Qlarant

Medicaid Managed Care Organization

Annual Technical Report

Calendar Year 2021

Maryland
DEPARTMENT OF HEALTH

Revised October 2022

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Maryland HealthChoice Program

2021 Annual Technical Report

Measurement Year 2020

Summary of Changes Revised October 2022

- Page 8, Conclusions portion of the Systems Performance Review section:
  - Additional statement was included to explain the partial review completed for Standard 4, Credentialing and Recredentialing in CY 2020. Further explanation was also provided to indicate intention for compliance in the CY 2021 SPR review.
  - Additional statement was included to explain that Standards 2 and 9 were previously exempt from the interim triennial review due to the MCOs attaining 100% compliance in previous SPRs.
- Page 27, Results portion of the EPSDT section:
  - Additional statement was included to explain that an update to scoring methodology for the 3-5 Year Anemia Test resulted in the element being reassessed which impacted the scores for three of the managed care organizations.
- Table 32, CY 2020 Laboratory Test/At-Risk Screenings Element Results
  - 3-5 Year Anemia Test results for ABH, ACC, and JMS were updated due to the scoring methodology updates. This scoring methodology update did not impact the overall composite component score
    - ABH's score changed from 85% to 83%.
    - ACC's score changed from 82% to 84%.
    - JMS' score changed from 90% to 93%.
- Page 88, EPSDT Section of JMS Strengths, Improvements, Opportunities, and Recommendations
  - Statement was corrected to include that JMS' largest decline in scoring for EPSDT components was the 3-5 Year Anemia Test element which declined 7 percentage points from 100% in CY 2019 to 93% in CY 2020.
- Page 207, MD SPR Standards to Part 438 Subpart D and QAPI Standards Crosswalk
  - Provider Selection was identified under Standard 5, Enrollee Rights and Standard 11, Fraud and Abuse.

Executive Summary

Background

As of December 31, 2020, the Maryland HealthChoice Program (HealthChoice) enrolled 1,334,796 participants. The Maryland Department of Health (MDH) contracted with nine Managed Care Organizations (MCOs) during this evaluation period. Those MCOs evaluated during this period were:

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- CareFirst Community Health Plan (CFCHP)[1]
- 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)

Table 1 highlights MCO profiles and quality characteristics.

Table 1. CY 2020 MCO Profiles

MCO	Contracted Since	CY 2020 Enrollment*	NCQA Accreditation Status**
ABH	2019	44,422	Accredited
ACC	1999	301,943	Accredited
CFCHP	2013	53,013	Accredited
JMS	1997	28,981	Accredited
KPMAS	2014	93,909	Accredited
MPC	1997	228,712	Accredited
MSFC	1997	99,962	Accredited
PPMCO	1995	325,516	Accredited
UHC	1997	158,335	Accredited

*Source: Maryland Department of Health, MCO enrollment as of December 28, 2020.
**Source: MetaStar (2021, September). Statewide Executive Summary Report HealthChoice Participating Organization HEDIS®[2] MY 2020 Results. Madison, WI.

Purpose

The Code of Federal Regulations (42 CFR §438.350) requires states contracting with MCOs to conduct annual, independent reviews of the managed care program. To meet these requirements, MDH contracts with Qlarant, an independent external quality review organization (EQRO). Qlarant evaluates the quality, accessibility, and timeliness of healthcare services furnished by the MCOs

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

through various mandatory activities following Centers for Medicare and Medicaid Services (CMS)-developed EQRO protocols.[3] Qlarant completed the following external quality review (EQR) activities in 2020-2021 to evaluate MCO performance for measurement year (MY) 2020:

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

Qlarant conducted optional activities that include:

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

In addition to these EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing how data from all activities conducted were aggregated and analyzed, and conclusions drawn as to the quality, accessibility, and timeliness of care furnished by the MCOs. This document serves as Qlarant's report to MDH on the assessment of MY 2020 MCO performance.

The Annual Technical Report (ATR) describes EQR methodologies for completing activities, results for compliance, and performance. It includes an overview of the quality, access, and timeliness of healthcare services provided to Maryland's Medicaid managed care enrollees. Recommendations for improvement are made, and if acted upon, may positively impact enrollee outcomes.

[3] The EQR Protocols are available for download at: www.cms.gov.

Key Findings

In MY 2020, the COVID-19 public health emergency spawned unique barriers which affected both data collection and performance in numerous EQR tasks. The performance trends for each task which highlight these challenges are outlined in the following sections.

Systems Performance Review

MCOs are expected to be fully compliant with federal and contract requirements. SPRs evaluate MCO compliance with structural and operational standards. For the MY 2020 review, Qlarant reviewed standards requiring a corrective action plan (CAP), scored as Met with Opportunities, or baseline from the CY 2019 review.

CAPs were required to address areas of continued non-compliance for five of the nine MCOs (ABH, ACC, CFCHP, KPMAS, and PPMCO), which should increase compliance rates if successfully implemented. Table 2 displays the number of CAPs required by each MCO and the number reviewed and successfully resolved.

Table 2. Total Corrective Action Plans per MCO

ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Total Corrective Action Plans Reviewed								
5	5	2	0	4	0	0	3	0
Total Corrective Action Plans Resolved								
3	4	0	0	2	0	0	2	0

Performance Improvement Projects

Eight MCOs (excluding ABH) conducted two performance improvement projects (PIPs). The Asthma Medication Ratio (AMR) PIP assessed quality of care, while the Lead Screening PIP assessed quality, timeliness, and accessibility of care. The HEDIS AMR measure was selected for the AMR PIP. Two measures were chosen for the Lead Screening PIP: HEDIS Lead Screening and Maryland Encounter Data.

Table 3 displays the percentage change in indicator results from MY 2019 to MY 2020 for each MCO.

Table 3. Percentage Change in PIP Results from MYs 2019 to 2020

Indicator	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Asthma Medication Ratio PIP Percentage Change								
AMR	6.5	3.5	(0.2)	(0.4)	5.1	3.1	7.8	1.6
Lead Screening PIP Percentage Change								
HEDIS Lead	(0.5)	(2.4)	⊖	(2.4)	(6.3)	(9.7)	(3.9)	(2.0)
Encounter Data	(5.5)	1.4	(1.6)	(7.2)	(7.6)	1.7	(4.2)	(3.8)

Green - ↑ Improvement from CY 2019; Pink - ↓ decline from CY 2019; White – ⊖ No change

Encounter Data Validation

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

Overall, validation findings indicate that the data are complete and accurate. MCOs achieved a match rate of 98%, meaning 98% of claims submitted were supported by medical record documentation. No CAPs were required as all MCOs exceeded the 90% standard.

Performance Measure Validation

The Value-Based Purchasing (VBP) activity uses financial incentives and disincentives to promote performance improvement. Calendar year (CY) 2020 VBP rates were drawn from HEDIS and encounter data rates reported by MCOs and/or Maryland Department of the Environment. For each of the nine selected measures, MDH calculates incentive, neutral, and disincentive ranges. These ranges are then used to determine if the MCO's quality improvement efforts have successfully resulted in improved health outcomes and if incentives should be awarded or disincentives should be assessed.

Table 4 identifies whether the MCO will receive an overall incentive or will be required to pay a disincentive based upon calculated incentive/disincentive amounts for each of the nine measures.

Table 4. Overall VBP Net Incentive Outcome by MCO

MCOs	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Outcome	D	I	D	I	I	D	I	D	D

I - Incentive, D - Disincentive

EPSDT Medical Record Review

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical record review assesses quality, timeliness, and accessibility of care. Over 2,500 medical records were reviewed for this activity. CY 2020 review indicators were based on current pediatric preventive care guidelines and MDH-identified priority areas. Compliance thresholds for each of the five components were set at 80%. For CY 2020, the medical record review (MRR) process remained a full desktop review due to the COVID-19 public health emergency. In comparison to CY 2019 results, all five component scores increased. CAPs were required for MCOs that did not meet the minimum compliance threshold.

Table 5 displays the total score of CY 2020 EPSDT components by MCO.

Table 5. EPSDT Aggregate Scores by MCO

MCOs	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Total Percentage	87	89	87	97	97	89	90	92	87

Green – Above 80% compliance threshold.

Consumer Report Card

The Consumer Report Card is meant to help Medicaid participants select a HealthChoice MCO. Information in the Report Card includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Maryland's encounter data measures. Table 6 displays the overall star rating changes from CY 2020 to CY 2021.

Table 6. Star Rating Changes from CY 2020 to 2021

Performance Areas	MCOs								
	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Access to Care	⊖	↓	⊖	↓	⊖	↓	⊖	↓	↓
Doctor Communication and Service	⊖	↓	⊖	⊖	↑	↑	↓	↑	⊖
Keeping Kids Healthy	N/A	⊖	⊖	⊖	⊖	↑	⊖	⊖	⊖

Performance Areas	MCOs								
	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Care for Kids with Chronic Illness	N/A	↓	↓	N/A	N/A	⊖	⊖	↑	⊖
Taking Care of Women	↑	⊖	⊖	⊖	⊖	⊖	↓	↓	⊖
Care for Adults with Chronic Illness	↓	⊖	⊖	⊖	⊖	↑	↓	⊖	⊖

Green - ↑ Improvement from CY 2020; Pink - ↓ decline from CY 2020; White - ⊖ No change; Gray – N/A – reported as Not Applicable for CY 2020 and/or CY 2021

Focused Review of Grievances, Appeals, and Denials

The focused review of grievances, appeals, and denials assessed MCO compliance with federal and state laws and regulations pertaining to the appropriateness of denials of service and the handling of grievances and appeals. This activity consisted of reviewing quarterly MCO grievance, appeal, and denial reports from the final two quarters in CY 2020 and the first two quarters in CY 2021, along with a CY 2020 annual record review.

Table 7 displays an overall MCO compliance score for the review period from quarterly report submissions based upon MDH established thresholds.

Table 7. MCO Overall Compliance with Regulatory Timeframes

MCOs	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Member Grievances	PM	M	M	M	M	M	M	PM	PM
Provider Grievances	PM	PM	M	M	N/A	M	M	M	PM
Member Appeals	PM	PM	M	M	PM	PM	M	PM	PM
Denial Determinations	PM	M	PM	PM	M	M	M	PM	M
Denial Notifications	M	M	M	PM	M	M	M	PM	M

Green - M (Met), Yellow - PM (Partially Met), Gray – N/A (Not Applicable)

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

Table 8 displays MCO overall compliance with the above components based on the annual record review.

Table 8. MCO Overall Compliance with Record Review Components

MCOs	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Member Grievances	PM	M	PM	M	PM	M	M	M	M
Member Appeals	PM	M	PM	N/A	PM	PM	M	PM	M
Pre-Service Denials Determinations	M	M	M	M	M	M	M	PM	M

Green - M (Met), Yellow - PM (Partially Met), Gray – N/A (Not Applicable)

Network Adequacy Validation

The Network Adequacy Validation (NAV) activity assessed the network adequacy of the nine MCOs to ensure that each has the ability to provide enrollees with timely access to needed care within a reasonable timeframe. This activity focused on two components: a survey of providers to assess compliance with State access and availability requirements and validating the accuracy of MCO online provider directories.

Survey results of primary care provider (PCP) compliance with urgent care appointment requirements were above the minimum compliance threshold of 80%. These results are displayed in Table 9.

Table 9. PCP Compliance with Routine and Urgent Care Appointments

CY 2021 NAV	Routine Care Appointment Compliance	Urgent Care Appointment Compliance	Minimum Compliance
Appointment Availability	94.0%	86.8%	80%
Appointment Timeframes	99.6%	86.8%	80%

Based on CY 2021 results, five MCOs (JMS, KPMAS, MPC, MSFC, and PPMCO) are required to submit CAPs to Qlarant to improve compliance.

Healthcare Effectiveness Data and Information Set

Maryland Department of Health (MDH) contracted with MetaStar, Inc. (MetaStar), a NCQA Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice managed care organizations and to summarize the results. For HEDIS Measurement Year (MY) 2020, MDH required HealthChoice managed care organizations to report the complete HEDIS measure set for services rendered in calendar year 2020 to HealthChoice enrollees. These measures provide meaningful managed care organization comparative information, and they measure performance relative to MDH's priorities and goals.

Maryland MCOs have historically had high performance in their HEDIS rates. For MY 2020, COVID-19 caused performance to decrease across multiple measure domains, primarily for access to care, prevention, and screening measures. In addition, it should be noted that due to COVID-19, NCQA allowed MCOs to rotate hybrid measure rates using HEDIS MY 2018 audited results for reporting in MY 2019. Therefore, some HEDIS MY 2020 hybrid rate changes

appear to be even more significant than what they may have been if hybrid rotation had not been allowed for HEDIS MY 2019. For additional findings and comprehensive details associated with the HEDIS MY 2020 results, see the full report linked in **Appendix D**.

Consumer Assessment of Healthcare Providers and Systems

In 2017, MDH contracted with the Center for the Study of Services (CSS), an NCQA-certified survey vendor, to administer and report the results of the CAHPS 5.0H Member Experience Survey. The overall goal of the survey is to provide performance feedback that is actionable, and that will aid health plans in improving overall member experience.

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

Conclusion

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

MDH continues to encourage an environment of compliance and quality improvement and sets high standards to promote access to quality care. The MY 2020 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality healthcare and services for Maryland managed care enrollees.

Maryland HealthChoice Program

2021 Annual Technical Report

Measurement Year 2020

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

The 2021 Annual Technical Report (ATR) is a compilation of quality assurance activity reports for services and activities rendered during measurement years 2019 and 2020. The ATR describes external quality review (EQR) methodologies for completing activities; provides MCO performance measure results; summarizes compliance results; and includes an overview of the quality, timeliness, and accessibility of healthcare services furnished by the contracted MCOs. The COVID-19 public health emergency presented unique challenges for HealthChoice MCOs in MY2020, which is reflected in performance assessed in the 2021 ATR.

As of December 31, 2020, the HealthChoice program enrolled 1,334,796 participants. MDH contracted with nine MCOs during this evaluation period. The MCOs evaluated during this period were:

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- CareFirst Community Health Plan (CFCHP)[4]
- 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)

[4] Formerly University of Maryland Health Partners.

MBMA's Quality Strategy

The overall goals of MBMA's Quality Strategy are to:

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

EQRO Program Assessment Activities

MDH is required to annually evaluate the quality of care provided by contracting MCOs in accordance with Federal law[5]. MDH contracts with Qlarant Quality Solutions, Inc., an external quality review organization (EQRO), to perform an independent annual review of services provided by each contracted MCO to ensure that the services provided to the participants meet the standards set forth in the regulations governing HealthChoice.
Federal regulations require that the EQRO perform four mandatory activities using methods consistent with CMS protocols:

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

Federal regulations also permit MDH to contract with an EQRO to validate encounter data submitted by the MCOs. Qlarant performed this activity on behalf of MDH in collaboration with The Hilltop Institute at the University of Maryland Baltimore County (Hilltop). Qlarant conducted each of the above activities in a manner consistent with the CMS protocols during CY 2020.

Additionally, Qlarant completed the following four review activities:

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

Separate report sections address each review activity and describe the methodology and data sources used to conclude the particular focus area. The final report sections summarize overall MCO strengths, opportunities, and recommendations and assess the status of previous findings and recommendations to MBMA and the MCOs to further improve the quality of, timeliness of, and access to healthcare services for HealthChoice participants.

[5] Federal law - Section 1932(c)(2)(A)(i) of the Social Security Act

Systems Performance Review

Objectives

The purpose of the SPR is to provide an annual assessment of the structures, processes, and outcomes of each MCO's internal quality assurance program. Through the systems review, Qlarant's review team is able to identify, validate, quantify, and monitor problem areas, as well as identify and promote best practices. The standards reviewed during the SPR may include:

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

Appendix B provides a crosswalk of these standards to achieve compliance with 42 CFR Part 438, Subpart D and Quality Assurance and Performance Improvement (QAPI) Standards.

Methodology

Qlarant conducted CY 2020's assessment as an interim desktop review in response to MDH's decision to move to comprehensive triennial, rather than annual, onsite reviews. Reviewers completed this assessment by applying systems performance standards developed in accordance with the Code of Maryland Regulation (COMAR) 10.67.04.03B(1), federal regulations, and guidelines from other quality assurance accrediting bodies such as the National Committee for Quality Assurance (NCQA). **Appendix B** provides a crosswalk of COMAR regulations and SPR standards reviewed for CY 2020's interim desktop review. Standards requiring a corrective action plan (CAP), scored as Met with Opportunity, or as baseline in the CY 2019 review were the focus of CY 2020's SPR. Additionally, a sample review of appeal, grievance, and adverse determination records was conducted to assess compliance with applicable standards.

Prior to initiation of the annual assessment, each MCO received a draft of the standards in advance for review and comment within 45 days from receipt. All comments were taken into consideration prior to finalizing standards. SPR standards were finalized after review and approval by the Division of HealthChoice Quality Assurance (DHQA).

During the desktop reviews conducted in January and February of 2021, the team reviewed all relevant documentation submitted by the MCOs to assess the standards. Reviews were conducted by a team of qualified healthcare professionals with over 50 years of combined EQRO experience.

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

actions to correct any identified deficiencies from the review process.

After completing the review, Qlarant documented its findings and level of compliance for each standard by element and component. Levels of compliance for each element and component received a review determination of "Met," "Met with Opportunity," "Partially Met," or "Unmet," as shown in Table 10. MDH had the discretion to change a review finding to "Unmet" if the element or component had been found "Partially Met" for more than one consecutive year.

Table 10. Levels of Compliance for Each Element and Component

Review Determination	Criteria
Met	Compliant with requirements
Met with Opportunity	Compliant with requirements but with an opportunity to improve
Partially Met	CAP required
Unmet	CAP required

Exit letters or the follow-up letter provided to each MCO after the desktop review described potential issues that could be addressed by supplemental documents, if available. The MCOs were given ten business days from receipt of the follow-up letter to submit any additional information to Qlarant. Documents received were subsequently reviewed against the standard(s) to which they were related.

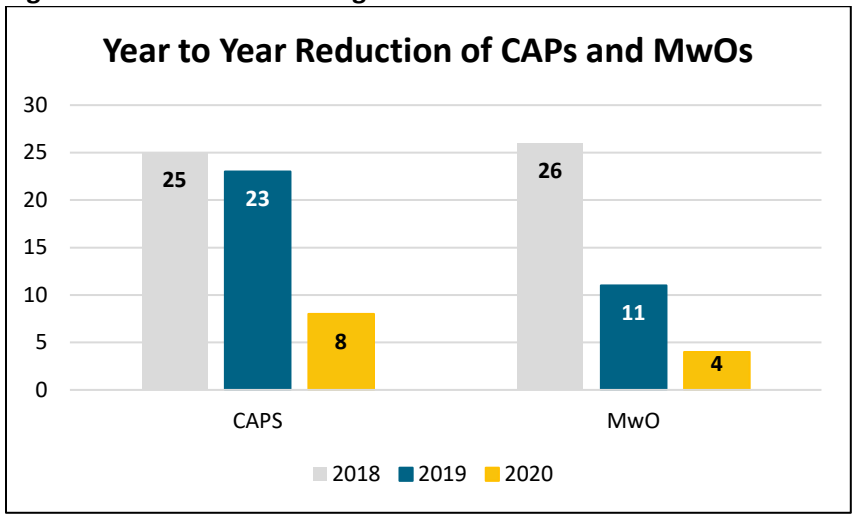
Final reports captured any appropriate revisions from additional documentation sent from the MCO. After receiving the final report, the MCO is given 45 calendar days to respond to Qlarant with required CAPs. The MCO could have also responded to any other issues contained in the report, at its discretion, within this same timeframe, and/or requested a consultation with DHQA and Qlarant to clarify issues or ask for assistance in preparing a CAP. Qlarant evaluates and determines the adequacy of compliance for all CAPs.

A CAP is determined adequate only if it addresses all required elements and components (such as timelines, action steps, and documented evidence).

Results

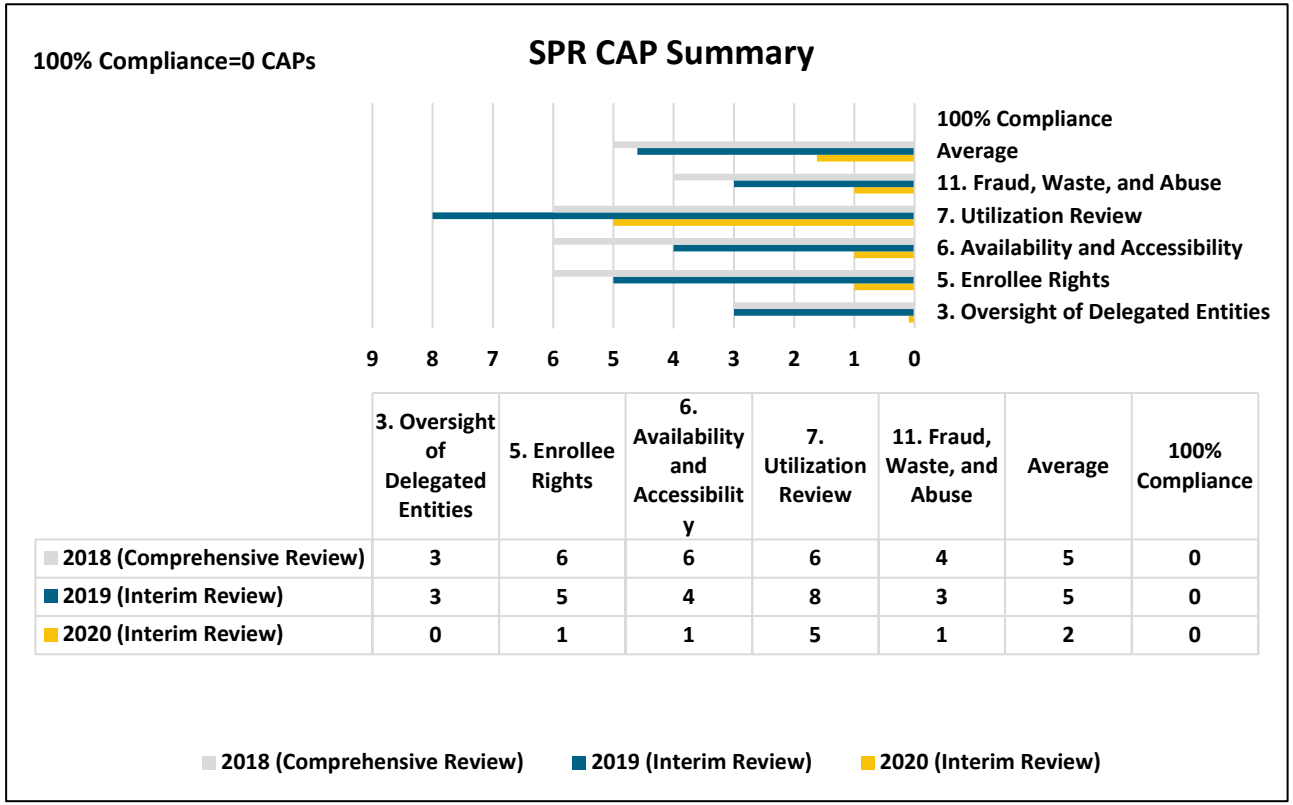
As a result of Maryland using a comprehensive triennial review format instead of an annual comprehensive review format, only select standards were reviewed during the CY 2020 interim SPR. Maryland will conduct the next comprehensive SPR in CY 2021, following the previous comprehensive SPR in CY 2018. All MCOs have demonstrated the ability to design and implement effective quality assurance systems. Although numerical scores were not provided in CY 2020 SPR, improvement was seen across all MCOs. Figure 1 demonstrates a three-year SPR CAP trend. The number of overall CAPs reduced from 25 in CY 2018 to 8 in CY 2020. The number of Met with Opportunity scores reduced from 26 in CY 2018 to 4 in CY 2020. Four MCOs (JMS, MPC, MSFC, and UHC) received a perfect score in the CY 2020 SPR.

Figure 1. Three-Year Trending of CAPs and MwOs



Any standard that scored less than 100% in the 2018 SPR required a CAP. These standards required review in the subsequent interim SPRs. Figure 2 demonstrates SPR CAPs per standard during each review period. Utilization Review (Standard 7) continues to reveal opportunities for MCOs to improve while Oversight of Delegated Entities (Standard 3) is now 100% compliant. There were no CAPs in Standards 1, 2, 4, 8, 9, and 10. The remaining standards (Standard 5, 6, and 11) are trending toward 100% compliance.

Figure 2. Three-Year SPR CAP Summary



	3. Oversight of Delegated Entities	5. Enrollee Rights	6. Availability and Accessibility	7. Utilization Review	11. Fraud, Waste, and Abuse	Average	100% Compliance
2018 (Comprehensive Review)	3	6	6	6	4	5	0
2019 (Interim Review)	3	5	4	8	3	5	0
2020 (Interim Review)	0	1	1	5	1	2	0

Overall MCO results and findings for the four standards assessed for CY 2020 with remaining opportunities for improvement are provided below. These standards address Enrollee Rights, Availability and Accessibility, Utilization Review, and Fraud and Abuse.

Standard 5: Enrollee Rights

Results and Findings: One MCO (CFCHP) has a continued improvement opportunity from the CY 2019 SPR and is required to submit quarterly updates on their CAP. Results are displayed in Table 11.

Table 11. Standard 5 Enrollee Rights Interim Desktop Review Results for CY 2019

Element/Component Reviewed	Element/Component Description	CFCHP
5.8e	MCO's electronic information provided to members must meet requirements set forth in COMAR.	**UM**

UM=Unmet
Red represents quarterly updates are required on CAP per MDH MCO Performance Monitoring Policies.

Standard 6: Availability and Accessibility

Results and Findings: One MCO (ABH) has a continued improvement opportunity from the CY 2019 SPR and is required to submit quarterly updates on their CAP. Results are displayed in Table 12.

Table 12. Standard 6 Interim Desktop Review Results for CY 2020

Element/Component Reviewed	Element/Component Description	ABH
6.2a	The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population as specified in COMAR.	**PM**

PM=Partially Met
Red represents quarterly updates that are required on the CAP per MDH Performance Monitoring Policy.

Standard 7: Utilization Review

Results and Findings: Six MCOs (ABH, ACC, CFCHP, KPMAS, MPC, and PPMCO) have improvement opportunities in the area of Utilization Review and five MCOs require CAPs to become compliant for the CY 2020 SPR. These five MCOs who require CAPs also require quarterly updates on their CAPs as continued opportunities from the CY 2019 SPR. Four MCOs (ACC, CFCHP, KPMAS, and MPC) received a finding of Met with Opportunity for improvement in the following elements/components to address for the CY 2020 SPR.

Results are displayed in Table 13.

Table 13. Standard 7 Interim Desktop Review Results for CY 2020

Element/Component Reviewed	Element/Component Description	ABH	ACC	CFCHP	KPMAS	MPC	PPMCO
7.3c	Corrective measures implemented must be monitored.	N/A	N/A	N/A	N/A	N/A	PM
7.4c	Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.	N/A	PM	N/A	N/A	N/A	UM
7.5b	Adverse determination letters include all required components.	PM	MwO	MwO	MwO	N/A	N/A
7.6a	The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.	N/A	PM	N/A	N/A	N/A	N/A
7.7a	The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and 10.67.09.05.	N/A	UM	MwO	N/A	N/A	N/A
7.7c	The MCO must adhere to appeal timeframes.	UM	UM	N/A	PM	MwO	UM
7.7e	Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.	UM	N/A	N/A	N/A	N/A	N/A
7.8c	The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	UM	PM	PM	PM	N/A	N/A

MwO=Met with Opportunity, **PM**=Partially Met, **UM**=Unmet
Red represents quarterly updates that are required on the CAP per MDH Performance Monitoring Policy.
Black represents quarterly updates on the CAP that are not required.

Standard 11: Fraud and Abuse

Results and Findings. One MCO (KPMAS) has a continued improvement opportunity from the CY 2019 SPR and is required to submit quarterly updates on their CAP. Results are displayed in Table 14.

Table 14. Standard 11 Interim Desktop Review Results for CY 2020

Element/Component Reviewed	Element/ Component Description	KPMAS
11.4c	Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate the MCO contracts with.	**UM**
11.4d	Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.	**UM**

UM=Unmet
Red represents quarterly updates that are required on CAP per MDH's Performance Monitoring Policy.

Conclusions

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. Although numerical scores were not provided in CY 2020, an improvement was seen across all MCOs. The number of overall CAPs reduced from 25 in CY 2018 to 8 in CY 2020. The number of *Met with Opportunity* scores reduced from 26 in CY 2018 to 4 in CY 2020. Four MCOs (JMS, MPC, MSFC, and UHC) received a perfect score in the CY 2020 SPR.

With regards to Standard 4, Credentialing and Recredentialing, this standard was previously exempt from the interim triennial review due to MCO compliance. The CY 2020 SPR review included a partial review of two new elements. The CY 2021 SPR review included a complete review of Standard 4 to become compliant per CMS feedback. Standard 2, Accountability to the Governing Body, and Standard 9, Health Education Plan were previously exempt from the interim triennial review due to MCOs attaining 100% compliance in previous SPRs. Standards 2 and 9 are scheduled for a full review during the CY 2022 Interim Review.

Maryland has set high standards for MCO quality assurance systems. HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. Qlarant will conduct a comprehensive onsite SPR for CY 2021 in January and February 2022.

For additional findings and comprehensive details associated with the CY 2020 SPR Report, see the link to the SPR Executive Summary in **Appendix D**.

Performance Improvement Projects

Objectives

Performance improvement projects (PIPs) are designed to achieve significant improvement sustained over time in clinical and non-clinical care areas. Projects are expected to have a favorable effect on health outcomes and enrollee satisfaction. PIPs must be designed, conducted, and reported in a methodologically sound manner. Qlarant uses the *Centers for Medicare & Medicaid Services (CMS) Protocol 1, Validation of Performance Improvement Projects,* as a PIP review activity guideline[6].

HealthChoice MCOs conduct two PIPs annually. As designated by MDH, the MCOs continued the Asthma Medication Ratio (AMR) PIP. The Lead Screening PIP replaced the Controlling High Blood Pressure PIP in 2018. Eight of the nine MCOs conducted PIPs in 2021. ABH did not conduct any PIPs for the CY 2020 measurement period since they joined the HealthChoice program in October 2017 but have now begun participation in the process with a Quarterly Lead PIP Report submission and continue with participation in the AMR PIP.

This year, the COVID-19 public health emergency presented a near-insurmountable challenge for many organizations, and MCOs were not exempt from these trials; some of the managed care challenges included: staffing shortages, ability to engage a rightfully alarmed membership, reduced opportunities for preventative care at times, overwhelmed/temporarily closed provider offices, technology challenges both in the workplace and in the community, and urgency to develop new strategies to overcome unimaginable healthcare barriers.

Methodology

Qlarant evaluates PIPs to determine if they were conducted in a methodical and sound manner. A successful PIP evaluation, one in which the PIP meets all or the majority of the nine steps required, can provide MDH with confidence in the validity of project indicator rates, sampling and data collection methodologies, robust interventions, and overall study findings. Using the CMS protocol as a guide, Qlarant assesses each PIP across a nine-step process.

Qlarant rates each component within a step as *Met (M)*, *Partially Met (PM)*, *Unmet (UM)*, or *Not Applicable (N/A),* which results in an assigned score as defined in Table 15 below. A final assessment is conducted for all nine steps, with numeric scores provided for each component and step of the validation process. A description of the rating and the associated score follows:

Table 15. Rating Scale for PIP Validation

Rating	Criteria	Score
Met (M)	All required components are present	100%
Partially Met (PM)	At least one but not all components are present	50%
Unmet (UM)	None of the required components are present	0%
Not Applicable	None of the components are applicable	N/A

Each component assessed within each step is of equal value. The total of all steps provides the PIP validation score that is used to evaluate whether the PIP is designed, conducted, and reported in a sound manner and determine the degree of confidence a state agency can have in reported results. Qlarant evaluates confidence levels based on the PIP Validation scores as follows in Table 16.

[6] CMS EQR Protocols

Table 16. Confidence Levels

MCO Reported Results	PIP Validation Score
High Confidence	90%-100%
Confidence	75%-89%
Low Confidence	60%-74%
Not Credible	59% or lower

PIP Data Overview

Data Collection and Review. PIP validation activities conducted by the EQRO included a detailed review of completed MCO questionnaires submitted for each PIP. Each PIP-specific questionnaire was developed by the EQRO based on the nine steps required by the CMS EQR PIP Validation Protocol. Since both PIPs were selected by MDH, Steps 1, 2, 3, and 5 were pre-populated in the questionnaire. MCOs that utilized sampling for any performance measure were required to complete all questions related to Step 4, Sampling Method. Data reviewed included type of sampling, methodology, sample size, and total population. Completion of all questions related to Steps 6 through 9 was required of each MCO. Data collection procedures were reviewed for Step 6, Data Collection Procedures, including data sources, data elements, instruments for data collection and frequency, and guidelines and qualifications of staff collecting medical record review data. For Step 7, Data Analysis and Interpretation of Results, each MCO's quantitative and qualitative data analyses were reviewed for measurement changes from baseline, statistical significance testing, factors threatening internal or external validity of findings, factors influencing comparability of results, assessment of project success, and identified system-wide member, provider, and MCO barriers. EQRO review of MCO data for Step 8, Improvement Strategies (Interventions), encompassed details of each intervention, barriers addressed, and analysis of the impact of the intervention, including use of the Plan, Do, Study, Act approach to test interventions. Step 9, Significant and Sustained Improvement, was reviewed based upon the quantitative data submitted by each MCO, which included performance results from baseline through the current MY, including the denominator, numerator, and rate. These numbers were validated by the EQRO against final audited rates for the HEDIS® measures and the final rates provided by MDH's contractor for the Value-Based Purchasing (VBP) lead screening measure.

Results

All AMR PIPs focused on increasing the percentage of enrollees 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the MY, according to HEDIS technical specifications.

Table 17 represents the 2021 Validation Results for all AMR PIPs.

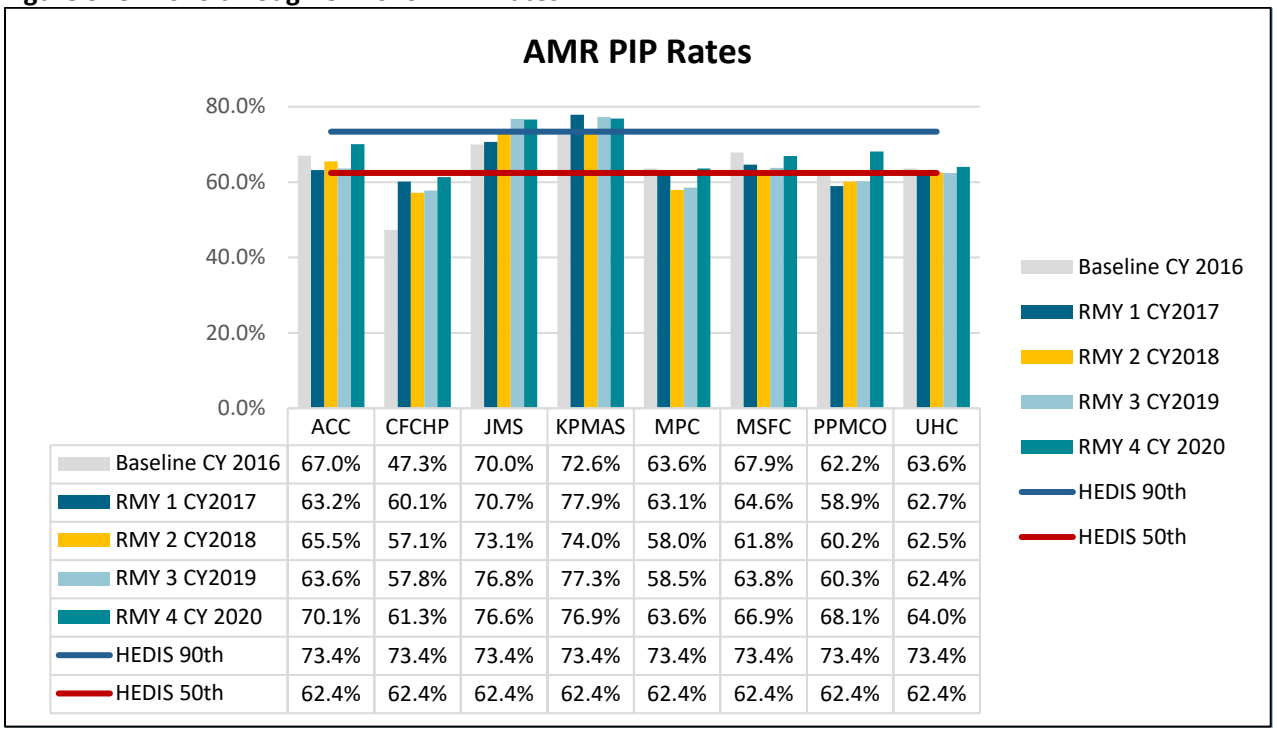
Table 17. 2021 AMR PIP Validation Results

Step/Description	2021 AMR PIP Validation Results							
	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Step 1. Topic	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 2. Aim Statement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 3. Identified Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 4. Sampling Method	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 5. Performance Measures and Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 6. Data Collection Procedures	PM	M	M	M	M	M	M	M
Step 7. Data Analysis and Interpretation of Results	M	PM	M	PM	M	M	M	PM
Step 8. Improvement Strategies (Interventions)	PM	PM	PM	PM	PM	PM	PM	PM
Step 9. Significant and Sustained Improvement	PM	M	M	PM	PM	PM	PM	PM

PIP Rating Scale: Green – M (Met); Yellow – PM (Partially Met); Red – UM (Unmet); Grey – N/A (Not Applicable)

CY 2020 is the fourth remeasurement year (RMY) of data collection for the AMR PIP. Figure 3 represents the AMR PIP indicator rates for all applicable MCOs.

Figure 3. CY 2016 through CY 2020 AMR Rates



	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Baseline CY 2016	67.0%	47.3%	70.0%	72.6%	63.6%	67.9%	62.2%	63.6%
RMY 1 CY2017	63.2%	60.1%	70.7%	77.9%	63.1%	64.6%	58.9%	62.7%
RMY 2 CY2018	65.5%	57.1%	73.1%	74.0%	58.0%	61.8%	60.2%	62.5%
RMY 3 CY2019	63.6%	57.8%	76.8%	77.3%	58.5%	63.8%	60.3%	62.4%
RMY 4 CY 2020	70.1%	61.3%	76.6%	76.9%	63.6%	66.9%	68.1%	64.0%
HEDIS 90th	73.4%	73.4%	73.4%	73.4%	73.4%	73.4%	73.4%	73.4%
HEDIS 50th	62.4%	62.4%	62.4%	62.4%	62.4%	62.4%	62.4%	62.4%

Note: Remeasurement Year (RMY)

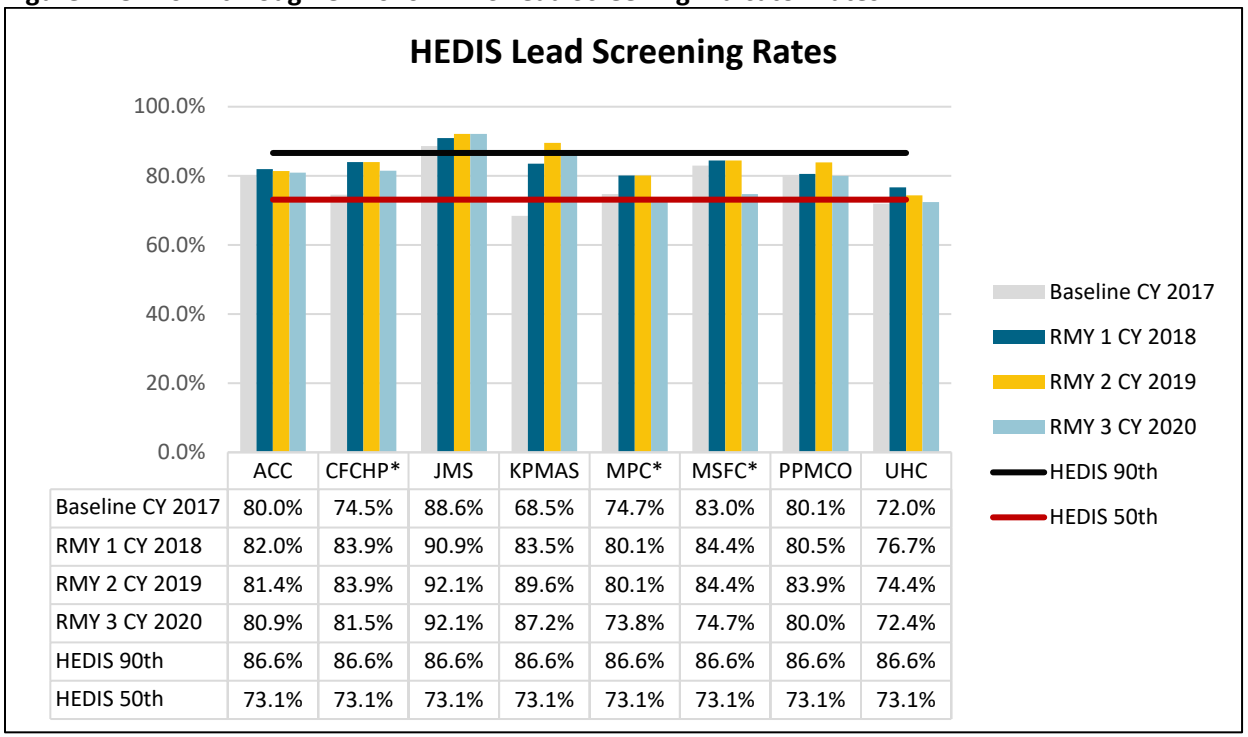
All Lead Screening PIPs focused on increasing the percentage of children 2 years of age who had one or more capillary or venous blood tests for lead poisoning by their second birthday (HEDIS® indicator) and the percentage of children ages 12-23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year (VBP indicator). CY 2020 is the third RMY of data collection for the Lead Screening PIP. Table 18 represents the 2021 Validation Results for all Lead Screening PIPs. Figure 4 represents the HEDIS indicator rates for the eight MCOs participating in this PIP, while Figure 5 represents the Maryland encounter data indicator rates.

Table 18. 2021 Lead Screening PIP Validation Results

Step/Description	2021 Lead Screening PIP Validation Results							
	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Step 1. Topic	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 2. Aim Statement	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 3. Identified Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 4. Sampling Method	N/A	M	N/A	M	N/A	M	N/A	N/A
Step 5. Performance Measures and Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Step 6. Data Collection Procedures	PM	M	M	PM	M	M	M	M
Step 7. Data Analysis and Interpretation of Results	M	PM	PM	PM	PM	PM	M	PM
Step 8. Improvement Strategies (Interventions)	PM	PM	M	PM	M	PM	PM	PM
Step 9. Significant and Sustained Improvement	PM	M	PM	M	PM	PM	PM	PM

PIP Rating Scale: Green – M (Met); Yellow – PM (Partially Met); Red – UM (Unmet); Grey – N/A (Not Applicable – due to State's predefined areas)

Figure 4. CY 2017 through CY 2020 HEDIS Lead Screening Indicator Rates

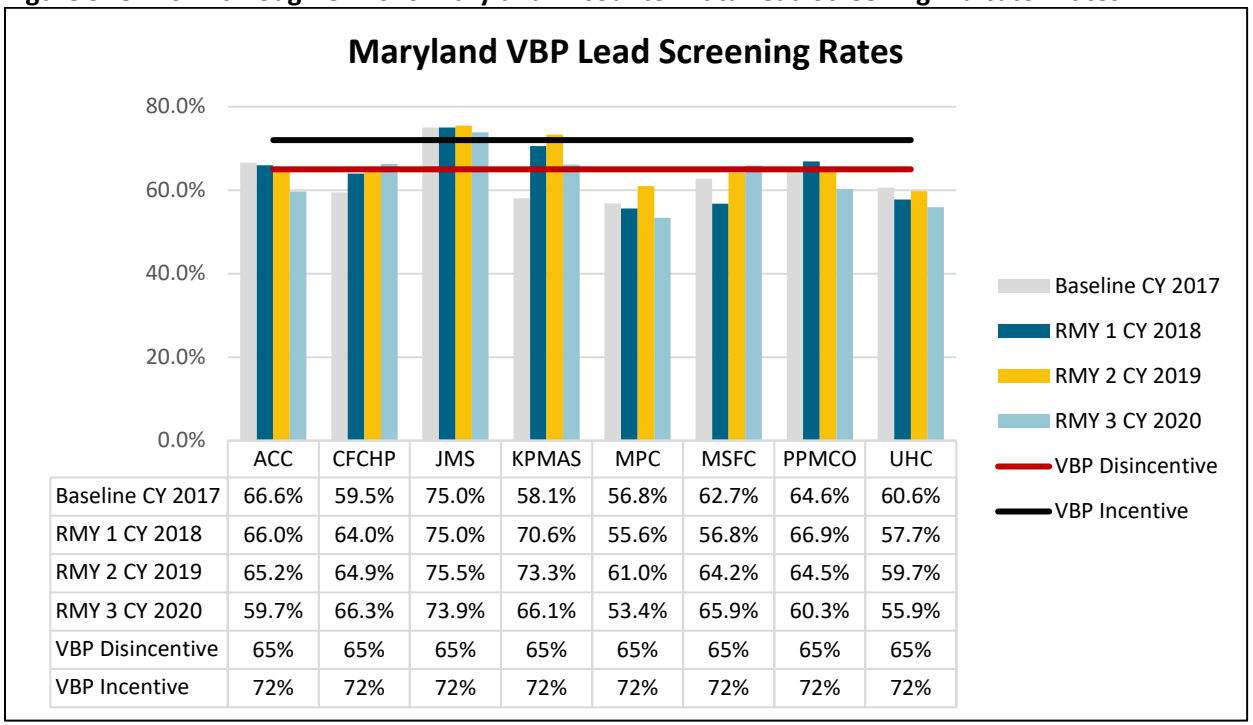


	ACC	CFCHP*	JMS	KPMAS	MPC*	MSFC*	PPMCO	UHC
Baseline CY 2017	80.0%	74.5%	88.6%	68.5%	74.7%	83.0%	80.1%	72.0%
RMY 1 CY 2018	82.0%	83.9%	90.9%	83.5%	80.1%	84.4%	80.5%	76.7%
RMY 2 CY 2019	81.4%	83.9%	92.1%	89.6%	80.1%	84.4%	83.9%	74.4%
RMY 3 CY 2020	80.9%	81.5%	92.1%	87.2%	73.8%	74.7%	80.0%	72.4%
HEDIS 90th	86.6%	86.6%	86.6%	86.6%	86.6%	86.6%	86.6%	86.6%
HEDIS 50th	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%	73.1%

Note: Remeasurement Year (RMY)

*These MCOs elected to report HEDIS® 2019 audited rates for HEDIS® 2020 hybrid measures based upon NCQA guidance in response to the impact of the COVID-19 public health emergency.

Figure 5. CY 2017 through CY 2020 Maryland Encounter Data Lead Screening Indicator Rates



	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Baseline CY 2017	66.6%	59.5%	75.0%	58.1%	56.8%	62.7%	64.6%	60.6%
RMY 1 CY 2018	66.0%	64.0%	75.0%	70.6%	55.6%	56.8%	66.9%	57.7%
RMY 2 CY 2019	65.2%	64.9%	75.5%	73.3%	61.0%	64.2%	64.5%	59.7%
RMY 3 CY 2020	59.7%	66.3%	73.9%	66.1%	53.4%	65.9%	60.3%	55.9%
VBP Disincentive	65%	65%	65%	65%	65%	65%	65%	65%
VBP Incentive	72%	72%	72%	72%	72%	72%	72%	72%

Note: Remeasurement Year (RMY)

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® and Maryland encounter data (VBP) measure findings for the selected indicators. Tables 19 and 20 identify the validation rating and the corresponding level of confidence Qlarant has assigned to each MCO's AMR and Lead Screening PIPs for CY 2020 PIP performance.

Table 19. 2021 AMR Screening PIP Validation Rating and Confidence Levels

2021 AMR PIP Validation Rating and Confidence Level	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
PIP Validation Rating	**81.07%**	**73.65%**	**94.19%**	**71.84%**	**67.12%**	**68.05%**	**88.79%**	**44.41%**
Confidence Level	**C**	**L**	**H**	**L**	**L**	**L**	**C**	**NC**

Confidence Levels: Green – H (High); Yellow – C (Confidence); Pink – L (Low); Red – NC (Not Credible)

Table 20. 2021 Lead Screening PIP Validation Rating and Confidence Levels

2021 Lead PIP Validation Rating and Confidence Level	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
PIP Validation Rating	**59.10%**	**68.66%**	**92.22%**	**87.80%**	**76.84%**	**86.51%**	**62.24%**	**52.32%**
Confidence Level	**NC**	**L**	**H**	**C**	**C**	**C**	**L**	**NC**

Confidence Levels: Green – H (High Confidence); Yellow – C (Confidence); Pink – L (Low Confidence); Red – NC (Not Credible)

Conclusions

Overall, performance indicator results were mixed. For the Lead PIP, four MCOs had assigned confidence levels of *High Confidence* and *Confidence* overall versus three MCOs for the AMR PIP. PIPs from the remaining MCOs were either assigned a level of *Low Confidence* or determined *Not Credible*. Past results demonstrated stronger performance for the Lead PIP, which suggested that the implementation of a Rapid Cycle PIP methodology had helped to facilitate more frequent assessments that led to adjustments in interventions. However, the impact of the COVID-19 public health emergency during MY 2020 was an exceptional confounding variable for the Lead PIP. The lead screening rates were challenged specifically due to the implementation of executive stay-at-home emergency orders. Therefore, many of the interventions were placed on hold during MY 2020 due to temporary closures of provider offices, diversion of lab resources to COVID-19 testing, and the discontinuation of in-home testing services. Progressing into MY 2021, the MCOs are working towards modifying active interventions and introducing new interventions in order to overcome the challenges presented by the COVID-19 public health emergency.

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

Encounter Data Validation

Objectives

States rely on valid and reliable encounter/claims[7] data submitted by MCOs to make key decisions. States use data to establish goals, assess and improve the quality of care, monitor program integrity, and set capitation payment rates. Valid and reliable encounter data is critical to states with Medicaid managed care programs as states aim to reach goals of transparency and payment reform to support efforts in quality measurement and improvement. Various provisions of the Affordable Care Act demonstrate transparency of payment and delivery of care as an important part of health reform.

CMS defines encounter data as the electronic records of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers were paid). Similar data is captured on standard claim forms like UB04 or CMS1500.
CMS requires states to conduct validation studies to assess the completeness and accuracy of encounter data submitted by MCOs. MDH contracted with Qlarant to conduct an encounter data validation (EDV) study of the Maryland HealthChoice Medicaid Program.

Validation of encounter data provides MDH a level of confidence in the completeness and accuracy of encounter data submitted by the MCOs.

[7] Encounter data consists of claims; therefore, these two terms, encounter and claims, are used interchangeably in this report.

Methodology

Qlarant conducted EDV in accordance with the *CMS 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 Activities 1, 2, 4, and 5, and The Hilltop Institute, University of Maryland Baltimore County (Hilltop) completed Activity 3 of the five sequential EDV activities shown in Table 21.

Table 21. EDV Activities

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

Source: The Hilltop Institute. (January 2022). *EQR protocol 5, activity 3: Validation of Encounter Data, CY 2018 to CY 2020.* Baltimore, MD: UMBC.

Results

State requirements for collecting and submitting encounter data. MDH sets forth the requirements for the collection and submission of encounter data by MCOs in Section II.I.4, and 5 of the CY 2020

HealthChoice MCO Agreement. Appendix N of the contract includes all Code of Maryland Regulations (COMAR) provisions applicable to MCOs, including regulations concerning encounter data.

MCO's capability to produce accurate and complete data. Qlarant assessed each MCO's capability for collecting accurate and complete encounter data. Prior to examining the quality of data produced by the MCO's information system, each MCO's information system process and capabilities in capturing complete and accurate encounter data were assessed through a review of the MCO's Information Systems Capabilities Assessment (ISCA) and interviews of MCO personnel, as needed. No issues were identified. Results of the document review and interview process reveal:

- All MCOs appear to have well-managed systems and processes.
- All MCOs are capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service.
- All MCOs appear to have information systems and processes capable of producing accurate and complete encounter data.
- The HealthChoice MCO average rate for processing clean claims in 30 days was 98.84%, with MCO-specific rates ranging from 95% to 100%.

Analysis of MCO's electronic encounter data for accuracy and completeness. Hilltop analyzed encounters failing initial EDI edits (rejected encounters). Overall, the number of rejected encounters increased by 259.5% during the evaluation period. This increase is largely attributed to the addition of provider enrollment encounter edits that went live beginning January 1, 2020. MDH worked with the MCOs for two years prior to the provider enrollment edits going live to ensure that MCOs' providers were enrolled in fee-for-service via the electronic provider revalidation and enrollment portal system, but many providers either failed to enroll by January 1, 2020 or submitted enrollment information that did not align with what was reflected on the encounters submitted to MDH. Rejected encounters due to invalid data experienced the greatest increase—52 percentage points—between CY 2019 and CY 2020. Table 22 presents the distribution of rejected encounters submitted by all MCOs, by category, for CY 2018 to CY 2020.

Table 22. Distribution of Encounter Submissions Rejected by EDI Rejection Category, CY 2018 through CY 2020

New	CY 2018		CY 2019		CY 2020	
	Number of Rejected	Percent of Total	Number of Rejected	Percent of Total	Number of Rejected	Percent of Total
Missing	725,751	38.4%	595,697	31.5%	1,053,540	15.5%
Not Eligible	638,633	33.8%	814,451	43.0%	450,374	6.6%
Not Valid	317,356	16.8%	334,314	17.7%	4,737,893	69.7%
Inconsistent	113,383	6.0%	46,438	2.5%	78,017	1.1%
Duplicate	96,115	5.1%	103,108	5.4%	480,007	7.1%
Total	**1,891,238**	**100.0%**	**1,894,008**	**100.0%**	**6,799,831**	**100.0%**

Source: The Hilltop Institute. (January 2022). *EQR protocol 5, activity 3: Validation of Encounter Data, CY 2018 to CY 2020.* Baltimore, MD: UMBC.

Effective analysis of the Medicaid program requires complete, accurate, and timely processing of encounter data. During CY 2020, fewer MCOs submitted encounters within 1 to 2 days than in CY 2019. Additionally, there was a decrease in encounters submitted within 3 to 7 days, a sharp decrease in encounters submitted within 8 to 31 days, and an increase in encounters submitted within 1 to 2 months and 2 to 6 months. The longer processing times may be attributed to the increase in rejected encounters in CY 2020. Table 23 displays the monthly processing time for submitted encounters in CY 2018 through CY 2020.

Table 23. Percentage of Accepted Encounters Submitted by Month and Processing Time, CY 2018 through CY 2020

Processing Time Range	Year	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	Annual Total
1-2 Days	CY 2018	43.8%	39.3%	38.9%	46.6%	44.9%	44.2%	40.6%	42.9%	45.1%	48.4%	43.8%	42.5%	**43.5%**
	CY 2019	42.7%	44.8%	46.9%	48.7%	44.2%	45.5%	45.0%	47.7%	41.8%	48.6%	45.9%	51.7%	**46.1%**
	CY 2020	34.0%	35.2%	46.8%	48.8%	46.8%	51.4%	42.9%	47.4%	49.3%	45.3%	46.7%	43.6%	**44.1%**
3-7 Days	CY 2018	11.2%	11.7%	11.1%	11.9%	8.8%	10.8%	10.2%	12.2%	15.3%	10.9%	13.1%	9.9%	**11.4%**
	CY 2019	11.4%	13.6%	13.6%	10.3%	9.7%	14.3%	11.4%	10.5%	13.6%	11.4%	8.7%	8.4%	**11.4%**
	CY 2020	9.6%	9.6%	6.4%	12.0%	12.3%	10.5%	11.2%	12.2%	11.3%	10.2%	7.7%	7.8%	**9.9%**
8-31 Days	CY 2018	25.0%	27.0%	27.2%	24.1%	29.8%	25.2%	31.2%	28.1%	22.5%	24.3%	26.0%	30.7%	**26.7%**
	CY 2019	28.6%	24.2%	21.1%	25.1%	31.0%	24.9%	27.4%	24.8%	30.1%	26.1%	30.5%	25.7%	**26.6%**
	CY 2020	20.9%	23.4%	19.2%	18.9%	21.0%	19.6%	21.8%	21.6%	18.5%	24.0%	25.2%	25.9%	**21.8%**
1-2 Months	CY 2018	5.0%	8.3%	5.4%	6.8%	4.2%	6.8%	5.7%	4.7%	4.8%	5.5%	5.9%	5.8%	**5.7%**
	CY 2019	4.5%	4.5%	6.2%	5.2%	5.3%	5.2%	5.9%	6.7%	5.8%	5.0%	5.3%	4.3%	**5.3%**
	CY 2020	8.1%	5.2%	8.1%	5.2%	5.1%	4.2%	5.6%	4.0%	5.5%	6.8%	6.4%	8.4%	**6.2%**
2-6 Months	CY 2018	8.1%	7.0%	11.7%	4.9%	6.5%	8.7%	7.6%	7.5%	9.0%	7.4%	9.7%	9.8%	**8.1%**
	CY 2019	8.6%	8.7%	7.8%	6.7%	6.0%	6.3%	6.3%	6.0%	5.1%	6.4%	8.6%	9.0%	**7.1%**
	CY 2020	14.0%	14.6%	11.0%	6.8%	6.2%	8.0%	12.3%	9.3%	11.2%	10.1%	10.6%	13.1%	**11.0%**
6-7 Months	CY 2018	0.8%	0.4%	0.5%	0.7%	1.9%	0.7%	0.6%	2.0%	0.4%	2.2%	0.4%	0.6%	**1.0%**
	CY 2019	0.7%	0.6%	1.3%	0.5%	0.4%	0.4%	0.4%	0.4%	1.5%	1.7%	0.2%	0.4%	**0.7%**
	CY 2020	2.0%	1.6%	0.6%	0.7%	3.0%	0.9%	0.9%	1.6%	1.1%	1.1%	2.5%	0.4%	**1.4%**
7-12 Months	CY 2018	2.6%	2.6%	3.5%	3.4%	3.2%	3.0%	3.6%	2.4%	2.9%	1.2%	1.1%	0.8%	**2.5%**
	CY 2019	1.9%	1.7%	1.4%	2.0%	3.0%	3.1%	3.3%	3.8%	2.1%	0.9%	0.7%	0.5%	**2.0%**
	CY 2020	6.7%	5.7%	5.1%	6.1%	4.4%	5.1%	5.0%	3.6%	2.9%	2.5%	1.0%	0.8%	**4.1%**

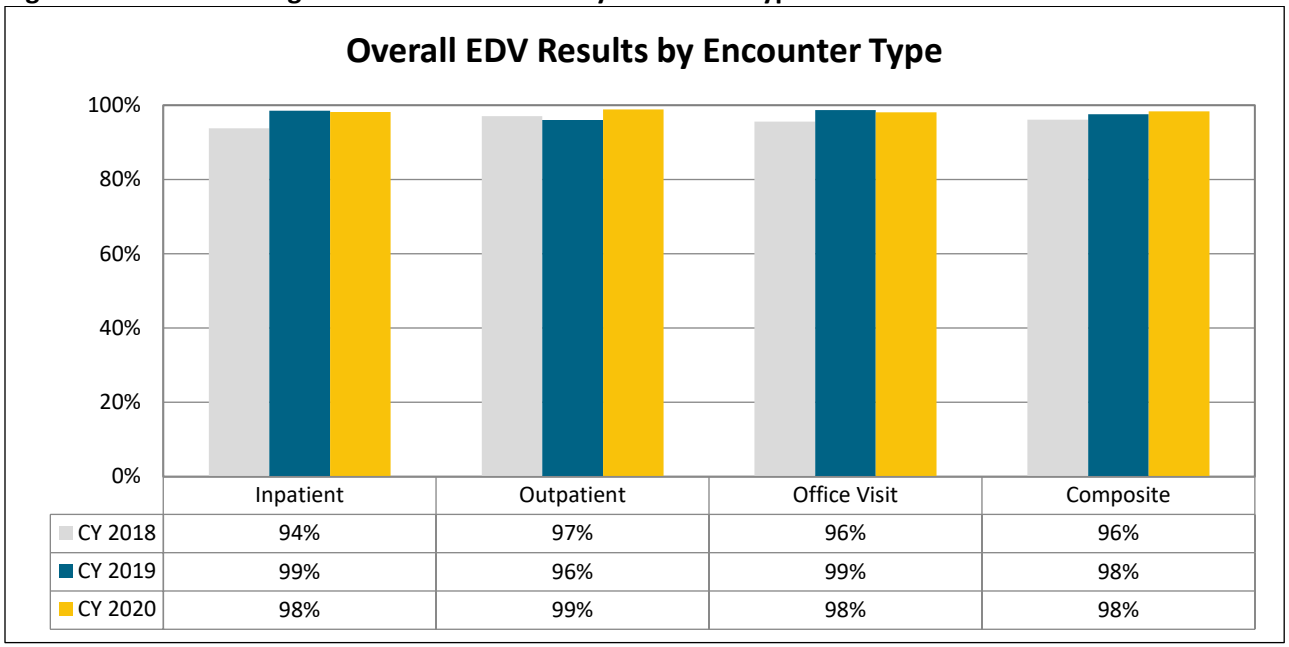
Processing Time Range	Year	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	Annual Total
More than 1 Year	CY 2018	3.4%	3.6%	1.8%	1.5%	0.7%	0.6%	0.5%	0.1%	0.0%	0.0%	0.0%	0.0%	**1.1%**
	CY 2019	1.8%	1.9%	1.7%	1.4%	0.4%	0.3%	0.2%	0.1%	0.0%	0.0%	0.0%	0.0%	**0.7%**
	CY 2020	4.8%	4.6%	2.8%	1.4%	1.3%	0.3%	0.2%	0.2%	0.1%	0.0%	0.0%	0.0%	**1.5%**
Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: The Hilltop Institute. (2021, December). *EQR protocol 5, activity 3: Validation of encounter data, CY 2018 to CY 2020.* Baltimore, MD: UMBC.

Analysis of medical records to confirm encounter data accuracy.

A review of enrollees' medical records offers another method to examine the completeness and accuracy of encounter data. Analysis of sample data was organized by review elements, including diagnosis, procedure, and revenue codes (applicable only for inpatient and outpatient). Overall EDV results for CY 2018 through CY 2020 by encounter type are displayed in Figure 6.

Figure 6. CY 2018 through CY 2020 EDV Results by Encounter Type



The composite match rate across all encounter types showed improvement from CY 2018 (96%) to CY 2019 (98%) and remained the same at 98% for CY 2020. Table 24 provides trending of the EDV records for CY 2017 through CY 2020 by encounter type. Compared to CY 2019, CY 2020 match rates for the outpatient setting increased 3 percentage points, while the inpatient setting and the office visit setting declined 1 percentage point.

Table 24. CY 2018 through CY 2020 EDV Results by Encounter Type

Encounter Type	Records Reviewed			Total Possible Elements*			Total Matched Elements			Matched Elements (%)		
	CY 2018	CY 2019	CY 2020	CY 2018	CY 2019	CY 2020	CY 2018	CY 2019	CY 2020	CY 2018	CY 2019	CY 2020
Inpatient	60	63	72	1,289	1,434	1,572	1,209	1,413	1,543	94%	99%	98%
Outpatient	575	538	492	7,386	7,288	6,149	7,170	7000	6,078	97%	96%	99%
Office Visit	1,871	1,877	1,934	8,597	8,833	8,860	8,220	8,718	8,692	96%	99%	98%
Total	**2,506**	**2,478**	**2,498**	**17,272**	**17,555**	**16,581**	**16,599**	**17,131**	**16,313**	**96%**	**98%**	**98%**

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

MCO encounter data validation results by encounter type. For CY 2020, all HealthChoice MCOs successfully achieved match rates that equal or score above the standard of 90% in all areas of review. Table 25 illustrates MCO and HealthChoice Aggregate match rates from CY 2018 through CY 2020 for inpatient, outpatient, and office visit encounters.

Table 25. CY 2017 through CY 2019 MCO and HealthChoice EDV Results by Encounter Type

MCO	Inpatient			Outpatient			Office Visits		
	CY 2018	CY 2019	CY 2020	CY 2018	CY 2019	CY 2020	CY 2018	CY 2019	CY 2020
ABH	99%*	99%	100%	98%*	96%	99%	96%*	99%	98%
ACC	95%	95%	99%	98%	98%	97%	95%	97%	97%
CFCHP	54%	95%	99%	97%	99%	99%	96%	99%	98%
JMS	95%	100%	92%	99%	97%	100%	92%	100%	100%
KPMAS	98%	100%	99%	100%	99%	100%	99%	99%	99%
MPC	98%	100%	100%	99%	97%	100%	96%	100%	97%
MSFC	98%	99%	99%	93%	90%	100%	95%	99%	100%
PPMCO	99%	99%	99%	98%	96%	99%	96%	98%	99%
UHC	95%	100%	100%	94%	95%	98%	96%	98%	97%
HealthChoice	**94%**	**99%**	**98%**	**97%**	**96%**	**99%**	**96%**	**99%**	**98%**

*CY 2018 was baseline for ABH, as this was their first encounter data review.
Note: Values reported are rounded to the nearest percentage for reporting only.

Conclusions

HealthChoice is a mature managed care program, and 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 CY 2020. Qlarant conducted a medical record review on a sample of inpatient, outpatient, and office visit encounters (2,498) to confirm the accuracy of codes.

Overall, MCOs achieved a match rate of 98%, meaning 98% of claims submitted were supported by medical record documentation. MCOs achieved a high match rate for each encounter setting: 98% for inpatient, 99% for outpatient, and 98% for office visit.

For additional findings and comprehensive details associated with the CY 2020 EDV Report, please access the link in **Appendix D**.

Performance Measure Validation

Objectives

Value-Based Purchasing

In 1999, MDH and the Center for Health Care Strategies began to develop a value-based purchasing (VBP) initiative with the goal of improving the health of core populations served by HealthChoice. Eventually, MDH and the Center for Health Care Strategies adopted the model of improving quality by awarding financial incentives to MCOs based on their performance.

As the EQRO, Qlarant conducts annual value-based purchasing (VBP) activities of each HealthChoice MCO by collaborating with MetaStar, Inc. (MetaStar), an NCQA-Licensed Organization, Hilltop.

HEDIS

MDH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives such as HEDIS. Performance is measured at both the organization level and on a statewide basis. HEDIS results are incorporated annually into a HealthChoice Consumer Report Card developed to assist HealthChoice enrollees in making comparisons when selecting a health plan. All nine HealthChoice organizations reported HEDIS in MY 2020. For HEDIS MY 2020, MDH required HealthChoice managed care organizations to report the complete HEDIS measure set for services rendered in calendar year 2020 to HealthChoice enrollees. These measures provide meaningful managed care organization comparative information, and they measure performance relative to MDH's priorities and goals.

Methodology

Value-Based Purchasing

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

For any measure that the MCO does not meet the minimum target, a disincentive of 1/9 of 1 percent of the total capitation amount paid to the MCO during the MY shall be collected. For any measure that the MCO meets or exceeds the incentive target, the MCO shall be paid an incentive payment of 1/9 of 1 percent of the total capitation amount paid to the MCO during the MY. Amounts are calculated for each measure, and total incentive payments made to the MCOs each year may not exceed the total amount of disincentives collected from the MCOs in the same year plus any additional funds allocated by MDH for a quality initiative.

HEDIS

Data collection and review. Each data source and process used by the MCOs to derive HEDIS measures was reviewed by MetaStar as a component of the HEDIS audit. For example, Medical Services Data (Claims), Enrollment Data, Practitioner Data, Medical Record Data (including data abstracted from medical records), Supplemental Data, as well as the processes used to transform and integrate the

data for HEDIS reporting. The audit process includes systems demonstrations and reports/query reviews to instill confidence that the data used for measure production are complete, accurate, and that NCQA's HEDIS audit criteria/standards are met.

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

Results

According to MetaStar's annual report, *Statewide Executive Summary Report HealthChoice Participating Organization HEDIS 2021*, all VBP HEDIS measures achieved "Reportable" (R) designations for all MCOs. Qlarant determined that all VBP encounter data measure rates calculated by Hilltop were "Reportable" (R).

Tables 26 and 27 illustrate the HealthChoice MCOs' VBP performance summary and VBP incentive or disincentive amounts for CY 2020.

Table 26. MCO CY 2020 VBP Performance Summary

Performance Measure	CY 2020 Target	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Adolescent Well-Care Visits	Incentive: ≥ 72% Neutral: 66 - 71% Disincentive: ≤ 65%	**33%**	**56%**	**39%**	**74%**	**49%**	**41%**	**46%**	**48%**	**49%**
Ambulatory Care Visits for SSI Adults	Incentive: ≥ 87% Neutral: 84% - 86% Disincentive: ≤ 83%	**57%**	**77%**	**76%**	**90%**	**69%**	**83%**	**80%**	**82%**	**77%**
Ambulatory Care Visits for SSI Children	Incentive: ≥ 87% Neutral: 84% - 86% Disincentive: ≤ 83%	**38%**	**75%**	**66%**	**90%**	**66%**	**79%**	**74%**	**77%**	**70%**
Asthma Medication Ratio	Incentive: ≥ 71% Neutral: 66% - 70% Disincentive: ≤ 65%	**70%**	**70%**	**61%**	**77%**	**77%**	**64%**	**67%**	**68%**	**64%**

Performance Measure	CY 2020 Target	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Breast Cancer Screening	Incentive: ≥ 74% Neutral: 70% - 73% Disincentive: ≤ 69%	**55%**	**64%**	**68%**	**76%**	**76%**	**61%**	**71%**	**61%**	**56%**
Comprehensive Diabetes Care - HbA1c Control	Incentive: ≥ 62% Neutral: 54% - 61% Disincentive: ≤ 53%	**47%**	**55%**	**52%**	**57%**	**57%**	**48%**	**54%**	**42%**	**48%**
Controlling High Blood Pressure	Incentive: ≥ 66% Neutral: 60% - 65% Disincentive: ≤ 59%	**47%**	**51%**	**50%**	**67%**	**76%**	**59%**	**55%**	**33%**	**55%**
Lead Screenings for Children - Ages 12 to 23 Months	Incentive: ≥ 72% Neutral: 66% - 71% Disincentive: ≤ 65%	**52%**	**60%**	**66%**	**74%**	**66%**	**53%**	**66%**	**60%**	**56%**
Well-Child Visits for Children - Ages 0 to 15 Months, 6 or more Visits	Incentive: ≥ 76% Neutral: 71% - 75% Disincentive: ≤ 70%	**42%**	**60%**	**72%**	**73%**	**73%**	**60%**	**58%**	**58%**	**54%**

Green: Incentive Range; Yellow: Neutral Range; Red: Disincentive Range

Table 27. MCO CY 2020 VBP Incentive/Disincentive Amounts

Performance Measure Incentive or Disincentive Amounts Per MCO for CY 2020								
ABH	**ACC**	**CFCHP**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**
Adolescent Well-Care Visits								
$ 193,622.71	$ 1,391,976.06	$ 301,286.44	$ 253,836.01	$ 419,158.93	$ 1,409,543.31	$ 578,131.04	$ 1,796,365.62	$ 806,684.76
Ambulatory Care Visits for SSI Adults								
$ 193,622.71	$ 1,391,976.06	$ 301,286.44	$ 253,836.01	$ 419,158.93	$ 1,409,543.31	$ 578,131.04	$ 1,796,365.62	$ 806,684.76
Ambulatory Care Visits for SSI Children								
$ 193,622.71	$ 1,391,976.06	$ 301,286.44	$ 253,836.01	$ 419,158.93	$ 1,409,543.31	$ 578,131.04	$ 1,796,365.62	$ 806,684.76
Asthma Medication Ratio (AMR)								
$ -	$ -	$ 301,286.44	$ 253,836.01	$ 419,158.93	$ 1,409,543.31	$ -	$ -	$ 806,684.76
Breast Cancer Screening								
$ 193,622.71	$ 1,391,976.06	$ 301,286.44	$ 253,836.01	$ 419,158.93	$ 1,409,543.31	$ -	$ 1,796,365.62	$ 806,684.76
Comprehensive Diabetes Care - HbA1c Control								
$ 193,622.71	$ -	$ 301,286.44	$ -	$ -	$ 1,409,543.31	$ -	$ 1,796,365.62	$ 806,684.76
Controlling High Blood Pressure								
$ 193,622.71	$ 1,391,976.06	$ 301,286.44	$ 253,836.01	$ 419,158.93	$ 1,409,543.31	$ 578,131.04	$ 1,796,365.62	$ 806,684.76
Lead Screenings for Children - Ages 12 to 23 Months								
$ 193,622.71	$ 1,391,976.06	$ -	$ 253,836.01	$ -	$ 1,409,543.31	$ -	$ 1,796,365.62	$ 806,684.76

Performance Measure Incentive or Disincentive Amounts Per MCO for CY 2020								
ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Well-Child Visits for Children - Ages 0 to 15 Months, 6 or more Visits								
$ 193,622.71	$ 1,391,976.06	$ -	$ -	$ -	$ 1,409,543.31	$ 578,131.04	$ 1,796,365.62	$ 806,684.76
Amount due to Normalized Score*								
$ -	$16,393,805.28	$ -	$ 6,287,936.52	$ 15,296,158.60	$ -	$10,854,699.50	$ -	$ -
Gross Incentives								
$ -	$ -	$ -	$ 1,776,852.07	$ 1,257,476.79	$ -	$ -	$ -	$ -
Gross Disincentives								
$(1,548,981.68)	$ (9,743,832.42)	$ (2,109,005.08)	$ -	$ (1,257,476.79)	$ (12,685,889.79)	$ (2,890,655.20)	$ (14,370,924.96)	$ (7,260,162.84)
Actuarial Adjustment**								
$ (677,679.46)	$ -	$ (753,216.09)	$ -	$ -	$ (6,342,944.90)	$ -	$ (6287,279.66)	$ (3,630,081.43)
Net Payout								
$ (871,302.22)	$ 6,649,972,86	$ (1,355,788.99)	$ 8,064,788.59	$ 15,296,158.60	$ (6,342,944.90)	$ 7,964,044.30	$ (8,083,645.30)	$(3,630,081.41)

Green: Incentive Range; Yellow: Neutral Range; Pink: Disincentive Range

*Distribution of funds for MCOs receiving the four highest normalized scores per COMAR 10.67.04.03B(3)(h)(vii).

**Adjusted disincentive amount for MCOs based on .5% of their capitation instead of 1% to account for actuarial soundness in accordance with 42 CFR 438.6 and 438.7.

For additional findings and comprehensive details associated with the CY 2020 Annual VBP Report, please access the link in **Appendix D**.

EPSDT Medical Record Review

Objectives

Maryland's EPSDT/Healthy Kids Program mission is to promote access to and ensure the availability of quality healthcare for HealthChoice children and adolescents through 20 years of age. In support of the program's mission, the primary objective of the EPSDT medical record review is to assess the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. The review includes an assessment of MCO performance for the following EPSDT components:

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

Methodology

Sampling methodology. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-certified PCPs from Hilltop's CY 2020 preventive care encounters sample listing of children and adolescents through 20 years of age. Sample size per MCO provided a 90% confidence level and a 5% margin of error.

Medical record review and scoring. All Qlarant's medical record data reviewers are trained nurses and experienced MDH Healthy Kids Program nurse consultants. Abstracted data from the medical record reviews were organized and analyzed within five age groups. Within each age group, specific elements were scored based on medical record documentation as follows in Table 28.

Table 28. CY 2020 Scores and Finding Equivalents

Score	Finding
Completed	2
Incomplete	1
Missing	0
Not Applicable*	N/A

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

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

For CY 2020, the MRR process was administered as a full desktop review due to the COVID-19 public health emergency, compared to prior reviews conducted onsite at providers' offices. Therefore, CY 2020 Laboratory Tests/At-Risk Screenings Element Results and CY 2020 Immunization Element Results should be reviewed with caution.

Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. Guidelines and criteria are divided into the five component areas. Tables 29 through 34 displays the MCO results for the five EPSDT component areas for CY 2020 and HealthChoice Aggregate Results for CY 2018, CY 2019, and CY 2020. In comparison to CY 2019 results, all five component scores increased. CAPs were required for MCOs that did not meet the minimum compliance threshold. Because of an update to the scoring methodology for the 3-5 Year Anemia Test, this element was reassessed. The results of the review impacted the scores for ABH, ACC, and JMS.

Table 29. CY 2020 EPSDT Component Results by MCO

Component	CY 2020 MCO Results									HealthChoice Aggregate Results		
	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	CY 2018	CY 2019*	CY 2020
Health & Developmental History	92%	92%	92%	99%	98%	93%	94%	94%	92%	**94%**	**88%**	**94%**
Comprehensive Physical Examination	94%	95%	93%	99%	100%	94%	95%	96%	95%	**97%**	**93%**	**96%**

Component	CY 2020 MCO Results									HealthChoice Aggregate Results		
	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	CY 2018	CY 2019*	CY 2020
Laboratory Tests/At-Risk Screenings*	71%	73%	71%	92%	90%	72%	73%	74%	72%	**87%**	**66%**	**77%**
Immunizations*	80%	86%	79%	94%	97%	84%	85%	92%	77%	**93%**	**71%**	**86%**
Health Education/ Anticipatory Guidance	93%	91%	94%	98%	99%	92%	94%	94%	93%	**94%**	**92%**	**94%**
Total Score	**87%**	**89%**	**87%**	**97%**	**97%**	**89%**	**90%**	**92%**	**87%**	**94%**	**83%**	**91%**

Underlined element scores denote scores below the 80% minimum compliance requirement.
*CY 2019 results are baseline as a result of the change in MRR process due to the COVID-19 public health emergency.

Table 30. CY 2020 Health and Developmental History Element Results

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
Recorded Medical History	97%	97%	97%	100%	100%	99%	97%	98%	97%	**98%**
Recorded Family History	90%	90%	93%	99%	92%	90%	93%	94%	85%	**92%**
Recorded Perinatal History	61%	62%	59%	95%	94%	63%	64%	63%	56%	**69%**
Recorded Maternal Depression Screening	63%	86%	50%	82%	97%	50%	65%	43%	47%	**66%**
Recorded Psychosocial History	97%	94%	96%	100%	97%	97%	97%	97%	96%	**97%**
Recorded Developmental Surveillance/ History	98%	95%	97%	95%	100%	98%	98%	98%	97%	**97%**

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
Recorded Developmental Screening Tool	88%	74%	89%	100%	100%	93%	85%	88%	79%	**89%**
Recorded Autism Screening Tool	73%	72%	74%	92%	100%	81%	81%	83%	75%	**81%**
Recorded Mental/ Behavioral Health Assessment	97%	97%	97%	100%	99%	98%	97%	96%	96%	**98%**
Recorded Substance Use Assessment	89%	89%	81%	100%	100%	87%	89%	91%	91%	**91%**
Depression Screening	76%	82%	81%	98%	97%	76%	87%	91%	82%	**86%**
Component Score	**92%**	**92%**	**92%**	**99%**	**98%**	**93%**	**94%**	**94%**	**92%**	**94%**

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

Table 31. CY 2020 Comprehensive Physical Examination Element Results

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
Documentation of Minimum 5 Systems Examined	100%	99%	99%	100%	100%	99%	100%	100%	100%	**100%**
Vision Assessment	99%	98%	98%	100%	99%	99%	99%	98%	96%	**99%**
Hearing Assessment	99%	96%	98%	100%	98%	98%	99%	97%	95%	**98%**
Nutritional Assessment	97%	96%	99%	100%	99%	98%	99%	99%	97%	**98%**
Conducted Oral Assessment	96%	96%	95%	99%	100%	95%	97%	95%	96%	**97%**
Measured Height	99%	100%	99%	100%	100%	98%	100%	99%	100%	**99%**
Graphed Height	88%	89%	86%	99%	100%	89%	89%	93%	93%	**92%**
Measured Weight	100%	100%	99%	100%	100%	99%	100%	100%	100%	**100%**
Graphed Weight	89%	89%	86%	99%	100%	90%	89%	93%	92%	**92%**

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
BMI Percentile	87%	91%	87%	100%	100%	90%	93%	93%	91%	**93%**
BMI Graphing	79%	89%	79%	100%	100%	86%	89%	85%	85%	**88%**
Measured Head Circumference	97%	94%	98%	91%	100%	92%	93%	95%	90%	**95%**
Graphed Head Circumference	71%	65%	68%	88%	99%	72%	70%	84%	78%	**77%**
Measured Blood Pressure	94%	96%	96%	100%	99%	97%	96%	98%	97%	**97%**
Component Score	**94%**	**95%**	**93%**	**99%**	**100%**	**94%**	**95%**	**96%**	**95%**	**96%**

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

Table 32. CY 2020 Laboratory Test/At-Risk Screenings Element Results

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
Newborn Metabolic Screen	47%	60%	41%	70%	82%	38%	60%	69%	57%	**56%**
Recorded TB Risk Assessment[1]	81%	80%	84%	99%	99%	84%	83%	86%	79%	**86%**
Recorded Cholesterol Risk Assessment	83%	84%	90%	100%	94%	85%	91%	90%	85%	**89%**
9-11 year Dyslipidemia Lab Test	44%	54%	35%	85%	60%	31%	40%	41%	34%	**49%**
18-21 year Dyslipidemia Lab Test	40%	71%	58%	100%	100%	44%	67%	50%	53%	**69%**
Conducted Lead Risk Assessment	91%	88%	90%	98%	100%	90%	89%	93%	88%	**92%**
12 Month Blood Lead Test	54%	55%	49%	80%	79%	56%	58%	54%	57%	**61%**

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
24 Month Blood Lead Test	45%	52%	59%	78%	90%	64%	57%	55%	63%	**64%**
3 – 5 Year (Baseline) Blood Lead Test	86%	81%	94%	95%	100%	92%	81%	93%	86%	**90%**
Referral to Lab for Blood Lead Test	86%	75%	84%	93%	97%	83%	85%	78%	79%	**85%**
Conducted Anemia Risk Assessment	77%	84%	78%	99%	99%	77%	82%	85%	81%	**85%**
12 Month Anemia Test[1]	53%	50%	41%	74%	81%	48%	49%	49%	54%	**56%**
24 Month Anemia Test	48%	55%	51%	80%	90%	61%	46%	50%	54%	**60%**
3-5 Year Anemia Test	83%^	84%^	88%	93%^	100%	89%	72%	93%	80%	**88%**
Recorded STI/HIV Risk Assessment	89%	91%	90%	99%	100%	88%	93%	89%	95%	**93%**
HIV Test Per Schedule	70%	45%	50%	100%	94%	60%	75%	69%	45%	**74%**
Component Score	**71%**	**73%**	**71%**	**92%**	**90%**	**72%**	**73%**	**74%**	**72%**	**77%**

Underlined element scores denote scores below the 80% minimum compliance requirement.
[1]Element criteria revised.
^Denotes results that were changed due to an update in scoring methodology for the 3-5 Year Anemia Test element.

Table 33. CY 2020 Immunization Element Results

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
Hepatitis B	82%	85%	78%	97%	98%	82%	84%	92%	76%	**86%**
Diphtheria/Tetanus/Acellular Pertussis (DTaP)	88%	88%	86%	98%	99%	90%	91%	96%	78%	**90%**
Haemophilus Influenza Type B (Hib)	87%	85%	86%	100%	99%	88%	90%	96%	79%	**90%**

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
Pneumococcal (PCV-7 or PCV-13 [Prevnar])	87%	85%	83%	99%	99%	89%	87%	94%	77%	**89%**
Polio (IPV)	81%	85%	78%	97%	97%	85%	84%	93%	75%	**86%**
Measles/Mumps/Rubella (MMR)	79%	87%	77%	97%	97%	85%	85%	93%	78%	**87%**
Varicella (VAR)	77%	86%	76%	97%	98%	84%	86%	93%	77%	**86%**
Tetanus/Diphtheria/Acellular Pertussis (TDaP)	66%	93%	81%	96%	99%	84%	86%	93%	80%	**87%**
Influenza (Flu)	71%	77%	66%	86%	97%	80%	81%	86%	77%	**81%**
Meningococcal (MCV4)	68%	95%	81%	97%	99%	84%	90%	97%	82%	**89%**
Hepatitis A	76%	84%	76%	95%	96%	82%	85%	91%	73%	**84%**
Rotavirus (RV)	95%	100%	97%	100%	94%	93%	100%	100%	100%	**97%**
Human Papillomavirus (HPV)[1]	67%	95%	81%	96%	95%	82%	89%	91%	77%	**87%**
Assessed Immunizations Up-to-Date	82%	84%	79%	81%	94%	85%	83%	88%	74%	**83%**
Component Score	**80%**	**86%**	**79%**	**94%**	**97%**	**84%**	**85%**	**92%**	**77%**	**86%**

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

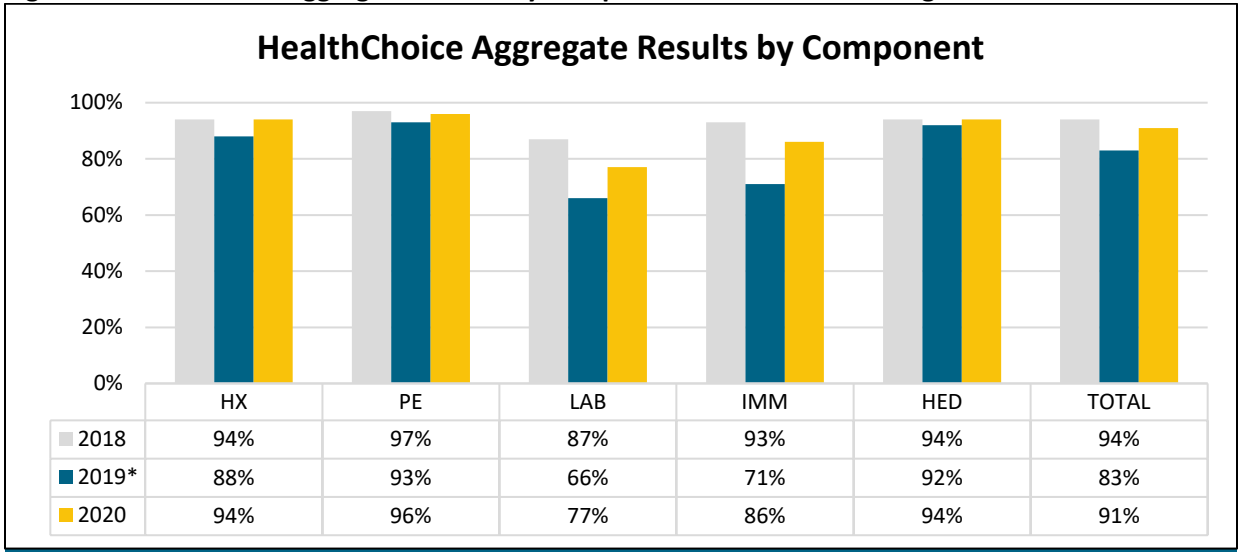
Table 34. CY 2020 Health Education/Anticipatory Guidance Element Results

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
Documented Age Appropriate Anticipatory Guidance	97%	95%	99%	100%	100%	97%	99%	98%	99%	**98%**

Element	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate
Documented Health Education/Referral for Identified Problems/Tests	99%	98%	99%	100%	100%	99%	99%	100%	99%	**99%**
Documented Referral to Dentist	84%	81%	87%	99%	98%	84%	87%	87%	82%	**88%**
Specified Requirements for Return Visit	89%	89%	89%	95%	99%	87%	92%	92%	91%	**91%**
Component Score	**93%**	**91%**	**94%**	**98%**	**99%**	**92%**	**94%**	**94%**	**93%**	**94%**

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

Figure 7. HealthChoice Aggregate Results by Component for CYs 2018 through 2020



*Results for LAB and IMM are baseline as a result of the change in MRR process due to the COVID-19 public health emergency.

Abbreviations for Components and MCO Total Composite Score

HX - Health and Developmental History

PE - Comprehensive Physical Exam

LAB - Laboratory Tests/At-Risk Screenings

IMM – Immunizations

HED - Health Education/Anticipatory Guidance

TOTAL - Total Composite Score

Conclusions

The HealthChoice Aggregate exceeded the 80% minimum compliance threshold set by MDH for four of the five components. Additionally, all five component scores increased when comparing CY 2020 scores to CY 2019 scores. Laboratory Tests/At-Risk Screenings and Immunizations increased by 11 and 15 percentage points, respectively. Health Education/Anticipatory Guidance (94%) remained more consistent in CY 2020, having only increased by two percentage points when compared to CY 2019 (92%). In CY 2019, the MRR process was changed from an onsite review to a full desktop review due to the COVID-19 public health emergency, which impacted all scoring areas, particularly Laboratory Test/At-Risk Screenings and Immunizations. In CY 2020, although the full desktop review process continued, the total score (91%) increased eight percentage points from the total score in CY 2019 (83%), moving closer to the CY 2018 total score (94%). Additionally, the component scores for three of the five components (Health & Developmental History, Comprehensive Physical Examination, and Health Education/Anticipatory Guidance) were comparable to CY 2018 scores. The remaining component scores for CY 2020 (Laboratory Tests/At-Risk Screenings and Immunizations) continued to present opportunities for improvement compared to CY 2018 component scores.

ABH, ACC, CFCHP, MPC, MSFC, PPMCO, and UHC were required to submit a CAP in the area of Laboratory Tests/At-Risk Screenings because they did not meet the minimum compliance score of 80%. CFCHP and UHC were required to submit a CAP in the area of Immunizations because they did not meet the minimum compliance score of 80%. ACC will be required to submit a quarterly CAP for the Laboratory Tests/At-Risk Screenings component due to continued non-compliance, in accordance with MDH's Performance Monitoring Policy.

For additional findings and comprehensive details associated with the CY 2020 EPSDT Report, please access the link in **Appendix D**.

Consumer Report Card

Objectives

The Consumer Report Card is designed to assist Medicaid participants in their selection of a HealthChoice MCO by facilitating relative comparisons of the quality of healthcare provided by the available health plans.

Measures are grouped into six reporting categories that are meaningful to participants. Based on a review of the potential measures available for the Report Card (HEDIS, CAHPS, and MDH's encounter data measures), Qlarant recommended the following reporting categories:

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

HealthChoice enrollees are directed to focus on MCO performance in the areas most important to them and their families. The first two categories are relevant to all participants; the remaining categories are relevant to specific enrollees (i.e., children, children with chronic illness, women, and adults with chronic illness).

Methodology

Each MCO's actual score on select performance measures is compared with the unweighted statewide MCO average for a particular reporting category. An icon or symbol denotes whether an MCO performed "above," "the same as" or "below" the statewide Medicaid MCO average. Performance measures are selected from HEDIS, CAHPS survey, and Maryland's encounter data measures.

Results

Tables 35 and 36 provide the results of the CY 2021 Consumer Report Card and the overall Star Rating changes year over year.

Table 35. CY 2021 Consumer Report Card Results

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

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

Table 36. Star Rating Changes from CY 2020 to CY 2021

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

Green - ↑ Improvement from CY 2020; Pink - ↓ decline from CY 2020; White - ⟲ No change; Gray – N/A – reported as Not Applicable for CY 2020 and/or CY 2021

For comprehensive details on the information reporting strategy and analytic methods associated with the production of the CY 2021 Consumer Report Card, please access the link to the Information Reporting Strategy and Analytic Methodology in **Appendix C**. English and Spanish versions of the 2021 Consumer Report Card are available in **Appendix D**.

Focused Review of Grievances, Appeals, and Denials

Objectives

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

- Validate data provided by MCOs in the quarterly grievance, appeal, and pre-service denial reports.
- Provide MCOs an opportunity to compare their individual performance with that of their peer group through distribution of quarterly reports.
- Identify MCO opportunities for improvement and provide recommendations.
- Request corrective action when an MCO demonstrates consistent non-compliance with one or more review components.

Methodology

MDH requires all HealthChoice MCOs to submit quarterly Grievance, Appeal, and Pre-Service Denial Reports within 30 days of the close of each quarter to Qlarant. Qlarant validates and compares data to identify areas of non-compliance and MCO-specific or statewide specific trends. MCOs were provided quarterly reviews of their submissions, which included required follow-up for data issues, ongoing non-compliance, or negative trends when identified.

In addition to quarterly reviews, Qlarant conducted an annual record review using a random sampling approach. Results of the overall grievance, appeal, and pre-service denial record reviews, including strengths, best practices, and opportunities for improvement, were provided to MDH as a component of each MCO's SPR report. Results of the record reviews were shared with appropriate staff of each MCO, and technical assistance provided as needed, to facilitate improved compliance.

Results

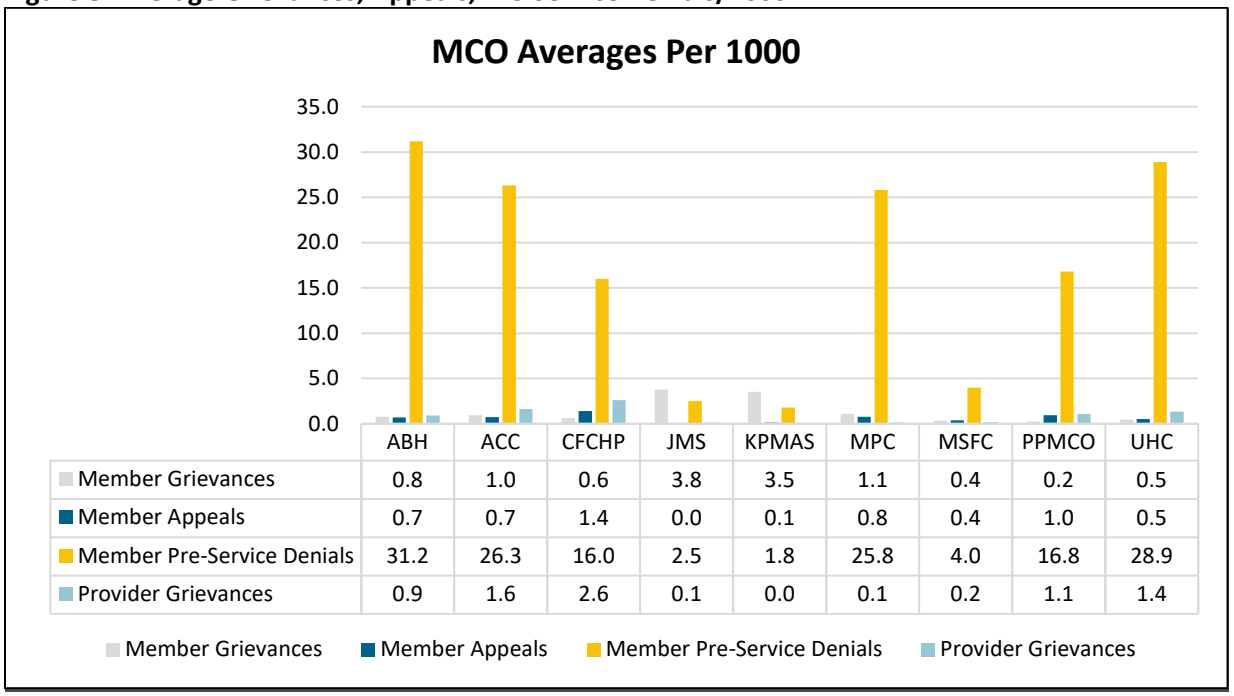
The percentage of compliance demonstrated for various components is represented by a review determination as displayed in Table 37.

Table 37. Review Determinations

Review Determinations	
Met (M)	Compliance consistently demonstrated
Partially Met (PM)	Compliance inconsistently demonstrated
Unmet (UM)	No evidence of compliance

Figure 8 displays a comparison of MCO averages of grievances, appeals, and pre-service denials per 1000 members and grievances per 1000 providers for the review period spanning from the third quarter of 2020 through the second quarter of 2021. Tables 38 and 39 displays MCO reported compliance with resolution timeframes for member grievances and provider grievances, based on MCO quarterly submissions.

Figure 8. Average Grievances, Appeals, Pre-Service Denials/1000



	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Member Grievances	0.8	1.0	0.6	3.8	3.5	1.1	0.4	0.2	0.5
Member Appeals	0.7	0.7	1.4	0.0	0.1	0.8	0.4	1.0	0.5
Member Pre-Service Denials	31.2	26.3	16.0	2.5	1.8	25.8	4.0	16.8	28.9
Provider Grievances	0.9	1.6	2.6	0.1	0.0	0.1	0.2	1.1	1.4

Table 38. MCO Reported Compliance with Member Grievance Resolution Timeframes

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	M	M	M	M	M	M	M	M	M
Q4 2020	PM	M	M	M	M	M	M	M	M
Q1 2021	M	M	M	M	M	M	M	M	PM
Q2 2021	PM	M	M	M	M	M	M	PM	M

Green – M (Met); Yellow – PM (Partially Met)

Table 39. MCO Reported Compliance with Provider Grievance Resolution Timeframes

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	M	UM	M	N/A	N/A	N/A	N/A	M	M
Q4 2020	UM	M	M	M	N/A	N/A	M	M	UM
Q1 2021	M	M	M	M	N/A	M	M	M	M
Q2 2021	M	M	M	M	N/A	M	N/A	M	M

Green – M (Met); Yellow – PM (Partially Met); Gray – N/A (Not Applicable) as the MCO did not receive any provider grievances during the reporting period.

Table 40 presents a comparison of the annual grievance record review results across MCOs. Table 41 displays a comparison of MCO reported compliance with resolution timeframes for enrollee appeals based on MCO quarterly submissions. Table 42 provides a comparison of appeal record review results across MCOs. Results are based upon a random selection of appeal records reviewed for CY 2020.

Table 40. CY 2020 MCO Annual Grievance Record Review Results

Requirement	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Appropriately Classified	M	M	M	M	M	M	M	M	M
Acknowledgement Letter Timeliness	PM	M	PM	M	M	M	M	M	M
Issue Is Fully Described	M	M	M	M	M	M	M	M	M
Resolution Timeliness	PM	M	M	M	M	M	M	M	M
Resolution Appropriateness	M	M	M	M	M	M	M	M	M
Resolution Letter Sent	M	M	M	M	PM	M	M	M	M

Green – M (Met); Yellow – PM (Partially Met)

Table 41. MCO Reported Compliance with Enrollee Appeal Resolution Timeframes

Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Q3 2020	PM	PM	M	N/A	UM	M	M	PM	M
Q4 2020	UM	PM	M	N/A	M	M	M	UM	M
Q1 2021	PM	PM	M	M	M	M	M	M	PM
Q2 2021	PM	UM	M	N/A	M	PM	M	M	PM

Green – M (Met); Yellow – PM (Partially Met); Gray – N/A (Not Applicable)/No data reported

Table 42. CY 2020 MCO Appeal Record Review Results

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

Green – M (Met); Yellow – PM (Partially Met); Pink – UM (Unmet); Gray – N/A **(N**ot Applicable) /No data reported

Table 43 displays results of the MCOs' reported compliance with pre-service determination timeframes. As a result of the State of Emergency declared by Governor Hogan in response to the COVID-19 pandemic, MDH agreed to relax the compliance threshold from 95% to 90% as of March 5, 2020.

Table 43. MCO Reported Compliance with Pre-Service Determination Timeframes (Quarterly Reports)

Report Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Compliance with Expedited Pre-Service Determination Timeframes for Medical Denials									
Q3 2020	100%	95%	100%	N/A	100%	100%	100%	50%	100%
Q4 2020	100%	91%	100%	N/A	N/A	100%	100%	73%	96%
Q1 2021	100%	96%	100%	N/A	100%	97%	N/A	85%	100%
Q2 2021	100%	95%	N/A	N/A	100%	100%	100%	96%	100%
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials									
Q3 2020	91%	95%	99%	N/A	99%	100%	100%	83%	99%
Q4 2020	74%	96%	96%	100%	99%	98%	100%	89%	98%
Q1 2021	89%	96%	98%	75%	98%	99%	100%	99%	99%
Q2 2021	98%	97%	71%	100%	99%	100%	100%	100%	99%
Compliance with Outpatient Pharmacy Pre-Service Determination Timeframes for Denials									
Q3 2020	100%	100%	100%	100%	N/A	99%	99%	94%	100%
Q4 2020	100%	100%	99%	100%	N/A	99%	100%	99%	100%
Q1 2021	100%	100%	100%	98%	N/A	99%	98%	99%	100%
Q2 2021	100%	100%	100%	100%	N/A	99%	98%	99%	100%

Green – M (Met); Pink – UM (Unmet - did not meet the relaxed 90% threshold); Gray – N/A (Not Applicable)

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Results are highlighted in Figure 9.

Figure 9. MCO Compliance with Pre-Service Determination Timeframes (Record Review)

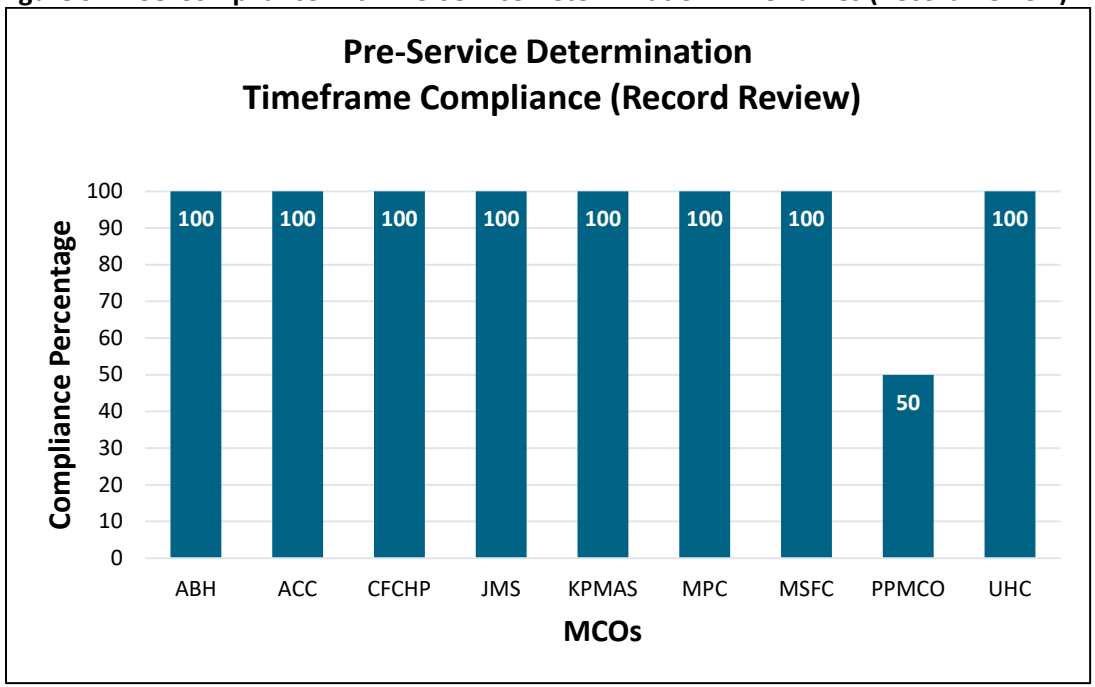


Table 44 displays the issues identified during a review of each MCO's adverse determination records.

Table 44. MCO Adverse Determination Record Review Issues

MCO	Issues Identified
ABH	Letter Components – Incorrect Timeframes
ACC	Letter Components – Incorrect Timeframes
CFCHP	Use of Plain Language in Enrollee Letters
PPMCO	Determination Turn Around Times & Use of Plain Language in Enrollee Letters

Note: No issues were identified for JMS, KPMAS, MPC, MSFC, or UHC

Results of MCO reported compliance with adverse determination notification timeframes based on the quarterly reports are highlighted in Table 45. In addition to relaxing the compliance threshold for preauthorization determination timeliness during the COVID-19 public health emergency, MDH also relaxed the threshold for adverse determination notification timeliness from 95% to 90% as of March 5, 2020.

Table 45. MCO-Reported Compliance with Adverse Determination Notification Timeframes (Quarterly Reports)

Report Quarter	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Compliance with Expedited Medical Adverse Determination Notification Timeframes									
Q3 2020	100%	96%	100%	N/A	100%	100%	100%	75%	100%
Q4 2020	100%	100%	100%	N/A	N/A	100%	100%	73%	96%
Q1 2021	100%	100%	100%	N/A	100%	92%	N/A	85%	100%
Q2 2021	100%	94%	N/A	N/A	100%	100%	100%	96%	100%
Compliance with Standard Medical Adverse Determination Notification Timeframes									
Q3 2020	99%	95%	100%	N/A	100%	99%	100%	80%	100%
Q4 2020	97%	97%	100%	100%	99%	99%	100%	85%	100%
Q1 2021	99%	98%	100%	100%	100%	98%	100%	97%	99%
Q2 2021	99%	94%	100%	88%	100%	100%	100%	100%	98%
Compliance with Outpatient Pharmacy Adverse Determination Notification Timeframes									
Q3 2020	100%	100%	100%	100%	N/A	100%	97%	100%	100%
Q4 2020	100%	100%	100%	100%	N/A	100%	100%	100%	100%
Q1 2021	100%	100%	99%	100%	N/A	100%	97%	100%	100%
Q2 2021	100%	100%	100%	100%	N/A	100%	97%	100%	100%
Compliance with Prescriber Notification of Outcome within 24 Hours									
Q3 2020	100%	100%	100%	100%	99%	100%	100%	97%	100%
Q4 2020	100%	100%	100%	100%	98%	100%	100%	99%	100%
Q1 2021	100%	100%	99%	100%	100%	99%	100%	98%	100%
Q2 2021	100%	100%	99%	100%	100%	100%	100%	99%	100%

Green – M (Met); Pink – UM (Unmet - did not meet the relaxed 90% threshold); Gray – N/A (Not Applicable)

Record reviews also were conducted to assess compliance with the COMAR requirement for timeliness of adverse determination notifications. Results are highlighted in Figure 10. Table 46 provides adverse determination record review results across MCOs from CY 2020.

Figure 10. MCO Compliance with Adverse Determination Notification Timeframes (Record Review)

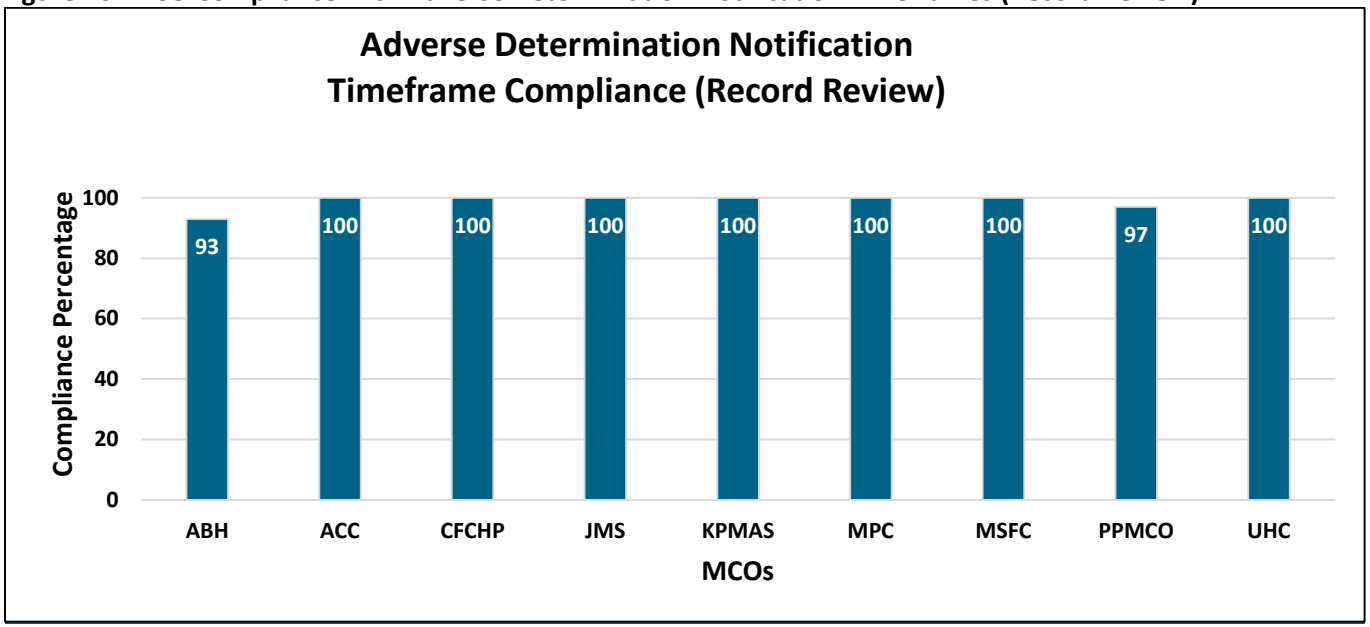


Table 46. Results of CY 2020 Adverse Determination Record Reviews

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

Green – M (Met); Yellow – PM (Partially Met); Gray – N/A (Not Applicable)/No data reported

Conclusions

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

- Appropriate classification and resolution of grievances (all MCOs)
- Timely written acknowledgment of receipt of enrollee grievances (ACC, JMS, KPMAS, MPC, MSFC, PPMCO, UHC)
- Full documentation of grievance issues (all MCOs)
- Timely resolution of enrollee grievances (ACC, CFCHP, JMS, KPMAS, MPC, MSFC)
- Timely resolution of provider grievances (CFCHP, JMS, MPC, MSFC, PPMCO) Note: KPMAS had no provider grievances.
- Grievance resolution letters sent to enrollees (ABH, ACC, CFCHP, JMS, MPC, MSFC, PPMCO, UHC)
- Appeals processed based upon the level of urgency (ACC, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC) Note: JMS had no appeals.
- Appeal decisions made by a health care professional with appropriate expertise urgency (ACC, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC) Note: JMS had no appeals.
- Appeal decisions are documented and available to the enrollee in easy to understand language (ABH, ACC, CFCHP, KPMAS, MSFC, UHC) Note: JMS had no appeals.
- Timely pre-service determinations (ACC, KPMAS, MPC, MSFC, UHC)
- Timely pre-service adverse determination written notifications (ABH, ACC, CFCHP, KPMAS, MPC, MSFC, UHC)
- Timely prescriber notifications of PA review outcome (all MCOs)
- Required components in adverse determination letters (all MCOs)
- Adverse determinations are appropriate based upon MCO medical necessity criteria and policies (all MCOs)

A major opportunities for improvement where five or more of the MCOs did not meet requirements on a consistent basis is identified in the following area:

- Timely resolution/written notification of enrollee appeal resolutions (ABH, ACC, KPMAS, MPC, PPMCO, UHC)

Validity of the data submitted by the MCOs, while much improved, continues to be a challenge evidencing an ongoing absence of quality oversight. Consequently, assessment results need to be considered with some caution. Recommendations have been provided to both MDH and the MCOs for increasing the validity of reports, such as routine quality oversight of report submissions, and cross-training of staff to ensure continuity in the event of staff turnover or absences.

For additional findings and comprehensive details associated with the 2021 Annual Focused Study report, please access the link in **Appendix D**.

Network Adequacy Validation

Objectives

MDH engages in a broad range of activities to monitor network adequacy and access. Starting in 2015, MDH began conducting Network Adequacy Validation (NAV) activities by surveying the MCOs and validating provider directories on an annual basis. This activity was transitioned to Qlarant in CY 2017. Now in its fifth year of conducting this task, Qlarant has streamlined and developed a robust survey process to address inaccuracies in the MCOs' directories and improve the enrollees' timely access to care.

The purpose of the NAV task is to:

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

Methodology

CMS has not issued an EQR protocol for evaluating network adequacy. To complete the CY 2021 NAV task, Qlarant conducted two separate surveys, a telephone survey to a sample of provider offices and a validation survey to verify the accuracy of MCO online provider directories.

A random sample for the telephone survey was selected from a listing of contracted PCPs obtained from each MCO. Two of the four surveyors and all three validators returned from CY 2020 survey activities, providing consistency in survey administration. The survey solicited responses to verify PCP information, including:

- Name and address of the PCP
- Whether the PCP accepts the listed MCO and new Medicaid enrollees
- Routine and urgent care appointment availability

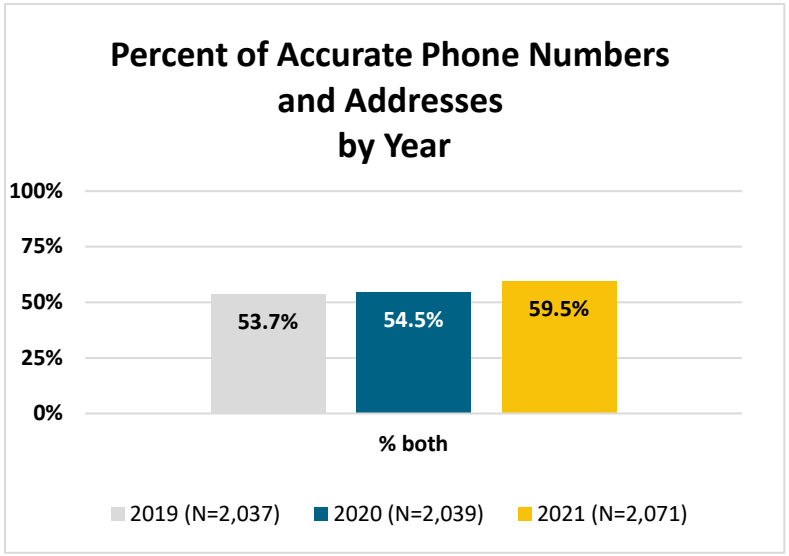
The validation survey verified the following information using the MCOs' online provider directories:

- Correct address as furnished by the MCO
- Correct phone number as furnished by the MCO
- Acceptance of new Medicaid patients
- Ages served by the PCP
- Languages spoken by the PCP
- Whether the practice had accommodations for disabled patients, and identified specific Americans with Disabilities Act (ADA) accessible equipment

Results

Accuracy of PCP information. When contact is made with the PCP, the PCP's pre-populated phone number and address are verified. Results for the percentage of phone numbers and addresses that match are presented in Figure 11, trended by year. Each percentage is based on the total number of calls attempted.

Figure 11. Accuracy of PCP Phone Numbers and Addresses

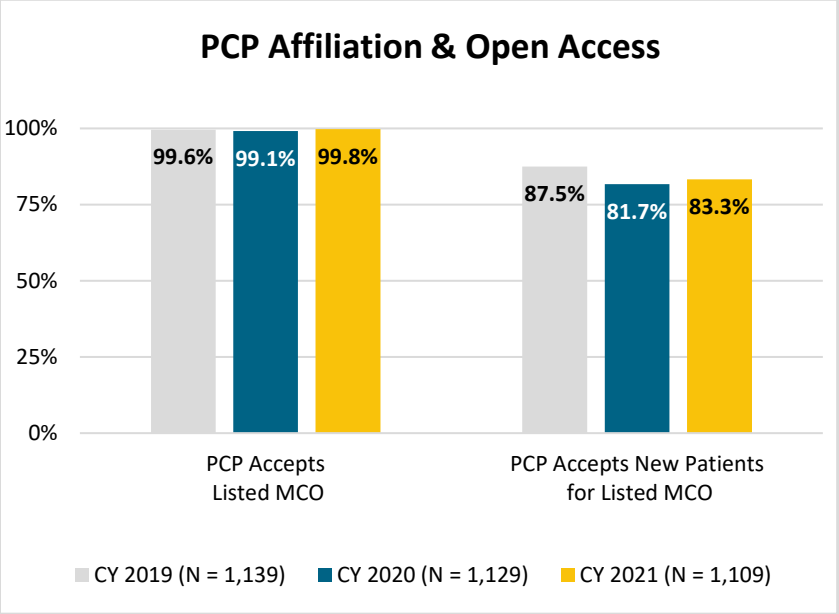


Accuracy of PCP Phone Numbers and Addresses

- More than half of attempted surveys indicated the correct phone number and address was provided prior to the telephonic survey.
- The percentage of accurate phone numbers and addresses has increased each year since CY 2019, to nearly 60% in CY 2021.

Survey results demonstrate the accuracy of PCP information provided by the MCOs has increased over the last three years in Figure 12.

Figure 12. PCP Affiliation & Open Access



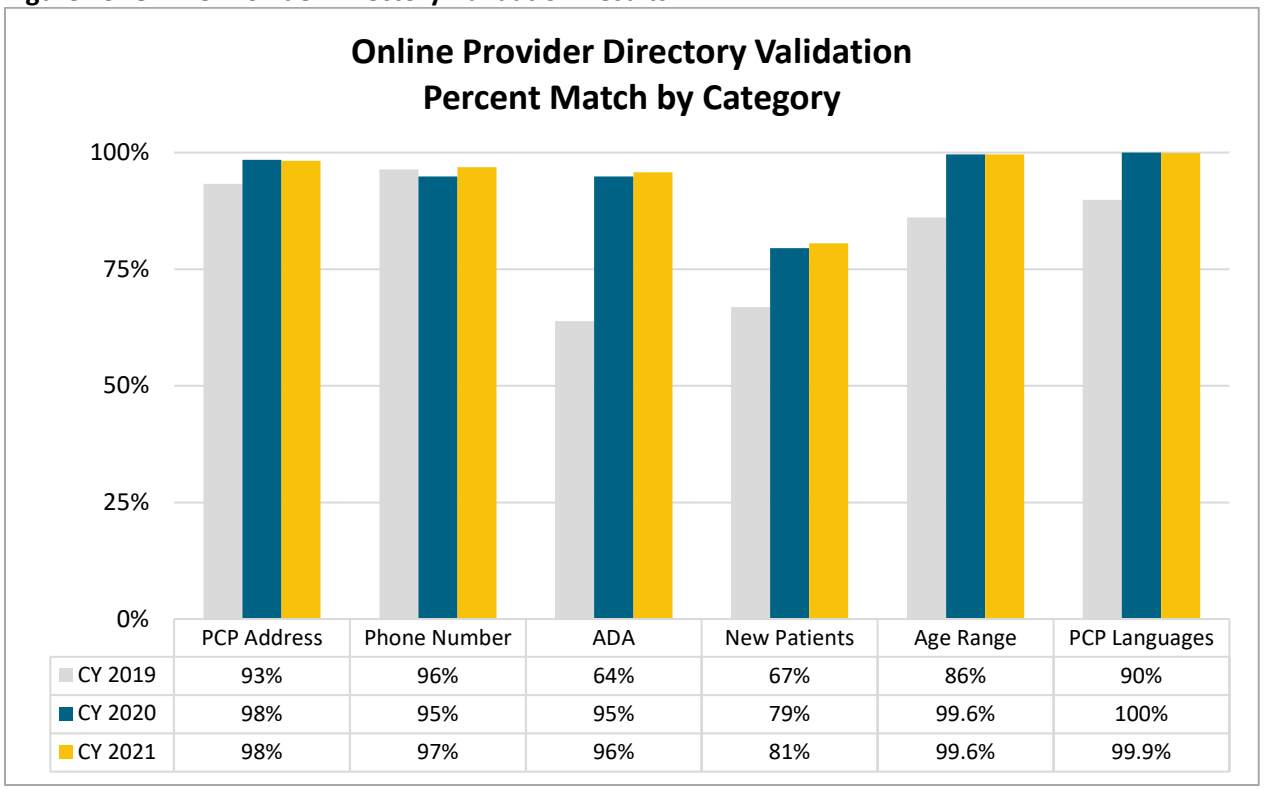
PCP Affiliation & Open Access

- In CY 2021, 99.8% of PCPs surveyed confirmed acceptance of the listed MCO. Only 2 PCPs surveyed were unable to confirm acceptance of the listed MCO.
- The majority of PCPs surveyed (83.3%) reported accepting new patients in CY 2021. Of those not accepting new patients, 13 were due to COVID-19.

Although the survey rate of 83.3% for PCPs accepting new Medicaid patients seems satisfactory, it is important to note that only 53.6% of the PCPs were successfully contacted by surveyors. Therefore, further analysis into open panels may warrant additional MCO oversight, as recommended in both CY 2020 and CY 2019 reports.

Validation of MCO online provider directories. Qlarant validated the information in the MCO's online provider directory for each PCP that completed the telephone survey. Results of the online provider directory survey validation are presented in Figure 13.

Figure 13. Online Provider Directory Validation Results



	PCP Address	Phone Number	ADA	New Patients	Age Range	PCP Languages
CY 2019	93%	96%	64%	67%	86%	90%
CY 2020	98%	95%	95%	79%	99.6%	100%
CY 2021	98%	97%	96%	81%	99.6%	99.9%

Providers who were unable to be validated have been excluded from this figure.

- Overall, results for CY 2021 remained fairly consistent or exceeded results from CY 2020. Most notably, the match rate for Accepting New Medicaid Patients increased significantly in CY 2020 (868 or 79%) from CY 2019 (725 or 67%) and has continued to increase in CY 2021 (853 or 81%).

HealthChoice aggregate results for validation of online provider directories. HealthChoice aggregate results for the validation of online provider directories are presented in Table 47.

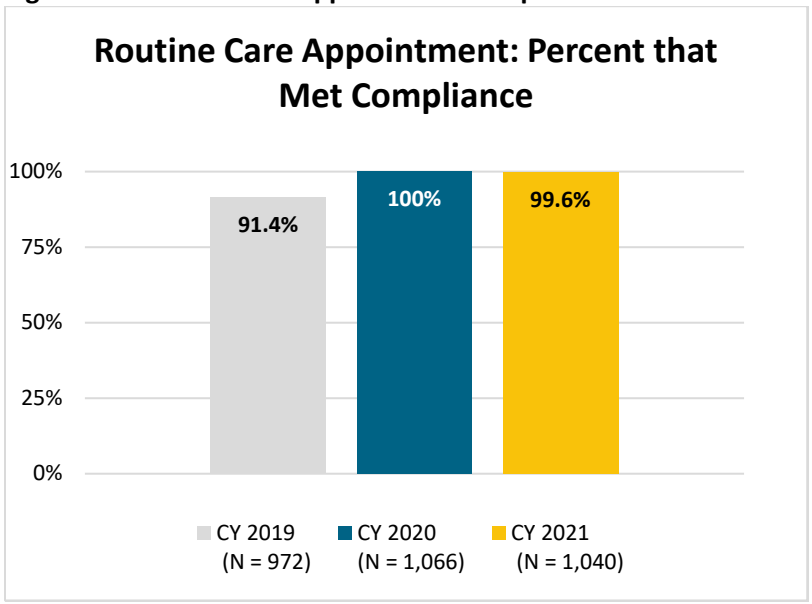
Table 47. CY 2020 HealthChoice Aggregate Results for Validation of Online Provider Directories

Requirement	HealthChoice Aggregate
PCP Listed in Online Directory	**95.9%** ↓
PCP's Practice Location Matched Survey Response	**98.2%** =
PCP's Practice Telephone Number Matched Survey Response	**96.9%** ↑
Specifies PCP Accepts New Medicaid Patients & Matches Survey Response	**80.5%** ↑
Specifies Age of Patients Seen	**99.6%** =
Specifies Languages Spoken by PCP	**99.9%** =
Practice has Accommodations for Patients with Disabilities (with specific details)	**95.7%** ↑

↑ Improvement from CY 2020; ↓ Decline from CY 2020; = Consistent with CY 2020

Compliance with routine appointment requirements. Survey results of PCP compliance with routine appointment requirements are presented in Figure 14.

Figure 14. Routine Care Appointment Compliance



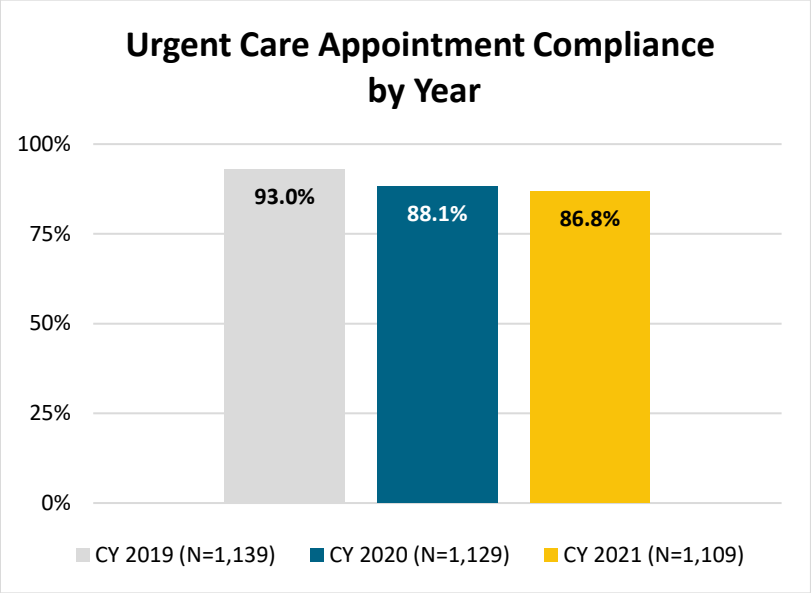
Routine Care Appointment Compliance

- Of the 1,109 PCPs successfully surveyed in CY 2021, 94% (1,040) provided routine care appointment availability, which is consistent with the percent in CY 2020.
- 99.6% (1,036) of PCPs that provided routine care appointment availability (1,040), achieved compliance with the routine appointment timeframes.

The percentage of PCPs meeting compliance within 30 days for routine care appointment availability in CY 2021 (99.6%) was consistent with the percentage of PCPs who were compliant in CY 2020 (100%). Of the compliant PCPs in CY 2021, 85 indicated telemedicine was available with the requested provider, and three indicated telemedicine was available with an alternate provider.

Compliance with urgent care appointments. Survey results for PCP compliance with urgent care appointments are presented in Figure 15.

Figure 15. Urgent Care Appointment Compliance



Urgent Care Appointment Compliance

- Of the 1,109 PCPs surveyed in CY 2021, the majority of PCPs provided urgent care appointments and achieved the 48-hour urgent care timeframes requests (86.8%).
- Urgent Care appointment compliance rates have decreased every year since CY 2019.

Of the 145 PCPs not meeting the urgent appointment compliance timeframes, 93.1% (135) directed enrollees to an urgent care clinic or an emergency department, and 6.8% (10) did not provide any guidance. The option of directing the enrollee to an urgent care clinic appears to be a standard practice among PCPs when an urgent care appointment cannot be made upon request. An investigation of member complaints or grievances may provide MDH further insight into whether the enrollees are accessing urgent care services or emergency services due to PCP referrals.

MCO-specific results for compliance with appointment requirements. Aggregate results for compliance with routine and urgent care appointment timeframe requirements are presented in Table 48.

Table 48. CY 2020 HealthChoice Aggregate Results for Compliance with Appointment Requirements

Requirement	HealthChoice Aggregate
Compliance with Routine Care Appointment Timeframe (within 30 days)*	
Compliant with Timeframe	**93.4%**
# of Wait Days (Average)	**7.4**
Range of Wait Days	**0-30**
Compliance with Urgent Care Appointment Timeframe (within 48 hours)	
Appointment Available w/ Requested PCP at Same Location	**57.6%**
Compliance with Urgent Care Appointment Timeframe (within 48 hours)*	
Appointment Available w/ Another PCP at Same Location	**29.2%**
Compliance w/ Urgent Care Appointment	**86.8%**

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

Conclusions

The overall response rate for CY 2021 surveys was 53.5%, a decrease of 1.9 percentage points from CY 2020 (55.4%). Although the provider listings are offered directly by the MCOs, a fluctuating trend of inaccurate information remains an issue. The rate of accuracy with PCP addresses and phone numbers improved continuously from CY 2019 (53.7%), CY 2020 (54.5%), and CY 2021 (59.5%) and resulted in a positive trend year over year. In CY 2021, 99.8% of PCPs surveyed for open access demonstrated that they accepted the listed MCO; this is comparable to both CY 2019 (99.6%) and CY 2020 (99.1%) results. Additionally, the majority of PCPs in CY 2021 (83.3%) accepted new patients for the listed MCO, which is a 1.6 percentage point increase compared to CY 2020 (81.7%) results but is a 4.2 percentage point decrease compared to CY 2019 (87.5%) results. Although acceptance of new Medicaid patients match rates remains the lowest percent match category, this category has increased 2 percentage points from CY 2020 (79%) to CY 2021 (81%); further, this category has increased 14 percentage points since CY 2019. Validation categories, Age Range (99.6%) and PCP Languages (100%) remained the highest percent match category when compared to CY 2020.

Overall, routine appointment compliance rates remained consistent from CY 2020 (100%) to CY 2021 (99.6%). A total increase of 8.2 percentage points was reflected in routine care appointment compliance, climbing from 91.4% in CY 2019 to 99.6% in CY 2021. Improvements may be due to allowing practices to schedule an appointment with another provider in the same practice location as an alternative when the surveyed PCP was unable to see a patient within the required care timeframe. Urgent care appointment compliance rates continued to decrease to 86.8% in CY 2021 from CY 2020 (88.1%) and CY 2019 (93%).

While improvements were demonstrated in CY 2021, staff at provider offices and online provider directories are still not accurately communicating or reflecting whether they are accepting new Medicaid patients, which prevents enrollees from scheduling appointments with their preferred PCP. Considering MDH relies on accurate data from the MCOs to ensure appropriate PCP coverage statewide, these barriers warrant further investigation to determine if they affect network adequacy determinations. Such barriers may

cause enrollees who are unable to access a PCP to seek care from urgent care facilities or emergency departments; this may lead to an increase in health care costs in Maryland. Furthermore, enrollees may delay annual preventive care visits for themselves or their children if they are unable to contact a PCP and/or obtain an appointment, which could lead to adverse health care outcomes.

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

MDH set a minimum compliance score of 80% for the network adequacy assessment. Based on CY 2021 results, JMS, KPMAS, MPC, and PPMCO are required to submit CAPs to Qlarant to improve online provider directory accuracy; KPMAS and MSFC are required to submit CAPs to improve compliance with the urgent care timeframe.

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

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS®[1]) is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and result calculation to promote a high degree of standardization of HEDIS measures. Reporting entities are required to register with NCQA and undergo an annual NCQA HEDIS Compliance Audit™. To ensure audit consistency, only NCQA-licensed organizations using NCQA-certified Auditors may conduct a HEDIS Compliance Audit. The audit conveys sufficient integrity to HEDIS data, such that it can be released to the public to provide potential enrollees with a means of comparing healthcare organization performance.

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

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

Consumer Assessment of Health Providers and Systems

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

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

The Health Plan CAHPS survey represents the enrollee experience component of the HEDIS measurement set. The survey measures enrollee experience of care and gives a general indication of how well the health plan meets enrollees' expectations. Surveyed enrollees are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months. The Maryland Department of Health (MDH) contracted with the Center for the Study of Services (CSS), an NCQA-certified survey vendor, to administer and report the results of the CAHPS® 5.1H Member Experience Survey. The overall goal of the survey is to provide performance feedback that is actionable and that will aid health plans in improving overall enrollee experience.

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

MCO Quality, Access, Timeliness Assessment

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

- **Quality**, as it pertains to external quality review, is defined as "the degree to which an MCO or Prepaid Inpatient Health Plan increases the likelihood of desired health outcomes of its participants (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics, 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 external quality review, 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, Opportunities, and Recommendations

Table 49. MCO Strengths, Improvements, Opportunities, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, Opportunities, and Recommendations
✓	✓	✓	**Systems Performance Review**
Strengths • MCOs demonstrate the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of their continuing progression to ensure the delivery of quality healthcare for their enrollees. **Improvements** • In the CY 2020 SPR, there was marked reduction in MCO corrective action plans and overall improved compliance. The number of overall CAPs reduced from 25 in CY 2018 to 8 in CY 2020. The number of Met with Opportunity scores reduced from 26 in CY 2018 to 4 in CY 2020. Four MCOs (JMS, MPC, MSFC, and UHC) received a perfect score in the CY 2020 SPR.			
✓	✓	✓	**Performance Improvement Projects**
Recommendations • Improve confidence levels of Performance Improvement Projects through utilizing tools provided by EQRO and MDH - including technical assistance sessions and evaluation by MDH Review Committee. • Complete an in-depth barrier analysis at least annually to identify root causes of suboptimal performance and to effectively drive improvement. • Develop robust, system-level interventions in response to identified barriers. • Implement timely interventions within the MY to have a meaningful impact on the measure rate. • Ensure that interventions address differences among population subgroups, such as differences in healthcare attitudes and beliefs among various racial/ethnic groups within the MCO's membership. • Ensure that interventions are focused on the priority population for the lead screening PIP. • Develop SMART objectives for all interventions to support evaluation of the effectiveness of interventions.			

Quality	Access	Timeliness	Strengths, Improvements, Opportunities, and Recommendations
• Demonstrate consistent use of the Institute for Healthcare Improvement's rapid cycle PDSA approach to test the effectiveness of interventions and initiate adjustments where outcomes are unsatisfactory. • Ensure that interventions address all system-wide barriers (member, provider, and MCO). • Ensure that all PIP submissions include final audited rates for each of the measures. • Ensure that the quantitative analysis of PIP results includes a comparison of results to the long-term approved goal in addition to any annual goals that the MCO has established. • Demonstrate a proactive approach to refining or developing new interventions when unforeseen challenges occur, such as the COVID-19 public health emergency. • Ensure that a comprehensive analysis is completed to identify any factors that influenced the comparability of initial and repeat measurements and any confounding variables that could have an obvious impact on outcomes when designing interventions. • In designing interventions, determine the methodology for evaluating effectiveness in achieving the established goal.			
✓	N/A	N/A	**Encounter Data Validation**
Strengths • MCOs appear to have well-managed systems and processes. • MCOs are capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • MCOs appear to have information systems and processes capable of producing accurate and complete encounter data. • The HealthChoice MCO average rate for processing clean claims in 30 days was 98.84%, an increase of almost 2 percentage points from the CY 2019 rate of 97%. • The CY 2020 composite match rate of 98% is consistent with the CY 2019 rate of 98% and 2 percentage points above the CY 2018 (96%). • All MCOs met the Qlarant recommended match rate of 90% for all encounter types reviewed. • Eight of the nine MCOs achieved a match rate of 97% or greater for inpatient encounters across all code types.			

Quality	Access	Timeliness	Strengths, Improvements, Opportunities, and Recommendations
✓	✓	✓	**EPSDT Medical Record Review**

Strengths

- The HealthChoice Aggregate exceeded the 80% minimum compliance threshold set by MDH for four of the five components.

Recommendations

- Establish a pandemic crisis-mitigation plan to ensure care is provided to Healthy Kids Program enrollees.
- Encourage providers to develop a plan to have medical records in compliance with audit requests.
- Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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.
- Educate the MCO provider network regarding revisions to and new standards of 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 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 during audit requests.
- When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP.
- Utilize MCO data to identify children who are not up-to-date 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.
- When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed health care appointments.
- Remind providers that they are required to enroll in MDH's Vaccines for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.

Quality	Access	Timeliness	Strengths, Improvements, Opportunities, and Recommendations
✓	N/A	✓	**Focused Review of Grievances, Appeals, and Denials**

Strengths

- Grievances were fully documented; appropriately classified and resolved; acknowledged and resolved timely; and written resolutions were provided to enrollees by the majority of MCOs.
- Appeals were processed based upon the level of urgency; decisions were made by healthcare professionals with appropriate expertise; and enrollees were provided written notification of appeal resolution in easy to understand language by the majority of MCOs.
- Adverse determinations in response to a preauthorization request were appropriate based upon MCO medical necessity criteria and policies; determinations and enrollee notifications were timely and included all required components for the majority of MCOs.

Opportunities

- Timely resolution/written notification of enrollee appeal resolutions.

Recommendations

- Cross train at least one additional staff member on quarterly grievance, appeal, and denial reports to ensure continuity in the event of staff turnover or absence.
- Educate appeal staff to process appeals filed by a provider on behalf of the enrollee consistent with the transmittal issued by MDH on March 16, 2020.
- Educate preauthorization staff on requirements to request additional clinical information as needed within two business days of receipt of the preauthorization request and make a determination within two business days of receipt of additional clinical information.
- The number of provider grievances appears to be under-reported by at least some of the MCOs. It does not appear that all MCOs have an effective process in place for capturing provider grievances which may be submitted to various departments. MCOs need to establish a cross functional work group to address the various points of entry and develop a process for aggregation of all grievances to support accurate reporting.

Quality	Access	Timeliness	Strengths, Improvements, Opportunities, and Recommendations
✓	✓	✓	**Network Adequacy Validation**

Strengths

- In CY 2021, 99.8% of PCPs surveyed for open access demonstrated that they accepted the listed MCO; this is comparable to both CY 2019 (99.6%) and CY 2020 (99.1%) results.
- Validation categories, Age Range (99.6%) and PCP Languages (100%), remained the highest percent match category when compared to CY 2020.
- Routine appointment compliance rates remained consistent from CY 2020 (100%) to CY 2021 (99.6%).

Improvements

- The rate of accuracy with PCP addresses and phone numbers improved continuously from CY 2019 (53.7%), CY 2020 (54.5%), and CY 2021 (59.5%) and resulted in a positive trend year over year.

Quality	Access	Timeliness	Strengths, Improvements, Opportunities, and Recommendations

- The majority of PCPs in CY 2021 (83.3%) accepted new patients for the listed MCO, which is a 1.6 percentage point increase compared to CY 2020 (81.7%) results.
- Although acceptance of new Medicaid patients match rates remains the lowest percent match category, this category has increased 2 percentage points from CY 2020 (79%) to CY 2021 (81%); further, this category has increased 14 percentage points since CY 2019.
  A total increase of 8.2 percentage points was reflected in routine care appointment compliance, climbing from 91.4% in CY 2019 to 99.6% in CY 2021.

Opportunities

- Accuracy of the provider telephone number and/or address remains an area of weakness across HealthChoice MCOs.
- Acceptance of new Medicaid patients match rates remains the lowest percent match category.
- Urgent care appointment compliance rates continued to decrease to 86.8% in CY 2021 from CY 2020 (88.1%) and CY 2019 (93%).

Recommendations

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

Assessment of Previous Recommendations

The following table identified recommendations made in the previous ATR (MY 2019) and the follow-up activities completed in 2020.

Table 50. 2020 Compliance with 2019 Recommendations

2020 Compliance with 2019 Recommendation	
2019 Recommendation	**2020 Compliance**
Performance Improvement Projects	
Consider further incentivizing MCOs to fully commit to demonstrating significant and sustainable improvement through implementation of robust, timely interventions.	MDH has developed an enhanced review of MCOs' PIP interventions to provide in-depth feedback on MCOs' improvement strategies and a framework to follow for future PIPs.
Encounter Data Validation	
Continue to monitor 8ER reports to identify trends and encourage encounter data quality improvement (The Hilltop Institute, 2020).	This continues to be a recommendation.
Review MCOs that have a significantly higher percentage of rejected encounters than accepted encounters (The Hilltop Institute, 2020).	The Department should continue to work with all MCOs to resolve rejected encounters. All MCOs experienced an increased incidence in provider-related rejections, although two MCOs also have non-provider related rejections.
Continue to work with the MCOs to improve the quality and integrity of encounter submissions with complete and accurate pay data (The Hilltop Institute, 2020). For CY 2020, MDH should ensure that MMIS2 continues to store the correct sum of the total paid institutional service lines (The Hilltop Institute, 2020).	The Department resolved an MMIS2 issue which allowed institutional pay to be captured more accurately in July 2020. This field appears to now be populated for all MCOs.
Continue to monitor monthly submissions to ensure that the MCOs submit data in a timely manner (The Hilltop Institute, 2020). MCOs that submit encounters more than 8 months after the date of service, which is the maximum time allotted for an encounter to be submitted to MDH, should be targeted for improvement (The Hilltop Institute, 2020).	This continues to be a recommendation.
Continue to monitor PCP visits by MCO in future encounter data validations (The Hilltop Institute, 2020).	This continues to be a recommendation.
Continue to review these data and compare trends in future annual encounter data validations to look for consistency (The Hilltop Institute, 2020).	This continues to be a recommendation.

2020 Compliance with 2019 Recommendation	
2019 Recommendation	**2020 Compliance**
Continue to review and audit the participant-level reports that Hilltop generated for delivery, dementia, and individuals over age 65, as well as missing age outlier data (The Hilltop Institute, 2020).	The Department should continue to review and audit the participant-level reports that Hilltop generated for delivery, dementia, and individuals over age 65, pediatric dental, as well as missing age outlier data. MCOs submitting the encounter outliers should be notified, and demographic information should be updated, or adjustments should be made as needed. The number of encounters with the date of service before the enrollee's date of birth declined dramatically between CY 2018 and CY 2020.
Instruct MCOs to have their providers update and maintain accurate billing/claims address information to reduce returned mail and thus increase the amount of records received for review. A total of 300 provider letters were returned to Qlarant for CY 2019, which contained requests for 697 patients.	This continues to be a recommendation. For CY 2020, a total of 133 provider letters were returned to Qlarant, which contained requests for 326 patients.
Communicate with provider offices to reinforce the requirement to supply all supporting medical record documentation for the encounter data review so that all minimum samples can be met in a timely manner.	Qlarant modified the provider medical record request letter to address this recommendation.
Work with Hilltop to remedy encounter data issues where the MCO is identified as the provider.	MDH, Qlarant, and Hilltop held meetings to address this recommendation and ensure the issue was not ongoing.
Grievances, Appeals, Denials	
Clarify requirements for Hepatitis C PA and appeal reporting requirements to ensure a consistent understanding among MCOs.	MDH transferred responsibility for review and approval of Hepatitis C medication PA requests to the MCOs.
Explore options for implementing the federal requirement for enrollee written consent for a provider or authorized representative to file an appeal on their behalf to ensure this regulation does not present an access issue.	MDH issued guidance to the MCOs regarding the processing of standard and written appeal requests filed by a provider on behalf of an enrollee.
Consider submitting revised language for COMAR 10.67.09.02 to replace grievance "decision timeframes" with "resolution and notification timeframes" and a recommendation to include the requirement for sending written acknowledgment of grievance receipt within 5 calendar days.	As an interim step to address the absence of COMAR language requiring written acknowledgment and written resolution of an enrollee grievance, MDH has included MCO requirements in the CY 2021 SPR standards.

2020 Compliance with 2019 Recommendation	
2019 Recommendation	**2020 Compliance**
Network Adequacy Validation	
Promote standards/best practices for MCOs' online provider directory information, including: • Use of consistent lexicon for provider detail information. • Use of placeholders with consistent descriptions for provider details that are missing, such as "none" or "none specified" rather than blanks. • Require all directories to state the date the information was last updated for easy monitoring.	This continues to be a recommendation.
Continue to monitor MCO complaints regarding the use of urgent care and emergency department services and review utilization trending to ensure members are not accessing these services due to an inability to identify or access PCPs.	This continues to be a recommendation.

State Recommendations

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

Performance Improvement Projects

- Providing a forum for MCOs to discuss barriers and share best practices may also be helpful in improving rates among all HealthChoice MCOs.

Encounter Data Validation

- Continue to work with the MCOs to resolve the provider data problems (The Hilltop Institute, 2022).
- Encourage MCOs to ensure that their providers are enrolled on the date of service and that they know how to check their current status to address the rise in rejected encounters (The Hilltop Institute, 2022).
- Continue to monitor monthly submissions to ensure that the MCOs submit data in a timely manner (The Hilltop Institute, 2022).
- Continue to monitor PCP visits by MCO in future encounter data validations (The Hilltop Institute, 2022).
- Continue to review inpatient visit, ED visit, and observation stay data and compare trends in future annual encounter data validations to look for consistency (The Hilltop Institute, 2022).
- Continue to review and audit the participant-level reports that Hilltop generated for delivery, dementia, individuals over age 65, pediatric dental, and missing age outlier data (The Hilltop Institute, 2022).
- Instruct MCOs to have their providers update and maintain accurate billing/claims address information to reduce returned mail and thus increase the number of records received for review. A total of 133 provider letters were returned to Qlarant for CY 2020, which contained requests for 336 patients.
- Communicate with provider offices and hospitals to reinforce the requirement to supply all supporting medical record documentation for the encounter data review so that all minimum samples can be achieved in a timely manner.

Focused Review of Grievances, Appeals, and Denials

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

resolution of grievance, and written acknowledgment of appeal receipt in the quarterly grievance and appeal reports submitted by the MCOs.

- When aligning MCO quarterly grievance reporting fields with a new CMS state-reporting template, assess the need for additional grievance service categories.

Network Adequacy Validation

- Promote standards/best practices for MCOs' online provider directory information, including:
  - Use of consistent lexicon for provider detail information.
  - Use of placeholders with consistent descriptions for provider details that are missing, such as "none" or "none specified" rather than blanks.
  - Require all directories to state the date the information was last updated for easy monitoring.
- Continue to monitor MCO complaints regarding the use of urgent care and emergency department services and review utilization trending to ensure members are not accessing these services due to an inability to identify or access PCPs.

Conclusion

The MCOs provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, the MCOs are performing well. MCOs are actively working to address deficiencies identified during the course of the review. The MCOs are able to 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 facilitate improvement in the areas of quality, access, and timeliness of care for the Maryland HealthChoice Medicaid program population.

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

Appendices/Attachments

Introduction

MCO-Specific Summaries

MCO profiles and summary findings are based on the quality assurance activities that took place in calendar years 2020-2021 for the Maryland HealthChoice program. Strengths, improvements, and opportunities for improvement are noted for each MCO, as applicable, within the tables that follow. Each table also presents whether strengths, improvements, or opportunities for improvement are related to quality (Q), access (A), and timeliness (T).

SPR Standards and Guidelines

The purpose of the SPR is to assess each MCO for the timeliness of, accessibility to, and quality of services provided to HealthChoice enrollees by conducting an assessment of the structure, processes, and outcomes of each MCO's internal quality assurance program. This assessment is completed by applying the system performance standards defined for CY 2021. Through the systems review, the team is able to identify, validate, quantify, and monitor problem areas.

Performance standards used to assess the MCOs' operational systems are developed through a review of the Code of Maryland Regulations (COMAR), federal regulations, and guidelines from other quality assurance accrediting bodies such as the National Committee for Quality Assurance (NCQA). Qlarant provides each MCO a draft of the standards in advance for review and comment within 45 calendar days from receipt. All comments are taken into consideration prior to finalizing the standards. The SPR standards are finalized after review and approval by DHQA.

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

2021 Final IRS and Methodology

This report explains the reporting strategy and analytic methods Qlarant used in developing the report card that MDH will release in 2020, based on data reported from the MCOs in CY 2021. The information reporting strategy explains the principles used to determine the most appropriate and effective methods of reporting quality information to Medicaid participants, the intended target audience. The analytic method provides a statistical basis and the analysis method used for reporting comparative MCO performance.

Report Resources

Identifies task-specific reports provided by Qlarant and where to access additional findings and comprehensive details associated with these reports.

Healthcare Effectiveness Data and Information Set. Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sources of healthcare performance measures in the United States. The program is maintained by the National Committee for Quality Assurance (NCQA). NCQA develops and publishes specifications for data collection and result calculation to promote a high degree of standardization of HEDIS measures. Reporting entities are required to register with NCQA and undergo an annual NCQA HEDIS Compliance Audit™. To ensure audit consistency, only NCQA-licensed organizations using NCQA-certified Auditors may conduct a HEDIS Compliance Audit. The audit conveys sufficient integrity to HEDIS data, such that it can be released to the public to provide consumers and purchasers with a means of comparing healthcare organization performance.

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

Consumer Assessment of Healthcare Providers and Systems. Introduced by the Agency for Healthcare Research and Quality (AHRQ) in the mid-1990s, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program encompasses the full range of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as accessibility of services and provider communication skills. The National Committee for Quality Assurance (NCQA) uses the Health Plan CAHPS survey in its Health Plan Accreditation Program as part of the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures health plan performance on important dimensions of care and service and is designed to provide purchasers and consumers with the information they need to reliably compare the performance of healthcare plans. The Health Plan CAHPS survey represents the patient (member) experience component of the HEDIS measurement set. The survey measures patient experience of care and gives a general indication of how well the health plan meets members' expectations. Parents or caretakers of surveyed members are asked to rate various aspects of the health plan based on their experience with the plan during the previous six months.

The Maryland Department of Health contracted with the Center for the Study of Services (CSS), an NCQA-certified survey vendor, to administer and report the results of the CAHPS® 5.1H Member Experience Survey. CSS administered the Adult Medicaid version of the CAHPS® Health Plan Survey for the Maryland Department of Health on behalf of the HealthChoice MCOs.

Appendix A: MCO-Specific Summaries

Aetna Better Health of Maryland (ABH) External Quality Review (EQR) Findings

Contracted Since: 2017 ● CY 2020 Enrollment: 44,422 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 3

Table 51. ABH Findings

Q	A	T	ABH Strengths, Improvements, Opportunities, and Recommendations
			Systems Performance Review
✓	✓	✓	**Strengths** • ABH demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of ABH's continuing progression to ensure quality health care delivery for their enrollees.
✓	✓	✓	**Improvements** • ABH successfully Met two of the three components in the Enrollee Rights standard identified as opportunities in the CY 2019 review. (The third was scored as baseline for the CY 2020 review.) • ABH successfully Met one of the three components in the Availability and Accessibility standard identified as opportunities in the CY 2019 review. (One was scored as baseline for the CY 2020 review.) • ABH successfully Met four of the eight components in the Utilization Review standard identified as opportunities in the CY 2019 review. • ABH successfully Met the one component in the Health Education standard identified as a Met with Opportunity in the CY 2019 review. • ABH successfully Met both components in the Fraud and Abuse standard identified as opportunities in the CY 2019 review.
N/A	✓	✓	**Opportunities** • ABH has two quarterly CAPs in the following standards: Availability and Accessibility and Utilization Review.

Q	A	T	ABH Strengths, Improvements, Opportunities, and Recommendations
✓	N/A	N/A	**Recommendations** • Enhance its current efforts to evaluate the effectiveness of its health education programs by comparing results of key metrics either pre- and post-program intervention and/or between program participants and non-program participants. Its current approach has limitations and may lead to false conclusions about program effectiveness.
			Encounter Data Validation
✓	N/A	N/A	**Strengths** • ABH appears to have an information system and processes capable of capturing complete and accurate encounter data. • ABH is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • ABH achieved match rates above the standard of 90% recommended by Qlarant in all areas of review.
✓	N/A	N/A	**Improvements** • ABH demonstrated the following improvements in its match rates: o A one percentage point increase in all inpatient codes reviewed from 99% in CY 2019 to 100% in CY 2020. o A three percentage point increase in all outpatient codes reviewed from 96% in CY 2019 to 99% in CY 2020
			Early and Periodic Screening, Diagnosis, and Treatment
✓	✓	N/A	**Strengths** • ABH achieved MDH's 80% minimum compliance threshold for four components (Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance). • Almost all elements in both the Comprehensive Physical Exam and the Health Education/Anticipatory Guidance components achieved the 80% minimum compliance threshold.
✓	✓	N/A	**Improvements** • Compared to CY 2019, all five components improved in CY 2020. • ABH's total composite rate in CY 2020 (87%) increased 8 percentage points from CY 2019 (79%).
✓	✓	N/A	**Opportunities** • ABH scored below the HealthChoice Aggregate in all five components. • The Laboratory Tests/At-Risk Screenings component score (71%) did not meet the minimum compliance threshold of 80%. • For the Health and Developmental History component, ABH did not meet the 80% minimum compliance threshold for 4 out of 11 elements.

Q	A	T	ABH Strengths, Improvements, Opportunities, and Recommendations
			• In the Comprehensive Physical Exam component, the BMI Graphing and the Graphed Head Circumference elements fell below the 80% minimum compliance threshold. • For the Laboratory Tests/At-Risk Screenings component, 9 out of 16 elements fell below the 80% minimum compliance threshold. • ABH scored below the HealthChoice Aggregate in 15 out of 16 elements in the Laboratory Tests/At-Risk Screenings component. • ABH scored below the HealthChoice Aggregate in all elements in the Immunization component and did not meet the 80% minimum compliance threshold for 7 out of 14 elements.
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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. • 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed healthcare appointments.

Q	A	T	ABH Strengths, Improvements, Opportunities, and Recommendations
			• 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.
Consumer Report Card			
✓	✓	✓	**Improvements** ★★ In one of the six performance areas (Taking Care of Women).
✓	✓	✓	**Opportunities** ★ In four of the six performance areas (Access to Care, Doctor Communication and Service, Keeping Kids Healthy, and Taking Care of Women). Note: The Care for Kids with Chronic Illness performance area had insufficient data and was noted as N/A which does not describe the performance or quality of care provided by the health plan.
Focused Review of Grievances, Appeals, and Denials			
✓	N/A	✓	**Strengths** • Consistent compliance was demonstrated in meeting the timeframes for adverse determination notifications. • Grievance records were well organized with an excellent layout and included a full description of the grievance and appropriate resolution. • All enrollee grievance letters were in plain language and fully described the grievance and the steps taken to resolve. • All appeal resolution letters were written in plain language. • All adverse determination letters were written in plain language and included a detailed explanation of the reason(s) for the determination.
✓	N/A	✓	**Improvements** • Adverse determination notifications Met or exceeded the compliance threshold in all quarters. • Consistent use of the approved appeal resolution template was demonstrated.

Q	A	T	ABH Strengths, Improvements, Opportunities, and Recommendations
✓	N/A	✓	**Opportunities** • Improve consistency in demonstrating compliance with timeframe requirements for written acknowledgement of grievances. • Improve consistency in demonstrating compliance with enrollee and provider grievance resolution, appeal resolution/notification, and pre-service determination timeframes. • Improve consistency in documenting reasonable attempts to provide enrollees with prompt verbal notice of a denial of an expedited appeal resolution. • Improve consistency in documenting reasonable attempts to provide enrollees with prompt verbal notice of an expedited appeal resolution. • Ensure adverse determination letters include correct timeframes for appeals and the continuation of benefits.
✓	N/A	✓	**Recommendations** • Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for grievances, appeals, pre-service determinations, and adverse determination notifications, including oral and written notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of adverse determination letters, including those issued by delegated entities, to ensure the accuracy of content.
Network Adequacy Validation			
N/A	✓	N/A	**Strengths** • ABH exceeded the MDH-required minimum compliance score for both routine and urgent care appointment timeframes. • ABH scored above the 80% compliance threshold established by MDH in all online validation categories and achieved 100% in Online Provider Directories Specifies Age Specifications of Patient Seen, Specifies Languages Spoken by PCP, and Specifies Practice Accommodations for Patients with Disabilities (with specifics).
N/A	✓	N/A	**Improvements** • ABH effectively implemented its two online directory CAPs from the CY 2020 validation to: o Include specifics regarding ADA accommodations for patients with disabilities, including offices, exam room(s), and equipment. The online validation category, Practice has Accommodations for Patients with Disabilities, rose from 69% in CY 2020 to 100% in CY 2021.

Q	A	T	ABH Strengths, Improvements, Opportunities, and Recommendations
			o Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory. The online validation category "PCP Accepts New Medicaid Patients and Matches Survey Response" climbed from 79% to 90%.

AMERIGROUP Community Care (ACC) External Quality Review (EQR) Findings

Contracted Since: 1999 ● CY 2020 Enrollment: 301,943 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 2

Table 52. ACC Findings

Q	A	T	ACC Strengths, Improvements, Opportunities, and Recommendations
Systems Performance Review			
✓	✓	✓	**Strengths** • ACC demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of ACC's continuing progression to ensure the delivery of quality healthcare for their enrollees.
✓	✓	✓	**Improvements** • ACC successfully Met the one component in the Oversight of Delegated Entities standard identified as an opportunity in the CY 2019 review. • ACC successfully Met the two components in the Enrollee Rights standard identified as opportunities in the CY 2019 review. • ACC successfully Met two of the eight components in the Utilization Review standard identified as opportunities in the CY 2019 review.
N/A	N/A	✓	**Opportunities** • ACC has one CAP in the following standard: Utilization Review. • ACC has one Met with Opportunity finding in the Utilization Review standard.
Performance Improvements Projects			
✓	N/A	N/A	**Strengths** • ACC has demonstrated a statistically significant improvement in the AMR rate from baseline to MY 2020.
✓	N/A	N/A	**Improvements** • ACC has demonstrated improvement in the AMR rate from MY 2019 to MY 2020.

Q	A	T	ACC Strengths, Improvements, Opportunities, and Recommendations
✓	✓	N/A	**Opportunities** • For both the AMR and Lead PIPs: o Data elements to be collected were not reported. • ACC did not demonstrate use of the Plan, Do, Study, Act cycle to test intervention effectiveness. For the Lead PIP: o Demonstrate implementation of evidence-based interventions that would likely have a positive impact on the HEDIS and VBP lead screening rates. o Implement timely and robust interventions focused on increasing the HEDIS and VBP rates. o Address MCO barriers when designing its interventions. o Demonstrate that it has completed a disparities analysis and implemented targeted interventions that are culturally and linguistically appropriate in response to identified opportunities. o Demonstrate improvement for both measures from baseline to MY 2021. o Demonstrate that reported performance improvement is related to its interventions and is statistically significant.
✓	✓	N/A	**Recommendations** • For the AMR PIP: o Develop improvement goals for each of its interventions and a methodology to evaluate the effectiveness of each intervention. o Conduct a more in-depth barrier analysis of subpopulations that have lower AMR adherence rates to inform more targeted interventions. o Consider confounding variables not only in designing new interventions but also for existing interventions as a component of the PDSA cycle. • For the Lead PIP: o Review all quantitative data to ensure it is accurately presented. o Revise interventions to focus on improving lead screening rates which may include concentrating on point-of-care testing or onsite labs. o Evaluate the effectiveness of its individual interventions against established goals and if there is minimal impact on improving outcomes among intervention participants or the priority population, ACC should either revise or terminate the intervention.

Q	A	T	ACC Strengths, Improvements, Opportunities, and Recommendations
Encounter Data Validation			
✓	N/A	N/A	**Strengths** • ACC appears to have an information system and processes capable of capturing complete and accurate encounter data. • ACC is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • ACC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review.
✓	N/A	N/A	**Improvements** • ACC demonstrated the following improvements in its match rates: o A four percentage point increase in all inpatient codes reviewed from 95% in CY 2019 to 99% in CY 2020.
Early and Periodic Screening, Diagnosis, and Treatment			
✓	✓	N/A	**Strengths** • ACC met MDH's 80% minimum compliance thresholds for four out of five components (Health and Developmental History, Comprehensive Physical Examination, Immunizations, and Health Education/Anticipatory Guidance). • Most elements in the Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components achieved the 80% minimum compliance threshold.
✓	✓	N/A	**Improvements** • ACC's total composite rate in CY 2020 (89%) increased 15 percentage points from CY 2019 (74%).
✓	✓	N/A	**Opportunities** • ACC did not meet the 80% minimum compliance threshold for 3 out of the 11 elements in the Health and Developmental History component; Recorded Perinatal History, Recorded Developmental Screening Tool, and Recorded Autism Screening Tool. • ACC did not reach the 80% minimum compliance threshold for the Graphed Head Circumference element under the Comprehensive Physical Exam component for the 2nd year in a row. • ACC's Laboratory Tests/At-Risk Screenings component score in CY 2020 (73%) noticed the most significant decline of 6 percentage points from the CY 2018 score of 79%. • ACC scored below the 80% compliance threshold in 9 of 16 elements that comprise the Laboratory Tests/At-Risk Screenings component. • For Laboratory Tests/At-Risk Screenings, the HIV Test Per Schedule element scored the lowest rate at 45% for CY 2020.

Q	A	T	ACC Strengths, Improvements, Opportunities, and Recommendations
			• For Immunizations, the score for the Influenza element (77%) did not meet the 80% minimum compliance threshold.
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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. • 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed healthcare appointments. • Remind providers that they are required to enroll in the Vaccines for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
Consumer Report Card			
✓	✓	N/A	**Strengths** ★★★ In one of the six performance areas (Keeping Kids Healthy).

Q	A	T	ACC Strengths, Improvements, Opportunities, and Recommendations
✓	✓	✓	**Opportunities** ★ In three of the six performance areas (Doctor Communication and Service, Care for Kids with Chronic Illness, Care for Adults with Chronic Illness).
			Focused Review of Grievances, Appeals, and Denials
✓	N/A	✓	**Strengths** • Consistent compliance demonstrated in meeting timeframes for enrollee grievance resolutions, pre-service determinations, and adverse determination notifications. • Enrollee grievances and steps to resolve were well described in case notes and resolution letters. • Enrollee grievance and appeal resolution and adverse determination letters were written in plain language.
✓	N/A	✓	**Improvements** • Effective management of the grievance process has resulted in improvements in case record documentation, categorization of grievances, and compliance with regulatory timeframes. • Compliance with enrollee grievance resolution timeframes has been consistently demonstrated. • Compliance with pre-service determination and adverse determination notification timeframes has been consistently demonstrated.
✓	N/A	N/A	**Opportunities** • Consistent compliance with resolving provider grievances within regulatory timeframes. • Consistency in demonstrating compliance with appeal resolution/ notification timeframes. • Adverse determination letters include correct timeframes for appeals and the continuation of benefits.
✓	N/A	N/A	**Recommendations** • Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for provider grievances and enrollee appeals. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of adverse determination letters to ensure accuracy of content.
			Network Adequacy Validation
N/A	✓	N/A	**Strengths** • ACC exceeded the MDH-required minimum compliance score for both routine and urgent care appointment timeframes. • ACC's online provider directory has an option to chat with a live member services representative. The directory also allows an enrollee to compare multiple providers side-by-side.

Q	A	T	ACC Strengths, Improvements, Opportunities, and Recommendations
			• ACC scored above the 80% percent compliance threshold established by MDH in all areas of the online provider directory, achieved 100% in Online Provider Directories Specifies Languages Spoken by PCP, and scored 99% in PCP's Practice Telephone Number Matched Survey Response and Online Provider Directories Specifies Languages Spoken by PCP.

CareFirst Community Health Plan (CFCHP) External Quality Review (EQR) Findings

Contracted Since: 2013 (originally Riverside Health of Maryland, acquired in 2015 as University of Maryland Health Partners, acquired in fall 2020) ● CY 2020 Enrollment: 53,013 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 4

Table 53. CFCHP Findings

Q	A	T	CFCHP Strengths, Improvements, Opportunities, and Recommendations
Systems Performance Review			
✓	✓	✓	**Strengths** • CFCHP demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of CFCHP's continuing progression to ensure the delivery of quality healthcare for their enrollees.
✓	✓	✓	**Improvements** • CFCHP successfully Met the three components in the Availability and Accessibility standard identified as opportunities in the CY 2019 review. • CFCHP successfully Met four of the seven components in the Utilization Review standard identified as opportunities in the CY 2019 review. • CFCHP successfully Met the one component in the Fraud and Abuse standard identified as an opportunity in the CY 2019 review.
✓	✓	✓	**Opportunities** • CFCHP has two CAPs in the Enrollee Rights and Utilization Review standards. • CFCHP has two Met with Opportunity findings in the Utilization Review standard.
✓	NA	NA	**Recommendations** • Update the Continuity and Coordination between Medical Care and Behavioral Healthcare Procedure document to reflect the current MCO name and the names of system partners. While procedures are still relevant, the document is very outdated.

Q	A	T	CFCHP Strengths, Improvements, Opportunities, and Recommendations
Performance Improvements Projects			
✓	✓	N/A	**Strengths** • CFCHP has demonstrated sustained and statistically significant improvement from baseline for its AMR PIP. • CFCHP has demonstrated sustained and statistically significant improvement from baseline for both the Lead PIP HEDIS and VBP rates.
✓	✓	N/A	**Improvements** • CFCHP demonstrated improvement in the AMR rate from CY 2019 to CY 2020. • CFCHP demonstrated improvement in the VBP lead screening rate from CY 2019 to CY 2020.
✓	✓	N/A	**Opportunities** • For both PIPs: o Utilize the SMART formula for goal setting in designing and evaluating interventions. o Conduct an in-depth analysis to identify the barriers (member, provider, and MCO) impacting the lower rates among its population subgroups and develop targeted interventions to address identified opportunities. o Demonstrate the continuous use of the PDSA cycle, including evaluations of tests of change. o Describe its process to identify possible causes and solutions to refine or terminate interventions if tests of change are not successful. • For the AMR PIP: o Quality oversight of the PIP process and submission. o Accurate and consistent results, including changes from baseline to the current MY and results of statistical significance testing. o MCO system-wide barriers in addition to member and provider barriers identified when developing interventions. • For the Lead PIP: o Identify lessons learned in response to any declines in performance. o Demonstrate interventions that are evidence-based, including the reference to the study. o Address provider barriers in addition to member and MCO barriers when developing its interventions.
✓	✓	N/A	**Recommendations** • For both PIPs: o Ensure all quantitative data is accurately presented.

Q	A	T	CFCHP Strengths, Improvements, Opportunities, and Recommendations
			○ Compare performance to the approved long-term goal of 68.00% in addition to any other goals/benchmarks it has selected for comparison. • For the AMR PIP: ○ Develop a methodology for evaluating the effectiveness of each intervention against an established AMR goal. ○ Ensure successful interventions are adequately resourced to maximize their impact on the AMR rate. • For the Lead PIP: ○ Provide an explanation as to how any identified factors may influence comparability between baseline and remeasurements. ○ Ensure that its PIP submissions focus on the MY year under review and limit any reference to the next MY to follow-up activities planned for that year. ○ Evaluate the effectiveness of its individual interventions against established goals and if there is minimal impact on improving outcomes among intervention participants or the priority population, CFCHP should either revise or terminate the intervention.
Encounter Data Validation			
✓	N/A	N/A	**Strengths** • CFCHP appears to have an information system and processes capable of capturing complete and accurate encounter data. • CFCHP is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • CFCHP achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. • CFCHP has shown an upward trend in matched inpatient encounters for three successive years.
✓	N/A	N/A	**Improvements** • CFCHP demonstrated the following improvements in its match rates: ○ A four percentage point increase in all inpatient codes reviewed from 95% in CY 2019 to 99% in CY 2020.
Early and Periodic Screening, Diagnosis, and Treatment			
✓	✓	N/A	**Strengths** • CFCHP met MDH's 80% minimum compliance threshold for three components: Health and Developmental History, Comprehensive Physical Exam, and Health Education/Anticipatory Guidance.

Q	A	T	CFCHP Strengths, Improvements, Opportunities, and Recommendations
			• Almost all elements in both the Comprehensive Physical Exam and the Health Education/Anticipatory Guidance components achieved the 80% minimum compliance threshold.
✓	✓	N/A	**Improvements** • CFCHP's CY 2020 score for the Depression Screening (81%) improved by 18 percentage points from CY 2019 (63%) and 5 percentage points since CY 2018 (76%), exceeding the MDH established minimum compliance threshold (80%). • CFCHP's score for Documented Referral to Dentist (87%) improved 14 percentage points from CY 2019 score (73%). • CFCHP's total composite rate in CY 2020 (87%) increased 10 percentage points from CY 2019 (77%).
✓	✓	N/A	**Opportunities** • CFCHP scored below the HealthChoice Aggregate in four out of five components. Its score for Health Education/Anticipatory Guidance matched the HealthChoice Aggregate. • The Laboratory Tests/At-Risk Screenings (71%) and Immunizations (79%) component scores did not meet the minimum compliance threshold of 80%. • For the Health and Developmental History component, CFCHP did not meet the 80% minimum compliance threshold for 3 out of 11 elements. • In the Comprehensive Physical Exam component, the Graphed Head Circumference element fell below the 80% minimum compliance threshold. • For the Laboratory Tests/At-Risk Screenings component, 9 out of 16 elements fell below the 80% minimum compliance threshold. • CFCHP scored below the HealthChoice Aggregate in all elements in the Laboratory Tests/At-Risk Screenings component, except Recorded Cholesterol Risk Assessment, 3-5 Year (Baseline) Blood Lead Test, and 3-5 Year Anemia Test. • CFCHP scored below the HealthChoice Aggregate in all elements in the Immunization component, except Rotavirus, and did not meet the 80% minimum compliance threshold for 7 out of 14 elements.
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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.

Q	A	T	CFCHP Strengths, Improvements, Opportunities, and Recommendations
			• 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed healthcare appointments. • Remind providers that they are required to enroll in the Vaccine for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
Consumer Report Card			
✓	✓	✓	**Opportunities** ★ In three of the six performance areas (Doctor Communication and Service, Care for Kids with Chronic Illness Care for Adults with Chronic Illness).
Focused Review of Grievances, Appeals, and Denials			
✓	N/A	✓	**Strengths** • Consistent compliance in meeting grievance resolution, appeal resolution/notification, and adverse determination notification timeframes was demonstrated throughout the review period. • Grievance resolution letters provide a full description of the grievance and the required steps to resolve. • All appeal resolution letters provided extremely detailed information in plain language to explain the reasoning for an uphold or overturn of the initial denial.

Q	A	T	CFCHP Strengths, Improvements, Opportunities, and Recommendations
✓	N/A	N/A	**Improvements** • Appropriate categorization of grievances. • Timely mailing of enrollee grievance resolution letters. • Consistent use of the adverse determination letter template.
✓	N/A	✓	**Opportunities** • Grievance resolution letters are supported by comprehensive case notes with full documentation of the grievance and required steps to resolve it. • Billing/financial-related enrollee grievances. • Compliance with sending written acknowledgment of enrollee grievances within five calendar days. • Consistent compliance with verbal notification of a denial of an expedited appeal request. • Consistent compliance with pre-service determination timeframes. • Adverse determination letters provide an explanation of requested service in plain language.
✓	N/A	✓	**Recommendations** • Retrain grievance staff on required case documentation and routinely audit a sample of cases to ensure compliance. • Consider conducting a root cause analysis of billing/financial-related enrollee grievances to identify opportunities for improvement. • Monitor timeliness of mailing of grievance acknowledgment letters on a routine basis. • Retrain appeal staff on the requirement for making a reasonable attempt to provide verbal notification of a denial of an expedited appeal request and routinely audit a sample of cases to ensure compliance. • Ensure an effective process is in place for monitoring compliance with regulatory timeframes for pre-service determinations. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of adverse determination letters to ensure consistent use of plain language.
Network Adequacy Validation			
N/A	✓	N/A	**Strengths** • CFCHP exceeded the MDH-required minimum compliance score for both routine and urgent care appointment timeframes. • CFCHP scored above the 80% compliance threshold established by MDH in all online validation categories, achieved 100% in PCP Listed in Online Directory, PCP's Practice Location Matched Survey Response, Online Provider Directories Specifies Age Specifications of Patient Seen, Specifies Languages Spoken by PCP, and scored over 99% in

Q	A	T	CFCHP Strengths, Improvements, Opportunities, and Recommendations
			PCP's Practice Telephone Number Matched Survey Response and Online Provider Directories Specifies Practice Accommodations for Patients with Disabilities (with specifics).

Jai Medical Systems, Inc. (JMS) External Quality Review (EQR) Findings

Contracted Since: 1997 ● CY 2020 Enrollment: 28,981 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 1

Table 54. JMS Findings

Q	A	T	JMS Strengths, Improvements, Opportunities, and Recommendations
Systems Performance Review			
✓	✓	✓	**Strengths** • JMS demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of JMS' continuing progression to ensure the delivery of quality healthcare for their enrollees.
✓	N/A	✓	**Improvements** • In CY 2020, JMS successfully addressed the three Met with Opportunity findings in the Utilization Review standard from the CY 2019 review.
✓	✓	N/A	**Opportunities** • Baseline components introduced in the CY 2020 review have opportunity for improvement in the next CY's SPR: o Standard 5 – Enrollee Rights, Element 5.11 o Standard 6 – Availability and Accessibility, Element 6.4
Performance Improvements Projects			
✓	✓	N/A	**Strengths** • JMS is performing above the HEDIS 2020 Medicaid 90th percentile for both the AMR and HEDIS Lead Screening rates. • JMS is the only MCO with Maryland VBP rates for lead screening that are in the incentive benchmark range. • JMS has demonstrated sustained improvement in the AMR rate over baseline.
✓	✓	N/A	**Opportunities** • For the AMR PIP: o Identify a specific goal for each intervention that will support an evaluation of its individual effectiveness. o Develop interventions to address MCO-specific barriers.

Q	A	T	JMS Strengths, Improvements, Opportunities, and Recommendations
			• For the Lead PIP: o Identify lessons learned in response to any decreases in the HEDIS®[8] or VBP lead screening rates. o Demonstrate improvement for both measures from baseline to MY 2021. o Demonstrate that any reported improvement from baseline to the current MY is statistically significant.
✓	✓	N/A	**Recommendations** • For the AMR PIP: o Identify barriers based upon a more in-depth analysis. • For the Lead PIP: o Review all quantitative data to ensure it is accurately presented. o Provide the source of any benchmark it is using for annual lead screening goals. Additionally, if JMS elects to have annual goals, they should be set above the baseline rate since the goal of a PIP is to improve the selected measure(s). o Focus its efforts on the VBP population, non-JMS providers, and Anne Arundel County that appear to present the greatest opportunities for improvement, including conducting an in-depth barrier analysis to inform targeted interventions. o Establish an individual goal for improvement in the lead screening measures using the Specific-Measurable-Achievable-Relevant-Time Bound (SMART) formula for each intervention. o Revise the goal for the percentage of children being screened after the education mailer is received to a higher percentage in order to increase the impact of the intervention. o Partner with local, community-based organizations and faith-based institutions that serve African American populations to increase its understanding of the barriers to lead testing and developing targeted interventions to address them. o Enlist the support of its core contracted centers to increase its percentage of members identified by race. o Evaluate the effectiveness of its individual interventions against established goals and if there is minimal impact on improving outcomes among intervention participants or the priority population, JMS should either revise or terminate the intervention.

[8] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Q	A	T	JMS Strengths, Improvements, Opportunities, and Recommendations
Encounter Data Validation			
✓	N/A	N/A	**Strengths** • JMS appears to have an information system and processes capable of capturing complete and accurate encounter data. • JMS is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • JMS achieved match rates above the standard of 90% recommended by Qlarant in all areas of review.
✓	N/A	N/A	**Improvements** • JMS demonstrated the following improvements in its match rates: o A three percentage point increase in all outpatient codes reviewed from 97% in CY 2019 to 100% in CY 2020.
Early and Periodic Screening, Diagnosis, and Treatment			
✓	✓	N/A	• JMS met MDH's 80% minimum compliance threshold for all five components (Health and Developmental History, Comprehensive Physical Exam, Laboratory Tests/At-Risk Screenings, Immunizations, and Health Education/Anticipatory Guidance). • All elements in the Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components achieved the 80% minimum compliance threshold. • JMS has sustained high-scoring component results.
✓	✓	N/A	**Opportunities** • The Laboratory Tests/At-Risk Screenings component score of 92% in CY 2020 noticed the most significant decline of seven percentage points from the CY 2018 score of 99%. • JMS element scores declined from CY 2019 scores in 12 Month Blood Lead Test, 24 Month Blood Lead Test, 3-5 Year (Baseline) Blood Lead Test, 12 Month Anemia Test, 24 Month Anemia Test, and 3-5 Year Anemia Test. The largest decline was in the 3-5 Year Anemia Test element, where JMS' score declined 7 percentage points from the CY 2019 score of 100% to 93% in CY 2020.
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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.

Q	A	T	JMS Strengths, Improvements, Opportunities, and Recommendations
			• 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed healthcare appointments. • Remind providers that they are required to enroll in the Vaccine for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
Consumer Report Card			
✓	✓	✓	**Strengths** ★★★ in four of the six performance areas (Doctor Communication and Service, Keeping Kids Healthy, Taking Care of Women, and Care for Adults with Chronic Illness). Note: The Care for Kids with Chronic Illness performance area had insufficient data and was noted as N/A, which does not describe the performance or quality of care provided by the health plan.

Q	A	T	JMS Strengths, Improvements, Opportunities, and Recommendations
Focused Review of Grievances, Appeals, and Denials			
✓	N/A	N/A	**Strengths** • All grievance resolution timeframes were consistently Met during the review period. • All enrollee grievance letters were written in plain language with a full description of the grievance and an appropriate resolution. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
✓	N/A	N/A	**Improvements** • Consistent compliance was demonstrated with resolution timeframes for enrollee grievances.
✓	N/A	✓	**Opportunities** • Billing/financial enrollee grievances. • Consistent compliance with pre-service determination and adverse determination notification timeframes.
✓	N/A	✓	**Recommendations** • Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for pre-service determinations and adverse determination notification timeframes. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of billing/financial-related enrollee grievances to identify opportunities for improvement.
Network Adequacy Validation			
N/A	✓	N/A	**Strengths** • JMS exceeded the MDH-required minimum compliance score for both routine and urgent care appointment timeframes. • JMS' online provider directory denotes within a provider's profile telemedicine options available, as well as their telemedicine availability and the telemedicine application options (e.g., Zoom). JMS also reports temporary COVID-19 hours, when applicable. • JMS achieved compliance with six out of the seven requirements for validation of the online provider directories. Additionally, JMS achieved 100% in PCP Listed in Online Directory, PCP's Practice Location Matched Survey Response, Online Provider Directories Specifies Age Specifications of Patient Seen, and Specifies Languages Spoken by PCP and 99% in PCP's Practice Telephone Number Matched Survey Response.

Q	A	T	JMS Strengths, Improvements, Opportunities, and Recommendations
N/A	✓	N/A	**Opportunities** • JMS' online provider directory specifying PCPs that accept new Medicaid patients for the listed MCO does not always align with survey responses.
N/A	✓	N/A	**Recommendations** • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory.

Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS) External Quality Review (EQR) Findings

Contracted Since: 2014 ● CY 2020 Enrollment: 93,909 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 4

Table 55. KPMAS Findings

Q	A	T	KPMAS Strengths, Improvements, Opportunities, and Recommendations
			Systems Performance Review
✓	✓	✓	**Strengths** • KPMAS demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of KPMAS' continuing progression to ensure the delivery of quality healthcare for their enrollees.
✓	✓	✓	**Improvements** • KPMAS successfully Met the three components in the Oversight of Delegated Entities standard identified as an opportunity in the CY 2019 review. • KPMAS successfully Met the five components in the Enrollee Rights standard identified as opportunities in the CY 2019 review. • KPMAS successfully Met four of the six components in the Utilization Review standard identified as opportunities in the CY 2019 review. • KPMAS successfully Met one of the two components in the Utilization Review standard identified as Met with Opportunity findings in the CY 2019 review.
✓	N/A	✓	**Opportunities** • KPMAS has two CAPs in the following standards: Utilization Review and Fraud and Abuse. • KPMAS has one Met with Opportunity finding in the Utilization Review standard.
N/A	N/A	✓	**Recommendations** • Consider adding enrollee notification timeline adherence to the Release of Medical Information Service Center process document.

Q	A	T	KPMAS Strengths, Improvements, Opportunities, and Recommendations
			• Clarify the standard timeframe applies to outpatient pharmacy adverse determinations if KPMAS wishes to continue referring to notification timeframes in the Assessing Compliance MD HealthChoice Determination and Notifications Policy in its MD HealthChoice Pharmacy Service Authorizations Policy.
Performance Improvements Projects			
✓	✓	N/A	**Strengths** • KPMAS is performing above the HEDIS 2020 Medicaid 90th percentile for both the AMR and Lead Screening rates. • KPMAS demonstrated sustained improvement from baseline to MY 2020 for the AMR PIP.
✓	N/A	N/A	**Opportunities** • For the AMR PIP: o Include in its qualitative analysis any factors that may influence comparability between baseline and repeat measurements for impact or describe its process for analysis if there are none. o Identify lessons learned for any decline in performance from the prior MY. o Demonstrate that its interventions are evidence-based. o Demonstrate more robust interventions in response to identified barriers that include a SMART goal and methodology for evaluating effectiveness. o Conduct an in-depth barrier analysis to inform targeted interventions that address subpopulation groups who have a lower AMR rate. o Demonstrate that improvement in the AMR rate from baseline to the current measurement is statistically significant. • For the Lead PIP: o Present its numerical PIP results and findings accurately and clearly.
✓	✓	N/A	**Recommendations** • For the AMR PIP: o Develop more robust, measurable interventions in the future to ensure further improvement in its AMR rate. • For the Lead PIP: o Establish an individual goal for improvement in the lead screening measures using the Specific-Measurable-Achievable-Relevant-Time Bound (SMART) formula for each intervention. o Combine the Dedicated Medicaid Outreach Team and the Centralized Telephone Outreach Dashboard into one intervention as their effectiveness cannot be measured independently of one another.

Q	A	T	KPMAS Strengths, Improvements, Opportunities, and Recommendations
			o Work with local, community-based organizations and faith-based institutions that serve African American populations to better understand barriers to screening and target interventions in response to identified opportunities within its African American lead screening population.
Encounter Data Validation			
✓	N/A	N/A	**Strengths** • KPMAS appears to have an information system and processes capable of capturing complete and accurate encounter data. • KPMAS is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • KPMAS achieved match rates above the standard of 90% recommended by Qlarant in all areas of review.
✓	N/A	N/A	**Improvements** • KPMAS demonstrated the following improvements in its match rates: o A one percentage point increase in all outpatient codes reviewed from 99% in CY 2019 to 100% in CY 2020.
Early and Periodic Screening, Diagnosis, and Treatment			
✓	✓	N/A	**Strengths** • All of the elements in the Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components achieved MDH's 80% minimum compliance threshold. • KPMAS has sustained high-scoring component results.
✓	✓	N/A	**Opportunities** • The Laboratory Tests/At-Risk Screenings component score of 90% in CY 2020 noticed the most significant decline of 6 percentage points from the CY 2018 score of 96%. • KPMAS' element scores declined from the CY 2019 scores in 9-11 Year Dyslipidemia Lab Test, 12 Month Blood Lead Test, Referral to Lab for Blood Lead Test, and 12 Month Anemia Test. The largest decline was in the 9-11 Year Dyslipidemia Lab Test, where KPMAS' score declined 9 percentage points from the CY 2019 score of 69% to 60% in CY 2020. • KPMAS did not meet the MDH-established 80% minimum compliance threshold for the 9-11 Year Dyslipidemia Lab Test (60%) and the 12 Month Blood Lead Test (79%) elements.

Q	A	T	KPMAS Strengths, Improvements, Opportunities, and Recommendations
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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. • 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed healthcare appointments. • Remind providers that they are required to enroll in the Vaccinations for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
Consumer Report Card			
✓	✓	✓	**Strengths** ★★★ In four of the six performance areas (Doctor Communication and Service, Keeping Kids Healthy, Taking Care of Women, and Care for Adults with Chronic Illness). Note: The Care for Kids with Chronic Illness performance area had insufficient data and was noted as N/A which does not describe the performance or quality of care provided by the health plan.

Q	A	T	KPMAS Strengths, Improvements, Opportunities, and Recommendations
✓	✓	N/A	**Improvements** ★★★ In one of the six performance areas (Doctor Communication and Service).
			Focused Review of Grievances, Appeals, and Denials
✓	N/A	✓	**Strengths** • Consistent compliance was demonstrated in meeting the timeframes for the resolution of enrollee grievances, pre-service determinations, and adverse determination notifications. • Thorough documentation of grievance and required steps to resolve, was evident in all case notes of records reviewed. • Appeal resolution letters were written in plain language. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
✓	N/A	N/A	**Improvements** • Consistent compliance was demonstrated in sending an acknowledgment of grievance receipt to enrollees and resolving grievances within regulatory timeframes. • Grievance resolution letters consistently include a description of the grievance and its resolution. • Adverse determination letters reflect accurate calculation of appeal filing deadlines.
✓	N/A	✓	**Opportunities** • Consistent compliance with sending enrollees a grievance resolution letter. • High percentage of attitude/service-related enrollee grievances. • Consistent compliance with appeal resolution/notification timeframes. • MDH-approved appeal letter templates are consistently used. • Consistent compliance with verbal and written notification of denial of an expedited appeal request.
✓	N/A	✓	**Recommendations** • Conduct routine audits of enrollee records to ensure that all grievances receive a written resolution letter. • Consider conducting a root cause analysis of service/attitude-related enrollee grievances to identify opportunities for improvement. • Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for appeal resolutions/notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Conduct routine audits of enrollee records to ensure consistent use of appeal letter templates.

Q	A	T	KPMAS Strengths, Improvements, Opportunities, and Recommendations
			• Retrain appeal staff and audit appeal case records to ensure there is documentation of a reasonable attempt to provide verbal and written notification of denial of an expedited appeal request.
Network Adequacy Validation			
N/A	✓	N/A	**Strengths** • KPMAS exceeded the MDH-required minimum compliance score for the routine care appointment timeframe. • KPMAS' online provider directory has options within a provider's profile to obtain directions to the provider's office from the enrollee's desired location via driving, transit, cycle, or walking. KPMAS also has the option to text or email a selected provider's profile information. • KPMAS scored above the 80% threshold in six out of seven categories, achieved 100% in PCP's Practice Telephone Number Matched Survey Response, Online Provider Directories Specifies Age Specifications of Patient Seen, Specifies Languages Spoken by PCP, achieved 99% in PCP Listed in Online Directory, and scored 98% percent in PCP's Practice Location Matched Survey Response.
N/A	✓	N/A	**Opportunities** • Compliance with the MDH-required minimum score for urgent care appointment timeframe. • KPMAS demonstrated a continued opportunity for improvement identified in the CY 2019 and CY 2020 validation to: o Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory.
N/A	✓	N/A	**Recommendations** • Ensure the MDH-required minimum compliance score for urgent care appointment timeframe is met. • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.

Maryland Physicians Care (MPC) External Quality Review (EQR) Findings

Contracted Since: 1997 ● CY 2020 Enrollment: 228,201 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 2

Table 56. MPC Findings

Q	A	T	MPC Strengths, Improvements, Opportunities, and Recommendations
Systems Performance Review			
✓	✓	✓	**Strengths** • MPC demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of MPC's continuing progression to ensure the delivery of quality healthcare for their enrollees.
✓	✓	✓	**Improvements** • MPC successfully Met the one component in the Enrollee Rights standard identified as a Met with Opportunity in the CY 2019 review. • MPC successfully Met the two components in the Availability and Accessibility standard identified as opportunities in the CY 2019 review. • MPC successfully Met four of the five components in the Utilization Review standard identified as opportunities in the CY 2019 review.
✓	N/A	✓	**Opportunities** • MPC has one Met with Opportunity finding in the Utilization Review standard.
Performance Improvements Projects			
✓	N/A	N/A	**Improvements** • MPC demonstrated improvement in the AMR rate from MY 2019 to MY 2020.
✓	✓	N/A	**Opportunities** • Both PIPs: o Demonstrate that improvement in performance appears to be the result of its interventions or is a statistically significant improvement from baseline to MY 2020. • For the AMR PIP: o Demonstrate that its interventions are evidence-based.

Q	A	T	MPC Strengths, Improvements, Opportunities, and Recommendations
			○ Demonstrate that it has a process in place to identify possible causes and solutions to refine or terminate an intervention if tests of change are not successful. • For the Lead PIP: ○ Identify any lessons learned for any decrease in measure performance. ○ Demonstrate improvement from baseline to MY 2020.
✓	✓	N/A	**Recommendations** • For the AMR PIP: ○ Ensure that all quantitative data is accurately presented. ○ Develop measurable goals for additional AMR interventions using the SMART formula and a methodology for evaluating the effectiveness of individual interventions on the AMR rate. ○ In interpreting the extent to which its improvement strategy was successful, include only those interventions where it has objective data based upon an evaluation of the effectiveness of the intervention in increasing the AMR rate. • For the Lead PIP: ○ Use the MDH reported VBP baseline rate in all future submissions. ○ Establish a goal for improvement in the lead screening measures using the Specific-Measurable-Achievable-Relevant-Time Bound (SMART) formula for each intervention. ○ Partner with local community-based organizations and faith-based institutions that serve African American populations, to increase its understanding of the barriers to lead testing and develop targeted interventions to address them. ○ Evaluate the effectiveness of its individual interventions against established goals and if there is minimal impact on improving outcomes among intervention participants or the priority population, either revise or terminate the intervention and develop more impactful and sustainable interventions.
Encounter Data Validation			
✓	N/A	N/A	**Strengths** • MPC appears to have an information system and processes capable of capturing complete and accurate encounter data. • MPC is capturing the appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • MPC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review.

Q	A	T	MPC Strengths, Improvements, Opportunities, and Recommendations
✓	N/A	N/A	**Improvements** • MPC demonstrated the following improvements in its match rates: o A three percentage point increase in all outpatient codes reviewed from 97% in CY 2019 to 100% in CY 2020.
Early and Periodic Screening, Diagnosis, and Treatment			
✓	✓	N/A	**Strengths** • MPC met MDH's 80% minimum compliance threshold in four of the five components (Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance). • Most of the elements in the Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components achieved the 80% minimum compliance threshold.
✓	✓	N/A	**Improvements** • MPC's total composite rate in CY 2020 (89%) increased 11 percentage points from CY 2019 (78%).
✓	✓	N/A	**Opportunities** • MPC did not meet the 80% minimum compliance threshold for 3 out of the 11 elements in the Health and Developmental History component; Recorded Perinatal History, Recorded Maternal Depression Screening, and Depression Screening. • MPC did not reach the 80% minimum compliance threshold for the Graphed Head Circumference element under the Comprehensive Physical Exam component for the 2nd year in a row. • MPC's Laboratory Tests/At-Risk Screenings component score in CY 2020 (72%) noticed the most significant decline of 13 percentage points from the CY 2018 score of 85%. • MPC scored below the HealthChoice Aggregate in 12 of the 16 elements that comprise the Laboratory Tests/At-Risk Screenings component. • For Laboratory Tests/At-Risk Screenings, the 9-11 Year Dyslipidemia Lab Test scored the lowest rate at 31% for CY 2020.
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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.

Q	A	T	MPC Strengths, Improvements, Opportunities, and Recommendations
			• 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer children who fail to make health care appointments to the local health department for assistance in bringing them into care. • Remind providers that they are required to enroll in the Vaccinations for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
Consumer Report Card			
✓	✓	N/A	**Strengths** ★★★ In one of the six performance areas (Doctor Communication and Service).
✓	✓	✓	**Improvements** ★★★ In one of the six performance areas (Doctor Communication and Service). ★★ In two of the six performance areas (Keeping Kids Healthy and Care for Adults with Chronic Illness).
✓	✓	N/A	**Opportunities** ★ In one of the six performance areas (Taking Care of Women).
Focused Review of Grievances, Appeals, and Denials			
✓	N/A	✓	**Strengths** • Consistent compliance in meeting timeframes for grievances, pre-service determinations, and adverse determination notifications was demonstrated throughout the review period.

Q	A	T	MPC Strengths, Improvements, Opportunities, and Recommendations
			• Case notes were very detailed in describing the grievance and steps to resolve. • All grievance letters were written in plain language and describe the grievance and its resolution. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial.
✓	N/A	✓	**Improvements** • Consistent compliance was demonstrated in meeting all grievance resolution timeframes. • Appeals are consistently processed based on the level of urgency. • Receipt date of the appeal is not revised to reflect the date of written consent. • Appeal decisions are made by health care professionals with appropriate clinical expertise consistent with the MCO's policies.
✓	N/A	✓	**Opportunities** • Consistent compliance with timeframes for appeal resolution/notification. • All appeal resolution letters are written in plain language.
✓	N/A	✓	**Recommendations** • Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for appeals. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Routinely audit a sample of appeal resolution letters to ensure they are written in plain language. Retrain letter staff, as indicated.
Network Adequacy Validation			
N/A	✓	N/A	**Strengths** • MPC exceeded the MDH-required minimum compliance score for both routine and urgent care appointment timeframes. • MPC achieved compliance with six out of the seven requirements for validation of the online provider directories. Additionally, MPC achieved 100% in Online Provider Directories Specifies Age Specification of Patient Seen and Specifies Languages Spoken by PCP and scored over 98% in PCP Listed in Online Directory and Online Provider Directories Specifies Practice Accommodations for Patients with Disabilities.
N/A	✓	N/A	**Opportunities** • MPC's online provider directory specifying PCPs that accept new Medicaid patients for the listed MCO does not always align with survey responses.

Q	A	T	MPC Strengths, Improvements, Opportunities, and Recommendations
N/A	✓	N/A	**Recommendations** • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.

MedStar Family Choice, Inc. (MSFC) External Quality Review (EQR) Findings

Contracted Since: 1997 ● CY 2020 Enrollment: 99,962 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 2

Table 57. MSFC Findings

Q	A	T	MSFC Strengths, Improvements, Opportunities, and Recommendations
Systems Performance Review			
✓	✓	✓	**Strengths** • MSFC demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of MSFC's continuing progression to ensure the delivery of quality healthcare for their enrollees.
✓	N/A	✓	**Improvements** • MSFC successfully Met the three components in the Utilization Review standard identified as opportunities in the CY 2019 review.
N/A	✓	N/A	**Recommendations** • Clarify in the Credentialing Criteria Policy that the Maryland ePREP site must be queried to verify provider enrollment in Maryland Medicaid at the time of initial credentialing. • Clarify in the Credentialing Criteria Policy that the Maryland ePREP site must be queried to verify provider enrollment in Maryland Medicaid at the time of recredentialing.
Performance Improvements Projects			
✓	✓	N/A	**Strengths** • MSFC demonstrated statistically significant improvement in the VBP rate for the Lead PIP from baseline to MY 2020.
✓	✓	N/A	**Improvements** • MSFC demonstrated improvement in the AMR rate from MY 2019 to MY 2020. • MSFC demonstrated improvement in the Lead PIP VBP rate from MY 2019 to MY 2020.
✓	✓	N/A	**Opportunities** • For both PIPS:

Q	A	T	MSFC Strengths, Improvements, Opportunities, and Recommendations
			○ Demonstrate that it has conducted a disparities analysis to identify subpopulations that have a lower rate and developed interventions in response to identified barriers. • For the AMR PIP: ○ Demonstrate that it has an effective process in place that identifies possible causes and solutions to refine or terminate interventions if tests of change were not successful. ○ Demonstrate improvement from baseline that appears to be the result of quality improvement interventions or is statistically significant. • For the Lead PIP: ○ Identify lessons learned in response to any decrease in either the HEDIS or Value-Based Purchasing (VBP) measures. ○ Demonstrate improvement for the HEDIS measure from baseline to MY 2020.
✓	✓	N/A	**Recommendations** • For the AMR PIP: ○ Revise its goal statement to include an annual goal for improvement in the AMR rate based upon the intervention. ○ Implement new interventions early in the MY to have a meaningful impact of any positive changes on the AMR rate. • For the Lead PIP: ○ Establish an individual goal for improvement in the lead screening measures using the Specific-Measurable-Achievable-Relevant-Time Bound (SMART) formula for each intervention.
Encounter Data Validation			
✓	N/A	N/A	**Strengths** • MSFC appears to have an information system and processes capable of capturing complete and accurate encounter data. • MSFC is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • MSFC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. • MSFC has shown an upward trend in matched office visit encounters for three successive years.
✓	N/A	N/A	**Improvements** • MSFC demonstrated the following improvements in its match rates:

Q	A	T	MSFC Strengths, Improvements, Opportunities, and Recommendations
			○ A significant 10 percentage point increase in all outpatient codes reviewed from 90% in CY 2019 to 100% in CY 2020. ○ A one percentage point increase in all office visit codes reviewed from 99% in CY 2019 to 100% in CY 2020.
Early and Periodic Screening, Diagnosis, and Treatment			
✓	✓	N/A	**Strengths** • MSFC achieved the MDH's 80% minimum compliance thresholds for four out of five components (Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance). • Most elements in the Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components achieved the 80% minimum compliance threshold.
✓	✓	N/A	**Improvements** • MSFC's total composite rate in CY 2020 (90%) increased 4 percentage points from CY 2019 (86%).
✓	✓	N/A	**Opportunities** • MSFC did not meet the 80% minimum compliance threshold for 2 out of the 11 elements in the Health and Developmental History component; Recorded Perinatal History and Recorded Maternal Depression Screening. • MSFC did not reach the 80% minimum compliance threshold for the Graphed Head Circumference element under the Comprehensive Physical Exam component for the 2nd year in a row. • MSFC's Laboratory Tests/At-Risk Screenings component score in CY 2020 (73%) noticed the most significant decline of 9 percentage points from the CY 2018 score (82%). • The CY 2020 Immunizations component score (85%) noticed the second most significant decline of 8 percentage points from the CY 2018 score (93%). • MSFC scored below the HealthChoice Aggregate in 11 of the 16 elements that comprise the Laboratory Tests/At-Risk Screenings component and 9 elements did not reach the 80% minimum compliance threshold. • For Laboratory Tests/At-Risk Screenings, the 9-11 Year Dyslipidemia Lab Test scored the lowest rate at 40% for CY 2020.
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests.

Q	A	T	MSFC Strengths, Improvements, Opportunities, and Recommendations
			• Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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. • 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed healthcare appointments. • Remind providers that they are required to enroll in the Vaccination for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
Consumer Report Card			
✓	✓	N/A	**Strengths** ★★★ In one of the six performance areas (Access to Care).
✓	✓	✓	**Opportunities** ★ In three of the six performance areas (Keeping Kids Healthy, Taking Care of Women, Care for Adults with Chronic Illness).
Focused Review of Grievances, Appeals, and Denials			
✓	N/A	✓	**Strengths** • Consistent compliance was demonstrated with all timeframes for grievances, appeals, pre-service determinations, and adverse determination notifications.

Q	A	T	MSFC Strengths, Improvements, Opportunities, and Recommendations
			• Case notes and resolution letters fully describe the grievance and steps to resolve. • All grievance letters were written in plain language. • All appeal resolution letters are in plain language and provide a detailed explanation of the reason for the upheld decision. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. • Enrollee resolution letters related to provider quality of service grievances include the provider's response.
✓	N/A	✓	**Improvements** • Consistent compliance was demonstrated with meeting regulatory timeframes for enrollee grievance resolutions. • Consistent compliance was demonstrated with meeting regulatory timeframes for pre-service determinations and adverse determination notifications.
✓	N/A	✓	**Opportunities** • Appeal receipt date is not changed to reflect the date of enrollee consent.
✓	N/A	✓	**Recommendations** • Retrain appeals staff to ensure the appeal receipt date is not revised to the date of written consent and revise appeal policies and procedures accordingly.
Network Adequacy Validation			
N/A	✓	N/A	**Strengths** • MSFC exceeded the MDH-required minimum compliance score for the routine care appointment timeframe. • MSFC's online provider directory provides a link for enrollees to schedule telemedicine appointments. • MSFC scored above the 80% compliance threshold established by MDH in all categories, achieved 100% in PCP's Practice Location Matched Survey Response, PCP's Practice Telephone Number Matched Survey Response, and Online Provider Directories Specifies Languages Spoken by PCP and scored 99% in PCP Listed in Online Directory and Online Provider Directories Specifies Age Specifications of Patient Seen.
N/A	✓	N/A	**Improvements** • MSFC effectively implemented its online directory CAP from the CY 2020 validation to: o Include specifics regarding ADA accommodations for patients with disabilities, including offices, exam room(s), and equipment.
N/A	✓	N/A	**Opportunities** • Compliance with the MDH-required minimum score for urgent care appointment timeframe.

Q	A	T	MSFC Strengths, Improvements, Opportunities, and Recommendations
N/A	✓	N/A	**Recommendations** • Ensure the MDH-required minimum compliance score for urgent care appointment timeframe is met.

Priority Partners (PPMCO) External Quality Review (EQR) Findings

Contracted Since: 1997 ● CY 2020 Enrollment: 325,516 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 3

Table 58. PPMCO Findings

Q	A	T	PPMCO Strengths, Improvements, Opportunities, and Recommendations
Systems Performance Review			
✓	✓	✓	**Strengths** • PPMCO demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of PPMCO's continuing progression to ensure the delivery of quality healthcare for their enrollees.
✓	✓	✓	**Improvements** • PPMCO successfully Met the three components in the Enrollee Rights standard identified as opportunities in the CY 2019 review. • PPMCO successfully Met the two components in the Availability and Accessibility standard identified as opportunities in the CY 2019 review. • PPMCO successfully Met four of the seven components in the Utilization Review standard identified as opportunities in the CY 2019 review.
✓	N/A	✓	**Opportunities** • PPMCO has one CAP in the Utilization Review standard.
Performance Improvements Projects			
✓	N/A	N/A	**Strengths** • The AMR rate demonstrated a statistically significant improvement from baseline to MY 2020.
✓	N/A	N/A	**Improvements** • The AMR rate increased from MY 2019 to MY 2020.
✓	✓	N/A	**Opportunities** • For both PIPs: o Demonstrate that it conducted a disparities analysis that includes race, ethnicity, and language data from its plan membership and develop targeted interventions in response to findings.

Q	A	T	PPMCO Strengths, Improvements, Opportunities, and Recommendations
			• For the Lead PIP: o Identify interventions that are in place during the MY that are evidence-based and the source of the study. o Develop robust interventions early in the MY that address member, provider, and MCO barriers, which include individual goals for increasing both rates. o Documented improvement in HEDIS and VBP lead screening rates. o Demonstrate performance improvement that appears to be the result of its interventions and is statistically significant.
✓	✓	N/A	**Recommendations** • For both PIPs: o Compare its performance to the long-term PIP goal in addition to the other goals it has selected. • For the AMR PIP: o Implement new interventions early in the MY to maximize any positive impact on the AMR rate. o Revise the goal for the Pharmacy Outreach Program because, as stated, it does not support evaluation of the impact of this specific intervention on the AMR rate. o Establish measurable AMR goals for each of its interventions and developing a methodology for evaluating the effectiveness of each intervention based upon its impact on the AMR rate. • For the Lead PIP: o Review all quantitative data to ensure it is accurately presented. o Ensure it provides an accurate assessment of the success of a project based on the improvement made from baseline to the current MY rates. o Establish individual and measurable goals for each intervention and ensure that it provides an accurate interpretation of which improvement strategy was successful by observing the change between the baseline and current MY rates.
Encounter Data Validation			
✓	N/A	N/A	**Strengths** • PPMCO appears to have an information system and processes capable of capturing complete and accurate encounter data. • PPMCO is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • PPMCO achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. • PPMCO has shown an upward trend in matched office visit encounters for three successive years.

Q	A	T	PPMCO Strengths, Improvements, Opportunities, and Recommendations
✓	✓	N/A	**Improvements** • PPMCO demonstrated the following improvements in its match rates: o A three percentage point increase in all outpatient codes reviewed from 96% in CY 2019 to 99% in CY 2020. o A one percentage point increase in all office visit codes reviewed from 98% in CY 2019 to 99% in CY 2020.
Early and Periodic Screening, Diagnosis, and Treatment			
✓	✓	N/A	**Strengths** • PPMCO achieved MDH's 80% minimum compliance threshold for four components: Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance. • All of the elements in Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components achieved the 80% minimum compliance threshold.
✓	✓	N/A	**Improvements** • PPMCO significantly improved in the Newborn Metabolic Screen element in the Laboratory Test/At-Risk Screening component. • PPMCO's total composite rate in CY 2020 (92%) increased 9 percentage points from CY 2019 (83%).
✓	✓	N/A	**Opportunities** • PPMCO scored below the HealthChoice Aggregate in the Laboratory Tests/At-Risk Screening component, yielding a composite result of 74%, which also did not meet the 80% minimum compliance threshold. • For the Health and Developmental History component, Recorded Perinatal History and Recorded Maternal Depression Screening did not reach the 80% minimum compliance. • For the Laboratory Tests/At-Risk Screenings component, PPMCO did not meet the 80% minimum compliance threshold for 9 out of 16 elements. • In CY 2020, 9-11 Year Dyslipidemia Lab Test scored the lowest rate at 41% for the Laboratory Tests/At-Risk Screenings component.
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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.

Q	A	T	PPMCO Strengths, Improvements, Opportunities, and Recommendations
			• 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed healthcare appointments. • Remind providers that they are required to enroll in the Vaccinations for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
Consumer Report Card			
✓	✓	✓	**Strengths** ★★★ In two of the six performance areas (Doctor Communication and Service, Care for Kids with Chronic Illness).
✓	✓	✓	**Improvements** ★★★ In two of the six performance areas (Doctor Communication and Service, Care for Kids with Chronic Illness).
✓	✓	✓	**Opportunities** ★ In two of the six performance areas (Taking Care of Women, Care for Adults with Chronic Illness).
Focused Review of Grievances, Appeals, and Denials			
✓	N/A	N/A	**Strengths** • Grievances and their resolution are well documented in case notes and resolution letters. • Consistent compliance was demonstrated in meeting the resolution timeframe for provider grievances.

Q	A	T	PPMCO Strengths, Improvements, Opportunities, and Recommendations
✓	N/A	✓	**Improvements** • Appropriate categorization of grievances (emergency-medically related, non-emergency medically related, and administrative) was demonstrated. • Appeals are processed based on the level of urgency. • Adverse determination letters consistently identify the correct deadline for requesting continuation of benefits.
✓	N/A	✓	**Opportunities** • Consistent compliance with enrollee grievance resolution timeframes. • Attitude/service-related enrollee grievances. • Consistent compliance for a reasonable attempt to provide verbal notification of an expedited appeal resolution. • Enrollee consent is documented in a case record when a provider is filing an appeal on behalf of the enrollee. • Consistent compliance with appeal resolution timeframes. • Appeal resolution letters reflect correct calculated dates, appeal receipt dates, and appeal resolution dates. • Consistent compliance with pre-service determination and adverse determination notification timeframes. • If additional clinical information is required, it is requested within 2 business days of receipt of the request. • Appeal and adverse determination letters consistently written in plain language.
✓	N/A	✓	**Recommendations** • Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with grievance, appeal, pre-service determinations, and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of attitude/service-related enrollee grievances to identify opportunities for improvement. • Retrain appeal staff and conduct routine audits on appeal case documentation requirements, including verbal notification of an expedited resolution and enrollee consent when a provider is filing an appeal on their behalf. • Audit appeal and adverse determination letters on a routine basis to ensure use of plain language and correct content.

Q	A	T	PPMCO Strengths, Improvements, Opportunities, and Recommendations
Network Adequacy Validation			
N/A	✓	N/A	**Strengths** • PPMCO exceeded the MDH-required minimum compliance score for both routine and urgent care appointment timeframes. • PPMCO scored above the 80% compliance threshold established by MDH in six of the seven categories and achieved 100% in PCP Listed in Online Directory, Online Provider Directories Specifies Age Specification of Patient Seen, and Specifies Languages Spoken by PCP. PPMCO also achieved above 98% in PCP's Practice Location Matched Survey Response.
N/A	✓	N/A	**Opportunities** • PPMCO evidenced a continued opportunity for improvement identified in the CY 2020 validation to: o Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory.
N/A	✓	N/A	**Recommendations** • Ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory.

UnitedHealthcare Community Plan (UHC) External Quality Review (EQR) Findings

Contracted Since: 1997 ● CY 2020 Enrollment: 158,335 ● NCQA Accreditation Status: Accredited ● Corrective Action Plans: 2

Table 59. UHC Findings

Q	A	T	UHC Strengths, Improvements, Opportunities, and Recommendations
Systems Performance Review			
✓	✓	✓	**Strengths** • UHC demonstrates the ability to design and implement effective quality assurance systems. The CY 2020 interim desktop review provided evidence of UHC's continuing progression to ensure the delivery of quality healthcare for their enrollees.
✓	N/A	✓	**Improvements** • UHC successfully Met the five components in the Utilization Review standard identified as opportunities in the CY 2019 review.
✓	N/A	✓	**Recommendations** • Educate its appeals staff on the 100% compliance threshold for appeal resolution/notification.
Performance Improvements Projects			
✓	✓	N/A	**Improvements** • The AMR rate demonstrated a slight increase from MY 2019 to MY 2020. • The HEDIS lead rate demonstrated improvement from baseline.
✓	✓	N/A	**Opportunities** • Both PIPs: o Specify a long-term improvement goal of at least 10 percentage points above the baseline result consistent with prior PIP submissions. o Demonstrate that its qualitative analysis identified factors that may influence comparability between baseline and repeat measurements. If no impacts are identified, UHC must describe its process for determining whether there were no impacts.

Q	A	T	UHC Strengths, Improvements, Opportunities, and Recommendations
			o Conduct a disparities analysis followed by an in-depth barrier analysis and targeted interventions in response to any identified opportunities for improvement. o Demonstrate the use of PDSA to test its interventions and to assess for continuous improvement/needed change. o Demonstrate that any improvement in performance appears to be the result of its interventions and is statistically significant. • AMR PIP: o Demonstrate that its qualitative analysis identifies any factors that may influence the internal or external validity of findings and impact. o Include in its qualitative analysis any lessons learned if there is no improvement in the AMR rate. o Demonstrate implementation of more robust interventions in response to identified barriers that include an individual goal for measuring their impact on the AMR rate. o Demonstrate that it identifies any confounding variables that could have an obvious impact on outcomes. o Demonstrate that any improvement in performance appears to be the result of its interventions and is statistically significant. • Lead PIP: o Provide an accurate assessment of project success and contributing factors that are based on appropriate improvement goals. o Demonstrate that its lead screening interventions are evidence-based and directly impact its HEDIS and VBP rates. o Implement timely and more robust interventions that have an individual measurable goal using the Specific-Measurable-Achievable-Relevant-Time Bound (SMART) formula for increasing lead screening rates. o Demonstrate improvement from baseline to MY 2021 for both measures.
✓	✓	N/A	**Recommendations** • **Lead PIP:** o Evaluate its interventions for effectiveness based upon their individual impact on improving outcomes among the participants or the priority population using the PDSA approach.
Encounter Data Validation			
✓	N/A	N/A	**Strengths** • UHC appears to have an information system and processes capable of capturing complete and accurate encounter data.

Q	A	T	UHC Strengths, Improvements, Opportunities, and Recommendations
			• UHC is capturing appropriate data elements for claims processing, including elements that identify the enrollee and the provider of service. • UHC achieved match rates above the standard of 90% recommended by Qlarant in all areas of review. • UHC has shown an upward trend in matched outpatient encounters for three successive years.
✓	N/A	N/A	**Improvements** • UHC demonstrated the following improvements in its match rates: o A three percentage point increase in all outpatient codes reviewed from 95% in CY 2019 to 98% in CY 2020.
Early and Periodic Screening, Diagnosis, and Treatment			
✓	✓	N/A	**Strengths** • UHC achieved MDH's 80% minimum compliance threshold for three components: Health and Developmental History, Comprehensive Physical Exam, and Health Education/Anticipatory Guidance. • Almost all elements in both Comprehensive Physical Exam and Health Education/Anticipatory Guidance components achieved the 80% minimum compliance threshold.
✓	✓	N/A	**Improvements** • UHC improved in the Documented Referral to Dentist element in the Health Education/Anticipatory Guidance component. • UHC's total composite rate in CY 2020 (87%) increased 10 percentage points from CY 2019 (77%).
✓	✓	N/A	**Opportunities** • UHC scored below the HealthChoice Aggregate in all five of the components. • Both Laboratory Tests/At-Risk Screenings and Immunizations did not meet the minimum compliance threshold of 80%, with scores of 72% and 77%, respectively. • For the Health and Developmental History component, UHC did not meet the 80% minimum compliance threshold for 4 out of the 11 elements. • The Graphed Head Circumference element in the Comprehensive Physical Exam component remained below the 80% minimum compliance threshold. • For the Laboratory Tests/At-Risk Screenings component, 10 out of the 16 elements fell below the 80% minimum compliance threshold. UHC's largest decline was in the 12 Month Anemia Test score, with a 31 percentage point decrease, dropping from CY 2018 (85%) to CY 2020 (54%). • UHC scored below the HealthChoice Aggregate in 14 out of the 16 elements in the Laboratory Tests/At-Risk Screenings component.

Q	A	T	UHC Strengths, Improvements, Opportunities, and Recommendations
			• UHC scored below the HealthChoice Aggregate 13 out of the 14 elements in the Immunizations component and did not meet the 80% minimum compliance threshold for 11 out of the 14 elements.
✓	✓	N/A	**Recommendations** • Establish a pandemic crisis mitigation plan to ensure care is provided to Healthy Kids Program enrollees. • Encourage providers to develop a plan to have medical records in compliance with audit requests. • Develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards. 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. • 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 during audit requests. • When a child is transferred to another PCP within the MCO network, facilitate the transfer of medical, immunization, and laboratory records to the newly assigned PCP. • Utilize MCO data to identify children who are not up to date 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. • When other outreach efforts have been unsuccessful, refer to the local health department for assistance in bringing children in for missed healthcare appointments. • Remind providers that they are required to enroll in the Vaccinations for Children Program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
Consumer Report Card			
✓	✓	✓	**Opportunities** ★ In two of the six performance areas (Taking Care of Women, Care for Adults with Chronic Illness).

Q	A	T	UHC Strengths, Improvements, Opportunities, and Recommendations
Focused Review of Grievances, Appeals, and Denials			
✓	N/A	✓	**Strengths** • Grievances and their resolution are well documented in case notes and in resolution letters. • All adverse determination letters were written in plain language and provided a detailed explanation of the reason for the denial. • Consistent compliance with pre-service determination and adverse determination notification timeframes was demonstrated in all four quarters. • Grievance case records provide comprehensive documentation of peer review in response to Quality of Care complaints and include all correspondence between service providers (i.e., PCPs, transportation vendors), as applicable. • Grievance resolution letters are written in plain language and provide a full description of the grievance and the steps required to resolve, including feedback from service providers in response to any quality of service issues. • All enrollee grievance, appeal, and adverse determination letters included the Non-Discrimination Statement in both English and Spanish.
✓	N/A	N/A	**Improvements** • Adverse determination letters consistently identify the correct deadlines for requesting an appeal and continuation of benefits.
✓	N/A	✓	**Opportunities** • Consistent compliance with the resolution timeframes for enrollee and provider grievances. • Billing/financial related enrollee grievances. • Consistent compliance with appeal resolution/notification timeframes.
✓	N/A	✓	**Recommendations** • Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with grievance and appeal timeframes. Increase frequency and scope of monitoring until consistent compliance is demonstrated. • Consider conducting a root cause analysis of billing/financial-related enrollee grievances to identify opportunities for improvement.

Q	A	T	UHC Strengths, Improvements, Opportunities, and Recommendations
Network Adequacy Validation			
N/A	✓	N/A	**Strengths** • UHC exceeded the MDH-required minimum compliance score for both routine and urgent care appointment timeframes. • UHC's online provider directory has a pop-up on their directory to view Additional Resources. They also have an option to select a provider with weekend/evening appointments. UHC's site includes a feature at the bottom of the individual providers' directory page entitled "Report Incorrect Information," encouraging enrollees to notify UHC of incorrect information. • UHC has scored above the 80% compliance threshold established by MDH in all online validation categories and achieved 99% in PCP's Practice Telephone Number Matched Survey Response, Online Provider Directories Specifies Age Specifications of Patient Seen, Specifies Languages Spoken by PCP, and Specifies Practice Accommodations for Patient with Disabilities (with specifics).

Appendix B:

CY 2020 Maryland MCO Systems Performance Standards and Guidelines

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.			
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 CY 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 as appropriate. There is evidence that this occurs. e. The guidelines are included in the provider manuals or disseminated to the providers	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. Decisions for UM, enrollee education, coverage of services, and other areas to which the guidelines apply are	• QA Plan • Policies & Procedures • Practice Guidelines • Proof of Guidelines Disseminated to Providers • Clinical Care Standards • QOC Study Designs • QOC Study Tools • QOC Project Plans • Quality Indicators • Data Analysis	42 CFR § 438.236

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	(electronically or faxed) as they are adopted. f. There are guidelines to address preventive health services for children and adults. g. The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a. h. The MCO's clinical guidelines policies and procedures must reflect how the guidelines are used for UM decisions, enrollee education, and coverage of services.	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 QOC provided by the MCO's providers. b. Appropriate clinicians monitor and evaluate quality through review of individual cases and through studies analyzing patterns of clinical care.	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 the study of clinical care and services through individual case review, provider utilization studies, and practice pattern analysis. The composition of the team is described in the QA Plan and/or related documents. There is evidence that through these activities, those areas requiring improvement are identified and acted upon.	• QA Plan • Data Analysis • Policies & Procedures • QA/QIC/MCO's internal Provider/Medical Advisory Committee (MAC) Meeting Minutes • QA/QIC/MAC Membership • QA/QIC/MAC Attendance Records	42 CFR § 438.330

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.			
1.5	The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The remedial/corrective action procedures specifically include: a. Performance thresholds to identify when actual or potential problems may exist that require remedial/corrective action. b. The individual(s) or department(s) responsible for making the final determinations regarding quality problems. c. The specific actions to be taken. d. The provision of feedback to the appropriate health	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 addresses all components of this element. This would include the identification, development, implementation and monitoring of CAPs.	• QA Plan • Policies & Procedures • Data Analysis • Provider Feedback • CAPs	HCQIS II.E.1-7 COMAR 10.67.04 10.67.04.03C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	professionals, providers, and staff (as appropriate). e. The schedule and accountability for implementing corrective actions. f. The approach to modifying the corrective action if improvements do not occur. g. The procedures for terminating health professionals, providers, or staff (as appropriate).			
1.6 Deleted in CY 2017.				
1.7	The QA Plan incorporates written guidelines for evaluation of the status of QAP activities and the continuity and effectiveness of the QAP. a. The MCO reviews the status of QAP activities against the QA Work Plan on a quarterly basis. b. There is evidence that QA activities are assessed to determine if they have contributed 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
1.8	A comprehensive annual written report on the QAP is completed. The	The annual report on the QAP must include all required components.	• Annual QAP Evaluation Report • QAC Meeting Minutes	42 CFR § 438.330(b)(2)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	annual report on the QAP must include: a. QA studies and other activities undertaken, results, and subsequent actions. b. Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results. c. Analysis of aggregate data on utilization and quality of services rendered. d. Demonstrated improvements in quality. e. Areas of deficiency. f. Recommendations for improvement to be included in the subsequent year's QA Work Plan. g. An evaluation of the overall effectiveness of the QAP.	**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.	• Governing Body Meeting Minutes	
1.9	The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.	The organizational chart must be comprehensive, indicating all appropriate positions and their relationships to one another.	• QAP Organizational Chart	42 CFR § 438.330
1.10	The MCO must have a Disaster Recovery Plan that is updated on an annual basis.	The MCO and its subcontractor(s) shall have robust contingency and disaster recovery plans in place to ensure that the services provided will be maintained in the event of a disruption to the	• Disaster Recovery Plan • Evidence that subcontractor disaster recovery plans are in place.	COMAR 10.67.04.15

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		MCO/subcontractor's operations (including, but not limited to, disruption to information technology systems), however caused.		
2.0	**Accountability to the Governing Body – The governing body of the MCO is the BOD or, where the Board's participation with the QI issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care.** **This standard will be reviewed until the MCO attains 100% compliance.**			
2.1	There is documentation that the governing body has oversight of the QAP and approves the annual QA Plan/Description and QA Work Plan.	The governing body is the BOD or the designated entity of senior management that has accountability and oversight of the operations of the MCO, including but not limited to the QAP. The QA Plan/Description must specify that the governing body has oversight of the QAP. The governing body meeting minutes must reflect review and approval of the annual QA Plan/Description and the annual QA Work Plan.	• QA Plan • MCO Organizational Chart • QA Organizational Chart • Governing Body Meeting Minutes	HCQIS III.A
2.2	The governing body formally designates an accountable 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	• Governing Body Meeting Minutes • QA Plan • QAC Meeting Minutes • QA Organizational Chart	HCQIS III.B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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.		
2.3	The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.	There must be evidence that the governing body receives written reports from the QAC. Reporting to the governing body should occur according to the timeframes documented in the QA Plan (e.g., monthly, quarterly, etc.).	• Governing Body Meeting Minutes • QA Plan	HCQIS III.C
2.4	The governing body formally reviews, at least annually, a written report on the QAP Evaluation.	There must be evidence in the governing body meeting minutes that this document was reviewed and approved by the governing body.	• QAP Annual Evaluation Report • Governing Body Meeting Minutes	HCQIS III.D
2.5	The governing body takes action when appropriate and directs that the operational QAP be modified to accommodate review of findings and issues of concern within the MCO.	The governing body receives regular written reports from the QAP delineating actions taken and improvements made (Element 2.3). As a result, the governing body takes action and provides follow-up when appropriate. These activities are documented in the minutes of the meetings in sufficient detail to demonstrate that it has directed and	• QA Plan • Governing Body Meeting Minutes • QAC Meeting Minutes	HCQIS III.E

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		followed up on necessary actions pertaining to the QAP.		
2.6 Deleted in CY 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 grievance and appeal system.	Delegates are subcontractors that administer a critical benefit on behalf of the MCO that impacts members directly (e.g., vision, claims, UM, pharmacy). Subcontractors are individuals or entities that have a contract with an MCO that relate directly or indirectly to the performance of the MOC's obligations under its contract with the state related to Medicaid (e.g., contractors providing outreach services, call center activities, or mobile laboratory vendors). Vendors are subcontractors that administer a function that does not directly impact member services or	• 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
		benefits (e.g., mailroom, print services, and janitorial services). The contract for delegated activities contains all items listed in component a. The MCO must provide evidence that it has provided information about the grievance and appeal system to all delegates and subcontractors. For new delegates, evidence must be provided at the time that they entered into a contract with the MCO. For existing delegates, the MCO must provide evidence of an amendment to the agreement with the grievance and appeal system information or documentation it has shared the information with the delegate, and the delegate's acknowledgment of receipt. Since Adult dental is an optional service, do not include any dental vendors in reviewing any delegation standards. The only delegates required for standard 3 are those who are delegated UM, claims, and/or appeals and grievances for mandatory services, such as vision, drug, radiology, PT.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
3.2	The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the QOC 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 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.	There is evidence that an appropriate committee or body within the MCO makes process improvement decisions and acts upon the conclusions drawn from delegated entity monitoring according to the MCO's internal policies and procedures and/or the terms set forth in the delegate's contract. The MCO must provide evidence of items a. through e.	• Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities • Delegation Committee Meeting Minutes • Delegated Entities' Complaints, Grievances, and Appeals Reports, where applicable • Delegated Entities' Claims Payment Monitoring Reports, where applicable • Delegated Entities' Utilization Activity Reports, where applicable	HCQIS VI.C 42 CFR § 438.230 (a & b) COMAR 10.67.04.17.D 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
	e. Review and approval of overutilization and underutilization reports, at least semi-annually, where applicable.			
3.4	The MCO has written policies and procedures for subcontractor termination that impacts the MCO's operations, services, or enrollees.	When the MCO terminates a subcontract, the MCO shall provide the Department with written notice regarding the termination that complies with the requirements of COMAR 10.67.04.17B(5).	• Subcontractor Policies and Procedures • Subcontractor Termination Notices	COMAR 10.67.04.65.17B(5)
4.0	**Credentialing and Recredentialing – The QAP contains all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services.** **This standard will be reviewed until the MCO attains 100% compliance.** **NOTE**: Due to State of Emergency, MDH and Qlarant will relax the compliance threshold for credentialing and rerecredentialing timeliness requirements to 90%.			
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	The MCO must have a comprehensive written Credentialing Plan and/or policies and procedures outlined in the QA Plan that describe the process for credentialing and recredentialing. The Credentialing Plan must designate the peer review body that has the authority to make recommendations regarding credentialing decisions and must identify the practitioners who fall under its authority.	• Credentialing Plan • Credentialing Process in QA Plan • Governing Body Meeting Minutes • Credentialing Policies & Procedures	HCQIS IX A-D Ins. Art. § 15-112 (a)(4)(ii)(9) Ins. Art. § 15-112 (d) COMAR 10.67.04.02M COMAR 10.67.04.17

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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.		
4.2	There is documentation that the MCO has the right to approve new	There are policies and procedures in place for the suspension, reduction,	• Credentialing Plan • Recredentialing Plan	HCQIS IX H-J

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 CY 2019.	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 Policies & Procedures • Provider Appeal Policy & Procedure • Provider Appeals Files • Facility Site Reviews (completed forms/files)	
4.3	If the MCO delegates credentialing/ recredentialing activities, the following must be present: a. A written description of the delegated activities. b. A description of the delegate's accountability for designated activities. c. Evidence that the delegate accomplished the credentialing activities.	The contract for delegated services includes a description of the delegated activities and the delegate's accountability for designated activities. The delegate provides reports to the MCO according to the contract requirements.	• Delegation Contract • Delegate Progress Reports to the MCO • MCO Monitoring/Auditing Documents	HCQIS IX G
4.4	The credentialing process must be ongoing and current. At a minimum,	The credentialing plan and policies and procedures require, at a minimum, that the MCO obtain the	• Credentialing Plan • Credentialing Policies & Procedures	HCQIS IX E.1-7 42 CFR § 438.214 (c-e)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	the credentialing process must include: a. A review of a current valid license to practice. b. A review of a valid DEA or CDS certificate, if applicable. c. A review of graduation from medical/ancillary (NP, PT, OT, SLP, etc.) school and completed a 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 CY 2017 SPR. h. A review of 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	information required in components a-k for the credentialing process. **Note:** (h) is applicable to those PCPs who deliver preventive health care services to enrollees less than 21 years of age. The reviewer will assess the MCO's methodology for verifying whether PCPs in the MCO's network that see patients under age 21 are EPSDT certified.	• Sample Credentialing Records • Written correspondence to providers.	COMAR 10.67.04.02.N 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
	Insurance Article Section 15-112(d). k. Verification that the provider is actively enrolled in Medicaid at the time of credentialing.			
4.5	The MCO should request and review information from recognized monitoring organizations regarding practitioners. The evidence must include: a. Any revocation or suspension of a State license or a DEA/BNDD number. b. Any curtailment or suspension of medical staff privileges (other than for incomplete medical records). c. Any sanctions imposed by Medicare and/or Medicaid. d. Information about the practitioner from the NPDB and the MBP.	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
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.	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.	• 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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. Attestation to the correctness and completeness of the application.	There must be evidence in the credentialing files that this statement is completed. The type of credentialing application must be reviewed and in compliance with MIA regulatory requirements noted.		
4.7	There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the ADA and the MCO's standards.	The credentialing plan and policies and procedures must require an initial visit to each potential primary care practitioner's office. There must be documentation that a review of the site includes both an evaluation of ADA compliance and medical record keeping, and that these practices are in conformance with the MCO's standards. Such standards should consider: • Handicapped designated parking clearly marked and close to the entrance. • Ramps for wheelchair access. • Door openings to the practice and restroom and hallways should facilitate access for disabled individuals. • Elevator availability for practices above ground level.	• Credentialing Plan • Credentialing Policies & Procedures • Site Visit Tool • Sample Completed Site Visit Tools • Sample Credentialing Records • Applicable Reports of On-site Visits • Credentialing Committee Meeting Minutes	HCQIS IX E.14 COMAR 10.67.04.02 H (1) 28 CFR Chapter 1, Part 36
4.8	There is evidence that recredentialing is performed at least every three years and:	The credentialing plan and policies and procedures indicate that recredentialing is performed at least every three years.	• Credentialing Plan • Recredentialing Policies & Procedures	HCQIS IX F.1-2 COMAR 10.67.04.02.N

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. Includes a review of information from the NPDB. b. Deleted in CY 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 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.	• Sample Credentialing Records • Credentialing Committee Meeting Minutes	Ins. Art. § 15-112 (d) MCO Transmittal PT-10-19
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 CY 2018. d. Office site compliance with ADA standards, if applicable.	There is evidence in provider recredentialing records that complaints, grievances, and the results of quality reviews were reviewed prior to the MCO's recredentialing of providers. There is a process in place to re-assess provider site ADA compliance when: • Provider relocates to a site that has not previously been evaluated and approved as being ADA compliant, or	• Credentialing Plan • Recredentialing Policies & Procedures • Sample Recredentialing Records	HCQIS IX F.3 a – e

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• There is evidence of ADA non-compliance issues with a particular site of care delivery.		
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 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.	The MCO must include in the notification: • An explanation of the EPSDT preventive screening services to which an enrollee is entitled according to the EPSDT periodicity schedule (only a summary is necessary if the periodicity schedule was included in the MCO's welcome packet); • Importance of accessing the EPSDT preventive screening services; and	• Policies and Procedures • Letters to Parents/Guardians	COMAR 10.67.05.05

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.	• 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. b. If the MCO is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided 90 days before the effective date of the termination. c. If the provider is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided within 15 days after the MCO receives the notice from the terminating provider.	• Network Provider Termination Policies and Procedures • Network Provider Termination Notices to MDH • Examples of completed MDH required forms	COMAR 10.67.04.17B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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: 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		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		have had an encounter with the provider in the previous 12 months.		
5.0	**Enrollee Rights – The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.** **NOTE**: Due to the State of Emergency, MDH and Qlarant will relax the compliance threshold for grievance resolution timeliness requirements to 90% (MCOs are permitted to extend grievance resolution timeframes an additional 14 calendar days under 42 CFR 438.408(c))			
5.1	The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04. a. There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09. b. The system requires documentation of the substance of the grievances and steps taken. c. The system ensures that the resolution of a grievance is documented according to policy and procedure. d. The policy and procedure describe the process for aggregation and analysis of grievance data and the use of	Timeframes for resolving grievances in the policy and procedure must be in accordance with the following: • Emergency medically related grievances not > 24 hours. • Non-emergency medically related grievances not > 5 days. • Administrative grievances not > 30 days. The policy and procedures must describe what types of information will be collected when grievances are recorded and processed. The MCO must have a grievance form. The policies and procedures must include the process stating how the form is used and how an enrollee can get assistance from the MCO in completing the form.	• Grievance Policies & Procedures • Grievance Form • Grievance Logs • Grievance Reports • Grievances Files • QAC/QIC Meeting Minutes • CAB Meeting Minutes • Quarterly Complaints/Grievances • Appeal Reports • Sample Grievance Letters to Members	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
	the data for QI. There is documented evidence that this process is in place and is functioning. e. Deleted in CY 2018. f. There is complete documentation of the substance of the grievances and steps taken in the case record. g. The MCO adheres to regulatory timeframes for written acknowledgment and written resolution of all grievances, even if the resolution was previously provided verbally. h. The MCO ensures that written resolution letters describe the grievance and the resolution in easy to understand language.	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 member via phone, the MCO must notify the member in writing that their grievance is being closed. The policies and procedures must describe the complete process from the registration through resolution of grievances. The policies and procedures must allow participation by the provider or an ombudsman, if appropriate, and must ensure the participation of individuals within the MCO who have authority to require corrective action.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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 and the QACs as required by COMAR. If problems are identified, the reviewer will track the progress of problem resolution.		
5.2	The MCO shall provide access to health care services and information in a manner consistent with the formatting and special access requirements of COMAR 10.67.05.01C.	COMAR 10.67.05.01C states that all written materials must: • Use language and a format that is easily understood; • Be available in alternative formats and through the provision of auxiliary aids and services • Be available in an appropriate manner that	• Enrollee Informational Materials	COMAR 10.67.04.02.H COMAR 10.67.05.01 42 CFR § 438.10 42 CFR § 438.206 (c)(2)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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.		
5.3	The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO: a. Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data. b. Ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential	The policies and procedures address all required components described in a-e. The MCO must provide evidence that these policies and procedures have been implemented. The MCO must provide documentation to demonstrate that it ensures patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information.	• Medical Records Policies & Procedures • Confidentiality Policies & Procedures • Sample Provider Contracts • Sample Provider Site Visit Evaluation Tool • Credentialing Policies & Procedures • Tools Related to Assessing Confidentiality of Patient Medical Records • Sample of MCO Employee	HCQIS X.1 42 CFR § 438.100 (d) 42 CFR § 438.224 HIPAA Health-General §§ 4-301

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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. Must ensure that the release of any information in response to a court order is reported to the patient in a timely manner. e. May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.		Confidentiality Statement • Signed MCO Employee Confidentiality Statements • Sample Vendor Contracts	

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	time timeframes for sending such information to the enrollee. b. Policies and procedures are in place for newborn enrollments, including the issuance of the MCO's ID card. c. The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution. d. The MCO includes the Continuity of Health Care Notice in the new enrollee packet. e. The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.	The MCO uses State-developed model enrollee handbooks and notices. New enrollee information packets are provided to new enrollees within 10 calendar days of MDH's notification to the MCO of enrollment. The packet includes the Continuity of Health Care Notice that is required by § 15-140(f) of the Insurance Article. The MCO has written procedures that track and monitor timeliness of receipt of ID cards (including newborns). Such monitoring is analyzed and if timelines are not met, there is evidence of corrective action and evaluation of progress. Performance is reported through the 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	• ID Card Fulfillment Reports • ID Card Fulfillment Tracking and Trending Analysis	42 CFR 438.10

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		Enrollment Report from the Department.		
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 • Member feedback/concerns • Accomplishments and Resolutions	• Policies and Procedures • Committee Charter • CAB Meeting Minutes • CAB Annual Summary	COMAR 10.67.04.12

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Opportunities for Improvement/Follow-up		
5.8	The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights. a. Materials distributed by the MCO to the enrollee will include a nondiscrimination notice and a language accessibility statement in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency 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 members must	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; 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	• Enrollee Handbook • Provider Directory • Enrollee Information/ Material • Screen Shot of the MCO Website • Pictures of Notices and Taglines posted at member events • Websites • Online Directories	45 CFR § 92.7 45 CFR § 92.8 42 CFR § 438.10 COMAR 10.67.05.01

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	meet requirements set forth in COMAR.	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 statement and taglines in at least the top 2 non-English languages. MCOs may use the Sample "Discrimination is Against the Law" statement to meet this requirement. The Notice and Taglines must be posted in a conspicuously-visible font size in a conspicuous location of		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		covered entity websites accessible from the home page, in significant communications and significant publications, and, where appropriate, in conspicuous physical locations where the entity interacts with the public. This applies to, but is not limited to: Marketing materials, enrollee communications related to health coverage, benefits, and prescription drug coverage, provider/pharmacy directories, formularies, enrollment forms, summary of benefits, and appeal and grievance notices. COMAR 10.67.05.01.D states that if the MCO provides enrollee information electronically (provider directory, EOB, member 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		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		can be electronically retained and printed; 4. The information is consistent with the content and language requirements of this section; 5. The enrollee is informed that the information is available in paper form without charge upon request; and 6. Should the enrollee request it, the MCO provides the information in paper form within 5 business days. MCOs should be prepared to provide evidence of materials referring enrollees to online information that advises them how to request printed material free of charge; evidence that the online information provided is downloadable and 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.	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	• Policies and Procedures • Member 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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. The MCO must provide adult enrollees with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618). c. The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.	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, member services, and outreach staff that would interact with members and advance directives. Additionally, network management staff should be educated since they have contact with the provider network. MCO must provide examples of completed staff training, such as signed attestations and rosters of staff showing dates of annual training completed.		COMAR 10.67.04.02
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	The MCO's marketing policies and procedures complies 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.	• Marketing Policies and Procedures • Marketing Requests and Approvals from the Department	42 CFR § 438.104 COMAR 10.67.04.23

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	prior approval of the Department. c. Deleted in CY 2018.	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.		
5.11	The MCO has implemented policies and procedures to ensure that the MCO does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.	The MCO's has written policies and procedure to ensure: a. that it does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following: i. The enrollee's health status, medical care, or treatment options, including any	• Policies and Procedures •	42 CFR § 438.102

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		cover to MDH consistent with the requirements in § 438.102 (b)(1)(i)(A)(B) c. enrollees are informed how they can obtain information from the State to access the service(s) excluded in 5.11, section a.		
6.0	**Availability and Accessibility – The MCO has established measurable standards for access and availability.**			
6.1	The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services. a. The MCO has developed and disseminated written access and availability standards. b. The MCO has processes in place to monitor performance against its access and availability standards at least quarterly. c. The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance.	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	• 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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. The MCO has documented a review of the Enrollee Services Call Center performance.	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. • 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		Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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.		
6.2	The MCO has a list of providers that are currently accepting new enrollees. a. The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population. b. At the time of enrollment, enrollees are provided with information about the MCO's providers. c. The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities. d. The MCO has evidence of monitoring performance against its network capacity	The MCO must conduct annual geo mapping to calculate average distance to ensure compliance with geographic access requirements. Specific network capacity and geographic access requirements are defined in COMAR 10.67.05.05.B and COMAR 10.67.05.06.B-D. Some of these are listed below: • Enrollee to physician ratio for local access area = 200:1 • Travel distance (urban) - 10 mile radius • Travel distance (suburban) – within 20 mile radius • Travel distance (rural) - within 30-mile radius. Annually compare percentages of network providers who communicate	• Provider Directory • Provider Manual • New Enrollee Packet • New Enrollee Orientation Materials • Availability & Access Standards • Access and Availability Policies & Procedures • Monitoring Methodology • Monitoring Reports • Committee Meeting Minutes • Top Ten Diagnoses for all Care Settings • Enrollee Complaint Reports • Documentation of any CAPs	HCQIS XI COMAR 10.67.05.02.C COMAR 10.67.05.05.B COMAR 10.67.05.06.B-D COMAR 10.67.05.01.A (3) 42 CFR § 438.10 (f) (2-6) 42 CFR § 438.206 (b) 42 CFR § 438.207 42 CFR § 438.10 (h) (1) (i-viii)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	and geographic access requirements at least annually by conducting geo mapping.	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 the provider has completed cultural competence training • An indication of whether or not access to the provider is otherwise limited (e.g. by age of patient or number of enrollees the provider will serve)	• Online Provider Directories • Provider Directory Machine Readable Format and File • Link to Online Provider Directory • Screenshots of Online Provider Directory	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• An indication of whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam rooms(s) and equipment The MCO must perform a quarterly review of the number of participating providers in the plan by type, geographic location, specialty, and acceptance of new patients. 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. The MCO has a methodology in place to assess and monitor the network needs of its Medicaid population. The methodology substantiates how the MCO determines that it has sufficient numbers and the types of specialists, as well as PCPs, within its network to meet the care and service needs of its		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		population in all care settings. The methodology includes: ● A process of monitoring that has the ability to identify problem areas that are reported through the MCO's established structure. ● Follow-up activities and progress towards resolution that are evident. ● Direct access to specialists. Each MCO must have a mechanism in place to allow enrollees with special health care needs who have been determined to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the enrollee's condition and identified needs. This is determined through an assessment by appropriate health care professionals and can be provided, for example, through a standing referral or an approved number of visits. According to COMAR, "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		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it."		
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 CY 2019. b. Deleted in CY 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 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 poststabilization care services for enrollees.	Policies and procedures must be in place to ensure payment is not denied for emergency and poststabilization treatment obtained under the following circumstances: a. An enrollee had an emergency medical	• Availability & Access Standards • Access and Availability Policies & Procedures • Claims Payment Policies & Procedures	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
		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). 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	• ED Policies & Procedures	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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 enrollee, for who is responsible in determining when the enrollee is sufficiently stabilized for transfer or discharge as responsible for coverage and payment.		
7.0	**Utilization Review – The MCO has a comprehensive UM program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement.** **NOTE**: Due to the State of Emergency, MDH and Qlarant will relax the compliance threshold for preauthorization decisions and notification timeliness requirements from 95% to 90%. MDH and Qlarant will relax the compliance threshold provider appeal acknowledgment and appeal decision timeliness requirements from 95% to 90%.			
7.1	There is a comprehensive written UR Plan.	The UR Plan is comprehensive and addresses components a-c.	• UR Plan • UR Meeting Minutes	HCQIS XIII A 42 CFR § 438.236

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 incentive or compensation.	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.	• Governing Body Meeting Minutes	
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	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	HCQIS XIII A COMAR 10.67.04.11 S 2

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 UR/UM criteria on at least an annual basis.		• Sign-in sheets, training logs, certificates of completion of annual training on UM criteria • Documentation of annual assessment of IRR among UM staff/physicians	
7.3	The written UR Plan has mechanisms in place to detect overutilization and underutilization of services. a. Services provided must be reviewed for overutilization and underutilization. b. UR reports must provide the ability to identify problems and take the 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)

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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. There is an exception for the HepC drugs. The enrollee, enrollee's representative, or the MCO may request an extension of the authorization timeframe of up to 14 calendar days. If the MCO extends the authorization timeframe, the MCO must provide evidence it notified enrollees in writing of the extension and the reason, as well as enrollees' right to file a grievance if they disagree with the MCO's decision. The state specified threshold for all preauthorization review decisions is 95%. A sample of preauthorization reviews must be reviewed for compliance with state specified timeliness by the MCO according to		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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	• Enrollee Adverse Determination Letter Policies and Procedure • Sample Enrollee Adverse Determination Letters • Selected UR Cases	HCQIS XIII.C 1-7 COMAR 10.67.09.02 COMAR 10.67.09.04F 42 CFR § 438.404 45 CFR § 92.7 45 CFR § 92.8

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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. 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.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		9. The enrollee may also appeal to the MCO directly by contacting the MCO (phone # or address) within 60 days from the date of receipt. 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 the cost of the services received during the appeal process. 11. Statement that the enrollee may represent self or use legal counsel, a relative, a friend, or other spokesperson. 12. There is evidence that the letter is copied to the requesting provider with copying the PCP optional. 13. A statement explaining the availability of the expedited review process, MCO phone		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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 timeliness of adverse determination notifications in response to preauthorization requests as specified by the State. b. The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.	MCOs shall notify the enrollee and the provider in writing whenever the provider's request for preauthorization for a service is denied. Written notice of decision to deny initial services must be provided to the enrollee: • within 24 hours of the expedited authorization determination, and • within 72 hours of receipt of the request, and • within 72 hours for standard requests and outpatient drug decisions.	• UR Plan • UR Policies & Procedures • UR Committee Meeting Minutes • Selected UR Cases • Enrollee Notices • TAT Compliance Reports	HCQIS XIII.C 1-7 COMAR 10.67.09.04 42 CFR § 438.10 (f & g)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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	There is evidence that appeals are resolved and notification provided within the timeframes established by the State. Timeframes for resolving and providing notification of appeal decisions in the policy and procedure must be in accordance with the following: • **Expedited Appeals** must be resolved and written notification of the decision	• UR Organizational Charts • UM Position Descriptions • QM Committee Meeting Minutes • Enrollee Appeals Policies & Procedures • Contract • Appeals Forms & Logs • Appeals Reports, including TAT compliance • Appeal Records	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)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	conflicts of interest when reviewing appeals. c. The MCO must adhere to appeal 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 member 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.	provided within 72 hours of receipt. The MCO must also make reasonable efforts to provide oral notice of the decision. • **Standard Appeals** must be resolved and written notice provided within 30 days, unless extended pursuant to 438.408 b & c. • Appeals may be extended up to 14 days. The MCO must ensure that decision makers on appeal were not involved in previous levels of review or decision making, were not subordinates of decision 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.	• Enrollee Notices	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
7.8	The MCO must have written policies and procedures pertaining to provider appeals. a. The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03. b. The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. c. The MCO must adhere to **regulatory timeframes for providing written acknowledgment of the appeal and written resolution.**	Compliant with the requirements of COMAR 10.67.09.03, the MCO must have written policies and procedures for provider appeals. **The state specified threshold for all provider appeal resolution is 95%. The MCO must provide evidence that it is monitoring compliance with written acknowledgment and written resolution timeframes through routine reports (i.e., weekly, monthly or quarterly) consistent with the MCO's policies that includes the compliance percentage for 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;	• Provider Appeals Policies & Procedures • TAT Tracking logs for monitoring compliance with **written acknowledgment and written resolution of provider appeals** • TAT Compliance Reports for **written acknowledgment and written resolution** • Appeal Records	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
		• Acknowledges receipt of provider appeals within 5 business days of receipt by the MCO; • Allows providers 90 business days from the date of a denial to file an initial appeal; • Allows providers at least 15 business days from the date of denial to file each subsequent level of appeal; • Resolves appeals, regardless of the number of appeal levels allowed by the MCO, within 90 business days of receipt of the initial appeal by the MCO; • Pays claim within 30 days of the appeal decision when a claim denial is overturned; • Provides at its final level an opportunity for the provider to be heard by the MCO's chief executive officer, or the chief executive officer's designee; • Provides timely written notice to the provider of the results of the internal appeal.		
7.9 (Formerly 7.6)	There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR	The intent of this element is to provide a mechanism for enrollees and providers to offer opinions on	• Enrollee & Provider Satisfaction Policies	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. a. The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures. b. The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee. c. The MCO acts upon identified issues as a result of the review of the data.	the UR process in place at the MCO and assure that the MCO is reviewing and acting upon identified issues. There must be evidence these processes are in place and functioning. There must be evidence that these policies and procedures have been followed. The policies and procedures must describe the process to evaluate the effects of the program using data on enrollee and provider satisfaction and/or other appropriate measures. **If the MCO conducts any independent surveys, data sources must include both the MCO's independent survey results and MDH-coordinated enrollee and provider satisfaction survey results.** It is expected that the MCO will review results of member 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.	and Procedures Relating to UR Program • Enrollee and Provider Satisfaction Surveys Evaluating UR Program • Data Reports Evidencing Review • Trending Reports • Action Plans • Committee Meeting Minutes	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
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. 4. Agree to pay the fixed case fee should the IRO rule against the MCO and has a	• Complaint Resolution/IRO Policy and Procedure • MCO Independent Review Organization Agreement • Online Account • Sample Case Record	COMAR 10.67.13.00

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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; • 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;		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• 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 CY 2019.				
8.0	**Continuity of Care – The MCO has put a basic system in place that promotes continuity of care and case management.**			
8.1	Enrollees with special needs and/or those with complex health care needs must have access to CM according to established criteria and must receive the appropriate services.	The MCO must have policies and procedures in place to identify enrollees with special needs and/or complex health care needs, such as diabetes, severe asthma and high-risk pregnancy, and to enroll them into CM according to the MCOs	• CM Plan • CM Criteria/ • Standards • CM Policies & Procedures • CM Cases	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
		established criteria. This system must allow the enrollee to access the appropriate services provided by the MCO. Per COMAR 10.67.04.04B, special needs populations are identified as: 1. Children with special health care needs. 2. Individuals with a physical disability. 3. Individuals with a developmental disability. 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:	• Committee Meeting Minutes (e.g., QA/UR) • Job Descriptions • Reports and Analysis • Orientation/ • Training Materials	2020 MCO Agreement

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		o Identification of children and adult enrollees with special needs o Assessments o Plans of care o Caseload • Committee reporting structure. • Minimum qualifications for case managers and case manager supervisors. • Orientation/Training for case managers. • Number of FTEs allocated for CM.		
8.2	The MCO must ensure appropriate initiation of care based on the results of HSNI data supplied to the MCO. This must include a process for gathering HSNI data, an ongoing 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,	• HSNI Policies and Procedures • Reports and Analysis	COMAR 10.67.02.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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.		
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 shelters, etc. Collaboration with other department activities such as quality and outreach.	• Continuity of Care Policies & Procedures	HCQIS XIV
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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
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, 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,	• Coordination with Behavioral Health and Substance Use Vendors Policy and Procedures • Enrollee Records	COMAR 10.67.04.14E

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		d. Provider education about the substance use release of information (ROI) process under 42 CFR, Part 2, and e. Provider education for Enrollee identification and referrals to the ASO or core service agencies for behavioral health services.		
8.7	The MCO must comply with providing the Continuity of Health Care Notice to members and have policies and procedures in place to provide services in accordance with the MIA requirements when requested by members.	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 Member Handbook. Examples of evidence may be derived from care management notes, documentation of single case agreements with out-of-network providers, member 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, member 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.** **This standard will be reviewed until the MCO attains 100% compliance.**			

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
9.1	The MCO has a comprehensive written HEP, which must include: a. The education plan's purpose and objectives. b. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events. c. A methodology for notifying enrollees and providers of available educational activities. d. A description of group and individual educational activities targeted at both providers and enrollees.	The MCO's HEP must contain all of the components listed in a-d. There must be an indication of how the objectives were established.	• HEP & Work Plan • Health Education Schedule of Events • Health Education Materials • Enrollee/Provider Notification Methodology	COMAR 10.67.04.03
9.2	The HEP incorporates activities that address needs identified 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 ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.	The HEP must describe the qualifications of the staff that will conduct the educational sessions (e.g., certified diabetes instructor, registered dietician, or certified mental health provider). The education plan must describe how a provider can access a health educator/ educational program through the MCO (e.g., the MCO may	• Data Analysis and Studies • HEP and Work Plan • Provider Manual • Impact Evaluation Methodology	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the members. 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 member referrals.	designate a contact person to assist the provider in connecting the enrollee to a health educator or program).		
9.4	The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.	Mechanisms to identify enrollees in special need of educational efforts may include CM, outreach, or PCP referral for one-on-one education of the enrollee with complex medical needs, the homebound enrollee, and the noncompliant enrollee with health issues.	• Special Educational Need Identification Mechanisms	COMAR 10.67.04.03
9.5	The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide: a. Samples of notifications, brochures, and mailings.	The MCO must demonstrate that enrollees are notified of educational programs and that they have been afforded the opportunity to evaluate these programs. The MCO must provide documentation in the form of notifications, attendance records and session evaluations. There must be evidence that providers are given the opportunity to evaluate enrollee	• Enrollee Mailings • Attendance Records • Completed Session Evaluations • Program Evaluations • Completed Provider Evaluations	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	b. Attendance records and session evaluations completed by enrollees. c. Provider evaluations of health education programs.	educational sessions and the overall health education program.		
10.0	**Outreach Plan – The MCO has developed a comprehensive written outreach services plan to assist enrollees in overcoming barriers in accessing health care services. The OP adequately describes the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.**			
10.1	The MCO has developed a written OP that describes the following: a. Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership. b. MCO's organizational capacity to provide both broad-based and enrollee-specific outreach. c. Unique features of the MCO's enrollee outreach initiatives. d. Community partnerships. e. Role of the MCO's provider network in performing outreach. f. MCO's relationship with each of the LHDs and ACCUs.	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 includes components 10.1a through 10.1f. Supporting policies and procedures must be in place to provide details regarding how these activities are carried out. The OP must include an overview of the populations to be served. At a minimum the populations must include: • Those in need of wellness/ preventive services.	• Educational Materials • DM and CM Program Descriptions • MOUs • Community Event Calendars or Education Program Schedules • Provider Manual • Provider Contracts • MOUs	COMAR 10.67.04.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Those children eligible for EPSDT services. • Those enrollees (both adults and children) who are difficult to reach or miss appointments. • Those enrollees comprising the following special populations defined in COMAR 10.67.04.04 B: 1) Children with special health care needs. 2) Individuals with a physical disability. 3) Individuals with a developmental disability. 4) Pregnant and postpartum women. 5) Individuals who are homeless. 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		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		outreach has been or is anticipated to be particularly challenging (i.e., rural population, non-English speaking populations). The OP must provide an overview of how the MCO's internal and external resources are organized to provide an effective outreach program. For example, the OP briefly describes the roles of various departments such as provider relations, enrollee services, CM, DM, health education, and delegated entities in the performance of outreach activities. The OP must briefly describe data management systems to be utilized in performing outreach activities. This may include data systems or software used to identify, track, and report outreach activities. 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		

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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		(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 CY 2019.	There must be evidence that the MCO has policies and procedures implemented for each of the activities in 10.2 a-d. The MCO identifies those enrollees in need of wellness/ preventive services and initiates activities to encourage utilization of these services. There is evidence that the MCO implements a system to track and monitor access	• 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.	to these services. For example, the MCO identifies and notifies enrollees of due dates for preventive services such as mammograms and cervical cancer screenings through reminder notices such as letters or postcards. The MCO must have policies and procedures in place to guide outreach staff in the outreach process. This guidance may be in the form of policies and procedures or process flow charts. There must be evidence that these processes are being followed. There must be evidence that the MCO utilizes a systematic process to provide outreach services that employs: • Telephone contact. • Written materials. • Face-to-face contact. There must be evidence that outreach activities are monitored. There must be evidence that the MCO monitors any delegated activities to assure that contracted or delegated activities are carried out. For example, if the MCO has an		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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: a. Deleted in CY 2019. b. Deleted in CY 2019. c. To promote the provision of EPSDT services and respond to no-shows and non-compliant behavior related to children in need of EPSDT services. d. To bring enrollees into care who are difficult to reach or who miss appointments.	There must be evidence that the MCO has implemented strategies to provide outreach to the populations in 10.3 c and d. The MCO identifies and tracks children (up to 21 years of age) who are eligible for EPSDT services or treatment. The MCO identifies those enrollees due for services, enrollees who miss appointments, and non-compliant enrollees. There is evidence that the MCO provides outreach to schedule those children in need of EPSDT services and/or to bring those children who miss appointments into care.	• Outreach Work Plan • Data Reports • Tracking/Referral logs • Enrollee Mailings • Provider Mailings	COMAR 10.67.05.03
11.0	**Fraud and Abuse - The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.**			
11.1	The MCO maintains administrative and management procedures,	The MCO demonstrates the ability to detect and identify inappropriate and	• Compliance Plan • Fraud Manual	42 CFR § 438.608 COMAR 10.67.07

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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, 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	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. 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.	• 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 dispensation of all incidences of reported suspected fraud and abuse	COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and abuse education of MCO staff, enrollees, and providers. e. A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation. f. A documented process to ensure that services billed to the MCO were 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:	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	• 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	42 CFR § 438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. Education and training for the Compliance Officer and the MCO's employees on detection of fraud and abuse. b. A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO's employees. c. A documented process for enforcing standards 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	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.	sessions regarding fraud and abuse	Organizations and PrePaid Health Plans"

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	sanctioning incidents of fraud and abuse. f. A documented process for the reporting by employees of suspected fraud and abuse within the organization, without fear of reprisal. g. A documented process for reporting by subcontractors of the 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	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 incidences.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Documentation of reported incidences of fraud and abuse to State Medicaid Agency • Documentation of collaboration and cooperation with State Medicaid Fraud Control Unit	42 CFR § 438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	within 30 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 is investigated.			
11.4	The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address: a. Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee. b. Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP. c. Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent	The MCO documents the mechanisms that evaluate the effectiveness of its fraud and abuse compliance plan through routine and random reports, CAPs and their implementation, administrative and management procedures. The MCO documents oversight of fraud and abuse activities for each delegate, including delegate compliance plans and fraud and abuse activity reports.	• Compliance Committee Minutes • Routine and Random Fraud and Abuse Reports • CAPs • CAP Implementation Reports • Delegate Fraud and Abuse Reports	42 CFR § 438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and PrePaid Health Plans"

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	fraud and abuse for each delegate that the MCO contracts with. d. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.			
11.5 (Formerly 2.8)	An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies. a. An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals or entities debarred by Federal Agencies. b. An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO's equity. c. An MCO must have written policies and procedures	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. Initial checks of all databases are required. Monthly checks of the following databases are required: List	• Governance Policies and Procedures • Subcontracting and Employment Policies and Procedures • Evidence of data 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
	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.	of Excluded Individuals/Entities and Excluded Parties List Systems/SAM.		

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

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

Appendix C: 2020 Final IRS and Methodology

Information Reporting Strategy & Analytic Methodology

2020 Maryland HealthChoice Consumer Report Card

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

The Report Card is meant to help Medicaid participants select a HealthChoice managed care organization (MCO). Information in the Report Card includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Maryland's encounter data measures.

This report explains the reporting strategy and analytic methods Qlarant will use in developing the Report Card that the MDH will release in 2020, based on data reported from the MCOs in CY 2019. This report is organized as follows:

Section II: Information Reporting Strategy explains the principles used to determine the most appropriate and effective methods of reporting quality information to Medicaid participants, the intended target audience.

Section III: Analytic Method provides a statistical basis and the analysis method to be used for reporting comparative MCO performance.

Appendices:

A. Reporting Categories and Measures
B. Questions Comprising CAHPS Measures for the Medicaid Product Line
C. Statistical Methodology to Compare MCO Performance

Information Reporting Strategy

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

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

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

ORGANIZING INFORMATION

Group relevant information in a minimal number of reporting categories and in single-level summary scores.

Recommendation—To enhance comprehension and interpretation of quality measurement information provided for a Medicaid audience, the Qlarant team will design the Report Card to include six categories, with one level of summary scores (measure roll-ups) per MCO, for each reporting category.

Rationale—Research has shown that people have difficulty comparing MCO performance when information is presented in too many topic areas. To include a comprehensive set of performance measures in an effective consumer-information product (one that does not present more information than is appropriate for an audience of Medicaid participants), measures must be combined into a limited number of reporting categories that are meaningful to the target audience.

Group measures into reporting categories that are meaningful to consumers.

Recommendation—Based on a review of the potential measures available for the Report Card (HEDIS, CAHPS, and Maryland's encounter data measures), the team recommends the following reporting categories:

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

Rationale—The recommended categories are based on measures reported by HealthChoice MCOs in 2018 and designed to focus on clearly identifiable areas of interest. Consumers may focus on MCO performance in the areas most important to them and their families.

The first two categories are relevant to all participants; the remaining categories are relevant to specific Maryland HealthChoice participants: children, children with chronic illness, women, and adults with chronic illness.

Reporting measures individually (in addition to the reporting categories listed above) is not recommended. Comparing the performance of a category composed of many measures with the performance of individual measures may give undue weight to the individual measures.

MEASURE SELECTION

Select measures that apply to project goals.

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

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

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

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

HEDIS Measures

Summary of HEDIS 2019 Measure Changes

The following Measure Specification and HEDIS General Updates do not affect the Report Card methodology. For detailed changes, refer to *HEDIS 2019, Volume 2: Technical Specifications for Health Plans.*

Measure Specific Updates

- *Breast Cancer Screening*:
  - No changes.

- *Appropriate Testing for Children With Pharyngitis*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Immunizations for Adolescents*:
  - Added optional exclusions for Tdap.

- *Appropriate Treatment for Children With Upper Respiratory Infection*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*:
  - Deleted guidelines regarding how to identify an ED visit or observation visit that resulted in an inpatient stay.

- *Controlling High Blood Pressure*:
  - Revised the definition of representative Blood Pressure (BP) to indicate the BP reading must occur on or after the second diagnosis of hypertension.
  - Removed the diabetes flag identification from the event/diagnosis criteria.
  - Added administrative method for reporting.
  - Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
  - Updated the Hybrid specification to indicate that sample size reduction is not allowed.
  - Removed the requirement to confirm the hypertension diagnosis.
  - Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

- *Comprehensive Diabetes Care*
  - Added telehealth into the measure specifications.
  - Added methods to identify bilateral eye enucleation.
  - Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
  - Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

HEDIS 2019 General Updates

- Telehealth is incorporated into several measures.
- Certified Federally Qualified Health Centers (FQHC) are considered PCPs. Certification must be reviewed and approved by an auditor.

CAHPS Patient Experience Survey Measures

Consistent with the 2019 Consumer Report Card, it is recommended that results of both the CAHPS Health Plan Survey 5.0H, Adult Version and the CAHPS Health Plan Survey 5.0H, Child Version with the Children With Chronic Conditions (CCC) measures be included.

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

Summary of CAHPS Measure Changes for 2019

- No modifications were made to the CAHPS Survey for CY 2019

Overall Reporting Category Changes for 2020 Report Card

- Access to Care
  - No changes
- Doctor Communication and Service
  - No changes
- Keeping Kids Healthy
  - No changes
- Care for Kids with Chronic Illness
  - No changes
- Taking Care of Women
  - No changes

- Care for Adults With Chronic Illness
  - No changes

FORMAT

Display information in a format that is easy to read and understand.

The following principles are important when designing Report Cards:

- *Space:* Maximize the amount to display data and explanatory text.
- *Message:* Communicate MCO quality in positive terms to build trust in the information presented.
- *Instructions:* Be concrete about how consumers should use the information.
- *Text:* Relate the utility of the Report Card to the audience's situation (e.g., new participants choosing an MCO for the first time, participants receiving the Annual Right to Change Notice and prioritizing their current healthcare needs, current participants learning more about their MCO) and reading level.
- *Narrative:* Emphasize *why* what is being measured in each reporting category is important, rather than giving a detailed explanation of *what* is being measured. For example, "making sure that kids get all of their shots protects them against serious childhood diseases" instead of "the percentage of children who received the following antigens…"
- *Design:* Use color and layout to facilitate navigation and align the star ratings to be left-justified ("ragged right" margin), consistent with the key.

Recommendation—An 11 x 18-inch, one-page document, with English on one side and Spanish on the opposite side. This one-page document allows presentation of all information. Measure explanations can be integrated on the same page as performance results, helping readers match the explanation to the data.

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

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

RATING SCALE

Rate MCOs on a tri-level rating scale.

Recommendation—Compare each MCO's performance with the average of all MCOs potentially available to the target audience; in this case, the average of all HealthChoice MCOs ("the Maryland HealthChoice MCO average"). Use stars or circles to represent performance that is "above," "the same as" or "below" the Maryland HealthChoice MCO average.

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

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

Analytic Method

The Report Card compares each MCO's actual score with the unweighted statewide MCO average for a particular reporting category. An icon or symbol denotes whether an MCO performed "above," "the same as" or "below" the statewide Medicaid MCO average.[9]

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

[9]For state performance reports directed at participants, 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 a MCO's performance relative to other MCOs, rather than presenting how well the state's Medicaid MCOs serve participants *overall*. In a Report Card, each MCO represents an equally valid option to the reader, regardless of enrollment size.

Handling Missing Values

Replacing missing values can create three issues. 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. Alternatives are fixed values (such as "zero" or "the 25th percentile for all MCOs in the nation"), calculated values (such as means or regression estimates), or probable selected values (such as multiplying imputed values). Finally, analysts determine the method used to replace missing values; one that should not provide an incentive for poorly performing plans to intentionally fail to report data. For example, if missing values are replaced with the mean of non-missing cases, scores for MCOs that perform below the mean would be higher if they fail to report.

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

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

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

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

- For HEDIS, health plans that followed the specifications but had too small a denominator (<30) to report a valid rate are assigned a measure result of N/A.
- For CAHPS, MCOs must achieve a denominator of at least 100 responses to obtain a reportable result. MCOs whose denominator for a survey result calculation is <100 are assigned a measure result of N/A.

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

- If fewer than 50 percent of the MCOs report a measure, the measure is dropped from the Report Card category.

- If an MCO has reported at least 50 percent of the measures in a reporting category, the missing values are replaced with the mean or minimum values, based on the reasons for the missing value.
- MCOs missing more than 50 percent of the measures composing a reporting category are given a designation of "Insufficient Data" for the measurement category.

Calculations in each category are based on the remaining reportable measures versus reportable MCOs. "N/A" and "BR/NR" designations will be treated differently where values are missing. "N/A" 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 nonsurvey measures (HEDIS, Maryland encounter data).

Handling New MCOs

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

Members Who Switch Products/Product Lines

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

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

Case-Mix Adjustment of CAHPS Data

Several field-tests indicate a tendency for CAHPS respondents in poor health to have lower satisfaction scores. It is not clear whether this is because members in poor health experience lower-quality healthcare 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 healthcare services—and their CAHPS responses do contain meaningful information about the quality of care delivered in this more intensive environment; therefore, case-mix adjustment is not planned for the CAHPS data used in this analysis.

Statistical Methodology

The statistical methodology includes the following steps:

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

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

Quality Control

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

Reporting Categories and Measures

CATEGORY: ACCESS TO CARE	DATA SOURCE	WEIGHT
Getting Needed Care (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Getting Care Quickly (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Customer Service (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Children and Adolescents' Access to Primary Care Practitioners (12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12-19 years)	HEDIS	1/7
Adults' Access to Preventive/Ambulatory Health Services (20 to 44 years and 45 to 64 years)	HEDIS	1/7
Access to Care - SSI Adult (21 years or older)*	MDH Encounter Data	1/7
Access to Care – SSI Children (ages 0-20)*	MDH Encounter Data	1/7
CATEGORY: DOCTOR COMMUNICATION AND SERVICE	**DATA SOURCE**	**WEIGHT**
Rating of All Health Care (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Rating of Personal Doctor (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Rating of Specialist Seen Most Often (rating mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
How Well Doctors Communicate (composite mean)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Shared Decision Making ("Yes" composite global proportion^)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Health Promotion and Education ("Yes" question summary rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
Coordination of Care ("Usually" and "Always" question summary rate)	CAHPS 5.0H MA CAHPS 5.0H MC	1/14 1/14
CATEGORY: KEEPING KIDS HEALTHY	**DATA SOURCE**	**WEIGHT**
Childhood Immunization Status (Combo 3)*	HEDIS	1/8
Appropriate Treatment for Children With Upper Respiratory Infections (3 months-18 years)	HEDIS	1/8
Appropriate Testing for Children With Pharyngitis (2-18 years)	HEDIS	1/8
Well-Child Visits in the First 15 Months of Life (6+ visit rate)	HEDIS	1/8

Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life*	HEDIS	1/8
Adolescent Well-Care Visits (12-21 years)*	HEDIS	1/8
Lead Screening (12 through 23 months)*	MDH Encounter Data, MDE Lead Registry, FFS Data	1/8
Immunization for Adolescents (Combo 1)*	HEDIS	1/8
CATEGORY: CARE FOR KIDS WITH CHRONIC ILLNESS	**DATA SOURCE**	**WEIGHT**
Access to Prescription Medicines (question mean)	CAHPS 5.0H MC	1/6
Access to Specialized Services: Special Medical Equipment or Devices (composite mean)	CAHPS 5.0H MC	1/6
Family Centered Care: Personal Doctor or Nurse Who Knows Child ("Yes" composite global proportion)	CAHPS 5.0H MC	1/6
Family Centered Care: Getting Needed Information (question mean)	CAHPS 5.0H MC	1/6
Coordination of Care for Children With Chronic Conditions ("Yes" composite global proportion)	CAHPS 5.0H MC	1/6
Asthma Medication Ratio [5-18 years (combine 5-11 years and 12-18 years)]*	HEDIS	1/6
CATEGORY: TAKING CARE OF WOMEN	**DATA SOURCE**	**WEIGHT**
Breast Cancer Screening*	HEDIS	1/5
Cervical Cancer Screening	HEDIS	1/5
Chlamydia Screening (Total Rate: 16-24 years)	HEDIS	1/5
Timeliness of Prenatal Care	HEDIS	1/5
Postpartum Care*	HEDIS	1/5
CATEGORY: CARE FOR ADULTS WITH CHRONIC ILLNESS	**DATA SOURCE**	**WEIGHT**
CDC: Hemoglobin A1c (HbA1c) Testing*	HEDIS	1/8
CDC: HbA1c Poor Control (>9.0%) Note: MCO rate used in the analysis is the inverse score, in order to provide consistency with other measures (i.e. higher % is better)	HEDIS	1/8
CDC: Eye Exam (Retinal) Performed	HEDIS	1/8
CDC: Medical Attention for Nephropathy	HEDIS	1/8
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	HEDIS	1/8
Use of Imaging Studies for Low Back Pain	HEDIS	1/8
Asthma Medication Ratio [19-64 years (combine 19-50 years and 51-64 years)]*	HEDIS	1/8
Controlling High Blood Pressure*	HEDIS	1/8

*Maryland Value-Based Purchasing measure

^Note this composite should be calculated using Composite Global Proportion instead of the Composite Mean

CAHPS 5.0H Measures for the Medicaid Product Line

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

Question	Getting Needed Care	Response Choices	Score Values
Q25=MA **Q46=MC**	In the last 6 months, how often was it easy to get appointments with specialists?	Never Sometimes Usually Always	1 1 2 3
Q14=MA **Q15=MC**	In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?	Never Sometimes Usually Always	1 1 2 3
Question	**Getting Care Quickly**	**Response Choices**	**Score Values**
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	1 1 2 3
Q6=MA **Q6=MC**	In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	Never Sometimes Usually Always	1 1 2 3
Question	**How Well Doctors Communicate**	**Response Choices**	**Score Values**
Q17=MA **Q32=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	1 1 2 3
Q18=MA **Q33=MC**	In the last 6 months, how often did your personal doctor listen carefully to you?	Never Sometimes Usually Always	1 1 2 3

Q19=MA **Q34=MC**	In the last 6 months, how often did your personal doctor show respect for what you had to say?	Never Sometimes Usually Always	1 1 2 3
Q20=MA **Q37=MC**	In the last 6 months, how often did your personal doctor spend enough time with you?	Never Sometimes Usually Always	1 1 2 3
Question	**Customer Service**	**Response Choices**	**Score Values**
Q31=MA **Q50=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	1 1 2 3
Q32=MA **Q51=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	1 1 2 3
Question	**Shared Decision Making**	**Response Choices**	**Score Values**
Q10=MA **Q11=MC**	Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?	Yes No	1 0
Q11=MA **Q12=MC**	Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?	Yes No	1 0
Q12=MA **Q13=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	1 0
Question	**Health Promotion and Education**	**Response Choices**	**Score Values**
Q8=MA **Q8=MC**	In the last 6 months, did you and a doctor or other health provider talk specific things you could do to prevent illness?	Yes No	1 0
Question	**Coordination of Care**	**Response Choices**	**Score Values**
Q22=MA **Q40=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	0 0 1 1

Question	Rating of Health Care	Response Choices	Score Values
Q13	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>=Q13<=6 Q13>=7<=8 Q13>=9<=10	1 2 3
Q14	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 child's health care in the last 6 months?	0>=Q14<=6 Q14>=7<=8 Q14>=9<=10	1 2 3
Question	**Rating of Personal Doctor**	**Response Choices**	**Score Values**
Q23	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>=Q23<=6 Q23>=7<=8 Q23>=9<=10	1 2 3
Q41	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 child's personal doctor?	0>=Q41<=6 Q41>=7<=8 Q41>=9<=10	1 2 3
Question	**Rating of Specialist**	**Response Choices**	**Score Values**
Q27	We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	0>=Q27<=6 Q27>=7<=8 Q27>=9<=10	1 2 3
Q48	We want to know your rating of the specialist your child saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?	0>=Q48<=6 Q48>=7<=8 Q48>=9<=10	1 2 3

Key*:* MA = CAHPS 5.0H Medicaid Adult Questionnaire MC = CAHPS 5.0H Medicaid Child Questionnaire (With CCC measure)

CAHPS 5.0H Child Questionnaire Measures

The following questions from the CAHPS 5.0H Child Questionnaire provide information on parents' experience with their child's health plan for the population of children with chronic conditions. The five CCC measures summarize satisfaction with basic components of care essential for

successful treatment, management and support of children with chronic conditions. The child is included in the CCC population calculations if one or more of the following survey-based screening criteria are true:

- Child currently needs/uses **medicine prescribed by a doctor** 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	Score Values
Q56	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	1 1 2 3
Question	**Access to Specialized Services**	**Response Choices**	**Score Values**
Q20	In the last 6 months, how often was it easy to get special medical equipment or devices for your child?	Never Sometimes Usually Always	1 1 2 3
Q23	In the last 6 months, how often was it easy to get this therapy for your child?	Never Sometimes Usually Always	1 1 2 3
Q26	In the last 6 months, how often was it easy to get this treatment or counseling for your child?	Never Sometimes Usually Always	1 1 2 3
Question	**Family-Centered Care: Personal Doctor Who Knows Child**	**Response Choices**	**Score Values**
Q38	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	1 0

Q43	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	1 0
Q44	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	1 0
Question	**Family-Centered Care: Getting Needed Information**	**Response Choices**	**Score Values**
Q9	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	1 1 2 3
Question	**Coordination of Care for Children With Chronic Conditions**	**Response Choices**	**Score Values**
Q18	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	1 0
Q29	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	1 0

Appendix D: Report Reference Page

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

Systems Performance Review

CY 2020 Statewide Executive Summary Report

Performance Improvement Projects

2021 Annual PIP Report

Encounter Data Validation

CY 2020 EDV Report

Value-Based Purchasing

CY 2020 VBP Report

Early and Periodic Screening, Diagnosis, and Treatment

CY 2020 EPSDT Statewide Executive Summary Report

Consumer Report Card

2021 Maryland Consumer Report Card English and Spanish

Focused Review of Grievances, Appeals, & Denials

2021 Annual Grievances, Appeals, & Denials Report

Network Adequacy Validation

CY 2021 Network Adequacy Report

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set
Statewide Executive Summary Report HealthChoice Participating Organizations HEDIS 2020

Consumer Assessment of Healthcare Providers and Systems

State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations Adult and Child Populations 2020 CAHPS 5.0H Member Experience Survey