**	**83**	**92**	**90**	**65**	**66**	**62**	**56**
Revenue Codes Total (#)	43	78	83	92	90	66	66	62	56
Revenue Codes Score (%)	100%	99%	100%	100%	100%	98%	100%	100%	100%
Total Codes Match (#)	**81**	**147**	**180**	**156**	**153**	**113**	**137**	**119**	**109**
Total Codes Total (#)	84	148	180	157	158	115	137	120	109
Total Codes Score (%)	96%	99%	100%	99%	97%	98%	100%	99%	100%
Number of Reviews	**6**	**7**	**9**	**6**	**5**	**5**	**6**	**5**	**5**

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

Outpatient Encounters. MY 2023's EDV review observed the following about match rates of HealthChoice performance for outpatient encounters, as shown in Table 81:

- The amount of *No Match* findings has increased for each code type for outpatient encounters comparing MY 2021 to MY 2023.
- The *No Match* encounters for diagnosis codes increased by 13 encounters from MY 2021 (29) to MY 2023 (42).
- Procedure codes had the largest increase of all code types for *No Match* findings by 72 encounters from MY 2021 (3) to MY 2023 (75).
- The revenue codes *No Match* findings had an increase from MY 2021 (6) to MY 2023 (25).
- The total *No Match* finding for all code types increased from MY 2021 (38) to MY 2023 (142).

Table 81. MYs 2021 to 2023 Outpatient Encounter Type by Code (EDV)

Match Rates by Code Type	MY 2021	MY 2022	MY 2023
Match	1,902	2,046	1,714
No Match	29	41	42
Total Elements	1,931	2,087	1,756
Diagnosis Match Percent	**98%**	**98%**	**98%**
Match	2,848	2,887	2,620
No Match	3	19	75
Total Elements	2,851	2,906	2,695
Procedure Match Percent	**100%**	**99%**	**97%**
Match	2,024	2,100	1,810
No Match	6	13	25
Total Elements	2,030	2,113	1,835
Revenue Match Percent	**100%**	**99%**	**99%**
Match	6,774	7,033	6,144
No Match	38	73	142
Total Elements	6,812	7,106	6,286
Total Match Percent	**99%**	**99%**	**98%**

MY 2023's EDV review observed the following about match rates of MCO performance by diagnosis, procedure, revenue, and total codes from outpatient encounters, as shown in Table 82:

- All MCOs achieved match rates at or above 90% for all outpatient encounter code types.
- KPMAS was the only MCO to achieve 100% match rates for each code type and the only MCO to achieve 100% match rates for diagnosis codes.
- KPMAS, MSFC, and UHC achieved 100% match rates for procedure codes and ABH, KPMAS, MSFC, and UHC achieved 100% match rates for revenue codes.
- Total match rates across all code types ranged from 94% (PPMCO) to 100% (KPMAS), exceeding the 90% compliance standard.

Table 82. MY 2023 MCO Outpatient Results by Code Type (EDV)

Code Types by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Diagnosis Codes Match (#)	**188**	**167**	**282**	**53**	**206**	**190**	**310**	**183**	**135**
Diagnosis Codes Total (#)	191	173	289	53	211	193	318	188	140
Diagnosis Codes Score (%)	98%	97%	98%	100%	98%	98%	98%	97%	96%
Procedure Codes Match (#)	**247**	**238**	**391**	**145**	**289**	**306**	**403**	**343**	**258**
Procedure Codes Total (#)	249	240	401	145	292	307	449	343	269
Procedure Codes Score (%)	99%	99%	98%	100%	99%	100%	90%	100%	96%
Revenue Codes Match (#)	**181**	**170**	**262**	**111**	**201**	**199**	**262**	**239**	**185**
Revenue Codes Total (#)	182	171	268	111	204	200	271	239	189
Revenue Codes Score (%)	100%	99%	98%	100%	99%	100%	97%	100%	98%
Total Codes Match (#)	**616**	**575**	**935**	**309**	**696**	**695**	**975**	**765**	**578**
Total Codes Total (#)	622	584	958	309	707	700	1038	770	598
Total Codes Score (%)	99%	99%	98%	100%	98%	99%	94%	99%	97%
Number of Review	**51**	**51**	**78**	**19**	**56**	**48**	**66**	**53**	**45**

Note: Values reported are rounded to the nearest percentage for reporting only.
MSFC was unable to meet the minimum sample required for reviews.

Office Visit Encounters. MY 2023's EDV review observed the following about match rates of HealthChoice performance for office visit encounters, as shown in Table 83:

- The *No Match* encounters for diagnosis and procedure codes have steadily increased from MY 2021 (43 and 25, respectively) to MY 2023 (294 and 199, respectively).

Table 83. MYs 2021 to 2023 Office Visit Encounter Type Results by Code (EDV)

Match Results by Code Type	MY 2021	MY 2022	MY 2023
Match	5,592	5,669	5,982
No Match	43	165	294
Total Elements	5,635	5,834	6,276
Diagnosis Match Percent	**99%**	**97%**	**95%**
Match	3,464	3,740	4,175
No Match	25	158	199
Total Elements	3,489	3,905	4,374
Procedure Match Percent	**99%**	**96%**	**95%**
Match	9,056	9,409	10,157
No Match	68	323	493
Total Elements	9,124	9,753	10,650
Total Match Percent	**99%**	**96%**	**95%**

MY 2023's EDV review observed the following about match rates of MCO performance by diagnosis, procedure, and total codes from office visit encounters, as shown in Table 84:

- Match rates for office visits ranged from 93% (MPC procedure codes) to 98% (KPMAS diagnosis codes and JMS diagnosis and procedure codes) across diagnosis and procedure code types.
- Total codes ranged from 94% (MPC) to 98% (JMS), exceeding the 90% compliance standard.

Table 84. MY 2023 MCO Office Visit Results by Code Type (EDV)

Code Type by MCO	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Diagnosis Codes Match (#)	**656**	**679**	**620**	**663**	**662**	**637**	**667**	**653**	**745**
Diagnosis Codes Total (#)	696	716	630	675	703	670	701	698	787
Diagnosis Codes Score (%)	94%	95%	98%	98%	94%	95%	95%	94%	95%
Procedure Codes Match (#)	**435**	**425**	**271**	**733**	**445**	**426**	**468**	**493**	**479**
Procedure Codes Total (#)	457	449	276	766	477	451	485	511	502
Procedure Codes Score (%)	95%	95%	98%	96%	93%	94%	96%	96%	95%
Total Codes Match (#)	**1,091**	**1,104**	**891**	**1,396**	**1,107**	**1,063**	**1,135**	**1,146**	**1,224**
Total Codes Total (#)	1,153	1,165	906	1,441	1,180	1,121	1,186	1,209	1,289
Total Codes Score (%)	95%	95%	98%	97%	94%	95%	96%	95%	95%
Number of Reviews	**220**	**217**	**188**	**250**	**214**	**219**	**213**	**220**	**226**

*Revenue codes are not applicable for office visit encounters.
Note: Values reported are rounded to the nearest percentage for reporting only.

Aggregate Validation Results for MY 2023 EDV. MY 2023's EDV review observed the following about match rates of MCO performance across MYs 2021 to 2023, as shown in Table 85:

- All MCOs achieved match rates ranging from three to ten percentage points above the minimum compliance standard of 90%, across all MYs from 2021 to 2023.
- Office visit encounters had the most fluctuation in range for match rates from 93% (MY 2022) to 98% (MY 2023).
- Match rates ranged from 96% to 100% for inpatient encounters for MY 2023.
- Outpatient encounters ranged from 94% to 100% for MY 2023.
- The HealthChoice Aggregate has remained comparable for each encounter type from MY 2021 to MY 2023; however, match rates for office visits have consistently declined from MY 2021 (99%) to MY 2023 (95%). Inpatient and outpatient encounter
- HealthChoice Aggregate match rates have decreased by one percentage point from MY 2022 (100% and 99%, respectively) to MY 2023 (99% and 98%, respectively).

Table 85. MYs 2021 to 2023 MCO and HealthChoice Results by Encounter Type (EDV)

MY	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice
Inpatient	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
MY 2021	100%	100%	96%	100%	100%	100%	98%	98%	100%	99%
MY 2022	100%	100%	100%	100%	99%	99%	100%	99%	100%	100%
MY 2023	96%	99%	100%	99%	97%	98%	100%	99%	100%	99%
Outpatient	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
MY 2021	98%	100%	99%	100%	99%	100%	99%	100%	99%	99%
MY 2022	99%	100%	99%	100%	99%	99%	97%	99%	99%	99%
MY 2023	99%	98%	98%	100%	98%	99%	94%	99%	97%	98%
Office Visit	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
MY 2021	99%	99%	99%	100%	100%	100%	99%	99%	98%	99%
MY 2022	95%	93%	96%	99%	96%	99%	97%	98%	94%	96%
MY 2023	95%	95%	98%	97%	94%	95%	96%	95%	95%	95%

Aggregate Results for *No Match* Findings. Comparing encounter and code types across MYs during MY 2023's EDV review observed lack of documentation and coding errors as the most frequent combination of errors for *No Match* findings. Lack of documentation continues to account for most of the *No Match* findings. Lack of documentation and coding errors are the reasons for *No Match* findings for all inpatient and outpatient encounters from MY 2021 to MY 2023 for all code types. For MY 2023, lack of documentation accounted for 77% of *No Match* findings for office visit procedure codes, followed by 19% of coding errors, and 4% of upcoding. Outpatient revenue code *No Match* findings were due to lack of documentation (92%) and coding errors (8%).

Coding "No Match" Summary. MY 2023's EDV review observed the following about "No Match" rates for coding errors, as shown in Table 86:

- Coding errors for diagnosis codes significantly increased from MY 2022 (0% for inpatient encounters, 5% for outpatient encounters, and 6% for office visit encounters) to MY 2023 (44% for inpatient encounters, 12% for outpatient encounters, and 24% for office visit encounters) followed by an increase in outpatient procedure coding errors from MY 2022 (0%) to MY 2023 (5%).

Table 86. MYs 2021 to 2023 Coding Error Reasons for *No Match* Findings by Encounter Type (EDV)

Encounter Type	MY 2021			MY 2022			MY 2023		
Diagnosis	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	1	20%	5	0	-	1	4	44%	9
Outpatient	2	7%	29	2	5%	41	5	12%	42
Office Visit	15	35%	43	9	6%	165	70	24%	249
Procedure	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	4	57%	7	0	-	0	0	-	2
Outpatient	0	0%	3	0	-	19	4	5%	75
Office Visit	11	44%	25	6	4%	158	38	19%	199
Revenue	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	1	100%	2	0	-	2	-	-	2
Outpatient	0	-	6	0	-	13	2	8%	25

Lack of Documentation "No Match" Summary. MY 2023's EDV review observed the following about "No Match" rates for all lack of documentation errors, as shown in Table 87:

- Lack of documentation for diagnosis codes decreased from MY 2022 (100% for inpatient encounters, 95% for outpatient encounters, and 95% for office visit encounters) to MY 2023 (56% for inpatient encounters, 88% for outpatient encounters, and 76% for office visit encounters).
- For MY 2023, all *No Match* findings for inpatient procedure codes were due to lack of documentation, which is an increase from MY 2022 (0%).
- Lack of documentation for outpatient procedure codes decreased from MY 2022 (100%) to MY 2023 (95%).
- Lack of documentation has accounted for 100% of *No Match* findings for inpatient revenue codes for MYs 2022 and 2023.

Table 87. MYs 2021 to 2023 Lack of Documentation Error Reasons for *No Match* Findings by Encounter Type (EDV)

Encounter Type	MY 2021			MY 2022			MY 2023		
Diagnosis	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	4	80%	5	1	100%	1	5	56%	9
Outpatient	27	93%	29	39	95%	41	37	88%	43
Office Visit	27	63%	43	156	95%	165	224	76%	294
Procedure	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	3	43%	7	0	-	0	2	100%	2
Outpatient	3	100%	3	19	100%	19	71	95%	75
Office Visit	14	56%	25	152	96%	158	154	77%	199
Revenue	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	-	2	2	100%	2	2	100%	2
Outpatient	6	100%	6	13	100%	13	23	92%	25

Upcoding "No Match" Summary. MY 2023's EDV review observed the following about "No Match" rates for all upcoding errors, as shown in Table 88:

- The only *No Match* findings for upcoding were for MY 2021 office visit diagnosis codes (2%) and MY 2023 office visit procedure codes (4%).

Table 88. MYs 2021 to 2023 Upcoding Error Reasons for *No Match* Findings by Encounter Type (EDV)

Encounter Type	MY 2021			MY 2022			MY 2023		
Diagnosis	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	-	5	0	-	1	0	-	9
Outpatient	0	-	29	0	-	41	0	-	42
Office Visit	1	2%	43	0	-	165	0	-	294
Procedure	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	-	7	0	-	0	0	-	2
Outpatient	0	-	3	0	-	19	0	-	75
Office Visit	0	-	25	0	-	158	7	4%	199
Revenue	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	-	2	0	-	2	0	-	2
Outpatient	0	-	6	0	-	13	0	-	25

Conclusion

Overall, analysis of the electronic encounter data submitted by MCOs indicates the data are valid (complete and accurate). Qlarant and Hilltop completed an EDV study for MDH based on an assessment of encounters paid during MY 2023. Qlarant conducted a medical record review on a sample of inpatient, outpatient, and office visit encounters (2,488) to confirm the accuracy of codes. MCOs achieved a match rate of 96%, meaning 96% of claims submitted were supported by medical record documentation. MCOs achieved a high match rate for each encounter setting: 99% for inpatient, 98% for outpatient, and 95% for office visits.

- **Quality** – MCOs must ensure accuracy and completeness of encounter data submitted to MDH, and when compared to medical record reviews. Areas of impact during the MY 2023 EDV review include:
  - The continued likelihood that inpatient and outpatient encounter documentation will result in coding errors, lack of documentation, or upcoding due to sustained performance in match rates from MY 2022 to MY 2023.
  - An increased likelihood that office visit encounter documentation will result in coding errors, lack of documentation, or upcoding due to the declining trend in performance from MY 2021 to MY 2023.
- **Access** – MCOs must ensure access to accurate, capable, and complete information systems, which analyze and maintain encounter data in MDH's Electronic Data Interchange Translation Processing System and MMIS. Areas of impact during the MY 2023 EDV review include:
  - An increase in the likelihood that MCOs are accurately demonstrating and reporting outcome information related to EDV due to the high percentage of match rates sustained at 95% or higher from MY 2021 to MY 2023.
- **Timeliness** – MCOs must ensure the timeliness of encounter data submissions. Areas of impact during the MY 2022 EDV review include:
  - The continued likelihood that MCOs' information systems are providing timely and accurate data due to eight out of nine MCOs having successfully provided encounter review data to meet the minimum sample for review while resulting in overall match rates across all code types at 96% or higher for MY 2023.
    - MSFC was the only MCO unable to successfully provide encounter review data to meet the minimum sample for review.

Quality Strategy Highlights

MDH set goals for match rates in the HealthChoice Quality Strategy for 2022-2024. In MY 2023, HealthChoice Aggregates performance met the MDH Quality Strategy goal of 99% for *Inpatient Match Rates*. *Outpatient Match Rates* and *Office Visits Match Rates* fell short of the MDH Quality Strategy Targets by one and five percentage points, respectively.

Table 89. MY 2023 HealthChoice Aggregate Performance Against Quality Strategy Targets (EDV)

Requirement: Minimum Compliance Score: ≥ 90%	MY 2023 HealthChoice Aggregate	MDH Quality Strategy Targets for MY 2024
Inpatient Match Rates	99%	99%
Outpatient Match Rates	98%	99%
Office Visits Match Rates	95%	99%

Source: *HealthChoice Quality Strategy*

For additional findings and comprehensive details associated with the MY 2023 EDV, please access the link to the MY 2023 EDV Report in **Appendix E**. The **MCO Quality, Access, and Timeliness section** and **Appendix A** provide informed conclusions from the EDV activity related to quality, access, and timeliness for the HealthChoice program.

Early and Periodic, Screening, Diagnosis, and Treatment

Objective

Maryland's EPSDT/Healthy Kids Program mission is to improve accessibility and ensure the availability of quality health care for HealthChoice children and adolescents through 20 years of age. The EPSDT medical record review supports this mission and assesses the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. Qlarant's MY 2023 medical record review assessed MCO performance for the following EPSDT components:

- Health and Developmental History (HX)
- Comprehensive Physical Exam (PE)
- Laboratory Tests/At-Risk Screenings (LAB)
- Immunizations (IMM)
- Health Education/Anticipatory Guidance (HED)

Methodology

Description of Data Obtained. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Upon receiving Hilltop's full MY 2023 preventive care encounters sample frame for children and adolescents through 20 years of age, Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs. A total sample of 2,531 medical records was included in the review for MY 2023 across all HealthChoice MCOs. Abstracted data from the MRRs was entered into Qlarant's EPSDT evaluation tool. Data was organized and analyzed in the following age groups:

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

Qlarant's methodology included scheduling onsite reviews, gathering updated fax numbers, faxing medical record requests, securely storing and receiving medical records, and conducting outreach attempts for missing information.

- **Scheduling Onsite Reviews.** For MY 2023, nurse reviewers conducted all MRRs onsite at the provider offices, except for providers with only one patient in the sample (singles). Qlarant's contracted administrative scheduler worked with the respective offices to determine the date and time of the review. If unsuccessful in initiating contact for scheduling after three attempts, Qlarant contacted the MCOs for assistance with solidifying provider contact and the scheduling of onsite MRR(s). In the event a provider office had more than one MCO identified, the MCO with the most patients on the listing was contacted first for assistance, with other MCOs contacted as backup when needed. Qlarant required access to the entire medical record to ensure adequate information was available to evaluate compliance with the EPSDT program guidelines. All documentation needed to be present at the time of the record review, as no documentation was accepted after the nurse left the practice site office.
- **Gathering Updated Fax Numbers.** Providers with only one patient in the sample (singles) were initially contacted to obtain their office fax number to submit the MY 2023 medical record request. Providers were notified that the fax request for medical records would be submitted to the fax number provided.
- **Faxing Medical Requests.** Qlarant directly faxed each sampled provider a letter with their specific record request.
- **Securely Storing and Receiving Medical Records.** Providers were asked to securely submit medical record information to Qlarant via secure fax or Qlarant's SecureShare portal.
- **Outreach Attempts for Missing Information.** Upon receipt of medical records via secure fax or SecureShare, Qlarant reviewed each record for completeness and outreached providers for any missing documentation. Qlarant conducted two outreach attempts for missing documentation. MCOs were notified when outreach attempts were exhausted for specific medical records and provided an opportunity to obtain this information. Any medical records with missing information not received by the conclusion of the EPSDT MRR activity were reviewed "as is" and scored accordingly.

Technical Methods of Data Collection and Analysis. Qlarant's medical record data reviewers are trained nurses and experienced MDH Healthy Kids Program nurse consultants. Prior to reviewing medical records, these nurses were required to complete Qlarant's EPSDT annual training and achieve an inter-rater reliability rate of 90% or above. The MY 2023 EPSDT review was conducted by eight nurses who completed the EPSDT

training and achieved a 90% or higher inter-rater reliability rate. Four of the eight nurses were HEDIS nurses, and three of the eight nurses had experience completing a prior EPSDT review.

Abstracted data from the medical record reviews were organized and analyzed within the five age groups identified previously. Within each age group, specific elements were scored based on medical record documentation.

Table 90. MY 2023 Validation Review Determinations and Scoring (EPSDT)

Review Determination	Score
Complete	2
Incomplete	1
Missing	0
Not Applicable*	NA
Compliance Threshold	**MDH established the minimum compliance for MY 2023 at 80%.**

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

Medical Record Review Sample. The random sampling methodology considers the following when assessing results:

- Randomized record sampling does not ensure 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-EPSDT-certified providers. Providers who have not been certified by the EPSDT program may not be familiar with the preventive care requirements. However, MCOs are still required by regulation to ensure preventive services are rendered to Medicaid enrollees 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.

Each record was reviewed for validity and completeness at the time of the onsite or desktop review. In the event a record was classified as invalid (incorrect date of birth, incorrect gender, incorrect date of service, patient not seen by provider, not an EPSDT record, or no record), the review for that medical record stopped and it did not count against the total score.

MRR samples contained total samples, completed reviews, and invalid records. Within the sample of patient records for MY 2023, no records of the HealthChoice Aggregate total sample were classified as invalid. During onsite or desktop reviews, nurse reviewers verified that all medical records matched the patient listing. Medical records were only considered valid if the reviewer successfully verified:

- Patient name
- Date of birth
- Gender
- Date of service
- EPSDT record

Table 91. MY 2023 MCO and HealthChoice Sample Size Summary (EPSDT)

MY 2023 Sample Sizes	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Minimum (90% CL with 5% Error)	265	266	261	269	270	267	270	269	270	**2,407**
Maximum (10% Oversample)	292	294	288	296	297	294	297	296	297	**2,651**
Total Valid Sample Reviewed	287	276	287	287	277	286	281	270	280	**2,531**

The following are areas Qlarant noted as most challenging regarding the MY 2023 MRR completion:

- Provider office compliance with adhering to the review schedule, causing delays with starting reviews
- Provider office compliance with reviewing and confirming the patient listing sent at the time of scheduling
- Provider office compliance with providing complete enrollee records (including immunizations, labs, and at-risk screenings) during the time of the review

Timeline. Qlarant conducted EPSDT activities from January 2024 to January 2025 to assess MCO's MY 2023 compliance with EPSDT and Healthy Kids requirements.

Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. Guidelines and criteria are divided into five component areas (HX, PE, LAB, IMM, and HED).

EPSDT Component Results. MY 2023's EPSDT review observed the following about aggregate MCO performance across all components:

- All MCOs' total composite scores met the minimum compliance threshold (80%).
- All MCOs exceeded the minimum compliance threshold (80%) for four out of five of the components.
- Seven out of nine MCOs fell below the minimum compliance threshold (80%) for *Laboratory Tests/At-Risk Screenings*, requiring a CAP (ABH, CFCHP, MPC, MSFC, PPMCO, UHC, and WPM).

- The HealthChoice Aggregate component scores ranged from 80% (*Laboratory Tests/At-Risk Screenings*) to 97% (*Comprehensive Physical Examination*).
- Each HealthChoice Aggregate component score declined from MY 2022 to MY 2023, with the greatest decline of five percentage points for the *Laboratory Tests/At-Risk Screenings* component (85% in MY 2022 to 80% in MY 2023).
- The total HealthChoice Aggregate score for MY 2023 (93%) has decreased by two percentage points compared to MY 2022 (95%).

Table 92. MY 2023 Component Results by MCO and Measurement Year Aggregates (EPSDT)

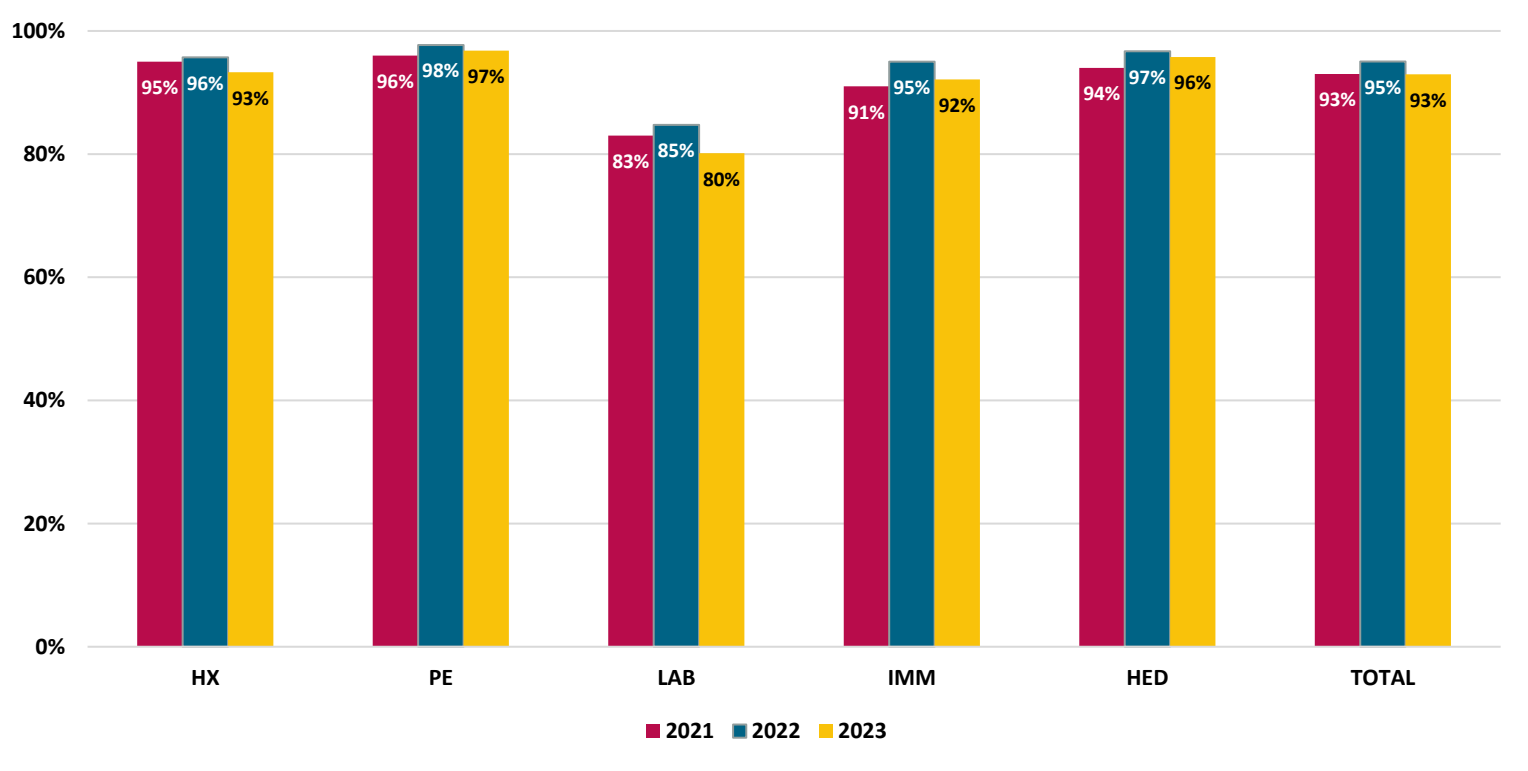
MY 2023 EPSDT Components	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2021	MY 2022	MY 2023
HED	92%	94%	99%	94%	91%	91%	95%	93%	91%	**95%**	**96%**	**93%**
PE	97%	96%	99%	97%	96%	96%	97%	96%	96%	**96%**	**98%**	**97%**
LAB	**79%**	**79%**	92%	92%	**78%**	**73%**	**75%***	**75%**	**75%**	**83%**	**85%**	**80%**
IMM	91%	91%	94%	98%	91%	88%	93%	91%	91%	**91%**	**95%**	**92%**
HED	93%	94%	99%	100%	95%	95%	96%	95%	93%	**94%**	**97%**	**96%**
Total Composite Score	**92%**	**92%**	**97%**	**97%**	**92%**	**90%**	**93%**	**92%**	**91%**	**93%**	**95%**	**93%**

RED denotes a CAP requirement for components scoring below the 80% minimum compliance threshold.
*Score fell below the minimum compliance threshold for multiple years and requires a quarterly CAP.

MY 2023's EPSDT review observed the following about trended MCO performance across all components:

- All component scores in MY 2023 displayed consistent scores in comparison to MY 2021 and MY 2022.
- In comparison to MY 2022, all elements displayed a slight decline, with the most significant being the *Laboratory Tests/At-Risk Screenings* (80%) and *Immunizations* (92%) components, with a difference of five and three percentage points, respectively.
- All five components within the HealthChoice Aggregate scored at or above the 80% minimum compliance threshold in MY 2023.

Figure 14. MYs 2021 to 2023 HealthChoice Aggregate Results by Component (EPSDT)



Health and Developmental History Results. MY 2023's EPSDT review observed the following about aggregate MCO performance across the *Health and Developmental History* component:

- All MCOs scored well above the minimum compliance threshold (80%) for the component score, ranging from 91% (MPC, MSFC, and WPM) to 99% (JMS).
- Ten out of 11 HealthChoice Aggregate scores for each element exceeded the minimum compliance threshold of 80%, except for the Recorded Maternal Depression Screening element, which fell below the minimum compliance threshold by 12 percentage points (68%).
- CFCHP, JMS, KPMAS, PPMCO, and UHC scored at or above the HealthChoice Aggregate component score, ranging from 93% (UHC) to 99% (JMS).
- JMS is the only MCO that scored above the minimum compliance threshold (80%) for each element.
- PPMCO scored above the minimum compliance threshold (80%) for ten out of 11 elements.

- MPC, UHC, and WPM scored below the minimum compliance threshold (80%) for the Recorded Perinatal History element at 75%, 79%, and 76%, respectively.
- ABH, CFCHP, KPMAS, MPC, MSFC, UHC, and WPM scored below the minimum compliance threshold (80%) for the Recorded Maternal Depression Screening element, ranging from 39% (KPMAS) to 76% (CFCHP).
- KPMAS, MSFC, and WPM scored below the minimum compliance threshold (80%) for the Recorded Developmental Screening Tool element at 65%, 76%, and 79%, respectively.
- ABH, CFCHP, PPMCO, and WPM scored below the minimum compliance threshold (80%) for the Recorded Autism Screening Tool element, ranging from 70% (WPM) to 78% (ABH and CFCHP).
- KPMAS was the only MCO that scored below the minimum compliance threshold (80%) for the Depression Screening element at 58%.
- Ten out of 11 HealthChoice Aggregate scores declined from MY 2022 to MY 2023.
- The HealthChoice Aggregate for the Recorded Medical History element and the Recorded Autism Screening Tool element have steadily decreased from MY 2021 (98% and 89%, respectively) to MY 2023 (95% and 82%, respectively).
- The HealthChoice Aggregate for the Recorded Substance Use Assessment element has steadily improved from MY 2021 (91%) to MY 2023 (94%).

Table 93. MY 2023 Health and Developmental History Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2021	MY 2022	MY 2023
Recorded Medical History	93%	97%	99%	99%	88%	93%	97%	94%	94%	98%	97%	95%
Recorded Family History	83%	89%	99%	96%	83%	83%	91%	87%	88%	93%	93%	89%
Recorded Perinatal History	88%	89%	95%	97%	**75%**	81%	88%	**79%**	**76%**	90%	90%	86%
Recorded Maternal Depression Screening	**63%**	**76%**	100%	**39%**	**73%**	**59%**	89%	**50%**	**75%**	**77%**	82%	**68%**
Recorded Psychosocial History	97%	96%	100%	92%	97%	95%	97%	96%	94%	97%	99%	96%
Recorded Developmental Surveillance/History	97%	96%	99%	99%	97%	94%	96%	96%	93%	97%	98%	96%
Recorded Developmental Screening Tool	92%	90%	97%	**65%**	87%	**76%**	88%	83%	**79%**	89%	93%	84%
Recorded Autism Screening Tool	**78%**	**78%**	96%	86%	80%	90%	**71%**	84%	**70%**	89%	88%	82%
Recorded Mental/Behavioral Health Assessment	97%	97%	100%	100%	96%	96%	99%	97%	93%	96%	98%	97%
Recorded Substance Use Assessment	89%	93%	100%	95%	95%	93%	98%	94%	90%	91%	93%	94%
Depression Screening	82%	88%	100%	**58%**	87%	88%	92%	86%	83%	83%	89%	87%

Underlined element scores denote scores below the 80% minimum compliance threshold.

Comprehensive Physical Examination Results. MY 2023's EPSDT review observed the following about aggregate MCO performance across the *Comprehensive Physical Examination* component:

- All MCO component scores and element scores exceeded the minimum compliance threshold (80%).
- Component scores ranged from 96% (CFCHP, MPC, MSFC, UHC, and WPM) to 99% (JMS).
- Four out of nine MCOs scored at or above the HealthChoice Aggregate component score of 97% (ABH, JMS, KPMAS, and PPMCO).
- All MCOs scored 100% for the Measured Weight element.
- JMS scored 100% for 12 of the 14 elements.
- Six out of 14 HealthChoice Aggregate scores declined from MY 2022 to MY 2023.
- The HealthChoice Aggregate scores for the Documentation of Minimum 5 Systems Examined element, Nutritional Assessment element, and Measured Weight element maintained from MY 2021 to MY 2023.
- The HealthChoice Aggregate scores for the Conducted Oral Assessment element steadily improved from MY 2021 (94%) to MY 2023 (98%).

- The HealthChoice Aggregate scores for the Graphed Height element and the Graphed Weight element improved from MY 2021 (96%) to MY 2022 (99%) and then maintained from MY 2022 to MY 2023.

Table 94. MY 2023 Comprehensive Physical Examination Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2021	MY 2022	MY 2023
Documentation of Minimum 5 Systems Examined	98%	98%	100%	100%	99%	99%	100%	98%	99%	99%	99%	99%
Vision Assessment	94%	91%	97%	88%	92%	90%	90%	89%	91%	92%	94%	91%
Hearing Assessment	93%	90%	97%	87%	90%	89%	90%	87%	90%	90%	93%	90%
Nutritional Assessment	97%	97%	100%	99%	98%	96%	98%	97%	98%	98%	98%	98%
Conducted Oral Assessment	99%	97%	100%	100%	99%	96%	98%	96%	97%	94%	96%	98%
Measured Height	99%	100%	100%	99%	99%	100%	100%	100%	99%	100%	100%	99%
Graphed Height	99%	99%	100%	99%	99%	99%	100%	99%	99%	96%	99%	99%
Measured Weight	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Graphed Weight	99%	99%	100%	99%	100%	99%	100%	99%	99%	96%	99%	99%
BMI Percentile	98%	98%	100%	99%	97%	97%	98%	97%	96%	96%	100%	98%
BMI Graphing	94%	95%	100%	99%	92%	93%	98%	95%	91%	95%	99%	95%
Measured Head Circumference	97%	94%	100%	97%	96%	90%	95%	97%	91%	96%	94%	95%
Graphed Head Circumference	97%	92%	100%	97%	93%	88%	95%	94%	86%	93%	92%	93%
Measured Blood Pressure	93%	96%	100%	95%	94%	95%	94%	96%	95%	98%	97%	95%

Laboratory Tests/At-Risk Screenings Results. MY 2023's EPSDT review observed the following about aggregate MCO performance across the *Laboratory Tests/At-Risk Screenings* component:

- Two of the nine MCO's component scores exceeded the minimum compliance threshold (80%) and the HealthChoice Aggregate component score of 80% (JMS and KPMAS at 92%) by 12 percentage points.
- Component scores ranged from 73% (MSFC) to 92% (JMS and KPMAS).
- Only two elements out of 16 (Conducted Lead Risk Assessment and Recorded STI/HIV Risk Assessment) resulted in MCO scores above the minimum compliance threshold (80%).
- Seven HealthChoice Aggregate element scores out of 16 (9-11 Year Dyslipidemia Lab Test at 59%, 18-21 Year Dyslipidemia Lab Test at 75%, 24 Month Blood Lead Test at 75%, 3-5 Year Blood Lead Test at 78%, 12 Month Anemia Test at 78%, 24 Month Anemia Test at 73%, and 3-5 Year Anemia Test at 76%) fell below the minimum compliance threshold (80%).
- The 9-11 Year Dyslipidemia Lab Test element had the lowest scores, ranging from 47% (MSFC) to 87% (JMS).

- MSFC had the most element scores fall below the minimum compliance threshold (80%) for 12 out of 16 elements, ranging from 44% (18-21 Year Dyslipidemia Lab Test) to 78% (Referral to Lab for Blood Test).
- CFCHP and WPM have the second most element scores that fell below the minimum compliance threshold of 80% for ten out of 16 elements.
- Five out of 16 HealthChoice Aggregate scores have had a steady decline from MY 2021 to MY 2023.
- The HealthChoice Aggregate scores for the Newborn Metabolic Screen and Conducted Anemia Risk Assessment maintained from MY 2022 to MY 2023 (81%).
- The HealthChoice Aggregate scores for the Recorded STI/HIV Risk Assessment element steadily improved from MY 2021 (8%) to MY 2023 (91%), and the HIV Test Per Schedule element increased from MY 2022 (89%) to MY 2023 (91%).

Table 95. MY 2023 Laboratory Tests/At-Risk Screenings Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2021	MY 2022	MY 2023
Newborn Metabolic Screen	87%	**79%**	**60%**	94%	81%	**71%**	100%	81%	**50%**	85%	81%	81%
Recorded TB Risk Assessment	89%	82%	100%	**64%**	84%	83%	**79%**	81%	86%	87%	89%	83%
Recorded Cholesterol Risk Assessment	83%	**75%**	100%	85%	81%	82%	82%	80%	**77%**	83%	85%	83%
9-11 Year Dyslipidemia Lab Test	**51%**	**53%**	87%	81%	**48%**	**47%**	**49%**	**54%**	**57%**	**67%**	**72%**	**59%**
18-21 Year Dyslipidemia Lab Test	**43%**	81%	90%	83%	**79%**	**44%**	81%	**79%**	**63%**	83%	80%	**75%**
Conducted Lead Risk Assessment	92%	91%	100%	89%	90%	89%	87%	83%	87%	92%	91%	90%
12 Month Blood Lead Test	**78%**	**79%**	89%	96%	80%	**73%**	**71%**	**70%**	**70%**	83%	86%	80%
24 Month Blood Lead Test	**74%**	**78%**	**79%**	94%	**70%**	**65%**	**71%**	**63%**	**73%**	80%	84%	**75%**
3-5 Year (Baseline) Blood Lead Test	82%	**63%**	85%	95%	**78%**	**69%**	90%	**65%**	86%	97%	95%	**78%**
Referral to Lab for Blood Test	86%	89%	83%	100%	87%	**78%**	85%	84%	84%	91%	90%	87%
Conducted Anemia Risk Assessment	**78%**	**75%**	100%	98%	**75%**	**74%**	**68%**	81%	**75%**	82%	81%	81%
12 Month Anemia Test	**75%**	**78%**	88%	95%	**76%**	**69%**	**71%**	**65%**	**72%**	80%	85%	**78%**
24 Month Anemia Test	**70%**	**75%**	**77%**	94%	**70%**	**59%**	**68%**	**57%**	**74%**	**79%**	82%	**73%**
3-5 Year Anemia Test	81%	**60%**	**73%**	94%	81%	**67%**	93%	**58%**	**75%**	96%	90%	**76%**
Recorded STI/HIV Risk Assessment	86%	90%	100%	100%	91%	83%	83%	94%	87%	87%	89%	91%
HIV Test Per Schedule	**60%**	80%	100%	100%	100%	**71%**	95%	80%	85%	94%	89%	91%

Underlined element scores denote scores below the 80% minimum compliance threshold.

Immunizations Results. MY 2023's EPSDT review observed the following about aggregate MCO performance across the *Immunizations* component:

- All nine MCO component scores exceeded the minimum compliance threshold of 80%.
- Component scores ranged from 88% (MSFC) to 98% (KPMAS).
- All 14 HealthChoice Aggregate element scores exceeded the minimum compliance threshold (80%), except for Influenza (69%).
- KPMAS was the only MCO to score above 80% in every element.
- Eight out of nine MCOs scored below the minimum compliance threshold (80%) for the Influenza element, ranging from 60% (UHC) to 69% (PPMCO).
- Three out of nine MCOs scored below the minimum compliance threshold of 80% for the Assessed Immunization Up to Date element (CFCHP at 79%, MSFC at 75%, and UHC at 79%).
- The HealthChoice Aggregate score for the Influenza element steadily declined from MY 2021 (83%) to MY 2023 (69%).
- The HealthChoice Aggregate scores for the Tetanus/Diphtheria/Acellular Pertussis element and Meningococcal element steadily improved from MY 2021 (92%) to MY 2023 (96%).
- Twelve out of 14 HealthChoice Aggregate scores declined from MY 2022 to MY 2023.

Table 96. MY 2023 Immunization Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2021	MY 2022	MY 2023
Hepatitis B	96%	97%	97%	99%	96%	92%	97%	96%	93%	92%	97%	96%
Diphtheria/Tetanus/Acellular Pertussis (DTaP)	98%	99%	98%	100%	97%	95%	98%	97%	95%	95%	99%	98%
Haemopilus Influenza Type B (Hib)	97%	98%	100%	97%	95%	90%	95%	98%	93%	95%	98%	96%
Pneumococcal (PCV -7 or PC-13)	98%	96%	99%	99%	95%	93%	97%	97%	95%	94%	99%	97%
Polio (IPV)	96%	96%	97%	99%	97%	92%	97%	96%	94%	92%	97%	96%
Measles/Mumps/Rubella (MMR)	95%	96%	97%	99%	96%	93%	98%	96%	94%	93%	97%	96%
Varicella (VAR)	95%	96%	97%	99%	96%	93%	98%	95%	94%	92%	97%	96%
Tetanus/Diphtheria/Acellular Pertussis (TDaP)	90%	92%	100%	100%	95%	93%	99%	95%	97%	92%	95%	96%
Influenza (Flu)	**68%**	**64%**	**66%**	97%	**66%**	**62%**	**69%**	**60%**	**68%**	83%	81%	**69%**
Meningococcal (MCV 4)	92%	94%	99%	99%	94%	93%	98%	97%	97%	92%	95%	96%

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2021	MY 2022	MY 2023
Hepatitis A	92%	94%	97%	98%	93%	91%	95%	95%	93%	91%	96%	94%
Rotavirus (RV)	98%	90%	100%	94%	92%	93%	100%	85%	89%	96%	100%	94%
Human Papillomavirus (HPV)*	88%	90%	98%	100%	90%	84%	91%	91%	94%	89%	93%	92%
Assessed Immunizations Up to Date	80%	**79%**	84%	95%	81%	**75%**	80%	**79%**	80%	86%	90%	81%

Underlined element scores denote scores below the 80% minimum compliance threshold.
*Data collected for informational purposes only; not used in the calculation of the overall component score.

Health Education/Anticipatory Guidance Results. MY 2023's EPSDT review observed the following about aggregate MCO performance across the *Health Education/Anticipatory Guidance* component:

- All nine MCOs scored above the minimum compliance threshold of 80% for the component score and all elements comprising the component.
- Component scores ranged from 93% (ABH and WPM) to 100% (KPMAS).
- Three out of nine MCOs met or exceeded the HealthChoice Aggregate component score of 96% (JMS, KPMAS, and PPMCO).
- JMS and KPMAS scored 100% for three out of the four elements.
- ABH had the lowest element score of 83% for Documented Referral to Dentist.
- The HealthChoice Aggregate score for the Documented Health Education/Referral for Identified Problems/Tests maintained from MY 2021 to MY 2023 (99%).
- Three out of four HealthChoice aggregate scores declined from MY 2022 to MY 2023.

Table 97. MY 2023 Health Education/Anticipatory Guidance Element Results and Measurement Year Aggregates (EPSDT)

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2021	MY 2022	MY 2023
Documented Age-Appropriate Anticipatory Guidance	98%	98%	100%	100%	99%	96%	100%	98%	97%	98%	99%	98%
Documented Health Education/Referral for Identified Problems/Tests	97%	98%	100%	100%	98%	99%	99%	98%	98%	99%	99%	99%
Documented Referral to Dentist	83%	88%	100%	100%	88%	91%	90%	92%	86%	85%	93%	91%
Specified Requirements for Return Visit	94%	92%	98%	99%	94%	94%	97%	93%	92%	95%	96%	95%

Conclusion

The analysis of the EPSDT MRR results ensures the MCOs' providers are delivering timely access to healthcare services for children and adolescents through 20 years of age population according to EPSDT standards. Overall, the MY 2023 EPSDT review demonstrates steady compliance in the HealthChoice Aggregate scores and MCO total composite scores from MY 2021 to MY 2023. All MCOs' total composite scores performed well above the minimum compliance threshold of 80%, ranging from 90% (MSFC) to 97% (JMS and KPMAS). The HealthChoice aggregate score for the *Laboratory Tests/At-Risk Screenings* component remains an opportunity for improvement as the HealthChoice aggregate score for MY 2023 (80%) decreased compared to MY 2022 by five percentage points. The *Laboratory Tests/At-Risk Screenings* component also contained the lowest scores across the majority of MCOs, with 73% (MSFC) being the lowest. Two out of five of the HealthChoice Aggregate scores for MY 2023 met or exceeded the MDH Quality Strategy Targets for MY 2024.

- **Quality** – Providers, and by extension the MCOs, increase the likelihood of desired health outcomes of timely screening and preventive care by maintaining compliance with the Maryland Schedule of Preventive Health Care standards. Areas of impact during the MY 2023 EPSDT review include:
    - The continued likelihood of more timely screening and preventive care across MCOs.
        - All HealthChoice Aggregate scores for each component met or exceeded the minimum compliance threshold (80%).
    - There is an increased risk of lower quality healthcare being provided to HealthChoice enrollees in the future due to:
        - The decline of each HealthChoice Aggregate component score from MY 2022 to MY 2023.
        - The possibility of the *Laboratory Tests/At-Risk Screenings* HealthChoice Aggregate component score falling below the minimum compliance threshold (80%) in the future, due to a decline in performance across all nine MCOs from MY 2022 to MY 2023.

- **Access** – Providers incorporate the timely use of services to achieve optimal outcomes. Areas of impact during the MY 2023 EPSDT review include:
    - The continued likelihood of healthier children and adolescents.
        - All MCOs scored 100% for the Measured Weight element of the *Comprehensive Physical Examination* component.
        - All component scores demonstrated sustained compliance from MY 2021 to MY 2023, with a total HealthChoice Aggregate Composite score of 93% for MY 2023.
    - The continued likelihood of age-appropriate health education/anticipatory guidance.
        - All nine MCOs scored above the minimum compliance threshold (80%) for the component score and all elements comprising the *Health Education/Anticipatory Guidance* component.

- **Timeliness** – Providers must ensure children and adolescents up to age 20 are receiving timely screenings and preventive care, according to guidelines specified in the Maryland Schedule of Preventive Health Care Standards. Areas of impact during MY 2023 EPSDT review include:
    - The continued likelihood of age-appropriate immunizations across MCOs.
        - The HealthChoice Aggregate score for the *Immunizations* component remained well above the minimum compliance threshold (80%).
        - All nine MCO component scores for the *Immunizations* component remained above the minimum compliance threshold (80%).
    - The continued likelihood that enrollees will receive age-appropriate health and development history evaluations, comprehensive physical examinations, immunizations, and health education/anticipatory guidance.
        - Each HealthChoice aggregate score exceeded the minimum compliance threshold (80%).
    - The continued increase in the likelihood that enrollees will not receive age-appropriate screenings.
        - **Laboratory Tests/At-Risk Screenings.** The HealthChoice Aggregate fell below the MY 2024 target of 87% by seven percentage points. HealthChoice Aggregate component scores ranged from 73% (MSFC) to 92% (JMS and KPMAS). Only two out of 16 elements (Conducted Lead Risk Assessment and Recorded STI/HIV Risk Assessment) resulted in MCO scores above the minimum compliance threshold (80%). Seven out of 16 HealthChoice Aggregate element scores fell below the minimum compliance threshold (80%).
    - The continued likelihood that enrollees will not receive the Influenza vaccine and will not receive an assessment of whether the enrollee's immunizations are Up to Date.
        - **Immunizations.** MCO scores for the Influenza and Assessed Immunizations Up to Date elements fell below the minimum compliance threshold (80%).

Quality Strategy Highlights

MDH set a task goal of increasing all EPSDT requirements to 80% or above by MY 2024 in the HealthChoice Quality Strategy for 2022-2024, based on pre-Covid public health emergency aggregate performance. Specific HealthChoice performance metrics and targets are displayed below.

All components comprising the EPSDT review met or exceeded the MDH minimum threshold (80%) in MY 2023. Two of the five components (*Comprehensive Physical Examination* and *Health Education/Anticipatory Guidance*) met or exceeded MDH's Quality Strategy Targets for MY 2024. The HealthChoice Aggregate total fell below the MY 2024 target by one percentage point. Results within this report include sample size, performance per component, trended results per component, and required CAPs.

Table 98. MY 2023 HealthChoice Aggregate Performance Against Quality Strategy Targets (EPSDT)

Requirement: Minimum Compliance Score: ≥80%	HealthChoice Aggregate MY 2023	MDH Quality Strategy Targets for MY 2024
HX	93%	94%
PE	97%	97%
LAB	80%	87%
IMM	92%	93%
HED	96%	94%
HealthChoice Aggregate Totals	**93%**	**≥94%**

Source: *HealthChoice Quality Strategy*

For additional findings and comprehensive details associated with the MY 2023 EPSDT review, please access the link to the MY 2023 EPSDT Statewide Executive Summary Report in **Appendix E**. The **MCO Quality, Access, and Timeliness section** and **Appendix A** provide informed conclusions from the EPSDT review related to quality, access, and timeliness for the HealthChoice program.

Consumer Report Card

Objective

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

Six reporting categories include measures meaningful to members. Consumers may focus on MCO performance in the areas most important to them and their families. Access to Care and Doctor Communication and Service categories are relevant to all participants. Remaining categories are relevant to specific members: adults (Keeping Adults Healthy), children (Keeping Kids Healthy), children with chronic illnesses (Care for Kids with Chronic Illness), and women (Taking Care of Women).

Methodology

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

Data Collection and Review. Qlarant selects performance measures from HEDIS, CAHPS survey results from both the Adult Questionnaire and the Child Questionnaire, and MDH's encounter data measures. Recommended categories are based on measures reported by MCOs in 2024 are designed to focus on clearly identifiable areas of interest.

Timeline. Qlarant conducted activities for the 2024 CRC from January 1, 2022 to December 31, 2022.

Results

Performance results of the 2024 Consumer Report Card are as follows.

Table 99. 2024 Results (CRC)

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

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

Comparison of the Star Ratings from the previous MY follows.

Table 100. Star Rating Changes from MY 2023 to MY 2024 (CRC)

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

Light Green and ↑ = improvement from MY 2021; **Pink** and ↓ = decline from MY 2021; **White** and Ø = no change from MY 2021; **Gray** and NA = reported as Not Applicable for both MYs 2021 and 2022

Conclusion

For additional findings and comprehensive details associated with the information reporting strategy and analytic methods associated with the production of the MY 2024 Consumer Report Card, please access the link to the Information Reporting Strategy and Analytic Methodology in **Appendix E**. English and Spanish versions of the 2024 Consumer Report Card are available in **Appendix E**. The **MCO Quality, Access, and Timeliness section** and **Appendix A** provide informed conclusions from the CRC activity related to quality, access, and timeliness for the HealthChoice program.

Grievances, Appeals, and Denials Focused Study

Objective

Qlarant conducts quality studies to ensure MCOs comply with federal and state regulations governing member and provider grievances, member appeals, pre-service authorization requests, and adverse determinations; facilitates increased compliance by illustrating trends and opportunities for improvement and providing recommendations; and ensures HealthChoice members are not denied access to medically necessary services and supports. These studies consist of quarterly and annual validations of data provided by the MCOs, annual record reviews, and a comparison of each MCO's performance with their peers, including year-over-year performance assessments when data is available.

Methodology

Description of Data Obtained. Qlarant assessed MCO compliance based on MCO-reported data. MDH requires all MCOs to submit GAD reports to Qlarant on a quarterly basis. In addition to quarterly reviews of the reports submitted by the MCOs, Qlarant conducted an annual record review of a MY 2023 sample of grievance, appeal, and pre-service denial records. Each MCO provided Qlarant with a listing of grievances,

appeals, and pre-service denials for MY 2023. Qlarant selected 35 cases from each listing using a random sampling approach and requested that each MCO upload the selected case records to the Qlarant portal. Reviews utilized the 10/30 rule, where initial samples of 10 grievance, 10 appeal, and 10 denial reports were reviewed, and an additional 20 records were reviewed for noncompliant component(s).

Technical Methods of Data Collection and Analysis. Qlarant develops MDH-approved templates for each reporting category as a review tool to validate and evaluate quarterly MCO reports. Following validation of the data MCOs submitted, these review tools allowed Qlarant to enter data from the MCO reports and identify areas of noncompliance. Aggregated MCO results allow peer comparisons and identification of MCO-specific trends after three-quarters of the data were available. Quarterly reports submitted to MDH included analysis of MCO data and recommendations, as appropriate. MCOs received separate reports with summarized quarterly review findings to identify areas for follow-up when data issues, ongoing noncompliance, or negative trends. MDH received results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, as a component of each SPR report. Appropriate staff for each MCO received results of the record reviews and received technical assistance, as needed, to facilitate improved compliance.

Annual record reviews and quarterly reports inform review determinations of MCO performance scores for various components and provide peer comparisons and trended performance.

Timeline. MY 2023's GAD reviews are quarterly and annual, with record requests from July 1 through October 31, 2023. This timeline allows MCOs an opportunity to address and fully implement any recent regulatory changes noted as incomplete during the SPR conducted earlier in 2023. Quarterly data reviews include the first through third quarters, while the fourth quarter includes review of annual data. Within 30 days of the closing of the first three quarters, all MCOs submit quarterly GAD reports to Qlarant. All MCOs submit annual reports 30 days after the close of the fourth quarter. MCOs receive MDH-approved templates for each reporting category as a review tool to validate and evaluate quarterly reports and facilitate a smoother reporting process. From MCO submissions, Qlarant provides MDH with quarterly reports analyzing MCO data and recommendations. MCOs receive separate reports for summarizing quarterly review findings, with areas for further follow-up when data issues, ongoing noncompliance, or negative trends are identified.

Table 101. MY 2023 Validation Review Determinations (GAD)

Review Determinations	Criteria
Met (M)	MCO achieved ≥ 95% for all reporting periods and demonstrated consistent compliance.
Partially Met (PM)	MCO achieved ≥ 95% for at least one reporting period, but not all reporting periods; and demonstrated inconsistent compliance.
Unmet (UM)	MCO achieved < 95% for all reporting periods and demonstrated no evidence of compliance.
Not Applicable (NA)	Used when information is not available for a category under review.
Compliance Threshold	**MDH established minimum compliance for MY 2023 at 95%.**

Results

Compliance with Resolution Timeframes. Quarterly and annual comparisons of MCO-reported compliance with resolution timeframes for member and provider grievances, and member appeals follow.

Table 102. MY 2023 Compliance with Resolution Timeframes (GAD MCO-Reported Results)

Timeframe	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Member Grievance	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	100%	100%	93%*	100%	100%	100%	88%	100%
Q2 2023	100%	100%	100%	100%	99%*	100%	100%	79%	100%
Q3 2023	100%	100%	100%	100%	100%	100%	99%	80%	100%
Annual 2022	**100%**	**91%**	**100%**	**99%**	**100%**	**85%***	**100%**	**100%**	**100%**
Annual 2023	**100%**	**99%**	**100%**	**97%***	**100%**	**100%**	**99%**	**84%***	**98%**
Provider Grievance	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	NA	NA	NA	100%	100%	100%	100%	100%
Q2 2023	100%	100%	NA	NA	100%	100%	100%	100%	100%
Q3 2023	100%	100%	100%	NA	100%	100%	100%	100%	100%
Annual 2022	**100%**	**85%**	**100%**	**NA**	**100%**	**100%**	**100%**	**100%**	**100%**
Annual 2023	**100%**	**100%**	**100%**	**NA**	**100%**	**100%**	**100%**	**94%**	**92%**
Member Appeal	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	100%	100%	100%	100%	50%	99%	98%	94%
Q2 2023	100%	100%	100%	100%	100%	100%	99%	96%	92%
Q3 2023	100%	100%	100%	100%	100%	100%	100%	99%	94%
Annual 2022	**100%**	**97%**	**100%**	**88%**	**93%**	**98%**	**100%**	**99%**	**93%**
Annual 2023	**100%**	**100%**	**100%**	**100%**	**96%**	**100%**	**100%**	**98%**	**96%**

*Average of all three grievance categories (medically-related emergency and non-emergency, and administrative) for the year.
Underlined ≥95% for at least one reporting period but not all reporting periods = Partially Met (PM)
Red font <95% for all reporting periods = Unmet (UM)

Quarterly Compliance with Determination Timeliness. Qlarant assessed self-reporting through MCO submissions of quarterly reports and an annual record review to determine compliance with COMAR requirements for the timeliness of pre-service and adverse determinations. Quarterly data represented the entire population or a statistically significant sample. Results of MCO-reported compliance with determination notifications for expedited, standard, and outpatient pharmacy timeframes for pre-service and adverse determinations follow. Prescriber notifications of outcomes (within 24 hours) relate only to adverse determinations.

Table 103. MY 2023 Compliance with Pre-Service Determination Timeframes (Quarterly and Annual Reports) (GAD MCO-Reported Results)

Quarterly and Annual Performance	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited (Medical Denials)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	100%	NA	100%	100%	100%	98%	100%	95%
Q2 2023	100%	100%	NA	NA	99%	100%	98%	100%	100%
Q3 2023	98%	100%	100%	100%	99%	100%	100%	100%	98%
Annual 2022	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**98%**	**100%**	**98%**
Annual 2023	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**98%**	**100%**	**99%**
Standard (Medical Denials)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	99%	100%	100%	98%	100%	98%	100%	100%	99%
Q2 2023	99%	97%	100%	100%	100%	100%	100%	100%	99%
Q3 2023	99%	100%	100%	99%	100%	98%	99%	100%	99%
Annual 2022	**98%**	**100%**	**100%**	**92%**	**100%**	**99%**	**99%**	**100%**	**84%**
Annual 2023	**99%**	**99%**	**100%**	**99%**	**100%**	**99%**	**99%**	**100%**	**99%**
Outpatient Pharmacy (Denials)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	99%	100%	NA	99%	100%	99%	100%	100%
Q2 2023	100%	100%	97%	NA	99%	100%	99%	100%	100%
Q3 2023	100%	100%	98%	100%	99%	100%	98%	100%	100%
Annual 2022	**100%**	**99%**	**99%**	**100%**	**99%**	**98%**	**99%**	**100%**	**100%**
Annual 2023	**100%**	**100%**	**98%**	**100%**	**99%**	**100%**	**99%**	**100%**	**100%**

Underlined ≥95% for at least one reporting period but not all reporting periods = Partially Met (PM)
Red font <95% for all reporting periods = Unmet (UM)

Table 104. MY 2023 Compliance with Adverse Determination Notification Timeframes (GAD MCO-Reported Results)

Quarterly and Annual Performance	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Expedited (Medical)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	100%	NA	100%	97%	100%	100%	100%	93%
Q2 2023	98%	100%	NA	NA	99%	100%	95%	100%	83%
Q3 2023	93%	100%	100%	100%	99%	100%	100%	100%	98%
Annual 2022	**100%**	**100%**	**100%**	**100%**	**98%**	**100%**	**95%**	**100%**	**97%**
Annual 2023	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**95%**	**100%**	**96%**
Standard (Medical)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	100%	100%	100%	100%	97%	100%	100%	99%
Q2 2023	98%	100%	100%	99%	100%	100%	86%	100%	99%
Q3 2023	97%	100%	93%	100%	100%	98%	99%	100%	100%

Quarterly and Annual Performance	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Annual 2022	**98%**	**100%**	**100%**	**96%**	**99%**	**99%**	**96%**	**100%**	**98%**
Annual 2023	**99%**	**100%**	**98%**	**100%**	**100%**	**99%**	**100%**	**100%**	**99%**
Outpatient Pharmacy	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	99%	100%	NA	100%	100%	100%	100%	100%
Q2 2023	100%	100%	100%	NA	100%	100%	100%	100%	100%
Q3 2023	100%	100%	100%	100%	100%	99%	100%	100%	100%
Annual 2022	**100%**	**99%**	**100%**	**100%**	**100%**	**97%**	**100%**	**100%**	**100%**
Annual 2023	**100%**	**99%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Prescriber Notification of Outcome (within 24 hours)	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**	**%**
Q1 2023	100%	98%	100%	99%	100%	100%	99%	100%	100%
Q2 2023	100%	96%	99%	98%	100%	99%	99%	100%	100%
Q3 2023	100%	100%	99%	100%	100%	100%	98%	100%	100%
Annual 2022	**100%**	**99%**	**99%**	**100%**	**100%**	**98%**	**99%**	**100%**	**100%**
Annual 2023	**100%**	**98%**	**99%**	**99%**	**100%**	**100%**	**99%**	**100%**	**100%**

Underlined ≥95% for at least one reporting period but not all reporting periods = Partially Met (PM)

Record Review for Grievance and Appeal Requirements. Results comparing record reviews across MCOs follow. A random selection of grievance and appeal records during MY 2023 determines results, respectively. Qlarant utilizes the 10/30 rule for review.

Table 105. MY 2023 MCO Annual Grievance Results (GAD Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriately Classified	100%	100%	100%	100%	100%	100%	100%	100%	100%
Acknowledgment Letter Timeliness	80%	84%	100%	100%	100%	100%	100%	93%	100%
Issue is Fully Described	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Timeliness	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Appropriateness	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Letter Timeliness	100%	100%	100%	100%	100%	100%	100%	100%	100%
Resolution Letter in Easy-to-Understand Language	100%	100%	100%	100%	100%	100%	100%	100%	100%

Red font <95% for reporting period = Unmet (UM)

Table 106. MY 2023 MCO Appeal Results (GAD Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Processed Based Upon Level of Urgency	100%	100%	100%	100%	100%	100%	97%	100%	100%
Compliance with Timeframe for Written Appeal Acknowledgement Letter	100%	100%	100%	100%	100%	100%	97%	100%	100%
Compliance with Verbal Notification of Denial of an Expedited Request	NA	25%	NA	100%	0%	NA	100%	100%	75%
Compliance with Written Notification of Denial of an Expedited Request	NA	100%	NA	100%	100%	NA	100%	100%	100%
Compliance with 72-hour Timeframe for Expedited Appeal Resolution Notification	NA	NA	100%	100%	NA	100%	80%	79%	100%
Compliance with Verbal Notification of Expedited Appeal Decision	NA	NA	0%	100%	NA	100%	80%	100%	100%
Compliance with Written Notification Timeframe for Non-Emergency Appeal	100%	100%	100%	100%	100%	100%	100%	100%	100%
Appeal Decision Documented	100%	100%	100%	100%	100%	100%	100%	100%	100%
Decision Made by Healthcare Professional with Appropriate Expertise	100%	100%	100%	100%	100%	100%	100%	100%	100%
Decision Available to Member in Easy-to-Understand Language	100%	100%	100%	100%	100%	100%	77%	100%	100%

Red font <95% for reporting period = Unmet (UM)
NA = Not Applicable

Record Review for Determination Timeliness. Record reviews were also conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Random selection of records from MY 2023 also informed results for pre-service and adverse determinations, respectively.

Figure 15. MY 2023 MCO Compliance with Pre-Service Determination Timeframes (GAD Record Review)

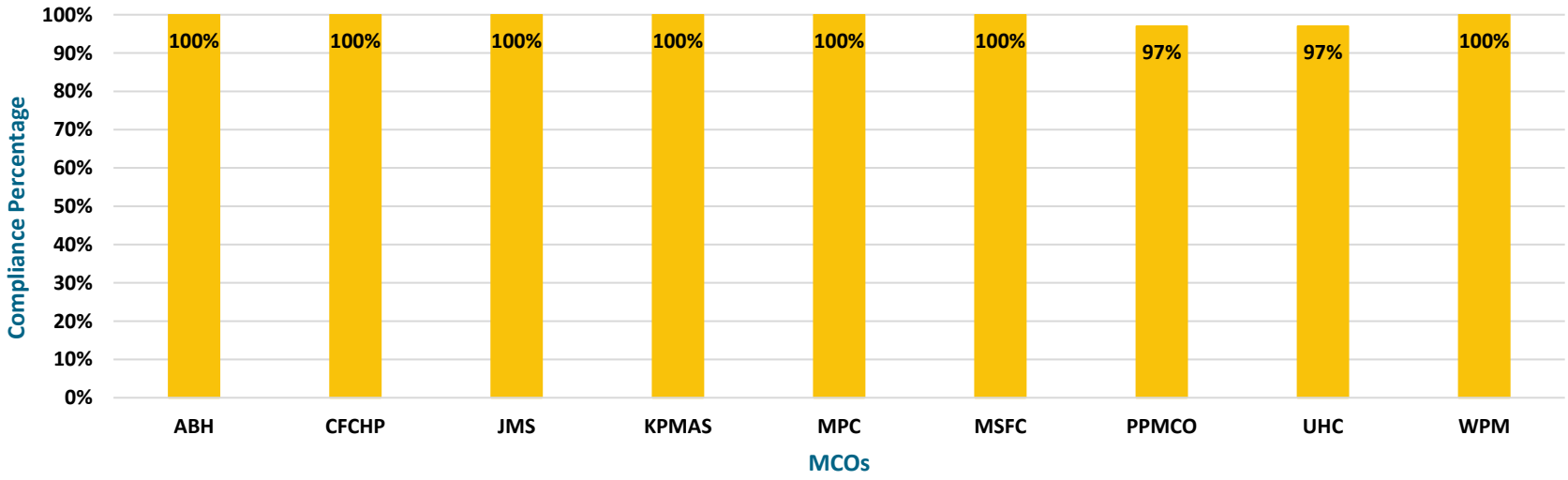


Figure 16. MY 2023 MCO Compliance with Adverse Determination Notification Timeframes (GAD Record Review)

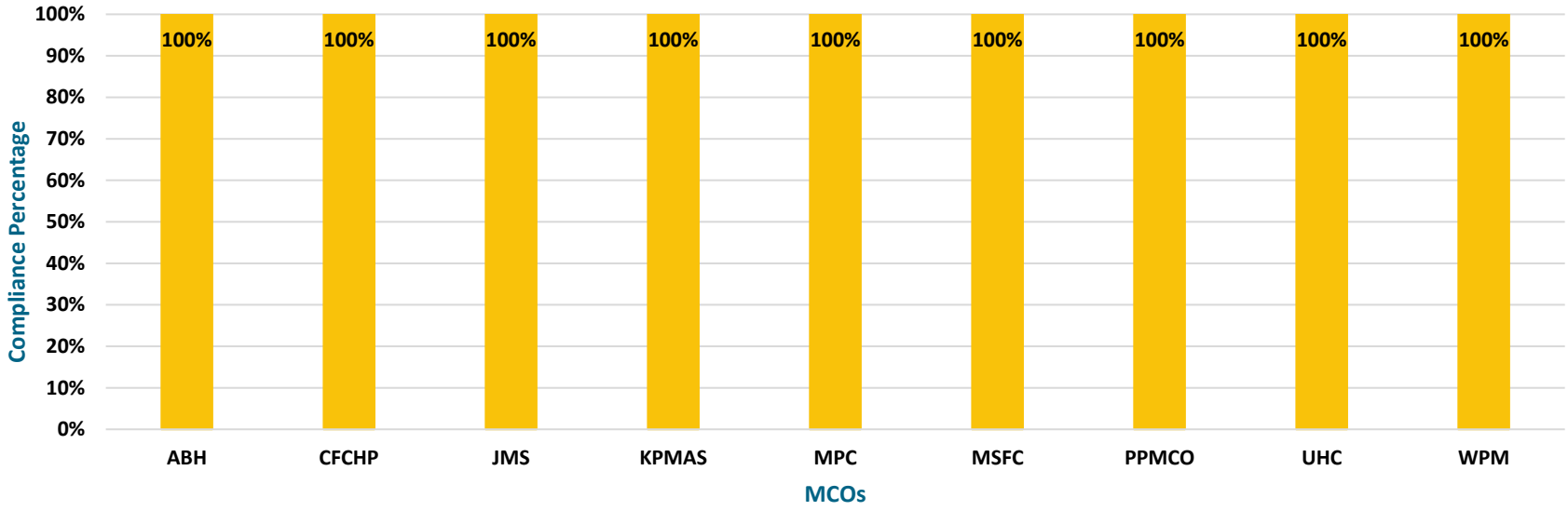


Table 107. MY 2023 MCO Adverse Determination Results (GAD Record Review)

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriateness of Adverse Determinations	100%	100%	100%	100%	100%	100%	100%	100%	100%
Compliance with Pre-Service Determination Timeframes	100%	100%	100%	100%	100%	100%	97%	97%	100%
Compliance with Adverse Determination Notification Timeframes	100%	100%	100%	100%	100%	100%	100%	100%	100%
Required Letter Components	100%	100%	100%	100%	100%	100%	73%	100%	100%
Compliance with Prescriber Notification	100%	NA	100%	NA	NA	100%	100%	0%	100%

Red font <95% for reporting period = Unmet
NA = Not Applicable

Table 108. MY 2023 MCO Pharmacy Request Issues for Adverse Determinations (GAD Record Review)

MCO	Error	Amount
JMS	Inappropriate categorization of one pre-service pharmacy request as "urgent."	1
MSFC	Inappropriate categorization of six pre-service pharmacy requests as "urgent."	6
UHC	Inappropriate categorization of four pre-service pharmacy requests as "urgent."	4

Table 109. MY 2023 Infrequent MCO Issues for Adverse Determinations (GAD Record Review)

MCO	Issues Identified
PPMCO	**Letter Components** – Inconsistent use of easy-to-understand language in member letters.
UHC	**Request for Additional Information** – Did not appear to request additional information before denying a preauthorization request for a covered outpatient drug for lack of information. **Language Accessibility Statement** – Included incomplete statement. Only two languages in addition to English were included.

Conclusion

Conclusions for the MY 2023 GAD review are drawn primarily from annual GAD reports and annual record review data. One MCO (KPMAS) had no negative record review findings.

Continued Improvement Summary

Opportunities for improvement still arose during the focused study review. Two MCOs accounted for 50% of the opportunities for improvement (PPMCO contributing 28% and UHC contributing 22%). Three MCOs had two record review findings (CFCHP, JMS, and WPM), and three MCOs had one record review finding (ABH, MPC, and MSFC).

Considering individual MCO performance and categories of opportunities, summaries of continued opportunities follow:

- **Category Frequency.** The three most frequent opportunities for improvement related to timeliness of grievance acknowledgement, documentation in case notes of verbal notification of denial of a request for an expedited appeal resolution or an expedited appeal resolution, and inappropriate classification of pharmacy requests as "urgent." These issues represent 61% of all identified from the record review.
- **Enrollee Grievance Resolution Timeliness.** Seven of the nine MCOs in MY 2023 met compliance with resolution timeliness for enrollee grievances in all three quarters and for the year. Two MCOs (KPMAS and UHC) were found non-compliant in MY 2023 for at least one quarter. KPMAS was non-compliant in the first quarter of MY 2023; however, the MCO quickly recovered to 100% for both quarters two and three. UHC showed a significant decline from MY 2022 and was below the established threshold (95%) for all reporting periods.

- **Provider Grievance Resolution Timeliness.** Eight of the nine MCOs in MY 2022 were compliant with resolution timeframes for provider grievances, with CFCHP as the outlier. Seven of the nine MCOs were compliant in MY 2023, with two MCOs (UHC and WPM) as the outliers.
- **Appeal Resolution Timeliness.** Six of the nine MCOs met resolution timeliness for appeals in MY 2022, with three MCOs (KPMAS, MPC, and WPM) non-compliant.
- **Pre-Service Denial Determinations and Notification Timeliness.** Seven of the nine MCOs met timeframes for pre-service denial determination and notification timeliness in MY 2022, with two non-compliant (KPMAS and WPM). All MCOs were compliant in MY 2023.

Table 110. MY 2023 Summary of Opportunities for Improvement (GAD)

Improvement Opportunities by End of MY 2023	MCO
Compliance with Enrollee Grievance Resolution Timeframes	KPMAS, UHC
Compliance with Provider Grievance Resolution Timeframes	UHC, WPM
Appropriately Classified	WPM
Acknowledgment Letter Timeliness	ABH, CFCHP, UHC
Compliance with Enrollee Appeal Resolution/Notification Timeframes	MPC
Compliance with Verbal Notification of Denial of an Expedited Request	CFCHP, MPC, WPM
Compliance with 72-hour Timeframe for Expedited Appeal Resolution/ Notification	PPMCO, UHC
Compliance with Verbal Notification of Expedited Appeal Decision	JMS, PPMCO
Decision Available to Enrollee in Easy-to-Understand Language	PPMCO
Letter Components – Use of Easy-to-Understand Language in Enrollee Letters	PPMCO
Inappropriate classification of pharmacy requests as “urgent”	JMS, MSFC, UHC
Required Letter Components	PPMCO
Compliance with 24-Hour Prescriber Notification	UHC

Table 111. Comparison of Opportunities for Improvement from MY 2022 to MY 2023 (GAD)

Improvement Opportunities Comparison	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Opportunities MY 2022 (#)	2	11	0	7	2	0	4	1	8
Total Opportunities MY 2023 (#)	1	2	2	1	3	1	5	6	3
MY 2022 to MY 2023 Comparison	↓	↓	↑	↓	↑	↑	↑	↑	↓

Light Green and ↓= decrease from MY 2022; **Pink** and ↑ = increase from MY 2022

Data Validity Analysis

Threats to the validity of the MCO-submitted quarterly grievance, appeal, and denial reports are assessed quarterly. For each quarter of MY 2023, MCOs continued to show improvements in GAD report documentation. In particular, MCOs had fewer report resubmissions and fewer errors within each report. Limitations in the accuracy of the self-reported MCO data are noted below.

- Maryland MCOs' GAD data for MY 2023 consists of three quarterly data submissions and one annual submission. As a result, positive or negative data trends over the quarters were not as easily determined.

- Service and reason codes reported by the MCOs in the category of "Other," increased in MY 2023. These codes do not support the identification and trending of relevant information. Qlarant performed an analysis of the frequency of these "other" codes in March 2024. Findings identified some examples of MCO service and reason code variances in MY 2023:

    - KPMAS is the only MCO with no Pharmacy Services in its top five.
    - MPC documents that 18% of their denials occurred in the NMN-Other category
    - PPMCO indicates Diagnostic/Lab: Radiology, which is 69% of its top five service categories, replaces Pharmacy Services as number one.
    - UHC has one unique service category, Inpatient/Admission Hospital Services.

- In December 2023, CMS revised the timeframes for reporting on the Managed Care Program Annual Report (MCPAR) related to resolved appeals to request 12-month rather than 11-month totals. The measurement year for 2023 considers 12 months of MCO GAD data, while 2022 was considered a calendar year with 11 months of MCO data.

Qlarant will continue to assess data disparities in MY 2024.

For additional findings and comprehensive details associated with the MY 2023 GAD focused study, please access the link to the MY 2023 GAD Annual Report in **Appendix E**. The **MCO Quality, Access, and Timeliness section** and **Appendix A** provide informed conclusions from the GAD activity related to quality, access, and timeliness for the HealthChoice program.

MCO Quality, Access, and Timeliness Assessment

Quality, Access, Timeliness

Qlarant identified strengths, improvements, and recommendations summarizing aggregate performance across MCOs, based on the results of the EQR activities. PMV includes findings from MetaStar's HEDIS audits and CSS' CAHPS® 5.1H Member Experience Survey results analysis. These strengths, improvements, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for these domains:

- **Quality,** as it pertains to EQR, is defined as "the degree to which an MCO or Prepaid Inpatient Health Plan increases the likelihood of desired health outcomes of its participants (as defined in 42 CFR §438.320[2]) through its structural and operational characteristics, through the provision of health services that are consistent with current professional knowledge, and interventions for performance improvement. *([CMS], Final Rule: Medicaid Managed Care; 42 CFR Part 400, et al. Subpart D – Quality Assessment and Performance Improvement, [June 2002]).*
- **Access** (or accessibility), as it pertains to EQR, is defined as "the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined in 42 CFR §438.68 (Network adequacy standards) and 42 CFR §438.206 (Availability of services)." *([CMS], Final Rule: Medicaid Managed Care; 42 CFR Part 400 et al. Subpart D – Quality Assessment and Performance Improvement, [June 2002]).*
- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether the "organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of healthcare." *(2006 Standards and guidelines for the Accreditation of Managed Care Organizations)*. An additional definition of timeliness given in the *Institute of Medicine National Health Care Quality Report* refers to "obtaining needed care and minimizing unnecessary delays in getting that care." *(Envisioning the National Health Care Quality Report, 2001)*

MCO Aggregate Strengths, Improvements, and Recommendations

This section highlights strengths, improvements, and recommendations summarizing aggregate performance across MCOs. Identified strengths, improvements, and recommendations correspond to the quality, access, and/or timeliness of services delivered to MCO enrollees. Applicable domains for each strength, improvement, or weakness are identified with a (↑) or (↓) and color-coded cells, indicating a positive or negative impact. Not all domains were impacted by each strength, improvement, or recommendation. Where appropriate, recommendations include opportunities.

Table 112. MY 2023 PIP Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	**Strengths:** • All MCOs performed at confidence levels of *Confidence* and *High Confidence*.	↑
NA	**Improvements:** • There are no formal improvements for the MCOs.	NA
Quality	**Recommendations:** • Identify and address root causes when statistically significant improvement of HEDIS rates was not demonstrated as a direct result of implemented interventions. • Assess the impact of interventions on health equity and modify as needed to further incorporate each component of the CLAS standards on an interventional level. Utilize enrollee and provider feedback to conduct a barrier analysis. Enrollee and provider feedback should also be incorporated in the design of the interventions to overcome barriers while prioritizing the disparate population to improve healthcare outcomes. • Conduct barrier analyses on an annual basis at a minimum. MCOs should consider enrollee, provider, and MCO barriers relevant to the PIP topics, the interventions, and the disparate populations. Identify the tool utilized to conduct the barrier analysis and identify the quality improvement process, such as PDSA. • Incorporate the proven-successful methodology outlined in evidence-based research to support interventions in one or more of the following areas: ○ Improving policies, processes, and protocols ○ Addressing social determinants of health ○ Establishing community partnerships ○ Overcoming cultural barriers related to the desired outcome of the intervention.	↓

Light Green and ↑ = Domain experienced positive impact from MCOs' performance; **Pink** and ↓ = Domain experienced negative impact from MCOs' performance; **White** and NA = Not Applicable

Table 113. MY 2023 HEDIS Strengths, Improvements, and Recommendations (PMV)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	**Strengths:** ***MetaStar observed the following strengths:*** • Several measures/indicators performed above/better than the NHM among eight of nine MCOs: BCS-E, CIS combos 3 and 7, PCE bronchodilator, PPC Timeliness of Prenatal Care, W30 15-30 months, and WCV. • All nine MCOs scored above/better than the NHM for HBD A1c good control <8, HBD A1c poor control >9, KED, LSC, and SPC. • Seven of the MCOs performed above the 75th percentile for HBD A1c good control <8 and PPC Postpartum, and of these seven, four MCOs performed above the 90th percentile.	↑
NA	**Improvements:** ***MetaStar observed the following improvements:*** • As applicable, MCOs were provided individual recommendations. There are no formal improvements from the previous measurement year for all MCOs.	NA
NA	**Recommendations:** ***MetaStar recommends the following actions:*** • There are no formal recommendations for the MCOs.	NA

Light Green and ↑ = Domain experienced positive impact from MCOs' performance; **White** and NA = Not Applicable

Table 114. MY 2023 CAHPS Strengths, Improvements, and Recommendations (PMV)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	**Strengths:** ***CSS observed the following strengths:*** • The HealthChoice aggregate performed on par with 2023 for all measures across measures for the Adult Medicaid survey. • HealthChoice exhibited a consistent positive trend for one measure (*Rating of Specialist Seen Most Often*) for the Adult Medicaid survey. • Two measures (*Rating of Health Plan* and *Customer Service*) saw statistically significant improvements for the Child Medicaid survey.	↑
NA	**Improvements:** ***CSS observed the following improvements:*** • There are no formal improvements from the previous measurement year for all MCOs for either the adult or child surveys.	NA
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no formal recommendations for all MCOs for either the adult or child surveys.	NA

Light Green and ↑ = Domain experienced positive impact from MCOs' performance; **White** and NA = Not Applicable

Table 115. MY 2023 PHIP Strengths, Improvements, and Recommendations (PMV)

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	**Strengths:** • All nine MCOs received a financial reward for Round 1 Tier 1 for performance. • Seven of the nine MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, and WPM) received a Round 1 Tier 2 improvement incentive. • The HBD: Poor HbA1c Control measure (>%9) MARR exceeded the quality strategy goal by five percentage points, as a lower rate for this measure indicates better performance. • The Postpartum Care measure MARR exceeded the quality strategy goal by 2.88 percentage points.	↑
Quality, Access, and Timeliness	**Improvements:** • The majority of MCOs demonstrated improved performance in MY 2023 for the following PHIP measures: Poor HbA1c Control, Lead, Postpartum Care, and Timeliness of Prenatal Care. • Overall, the PHIP activities' results demonstrate steady improvement in meeting or exceeding MY 2023's benchmarks and improving year over year.	↑
NA	**Recommendations** • There are no formal recommendations for all MCOs.	NA

Light Green and ↑ = Domain experienced positive impact from MCOs' performance; **White** and NA = Not Applicable

Table 116. MY 2023 SPR Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access	**Strengths:** • All MCOs demonstrated the ability to design and implement effective quality assurance systems. • Five MCOs (ABH, JMS, MSFC, PPMCO, and UHC) received a finding of *Met* or *Met with Opportunity* for all standards reviewed.	↑
Quality, Access	**Improvements:** • All MCOs continue to make improvements in quality assurance monitoring policies, procedures, and processes while working to provide appropriate levels and types of healthcare services to managed care members.	↑
Quality, Access, Timeliness	**Recommendations:** • All MCOs requiring a CAP received recommendations that, if implemented, should improve performance for future reviews.	↑

Light Green and ↑ = Domain experienced positive impact from MCOs' performance

Table 117. MY 2023 NAV Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
NA	**Strengths:** • All MCOs performed at confidence levels of *Moderate Confidence* and *High Confidence*.	NA
NA	**Improvements:** • There are no formal improvements from the previous measurement year for all MCOs, as MY 2023 is the first year of implementation of CMS' Validation of Network Adequacy Protocol 4.	NA
NA	**Recommendations:** • There are no formal recommendations as MY 2023 and this is the first year of implementation of CMS' Validation of Network Adequacy Protocol 4.	NA

White and NA = Not Applicable

Table 118. MY 2023 NAV Focused Review Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access	**Strengths:** • HealthChoice's aggregate performance exceeded the 80% minimum compliance threshold for all nine requirements.	↑
Quality, Access	**Improvements:** • There was an increase in overall compliance with urgent care appointment timeframes compared to MY 2022 and MY 2023.	↑
Quality, Access, Timeliness	**Recommendations:** • All MCOs requiring a CAP received recommendations that, if implemented, should improve performance for future reviews.	↑

Light Green and ↑ = Domain experienced positive impact from MCOs' performance

Table 119. MY 2023 EDV Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	**Strengths:** • MCOs achieved a high match rate for each encounter setting (inpatient, outpatient, and office visits).	↑
Quality, Access	**Improvements:** • Per Hilltop's overall analysis, there was improvement in provider enrollment-related denied encounters.	↑
NA	**Recommendations:** • All MCOs should conduct a root cause analysis to identify and overcome reasons for the decline in match rates for office visit encounters. • All MCOs should conduct a root cause analysis to identify and overcome reasons for the decline in inpatient procedure code match rates. • All MCOs should conduct a root cause analysis for the significant increase in diagnosis code coding errors from MY 2022 to MY 2023 across all encounter types. • MCOs should conduct a root cause analysis to identify and overcome barriers to improving documentation for accurate coding across all encounter types. • All MCOs received recommendations that, if implemented, should improve performance for future reviews.	NA

Light Green and ↑ = Domain experienced positive impact from MCOs' performance; **White** and NA = Not Applicable

Table 120. MY 2023 EPSDT Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and Timeliness	**Strengths:** • All MCOs met the MDH-established minimum compliance threshold (80%) for total composite scores for each component. • All MCOs scored above the MDH-established minimum compliance threshold (80%) for each element in the *Comprehensive Physical Examination* component. • All MCOs scored above the MDH-established minimum compliance threshold (80%) for each element in the *Health Education/Anticipatory Guidance* component.	↑
Quality, Access, and Timeliness	**Improvements:** • The HealthChoice Aggregate score for the *Comprehensive Physical Examination* component increased by one percentage point from MY 2021 (96%) to MY 2023 (97%). • The HealthChoice Aggregate score for the *Immunizations* component increased by one percentage point from MY 2021 (91%) to MY 2023 (92%).	↑

Domain	Strengths, Improvements, and Recommendations	Assessment
	• The HealthChoice Aggregate score for the *Health Education/Anticipatory Guidance* component increased by two percentage points from MY 2021 (94%) to MY 2023 (96%).	
Quality, Access, and Timeliness	**Recommendations:** • Collaborate with the assigned state Healthy Kids/EPSDT Nurse Consultants to assist in re-educating providers on the Healthy Kids/EPSDT Program requirements and develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. • Prepare and encourage provider cooperation and assistance with audit review scheduling, confirming the enrollee list to be reviewed, adherence to review start times, and demonstration of compliance or the supplying of records including enrollee immunizations. • Educate the MCO provider network regarding revisions and new standards to the Maryland Schedule of Preventive Health Care using the MCO provider newsletter and/or practice visits by MCO staff. • Encourage network providers to use the Maryland Healthy Kids Program's age-appropriate encounter forms, risk assessment forms, and questionnaires that are designed to assist with documenting preventive services according to the Maryland Schedule of Preventive Health Care. Reinforce preventive care standards as they apply to adolescents and young adults assigned to family practice and internal medicine PCPs. • Assist practices as they implement electronic medical records to ensure all Maryland Healthy Kids Program requirements are incorporated into these tools and records are accessible for demonstration by provider offices during audit requests. • Facilitate the transfer of medical, immunization, and laboratory records when a child is transferred to a newly assigned PCP within the MCO network. • Utilize MCO data to identify children who are not up to date with EPSDT visits according to the Maryland Schedule of Preventive Health Care, check if children received services from a previous PCP or MCO to prevent duplication, and assist the PCP by scheduling a preventive care visit based on this information. • Refer to the local health department for assistance in bringing children in for missed healthcare appointments when other outreach efforts have been unsuccessful. • Remind providers that they are required to enroll in the VFC program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.	↓

Light Green and ↑ = Domain experienced positive impact from MCOs' performance; **Pink** and ↓ = Domain experienced negative impact from MCOs' performance

Table 121. 2024 CRC Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	**Strengths:** • Three MCOs (CFCHP, JMS, and MPC) either maintained or increased 2024's star rating.	↑
Quality, Access	**Improvements:** • Two MCOs (CFCHP and JMS) improved from 2023's star rating for Access to Care. • Two MCOs (MPC and PPMCO) improved from 2023's star rating for Doctor Communication and Service. • Two MCOs (CFCHP and PPMCO) improved from 2023's star rating for Taking Care of Women.	↑
NA	**Recommendations:** • There are no formal recommendations for the MCOs.	NA

Light Green and ↑ = Domain experienced positive impact from MCOs' performance; **White** and NA = Not Applicable

Table 122. MY 2023 GAD Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality	**Strengths:** • MCOs show improvements in reporting and regulatory compliance over the course of MY 2023.	↑
Quality	**Improvements:** • MY 2023 opportunities dropped to 24 compared to 34 opportunities for improvement in MY 2022.	↑
Quality, Timeliness	**Recommendations:** • All MCOs received recommendation that, if implemented, should improve performance for future reviews.	↑

Light Green and ↑ = Domain experienced positive impact from MCOs' performance;

Assessment of Previous Recommendations

While conducting 2024 EQR activities, Qlarant evaluated MCO compliance in addressing previous annual recommendations that resulted in the need for corrective action.[6] Assessment outcomes, included in this section, identify if the MCO adequately addressed 2022 recommendations. Color-coded cells and symbols (light green and ↑, yellow and ⭘, and pink and ↓) specify the degree to which the MCOs addressed recommendations (MCO addressed the recommendation, MCO did not fully address the recommendation, and MCO did not address the recommendation), respectively.

[6] In some instances, one recommendation may summarize or capture multiple, but similar, issues. The number of recommendations per MCO should not be used to gauge MCO performance alone.

ABH

Table 123. ABH Assessment of Previous Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendation(s)
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ●**
ABH should consider the following recommendations from the MY 2022 review: • Component 7.5a: Demonstrate adverse determination notices are written in easy-to-understand language. • Component 7.5b: Remove the five calendar day mailing timeframe from the required adverse determination letter components. • Component 7.5b: Demonstrate that explanations of the reasons for the adverse determination are in easy-to-understand language in adverse determination letters.	ABH initiated a corrective action plan that was reviewed by both Qlarant and MDH. ABH was then found to be compliant in Component 7.5a and 7.5b during MY 2023.	↑
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ●**
There were no formal MY 2023 recommendations that would require action to be taken.		
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ●**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Light Green and ↑ = MCO addressed the recommendation

CFCHP

Table 124. CFCHP Assessment of Previous Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ⊙**
CFCHP should consider the following recommendations from the MY 2022 review: • Component 5.1a: Revise the Member Grievances Standard Operating Procedure to state the correct timeframe for sending a written acknowledgment of a grievance and require an acknowledgment letter be sent for medically related grievances that are not anticipated to be resolved within five calendar days or within the regulatory requirement, whichever is less. • Component 5.1g: Demonstrate compliance with timeframes for written grievance acknowledgment and grievance resolution at or above the MDH threshold of 95% on at least a quarterly basis for each of the four quarters of the review period. • Component 5.1h: Demonstrate compliance with its written grievance resolution timeframe at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. In addition, CFCHP must revise its Member Grievance Policy to include written notification timeframes for all grievance	CFCHP initiated corrective action plans that were reviewed by both Qlarant and MDH. CFCHP was then found to be compliant in the following Elements/Components: • 5.1a • 5.1g • 5.1h • 5.8d • 7.4c • 7.5a • 7.6a • 7.7g • 7.9c • 7.10 • 9.3c • 9.5b • 9.5c CFCHP did not meet compliance for 7.7c, 7.7e, and 7.8c. CFCHP will remain on a quarterly corrective action plan for 7.8c and a quarterly corrective action will be implemented for 7.7c and 7.7e due to continued noncompliance.	⊙

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
types in accordance with the MDH MCO Model Notice guidance. • Component 5.8d: Provide evidence of notices and taglines being posted in conspicuous physical locations, where appropriate, when interacting with the public. • Component 7.4c: Revise both the Pharmacy Prior Authorization Policy and the Pharmacy Prior Authorization Desktop Procedure to specify the requirement to "approve, deny, or request additional information by telephone or other telecommunication device from the requesting provider within 24 hours of the PA request for all covered outpatient drugs." • Component 7.4c: Demonstrate compliance with determination timeframes for all PA requests at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Component 7.4c: Demonstrate compliance with notifying the prescriber of the determination of a covered outpatient PA request (approve, deny, request additional clinical) by telephone or other telecommunication device within 24 hours of the request at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Component 7.5a: Demonstrate all adverse determination letters are written in easy-to-understand language		

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
• Component 7.6a: Revise the Timeliness of Utilization Management Decisions Standard Operating Procedure and the Timeliness of Utilization Management Decisions Policy to eliminate the inconsistency in the timeframe for sending enrollees an adverse determination letter for an expedited PA request. • Component 7.7c: Demonstrate compliance with timeframes for written appeal acknowledgment and resolution/notification at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Component 7.7e: No denials of a request for an expedited appeal resolution were found in the sample review of ten appeal records. Additionally, no denials were found within the additional 20 records reviewed. This component will be reviewed again in the next annual review since there were no cases found in this year's sample. This item will remain as Partially Met until a record review is completed that results in a met finding. • Component 7.7g: Remove all references to requiring written confirmation of an oral appeal in the Member Appeals Policy. • Component 7.8c: Demonstrate turnaround time compliance for written acknowledgment and written resolution of provider appeals at or above the MDH-established threshold of 95% on at least a		

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
quarterly basis for all four quarters of the review period. • Component 7.9c: Demonstrate that it acts on identified opportunities for improvement related to utilization management measures as a result of CAHPS® survey results. These interventions need to be reported in the MEC meeting minutes and submitted to the QIC for approval consistent with its charter. • Element 7.10: Revise the Provider Appeals – Independent Review Organization Request Policy or the desktop procedure to include a process for ensuring that all IRO invoices are paid within the required 60-day timeframe. • Component 9.3c: Provide evidence that notification to providers of the availability and contact information for accessing a health educator/educational program for enrollee referrals is effective in the form of documented provider referrals of enrollees for health education. • Component 9.5b: Provide a sample of completed evaluations of HEPs/events completed by enrollees. • Component 9.5c: Demonstrate provider evaluations of its HEPs. This could be either through formal provider surveys or documented discussion of the HEP at a CFCHP committee attended by providers.		
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ●**
The phone number listed in CFCHP's online provider directory does not align with the	After implementing corrective action for MY 2023, CFCHP improved the accuracy of accepting new Medicaid	↑

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
phone number obtained during the telephone survey (70.9%). CFCHP must submit a CAP to achieve compliance in the MY 2023 validations and ensure staff responses regarding the PCP's phone number align with information provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. CFCHP's online provider directory fell below compliance for the cateogory *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* (65.1%). CFCHP must submit a CAP to ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory through provider staff education. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. CFCHP should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.	patients by 19.9 percentage points (65.1% in MY 2023 to 85.0% in MY 2024).	
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ⊙**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Light Green and ↑ = MCO addressed the recommendation; **Yellow** and ⊙ = MCO did not fully address the recommendation

JMS

Table 125. JMS Assessment of Previous Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ●**
Due to multiple years of not meeting this requirement, JMS must submit a quarterly CAP to achieve compliance in the MY 2024 validations to address the following: • Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. JMS should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.	After implementing corrective action for MY 2023, JMS improved the accuracy of accepting new Medicaid patients by 12.3 percentage points (73.3% in MY 2023 to 85.6% in MY 2024).	↑
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ●**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Light Green and ↑ = MCO addressed the recommendation

KPMAS

Table 126. KPMAS Assessment of Previous Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ⊙**
KPMAS should consider the following recommendations from the MY 2022 review: • Component 5.1d: Demonstrate that it tracks and trends grievance data to identify opportunities for improvement and implements action plans, as indicated, specifically for MD HealthChoice. • Component 5.1g: Demonstrate compliance with timeframes for grievance acknowledgment and resolution at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Component 5.1h: Demonstrate compliance with written resolution timeframes at or above the MDH threshold on at least a quarterly basis for all four quarters of the review period. • Component 7.4c: Demonstrate compliance with determination timeframes in response to preauthorization requests at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Component 7.7c: Demonstrate compliance with written appeal acknowledgment and	KPMAS initiated corrective action plans that were reviewed by both Qlarant and MDH. KPMAS was then found to be compliant in the following Elements/Components: • 5.1d • 5.1g • 5.1h • 7.4c • 7.7c • 7.9c KPMAS did not meet compliance for 7.8c requiring a quarterly CAP.	⊙

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
written appeal resolution notification timeframes at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Component 7.7c: Demonstrate written notification within the required timeframe and oral notification of any denial of a request for an expedited appeal resolution. • Component 7.8c: Demonstrate compliance with written acknowledgment of provider appeals at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period as required by Maryland Medicaid. • Component 7.9c: Demonstrate that it acts upon identified issues from the CAHPS® and Provider Satisfaction surveys that specifically target identified opportunities for improvement in measurable results.		
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ⊙**
KPMAS' scores for compliance with routine and urgent care appointment timeframes both fell below the 80% compliance threshold at 68.0% and 77.7%, respectively. To achieve compliance in the MY 2024 validations, KPMAS must submit a CAP to address the following: Ensure provider offices are able to accommodate requirements for routine care appointment scheduling within 30 days of the call date and urgent care appointment scheduling within 48 hours of the call date at the same location with either the requested provider, an alternate provider, or telemedicine. KPMAS should consider	After implementing corrective action for MY 2023, KPMAS significantly improved compliance with routine care appointment timeframes by 16.7 percentage points (68.0% in MY 2023 to 84.7% in MY 2024). Despite KPMAS' improvement with urgent care appointment timeframes (77.7% for MY 2023 to 79.3% for MY 2024), the score for urgent care appointment timeframes remains below the 80% minimum compliance threshold established by MDH. To achieve compliance in the MY 2025 validations, KPMAS must submit quarterly CAPs to address the following: Ensure provider offices are able to accommodate requirements for urgent care appointment scheduling	⊙

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.	within 48 hours of the call date at the same location with either the requested provider, an alternate provider, or telemedicine. KPMAS must review the root causes for the decline in performance and address the identified issues to improve performance.	
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ⊙**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Yellow and ⊙ = MCO did not fully address the recommendation

MPC

Table 127. MPC Assessment of Previous Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ⊙**
MPC should consider the following recommendations from the MY 2022 review: • Component 4.4i: Demonstrate consistent compliance with the required TAT for processing the credentialing application in less than or equal to 150 days from the receipt of the application. • Component 4.4j: Provide evidence of sending the practitioner the 30-day notice that informs the practitioner of the MCO's intent to move forward with the initial credentialing process.	MPC initiated a corrective action plan that was reviewed by both Qlarant and MDH. MPC was then found to be compliant in the following Elements/Components: • 4.4i • 4.4j • 7.4c MPC did not meet compliance for component 7.7c requiring a quarterly CAP.	⊙

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
• Component 7.4c: Demonstrate compliance with the 24-hour timeframe for prescriber notification of covered outpatient pharmacy decisions within the MDH threshold of 95% for each quarter of the review period. • Component 7.7c: Demonstrate compliance with the timeframe for written expedited appeal resolutions within the MDH threshold of 95% for each quarter of the review period.		
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ⊙**
There were no formal MY 2023 recommendations that would require action to be taken.		
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ⊙**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Yellow and ⊙ = MCO did not fully address the recommendation

MSFC

Table 128. MSFC Assessment of Previous Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ⦿**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ⦿**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ⦿**
MSFC should consider the following recommendations from the MY 2022 review: Component 7.7c: Demonstrate compliance with appeal resolution notification timeframes within MDH's 95% threshold on at least a quarterly basis for all four quarters of the review period.	MSFC initiated a corrective action plan that was reviewed by both Qlarant and MDH. MSFC was then found to be compliant in 7.7c during MY 2023.	↑
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ⦿**
There were no formal MY 2023 recommendations that would require action to be taken.		
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ⦿**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ⦿**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ⦿**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Light Green and ↑ = MCO addressed the recommendation

PPMCO

Table 129. PPMCO Assessment of Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ⊙**
PPMCO should consider the following recommendations from the MY 2022 review: • Component 5.8e: Provide a report that indicates their electronic information provided to enrollees meets requirements set forth in COMAR. • Component 7.4c: Provide determination timeframe and prescriber 24-hour notification compliance results on at least a quarterly basis for all four quarters of the review period, specifically for the Medicaid LOB. • Component 7.5b: Revise the appeal filing timeframe to "within 60 calendar days from the date of the adverse determination notice" in the list of adverse determination letter components included in the Clinical and Administrative Denial Policy. • Component 7.7c: Demonstrate timeframe compliance at or above the MDH established threshold of 95% for written appeal acknowledgments and written resolution/notifications on at least a quarterly basis for all four quarters of the review period. Additionally, case notes must reflect that PPMCO made a	PPMCO initiated a corrective action plan that was reviewed by both Qlarant and MDH. PPMCO was then found to be compliant in the following Elements/Components: • 5.8e • 7.4c • 7.5b • 7.7c • 7.7e • 7.7g • 9.3a • 9.3c • 9.4 • 10.1a	↑

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
reasonable attempt to provide the enrollee with oral notification of an expedited resolution. • Component 7.7e: Demonstrate that if it denies a request for an expedited appeal resolution, reasonable efforts are made to provide the enrollee with oral notice of the denial. • Component 7.7g: Eliminate the requirement for written confirmation of an oral appeal in the Priority Partners Enrollee Appeals Policy. • Component 9.3a: Include process and outcome measures in its evaluation of the impact of the HEP on PPMCO enrollees. For example, HEDIS® data could be used pre and post program participation or ED visits or hospital admissions pre and post for select diagnoses such as diabetes. PPMCO could also use the Healthy People 2030 recommendations to develop measurable goals for its HEP classes. • Component 9.3c: Provide evidence that providers are referring enrollees in need of health education to the program. For example, case notes demonstrating referrals or completed referral forms could be submitted as evidence. • Component 9.4: Demonstrate that these mechanisms are in place and functioning effectively to identify enrollees in special need of educational efforts. • Component 10.1a: Provide the total number of enrollees comprising the SNP categories as defined in COMAR		

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
10.67.04.04 B. Categories and totals must include PPMCO's postpartum population.		
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ⊙**
Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. PPMCO should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.	PPMCO initiated a corrective action plan that was reviewed by both Qlarant and MDH. PPMCO was then found to be compliant during MY 2023, requiring no further corrective action.	↑
Ensure PCP's online provider directories include information regarding their practice's accommodations for patients with disabilities. PPMCO should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.		
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ⊙**
Monitor the Laboratory Tests/At-Risk Screenings component for root causes for the decrease in performance.	PPMCO's CAP for the Laboratory Tests/At-Risk Screenings component requires quarterly CAP submissions to include a two-year provider education project due to not meeting the minimum threshold (80%) for multiple consecutive years.	↓
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ⊙**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Light Green and ↑ = MCO addressed the recommendation; **Pink** and ↓ = MCO did not address the recommendation

UHC

Table 130. UHC Assessment of Previous Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ●**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ●**
UHC should consider the following recommendations from the MY 2022 review: • Component 7.3c: Provide evidence in the HQUMC meeting minutes of discussion of current UM initiatives to address areas of overutilization and underutilization in addition to the presentation of the quarterly measure results and the HQUM workplan. • Component 7.10: Provide a documented process that is designed to assure IRO invoices are paid within the 60-day timeframe required by COMAR. This could be added to either the Provider Grievance and Appeal Policy or a desktop procedure and include, for example, communication and follow-up on a routine basis with the Accounts Payable Department to assure all IRO invoices are paid within 60 days of receipt.	UHC initiated a corrective action plan that was reviewed by both Qlarant and MDH. UHC was then found to be compliant in 7.3c and 7.10 during MY 2023 requiring no further corrective action.	↑
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ●**
Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same	UHC initiated a corrective action plan that was reviewed by both Qlarant and MDH. UHC was then found to be compliant during MY 2023, requiring no further corrective action.	↑

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
information when calling the provider directly. UHC should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.		
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ⊙**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Light Green and ↑ = MCO addressed the recommendation

WPM

Table 131. WPM Assessment of Previous Annual Recommendations

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
MY 2022 PIP	**MY 2023 PIP**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 PMV	**MY 2023 PMV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 SPR	**MY 2023 SPR**	**↑, ↓, or ⊙**
WPM should consider the following recommendations from the MY 2022 review: • Component 5.1h: Revise the Member Grievances - MD Policy to specify a timeframe for providing the enrollee written notice of grievance resolution for each grievance category. • Component 5.1h: Demonstrate compliance with these timeframes at or above the MDH threshold on at least a quarterly basis for all four quarters of the review period.	WPM initiated a corrective action plan that was reviewed by both Qlarant and MDH. WPM was then found to be compliant in the following Elements/Components: • 5.1h • 5.5c • 5.8d • 7.4c • 7.6b • 7.10 • 8.5c • 9.2 • 9.3a	⊙

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
• Component 5.5c: Provide evidence of any additional means by which providers were informed of assessment results, such as an online provider portal. • Component 5.8d: Provide evidence of posted notices and taglines during public interactions, in conspicuous physical locations. • Component 7.4c: Demonstrate compliance with medical and pharmacy PA determination timeframes for all PA requests at or above the MDH threshold of 95% for all four quarters of the review period. • Component 7.4c: Demonstrate compliance with 24-hour prescriber notification of the outcome of a PA request for a covered outpatient drug at or above the MDH threshold of 95% for all four quarters of the review period. • Component 7.6b: Demonstrate consistent compliance with adverse determination notification timeframes for expedited requests at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Component 7.7c: Demonstrate compliance with timeframes for written appeal acknowledgment and written resolution at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Component 7.7c: Demonstrate compliance with a reasonable attempt to provide the	• 9.5b WPM did not meet compliance for component 7.7c requiring a quarterly CAP.	

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
enrollee with oral notice of an expedited appeal resolution. • Component 7.10: Include all MCO requirements for supporting the IRO dispute resolution process in its Provider Claim Payment Dispute Process Policy. This includes documenting a process for assuring IRO invoices are paid within 60 calendar days of receipt. • Component 9.2: Demonstrate analysis of data such as diagnoses, utilization, and HRA results to identify the health education needs of its enrollees. Programs must be based on identified needs. • Component 9.3a: Have a written methodology for evaluating the impact of the health education program on process and/or outcome measures and must submit an annual evaluation that is based upon this methodology. • Component 9.3b: Provide evidence of the qualifications of staff or external organizations that develop and conduct educational sessions to support the needs of enrollees such as job descriptions, specialized training, certifications, education, and experience. • Component 9.5b: Provide sample attendance records and completed evaluations of health education sessions completed by enrollees. • Component 9.5c: Demonstrate that its health education programs are evaluated by providers. This could be accomplished by formal written provider surveys or		

Recommendation	Assessment and Action(s) Taken	MCO Addressed Recommendations
presentation of the health education plan for review and discussion at any WPM committee meetings attended by providers.		
MY 2023 NAV Focused Study	**MY 2024 NAV Focused Study**	**↑, ↓, or ⊙**
Ensure staff responses regarding practice location match the online provider directory accurately. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. WPM should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.	WPM initiated a corrective action plan that was reviewed by both Qlarant and MDH. WPM was then found to be compliant during MY 2023, requiring no further corrective action.	↑
MY 2022 EDV	**MY 2023 EDV**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 EPSDT	**MY 2023 EPSDT**	**↑, ↓, or ⊙**
There were no formal MY 2022 recommendations that would require action to be taken.		
MY 2022 GAD	**MY 2023 GAD**	**↑, ↓, or ⊙**
Any corrective action needed to address non-compliant GAD findings was requested at the time of the annual SPR.		

Light Green and ↑ = MCO addressed the recommendation; **Yellow** and ⊙ = MCO did not fully address the recommendation

State Recommendations

As identified in the introduction of this report, MDH aims to deliver high quality, accessible care to managed care enrollees. To achieve this goal, MDH developed a framework to focus quality improvement efforts for the managed care programs. This section identifies goals and objectives described in the *HealthChoice Quality Strategy*.

Table 132. HealthChoice Program Goals and Objectives

Goal	Objective
1. Improve HealthChoice aggregate performance on Medicaid HEDIS measures by reaching or exceeding the pre-pandemic HealthChoice aggregate by MY 2024.	1. Increase the number of HEDIS measures that meet or exceed the HealthChoice aggregate achieved in MY 2018 or MY 2019, whichever is highest, by MY 2024. 2. Once Objective 1 is achieved, ensure HealthChoice aggregate meets or exceeds the NCQA National HEDIS Means by MY 2024.

Goal	Objective
2. Improve overall health outcomes for HealthChoice enrollees through expanding the network of available provider types, creating targeted quality and operational initiatives to enhance enrollee access to care, and promoting health service delivery innovation.	1. Increase the HealthChoice aggregate for the HEDIS Prenatal and Postpartum Care measures by three percentage points no later than MY 2024. 2. Improve the HealthChoice aggregate for measures tracking chronic health outcomes by MY 2024.
3. Ensure HealthChoice MCOs are complying with all state and federal requirements by meeting or exceeding the minimum compliance scores for all administrative quality assurance activities.	1. Increase the HealthChoice aggregate scores to 100% for all Systems Performance Review standards by MY 2024. 2. Increase the HealthChoice aggregate scores to at least 80% for all EPSDT/Healthy Kids Medical Record Review components by MY 2024. 3. Increase the HealthChoice aggregate scores to at least 85% for all network adequacy validation activities by MY 2024. 4. Increase the HealthChoice aggregate scores to at least 90% for encounter data validation by MY 2024. 5. Increase the HealthChoice aggregate to minimum compliance for each element of review for grievances, appeals, and pre-service determinations by MY 2024.

Source: *HealthChoice Quality Strategy*

Recommendations on How the State Can Target Quality Strategy Goals and Objectives

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

Performance Improvement Project Validation

- MDH should continue to monitor the MCOs' progress with the implementation of interventions and observed improvement on the correlating HEDIS measure rates during upcoming remeasurement years.

In an effort to further encourage MCOs to implement these improvement recommendations on intervention planning, design, and evaluation, MDH has developed an enhanced review of MCOs' PIPs to provide in-depth feedback on MCOs' improvement strategies. With this more in-depth review, MCOs may be able to attain critical insight and increased intervention efficacy. Furthermore, providing a forum for MCOs to discuss barriers and share best practices also may be helpful in improving rates among all HealthChoice MCOs. Qlarant also provides technical assistance meetings individually with MCOs to address ongoing challenges in developing SMART objectives and/or using the PDSA process.

Performance Measure Validation

- Metastar did not make any formal recommendations in their Statewide Executive Summary Report for HEDIS MY 2023, however they provided the below Implications and Discussion:
  - There were several measures/indicators where eight of nine MCO rates were above/better than the NHM: BCS-E, CIS combos 3 and 7, PCE bronchodilator, PPC Timeliness of Prenatal Care, W30 15-30 months, and WCV.
  - All nine MCOs scored above/better than the NHM for HBD A1c good control <8, HBD A1c poor control >9, KED, LSC, and SPC.
  - In addition, seven of nine MCOs performed above the 75th percentile for HBD A1c good control <8 and PPC Postpartum. CareFirst, JMS, and Kaiser performed at or above the 90th percentile for PPC Postpartum, and CareFirst performed above the 90th percentile for HBD good control <8.

- CSS did not make any formal recommendations in their Statewide Executive Summary Report for 2024 CAHPS® 5.1H Member Experience Survey, but provided the below Key Driver Analysis:
  - Adult Medicaid member ratings of the plan are strongly related to having access to highly rated providers (Q18 and Q22). More generally, access to needed care, tests, and treatment (Q9), including urgent (Q4) and specialty (Q19) care, are all significant drivers of member experience.
  - Child Medicaid member ratings of the plan are strongly related to having access to highly rated providers (Q36 and Q43). More generally, access to needed care, tests, and treatment (Q10), including urgent (Q4) and specialty (Q40) care, are all significant drivers of member experience.

Network Adequacy Validation

- MCOs employed different methods in conducting NAV for their provider-to-enrollee ratios, based on the language listed in COMAR. If the state wishes to make objective comparisons across MCOs, Qlarant recommends updating contract language to specify which provider types should be monitored.
- MDH should encourage MCOs to monitor and report provider-to-enrollee ratios for providers that are accepting new patients. This will provide additional insight into their capacity and can help inform recruiting and retention efforts for providers.
- MDH should add hematology/oncology to the list of major specialty providers.
- MDH should add clarifying language to ancillary providers, such as diagnostic/x-rays, to focus on individuals and/or facilities.
- MDH should reconsider or reinforce the maximum ratio threshold of 2,000 enrollees to one provider to align with NCQA accreditation standards for high impact/high volume specialists.
- MDH should provide MCOs with specific age and gender parameters when reporting provider-to-enrollee ratios and time and distance calculation results. For example, indicators looking at PCPs should include enrollees for all ages while indicators looking at Pediatric PCPs

should include enrollees between the ages of 0 and 20. Indicators related to women's health providers should include female enrollees ages 12 and older.

Network Adequacy Validation Focused Study

- Continue to promote standards/best practices for MCOs' online provider directories to include consistent and accurate provider information.
- Require all directories to state the date the information was last updated for easy monitoring.
- Continue to monitor the use of urgent care and emergency department services, and review utilization trends to ensure enrollees are not accessing these services due to an inability to identify or access PCPs.
- Continue allowing telemedicine appointments for routine or urgent care appointments to accommodate enrollee preferences and needs when appropriate.
- Ensure MCOs are providing an adequate provider network to promote access and timeliness of care by monitoring MCO enrollee-to-provider ratios.
- Ensure MCOs are implementing policies and procedures to promote health equity and monitor the availability of diverse providers with language fluencies other than English.

Encounter Data Validation

- MDH should encourage MCOs to conduct internal investigations/audits in order to determine the cause for the continued decline of office visit match rates and monitor the MCO root causes. Although MDH has achieved its Objective 4 goal of increasing the HealthChoice aggregate scores to at least 90% by MY 2024, MDH has set a specific EDV target goal of 99% match rates for all encounter types. At this time, office visit encounters are not meeting that target goal by four percentage points.
- MDH should monitor match rates for outpatient encounters to ensure the 99% target goal for MY 2024 is met. At this time, outpatient encounters are not meeting that target goal by one percentage point.

Hilltop provided the following recommendations to target quality strategy goals and objectives in their 2024 report:

- MDH should continue to monitor and work with the MCOs to resolve the usage of the MDH Provider Master File and NPI Crosswalk process.
- MDH should continue to work with the MCOs to instill best practices to improve their numbers of denied encounters.
- MDH should take into consideration the variance between an MCO's share of all denial compared to its share of all accepted encounters.

- MDH should require MCOs with unusually high volumes of $0 encounters provide an explanation and to MDH and ensure accuracy with future submissions.
- MDH should consider implementing measures to enforce adherence to this requirement, such as automatic denial of $0 encounters submitted without an indicator.
- MDH should continue to work with the MCOs to ensure appropriate utilization and improvement in the accuracy of the provider reimbursement field on accepted encounters.
- To address the high volume of denied encounters, MDH should continue to encourage MCOs to work with their providers to ensure that they are enrolled on the date of service and that they know how to check their current status.
- MCOs that submit encounters more than eight months after the date of service—the maximum time allotted for an encounter to be submitted to MDH—should be flagged for improvement. MDH should consider automatically denying encounters submitted after this period has ended.
- Hilltop reviewed the volume of inpatient visits, ED visits, and observation stays by MCO. Trends in service type were consistent across MCOs and years. There was a slight increase in ED visits between CY 2021 and CY 2023. MDH should continue to review these data and compare trends in future annual encounter data validations to ensure consistency.
- MDH should continue to review and audit the participant-level, MCO-specific reports that Hilltop generated for delivery, dementia, individuals over age 65, dental, and missing age outlier data measures. MCOs that submit the encounter outliers should be notified, demographic information should be updated, and adjustments should be made, as needed.

Early and Periodic Screening, Diagnosis, and Treatment

- MDH should continue to consider adopting an alternate methodology to improve the MRR process.
- MDH should encourage MCOs performing below the minimum compliance threshold (80%) to perform frequent monitoring of the quality of clinical care provided to all children younger than 21 years old.
- MDH should consider monitoring the Laboratory Tests/At-Risk Screenings component to identify and assist MCOs in identifying and overcoming root causes for the decline in performance, which continues to score below MDH's quality strategy target goal of 87% for MY 2024.

Grievance, Appeal, and Denial Focused Study

- **Pharmacy Preauthorization Requests** - Many MCOs continue to process preauthorization requests for covered outpatient drugs as "urgent", whether or not explicitly requested by the provider. One of the key drivers of this is thought to be MCOs'/pharmacy vendors' Pharmacy Preauthorization forms that include a checkbox for marking the request "urgent". Additionally,, MCOs appear to be following NCQA requirements for pharmacy preauthorization requests. Specifically, for Medicaid urgent pre-service pharmacy decisions, NCQA

requires the organization to provide electronic or written notification of the decision to members and practitioners within 24 hours of the request. Similarly, for Medicaid non-urgent pre-service decisions, NCQA requires the organization to provide electronic or written notification of the decision to members and practitioners within 24 hours of the request. This extremely short turnaround time appears to minimize requests for additional information to demonstrate medical necessity, which contributes to the high level of adverse determinations and appeals observed over the past few years. There also may be some confusion among MCOs regarding the requirement for notifying the prescriber of the outcome of the preauthorization request for a covered outpatient drug within 24 hours of receipt. While the standards clearly specify the outcome as either approve, deny, or request additional information, some MCO staff may be unaware of this. In view of all these issues, Qlarant recommends that MDH clarify the preauthorization requirements for covered outpatient drugs and the expectation that additional information, if needed to demonstrate medical necessity, be requested at the time of submission of the preauthorization request.

- **Expedited Appeals** - In reviewing appeal records, it appears that not all MCOs are aware that a written acknowledgment letter is no longer required for expedited appeals. Due to the 72-hour resolution timeframe of the expedited appeal, written notification of receipt isn't logical, however, the MCO is required to make reasonable efforts to provide verbal notice of the decision along with a written notification of the decision. Qlarant recommends these requirements be clarified and communicated to the MCOs with a copy to Qlarant.

Conclusion

As Maryland's contracted EQRO, Qlarant evaluated the HealthChoice managed care program to assess compliance with federal and state-specific requirements. Review and validation activities occurred over the course of 2024 and assessed MY 2023 and MY 2024 performance, as applicable.

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

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

Appendices Introduction

Section Summaries

MCO-Specific Summaries

Quality assurance activities that took place in MYs 2023 and 2024 are the basis for findings in **Appendix A's** profiles and summary of MCO performance. Each table also identifies positive or negative impacts on quality, access, and timeliness as strengths, improvements, or recommendations. These profiles are extensions of content from the **MCO Quality, Access, and Timeliness Assessment** section.

SPR Standards and Guidelines

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

Hilltop's MY 2023 Encounter Data Validation Report

MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. MDH elected to contract with Hilltop to analyze and evaluate the validity of encounter data in order to complete Activity 3 (analyzing MCO electronic encounter data for accuracy and completeness). Hilltop performed an evaluation of all electronic encounter data submitted by the MCOs for MYs 2021 to 2023 to determine the validity of the encounter data and ensure complete, accurate and high-quality data. **Appendix C** provides the full report of Hilltop's encounter data validation.

2024 Final IRS and Methodology

Appendix D explains the reporting strategy and analytic methods Qlarant used in developing the report card that MDH released in 2024, based on data reported by MCOs during calendar year 2023 for MY 2022. The information reporting strategy explains the criteria used to determine the most appropriate and effective methods of reporting quality information to Medicaid enrollees, the intended target audience. The analytic method provides a statistical basis and the analysis method used for reporting comparative MCO performance.

Report Reference Page

Appendix E identifies task-specific reports provided by Qlarant and provides webpage links to access additional findings and comprehensive details associated with these reports.

Appendix A: MCO-Specific Summaries

This section highlights strengths, improvements, and recommendations summarizing performance per MCO. Identified strengths, improvements, and recommendations correspond to quality, access, and/or timeliness of services delivered to MCO enrollees. Applicable domains for each strength, improvement, or recommendation are identified with an arrow (↑) or (↓) and color-coded cells, indicating a positive or negative impact. Not all domains were impacted by each strength, improvement, or recommendation. Where appropriate, recommendations include opportunities.

Table 133. ABH Strengths, Improvements, and Recommendations

Domain	ABH Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *High Confidence* for both PIP topics. • Continued to demonstrate and enhance efforts toward incorporating a health equity focus within its interventions. Interventions are assessed following the PDSA cycle and barriers have been identified on the enrollee, provider, and MCO levels. • Conducted a disparity analysis stratified by race/ethnicity for each strategy. • Reviewed data on a quarterly basis.	↑
Quality, Access	**Improvements:** • Improved the Prenatal Care HEDIS rate by 5.4 percentage points from MY 2022 to MY 2023. • Improved the Postpartum Care HEDIS rate by 4.7 percentage points from MY 2022 to MY 2023. • Improved the W30 (0-15 months) and W30 (15-30 months) HEDIS rates by 2.7 and 3.3 percentage points, respectively, from MY 2022 to MY 2023.	↑
Quality	**Recommendations:** • Identify and address root causes for barriers impacting desired improvement outcomes. Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions.	↓
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** ***MetaStar observed the following strengths:***	↑

Domain	ABH Strengths, Improvements, and Recommendations	Assessment
	• Provided a standardized and well-documented HEDIS MY 2023 Roadmap on time, which greatly facilitated both the offsite and virtual onsite phases of the HEDIS Compliance Audit. No issues were identified with the completion of the Roadmap General Information or Append sections. • Utilized a software vendor with NCQA-certified measures. The auditor confirmed via the IDSS that the certified version of the software was used for each measure by ensuring the IDSS did not produce any warnings regarding the globally unique identifiers. There were no Tier 4 warnings identified by NCQA for ABH. • Maintained excellent communication with the auditor throughout the audit process, and alerted the auditor when there were concerns that could potentially impact the audit. • Provided all required documents, databases, and rate files on or prior to the required deadlines. Provided all requested follow-up items for the audit in a timely manner.	
Quality, Access	**Improvements:** ***MetaStar observed the following improvements:*** • Captured race and ethnicity through enrollment files. Deemed incomplete in MY 2022, ABH was encouraged to work with MDH to capture more complete race and ethnicity data. MDH began requiring enrollees to complete race and ethnicity on the enrollment forms. This requirement resulted in improvement on the amount of data captured and provided on race and ethnicity.	↑
Quality, Access	**Recommendations:** ***MetaStar recommends the following actions:*** • Continue working with MDH to obtain better race and ethnicity data. Data appeared better than in prior years; however, there were still enrollees with unknown race and ethnicity. • Continue to explore reasons for any low-reported rates to improve for future HEDIS reporting. The auditor solicited further explanation, as needed, for rates above the 90th percentiles or below the 10th percentiles, or rates that changed by more than five percentage points from the prior year.	↓
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** ***CSS observed the following strengths:*** • *How Well Doctors Communicate* showed a slight positive trend since 2022 for the adult CAHPS survey. • *Rating of Specialist Seen Most Often* scored in the top third decile for the child CAHPS survey.	↑
NA	**Improvements:** ***CSS observed the following improvements:*** • ABH did not demonstrate formal improvement from the previous measurement year for the adult CAHPS survey.	NA

Domain	ABH Strengths, Improvements, and Recommendations	Assessment
	• ABH did not demonstrate formal improvement from the previous measurement year for the child CAHPS survey.	
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no formal recommendations for ABH for either the adult or child CAHPS survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑, ↓, or NA**
NA	**Strengths:** • ABH did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:** • ABH did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for ABH.	NA
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality	**Strengths:** • Demonstrated the ability to design and implement effective quality assurance systems. The MY 2023 interim desktop review provided evidence of ABH's continuous commitment to ensuring quality healthcare delivery for its enrollees. • Received a finding of *Met* for all elements/components reviewed during the interim desktop review.	↑
Quality, Timeliness	**Improvements:** • Utilized easy-to-understand language in ABH's sample of adverse determination notices. • Revised the Medicaid Administrators LLC Utilization Management (UM) Timeliness Standards and Decision Notification – Maryland Policy to eliminate the five-calendar-day mailing timeframe from the list of adverse determination letter components. • Revised the Provider Appeals Policy to require a written appeal decision notice be sent to the provider via electronic mail, fax, or surface mail within three business days from the date of the appeal decision. • ABH's Compliance Committee reviewed each delegate's quarterly Fraud, Waste, and Abuse reports on a quarterly basis throughout the MY 2023.	↑
NA	**Recommendations:** • There are no formal recommendations for ABH.	NA
Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality, Access	**Strengths:**	↑

Domain	ABH Strengths, Improvements, and Recommendations	Assessment
	• Achieved a confidence level of *High Confidence* for validation of all Provider-to-Enrollee Ratio indicators. • Achieved a confidence level of *High Confidence* for all Time and Distance Standards indicators.	
NA	**Improvements:** • ABH did not demonstrate formal improvement from the previous measurement year, as MY 2023 is the first year of implementation of CMS' Validation of Network Adequacy Protocol 4.	NA
Quality, Access	**Recommendations:** • Continue to work towards setting ratio goals to meet COMAR regulations.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • ABH's scores for compliance with routine and urgent care appointment timeframes remained above the 80% threshold established by MDH by 3.9 to 11.6 percentage points.	↑
NA	**Improvements:** • ABH did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access	**Recommendations:** • Encouraged to review and address root causes for having the most significant increase in "PCP Response" for *Wrong Location Listed for Provider* by 60 percentage points. • Encouraged to review and address root causes for the significant increase in "No Contact" due to *Reached Voicemail* (33.3%) and *Hold Time >5 Minutes* (24.6%). • ***CAP:* ABH must submit a CAP to achieve compliance in MY 2025:** ○ Identify and address the root causes for the decline in performance and address the identified issues to improve performance. Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory through provider staff education. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.	↓
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • ABH's encounter and code type match rates exceeded the minimum compliance standard of 90%.	↑
NA	**Improvements:** • ABH did not demonstrate formal improvement from the previous measurement year.	NA
Quality	**Recommendations:**	↓

Domain	ABH Strengths, Improvements, and Recommendations	Assessment
	• Identify and address the root causes of the decline in performance to ensure inpatient match rates remain above the minimum compliance standard. ABH had a slight decline of four percentage points from MY 2022 (100%) to MY 2023 (96%) for total inpatient match rates.	
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Met or exceeded the MDH-established minimum compliance threshold (80%) for four out of the five component areas in MY 2023. • All of the elements comprising the *Health Education/Anticipatory Guidance* component exceeded the MDH-established compliance threshold (80%) for MY 2023. • All of the elements comprising the *Comprehensive Physical Exam* component exceeded the MDH-established minimum compliance threshold (80%). • Met or exceeded the MDH-established minimum compliance threshold (80%) for 13 of the 14 elements comprising the *Immunizations* component. • Met the HealthChoice Aggregate score for the *Comprehensive Physical Exam* component.	↑
NA	**Improvements:** • ABH did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access, and Timeliness	**Recommendations:** • Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule and that immunizations documented in Immunet match the provider office documentation. • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the Healthy Kids webpage and the last two pages in the EPSDT Orientation Manuals published on the MCO resource site. • Ensure providers have a copy of the Healthy Kids Provider Manual and specifically have a full understanding of Section 3: Healthy Kids/EPSDT Screening Components, Part C. Laboratory Tests that begin on page 50. • Educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion. • Collaborate with the assigned state Healthy Kids/EPSDT Nurses to assist in re-educating providers and supporting staff on current standards of preventive health care. • Conduct a root cause analysis for the Laboratory Tests/At-Risk Screenings component to identify causes for the decline in performance and overcome barriers to meeting compliance in MY 2024.	↓

Domain	ABH Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality, Access	**Strengths:** • Maintained MY 2023's star rating in three performance areas (Access to Care, Keeping Kids Healthy, and Taking Care of Women).	↑
NA	**Improvements:** • ABH did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for ABH.	NA
Quality, Access, and/or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑, ↓, or NA**

Quality, Timeliness	**Strengths:**
	• Consistently self-reported quarterly and annual GAD reports error free.
	• Appropriately categorized and resolved all grievances.
	• Consistently exceeded compliance thresholds for timeliness of:
	  ○ Grievance resolutions and resolution notifications;
	  ○ Appeal acknowledgement and resolution notifications; and
	  ○ Prescriber notifications, pre-service determinations, and adverse determination notifications.
	• Excellent use of easy-to-understand language in appeal resolution notifications.
		↑

Quality	**Improvements:** • Compliance with turnaround times exceeded the threshold in all categories, which is an improvement over Q3 MY 2023, when expedited pre-service medical denials' notification turnaround times were at 93%. • Wrote adverse determination notifications in easy-to-understand language.	↑
Quality, Timeliness	**Recommendations:** • Routinely monitor timeliness of grievance acknowledgement letters. • Review grievance records before submission to ensure no duplicates (#17 was a duplicate of #5 and #12 a duplicate of #15).	↓

Table 134. CFCHP Strengths, Improvements, and Recommendations

Domain	CFCHP Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *High Confidence* for the Prenatal Care PIP and *Confidence* for the Postpartum Care-Related PIP. • Conducted a disparity analysis stratified by race/ethnicity data for each strategy. • Reviewed data on a quarterly basis.	↑
Quality, Access	**Improvements:** • Improved the Prenatal Care HEDIS rate by 4.4 percentage points from MY 2022 to MY 2023. • Improved the Postpartum Care HEDIS rate by 4.8 percentage points from MY 2022 to MY 2023. • Improved the Childhood Immunization Status HEDIS rate by 4.4 percentage points from MY 2022 to MY 2023.	↑
Quality, Access	**Recommendations:** • Ensure comparability between each MY by following the same methodology for sampling verses studying an entire population. • Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions. CFCHP should consider conducting a root cause analysis for barriers impacting desired improvement outcomes. • Correctly report accurate HEDIS numerators, denominators, and rates for each MY. • Incorporate proven-successful methodology outlined in evidence-based research to increase the likelihood that interventions will result in the desired outcomes.	↓
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** ***MetaStar observed the following strengths:*** • Responsive to auditor requests and provided information and documentation in a timely manner. CFCHP's HEDIS team served as subject matter experts for all organization functions and worked diligently to identify root causes of reporting issues and implement corrections when necessary to ensure successful reporting.	↑
Quality	**Improvements:** ***MetaStar observed the following improvements:*** • Updated data processes to incorporate race/ethnicity data to successfully report the stratifications for the MY 2023 Medicare Sub IDs 13506 and 13156. • Expanded the list of supplemental data sources to include a Data Aggregator Validation source, Fig-MD.	↑

Domain	CFCHP Strengths, Improvements, and Recommendations	Assessment
Quality	**Recommendations:** ***MetaStar recommends the following actions:*** • Incorporate race/ethnicity data for Medicare Sub IDs 15499 and 15934 into Facets and/or the HEDIS reporting repository for future reporting. • More easily identify the data source groups and link back the list of approved sources for the supplemental data impact reports. • Update the Roadmap and audit process documents for future audits to incorporate processes for the Medicare Subs IDs 155499 and 15934.	↓
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑,↓, NA**
Quality, Access, and Timeliness	**Strengths:** ***CSS observed the following strengths:*** • One of two MCOs with no measures scoring in the bottom decile, with *How Well Doctors Communicate* performing the highest of all MCOs in the top decile, and *Coordination of Care* performing in the top third for the adult CAHPS survey. • One non-CCC measure performed in the top third decline for the child CAHPS survey.	↑
Quality, Access, and Timeliness	**Improvements:** ***CSS observed the following improvements:*** • CFCHP did not demonstrate formal improvement from the previous measurement year for the adult CAHPS survey. • One of two MCOs to see statistically significant performance gains compared to the previous measurement year for the child CAHPS survey. For CFCHP, these measures were *Rating of Health Plan* and *Customer Service*.	↑
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no formal recommendations for CFCHP for either the adult or child CAHPS survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑,↓, NA**
NA	**Strengths:** • CFCHP did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:** • CFCHP did not demonstrate any formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for CFCHP.	NA

Domain	CFCHP Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality	**Strengths:** • Demonstrated the ability to design and implement effective quality assurance systems. The MY 2023 interim desktop review provided evidence of CFCHP's continuous commitment to ensuring quality healthcare delivery for its members.	↑

Quality, Access, Timeliness	**Improvements:**
	• Revised the following documentation:
	  ○ The Member Grievances Standard Operating Procedure (SOP) to state the correct timeframe for sending a written acknowledgement of a grievance and requiring an acknowledgement letter be sent for medically related grievances that are not anticipated to be resolved within five calendar days or within the regulatory requirement, whichever is less.
	  ○ Both the Pharmacy Prior Authorization Policy and the Pharmacy Prior Authorization Desktop Procedure to specify the requirements to "approve, deny, or request additional information by telephone or other telecommunication device from the requesting provider within 24 hours of the preauthorization request for all covered outpatient drugs."
	  ○ Both the Timeliness of Utilization Management Decisions Policy and the Timeliness of Utilization Management Decisions Standard Operating Procedure to clearly indicate a determination and notification will be made within 72 hours of receipt of an expedited preauthorization request.
	  ○ The Member Appeals Policy to eliminate the requirement for written confirmation of oral requests for an appeal.
	  ○ The Provider Advisory Council Charter to include among its responsibilities review and trending of results from the annual CAHPS and Provider Satisfaction surveys, including provider satisfaction with the utilization management process.
	  ○ The Provider Appeals – Independent Review Organization Request Standard Operating Procedure to include the process for ensuring Independent Review Organization invoices are paid within the required 60-day timeframe.
	• Demonstrated improved compliance with the following GAD elements at or above the MDH-established threshold (95%) on at least a quarterly basis for all four quarters of MY 2023:
	  ○ Upholding timeframes for written grievance acknowledgement and grievance resolution, and
	  ○ Upholding CFCHP's written grievance resolution timeframe.
	• Exceeded the MDH-established threshold (95%) for resolution letter timeliness of expedited and standard appeals for all four quarters of MY 2023.
		↑

Domain	CFCHP Strengths, Improvements, and Recommendations	Assessment
	• Demonstrated a more-timely review of CAHPS and Provider Satisfaction survey results to facilitate the development and implementation of action plans to resolve identified opportunities for improvement in utilization management-related measures. • Provided the following as evidence to support claims: ○ Examples of notices and taglines posted in conspicuous physical locations when interacting with the public to notify current and prospective members of their nondiscrimination rights; ○ Examples of provider referrals of members for health education to demonstrate an effective process for notifying providers of the availability and contact information of a health educator/educational program for members; ○ Evidence to demonstrate that CFCHP acts upon identified opportunities for improvement from CAPHS survey results related to utilization management measures; ○ Four job descriptions of staff members and two vendors who provide education to members on health-related issues to demonstrate appropriate qualifications; ○ A more-comprehensive sample of member notifications, brochures, and mailings oriented toward providing health education; ○ Evidence to demonstrate evaluation of the annual health education plan by CFCHP's providers; ○ A sample of completed evaluations from members of health education programs/events; and ○ Meeting minutes of the Compliance Regulatory Committee to demonstrate review and approval of four quarters of delegates' Fraud, Waste, and Abuse reports. • Utilized easy-to-understand language in CFCHP's sample of adverse determination letters. • Conducted the annual Population Management Health Evaluation to assess the impact of CFCHP's Health Education Program on 14 HEDIS measures and identified opportunities for improvement if established goals were not met.	
Quality	**Recommendations:** • Include a survey item in its Community Health Fairs evaluation form to address the effectiveness of health education provided, such as "Did the enrollee learn anything new that will help them in improving their health."	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved a confidence level of *High Confidence* for validation of 12 of the 14 Provider-to-Enrollee Ratio indicators. • Achieved confidence levels of *High Confidence* and *Moderate Confidence* for all Time and Distance Standards indicators.	↑

Domain	CFCHP Strengths, Improvements, and Recommendations	Assessment
NA	**Improvements:** • CFCHP did not demonstrate formal improvement from the previous measurement year, as MY 2023 is the first year of implementation of CMS' Validation of Network Adequacy Protocol 4.	NA
Quality, Access, and Timeliness	**Recommendations:** • Increase monitoring activity to include provider-to-enrollee ratios for major specialties. Update provider-to-enrollee ratio monitoring for pediatric providers and specialists to focus on the pediatric population. Update provider-to-enrollee ratio monitoring for women's health providers and specialists to focus on the women's population.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑,↓, or NA**
Quality, Timeliness	**Strengths:** • Performance remained above the 80% threshold for compliance with routine and urgent care appointments.	↑
Quality, Access	**Improvements:** • Improved compliance for the accuracy of accepting new Medicaid patients after implementing corrective action for MY 2023.	↑
Quality, Access, and Timeliness	**Recommendations:** • Review and address root causes for the increase in the unsuccessful call categories *No Answer* and *Wrong Location Listed for Provider.* • Ensure PCP's telephone numbers are accurate and updated in the online provider directory. • ***CAP:* CFCHP must submit a CAP to achieve compliance in MY 2025:** ○ Identify and address the root causes for the decline in performance and address the identified issues to improve MY 2025 performance. Ensure PCP's telephone numbers are accurate and updated in the online provider directory to improve enrollee access to contacting PCPs.	↓
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • CFCHP's encounter and code type match rates exceeded the minimum compliance standard of 90%.	↑
NA	**Improvements:** • CFCHP did not demonstrate formal improvement from the previous measurement year.	NA
Quality	**Recommendations:** • Monitor documentation and coding errors for office visit encounters to ensure office visit match rates remain above the minimum compliance standard. CFCHP has maintained a match rate of 95% for office visit diagnosis and procedure codes.	↓

Domain	CFCHP Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Met or exceeded the MDH-established minimum compliance threshold (80%) in four out of the five component areas. • Nine of the 11 elements comprising the *Health and Developmental History* component met or exceeded the MDH-established minimum compliance threshold (80%). • All of the elements comprising the *Comprehensive Physical Exam* component exceeded the MDH-established minimum compliance threshold (80%). • All of the elements comprising the *Health Education/Anticipatory Guidance* component exceeded the MDH-established compliance threshold (80%) for MY 2023. • Met or exceeded the MDH-established minimum compliance threshold (80%) for 12 of the 14 elements comprising the *Immunizations* component. • Exceeded the HealthChoice Aggregate score (93%) for the *Health and Developmental History* component (94%). • Displayed the most significant improvement from MY 2022 to MY 2023, by two percentage points, for the Measured Blood Pressure element in the *Comprehensive Physical Exam* component. • Displayed the most significant improvement in MY 2023, with an increase of 17 percentage points, for the HIV Test Per Schedule in the *Laboratory Tests/At-Risk Screenings* component.	↑
NA	**Improvements:** • CFCHP did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access, and Timeliness	**Recommendations:** • Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule and that immunizations documented in Immunet match the provider office documentation. • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the Healthy Kids webpage and the last two pages in the EPSDT Orientation Manuals published on the MCO resource site. • Ensure providers have a copy of the Healthy Kids Provider Manual and specifically have a full understanding of Section 3: Healthy Kids/EPSDT Screening Components, Part C. Laboratory Tests that begin on page 50. • Educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion.	↓

Domain	CFCHP Strengths, Improvements, and Recommendations	Assessment
	• Collaborate with the assigned state Healthy Kids/EPSDT Nurses to assist in re-educating providers and supporting staff on current standards of preventive health care. • Conduct a root cause analysis for the *Laboratory Tests/At-Risk Screenings* component to identify causes for the decline in performance and overcome barriers to meeting compliance in MY 2024.	
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality, Access	**Strengths:** • Maintained MY 2023's star rating in Doctor Communication and Service, Keeping Kids Healthy, and Care for Kids with Chronic Illness.	↑
Quality, Access	**Improvements:** • Improved MY 2023's star rating in Access to Care and Taking Care of Women.	↑
NA	**Recommendations:** • There are no formal recommendations for CFHCP.	NA
Quality, Access, and/or Timeliness	**Grievances, Appeals, and Denials Focused Study**	**↑, ↓, or NA**

Quality, Timeliness	**Strengths:**
	• Appropriately categorized and resolved all grievances.
	• Consistently exceeds the compliance threshold for timeliness of:
	  ○ Grievance resolution and resolution notifications,
	  ○ Appeal acknowledgement and resolution notifications, and
	  ○ Pre-service determinations and adverse determination notifications.
		↑

Quality, Timeliness	**Improvements:**
	• Consistent compliance with the following:
	  ○ Timeliness of grievance resolutions and resolution notifications, and
	  ○ Required content for grievance resolution notifications (description of grievance).
	• Included documentation of investigation and resolution in grievance case notes.
	• Used correct template for grievance resolution notifications.
	• Wrote adverse determination and appeal resolution notifications in easy-to-understand language.
		↑

Quality, Timeliness	**Recommendations:** • Routinely monitor timeframe compliance with written grievance acknowledgements. • Routinely monitor case notes for documentation of a reasonable attempt to provide the member with oral notification of denial of a request for an expedited appeal resolution. • Review records before submission to ensure all are pre-service requests. Two records (15 and 16) were post-service requests.	↓

Table 135. JMS Strengths, Improvements, and Recommendations

Domain	JMS Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *High Confidence* for both PIP topics. • Continued to demonstrate and enhance efforts towards incorporating a health equity focus within its interventions. • Conducted a disparity analysis stratified by race/ethnicity for each strategy. • Reviewed data on a quarterly basis.	↑
Quality, Access, and Timeliness	**Improvements:** • Improved the W30 (0-15 months) HEDIS rate by 3.7 percentage points from MY 2022 to MY 2023. • Improved the W30 (15-30 months) HEDIS rate by three percentage points from MY 2022 to MY 2023.	↑
Quality	**Recommendations:** • Identify and address root causes for barriers impacting desired improvement outcomes. Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions.	↓
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality Timeliness	**Strengths:** ***MetaStar observed the following strengths:*** • Extremely responsive to auditor requests. JMS' HEDIS team served as subject matter experts for all organization functions, was dedicated to ensuring successful reporting, and provided information/documentation in a timely manner. There was robust oversight of data used for HEDIS reporting. • Completed many HEDIS milestones prior to deadlines, which assisted in ensuring a complete reporting well prior to the HEDIS submission deadlines.	↑
Quality Access	**Improvements:** ***MetaStar observed the following improvements:*** • Expanded the number of supplemental data sources used for MY 2023 reporting. This included the lead registry data and the Optum behavioral health claims data from the State of Maryland. Added additional data components for sources, such as CRISP lab data and Mastermind immunizations data. • Incorporated behavioral health pharmacy data from the MDH as encounter data.	↑
Quality Access	**Recommendations:** ***MetaStar recommends the following actions:***	↓

Domain	JMS Strengths, Improvements, and Recommendations	Assessment
	• Investigate data sources to enable the reporting of other electronic clinical data systems (ECDS) measures. JMS continued to report the required ECDS measures, BCS-E, PRS-E, and AIS-E measure. • Continue to explore additional supplemental data sources for future reporting periods. This includes obtaining and incorporating electronic medical record data from various provider groups and Data Aggregator Validation sources as supplemental data. Such data sources would reduce the burden of MRR and possibly improve data completeness.	
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑,↓, or NA**
Quality, Access, and Timeliness	**Strengths:** ***CSS observed the following strengths:*** • Three measures performed in the top third decile for the adult CAHPS survey. • *Rating of Personal Doctor* achieved the highest score for the adult CAHPS survey. • Identified by CSS as one of the best performing MCOs, with six of the highest-scoring non-CCC measures and one of the highest-scoring CCC measures (*Getting Needed Information*) for the child CAHPS survey. • One non-CCC measure (*Customer Service*) scored in the top decile, which no other MCO achieved for the child CAHPS survey. • *Getting Care Quickly* performed statistically significantly higher than the HealthChoice Aggregate for the child CAHPS survey.	↑
Quality, Access	**Improvements:** ***CSS observed the following improvements:*** • *Rating of All Health Care* saw statistically significant performance gains from the previous measurement year for the adult CAHPS survey. CFCHP is one of three MCOs to achieve this improvement. • JMS did not demonstrate formal improvement form the previous measurement year for the child CAHPS survey.	↑
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no formal recommendations for JMS for either the adult or child CAHPS survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑,↓, or NA**
NA	**Strengths:** • JMS did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:** • JMS did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:**	NA

Domain	JMS Strengths, Improvements, and Recommendations	Assessment
	• There are no formal recommendations for JMS.	
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Component 5.1a was the only standard with a *Met with Opportunity* finding requiring review for MY 2023 interim desktop review. • Demonstrated the ability to design and implement an effective quality assurance system. The MY 2023 interim desktop review provided evidence of JMS' continuous commitment to ensuring quality healthcare delivery for its enrollees.	↑
Quality, Timeliness	**Improvements:** • Met requirements for 5.1a by revising its Member Grievance and Appeal Policy as recommended in the MY 2022 interim desktop review. • Revised the Enrollee Grievance and Appeal Policy to specify that enrollee written grievance acknowledgments may be waived if "the MCO resolves the grievance within five calendar days or within the regulatory requirement, whichever is less."	↑
NA	**Recommendations:** • There are no formal recommendations for JMS.	NA
Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved a confidence level of *High Confidence* for validation of all Provider-to-Enrollee Ratio indicators. • Achieved a confidence level of *High Confidence* for all Time and Distance Standards indicators.	↑
NA	**Improvements:** • JMS did not demonstrate improvement from the previous measurement year, as MY 2023 is the first year of implementation of the CMS Validation of Network Adequacy Protocol 4.	NA
Quality, Access, and Timeliness	**Recommendations:** • Continue to work towards setting ratio goals to meet COMAR regulations. Expand geographic monitoring to enrollees in designated rural areas.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Scores for compliance with routine and urgent care appointment timeframes exceeded the 80% threshold.	↑
Quality, Access	**Improvements:**	↑

Domain	JMS Strengths, Improvements, and Recommendations	Assessment
	• Improved the accuracy of accepting new Medicaid patients after implementing corrective action for MY 2023.	
NA	**Recommendations:** • There are no formal recommendations for JMS.	NA
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • JMS' encounter and code type match rates exceeded the minimum compliance standard of 90%.	↑
NA	**Improvements:** • JMS did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for JMS.	NA
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved a total composite score of 97% for MY 2023, exceeding the HealthChoice Aggregate composite score of 93%. • Met or exceeded the MDH-established minimum compliance threshold (80%) for all five component areas. • Exceeded the MDH-established minimum compliance threshold (80%) and the HealthChoice Aggregate scores for all elements comprising the *Health and Developmental History* component. • All of the elements exceeded the MDH-established minimum compliance threshold (80%) and the HealthChoice Aggregate scores in all elements comprising the *Comprehensive Physical Exam* component. Compared to MY 2022, JMS sustained performance in all 14 elements. • All of the elements exceeded the MDH-established minimum compliance threshold (80%) and the HealthChoice Aggregate scores comprising the *Health Education/Anticipatory Guidance* component.	↑
NA	**Improvements:** • JMS did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access, and Timeliness	**Recommendations:** • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the Healthy Kids webpage and the last two pages in the EPSDT Orientation Manuals published on the MCO resource site. • Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule.	↓

Domain	JMS Strengths, Improvements, and Recommendations	Assessment
	• Work with provider offices to implement protocols for appropriate documentation of physician recommendations and/or refusals of immunizations from the patient or guardian. • Continue to educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion.	
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality	**Strengths:** • Maintained MY 2023's star rating in Doctor Communication and Service, Keeping Kids Healthy, Taking Care of Women, Keeping Adults Healthy.	↑
Quality, Access	**Improvements:** • Improved MY 2023's star rating in Access to Care.	↑
NA	**Recommendations:** • There are no formal recommendations for CFCHP.	NA
Quality, Access, and/or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Appropriately categorized and resolved all grievances. • Consistently exceeded compliance thresholds for timeliness of grievance resolution and grievance resolution notifications. • Consistently exceeded compliance thresholds for timeliness of appeal acknowledgment and resolution notifications. • Consistently exceeded compliance thresholds for timeliness of pre-service determinations, prescriber notifications, and adverse determination notifications.	↑
NA	**Improvements:** • JMS did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Timeliness	**Recommendations:** • Routinely audit case notes for documentation of reasonable attempt to provide enrollee with oral notice of expedited appeal resolution. • Retrain staff as there is no "urgent" category for covered outpatient drug preauthorization requests. All covered outpatient drug preauthorization requests are subject to the same requirements.	↓

Table 136. KPMAS Strengths, Improvements, and Recommendations

Domain	KPMAS Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Acheived a confidence level of *High Confidence* for the Prenatal Care PIP and *Confidence* for the Postpartum Care-Related PIP. • Continued to enhance efforts towards a health equity focus. • Conducted a disparity analysis stratified by race/ethnicity. • Reviewed data on a quarterly basis.	↑
Quality, Access, and Timeliness	**Improvements:** • Improved the Prenatal Care HEDIS rate by 5.8 percentage points from MY 2022 to MY 2023. • Improved the Postpartum Care HEDIS rate by four percentage points from MY 2022 to MY 2023. • Improved the W30 (15-30 months) HEDIS rate by 1.2 percentage points from MY 2022 to MY 2023.	↑
Quality, Timeliness	**Recommendations:** • Clearly identify, define, and provide time-specifications for PIP variables. • Clearly identify the special populations utilized to address each PIP topic. • Ensure comparability between each MY by following the same methodology for sampling versus studying an entire population. • Include enrollee, provider, and MCO barriers related to each PIP topic, interventions, and the identified disparate population. • Identify and address root causes for barriers impacting desired improvement outcomes. Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions.	↓
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** ***MetaStar observed the following strengths:*** • Reported valid rates for all relevant measures to meet accreditation and MDH-reporting requirements. • Maintained race and ethnicity data and methodology for mapping to meet NCQA requirements. KPMAS continued to capture race and ethnicity data at a high rate of completion from enrollee direct sources. • Conducted internal data analysis on the MDH-provided behavioral health pharmacy data file, which identified some data integrity concerns, and coordinated with both MDH and MDH's vendor related to findings to improve the accuracy of the data file in the future.	↑
NA	**Improvements:**	NA

Domain	KPMAS Strengths, Improvements, and Recommendations	Assessment
	MetaStar observed the following improvements: • KPMAS did not demonstrate formal improvement from the previous measurement year.	
Quality	**Recommendations:** ***MetaStar recommends the following actions:*** • Explore workflows to integrate data to support the Social Need Screening and Intervention measures for future year reporting.	↓
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑,↓, or NA**
Quality, Access	**Strengths:** ***CSS observed the following strengths:*** • One of two MCOs to have one measure (*Coordination of Care*) score in the top decile for the adult CAHPS survey. KPMAS' score was also the highest score for this measure among all MCOs. • Scored above all MCOs for *Access to Prescription Medicines* for the child CAHPS survey.	↑
Quality, Access	**Improvements:** ***CSS observed the following improvements:*** • One of three MCOs to see statistically significant performance gains from the previous measurement year for the adult CAHPS survey. For KPMAS, this measure was *Coordination of Care*. • KPMAS did not demonstrate formal improvement from the previous measurement year for the child CAHPS survey.	↑
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no formal recommendations for KPMAS for either the adult or child CAHPS survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑,↓, or NA**
NA	**Strengths:** • KPMAS did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:** • KPMAS did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for KPMAS.	NA
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality, Access	**Strengths:**	↑

Domain	KPMAS Strengths, Improvements, and Recommendations	Assessment
	• Demonstrated the ability to design and implement effective quality assurance systems. The MY 2023 interim desktop review provided evidence of KPMAS' continuous commitment to ensuring quality healthcare delivery for its enrollees.	
Quality, Timeliness	**Improvements:** • Received a finding of *Met* for standards 5.1, 7.4, 7.7, and 7.9 for the MY 2023 interim desktop review. • Achieved compliance with timeframes for grievance acknowledgment and resolution, at or above the MDH threshold (95%), on at least a quarterly basis for all four quarters of the review period. • Achieved compliance with written grievance resolution timeframes, at or above the MDH threshold (95%), on at least a quarterly basis for all four quarters of the review period. • Achieved compliance with determination timeframes in response to preauthorization requests, at or above the MDH threshold (95%), on at least a quarterly basis for all four quarters of the review period. • Achieved compliance with written appeal acknowledgment and written appeal resolution notification timeframes, at or above the MDH threshold (95%), on at least a quarterly basis for all four quarters of the review period. • Regional Utilization Management Committee meeting minutes demonstrated KPMAS acts upon identified issues from the CAHPS® and Provider Satisfaction surveys that specifically target opportunities for improvement in utilization management measure results.	↑
Quality, Access, and Timeliness	**Recommendations:** • Demonstrate compliance with written acknowledgment of provider appeals at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. • Provide a brief summary of MD HealthChoice grievance trends and opportunities rather than just noting a document was approved containing this information in the Regional Quality Improvement Committee meeting minutes. • Develop specific quantifiable goals that address access to care and getting needed care to determine the success of its initiatives. This could include interim surveys of enrollees and providers outside of the annual MDH coordinated surveys and regular monitoring of specific timeframes for referral processing to assess for improvement.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved a confidence level of *High Confidence* for validation of all Provider-to-Enrollee Ratio indicators. • Achieved a confidence level of *High Confidence* for all Time and Distance Standards indicators.	↑
NA	**Improvements:**	NA

Domain	KPMAS Strengths, Improvements, and Recommendations	Assessment
	• KPMAS did not demonstrate formal improvement from the previous measurement year, as MY 2023 is the first year of implementation of the CMS Validation of Network Adequacy Protocol 4.	
Quality, Access, and Timeliness	**Recommendations:** • Increase monitoring activity to include provider-to-enrollee ratios for core, major, and pediatric specialties.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Significantly improved compliance with routine care appointment timeframes by 16.7 percentage points after implementing corrective action for MY 2023.	↑
Quality, Access, and Timeliness	**Improvements:** • Improved performance for urgent care appointment timeframes from MY 2023; however, note that despite the improvement the score for urgent care appointment timeframes was 0.7% below the 80% minimum compliance threshold established by MDH and thus required a CAP.	↑
Quality, Access, and Timeliness	**Recommendations:** • ***CAP***: **KPMAS must submit a CAP to achieve compliance in MY 2025:** ○ Identify and address the root causes for the decline in performance and address the identified issues to improve performance. Ensure provider offices are able to accommodate requirements for urgent care appointment scheduling within 48 hours of the call date at the same location with either the requested provider, an alternate provider, or telemedicine. Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory through provider staff education. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.	↓
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • KPMAS' encounter and code type match rates exceeded the minimum compliance standard (90%).	↑
NA	**Improvements:** • KPMAS did not demonstrate formal improvement from the previous measurement year.	NA
Quality	**Recommendations:** • Identify and address root causes for the decline in performance to ensure office visit match rates remain above the minimum compliance standard. KPMAS has had a steady decline in performance for office visit encounter match rates from MY 2021 (100%) to MY 2023 (97%).	↓
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**

Domain	KPMAS Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and Timeliness	**Strengths:** • Displayed a MY 2023 total composite score of 97%, which exceeds the HealthChoice Aggregate composite score of 93%. • Exceeded the MDH-established minimum compliance threshold (80%) for all five component areas. • All of the elements comprising the *Comprehensive Physical Exam* component exceeded the MDH-established minimum compliance threshold (80%). Met or exceeded the HealthChoice Aggregate scores in 12 of the 14 elements. • Met or exceeded the MDH-established minimum compliance threshold (80%) for 15 of the 16 elements comprising the *Laboratory Tests/At-Risk Screenings* component. Met or exceeded HealthChoice Aggregate scores in 14 of the 16 elements. • Exceeded the MDH-established minimum compliance threshold (80%) in all 14 elements comprising the *Immunizations* component. Met or exceeded the HealthChoice Aggregate scores in all 14 elements. • All of the *Health Education/Anticipatory Guidance* elements exceeded the MDH-established minimum compliance threshold (80%) and the HealthChoice Aggregate scores.	↑
NA	**Improvements:** • KPMAS did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access, and Timeliness	**Recommendations:** • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the Healthy Kids webpage and the last two pages in the EPSDT Orientation Manuals published on the MCO resource site. • Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule. • Work with provider offices to implement protocols for appropriate documentation of physician recommendations and/or refusals of immunizations from the patient or guardian. • Continue to educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion.	↓
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality, Access	**Strengths:** • Maintained MY 2023's star rating in Keeping Kids Healthy, Taking Care of Women, and Keeping Adults Healthy.	↑
NA	**Improvements:** • KPMAS did not demonstrate formal improvement in star ratings from the previous measurement year.	NA

Domain	KPMAS Strengths, Improvements, and Recommendations	Assessment
NA	**Recommendations:** • There are no formal recommendations for KPMAS.	NA
Quality, Access, and/or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Appropriately categorized and resolved all grievances. • In records, consistently exceeded compliance thresholds for timeliness of grievance resolution and grievance resolution notifications. • Consistently exceeded compliance thresholds for timeliness of appeal acknowledgment and resolution notifications. • Consistently exceeded compliance thresholds for timeliness of pre-service determinations and adverse determination notifications.	↑
Quality, Timeliness	**Improvements:** • Consistent compliance with expedited appeal resolution notification timeframe. • Consistent compliance with notifying enrollees orally and in writing of the denial of a request for an expedited resolution. • Consistent compliance with pre-service determination timeframes.	↑
Quality, Timeliness	**Recommendations:** • Review the 12 emergency medically related grievance cases from MY 2023 to determine what processes are delaying the resolution turnaround time. • Routinely review appeal resolution letters to ensure language is consistent with the HealthChoice program.	↓

Table 137. MPC Strengths, Improvements, and Recommendations

Domain	MPC Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *High Confidence* for both PIP topics. • Continued to enhance efforts towards a health equity focus. • Conducted a disparity analysis stratified by race/ethnicity for each strategy. • Reviewed data on a quarterly basis.	↑
Quality, Access, and Timeliness	**Improvements:** • Improved the Prenatal Care HEDIS rate by 2.4 percentage points from MY 2022 to MY 2023. • Improved the W30 (15-30 months) HEDIS rate by 1.1 percentage points from MY 2022 to MY 2023.	↑

Domain	MPC Strengths, Improvements, and Recommendations	Assessment
Quality	**Recommendations:** • Identify and address the root cause for barriers impacting desired improvement outcomes. Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions.	↓
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality, Access	**Strengths:** ***MetaStar observed the following strengths:*** • Reported valid rates for all relevant measures to meet accreditation and MDH-reporting requirements. • Knowledgeable and skilled staff dedicated to support the HEDIS project, which helps to maximize performance measure rates. • Maintained race and ethnicity data and methodology for mapping to meet NCQA requirements. • Integrated behavioral health pharmacy claims data from MDH's vendor related to carve-out services per MDH's direction. • Developed methodology to identify dual-eligible enrollees and exclude them from reporting, which is consistent with NCQA guidelines and results in more accurate performance measure rates. • Successfully identified and mapped some point-of-service immunizations to improve data capture for the Adult Immunization Status (AIS-E) measure.	↑
NA	**Improvements:** ***MetaStar observed the following improvements:*** • MPC did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access	**Recommendations:** ***MetaStar recommends the following actions:*** • Explore workflows to integrate data to support the Social Need Screening and Intervention measures for future year reporting. There were no concerns with MY 2023 reported rates.	↓
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑, ↓, or NA**
Quality	**Strengths:** ***CSS observed the following strengths:*** • Three measures performed in the top third decile, with one measure (*Rating of Specialist Seen Most Often*) being the highest of all MCOs for the adult CAHPS survey. • Identified by CSS as the top-scoring MCO for the *Personal Doctor Who Knows Child* measure for the child CAHPS survey.	↑
Quality	**Improvements:**	↑

Domain	MPC Strengths, Improvements, and Recommendations	Assessment
	CSS observed the following improvements: • One of three MCOs to see statistically significant performance gains from the previous measurement year for the adult CAHPS survey. For MPC, this measure was *Rating of Specialist Seen Most Often*. • MPC did not demonstrate formal improvement from the previous measurement year for the child CAHPS survey.	
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no formal recommendations for MPC for either the adult or child CAHPS survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑, ↓, or NA**
NA	**Strengths:** • MPC did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:** • MCP did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for MPC.	NA
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality	**Strengths:** • Demonstrated the ability to design and implement effective quality assurance systems. The MY 2023 interim desktop review provided evidence of MPC's continuous commitment to ensuring quality healthcare delivery for its enrollees.	↑
Quality, Timeliness	**Improvements:** • Received a finding of *Met* for standards 4.4 and 7.4 for the MY 2023 interim desktop review. • In a review of ten initial credentialing records, all ten demonstrated compliance with the required turnaround time for processing the credentialing application in less than or equal to 150 days from receipt of the application. • In a review of ten initial credentialing records, all ten included the 30-day notice to inform the practitioner of the intent to move forward with the initial credentialing process. • Compliance with 24-hour prescriber notification exceeded the 95% threshold for all four quarters of the measurement year.	↑
Quality, Timeliness	**Recommendations:** • Demonstrate compliance with the timeframe for written expedited appeal resolutions within the MDH threshold (95%) for each quarter of the review period.	↓

Domain	MPC Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved confidence levels of *High Confidence* and *Moderate Confidence* for validation of all Provider-to-Enrollee Ratio indicators. • Achieved confidence levels of *High Confidence* and *Moderate Confidence* for all Time and Distance Standards indicators.	↑
NA	**Improvements:** • MPC did not demonstrate formal improvement from the previous measurement year, as MY 2023 is the first year of implementation of the CMS Validation of Network Adequacy Protocol 4.	NA
Quality, Access	**Recommendations:** • Expand monitoring activity to include the pediatric population in specialty areas where there is not a pediatric provider (e.g. major specialties).	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑. ↓, or NA**
Quality, Access	**Strengths:** • Improved or maintained all "Accuracy of PCP information" components from MY 2023 to MY 2024.	↑
Quality, Access, and Timeliness	**Improvements:** • MPC's compliance with routine and urgent care appointment timeframes exceeded the 80% threshold. • All online provider directory validations were comparable to MY 2023 and have exceeded the 80% threshold.	↑
NA	**Recommendations:** • There are no formal recommendations for MPC.	NA
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • MPC's encounter type match rates exceeded the minimum compliance standard of 90%.	↑
NA	**Improvements:** • MPC did not demonstrate formal improvement from the previous measurement year.	NA
Quality	**Recommendations:** • Identify and address root causes for the decline in performance to ensure inpatient match rates remain above the minimum compliance standard. MPC's match rates for inpatient procedure codes (88%) fell below the minimum compliance standard.	↓

Domain	MPC Strengths, Improvements, and Recommendations	Assessment
	• Identify and address root causes for the steady decline in performance to ensure office visit match rates remain above the minimum compliance standard. MPC has had a steady decline in performance for office visit match rates from MY 2021 (100%) to MY 2023 (94%).	
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved a MY 2023 total composite score of 92%, which is one percentage point lower than the HealthChoice Aggregate composite score of 93%. • Met or exceeded the MDH-established minimum compliance threshold (80%) in four out of the five component areas. • Nine of the 11 elements comprising the *Health and Developmental History* component exceeded the MDH-established minimum compliance threshold (80%). • All of the elements comprising the *Comprehensive Physical Exam* component exceeded the MDH-established minimum compliance threshold (80%). • Displayed the most significant improvement, compared to MY 2022, with an increase of 33 percentage points for the HIV Test per Schedule (100%) element in the *Laboratory Tests/At-Risk Screenings* component. • Met or exceeded the MDH-established minimum compliance threshold (80%) for 13 of the 14 elements comprising the *Immunizations* component. • All of the elements comprising the *Health Education/Anticipatory Guidance* component exceeded the MDH-established compliance threshold (80%) for MY 2023.	↑
NA	**Improvements:** • MPC did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access, and Timeliness	**Recommendations:** • Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule and that immunizations documented in Immunet match the provider office documentation. • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the Healthy Kids webpage and the last two pages in the EPSDT Orientation Manuals published on the MCO resource site. • Ensure providers have a copy of the Healthy Kids Provider Manual and specifically have a full understanding of Section 3: Healthy Kids/EPSDT Screening Components, Part C. Laboratory Tests that begin on page 50.	↓

Domain	MPC Strengths, Improvements, and Recommendations	Assessment
	• Educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion. • Collaborate with the assigned state Healthy Kids/EPSDT Nurses to assist in re-educating providers and supporting staff on current standards of preventive health care. • Conduct a root cause analysis for the *Laboratory Tests/At-Risk Screenings* component to identify causes for the decline in performance and overcome barriers to meeting compliance in MY 2024.	
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality, Access	**Strengths:** • Maintained MY 2023's star rating in Access to Care, Care for Kids with Chronic Illness, and Taking Care of Women.	↑
Quality, Access	**Improvements:** • Improved MY 2023's star rating in Doctor Communication and Service and Keeping Adults Healthy.	↑
NA	**Recommendations:** • There are no formal recommendations for MPC.	NA
Quality, Access, and/or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Appropriately categorized and resolved all grievances. • Consistently exceeded compliance thresholds for timeliness of grievance resolution and grievance resolution notification. • Consistently exceeded compliance thresholds for timeliness of appeal acknowledgment and resolution notifications in record review. • Consistently exceeded compliance thresholds for timeliness of pre-service determinations and adverse determination notifications. • Excellent use of easy-to-understand language in adverse determination notifications.	↑
NA	**Improvements:** • Could not be determined as no expedited appeals or outpatient pharmacy requests for preauthorization were included in the sample of records reviewed.	NA
Quality, Timeliness	**Recommendations:** • Request written follow-up from Provider Relations regarding results of investigation to close the loop when referring an enrollee grievance to Provider Relations for investigation. • Retrain G & A staff on requirement for documenting in case notes reasonable attempt to provide enrollee with oral notice of denial of an expedited request. Due to the large number of expedited requests being	↓

Domain	MPC Strengths, Improvements, and Recommendations	Assessment
	denied due to failure to meet criteria consider educating providers on criteria for expedited review through blast fax and/or provider newsletter.	

Table 138. MSFC Strengths, Improvements, and Recommendations

Domain	MSFC Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *High Confidence* for both PIP topics. • Continued to enhance efforts towards a health equity focus. • Conducted a disparity analysis stratified by race/ethnicity for each strategy. • Reviewed data on a quarterly basis.	↑
Quality, Access, and Timeliness	**Improvements:** • Improved the W30 (15-30 months) HEDIS rate by three percentage points from MY 2022 to MY 2023.	↑
Quality	**Recommendations:** • Identify and address root causes for barriers impacting desired improvement outcomes.Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions.	↓
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** ***MetaStar observed the following strengths:*** • Provided a standardized and well-documented MY 2023 HEDIS Roadmap on time, which greatly facilitated both the offsite and virtual onsite phases of the HEDIS Compliance Audit. No issues were identified with completion of the Roadmap General Information or Appendix sections. • Utilized a software vendor with NCQA-certified measures. The auditor confirmed via the IDSS that the certified version of the software was used for each measure by ensuring the IDSS did not produce any warnings regarding the globally unique identifiers. There were no Tier 4 warnings identified by NCQA.	↑
Quality	**Improvements:** ***MetaStar observed the following improvements:*** • Captured race and ethnicity through the MDH enrollment files, an incomplete process in MY 2022. Previously, MSFC was encouraged to work with MDH to capture more complete race and ethnicity data. MDH began requiring enrollees to complete race and ethnicity on enrollment forms. This requirement has resulted in improvement on the amount of data captured and provided on race and ethnicity.	↑

Domain	MSFC Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and Timeliness	**Recommendations:** ***MetaStar recommends the following actions:*** • Have appropriate staffing for future reporting to ensure all tasks are completed properly and timelines are met. Experienced HEDIS staff left in February, resulting in a breakdown in MSFC's reporting process, missed deadlines, critical errors in MRR abstraction, and relatively new staff responsible for critical tasks. These issues almost resulted in determining measures unreportable. • Track quality improvement projects and identify issues and improvements for future reporting. The auditor solicited further explanations as needed for rates above the 90th percentiles or below the 10th percentiles, or rates that changed by more than five percentage points from the prior year. With the previously mentioned exodus of HEDIS-experienced staff, MSFC's remaining staff member attempted to determine reasons for rate changes and many reasons appeared unknown. • Continue working with MDH to obtain better race and ethnicity data. Race and ethnicity data appeared better than in prior years; however, there were still enrollees with unknown race and ethnicity.	↓
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** **CSS observed the following strengths:** • Identified by CSS as the best performing MCO, with top scores on three of ten measures, for the adult CAHPS survey. Measures included in this observation were: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. • No scores performed in the bottom decile for the adult CAHPS survey. • MSFC did not demonstrate any strengths in performance in for the child CAHPS survey.	↑
NA	**Improvements:** **CSS observed the following improvements:** • MSFC did not demonstrate formal improvement from the previous measurement year for either the adult or child CAHPS survey.	NA
NA	**Recommendations:** **CSS recommends the following actions:** • There are no formal recommendations for MSFC for either the adult or child CAHPS survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑,↓, or NA**
NA	**Strengths:** • MSFC did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:**	NA

Domain	MSFC Strengths, Improvements, and Recommendations	Assessment
	• MSFC did not demonstrate formal improvement from the previous measurement year.	
NA	**Recommendations:** • There are no formal recommendations for MSFC.	NA
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality	**Strengths:** • Demonstrated the ability to design and implement effective quality assurance systems. The MY 2023 interim desktop review provided evidence of MSFC's continuous commitment to ensuring quality healthcare delivery for its enrollees.	↑
Quality, TImeliness	**Improvements:** • Received a finding of *Met* for standards 7.7 and 9.5 for the MY 2023 interim desktop review. • Compliance with appeal resolution notification timeframes exceeded MDH's threshold (95%) for all four quarters of the MY. • Submitted several examples of formal evaluations of health education programs completed by individual enrollees.	↑
NA	**Recommendations:** • There are no formal recommendations for MSFC.	NA
Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved a confidence level of *High Confidence* for validation of all Provider-to-Enrollee Ratio indicators. • Achieved a confidence level of *High Confidence* for all Time and Distance Standards indicators.	↑
NA	**Improvements:** • MSFC did not demonstrate formal improvement from the previous measurement year, as MY 2023 isthe first year of implementation of the CMS Validation of Network Adequacy Protocol 4.	NA
Quality, Access, and Timeliness	**Recommendations:** • Increase monitoring activity to include provider-to-enrollee ratios for core, major, and pediatric specialties.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Exceeded the minimum compliance timeframe for routine and urgent care appointments. • MSFC's scores for online provider validations all exceeded the 80% threshold.	↑
NA	**Improvements:** • MSFC did not demonstrate formal improvement from the previous measurement year.	NA

Domain	MSFC Strengths, Improvements, and Recommendations	Assessment
NA	**Recommendations:** • There are no formal recommendations for MSFC.	NA
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • MSFC's encounter and code type match rates exceeded the minimum compliance standard of 90%.	↑
NA	**Improvements:** • MSFC did not demonstrate formal improvement from the previous measurement year.	NA
Quality	**Recommendations:** • Complete internal audits to ensure the coding issue identified in the root cause for the invalid records has been corrected. • Identify and address root causes for the steady decline in performance to ensure inpatient match rates remain above the minimum compliance standard. MSFC has had a steady decline in performance for inpatient match rates from MY 2021 (100%) to MY 2023 (98%). • Identify and address root causes for the steady decline in performance to ensure office visit match rates remain above the minimum compliance standard. MSFC has had a steady decline in performance for office visit match rates from MY 2021 (100%) to MY 2023 (95%).	↓
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved a MY 2023 total composite score of 90%, which is three percentage points lower than the HealthChoice Aggregate composite score of 93%. • Exceeded the MDH-established minimum compliance threshold (80%) for four out of the five component areas. • Nine of the 11 elements comprising the *Health and Developmental History* component exceeded the MDH-established minimum compliance threshold (80%). • All of the elements comprising the *Comprehensive Physical Exam* component exceeded the MDH-established minimum compliance threshold (80%). • Met or exceeded the MDH-established minimum compliance threshold (80%) for 12 of the 14 elements comprising the *Immunizations* component.	↑
NA	**Improvements:** • MSFC did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access, and Timeliness	**Recommendations:**	↓

Domain	MSFC Strengths, Improvements, and Recommendations	Assessment
	• Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule and that immunizations documented in Immunet match the provider office documentation. • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the Healthy Kids webpage and the last two pages in the EPSDT Orientation Manuals published on the MCO resource site. • Ensure providers have a copy of the Healthy Kids Provider Manual and specifically have a full understanding of Section 3: Healthy Kids/EPSDT Screening Components, Part C. Laboratory Tests that begin on page 50. • Educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion. • Collaborate with the assigned state Healthy Kids/EPSDT Nurses to assist in re-educating providers and supporting staff on current standards of preventive health care. • Identify and address root causes for the *Laboratory Tests/At-Risk Screenings* component to identify causes for the decline in performance and overcome barriers to meeting compliance in MY 2024.	
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality, Access	**Strengths:** • Maintained MY 2023's star rating in Access to Care, Care for Kids with Chronic Illness, and Taking Care of Women.	↑
NA	**Improvements:** • MSFC did not demonstrate formal improvement in star ratings from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for MSFC.	NA
Quality, Access, and/or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Provided clear understanding of performance variances from quarter to quarter. • Appropriately categorized and resolved all grievances. • Consistently exceeded compliance threshold for timeliness of grievance resolution and grievance resolution notifications. • Consistently exceeded compliance threshold for timeliness of appeal acknowledgment and resolution notifications and provides enrollee with oral notification of an expedited appeal resolution.	↑

Domain	MSFC Strengths, Improvements, and Recommendations	Assessment
	• Consistently exceeded compliance threshold for timeliness of pre-service determinations, prescriber notifications, and adverse determination notifications. • Best practice in use of easy-to-understand language for even common terms such as authorization (permission) and denied (not approved) in adverse determination and appeal resolution notifications.	
NA	**Improvements:** • Could not be determined as there were no non-emergency medically related grievances included in the sample of records reviewed.	NA
Quality	**Recommendations:** • Retrain staff as there is no "urgent" category for covered outpatient drug preauthorization requests. All covered outpatient drug preauthorization requests are subject to the same requirements.	↓

Table 139. PPMCO Strengths, Improvements, and Recommendations

Domain	PPMCO Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *High Confidence* for both PIP topics. • Continued to demonstrate and enhance efforts towards the health equity focus. • Conducted a disparity analysis stratified by race/ethnicity data for each strategy. • Reviewed data on a quarterly basis.	↑
Quality, Access, and Timeliness	**Improvements:** • Improved the Childhood Immunization Status HEDIS rate by 1.4 percentage points from MY 2022 to MY 2023.	↑
Quality	**Recommendations:** • Identify and address root causes for barriers impacting desired improvement outcomes. Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions. • Provide correct statistical significance testing calculations, preferably utilizing a z-score formula.	↓
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** ***MetaStar observed the following strengths:*** • Continued to manage well the processes with PPMCO's transactional systems to ensure all data were appropriately incorporated for HEDIS reporting. MY 2023 was the first full year in the new systems.	↑

Domain	PPMCO Strengths, Improvements, and Recommendations	Assessment
	• Provided all required and requested documentation in a timely manner. PPMCO's HEDIS team was dedicated to ensuring successful reporting and maintained robust oversight of data processes involved in HEDIS reporting.	
Quality, Access	**Improvements:** ***MetaStar observed the following improvements:*** • Incorporated the behavioral health pharmacy data provided by MDH. This helped to augment rates for MY 2023 reporting.	↑
Quality, Access	**Recommendations:** ***MetaStar recommends the following actions:*** • Investigate and incorporate additional supplemental data sources for future reporting periods, including sources such as the health information exchange data. Such data sources would reduce the burden of MRRs and possibly improve data completeness. • Separate supplemental data sources from electronic medical record (EMR) data sources for lead/immunization data. Ensure all applicable sources are detailed and their processes noted in the Roadmap, as this is needed to review and approve all sources for the EMR data source. PPMCO will need to provide a separate Section 5 in future years. • Provide a list of cases for either all abstracted data or based on the eligible population in future years, not just for the non-standard supplemental data source. PPMCO provided a list of cases based on events determined to be positive events for the hybrid sample for the primary source review.	↓
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** ***CSS observed the following strengths:*** • PPMCO did not demonstrate any strengths in performance for the adult CAHPS survey. • Identified by CSS as the best-performing MCO, as the only plan with all measures scoring in the middle third or higher decile for the child CAHPS survey. The *Coordination of Care for Children with Chronic Conditions* measure scored in the top decile. • *Rating of All Health Care* scored in the top third decile for the child CAHPS survey. • Two measures saw a three-year positive trend for the child CAHPS survey. • PPMCO also scored the highest for the *Coordination of Care for Children With Chronic Conditions* measure, compared to all MCOs for the child CAHPS survey.	↑
NA	**Improvements:** ***CSS observed the following improvements:***	NA

Domain	PPMCO Strengths, Improvements, and Recommendations	Assessment
	• PPMCO did not demonstrate formal improvement from the previous measurement year for the adult or child CAHPS survey.	
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no formal recommendations for PPMCO for either the adult or child CAHPS survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑, ↓, or NA**
NA	**Strengths:** • PPMCO did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:** • PPMCO did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for PPMCO.	NA
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality	**Strengths:** • Demonstrated the ability to design and implement effective quality assurance systems. The MY 2023 interim desktop review provided evidence of PPMCO's continuous commitment to ensuring quality healthcare delivery for its enrollees. • Demonstrated an effective strategy for enlisting providers to refer enrollees who could benefit from one of the many health education programs it offers.	↑
Quality, Access, and Timeliness	**Improvements:** • Received a finding of *Met* for standards 5.8, 7.4, 7.5, 7.7, 9.3, 9.4, 9.5, and 10.1 for the MY 2023 interim desktop review. • Requirements set forth in COMAR relating to electronic information provided to enrollees were met based on the MCO's Digital Communications Policy and screenshots of its 508-compliant website. • Compliance with preauthorization determination and prescriber notification timeframes exceeded the 95% threshold established by MDH throughout the MY. • Revised the Clinical and Administrative Denial Policy to state the correct filing timeframe as "within 60 calendar days from the date of the adverse determination notice." • Compliance with appeal acknowledgment and resolution/notification timeframes exceeded the 95% threshold established by MDH throughout the MY. • A sample review of case records demonstrated a reasonable attempt to provide the enrollee with prompt verbal notice of the denial of a request for an expedited appeal resolution.	↑

Domain	PPMCO Strengths, Improvements, and Recommendations	Assessment
	• Revised the Priority Partners Enrollee Appeals Policy to eliminate the requirement for written confirmation of an oral appeal request. • Multiple listings of provider referrals of enrollees in need of education on various health topics demonstrated providers are well informed of the availability and contact information for accessing a health educator/educational program for enrollees. • Mechanisms are in place and functioning effectively to identify enrollees in special need of educational efforts based upon several case examples. • The 2023 Outreach Workplan includes the total number of enrollees by category comprising each of the special needs and postpartum populations.	
Quality	**Recommendations:** • Develop strategies to increase participation in the many health education programs it offers. According to PPMCO, a total of 939 enrollees registered for these programs while only 21% (194) attended in 2023.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *High Confidence* for validation of all Provider-to-Enrollee Ratio indicators. • Achieved a confidence level of *High Confidence* for all Time and Distance Standards indicators.	↑
NA	**Improvements:** • PPMCO did not demonstrate formal improvement from the previous measurement year, as MY 2023 is the first year of implementation of CMS' Validation of Network Adequacy Protocol 4.	NA
Quality	**Recommendations:** • Report monitoring activity by provider type for pediatric subspecialties.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Compliance with routine and urgent care appointment timeframes exceeded the 80% threshold. • All online provider directory validations exceeded the 80% threshold.	↑
Quality, Access	**Improvements:** • Improved the accuracy of accepting new Medicaid patients and PCPs specifying if accommodations for patients with disabilities are available after implementing corrective action for MY 2023.	↑
NA	**Recommendations:** • There are no formal recommendations for PPMCO.	NA
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**

Domain	PPMCO Strengths, Improvements, and Recommendations	Assessment
Quality	**Strengths:** • PPMCO's encounter and code type match rates exceeded the minimum compliance standard (90%).	↑
NA	**Improvements:** • PPMCO did not demonstrate formal improvement from the previous measurement year.	NA
Quality	**Recommendations:** • Identify and address root causes for performance to ensure outpatient match rates remain above the minimum compliance standard. PPMCO's match rates for outpatient procedure codes just met the minimum compliance standard of 90% for MY 2023. • Identify and address root causes for the decline in performance to ensure outpatient match rates remain above the minimum compliance standard. PPMCO has had a steady decline in performance for outpatient match rates from MY 2021 (99%) to MY 2023 (94%). • Identify and address root causes for the decline in performance to ensure office visit match rates remain above the minimum compliance standard. PPMCO has had a steady decline in performance for office visit match rates from MY 2021 (99%) to MY 2023 (96%).	↓
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Displayed a MY 2023 total composite score of 93%, which equals the HealthChoice Aggregate composite score. • Met or exceeded the MDH-established minimum compliance threshold (80%) in four out of the five component areas. • Ten of the 11 elements comprising the *Health and Developmental History* component met or exceeded the MDH-established minimum compliance threshold (80%). PPMCO met or exceeded the HealthChoice Aggregate scores in ten of the 11 elements. • All of the elements comprising the *Comprehensive Physical Exam* component exceeded the MDH-established minimum compliance threshold (80%). PPMCO met or exceeded the HealthChoice Aggregate scores in eleven of the 14 elements. • Displayed the most significant improvement in MY 2023, with an increase of 28 percentage points, for the HIV Test Per Schedule element for the *Laboratory Tests/At-Risk Screenings* component. • Met or exceeded the MDH-established minimum compliance threshold (80%) for 13 of the 14 elements comprising the *Immunizations* component. • All of the elements comprising the *Health Education/Anticipatory Guidance* component exceeded the MDH-established compliance threshold (80%) for MY 2023. Three of the four elements met or exceeded the HealthChoice Aggregate scores.	↑

Domain	PPMCO Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and Timeliness	**Improvements:** • Improved the *Health and Developmental History* component by one percentage point from MY 2022 to MY 2023.	↑
Quality, Access, and Timeliness	**Recommendations:** • Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule and that immunizations documented in Immunet match the provider office documentation. • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the Healthy Kids webpage and the last two pages in the EPSDT Orientation Manuals published on the MCO resource site. • Ensure providers have a copy of the Healthy Kids Provider Manual and specifically have a full understanding of Section 3: Healthy Kids/EPSDT Screening Components, Part C. Laboratory Tests that begin on page 50. • Educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion. • Collaborate with the assigned state Healthy Kids/EPSDT Nurses to assist in re-educating providers and supporting staff on current standards of preventive health care. • Identify and address root causes for the *Laboratory Tests/At-Risk Screenings* component to identify causes for the decline in performance and overcome barriers to meeting compliance in MY 2024.	↓
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality, Access	**Strengths:** • Maintained MY 2023's star rating in Access to Care and Care for Kids with Chronic Illness.	↑
Quality, Access	**Improvements:** • Improved MY 2023's star rating in Doctor Communication and Service and Taking Care of Women.	↑
NA	**Recommendations:** • There are no formal recommendations for PPMCO.	NA
Quality, Access, and/or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Appropriately categorized and resolved grievances. • Consistently exceeded compliance threshold for timeliness of grievance acknowledgment, resolution, and resolution notifications.	↑

Domain	PPMCO Strengths, Improvements, and Recommendations	Assessment
	• Consistently exceeded compliance threshold for timeliness of appeal acknowledgment and non-emergency appeal resolution notifications. • Consistently exceeded compliance threshold for timeliness of pre-service determinations, prescriber notifications, and adverse determination notifications.	
Quality, Timeliness	**Improvements:** • Consistent compliance with timeframes for resolution of medically related grievances. • Compliance with timeframe for appeal acknowledgments exceeded the compliance threshold (95%).	↑
Quality, Timeliness	**Recommendations:** • Routinely monitor turnaround time for expedited appeal resolution and documentation of reasonable attempt to provide enrollee with oral notification of appeal resolution. • Routinely audit a sample of appeal resolution and adverse determination notifications to ensure written in easy-to-understand language. Retrain staff in the use of easy-to-understand language as this has been an ongoing issue. Perhaps consider developing a library of common terms for use by staff. Use Consumer Advisory Board for feedback. • Review all case records submitted to ensure they are from the year under review. One grievance record (#12) was from 2022.	↓

Table 140. UHC Strengths, Improvements, and Recommendations

Domain	UHC Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *Confidence* for both PIP topics. • Continued to demonstrate and enhance efforts towards the health equity focus. • Conducted a disparity analysis stratified by race/ethnicity data for each strategy. • Reviewed data on a quarterly basis.	↑
Quality, Access, and Timeliness	**Improvements:** • Improved the Postpartum Care HEDIS rate by 2.7 percentage points from MY 2022 to MY 2023. • Improved the Childhood Immunization Status HEDIS rate by 1.5 percentage points from MY 2022 to MY 2023.	↑
Quality	**Recommendations:** • Identify the full name of each HEDIS measure. • Ensure all administrative data sources are found to be accurate, complete, and comparable across systems.	↓

Domain	UHC Strengths, Improvements, and Recommendations	Assessment
	• Incorporate each component of the CLAS standards on an interventional level to ensure interventions are culturally and linguistically appropriate. • Review and identify confounding variables that could have an obvious impact on outcomes. • Provide a brief summary of the impact or effectiveness of its strategies. • Identify and address root causes for barriers impacting desired improvement outcomes. Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions.	
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** ***MetaStar observed the following strengths:*** • Extremely responsive to auditor requests and provided information/documentation in a timely manner. UHC's HEDIS team served as subject matter experts for all organization functions and was dedicated to ensuring successful reporting. There was robust oversight of data used for HEDIS reporting. • Ensured the MRR project was completed by the May 3, 2024 deadline and finalized the IDSS submission by the June 14, 2024 deadline despite experiencing issues due to Optum Health's cybercrimes issue.	↑
NA	**Improvements:** ***MetaStar observed the following improvements:*** • UHC did not demonstrate formal improvement from the previous measurement year.	NA
Quality and Access	**Recommendations:** ***MetaStar recommends the following actions:*** • Continue to explore additional supplemental data sources for future reporting periods, including obtaining and incorporating Data Aggregation Validation sources as supplemental data. Such data sources would reduce the burden of MRR and possibly improve data completeness.	↓
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑, ↓, or NA**
Quality	**Strengths:** ***CSS observed the following strengths:*** • Two measures (*Rating of Health Plan* and *Rating of All Health Care*) scored the highest among MCOs for the adult CAHPS survey. • *Rating of All Health Care* scored in the top third decile for the child CAHPS survey. • *Customer Service* saw a three-year positive trend for the child CAHPS survey.	↑
NA	**Improvements:** ***CSS observed the following improvements:***	NA

Domain	UHC Strengths, Improvements, and Recommendations	Assessment
	• UHC did not demonstrate formal improvement from the previous measurement year for either the adult or child survey.	
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no formal recommendations for UHC for either the adult or child survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑, ↓, or NA**
NA	**Strengths:** • UHC did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:** • UHC did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for UHC.	NA
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality	**Strengths:** • Demonstrated the ability to design and implement effective quality assurance systems. The MY 2023 interim desktop review provided evidence of UHC's continuous commitment to ensuring quality healthcare delivery for its enrollees.	↑
Quality, Access	**Improvements:** • Received a finding of *Met* for standards 7.3, 7.10, 9.3, 9.4, and 9.5 for the MY 2023 interim desktop review. • Minutes from two Healthcare Quality and Utilization Management Committee meetings were submitted as examples of its monitoring of initiatives to address areas of overutilization and underutilization. • Revised the MD External Review Standard Operating Procedure (SOP) to outline the process for ensuring Independent Review Organization invoices are paid within the regulatory timeframe. • Provided evidence demonstrating the use of outcome data to measure the effectiveness of its Health Education Program. • Examples of two enrollees identified as in need of health education demonstrated the MCO has effective mechanisms in place to identify enrollees in special need of educational efforts. • Minutes from the December 2023 Provider Advisory Council meeting demonstrated the presentation and discussion of the annual Health Education Program by representatives of its provider network.	↑
Quality	**Recommendations:** • Include in Healthcare Quality and Utilization Management Committee meeting minutes an assessment of improvement in select rates resulting from the implementation of initiatives to address areas of	↓

Domain	UHC Strengths, Improvements, and Recommendations	Assessment
	overutilization and underutilization. This will assist the committee in determining whether the intervention is successful or if additional interventions or revisions to the existing intervention are needed. • Expand the evaluation of the effectiveness of its health education program beyond one or two measures and evaluating process and outcome measures using comparative data, such as comparing enrollees participating in the program with those who did not or comparing performance in the current MY with the prior MY to determine the direction and extent of the change.	
Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved confidence levels of *High Confidence* and *Moderate Confidence* for validation of all Provider-to-Enrollee Ratio indicators except for one. • Achieved confidence levels of *High Confidence* and *Moderate Confidence* for all Time and Distance Standards indicators.	↑
NA	**Improvements:** • UHC did not demonstrate formal improvement from the previous measurement year, as MY 2023 is the first year of implementation of the CMS Validation of Network Adequacy Protocol 4.	NA
Quality, Access, and Timeliness	**Recommendations:** • Streamline efforts to report the same metric across multiple deliverables. Increase monitoring activity to include provider-to-enrollee ratios for major and pediatric specialties. Update provider-to-enrollee ratio monitoring for pediatric providers to focus on the pediatric population.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Compliance with routine and urgent care appointment timeframes remained above the threshold (80%).	↑
Quality, Access	**Improvements:** • Improved the accuracy of accepting new Medicaid patients after implementing corrective action for MY 2023.	↑
NA	**Recommendations:** • There are no formal recommendations for UHC.	NA
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • UHC's encounter and code type match rates exceeded the minimum compliance standard (90%).	↑
NA	**Improvements:**	NA

Domain	UHC Strengths, Improvements, and Recommendations	Assessment
	• UHC did not demonstrate formal improvement from the previous measurement year.	
Quality	**Recommendations:** • Identify and address root causes for the decline in performance to ensure office visit match rates remain above the minimum compliance standard. UHC has had a steady decline in performance for office visit match rates from MY 2021 at 99% to MY 2023 at 95%. Qlarant recommends UHC	↓
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Displayed a MY 2023 total composite score of 92%, which was one percentage point lower than the HealthChoice Aggregate composite score of 93%. • Met or exceeded the MDH-established minimum compliance threshold (80%) for four out of the five component areas. • Nine of the 11 elements comprising the *Health and Developmental History* component exceeded the MDH-established minimum compliance threshold (80%). • All of the elements comprising the *Comprehensive Physical Exam* component exceeded the MDH-established minimum compliance threshold (80%). UHC met or exceeded the HealthChoice Aggregate scores in eight of the 14 elements. Compared to MY 2022, UHC sustained or improved in nine of the 14 elements. • Met or exceeded the MDH-established minimum compliance threshold (80%) for 12 of the 14 elements comprising the *Immunizations* component. UHC met or exceeded the HealthChoice Aggregate scores in seven of the 14 elements. Compared to MY 2022, UHC improved or sustained in scores in seven of the 14 elements. • All of the elements comprising the *Health Education/Anticipatory Guidance* component exceeded the MDH-established compliance threshold (80%) for MY 2023.	↑
NA	**Improvements:** • UHC did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access, and Timeliness	**Recommendations:** • Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule and that immunizations documented in Immunet match the provider office documentation. • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the Healthy Kids webpage and the last two pages in the EPSDT Orientation Manuals published on the MCO resource site.	↓

Domain	UHC Strengths, Improvements, and Recommendations	Assessment
	• Ensure providers have a copy of the Healthy Kids Provider Manual and specifically have a full understanding of Section 3: Healthy Kids/EPSDT Screening Components, Part C. Laboratory Tests that begin on page 50. • Educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion. • Collaborate with the assigned state Healthy Kids/EPSDT Nurses to assist in re-educating providers and supporting staff on current standards of preventive health care. • Identify and address root causes for the *Laboratory Tests/At-Risk Screenings* component to identify causes for the decline in performance and overcome barriers to meeting compliance in MY 2024.	
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality, Access	**Strengths:** • Maintained MY 2023's star rating in Access to Care, Doctor Communication and Service, and Keeping Adults Healthy.	↑
NA	**Improvements:** • UHC did not demonstrate formal improvement in star ratings from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for UHC.	NA
Quality, Access, and/or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Appropriately categorized and resolved grievances. • Consistently exceeded compliance thresholds for timeliness of grievance resolutions and resolution notifications. • Consistently exceeded compliance thresholds for timeliness of appeal acknowledgment and non-emergency appeal resolution notifications. • Consistently exceeded compliance thresholds for oral and timely written notice of denial of a request for an expedited appeal resolution. • Consistently exceeded compliance thresholds for timeliness of pre-service determinations and adverse determination notifications.	↑
Quality, Timeliness	**Improvements:** • Improved compliance in the emergency, medically related grievance resolution turnaround time from 67% to 80%.	↑
Quality, Timeliness	**Recommendations:**	↓

Domain	UHC Strengths, Improvements, and Recommendations	Assessment
	• Identify and address root causes and create an action plan to address the poor performing turnaround time metric as part of UCH's quality improvement program. For Category 2: Non-Emergency Member grievances, compliance fell to 74%; and was below 95% for each quarter of the year. • Routinely monitor timeframe compliance for grievance acknowledgment notifications. • Routinely monitor timeframe compliance for written notification of expedited appeal resolutions. • Routinely monitor use of appropriate letter template for grievance acknowledgment letters. • Routinely audit a sample of all grievance, appeal, and adverse determination notifications to ensure use of the complete Language Accessibility Statement. • Retrain staff who process pharmacy preauthorization requests on 24-hour prescriber notification requirement. • Retrain pharmacy staff to request additional information before an adverse determination is rendered. There was no evidence to suggest that additional information was initially requested for covered outpatient drug preauthorization requests that were denied for lack of information.	

Table 141. WPM Strengths, Improvements, and Recommendations

Domain	WPM Strengths, Improvements, and Recommendations	Assessment
Quality, Access, and/or Timeliness	**Performance Improvement Project Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • Achieved a confidence level of *Confidence* for both PIP topics. • Continued to demonstrate and enhance efforts towards the health equity focus. • Conducted a disparity analysis stratified by race/ethnicity data for each strategy. • Reviewed data on a quarterly basis.	↑
Quality, Access, and Timeliness	**Improvements:** • Improved the Postpartum Care HEDIS rate by 2.8 percentage points from MY 2022 to MY 2023.	↑
Quality	**Recommendations:** • Provide details utilizing WPM-specific data demonstrating how the PIP topics present opportunities for improvement for WPM. • Identify the priority service area(s) addressed by each PIP topic. • Ensure encounter and utilization data is submitted by primary care providers for all encounters, if primary care data is used. • Incorporate each component of the CLAS standards on an interventional level to ensure interventions are culturally and linguistically appropriate.	↓

Domain	WPM Strengths, Improvements, and Recommendations	Assessment
	• Identify and address root causes for barriers impacting desired improvement outcomes. Demonstrate statistically significant improvement for each HEDIS rate that aligns with the PIP strategies through the implementation of its interventions.	
Quality, Access, and/or Timeliness	**Healthcare Effectiveness Data and Information Set (PMV)**	**↑, ↓, or NA**
Quality	**Strengths:** ***MetaStar observed the following strengths:*** • Continued to employ a coordinated effort between regional and corporate teams to ensure that all regional reporting requirements are managed appropriately, due to WPM's large corporate structure and multiple national markets, data sources, and systems. Specifically for MY 2023, WPM moved the reporting of all lines of business to one certified software program, Cotiviti. • Continued to maintain a centralized process across all corporate markets for MRRs, which included oversight of abstraction, and conducting training and ongoing quality checks.	↑
Quality	**Improvements:** ***MetaStar observed the following improvements:*** • Updated some of the supplemental data documentation to indicate the supplemental data integration processes that are followed for the different sources and provided more consolidated documentation for sources that follow the same processes.	↑
Quality, Timeliness	**Recommendations:** ***MetaStar recommends the following actions:*** • Ensure the Roadmap responses comprehensively reflect the processes of the sources for the audit process. Use a consistent naming convention for WPM's supplemental data sources across the documentation provided for the audit. • Investigate approaches to determining more timely and accurate supplemental impact reports. WPM had a large volume of supplemental data sources for consideration. WPM submitted multiple sources of supplemental data, which were ultimately either of no impact to reported rates, had not been fully loaded for reporting, or submitted after audit deadlines. The initial supplemental data impact was determined based on the prospective HEDIS runs for determining sources with potential impact to Maryland Medicaid since supplemental data had not been fully loaded to MY 2023 HEDIS build utilized for reporting. Additionally, WPM should ensure that Member ID are accurately linked to enrollees for the supplemental data.	↓
Quality, Access, and/or Timeliness	**Consumer Assessment of Healthcare Providers and Systems (PMV)**	**↑, ↓, or NA**
Quality	**Strengths:**	↑

Domain	WPM Strengths, Improvements, and Recommendations	Assessment
	CSS observed the following strengths: • WPM did not demonstrate any strengths in performance for the adult CAHPS survey. • Identified by CSS as one of the best-performing plans, with four of the highest-scoring non-CCC measures for the child CAHPS survey. *Rating of Health Plan* scored statistically significantly better than the HealthChoice Aggregate. • No measures scored in the bottom decile for the child CAHPS survey.	
Quality	**Improvements:** ***CSS observed the following improvements:*** • WPM did not demonstrate formal improvement from the previous measurement year for the adult CAHPS survey. • *Rating of Health Plan* saw statistically significant performance gains compared to the previous measurement year for the child CAHPS survey.	↑
NA	**Recommendations:** ***CSS recommends the following actions:*** • There are no format recommendations for WPM for either the adult or child CAHPS survey.	NA
Quality, Access, and/or Timeliness	**Population Health Incentive Program (PMV)**	**↑, ↓, or NA**
NA	**Strengths:** • WPM did not demonstrate any strengths in performance in MY 2023.	NA
NA	**Improvements:** • WPM did not demonstrate formal improvement from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for WPM.	NA
Quality, Access, and/or Timeliness	**Systems Performance Review**	**↑, ↓, or NA**
Quality	**Strengths:** • Demonstrated the ability to design and implement effective quality assurance systems. The MY 2023 interim desktop review provided evidence of WPM's continuous commitment to ensuring quality healthcare delivery for its enrollees.	↑
Quality, Access, and Timeliness	**Improvements:** • Received a finding of *Met* for standards 5.5, 5.8, 6.2, 7.4, 7.6, 9.1, 9.3, and 9.5 for the MY 2023 interim desktop review. • Revised the Member Grievances – MD Policy to specify a timeframe for providing the member written notice of grievance resolution for each grievance category.	↑

Domain	WPM Strengths, Improvements, and Recommendations	Assessment
	• Compliance with MCO timeframes for providing the member with written notice of grievance resolution at or above the MDH threshold (95%) was demonstrated on a quarterly basis throughout MY 2023. • Informed MCO providers of CAHPS survey results via the online provider portal, as evidenced by screenshots of the provider website. • Photos of postings of notices and taglines during MCO interactions with the public demonstrated enrollees and prospective enrollees are informed about their nondiscrimination rights. • The New Member Materials Policy and a sample New Member Welcome Packet indicated enrollees are provided with information about the MCO's providers at the time of enrollment. • Compliance with medical and pharmacy determination timeframes for all preauthorization requests at or above the MDH threshold (95%) was demonstrated in all four quarters of the MY. • Compliance with 24-hour prescriber notification of the outcome of a preauthorization request for a covered outpatient drug at or above the MDH threshold (95%) was demonstrated in all four quarters of the MY. • Compliance with adverse determination notification timeframes at or above the MDH threshold (95%) was demonstrated in all four quarters of the MY. • The Health Education Plan 2023 indicates WPM publishes health education materials and develops programs as evidenced by a review of the enrollee website where several on-demand health education classes on topics such as anxiety, diabetes, asthma, fitness, stress management, heart disease, alcohol and drug use, tobacco use, and maternal health were found. Community health events also were held throughout the year. • Completed an annual evaluation of the impact of the health education program on process and outcome measures. • Staff and external organizations that develop and conduct educational sessions for enrollees have appropriate qualifications and experience. • Enrollees completed sample attendance records and evaluations of health education sessions. • Providers evaluated the Health Education Plan.	
Quality, Timeliness	**Recommendations:** • Report compliance with its written resolution timeframe for administrative grievances consistent with its Member Grievances - MD Policy. This would require two categories, one within five business days of the decision and the other one within 30 calendar days of grievance receipt for those written resolutions that would not meet the five business day timeframe due to the timing of the resolution. • Demonstrate compliance with timeframes for written appeal resolution at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.	↓

Domain	WPM Strengths, Improvements, and Recommendations	Assessment

	• Indicate the frequency of review of Independent Review Organization invoice logs and the position responsible for this review. A copy of this log also must be submitted for the MY 2024 review.
	• Demonstrate it analyzes the following annual reports to determine areas of focus for health education consistent with its Health Education Plan:
	  ○ Quality Management Evaluation
	  ○ HEDIS Rates
	  ○ Whole Health Population/Demographic Tool (Social Determinants of Health/Disparities Data)
	• Care Management Program Evaluation
	• Evaluate individual educational components of its Health Education Plan on outcome measures such as enrollees who received education through Green and Healthy Homes. By focusing on these individual programs WPM will be able to determine which programs are having a positive impact to encourage increased participation and which programs either need to be revised or terminated allowing for improved resource utilization.	

Quality, Access, and/or Timeliness	**Network Adequacy Validation**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Achieved a confidence level of *High Confidence* for validation of all Provider-to-Enrollee Ratio indicators. • Achieved a confidence level of *High Confidence* for all Time and Distance Standards indicators.	↑
NA	**Improvements:** • WPM did not demonstrate formal improvement from the previous measurement year, as MY 2023 is the first year of implementation of the CMS Validation of Network Adequacy Protocol 4.	NA
Quality, Access, and Timeliness	**Recommendations:** • Continue to work towards setting ratio goals to meet COMAR regulations.	↓
Quality, Access, and/or Timeliness	**Network Adequacy Validation Focused Review**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Compliance with routine and urgent care appointment timeframes exceeded the 80% threshold.	↑
Quality, Access	**Improvements:** • Improved accuracy of PCP addresses after implementing corrective action for MY 2023.	↑
Quality, Access	**Recommendations:** • ***CAP***: **WPM must submit a CAP to achieve compliance in MY 2025:** ○ Identify and address root causes for the decline in performance and address the identified issues to improve performance. Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory through provider staff education. Enrollees use	↓

Domain	WPM Strengths, Improvements, and Recommendations	Assessment
	the online directory to search for new PCPs and should receive the same information when calling the provider directly.	
Quality, Access, and/or Timeliness	**Encounter Data Validation**	**↑, ↓, or NA**
Quality	**Strengths:** • WPM's encounter and code type match rates exceeded the minimum compliance standard (90%).	↑
NA	**Improvements:** • WPM did not demonstrate formal improvement from the previous measurement year.	NA
Quality	**Recommendations:** • Identify and address root causes for the decline in performance to ensure outpatient match rates remain above the minimum compliance standard. WPM had a decline in outpatient match rates from MYs 2021 and 2022 (99%) to MY 2023 (97%). Qlarant recommends WPM. • Identify and address the root cause for the decline in performance to ensure office visit match rates remain above the minimum compliance standard. WPM has had a steady decline in performance for office visit match rates from MY 2021 (98%) to MY 2023 (95%).	↓
Quality, Access, and/or Timeliness	**Early and Periodic Screening, Diagnosis, and Treatment**	**↑, ↓, or NA**
Quality, Access, and Timeliness	**Strengths:** • Exceeded the MDH-established minimum compliance threshold (80%) in four out of the five component areas. • All of the elements comprising the *Comprehensive Physical Exam* component scored above the established compliance threshold and aligned with the HealthChoice Aggregate scores for MY 2023. The element Measured Weight demonstrated consistency at 100% for two consecutive years. • WPM demonstrated sustained scoring for the *Health Education/Anticipatory Guidance* component. All four elements maintained scores above the established compliance threshold and are comparable to the HealthChoice Aggregate scores for MY 2023.	↑
NA	**Improvements:** • WPM did not demonstrate formal improvement from the previous measurement year.	NA
Quality, Access, and Timeliness	**Recommendations:** • Work with provider offices to ensure providers are following the Recommended Childhood Immunization Schedule and that immunizations documented in Immunet match the provider office documentation. • Utilize the screening tools provided on the Healthy Kids webpage to educate provider offices on EPSDT risk screening requirements and the Maryland Healthy Kids Preventive Health Schedule. This is available on the	↓

Domain	WPM Strengths, Improvements, and Recommendations	Assessment
	Healthy Kids webpage and on the last two pages of the EPSDT Orientation Manuals published on the MCO resource site. • Ensure providers have a copy of the Healthy Kids Provider Manual and specifically have a full understanding of Section 3: Healthy Kids/EPSDT Screening Components, Part C. Laboratory Tests that begin on page 50. • Educate provider offices on the EPSDT task and its requirements; also the importance of participation and compliance with task scheduling and review completion. • Collaborate with the assigned state Healthy Kids/EPSDT Nurses to assist in re-educating providers and supporting staff on current standards of preventive health care. • Conduct a root cause analysis for the *Laboratory Tests/At-Risk Screenings* component to identify causes for the decline in performance and overcome barriers to meeting compliance in MY 2024.	
Quality, Access, and/or Timeliness	**Consumer Report Card**	**↑, ↓, or NA**
Quality, Access	**Strengths:** • Maintained MY 2023's star rating in Access to Care, Doctor Communication and Service, Keeping Kids Healthy, Care for Kids with Chronic Illness, and Taking Care of Women.	↑
NA	**Improvements:** • WPM did not demonstrate formal improvement in star ratings from the previous measurement year.	NA
NA	**Recommendations:** • There are no formal recommendations for WPM.	NA
Quality, Access, and/or Timeliness	**Grievance, Appeal, and Denial Focused Study**	**↑, ↓, or NA**
Quality, Timeliness	**Strengths:** • Consistently exceeded compliance thresholds for timeliness of grievance acknowledgment, resolution, and resolution notifications. • Consistently exceeded compliance thresholds for timeliness of appeal acknowledgment and written appeal resolution notifications. • Consistently exceeded compliance thresholds for timeliness of pre-service determinations, prescriber notifications, and adverse determination notifications.	↑
Quality, Timeliness	**Improvements:** • Consistent compliance with timeframes for grievance resolutions. • Consistent compliance with appeal acknowledgment timeframe. • Consistent compliance with expedited appeal resolution notification timeframe and oral notice to the enrollee of the resolution.	↑

Domain	WPM Strengths, Improvements, and Recommendations	Assessment
	• Consistent compliance with pre-service determination timeframes.	
Quality, Timeliness	**Recommendations:** • Retrain grievance staff on appropriate categorization of grievances and routinely audit to ensure appropriate assignment. • Routinely audit case files to ensure documentation of a reasonable attempt to provide oral notice to the enrollee of denial of an expedited appeal request. • Routinely audit appeal acknowledgment letters to ensure correct template is used. • Audit case records before they are submitted to ensure they include the appropriate records. Grievance records rather than appeals were submitted initially.	↓

Appendix B: MY 2023 Maryland Standards Crosswalks and Guidelines

Guidelines

SPR Standards and Guidelines

As seen in the *MY 2023 MCO Orientation Manual* as the "MY 2023 Maryland MCO Systems Performance Standard and Guidelines Final."

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

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

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	as appropriate. There is evidence that this occurs. *e. The guidelines are included in the provider manuals or disseminated to the providers (electronically or faxed) as they are adopted.* *f.* There are guidelines to address preventive health services for children and adults. *g. The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a.* *h. The MCO's clinical guidelines policies and procedures must reflect how the guidelines are used for utilization management (UM) decisions, enrollee education, and coverage of services.*	which the guidelines apply are consistent with the clinical guidelines.		
1.4	The QAP has written guidelines for its QOC studies and related activities that require the analysis of clinical and related services. a. The QAP has written guidelines to evaluate	The QA Plan and/or related documents describe the methodology for monitoring the quality of care provided by the MCO's providers. This may be through a study of clinical care and services through individual case reviews, provider utilization studies, and practice pattern analysis.	• QA Plan • Data Analysis • Policies & Procedures • QA/QIC/MCO's internal Provider/Medical Advisory Committee (MAC) Meeting Minutes	42 CFR §438.330b(3)-b(4)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	the quality of care provided by the MCO's providers. b. Appropriate clinicians monitor and evaluate quality through the review of individual cases and through studies analyzing patterns of clinical care. c. Multidisciplinary teams are used to analyze, identify, and address systems issues. d. Clinical and related service areas requiring improvements are identified through activities described in a. and b. above. e. Deleted for MY 2023. f. Mechanisms to assess the quality and appropriateness of the care provided to enrollees with special health care needs.	The composition of the team is described in the QA Plan and/or related documents. There is evidence that through these activities those areas requiring improvement are identified and acted upon.	• QA/QIC/MAC Membership • QA/QIC/MAC Attendance Records	
1.5	The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The remedial/corrective action procedures specifically include:	The QA Plan specifies the process for identifying problems and taking appropriate corrective actions. Documentation must be provided to ensure that policies and procedures are in place that support the process and address all components of this element. This would include the identification, development,	• QA Plan • Policies & Procedures • Data Analysis • Provider Feedback • CAPs	HCQIS II.E.1-7

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. Performance thresholds to identify when actual or potential problems may exist that require remedial/corrective action. b. The individual(s) or department(s) responsible for making the final determinations regarding quality problems. c. The specific actions to be taken. d. The provision of feedback to the appropriate health professionals, providers, and staff (as appropriate). e. The schedule and accountability for implementing corrective actions. f. The approach to modifying the corrective action if improvements do not occur. g. The procedures for terminating health professionals, providers, or staff (as appropriate).	implementation, and monitoring of Corrective Action Plans (CAPs).		
1.6 Deleted in MY 2017.				

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
1.7	The QA Plan incorporates written guidelines for evaluation of the status of QAP activities and the continuity and effectiveness of the QAP. a. The MCO reviews the status of QAP activities against the QA Work Plan on a quarterly basis. b. There is evidence that QA activities are assessed to determine if they have contributed to improvements in the care and services delivered to enrollees.	The QA Plan describes the method to be used to assure that the QAP is routinely reviewed to assess its scope and content. Documentation must be provided to substantiate that QA activities have resulted in improvements to care. And if not, what is being done to address areas of opportunity for improvement. QOC study data, analysis, reports and findings may support these improvements.	• QA Plan • Policies and Procedures • QAC Meeting Minutes • QOC Studies • QAP Annual Report	42 CFR §438.330(e)
1.8	*A comprehensive annual written report on the QAP is completed. The annual report on the QAP must include:* *a. QA studies and other activities undertaken, results, and subsequent actions.* *b. Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results.* *c. Analysis of aggregate data on utilization and quality of services rendered.*	The annual report on the QAP must include all required components. **Note:** Element 2.1 requires this report to be reviewed and approved by the governing body to assess the QAP's continuity, effectiveness, and current acceptability.	• Annual QAP Evaluation Report • QAC Meeting Minutes • Governing Body Meeting Minutes	42 CFR §438.330(e) NCQA: QI 1 Element C and D

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. Demonstrated improvements in quality. *e. Areas of deficiency.* *f. Recommendations for improvement to be included in the subsequent year's QA Work Plan.* *g. An evaluation of the overall effectiveness of the QAP.*			
1.9	The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.	The organizational chart must be comprehensive, indicating all appropriate positions and their relationships to one another.	• QAP Organizational Chart	42 CFR §438.330
1.10	The MCO must have a Continuity of Operations Plan and a Disaster Recovery Plan that is updated on an annual basis.	The MCO and its subcontractor(s) shall have robust continuity of operations and disaster recovery plans in place to ensure that the services provided will be maintained in the event of disruption to the MCO/subcontractor's operations (including, but not limited to, disruption to information technology systems), however caused.	• Disaster Recovery Plan • Continuity of Operations Plan • Evidence that subcontractor disaster recovery plans are in place.	COMAR 10.67.04.15(I) MCO Agreement: Section II.A.5 https://health.maryland.gov/mmcp/healthchoice/Documents/CY%202022%20HealthChoice%20MCO%20Agreement%20%28Master%20-%20Combined%29.pdf
2.0	**Accountability to the Governing Body – The governing body of the MCO is the Board of Directors (BOD) or, where the Board's participation with the quality improvement (QI) issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care.**			
2.1	There is documentation that the governing body has oversight of the QAP and approves the annual QA Plan/Description and QA Work Plan.	The governing body is the BOD or the designated entity of senior management that has accountability and oversight of the operations of the MCO, including but not limited to the QAP.	• QA Plan • MCO Organizational Chart • QA Organizational Chart	HCQIS III.A

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

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	grievance and appeal system.	The contract for delegated activities contains all items listed in component a. The MCO must provide evidence that it has provided information about the grievance and appeal system to all delegates and subcontractors. For new delegates, the evidence must be provided at the time that they entered into a contract with the MCO. For existing delegates, the MCO must provide evidence of an amendment to the agreement with the grievance and appeal system information or documentation it has shared with the delegate, and the delegate's acknowledgment of receipt. The only delegates required for Standard 3 are those who are delegated UM, claims, and/or appeals and grievances for mandatory services, such as vision, drug, radiology, and physical therapy (PT).		
3.2	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 has policies and procedures in place to monitor and evaluate the delegated functions and for verifying the care provided.	• Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities	HCQIS VIIL B COMAR 10.67.04.17.D
3.3	There is evidence of continuous and ongoing evaluation of delegated activities, including: a. Oversight of delegated entities' performance to ensure the quality of the care and/or service	There is evidence that an appropriate committee or body within the MCO makes process improvement decisions and acts upon the conclusions drawn from delegated entity monitoring according to the MCO's internal policies and procedures and/or the terms set forth in the delegate's contract.	• Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities • Delegation Committee Meeting Minutes	HCQIS VI.C 42 CFR §438.230 (a & b) COMAR 10.67.04.17D COMAR 31.10.11 COMAR 31.10.23.01 Ins. Art. §15-1004 Ins. Art. §15-1005

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	provided, through the review of regular reports, annual reviews, site visits, etc. b. Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. c. Review and approval of claims payment activities at least semi-annually, where applicable. d. Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable. e. Review and approval of overutilization and underutilization reports, at least semi-annually, where applicable.	The MCO must provide evidence of items a. through e.	• Delegated Entities' Complaints, Grievances, and Appeals Reports, where applicable • Delegated Entities' Claims Payment Monitoring Reports, where applicable • Delegated Entities' Utilization Activity Reports, where applicable	
3.4	The MCO has written policies and procedures for subcontractor termination that impacts the MCO's operations, services, or enrollees.	When the MCO terminates a subcontract, the MCO shall provide the Department with written notice regarding the termination that complies with the requirements of COMAR 10.67.04.17B(5).	• Subcontractor Policies and Procedures • Subcontractor Termination Notices	COMAR 10.67.04.65.17B(5)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.0	**Credentialing and Recredentialing – The QAP contains all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services.** **NOTE: As of 10/1/21, the compliance threshold changed from 100% to 95% for credentialing and recredentialing timeliness requirements.**			
4.1	The MCO has written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. *a. The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process.* *b. The Credentialing Plan designates a CC or other peer review body that makes recommendations regarding credentialing decisions.* *c. The Credentialing Plan must identify the practitioners who fall under its scope of authority and action.* d. The Credentialing Plan must include policies and procedures for communication with providers regarding	The MCO must have a comprehensive written Credentialing Plan and/or policies and procedures outlined in the QA Plan that describe the process for credentialing and recredentialing. The Credentialing Plan must designate the peer review body that has the authority to make recommendations regarding credentialing decisions and must identify the practitioners who fall under its authority. Within 30 days of receipt of a completed application, the MCO shall send to the provider at the address listed in the application written notice of the MCO's: • Intent to continue to process the provider's application to obtain necessary credentialing information. • Rejection of the provider for participation in the MCO's provider panel. If the MCO provides notice to the provider of its intent to continue to process the provider's application, the MCO, within 120 days after the date the notice is provided, shall:	• Credentialing Plan • Credentialing Process in QA Plan • Governing Body Meeting Minutes • Credentialing Policies & Procedures	HCQIS IX A-D Ins. Art. §15-112 (a)(4)(ii)(9) Ins. Art. §15-112 (d) COMAR 10.67.04.02M COMAR 10.67.04.17 42 CFR §438.214 NCQA: CR 1 Element A-B CR 2 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	provider applications within the timeframes specified in Insurance Article Section 15-112(d).	• Accept or reject the provider for participation on the MCO's provider panel. • Send written notice of the acceptance or rejection to the provider at the address on the application. After the MCO receives the completed application, the MCO is subject to the aforementioned timeframes for completed application processing. When an "online credentialing system" is utilized by the MCO the following applies: • The MCO is required to track the date of the application i.e. query the online credentialing system so that dates of credentialing can be calculated. • The "10-Day Letter" is not applicable since the entire application must be completed prior to exiting the application. • The "30-Day Letter" still applies with the above-mentioned timeframes. If an MCO does not accept applications through an "online credentialing system", notice shall be given to the provider at the address listed in the application within 10 days after the date the application is received that the application is complete.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.2	There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. Documentation includes: a. Written policies and procedures for the suspension, reduction, or termination of practitioner privileges. b. A documented process for, and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner. c. Deleted in MY 2019.	There are policies and procedures in place for the suspension, reduction, or termination of practitioner privileges. There is evidence that these policies and procedures have been implemented. The policies and procedures must identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place.	• Credentialing Plan • Recredentialing Plan • Credentialing Policies & Procedures • Provider Appeal Policy & Procedure • Provider Appeals Files • Facility Site Reviews (completed forms/files)	HCQIS IX H-J
4.3	*If the MCO delegates credentialing/ recredentialing activities, the following must be present:* *a. A written description of the delegated activities.* *b. A description of the delegate's accountability for designated activities.* c. *Evidence that the delegate accomplished*	The contract for delegated services includes a description of the delegated activities and the delegate's accountability for designated activities. The delegate provides reports to the MCO according to the contract requirements.	• Delegation Contract • Delegate Progress Reports to the MCO • MCO Monitoring/ Auditing Documents	HCQIS IX G 42 CFR §438.214 NCQA: CR 8 Element A-D

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	the credentialing activities.			
4.4	The credentialing process must be ongoing and current. At a minimum, the credentialing process must include: a. A review of a current valid license to practice. b. A review of a valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable. c. A review of graduation from medical/ancillary (NP, PT, OT, SLP etc.) school and completed residency or post-graduate training, as applicable. d. A review of work history. e. A review of a professional and liability claims history. f. A review of current adequate malpractice insurance according to the MCO's policy. g. Deleted as of the MY 2017 SPR. h. A review of Early Periodic Screening Diagnosis and	The credentialing plan and policies and procedures require, at a minimum, that the MCO obtain the information required in components a-k for the credentialing process. **Note:** (h) is applicable to those primary care providers (PCPs) who deliver preventive health care services to enrollees less than 21 years of age. The reviewer will assess the MCO's methodology for verifying whether PCPs in the MCO's network that see patients under age 21 are EPSDT certified.	• Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Written correspondence to providers • Screenshots from ePREP showing validation of provider enrollment in Medicaid • Provider agreement (for new contracts)	HCQIS IX E.1-7 42 CFR §438.214 (c-e) COMAR 10.67.04.02N Ins. Art. §15-112 (a)(4)(ii)(9) Ins. Art. §15-112 (d) MCO Transmittal PT 10-19

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

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

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
4.9	There is evidence that the recredentialing process includes a review of the following: *a. Enrollee complaints/grievances.* *b. Results of quality reviews.* c. Deleted in MY 2018. d. Office site compliance with ADA standards, if applicable.	There is evidence in provider recredentialing records in which complaints, grievances, and the results of quality reviews were reviewed prior to the MCO's recredentialing of providers. There is a process in place to re-assess provider site ADA compliance when: • Provider relocates to a site that has not previously been evaluated and approved as being ADA-compliant, or • There is evidence of ADA non-compliance issues with a particular site of care delivery.	• Credentialing Plan • Recredentialing Policies & Procedures • Sample Recredentialing Records	HCQIS IX F.3 a – e 42 CFR §438.214 NCQA: CR 5 Element A
4.10	The MCO must have policies and procedures regarding the selection and retention of providers. a. The MCO must have written policies and procedures for selection and recruitment of providers in the HealthChoice Program. b. The MCO must have written policies and procedures for the retention of providers in the HealthChoice Program.	Policies and procedures should be directed at ensuring that recipient choice is enhanced by providers participating in multiple MCOs. Also, ensuring that providers are retained within the Medicaid network.	• Credentialing Plan • Credentialing Policies and Procedures	42 CFR §438.214 42 CFR §438.207
4.11	The MCO must ensure that enrollees' parents/guardians are notified if they have chosen for	The MCO must include in the notification:	• Policies and Procedures • Letters to Parents/Guardians	COMAR 10.67.05.05

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	their child to be treated by a non-EPSDT certified PCP. a. The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired. b. The MCO must provide evidence of notification to parents/guardians that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.	• An explanation of the EPSDT preventive screening services to which an enrollee is entitled according to the EPSDT periodicity schedule (only a summary is necessary if the periodicity schedule was included in the MCO's welcome packet); • Importance of accessing the EPSDT preventive screening services; and • Process for requesting a change to an EPSDT-certified PCP to obtain preventive screening services.		
4.12	The MCO must have written policies and procedures for notifying the Department of provider terminations.	MCO must be compliant with the following COMAR 10.67.04.17B(4) requirements for notifying and reporting provider terminations: a. When an MCO and provider terminate their contract, the MCO shall provide the Department with a written notice regarding the termination.	• Network Provider Termination Policies and Procedures • Network Provider Termination Notices to MDH • Examples of completed MDH required forms	COMAR 10.67.04.17B 42 CFR § 438.10

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		b. If the MCO is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided at the later of: i. 30 calendar days before the effective date of the termination; or ii. 15 calendar days after receipt or issuance of the termination notice. c. If the provider is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided within 15 days after the MCO receives the notice from the terminating provider. d. If 50 to 99 enrollees are affected, the notice shall contain the: i. Date of termination; ii. Name or names of providers or subcontractors terminating; iii. Number of enrollees affected; and iv. MCO's plan for transitioning enrollees to other providers. e. If more than 99 enrollees are affected, the MCO shall provide the Department with a Department-approved termination survey. f. In determining the number of enrollees affected under §B(4)(d) and (e) of this regulation, the MCO shall consider:	• Evidence of terminated provider notices to enrollees.	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		i. For PCPs, the number of enrollees assigned to the PCP; and ii. For all other providers, the number of enrollees who are in active treatment or who have had an encounter with the provider in the previous 12 months. Additionally, per 42 CFR § 438.10, the MCO must make a good faith effort to give written notice of termination of contracted providers to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The MCO must provide notice to enrollees by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt of issuance of the termination notice.		
5.0	**Enrollee Rights – The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.** **NOTE: As of 10/1/21, the compliance threshold changed from 100% to 95% for credentialing and recredentialing timeliness requirements.**			
5.1	The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04. a. There are written procedures in place for registering and responding to grievances in	Timeframes for resolving grievances in the policy and procedure must be in accordance with the following: • Emergency medically related grievances not > 24 hours. • Non-emergency medically related grievances not > 5 days. • Administrative grievances not > 30 days.	• Grievance Policies & Procedures • Grievance Form • Grievance Logs • Grievance Reports • Grievances Files • TAT Grievance Compliance Reports for acknowledgment letters, resolution, and resolution letters	HCQIS X.E.1-5 COMAR 10.67.09.02 COMAR 10.67.09.04 COMAR 10.67.09.05 42 CFR §438.402 (a & b) 42 CFR §438.406 (a & b) 42 CFR §438.408 (a-f)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	accordance with COMAR 10.67.09. b. The system requires documentation of the substance of the grievances and steps taken. c. The system ensures that the resolution of a grievance is documented according to policy and procedure. d. The policy and procedure describe the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning. e. Deleted in MY 2018. f. There is complete documentation of the substance of the grievance, steps taken to resolve, and the resolution in the case record. g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe	The policy and procedures must describe what types of information will be collected when grievances are recorded and processed. The MCO must have a grievance form. The policies and procedures must include the process stating how the form is used and how an enrollee can get assistance from the MCO in completing the form. The MCO must have a documented procedure for written notification of the MCO's determination: • To the enrollee who filed the grievance • To those individuals and entities required to be notified of the grievance • To the Department's complaint unit for complaints referred to the MCO by the Department's complaint unit or ombudsman program If closing the grievance case due to not being able to contact the enrollee via phone, the MCO must notify the enrollee in writing that their grievance is being closed. The policies and procedures must describe the complete process from the registration through resolution of grievances. The policies and procedures must allow participation by the provider or an ombudsman, if appropriate, and must ensure the participation of individuals within the MCO who have authority to require	monthly or quarterly for the entire review period. • Grievance Committee meeting minutes • QAC/QIC Meeting Minutes • Consumer Advisory Board (CAB) Meeting Minutes • Quarterly Complaints/Grievances • Sample Grievance Letters to Enrollees	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	for resolution of all grievances within the MDH-established threshold of 95%. h. The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and within the MDH established threshold of 95%. i. Written resolution letters describe the grievance and the resolution in easy-to-understand language.	corrective action. A sample of selected grievances is reviewed to assure that the process is complete and is being followed. The policies and procedures describe the process to be used for data collection and analysis. This must include timeframes for collection and reporting. (e.g., collected and analyzed quarterly, reported to the QAC quarterly). The policies and procedures must include the notification of results to the provider involved, if applicable, the Consumer Advisory Board, and the QACs as required by COMAR. If problems are identified, the reviewer will track the progress of problem resolution. The state specified threshold for timeliness of all grievance acknowledgment letters, resolutions, and resolution letter decisions is 95%. A sample of grievance files must be reviewed for compliance with state and MCO (for resolution letter) specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
5.2	*The MCO shall provide access to health care services and*	COMAR 10.67.05.01C states that all written materials must:	• Enrollee Informational Materials	COMAR 10.67.04.02H

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	information in a manner consistent with the formatting and special access requirements of COMAR 10.67.05.01C.	• Use language and a format that is easily understood; • Be available in alternative formats and through the provision of auxiliary aids and services; • Be available in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency. Enrollee information including, but not limited to, enrollee handbook, newsletters, and health education materials are written at the appropriate reading comprehension level for the Medicaid population. The SMOG formula or the Flesch-Kincaid Grade Level Index will be applied to determine readability.		COMAR 10.67.05.01 42 CFR §438.10 42 CFR §438.206 (c)(2) NCQA: MED 12
5.3	The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO: *a. Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data.* b. Ensures that patient care offices/sites have	The policies and procedures address all required components described in a-e. The MCO must provide evidence that these policies and procedures have been implemented. The MCO must provide documentation to demonstrate that it ensures patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information.	• Medical Records Policies & Procedures • Confidentiality Policies & Procedures • Sample Provider Contracts • Sample Provider Site Visit Evaluation Tool • Credentialing Policies & Procedures • Tools Related to Assessing Confidentiality of Patient Medical Records	HCQIS X.1 42 CFR §438.100 (d) 42 CFR §438.224 HIPAA Health-General §§ 4-301 NCQA: MED 4 Elements A - C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO. c. Must hold confidential all information obtained by its personnel about enrollees related to their care and shall not divulge it without the enrollee's authorization unless: (1) it is required by law, (2) it is necessary to coordinate the patient's care, or (3) it is necessary in compelling circumstances to protect the health or safety of an individual. d. Deleted in 2023. e. May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise		• Sample of MCO Employee Confidentiality Statement • Signed MCO Employee Confidentiality Statements • Sample Vendor Contracts	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	disclose participant identity in any manner.			
5.4	The MCO has written policies and procedures regarding the appropriate treatment of minors, including minor consent to treatment and confidentiality requirements. Without the consent of or over the express objection of a minor, a licensed health care practitioner may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor under this section, except information about an abortion.	The MCO has a written policy addressing the appropriate treatment of minors. This policy must address the minor's right to receive treatment without parental consent in cases of sexual abuse, rape, family planning, and sexually transmitted diseases.	• Treatment of Minors Policy and associated procedures	HCQIS X.J Health General 20-102 HIPAA
5.5	As a result of the enrollee satisfaction surveys, the MCO: a. Identifies and investigates sources of dissatisfaction. b. Implements steps to follow up on the findings. c. Informs practitioners and providers of assessment results. d. Reevaluates the effects of b. above at least quarterly.	There is a process in place for identifying sources of dissatisfaction. The MCO must have mechanisms in place to identify problems, develop plans to address problems, and provide follow-up. There must be documentation (e.g. meeting minutes, CAPs) to demonstrate that policies and procedures are in place and are being followed. There is a mechanism in place to provide survey information to providers as a group, and to an individual provider(s) if warranted.	• Patient Satisfaction Evaluation Policies and Procedures • Patient Satisfaction Evaluation Tool • Patient Satisfaction Survey Data Analysis • Corrective Action Plans • Appropriate Committee Meeting Minutes Showing CAHPS Results Review	HCQIS X.K.3 a-c HCQIS X.K.4 42 CFR §438.206 (c)
5.6	The MCO has systems in place to assure that new enrollees	Policies and procedures address the content of new enrollee information packets and	• Enrollee Handbook • Enrollee Notices	COMAR 10.67.05.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	receive required information within established timeframes. a. Policies and procedures are in place that address the content of new enrollee packets of information and specify the time timeframes for sending such information to the enrollee. b. Policies and procedures are in place for newborn enrollments, including issuance of the MCO's ID card. c. The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution. d. The MCO includes the Continuity of Health Care Notice in the new enrollee packet. e. The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.	timeframes for receipt of the packets. At a minimum, new enrollee information packets contain: • Enrollee ID card • Enrollee handbook • Provider Directory The MCO uses State-developed model enrollee handbooks and notices. New enrollee information packets are provided to new enrollees within 10 calendar days of MDH's notification to the MCO of enrollment. The packet includes the Continuity of Health Care Notice that is required by § 15-140(f) of the Insurance Article. The MCO has written procedures that track and monitor timeliness of receipt of ID cards (including newborns). Such monitoring is analyzed and if timelines are not met, there is evidence of corrective action and evaluation of progress. Performance is reported through a committee or the MCO's administrative structure. There is a documented process for newborn enrollment that includes timeframes. The MCO has a documented internal mechanism for processing and follow-up on the Daily MCO Newborn Enrollment Report from the Department.	• Sample New Enrollee Information Packet • New Enrollee Policies & Procedures • Committee Meeting Minutes • ID Card Fulfillment Reports • ID Card Fulfillment Tracking and Trending Analysis	COMAR 10.67.04.02.G(3) COMAR 10.67.02.02 Ins. Art. §15-140 42 CFR 438.10

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.7	The MCO must have an active Consumer Advisory Board (CAB). a. The MCO's CAB membership must reflect the special needs population requirements. b. The CAB must meet at least six times a year. c. The MCO must have a mechanism for tracking enrollee feedback from the meetings.	An MCO shall establish a CAB to facilitate the receipt of input from enrollees. The CAB membership shall consist of enrollees and enrollees' family members, guardians, or caregivers. It is to be comprised of no less than 1/3 representation from the MCO's special needs populations, or their representatives. Pursuant to regulation, the CAB shall annually report its activities and recommendations to the MDH. The CAB Annual Report will, at a minimum, include the following information: • CAB Charter or P&P • Mission/Vision Statement for the CAB • Goals for the CAB • Structure of and member composition of the CAB • Dates, times, and locations for each CAB meeting • Summary of topics/issues discussed • Enrollee feedback/concerns • Accomplishments/Resolutions • Opportunities for Improvement/Follow-up	• Policies and Procedures • Committee Charter • CAB Meeting Minutes • CAB Annual Summary	COMAR 10.67.04.12 and 10.67.04.15
5.8	The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights. *a. Materials critical to obtaining services that are distributed by the MCO to the enrollee will include a*	The MCO shall notify enrollees of the following services and make them available free of charge to the enrollee: 1. Written materials in the prevalent non-English languages identified by the State; 2. Written materials in alternative formats;	• Enrollee Handbook • Provider Directory • Enrollee Information/ Material • Screen Shot of the MCO Website	45 CFR §92.101 42 CFR §438.10 COMAR 10.67.05.01 NCQA: MED 12 Element D-H MED 13 Element B-C NET 5 Element J ME 7 A-B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	nondiscrimination notice and a language accessibility statement in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency in Maryland. b. Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page. c. Notices and Taglines must be posted in significant communications and publications. d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public. e. MCO's electronic information provided to enrollees must meet requirements set forth in COMAR.	3. Oral interpretation services in all non-English languages; and 4. Auxiliary aids and services, such as: a. Teletypewriter/Telecommunication Device for the Deaf (TTY/TTD); and b. American Sign Language. The MCO shall include taglines with its written materials that: 1. Explain the availability of written translation or oral interpretation to understand the information provided; and 2. Provide the toll-free and TTY/TTD telephone number of the MCO's customer service unit. MCOs must take steps to notify enrollees and prospective enrollees about their rights under Section 1557 of the ACA. Specifically, MCOs must post a nondiscrimination Notice in English and in at least the top 15 non-English languages spoken by the individuals with limited English proficiency of the relevant State or States. MCOs may combine the content of the Notice with other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Small-size material (trifold brochures) must have statements and taglines in at least the top 2 non-English languages. MCOs may use the Sample "Discrimination is Against the Law" statement to meet this requirement.	• Pictures of Notices and Taglines posted at enrollee events • Websites • Online Directories	ME 2 Element A-B UM 3 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		The Notice and Taglines must be posted in a conspicuously-visible font size in a conspicuous location of covered entity websites accessible from the home page, in written materials critical to obtaining services, in significant communications and significant publications, and, where appropriate, in conspicuous physical locations where the entity interacts with the public. This applies to, but is not limited to: Marketing materials, enrollee communications related to health coverage, benefits, and prescription drug coverage, provider/pharmacy directories, formularies, enrollment forms, a summary of benefits, and appeal and grievance notices. COMAR 10.67.05.01.D states that if the MCO provides enrollee information electronically (provider directory, EOB, enrollee handbook), the following requirements must be met: 1. The format is readily accessible; 2. The information is placed in a location on the MCO's website that is prominent and readily accessible; 3. The information is provided in an electronic form which can be electronically retained and printed; 4. The information is consistent with the content and language requirements of this section;		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		5. The enrollee is informed that the information is available in paper form without charge upon request; and 6. Should the enrollee request it, the MCO provides the information in paper form within 5 business days. MCOs should be prepared to provide evidence of materials referring enrollees to online information that advises them how to request printed material free of charge; evidence that the online information provided is downloadable and printable; and information/reports that are uploaded to the MCO website should be 508c accessible.		
5.9	The MCO must maintain written policies and procedures for advance directives. a. The MCO must educate staff regarding advance directives policies and procedures. b. The MCO must provide adult enrollees with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618). c. The MCO must amend advance directive	The MCO must have written policies and procedures for advance directives. Advance directives are written instructions, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. MCOs must educate staff on advance directives. Staff should include clinical staff, case management, enrollee services, and outreach staff that would interact with enrollees and advance directives. Additionally, network management staff should be educated since they have contact with the provider network.	• Policies and Procedures • Enrollee Handbook • Enrollee Notices • Staff Notices • Evidence of staff training	42 CFR §422.128 42 CFR §438.3(j)(1) 42 CFR §489.100 Hlth Gen Art §5-601-618 COMAR 10.67.04.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.	MCO must provide examples of completed staff training such as signed attestations and rosters of staff showing dates of annual training completed.		
5.10	MCO must comply with the marketing requirements of COMAR 10.67.04.23. a. An MCO may not have face-to-face contact with a recipient who is not an enrollee of the MCO unless contact is authorized by the Department or contact is initiated by the recipient. b. An MCO cannot engage in marketing activities without prior approval of the Department. c. Deleted in MY 2018.	The MCO's marketing policies and procedures comply with the requirements of COMAR 10.67.04.23. An MCO may not have face-to-face or telephone contact with a recipient, or otherwise solicit a recipient who is not an enrollee of the MCO, unless authorized by the Department or the recipient initiates the contact. Subject to prior approval by the Department, an MCO may engage in marketing activities designed to make recipients aware of their availability, as well as any special services they offer. These marketing activities may involve campaigns using but not limited to Television; Radio; Newspaper; Informational booths at public events; Billboards and other public displays; Addressee-blind informational mailings, but only when mailed to the MCO's entire service area; Magazines; Airborne marketing displays; or Public conveyances.	• Marketing Policies and Procedures • Marketing Requests and Approvals from the Department	42 CFR §438.104 COMAR 10.67.04.23
5.11	The MCO has implemented policies and procedures to ensure that the MCO does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising	The MCO has written policies and procedure to ensure: a. that it does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice,	• Policies and Procedures • Provider manual • Enrollee handbook	42 CFR §438.102

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	or advocating on behalf of an enrollee who is his or her patient.	from advising or advocating on behalf of an enrollee who is his or her patient, for the following: i. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. ii. Any information the enrollee needs to decide among all relevant treatment options. iii. The risks, benefits, and consequences of treatment or non-treatment. iv. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. b. that if the MCO objects to providing, reimbursing for, or providing coverage of a counseling of referral service on moral or religious grounds for the requirements in 5.11, section a, then the MCO must furnish information about the services it does not cover to MDH consistent with the requirements in § 438.102 (b)(1)(i)(A)(B)		

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	Call Center performance.	• Quarterly survey results should be reviewed, reported, and trended by the MCO. • Providers failing the survey for not meeting access standards will be provided education and included in a survey within the next 6th months to ensure compliance. If the provider fails the following survey, they will be placed on a Corrective Action Plan by the MCO. The MCO has also established policies and procedures for the operations of its internal customer/enrollee services. Performance standards have been developed, such as telephone answering time, wait time, abandoned call rates, and timeframes for response to enrollees' inquiries. Such standards are measured for performance and identification of issues that affect enrollee services and are reported through established channels, such as committees.		NCQA: NET 1 Element B-C
6.2	The MCO has a list of providers that are currently accepting new enrollees. a. The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population. b. At the time of enrollment, enrollees are provided with	The MCO must conduct annual geo mapping to calculate the average distance to ensure compliance with geographic access requirements. Specific network capacity and geographic access requirements are defined in COMAR 10.67.05.05.B and COMAR 10.67.05.06.B-D. Some of these are listed below: • Enrollee to physician ratio for local access area = 200:1 • Travel distance (urban) - 10-mile radius	• Provider Directory • Provider Manual • New Enrollee Packet • New Enrollee Orientation Materials • Availability & Access Standards • Access and Availability Policies & Procedures • Monitoring Methodology • Monitoring Reports	HCQIS XI COMAR 10.67.05.02C COMAR 10.67.05.05B COMAR 10.67.05.06B-D COMAR 10.67.05.01A (3) 42 CFR §438.10 (f) (2-6) 42 CFR §438.206 (b) 42 CFR §438.207

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	information about the MCO's providers. c. *The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities.* d. *The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.*	• Travel distance (suburban) – 20-mile radius • Travel distance (rural) - 30-mile radius. Annually compare percentages of network providers who communicate in non-English languages most common among enrollees. As defined in COMAR, the MCO must make available a listing of individual practitioners who are the MCO's primary and specialty care providers. Information must include: • Name as well as any group affiliation • Street address • Telephone number • Website URL, as appropriate • Specialty, as appropriate • An indication of whether or not the provider is accepting new Medicaid patients • The provider's cultural and linguistic capabilities (including American Sign Language) • An indication of whether or not access to the provider is otherwise limited (e.g. by age of patient or number of enrollees the provider will serve) • An indication of whether the provider's office/facility has accommodations for people with physical disabilities, including	• Committee Meeting Minutes • Top Ten Diagnoses for all Care Settings • Enrollee Complaint Reports • Documentation of any CAPs • Online Provider Directories • Provider Directory Machine Readable Format and File • Link to Online Provider Directory • Screenshots of Online Provider Directory	42 CFR §438.10 (h) (1) (i-viii) 42 CFR §438.236 NCQA: NET 1 Elements A-C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		offices, exam rooms(s), and equipment The MCO must perform a quarterly review of the number of participating providers in the plan by type, geographic location, specialty, and acceptance of new patients. The directory must also include: ● A listing of the MCO's hospital providers, of both inpatient and outpatient services, in the enrollee's county with their addresses and services provided. Provider directories must be made available on the MCO's website in a machine-readable file and format. Hardcopy provider directory updates must be made quarterly if the MCO has a mobile-enabled electronic provider directory. Hardcopy provider directory updates must be made monthly if the MCO does not have a mobile-enabled electronic provider directory. Electronic provider directories must be updated no later than 30 calendar days after the MCO receives updated provider information. The MCO has a methodology in place to assess and monitor the network needs of its Medicaid population. The methodology		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		substantiates how the MCO determines that it has sufficient numbers and the types of specialists, as well as PCPs, within its network to meet the care and service needs of its population in all care settings. The methodology includes: • A process of monitoring that has the ability to identify problem areas that are reported through the MCO's established structure. • Follow-up activities and progress toward resolution that are evident. • Direct access to specialists. Each MCO must have a mechanism in place to allow enrollees with special health care needs who have been determined to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the enrollee's condition and identified needs. This is determined through an assessment by appropriate health care professionals and can be provided for example, through a standing referral or an approved number of visits. "An MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its enrollees, including, but not limited to, the delivery of services and information to enrollees: In a manner that accommodates individuals with disabilities consistent with		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it."		
6.3	The MCO has implemented policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services. a. Deleted in MY 2019. b. Deleted in MY 2019. c. Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	Policies and procedures must be in place and address trending and analysis of wellness services. The analysis must be included in the QAP with CAPs developed as appropriate. Documentation must be provided to substantiate that timeframes are adhered to and that tracking procedures are in place. The MCO has a written procedure/methodology that tracks and monitors timeliness of Initial Health Assessments (IHAs). Such monitoring is analyzed and if un-timeliness is identified, there is evidence of corrective action and evaluation of progress. Performance is reported through a committee or the MCO's administrative structure.	• Scheduling of IHA Policies & Procedures • IHA completion analysis • QAP	HCQIS XI COMAR 10.67.03.06 COMAR 10.67.05.03 COMAR 10.67.05.07
6.4	The MCO has implemented policies and procedures to ensure coverage and payment of emergency services and post-stabilization care services for enrollees.	Policies and procedures must be in place to ensure payment is not denied for emergency and post-stabilization treatment obtained under the following circumstances: a. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in §438.114(a)(b)(c)(1)(i)(ii).	• Availability & Access Standards • Access and Availability Policies & Procedures • Claims Payment Policies & Procedures • Emergency Department (ED) Policies & Procedures • Enrollee handbook • Provider manual	42 CFR §438.114 10.67.05.08B 10.67.06.28 10.67.04.20B

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		enrollee, for who is responsible in determining when the enrollee is sufficiently stabilized for transfer or discharge as responsible for coverage and payment.		
7.0	**Utilization Review (UR) – The MCO has a comprehensive UM program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement.** **NOTE: As of 10/1/21, the compliance threshold changed from 100% to 95% for credentialing and recredentialing timeliness requirements.**			
7.1	There is a comprehensive written UR Plan. *a. This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.* *b. The scope of the UR Plan includes a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services.* c. There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial	The UR Plan is comprehensive and addresses components a-c. Component 7.1(c) requires that the MCO documentation reflect that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	• UR Plan • UR Meeting Minutes • Governing Body Meeting Minutes • Enrollee Handbook • Provider Manual • UR Staff signed affirmations	HCQIS XIII A 42 CFR §438.236 NCQA: UM 1 Element A UM 2 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	incentive or compensation.			
7.2	The UR Plan specifies criteria for UR/UM decisions. *a. The criteria used to make UR/UM decisions must be based on acceptable medical practice.* *b. The UR Plan must describe the mechanism or process for the periodic updating of the criteria.* *c. The UR Plan must describe the involvement of participating providers in the review and updating of criteria.* *d. There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures.* e. There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM criteria/guidelines. *f. There is evidence that the MCO evaluates the consistency with which all staff involved apply*	There is evidence that UR criteria are based on acceptable medical practice. The UR Plan must describe the process for reviewing and updating the criteria and for involving providers. There must be evidence that criteria are reviewed and updated per the policies and procedures. The MCO must use an appropriate mechanism to assess the consistency with which physician and non-physician reviewers apply medical necessity criteria.	• UR Plan • Documentation of review/approval of new medical necessity criteria/updates • Policies & Procedures for Criteria Review/Revision, annual IRR assessment, and annual training on UM criteria • UR Committee Meeting Minutes • Sign-in sheets, training logs, certificates of completion of annual training on UM criteria • Documentation of annual assessment of IRR among UM staff/physicians	HCQIS XIII A COMAR 10.67.04.11 S 2 42 CFR §438.210(a) NCQA: UM 1 Element A UM 2 Element A and C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	UR/UM criteria on at least an annual basis.			
7.3	The written UR Plan has mechanisms in place to detect overutilization and underutilization of services. a. Services provided must be reviewed for overutilization and underutilization. b. UR reports must provide the ability to identify problems and take the appropriate corrective action. c. Corrective measures implemented must be monitored.	The UR Plan describes the process to be used for detecting overutilization and underutilization of services. UR reports and data analysis must be available and should demonstrate the ability to identify problems. There must be documentation to support that the MCO has developed, implemented, and provided follow-up of corrective actions for the identified issues.	• UR Plan • UR Policies & Procedures • Data Reports and Analysis • CAPs • UR Committee Meeting Minutes • Provider Profiles	HCQIS XIII 42 CFR §438.330 (b) NCQA: MED 7 Element A
7.4	The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation. *a. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.*	MCO policies and procedures must be compliant with the requirements of COMAR 10.67.09.04. The MCO must demonstrate that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. For standard preauthorization requests, the MCO shall provide the preauthorization in a timely manner so as not to adversely affect the health of the enrollee and within 2 business days of receipt of necessary clinical information but not later than 14 calendar	• UR Plan • UR Policies & Procedures • UR Organizational Charts • UM Position Descriptions • UM Staffing Plan • UR Committee Meeting Minutes • Delegate Reports to MCO • MCO Monitoring of Delegate Reports • TAT Compliance Reports monthly or	HCQIS XIII.C 1-7 COMAR 10.67.09.04 42 CFR §438.210 (c & d) 42 CFR §438.236 NCQA: UM 4 Element A-B, F

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate. c. Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.	days from the date of the initial request. If additional clinical information is required, it must be requested within 2 business days of receipt of the request. For expedited authorization requests, the MCO shall make a preauthorization determination and provide notice in a timely manner so as not to adversely affect the health of the enrollee and no later than 72 hours after receipt if the provider indicates or the MCO determines following the standard timeframe could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. For outpatient drug preauthorization decisions, the MCO shall approve, deny, or request additional information by telephone or other telecommunication device to the requesting provider within 24 hours of request. The enrollee, enrollee's representative, or the MCO may request an extension of the authorization timeframe of up to 14 calendar days. If the MCO extends the authorization timeframe, the MCO must provide evidence it notified enrollees in writing of the extension and the reason, as well as enrollees' right to file a grievance if they disagree with the MCO's decision. The state specified threshold for all preauthorization review decisions is 95%. A sample of preauthorization reviews must be	quarterly for the entire review period.	

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		5. Description of any additional information MCO needs for reconsideration, if appropriate from enrollee and/or provider. 6. Statement of the availability and contact information of the MCO representative who made the decision if the enrollee's provider would like to contact him/her. 7. The enrollee's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO's action. This includes a copy of the enrollee's medical record, provided free of charge. 8. Direction to the enrollee to call the HealthChoice Help Line for assistance. 9. The enrollee may also appeal to the MCO directly by contacting the MCO (phone # or address) within 60 days from the date of the adverse determination notice. 10. Explanation to the enrollee that if he/she is currently receiving ongoing services that are being denied or reduced, he/she may be able to continue receiving these services during the appeal process by calling the MCO or the HealthChoice Help Line within 10 days from receipt of this letter. If the enrollee's appeal is denied, he/she may be required to pay for		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		the cost of the services received during the appeal process. 11. Statement that the enrollee may represent themself or use legal counsel, a relative, a friend, or another spokesperson. 12. There is evidence that the letter is copied to the requesting provider with copying the PCP optional. 13. A statement explaining the availability of the expedited review process, MCO phone number, and timeframe for making a determination. 14. A statement that the enrollee or their representative may request an extension of the timeframe for appeals by up to 14 calendar days. 15. A statement of availability of the letter in other languages and alternate formats. 16. Notice of Nondiscrimination and Appeals and Grievance Rights document.		
7.6	The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials. a. The MCO maintains policies and procedures pertaining to the timeliness of adverse determination notifications in response	MCOs shall notify the enrollee and the provider in writing whenever the provider's request for preauthorization for a service is denied. Written notice of the decision to deny initial services must be provided to the enrollee: • within 24 hours of the expedited authorization determination, **and** • within 72 hours of receipt of the request, **and**	• UR Plan • UR Policies & Procedures • UR Committee Meeting Minutes • Selected UR Cases • Enrollee Notices • Turnaround Time (TAT) Compliance Reports <u>monthly or quarterly for the entire review period.</u>	HCQIS XIII.C 1-7 COMAR 10.67.09.04 42 CFR §438.10 (f & g)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	to preauthorization requests as specified by the State. b. The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.	• within 72 hours for standard requests and outpatient drug decisions. For any previously authorized service, written notice to the enrollee must be provided at least 10 days prior to reducing, suspending, or terminating a covered service. The state-specified threshold for all adverse determination notifications is 95%. A sample of adverse determination notifications must be reviewed for compliance with state-specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.7	The MCO must have written policies and procedures pertaining to enrollee appeals. a. The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05. *b. The MCO's appeals policies and procedures must include staffing safeguards to avoid conflicts of interest when reviewing appeals.*	There is evidence that appeals are resolved, and notification is provided within the timeframes established by the State. Timeframes for resolving and providing notification of appeal decisions in the policy and procedure must be in accordance with the following: • Expedited Appeals must be resolved and written notification of the decision provided within 72 hours of receipt. The MCO must also make reasonable efforts to provide oral notice of the decision.	• UR Organizational Charts • UM Position Descriptions • QM Committee Meeting Minutes • Enrollee Appeals Policies & Procedures • Contract • Appeals Forms & Logs • Appeals Reports including TAT compliance monthly or quarterly for the entire review period. • Appeal Records	HCQIS XIII.C 1-7 COMAR 10.67.09.02 COMAR 10.67.09.05 42 CFR §438.404 (b) 42 CFR §438.406 (a & b) 42 CFR §438.408 (a-f) 42 CFR §438.402 (c)(3)(ii) NCQA: UM 8 Element A UM 9 Element A MED 10 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	c. The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes. d. The MCO's appeal policies must include procedures for how the MCO will assist enrollees with the appeal process. e. Reasonable efforts are made to give the enrollee prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request. f. Written notifications to enrollees include appeal decisions that are documented in easy-to-understand language. *g. The MCO's appeal policies and procedures must include oral inquiries seeking to appeal are treated as appeals.*	• Standard Appeals must be resolved and written notice provided within 30 days unless extended pursuant to 438.408 b & c. • Appeals may be extended up to 14 days. The MCO must ensure that decision-makers on an appeal were not involved in previous levels of review or decision-making, were not subordinates of decision-makers involved in previous levels of decision-making, and are health care professionals with clinical expertise in treating the enrollee's condition or disease. The method to collect information for review decisions is documented. A selected sample of enrollee appeals, or provider appeals submitted on behalf of the enrollee, will be reviewed to assure that the policies and procedures are being followed. <u>The state-specified threshold for all enrollee appeal acknowledgment and resolution letters is 95%. A sample of enrollee appeals must be reviewed for compliance with state-specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.</u>	• Enrollee Notices	
7.8	The MCO must have written policies and procedures pertaining to provider	Compliant with the requirements of COMAR 10.67.09.03, the MCO must have written policies and procedures for provider	• Provider <u>Administrative</u> Appeals Policies & Procedures	HCQIS XIII.C 1-7 COMAR 10.67.09.03 42 CFR §438.236

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	administrative appeals, including but not limited to claims appeals. a. The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03. b. The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. This component is limited to provider administrative appeals. Provider medical necessity appeals are always post-payment. Pre-service medical necessity reviews are member appeals. c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	appeals. The state specified threshold for all provider appeal resolution is 95%. The MCO must provide evidence that it is monitoring compliance with written acknowledgment, resolution at each level, and written resolution timeframes through routine reports (i.e. weekly, monthly, or quarterly) consistent with the MCO's policies that includes the compliance percentage for each of the regulatory timeframes. The MCO can include either all provider appeals or a statistically valid sample in reporting compliance. If using a sample the MCO must use a statistically valid sample size with a confidence level of 95% and a sampling error of 5%. The MCO must include in its provider complaint process at least the following elements: An appeal process which: • Is available when the provider's appeal or grievance is not resolved to the provider's satisfaction; • Acknowledges receipt of provider appeals within 5 business days of receipt by the MCO; • Allows providers 90 business days from the date of a denial to file an initial appeal; • Allows providers at least 15 business days from the date of denial to file each subsequent level of appeal;	• TAT Tracking logs for monitoring compliance with written acknowledgment and written resolution of provider appeals • TAT Compliance Reports for written acknowledgment and written resolution monthly or quarterly for the entire review period.	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Resolves appeals, regardless of the number of appeal levels allowed by the MCO, within 90 business days of receipt of the initial appeal by the MCO; • Pays claim within 30 days of the appeal decision when a claim denial is overturned; • Provides at its final level an opportunity for the provider to be heard by the MCO's chief executive officer or the chief executive officer's designee; • Provides timely written notice to the provider of the results of the internal appeal consistent with the timeframe documented in its policies.		
7.9 (Formerly 7.6)	There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. a. The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures. b. The MCO demonstrates a review of the data on	The intent of this element is to provide a mechanism for enrollees and providers to offer opinions on the UR process in place at the MCO and assure that the MCO is reviewing and acting upon identified issues. There must be evidence these processes are in place and functioning. There must be evidence that these policies and procedures have been followed. The policies and procedures must describe the process to evaluate the effects of the program using data on enrollee and provider satisfaction and/or other appropriate measures. **If the MCO conducts any independent surveys, data sources must include both the MCO's independent**	• Enrollee & Provider Satisfaction Policies and Procedures Relating to UR Program • Enrollee and Provider Satisfaction Surveys Evaluating UR Program • Data Reports Evidencing Review of enrollee and provider satisfaction with UR survey results • Trending Reports • Action Plans to specifically address UR satisfaction opportunities for improvement	COMAR 10.67.04.03

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		4. Agree to pay the fixed case fee should the IRO rule against the MCO and has a documented process to assure IRO invoices are paid within 60 days per COMAR 10.67.13.07C(2).		
7.11 (Formerly 7.8)	The MCO must have written policies and procedures for establishing a corrective managed care plan for enrollee abuse of medical assistance pharmacy benefits consistent with the Department's corrective managed care plan. a. The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation. b. The MCOs must provide evidence of implementation of the corrective managed care plan.	The MCO must have documented policies and procedures for a corrective managed care plan for abuse of pharmacy benefits consistent with COMAR 10.67.12. An MCO's corrective managed care plan shall cover enrollee abuse of medical assistance pharmacy benefits. For all pharmacy benefit abuse covered by an MCO's corrective managed care plan, the plan shall: • Use the criteria as described in Regulation .01B of this regulation to determine if enrollees have abused benefits; • Provide for a medical review of the alleged abuse consistent with §C of this regulation; • Provide that an enrollee found to have abused pharmacy benefits will be enrolled in the program for 24 months; • Provide that an enrollee who has been enrolled in a 24-month plan and is subsequently found to have abused MCO pharmacy benefits shall be enrolled in the plan for an additional 36 months;	• Corrective Managed Care Plan Policies and Procedures • Corrective Managed Care Plans • Notices to and Correspondence with Enrollees • Evidence of Record Reviews Completed by Licensed Medical Professionals	COMAR 10.67.12.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Provide for the MCO to select any participating pharmacy that meets the requirements of COMAR 10.67.12.02B(5) to serve as the enrollee's designated pharmacy provider for enrollees in corrective managed care; • Require an enrollee to obtain prescribed drugs only from a single designated pharmacy provider, which may be any pharmacy or any single branch of a pharmacy chain that participates in the MCO and meets the requirements of COMAR 10.67.05.06B and .07C(2) unless the prescription is: a) Pursuant to an emergency department visit; b) Pursuant to hospital inpatient treatment; or c) A specialty drug as defined in COMAR 10.67.06.04; • Provide enrollees determined to have abused pharmacy benefits the ability to suggest pharmacy providers; • Require the MCO to accept the enrollee's suggestion referenced in §B(7) of this regulation unless the MCO determines that the recipient's choice of provider would not serve the enrollee's best interest in achieving appropriate use of the health care systems and benefits available through the MCO;		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Provide an enrollee determined to have abused pharmacy benefits 20 days from the date of the notice to present additional documentation to explain the facts that serve as the basis for the MCO's determination of benefit abuse, consistent with §D of this regulation; • Provide for the designation of a new pharmacy provider if the enrollee moves out of the service area of the current pharmacy provider; • Provide for prompt reporting to the Department the name of any enrollee enrolled in the MCO's program, the duration of enrollment, or any change in the duration of enrollment; and • Be submitted to the Department for review and approval: a) Within 60 days of the effective date of this regulation; and b) Before the implementation of any modification.		
7.12 Deleted in MY 2019.				
8.0	**Continuity of Care – The MCO has put a basic system in place that promotes continuity of care and case management (CM).**			
8.1	Enrollees with special needs and/or those with complex health care needs must have access to CM according to established criteria and must receive the appropriate services.	The MCO must have policies and procedures in place to identify enrollees with special needs and/or complex health care needs, such as diabetes, severe asthma and high-risk pregnancy, and to enroll them into CM according to the MCOs established criteria. This system must allow the enrollee to access the appropriate services provided by the MCO.	• CM Plan • CM Criteria/ • Standards • CM Policies & Procedures • CM Cases • Committee Meeting Minutes (e.g., QA/UR)	HCQIS XIV COMAR 10.67.03.06 COMAR 10.67.04.04-11 42 CFR §438.208(c)(1,2)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References

		Per COMAR 10.67.04.04B, special needs populations are identified as:
		
		1. Children with special health care needs.
		2. Individuals with a physical disability.
		3. Individuals with a developmental disability.
		4. Pregnant and postpartum women.
		5. Individuals who are homeless.
		6. Individuals with HIV/AIDS.
		7. Children in State supervised care.
		
		Specifically, the MCO has documented evidence of the following:
		
		• CM Plan that describes the MCO's CM program and/or CM policies and procedures.
		• CM criteria and/or standards for the following:
		  ○ Identification of children and adult enrollees with special needs
		  ○ Assessments
		  ○ Plans of care
		  ○ Caseload
		• Committee reporting structure.
		• Minimum qualifications for case managers and case manager supervisors.
		• Orientation/Training for case managers.
		• Number of FTEs allocated for CM.
			• Job Descriptions
			• Reports and Analysis
			• Orientation/
			• Training Materials	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
8.2	The MCO must ensure appropriate initiation of care based on the results of HSNI data supplied to the MCO. This must include a process for gathering Health Services Needs Information (HSNI) data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.	There is documented evidence of HSNI: • data collection methodology • data analysis activities, and • evidence that follow-up based on the results of the analysis is occurring in a timely manner. If MDH does not transmit HSNI for an enrollee to the MCO within 10 calendar days of enrollment, the MCO shall make at least two attempts to conduct an initial screening of the enrollee's needs, within 90 calendar days of the effective date of enrollment. At least one of these attempts shall be during non-working hours. If the MCO does not receive the HSNI within the 10-day window, the MCO should attempt to perform the screening. **NOTE:** The HSNI is completed at the time of enrollment into HealthChoice and this data is sent to the MCO from the state. The HSNI is NOT the Health Risk Assessment (HRA) performed by CM.	• HSNI Policies and Procedures • Reports and Analysis of TATs	COMAR 10.67.02.03 COMAR 10.67.05.07
8.3	The MCO must have policies and procedures in place to coordinate care with primary care, Local Health Departments (LHDs), school health programs, and other frequently involved community-based organizations (CBOs).	The MCO must have policies and procedures in place to assure the coordination of services for its enrollees, including coordination of care/services with the enrollee's PCP, LHDs (ACCU/Ombudsman, and transportation), school-based health centers, and other CBOs where coordination with the MCO is necessary to ensure enrollee services are coordinated. Other CBOs might include Chase Brexton for HIV/AIDS, homes and domestic violence	• Continuity of Care Policies & Procedures	HCQIS XIV

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		b. Assistance with the development and coordination of appropriate treatment plans for Enrollees c. Provider education and promotion for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process, d. Provider education about the substance use release of information (ROI) process under 42 CFR, Part 2, and e. Provider education for Enrollee identification and referrals to the Administrative Services Organization (ASO) or core service agencies for behavioral health services.		
8.7	The MCO must comply with providing the Continuity of Health Care Notice to enrollees and have policies and procedures in place to provide services in accordance with the MIA requirements when requested by enrollees.	The MCO has policies and procedures for complying with the Continuity of Health Care Notice and provides documentation of compliance. Evidence of compliance is not showing the Continuity of Health Care Notice in the Enrollee Handbook. Examples of evidence may be derived from care management notes, documentation of single case agreements with out-of-network providers, enrollee letters to show continued approval of a service received through an out-of-network provider, etc.	• Policies and Procedures • Care management notes, single case agreements with out-of-network providers, enrollee letters	Ins. Art. §15-140(f)
9.0	**Health Education Plan – The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the enrollee population.**			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
9.1	The MCO has a comprehensive written Health Education Plan (HEP), which must include: a. The education plan's purpose and objectives. b. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events. c. A methodology for notifying enrollees and providers of available educational activities. d. A description of group and individual educational activities targeted at both providers and enrollees.	The MCO's HEP must contain all of the components listed in a-d. There must be an indication of how the objectives were established.	• HEP Description • Health Education Schedule of Events • Health Education Work Plan • Health Education Materials • Enrollee/Provider Notification Methodology • Samples of enrollee and provider notifications of available educational activities. • Descriptions of group and individual educational activities targeted at both enrollees and providers	COMAR 10.67.04.03
9.2	The HEP incorporates activities that address needs identified through the analysis of enrollee data.	The MCO must provide evidence that enrollee data were analyzed to determine the need for certain health education programs.	• HEP • Enrollee Data Analysis • Health Education Calendar of Events	COMAR 10.67.04.03
9.3	The MCO's HEP must: a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room (ER) utilization, avoidable hospital admissions,	The HEP must describe the qualifications of the staff or external providers that will conduct the educational sessions (e.g., certified diabetes instructor, registered dietician, or certified mental health provider). The education plan must describe how a provider can access a health educator/ educational program through the MCO (e.g., the MCO may designate a contact person to	• Data Analysis and Studies • HEP and Work Plan • Impact Evaluation Methodology that includes process and outcome measures • Annual evaluation of the impact of the HEP on process and/or outcome measures	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	utilization of preventive services, and clinical measures. b. Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the enrollees. c. Contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for enrollee referrals.	assist the provider in connecting the enrollee to a health educator or program).	• Provider Manual • Provider newsletters • Sample of provider referrals of enrollees for health education • Job descriptions of health education staff • Brochures of health education programs from external organizations demonstrating qualifications of program presenters.	
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. **Note:** This component is not limited to individuals in a special needs population.	Mechanisms to identify enrollees in special need of educational efforts may include CM, outreach, or PCP referral for one-on-one education of the enrollee with complex medical needs, the homebound enrollee, and the noncompliant enrollee with health issues.	• Special Educational Need Identification Mechanisms • Evidence that mechanisms are in place and functioning to identify enrollees in special need of education efforts	COMAR 10.67.04.03
9.5	The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide:	The MCO must demonstrate that enrollees are notified of educational programs and that they have been afforded the opportunity to evaluate these programs. The MCO must provide documentation in the form of notifications, attendance records	• Enrollee Mailings such as brochures, postcards, flyers • Enrollee attendance records	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. Samples of notifications, brochures, and mailings. b. Attendance records and session evaluations completed by enrollees. c. Provider evaluations of health education programs.	and session evaluations. There must be evidence that providers are given the opportunity to evaluate enrollee educational sessions and the overall health education program.	• Completed Session Evaluations by individual attendees • Program Evaluations • Completed Provider Evaluations of the MCO's health education programs.	
10.0	**Outreach Plan (OP) – The MCO has developed a comprehensive written outreach services plan to assist enrollees in overcoming barriers in accessing health care services. The OP adequately describes the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.**			
10.1	The MCO has developed a written OP that describes the following: a. Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership. b. MCO's organizational capacity to provide both broad-based and enrollee-specific outreach. c. Unique features of the MCO's enrollee outreach initiatives. d. Community partnerships. e. Role of the MCO's provider network in performing outreach.	Each of the MCOs participating in HealthChoice is unique in the manner in which it facilitates the outreach requirements. The OP must describe the individual MCO's approach to providing outreach. This written plan must provide an overview of outreach activities that include components 10.1a through 10.1f. Supporting policies and procedures must be in place to provide details regarding how these activities are carried out. The OP must include an overview of the populations to be served. At a minimum, the populations must include: • Those in need of wellness/ preventive services. • Those children eligible for EPSDT services. • Those enrollees (both adults and children) who are difficult to reach or miss appointments.	• Educational Materials • DM and CM Program Descriptions • MOUs • Community Event Calendars or Education Program Schedules • Provider Manual • Provider Contracts	COMAR 10.67.04.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	f. MCO's relationship with each of the LHDs and Administrative Care Coordination Units (ACCUs).	• Those enrollees comprising the following special populations defined in COMAR 10.67.04.04 B: 1) Children with special health care needs. 2) Individuals with a physical disability. 3) Individuals with a developmental disability. 4) Pregnant and postpartum women. 5) Individuals who are homeless. 6) Individuals with HIV/AIDS. 7) Children in State supervised care. • The OP must briefly describe common health problems within the MCO's membership (i.e., diabetes, HIV/AIDS, pediatric asthma) and any identified barriers or specific areas where outreach has been or is anticipated to be particularly challenging (i.e., rural population, non-English speaking populations). The OP must provide an overview of how the MCO's internal and external resources are organized to provide an effective outreach program. For example, the OP briefly describes the roles of various departments such as provider relations, enrollee services, CM, DM, health education, and delegated entities in the performance of outreach activities.		

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

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	c. The provision of outreach via telephone, written materials, and face-to-face contact. d. Monitoring of all outreach activities, including those delegated or subcontracted to other entities.	enrollees of due dates for preventive services such as mammograms and cervical cancer screenings through reminder notices such as letters or postcards. The MCO must have policies and procedures in place to guide outreach staff in the outreach process. This guidance may be in the form of policies and procedures or process flow charts. There must be evidence that these processes are being followed. There must be evidence that the MCO utilizes a systematic process to provide outreach services that employ: • Telephone contact. • Written materials. • Face-to-face contact. There must be evidence that outreach activities are monitored. There must be evidence that the MCO monitors any delegated activities to assure that contracted or delegated activities are carried out. For example, if the MCO has an agreement with the LHD to perform specific outreach activities such as face-to-face contact with enrollees, the MCO must have a mechanism for monitoring outcomes of these activities (i.e., number of enrollees referred for LHD outreach and number successfully reached).		
10.3	The MCO has implemented strategies:	There must be evidence that the MCO has implemented strategies to provide outreach to the populations in 10.3 c and d.	• Outreach Work Plan • Data Reports • Tracking/Referral logs	COMAR 10.67.05.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. Deleted in MY 2019. b. Deleted in MY 2019. c. To promote the provision of EPSDT services and respond to no-shows and non-compliant behavior related to children in need of EPSDT services. d. To bring enrollees into care who are difficult to reach or who miss appointments.	The MCO identifies and tracks children (up to 21 years of age) who are eligible for EPSDT services or treatment. The MCO identifies those enrollees due for services, enrollees who miss appointments, and non-compliant enrollees. There is evidence that the MCO provides outreach to schedule those children in need of EPSDT services and/or to bring those children who miss appointments into care.	• Enrollee Mailings • Provider Mailings	
11.0	**Fraud and Abuse - The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.**			
11.1	The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include: a. Documentation that articulates the organization's commitment to comply with all applicable Federal and State laws,	The MCO demonstrates the ability to detect and identify inappropriate and unlawful conduct, fraudulent activities, and abusive patterns through detailed policies, procedures, education, and training. The MCO demonstrates the ability to internally monitor and audit for potential fraud and abuse in such areas as encounter data, claims submission, claims processing, billing procedures, underutilization, customer service, enrollment and disenrollment, marketing, and provider/enrollee education materials. The MCO documents its processes used to detect and identify incidences of fraud and abuse.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Compliance Officer Job Description and Qualifications • Compliance Committee Membership • Compliance Committee Meeting Minutes • Communication Between Compliance Officer & Compliance Committee • Routine and Random Audit Reports for Fraud and Abuse • Reports tracking the receipt and	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	regulations, and standards. b. Designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and is responsible for ongoing monitoring of the MCO's mandatory compliance plan. c. Designation of a Compliance Officer to serve as the liaison between the MCO and the Department. d. A documented process for internal monitoring and auditing, both routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and abuse education of MCO staff, enrollees, and providers.	The MCO documents its processes used to ensure services were actually provided to the enrollee. There must be evidence of the process such as policies and procedures, reports, trending, meeting minutes, studies, call scripts, data results, etc.	dispensation of all incidences of reported suspected fraud and abuse	CMS Resource Handout- "Medicaid Managed Care: Compliance Program Requirements https://www.cms.gov/files/document/mcpresourcehandout011416pdf

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	e. A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation. f. A documented process to ensure that services billed to the MCO were actually received by the enrollee.			
11.2	The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include: a. Education and training for the Compliance Officer and the MCO's employees on detection of fraud and abuse. b. A documented process for distributing and	The MCO demonstrates clear and well-publicized communication of disciplinary guidelines to employees, subcontractors of the MCO, and enrollees to sanction fraud and abuse offenses. The MCO demonstrates its process exists, e.g. a hotline, which allows employees, subcontractors of the MCO, and enrollees to report suspected fraud and abuse without fear of reprisal. The MCO will also demonstrate its procedures for timely investigation, dispensation, and tracking of reported suspected incidences of fraud and abuse.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Staff orientation, education, and training protocols pertaining to fraud and abuse • Sign-in rosters for employee training sessions regarding fraud and abuse	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO's employees. c. A documented process for enforcing standards by means of clear communication to employees, in well-publicized guidelines, to sanction incidents of fraud and abuse. d. A documented process for enforcement of standards through clear communication of well-publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse. e. A documented process for enforcement of standards through clear communication of well-publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse. f. A documented process for the reporting by employees of suspected			CMS Resource Handout- "Medicaid Managed Care: Compliance Program Requirements https://www.cms.gov/files/document/mcpresourcehandout011416pdf

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	calendar days of the initial report. b. A documented process for cooperating with the MDH Office of the Inspector General and the State Medicaid Fraud Control Unit when suspected fraud and abuse are investigated.			CMS Resource Handout- "Medicaid Managed Care: Compliance Program Requirements https://www.cms.gov/files/document/mcpresourcehandout011416pdf
11.4	The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address: a. Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee. b. Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP. c. Evidence of the Compliance Committee's review and approval of administrative and management	The MCO documents the mechanisms that evaluate the effectiveness of its fraud and abuse compliance plan through routine and random reports, CAPs and their implementation, administrative and management procedures. The MCO documents oversight of fraud and abuse activities for each delegate, including delegate compliance plans and fraud and abuse activity reports.	• Compliance Committee Minutes • Routine and Random Fraud and Abuse Reports • CAPs • CAP Implementation Reports • Delegate Fraud and Abuse Reports	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf CMS Resource Handout- "Medicaid Managed Care: Compliance Program Requirements https://www.cms.gov/files/document/mc

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with. d. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.			presourcehandout011416pdf
11.5 (Formerly 2.8)	An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies. a. An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals or entities debarred by Federal Agencies. b. An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial	An MCO may not have a relationship with an individual or entities who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. An MCO may not have an affiliation with an individual or entities who have been debarred by Federal Agencies, as defined in the Federal Acquisition Regulation. Checks of all databases are required at the time of initial credentialing and recredentialing. Monthly checks of the following databases are required: List of Excluded Individuals/Entities and Excluded Parties List Systems/SAM.	• Governance Policies and Procedures • Subcontracting and Employment Policies and Procedures • Evidence of database checks	42 CFR §438.610(a) 42 CFR §438.610(b) 42 CFR §438.610(c) COMAR 10.67.03.03 42 CFR §455.436 COMAR 10.67.07.03G

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

Crosswalks

Deeming Eligibility

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

Standards are evaluated and compared to NCQA health plan accreditation standards and MCO performance to identify qualifications for deeming.
Green Y = Standard is deemable
Red N = Standard is not deemable
Yellow = Standard is partially deemable
Gray = Not applicable as standards have been deleted

SPR Standards to Part 438 Subpart D and QAPI Standards Crosswalk

Standards	Availability of Services	Assurances of Adequate Capability and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Provider Selection	Confidentiality	Grievance and Appeal Systems	Subcontractual Relationships and Delegation	Practice Guidelines	Health Information Systems	Quality Assessment and Performance Improvement Project	Disenrollment*
CFR Reference	438.206	438.207	438.208	438.210	438.214	438.224	438.228	438.230	438.236	438.242	438.330	438.56
1: Systematic Process of Quality Assessment and Improvement	✓	✓	✓	✓	-	-	✓	✓	✓	✓	✓	-
2: Accountability to the Governing Body	-	-	-	✓	-	-	-	-	-	-	✓	-
3: Oversight of Delegated Entities and Subcontractors	-	-	-	-	-	-	✓	✓	-	-	✓	-
4: Credentialing and Recredentialing	✓	✓	✓	-	✓	-	✓	✓	-	-	✓	-
5: Enrollee Rights	✓	-	✓	-	✓	✓	✓	-	-	✓	✓	*
6: Availability and Accessibility	✓	✓	✓	✓	-	-	-	-	✓	-	✓	-
7: Utilization Review	✓	-	✓	✓	-	-	✓	-	✓	✓	✓	-
8: Continuity of Care	✓	-	✓	-	-	-	-	-	-	✓	✓	-
9: Health Education Plan	✓	-	✓	-	-	-	-	-	-	-	✓	-
10: Outreach Plan	✓	-	✓	-	-	-	-	-	-	-	✓	-
11: Fraud and Abuse	-	-	✓	✓	✓	-	✓	-	-	-	✓	-
12: Disenrollment*												

*The State of Maryland is currently monitoring disenrollment and requires MCOs to use the MCO Member Manual Template for enrollee handbooks, which includes disenrollment information. MY 2024 comprehensive SPR will evaluate MCOs for 42 CFR §438.56 Disenrollment.

Appendix C: Hilltop's MY 2023 Encounter Data Validation Report

The Hilltop Institute
UMBC

report

EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2021 to CY 2023

December 20, 2024

Qlarant

Suggested Citation: The Hilltop Institute. (2024, December 20). *EQR protocol 5, activity 3: Validation of encounter data, CY 2021 to CY 2023.* Baltimore, MD: UMBC

EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2021 to CY 2023

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EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2021 to CY 2023

Introduction

HealthChoice—Maryland's statewide mandatory Medicaid and Children's Health Insurance Program (CHIP) managed care system—was implemented in 1997 under the Social Security Act's §1115 waiver authority and provides participants with access to a wide range of health care services arranged or provided by managed care organizations (MCOs). In calendar year (CY) 2023, nearly 90% of the state's Medicaid and Maryland Children's Health Program (MCHP) populations were enrolled in HealthChoice. HealthChoice participants are given the opportunity to select an MCO and primary care provider (PCP) from their MCO's network to oversee their medical care. Participants who do not select an MCO or PCP are automatically assigned to one. HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid (including MCHP) participants through the fee-for-service (FFS) system.

In addition to providing a wide range of services, one of the goals of the HealthChoice program is to improve the access to and quality of health care services delivered to participants by the MCOs. The Maryland Department of Health (the Department) contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to analyze and evaluate the validity of encounter data submitted by the HealthChoice MCOs. Hilltop has conducted the annual encounter data evaluations and assisted the Department with improving the quality and integrity of encounter data submissions since the inception of the HealthChoice program.

In 2012, the Centers for Medicare & Medicaid Services (CMS) issued a set of external quality review (EQR) protocols to states receiving encounter data from contracted MCOs. The EQR process included eight protocols—three mandatory and five optional—used to analyze and evaluate state encounter data for quality, timeliness, and access to health care services (CMS, 2012). In April 2016, CMS released its final rule on managed care,[1] which included a new regulation that states must require contracted MCOs to submit encounter data that comply with specified standards, formatting, and criteria for accuracy and completeness.[2] This final rule required substantive changes to the EQR protocols[3] and provided an opportunity to revise the protocol design. In October 2019, CMS released updated protocols for the EQR to help states and external quality review organizations (EQROs) improve reporting in EQR technical reports. Hilltop evaluated the new managed care final rule released in November 2020 and found that it did not include substantive changes to the EQR regulations.[4] Hilltop reviewed a managed care final rule released in May 2024 and found that CMS is required to issue protocols to support a requirement that states' EQR technical reports must include outcomes data and results from

[1] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,498 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).

[2] 42 CFR § 438.818.

[3] 42 CFR § 438.350–438.370; 457.1250.

[4] Medicaid and CHIP Managed Care Final Rule. 85 Fed. Reg. 72,574 (November 13, 2020) (to be codified at 42 CFR Parts 438 and 457).

quantitative assessments in addition to validation information.[5] States will have one year to begin implementation after CMS publishes the protocols; Hilltop will monitor the release of the updated protocols.

In 2018, the Department asked Hilltop to work with Qlarant, Maryland's EQRO, to evaluate all electronic encounter data submitted by the MCOs on an annual basis as part of the encounter data validation activity. Hilltop serves as the Department's data warehouse and currently stores and evaluates all Maryland Medicaid encounter data, providing data-driven policy consultation, research, and analytics. This specific analysis—Activity 3 of the CMS EQR Protocol 5 for encounter data validation—is the core function used to determine the validity of encounter data and ensure the data are complete, accurate, and of high quality. The Department can use the results of the evaluation to monitor and collaborate with the MCOs to improve the quality and usefulness of their data submissions.

Hilltop evaluated all electronic encounter data submitted by the MCOs for CY 2021 through CY 2023. The two primary validation areas are 1) the Department's encounter data processing before acceptance of data and 2) the accepted encounter data review. Documentation of the data processing involves an overview of the electronic data interchange (EDI) and the Medicaid Management Information System (MMIS), as well as the validation process for submitted encounters before acceptance. For this analysis, Hilltop obtained information from the Department about encounter data that failed or were denied during the edit checks (previously referred to as rejected records)[6] and the reasons for failure. Hilltop conducted a review of accepted encounters and analyzed the volume and consistency of encounters submitted over time, utilization rates, data accuracy and completeness of identified fields, appropriateness of diagnosis and procedure codes, and the timeliness of MCOs' submissions to the Department.

Methodology

The following methodology was designed to address the five required activities of CMS EQR Protocol 5:

- Activity 1: Review state requirements
- Activity 2: Review MCO's capability
- Activity 3: Analyze electronic encounter data
- Activity 4: Review of medical records
- Activity 5: Submission of findings

Information from Activities 1 and 2 is necessary to evaluate Activity 3. The primary focus of Activity 3 is to analyze the electronic encounter data submitted by the MCOs, and this analysis composes a substantive portion of this report. Activity 1 is necessary to develop the plan for

[5] Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule. 89 Fed. Reg. 41,003 (May 10, 2024) (to be codified at 42 CFR Parts 430, 438 and 457).

[6] If encounters are "non-compliant 837," they are rejected and sent back to the MCO for resubmission.

encounter analysis given that its directive is to ensure the EQRO has a complete understanding of state requirements and standards for collecting and submitting encounter data (CMS, 2023). Activity 1 includes types of encounters to validate, definitions of encounter data error types, format for submitting encounters (837 standard transactions), and edit checks. Activity 2 is the evaluation of MCOs' information systems and capability to collect complete and accurate encounter data and report high-quality encounter data, understand the flow of data, and how encounter processing issues are handled.

The Department required the MCOs to submit all CY 2023 encounters by June 28, 2024. In July 2024, Hilltop reviewed the 2023 release of the CMS Protocol 5 requirements and encounter data validation activities and found that no changes were required to the procedures for data validation (CMS, 2023). Hilltop also participated in Encounter Data Workgroup meetings with the Department and MCOs regarding the quality of encounter data. Hilltop then confirmed the proposed procedures for data validation with the Department and reviewed and finalized the methodology prior to performing this encounter data validation analysis. Next, Hilltop analyzed encounter data as of August 2024, including both denied encounters and accepted encounters with 2023 dates of service. The review and audit processes for CY 2023 encounters concluded in October 2024.

Activity 3. Analysis of Electronic Encounter Data

In accordance with Hilltop's interagency governmental agreement with the Department to host a secure data warehouse for its encounters and provide data-driven policy consultation, research, and analytics, Hilltop completed Activity 3 of the encounter data validation.

Activity 3 requires the following four steps for analysis:

1. Develop a data quality test plan based on data element validity requirements
2. Encounter data macro-analysis—verification of data integrity
3. Encounter data micro-analysis—generate and review analytic reports
4. Compare findings to state-identified benchmarks

Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements

Hilltop incorporated information in Activities 1 and 2 to develop a data quality test plan. This plan accounts for the MMIS (front-end) edits and adjudication edits built into the state's data system (MMIS) so that it pursues data problems that the state may have inadvertently missed or allowed (CMS, 2023).

Hilltop first met with the Department in August 2018 to obtain pertinent information regarding the processes and procedures used to receive, evaluate, and report on the validity of MCO encounter data. Hilltop also interviewed the Department staff to document state processes for

accepting and validating the completeness and accuracy of encounter data; this information was used to investigate and determine the magnitude and types of missing encounter data and identify potential data quality and MCO submission issues. Information provided included, but was not limited to, the following:

- MCO submission of encounter data in an X12 data standard (837), via a secure EDI system, to the Department; the transfer of those data to the Department's mainframe for processing and validation checks; generation of exception (error) reports (8ER) and Remittance Advice (835).
    - The 837 transaction set contains patient claim information, and the 835 transaction set contains the claim remittance advice/payment and/or explanation of benefits data.
    - The Department's EDI system receives encounter data from the MCOs in a format that is HIPAA EDI X12 837-compliant. If the 837 is non-compliant it will be rejected back to the MCO for resubmission and MMIS never sees this type of rejection. Once MMIS confirms that the 837 compliance is sound, it then translates the data for MMIS to adjudicate. The results of the adjudication are then given back to the EDI system to generate exception (error) reports and a HIPAA X12 835-compliant file. The summarized version of exceptions is known to the Department and the MCOs as the "8ER" report.
- Encounter data fields validated through the MMIS process include recipient ID, sex, age, diagnosis codes, and procedure codes.
    - Beyond checking for numeric characters, the MMIS does not perform validation checks on the completeness or accuracy of provider reimbursement fields,[7] (those showing how much the MCO paid the provider for delivering the service).
- The Department processes incoming encounter data from the MCOs within one to two business days.
- Error code (exception) reports (835 and 8ER) are generated by the adjudication process and sent to the MCOs.

Hilltop receives the daily EDI error report data (the 8ER report) and analyzes the number, types, and reasons for failed/denied encounter submissions for each MCO. This report includes an analysis of the frequency of different error types and denial categories. The 8ER error descriptions were used to develop a comprehensive overview of the validation process.

Hilltop also reviews the accepted encounter data for accuracy, completeness, and timeliness of MCO data submission.

Hilltop meets with the Department annually to discuss encounter data analysis, strategize efforts for improvement, and coordinate messaging on these topics. Major topics of discussion have

[7] For Institutional and Medical encounters, this is the "amt_pay_by_mco" field.

included the completion of provider reimbursement fields, the use of sub-indicators in the same, provider enrollment edits, and denied encounter error rates. Hilltop also discussed with the Department the provider enrollment edits that took effect in January 2020. These edits were a response to the 2016 Medicaid managed care final rule, which required states to screen and enroll all managed care network providers who are not already enrolled in FFS.[8] Hilltop met with the Department regarding the increase in provider-related encounter denials in May 2021, October 2022, July 2023, February 2024, and June 2024 to coordinate further investigation of the issue. In consultation with the Department, Hilltop developed and maintains the categorization of provider-related denial codes to distinguish the provider-related issues tied to enrollment from all other provider-related denial codes.

The CY 2023 MCO contract initially established potential penalties for MCOs for submitting a high volume of denied encounters. This penalty was intended to improve the accuracy and quality of encounter data used for risk adjustment of capitated rates and to maintain compliance with the federal rule strengthening the requirements for data, transparency, and accountability.

During 2023, in response to concerns about the increased number of denied encounters impacting rate setting and risk adjustment, the Department requested that Hilltop collect denied encounters from the MCOs. Hilltop was able to identify denied encounters (or encounters with a claim status type 'X')[9] in its data warehouse that were previously unknown and therefore did not need to separately collect these encounters from the MCOs directly. Hilltop analyzed these denied encounters and found they may provide a more complete picture of the final adjudication status of encounters than using the 8ER reports alone. This analysis uses a methodology developed by Hilltop to de-duplicate the encounter submissions, which is not done when generating the 8ER reports. Per the MCO CY 2024 contract, the Department convened workgroups with the MCOs and Hilltop to further refine the appropriateness of these denials. The universe of encounters that were appropriately denied will then be sent to the state's auditor. The auditor will ensure that these encounters are not included in MCO HealthChoice Financial Monitoring Report (HFMR) costs, which are used to set MCO capitation for future calendar years. See Appendix A for additional instructions on which denied encounters to include and exclude in the HFMR.

Hilltop compared the Claim Status Type X (CLMSTAT=X) data sets[10] and the 8ER data and determined these data sets can be linked to identify the procedure/revenue codes causing specific kinds of errors. For example, Hilltop examined the invoice control numbers (ICNs) with error code 437 and linked them to the 8ER data to determine which procedure or revenue code caused the error. Hilltop generated a complete list of procedure and revenue codes that triggered the 437 exceptions and identified which codes occur most often and can be included in

[8] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,890 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).

[9] X is an internal MMIS code that goes to Hilltop.

[10] Data sets are now maintained as part of Hilltop's data warehouse.

the HFMR. For validation, Hilltop examined 835 data that contained an associated error of 437 and linked the ICN to the equivalent 8-ER and CLMSTAT=X data sets.

The Encounter Data Workgroup with the MCOs has addressed the issues of exception errors, encounter denials, provider enrollment, and provider enrollment edit exceptions ("free agent") usage and monitoring. The Department also provided updates on the Transformed Medicaid Statistical Information System (T-MSIS),[11] procedure codes, diagnosis codes, duplicate denials, and encounter processing resolutions, including a solution for avoiding duplicate denied encounters with instructions on how to bill for specific modifiers. Hilltop also presented the rejected encounter error rate and de-duplication methodology, and the Department explained that this process was designed to help define the encounters that should be excluded from the HFMR. During the April 2024 Workgroup meeting, Hilltop presented the HFMR instructions, the results of the exception code 437 analysis, conditions where the provider paid amount is $0, and the MCO suggested exceptions.

Hilltop used the Department's information regarding encounter data that failed the edit checks (denied encounters), reasons for failure by the EDI, and comparisons with CY 2021 through CY 2023 denial results to conduct analyses. Hilltop also used these data and knowledge of the MCOs' relationships with providers to identify specific areas to investigate for missing services; data quality problems, such as the inability to process or retain certain fields; and problems MCOs might have compiling their encounter data and submitting the data files.

Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity

Hilltop reviewed encounter data for accuracy and completeness by conducting integrity checks of the data files and automating the analyses. The analysis includes verifying that the state's identifiers (IDs)[12] are accurately incorporated into the MCO information system; applying other consistency checks, such as verifying critical fields containing non-missing data; and inspecting the data fields for quality and general validity. Hilltop evaluated the ratio of participants to total accepted encounters by MCO to assess whether the distribution was similar across MCOs. Selected fields not verified by the Department during the EDI process in Step 1 were assessed for completeness and accuracy. Hilltop investigated how completely and accurately the MCOs populated provider reimbursement fields when submitting encounter data to the Department following the new mandate effective January 1, 2018.

Hilltop then assessed how many medical encounters with a provider reimbursement amount of $0 were identified as sub-capitated reimbursements or denied reimbursements (MCO denied the provider claim) and compared the amount entered in the provider reimbursement field with the amount listed in the FFS fee schedule. In addition, Hilltop analyzed the completion of the institutional provider reimbursement data. Hilltop performed an analysis of the $0

[11] See August 10, 2018 letter to State Health Officials (SHO# 18-008) providing guidance to states regarding expectations for Medicaid and CHIP data and ongoing T-MSIS implementation at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO18008.pdf

[12] recipno, begdos, enddos, ICN, prov, icd10 diagnosis codes, icd10 procedure codes, billdate.

reimbursement encounters by MCO, aggregated by the contract information segment, CN1, with indicators of 05 (sub-capitated), 09 (denied), and indicator not present.

Hilltop investigated the third-party liability (TPL) variable in MCO encounters to determine whether MCOs are reporting these encounters appropriately. Finally, Hilltop assessed the MCO provider numbers to ensure that encounters received and accepted only included providers currently active within the HealthChoice program.

Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports

Hilltop analyzed and interpreted data based on the submitted fields, volume and consistency of the encounter data, and utilization rates. Hilltop specifically conducted analyses for other volume/consistency dimensions in three primary areas: time, service type, and appropriateness of diagnosis and procedure codes based on patient age. The Department helped identify several specific analyses for each primary area related to policy interests; the results can inform the development of long-term strategies for monitoring and assessing the quality of encounter data.

Hilltop conducted an analysis of encounter data by time dimensions (i.e., service date and processing date) to show trends and evaluate data consistency. After establishing the length of time between service dates and processing dates, Hilltop compared these dimensions with state standards or benchmarks for data submission and processing. Hilltop also compared time dimension data between MCOs to determine whether they process data within similar time frames.

The service type analysis concentrated on three main service areas: inpatient hospitalizations, emergency department (ED) visits, and observation stays. The CY 2021 analysis provides baseline data and allows the Department to identify any inconsistencies in utilization patterns for these types of services in CY 2022 and CY 2023. Rates of inpatient hospitalizations and observation stays remained stable, while ED visits increased slightly over the evaluation period.

Finally, Hilltop analyzed the age appropriateness of diagnosis and procedure codes. Specifically, Hilltop conducted analyses of enrollees aged 66 years or older, deliveries (births), the presence of Alzheimer's disease and other types of dementia diagnosis, and dental services. Hilltop conducted an analysis for delivery diagnosis codes. Participants older than 65 are ineligible for HealthChoice; therefore, any encounters for this population were noted, which could indicate an error in a participant's date of birth. Hilltop also conducted an analysis of dental encounters for enrollees whose dental services should have been covered through the FFS system.

Step 4. Compare Findings to State-Identified Benchmarks

In Steps 2 and 3, Hilltop compared the encounter data submitted by each MCO with benchmarks identified by the Department. Hilltop performed the analyses by MCO and calendar year to benchmark each MCO against its own performance over time, as well as against other MCOs. Hilltop also identified and compared outlier data with overall trends noted among the MCOs.

Results of Activity 3: Analysis of Electronic Encounter Data

Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements

The Department sent Hilltop the 8ER reports for CY 2021 through CY 2023, which included encounters that failed the initial National Provider ID (NPI) Crosswalk process (denied encounters). Overall, Hilltop classifies the MMIS edits resulting in denied encounters into five categories: missing data, participant not eligible for service, value not valid for the field, inconsistent data, and duplicates[13] (Note: duplicates are not reported in the 8ER file).

Hilltop performed checks on critical fields for missing, invalid (incorrect), and inconsistent data, including provider number, units of service, drug number, drug quantity, revenue code, procedure code, and diagnosis code. Hilltop identified eligibility issues for participants who were not eligible for MCO services at the time of the service. Examples of inconsistent data include discrepancies between dates, inconsistencies between diagnosis and age or sex, and inconsistencies between original and resubmitted encounters.

Table 1 presents the distribution of denied encounters submitted by all MCOs, by category, for CY 2019 to CY 2023.

Table 1. Distribution of Denied Encounter Submissions by EDI Denial Category, CY 2019–CY 2023

Denial Category	CY 2019 (Baseline)		CY 2020		CY 2021		CY 2022		CY 2023	
	# of Denied Encounters	% of Total	# of Denied Encounters	% of Total	# of Denied Encounters	% of Total	# of Denied Encounters	% of Total	# of Denied Encounters	% of Total
Duplicate	**103,108**	**5.4%**	**480,007**	**7.1%**	77,347	1.8%	60,723	1.6%	49,319	1.6%
Inconsistent	**46,438**	**2.5%**	**78,017**	**1.1%**	40,841	0.9%	123,034	3.2%	51,590	1.6%
Missing	**595,697**	**31.5%**	**1,053,540**	**15.5%**	753,586	17.1%	533,411	13.8%	456,532	14.4%
Not Eligible	**814,451**	**43.0%**	**450,374**	**6.6%**	321,135	7.3%	529,468	13.7%	440,067	13.8%
Not Valid	**334,314**	**17.7%**	**4,737,893**	**69.7%**	3,224,378	73.0%	2,613,590	67.7%	2,180,179	68.6%
Total	**1,894,008**	**100%**	**6,799,831**	**100%**	**4,417,287**	**100%**	**3,860,226**	**100%**	**3,177,687**	**100%**

Overall, the number of denied encounters decreased by 28.1% from CY 2021 to CY 2023. However, the number of denied encounters increased from 1,894,008 in CY 2019 to 6,799,831 in CY 2020; an increase of 259%. While the denied encounters from the 8ER reports are not de-duplicated, the number of rejected encounters in CY 2023 is still much higher as compared to CY 2019. In 2023, the Department asked Hilltop to analyze denied encounters for purposes of capitated rate risk adjustment. To determine the total number of denied encounters that were potentially missing from the base data used for risk adjustment, Hilltop developed a process to identify and de-duplicate denied encounters using data received from MMIS, which is not done when generating the 8ER reports. The 8ER reports include many encounters that are resubmitted with new ICNs for a previously submitted denied encounter that had a different ICN.

[13] Refer to Appendix C for categorization of denials.

Most of the denied encounters were due to invalid data or incorrect provider data, and this can largely be attributed to the addition of provider enrollment encounter (NPI Crosswalk) edits that went live on January 1, 2020 (see Provider Enrollment-Related Encounter Data Validation section below for details). The Department worked with the MCOs for two years prior to the provider enrollment edits becoming effective to ensure that their providers were enrolled in FFS via the electronic provider revalidation and enrollment portal (ePREP). In addition, the Department worked with the MCOs on how to implement the Provider Master File and crosswalk the Billing/PayTo and Rendering NPI to a Medicaid Provider ID using the NPI crosswalk flowchart. However, many providers failed to enroll by January 1, 2020, or submitted enrollment information that was inconsistent with the encounter data submitted to the Department. The total number of denied encounters due to invalid data decreased by 32.4% during the evaluation period, but the share of all denied encounters attributed to invalid data decreased by only 4.4 percentage points between CY 2021 and CY 2023.

Throughout the reporting period, "Not Valid" denials were the most common, with "Missing" and "Not Eligible" denials rounding out the top three. The following categories of denials decreased in number: duplicate encounters, missing encounters, and invalid encounters.

Analyzing denied encounters by MCO is useful for assessing trends and identifying issues that are specific to each MCO. This allows the Department to monitor and follow up with the MCOs on potential problem areas. Table 2 presents the distribution of denied and accepted encounter submissions across MCOs for CY 2021 through CY 2023.

Table 2. Distribution of Denied and Accepted Encounter Submissions by MCO, CY 2021–CY 2023

Denied Encounters						
MCO	CY 2021		CY 2022		CY 2023	
	Number of Denied Encounters	Percentage of All Denied Encounters	Number of Denied Encounters	Percentage of All Denied Encounters	Number of Denied Encounters	Percentage of All Denied Encounters
ABH	432,360	9.8%	105,659	2.7%	86,015	2.7%
CFCHP	323,604	7.3%	342,384	8.9%	92,812	2.9%
JMS	197,734	4.5%	252,155	6.5%	39,812	1.3%
KPMAS	286,174	6.5%	218,981	5.7%	163,828	5.2%
MPC	768,064	17.4%	585,477	15.2%	548,767	17.3%
MSFC	170,138	3.9%	70,142	1.8%	354,471	11.2%
PPMCO	977,473	22.1%	1,346,750	34.9%	1,102,763	34.7%
UHC	666,075	15.1%	558,659	14.5%	369,009	11.6%
WPM*	595,665	13.5%	380,019	9.8%	420,210	13.2%
Total	**4,417,287**	**100%**	**3,860,226**	**100%**	**3,177,687**	**100%**
Accepted Encounters						
MCO	CY 2021		CY 2022		CY 2023	
	Number of Accepted Encounters	Percentage of All Accepted Encounters	Number of Accepted Encounters	Percentage of All Accepted Encounters	Number of Accepted Encounters	Percentage of All Accepted Encounters
ABH	1,312,880	3.0%	1,465,995	3.2%	1,493,493	3.3%
CFCHP	1,892,492	4.3%	2,393,506	5.3%	2,833,925	6.2%
JMS	1,235,612	2.8%	1,141,684	2.5%	1,056,101	2.3%
KPMAS	2,914,875	6.6%	3,059,397	6.7%	3,148,718	6.9%
MPC	8,250,416	18.6%	8,240,573	18.1%	8,080,070	17.6%
MSFC	3,413,822	7.7%	3,340,877	7.3%	3,389,419	7.4%
PPMCO	11,472,685	25.9%	12,115,262	26.6%	11,833,483	25.8%
UHC	5,390,628	12.2%	5,195,084	11.4%	5,030,139	11.0%
WPM*	8,399,279	19.0%	8,614,423	18.9%	8,973,366	19.6%
Total	**44,282,689**	**100%**	**45,566,801**	**100%**	**45,838,714**	**100%**

* Wellpoint Maryland (WPM). Previously Amerigroup Community Care (ACC) prior to January 1, 2023.

The volume of denied encounters decreased across many MCOs between CY 2021 and CY 2023, largely due to the implementation and usage of the Department's Provider Master File. While there was an overall increase in denied encounters for MedStar Family Choice, Inc. (MSFC) and Priority Partners (PPMCO), there were decreases for Aetna Better Health (ABH), CareFirst Community Health Plan (CFCHP), and Jai Medical Systems (JMS), followed by Kaiser Permanente of the Mid-Atlantic States (KPMAS), Maryland Physicians Care (MPC), United Health Care (UHC), and Wellpoint Maryland (WPM).

PPMCO had the highest share (34.7%) of all denials in CY 2023—an increase of 12.6 percentage points from CY 2021. Also notable, MPC had 17.3% of all denials although that rate has been steady from CY 2021 to CY 2023. MSFC had 11.2% of all denials in CY 2023, an increase of 9.4

percentage points from CY 2022, and an increase of 7.3 percentage points from CY 2021. ABH remained at 2.7% from CY 2022 to CY 2023, a decrease of 7.1 percentage points from CY 2021. CFCHP submitted 2.9% of the total denied encounters in CY 2023—a decrease of 6.0 percentage points from CY 2022, and a decrease of 4.4 percentage points from CY 2021. Additionally, JMS experienced a decrease of 3.4 percentage points of all denials from CY 2021 to 2023 followed by UHC with a decrease of 3.5 percentage points.

ABH, CFCHP, JMS, and KPMAS each had less than 6.0% of the denied encounters in CY 2023. KPMAS decreased its share of denials by 1.3 percentage points from CY 2021 to CY 2023, while ABH's, CHFCHP's, and JMS's share of denials fluctuated during the evaluation period.

Although there was some variation among MCOs in the distribution of the total denied encounters from CY 2021 to CY 2023, there was very little variation in the distribution of accepted encounters among MCOs, except for UHC and MPC, whose shares decreased by 1.2 and 1.0 percentage points, respectively, and CFCHP, whose shares increased by 1.9 percentage points. All the other MCOs had less than a 1.0 percentage point change during the evaluation period.

Tables 3 and 4 show the rate of encounters denied by the MMIS by category and MCO. Specifically, Table 3 presents the percentage of denied encounters by MMIS denial category and MCO for CY 2023. See Appendix B for a graphical representation of Table 3.

Table 3. Percentage of Denied Encounters by MMIS Denial Category by MCO, CY 2023

Denial Category	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Duplicate	0.2%	0.9%	1.5%	0.9%	0.6%	2.2%	0.5%	6.9%	0.9%
Inconsistent	0.5%	0.2%	0.2%	2.1%	0.5%	0.1%	0.1%	2.7%	7.9%
Missing	18.8%	12.2%	11.1%	22.5%	13.5%	15.4%	13.3%	11.4%	16.6%
Not Eligible	2.8%	13.6%	28.5%	8.4%	9.4%	24.4%	13.3%	12.7%	16.3%
Not Valid	77.7%	73.1%	58.7%	66.1%	75.9%	57.9%	72.8%	66.2%	58.3%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

For all MCOs, the primary reasons for denial of encounters in CY 2023 were categorized as "Not Valid" (ranging from 57.9% to 77.7%). The second most common denial category was tied between "Missing" and "Not Eligible." ABH, KPMAS, MPC, and WPM had "Missing" as their second-highest category, while CFCHP, JMS, MSFC, and UHC had "Not Eligible" as their second-highest category. PPMCO's second-highest category was equally distributed between "Missing" and "Not Eligible." For all MCOs, encounters denied for reasons grouped under the "Duplicate" category remained below 3.0%, other than UHC, where "Duplicate" represented 6.9% of denied encounters. Encounters denied as "Inconsistent" remained below 3.0% for all MCOs except WPM, where "Inconsistent" represented 7.9% of denied encounters.

Table 4 presents the distribution of the rejection reason category and how it changed for each MCO between CY 2021 and CY 2023.

Table 4. Number and Percentage of Denied Encounters by Denial Category and MCO, CY 2021–CY 2023

Denial Category	Year	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Duplicate	CY 2021	2,054	39,546	665	3,790	11,082	45	2,439	16,205	1,521	**77,347**
		0.5%	12.2%	0.3%	1.3%	1.4%	0.0%	0.2%	2.4%	0.3%	**1.8%**
	CY 2022	16	8,759	957	823	27,283	607	3,738	14,558	3,982	**60,723**
		0.0%	2.6%	0.4%	0.4%	4.7%	0.9%	0.3%	2.6%	1.0%	**1.6%**
	CY 2023	186	843	594	1,430	3,309	7,729	5,892	25,473	3,863	**49,319**
		0.2%	0.9%	1.5%	0.9%	0.6%	2.2%	0.5%	6.9%	0.9%	**1.6%**
Inconsistent	CY 2021	6,386	2,399	209	3,771	6,792	3,000	1,145	9,450	7,689	**40,841**
		1.5%	0.7%	0.1%	1.3%	0.9%	1.8%	0.1%	1.4%	1.3%	**0.9%**
	CY 2022	5,162	62,819	75	3,523	1,501	741	1,253	42,262	5,698	**123,034**
		4.9%	18.3%	0.0%	1.6%	0.3%	1.1%	0.1%	7.6%	1.5%	**3.2%**
	CY 2023	396	190	76	3,472	2,865	349	1,090	9,883	33,269	**51,590**
		0.5%	0.2%	0.2%	2.1%	0.5%	0.1%	0.1%	2.7%	7.9%	**1.6%**
Missing	CY 2021	82,627	31,378	78,907	55,501	89,383	52,811	189,734	82,140	91,105	**753,586**
		19.1%	9.7%	39.9%	19.4%	11.6%	31.0%	19.4%	12.3%	15.3%	**17.1%**
	CY 2022	14,259	28,442	73,168	43,191	55,069	9,998	193,751	62,825	52,708	**533,411**
		13.5%	8.3%	29.0%	19.7%	9.4%	14.3%	14.4%	11.2%	13.9%	**13.8%**
	CY 2023	16,175	11,279	4,430	36,940	74,222	54,668	147,022	42,153	69,643	**456,532**
		18.8%	12.2%	11.1%	22.5%	13.5%	15.4%	13.3%	11.4%	16.6%	**14.4%**
Not Eligible	CY 2021	2,201	36,708	12,929	13,326	37,778	8,609	129,848	60,205	19,531	**321,135**
		0.5%	11.3%	6.5%	4.7%	4.9%	5.1%	13.3%	9.0%	3.3%	**7.3%**
	CY 2022	1,887	23,185	12,291	19,887	83,513	8,762	304,498	50,187	25,258	**529,468**
		1.8%	6.8%	4.9%	9.1%	14.3%	12.5%	22.6%	9.0%	6.6%	**13.7%**
	CY 2023	2,393	12,665	11,331	13,768	51,771	86,358	146,334	47,036	68,411	**440,067**
		2.8%	13.6%	28.5%	8.4%	9.4%	24.4%	13.3%	12.7%	16.3%	**13.8%**
Not Valid	CY 2021	339,092	213,573	105,024	209,786	623,029	105,673	654,307	498,075	475,819	**3,224,378**
		78.4%	66.0%	53.1%	73.3%	81.1%	62.1%	66.9%	74.8%	79.9%	**73.0%**
	CY 2022	84,335	219,179	165,664	151,557	418,111	50,034	843,510	388,827	292,373	**2,613,590**
		79.8%	64.0%	65.7%	69.2%	71.4%	71.3%	62.6%	69.6%	76.9%	**67.7%**
	CY 2023	66,865	67,835	23,381	108,218	416,600	205,367	802,425	244,464	245,024	**2,180,179**
		77.7%	73.1%	58.7%	66.1%	75.9%	57.9%	72.8%	66.2%	58.3%	**68.6%**
Total Denied Encounters	**CY 2021**	**432,360**	**323,604**	**197,734**	**286,174**	**768,064**	**170,138**	**977,473**	**666,075**	**595,665**	**4,417,287**
	CY 2022	**105,659**	**342,384**	**252,155**	**218,981**	**585,477**	**70,142**	**1,346,750**	**558,659**	**380,019**	**3,860,226**
	CY 2023	**86,015**	**92,812**	**39,812**	**163,828**	**548,767**	**354,471**	**1,102,763**	**369,009**	**420,210**	**3,177,687**

The greatest number of denied encounters during the evaluation period were in the "Not Valid" category. The total number of "Not Valid" encounters decreased from 3,224,378 to 2,180,179 between CY 2021 and CY 2023, but the proportion of all denied encounters categorized as "Not Valid" remained fairly stable. The impact of invalid data was not spread evenly across MCOs throughout the evaluation period. In CY 2023, the rate of denials categorized as "Not Valid" ranged from 57.9% of MSFC's denials on the low end to 77.7% of ABH's denials at the high end.

In the "Missing" denial category, all MCOs except one experienced a decrease in the number of denials throughout the evaluation period. From CY 2021 to CY 2023, MSFC experienced an increase of 1,857 encounter denials.

MCOs showed varied results in the numbers and percentages of denied encounters in the "Inconsistent" category. The total number of denials categorized as "Inconsistent" during the evaluation period decreased for all MCOs except UHC, which increased slightly (4.6% increase), and WPM, which increased significantly (over 300% increase). Expressed as a percentage of all denied encounters, JMS, KPMAS, MPC, MSFC, and PPMCO demonstrated stability in the rate of denials categorized as "Inconsistent," with year-over-year changes of one percentage point or less. By contrast, the rate for ABH, CFCHP, UHC, and WPM varied widely, up to 18.1 percentage points (CFCHP, CY 2022 to CY 2023).

While the number of encounter denials categorized as "Duplicate" increased for four of the nine MCOs (MSFC, PPMCO, UHC, and WPM), the remaining MCOs (ABH, CFCHP, JMS, KPMAS, and MPC) decreased in the number of these denials, with CFCHP having the greatest decline from 39,546 in CY 2021 to 843 in CY 2023. UHC saw the largest increase in the number of denials categorized as "Duplicate," from 16,205 in CY 2021 to 25,473 in CY 2023.

In CY 2023, JMS had the largest percentage of encounters denied in the "Not Eligible" category (28.5%), and ABH had the lowest (2.8%). The percentage of denials for all MCOs increased from CY 2021 to CY 2023—except for PPMCO, which initially increased from 13.3% in CY 2021 to 22.6% in CY 2022 and decreased to 13.3% in CY 2023.

Overall, between CY 2021 and CY 2023, there was a decrease in denials marked "Duplicate," "Missing," and "Not Valid" while there was an increase in denials marked "Inconsistent" and "Not Eligible," though both decreased since CY 2022. In CY 2023, the greatest decrease in the share of denials was in the "Not Valid" category, which decreased by 4.4 percentage points.

Provider Enrollment-Related Encounter Data Validation

Hilltop conducted an additional review of the 8ER reports to analyze the high rates of encounters that failed initial MMIS edits—particularly for incorrectly submitted or invalid data. Further research revealed that the 8ER high denial rates were related to issues with the MCO implementation and usage of the Provider Master File. The provider data, which are collected via ePREP and rekeyed into MMIS, underwent changes that affected the data beginning January 1, 2020. After two years of collaborative preparation with the MCOs, the provider system

implemented new rules that require the NPI on any encounter to match the active NPI under which the provider enrolled with Medicaid for both the billing and rendering fields.[14] To remain actively enrolled with Medicaid, providers must perform actions such as updating their licensure on the ePREP portal. Failure to do so can affect a provider's active status and thus jeopardize the successful submission of encounters.

Prior to 2020, MCOs used the MCO Network Provider File and could use any NPI on the encounter in the billing and rendering fields if it matched an active Medicaid Provider ID on the MCO Network Provider File stored in MMIS. The encounter process would attempt to link the NPI with that provider and adjudicate the encounter (accepted/denied). The provider enrollment edits—intended to improve the accuracy of provider details—were implemented in response to CMS requirements. See Appendix C for a list of denial codes divided into those relating to provider data and all others, and then subdivided by denial category for CY 2023 encounters.

Table 5 presents denied encounters by MCO, divided into provider enrollment-related and all other denials for CY 2021 to CY 2023. See Appendix D for more specific information about the top three most common MCO-specific EDI denial codes (errors) for CY 2023.

Table 5. Number of Denied Encounters for Provider Enrollment-Related and Other Denial Types by MCO, CY 2021–CY 2023

Denial Type	MCO	CY 2021	CY 2022	CY 2023
Provider Enrollment-Related	ABH	213,977	61,134	47,145
	CFCHP	171,835	167,242	47,600
	JMS	87,223	79,497	8,082
	KPMAS	161,576	101,865	70,375
	MPC	462,622	316,131	332,459
	MSFC	44,877	29,275	62,434
	PPMCO	428,998	605,207	592,545
	UHC	323,994	250,417	179,948
	WPM	358,314	221,095	170,511
	Subtotal	**2,253,416**	**1,831,863**	**1,511,099**
Other	ABH	218,383	44,525	38,870
	CFCHP	151,769	175,142	45,212
	JMS	110,511	172,658	31,730
	KPMAS	124,598	117,116	93,453
	MPC	305,442	269,346	216,308
	MSFC	125,261	40,867	292,037
	PPMCO	548,475	741,543	510,218
	UHC	342,081	308,242	189,061
	WPM	237,351	158,924	249,699
	Subtotal	**2,163,871**	**2,028,363**	**1,666,588**
Total		**4,417,287**	**3,860,226**	**3,177,687**

*In the CY 2020 to CY2022 report, one denial code was miscategorized as "other" instead of "provider-enrollment related." This has been corrected, and the results for CY 2021 and 2022 were revised.

[14] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,890 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440,457 and 495).

The number of provider enrollment-related denials decreased for all MCOs from CY 2021 to CY 2023, except for MSFC and PPMCO. The decline was lowest for MPC (28.1%) and highest for JMS (90.7%). Almost all MCOs had a notable decrease in the number of denials due to provider enrollment-related encounters from CY 2022 to CY 2023, except for MPC (increased by 5.2%), and MSFC (increased by 113.3%).

Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity

During CY 2023, the MCOs submitted a total of 45.8 million accepted encounters (records), which was an increase from 45.6 million in CY 2022 and 44.3 million in CY 2021. Enrollment continued to be high during the evaluation period due to continuous eligibility requirements of the COVID-19 public health emergency (PHE), which ended May 11, 2023.[15] Although with the Department's redetermination efforts, enrollment remained high through the end of CY 2023, despite the unwinding of the continuous eligibility requirements.[16] Utilization as measured by the volume of accepted encounters continued to rise from CY 2021 through CY 2023. To estimate the overall total number of encounters submitted, Hilltop added the number of accepted encounters to the number of MMIS-denied encounters. Using that method, a total of approximately 48.7 million encounters were submitted in CY 2021. This number increased to 49.4 million encounters in CY 2022 but fell to 49.0 million encounters in CY 2023. Approximately 93.5% of the CY 2023 encounters were accepted into MMIS, which is higher than the 92.2% acceptance rate during CY 2022 and the 90.0% acceptance rate during CY 2021.

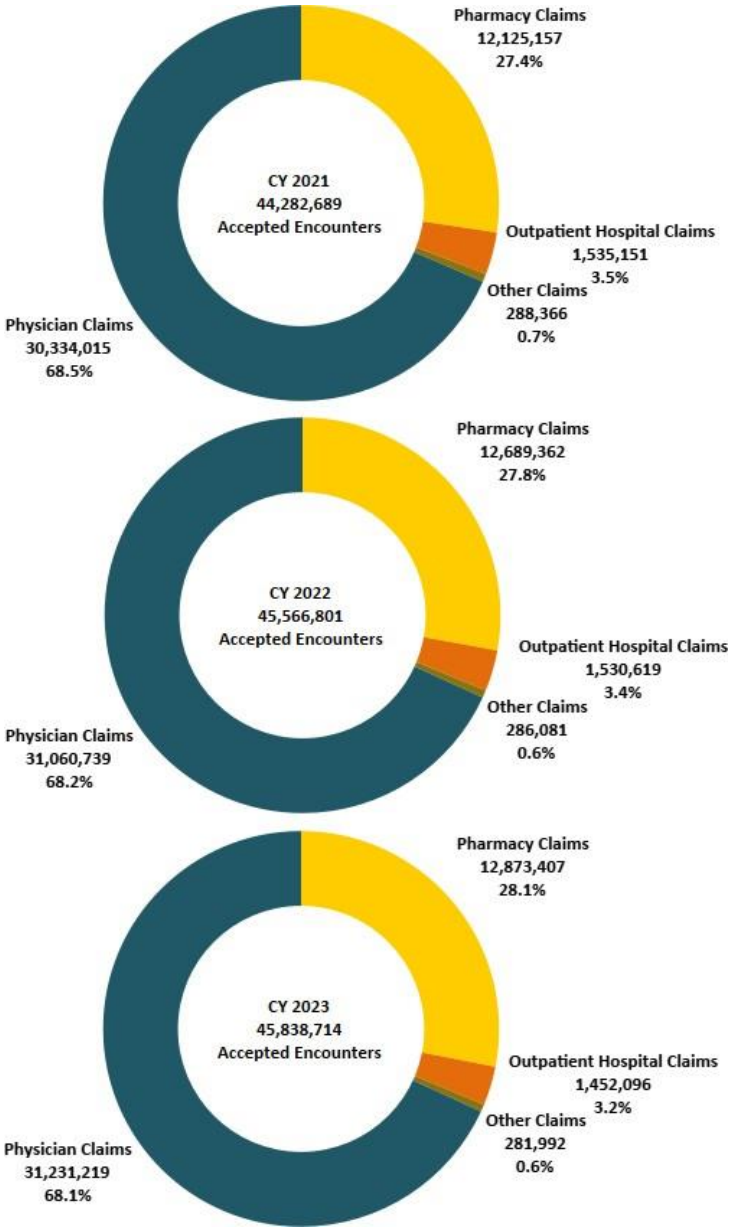
Hilltop received a monthly copy of all encounters accepted by MMIS. Upon receipt of the accepted encounters, Hilltop performed several validation assessments and integrity checks of the fields to analyze and interpret the accuracy and completeness of the data. These assessments included determining whether there was an invalid end date of service or other errors. The Department sends monthly encounter files to Hilltop. Denied encounter records are excluded before being imported into Hilltop's data warehouse.

Figure 1 shows the distribution of accepted encounter submissions by claim type (physician claim, pharmacy claim, outpatient hospital claim, and other claims) from CY 2021 to CY 2023.

[15] https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning- regular-operations-after-covid-19/index.html

[16] https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-recognized-as-a-top-state-as-it- completes-yearlong-Medicaid-redeterminations-process.aspx

Figure 1. Number and Percentage of Accepted Encounters by Claim Type, CY 2021–CY 2023



The distribution of accepted encounters by claim type changed slightly from CY 2021 to CY 2023. Physician claims represented most of the encounters during the evaluation period (roughly two-thirds), followed by pharmacy claims (just over one-quarter). Across the evaluation period, other encounters—including inpatient hospital stays, community-based services, and long-term care services—accounted for less than 1% of services.

Table 6 displays the percentage and number of accepted encounters by claim type for each MCO from CY 2021 to CY 2023.

Table 6. Distribution of Accepted Encounters by Claim Type and MCO, CY 2021–CY 2023

Claim Type	Year	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Physician Claims	CY 2021	71.8%	67.5%	62.6%	75.9%	66.8%	67.7%	67.2%	73.3%	67.2%
		943,246	1,277,419	773,641	2,212,349	5,510,114	2,311,286	7,710,525	3,949,335	5,646,100
	CY 2022	69.1%	68.7%	59.8%	74.5%	66.3%	66.5%	67.6%	72.1%	67.5%
		1,013,129	1,644,307	682,602	2,280,214	5,463,440	2,222,432	8,191,130	3,745,792	5,817,693
	CY 2023	67.4%	69.1%	58.0%	73.7%	67.3%	68.9%	65.6%	71.6%	69.0%
		1,006,943	1,958,456	612,772	2,321,226	5,439,299	2,335,553	7,765,292	3,603,109	6,188,569
Pharmacy Claims	CY 2021	24.4%	27.4%	33.1%	22.4%	28.3%	28.4%	29.0%	22.9%	28.0%
		319,923	517,959	408,946	653,626	2,333,598	969,219	3,330,404	1,235,855	2,355,627
	CY 2022	26.4%	27.5%	36.2%	23.7%	29.2%	29.2%	28.5%	23.9%	28.3%
		386,874	657,020	413,751	726,213	2,406,846	973,973	3,447,617	1,241,078	2,435,990
	CY 2023	29.0%	26.9%	37.3%	24.5%	29.1%	27.6%	29.4%	24.9%	27.8%
		433,636	763,158	394,177	772,994	2,350,299	935,295	3,478,092	1,253,464	2,492,292
Outpatient Hospital Claims	CY 2021	3.0%	4.2%	3.9%	1.0%	4.0%	3.1%	3.3%	3.2%	4.1%
		39,698	79,830	47,750	30,602	332,752	106,394	381,918	171,970	344,237
	CY 2022	3.7%	3.1%	3.6%	1.1%	3.7%	3.5%	3.5%	3.3%	3.6%
		54,446	74,166	40,800	34,086	306,000	115,292	425,008	171,977	308,844
	CY 2023	2.9%	3.2%	3.7%	1.1%	3.0%	2.8%	4.4%	2.9%	2.8%
		43,665	91,048	38,968	35,585	238,727	94,068	515,552	145,480	249,003
Other Claims	CY 2021	0.8%	0.9%	0.4%	0.6%	0.9%	0.8%	0.4%	0.6%	0.6%
		10,013	17,284	5,275	18,298	73,952	26,923	49,838	33,468	53,315
	CY 2022	0.8%	0.8%	0.4%	0.6%	0.8%	0.9%	0.4%	0.7%	0.6%
		11,546	18,013	4,531	18,884	64,287	29,180	51,507	36,237	51,896
	CY 2023	0.6%	0.8%	1.0%	0.6%	0.6%	0.7%	0.6%	0.6%	0.5%
		9,249	21,263	10,184	18,913	51,745	24,503	74,547	28,086	43,502
Total (100%)	**CY 2021**	**1,312,880**	**1,892,492**	**1,235,612**	**2,914,875**	**8,250,416**	**3,413,822**	**11,472,685**	**5,390,628**	**8,399,279**
	CY 2022	**1,465,995**	**2,393,506**	**1,141,684**	**3,059,397**	**8,240,573**	**3,340,877**	**12,115,262**	**5,195,084**	**8,614,423**
	CY 2023	**1,493,493**	**2,833,925**	**1,056,101**	**3,148,718**	**8,080,070**	**3,389,419**	**11,833,483**	**5,030,139**	**8,973,366**

The distribution of accepted encounters remained relatively consistent across MCOs and calendar years. In CY 2023, physician encounters ranged from 58.0% of encounters (JMS) to 73.7% of encounters (KPMAS). JMS had the largest percentage of CY 2023 pharmacy encounters (37.3%), while KPMAS had the lowest percentage (24.5%). Outpatient hospital encounters in CY 2023 ranged from a low of 1.1% for KPMAS to a high of 4.4% for PPMCO.

See Appendix E for a visual display of the number and percentage of accepted encounters by claim type and MCO in CY 2023.

Table 7 illustrates the distribution of HealthChoice participants and the volume of accepted encounters for each MCO during CY 2021 through CY 2023.

Table 7. Percentage of HealthChoice Participants and Accepted Encounters by MCO, CY 2021–CY 2023

MCO	CY 2021		CY 2022		CY 2023	
	Percentage of Total Participants	Percentage of All Accepted Encounters	Percentage of Total Participants	Percentage of All Accepted Encounters	Percentage of Total Participants	Percentage of All Accepted Encounters
ABH	4.0%	3.0%	4.1%	3.2%	4.5%	3.3%
CFCHP	5.0%	4.3%	5.8%	5.3%	6.7%	6.2%
JMS	2.2%	2.8%	2.1%	2.5%	2.1%	2.3%
KPMAS	7.9%	6.6%	8.1%	6.7%	8.4%	6.9%
MPC	17.1%	18.6%	16.8%	18.1%	16.5%	17.6%
MSFC	7.6%	7.7%	7.4%	7.3%	7.2%	7.4%
PPMCO	24.1%	25.9%	23.7%	26.6%	23.5%	25.8%
UHC	11.9%	12.2%	11.7%	11.4%	11.6%	11.0%
WPM	22.3%	19.0%	21.9%	18.9%	21.5%	19.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

PPMCO and WPM were the largest MCOs in CY 2023, followed by MPC, UHC, KPMAS, MSFC, CFCHP, ABH, and JMS. The distribution of accepted encounters among MCOs in CY 2021 through CY 2023 was nearly proportional to the participant distribution. For example, in CY 2023, MPC had 16.5% of all HealthChoice participants and 17.6% of all MMIS encounters.

Managed Care Regulations: Accurate and Complete Encounter Data

In 2016, CMS issued its final rule, updating Medicaid managed care regulations.[17] One of the requirements specified that MCOs must submit encounter data that are accurate and complete by January 2018.[18] To address this requirement, the Department notified Maryland MCOs in September 2017 that all encounter data submitted to the Department on or after January 1,

[17] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,498 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).

[18] 42 CFR § 438.818(a)(2).

2018, must include allowed amounts and provider reimbursement amounts on each encounter (Maryland Department of Health, 2017). In November 2020, CMS released a new final rule on managed care[19] that included technical modifications; however, it did not include changes to the EQR or encounter data reporting regulations.

In 2010, the Department and the MCOs worked together to ensure the complete and accurate submission of data showing the amount paid on behalf of MCO members for their pharmacy encounters. Pharmacy encounter data flow through a point of sale (POS) system, which ensures data accuracy at the time of submission. For nearly a decade, pharmacy encounters have been reliable, and the Department has confidence in the integrity and quality of the payment data. Beginning in October 2017, the Department used the pharmacy paid encounter process as a framework to begin receiving provider reimbursement data for all encounters.

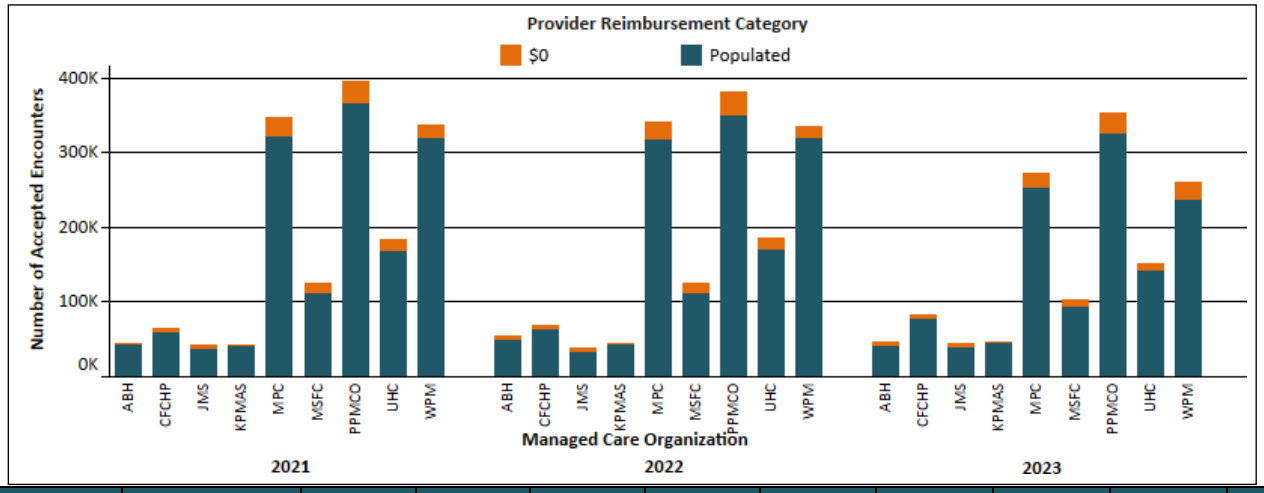
The Department staff prepared MMIS to accept provider reimbursement data for all encounters in the fall of 2017, convened technical MCO workgroups, and updated the 837 Companion Guides for professional (medical) and institutional encounters. Soon after MCOs began submitting provider reimbursement data for all encounters in January 2018, the Department staff identified errors in processing the reimbursement amount for medical and institutional encounters. In February 2018, the Department reviewed MCO submissions to determine how many encounters had missing provider reimbursement data, how many were $0 (separated by denied ('09' on the CN1 segment) and sub-capitated ('05' on the CN1 segment), and how many were or were not populated with any data at all. The Department shared its findings and met with MCOs individually to improve their submission processes. By August 2018, MMIS had received populated provider reimbursement data for all medical encounters.

In Fall 2018, the Department staff discovered that only the provider reimbursement amount for the first service line of each institutional encounter was being recorded, which underreported the total amount paid. This issue was corrected in mid-2020; MMIS now stores the correct sum for all the total paid institutional service lines. The Department continues to work with the MCOs to ensure the validity of institutional and medical encounter data.

Figure 2 displays the distribution of provider reimbursement category for accepted institutional encounter data by MCO from CY 2021 to CY 2023.

[19] Medicaid and CHIP Managed Care Final Rule. 85 Fed. Reg. 72,574 (November 13, 2020) (to be codified at 42 CFR Parts 438 and 457).

Figure 2. Number of Accepted Institutional Encounters by MCO and Provider Reimbursement Category, CY 2021–CY 2023



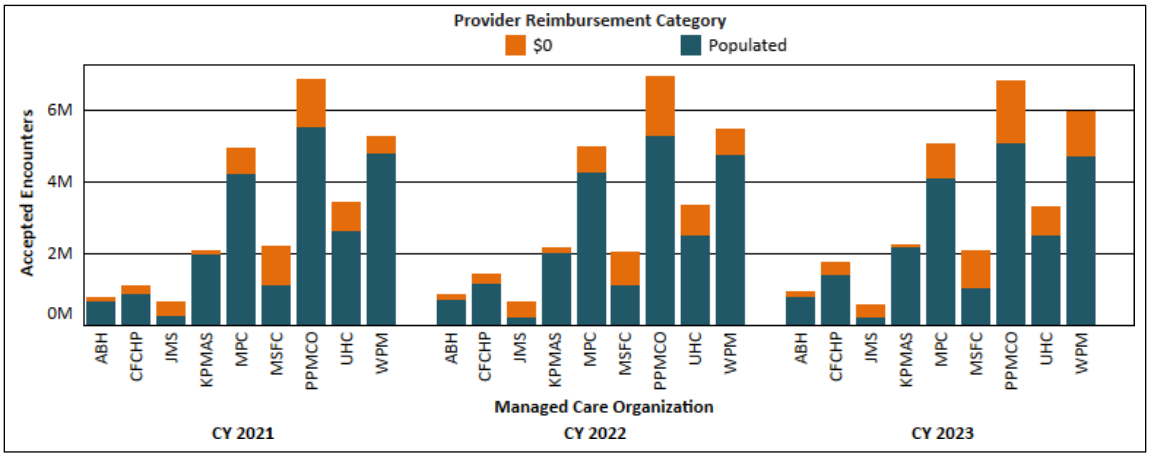
Year	Pay Category	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
CY 2021	Populated	95.1%	90.0%	84.6%	93.8%	92.7%	89.4%	92.0%	91.0%	94.7%
		42,079	57,983	36,632	39,840	320,922	111,588	364,217	167,132	318,900
	$0	4.9%	10.0%	15.4%	6.2%	7.3%	10.6%	8.0%	9.0%	5.3%
		2,178	6,451	6,648	2,638	25,219	13,300	31,556	16,432	17,700
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		44,257	**64,434**	**43,280**	**42,478**	**346,141**	**124,888**	**395,773**	**183,564**	**336,600**
CY 2022	Populated	90.0%	91.6%	83.1%	94.0%	92.8%	88.9%	91.4%	90.7%	95.1%
		48,316	62,241	32,292	42,532	316,808	110,643	348,593	168,690	319,452
	$0	10.0%	8.4%	16.9%	6.0%	7.2%	11.1%	8.6%	9.3%	4.9%
		5,367	5,695	6,562	2,691	24,422	13,816	32,885	17,318	16,372
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		53,683	**67,936**	**38,854**	**45,223**	**341,230**	**124,459**	**381,478**	**186,008**	**335,824**
CY 2023	Populated	87.6%	92.2%	86.5%	93.5%	92.4%	91.6%	92.0%	92.9%	90.6%
		40,833	76,305	37,767	43,644	251,297	93,735	324,549	140,516	236,450
	$0	12.4%	7.8%	13.5%	6.5%	7.6%	8.4%	8.0%	7.1%	9.4%
		5,775	6,487	5,875	3,016	20,679	8,631	28,090	10,736	24,536
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		46,608	**82,792**	**43,642**	**46,660**	**271,976**	**102,366**	**352,639**	**151,252**	**260,986**

The MCOs showed mixed results over the evaluation period: CFCHP, JMS, MSFC, and UHC increased the percentage of institutional encounters with populated provider reimbursement amounts, while ABH, KPMAS, MPC, and WPM decreased and PPMCO remained the same (92.0%). In CY 2023, the percentage of institutional encounters with a populated amount ranged from 86.5% (JMS) to 93.5% (KPMAS).

Figure 3 displays the number and percentage of accepted medical encounters by MCO and provider reimbursement category for CY 2021 through CY 2023. Appendix F displays the number

of accepted medical encounters by MCO and provider reimbursement category for CY 2021 to CY 2023.

Figure 3. Number of Accepted Medical Encounters by MCO and Provider Reimbursement Category, CY 2021 to 2023

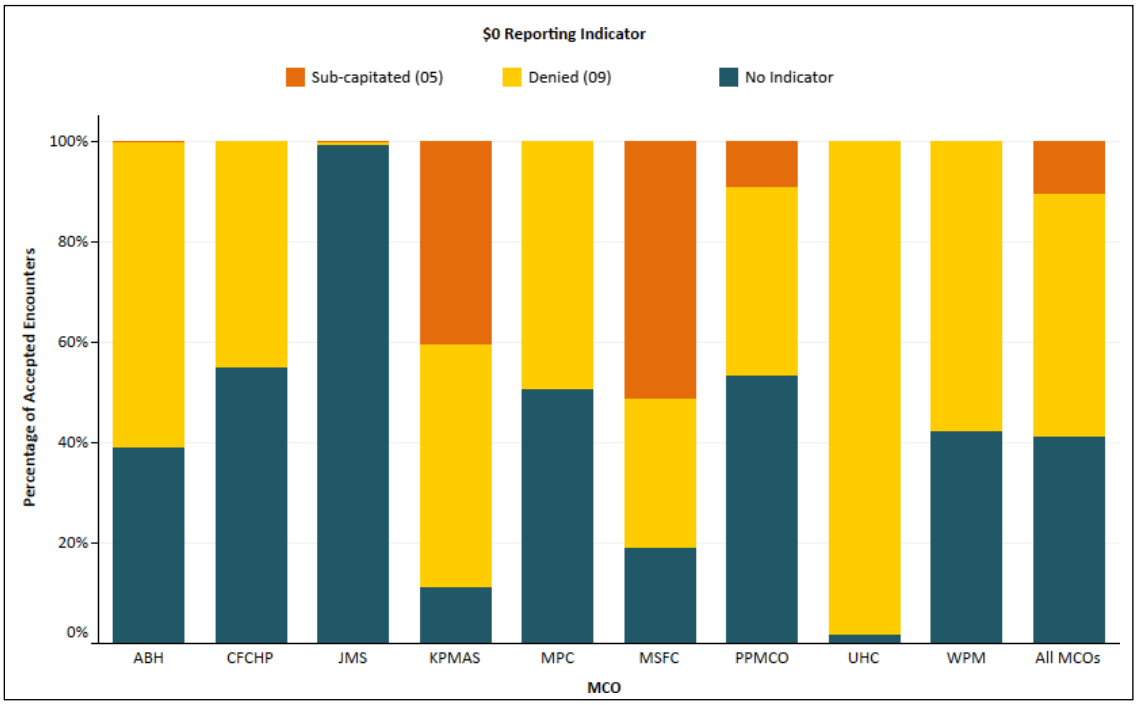


Year	Pay Category	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
CY 2021	Populated	82.0%	78.6%	37.5%	94.3%	85.5%	51.0%	80.5%	76.3%	90.8%
		639,721	869,961	247,332	1,973,718	4,217,329	1,117,795	5,531,945	2,622,037	4,789,407
	$0	18.0%	21.4%	62.5%	5.7%	14.5%	49.0%	19.5%	23.7%	9.2%
		140,020	237,519	412,501	118,827	717,480	1,074,314	1,341,220	814,233	488,070
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		779,741	**1,107,480**	**659,833**	**2,092,545**	**4,934,809**	**2,192,109**	**6,873,165**	**3,436,270**	**5,277,477**
CY 2022	Populated	80.8%	79.8%	34.2%	93.7%	84.7%	55.2%	76.3%	74.8%	86.2%
		697,565	1,151,967	222,651	2,021,446	4,230,981	1,117,555	5,284,443	2,511,339	4,729,467
	$0	19.2%	20.2%	65.8%	6.3%	15.3%	44.8%	23.7%	25.2%	13.8%
		165,635	290,813	428,663	136,943	766,411	907,070	1,641,938	845,955	757,248
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		863,200	**1,442,780**	**651,314**	**2,158,389**	**4,997,392**	**2,024,625**	**6,926,381**	**3,357,294**	**5,486,715**
CY 2023	Populated	79.6%	79.2%	35.9%	96.3%	80.4%	50.3%	73.9%	74.4%	78.9%
		757,319	1,384,037	212,726	2,155,695	4,089,597	1,037,694	5,050,314	2,475,091	4,693,008
	$0	20.4%	20.8%	64.1%	3.7%	19.6%	49.7%	26.1%	25.6%	21.1%
		194,248	364,427	379,478	83,740	994,630	1,027,232	1,785,564	849,931	1,257,830
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		951,567	**1,748,464**	**592,204**	**2,239,435**	**5,084,227**	**2,064,926**	**6,835,878**	**3,325,022**	**5,950,838**

During CY 2023, JMS submitted 64.1% of its medical encounters with a $0 provider reimbursement amount, and MSFC submitted nearly half of its medical encounters the same way. All other MCOs ranged from 3.7% (KPMAS) to 26.1% (PPMCO) of accepted medical encounters with $0 provider reimbursement. Only CFCHP and KPMAS had a lower share of encounters with $0 provider reimbursement during CY 2023 than in CY 2021.

Figure 4 displays the percentage of accepted medical encounters with a $0 provider reimbursement amount with the sub-capitated reporting indicator (05) on the CN1 segment, the denied reporting indicator (09) on the CN1 segment, and no indicator by MCO.

Figure 4. Accepted Medical Encounters with $0 Provider Reimbursement Data By Reporting Indicator (05/09) and MCO, CY 2023



$0 Reporting Indicator	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	All MCOs
Sub-capitated (05)	0.1%	0.0%	0.0%	40.5%	0.0%	51.5%	9.4%	0.0%	0.0%	**10.5%**
Denied (09)	61.1%	45.1%	0.9%	48.5%	49.4%	29.6%	37.4%	98.5%	57.9%	**48.4%**
No Indicator	38.8%	54.9%	99.1%	11.0%	50.6%	18.9%	53.2%	1.5%	42.1%	**41.1%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Adherence to the requirement that encounters with $0 provider reimbursement include a reporting indicator varied significantly among the MCOs during CY 2023. UHC was the only MCO that submitted nearly all its $0 medical encounters with an indicator. By contrast, CFCHP, MPC, and PPMCO submitted more than one-half and JMS close to 100% of their $0 provider reimbursement medical encounters without an indicator. The percentage of $0 provider reimbursement medical encounters without an indicator submitted by the remaining MCOs were 11% (KPMAS), 18.9% (MSFC), 38.8% (ABH), and 42.1% (WPM). Appendix G displays the number and percentage of accepted institutional encounters by MCO with $0 reimbursement data by reporting indicator and MCO.

In October 2024, the Department distributed files to each MCO detailing their CY 2023 $0 reimbursement encounters submitted with a 05 and 09 indicator on the CN1 segment and without an indicator. This data will help the MCOs estimate the impact of failing to comply with the requirement to include a reporting indicator on $0 medical encounters and to improve the quality of their encounter data.

Hilltop also analyzed the accepted medical encounters during CY 2023 by comparing the price paid against the price listed for the same service on the FFS fee schedule. Of the almost 29 million medical encounters in this analysis, 24% of the encounters were reported with a $0 pay amount. Approximately 40% of these were laboratory procedures. The proportion of encounters with $0 ranged greatly by MCO from less than 10% to over 60%. Of the encounters matched to the fee schedule with a non-zero payment amount, nearly 50% of encounters had some degree of difference between the amount paid by MCOs and the amount specified in the fee schedule. Of those encounters matched to the FFS fee schedule with a non-zero payment amount where there was some degree of difference, 70% were greater than the fee schedule payment amount and 30% were less; more than a third of these encounters were more than 20% greater than the FFS payment amount. The range by MCO of the percentage of encounters matched to the FFS fee schedule with a non-zero payment that was greater than the FFS fee schedule was from 19% to 84%.

In CY 2019, Hilltop determined that TPL was reported inconsistently in MMIS across MCOs. Some MCOs had up to 95% of their encounters with a positive TPL amount in a sample of trauma encounters from CY 2019, whereas others had no encounters with a positive TPL amount during the same time period. FFS claims generally had positive TPL amounts in 1% to 3% of cases. Further analysis of a sample of trauma encounters from CY 2021 showed that the inconsistencies remained; three MCOs had no TPL for any encounters, and six MCOs had positive TPL in 85% to 99% of the encounters.

The Department reported that TPL for professional encounters was corrected in MMIS as of May 1, 2022. Analysis of trauma encounters from CY 2022 pulled from the professional file found that inconsistencies still remained in TPL reporting, suggesting that only two MCOs have TPL properly recorded in professional files in CY 2022. The 2023 analysis of trauma encounters found more consistency, with four MCOs reporting TPL payments on 1% to 6% of their encounters. However, the other five MCOs did not report any TPL on their encounters, suggesting that TPL may be routinely missing from MMIS reporting for some MCOs. Hilltop will continue to investigate TPL on all encounters and will review the results with the Department.

Hilltop has not used the MCO-reported TPL amount in any analyses since CY 2018.

Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports

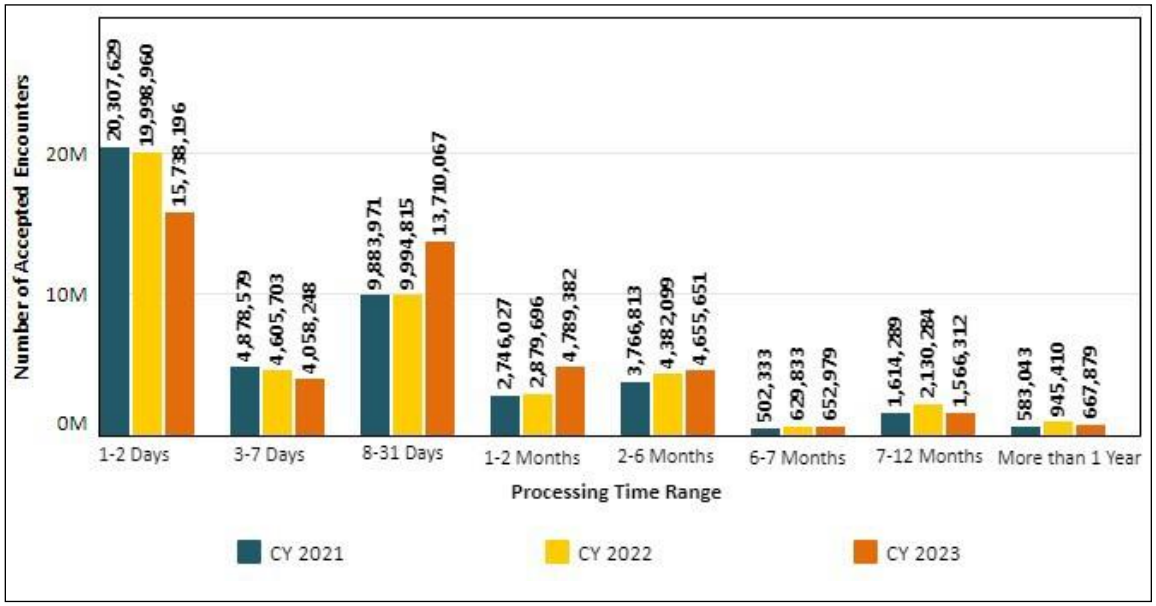
Time Dimension Analysis

Effective analysis of the Medicaid program requires complete, accurate, and timely processing of encounter data.

Encounter processing time spans the interval between the end date of service and the date on which the encounter is submitted to the Department. After providers render a service, they are required to invoice the MCO within six months. The MCO must then adjudicate the encounter within 30 days of invoice submission.[20] Maryland regulations require MCOs to submit encounter data to the Department "within 60 calendar days after receipt of the claim from the provider."[21] Therefore, the maximum acceptable processing time allotted for an encounter between the end date of service and the date of submission to the Department is eight months.

The Medicaid program requires MCOs to submit encounters in a timely fashion; however, delays in submission occur, and some variation from month to month is expected. Noticeable changes related to timeliness may indicate irregular submission of encounter data. Figure 5 shows the timeliness of processing accepted encounter submissions from the end date of service for CY 2021 through CY 2023.

Figure 5. Number of Accepted Encounters Submitted by Processing Time, CY 2021-CY 2023



Note for Figure 5 and Tables 8-10: An encounter is labeled as "1-2 months" if the encounter was submitted between 32 and 60 days after the date of service; "2-6 months" if the encounter was submitted between 61 and 182 days after the date of service; "6-7 months" if the encounter was submitted between 183 and 212 days after the date of service; and "7-12 months" if the encounter was submitted between 213 and 364 days after the date of service. In addition, there was an error in the reporting of timeliness in last year's report that has been corrected.

Overall, timelines of encounter submissions declined during the evaluation period, with MCOs submitting fewer encounters within 1 to 7 days in CY 2023. However, there was an increase in encounters submitted between 8 and 31 days.

[20] Md. Code Ann., Health-Gen. § 15-102.3; § 15-1005.
[21] COMAR 10.09.65.15(B)(4).

Table 8 shows the processing times for encounters submitted by claim type for CY 2021 through CY 2023.

Table 8. Distribution of the Total Number of Accepted Encounters Submitted, by Claim Type and Processing Time, CY 2021 – CY 2023

Processing Time Range	Pharmacy Claims			Physician Claims			Outpatient Hospital Claims			Other Claims		
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
1-2 Days	82.7%	82.8%	61.6%	32.6%	29.4%	24.0%	22.6%	20.3%	18.1%	17.0%	15.2%	15.5%
	10,026,380	10,510,053	7,933,056	9,884,739	9,135,115	7,498,311	347,471	310,346	263,259	49,039	43,446	43,570
3-7 Days	11.5%	11.1%	10.2%	11.0%	9.9%	8.4%	8.8%	7.7%	7.0%	8.0%	6.7%	6.7%
	1,392,401	1,407,027	1,317,925	3,327,402	3,061,363	2,619,596	135,723	118,118	101,900	23,053	19,195	18,827
8-31 Days	5.4%	5.4%	24.1%	28.8%	28.4%	32.4%	26.9%	26.7%	28.1%	30.8%	27.4%	28.5%
	650,512	680,381	3,097,107	8,731,435	8,826,893	10,125,137	413,259	409,013	407,392	88,765	78,528	80,431
1-2 Months	0.3%	0.2%	3.7%	8.2%	8.3%	13.0%	12.9%	14.6%	14.5%	12.6%	14.9%	15.5%
	32,578	26,697	473,473	2,478,225	2,587,218	4,061,330	198,767	223,184	210,900	36,457	42,597	43,679
2-6 Months	0.2%	0.3%	0.2%	11.3%	12.7%	13.8%	17.6%	21.1%	18.9%	18.2%	23.0%	18.5%
	21,363	39,678	31,399	3,423,369	3,953,948	4,297,378	269,617	322,630	274,650	52,464	65,843	52,224
More than 6 Months	0.0%	0.2%	0.2%	8.2%	11.3%	8.4%	11.1%	9.6%	13.4%	13.4%	12.7%	15.3%
	1,923	25,526	20,447	2,488,840	3,496,201	2,629,467	170,314	147,328	193,995	38,588	36,472	43,261
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	12,125,157	**12,689,362**	**12,873,407**	**30,334,010**	**31,060,738**	**31,231,219**	**1,535,151**	**1,530,619**	**1,452,096**	**288,366**	**286,081**	**281,992**

*"Outpatient hospital claims" include emergency department (ED) visits. **"Other" includes inpatient hospital stays, community-based services, and long-term care services.

In both CYs 2021 and 2022, over 80% of pharmacy encounters were submitted within 1 to 2 days; in CY 2023, this dropped to 61.6%. During the evaluation period, the share of all physician encounters submitted within 31 days decreased by 7.6 percentage points from over 70% in CY 2021 to under 65% in CY 2023. Outpatient hospital encounters showed a similar but less severe decline, by 5.1 percentage points between CY 2021 and CY 2023. See Appendix H for a visual display of the number and percentage of encounters submitted by time processing range and claim type in CY 2021 through CY 2023.

Table 9 displays the monthly processing time for accepted encounters in CY 2021 through CY 2023.

Table 9. Percentage of Accepted Encounters Submitted, by Month and Processing Time, CY 2021–CY 2023

Processing Time Range	Year	January	February	March	April	May	June	July	August	September	October	November	December	Annual Total
1-2 Days	CY 2021	35.9%	41.0%	47.1%	41.9%	44.5%	51.4%	47.1%	50.9%	46.6%	45.5%	51.4%	45.6%	**45.9%**
	CY 2022	40.9%	42.4%	45.4%	45.8%	45.2%	43.9%	43.2%	48.0%	35.2%	44.6%	44.5%	47.4%	**43.9%**
	CY 2023	6.2%	39.0%	5.0%	37.3%	6.5%	45.7%	42.2%	46.1%	48.1%	47.3%	49.7%	45.9%	**34.3%**
3-7 Days	CY 2021	11.9%	15.1%	9.9%	11.7%	12.4%	10.7%	10.6%	10.2%	11.6%	12.9%	5.8%	10.2%	**11.0%**
	CY 2022	10.6%	11.7%	10.7%	10.9%	9.6%	10.5%	13.1%	9.4%	10.9%	10.0%	6.7%	7.7%	**10.1%**
	CY 2023	9.9%	0.0%	10.5%	0.0%	7.9%	11.7%	12.1%	11.0%	11.7%	10.1%	10.8%	10.2%	**8.9%**
8-31 Days	CY 2021	23.8%	22.3%	22.0%	24.8%	24.2%	19.0%	21.6%	19.7%	22.5%	22.2%	22.0%	23.9%	**22.3%**
	CY 2022	23.0%	21.4%	23.5%	21.1%	23.4%	23.4%	20.7%	18.4%	24.9%	17.5%	24.4%	21.6%	**21.9%**
	CY 2023	57.3%	0.0%	62.2%	0.0%	64.5%	22.6%	26.2%	25.0%	21.8%	25.0%	20.8%	24.7%	**29.9%**
1-2 Months	CY 2021	9.8%	6.1%	5.5%	6.4%	4.7%	6.0%	5.0%	5.1%	6.3%	5.9%	7.3%	6.5%	**6.2%**
	CY 2022	6.9%	7.5%	4.8%	5.9%	4.6%	6.0%	4.6%	5.7%	8.0%	10.3%	5.7%	5.7%	**6.3%**
	CY 2023	0.7%	44.0%	0.0%	46.9%	4.4%	5.5%	6.0%	4.7%	5.1%	5.0%	6.5%	0.0%	**10.4%**
2-6 Months	CY 2021	9.1%	7.5%	7.6%	7.5%	7.0%	5.5%	5.6%	6.9%	8.9%	9.7%	13.0%	13.3%	**8.5%**
	CY 2022	8.2%	7.4%	6.9%	7.2%	6.7%	7.4%	7.8%	9.1%	12.0%	9.7%	16.0%	16.4%	**9.6%**
	CY 2023	16.3%	11.0%	15.7%	8.0%	7.9%	6.9%	6.5%	5.7%	7.1%	7.3%	10.4%	18.5%	**10.2%**
6-7 Months	CY 2021	1.2%	1.2%	0.7%	0.5%	0.5%	0.5%	2.3%	1.7%	0.9%	3.3%	0.3%	0.5%	**1.1%**
	CY 2022	1.5%	0.8%	0.9%	0.8%	0.8%	0.4%	1.2%	1.2%	1.3%	5.2%	1.6%	0.6%	**1.4%**
	CY 2023	3.2%	1.2%	1.6%	1.0%	0.6%	0.6%	0.0%	2.1%	0.7%	3.6%	1.4%	0.6%	**1.4%**
7-12 Months	CY 2021	2.8%	3.1%	3.3%	4.1%	6.4%	6.9%	7.8%	5.5%	3.3%	0.5%	0.3%	0.0%	**3.6%**
	CY 2022	3.0%	3.7%	2.8%	3.4%	8.4%	7.4%	7.1%	8.2%	7.9%	2.6%	1.0%	0.7%	**4.7%**
	CY 2023	2.6%	1.8%	2.2%	3.6%	4.4%	6.6%	6.9%	5.5%	5.4%	1.7%	0.5%	0.0%	**3.4%**
More than 1 Year	CY 2021	5.5%	3.7%	3.8%	3.0%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.3%**
	CY 2022	5.9%	5.1%	5.1%	5.0%	1.3%	0.9%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	**2.1%**
	CY 2023	3.9%	3.1%	2.9%	3.2%	3.8%	0.3%	0.0%	0.0%	N/A	N/A	N/A	N/A	**1.5%**
Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

The timeliness of encounter submissions remained relatively consistent across all months for CY 2021 and CY 2022. In CY 2023, there was a significant increase in processing time in January, March, and May, with only 6.2%, 5.0%, and 6.5% of accepted encounters submitted within 1-2 days, respectively. On average, 34.3% of CY 2023 encounters were processed within 1 to 2 days of the end date of service—a decrease from 45.9% in CY 2021 and 43.9% in CY 2022.

Table 10 displays processing times for accepted encounters submitted to the Department by MCO from CY 2021 to CY 2023.

Table 10. Percentage of Accepted Encounters Submitted by MCO and Processing Time, CY 2021–CY 2023

MCO	1-2 Days			3-7 Days			8-31 Days			1-2 Months		
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
ABH	35.7%	33.3%	29.2%	8.9%	7.3%	7.9%	21.7%	17.1%	28.2%	7.7%	5.1%	10.3%
CFCHP	42.2%	54.0%	39.2%	9.3%	10.7%	8.6%	17.4%	16.6%	21.8%	8.4%	5.8%	7.5%
JMS	27.9%	30.6%	23.5%	4.1%	4.0%	3.9%	15.9%	16.7%	21.2%	17.4%	14.8%	15.2%
KPMAS	60.0%	57.5%	45.3%	14.0%	13.4%	11.0%	18.8%	21.2%	30.7%	2.1%	2.1%	8.0%
MPC	46.4%	47.1%	36.3%	10.2%	9.9%	8.8%	16.9%	17.5%	29.0%	4.9%	4.7%	8.5%
MSFC	28.0%	25.3%	26.4%	8.6%	5.7%	7.7%	35.5%	23.4%	33.9%	11.3%	17.4%	14.2%
PPMCO	56.2%	46.2%	33.5%	12.5%	10.7%	8.9%	19.0%	22.4%	30.1%	4.2%	5.8%	11.2%
UHC	28.8%	32.7%	24.1%	10.4%	10.5%	8.3%	35.7%	34.6%	36.4%	9.7%	7.4%	13.9%
WPM	49.5%	47.5%	39.1%	11.9%	10.9%	9.6%	21.6%	20.5%	29.0%	5.0%	4.4%	9.1%
MCO	**2-6 Months**			**6-7 Months**			**7-12 Months**			**More than 1 Year**		
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
ABH	12.1%	16.5%	11.4%	1.7%	3.9%	1.8%	8.1%	10.3%	6.5%	4.0%	6.5%	4.7%
CFCHP	15.8%	9.5%	7.4%	1.4%	0.6%	1.0%	4.3%	2.3%	5.0%	1.1%	0.6%	9.5%
JMS	11.8%	14.6%	27.6%	2.6%	2.4%	4.6%	15.5%	13.1%	3.8%	4.9%	3.8%	0.3%
KPMAS	3.8%	3.2%	2.9%	0.5%	0.5%	0.3%	0.7%	1.7%	1.0%	0.1%	0.5%	0.7%
MPC	10.6%	10.2%	8.3%	2.0%	1.6%	2.8%	7.3%	5.8%	5.7%	1.7%	3.2%	0.7%
MSFC	12.1%	17.3%	10.6%	1.7%	1.9%	0.9%	2.2%	6.9%	5.5%	0.5%	1.9%	1.0%
PPMCO	5.2%	8.6%	10.9%	0.6%	1.4%	1.0%	1.5%	3.6%	3.0%	0.9%	1.3%	1.4%
UHC	11.2%	10.3%	13.6%	1.2%	1.1%	1.3%	2.5%	2.4%	2.1%	0.4%	0.9%	0.3%
WPM	6.7%	7.6%	9.9%	0.6%	1.0%	1.2%	2.8%	5.2%	1.6%	2.0%	2.8%	0.4%

All the MCOs submitted a lower percentage of their encounters within 1 to 2 days in CY 2023 than in CY 2021. MSFC experienced an increase in the percentage of encounters submitted within 1 to 2 days from CY 2022 to CY 2023. In CY 2023, the percentage of encounters submitted by MCOs within 1 to 2 days ranged from 23.5% (JMS) to 45.3% (KPMAS). The percentage of encounters submitted within 3 to 7 days decreased for all MCOs between CY 2021 and CY 2023. JMS had the lowest (3.9%) percentage of encounters submitted within 3 to 7 days in CY 2023.

See Appendix I for a stacked bar chart displaying the number and percentage of encounters within each claim type from CY 2021 to CY 2023 by processing time. Appendix J provides a table outlining the number and percentage of encounters submitted by MCOs by processing time in CY 2023. See Appendix K for a stacked bar chart displaying the percentage of encounters submitted by MCO by processing time in CY 2020 through CY 2023.

Service Type Analysis

Table 11 shows the number and percentage of encounter visits for inpatient hospitalizations, ED visits, and observation stays by MCO for CY 2021 to CY 2023.

Table 11. Number and Percentage of Inpatient Visits, ED Visits, and Observation Stays by MCO, CY 2021–CY 2023

Visits	Year	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Number of Visits	CY 2021	613,502	887,454	502,290	1,144,056	4,035,993	1,699,091	5,534,477	2,470,312	4,296,251	**21,183,426**
	CY 2022	672,857	1,093,093	469,075	1,143,675	4,048,013	1,666,516	5,512,901	2,393,716	4,316,397	**21,316,243**
	CY 2023	725,534	1,286,938	455,712	1,155,967	4,023,229	1,590,177	5,456,680	2,345,972	4,320,909	**21,361,118**
Percentage of All Visits	CY 2021	2.9%	4.2%	2.4%	5.4%	19.1%	8.0%	26.1%	11.7%	20.3%	**100%**
	CY 2022	3.2%	5.1%	2.2%	5.4%	19.0%	7.8%	25.9%	11.2%	20.2%	**100%**
	CY 2023	3.4%	6.0%	2.1%	5.4%	18.8%	7.4%	25.5%	11.0%	20.2%	**100%**
Number of Inpatient Visits	CY 2021	4,047	6,080	3,556	7,609	22,247	9,141	29,423	13,042	22,569	**117,714**
	CY 2022	4,176	6,923	3,086	7,679	20,100	9,272	28,102	12,816	22,277	**114,431**
	CY 2023	4,850	8,579	3,237	8,050	21,226	8,333	29,778	12,871	22,688	**119,612**
Percentage of Visits that were Inpatient	CY 2021	0.7%	0.7%	0.7%	0.7%	0.6%	0.5%	0.5%	0.5%	0.5%	**0.6%**
	CY 2022	0.6%	0.6%	0.7%	0.7%	0.5%	0.6%	0.5%	0.5%	0.5%	**0.5%**
	CY 2023	0.7%	0.7%	0.7%	0.7%	0.5%	0.5%	0.5%	0.5%	0.5%	**0.6%**
Number of ED Visits	CY 2021	21,509	30,394	20,795	23,246	125,517	51,392	165,869	73,567	131,335	**643,624**
	CY 2022	23,569	33,155	18,701	25,341	127,470	54,528	170,435	75,401	135,907	**664,507**
	CY 2023	25,879	39,534	18,633	26,038	128,584	47,049	172,795	77,602	135,116	**671,230**
Percentage of Visits that were ED	CY 2021	3.5%	3.4%	4.1%	2.0%	3.1%	3.0%	3.0%	3.0%	3.1%	**3.0%**
	CY 2022	3.5%	3.0%	4.0%	2.2%	3.1%	3.3%	3.1%	3.1%	3.1%	**3.1%**
	CY 2023	3.6%	3.1%	4.1%	2.3%	3.2%	3.0%	3.2%	3.3%	3.1%	**3.1%**
Number of Observation Stays	CY 2021	1,239	1,994	1,173	1,472	8,926	3,134	10,698	6,789	8,115	**43,540**
	CY 2022	1,430	1,811	979	1,623	8,416	2,738	9,413	7,951	6,928	**41,289**
	CY 2023	1,723	2,282	949	1,741	8,052	2,273	9,513	7,601	6,925	**41,059**
Percentage of Visits that were Observation Stays	CY 2021	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%	0.3%	0.2%	**0.2%**
	CY 2022	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%	0.3%	0.2%	**0.2%**
	CY 2023	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%	0.3%	0.2%	**0.2%**

Note: Visits were duplicated between inpatient visits, ED visits, and observation stays.

For this analysis, a visit was defined as one encounter per person per provider per day. MCOs reported a consistent distribution of visits by service type for all years of the evaluation period. Total inpatient hospitalizations and observation stays combined made up less than 1.0% of all visits each year. ED visits, which were 3.1% of all visits in CY 2023, ranged from 2.3% of all visits (KPMAS) to 4.1% of all visits (JMS). Overall, during the evaluation period, the percentage of all inpatient visits decreased from 0.6% in CY 2021 to 0.5% in CY 2022 but increased back to 0.6% in CY 2023. The percentage of all ED visits increased slightly from CY 2021 (3.0%) to CY 2022 (3.1%) and remained stable through CY 2023 (3.1%). As shown in the annual HealthChoice evaluation, the overall percentage of HealthChoice participants with an outpatient ED visit and inpatient admission decreased between CY 2018 and CY 2022 (The Hilltop Institute, 2024).

Outlier Data Analysis

Hilltop conducted an analysis of encounter data submitted by MCOs to determine the effectiveness of encounter data edit checks between CY 2021 and CY 2023. The following areas were analyzed: 1) individuals over age 65 with encounters, 2) individuals with a service date before their date of birth, 3) age-appropriate diagnoses for delivery (births), 4) age-appropriate dementia diagnoses, 5) children aged 0 to 20 years with dental encounters, and 6) duplicate behavioral health services submitted both as encounters and as claims through the FFS system.

Because participants older than 65 are ineligible for HealthChoice, Hilltop searched for any encounters for those aged 66 or older. The number of MCO participants aged 66 or older who had encounters during the evaluation period reached a peak in CY 2022 before falling again in CY 2023.[22] The number of individuals with a service date before their date of birth increased between CY 2021 and CY 2022 before falling again in CY 2023.

Through CY 2022, the Maryland Healthy Smiles Dental Program (Healthy Smiles) provided dental coverage for children under the age of 21. As of January 1, 2023, Healthy Smiles was available to adults who received full Medicaid benefits.[23] The program is paid on an FFS basis—not through the MCO service package. Hilltop found very few dental encounters for children under the age of 21 covered by an MCO in CY 2021 through CY 2022. During CY 2023, the total number of dental encounters was not directly comparable to previous years due to the expansion of Healthy Smiles to include adults.[24] Nearly all dental encounters took place during January 2023 when the Healthy Smiles transition began. Roughly one-third of these encounters were submitted with a provider reimbursement amount. This may indicate that MCOs were paying for dental care inappropriately during this period.

Hilltop analyzed the volume of participants who had a diagnosis for delivery by age group between CY 2021 and CY 2023. Participants aged 0 to 11 and 51 or older are typically considered to be outside of the expected age range for delivery. This analysis considers both female and

[22] Data not shown due to small cell sizes.

[23] 2022 MD Laws Ch. 303.

[24] Prior to CY 2023, some MCOs offered limited dental services to adult participants as a value-added incentive for enrollment. The Healthy Smiles expansion made these benefits redundant.

male participants with a delivery diagnosis.[25] Across all MCOs, the number of participants identified as delivering outside of the expected age ranges was 122 in CY 2021, 136 in CY 2022, and 124 in CY 2023. The data substantiate that, overall, the encounters submitted are age-appropriate for delivery. See Appendix L for delivery codes.

The fifth analysis focused on age-appropriate diagnoses of dementia (see Appendix M for dementia codes) from CY 2021 to CY 2023. Although dementia is a disease generally associated with older age, onset can occur as early as 30 years of age. Thus, the prevalence of dementia diagnoses should increase with age after 30. Hilltop identified the number of participants under the age of 30 with an encounter with a dementia diagnosis. While each MCO had participants under the age of 30 with a dementia diagnosis, the total numbers were relatively small (226 participants were reported across all MCOs in CY 2023).[26]

In late 2024, the Department requested that Hilltop analyze the extent to which each MCO submitted behavioral health encounters that were duplicates of claims submitted through the FFS system. The Department continues to analyze the results.

Recommendations

Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements

In Step 1, Hilltop reviewed 8ER reports and found that, out of approximately 49.0 million overall encounters, more than 3.1 million encounters (approximately 6.5%) were denied by the Department in CY 2023. This represents a decrease from 3.9 million denied encounters in CY 2022 and 4.4 million in CY 2021. The main cause of this decrease in denied encounters is an improvement in invalid encounters related to provider information, which indicates a positive trend. However, in CY 2019—before the use of the provider NPI crosswalk, validation, and provider enrollment edits was implemented—the number of denied encounters was 1.9 million, which increased by 259% in CY 2020. The volume of denied encounters continues to decline, although it remains high relative to CY 2019. The Department should continue to monitor and work with the MCOs to resolve the usage of the Department Provider Master file and NPI Crosswalk process.

From CY 2021 to CY 2023, all MCOs except for MSFC and PPMCO experienced a decrease in the incidence of provider enrollment-related denied encounters. From CY 2022 to CY 2023, all MCOs except for MPC (which increased by 5.2%) and MSFC (which increased by 113.3%) experienced a decrease. MSFC and WPM are the only MCOs to have an increase in denied encounters due to non-provider exception codes from CY 2022 to CY 2023, with MSFC increasing by over 600%.

There was an increase in MSFC's denied encounters for both provider enrollment-related and other reasons from CY 2022 to CY 2023, while there was a decrease in its share of all

[25] In MMIS, male or female are the only two options.

[26] Data not shown by MCO due to small cell sizes.

HealthChoice participants (from 7.6% in CY 2022 to 7.2% in CY 2023). This may indicate problems with MSFC's encounter submission processes. It is also possible that multiple submissions of the same encounters with different ICNs as recorded in the 8ER reports are contributing to the increase. The 8ER reports include many encounters that are resubmissions for a previously denied encounter, but each has a different ICN upon resubmission. The Department should continue to work with the MCOs to instill best practices to improve their numbers of denied encounters.

The variance between an MCO's share of all denials and its share of all accepted encounters might warrant further attention. If an MCO's share of denials is much higher than its share of accepted encounters, then the organization might have a specific problem. If, on the other hand, the share of accepted encounters is greater than the share of denials, then the MCO might have some best practices to share. PPMCO had 34.7% of all rejected encounters in CY 2023, but only 25.8% of accepted encounters. Conversely, WPM's share of accepted encounters (19.6%) exceeded its share of rejections (13.2%) during the same period.

Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity

Hilltop analyzed and interpreted the encounter data and found that, during CY 2023, the MCOs submitted a total of 45.8 million accepted encounters (records), an increase from 44.3 million in CY 2021 and 45.6 million in CY 2022. Hilltop reviewed encounters by claim type and found the distribution to be similar among MCOs. Each MCO's distribution of encounters across claim types remained stable and consistent throughout the years. Hilltop also compared the proportion of HealthChoice participants by MCO with the proportion of accepted encounters by MCO and found similar trends.

Hilltop conducted an analysis of provider reimbursement data on medical encounters and found that all HealthChoice MCOs continued to submit their medical encounters with populated provider reimbursement fields from CY 2021 to CY 2023, as required. However, all MCOs except for CFCHP and KPMAS increased the share of medical encounters with $0 provider reimbursement over the evaluation period, which could indicate that the MCOs are not accurately populating the provider reimbursement field. During CY 2023, JMS submitted 64.1% of its medical encounters with a $0 provider reimbursement amount, and MSFC submitted nearly half of its medical encounters the same way. All other MCOs ranged from 3.7% (KPMAS) to 26.1% (PPMCO) of accepted medical encounters with $0 provider reimbursement. The MCOs with unusually high volumes of $0 encounters should provide an explanation to the Department and ensure accuracy with future submissions.

Hilltop further analyzed the MCOs' use of the 05/09 indicator on the CN1 segment on accepted medical encounters with $0 in the provider reimbursement field. Adherence to this requirement is uneven across MCOs, and none demonstrated full compliance in CY 2023, although ABH, KPMAS, MSFC, UHC, and WPM submitted the majority of their $0 encounters with an indicator. The issue was particularly pronounced with JMS, which had no indicator for nearly all its $0 medical encounters. The Department should consider implementing measures to enforce

adherence to this requirement, such as automatic denial of $0 encounters submitted without an indicator.

Hilltop also analyzed the variance between the provider reimbursement amounts included in accepted encounters and the FFS fee schedule. The overall utilization of the provider reimbursement field had not changed significantly in CY 2023 as compared to previous years. The Department should continue to work with the MCOs to ensure appropriate utilization and improvement in the accuracy of the provider reimbursement field on accepted encounters. The Department also resolved an MMIS issue, which allowed accepted institutional provider reimbursement to be more accurately captured in July 2020. This field is now populated for all MCOs. Hilltop analyzed TPL data and determined that the TPL was not captured consistently across MCOs, so the MCO TPL amount in accepted encounters is not used in any analyses. Hilltop will continue to investigate the MCO TPL-reported amounts and will work with the Department to continue to develop a resolution.

To address the high volume of denied encounters, the Department should continue to encourage MCOs to work with their providers to ensure that they are enrolled on the date of service and that they know how to check their current status.

Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports

Time Dimension Analysis

Hilltop compared dates of service with MCO encounter submission dates and found that most encounters in CY 2023 were submitted to the Department within one month of the end date of service, which is consistent with CY 2022 and CY 2021 findings. In CY 2021 and 2022, nearly all (82.7% and 82.8%, respectively) pharmacy encounters were submitted within one to two days of the date of service. In CY 2023, this rate fell to 61.6%. All MCOs demonstrated a decline in the submission of accepted encounters within two days of the end date of service. MCOs that submit encounters more than eight months after the date of service—the maximum time allotted for an encounter to be submitted to the Department—should be flagged for improvement. The Department should consider automatically denying encounters submitted after this period has ended.

Service Type Analysis

Hilltop reviewed the volume of inpatient visits, ED visits, and observation stays by MCO. Trends in service type were consistent across MCOs and years. There was a slight increase in ED visits between CY 2021 and CY 2023. The Department should continue to review these data and compare trends in future annual encounter data validations to ensure consistency.

Outlier Data Analysis

The MCOs and the Department continued to improve the quality of reporting encounter data for age-appropriate diagnoses in CY 2023. The Department should continue to review and audit the

participant-level, MCO-specific reports that Hilltop generated for delivery, dementia, individuals over age 65, dental, and missing age outlier data measures. MCOs that submit the encounter outliers should be notified, demographic information should be updated, and adjustments should be made, as needed.

Conclusion

HealthChoice is a mature managed care program; overall, analysis of the CY 2023 electronic encounter data submitted indicates improvements in provider enrollment-related denied encounters. Although the MCOs continue to struggle with the changes in encounter editing logic, the Department and the MCOs have continued to strengthen gains made in recent years.

The most concerning issue in CY 2023 data is the continued volume of encounter denials, largely due to the change in encounter editing logic. Although the Department did not use encounter data from CY 2021 for rate setting because of the COVID-19 PHE, it should continue to work with the MCOs to resolve their NPI Crosswalk and provider exceptions and enrollment issues, which will allow for more accurate rate setting in the future. In the MCO CY 2024 contract, workgroup meetings with MCOs continued to refine encounters that should be removed from the HFMR. The Department will work with the MCOs to ensure that appropriately denied encounters will not be reported on the HFMR. In addition, of concern is that some of the MCOs had unusually high volumes of $0 encounters, which should also not be reported on the HFMRs. The Department will continue to work with the MCOs to provide an explanation and ensure the accuracy of the provider reimbursement field with future submissions.

In general, the MCOs have similar distributions of denials, types of encounters, types of visits, and outliers, except where specifically noted in the results. This analysis identified minor outliers that merit further monitoring and investigation, although the MCOs have made progress. Hilltop generated recipient-level reports for Department staff to discuss with the MCOs. The Department should review the content standards and criteria for accuracy and completeness with the MCOs. Continued work with each MCO to address identified discrepancies will improve the quality and integrity of encounter submissions and increase the Department's ability to assess the efficiency and effectiveness of the Medicaid program.

Hilltop found that the volume of accepted encounters was generally consistent with MCO enrollment. Although the time dimension analysis showed some variation among MCOs regarding the timeliness of encounter submissions, most encounters were submitted within the eight-month maximum time frame allotted by the Department. The decreases in encounters submitted within one to two days and three to seven days that were observed for CY 2023 are offset by the increase in the number of encounters submitted within eight to 31 days and one to two months. The Department should work with MCOs to improve the timeliness of encounter submissions, especially for MCOs with high rates of submissions occurring more than eight months after the end date of service.

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Appendix A. Ineligible, Improper Costs Removal from the CY 2023 HFMR

An "Office of Legislative Audits" (OLA) report dated June 21, 2023, relayed three findings. One of those findings stated that ineligible, improper costs reported by the MCOs were included in HFMRs and therefore in capitation rate calculations. These ineligible costs included 1) denied claims (e.g., duplicates) and claims which were not the responsibility of the MCO, such as, 2) claims for carved out services (e.g., behavioral health) or for 3) incarcerated individuals.

Regarding denied claims the items below should be included in the HFMR.

1. Error/Exception Codes 437 (Procedure Not Covered For Date of Service), 430 (Procedure or Revenue Code Not on File) when paired with revenue code 810 or 948, and 986 (Duplicate NDC Code), 435 (Recipient Sex Not Valid for Procedure) when associated with gender-neutral CPTs 81479 (Unlisted Molecular Pathology) or 81400-81408 (Molecular Pathology Levels 1-9).
2. $0 Pay Encounters, 05-Subcapitated reporting indicators.
3. Claim amounts for encounters denied for ePREP-related reasons (i.e., related to provider enrollment defined as falling under error/exception codes 122, 412, 951, 961, 962, 963, 964, 965, 971, 975, 976).

Also, the instances below should not be considered duplicates and therefore should not be excluded as duplicates (i.e., they should be included in the HFMR).

1. Anesthesia codes billed for the same date of service by different providers with different modifiers (QZ nurse anesthetist without medical direction by physician, QY medical direction of nurse anesthetist by anesthesiologist, QX non-physician anesthetist with medical direction by physician, QK medical direction of concurrent anesthesia procedures).
2. Modifiers 76 (repeat procedure by same physician) and 77 (repeat procedure by another physician).
3. Modifier 59 is not meant to identify a repeat procedure, rather procedures not normally reported together but appropriate under the circumstances (per the MCS CPT Manual). This modifier is frequently billed by providers WITHOUT the provider billing a separate line that does NOT include the modifier; denial of such encounters based on the use of modifier 59 is not appropriate.

The items below should be excluded from the HFMR.

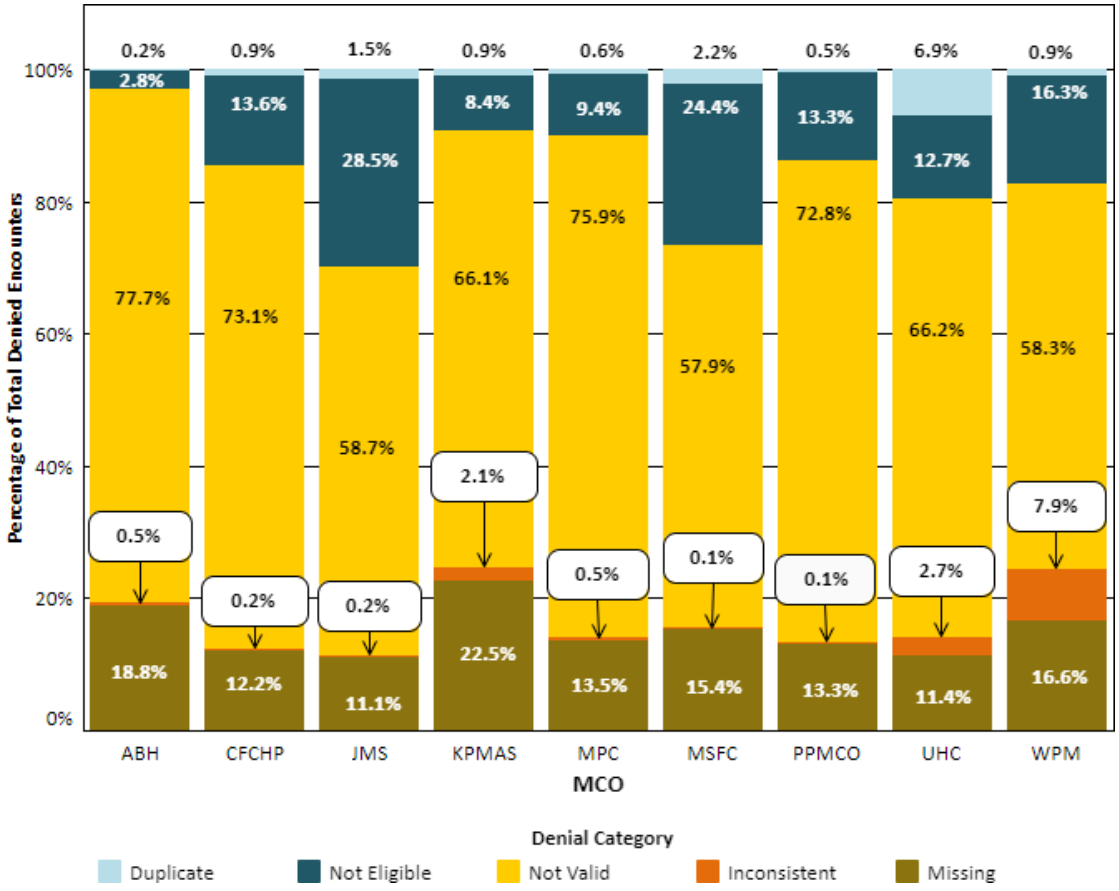
1. All denied encounters, except for error codes listed above.
2. $0 Pay Encounters, 09-Denied reporting indicators.
3. $0 Pay Encounters with no indicator.

CY 2023 HFMRs will be audited to ensure that denied encounters and $0 pay encounters are appropriately excluded from reporting as described above. All denied encounters and their associated diagnosis codes will be utilized for risk adjustment (i.e., RAC assignments.)

Regarding carved out or reimbursable services, please ensure that 1) behavioral health, 2) rare and expensive case management (REM), and 3) high cost, low utilization drugs are excluded from the HFMR but instead itemized in § V.II.

Regarding incarcerated individuals, since their healthcare costs are generally covered by the Department of Public Safety and Correctional Services (DPSCS), these costs should be excluded.

Appendix B. Percentage of Encounters Denied by EDI Denial Category, by MCO, CY 2023



Appendix C. Denial Codes, Errors, by Category with Provider-Related and Other Denial Codes, CY 2023

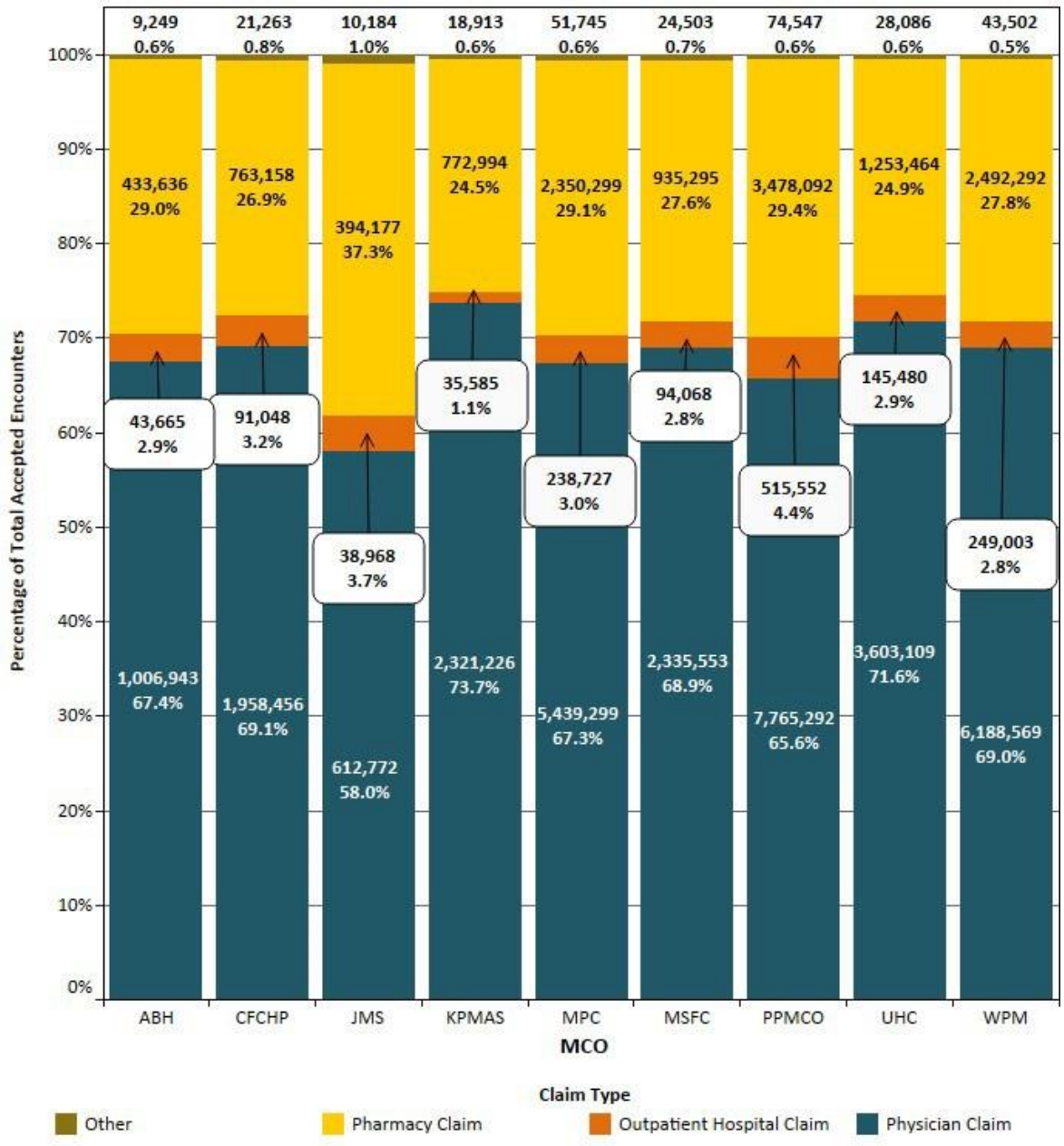
Denial Type	Denial Category	Last 3 of ICN	Error Description
Provider-related	Provider Enrollment	122	INVALID RENDERING PROV NUMBER
		412	REND PROV NOT ON FILE
		951	PROVIDER NUMBER NOT VALID
		961	PAY-TO/FAC PROVIDER SUSPENDED
		962	RENDERING PROVIDER SUSPENDED
		963	PAY-TO/FAC PROV NOT ACT DOS
		964	REND PROV NOT ACT ON DOS
		965	BILL/PAY2 PROV NPI <> MA ID
		971	NPI NUMBER INVLD FR PYTOPROV
		975	NPI#NFDONPROVFLFRENREFFACLTY
		976	REND PROV NPI NO MATCH FFS ID
	Not Valid	367	PRO TYP RENDPROV N/ATH REP PRO
		531	SVC/REND PROV# N/9 NUM DIGITS
		922	INVLD DEFAULT PROVIDER NUMBER
		950	SUB PROV NOT ON MASTER FILE
Other	Inconsistent	113	ADMIT DATE AFTER 1ST DATE SER
		126	THRU DOS PRIOR TO BEGIN DOS
		182	PAT STAT CD DISCHRG DTE CNFLT
		190	FIRST SURG DOS W/IN SVC PERIOD
		290	ORIG ENC TP A/RES DN AGREE
		435	SEX RECIP N/VALD F/REPT PROC
		454	FIRST DIAGNOSIS AGE CONFLICT
		455	FIRST DIAGNOSIS SEX CONFLICT
		464	2ND DIAGNOSIS AGE CONFLICT
		465	2ND DIAG SEX CONFLICT
		474	3RD DIAGNOSIS AGE CONFLICT
		484	4TH DIAGNOSIS AGE CONFLICT
		485	4TH DIAGNOSIS SEX CONFLICT
		589	FRM DOS PRIOR TO RECIP DOB
		901	ORIG ICN N/FOUND ON HISTORY
		912	VD/RESB MCO# NOT EQL HISTORY
		913	VOID RESUBMIT RECPT NOT = HIST
	Missing	135	BILLING PROV NUM MISSING
		170	INV/MISS PLACE OF SERVICE
		172	INVLD OR MISS REV/HCPCS CODE
		249	UNITS OF SERVICE EQUAL ZERO

Denial Type	Denial Category	Last 3 of ICN	Error Description
		259	PROC CODE REQ DIAG CODE
		361	TOOTH # REQD FOR PROC IS MISS
		362	TOOTH SURF REQ F/PROC IS MISS
		970	NPI NUMBER IS MISSING
		971	NPI ON ENC NOT FOUND IN MMIS
		982	NDC MISSING OR NOT VALID
		985	NDC QUANTITY MISSING
	Not Eligible	250	RECPT NOT ON ELIGIBILITY FILE
		271	RECIP NOT ENRLD W/RPT MCO DOS
		437	PROC/REV CODE NOT COVD DOS
		961	EXCEPTION 961
		962	EXCEPTION 962
		963	EXCEPTION 963
		964	EXCEPTION 964
	Not Valid	124	FIRST DOS NOT STRUCTURED PROP
		129	RECPT NUMBER NOT 11 NUM DIGITS
		138	UB92 TYPE OF BILL INVALID
		144	LAST DOS AFTER BATCH PROC DATE
		153	NDC NOT VALID STRUCTURE
		167	ADMIT DATE NOT STRUCTURED PROP
		197	1ST SURG PROC DATE INVALID
		207	PATIENT DISCHARGE STATUS INVAL
		213	CHARGE EXCEEDS EXCESS AMOUNT
		217	FACILITY NUMBER NOT VALID
		430	PROC/REV CODE NOT ON FILE
		450	FIRST DIAGNOSIS NOT ON FILE
		460	2ND DIAG NOT ON FILE
		470	3RD DIAG NOT ON FILE
		480	4TH DIAG NOT ON FILE
		550	FIRST PROC NOT ON FILE
		560	SECOND PROC NOT ON FILE
		600	CLAIM EXCEEDS 50 SERVICE LINES
		896	RELATED HISTORY REC MAX EXCEED
		898	RECIP CLAIM OVERFLOW
		900	VD/RESB RECD WOUT/ORIG ICN.
		925	PROC BLD N/VLD F CLMTYP
		926	DENTAL CODE NOT VALID FOR DOS.
		973	NPI/MA# NOT MATCHED IN MMIS
	Duplicate	902	ORIG ICN FD ON HIST ALRD VOID
		986	NDC CODE IS DUPLICATE

Appendix D. Top Three EDI Denial Descriptions by Number of Denied Encounters by MCO, CY 2023

MCO	Error Description	CY 2021	Error Description	CY 2022	Error Description	CY 2023
ABH	PROVIDER NUMBER NOT VALID	95,559	PROVIDER NUMBER NOT VALID	20,227	PROVIDER NUMBER NOT VALID	17,185
	BILLING PROV NUM MISSING	81,186	INVALID RENDERING PROV NUMBER	14,422	NPI NUMBER INVLD FR PYTOPROV	15,981
	INVALID RENDERING PROV NUMBER	75,487	BILLING PROV NUM MISSING	13,144	BILLING PROV NUM MISSING	15,339
CFCHP	INVALID RENDERING PROV NUMBER	71,050	INVALID RENDERING PROV NUMBER	70,336	PAY-TO/FAC PROV NOT ACT DOS	15,483
	ORIG ICN FD ON HIST ALRD VOID	38,922	ORIG ICN N/FOUND ON HISTORY	62,413	PROVIDER NUMBER NOT VALID	14,852
	BILLING PROV NUM MISSING	30,250	PROVIDER NUMBER NOT VALID	40,799	BILLING PROV NUM MISSING	10,297
JMS	BILLING PROV NUM MISSING	78,790	PROVIDER NUMBER NOT VALID	73,311	RECIP NOT ENRLD W/RPT MCO DOS	7,315
	NPI NUMBER INVLD FR PYTOPROV	78,619	BILLING PROV NUM MISSING	72,728	PROVIDER NUMBER NOT VALID	4,398
	PROC/REV CODE NOT COVD DOS	7,333	NPI NUMBER INVLD FR PYTOPROV	72,713	PROC/REV CODE NOT COVD DOS	3,777
KPMAS	REND PROV NOT ACT ON DOS	65,188	PROVIDER NUMBER NOT VALID	45,888	NPI NUMBER INVLD FR PYTOPROV	35,222
	NPI NUMBER INVLD FR PYTOPROV	50,865	NPI NUMBER INVLD FR PYTOPROV	43,197	PROVIDER NUMBER NOT VALID	34,596
	BILLING PROV NUM MISSING	49,696	BILLING PROV NUM MISSING	41,877	BILLING PROV NUM MISSING	33,992
MPC	INVALID RENDERING PROV NUMBER	189,825	PAY-TO/FAC PROV NOT ACT DOS	119,963	PAY-TO/FAC PROV NOT ACT DOS	113,794
	PAY-TO/FAC PROV NOT ACT DOS	125,802	PROVIDER NUMBER NOT VALID	85,691	PROVIDER NUMBER NOT VALID	78,369
	PROVIDER NUMBER NOT VALID	124,747	RECIP NOT ENRLD W/RPT MCO DOS	67,711	BILLING PROV NUM MISSING	66,895
MSFC	BILLING PROV NUM MISSING	47,996	PAY-TO/FAC PROV NOT ACT DOS	20,532	RECPT NUMBER NOT 11 NUM DIGITS	72,328
	PAY-TO/FAC PROV NOT ACT DOS	30,791	PROVIDER NUMBER NOT VALID	11,300	RECIP NOT ENRLD W/RPT MCO DOS	64,967
	PROVIDER NUMBER NOT VALID	30,182	BILLING PROV NUM MISSING	6,398	PROVIDER NUMBER NOT VALID	64,192
PPMCO	PROVIDER NUMBER NOT VALID	199,364	RECIP NOT ENRLD W/RPT MCO DOS	227,772	PAY-TO/FAC PROV NOT ACT DOS	192,012
	BILLING PROV NUM MISSING	180,024	PROVIDER NUMBER NOT VALID	225,291	PROVIDER NUMBER NOT VALID	183,527
	NPI NUMBER INVLD FR PYTOPROV	122,306	BILLING PROV NUM MISSING	159,157	BILLING PROV NUM MISSING	135,870
UHC	PROVIDER NUMBER NOT VALID	157,534	PROVIDER NUMBER NOT VALID	131,176	PROVIDER NUMBER NOT VALID	59,159
	PAY-TO/FAC PROV NOT ACT DOS	125,534	NPI#NFDONPROVFLFRENREFFACLTY	86,177	PAY-TO/FAC PROV NOT ACT DOS	38,732
	INVALID RENDERING PROV NUMBER	72,331	PAY-TO/FAC PROV NOT ACT DOS	55,829	RENDERING PROVIDER SUSPENDED	37,611
WPM	PAY-TO/FAC PROV NOT ACT DOS	148,131	PAY-TO/FAC PROV NOT ACT DOS	96,012	PROVIDER NUMBER NOT VALID	66,543
	PROVIDER NUMBER NOT VALID	103,159	PROVIDER NUMBER NOT VALID	62,768	NPI NUMBER INVLD FR PYTOPROV	64,340
	BILLING PROV NUM MISSING	85,744	NPI NUMBER INVLD FR PYTOPROV	48,722	BILLING PROV NUM MISSING	60,597

Appendix E. Number and Percentage of Accepted Encounters by Claim Type and MCO, CY 2023



Note: "Other" is a combination of inpatient hospital claims, community-based services claims, and long-term care claims.

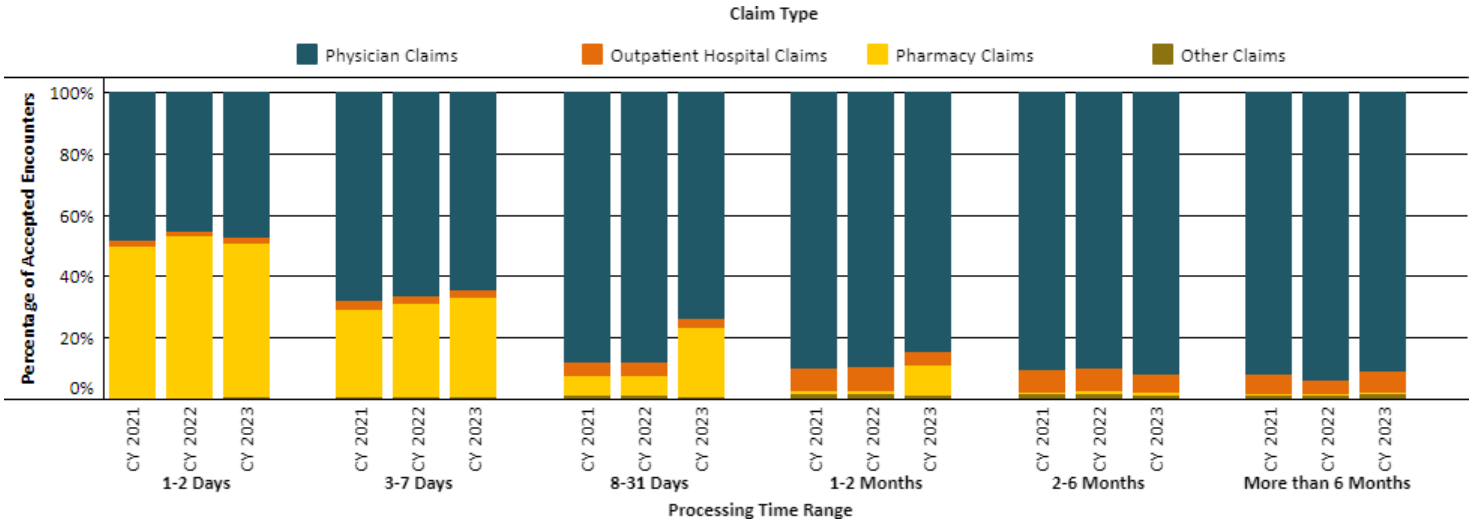
Appendix F. Number of Accepted Medical Encounters by MCO and Provider Reimbursement Category, CY 2021–CY 2023

MCO	Populated			$0		
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
ABH	639,721	697,565	757,319	140,020	165,635	194,248
CFCHP	869,961	1,151,967	1,384,037	237,519	290,813	364,427
JMS	247,332	222,651	212,726	412,501	428,663	379,478
KPMAS	1,973,718	2,021,446	2,155,695	118,827	136,943	83,740
MPC	4,217,329	4,230,981	4,089,597	717,480	766,411	994,630
MSFC	1,117,795	1,117,555	1,037,694	1,074,314	907,070	1,027,232
PPMCO	5,531,945	5,284,443	5,050,314	1,341,220	1,641,938	1,785,564
UHC	2,622,037	2,511,339	2,475,091	814,233	845,955	849,931
WPM	4,789,407	4,729,467	4,693,008	488,070	757,248	1,257,830
Total	**22,009,245**	**21,967,414**	**21,855,481**	**5,344,184**	**5,940,676**	**6,937,080**

Appendix G. Accepted Institutional Encounters with $0 Reimbursement Data by Reporting Indicator and MCO, CY 2023

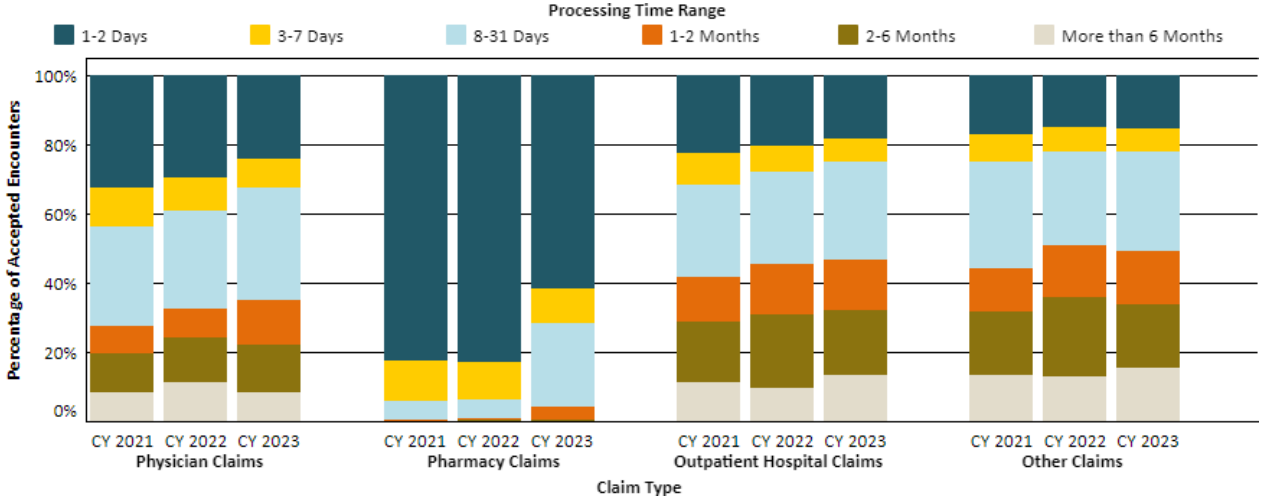
$0 Reporting Indicator	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Denied (09)	5,050	6,263	0	0	15,760	8,040	27,138	10,632	22,256	**95,139**
	87.4%	96.5%	0.0%	0.0%	76.2%	93.2%	96.6%	99.0%	90.7%	**83.6%**
No Indicator	725	224	5,875	3,016	4,919	591	952	104	2,280	**18,686**
	12.6%	3.5%	100%	100%	23.8%	6.8%	3.4%	1.0%	9.3%	**16.4%**
Total	**5,775**	**6,487**	**5,875**	**3,016**	**20,679**	**8,631**	**28,090**	**10,736**	**24,536**	**113,825**
	100%	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Appendix H. Distribution of Accepted Encounters by Processing Time and Claim Type, CY 2021–CY 2023



Processing Time Range	CY 2021				CY 2022				CY 2023			
	Physician Claims	Outpatient Hospital Claims	Pharmacy Claims	Other Claims	Physician Claims	Outpatient Hospital Claims	Pharmacy Claims	Other Claims	Physician Claims	Outpatient Hospital Claims	Pharmacy Claims	Other Claims
1-2 Days	48.7%	1.7%	49.4%	0.2%	45.7%	1.6%	52.6%	0.2%	47.6%	1.7%	50.4%	0.3%
	9,884,739	347,471	10,026,380	49,039	9,135,115	310,346	10,510,053	43,446	7,498,311	263,259	7,933,056	43,570
3-7 Days	68.2%	2.8%	28.5%	0.5%	66.5%	2.6%	30.5%	0.4%	64.5%	2.5%	32.5%	0.5%
	3,327,402	135,723	1,392,401	23,053	3,061,363	118,118	1,407,027	19,195	2,619,596	101,900	1,317,925	18,827
8-31 Days	88.3%	4.2%	6.6%	0.9%	88.3%	4.1%	6.8%	0.8%	73.9%	3.0%	22.6%	0.6%
	8,731,435	413,259	650,512	88,765	8,826,893	409,013	680,381	78,528	10,125,137	407,392	3,097,107	80,431
1-2 Months	90.2%	7.2%	1.2%	1.3%	89.8%	7.8%	0.9%	1.5%	84.8%	4.4%	9.9%	0.9%
	2,478,225	198,767	32,578	36,457	2,587,218	223,184	26,697	42,597	4,061,330	210,900	473,473	43,679
2-6 Months	90.9%	7.2%	0.6%	1.4%	90.2%	7.4%	0.9%	1.5%	92.3%	5.9%	0.7%	1.1%
	3,423,369	269,617	21,363	52,464	3,953,948	322,630	39,678	65,843	4,297,378	274,650	31,399	52,224
More than 6 Months	92.2%	6.3%	0.1%	1.4%	94.4%	4.0%	0.7%	1.0%	91.1%	6.7%	0.7%	1.5%
	2,488,840	170,314	1,923	38,588	3,496,201	147,328	25,526	36,472	2,629,467	193,995	20,447	43,261
Total	**68.5%**	**3.5%**	**27.4%**	**0.7%**	**68.2%**	**3.4%**	**27.8%**	**0.6%**	**68.1%**	**3.2%**	**28.1%**	**0.6%**
	30,334,010	**1,535,151**	**12,125,157**	**288,366**	**31,060,738**	**1,530,619**	**12,689,362**	**286,081**	**31,231,219**	**1,452,096**	**12,873,407**	**281,992**

Appendix I. Percentage of the Total Number of Accepted Encounters Submitted by Claim Type and Processing Time, CY 2021–CY 2023

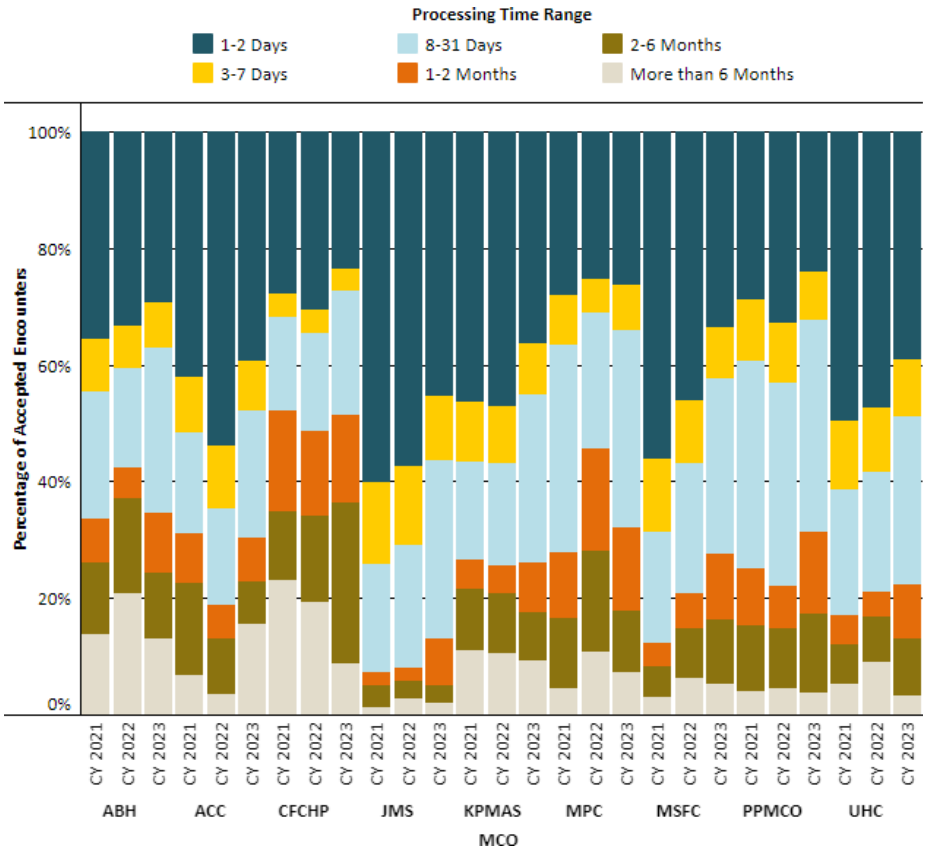


Processing Time Range	Physician Claims			Pharmacy Claims			Outpatient Hospital Claims			Other Claims		
	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023	CY 2021	CY 2022	CY 2023
1-2 Days	32.6%	29.4%	24.0%	82.7%	82.8%	61.6%	22.6%	20.3%	18.1%	17.0%	15.2%	15.5%
	9,884,739	9,135,115	7,498,311	10,026,380	10,510,053	7,933,056	347,471	310,346	263,259	49,039	43,446	43,570
3-7 Days	11.0%	9.9%	8.4%	11.5%	11.1%	10.2%	8.8%	7.7%	7.0%	8.0%	6.7%	6.7%
	3,327,402	3,061,363	2,619,596	1,392,401	1,407,027	1,317,925	135,723	118,118	101,900	23,053	19,195	18,827
8-31 Days	28.8%	28.4%	32.4%	5.4%	5.4%	24.1%	26.9%	26.7%	28.1%	30.8%	27.4%	28.5%
	8,731,435	8,826,893	10,125,137	650,512	680,381	3,097,107	413,259	409,013	407,392	88,765	78,528	80,431
1-2 Months	8.2%	8.3%	13.0%	0.3%	0.2%	3.7%	12.9%	14.6%	14.5%	12.6%	14.9%	15.5%
	2,478,225	2,587,218	4,061,330	32,578	26,697	473,473	198,767	223,184	210,900	36,457	42,597	43,679
2-6 Months	11.3%	12.7%	13.8%	0.2%	0.3%	0.2%	17.6%	21.1%	18.9%	18.2%	23.0%	18.5%
	3,423,369	3,953,948	4,297,378	21,363	39,678	31,399	269,617	322,630	274,650	52,464	65,843	52,224
More than 6 Months	8.2%	11.3%	8.4%	0.0%	0.2%	0.2%	11.1%	9.6%	13.4%	13.4%	12.7%	15.3%
	2,488,840	3,496,201	2,629,467	1,923	25,526	20,447	170,314	147,328	193,995	38,588	36,472	43,261
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	30,334,010	**31,060,738**	**31,231,219**	**12,125,157**	**12,689,362**	**12,873,407**	**1,535,151**	**1,530,619**	**1,452,096**	**288,366**	**286,081**	**281,992**

Appendix J. Distribution of Accepted Encounters Submitted by MCO and Processing Time, CY 2023

Processing Time Range	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
1-2 Days	29.2%	39.2%	23.5%	45.3%	36.3%	26.4%	33.5%	24.1%	39.1%	**34.3%**
	436,424	1,111,769	248,009	1,425,446	2,931,085	895,547	3,969,354	1,210,221	3,510,341	**15,738,196**
3-7 Days	7.9%	8.6%	3.9%	11.0%	8.8%	7.7%	8.9%	8.3%	9.6%	**8.9%**
	118,293	243,889	40,758	346,685	708,388	260,073	1,054,972	419,895	865,295	**4,058,248**
8-31 Days	28.2%	21.8%	21.2%	30.7%	29.0%	33.9%	30.1%	36.4%	29.0%	**29.9%**
	421,664	619,121	223,570	967,416	2,342,359	1,148,013	3,557,681	1,829,418	2,600,825	**13,710,067**
1-2 Months	10.3%	7.5%	15.2%	8.0%	8.5%	14.2%	11.2%	13.9%	9.1%	**10.4%**
	153,515	211,916	160,507	251,782	688,018	480,899	1,326,303	699,585	816,857	**4,789,382**
2-6 Months	11.4%	7.4%	27.6%	2.9%	8.3%	10.6%	10.9%	13.6%	9.9%	**10.2%**
	169,852	209,377	291,337	92,716	670,078	358,299	1,288,934	683,856	891,202	**4,655,651**
6-7 Months	1.8%	1.0%	4.6%	0.3%	2.8%	0.9%	1.0%	1.3%	1.2%	**1.4%**
	26,764	29,472	48,209	10,252	222,856	28,960	114,190	64,633	107,643	**652,979**
7-12 Months	6.5%	5.0%	3.8%	1.0%	5.7%	5.5%	3.0%	2.1%	1.6%	**3.4%**
	97,175	140,371	40,368	31,923	461,608	185,248	359,140	106,309	144,170	**1,566,312**
More than 1 Year	4.7%	9.5%	0.3%	0.7%	0.7%	1.0%	1.4%	0.3%	0.4%	**1.5%**
	69,806	268,010	3,343	22,498	55,678	32,380	162,909	16,222	37,033	**667,879**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	1,493,493	**2,833,925**	**1,056,101**	**3,148,718**	**8,080,070**	**3,389,419**	**11,833,483**	**5,030,139**	**8,973,366**	**45,838,714**

Appendix K. Percentage of Accepted Encounters Submitted by MCO and Processing Time, CY 2021–CY 2023



MCO	Year	1-2 Days	3-7 Days	8-31 Days	1-2 Months	2-6 Months	More than 6 Months
ABH	CY 2021	35.7%	8.9%	21.7%	7.7%	12.1%	13.9%
	CY 2022	33.3%	7.3%	17.1%	5.1%	16.5%	20.7%
	CY 2023	29.2%	7.9%	28.2%	10.3%	11.4%	13.0%
CFCHP	CY 2021	42.2%	9.3%	17.4%	8.4%	15.8%	6.8%
	CY 2022	54.0%	10.7%	16.6%	5.8%	9.5%	3.5%
	CY 2023	39.2%	8.6%	21.8%	7.5%	7.4%	15.5%
JMS	CY 2021	27.9%	4.1%	15.9%	17.4%	11.8%	23.0%
	CY 2022	30.6%	4.0%	16.7%	14.8%	14.6%	19.4%
	CY 2023	23.5%	3.9%	21.2%	15.2%	27.6%	8.7%
KPMAS	CY 2021	60.0%	14.0%	18.8%	2.1%	3.8%	1.3%
	CY 2022	57.5%	13.4%	21.2%	2.1%	3.2%	2.7%
	CY 2023	45.3%	11.0%	30.7%	8.0%	2.9%	2.1%
MPC	CY 2021	46.4%	10.2%	16.9%	4.9%	10.6%	11.0%
	CY 2022	47.1%	9.9%	17.5%	4.7%	10.2%	10.6%
	CY 2023	36.3%	8.8%	29.0%	8.5%	8.3%	9.2%
MSFC	CY 2021	28.0%	8.6%	35.5%	11.3%	12.1%	4.4%
	CY 2022	25.3%	5.7%	23.4%	17.4%	17.3%	10.8%
	CY 2023	26.4%	7.7%	33.9%	14.2%	10.6%	7.3%
PPMCO	CY 2021	56.2%	12.5%	19.0%	4.2%	5.2%	3.0%
	CY 2022	46.2%	10.7%	22.4%	5.8%	8.6%	6.3%
	CY 2023	33.5%	8.9%	30.1%	11.2%	10.9%	5.4%
UHC	CY 2021	28.8%	10.4%	35.7%	9.7%	11.2%	4.1%
	CY 2022	32.7%	10.5%	34.6%	7.4%	10.3%	4.5%
	CY 2023	24.1%	8.3%	36.4%	13.9%	13.6%	3.7%
WPM	CY 2021	49.5%	11.9%	21.6%	5.0%	6.7%	5.4%
	CY 2022	47.5%	10.9%	20.5%	4.4%	7.6%	9.1%
	CY 2023	39.1%	9.6%	29.0%	9.1%	9.9%	3.2%

Appendix L. Delivery Codes

Delivery services were identified as any encounter that had one of the ICD-10 diagnosis codes listed in the table below during CY 2021 through CY 2023.

Code Type	Codes Used in Analysis
ICD-10 Diagnosis Codes	O60.1x, O60.2x, O61.x, O64.x, O65.x, O66.x, O67.x, O68*, O69.x, O70.x, O71.x, O72.x, O73.x, O74.x, O75.x, O76*, O77.x, O80*, O82*, Z37.x

*Only the three-character code listed in the table (e.g., 068, 076, and O80) was included as a valid diagnosis. For all other diagnosis codes, the analysis included all other codes that began with the diagnosis code listed in the table (e.g., O61.x), where x equals any number of digits after the decimal. For example, O61.x, the "x" can represent any number of digits after the decimal (e.g., 061.1 or 061.14) or no digits after the decimal (e.g., O61).

Appendix M. Dementia Codes

Dementia-related services in CY 2023 were identified as any encounter that had one of the ICD-10 diagnosis codes listed in the table below. These codes indicate services for Alzheimer's disease and other types of dementia.

Code Type	Codes Used in Analysis
ICD-10 Diagnosis Codes*	F01, F02, F03, G30, G31

* The three-character codes can include any number of alphanumeric characters after the decimal, such as F03.A.

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Appendix D: 2024 Maryland HealthChoice Consumer Report Card

Information Reporting Strategy and Analytic Methodology

Introduction

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

The CRC is meant to help Medicaid enrollees compare and select a HealthChoice managed care organization (MCO). The report card includes ratings for each MCO from a number of performance measures selected from the Healthcare Effectiveness Data and Information Set (HEDIS®[1]), the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) survey, and Maryland's encounter data measures.

This report explains the reporting strategy and analytic methods Qlarant will use to develop the 2024 CRC, which reflects data reported from MCOs during the 2023 calendar year (CY) for measurement year (MY) 2022. This report is organized as follows:

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

Information Reporting Strategy

The most formidable challenge facing all consumer information projects is communicating a large amount of complex information in a clear and meaningful manner while fairly and accurately representing the data. The reporting strategy presented incorporates methods and recommendations based on experience and research regarding how to best present quality information to consumers. Based on a review of

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

available HEDIS and CAHPS measures, Qlarant recommends the following reporting categories, outlined with associated measures in the tables that follow:

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

The recommended categories are based on measures reported by HealthChoice MCOs during MY 2022 and are designed to focus on clearly identifiable areas of interest. Consumers may focus on MCO performance in areas most important to them and their families. The first two categories are relevant to all enrollees; the remaining categories are relevant to specific Maryland HealthChoice enrollees, including children, children with chronic illness, women, and adults. Reporting measures individually (in addition to the reporting categories listed above) is not recommended. Comparing the performance of a category composed of many measures with the performance of individual measures may give undue weight to the individual measures.

Measure Selection

The measures considered for inclusion in the CRC are derived from those required by MDH for MCOs to report. These include HEDIS measures, the CAHPS results from both the Adult Questionnaire and the Child Questionnaire, and MDH's encounter data measures.[7]

HEDIS Measures

The following table identifies Measure Specifications and HEDIS General Updates for each performance measure. For detailed changes, refer to *HEDIS Measurement Year 2022, Volume 2: Summary Table of Measures, Product Lines, and Changes.*

[7] See Appendix A for a complete list of HEDIS, CAHPS, and Maryland encounter data measures recommended for inclusion in each reporting category.

Table 1. Measure Specific Updates

Performance Measures	Reporting Category	Changes for MY 2022 reflected in 2024 Report Card Calculations
Appropriate Testing for Pharyngitis (CWP)	Keeping Kids Healthy	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • "Dicloxacillin" was removed from the CWP Antibiotics Medications List.
Appropriate Treatment Upper Respiratory Infection (URI)	Keeping Kids Healthy	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion.
Asthma Medication Ratio (AMR)	Care for Kids with Chronic Illness	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion.
Avoidance of Antibiotic Treatment For Acute Bronchitis/Bronchiolitis (AAB)	Keeping Adults Healthy	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion.
Cervical Cancer Screening (CCS)	Taking Care of Women	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion.
Controlling High Blood Pressure (CBP)	Keeping Adults Healthy	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • Instructions were added to report rates stratified by race and ethnicity for each product line. • The numerator of the Hybrid Specification was clarified that BP readings taken by the member are eligible for use in reporting. • The numerator of the Hybrid Specification was clarified that ranges and thresholds do not meet criteria. • The numerator of the Hybrid Specification was clarified that a BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use. • New data elements tables were added for race and ethnicity stratification reporting.
Breast Cancer Screening (BCS)	Taking Care of Women	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • Optional exclusions were clarified that unilateral mastectomy and bilateral modifier must be from the same procedure.
Breast Cancer Screening (BCS-E)	Taking Care of Women	• The logic for the measure to be expressed in Fast Healthcare Interoperable Resources (FHIR) was updated.
Hemoglobin A1c Control for Patients With Diabetes (HBD)	Keeping Adults Healthy	• This measure resulted from the separation of indicators that replaces the former Comprehensive Diabetes Care measure. • The Hemoglobin A1c (HbA1c) Testing indicator was removed.

Performance Measures	Reporting Category	Changes for MY 2022 reflected in 2024 Report Card Calculations
		• Members in hospice or using hospice services any time during the measurement year are a required exclusion. • Instructions were added to report rates stratified by race and ethnicity for each product line. • The optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes was revised to be required exclusions. • The Hybrid Specification to clarify the rules for sample size reduction was updated. • New data elements tables were added for race and ethnicity stratification reporting.
Eye Exam for Patients With Diabetes (EED)	Keeping Adults Healthy	• This measure resulted from the separation of indicators that replaces the former Comprehensive Diabetes Care measure. • Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • The optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes was revised to be required exclusions. • The Hybrid Specification was updated to clarify the rules for sample size reduction.
Blood Pressure Control for Patients With Diabetes (BPD)	Keeping Adults Healthy	• This measure resulted from the separation of indicators that replaces the former Comprehensive Diabetes Care measure. • Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • The optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes was revised to be required exclusions. • The Administrative Specification was updated to make it consistent with the Hybrid Specification; replaced the visit type requirement with a visit type exclusion. • The Hybrid Specification was updated to clarify the rules for sample size reduction. • The numerator of the Hybrid Specification was clarified that BP readings taken by the member are eligible for use in reporting. • The numerator of the Hybrid Specification was clarified that ranges and thresholds do not meet criteria.

Performance Measures	Reporting Category	Changes for MY 2022 reflected in 2024 Report Card Calculations
		• The numerator of the Hybrid Specification was clarified that a BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.
Chlamydia Screening in Women (CHL)	Taking Care of Women	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion.
Prenatal and Postpartum Care (PPC)	Taking Care of Women	• Instructions were added to report rates stratified by race and ethnicity for each product line. • The definition of last enrollment segment and clarified continuous enrollment requirements for steps 1 and 2 of the Timeliness of Prenatal Care numerator was removed. • Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • Services provided during a telephone visit, e-visit or virtual check-in may be used for Administrative and Hybrid collection methods were clarified. • New data elements tables were added for race and ethnicity stratification reporting.
Childhood Immunization Status (CIS)	Keeping Kids Healthy	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • Optional exclusions for immunocompromising conditions (e.g., immunodeficiency) were revised to be required exclusions. • Optional exclusions for anaphylaxis due to vaccine were revised to be numerator compliant for specific indicators. • Value sets and logic were updated for the MMR numerator, because single antigen vaccines are no longer used.
Child Immunization Status (CIS-E)	Keeping Kids Healthy	• This is the first year the measure is reported using Electronic Clinical Data Systems (ECDS).
Well-Child Visits in the First 30 Months of Life (W30)	Keeping Kids Healthy	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • Well-care visit stratifications were added to the Rules for Allowable Adjustments.
Child and Adolescent Well-Care Visits (WCV)	Keeping Kids Healthy	• A Note in the Description to clarify that the Guidelines for Effectiveness of Care Measures should be used when calculating this measure was added. • Members in hospice or using hospice services anytime during the measurement year are a required exclusion.

Performance Measures	Reporting Category	Changes for MY 2022 reflected in 2024 Report Card Calculations
		• Instructions were added to report rates stratified by race and ethnicity for each product line. • New data elements tables were added for race and ethnicity stratification reporting.
Immunization for Adolescents (IMA)	Keeping Kids Healthy	• Members in hospice or using hospice services anytime during the measurement year are a required exclusion. • Optional exclusions were revised for anaphylaxis due to vaccine to be numerator compliant for specific indicators. • The example for the two-dose HPV vaccination series was clarified that the second vaccine must be on or after July 25.
Immunizations for Adolescents (IMA-E)	Keeping Kids Healthy	• This is the first year the measure is reported using ECDS. • The logic was updated for the measure to be expressed in FHIR.
Use of Imaging Studies for Low Back Pain (LBP)	Keeping Adults Healthy	• The age range was expanded to increase the upper age limit to 75 years. • Age stratifications were added.

CAHPS Patient Experience Survey Measures

Consistent with the 2023 CRC, it is recommended that results of both the CAHPS Health Plan Survey 5.1H, Adult Version, and the CAHPS Health Plan Survey 5.1H, Child Version with the Children with Chronic Conditions (CCC) measures be included.

The sampling protocol for the CAHPS 5.1H Child Questionnaire allows reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic illness. For each population, results include the same ratings, composites, and individual question summary rates. In addition, five CCC measures are reported for the population of children with chronic conditions.

The CAHPS 5.1H Measures for the Medicaid Product Line section of this report shows the questions comprising the CAHPS 5.1H measures recommended for the CRC and their score values.

Format

Table 2 includes considerations which are important when designing the CRC.

Table 2. Formatting Elements

Format Element	Instructions
Space	Maximize the amount to display data and explanatory text.
Message	Communicate MCO quality in positive terms to build trust in the information presented.
Instructions	Be concrete about how consumers should use the information.
Text	Relate the utility of the report card to the audience's situation (e.g., new enrollees choosing an MCO for the first time, enrollees receiving the Annual Right to Change Notice and prioritizing their current health care needs, current enrollees learning more about their MCO) and reading level.
Narrative	Emphasize why what is being measured in each reporting category is important, rather than giving a detailed explanation of what is being measured. For example, "making sure that kids get all of their shots protects them against serious childhood diseases" instead of "the percentage of children who received the following antigens…"
Design	Use color and layout to facilitate navigation and align the star ratings to be left-justified ("ragged right" margin), consistent with the key.

Recommendation

The following formatting recommendations have been made to increase the CRC's level of clarity and effectiveness for consumers:

- Measure explanations and performance results should be presented on a one-page document, helping readers match explanations to their respective data.
- The document should be 11 x 18 inches with English on one side and Spanish on the other.
- The document's contents should be written at a sixth-grade reading level with short, direct sentences intended to relate to the audience's particular concerns.
- The document will avoid terms and concepts unfamiliar to the general public.
- Explanations of performance ratings, measure descriptions, and instructions for using the report card will be straightforward and action-oriented.
- The document contents should be translated into Spanish using an experienced translation vendor.

Rationale

Cognitive testing conducted for similar projects showed that Medicaid enrollees had difficulty associating data in charts with explanations if they were presented elsewhere in the report card. Consumers prefer a format that groups related data onto a single page. Given the number of MCOs whose information is being presented in Maryland's HealthChoice CRC, a one-page document will allow easy access to all information.

Rating Scale

Rate MCOs on a tri-level rating scale.

Recommendation
The following recommendations have been made for the tri-level rating scale:

- Compare each MCO's performance with the average performance of all MCOs potentially available to the target audience (i.e., the average of all HealthChoice MCOs aka "the Maryland HealthChoice MCO average").
- Use stars or circles to represent performance as "above," "the same as," or "below" the Maryland HealthChoice MCO average.

Rationale
A tri-level rating scale matrix displaying performance across categories provides enrollees with an easy-to-read "picture" of quality across plans and presents data in a manner that emphasizes meaningful differences between available MCOs (refer to the Analytic Method section below). This methodology differs from similar methodologies comparing MCO performance with ideal targets or national percentiles. This approach is more useful in an environment where enrollees must choose from a group of MCOs. At this time, developing an overall performance rating for each MCO is not recommended. The current reporting strategy allows report card users to decide which performance areas are most important to them when selecting an MCO.

Analytic Method

The CRC compares each MCO's actual score with the unweighted statewide MCO average for a particular reporting category. A symbol (i.e., a star) denotes whether an MCO performed "above," "the same as," or "below" the Maryland HealthChoice MCO average.[8] This analysis aims to generate reliable and useful information Medicaid enrollees can use to compare the quality of health care provided by Maryland's HealthChoice MCOs. A statistically reliable index of differences should compare MCO-to-MCO quality performance directly, allowing consumers to easily detect differences in MCO performance.

Handling Missing Values

Missing values are addressed in the following ways:

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

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

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

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

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

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

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

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

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

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

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

3. If an MCO is missing more than 50% of the measures composing a reporting category a designation of "Insufficient Data" is given for the measurement category.

Calculations in each category are based on the remaining reportable measures versus reportable MCOs. "NA" and "BR/NR" designations will be treated differently when values are missing. "NA" values will be replaced with the mean of non-missing observations, and "BR/NR" values will be replaced with the minimum value of non-missing observations. This minimizes any disadvantage to MCOs that are willing to report data but are unable to. Variances for replaced rates are calculated differently for CAHPS survey measures and for non-survey measures (HEDIS, Maryland encounter data).

Handling New MCOs

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

Members Who Switch Products/Product Lines

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

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

Qlarant's statistical methodology includes the following steps:

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

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

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

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

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

6. Categorize MCOs into three categories based on these CIs:

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

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

Quality Control

Qlarant includes quality control processes to ensure all data in the report card are accurately presented and support public reporting of the report card. This process includes:

- the Qlarant team closely reviewing the project's agreed-upon requirements and specifications of each measure so that the impact(s) of any changes are assessed and clearly delineated,

- having two analysts independently review the specifications and code the report card,
- having two analysts independently checking all data results,
- having each analyst complete quality reviews of the data, and
- having analysts meet to discuss and resolve any discrepancies in the analysis.

Reporting Categories and Measures

Category: Access to Care	Data Source	Weight
Getting Needed Care (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Getting Care Quickly (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Customer Service (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Adults' Access to Preventive/Ambulatory Health Services - 20-44 years (AAP) Adults' Access to Preventive/Ambulatory Health Services - 45-64 years (AAP)	HEDIS	1/6
Access to Care - SSI Adult - 21 years or older[1]	MDH Encounter Data	1/6
Access to Care - SSI Children - ages 0-20[1]	MDH Encounter Data	1/6
Category: Doctor Communication & Service	**Data Source**	**Weight**
Rating of All Health Care (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Rating of Personal Doctor (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Rating of Specialist Seen Most Often (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
How Well Doctors Communicate (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Shared Decision Making ("Yes" Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Health Promotion and Education ("Yes" summary rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Coordination of Care ("Usually" & "Always" Question Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14

Category: Keeping Kids Healthy	Data Source	Weight
Childhood Immunization Status (Combo 3) (CIS)[3]	HEDIS	1/8
Appropriate Treatment for Upper Respiratory Infections - 3 months - 18 years (URI)	HEDIS	1/8
Appropriate Testing for Pharyngitis - 2-18 years (CWP)	HEDIS	1/8
Well-Child Visits in the First 30 Months of Life (W30)	HEDIS	1/8
Child and Adolescent Well-Care Visits- Ages 3-11 (WCV)	HEDIS	1/8
Child and Adolescent Well-Care Visits- Ages 12-17 and Ages 18-21 (WCV)	HEDIS	1/8
Lead Screening - 12-23 months[1]	MDH Encounter Data, MDE Lead Registry, FFS Data	1/8
Immunization for Adolescents (Combo 1) (IMA)[3]	HEDIS	1/8
Category: Care for Kids with Chronic Illness	**Data Source**	**Weight**
Access to Prescription Medicines (Rating Mean)	CAHPS 5.1H MC	1/6
Access to Specialized Services: Special Medical Equipment or Devices (Summary Rate)	CAHPS 5.1H MC	1/6
Family Centered Care: Personal Doctor or Nurse Who Knows Child ('Yes" Summary Rate)	CAHPS 5.1H MC	1/6
Family Centered Care: Getting Needed Information (Rating Mean)	CAHPS 5.1H MC	1/6
Coordination of Care for Children with Chronic Conditions ("Yes" Summary Rate)	CAHPS 5.1H MC	1/6
Asthma Medication Ratio - 5-11 years (AMR)[1] Asthma Medication Ratio - 12-18 years (AMR)[1]	HEDIS	1/6
Category: Taking Care of Women	**Data Source**	**Weight**
Breast Cancer Screening (BCS)[3]	HEDIS	1/5
Cervical Cancer Screening (CCS)	HEDIS	1/5
Chlamydia Screening - Total Rate: 16-24 years (CHL)	HEDIS	1/5
Timeliness of Prenatal Care (PPC)[1]	HEDIS	1/5
Postpartum Care (PPC)[1]	HEDIS	1/5
Category: Keeping Adults Healthy	**Data Source**	**Weight**
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Control (<8.0%) (HBD)	HEDIS	1/8
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (>9.0%) (HBD)[1,2]	HEDIS	1/8
Eye Exam for Patients With Diabetes (EED)	HEDIS	1/8
Blood Pressure Control for Patients With Diabetes (BPD)	HEDIS	1/8
Avoidance of Antibiotic Treatment Acute Bronchitis/Bronchiolitis - 18-64 years (AAB)[2]	HEDIS	1/8
Use of Imaging Studies for Low Back Pain (LBP)[2]	HEDIS	1/8
Asthma Medication Ratio - 19-50 years (AMR)[1] Asthma Medication Ratio - 51-64 years (AMR)[1]	HEDIS	1/8
Controlling High Blood Pressure (CBP)	HEDIS	1/8

[1] Maryland Population Health Incentive Program Measure

[2] Note: MCO rate used in the analysis is the inverse score in order to provide consistency with other measures (i.e., higher % is better).
[3] For measures that NCQA allows both traditional and Electronic Clinical Data Systems (ECDS) reporting methods, a weighted average is used in calculation of a plan score for that category.

CAHPS 5.1H Measures for the Medicaid Product Line

The table below displays the questions, response choices, and corresponding score values used to calculate results for the CAHPS 5.1H MY2022 Adult Questionnaire and Child Questionnaire [with Children with Chronic Conditions measure (CCC)]. The sampling protocol for the Child Questionnaire allows for the reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic conditions.

CAHPS 5.1H Adult Questionnaire Measures

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

Q13=MA Q28=MC	In the last 6 months, how often did your personal doctor listen carefully to you?	Never Sometimes Usually Always
Q14=MA Q29=MC	In the last 6 months, how often did your personal doctor show respect for what you had to say?	Never Sometimes Usually Always
Q15=MA Q32=MC	In the last 6 months, how often did your personal doctor spend enough time with you?	Never Sometimes Usually Always
Question	**Customer Service**	**Response Choices**
Q24=MA Q45=MC	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	Never Sometimes Usually Always
Q25=MA Q46=MC	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	Never Sometimes Usually Always
Question	**Coordination of Care**	**Response Choices**
Q17=MA Q35=MC	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	Never Sometimes Usually Always
Question	**Rating of All Health Care**	**Response Choices**
Q8=MA Q9=MC	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	0 (worst) through 10 (best)
Question	**Rating of Personal Doctor**	**Response Choices**
Q18=MA Q36=MC	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	0 (worst) through 10 (best)

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

MA = CAHPS 5.1H MY 2022 Medicaid Adult Questionnaire
MC = CAHPS 5.1H MY 2022 Medicaid Child Questionnaire (With CCC Measure)

CAHPS 5.1H Child Questionnaire Measures

The following questions from the CAHPS 5.1H MY2022 Child Questionnaire provide information on parents' experience with their child's health plan for the population of children with chronic conditions. The five CCC measures summarize satisfaction with the basic components of care essential for the successful treatment, management, and support of children with chronic conditions. The child is included in the CCC population calculations if one or more of the following survey-based screening criteria are true:

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

Question	Access to Prescription Medicines	Response Choices
Q51	In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?	Never Sometimes Usually Always
Question	**Access to Specialized Services**	**Response Choices**
Q15	In the last 6 months, how often was it easy to get special medical equipment or devices for your child?	Never Sometimes Usually Always
Q18	In the last 6 months, how often was it easy to get this therapy for your child?	Never Sometimes Usually Always
Q21	In the last 6 months, how often was it easy to get this treatment or counseling for your child?	Never Sometimes Usually Always
Question	**Family-Centered Care: Personal Doctor Who Knows Child**	**Response Choices**
Q33	In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?	Yes No
Q38	Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	Yes No
Q39	Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?	Yes No
Question	**Family-Centered Care: Getting Needed Information**	**Response Choices**
Q8	In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?	Never Sometimes Usually Always
Question	**Coordination of Care for Children with Chronic Conditions**	**Response Choices**
Q13	In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	Yes No

Q24	In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	Yes No

Appendix E: Report Reference Page

Access the links below to find identified reports on MDH's Quality Assurance **website**.

Performance Improvement Projects

MY 2023 PIP Report

Performance Measure Validation

Population Health Incentive Program:
MY 2023 PHIP Report

Healthcare Effectiveness Data and Information Set:
MetaStar's Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2023 Results

Consumer Assessment and Healthcare Providers and Systems: **State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations' Adult and Child Populations 2024 CAHPS 5.1H Member Experience Survey**

Systems Performance Review

MY 2023 SPR Statewide Executive Summary Report

Network Adequacy Validation

MY 2023 NAV Protocol 4 Report

MY 2024 NAV Focused Study Report

Encounter Data Validation

MY 2023 EDV Report

Early and Periodic Screening, Diagnosis, and Treatment

MY 2023 EPSDT Statewide Executive Summary Report

Consumer Report Card

MY 2024 Consumer Report Card in **English** and **Spanish**

Grievances, Appeals, and Denials Focused Study

MY 2023 GAD Annual Report