Qlarant

Maryland HealthChoice Program

Annual Technical Report

Calendar Year 2023

Maryland
DEPARTMENT OF HEALTH

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Executive Summary

Introduction

The Maryland Department of Health (MDH) contracts with Qlarant, an external quality review organization (EQRO), to evaluate Maryland's managed care program, known as HealthChoice. HealthChoice has been operational since June 1997 under the authority of an 1115 waiver of the Social Security Act. HealthChoice's guiding principle is to provide quality health care that is patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. Managed care organizations (MCOs) contracted to provide HealthChoice services include:

- Aetna Better Health of Maryland (ABH)
- CareFirst Community Health Plan (CFCHP)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- Wellpoint Maryland (WPM) [1]

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

- Performance Improvement Project (PIP) Validation
- Performance Measure Validation (PMV)
- Compliance Review, also referenced as Systems Performance Review (SPR)
- Network Adequacy Validation (NAV)
- Encounter Data Validation (EDV)

[1] Formerly known as AMERIGROUP Community Care (ACC)

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

Qlarant conducted EQR activities throughout 2023 and evaluated MCO compliance and performance for measurement years (MYs) 2022 and 2023, as applicable. Comparisons between the Code of Maryland Regulations (COMAR) and the Code of Federal Regulations (CFR) set standards for compliance and performance. Qlarant followed Centers for Medicare and Medicaid Services (CMS) EQR Protocols to conduct activities.[2] This report summarizes results from all EQR activities and includes conclusions drawn regarding the quality, accessibility, and timeliness of care furnished by the MCOs.

Key Findings

Key findings are summarized below for the HealthChoice MCOs. Strengths, weaknesses, and recommendations for each MCO are identified within the **MCO Quality, Access, and Timeliness Assessment section** of the report. MCO findings correspond to performance areas, including the quality, accessibility, and timeliness of services provided to their members.

Performance Improvement Project Validation. PIPs are designed to achieve significant improvement, sustained over time, in clinical care and non-clinical care areas. Projects are expected to have a favorable effect on health outcomes and enrollee satisfaction. HealthChoice MCOs conduct two PIPs annually. As designated to align with statewide public health and Medicaid innovation initiatives, specifically, the Statewide Integrated Health Improvement Strategy to reduce severe maternal morbidity, MDH introduced the Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Prenatal Care PIP) and the Maternal Health and Infant/Toddler Care During the Postpartum Period (Postpartum Care-Related PIP) PIP topics to replace the Asthma Medication Ratio (AMR) PIP and the Lead Screening PIP for measurement year (MY) 2022. Table 1 displays the baseline percentage indicator results from MY 2022 for each MCO.

[2] CMS EQR Protocols

Table 1. MY 2022 PIP Baseline Indicator Rate Percentages

Indicator	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Timeliness of Prenatal Care and Identification of High-Risk Pregnancies									
Prenatal and Postpartum Care: Prenatal Care (PPC-CH)	84.2%	88.9%	87.7%	88.6%	89.1%	83.2%	92.2%	87.4%	90.0%
Maternal Health and Infant/Toddler Care During the Postpartum Period									
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	78.6%	83.5%	85.3%	87.3%	83.5%	88.0%	82.0%	74.9%	80.4%
Well-Child Visits in the First 30 Months of Life (W30 0-15 Months)	48.8%	52.0%	56.1%	74.9%	58.7%	53.4%	57.1%	58.9%	57.2%
Well-Child Visits in the First 30 Months of Life (W30 15-30 Months)	65.3%	66.2%	70.1%	74.4%	67.5%	67.9%	71.7%	72.1%	75.6%
Childhood Immunization Status: Combo 3 (CIS-3)	63.3%	63.8%	66.9%	79.9%	66.7%	70.1%	70.6%	66.9%	72.0%

Performance Measure Validation. The Population Health Incentive Program (PHIP) is an incentive program designed to provide financial incentives to MCOs, based on performance within certain measures. MY 2022 is the first implementation year of the two-round design for selected Healthcare Effectiveness Data and Information Set (HEDIS®) measures and MDH-developed encounter measures. Qlarant completed PHIP activities in collaboration with MetaStar, Inc. (MetaStar) and The Hilltop Institute at the University of Maryland, Baltimore County (Hilltop). MDH elected to contract with MetaStar to validate measures and conduct the NCQA HEDIS® Compliance Audits™[3]. Hilltop calculated encounter data measures. Qlarant validated the three encounter data measures and analysis to determine financial incentives.

Performance incentives rewarded MCO scores against benchmarks at or above the 50th percentile during the MY. Improvement incentives rewarded year-over-year improvement. All nine MCOs received a financial reward for Round 1 – Tier 1 for performance, while six of the nine MCOs (ABH, CFCHP, MPC, MSFC, PPMCO, and UHC) received a Round 1 – Tier 2 incentive for improvement. No MCOs received a Round 2 incentive. Table 2 provides a summary of which MCOs received incentives for Round 1 tiers.

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

Table 2. Overall PHIP Net Outcomes by MCO for Round 1

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

Yes indicates the MCO received an incentive; **No** indicates the MCO did not receive an incentive

Systems Performance Review. Qlarant evaluated MY 2022 MCO compliance with federal and contractual requirements as an interim desktop review. Interim desktop reviews reflect MDH's decision to move to triennial, rather than annual onsite reviews, and review standards which were scored as *Baseline* or *Met with Opportunities*, or required a corrective action plan (CAP). The next comprehensive review will occur for MY 2024. MDH set the minimum compliance rate for each federal and contractual quality assurance standard at 100%. SPRs evaluate MCO compliance with structural and operational standards.

CAPs were required to address areas of noncompliance for eight of the nine MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC, and WPM), which should improve compliance rates if successfully implemented. One MCO (JMS) maintained compliance, without required CAPs, for multiple years. CAPs were calculated by standard, instead of by individual components or elements. Table 3 identifies the number of CAPs required by each MCO and the number reviewed and successfully closed.

Table 3. MY 2022 SPR Total Corrective Action Plans per MCO

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Corrective Action Plans Required	1	3	0	2	2	1	4	1	3
Total Corrective Action Plans Closed	2	2	0	2	1	1	0	2	0
CAP Comparison to MY 2021	↓	↓	Ø	↓	↓	Ø	↑	↓	↑

↑ Increase from MY 2021; ↓ Decrease from MY 2021; Ø no change

Network Adequacy Validation. Qlarant evaluated the network adequacy of HealthChoice MCOs to ensure MCOs can provide enrollees with timely access to necessary care and a sufficient number of in-network providers as outlined in COMAR. In MY 2023, 2,074 primary care providers (PCPs) were part of the survey sample to monitor available coverage for current HealthChoice enrollees. Successful contact yielded a response rate of 59.3%, which represents 1,229 PCPs. Qlarant's surveyors verified:

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

- First availability for urgent care appointments.

MDH set a compliance threshold of 80% for each component reviewed. One MCO (ABH) maintained compliance, without required CAPs, for multiple years. CAPs were required to address areas of noncompliance for six of the nine MCOs (CFCHP, JMS, KPMAS, PPMCO, UHC, and WPM), which should improve compliance rates if successfully implemented. CAPs were calculated by standard, instead of by individual requirements. Table 4 identifies the number of CAPs required by each MCO and the number reviewed and successfully closed.

Table 4. MY 2023 NAV Total Corrective Action Plans per MCO

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Corrective Action Plans Required	0	1	1	2	0	0	2	1	1
Total Corrective Action Plans Closed	0	1	1	1	1	1	0	0	1
CAP Comparison to MY 2022	**Ø**	**Ø**	**↓**	**↑**	**↓**	**↓**	**↑**	**↓**	**Ø**

↑ Increase from MY 2022; ↓ Decrease from MY 2022; Ø no change

Encounter Data Validation. Qlarant conducted a medical record review on a sample of inpatient, outpatient, and office visit encounters 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: 100% for inpatient, 99% for outpatient, and 96% for office visits. There were no corrective action plans required as a result of the MY 2022 review, demonstrating that all of the HealthChoice MCOs achieved match rates that were equal to or above the 90% standard.

Table 5. MY 2022 MCO and HealthChoice Results by Encounter Type

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

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews. The EPSDT medical record review assesses the quality, timeliness, and accessibility of care. Over 2,400 medical records were reviewed for the MY 2022 activity. Review indicators were based on current pediatric preventive care guidelines and MDH-identified priority areas. MY 2022's medical record review process adopted a pre-COVID methodology to complete the majority of reviews onsite at provider offices. Medical record review completion encountered the following challenges:

- Nurse reviewer willingness to travel onsite to provider offices
- Nurse reviewer availability and scheduling
- Provider office compliance, including participation and lack of education

Qlarant worked in close collaboration with MDH to address, monitor, and combat these barriers from having an adverse effect on review completion. Qlarant discussed the above barriers during the Quality Assurance Liaison Committee (QALC) discussion. Medical record review completion challenges were addressed by conducting additional recruitment for full-time nurses to complete onsite record reviews and by extending the EPSDT task until the sample was met. Qlarant continued to conduct outreach to provider offices, with limited offices willing to schedule, until the sample size was met. Provider compliance challenges were addressed by identifying specific providers with the MCOs that were the main concern in regards to noncompliance, and what effects the lack of participation would have on MCO scoring.

MDH set a compliance threshold of 80% for each component reviewed. CAPs were required to address areas of noncompliance for one of the nine MCOs (PPMCO), which should improve compliance rates if successfully implemented. CAPs were calculated by component, instead of individual measures. Table 6 identifies the number of CAPs required by each MCO and the number reviewed and successfully closed.

Table 6. MY 2022 EPSDT Total Corrective Action Plans per MCO

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total Corrective Action Plans Required	0	0	0	0	0	0	1	0	0
Total Corrective Action Plans Closed	0	0	0	0	0	0	0	1	0
CAP Comparison to MY 2021	**Ø**	**Ø**	**Ø**	**Ø**	**Ø**	**Ø**	**↑**	**↓**	**Ø**

↑ Increase from MY 2021; ↓ Decrease from MY 2021; Ø No change

Consumer Report Card. The CRC assists Medicaid participants when selecting a HealthChoice MCO. Information in the CRC includes performance measures from the HEDIS, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and Maryland's encounter data measures.

Tables 7 and 8 display the MY 2022 Consumer Report Card results and the overall star rating changes from MY 2022 to MY 2023.

Table 7. MY 2023 Consumer Report Card Results

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

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

Table 8. CRC Star Rating Changes from MY 2022 to MY 2023

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

Light Green = ↑ improvement from MY 2022; Pink = ↓ decline from MY 2022; White = Ø no change from MY 2022; Gray = NA reported as Not Applicable for MY 2022 and/or MY 2023

Grievances, Appeals, and Denials Focused Study. Qlarant assessed MCO compliance of grievances, appeals, and pre-service denials against performance standards established for MY 2022 and based on federal and state laws and regulations pertaining to the appropriateness of denials of service and the handling of grievances and appeals. Quarterly submissions of MCO grievance, appeal, and pre-service denial reports were reviewed with the first through third quarters of MY 2022 data, while the fourth quarter reviewed annual MY 2022 data. Enrollee grievances, appeals, and pre-service denials submitted by enrollees during MY 2022 were assessed through an annual record review.

Table 9 captures overall MCO compliance scores from quarterly report submissions against MDH's compliance threshold of 95%.

Table 9. MY 2022 MCO Overall Compliance with Regulatory Timeframes

Categories	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Enrollee Grievances	M	PM	M	PM	M	M	M	M	M
Provider Grievances	M	PM	M	NA	M	M	M	M	M
Enrollee Appeals	M	M	M	PM	PM	M	M	M	PM
Adverse Determinations	M	M	M	PM	M	M	M	M	PM
Adverse Notifications	M	M	M	M	M	M	M	M	M

M = Met; PM = Partially Met

Annual record reviews assessed MCO compliance with grievance, appeal, and denial processing requirements, timeliness of notifications to enrollees, and content requirements and ease of understanding letters to enrollees. Table 10 captures overall MCO compliance with annual record review components.

Table 10. MY 2022 MCO Overall Compliance with Record Review Components

Categories	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Enrollee Grievances	M	PM	M	M	M	M	M	M	PM
Enrollee Appeals	M	PM	M	PM	M	M	PM	M	PM
Adverse Determinations	M	M	M	PM	M	M	M	M	PM
Adverse Notifications	PM	PM	M	M	PM	M	M	M	M

M = Met; PM = Partially Met

Healthcare Effectiveness Data and Information Set (HEDIS)

MDH contracted with MetaStar, Inc. (MetaStar), a National Committee for Quality Assurance (NCQA) Licensed Organization, to conduct HEDIS Compliance Audits of all HealthChoice managed care organizations and to summarize the results. For HEDIS MY 2022, MDH required HealthChoice MCOs to report the complete HEDIS measure set for services rendered in MY 2022 to HealthChoice enrollees. These measures provide meaningful MCO comparative information, and they evaluate performance relative to MDH's priorities and goals.

Although COVID-19 waxed and waned during the 2022 measurement period, health care delivery overall was not impacted as significantly as it had been in 2020 and 2021. Broadly speaking, Maryland MCO performance for their HEDIS rates normalized somewhat to performance prior to the COVID-19 pandemic. For additional findings and comprehensive details associated with the HEDIS MY 2021 results, see the full report linked in **Appendix E**.

Consumer Assessment of Healthcare Providers and Systems

MDH contracted with the Center for the Study of Services (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 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 10 and May 10, 2023. For additional findings and comprehensive details associated with the 2023 CAHPS results, see the full report linked in **Appendix E**.

Conclusion

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

MDH continues to encourage an environment of compliance and quality improvement and sets high standards to promote access to quality care. The MYs 2022 and 2023 review activities provided evidence of the MCOs' continuing progression and demonstration of their abilities to ensure the delivery of quality health care and services for Maryland Medicaid managed care enrollees.

Maryland HealthChoice Program

External Quality Review

2023 Annual Technical Report

Introduction

Background

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

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

The 2023 Annual Technical Report (ATR) is a compilation of quality assurance activity reports for services and activities conducted during measurement years (MYs) 2022 and 2023. The ATR describes EQR methodologies for completing activities; provides MCO performance measure results; summarizes compliance results; and includes an overview of the quality, timeliness, and accessibility of health care services provided by the contracted MCOs.

As of December 31, 2022, HealthChoice enrolled 1,525,824 participants. MDH contracted with nine MCOs during this evaluation period:

- Aetna Better Health of Maryland (ABH)
- CareFirst Community Health Plan (CFCHP)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)

- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- Wellpoint Maryland (WPM) [4]

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

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

In order to achieve these overreaching goals, MDH has identified three specific goals and measurable objectives in Table 11. Maryland also requires MCOs to attain and maintain National Committee for Quality Assurance (NCQA) accreditation. The accreditation signifies a plan's commitment to quality improvement. NCQA evaluates health care quality provided by plans to their members. The accreditation encompasses an audit of NCQA standards, Healthcare Effectiveness Data and Information Set (HEDIS®), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®).[5, 6]

[4] Formerly known as AMERIGROUP Community Care (ACC).
[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 11. HealthChoice Program Goals and Objectives

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

Source: *HealthChoice Quality Strategy*[7]

Table 12 displays MCO profiles and quality characteristics for those MCOs evaluated during this period.

[7] Quality Strategy, revised April 8, 2024.

Table 12. MY 2022 MCO Profiles

MCOs	Contracted Since	MY 2022 Enrollment[8]	NCQA Accreditation Status[9]	Next NCQA Review Date
ABH	2019	58,240	Accredited	05/19/2026
CFCHP	2013	85,634	Accredited	02/25/2025
JMS	1997	30,170	Accredited	06/02/2026
KPMAS	2014	120,784	Accredited	05/27/2025
MPC	1997	253,546	Accredited	12/03/2024
MSFC	1997	110,585	Accredited	04/01/2027
PPMCO*	1995	358,306	Provisional	06/11/2024
UHC	1997	174,663	Accredited	02/02/2027
WPM[10]	1999	333,893	Accredited	01/07/2025

Source: *HealthChoice Quality Strategy*
**PPMCO is under corrective action with provisional accreditation status. The next NCQA review date is 6/11/2024.*

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 health care services furnished by the MCOs through various mandatory activities following CMS-developed EQR protocols. Qlarant completed the following EQR activities in calendar years (CYs) 2022 and 2023 to evaluate MCO performance for MY 2022:

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

Qlarant conducted optional activities that include:

- Encounter Data Validation (EDV)
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Reviews

[8] Source: Maryland Department of Health, MCO enrollment as of 12/31/2022.

[9] Source: MetaStar (2022, August). Statewide Executive Summary Report HealthChoice Participating Organization HEDIS MY 2021 Results. Madison, WI.

[10] ACC's name changed to Wellpoint Maryland, effective January 1, 2023 and will be reflected in MY 2023's report.

- Development and production of an annual Consumer Report Card (CRC)
- Quarterly focused reviews of MCO grievances, appeals, and denials (GAD)

In addition to these EQR activities, 42 CFR §438.364(a) requires the EQRO to produce a detailed technical report describing how data from all activities conducted were aggregated and analyzed, and how conclusions were drawn regarding the quality, accessibility, and timeliness of care furnished by the MCOs. This ATR serves as Qlarant's report to MDH on the assessment of MY 2022 MCO performance, describes EQR methodologies for completing activities, provides compliance results, and analyzes performance. Additionally, included are an overview of the quality, access, and timeliness of health care services provided to Maryland's HealthChoice enrollees; and recommendations for improvement, which if implemented, may positively impact enrollee outcomes.

Performance Improvement Project Validation

Objective

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

Methodology

Qlarant uses the *Centers for Medicare & Medicaid Services (CMS) Protocol 1, Validation of Performance Improvement Projects* as a guideline in PIP review activities and to verify that the MCOs used sound methodology in designing, implementing, analyzing, and reporting PIP activities. MDH required the MCOs to conduct two PIPs during MY 2022.

To align with statewide public health and Medicaid innovation initiatives, two new PIPs replaced the previous Asthma Medication Ratio PIP and the Lead Screening PIP. Specifically, the Statewide Integrated Health Improvement Strategy aims to reduce severe maternal morbidity, which is represented in the new PIP topics for Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Prenatal Care PIP) and the Maternal Health and Infant/Toddler Care During the Postpartum Period (Postpartum Care-Related PIP).

MDH provided a list of strategies for the MCOs to choose from for each PIP topic. The prenatal care PIP topic consists of one mandatory strategy, improve completion and use of the Maryland Prenatal Risk Assessment (M-PRA), and MCOs were to choose two additional strategies. The postpartum care-related PIP topic focused on two strategies selected by the MCO. MCOs were to select PIP strategies most appropriate for their

member populations and available resources. All strategies selected were required to include a health equity focus to address health outcomes among the most disparate populations by conducting disparity analyses, including member feedback, and examining resources.

Description of Data Obtained. During the MY 2022 baseline year, MCOs focused on research, planning, and development of PIP strategies and interventions. Using Qlarant-developed reporting templates and worksheets, MCOs submitted PIP progress and updates on a quarterly basis during quarters one through three for Qlarant and MDH to provide real-time feedback and guidance following the rapid cycle and Plan, Do, Study, Act (PDSA) process. Quarter four consisted of the MCO annual submission where the MCOs were required to submit an annual barrier analysis for each PIP topic. Annual analysis reports identified root causes, barriers to optimal performance, and potential opportunities for improvement. Reports included validated performance measure results, a data and barrier analysis, and identified PIP follow-up activities. Qlarant provided technical assistance to the MCOs, as requested.

Technical Methods of Data Collection and Analysis.

1. **Review the selected PIP topic.** MDH selected the PIP topic.
2. **Review the PIP aim statement.** For baseline MY 2022, MCOs were provided aim statements to align with statewide public health and Medicaid innovation initiatives. Strategies and process metrics were additionally provided to MCOs.
3. **Review the identified PIP population, selected PIP variables, and performance measures[11].**
    a. ***Population:*** Qlarant determines whether the MCO identifies the PIP population in congruence with the aim statement.
    b. ***PIP Variables:*** Qlarant assesses whether the selected PIP variables are appropriate for measuring and tracking improvement.
    c. ***Performance Measures:*** Performance measures should be objective and measurable, clearly defined, based on current clinical knowledge or research, and focused on enrollee outcomes.
4. **Review the sampling method.** When the MCO studies the entire population, this step is not required. When the MCO studies a sample of the population, rather than the entire population, Qlarant assesses the appropriateness of the MCO's sampling technique.
5. **Review the data collection procedures.** Qlarant evaluates the validity and reliability of MCO procedures used to collect the data displaying PIP measurements.
6. **Review the data analysis and interpretation of PIP results.** Qlarant assesses the quality of data analysis and interpretation of PIP results. The review determines whether appropriate techniques were used and if the MCO's analysis and interpretation were accurate. A comprehensive quantitative and qualitative analysis is required for each project indicator. In the quantitative analysis, current performance compared to baseline and previous measurements are assessed. Performance is also evaluated against goals/benchmarks. The qualitative analysis focuses more on the project's level of success and identified barriers and provides an assessment of interventions. Each intervention utilizes the continuous quality improvement process using a Plan-Do-Study-Act (PDSA) analysis to determine whether the intervention is achieving the desired outcome. This analysis reflects the study findings and includes a description of the rationale for continuing, discontinuing, or altering the planned activity.

[11] *Qlarant executed steps 3 & 5 according to CMS EQR Protocol 1 and is cross-walked in step 3.*

7. **Assess the improvement strategies (interventions).** Qlarant assesses the appropriateness of interventions for achieving improvement. Each intervention is assessed to ensure that barriers are addressed. Interventions must be multi-faceted and produce permanent change. Effective interventions are tailored using specific, measurable, achievable, relevant, and time-oriented (SMART) objectives designed for the priority population. Interventions use upstream approaches, such as policy reforms, workflow changes, and resource investments.
8. **Assess the likelihood that significant and sustained improvement occurred.** Qlarant evaluates improvement by validating statistical significance testing results and evaluating improvement compared to baseline performance. Improvement should also be linked to interventions and based on desired outcomes, as opposed to an unrelated occurrence or solely a participation tally. This assessment is correlated to Step 8, Improvement Strategies. If interventions are assessed as reasonable and expected to improve outcomes, then the improvement is correlated to the project's interventions. Sustained improvement is assessed after the second remeasurement has been reported. Results are compared to baseline to confirm consistent and sustained improvement.
9. **State-Specific Strategies[12].** Qlarant evaluates evidence provided to determine if interventions were modified to improve the effectiveness of the strategy based on process metric feedback. Improvement strategies must identify and prioritize enrollees specific to the selected strategies. MCOs were provided a list of strategies to choose from for each PIP topic. All strategies selected were required to include a health equity focus to address health outcomes among the most disparate populations by conducting disparity analyses, including member feedback, and examining resources.

Qlarant rates each component within a step as *Met (M), Partially Met (PM), Unmet (UM), or Not Applicable (NA)*, which results in an assigned score as defined in Table 13 below. A final assessment is made 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 13. MY 2022 PIP Validation Review Determinations and Scoring

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

Qlarant PIP reviewers evaluated each element of PIP development and reporting by answering a series of applicable questions for each step, consistent with CMS protocol worksheets and requirements. Reviewers sought additional information and/or corrections from MCOs when

[12] *Step 9 has been added by MDH and Qlarant.*

needed, during the evaluation. Qlarant determined a validation rating, or level of confidence, for each PIP based on the total validation score.[13] Table 14 includes confidence levels.

Table 14. MY 2022 PIP Validation Confidence Levels and Scoring

MCO-Reported Results	Criteria	Score
High Confidence (High)	**High confidence** in MCO compliance	90% to 100%
Confidence (C)	**Moderate confidence** in MCO compliance	75% to 89%
Low Confidence (Low)	**Low confidence** in MCO compliance	60% to 74%
Not Credible (NC)	**No confidence** in MCO compliance	59% or lower

Qlarant uses a Diamond Rating System to compare the MCOs' PIP performance to NCQA benchmarks, as follows in Table 15.

Table 15. MY 2022 Diamond Rating System Used to Compare MCO Performance to Benchmarks

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

Results

Validation results for MY 2022's baseline performance for the two new PIPs are captured throughout the results section, by PIP focus. Table 16 highlights key elements of the two MY 2022 PIPs.

[13] Validation rating refers to the overall confidence that an MCO adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced significant evidence of improvement (CMS EQR Protocol 1 – Validation of Performance Improvement Projects).

Table 16. MY 2022 MDH-Selected PIPs

MY 2022 PIPs	Prenatal Care PIP	Postpartum Care-Related PIP
Topic	Timeliness of Prenatal Care and Identification of High-Risk Pregnancies	Maternal Health and Infant/Toddler Care During the Postpartum Period
Performance Measure(s)	• Prenatal and Postpartum Care: Prenatal Care (PPC-CH)	• Prenatal and Postpartum Care: Postpartum Care (PPC-AD) • Well-Child Visits in the First 30 Months of Life (W30 0-15 Months) • Well-Child Visits in the First 30 Months of Life (W30 15-30 Months) • Childhood Immunization Status: Combo 3 (CIS-3)
Aim	Will the implementation of targeted interventions focused on enrollees, providers, and the MCO improve and sustain annual HEDIS performance rates in the area of Timeliness of Prenatal Care?	Will the implementation of targeted interventions focused on enrollees, providers, and the MCO improve and sustain annual HEDIS performance rates in the area of Postpartum Care; Well-Child Visits in the First 30 Months of Life; and/or Childhood Immunization Status?
State-Specific Strategies	The prenatal care PIP topic consists of one mandatory strategy, *improve completion and use of the Maryland Prenatal Risk Assessment (M-PRA)*, and MCOs were to select two additional PIP strategies most appropriate to their enrollee populations and available resources.	The postpartum care-related PIP topic focused on two strategies selected by the MCO. MCOs were to select PIP strategies most appropriate for their enrollee populations and available resources.
Phase	Baseline	Baseline

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

All Prenatal Care PIPs focused on the overarching goal of increasing the percentage of pregnant enrollees' engagement with timely prenatal care visits during MY 2022 by focusing on the HEDIS Prenatal and Postpartum Care: Prenatal Care (PPC-CH) measure rates. The HEDIS Prenatal Care measure assesses the access to prenatal care by the percentage of deliveries in which members had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization.

PIP Validation Step Results. An assessment of the validity and reliability of the PIP study design and results reflects a detailed review of each MCO's PIPs and audited HEDIS measure findings for the selected indicators. Table 17 identifies the validation rating and the corresponding level of confidence Qlarant assigned to each MCO for the Prenatal Care PIP during MY 2022. All MCOs received a rating of *NA* for Step 2 (Aim Statement) since MDH provided the aim statement. Four of the nine MCOs' performances resulted in a confidence level of *High Confidence* for prenatal care PIP validations at a rating of 93% for JMS, MPC, and MSFC and 90% for PPMCO. The five remaining MCOs' performances resulted in a *Confidence* level ranging from 75% (UHC) to 88% (ABH).

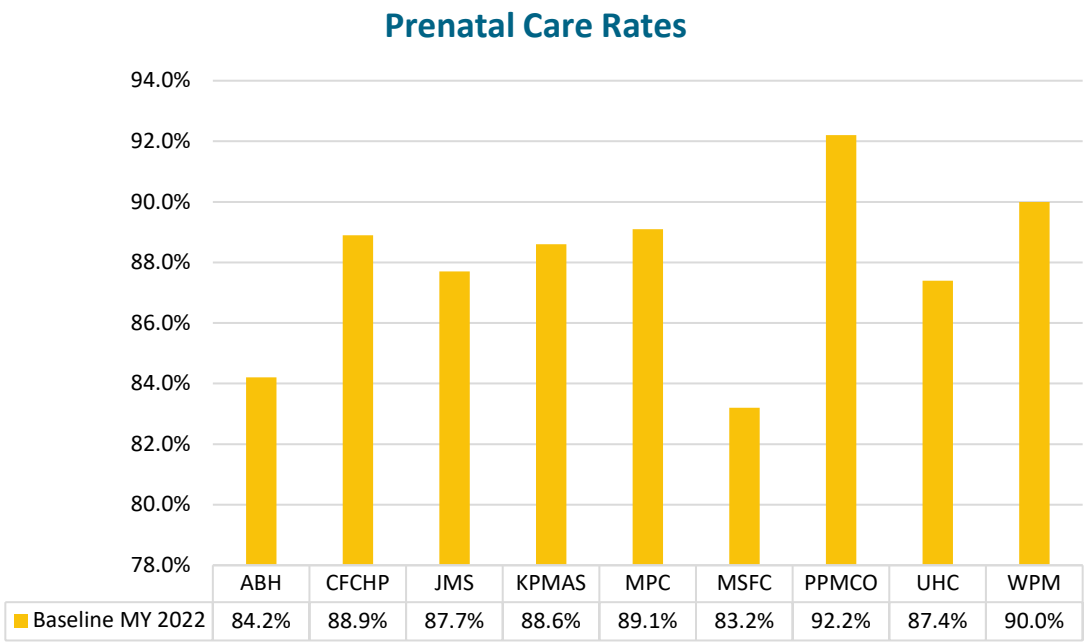
Table 17. MY 2022 Prenatal Care PIP Validation Rating and Confidence Levels

Step/Description	MY 2022 Prenatal Care PIP Validation Results								
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Step 1. Topic	M	M	M	PM	M	M	M	M	PM
Step 2. Aim Statement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Performance Measures and Population	PM	M	M	PM	M	M	M	M	M
Step 4. Sampling Method	NA	NA	NA	NA	M	M	NA	M	M
Step 5. Data Collection Procedures	M	M	M	PM	M	M	PM	PM	M
Step 6. Data Analysis and Interpretation of Results	PM	PM	M	PM	M	M	PM	M	M
Step 7. Improvement Strategies (Interventions)	PM	PM	PM	PM	PM	PM	M	PM	PM
Step 8. Significant and Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 9. State Specific Strategies	M	UM	M	M	M	M	M	M	M
PIP Numerical Score	60	53	64	54	69	69	61	50	59
PIP Total Available Points	68	68	69	68	74	74	68	67	73
PIP Validation Rating	88%	78%	93%	79%	93%	93%	90%	75%	81%
Confidence Level	C	C	High	C	High	High	High	C	C

Validation Results: Light Green – M (*Met*); Light Yellow – PM (*Partially Met*); Light Red – UM (*Unmet*); Gray – N/A (*Not Applicable*)
Confidence Levels: Green – High (*High Confidence*); Yellow – C (*Confidence*); Orange – Low (*Low Confidence*); Red – NC (*Not Credible*)
*Available points may vary based on whether or not answers were applicable or not applicable, such as whether or not a MCO utilized sampling.

MY 2022 is the baseline MY with data collection for the Prenatal Care PIP. Figure 1 represents the Prenatal Care PIP indicator rates for all MCOs. Table 18 compares the MCO indicator rates to the HEDIS 2022 NCQA Quality Compass Medicaid benchmarks.

Figure 1. MY 2022 Prenatal Care Indicator Rates



The MCOs' prenatal care rates range from 83.2% (MSFC) to 92.2% (PPMCO) for MY 2022.

Table 18. MY 2022 Prenatal Care Performance Comparison to Benchmarks by MCO

Prenatal Care Measure Rates		
MCO	**MY 2022 Rate**	**Qlarant Diamond Rating**
ABH	84.2%	♦
CFCHP	88.9%	♦♦♦
JMS	87.7%	♦♦
KPMAS	88.6%	♦♦♦
MPC	89.1%	♦♦♦
MSFC	83.2%	♦
PPMCO	92.2%	♦♦♦♦
UHC	87.4%	♦♦
WPM	90.0%	♦♦♦

The majority of MCOs' performance rates for prenatal care met or exceeded the HEDIS 75th percentile (CFCHP at 88.9%, KPMAS at 88.6%, MPC at 89.1%, and WPM at 90.0%). PPMCO was the only MCO that met or exceeded the HEDIS 90th percentile at 92.2%. JMS and UHC met or exceeded the HEDIS 50th percentile at 87.7% and 87.4%, respectively. ABH and MSFC's performance rates fell below the HEDIS 50th percentile at 84.2% and 83.2%, respectively.

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

For the Postpartum Care-Related PIP topic, MCOs selected two strategies in the areas of Prenatal and Postpartum Care: Postpartum Care (PPC-AD), Well-Child Visits in the First 30 Months of Life (W30 First 15 Months and W30 15 Months to 30 Months), and Childhood Immunization Status: Combo 3 (CIS-3). MCOs' goals for improving specific HEDIS measure rates depended on what HEDIS measure rates aligned with the MCOs' selected strategies. For example, MCOs that selected the "Value-added benefits for well-child care" and "Improve immunization rates" strategies set goals to improve the W30 and CIS-3 HEDIS measure rates.

PIP Validation Step Results. An assessment of the validity and reliability of the PIP study design and results reflects a detailed review of each MCO's PIPs and audited HEDIS measure findings for the selected indicators. Table 19 identifies the validation rating and the corresponding level of confidence Qlarant assigned to each MCO for the Postpartum Care-Related PIP during MY 2022. All MCOs received a rating of *NA* for Step 2 (Aim Statement) due to MDH providing the aim statement. Four of the nine MCOs' performances resulted in a *High Confidence* level for postpartum care-related PIP validations at ratings of 93% for JMS and MPC, 91% for ABH, and 90% for CFCHP. The remaining five MCOs' performances resulted in a *Confidence* level ranging from 76% (KPMAS) to 86% (UHC and WPM).

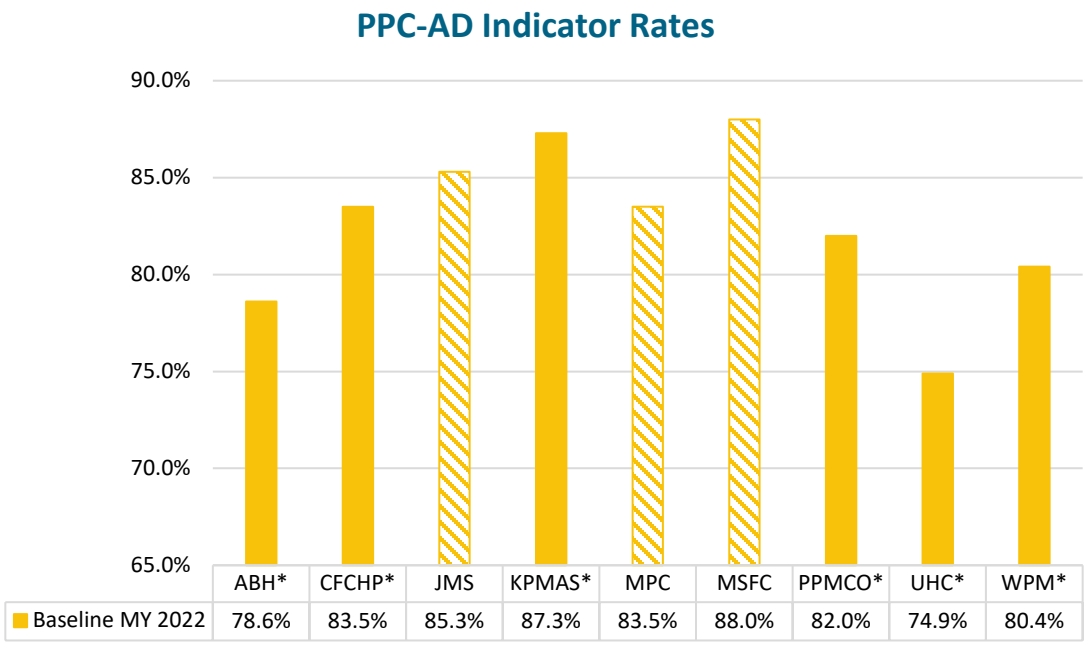
Table 19. MY 2022 Postpartum Care-Related PIP Validation Rating and Confidence Levels

Step/Description	MY 2022 Postpartum Care-Related PIP Validation Results								
	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Step 1. Topic	M	M	M	PM	M	M	M	M	PM
Step 2. Aim Statement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 3. Performance Measures and Population	PM	PM	M	PM	M	PM	M	M	M
Step 4. Sampling Method	NA	NA	M	NA	M	M	NA	NA	M
Step 5. Data Collection Procedures	M	M	M	PM	M	M	PM	M	M
Step 6. Data Analysis and Interpretation of Results	M	M	M	PM	M	PM	PM	M	M
Step 7. Improvement Strategies (Interventions)	PM	PM	PM	PM	PM	PM	PM	PM	PM
Step 8. Significant and Sustained Improvement	NA	NA	NA	NA	NA	NA	NA	NA	NA
Step 9. State Specific Strategies	M	M	M	M	M	UM	M	M	M
PIP Numerical Score	59	60	70	52	70	55	56	59	59
PIP Total Available Points	65	67	75	68	75	70	68	69	69
PIP Validation Rating	91%	90%	93%	76%	93%	79%	82%	86%	86%
Confidence Level	High	High	High	C	High	C	C	C	C

Validation Results: Light Green – M (*Met*); Light Yellow – PM (*Partially Met*); Light Red – UM (*Unmet*); Gray – N/A (*Not Applicable*)
Confidence Levels: Green – High (*High Confidence*); Yellow – C (*Confidence*); Orange – Low (*Low Confidence*); Red – NC (*Not Credible*)
*Available points may vary based on whether or not answers were applicable or not applicable, such as whether or not a MCO utilized sampling.

MY 2022 is the baseline MY with data collection for the Postpartum Care-Related PIP. Figures 2 to 5 represent indicator rates for all measures within this PIP. Figure 2 represents the Postpartum Care-Related PIP indicator rates for all MCOs. Figure 3 represents the indicator rates for the Well-Child Visits HEDIS measure relating to birth to 15 months, while Figure 4 represents the indicator rates for 15 to 30 months. Figure 5 represents indicator rates for the Childhood Immunization Status: Combo 3 HEDIS measure. Table 20 compares the MCO indicator rates to the HEDIS 2022 NCQA Quality Compass Medicaid benchmarks.

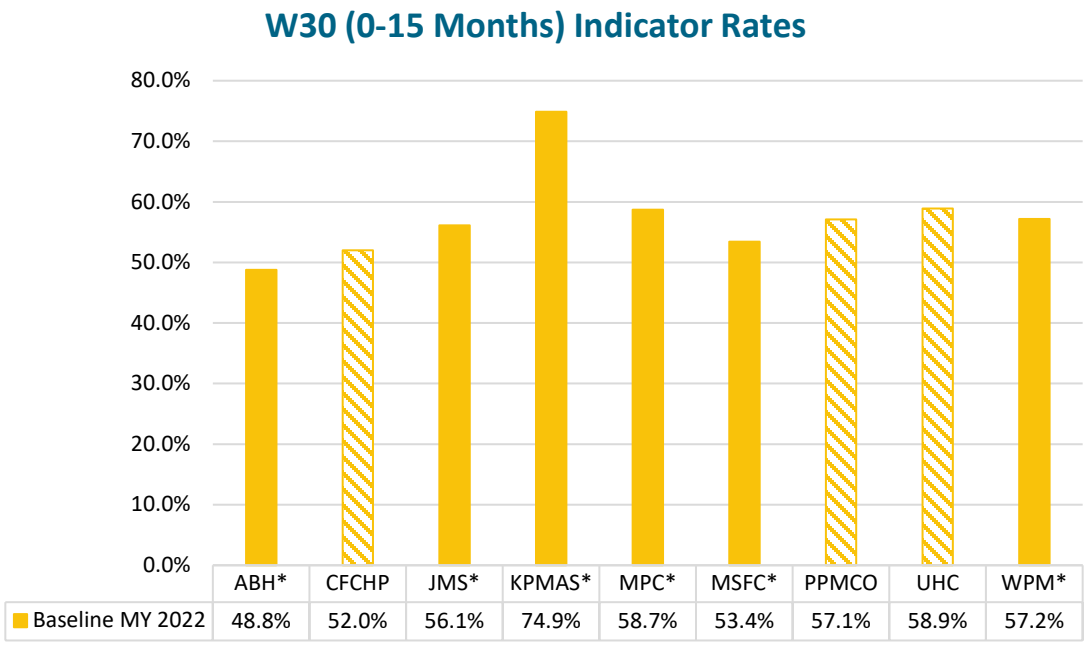
Figure 2. MY 2022 Postpartum Care (PPC-AD) Indicator Rates



*Solid Bar Color: MCO's selected strategy aligns with the improvement of its specific HEDIS rate.
Striped Bar Color: MCO's selected strategy does not align with the improvement of its specific HEDIS rate.

The MCO postpartum care rates range from 74.9% (UHC) to 88.0% (MSFC) for MY 2022.

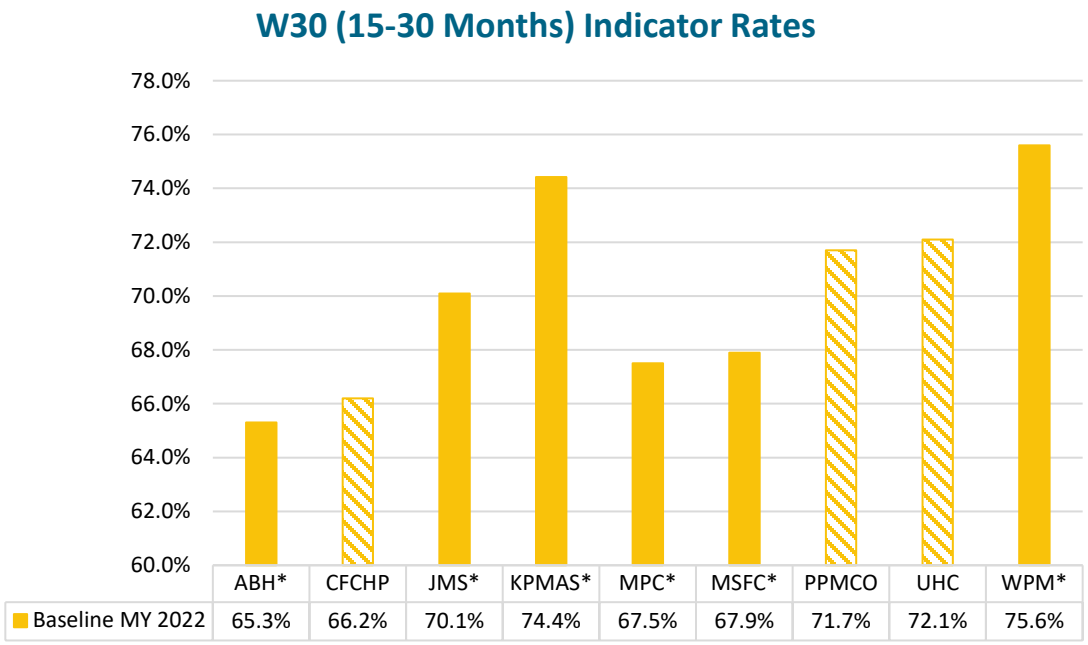
Figure 3. MY 2022 Well-Child Visits in the First 30 Months of Life (0-15 Months) Indicator Rates



*Solid Bar Color: MCO's selected strategy aligns with the improvement of its specific HEDIS rate.
Striped Bar Color: MCO's selected strategy does not align with the improvement of its specific HEDIS rate.

The W30 (0-15 Months) rates range from 48.8% (ABH) to 74.9% (KPMAS).

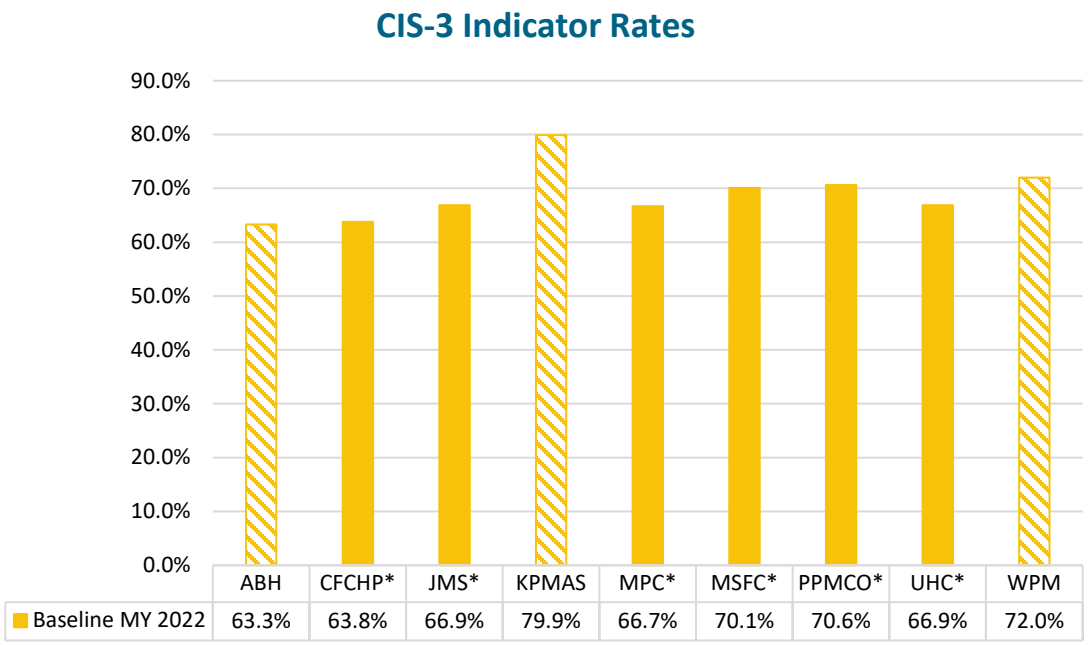
Figure 4. MY 2022 Well-Child Visits in the First 30 Months of Life (15-30 Months) Indicator Rates



*Solid Bar Color: MCO's selected strategy aligns with the improvement of its specific HEDIS rate.
Striped Bar Color: MCO's selected strategy does not align with the improvement of its specific HEDIS rate.

The W30 (15-30 Months) rates range from 65.3% (ABH) to 75.6% (WPM).

Figure 5. MY 2022 Childhood Immunization Status: Combo 3 Indicator Rates



	ABH	CFCHP*	JMS*	KPMAS	MPC*	MSFC*	PPMCO*	UHC*	WPM
Baseline MY 2022	63.3%	63.8%	66.9%	79.9%	66.7%	70.1%	70.6%	66.9%	72.0%

*Solid Bar Color: MCO's selected strategy aligns with the improvement of its specific HEDIS rate.
Striped Bar Color: MCO's selected strategy does not align with the improvement of its specific HEDIS rate.

The CIS-3 rates range from 63.3% (ABH) to 79.9% (KPMAS).

Table 20. MY 2022 Postpartum Care-Related Performance Comparison to Benchmarks by MCO

Postpartum Care-Related Measure Rates								
MCO	**MY 2022 PPC-AD Rate**	**PPC-AD Diamond Rating**	**W30 (0-15) Rate**	**W30 (0-15) Diamond Rating**	**W30 (15-30) Rate**	**W30 (15-30) Diamond Rating**	**CIS-3 Rate**	**CIS-3 Diamond Rating**
ABH	78.6%	♦♦	48.8%	♦	65.3%	♦	63.3%	♦
CFCHP	83.5%	♦♦♦	52.0%	♦	66.2%	♦	63.8%	♦
JMS	85.3%	♦♦♦♦	56.1%	♦	70.1%	♦♦	66.9%	♦♦
KPMAS	87.3%	♦♦♦♦	74.9%	♦♦♦♦	74.4%	♦♦♦	79.9%	♦♦♦♦
MPC	83.5%	♦♦♦	58.7%	♦♦	67.5%	♦♦	66.7%	♦♦
MSFC	88.0%	♦♦♦♦	53.4%	♦	67.9%	♦♦	70.1%	♦♦♦
PPMCO	82.0%	♦♦♦	57.1%	♦	71.7%	♦♦♦	70.6%	♦♦♦
UHC	74.9%	♦	58.9%	♦♦	72.1%	♦♦♦	66.9%	♦♦
WPM	80.4%	♦♦	57.2%	♦	75.6%	♦♦♦	72.0%	♦♦♦

*Not every MCO's selected strategies align with the improvement of each specific HEDIS rate. Refer to Figures 2-5 for MCO selected strategy and those associated rates.

For the baseline MY 2022 PPC-AD measure, UHC is the only MCO that performed below the 50th percentile at 74.9%. ABH and WPM performed above the 50th percentile, but below the 75th percentile at 78.6% and 80.4%, respectively. CFCHP (83.5%), MPC (83.5%), and PPMCO (82%) performed above the 75th percentile, but below the 90th percentile. JMS (85.3%), KPMAS (87.3%), and MSFC (88%) performed above the 90th percentile.

For the baseline MY 2022, the W30 (First 15 Months) measure resulted in the most MCOs performing below the 50th percentile out of the four measures (ABH 48.8%, CFCHP 52%, JMS 56.1%, MSFC 53.4%, PPMCO 57.1%, and WPM 57.2%). MPC (58.7%) and UHC (58.9%) performed above the 50th percentile but below the 75th percentile. KPMAS (74.9%) was the only MCO to perform above the 75th and the 90th percentiles.

For the baseline MY 2022 W30 (15-30 Months) measure, two of the nine MCOs performed below the 50th percentile (ABH 65.3% and CFCHP 66.2%). Three of the nine MCOs performed above the 50th percentile, but below the 75th percentile (JMS 70.1%, MPC 67.5%, and MSFC 67.9%). KPMAS (74.4%), PPMCO (71.7%), UHC (72.1%), and WPM (75.6%) performed above the 75th percentile, but below the 90th percentile. There were no MCOs that met or exceeded the 90th percentile.

For the baseline MY 2022 CIS-3 measure rate, ABH (63.3%) and CFCHP (63.8%) performed below the 50th percentile. JMS (66.9%), MPC (66.7%), and UHC (66.9%) performed above the 50th percentile, but below the 75th percentile. Three of the nine MCOs performed above the 75th

percentile, but below the 90th percentile (MSFC 70.1%, PPMCO 70.6%, and WPM 72%). KPMAS was the only MCO to perform above the 90th percentile at 79.9%.

ABH and CFCHP performed below the 50th percentile for three of the four measures for MY 2022. KPMAS performed the highest across all four measures.

It should be noted for the upcoming remeasurement years, MCOs will only be scored on the improvement of the HEDIS measure rates that align with the MCO's selected strategies.

Conclusion

For the baseline MY 2022, all MCOs performed at *Confidence* and *High Confidence* levels. Four of the nine MCOs performed at a *High Confidence* level for the prenatal care PIP topic (JMS: 93%, MPC: 93%, MSFC: 93%, and PPMCO: 90%). Three of the nine MCOs performed at a *High Confidence* level for the postpartum care-related PIP topic (ABH: 91%, JMS: 93%, and MPC: 93%). Two of the nine MCOs, JMS and MPC, performed at *High Confidence* levels for both PIP topics. Although all MCOs' performed at levels of *Confidence* and *High Confidence,* opportunities for improvement and recommendations were identified and additional guidance was provided for each MCO.

The upcoming remeasurement years will assess the effectiveness of the MCOs' interventions in improving the HEDIS rates that align with the MCOs' selected strategies. Quarterly monitoring through the rapid cycle PIP process will provide MCOs with additional guidance and feedback to ensure interventions are impactful, sustainable, and leading to the desired outcomes.

Quality Strategy Highlights

To achieve MDH's goal of delivering high quality, accessible care to managed care enrollees, MDH developed a framework to focus on quality improvement efforts for the HealthChoice programs. MDH set task goals of increasing the HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care measure rate and the HEDIS Prenatal and Postpartum Care: Postpartum Care measure rate for all MCOs. Specific HealthChoice performance metrics, identified in the HealthChoice Quality Strategy for 2022-2024, are displayed in Table 21 below.

Table 21. MY 2022 PIP HealthChoice Performance Against Quality Strategy Targets

Performance Measures	MDH Quality Strategy Targets for MY 2024	HealthChoice Average Baseline MY 2022 Performance
Prenatal Care PIP		
HEDIS Prenatal and Postpartum Care: Timeliness of Prenatal Care	88.2%	87.9%
Postpartum Care-Related PIP		
HEDIS Prenatal and Postpartum Care: Postpartum Care	81.3%	82.6%

Source: HealthChoice Quality Strategy

Each MCO is expected to improve the baseline MY 2022 measure rates (with the exception of Childhood Immunization Status: Combo 3) by five percentage points over the life of the prenatal care and postpartum care PIPs for MCOs that are performing within the 90th percentile. MCOs are expected to improve the baseline MY 2022 measure rate for the Childhood Immunization Status: Combo 3 (CIS-3) measure to perform above the 90th percentile by the end of the life of the PIP.

For additional findings and comprehensive details associated with the MY 2022 PIP validation, please access the link to the MY 2022 PIP Report in **Appendix E**. The **MCO Quality, Access, and Timeliness Assessment section** includes informed conclusions from the PIP validation related to quality, access, and timeliness for the HealthChoice program.

Performance Measure Validation

Objective

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

MDH utilizes PHIP activities as part of an incentive program designed to provide financial incentives to MCOs based on the performance of certain HEDIS and MDH-developed encounter measures. Analysis of select PHIP measures to determine incentivized performance promotes the delivery of high-quality care within the HealthChoice managed care program and evaluates access to timely services to promote desired health outcomes.

Methodology

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

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

Healthcare Effectiveness Data and Information Set

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

MDH incorporates six HEDIS measures in its PHIP activities, with the intent of the program to improve MCO performance with incentivized rewards. MDH contracted with MetaStar for HEDIS validations. For additional findings and comprehensive details associated with HEDIS validations, please access MetaStar's Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2022 Results in **Appendix E**.

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

- MDH provided all of the MetaStar data, Hilltop data, and benchmark percentiles for each MCO.
- MetaStar provided HEDIS Final Audit Reports, and reports summarizing results from the NCQA HEDIS Compliance Audits.™[14]

Technical Methods of Data Collection and Analysis. MDH contracted with MetaStar to validate measures and conduct the NCQA HEDIS Compliance Audits. MetaStar validated six HEDIS measures and conducted the audits to ensure HEDIS data reported publicly by MCOs are accurate and reliable. The audit is conducted in three phases: a pre-site visit, a site visit, and a post-site visit (reporting), as displayed in Table 22.

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

Table 22. MY 2022 HEDIS Audit Phases and Activities

Audit Phase	Activities
Pre-site	• Perform a review of each MCO's HEDIS Record of Administration, Data Management, and Processes (Roadmap). The Roadmap captures self-reported information about an MCO's data systems and processes used for HEDIS data reporting. • Perform source code review and supplemental data validation; provide medical record review validation results; and select HEDIS measures to audit in further detail (results are then extrapolated to the rest of the HEDIS measures). • Conduct conference calls with each MCO to review any HEDIS guideline updates or measure specification changes and provide technical assistance.
Site	• Investigate issues identified in the Roadmap, interview key staff, and review systems and processes used to collect data and produce HEDIS measures.
Post-site	• Provide all MCOs with a list of follow-up items needed to complete the audit. • Require the MCO to implement corrective actions, which need to be completed with enough time to allow the auditor to assess the effect on measure results prior to final rate submission, if applicable. • Complete a final audit report and assign possible audit designations (Table 23) when the MCO has provided all requested documents and performed the recommended corrective actions. • Submit final HEDIS data to NCQA. • Provide a final audit report to the MCO and NCQA.

Table 23 displays HEDIS Compliance Audit Designations.

Table 23. MY 2022 HEDIS Compliance Audit Designations

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

HEDIS Validation Results

Table 24 illustrates MY 2022's HEDIS measure validation results provided by MetaStar.

Table 24. MY 2022 MetaStar HEDIS Measure Validation Results

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

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

Table 25 displays an analysis of change from comparisons of MY 2022's HEDIS measure results to MY 2021's results, and indicates whether an MCO experienced a lower or higher change in HEDIS rates. Additional columns indicate changes in MARR (2022 rate minus 2022 rate) or NHM (2022 rate minus 2021 rate). MetaStar's *Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2022 Results* report provided the information in the following table and excludes new measures or indicators with no trending history, HEDIS MY 2022 results which were reported as *NA*, or measures where the rates stayed the same from last year and did not increase or decrease.

Table 25. Summary of MetaStar's MY HEDIS Measure Results

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR change	MARR	NHM Change	NHM
Breast Cancer Screening (BCS)	↑	↓	↓	↑	↓	↓	↑	↑	↑	4	5		-0.7%	↓	1.4%	↑
Cervical Cancer Screening (CCS)	↑	↓	↑	↑	↑	↓	↑	↑	↓	3	6		1.4%	↑	-0.3%	↓
Chlamydia Screening in Women (CHL), 16-20 years	↑	↑	↓	↓	↑	↓	↑	↑	↑	3	6		0.5%	↑	0.5%	↑
Chlamydia Screening in Women (CHL), 21-24 years	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		1.7%	↑	0.6%	↑
Chlamydia Screening in Women (CHL), Total	↑	↑	↑	↑	↑	↓	↑	↑	↑	1	8		1.1%	↑	0.6%	↑
Appropriate Testing for Pharyngitis (CWP)	↑	↓	↑	↑	↑	↓	↑	↑	↑	2	7		7.4%	↑	3.4%	↑
Childhood Immunization Status (CIS), Combo 10	↓	↓	↓	↓	↓	↓	↓	↓	↓	9	0		-5.4%	↓	-4.0%	↓
Childhood Immunization Status (CIS), Combo 3	↑	↓	↑	↑	↑	↑	↑	↓	↓	3	6		0.5%	↑	0.1%	↑
Childhood Immunization Status (CIS), Combo 7	↓	↓	↑	↑		↑	↑	↓	↓	4	4		-0.1%	↓	0.7%	↑
Immunizations for Adolescents (IMA), Combo 1	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		3.4%	↑	0.6%	↑
Immunizations for Adolescents (IMA), Combo 2	↑	↓	↑	↑	↑	↓	↓	↑	↓	4	5		0.3%	↑	-0.6%	↓
Lead Screening in Children (LSC)	↑	↓	↓	↑	↓	↓	↓	↓	↓	7	2		-2.0%	↓	-2.9%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for	↓	↑	↓	↑	↑	↓	↑		↓	4	4		4.7%	↑	0.6%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR change	MARR	NHM Change	NHM
Children/Adolescents (WCC), BMI Percentile Documentation, Total																
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Nutrition, Total	↓	↑	↓	↑	↑	↓	↑	↓	↓	5	4		2.2%	↑	-1.1%	↓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Physical Activity, Total	↓	↑	↓	↑	↑	↓	↑	↓	↓	5	4		3.0%	↑	-1.0%	↓
Appropriate Treatment for Upper Respiratory Infection (URI), Total	↑	↑	↓	↑	↑	↑	↑	↑	↑	1	8		1.0%	↑	0.3%	↑
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB), Total	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		8.0%	↑	6.6%	↑
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	↓	↓		↑	↓	↓	↑	↓	↓	2	6	L	-0.1%	↓	-0.1%	↓
Risk of Continued Opioid Use (COU), 15 Days, Total	↑	↓	↓	↓	↓	↓	↓	↓	↑	2	7	L	-0.5%	↓	0.0%	↓
Risk of Continued Opioid Use (COU), 31 Days, Total	↑	↓	↓	↓	↓	↑	↑	↓	↑	4	5	L	-0.3%	↓	0.0%	↓
Use of Opioids at High Dosage (HDO)	↓	↓	↑	↑	↓	↓	↑	↑	↓	4	5	L	-0.6%	↓	-0.6%	↓

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR change	MARR	NHM Change	NHM
Use of Opioids From Multiple Providers (UOP), Multiple Pharmacies	↓	↓	↓	↑	↓	↓	↓	↓	↓	1	8	L	-1.9%	↓	-0.4%	↓
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers	↓	↑	↑	↓	↓	↓	↑	↓	↓	3	6	L	-0.9%	↓	0.0%	↓
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers and Multiple Pharmacies	↑	↓	↓	↑	↓	↓	↓	↓	↑	3	6	L	-0.8%	↓	-0.3%	↓
Asthma Medication Ratio (AMR), Total	↓	↑	↓	↑	↑	↓	↓	↓	↓	6	3		0.3%	↑	0.7%	↑
Pharmacotherapy Management of COPD Exacerbation (PCE), Bronchodilator	↓	↓	↓	↓	↓	↑	↓	↓	↓	8	1		-1.7%	↓	0.3%	↑
Pharmacotherapy Management of COPD Exacerbation (PCE) Systemic Corticosteroid	↓	↓	↓	↓	↓	↑	↓	↑	↑	6	3		-3.6%	↓	0.9%	↑
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)		↓	↑	↑	↓	↓	↓	↓	↑	5	3		-0.1%	↓	-1.9%	↓
Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 years	↓	↓	↓	↓	↓	↓	↓	↓	↓	9	0		-3.6%	↓	-3.3%	↓
Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 years	↓	↓	↓	↓	↓	↓	↓	↓	↓	9	0		-2.3%	↓	-1.9%	↓
Cardiac Rehabilitation – Achievement (CRE)	↑	↓	↑		↑		↑	↑	↑	1	6		32.8%	↑	0.5%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR change	MARR	NHM Change	NHM
Cardiac Rehabilitation – Engagement1 (CRE)	↑	↓	↑		↑		↑	↑	↑	1	6		-20.4%	↓	1.0%	↑
Cardiac Rehabilitation – Engagement2 (CRE)	↓	↓	↑		↑		↑	↑	↑	2	5		-1.8%	↓	0.9%	↑
Cardiac Rehabilitation – Initiation (CRE)		↓			↓	↑	↑	↑	↓	3	3		-28.8%	↓	0.7%	↑
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)							↓			1	0		-6.0%	↓	1.0%	↑
Controlling High Blood Pressure (CBP)	↑	↓	↓	↓	↑	↑	↑	↓	↓	5	4		0.8%	↑	2.2%	↑
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)				↓	↓	↓	↓	↓	↑	5	1		-2.4%	↓	-0.8%	↓
Statin Therapy for Patients With Cardiovascular Disease (SPC), Received Statin Therapy, Total	↓	↓	↓	↓	↓	↓	↓	↓	↑	8	1		-0.9%	↓	0.2%	↑
Statin Therapy for Patients With Cardiovascular Disease (SPC), Statin Adherence 80%, Total	↓	↑	↑	↑	↑	↓	↑	↑	↑	2	7		0.8%	↑	-0.3%	↓
Prenatal and Postpartum Care (PPC), Postpartum Care	↓	↑	↓	↓	↓	↑	↓	↓	↓	7	2		-1.1%	↓	0.8%	↑
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care	↑	↑	↓	↓	↑	↓	↑	↓	↓	5	4		-1.0%	↓	-0.6%	↓

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR change	MARR	NHM Change	NHM
Blood Pressure Control for Patients with Diabetes (BPD)	↑	↑	↓	↑	↑	↑	↑	↑	↓	2	7		6.1%	↑	3.3%	↑
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)					↑	↑	↓	↓	↑	2	3		4.9%	↑	0.8%	↑
Eye Exam for Patients with Diabetes (EED)	↑	↑	↑	↑	↑	↓	↓	↑	↓	3	6		2.8%	↑	0.7%	↑
Hemoglobin A1c Control for Patients with Diabetes (HBD), Control (<8.0%)	↑		↑	↓	↓	↑	↑	↑	↓	3	5		1.0%	↑	2.5%	↑
Hemoglobin A1c Control for Patients with Diabetes (HBD), Poor Control (>9.0%)	↑	↓	↑	↑	↑	↓	↓	↓	↓	4	5	L	-0.7%	↓	-1.9%	↓
Kidney Health Evaluation for Patients with Diabetes (KED)	↑	↓	↑	↑	↑	↓	↑	↑	↑	2	7		1.0%	↑	1.1%	↑
Statin Therapy for Patients with Diabetes (SPD), Received Statin Therapy	↑	↑	↑	↓	↓	↓	↓	↓	↓	6	3		-0.4%	↓	-0.9%	↓
Statin Therapy for Patients with Diabetes (SPD), Statin Adherence 80%	↓	↑	↑	↑	↑	↑	↑	↓	↑	2	7		1.4%	↑	-0.1%	↓
Child and Adolescent Well-Care Visits (WCV), 12-17 years	↓	↓	↓	↓	↓	↓	↓	↓	↓	9	0		-3.3%	↓	-1.6%	↓
Child and Adolescent Well-Care Visits (WCV), 18-21 years	↓	↓	↓	↓	↓	↓	↓	↓	↓	9	0		-3.2%	↓	-1.1%	↓

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR change	MARR	NHM Change	NHM
Child and Adolescent Well-Care Visits (WCV), 3-11 years	↓	↓	↑	↓	↓	↓	↓	↓	↓	8	1		-2.7%	↓	-0.6%	↓
Child and Adolescent Well-Care Visits (WCV), Total	↓	↓	↓	↓	↓	↓	↓	↓	↓	9	0		-3.1%	↓	-0.9%	↓
Inpatient Utilization – General Hospital Acute Care (IPU), Total Inpatient: Total Average Length of Stay	↑	↑	↑	↑	↑	↑	↑	↑	↑	0	9		49.03	↑	9.00	↑
Inpatient Utilization – General Hospital Acute Care (IPU), Total Inpatient: Total Discharges/1000 MM	↓	↓	↑	↑	↑	↑	↑	↓	↑	3	6		0.06	↑	-43.79	↓
Plan All-Cause Readmissions (PCR) – Observed	↑	↑	↑	↑	↑	↑	↑	↑	↓	32	4	L	0.5%	↑	0.0%	↓
Plan All-Cause Readmissions (PCR) – Observed/Expected	↑	↑	↓	↑	↓	↓	↑	↑	↓	20	16	L	0.04	↑	-9.15	↓
Well-Child Visits in the First 30 Months of Life (W30), 15 months	↑	↑	↑	↑	↑	↓	↑	↑	↑	1	8		2.7%	↑	2.7%	↑
Well-Child Visits in the First 30 Months of Life (W30), 15-30 months	↓	↓	↓	↑	↓	↓	↓	↓	↓	8	1		-3.4%	↓	0.8%	↑
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				↓			↓	↓		3	0		-13.7%	↓	0.2%	↑

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR change	MARR	NHM Change	NHM
Antidepressant Medication Management (AMM), Acute Phase				↓			↓			2	0		-2.1%	↓	0.1%	↑
Antidepressant Medication Management (AMM), Continuation Phase				↓			↓			2	0		3.1%	↑	-0.2%	↓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				↑	↑		↓	↓	↓	3	2		0.4%	↑	-0.2%	↓
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Acute Phase		↑		↓	↑		↑	↑	↑	1	5		6.2%	↑	3.9%	↑
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation Phase					↑		↑	↑	↑	0	4		5.8%	↑	3.1%	↑
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Blood Glucose and Cholesterol Total				↓			↑	↓		2	1		-2.7%	↓	-0.3%	↓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Blood Glucose Total				↓			↑	↑		1	2		-2.8%	↓	0.5%	↑
Metabolic Monitoring for Children and Adolescents				↓			↑	↓		2	1		-2.4%	↓	-0.3%	↓

HEDIS Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Unfavorable	Favorable	Lower Better	MARR change	MARR	NHM Change	NHM
on Antipsychotics (APM), Cholesterol Total																
Pharmacotherapy for Opioid Use Disorder (POD), Total					↓		↓	↑	↓	3	1		-7.9%	↓	-0.5%	↓
Prenatal Immunization Status (PRS-E)	↑	↑	↓	↓	↑		↓	↓	↑	4	4		-1.6%	↓	-0.9%	↓

Source: *MetaStar's Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2022 Results*

Encounter Data Measure Validation

PHIP encounter data measures were calculated by Hilltop. Hilltop used encounter data submitted by the MCOs, Lead Registry data submitted by the Maryland Department of Environment (MDE), and fee-for-service data, respectively, to calculate the below encounter data measures:

- Ambulatory Care Visits for SSI Adults
- Ambulatory Care Visits for SSI Children
- Lead Screenings for Children - Ages 12 to 23 Months

Qlarant validated the three measures by reviewing both data collection and processing systems and reviewing the source code for each measure to determine compliance with MDH's measure specifications. Validation designations were used to characterize the findings, as shown in Table 26.

Table 26. MY 2022 Validation Designation for Encounter Data Measures

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

Encounter Data Measure Validation Results

Table 27 illustrates MY 2022'sencounter data measure validation results, validated by Qlarant.

Table 27. MY 2022 Encounter Data Measure Validation Results

Performance Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults	R	R	R	R	R	R	R	R	R
Ambulatory Care Visits for SSI Children	R	R	R	R	R	R	R	R	R
Lead Screenings for Children – Ages 12 to 23 Months	R	R	R	R	R	R	R	R	R

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

Population Health Incentive Program

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

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

Technical Methods of Data Collection and Analysis. Selected HEDIS measures are calculated and validated per *HEDIS Volume 2: Technical Specifications for Health Plans* and then compared to the nationally calculated Quality Compass percentiles. These percentiles are used as incentive benchmarks to determine if the MCOs' quality improvement efforts have successfully resulted in improved health outcomes. MDH and Hilltop calculate percentiles for comparison across MCOs for the state-specific performance measures.

MDH selected performance measures with input from stakeholders, including MCOs and the Maryland Medicaid Advisory Committee. Measure selection was based on legislative priorities, HealthChoice enrollee health care needs, and the below criteria:

- Whether the topic is relevant to the HealthChoice core populations, which include children, special needs children, pregnant women, adults with disabilities, and adults with chronic conditions;
- Whether the topic is prevention-oriented to promote optimum health;
- Whether the topic is measurable with data availability;

- Whether the topics is consistent with CMS Medicaid Core Set or HEDIS performance measures; and
- Whether the MCOs can achieve quality improvement and positive health outcomes in this topic.

MY 2022 PHIP rates were drawn from HEDIS and encounter data rates reported by MCOs and/or the MDE.

MDH selected the following HEDIS measures, reported by the MCO:

- Asthma Medication Ratio (AMR)
- Continued Opioid Use (COU): ≥31 days covered
- Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)
- Lead Screening in Children (LSC)*
- Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care
- Prenatal and Postpartum Care (PPC): Postpartum Care

*This measure is valued as a composite combining two sub-measures, weighted each at 50%, and includes both the HEDIS measure for lead screenings in children (LSC) and an MDH-homegrown measure for lead screenings in children.

MDH selected the following encounter data measures, reported by the MCO:

- Ambulatory Care Visits for Supplemental Security Income (SSI) Adults
- Ambulatory Care Visits for SSI Children

The following measure is from a combination of measure sources (encounter, lead registry, and fee for service data) as well as a combination of reporting entities (MCO and MDE): Lead Screenings for Children: Ages 12 to 23 Months.

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

- In Round 1, payments to plans are made from the allocated incentive funding based on performance during the measurement year and improvement from the previous year. The maximum possible allocated incentive for each MCO will be up to 0.5% of total capitation payments during the measurement year (excluding supplemental payments). The amount will be determined by MDH budget allocations for the performance year under review.
- In Round 2, unallocated funds from Round 1 are redistributed among high-performing MCOs as additional incentives, up to a per-plan limit of 1% of the plan's measurement year capitation as total payment from Round 1 and Round 2.

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

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

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

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

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

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

The improvement incentives in Tier 2 are intended to reward objectively strong improvement for MCOs that did not achieve superlative performance in the measurement year. For each measure, MCOs would receive 1/3 of the 1/8 of 0.5 percent of capitation if the following requirements are met:

- The MCO demonstrated improvement of at least 0.5 percentage points in the measure from the previous year, **AND**
- The MCO's current measurement year score is greater than or equal to the national 50th percentile.

- For any performance measures in which a lower score indicates stronger performance, year-over-year "improvement" is a reduction in the score for that measure.

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

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

The incentive payments from Round 2 are not to exceed more than 1% of capitation in total across both rounds of incentives for any individual MCO. If the remaining funds from Round 1 are not sufficient to settle all qualifying MCOs up to 1% of capitation in Round 2, then the remaining funds will be disbursed proportionally among qualifying MCOs based on the amount of funding needed to achieve 1% of total capitation.

If the leftover funds from Round 1 are not sufficient to settle all qualifying MCOs up to 1% of capitation in Round 2, then the leftover funds will be disbursed proportionally among qualifying MCOs based on the amount of funding needed to achieve 1% of total capitation.

If there are additional funds remaining after settling qualifying MCOs up to 1% of capitation across both rounds, then MDH may, within its discretion, make additional payments to MCOs that are below 1% of capitation based on improvement or performance, or place remaining funds into a non-lapsing pool.

PHIP Validation Results

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

Table 28. Total Available Funds for MY 2022 PHIP

Capitation Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total available for Round 1 incentives	$1,430,493	$2,271,024	$1,078,815	$2,775,057	$7,018,433	$2,986,805	$9,172,929	$4,231,117	$7,157,234
Max payout for each of the full measures (1/8th of available cap)	$178,812	$283,878	$134,852	$346,882	$877,304	$373,351	$1,146,616	$528,890	$894,654

Capitation Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Max payout for each of the lead sub-measures (1/16th of available cap)	$89,406	$141,939	$67,426	$173,441	$438,652	$186,675	$573,308	$264,445	$447,327

Performance Measure Results

Table 29. Tier 1 Performance Incentives: MY 2022 PHIP Benchmark Percentiles

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	58.6%	72.6%	87.1%	70.9%	82.6%	79.6%	82.0%	76.2%	77.9%
Ambulatory Care Visits for SSI Children (MDH)	47.0%	70.5%	81.3%	71.0%	81.9%	75.3%	82.6%	75.2%	78.8%
Asthma Medication Ratio (AMR)	56.2%	75.8%	68.6%	98.1%	71.4%	65.4%	67.3%	56.8%	66.9%
Continued Opioid Use (COU): ≥31 days covered^	3.5%	3.4%	3.9%	0.8%	3.8%	2.3%	3.9%	3.4%	2.4%
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)^	38.0%	38.0%	29.2%	30.7%	32.9%	30.7%	32.4%	36.3%	37.2%
Lead Screening in Children (LSC)*	66.2%	67.2%	82.2%	84.8%	65.0%	75.4%	72.0%	67.3%	74.0%
Lead Screenings for Children – Ages 12 to 23 Months* (MDH)	53.5%	58.0%	74.5%	69.6%	55.9%	61.0%	63.2%	56.0%	60.2%
Prenatal and Postpartum Care (PPC): Postpartum Care	78.6%	83.5%	85.3%	87.3%	83.5%	88.0%	82.0%	74.9%	80.4%
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	84.2%	88.9%	87.7%	88.6%	89.1%	83.2%	92.2%	87.4%	90.0%

Red = <50th percentile (no incentive); Yellow = 50-74th percentile (strong); Light green = 75-89th percentile (very strong); Dark green = 90th percentile (superlative)
*These measures are valued as a composite combining two submeasures, with each weighted at 50%: an MDH-homegrown measure for lead screenings in children, and a HEDIS measure for lead screening in children (LSC).
^A lower rate indicates better performance.

Table 30. Tier 2 Improvement Incentives: MY 2022 Summary of Year-over-Year Improvement

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	No	No	No	No	No	No	No	No	No
Ambulatory Care Visits for SSI Children (MDH)	No	No	No	No	No	No	No	No	No
Asthma Medication Ratio (AMR)	No	**Yes**	No	No	**Yes**	No	No	No	No
Continued Opioid Use (COU): ≥31 days covered^	No	No	No	No	No	No	No	No	No
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)^	No	**Yes**	No	No	No	**Yes**	**Yes**	**Yes**	No
Lead Screening in Children (LSC)*	**Yes**	No	No	No	No	No	No	No	No
Lead Screenings for Children – Ages 12 to 23 Months* (MDH)	No	No	No	No	No	No	**Yes**	No	No
Prenatal and Postpartum Care (PPC): Postpartum Care	No	**Yes**	No	No	No	No	No	No	No
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	**Yes**	**Yes**	No	No	**Yes**	No	No	No	No

Blue Yes = Improvement; Gray No = No Improvement

*These measures are valued as a composite combining two submeasures, with each weighted at 50%: an MDH-homegrown measure for lead screenings in children, and a HEDIS measure for lead screening in children (LSC).

^A lower rate indicates better performance.

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

Round 1 Financial Incentive Results

Table 31. MY 2022 Tier 1 Performance Measure Incentive Dollars Awarded

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	$0	$0	$134,852	$0	$584,869	$124,450	$382,205	$0	$0
Ambulatory Care Visits for SSI Children (MDH)	$0	$0	$44,951	$0	$292,435	$0	$764,411	$0	$298,218
Asthma Medication Ratio: Ages 5-64	$0	$189,252	$44,951	$346,882	$584,869	$0	$382,205	$0	$298,218
Risk of Continued Opioid Use (COU): ≥31 days covered	$0	$94,626	$0	$346,882	$0	$124,450	$0	$176,297	$298,218
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	$59,604	$94,626	$134,852	$231,255	$584,869	$248,900	$764,411	$176,297	$298,218
Lead Screening in Children (HEDIS)*	$29,802	$47,313	$67,426	$173,441	$146,217	$124,450	$382,205	$88,148	$298,218
Lead Screenings for Children (MDH)*	$0	$0	$67,426	$173,441	$0	$62,225	$191,103	$0	$0
Prenatal and Postpartum Care: Postpartum Care	$59,604	$189,252	$134,852	$346,882	$584,869	$373,351	$764,411	$0	$298,218
Prenatal and Postpartum Care: Timeliness of Prenatal Care	$59,604	$189,252	$44,951	$231,255	$584,869	$0	$1,146,616	$176,297	$596,436
TOTAL	**$208,614**	**$804,321**	**$674,259**	**$1,850,038**	**$3,362,999**	**$1,057,827**	**$4,777,567**	**$617,038**	**$2,385,745**

These measures are valued as a composite combining two submeasures, with each weighted at 50%: an MDH-homegrown measure for lead screenings in children, and a HEDIS measure for lead screening in children (LSC).
Color coding correlates with Table 29. Tier 1 Performance Incentives: MY 2022 PHIP Benchmark Percentiles.

Table 32. MY 2022 Tier 2 Improvement Incentive Dollars Awarded

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Ambulatory Care Visits for SSI Children (MDH)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Asthma Medication Ratio: Ages 5-64	$0	$94,626	$0	$0	$292,435	$0	$0	$0	$0
Risk of Continued Opioid Use (COU): ≥31 days covered	$0	$0	$0	$0	$0	$0	$0	$0	$0
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	$0	$94,626	$0	$0	$0	$124,450	$382,205	$176,297	$0
Lead Screening in Children (HEDIS)*	$29,802	$0	$0	$0	$0	$0	$0	$0	$0
Lead Screenings for Children (MDH)*	$0	$0	$0	$0	$0	$0	$191,103	$0	$0
Prenatal and Postpartum Care: Postpartum Care	$0	$94,626	$0	$0	$0	$0	$0	$0	$0
Prenatal and Postpartum Care: Timeliness of Prenatal Care	$59,604	$94,626	$0	$0	$292,435	$0	$0	$0	$0
TOTAL	**$89,406**	**$378,504**	**$0**	**$0**	**$584,869**	**$124,450**	**$573,308**	**$176,297**	**$0**

*These measures are valued as a composite combining two submeasures, with each weighted at 50%: an MDH-homegrown measure for lead screenings in children, and a HEDIS measure for lead screening in children (LSC).
Color coding correlates with Table 30. Tier 2 Improvement Incentives.

Table 33. MY 2022 PHIP Round 1 Incentive Award Summary (Tier 1 & Tier 2)

Total Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	All MCOs
Tier 1- Performance Incentives	$208,614	$804,321	$674,259	$1,850,038	$3,362,999	$1,057,827	$4,777,567	$617,038	$2,385,745	$15,738,407
Tier 2 – Improvement Incentives	$89,406	$378,504	$0	$0	$584,869	$124,450	$573,308	$176,297	$0	$1,926,834
TOTAL INCENTIVES FOR ROUND 1	**$298,019**	**$1,182,825**	**$674,259**	**$1,850,038**	**$3,947,868**	**$1,182,277**	**$5,350,875**	**$793,334**	**$2,385,745**	**$17,665,241**
Maximum Possible Incentives from Round 1	$1,430,493	$2,271,024	$1,078,815	$2,775,057	$7,018,433	$2,986,805	$9,172,929	$4,231,117	$7,157,234	$38,121,907
Proportion of Potential Round 1 Incentives Earned	**21%**	**52%**	**63%**	**67%**	**56%**	**40%**	**58%**	**19%**	**33%**	**46%**

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

Summary Financial Incentive Results. Table 34 displays a summary of incentives rewarded across both Round 1 and Round 2. After Round 1 and Round 2 incentives were earned, $20,456,666 was left as unallocated funds from Round 2. MDH credited this remaining amount to a non-lapsing fund.

Table 34. MY 2022 PHIP Summary for Round 1 and Round 2 Incentives Awarded

Total Payments	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	All MCOs
Round 1 – Performance (Tier 1)	$208,614	$804,321	$674,259	$1,850,038	$3,362,999	$1,057,827	$4,777,567	$617,038	$2,385,745	$15,738,407
Round 1 – Improvement (Tier 2)	$89,406	$378,504	$0	$0	$584,869	$124,450	$573,308	$176,297	$0	$1,926,834
TOTAL INCENTIVES FOR ROUND 1	**$298,019**	**$1,182,825**	**$674,259**	**$1,850,038**	**$3,947,868**	**$1,182,277**	**$5,350,875**	**$793,334**	**$2,385,745**	**$17,665,241**
Round 2	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Incentives (Round 1 and Round 2)	**$298,019**	**$1,182,825**	**$674,259**	**$1,850,038**	**$3,947,868**	**$1,182,277**	**$5,350,875**	**$793,334**	**$2,385,745**	**$17,665,241**
Percent of 2022 Capitation Earned as Incentives	**0.10%**	**0.26%**	**0.31%**	**0.33%**	**0.28%**	**0.20%**	**0.29%**	**0.09%**	**0.17%**	**0.23%**

Conclusion

All nine MCOs received a financial reward for Round 1 Tier 1 for performance. Six of the nine MCOs (ABH, CFCHP, MPC, MSFC, PPMCO, and UHC) received a Round 1 Tier 2 improvement incentive. No MCO received a Round 2 incentive. Remaining funds were credited to a non-lapsing fund.

Quality Strategy Highlights

MDH set task goals for the following HEDIS measures in the HealthChoice Quality Strategy for 2022-2024, based on pre-Covid public health emergency aggregate performance. Quality Strategy targets for the MDH-developed measures are currently in development. Specific HealthChoice performance metrics and targets are displayed in Table 35 below.

Table 35. MY 2022 PHIP Maryland Reportable Rate against Quality Strategy Targets

Performance Measures	MDH Quality Strategy Targets for MY 2024	Maryland Average Reportable Rate for MY 2022
Asthma Medication Ratio (AMR)	70.6%	69.6%
Continued Opioid Use (COU): ≥31 days covered*	1.9%	3.0%
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)*^	36.9%	33.9%
Lead Screening in Children (LSC)	82.8%	72.7%
Prenatal and Postpartum Care (PPC): Postpartum Care	81.3%	82.6%
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	88.2%	87.9%

*A lower rate indicates better performance.
^Previously Comprehensive Diabetes Care (CDC), HbA1c Poor Control (>9.0%).
Sources: *HealthChoice Quality Strategy* and *MetaStar's Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2022 Results*

The HBD Poor HbA1c control measure (>9%) MARR exceeded the quality goal by three percentage points, as a lower rate for this measure indicates better performance. The Maryland Average Reportable Rate for postpartum care measures exceeded the quality strategy goal, by 1.3 percentage points.

For additional findings and comprehensive details associated with the MY 2022 PHIP validation, please access the link to the MY 2022 PHIP report in **Appendix E**. The **MCO Quality, Access, and Timeliness Assessment section** includes informed conclusions from the PHIP validation activity related to quality, access, and timeliness for the HealthChoice program.

Systems Performance Review

Objective

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

Methodology

Qlarant conducted MY 2022's assessment as an interim desktop review in response to MDH's decision to move to triennial, rather than annual, onsite reviews. Reviewers completed the interim assessment by applying systems performance standards. Performance standards used to assess each MCO's operational systems were developed through the review of the Code of Maryland Regulations (COMAR) 10.67.04.03B(1); federal regulations, such as CFR, Subpart D and Quality Assurance and Performance Improvement (QAPI) standards; and guidelines from other quality assurance accrediting bodies, such as the NCQA. **Appendix B** provides a crosswalk of COMAR regulations and SPR standards reviewed for MY 2022's interim desktop review. Standards requiring a CAP or scored as *Baseline* in the MY 2021 comprehensive onsite review were the focus of MY 2022's SPR. A sample review of appeal, grievance, and adverse determination records was also conducted to assess compliance with applicable standards.

Prior to individual desktop reviews, each MCO received a draft of the standards for review and comment within 45 days from receipt. All comments were considered before finalizing the standards. SPR standards were finalized after the review and approval by the Division of HealthChoice Quality Assurance (DHQA).

During the desktop reviews conducted in January and February of 2023, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation submitted by the MCOs to assess compliance with standards. Qualified healthcare professionals conducted reviews, utilizing over 50 years of combined EQR experience and 40 years of HealthChoice experience.

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

Final reports captured revisions from the review of the additional documentation that was sent from the MCOs. After receiving the final report, the MCOs were given 45 calendar days to respond to Qlarant with the required CAPs. The MCOs also had the opportunity, within this timeframe, to respond to any other issues contained in the report, at its discretion, and/or request a consultation with DHQA and Qlarant to clarify issues or ask for assistance in preparing a CAP. Qlarant evaluated and determined the adequacy of compliance for all CAPs. A CAP was determined adequate only if it addressed all required elements and components (such as timelines, action steps, and documented evidence).

Data Collection and Review. Prior to the annual review, the MCOs were required to submit a completed pre-audit survey form and provide documentation for various processes: quality assurance and governance, delegation of activities, credentialing and recredentialing, enrollee rights, availability and accessibility, utilization review, continuity of care, health education, outreach, and fraud and abuse. Documentation provided by the MCOs included policies and procedures; meeting minutes; program descriptions; annual evaluations; work plans; tracking and monitoring reports; focused studies; delegate reports; population assessments; HEDIS and CAHPS results; enrollee handbooks and materials;

provider manuals, directories, 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 defined in Table 36. MDH had the discretion to change a review finding to *Unmet* if the element or component was *Partially Met* for more than one consecutive year.

Table 36. MY 2022 SPR Validation Review Determinations

Determination Category	Review Determination	Criteria
Performance Evaluation Status	**Met (M)**	Compliant with requirements
	Met with Opportunity (MwO)	Compliant with requirements, but with an opportunity to improve; CAP is not required
	Partially Met (PM)	CAP required
	Unmet (UM)	CAP required
Review Inclusion Status	**Baseline (B)**	Reviewed, not scored
	Deemed (D)	Not reviewed as MCO scored 100% on the applicable NCQA standards
	Not Applicable (NA)	Not Applicable

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

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

To qualify for deeming, MDH established the following criteria:

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

Using this information and the NCQA *Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards*[15] (Effective July 1, 2020 – June 30, 2021), Qlarant evaluated whether the MCO qualified for deeming of federal regulations. **Appendix B** provides a crosswalk of the SPR standards in which MDH permitted deeming for MY 2022's interim desktop review.

Results

Tables 37 to 43 identify MCO performance results providing opportunities for improvement and requiring corrective action before MY 2023's SPR, across structural and operational standards.

Standard 4 Results and Findings for Credentialing and Recredentialing: Eight MCOs (ABH, CFCHP, JMS, KPMAS, MSFC, PPMCO, UHC, and WPM) met minimum compliance (100%) for elements and components reviewed for MY 2022 under Standard 4. MPC is the only MCO with continued opportunities for improvement requiring quarterly CAP monitoring.

Table 37. MY 2022 Standard 4: Credentialing and Recredentialing Findings by MCO

MCO	PM	UM	MwO
MPC	NA	4.4i and 4.4j	NA

Red font represents quarterly updates that are required on the CAP per MDH's Performance Monitoring Policy

Standard 5 Results and Findings for Enrollee Rights: Five MCOs (ABH, JMS, MPC, MSFC, and UHC) scored minimum compliance (100%) for all elements and components reviewed for MY 2022 under Standard 5. Four MCOs (CFCHP, KPMAS, PPMCO, and WPM) have opportunities for improvement requiring CAP submissions; three MCOs (CFCHP, KPMAS, and WPM) require quarterly CAP monitoring. JMS is the only MCO receiving a *Met with Opportunity* finding, indicating compliance with requirements, but identifying opportunities to improve before MY 2023's SPR.

Table 38. MY 2022 Standard 5: Enrollee Rights Findings by MCO

MCO	PM	UM	MwO
CFCHP	NA	5.1a, 5.1g, 5.1h, and 5.8d	NA
JMS	NA	NA	5.1a
KPMAS	NA	5.1d, 5.1g, and 5.1h	NA
PPMCO	5.8e	NA	NA
WPM	NA	5.1h, 5.5c, and 5.8d	NA

Red font represents quarterly updates that are required on the CAP per MDH's Performance Monitoring Policy

[15] National Committee for Quality Assurance. (2020) *Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards*. Retrieved from

Standard 6 Results and Findings for Availability and Accessibility: All nine MCOs met minimum compliance (100%) for all elements and components reviewed for MY 2022 under Standard 6. WPM is the only MCO receiving a *Met with Opportunity* finding, indicating compliance with requirements, but identifying opportunities to improve before MY 2023's SPR.

Table 39. MY 2022 Standard 6: Availability and Accessibility Findings by MCO

MCO	PM	UM	MwO
WPM	NA	NA	6.2b

Standard 7 Results and Findings for Utilization Review: JMS is the only MCO to score minimum compliance (100%) for all elements and components reviewed for MY 2022 under Standard 7. Eight MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC, and WPM) have opportunities for improvement requiring CAP submissions; five MCOs (CFCHP, KPMAS, PPMCO, UHC, and WPM) require quarterly CAP monitoring. Two MCOs (ABH and CFCHP) received a *Met with Opportunity* finding, indicating compliance with requirements, but identifying opportunities to improve before MY 2023's SPR.

Table 40. MY 2022 Standard 7: Utilization Review Findings by MCO

MCO	PM	UM	MwO
ABH	7.5a and 7.5b	NA	7.8c
CFCHP	7.5a, 7.7c, and 7.7e	7.4c, 7.6a, 7.7g, 7.8c, 7.9c, and 7.10	7.9b
KPMAS	7.4c and 7.7c	7.8c and 7.9c	NA
MPC	7.4c and 7.7c	NA	NA
MSFC	7.7c	NA	NA
PPMCO	7.4c, 7.5b, and 7.7c	7.7e and 7.7g	NA
UHC	7.3c	7.10	NA
WPM	7.4c	7.6b, 7.7c, and 7.10	NA

Red font represents quarterly updates that are required on the CAP per MDH's Performance Monitoring Policy

Standard 9 Results and Findings for Health Education Plan: Four MCOs (ABH, JMS, KPMAS, and MPC) met minimum compliance (100%) for all elements and components reviewed for MY 2022 under Standard 9. Three MCOs (CFCHP, PPMCO, and WPM) have opportunities for improvement requiring CAP submissions. Five MCOs (CFCHP, MSFC, PPMCO, UHC, and WPM) received a *Met with Opportunity* finding, indicating compliance with requirements, but identifying opportunities to improve before MY 2023's SPR.

Table 41. MY 2022 Standard 9: Health Education Plan Findings by MCO

MCO	PM	UM	MwO
CFCHP	9.3c and 9.5b	9.5c	9.3a, 9.3b, and 9.5a
MSFC	NA	NA	9.5b
PPMCO	9.3a, 9.3c, and 9.4	NA	9.5b
UHC	NA	NA	9.3a, 9.4, and 9.5c
WPM	9.2	9.3a, 9.3b, 9.5b, and 9.5c	9.1b

Standard 10 Results and Findings for Outreach Plan: Eight of the nine MCOs met minimum compliance (100%) for all elements and components reviewed for MY 2022 under Standard 10. PPMCO is the only MCO with opportunities for improvement requiring a CAP submission.

Table 42. MY 2022 Standard 10: Outreach Plan Findings by MCO

MCO	PM	UM	MwO
PPMCO	10.1a	NA	NA

Standard 11 Results and Findings for Fraud and Abuse: All nine MCOs met minimum compliance (100%) for all elements and components reviewed for MY 2022 under Standard 11. Two MCOs (ABH and CFCHP) received a *Met with Opportunity* finding, indicating compliance with requirements, but identifying opportunities to improve before MY 2023's SPR.

Table 43. MY 2022 Standard 11: Fraud and Abuse Findings by MCO

MCO	PM	UM	MwO
ABH	NA	NA	11.4d
CFCHP	NA	NA	11.4d

Conclusions

All MCOs demonstrated the ability to design and implement effective quality assurance systems. Quality assurance monitoring policies, procedures, and processes receive improvements while MCOs continue to provide the appropriate levels and types of healthcare services to managed care enrollees.

One MCO (JMS) received a *Met* and/or *Met with Opportunity* finding for all standards reviewed. Eight MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC, and WPM) were required to submit CAPs for MY 2022. As a result of the MY 2022 SPR, six MCOs (CFCHP, KPMAS, MPC, PPMCO, UHC, and WPM) have quarterly CAP monitoring. CFCHP and KPMAS have continued quarterly CAP monitoring for component 7.8c. Deficiencies noted in MCO CAP submissions received recommendations in areas where, if implemented, performance should improve for future reviews.

For comprehensive details associated with the MY 2022 SPR, please access the link to the SPR Executive Summary Report in **Appendix E**. The **MCO Quality, Access, and Timeliness Assessment section** includes informed conclusions from the SPR activity related to quality, access, and timeliness for the HealthChoice program.

Network Adequacy Validation

Objective

Qlarant evaluated the network adequacy of HealthChoice MCOs to ensure MCOs can provide enrollees with timely access to necessary care and a sufficient number of in-network providers.

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

This report identifies Qlarant's NAV activities conducted for MY 2023, which took place in June and July 2023, for all nine MCOs.

Methodology

Description of Data Obtained. MDH established the following goals for MY 2023 NAV activities:

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

Table 44 defines MDH's directory requirements as well as access and availability requirements outlined in the COMAR.

Table 44. MY 2023 Provider Directory and Access and Availability Requirements

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

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

Qlarant's subcontractor conducted telephone surveys, and Qlarant conducted validation of online provider directories for each PCP in the sample. MY 2023 orientation training for telephone surveyors and Qlarant provider directory validators included:

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

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

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

Qlarant requested and received a list of contracted PCPs from each MCO. Qualifying providers for MY 2023 NAV activities specialized in one of the following areas: primary care, adult medicine, internal medicine, general practice, family medicine, or pediatrics. Qlarant instructed MCOs to submit the following information for each PCP:

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

Qlarant assessed each MCO's submission for completeness. Corrections were requested if issues regarding incomplete data, non-PCPs included in the listings, or incorrect telephone numbers were identified. MCOs provided lists for 138 PCPs contracted in contiguous states to Maryland:

- Delaware (15)
- District of Columbia (102)
- Pennsylvania (1)
- Virginia (5)
- West Virginia (15)

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

Technical Methods of Data Collection and Analysis. The HealthChoice program network has 22,312 contracted PCPs across all nine MCOs. A random sample, based on the number of contracted PCPs, was selected for each MCO using a 90% confidence level (CL) and a 5% margin of error. Table 45 shows the total number of contracted PCPs per MCO and the respective sample sizes. The final sample included 2,074 PCPs.

Table 45. MY 2023 Contracted PCPs and Sample Size by MCO

MCO	Number of Contracted PCPs	Sample Size (90% CL +/- 5%)
ABH	2,343	243
CFCHP	3,266	250
JMS	724	198
KPMAS	392	161
MPC	2,364	243
MSFC	1,902	237
PPMCO	6,394	260
UHC	1,538	231
WPM	3,389	251
Total	**22,312**	**2,074**

Each PCP can only be sampled once for each MCO; therefore, if a PCP of a different name but the same address was included in the MCO's sample, it was replaced with a different PCP. This practice increased the number of unique PCPs in the sample for each MCO. PCPs with the same NPI number who are providing services at other practice locations (different addresses), as submitted by the MCOs, were not removed as duplicates from the sample. Surveys were conducted on weekdays during normal business hours from 9:00 a.m. to 5:00 p.m. Eastern Standard Time. Responses to the survey questions were documented in the survey tool and stored electronically on Qlarant's secure web-based portal.

The telephone survey solicited responses to verify PCP information, including:

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

The validation of network adequacy was completed in two steps. Step 1 verified that the information obtained during the ten-question telephone survey matched the information provided by the MCO:

- Address
- Phone number

Step 2 verified the MCOs' online provider directories matched the following information for PCPs in the sample provided during the survey calls:

- Status of accepting new Medicaid patients

- Ages served by the PCP
- Languages spoken by the PCP
- Availability of accommodations for disabled patients and identified specific Americans with Disabilities Act of 1990 (ADA)-accessible equipment

Surveyors conducted and documented at least three call attempts. If the first call attempt resulted in no contact with a live respondent, surveyors attempted to call again on another day and time. At least three attempts were made for each call unless the surveyor reached the wrong number or if the office was found permanently closed. Surveyors confirmed wrong PCP telephone numbers by calling the telephone number twice; if the call resulted in a wrong number or the office was permanently closed, the survey ended. Surveyors ended the call on the third attempt if they were prompted to leave a message, were on hold for more than 5 minutes, or had no answer. Other reasons for a surveyor ending the call were:

- Respondent refused to participate
- PCP was not with the practice or did not practice at that location
- Provider listed was not a primary care provider
- PCP listed was not in the identified MCO's network

If the surveyor was given any of the above reasons or was unable to reach a live person after the third attempt, the call was considered to be unsuccessful and recorded as such.

Surveys were considered 'successful' if the surveyor reached the PCP within three call attempts and completed the survey. Successful telephone surveys were validated against the details noted in the MCO's online directory. If the PCP was not in the MCO's online provider directory, the validation survey ended.

MDH set an 80% minimum compliance score for the MY 2023 network adequacy assessment to ensure MCOs are complying with all state and federal requirements.

Results

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

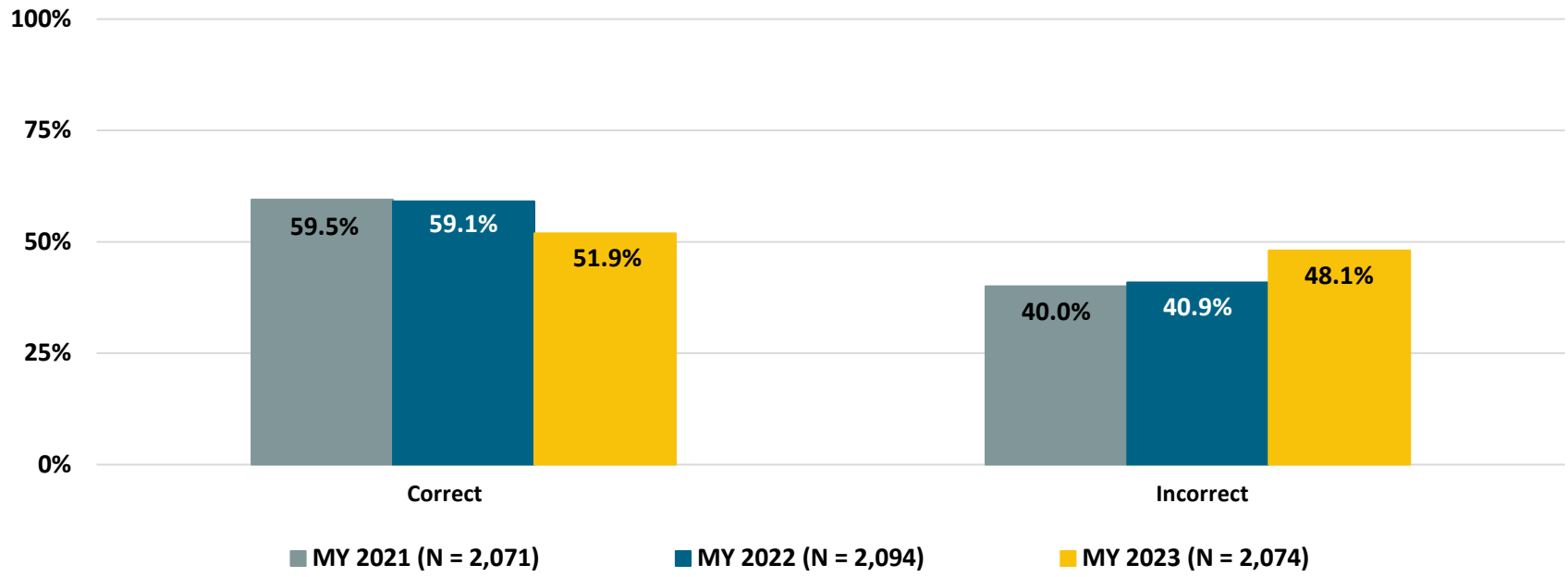
- Accuracy of PCP Information
  - PCP Information
  - PCP Affiliation & Open Access

- Successful Contacts
- Unsuccessful Contacts
  - "No Contact" Categories
  - "PCP Response" Categories
- Compliance with Appointment Standards
  - Routine Appointment Requirements
  - Urgent Care Appointment Requirements
- Validation of MCO Online Provider Directories

Accuracy of PCP Information

Accuracy of PCP Information – Phone Numbers and Addresses: When contact is made with the PCP, the PCP's pre-populated phone number and address are verified. Results for the percentage of PCPs where the provided phone number and address match the information provided by the MCO are demonstrated in Figure 6, trended by year. In MY 2023, there was an increase of 7.2 percentage points for incorrect provider information compared to MY 2022 at 40.9%. Incorrect provider information increased by 8.1 percentage points in MY 2023 to 48.1% compared to MY 2021 at 40.0%.

Figure 6. MYs 2021 to 2023 Accuracy of Provider Contact Information (Phone Number and Address)



Successful Contacts

Results summarizing the total successful PCP contacts are captured in Figures 7 through 9. The total for successful PCP contacts, trended by year, are displayed in Figure 7. The number of attempted PCP surveys conducted decreased from 2,094 in MY 2022 to 2,074 in MY 2023. The percentage of successful contacts decreased by 4.4 percentage points from MY 2022 (63.7%) to MY 2023 (59.3%). The percentage of successful contacts from MY 2021 to MY 2023 is displayed in Figure 8. Figure 9 illustrates the number of call attempts surveyors used to reach PCPs before making contact and successfully completing the survey. Approximately 80% of providers were contacted on the first call attempt, 14.7% on the second call attempt, and 4.9% on the third attempt.

Figure 7. MYs 2021 to 2023 Number of Surveys Conducted and Number of Successful PCP Contacts

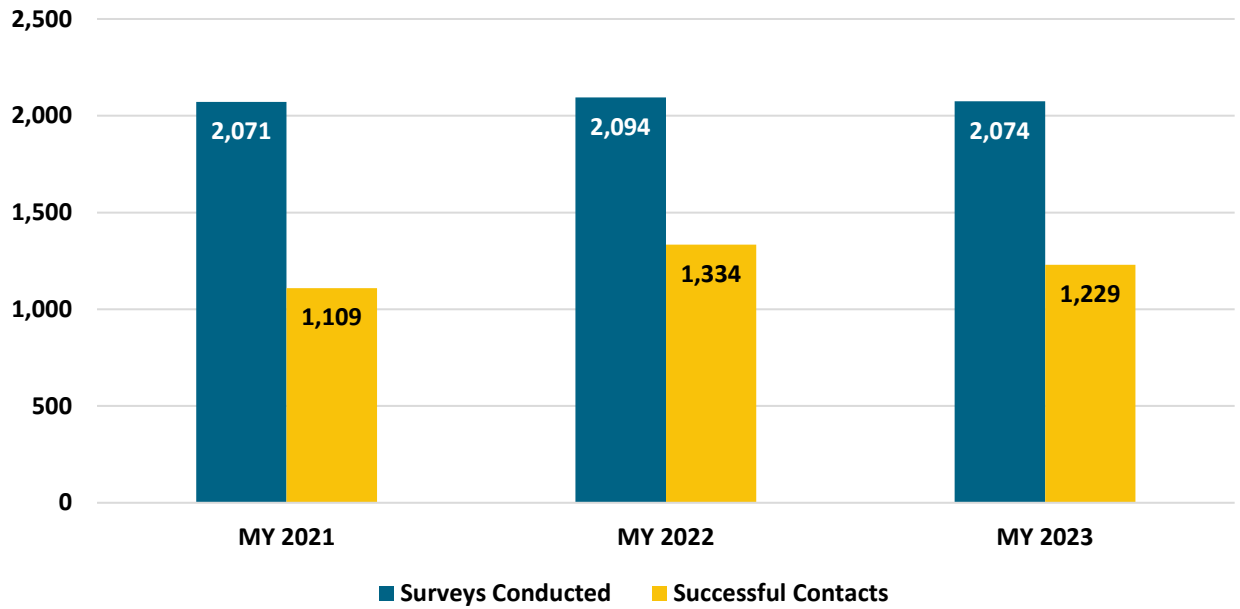


Figure 8. Percent of Successful PCP Contacts from MYs 2021 to 2023

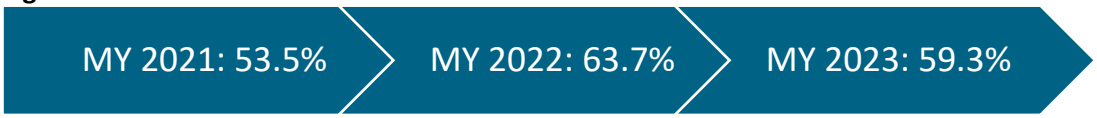
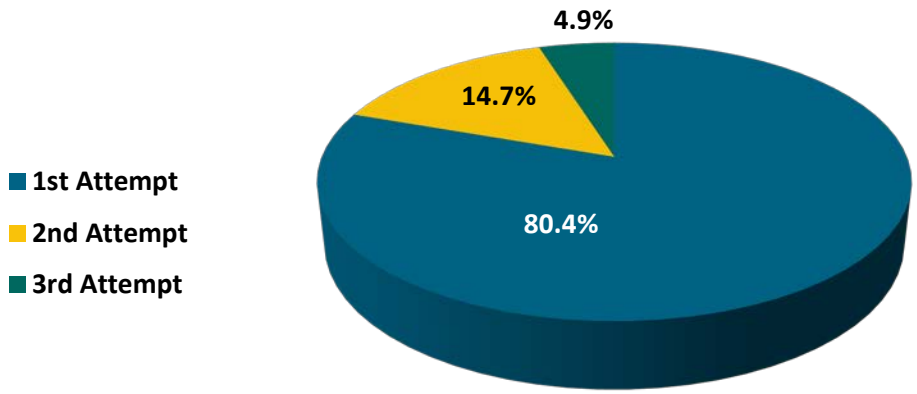
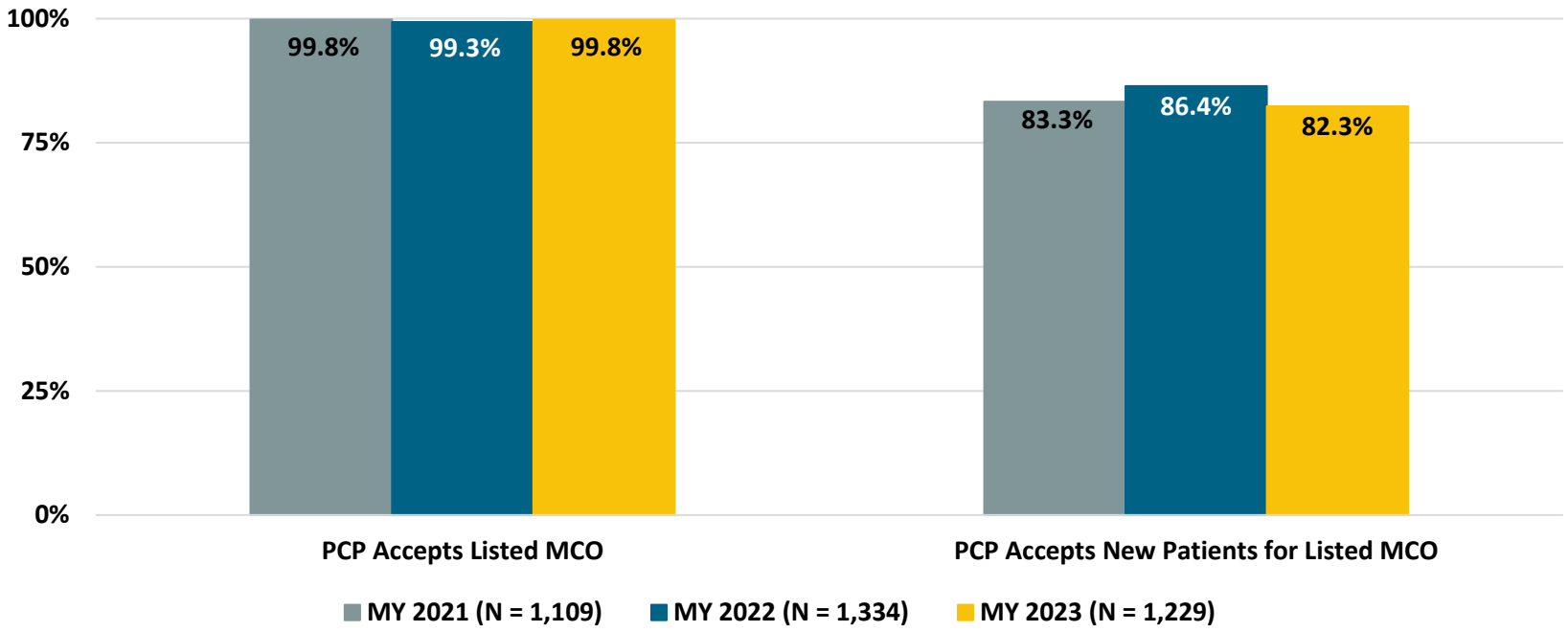


Figure 9. MY 2023 Responses by Call Attempt for Successful Contacts



Accuracy of PCP Information - PCP Affiliation and Open Access. When contact is made with the PCP, verifications assess whether the PCP's affiliation with a listed MCO(s) and acceptance of new Medicaid patients is correct. Results for the accuracy of PCP information for MY 2023 successful survey contacts are displayed in Table 46. Figure 10 displays the results for these survey elements per MY, trended by year. MY 2023 results are consistent with MYs 2021 and 2022. MY 2021 and 2023's results both indicated 99.8% of PCPs accepted the listed MCO. MY 2023 performance decreased from both MY 2021 and 2022, indicating 82.3% of PCPs accepting new patients for the listed MCO, which is a 4.1 percentage point decrease from MY 2022 (83.3%).

Figure 10. MYs 2021 to 2023 PCP Affiliation & Open Access



Accuracy of Information for Successful Contacts. Table 46 displays the accuracy of PCP information (accurate PCP address and accuracy for responses to acceptance of listed MCO and new Medicaid patients) for successful survey contacts for MY 2023. Compared to all other MCOs, contact with PPMCO's providers was least likely to be successful (43.8%). WPM had the lowest percentage of providers with accurate addresses (79.6%). All nine MCOs achieved greater than 99% for acceptance of the listed MCO. JMS and KPMAS had the lowest percentage of PCP acceptance of new Medicaid patients at 73.3% and 73.8%, respectively.

Table 46. MY 2023 MCO Results from Successful Contacts for Accuracy of PCP Information

Calls Per MCO		Successful Contacts		Accurate PCP Address Provided		Accepts Listed MCO		Accepts New Medicaid Patients Listed for MCO	
MCO	# of Calls	#	%	#	%	#	%	#	%
ABH	243	127	52.3%	108	85.0%	127	100.0%	113	89.0%
CFCHP	250	149	59.6%	133	89.3%	148	99.3%	117	78.5%
JMS	198	116	58.6%	110	94.8%	115	99.1%	85	73.3%
KPMAS	161	103	64.0%	102	99.0%	103	100.0%	76	73.8%
MPC	243	159	65.4%	136	85.5%	159	100.0%	140	88.1%
MSFC	237	156	65.8%	144	92.3%	156	100.0%	137	87.8%
PPMCO	260	114	43.8%	101	88.6%	114	100.0%	95	83.3%
UHC	231	168	72.7%	157	93.5%	167	99.4%	131	78.0%
WPM	251	137	54.6%	109	79.6%	137	100.0%	118	86.1%
Total	**2,074**	**1,229**	**59.3%**	**1,100**	**89.5%**	**1,226**	**99.8%**	**1,012**	**82.3%**

Unsuccessful Contacts

Of the 2,074 PCP surveys attempted in MY 2023, 845 PCP surveys were unsuccessful. Reasons for unsuccessful surveys were divided into two categories: “No Contact” and “PCP Response.”

Unsuccessful Contacts within the “No Contact” Category. Unsuccessful surveys categorized as “No Contact” included calls in which the surveyor could not reach the PCP for one of the following reasons:

- The number did not reach the intended provider (e.g., wrong number, office closed, or provider not with practice)
- No answer
- Reached voicemail
- Hold time exceeded 5 minutes

Approximately 77.5% of telephone surveys were unsuccessful due to “No Contact.” Reasons for unsuccessful contact with the PCP, with process descriptions and percentages, are noted in Figure 11. There was an increase in “No Contact” made to provider offices due to “No Answer” (14.7%) and “Reached Voicemail” (19.9%) compared to MY 2022 at 7.6% and 9.2%, respectively. Table 47 provides MCO-specific information

regarding the "No Contact" categories. Results indicate the most common reason for unsuccessful calls for all MCOs was due to not reaching the intended provider (46.1%). Additional findings by MCO indicate the following:

- WPM had the highest percentage of survey calls that were unsuccessful due to not reaching the intended provider at 62.2%, followed by JMS at 57.4% and MPC at 54.4%.
- MSFC and UHC providers were more likely than other MCOs not to answer the survey call at 31.8% and 24.0%, respectively.
- CFCHP and MPC providers were more likely than other MCOs to send the surveyor to voicemail at 32.2% and 32.4%, respectively.
- JMS, MPC, and WPM providers were less likely than other MCOs to place the surveyor on hold for more than five minutes at 1.9%, 1.5%, and 1.1%, respectively. KPMAS providers had the highest rate of placing the surveyor on hold for more than five minutes at 34.6%.

Figure 11. MYs 2021 to 2023 Unsuccessful Surveys due to "No Contact"

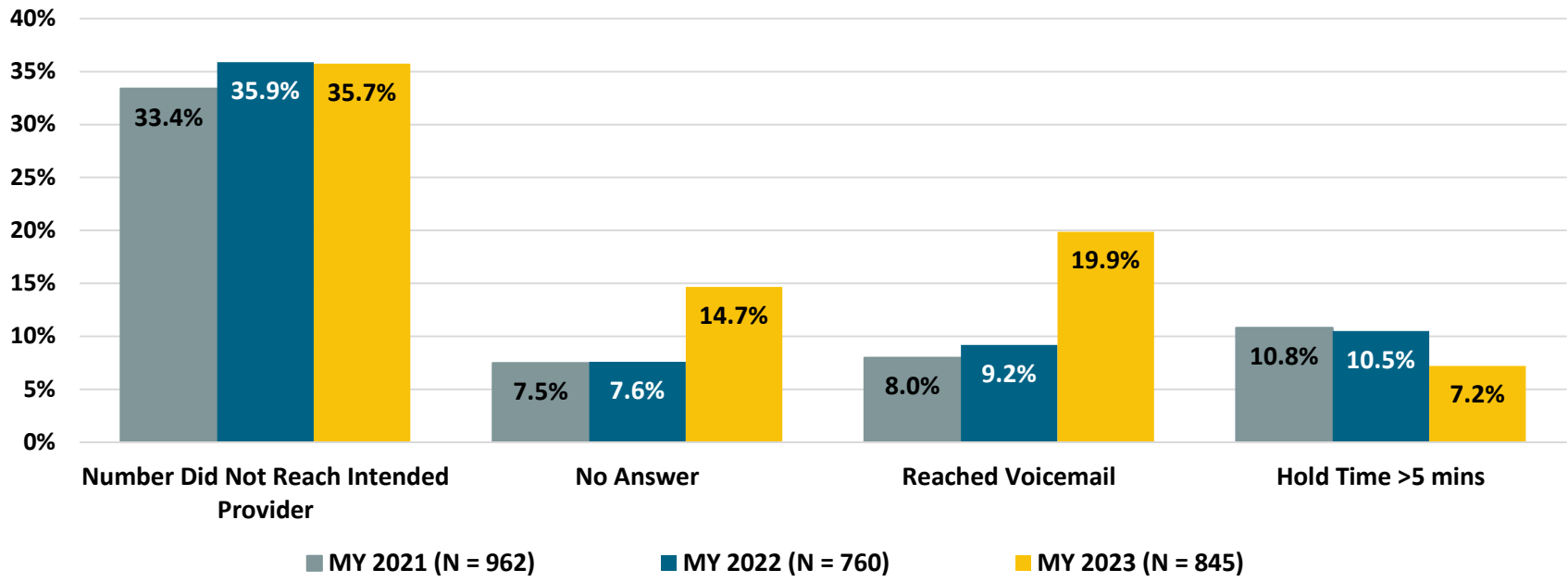


Table 47. MY 2023 "No Contact" Categories by MCO

MCO	Did Not Reach Intended Provider	No Answer	Reached Voicemail	Hold Time >5 Minutes	MCO Total
ABH	38.5%	21.9%	27.1%	12.5%	**96**
CFCHP	38.9%	20.0%	32.2%	8.9%	**90**
JMS	57.4%	14.8%	25.9%	1.9%	**54**
KPMAS	30.8%	11.5%	23.1%	34.6%	**26**
MPC	54.4%	11.8%	32.4%	1.5%	**68**
MSFC	30.3%	31.8%	27.3%	10.6%	**66**
PPMCO	50.4%	15.7%	20.9%	13.0%	**115**
UHC	40.0%	24.0%	22.0%	14.0%	**50**
WPM	62.2%	16.7%	20.0%	1.1%	**90**
Total	**46.1%**	**18.9%**	**25.6%**	**9.3%**	**655**

Unsuccessful Contacts within the "PCP Response" Category. Unsuccessful surveys categorized as "PCP Response" included calls that ended after the initial communication with a respondent for one of the following reasons:

- Wrong location was listed for the provider
- Provider identified for the survey is not a PCP
- Provider does not accept the listed MCO
- Respondent refused to participate in the survey

The purpose of the survey is to identify barriers enrollees may face when attempting to contact their PCP to obtain primary care services, except for PCP offices that refused to participate. Approximately 23% of telephone surveys were unsuccessful due to "PCP Response." The percentage of providers who refused to participate in the survey for MY 2023 was 3.4%. Figure 12 displays the percentage of unsuccessful calls due to "PCP Response" by MY. All four categories for unsuccessful surveys declined from MY 2022 to MY 2023. The proportion of unsuccessful surveys due to providers having the wrong location information declined from 10.8% to 2.6% in MY 2023. The proportion of unsuccessful surveys due to providers that were not PCPs declined from 6.3% to 5.0% from MY 2022 to MY 2023. After a slight increase from MY 2021 at 13.1% to MY 2022 at 13.9%, providers that did not accept the MCO insurance decreased to 11.5% in MY 2023. After an increase from MY 2021 at 0.8% to 5.7% in MY 2022, PCP offices that refused to participate in the survey declined to 3.4% in MY 2023. Table 48 displays unsuccessful surveys due to "PCP Response" per MCO. Results indicate the most common unsuccessful survey reason for "PCP Response" for all MCOs was that the provider did not accept the MCO's insurance (51.1%). Additional findings per MCO indicate the following:

- WPM was more likely than other MCOs to have the wrong location listed for the provider at 37.5%.

- PPMCO and UHC were more likely than other MCOs to have a provider listed that was not a PCP at 45.2% and 53.8%, respectively.
- JMS and KPMAS were more likely than other MCOs to have PCPs not accept the MCO's insurance at 64.3% and 68.8%, respectively.
- MPC was more likely than other MCOs to have PCPs refuse to participate in the survey at 43.8%.

Figure 12. MYs 2021 to 2023 Unsuccessful Surveys due to "PCP Response"

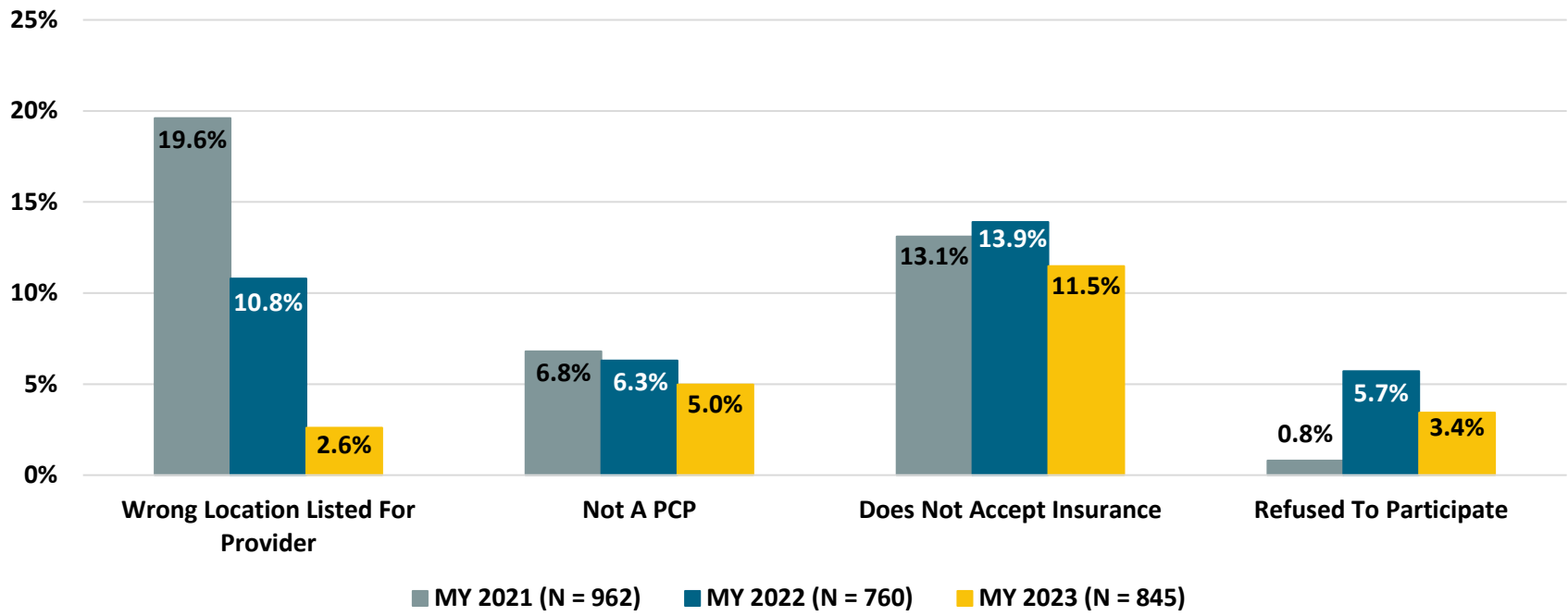


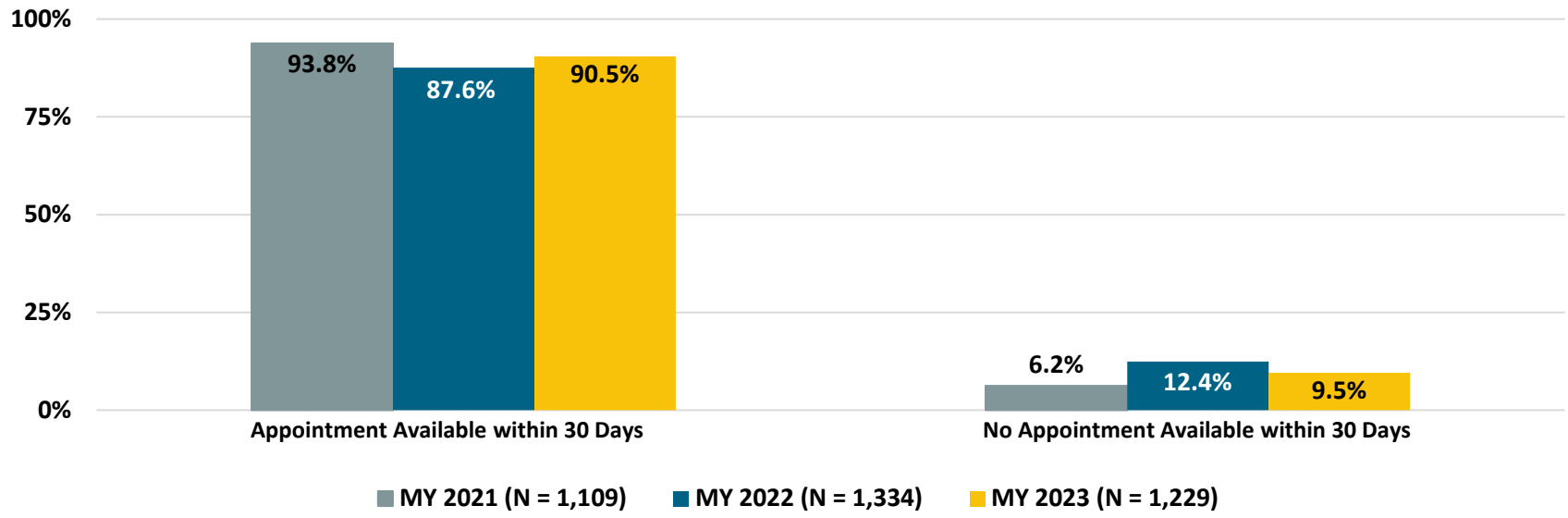
Table 48. MY 2023 "PCP Response" per MCO

MCO	Wrong Location Listed for Provider	Not a PCP	Does Not Accept Insurance	Refused to Participate	MCO Total
ABH	15.0%	35.0%	45.0%	5.0%	**20**
CFCHP	0.0%	27.3%	54.5%	18.2%	**11**
JMS	10.7%	21.4%	64.3%	3.6%	**28**
KPMAS	0.0%	3.1%	68.8%	28.1%	**32**
MPC	12.5%	6.3%	37.5%	43.8%	**16**
MSFC	13.3%	20.0%	60.0%	6.7%	**15**
PPMCO	6.5%	45.2%	41.9%	6.5%	**31**
UHC	7.7%	53.8%	38.5%	0.0%	**13**
WPM	37.5%	0.0%	37.5%	25.0%	**24**
Total	**11.6%**	**22.1%**	**51.1%**	**15.3%**	**190**

Compliance with Appointment Standards

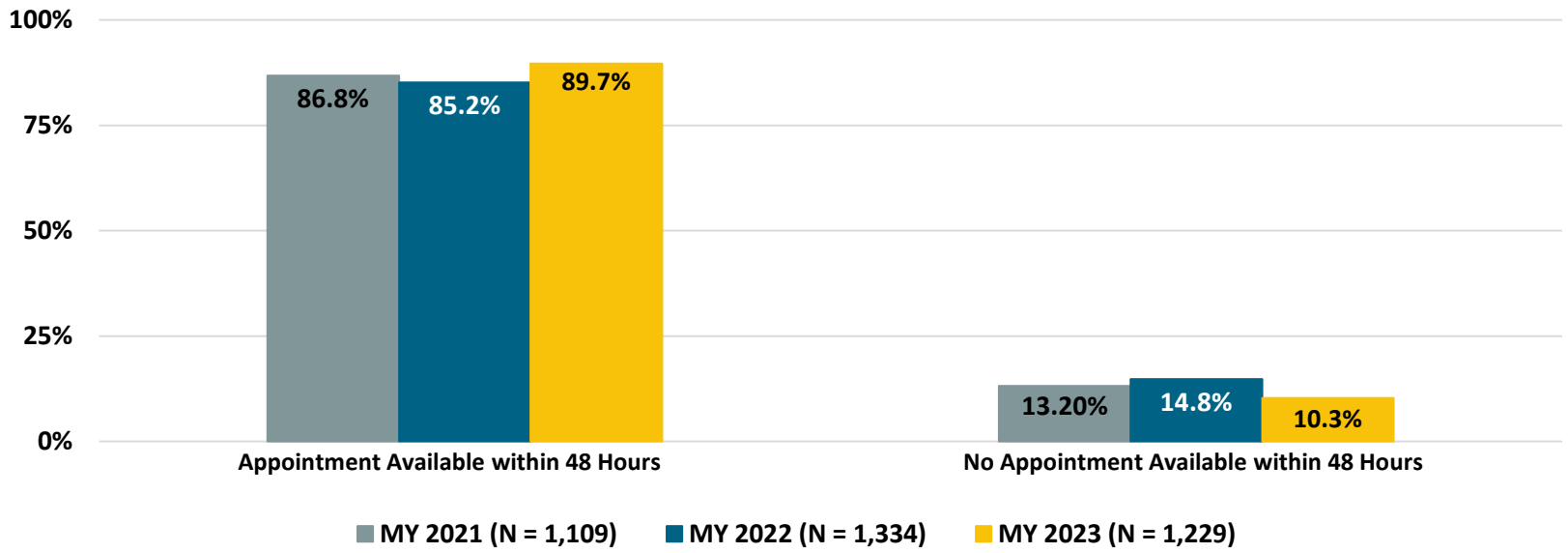
Compliance with Routine Care Appointment Requirements. To meet compliance, providers had to have an appointment (in-person or telemedicine) available within 30 days of the survey call date with the service provider or an alternative provider at the same location. Survey results of PCP compliance with routine care appointment requirements are displayed in Figure 13. PCP compliance with routine care appointment requirements increased by 2.9 percentage points in MY 2023 at 90.5%, compared to MY 2022 at 87.6%. Although compliance for routine care appointment availability within 30 calendar days increased from MY 2022, a decline in percentage points remains when comparing MY 2023's compliance (90.5%) to MY 2021 (93.8%).

Figure 13. MYs 2021 to 2023 Percent of PCPs in Compliance with Routine Care Appointment Requirements



Compliance with Urgent Care Appointment Requirements. To meet compliance, providers had to have an urgent care appointment (in-person or telemedicine) available within 48 hours either with the service provider or an alternative provider at the same location. Survey results for PCP compliance with urgent care appointments are displayed in Figure 14. PCP compliance with urgent care appointment requirements for MY 2023 (89.7%) increased by 2.9 percentage points compared to MY 2021 at 86.8% and increased by 4.5 percentage points compared to MY 2022 at 85.2%.

Figure 14. MYs 2021 to 2023 Percent of PCPs in Compliance with Urgent Care Appointment Requirements



HealthChoice Results for Compliance with Appointment Timeframe Requirements. Aggregated HealthChoice and MCO-specific results for compliance with routine care and urgent care appointment timeframe requirements are displayed in Table 49. Results for compliance with routine care appointment availability within 30 days averaged 90.5% and ranged from 68.0% (KPMAS) to 97.6% (ABH). All MCOs except for KPMAS met the MDH-required minimum compliance score (80%) for compliance with the routine care appointment timeframe. The average wait time for a routine care appointment fell between six days (ABH) and 14 days (WPM), with the average being nine days. KPMAS will be required to submit a CAP to improve compliance with the routine appointment timeframe.

Results for compliance with urgent care appointments within 48 hours averaged 89.7% and ranged from 77.7% (KPMAS) to 94.5% (ABH). Most MCOs demonstrated a greater percentage of appointments with the requested PCP at the same location within 48 hours at 80.7%, ranging from 48.5% (KPMAS) to 87.4% (MPC). All MCOs except for KPMAS exceeded the MDH-required minimum compliance score (80%). KPMAS will be required to submit a CAP to improve compliance with the urgent care appointment timeframe.

Table 49. MY 2023 MCO Results for Compliance with Appointment Requirements

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Compliance with Routine Care Appointment Timeframe (within 30 days) *										
Compliance w/ Routine Care Appointment	97.6%	91.3%	85.3%	68.0%	94.3%	91.7%	94.7%	91.7%	93.4%	**90.5%**
# of Wait Days (Average)	6	11	8	8	12	8	7	8	14	**9 Days**
# of Wait Days (Range)	0-27	0-29	0-28	0-29	0-30	0-26	0-22	0-28	0-30	**0-30 Days**
Compliance with Urgent Care Appointment Timeframe (within 48 hours) *										
Compliance w/ Urgent Care Appointment	94.5%	91.3%	88.8%	77.7%	89.9%	89.1%	89.5%	93.5%	89.1%	**89.7%**
Appointment Available w/ Requested PCP at Same Location w/ 48 hours (including telemedicine)	83.5%	84.6%	82.8%	48.5%	87.4%	82.7%	80.7%	82.7%	83.9%	**80.7%**
Appointment Available w/ Another PCP at Same Location w/ 48 hours (including telemedicine)	11.0%	6.7%	6.0%	29.1%	2.5%	6.4%	8.8%	10.7%	5.1%	**9.0%**

Underline denotes that the 80% minimum compliance score is unmet.

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 between June and July 2023. The online directories were reviewed for the following information:

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

The MCOs' online provider directories demonstrated the following best practices:

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

Figure 15 shows the proportion of telephone survey results matching the online provider directories by each of the review components listed above.[16] The proportion of successful telephone surveys matching the information within the online directory for MY 2023 is comparable to MY 2021 and MY 2022 across all review components. MY 2023 showed slight declines compared to MY 2022 in PCP address (90.5% from 93.0%) and accepting new patients (77.8% from 78.3%). MY 2023 showed increases compared to MY 2022 for provider phone number (91.0% to 92.6%), ADA (92.4% to 94.7%), specifying age ranges (96.6% to 97.4%), and specifying PCP languages (96.6% to 96.9%).

MCO-specific results for the validation of online provider directories are displayed in Table 50. Validation of the MCO online provider directories demonstrates:

- Rates for PCPs listed in the online provider directories ranged from 89.9% (UHC) to 100% (JMS and PPMCO).
- Four out of seven components of the online provider directory validation improved compared to MY 2022:
    - The HealthChoice Aggregate percentage of PCP's *Practice Location Matched Survey Response* decreased 2.5 percentage points in MY 2023 (90.5%) compared to MY 2022 (93.0%).
    - The percentage of *PCP's Practice Telephone Number Matched Survey Response* declined for all MCOs compared to MY 2022, except for CFCHP (92.6%).
    - The percentage of online provider directories that specified the age of patients seen increased for all MCOs except for KPMAS (99.0%) and MPC (98.1%). PPMCO remained at 100.0% from MY 2022 to MY 2023.
    - All MCOs scored above the 80% minimum compliance score for *PCP Listed in Online Directory*, *PCP's Practice Telephone Number Matched Survey Response*, *Specifies Age of Patients Seen*, and *Specifies Languages Spoken by PCP*.
    - WPM was the only MCO that scored below the minimum compliance score of 80% for *PCP's Practice Location Matched Survey Response* (79.6%).
    - CFCHP (65.1%), JMS (75.9%), PPMCO (68.4%), and UHC (72.0%) scored below the minimum compliance score for *Specifies PCP Accepts New Medicaid Patients* & *Matches Survey Response*; however, JMS and PPMCO's individual percentages are an improvement from MY 2022 (75.5% and 54.6%, respectively).
    - PPMCO was the only MCO that scored below the minimum compliance score of 80% for *Practice has Accommodations for Patients with Disabilities (with specific details)* (74.6%).

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

- All MCOs scored above 90% for *Specifies Age of Patients Seen* and *Specifies Languages Spoken by PCP* components.

Figure 15. MYs 2021 to 2023 Online Provider Directory Validation Results

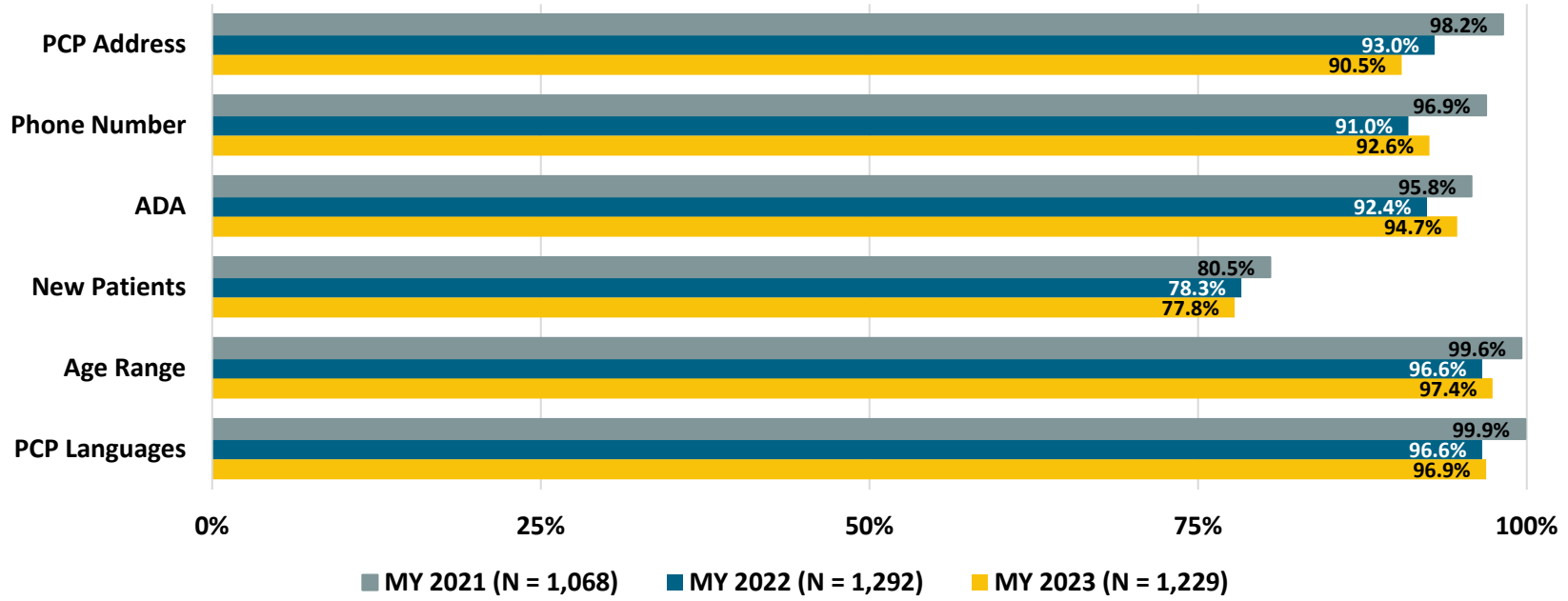


Table 50. MY 2023 MCO Results for Validation of Online Provider Directories

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
PCP Listed in Online Directory	94.5% ↓	99.3% ↑	100.0% ↑	99.0% ↓	98.1% ↓	99.4% ↑	100.0% =	89.9% ↑	97.8% ↑	**97.3%** ↑
PCP's Practice Location Matched Survey Response	86.6% ↓	90.6% ↓	96.6% ↑	99.0% ↑	93.1% ↑	96.2% ↑	92.1% ↓	83.9% ↓	79.6% ↓	**90.5%** ↓
PCP's Practice Telephone Number Matched Survey Response	90.6% ↓	92.6% ↑	97.4% ↓	86.4% ↓	94.3% ↓	96.8% ↓	96.5% ↓	86.3% ↓	92.7% ↓	**92.6%** ↑
Specifies PCP Accepts New Medicaid Patients & Matches Survey Response	81.9% ↓	65.1% ↓	75.9% ↑	80.6% ↑	85.5% ↑	87.8% ↑	68.4% ↑	72.0% ↓	81.8% ↑	**77.8%** ↓
Specifies Age of Patients Seen	94.5% ↑	99.3% ↑	100.0% ↑	99.0% ↓	98.1% ↓	99.4% ↑	100.0% =	90.5% ↑	97.8% ↑	**97.4%** ↑
Specifies Languages Spoken by PCP	94.5% ↑	99.3% ↑	100.0% ↑	99.0% ↓	98.1% ↓	98.1% ↑	96.5% ↓	90.5% ↑	97.8% ↑	**96.9%** ↑
Practice has Accommodations for Patients with Disabilities	94.5% ↑	99.3% ↑	99.1% ↑	99.0% ↓	98.1% ↓	99.4% ↓	77.2% ↓	89.9% ↑	94.2% ↓	**94.7%** ↓

Underline denotes that the 80% minimum compliance score is unmet.
↑ Improvement from MY 2022; ↓ Decline from MY 2022; = No Change from MY 2022

Conclusion

Considering individual MCO performance and categories of opportunities, the following observations identify specific opportunities identified during MY 2023 surveys:

- Overall response rate for MY 2023 surveys decreased by 4.4 percentage points from MY 2022 (MY 2023's 59.3% compared to MY 2022's 63.7%).
- Successful survey calls per MCO varied in consistency compared to MY 2022, with declines in total percent of successful calls for ABH (88.4% to 52.3%), CFCHP (71.1% to 59.6%), KPMAS (67.5% to 64.0%), UHC (77.4% to 72.7%), and WPM (54.8% to 54.6%).
- Unsuccessful contacts increased for MY 2023 compared to MY 2022, specifically affecting unsuccessful contacts made to provider offices due to no answer (14.7% compared to 7.6%) and having reached a voicemail (19.9% compared to 9.2%).
- Unsuccessful survey calls due to "No Contact" per MCO are consistent from MY 2022 to MY 2023.

- Surveyors reaching a PCP's voicemail increased by 11 percentage points compared to MY 2022 (14.6% to 25.6%).
- Providers inaccurately listed as a PCP in the MCO-supplied provider list increased from 17.2% in MY 2022 to 22.1% in MY 2023, with PPMCO and UHC resulting in the highest percentages at 45.2% and 53.8%, respectively.
- The percentage of providers that did not accept the listed MCO increased from 38.0% to 51.1%.

With the exception of performance identified above, MCOs demonstrated strengths for performance in MY 2023 surveys:

- Successfully completed calls most notably increased for MSFC compared to MY 2022 performance (from 57.2% in MY 2022 to 65.8% in MY 2023).
- Unsuccessful survey calls due to "PCP Response" per MCO varied compared to MY 2022. Overall, MCOs with the wrong location listed for a provider decreased from 29.4% to 11.6%, with CFCHP and KPMAS resulting in 0%.

MDH has set a task goal of increasing all NAV requirements to 85% or above by MY 2024. This goal is based on pre-Covid public health emergency aggregate performance, and progress on specific HealthChoice performance metrics and targets are displayed in Table 51. Eight of the nine NAV requirements for MY 2023 exceeded MDH's quality strategy goal of 85% or above; however, one out of the nine requirements met or exceeded the quality strategy target for MY 2024, *PCP Listed in Online Directory* (97.3%). One of the NAV requirements for MY 2023 fell below MDH's goal of 85%. The HealthChoice Aggregate for *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* was 7.2 percentage points from reaching the quality strategy goal. This category also fell below the MDH-established compliance threshold of 80% by 2.2 percentage points.

Table 51. MY 2023 NAV HealthChoice Aggregate Performance Against Quality Strategy Targets

Requirement: Minimum Compliance Score: ≥ 80%	HealthChoice Aggregate	MDH Quality Strategy Targets for MY 2024: ≥85%
Compliance with Appointment Timeframe Requirements		
Compliance with Routine Care Appointment Timeframe	90.5%	100%
Compliance with Urgent Care Appointment Timeframe	89.7%	93%
Compliance with Validation of Online Provider Directories		
PCP Listed in Online Directory	97.3%	97%
PCP's Practice Location Matched Survey Response	90.5%	98%
PCP's Practice Telephone Number Matched Survey Response	92.6%	96%
Specifies PCP Accepts New Medicaid Patients & Matches Survey Response	77.8%	80%
Specifies Age of Patient Seen	97.4%	100%
Specifies Languages Spoken by PCP	96.9%	100%
Practice has Accommodations for Patients with Disabilities	94.7%	100%

Source: *HealthChoice Quality Strategy*

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

Encounter Data Validation

Objective

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

Methodology

Description of Data Obtained. Qlarant conducted EDV for MY 2022, encompassing January 1, 2022 through December 31, 2022, for all nine MCOs. Qlarant obtained the following data to complete the EDV study:

- Electronic encounter data submitted by the MCOs
- Information Systems Capabilities Assessment documentation from the MCOs
- Medical records from providers

Qlarant reviews aggregate encounters to determine the timeliness of submission, number, and type of rejections, accuracy of the data when compared to medical record reviews, and resolution of any outliers identified. Validation of encounter data provides MDH with a level of confidence in the completeness and accuracy of encounter data submitted by the MCOs.

Technical Methods of Data Collection and Analysis. Qlarant conducted EDV in accordance with the *CMS External Quality Review (EQR) Protocol 5*, *Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan.*[17] To assess the completeness and accuracy of encounter data, Qlarant completed the following activities:

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

[17] CMS EQRO Protocols

2. **Reviewed the MCO's capability to produce accurate and complete encounter data.** Qlarant completed an evaluation of the MCO's Information Systems Capabilities Assessment (ISCA) to determine whether the MCO's information system is able to collect and report high-quality encounter data.

3. **Analyzed MCO electronic encounter data for accuracy and completeness.** MDH elected to contract with Hilltop to analyze and evaluate the validity of encounter data in order to complete Activity 3. Hilltop performed an evaluation of all electronic encounter data submitted by the MCOs for MY 2020 through MY 2022 to determine the validity of the encounter data and ensure the data are complete, accurate, and of high quality.

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

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

Results

Activity 1

State Requirements for Collecting and Submitting Encounter Data. Qlarant reviewed information regarding MDH's requirements for collecting and submitting encounter data. MDH provided Qlarant with:

- MDH's requirements for collecting and submitting encounter data by MCOs, including specifications in the contracts between the State and the MCO.
- Data submission format requirements for MCOs.
- Requirements specifying the types of encounters that must be validated.
- MDH's abridged data dictionary.
- A description of the information flow from the MCO to the State, including the role of any contractors or data intermediaries.
- MDH's standards for encounter data completeness and accuracy.
- A list and description of edit checks built into MDH's Medicaid Management Information System (MMIS) that identifies how the system treats data that fails edit checks.
- Requirements regarding timeframes for data submission.

- Prior year's EQR report on validating encounter data.
- Hilltop's report, *EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2020 to CY 2022*.
- Any other information relevant to encounter data validation.

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

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

The system treats encounters that fail the MMIS edit checks in the following manner:

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

Performance standards used to define requirements for encounters in MY 2022 are established by MDH in MY 2022 HealthChoice MCO Agreements and Appendix M of MCO contracts. MDH specifies the encounter data requirements for the collection and submission of encounter data by MCOs in Section II.I.4, and 5 of the MY 2022 HealthChoice MCO Agreement (pages 12-13). All COMAR provisions applicable to MCOs, including regulations concerning encounter data, are established in Appendix M of each MCO's contract. Regulations applying to encounters in MY 2022 are noted in Table 52.

Table 52. MY 2022 Encounter Data Requirements

COMAR	Requirement
10.67.03.11A	A description of the applicant's management information system, including, but not limited to: • Capacities, including: o The ability to generate and transmit electronic claims data consistent with the Medicaid Statistical Information System (MSIS) requirements or successor systems; o The ability to collect and report data on enrollee and provider characteristics and on all services furnished to enrollees through an encounter data system; o The ability to screen the data collected for completeness, logic, and consistency; and o The ability to collect and report data from providers in standardized formats using secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts; • Software; • Characteristics; and • Ability to interface with other systems
10.67.03.11B	A description of the applicant's operational procedures for generating service-specific encounter data.
10.67.03.11C	Evidence of the applicant's ability to report, on a monthly basis, service-specific encounter data in UB04 or CMS1500 format.
10.67.07.03A(1)	MCOs shall submit to MDH the following: Encounter data in the form and manner described in COMAR 10.67.04.15B, 42 CFR §438.242(c), and 42 CFR §438.818.
10.67.07.03B	MCOs shall report to MDH any identified inaccuracies in the encounter data reported by the MCOs or its subcontractors within 30 days of the date discovered regardless of the effect which the inaccuracy has upon MCOs reimbursement.
10.67.04.15B	Encounter Data: • MCOs shall submit encounter data reflecting 100% of provider-enrollee encounters, in CMS1500 or UB04 format or an alternative format previously approved by MDH. • MCOs may use alternative formats including: o ASC X12N 837 and NCPDP formats; and o ASC X12N 835 format, as appropriate. • MCOs shall submit encounter data that identifies the provider who delivers any items or services to enrollees at a frequency and level of detail to be specified by CMS and MDH, including, at a minimum: o Enrollee and provider identifying information; o Service, procedure, and diagnosis codes; o Allowed, paid, enrollee responsibility, and third party liability amounts; and o Service, claims submissions, adjudication, and payment dates. • MCOs shall report encounter data within 60 calendar days after receipt of the claim from the provider. • MCOs shall submit encounter data utilizing a secure online data transfer system.

MDH sets forth requirements regarding timeframes for data submission in COMAR 10.67.04.15B, which specifies that MCOs must report encounter data within 60 calendar days after receipt of the claim from the provider. For daily data exchanges, the cutoff time is 3 PM for transmission of a single encounter data file for an MCO to receive an 835 the next day.

Activity 2

MCO's Capability to Produce Accurate and Complete Encounter Data. Qlarant assessed each MCO's capability for collecting accurate and complete encounter data. Each MCO's information systems process and capabilities in capturing complete and accurate encounter data will be assessed through the following steps:

1. Review of the MCO's Information Systems Capability Assessments (ISCA).
2. Interview MCO personnel, as needed.

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

After reviewing the findings from the ISCA, Qlarant conducted follow-up interviews with MCO personnel, as needed, to supplement the information and ensure an understanding of the MCO's information systems and processes. Results of the document review and interview process are summarized in Table 53 below.

Table 53. MY 2022 ISCA Summary

Information Systems Component	HealthChoice Aggregate
Captures accurate encounter data	Yes
Captures all appropriate data elements for claims processing	Yes
Clean Claims in 30 Days Timeliness Standard	96%
Clean Claims in 30 Days Timeliness Rate	97%
Electronic professional and facility claims	96%

Activity 3

Analysis of MCO's Electronic Encounter Data for Accuracy and Completeness. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Therefore, Hilltop completed Activity 3 of the EDV. Results of Activity 3 are copied here, and the full report of Hilltop's encounter data validation can be found in **Appendix C**.

Activity 3 requires the following four steps for analyses:

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

Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements. MDH began evaluating the MCO electronic encounter data by performing a series of validation checks on the EDI data. This process included analysis of critical data fields, consistency between data points, duplication, and validity. Encounters that failed to meet these standards were reported to the MCOs, and the 835 and the 8ER reports were returned to the MCOs for possible correction and resubmission.

MDH sent Hilltop the 8ER reports for MY 2020 through MY 2022, which included encounters that failed initial EDI edits (rejected encounters). Hilltop classified these rejected encounters into five categories: missing data, participant not eligible for service, value not valid for the field, inconsistent data, and duplicates.

Hilltop performed checks on critical fields for missing, invalid, and inconsistent data, including provider number, units of service, drug number, drug quantity, revenue code, procedure code, and diagnosis code. Hilltop identified eligibility issues for participants who were not eligible for MCO services at the time of the service. Examples of inconsistent data include discrepancies between dates, inconsistencies between diagnosis and age or sex, and inconsistencies between original and resubmitted encounters.

Overall, the number of rejected encounters decreased by 43.2% from MY 2020 to MY 2022. However, the number of rejected encounters increased from 1,894,008 in MY 2019 to 6,799,831 in MY 2020; an increase of 259%. While the rejected encounters from the 8ER reports are not de-duplicated, the number of rejected encounters in MY 2022 is still much higher as compared to MY 2019. In 2023, MDH required via MCO contracts that less than 5% of total encounters be rejected. MDH asked Hilltop to analyze rejected encounters for purposes of capitated rate risk adjustment. To determine the total number of rejected encounters that were potentially missing from the base data used for risk adjustment, Hilltop developed a process to identify and de-duplicate rejected encounters using data received via MMIS2 rather than the 8ER reports. Once

de-duplicated, all MCOs would have met the 5% threshold in MY 2022 had it been in effect. This indicates that the 8ER reports include many duplicate encounters.

Most of the rejected encounters were due to invalid data, and this can largely be attributed to the addition of provider enrollment encounter edits that went live on January 1, 2020 (see Provider Enrollment-Related Encounter Data Validation section below for details). MDH worked with the MCOs for two years prior to the provider enrollment edits becoming effective to ensure that their providers were enrolled in FFS via the electronic provider revalidation and enrollment portal (ePREP). However, many providers failed to enroll by January 1, 2020, or submitted enrollment information that was inconsistent with the encounter data submitted to MDH. The total number of rejected encounters due to invalid data decreased by 44.8% during the evaluation period, but the share of all rejected encounters attributed to invalid data only experienced a slight decrease by 2.0 percentage points between MY 2020 and MY 2022.

The two primary reasons encounters were rejected in MY 2020 and MY 2021 were missing data and invalid data for MCO services. In MY 2022, a third top reason arose. The share of rejected encounters due to participants ineligible for MCO services increased by 7.1 percentage points between MY 2020 and MY 2022, with a 17.6% increase from 450,374 in MY 2020 to 529,468 in MY 2022. The following categories of rejections decreased in number: duplicate encounters, missing encounters, and invalid encounters.

Analyzing rejected encounters by MCO is useful for assessing trends and identifying issues that are specific to each MCO. This allows MDH to monitor and follow up with the MCOs on potential problem areas.

The volume of rejected encounters decreased across many MCOs between MY 2020 and MY 2022, largely due to improvements in provider data, explained in greater detail below. While there was an overall increase for ABH, JMS, and KPMAS, there was a dramatic decrease for WPM and CFCHP, followed by MPC, MSFC, PPMCO, and UHC.

PPMCO had the highest share (34.9%) of all rejections in MY 2022—a notable increase from 22.1% in MY 2021, and an increase of 13.6 percentage points since MY 2020. MPC had 15.2% of all rejections in MY 2022—a decrease of 2.2 percentage points from MY 2021 and a decrease of 0.3 percentage points from MY 2020. UHC submitted 14.5% of the total rejected encounters in MY 2022—a decrease of 0.6 percentage points from MY 2021, and an increase of 2.3 percentage points from MY 2020. WPM had 9.8% of all rejections in MY 2022, which was a decrease of 3.7 percentage points from MY 2021 and a decrease of 8.1 percentage points from MY 2020.

ABH, CFCHP, JMS, KPMAS, and MSFC each had less than 9% of the rejected encounters in MY 2022. MSFC decreased its share of rejections by 3.5 percentage points from CY 2020 to MY 2022, while ABH's, JMS's, and KPMAS's share of rejections fluctuated during the evaluation period.

Although there was some variation among MCOs in the distribution of the total rejected encounters from MY 2020 to MY 2022, there was very little variation in the distribution of accepted encounters among MCOs, except for KPMAS and PPMCO, whose shares increased by 1.4 and 1.6 percentage points, respectively. All the other MCOs had less than 1.0 percentage points change during the evaluation period.

For all MCOs, the primary reasons for rejection of encounters in MY 2022 were categorized as "Not Valid" (from 62.6% to 79.8%). The second most common rejection category for most MCOs was "Missing"—except for CFCHP, which was "Inconsistent," and MPC and PPMCO, which was "Not Eligible." For all MCOs, encounters rejected for reasons grouped under the "Duplicate" category remained below 5.0%. Encounters rejected as "Not Eligible" showed mixed performance across MCOs, ranging from 1.8% to 22.6%.

The greatest number of rejected encounters during the evaluation period were in the "Not Valid" category. The total number of "Not Valid" encounters decreased from 4,737,893 to 2,613,590 between MY 2020 and MY 2022, but the proportion of all rejected encounters categorized as "Not Valid" remained fairly stable throughout the evaluation period. The impact of invalid data was not spread evenly across MCOs. In MY 2022, more than one-half (62.6%) of PPMCO's rejections were in this category on the low end, with ABH closer to 80.0% on the high end.

The second most common rejection category for all MCOs during the evaluation period was "Missing." The number of rejections categorized as "Missing" decreased for the majority of MCOs: CFCHP, MPC, MSFC, PPMCO, UHC, and WPM. However, there was an increase in missing encounters for ABH, JMS, and KPMAS.

MCOs showed varied results in the numbers and percentages of rejected encounters in the "Inconsistent" category. The total number of rejections categorized as "Inconsistent" fluctuated for all MCOs during the evaluation period, except for MPC, which decreased throughout the evaluation period from 14,243 in MY 2020 to 1,501 in MY 2022. Notable outliers include the steep increases for UHC between MY 2021 and MY 2022 (1.4% to 7.6%) and CFCHP between MY 2021 and MY 2022 (0.7% to 18.3%). CFCHP had the highest percentage of rejections for inconsistency in MY 2022, followed by UHC at 7.6%.

While the number of encounter rejections categorized as "Duplicate" increased for five of the nine MCOs (JMS, KPMAS, MPC, MSFC, and PPMCO), the remaining MCOs (ABH, CFCHP, UHC, and WPM) decreased in the number of these rejections, with CFCHP having the greatest decline from 440,785 in CY 2020 to 8,759 in MY 2022. In MY 2022, PPMCO had the largest percentage of encounters rejected in the "Not Eligible" category (22.6%), and ABH had the lowest (1.8%).

Overall, there was a decrease in rejections marked "Duplicate," "Missing," and "Not Valid," while there was an increase in rejections marked "Inconsistent" and "Not Eligible" between MY 2020 and MY 2022. In MY 2022, the greatest decrease in the share of rejections was in the "Duplicate" category, which decreased by 5.5 percentage points.

Hilltop conducted an additional review of the 8ER reports to analyze the high rates of encounters that failed initial EDI edits—particularly for invalid data. Further research revealed that the 8ER high rejection rates were related to provider enrollment issues. The provider data, which are collected via ePREP, underwent changes that affected data beginning January 1, 2020. After two years of collaborative preparation with the MCOs, the provider system implemented new rules that require the National Provider Identifier (NPI) on any encounter to match the active NPI under which the provider enrolled with Medicaid for both the billing and rendering fields. To remain actively enrolled with Medicaid, providers must perform actions such as updating their licensure on the ePREP portal. Failure to do so can affect a provider's active status and thus jeopardize the successful submission of encounters.

Prior to 2020, a provider could use any NPI on the encounter in the billing and rendering fields; as long as it matched any active NPI in MMIS2, the encounter linked with that provider/claim was accepted. The provider enrollment edits—intended to improve the accuracy of provider details—were implemented in response to CMS requirements.

The number of provider enrollment-related rejections decreased for all MCOs from MY 2020 to MY 2022, except for JMS and KPMAS. The decline was lowest for ABH (2.7%) and highest for MSFC (82.3%). Almost all MCOs had a notable decrease in the number of rejections due to provider enrollment-related encounters from MY 2021 to MY 2022, except for PPMCO (increased by 41.1%).

Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity. During MY 2022, the MCOs submitted a total of 45.6 million accepted encounters (records), which was an increase from 39.5 million in MY 2020 and 44.3 million in MY 2021. Despite increased enrollment in MY 2020, overall utilization decreased across all MCOs due to the COVID-19 pandemic. However, utilization started to rebound in MY 2021. Because the 8ER data received do not include dates of service, Hilltop estimated the total number of encounters submitted by adding the number of EDI rejected encounters to the number of accepted encounters. Using that method, a total of approximately 46.3 million encounters were submitted in MY 2020. This number increased to 48.7 million encounters in MY 2021 and 49.4 million encounters in MY 2022. Approximately 92% of the MY 2022 encounters were accepted into MMIS2, which is higher than the 91% acceptance rate during MY 2021 and the 85% acceptance rate during MY 2020.

Hilltop received a monthly copy of all encounters accepted by MMIS2. Upon receipt of the accepted encounters, Hilltop performed several validation assessments and integrity checks of the fields to analyze and interpret the accuracy and completeness of the data. These assessments included determining whether there was an invalid end date of service or other errors. The files with errors were excluded before being imported into Hilltop's data warehouse.

The distribution of accepted encounters by claim type changed slightly from MY 2020 to MY 2022. Physician claims represented most of the encounters during the evaluation period (roughly two-thirds), followed by pharmacy claims. Across the evaluation period, other encounters—including inpatient hospital stays, community-based services, and long-term care services—accounted for less than 1% of services.

The distribution of accepted encounters remained relatively consistent across MCOs and calendar years. In MY 2022, physician encounters ranged from 59.8% of encounters (JMS) to 74.5% of encounters (KPMAS). JMS had the largest percentage of MY 2022 pharmacy encounters (36.2%), while KPMAS had the lowest percentage (23.7%). Outpatient hospital encounters ranged from a low of 1.1% for KPMAS to a high of 3.7% for ABH and MPC.

All MCOs except for UHC increased the percentage of institutional encounters with a populated pay amount during the evaluation period. In MY 2022, the percentage of institutional encounters with a populated amount ranged from 83.1% (JMS) to 95.1% (WPM). The MCOs showed mixed results from MY 2021 to MY 2022: CFCHP, KPMAS, MPC, and WPM increased the percentage of populated pay amounts, while ABH, JMS, MSFC, PPMCO, and UHC decreased.

During MY 2022, JMS submitted 65.8% of its medical encounters with a $0 pay amount, and MSFC submitted nearly half of its medical encounters the same way. All other MCOs ranged from 6.3% (KPMAS) to 25.2% (UHC) of accepted medical encounters with $0 pay. Only JMS, MPC, and MSFC among all the MCOs had a lower share of encounters with $0 pay during MY 2022 than in MY 2020.

Adherence to the requirement that encounters with $0 pay include a reporting indicator varied significantly among the MCOs during MY 2022. MSFC and UHC submitted nearly all their $0 encounters with an indicator. By contrast, CFCHP, MPC, and WPM submitted more than one-half and JMS more than three-quarters of their $0 pay medical encounters without an indicator. The percentage of $0 pay medical encounters without an indicator submitted by the remaining MCOs ranged from 17.4% (KPMAS), 32% (PPMCO), to 39.4% (ABH).

Hilltop also analyzed the accepted medical encounters during MY 2022 by comparing the price paid against the price listed for the same service on the FFS fee schedule. Of the almost 28 million medical encounters in this analysis, around 20% of the encounters were reported with a $0 pay amount. Approximately 40% of these were laboratory procedures. The proportion of encounters with $0 ranged greatly by MCO from less than 10% to over half. Of the encounters matched to the fee schedule with a non-zero payment amount, nearly 50% of encounters had some degree of difference between the amount paid by MCOs and the amount specified in the fee schedule. Of those encounters matched to the FFS fee schedule with a non-zero payment amount, 75% were greater than the fee schedule payment amount and 25% were less; a third of these encounters were more than 20% greater than the FFS payment amount. The range by MCO of the percentage of encounters matched to the FFS fee schedule with a non-zero payment that was greater than the FFS fee schedule was from 54% to 99%. The overall utilization of the pay field has not changed significantly in MY 2022 as compared to previous years. MDH should continue to work with the MCOs to ensure that appropriate utilization and accuracy of the pay field on accepted encounters improves.

In MY 2019, Hilltop determined that TPL was reported inconsistently in MMIS2 across MCOs. Some MCOs had up to 95% of their encounters with a positive TPL amount in a sample of trauma encounters from MY 2019, whereas others had no encounters with a positive TPL amount during the same time period. FFS claims generally had positive TPL amounts in 1% to 3% of cases. Further analysis of a sample of trauma

encounters from MY 2021 showed that the inconsistencies remained; three MCOs had no TPL for any encounters, and six MCOs had positive TPL in 85% to 99% of the encounters.

MDH reported that TPL for professional encounters was corrected in MMIS2 as of May 1, 2022. Analysis of trauma encounters pulled from the professional file found that the two MCOs who previously had no TPL still had no TPL after May 1, 2022. Four MCOs had TPL on the majority of their claims before May 1, 2022, and no TPL at all after May 1, 2022. Two MCOs had TPL on the majority of their encounters before May 1, 2022, and TPL on a small number of encounters after May 1, 2022. Finally, one MCO had TPL on a majority of their encounters before and after May 1, 2022 through the end of MY 2022. This suggests that only two MCOs have TPL properly recorded in professional files in MY 2022. Hilltop will continue to investigate TPL on all encounters and will review the results with MDH to develop a resolution.

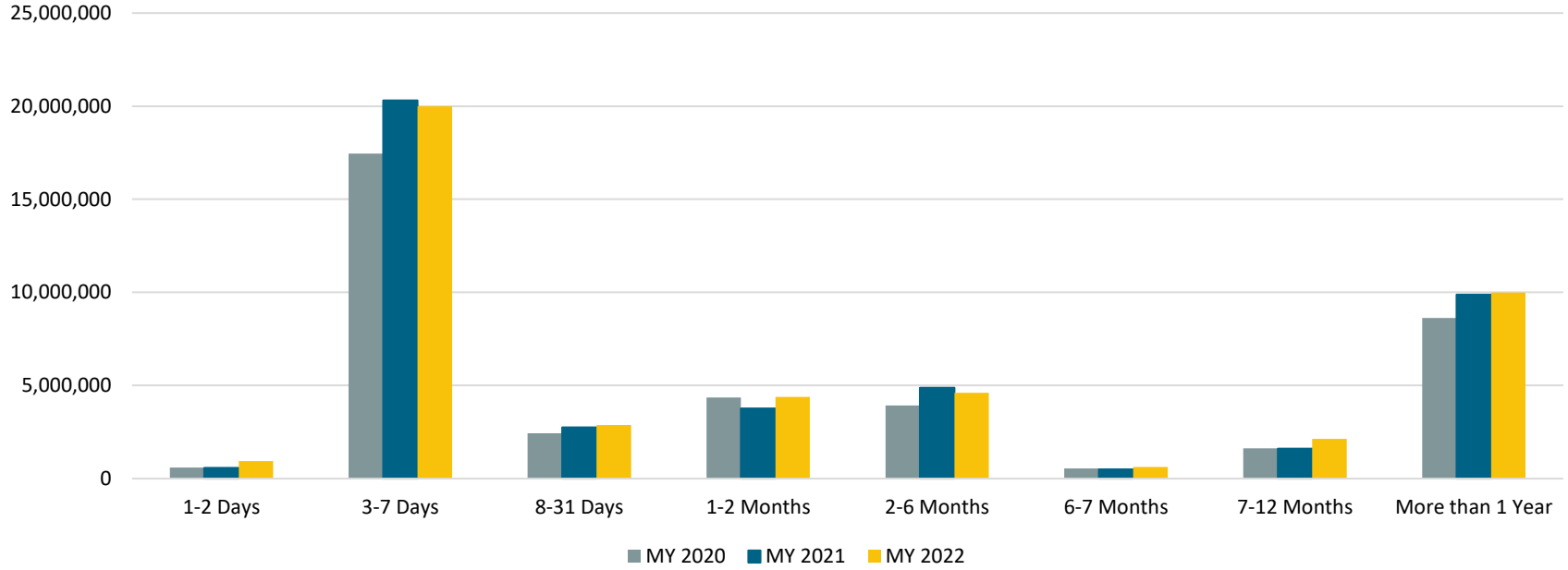
Hilltop has not used the MCO-reported TPL amount in any analyses since MY 2018.

Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports

Time Dimension Analysis. Effective analysis of the Medicaid program requires complete, accurate, and timely processing of encounter data. Encounter processing time spans the interval between the end date of service and the date on which the encounter is submitted to MDH. After providers render a service, they are required to invoice the MCO within six months. The MCO must then adjudicate the encounter within 30 days of invoice submission. Maryland regulations require MCOs to submit encounter data to MDH "within 60 calendar days after receipt of the claim from the provider." Therefore, the maximum acceptable processing time allotted for an encounter between the end date of service and the date of submission to MDH is eight months.

The Medicaid program requires MCOs to submit encounters in a timely fashion; however, delays in submission occur, and some variation from month to month is expected. Noticeable changes related to timeliness may indicate irregular submission of encounter data. Figure 16 shows the timeliness of processing accepted encounter submissions from the end date of service for MY 2020 through MY 2022.

Figure 16. MYs 2020 to 2022 Number of Accepted Encounters Submitted by Processing Time



Overall, timelines of encounter submissions improved during the evaluation period, with more MCOs submitting encounters within 1 to 2 days in MY 2022, and an increase in encounters submitted between 8 days and 2 months.

Most pharmacy encounters were submitted within 1 to 2 days throughout the evaluation period (over 80%), and more than 65% of all physician encounters were submitted within 31 days. Over 50% of outpatient hospital encounters were submitted within 31 days during the evaluation period.

The timeliness of encounter submissions remained relatively consistent across all months. An average of 43.9% of MY 2022 encounters were processed by MDH within 1 to 2 days of the end date of service—a decrease from 44.1% in MY 2020 and 45.9% in MY 2021.

While six MCOs (ABH, CFCHP, JMS, KPMAS, MPC, and WPM) submitted a higher percentage of their encounters within 1 to 2 days in MY 2022 than in MY 2020, half of these MCOs (ABH, KPMAS, and WPM) experienced a decrease in the percentage of encounters submitted within 1 to 2 days from MY 2021 to MY 2022. In MY 2022, the percentage of encounters submitted by MCOs within 1 to 2 days ranged from 25.3% (MSFC) to 57.5% (KPMAS). The percentage of encounters submitted within 3 to 7 days increased slightly for ABH, CFCHP, JMS, KPMAS, UHC, and WPM and decreased for MPC, MSFC, and PPMCO. JMS had the lowest (4.0%) percentage of encounters submitted within 3 to 7 days in MY 2022.

Provider Analysis. Evaluating encounters by provider type for fluctuations across MCOs contributes to the assessment of encounter data volume and consistency. The following provider analysis examines encounter data for PCPs and establishes a comparison rate of PCP visits in HealthChoice. For this analysis, Hilltop matched the Medicaid identification numbers the MCOs provided for their members to eligibility data in MMIS2. Only participants listed in an MCO's files and enrolled in MMIS2 were included in the analysis.

The MY 2022 PCP visit rate (defined as a visit to the assigned PCP, group practice, or partner PCP) ranged from 34.7% (ABH) to 71.5% (KPMAS). Using the broadest definition of a PCP visit—that is, a visit to any PCP within any MCO's network—the PCP visit rate ranged from 62.6% (ABH) to 78.6% (WPM). The PCP visit rate increased across all measures between MY 2020 and MY 2022, but the percentage of participants with a visit to any PCP in any MCO network and a visit with their assigned PCP, group practice, or partner PCPs decreased slightly from MY 2021 to MY 2022.

Service Type Analysis. For this analysis, a visit was defined as one encounter per person per provider per day. MCOs reported a consistent distribution of visits by service type for all years of the evaluation period. The percentages for both the total inpatient hospitalizations and observation stays combined were less than 1.0% of visits each year. ED visits, which were 3.1% of all visits in MY 2022, ranged from 2.2% of all visits (KPMAS) to 4.0% of all visits (JMS). Overall, during the evaluation period, the percentage of inpatient visits decreased slightly, and ED visits increased slightly. As shown in the annual HealthChoice evaluation, the overall percentage of HealthChoice participants with an outpatient ED visit and inpatient admission decreased between MY 2017 and MY 2021 (The Hilltop Institute, 2023).

Analysis by Age and Sex. Hilltop conducted an analysis of encounter data submitted by MCOs to determine the effectiveness of encounter data edit checks between MY 2020 and MY 2022. The following areas were analyzed: 1) individuals over age 65 with encounters, 2) individuals with a service date before their date of birth, 3) age-appropriate and sex-appropriate diagnoses for delivery, 4) age-appropriate dementia diagnoses, and 5) children aged 0 to 20 years with dental encounters.

Because participants older than 65 are ineligible for HealthChoice, Hilltop searched for any encounters for those aged 66 or older. Between MY 2020 and MY 2021, the number of encounters for MCO participants aged 66 or older fell before rising again in MY 2022. The number of individuals with a service date before their date of birth decreased between MY 2020 and MY 2022, although the number of such individuals fell to its lowest point during MY 2021. The MCOs and MDH improved the quality of reporting encounter data for age-appropriate diagnoses in MY 2021.

The Maryland Healthy Smiles Dental Program (Healthy Smiles) provides dental coverage for children under the age of 21. The program is paid on an FFS basis—not through the MCO service package. Hilltop found very few dental encounters for children under the age of 21 covered by an MCO in MY 2020 through MY 2022. As of January 1, 2023, Healthy Smiles is available to adults who receive full Medicaid benefits and will be included in the analysis for MY 2023's report.

Hilltop analyzed the volume of participants who had a diagnosis for delivery (births) by age group between MY 2020 and MY 2022. Participants aged 0 to 11 and 51 or older are typically considered to be outside of the expected age range for delivery. This analysis only considers female participants with a delivery diagnosis. Across all MCOs, the number of female participants identified as delivering outside of the expected age ranges was 118 in MY 2020, 122 in MY 2021, and 136 in MY 2022. The data substantiate that, overall, the encounters submitted are age-appropriate for delivery. See Appendix K for delivery codes.

Hilltop also validated encounter data for sex-appropriate delivery diagnoses. A diagnosis for delivery should typically be present only on encounters for female participants. All MCOs had a similar distribution, with nearly 100% of deliveries being reported for females. Delivery diagnoses for male participants in the encounter data are negligible, totaling 45 reported deliveries across all MCOs in MY 2020, 52 deliveries in MY 2021, and 48 deliveries in MY 2022.

The final analysis focused on age-appropriate diagnoses of dementia (see Appendix L for dementia codes) from MY 2020 to MY 2022. Although dementia is a disease generally associated with older age, onset can occur as early as 30 years of age. Thus, the prevalence of dementia diagnoses should increase with age after 30. Hilltop identified the number of participants under the age of 30 with an encounter with a dementia diagnosis. While each MCO had participants under the age of 30 with a dementia diagnosis, the total numbers were relatively small (298 participants were reported across all MCOs in MY 2022).

Step 4. Compare Findings to State-Identified Benchmarks. In Steps 2 and 3, Hilltop compared the encounter data submitted by each MCO with benchmarks identified by MDH. Hilltop performed the analyses by MCO and calendar year to benchmark each MCO against its own performance over time, as well as against other MCOs. Hilltop also identified and compared outlier data with overall trends noted among the MCOs.

Activity 4

Analysis of Medical Records to Confirm Encounter Data Accuracy. Review of enrollees' medical records offers a method to examine the completeness and accuracy of encounter data. Using the encounter/claims data file prepared by MDH's vendor (Hilltop), Qlarant identified all enrollees with inpatient, outpatient, and office visit service claims. The sample size was selected to ensure a 90% confidence interval with a +/- 5% margin of error rate for sampling. Oversampling was used to ensure adequate numbers of medical records were received to meet the required sample size. Hospital inpatient and outpatient encounter types were oversampled by 300%, while office visit encounter types were oversampled by 400% for each MCO.

Records were requested directly from the billing providers. Qlarant mailed each sampled provider a letter with the specific record request, which included the patient's name, medical assistance identification number, date of birth, date(s) of service, and treatment setting. Targeted follow-up was conducted with providers who had not responded to the initial request, including phone calls and fax requests. Providers were asked to securely submit medical record information to Qlarant with the following instructions:

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

The total number of EDV minimum samples required, classified by encounter type, is displayed in Table 54 below.

Table 54. MYs 2020 to 2022 EDV Minimum Sample Required for Review by Encounter Type

Sample Size by Encounter Type	MY 2020	MY 2021	MY 2022
Inpatient	64 (3%)	55 (2%)	52 (2%)
Outpatient	484 (20%)	507 (21%)	497 (20%)
Office Visit	1,906 (78%)	1,892 (77%)	1,907 (78%)
Total	**2,454**	**2,454**	**2,456**

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

MY 2022's minimum sample slightly increased from MYs 2020 and 2021 (2,454 compared to 2,456, respectively). The majority of encounters in the sample were office visits (78%), followed by outpatient encounters (20%), and inpatient encounters (2%). The percentage of inpatient encounters in the sample remained the same for both MYs 2021 and 2022 (2%), but decreased in actual percentage from MY 2020 (3%) and actual count (52) from MYs 2020 (64) and 2021 (55). The reduced number of inpatient encounters within the sample may indicate a trend toward fewer inpatient encounters within the HealthChoice program. The percentage of outpatient records remained the same for MY 2020 (20%), while the amount of records increased from MY 2020 (484 compared to 497) and decreased from MY 2021 (507 compared to 497). The percentage of office visit encounters in the sample remained the same as in MY 2020 (78%), from a smaller percentage in MY 2021 (77%), while the amount increased from both MYs 2020 and 2021 (1,906 compared to 1,907 and 1,892 compared to 1,907).

The total number of MCO record review response rates by encounter type is displayed in Table 55 below.

Table 55. MY 2022 MCO EDV Medical Record Review Response Rates by Encounter Type

MCO	Inpatient Records			Outpatient Records			Office Visit Records		
	# Reviewed	Minimum Reviews Required	Sample Size Achieved?	# Reviewed	Minimum Reviews Required	Sample Size Achieved?	# Reviewed	Minimum Reviews Required	Sample Size Achieved?
ABH	8	6	Yes	66	60	Yes	213	206	Yes
CFCHP	6	6	Yes	53	51	Yes	221	216	Yes
JMS	8	7	Yes	75	74	Yes	197	191	Yes
KPMAS	4	4	Yes	18	17	Yes	254	252	Yes
MPC	7	6	Yes	73	66	Yes	210	201	Yes
MSFC	6	6	Yes	57	55	Yes	217	212	Yes
PPMCO	6	6	Yes	61	61	Yes	209	207	Yes
UHC	6	6	Yes	58	58	Yes	218	209	Yes
WPM	5	5	Yes	56	55	Yes	214	213	Yes
Total	**56**	**52**	**Yes**	**517**	**497**	**Yes**	**1,953**	**1,907**	**Yes**

All MCOs submitted the sufficient number of medical records required to meet the minimum samples for each setting type of the encounter data review.

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

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

For MY 2022, Qlarant received 2,456 medical records collectively from all nine MCOs. Analysis of the data was organized by review elements including diagnosis, procedure, and revenue codes (applicable only for inpatient and outpatient).

Table 56. MYs 2020 to 2022 EDV Results by Encounter Type

Encounter Type	Records Reviewed			Total Possible Elements			Total Matched Elements			Percentage of Matched Elements		
	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022
Inpatient	72	56	56	1,572	1,186	1,206	1,543	1156	1,203	98%	97%	100%
Outpatient	492	514	517	6,149	6,812	7,106	6,078	6,774	7,033	99%	99%	99%
Office Visit	1,934	1,915	1,953	8,860	9,124	9,753	8,692	9,056	9,409	98%	99%	96%
Total	**2,498**	**2,485**	**2,526**	**16,581**	**17,122**	**18,065**	**16,313**	**16,986**	**17,645**	**98%**	**99%**	**98%**

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

The percentage of matched element rates remained above the standard compliance of 90% by six percentage points or above for all three encounter types and the composite rates. The composite match rate decreased by one percentage point from MY 2021 (99% to 98%), maintaining MY 2020's match rate. Inpatient match rates increased by three percentage points from MY 2021 (97% to 100%). Outpatient match rates remained the same across all three trended MYs from 2020 to 2022 (99%). Office visit match rate decreased by three percentage points from MY 2021 (96% compared to 99%).

Inpatient Encounters. MY 2022 inpatient encounter types achieved match rates of 100% across all code types (diagnosis, procedure, revenue, and the total composite rate). Revenue codes sustained a 100% match rate from MY 2021. Procedure codes increased by eight percentage points from MY 2021 to MY 2022 (92% to 100%, respectively).

Table 57. MYs 2020 to 2022 EDV Inpatient Encounter Type Results by Code

Inpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total Codes		
	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022
Match	593	473	469	115	85	117	835	615	617	1,543	1,173	1,203
No Match	9	5	1	9	7	0	11	1	2	29	13	3
Total	602	478	470	124	92	117	846	616	616	1,572	1,186	1,206
Match Percent	**99%**	**99%**	**100%**	**93%**	**92%**	**100%**	**99%**	**99%**	**100%**	**98%**	**99%**	**100%**

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

Total diagnosis codes, procedure codes, revenue codes, and total codes all received a match rate of 100% for MY 2022. Total revenue codes increased by one percentage point from MY 2021 to MY 2022, after maintaining MY 2020's performance (99%). Total procedure codes increased by eight percentage points from MY 2021 to achieve a match rate of 100% for MY 2022.

The amount of inpatient encounter types *No Match* findings successfully decreased for diagnosis codes and procedure codes for MY 2022. Procedure codes matched all records. Diagnosis and revenue codes had one and two *No Match* findings, respectively. Diagnosis, procedure, and revenue codes decreased the amount of *No Match* findings from MY 2020 to MY 2021 (Diagnosis Codes: nine for MY 2020 to five for MY 2021; Procedure Codes: nine for MY 2020 to seven for MY 2021; and Revenue Codes: 11 for MY 2020 to one for MY 2021).

Table 58. MY 2022 MCO Inpatient Results by Code Type

MCO	# of Reviews	Diagnosis Codes			Procedure Codes			Revenue Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ABH	8	75	75	100%	43	43	100%	89	89	100%	207	207	100%
CFCHP	6	57	57	100%	14	14	100%	75	75	100%	146	146	100%
JMS	8	80	80	100%	7	7	100%	96	96	100%	183	183	100%
KPMAS	4	29	29	100%	5	5	100%	36	36	100%	70	70	100%
MPC	7	52	52	100%	8	8	100%	63	64	98%	123	124	99%
MSFC	6	45	45	100%	10	10	100%	77	78	99%	132	133	99%
PPMCO	6	43	43	100%	7	7	100%	64	64	100%	114	114	100%
UHC	6	55	56	98%	12	12	100%	74	74	100%	141	142	99%
WPM	5	33	33	100%	11	11	100%	43	43	100%	87	87	100%

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

UHC was the only MCO with *No Match* findings (2%) for diagnosis codes with all other MCOs achieving 100%. All MCOs achieved 100% match rates for procedure codes. MPC and MSFC were the only two MCOs with *No Match* findings for revenue codes (2% and 1%, respectively) with all other MCOs achieving 100%.

Outpatient Encounters. All code types for outpatient encounters maintained 98% or higher match rates across MYs 2020 to 2022. Diagnosis codes maintained performance from MY 2021 (98%), after decreasing by one percentage point from MY 2020 to MY 2021 (99% to 98%). Procedure and revenue codes decreased performance from MY 2021 by one percentage point (from a 100% match rate in MY 2021 to 99% in MY 2022), after an increase of one percentage point from MY 2020 to MY 2021 (99% to 100%).

Table 59. MYs 2020 to 2022 EDV Outpatient Encounter Type by Code

Outpatient Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total Codes		
	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022
Match	1,628	1,902	2,046	2,525	2,848	2,887	1,925	2,024	2,100	6,078	6,774	7,033
No Match	24	29	41	30	3	19	17	6	13	71	38	73
Total	1652	1,931	2,087	2,555	2,851	2,906	1,942	2,030	2,113	6,149	6,812	7,106
Match Percent	**99%**	**98%**	**98%**	**99%**	**100%**	**99%**	**99%**	**100%**	**99%**	**99%**	**99%**	**99%**

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

The amount of *No Match* findings for outpatient encounter types increased from MY 2021 (38) to MY 2022 (73). Diagnosis and total codes maintained MY 2021's match rate of 98% and 99%, respectively. Total codes maintained a 99% match rate for MYs 2020 to 2022. Procedure and revenue codes decreased by one percentage point from MY 2021 (100% to 99%).

Table 60. MY 2022 MCO Outpatient Results by Code Type

MCO	# of Reviews	Diagnosis Codes			Procedure Codes			Revenue Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%	Match	Total	%
ABH	66	269	276	98%	287	289	99%	200	200	100%	756	765	99%
CFCHP	53	220	221	100%	318	318	100%	222	222	100%	760	761	100%
JMS	75	268	275	98%	414	415	100%	318	319	100%	1,000	1,009	99%
KPMAS	18	61	61	100%	144	144	100%	93	93	100%	298	298	100%
MPC	73	322	327	99%	356	357	100%	258	259	100%	936	943	99%
MSFC	57	216	221	98%	318	318	100%	233	234	100%	767	773	99%
PPMCO	61	264	276	96%	407	416	98%	266	273	97%	937	965	97%
UHC	58	212	212	100%	284	287	99%	238	239	100%	734	738	100%
WPM	56	214	218	98%	359	362	99%	272	274	99%	845	854	99%

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

All MCOs achieved match rates at or above 96% for outpatient encounters, representing six to ten percentage points above minimum compliance of 90%. Across all code types, PPMCO had the lowest match rate for MY 2022 (ranging from 96% to 98%).

Office Visit Encounters. Diagnosis, procedure, and composite codes achieved 96% and higher across MYs 2020 to 2022 for office visit encounters. Diagnosis, procedure, and composite codes all decreased in match rate by two and three percentage points. Diagnosis and

procedure codes decreased by two percentage points from MY 2021 (99%) to MY 2022 (97%). Procedure codes decreased by three percentage points from MY 2021 (99%) to MY 2022 (96%).

Table 61. MYs 2020 to 2022 EDV Office Visit Encounter Type Results by Code*

Office Visit Encounter Type	Diagnosis Codes			Procedure Codes			Total		
	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022
Match	5,403	5,592	5,669	3,289	3,464	3,740	8,692	9,056	9,409
No Match	102	43	165	66	25	158	168	68	323
Total Elements	5,505	5,635	5,834	3,355	3,489	3,898	8,860	9,124	9,732
Match Percent	**98%**	**99%**	**97%**	**98%**	**99%**	**96%**	**98%**	**99%**	**97%**

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

The diagnosis and procedure codes match rates decreased from MY 2020 to MY 2022 by two and three percentage points, respectively.

Table 62. MY 2022 MCO Office Visit Results by Code Type*

MCO	# of Reviews	Diagnosis Codes			Procedure Codes			Total Codes		
		Match	Total	%	Match	Total	%	Match	Total	%
ABH	213	639	663	96%	393	421	93%	1,032	1,084	95%
CFCHP	221	628	672	94%	430	466	92%	1,058	1,138	93%
JMS	197	567	586	97%	299	312	96%	866	898	96%
KPMAS	254	702	706	99%	461	467	99%	1,163	1,173	99%
MPC	210	597	617	97%	348	364	96%	945	981	96%
MSFC	217	654	659	99%	480	490	98%	1,134	1,149	99%
PPMCO	209	614	630	98%	497	515	97%	1,111	1,145	97%
UHC	218	671	680	99%	460	476	97%	1,131	1,156	98%
WPM	214	597	635	94%	372	394	94%	969	1,029	94%

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

Office visit encounters accounted for the highest range of match rates from (92%) to (99%), still achieving percentage point increases of two to nine above the standard compliance (90%).

All Encounters "No Match" Summary. When comparing encounter and code types across MYs, lack of documentation and coding errors are the most frequent combination of errors. Lack of documentation and coding errors are the reasons for *No Match* findings for diagnosis codes across

all encounter types, with the highest percentage being lack of documentation (95%) for both outpatient and office visit encounters. Reasons for *No Match* findings for procedure codes for MY 2022 office visit encounters consisted of coding errors and lack of documentation, with lack of documentation being the highest percentage (96%). Coding errors and lack of documentation accounted for nearly 100% of the reason for *No Match* findings across MYs 2020 to 2022.

A few notable observations when comparing the amount of *No Match* findings across MYs are procedure codes for MY 2022 inpatient encounters that did not have any *No Match* findings; total reasons for inpatient encounters have successfully declined from MYs 2020 to 2022, indicating a higher match rate. Office visit encounters account for the majority of total *No Match* findings across MYs 2020 to 2022 for diagnosis and procedure codes.

Table 63. MYs 2020 to 2022 Coding Error Reasons for "No Match" by Encounter Type

Encounter Type	MY 2020			MY 2021			MY 2022		
Diagnosis	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	0%	9	1	20%	5	0	0%	1
Outpatient	2	8%	24	2	7%	29	2	5%	41
Office Visit	27	26%	102	15	35%	43	9	6%	165
Procedure	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	4	44%	9	4	57%	7	0	--	0
Outpatient	1	3%	30	0	0%	3	0	0%	19
Office Visit	9	14%	66	11	44%	25	6	4%	158
Revenue	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	0%	11	1	100%	2	0	0%	2
Outpatient	0	0%	17	0	0%	6	0	0%	13

Lack of documentation continues to account for the majority reason for *No Match* findings across encounter and code types. Lack of documentation was the only reason for *No Match* findings in diagnosis and revenue codes for inpatient encounters in MYs 2020 and 2022, and procedure codes for MY 2022 outpatient encounters. MY 2022 revenue codes across both inpatient and outpatient encounters had a lack of documentation as the only reason for *No Match* findings. Outpatient encounters, across MYs 2020 to 2022, had a lack of documentation as the only reason for *No Match* findings for revenue codes and procedure codes for MYs 2021 and 2022.

Table 64. MYs 2020 to 2022 Lack of Documentation Error Reasons for "No Match" by Encounter Type

Encounter Type	MY 2020			MY 2021			MY 2022		
Diagnosis	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	9	100%	9	4	80%	5	1	100%	1
Outpatient	22	92%	24	27	93%	29	39	95%	41
Office Visit	75	72%	102	27	63%	43	156	95%	165
Procedure	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	5	56%	9	3	43%	7	0	--	0
Outpatient	29	97%	30	3	100%	3	19	100%	19
Office Visit	57	86%	66	14	56%	25	152	96%	158
Revenue	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	11	100%	11	0	0%	2	2	100%	2
Outpatient	17	100%	17	6	100%	6	13	100%	13

Upcoding accounted for only one element across MYs 2020 to 2022, with the finding being a *No Match* in MY 2021.

Table 65. MYs 2020 to 2022 Upcoding Error Reasons for "No Match" by Encounter Type

Encounter Type	MY 2020			MY 2021			MY 2022		
Diagnosis	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	0%	9	0	0%	5	0	0%	1
Outpatient	0	0%	24	0	0%	29	0	0%	41
Office Visit	0	0%	102	1	2%	43	0	0%	165
Procedure	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	0%	9	0	0%	7	0	--	0
Outpatient	0	0%	30	0	0%	3	0	0%	19
Office Visit	0	0%	66	0	0%	25	0	0%	158
Revenue	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**	**#**	**%**	**Total Elements**
Inpatient	0	0%	11	0	0%	2	0	0%	2
Outpatient	0	0%	17	0	0%	6	0	0%	13

MCO Encounter Data Validation Results. MCO results by encounter type are displayed in Table 66.

Table 66. MYs 2020 to 2022 MCO and HealthChoice Results by Encounter Type

MCO	Inpatient			Outpatient			Office Visit		
	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022	MY 2020	MY 2021	MY 2022
ABH	100%	100%	100%	99%	98%	99%	98%	99%	95%
CFCHP	99%	100%	100%	99%	100%	100%	98%	99%	93%
JMS	92%	96%	100%	100%	99%	99%	100%	99%	96%
KPMAS	99%	100%	100%	100%	100%	100%	99%	100%	99%
MPC	100%	100%	99%	100%	99%	99%	97%	100%	96%
MSFC	99%	100%	99%	100%	100%	99%	100%	100%	99%
PPMCO	99%	98%	100%	99%	99%	97%	99%	99%	97%
UHC	100%	98%	99%	98%	100%	99%	97%	99%	98%
WPM	99%	100%	100%	97%	99%	99%	97%	98%	94%
HealthChoice	**98%**	**99%**	**100%**	**99%**	**99%**	**99%**	**98%**	**99%**	**96%**

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

All MCOs achieved match rates ranging from two to ten percentage points above the standard of compliance (90%), across all MYs from 2020 to 2022. Inpatient encounters ranged the most in match rates from 92% to 100% across MYs 2020 to 2022. MY 2022 office visit encounters ranged from 93% to 99% for match rates. Inpatient encounters ranged from 99% to 100% match rates for MY 2022. Outpatient encounters ranged from 97% to 100% for MY 2022.

Trended HealthChoice aggregate match rates revealed a few notable observations. Office visit encounter match rates dropped three percentage points from MY 2021 to MY 2022, after an increase of one percentage point from MY 2020 to MY 2021 (98% to 99%, respectively). Inpatient encounter match rates steadily increased one percentage point each MY, starting at 98% and achieving a 100% match rate for MY 2022. Outpatient encounter match rates maintained a match rate of 99% for MYs 2020 to 2022.

Conclusion

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 MY 2022. Qlarant conducted a medical record review on a sample of inpatient, outpatient, and office visit encounters (2,456) 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: 100% for inpatient, 99% for outpatient, and 96% for office visits.

MDH has set a task goal of increasing the HealthChoice aggregate EDV scores to 90% or above by MY 2024. This goal is based on pre-Covid public health emergency aggregate performance, and progress on specific HealthChoice performance metrics and targets are displayed in Table 67. HealthChoice aggregate scores for each encounter type exceeded the quality strategy targets set for MY 2024.

Table 67. MY 2022 EDV HealthChoice Aggregate Performance Against Quality Strategy Goals

Requirement: Minimum Compliance Score: ≥ 90%	MY 2022 HealthChoice Aggregate	MDH Quality Strategy Targets for MY 2024
Inpatient Match Rates	100%	99%
Outpatient Match Rates	99%	99%
Office Visits Match Rates	96%	99%

Source: HealthChoice Quality Strategy

For additional findings and comprehensive details associated with the MY 2022 EDV, please access the link to the MY 2022 EDV Report in **Appendix E**. The **MCO Quality, Access, and Timeliness Assessment section** includes informed conclusions from the EDV activity related to quality, access, and timeliness for the HealthChoice program.

Early and Periodic, Screening, Diagnosis, and Treatment

Objective

Maryland's EPSDT/Healthy Kids Program mission is to improve accessibility and ensure the availability of quality health care for HealthChoice children and adolescents through 20 years of age. The EPSDT medical record review supports this mission and assesses the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. Qlarant's MY 2022 medical record review assessed MCO performance for the following EPSDT components:

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

Methodology

Description of Data Obtained. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs from MY 2022 preventive care

encounters for children and adolescents through 20 years of age. Sample size per MCO provided a 90% confidence level with a 5% margin of error.

Technical Methods of Data Collection and Analysis. 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 shown in Table 68.

Table 68. MY 2022 EPSDT Validation Review Determinations and Scoring

Review Determination	Score
Completed	2
Incomplete	1
Missing	0
Not Applicable*	N/A
Compliance Threshold	**MDH-established minimum compliance for MY 2022 at 80%.**

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

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. CAPs are required if the minimum compliance score is not met. New elements or elements with revised criteria are scored as baseline for MY 2022.

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

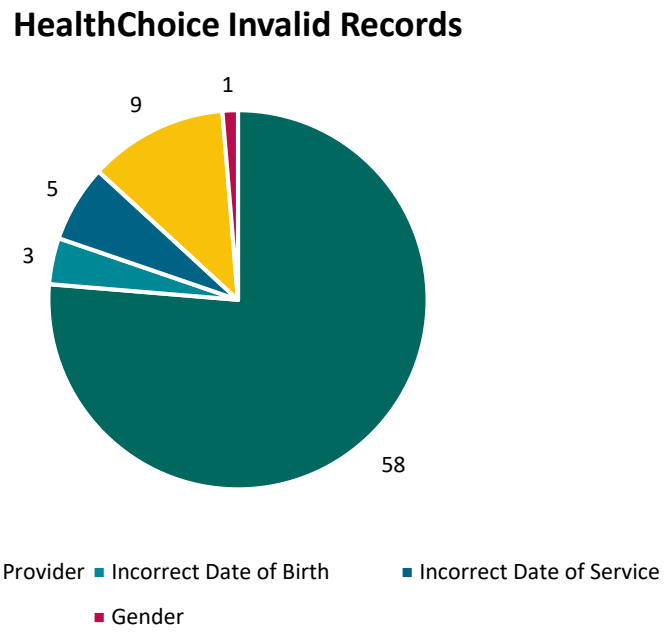
Medical record review samples contained total samples, completed reviews, and invalid records. Within this sample of 2,521 patient records, three percent of the HealthChoice Aggregate total sample was classified as invalid, as shown in Table 69.

Table 69. HealthChoice Summary of Total Sample for MY 2022

MCO	Total Sample	Valid Reviews Completed	Invalid Records	Percent of Sample
ABH	268	256	12	5%
CFCHP	275	266	9	3%
JMS	289	287	2	1%
KPMAS	293	291	2	1%
MPC	278	270	8	3%
MSFC	271	263	8	3%
PPMCO	293	282	11	5%
UHC	279	268	11	4%
WPM	275	262	13	5%
HealthChoice Aggregate	**2,521**	**2,445**	**76**	**3%**

Figure 17 illustrates the invalid record totals for each invalid category for all MCOs.

Figure 17. MY 2022 HealthChoice Invalid Records



Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. Guidelines and criteria are divided into five component areas (HX, PE, LAB, IMM, and HED). Tables 70 through 75 and Figure 18 display MCO results for the five EPSDT component areas evaluated for MY 2022 and both HealthChoice aggregate results for MYs 2020 to 2022 and total composite scores.

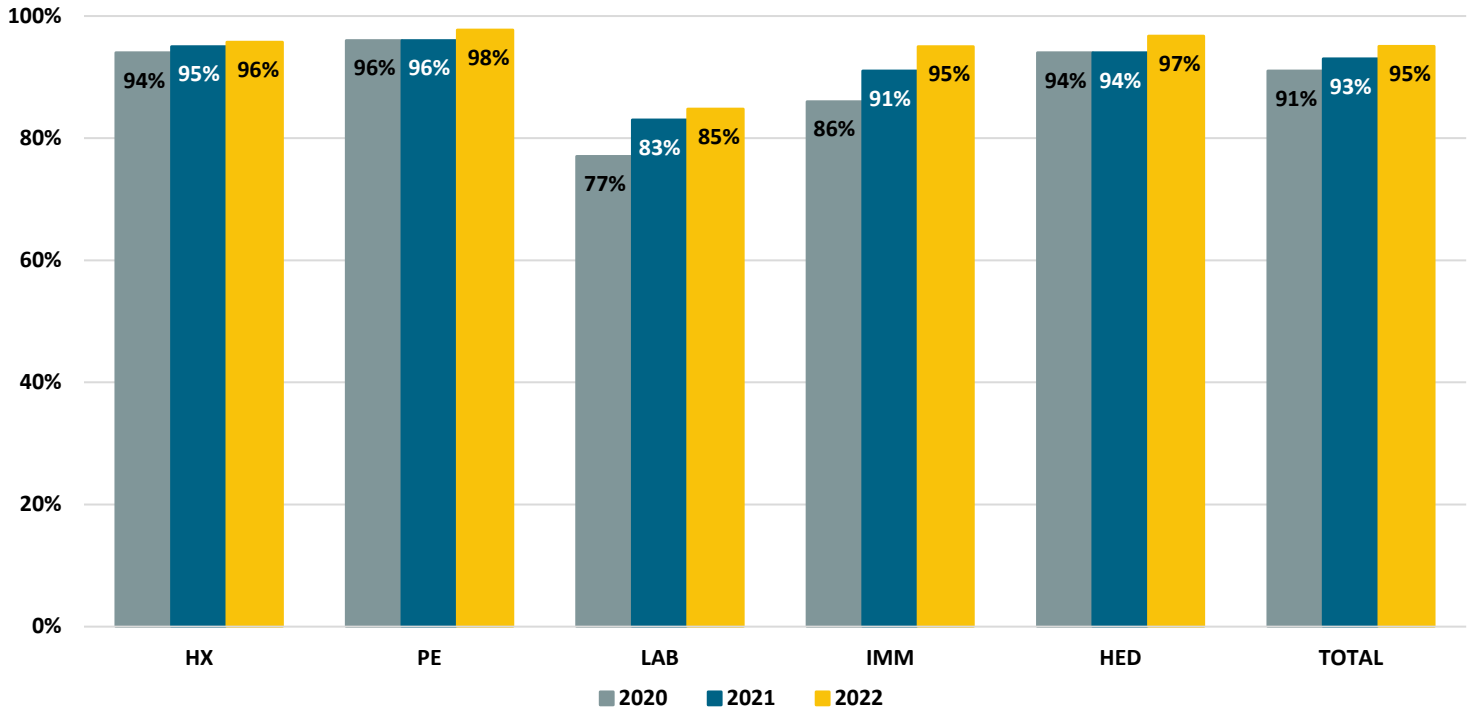
Table 70. MY 2022 EPSDT Component Results by MCO

MY 2022 EPSDT Components	ABH	CFCHP	JMS	KMPAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2020	MY 2021	MY 2022
HX	94%	94%	99%	100%	94%	95%	94%	95%	94%	**94%**	**95%**	**96%**
PE	98%	98%	99%	98%	97%	97%	97%	97%	98%	**96%**	**96%**	**98%**
LAB	80%	80%	99%	98%	80%	81%	76%	83%	84%	**77%**	**83%**	**85%**
IMM	94%	95%	97%	98%	94%	94%	94%	93%	95%	**86%**	**91%**	**95%**
HED	96%	95%	100%	100%	96%	97%	97%	95%	94%	**94%**	**94%**	**97%**
Total Composite Score	**94%**	**94%**	**99%**	**99%**	**94%**	**94%**	**93%**	**94%**	**94%**	**91%**	**93%**	**95%**

Underline denotes scores below the 80% minimum compliance requirement.

- All MCOs' total composite scores met the MDH-established minimum compliance threshold (80%).
- All MCOs met or exceeded the minimum compliance threshold for each component, except for PPMCO's Laboratory Tests/At-Risk Screenings score (75%).
- PPMCO had the lowest total composite score (93%) and JMS and KPMAS scored the highest (99%).
- The Laboratory Tests/At-Risk Screenings component had the greatest range in scores from 75% (PPMCO) to 99% (JMS).
- The component HealthChoice Aggregate scores ranged from 85% (Laboratory Tests/At-Risk Screenings) to 98% (Comprehensive Physical Exam).
- The total HealthChoice Aggregate score has steadily increased from MY 2020 to MY 2022 from 91% to 95%.
- The HealthChoice Aggregate score for each component has steadily increased from MY 2020 to MY 2022, with the greatest increase of nine percentage points for the Immunizations component (86% in MY 2020 to 95% in MY 2022).

Figure 18. MYs 2020 to 2022 HealthChoice Aggregate Results by Component



HealthChoice Aggregate Results:

- All component scores in MY 2022 demonstrated sustained improvement from MY 2020, with a total HealthChoice Aggregate component score increase of four percentage points.
- The Immunizations component displays the most substantial increase, improving four percentage points compared to MY 2021 and nine percentage points compared to MY 2020.
- The Laboratory Tests/At-Risk Screenings component continues to display a substantial increase, improving two percentage points compared to MY 2021 and eight percentage points compared to MY 2020.
- All five components scored above the minimum compliance threshold (80%) in MY 2022.

Table 71. MY 2022 Health and Developmental History Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Recorded Medical History	95%	95%	99%	100%	95%	98%	96%	96%	94%	**97%**
Recorded Family History	91%	89%	99%	100%	91%	92%	92%	93%	91%	**93%**
Recorded Perinatal History	86%	93%	100%	97%	72%	91%	89%	91%	90%	**90%**
Recorded Maternal Depression Screening	72%	79%	100%	100%	77%	81%	92%	81%	42%	**82%**
Recorded Psychosocial History	98%	98%	100%	100%	99%	99%	98%	97%	98%	**99%**
Recorded Developmental Surveillance/History	98%	98%	98%	100%	98%	99%	97%	98%	98%	**98%**
Recorded Developmental Screening Tool	89%	88%	100%	100%	89%	96%	87%	95%	91%	**93%**
Recorded Autism Screening Tool	81%	84%	100%	100%	88%	88%	79%	92%	74%	**88%**
Recorded Mental/Behavioral Health Assessment	98%	98%	100%	100%	100%	96%	99%	95%	97%	**98%**
Recorded Substance Use Assessment	93%	93%	100%	100%	94%	83%	86%	94%	92%	**93%**
Depression Screening	83%	83%	100%	100%	80%	91%	84%	89%	88%	**89%**
Component Score	**94%**	**94%**	**98%**	**100%**	**94%**	**95%**	**94%**	**95%**	**94%**	**96%**

Underline denotes scores below the 80% minimum compliance requirement.

Health and Developmental History Results:

- All MCOs scored well above the minimum compliance threshold (80%) for the Health and Developmental History component score, ranging from 94% (ABH, CFCHP, MPC, PPMCO, and WPM) to 100% (KPMAS).
- The HealthChoice Aggregate score for each element exceeded the minimum compliance threshold.
- JMS and KPMAS scored above the HealthChoice Aggregate score (96%) at 99% and 100%, respectively.
- JMS, KPMAS, MSFC, and UHC scored above the minimum compliance threshold for all elements comprising the Health and Developmental History component.
- KPMAS scored 100% for ten of the 11 elements comprising the Health and Developmental History component.
- ABH and CFCHP scored below the minimum compliance threshold for the Recorded Maternal Depression Screening element by eight and one percentage point, respectively (ABH at 72% and CFCHP at 79%).
- MPC scored below the minimum compliance threshold for the Recorded Perinatal History and the Recorded Maternal Depression Screening by eight and three percentage points, respectively (72% and 77%).

- PPMCO scored below the minimum compliance threshold for the Recorded Autism Screening Tool by one percentage point (79%).
- WPM had the lowest score across all elements comprising the Health and Developmental History component for the Recorded Maternal Depression Screening, which scored below the minimum compliance threshold by 38 percentage points (42%). WPM also scored below the minimum compliance threshold for the Recorded Autism Screening Tool by six percentage points (74%).

Table 72. MY 2022 Comprehensive Physical Exam Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Documentation of Minimum 5 Systems Explained	100%	99%	100%	100%	100%	100%	99%	98%	100%	**99%**
Vision Assessment	96%	96%	97%	92%	93%	93%	93%	93%	94%	**94%**
Hearing Assessment	95%	95%	97%	91%	94%	92%	92%	93%	92%	**93%**
Nutritional Assessment	99%	98%	100%	100%	98%	97%	98%	97%	98%	**98%**
Conducted Oral Assessment	97%	96%	100%	99%	96%	94%	93%	95%	97%	**96%**
Measured Height	100%	100%	100%	100%	100%	100%	99%	100%	99%	**100%**
Graphed Height	98%	100%	100%	100%	99%	99%	99%	99%	99%	**99%**
Measured Weight	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
Graphed Weight	98%	100%	100%	100%	99%	98%	99%	99%	99%	**99%**
BMI Percentile	99%	99%	100%	100%	99%	100%	100%	100%	99%	**100%**
BMI Graphing	99%	99%	100%	100%	99%	100%	99%	100%	99%	**99%**
Measured Head Circumference	89%	96%	100%	97%	95%	92%	97%	88%	97%	**94%**
Graphed Head Circumference	82%	95%	100%	97%	93%	90%	91%	88%	93%	**92%**
Measured Blood Pressure	98%	94%	100%	96%	94%	96%	97%	99%	98%	**97%**
Component Scores	**98%**	**98%**	**99%**	**98%**	**97%**	**97%**	**97%**	**97%**	**98%**	**98%**

Comprehensive Physical Examination Results:

- All MCO component scores and element scores exceeded the minimum compliance threshold (80%).
- Component scores ranged from 97% (MPC, MSFC, PPMCO, and UHC) to 99% (JMS).
- Five of the nine MCOs scored at or above the HealthChoice Aggregate component score of 98% (ABH, CFCHP, JMS, KPMAS, and WPM).
- All MCOs scored 100% for the Measured Weight element.
- JMS scored 100% for 12 of the 14 elements comprising the Comprehensive Physical Exam component.
- ABH had the lowest score across all elements for the Graphed Head Circumference element (82%).

Table 73. MY 2022 Laboratory Tests/At-Risk Screenings Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Newborn Metabolic Screen	93%	84%	92%	92%	55%	50%	94%	75%	86%	**81%**
Recorded TB Risk Assessment	84%	85%	100%	100%	86%	87%	80%	86%	87%	**89%**
Recorded Cholesterol Risk Assessment	77%	78%	100%	100%	84%	85%	76%	83%	77%	**85%**
9-11 Year Dyslipidemia Lab Test	59%	72%	96%	82%	62%	64%	53%	71%	75%	**72%**
18-21 Year Dyslipidemia Lab Test	50%	79%	100%	100%	94%	58%	65%	63%	71%	**80%**
Conducted Lead Risk Assessment	86%	89%	100%	100%	86%	93%	87%	86%	93%	**91%**
12 Month Blood Lead Test	83%	81%	97%	95%	83%	86%	80%	83%	89%	**86%**
24 Month Blood Lead Test	83%	80%	96%	98%	74%	81%	76%	83%	86%	**84%**
3-5 Year (Baseline) Blood Lead Test	87%	79%	100%	100%	93%	100%	90%	100%	97%	**95%**
Referral to Lab for Blood Test	91%	83%	100%	100%	87%	87%	85%	86%	86%	**90%**
Conducted Anemia Risk Assessment	70%	75%	100%	100%	74%	75%	69%	82%	78%	**81%**
12 Month Anemia Risk	84%	78%	98%	94%	82%	79%	77%	81%	87%	**85%**
24 Month Anemia Risk	79%	72%	98%	98%	72%	74%	71%	85%	85%	**82%**
3-5 Year Anemia Test	79%	54%	100%	100%	100%	75%	85%	94%	97%	**90%**
Recorded STI/HIV Risk Assessment	80%	86%	100%	100%	84%	83%	77%	93%	93%	**89%**
HIV Test Per Schedule	92%	63%	100%	100%	67%	86%	67%	89%	86%	**89%**
Component Score	**80%**	**80%**	**99%**	**98%**	**80%**	**81%**	**76%**	**83%**	**84%**	**85%**

Underline denotes scores below the 80% minimum compliance requirement.

Laboratory Tests/At-Risk Screenings Results:

- Eight of the nine MCO component scores met or exceeded the minimum compliance threshold (80%).
- Component scores ranged from 76% (PPMCO) to 99% (JMS).
- Only four elements out of 16 (Recorded TB Risk Assessment, Conducted Lead Risk Assessment, 12 Month Blood Lead Test, and Referral to Lab for Blood Test) resulted in all MCO scores above the minimum compliance threshold.
- The HealthChoice Aggregate for the 9-11 Year Dyslipidemia Lab Test element was the only element to score below the minimum compliance threshold (72%).

- JMS and KPMAS scored above the HealthChoice Aggregate component score (85%) by 14 and 13 percentage points, respectively (JMS at 99% and KPMAS at 98%).
- JMS and KPMAS were the only two MCOs to score above the minimum compliance threshold for all elements comprising the Laboratory Test/At-Risk Screenings component.
- ABH and MSFC had the lowest scores across all elements (50%) for the 9-11 Year Dyslipidemia Lab Test (ABH) and the Newborn Metabolic Screen (MSFC).
- CFCHP and PPMCO had the most element scores to fall below the minimum compliance threshold, nine out of the 16 elements.

Table 74. MY 2022 Immunization Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Hepatitis B	96%	98%	100%	99%	97%	97%	95%	96%	97%	**97%**
Diphtheria/Tetanus/Acellular Pertussis (DTaP)	98%	100%	100%	100%	99%	98%	97%	99%	98%	**99%**
Haemophilus Influenza Type B (Hib)	97%	100%	100%	100%	98%	97%	97%	99%	97%	**98%**
Pneumococcal (PCV-7 or PCV-13) [Prevnar]	98%	99%	100%	100%	98%	98%	98%	99%	97%	**99%**
Polio (IPV)	96%	98%	100%	98%	98%	97%	95%	95%	98%	**97%**
Measles/Mumps/Rubella (MMR)	96%	98%	100%	98%	98%	98%	95%	96%	98%	**97%**
Varicella (VAR)	96%	97%	100%	98%	97%	97%	95%	95%	98%	**97%**
Tetanus/Diphtheria/Acellular Pertussis (TDaP)	87%	95%	100%	97%	96%	95%	95%	91%	98%	**95%**
Influenza (Flu)	81%	80%	83%	96%	70%	77%	80%	80%	80%	**81%**
Meningococcal (MCV4)	88%	96%	100%	97%	97%	94%	97%	90%	97%	**95%**
Hepatitis A	94%	95%	99%	98%	96%	96%	94%	95%	97%	**96%**
Rotavirus (RV)	100%	100%	100%	98%	100%	100%	100%	100%	100%	**100%**
Human Papillomavirus (HPV)	83%	91%	100%	96%	93%	91%	93%	92%	95%	**93%**
Assessed Immunizations Up to Date	90%	90%	89%	96%	86%	91%	91%	88%	90%	**90%**
Component Score	**94%**	**95%**	**97%**	**98%**	**94%**	**95%**	**94%**	**93%**	**95%**	**95%**

Underline denotes scores below the 80% minimum compliance requirement.

Immunizations Results:

- All nine MCO component scores and the HealthChoice Aggregate for each element comprising the Immunizations component exceeded the minimum compliance threshold (80%).
- Component scores ranged from 93% (UHC) to 98% (KPMAS).
- Influenza was the only element to have MCO scores below the minimum compliance threshold (MPC at 70% and MSFC at 77%).
- The Rotavirus element had the highest scores with eight MCOs scoring 100% and one MCO (KPMAS) scoring 98%.

Table 75. MY 2022 Health Education/Anticipatory Guidance Element Results

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
Documented Age-Appropriate Anticipatory Guidance	98%	98%	100%	100%	98%	99%	98%	97%	99%	**99%**
Documented Health Education/Referral for Identified Problems/Tests	100%	99%	100%	100%	99%	100%	99%	98%	99%	**99%**
Documented Referral to Dentist	91%	88%	99%	100%	93%	92%	92%	91%	87%	**93%**
Specified Requirements for Return Visit	96%	93%	99%	100%	93%	96%	98%	94%	91%	**96%**
Component Score	**96%**	**95%**	**100%**	**100%**	**96%**	**97%**	**97%**	**95%**	**94%**	**97%**

Health Education/Anticipatory Guidance Results:

- All nine MCOs scored above the minimum compliance threshold (80%) for the component score and all elements comprising the Health Education/Anticipatory Guidance component.
- Component scores ranged from 94% (WPM) to 100% (JMS and KPMAS).
- Four of the nine MCOs (JMS, KPMAS, MSFC, and PPMCO) met or exceeded the HealthChoice Aggregate score (97%).
- KPMAS scored 100% for each element comprising the Health Education/Anticipatory Guidance component.
- WPM had the lowest element score (87%) for the Documented Referral to Dentist element.

Conclusion

HealthChoice is a mature managed care program and the analysis of the EPSDT medical record review results ensures the MCOs' providers are delivering timely access to healthcare services according to EPSDT standards for its population of children and adolescents through 20 years of

age. Overall, the MY 2022 EPSDT review demonstrates steady improvement in the HealthChoice Aggregate scores and MCO total composite scores from MY 2020 to MY 2022. All MCOs' total composite scores performed well above the MDH-established minimum compliance threshold (80%), ranging from 93% (PPMCO) to 99% (JMS and KPMAS). The Laboratory Tests/At-Risk Screenings component presents an area of opportunity with scores just five percentage points above the minimum compliance threshold (80%). The Laboratory Tests/At-Risk Screenings components also contained the lowest scores across the majority of MCOs with 76% (PPMCO) being the lowest.

MDH set a task goal, based on pre-Covid public health emergency aggregate performance, to increase all EPSDT requirements to 80% or above by MY 2024. Table 76 identifies specific HealthChoice performance metrics and targets from the HealthChoice Quality Strategy for 2022-2024. All six components comprising the EPSDT review exceeded the MDH minimum threshold of 80%. Five of those six components exceeded MDH's targets for MY 2024. Laboratory Tests/At-Risk Screenings was the only component that fell slightly below the quality strategy goal percentage of 87% by two percentage points.

Table 76. MY 2022 EPSDT HealthChoice Aggregate Performance Against Quality Strategy Targets

Requirement: Minimum Compliance Score: ≥80%	HealthChoice Aggregate	MDH Quality Strategy Targets for MY 2024
HX	96%	94%
PE	98%	97%
LAB	85%	87%
IMM	95%	93%
HED	97%	94%
HealthChoice Aggregate Totals	**95%**	**94%**

Source: *HealthChoice Quality Strategy*

For additional findings and comprehensive details associated with the MY 2022 EPSDT review, please access the link to the MY 2022 EPSDT Statewide Executive Summary Report in **Appendix E**. The **MCO Quality, Access, and Timeliness Assessment section** includes informed conclusions from the EPSDT review related to quality, access, and timeliness for the HealthChoice program.

Consumer Report Card

Objective

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

Measures are grouped into six reporting categories meaningful to enrollees. Based on a review of available measures (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 (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.

Data Collection and Review. Performance measures are selected from HEDIS, CAHPS survey results from both the Adult Questionnaire and the Child Questionnaire, and MDH's encounter data measures. Recommended categories are based on measures reported by MCOs in 2021 and are designed to focus on clearly identifiable areas of interest.

Results

Tables 77 and 78 provide results of the 2023 Consumer Report Card and the overall Star Rating changes year over year.

Table 77. 2023 Consumer Report Card Results

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

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

Table 78. CRC Star Rating Changes from MY 2022 to MY 2023

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

Light Green = ↑ improvement from MY 2022; Pink = ↓ decline from MY 2022; White = Ø no change from MY 2022; Gray = NA reported as Not Applicable for MY 2022 and/or MY 2023

Conclusion

For additional findings and comprehensive details associated with the information reporting strategy and analytic methods associated with the production of the MY 2023 Consumer Report Card, please access the link to the Information Reporting Strategy and Analytic Methodology in **Appendix D**. English and Spanish versions of the 2023 Consumer Report Card are available in **Appendix E**. The **MCO Quality, Access, and Timeliness Assessment section** includes informed conclusions from the CRC activity related to quality, access, and timeliness for the HealthChoice program.

Grievances, Appeals, and Denials Focused Study

Objective

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

Methodology

Description of Data Obtained. Qlarant assesses MCO compliance based on MCO-reported data. MDH requires all MCOs to submit quarterly GAD reports to Qlarant within 30 days of the close of each quarter, with the annual report submitted 30 days after the close of the fourth quarter. In addition to quarterly reviews of the reports submitted by the MCOs, Qlarant conducted an annual record review of a MY 2022 sample of grievance, appeal, and pre-service denial records. Records were requested from July 1 through October 31, 2022, to allow MCOs an opportunity to address and fully implement several recent regulatory changes noted as incomplete during the SPR conducted in early 2022. Each MCO provided Qlarant with a listing of grievances, appeals, and pre-service denials for MY 2022. Qlarant selected 35 cases from each listing, using a random sampling approach; and requested each MCO to upload the selected case records to the Qlarant portal. Reviews were conducted utilizing the 10/30 rule, where initial samples of 10 grievance, 10 appeal, and 10 denial records were reviewed and an additional 20 records were reviewed if an area of noncompliance was discovered.

Technical Methods of Data Collection and Analysis. Qlarant develops MDH-approved templates for each reporting category as a review tool to validate and evaluate quarterly MCO reports. Following validation of the data MCOs submitted, these review tools allowed Qlarant to enter data from the MCO reports and identify areas of noncompliance. Aggregated MCO results allow MCO comparisons and identification of MCO-specific trends after three-quarters of the data were available. Quarterly reports submitted to MDH included an analysis of MCO data and recommendations, as appropriate. MCOs were provided separate reports for summarizing quarterly review findings, which included areas for follow-up when data issues, ongoing noncompliance, or negative trends were identified. 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 also shared with the appropriate staff for each MCO, including technical assistance as needed, to facilitate improved compliance.

Compliance criteria represent the scores for various components, defined as review determinations, in Table 79. Annual record reviews and quarterly reports inform these results and provide comparisons of MCO performance over time and in relation to peers.

Table 79. MY 2022 GAD Validation Review Determinations

Review Determinations	Criteria
Met (M)	Achieves ≥ 95% for all quarters and demonstrates consistent compliance.
Partially Met (PM)	Achieves ≥ 95% for at least one quarter, but not all quarters; and demonstrates inconsistent compliance.
Unmet (UM)	Achieves < 95% for all quarters and demonstrates no evidence of compliance.
Not Applicable (NA)	Used when information is not available for a category under review.
Compliance Threshold	**MDH established minimum compliance for MY 2022 at 95%.**

Results

Compliance with Resolution Timeframes. Tables 80 through 82 capture quarterly and annual comparisons of MCO-reported compliance with resolution timeframes. Enrollee grievances, provider grievances, and enrollee appeals are captured in the following tables, respectively.

Table 80. MY 2022 Enrollee Grievance Resolution Timeframes

	MCO-Reported Compliance								
Timeframe	**ABH**	**CFCHP**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**WPM**
Q1 2022	M	M	M	M	M	M	PM	M	M
Q2 2022	M	M	M	PM	M	M	PM	M	M
Q3 2022	M	PM	M	PM	M	PM	PM	M	M
Annual 2022	**M**	**PM**	**M**	**PM**	**M**	**M**	**M**	**M**	**M**

Table 81. MY 2022 Provider Grievance Resolution Timeframes

	MCO-Reported Compliance								
Timeframe	**ABH**	**CFCHP**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**WPM**
Q1 2022	M	M	M	NA	M	M	M	M	M
Q2 2022	M	M	M	NA	M	M	M	M	M
Q3 2022	NA	M	M	NA	NA	NA	M	M	M
Annual 2022	**M**	**PM**	**M**	**NA**	**M**	**M**	**M**	**M**	**M**

Table 82. MY 2022 Enrollee Appeal Resolution Timeframes

MCO-Reported Compliance									
Timeframe	**ABH**	**CFCHP**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**WPM**
Q1 2022	M	M	M	PM	PM	PM	M	PM	PM
Q2 2022	M	M	M	M	M	M	M	M	M
Q3 2022	M	M	M	M	M	M	M	M	M
Annual 2022	**M**	**M**	**M**	**PM**	**PM**	**M**	**M**	**M**	**PM**

Quarterly Compliance with Determination Timeliness. Compliance with COMAR requirements for the timeliness of pre-service determinations was assessed based on self-reporting through MCO submissions of quarterly reports and an annual record review. Quarterly data represented the entire population or a statistically significant sample. Tables 83 and 84 capture results of MCO-reported compliance with determination notification timeframes, capturing pre-service determination timeframes and adverse determination notification timeframes, respectively.

Table 83. MY 2022 Pre-Service Determination Timeframes

MCO-Reported Compliance									
Timeframe	**ABH**	**CFCHP**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**WPM**
Expedited Timeframe (Medical Denials)									
Q1 2022	100%	100%	NA	100%	100%	100%	99%	100%	100%
Q2 2022	92%	100%	100%	100%	100%	100%	97%	100%	96%
Q3 2022	100%	100%	NA	100%	98%	NA	96%	100%	94%
Annual 2022	**99%**	**100%**	**100%**	**100%**	**99%**	**100%**	**98%**	**100%**	**98%**
Standard Timeframe (Medical Denials)									
Q1 2022	98%	99%	100%	96%	100%	99%	99%	100%	98%
Q2 2022	99%	100%	100%	96%	100%	99%	100%	100%	94%
Q3 2022	99%	100%	100%	88%	100%	98%	100%	100%	78%
Annual 2022	**98%**	**100%**	**100%**	**92%**	**100%**	**99%**	**99%**	**100%**	**84%**
Outpatient Pharmacy Timeframe (Denials)									
Q1 2022	100%	100%	100%	NA	100%	96%	99%	100%	100%
Q2 2022	100%	99%	100%	100%	99%	97%	99%	100%	100%
Q3 2022	99%	99%	99%	100%	98%	100%	99%	100%	100%
Annual 2022	**100%**	**99%**	**99%**	**100%**	**99%**	**98%**	**99%**	**100%**	**100%**

Table 84. MY 2022 Adverse Determination Notification Timeframe

MCO-Reported Compliance									
Timeframe	**ABH**	**CFCHP**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**WPM**
Expedited Timeframe (Medical)									
Q1 2022	100%	100%	NA	100%	100%	100%	98%	100%	96%
Q2 2022	100%	100%	100%	100%	100%	100%	96%	100%	98%
Q3 2022	100%	100%	NA	100%	95%	NA	95%	100%	100%
Annual 2022	**100%**	**100%**	**100%**	**100%**	**98%**	**100%**	**95%**	**100%**	**97%**
Standard Timeframe (Medical)									
Q1 2022	98%	100%	100%	91%	100%	99%	99%	100%	98%
Q2 2022	99%	100%	100%	97%	100%	100%	99%	100%	98%
Q3 2022	99%	100%	100%	95%	98%	99%	99%	100%	98%
Annual 2022	**98%**	**100%**	**100%**	**96%**	**99%**	**99%**	**96%**	**100%**	**98%**
Outpatient Pharmacy Timeframe									
Q1 2022	100%	100%	100%	NA	100%	91%	100%	100%	100%
Q2 2022	100%	99%	99%	100%	100%	98%	100%	100%	100%
Q3 2022	99%	99%	100%	100%	100%	100%	100%	100%	100%
Annual 2022	**100%**	**99%**	**100%**	**100%**	**100%**	**97%**	**100%**	**100%**	**100%**
Prescriber Notification of Outcome (within 24 hours)									
Q1 2022	100%	100%	100%	100%	100%	96%	99%	100%	100%
Q2 2022	100%	99%	100%	100%	100%	98%	99%	100%	100%
Q3 2022	100%	100%	99%	100%	99%	100%	99%	100%	100%
Annual 2022	**100%**	**99%**	**99%**	**100%**	**100%**	**98%**	**99%**	**100%**	**100%**

Record Review for Grievance and Appeal Requirements. Tables 85 and 86 compare results from record reviews across MCOs. Results are based upon a random selection of grievance and appeal records during MY 2022, respectively.

Table 85. MY 2022 MCO Annual Grievance Record Review Results

Requirement	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Appropriately Classified	M	M	M	M	M	M	M	M	PM
Acknowledgment Letter Timeliness	M	PM	M	M	M	M	M	M	M
Issue is Fully Described	M	UM	M	M	M	M	M	M	M
Resolution Timeliness	M	PM	M	M	M	M	M	M	PM
Resolution Appropriateness	M	M	M	M	M	M	M	M	M
Resolution Letter Timeliness	M	PM	M	M	M	M	M	M	NA
Resolution Letter in Easy-to-Understand Language	M	PM	M	M	M	M	M	M	M

Table 86. MY 2022 MCO Appeal Record Review Results

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

Record Review for Determination Timeliness. Record reviews were also conducted to assess compliance with the COMAR requirement for timeliness of pre-service determinations. Random selection of records from MY 2022 also informed results for pre-service and adverse determinations. Results for pre-service determinations are captured in Figure 19 and results for adverse determinations are captured in Figure 20, and Tables 87 and 88.

Figure 19. MY 2022 MCO Compliance with Pre-Service Determination Timeframes (Record Review)

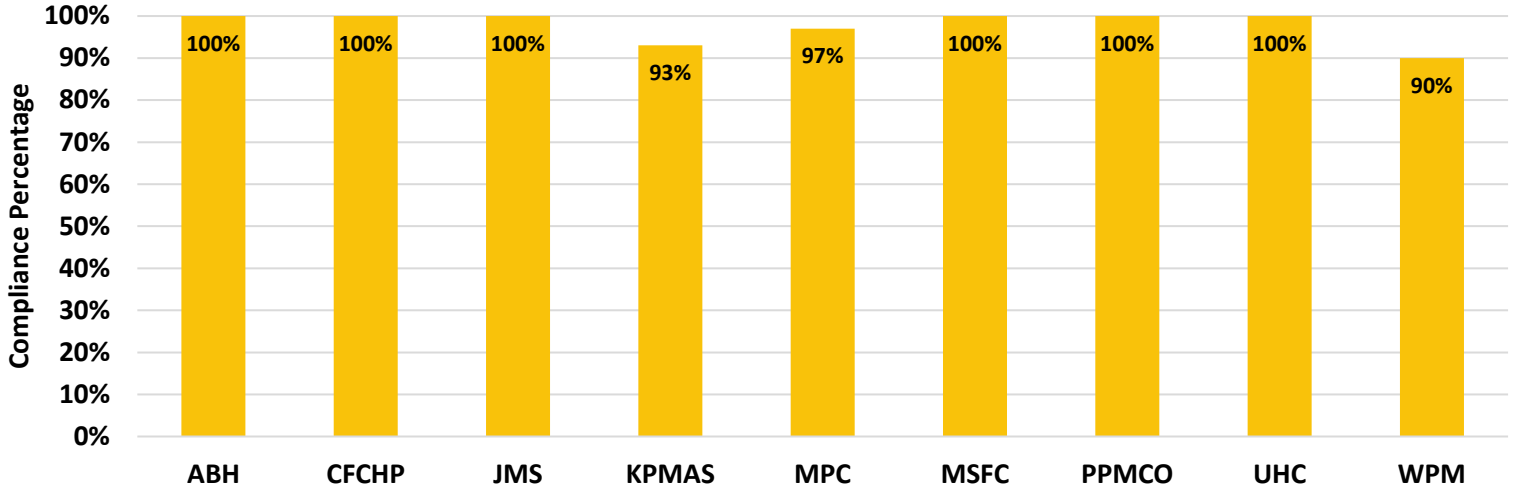


Figure 20. MY 2022 MCO Compliance with Adverse Determination Notification Timeframes (Record Review)

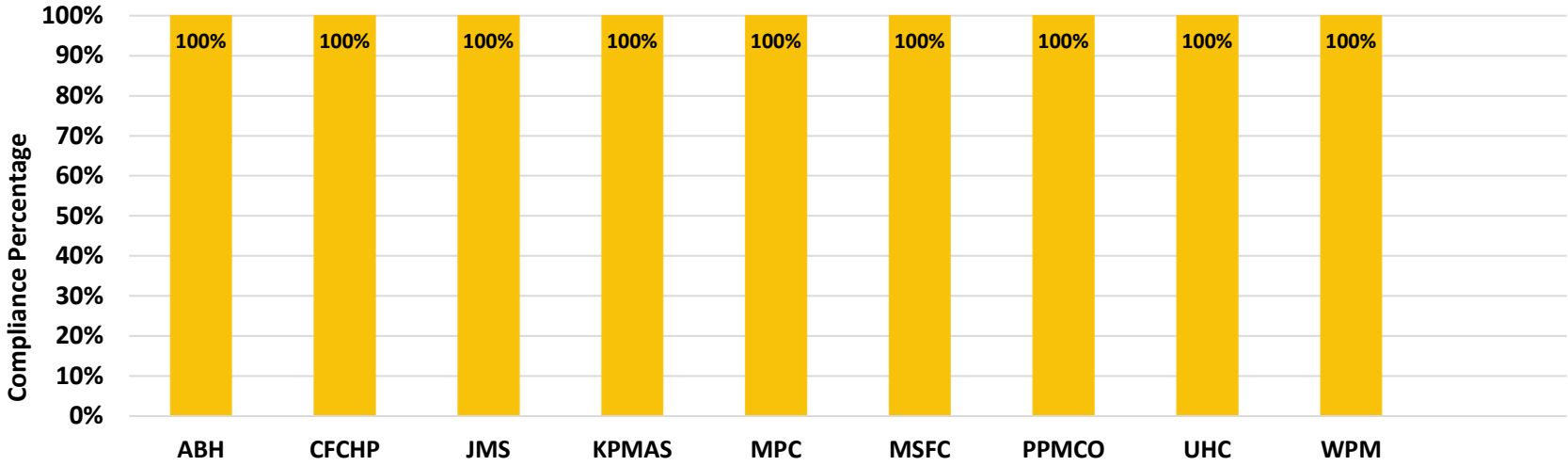


Table 87. MY 2022 MCO Adverse Determination Record Review Issues

MCO	Issues Identified
ABH	Letter Components – Use of Easy to Understand Language in Enrollee Letters
CFCHP	Letter Components – Use of Easy to Understand Language in Enrollee Letters
UHC	Several pharmacy requests were identified as "expedited." Based upon COMAR, there is no "expedited" category for pharmacy requests.

Note: No other issues were identified in the remaining six MCOs.

Table 88. MY 2022 Results of MY 2022 Adverse Determination Record Reviews

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

Conclusion

Conclusions for the MY 2022 GAD review were drawn from MCO-reported compliance in annual GAD reports and annual record review data. Opportunities for improvement still arose during the focused study review. Four MCOs (CFCHP, KPMAS, PPMCO, and WPM) account for 85% of the opportunities for improvement, with PPMCO contributing 13% of the opportunities. JMS and MSFC had no negative findings at the end of the year. ABH and MPC had two, and UHC only one. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice enrollees is timely and accessible.

Considering individual MCO performance and categories of opportunities, Tables 89 through 91 summarize the following observations and identify the specific opportunities identified from a review of these data.

- Adverse determinations accounted for ABH and UHC findings.
- Grievance system timeliness and documentation predominately categorized CFCHP's issues.
- Appeals resolution/notification timeliness and documentation of prescriber notification concerned MPC's issues.
- Improving documentation in appeal records categorized PPMCO's issues.
- Findings for KPMAS and WPM cross all three GAD categories.

Table 89. MY 2022 GAD Review Summary of Grievance Opportunities for Improvement

Improvement Opportunities by End of MY 2022	CFCHP	KPMAS	WPM
GAD Reports			
Compliance with Enrollee Grievance Resolution Timeframes	X	X	–
Compliance with Provider Grievance Resolution Timeframes	X	–	–
Record Review Results			
Appropriately Classified	–	–	X
Acknowledgment Letter Timeliness	X	–	–
Issue is Fully Described	X	–	–
Resolution Timeliness	X	–	X
Resolution Letter Timeliness	X	–	–
Resolution Letter in Easy-to-Understand Language	X	–	–

X = Opportunity for improvement; (-) = No opportunity for improvement

Table 90. MY 2022 GAD Review Summary of Appeal Opportunities for Improvement

Improvement Opportunities by End of MY 2022	CFCHP	KPMAS	MPC	PPMCO	WPM
GAD Reports					
Compliance with Enrollee Appeal Resolution/Notification Timeframes	–	X	X	–	X
Record Review Results					
Compliance with Timeframe for Written Appeal Acknowledgement Letter	X	–	–	X	X
Compliance with Verbal Notification of Denial of an Expedited Request	–	–	–	X	–
Compliance with 72-hour Timeframe for Expedited Appeal Resolution/Notification	–	X	–	–	–
Compliance with Verbal Notification of Expedited Appeal Decision	–	X	–	X	X
Decision Available to Enrollee in Easy-to-Understand Language	X	–	–	X	–

X = Opportunity for improvement; (-) = No opportunity for improvement

Table 91. MY 2022 GAD Review Summary of Pre-Service Determination Opportunities for Improvement

Improvement Opportunities by End of MY 2022	ABH	CFCHP	KPMAS	MPC	UHC	WPM
Pre-Service Denials – GAD Reports						
Compliance with Standard Pre-Service Determination Timeframes for Medical Denials	–	–	X	–	–	X
Pre-Service Determination Timeframes (Record Review)	–	–	X	–	–	X
Adverse Determination Record Review Results						
Letter Components – Use of Easy-to-Understand Language in Enrollee Letters	X	X	–	–	–	–
Inappropriate classification pharmacy requests were identified as "expedited"	–	–	–	–	X	–
Adverse Determination Record Reviews						
Compliance with Pre-Service Determination Timeframes	–	–	X	–	–	X
Required Letter Components	X	X	–	–	–	–
Compliance with Prescriber Notification	–	–	–	X	–	–

X = Opportunity for improvement; (-) = No opportunity for improvement

With the exception of outliers noted above, MCO strengths are identified in specific review components where all or a majority of the MCOs were in compliance:

- Appropriate classification and resolution of grievances
- Timely written acknowledgment of receipt of enrollee grievances
- Full documentation of grievance issues
- Timely resolution of enrollee grievances
- Timeliness of grievance resolution letters
- Grievance resolution letters are written in easy-to-understand language
- Appeals are processed based on the level of urgency of enrollee appeal resolutions
- Appeal decisions are made by a healthcare professional with appropriate expertise
- Appeal decisions are documented and available to the enrollee in an easy-to-understand language
- Timely pre-service determinations
- Timely pre-service adverse determination written notifications
- Timely prescriber notifications of prior authorization review outcome
- Required components are included in adverse determination letters
- Appropriate adverse determinations were based on MCO medical necessity criteria and policies

Threats to the validity of the MCO-submitted quarterly grievance, appeal, and denial reports continue to be assessed. MCOs showed improvements in GAD report documentation for each quarter of MY 2022. In particular, MCOs had fewer report resubmissions and fewer errors

within each report. Limitations in the accuracy of the self-reported MCO data are noted below. Going forward, these continuing opportunities for improvement must be addressed to ensure data accuracy and validity.

- Feedback from the MCOs identified ongoing formula errors, uncertainty with what template to use, and general frustration with the data entry process. When needed, only two MCOs routinely documented why their data was skewed. Despite MCOs having to submit a signed attestation to the accuracy of their reports, there still seem to be some instances of limited quality oversight of the GAD process.
- Several factors threatened the validity of the data reported early in Q1. At the beginning of the year, incorrect formulas in the MCOs' appeals reporting template required manual recalculation. Some MCOs were able to override the formulas in the locked cells which did not appear to impact the accuracy of the data reported, such as reporting the per 1,000 rate at two or more decimal points when the formula appeared to be limited to only whole numbers. Some of the data fields in the denial report template had formulas based upon incorrect instruction; the denominator for the percentages of prior authorization requests approved and denied is based upon the overall total of prior authorization requests rather than the overall total of prior authorization requests resolved. These fields and the related instructions have been identified for updates. Additionally, the formula for rates per 1,000 needed to be revised to allow for trending.
- Some of the GAD service and reason codes may limit actionable interventions. For example, codes reported by the MCOs in the category of "Other," are too vague and do not support identification and trending of relevant information.
- Another potential limitation to the accuracy of the data is underreporting grievances. Because of a corporate audit, one MCO discovered that many grievances resolved and closed by the Customer Service Department were not being logged into their complaint and grievance-tracking database. A new workflow was created to address this issue.
- A final limitation to consider is that Maryland MCOs' GAD data for MY 2022 consists of three quarters and one annual submission for what would be the fourth quarter. As a result, positive or negative data trends were not as easily determined. Trending will be determined as more annual data becomes available.

For additional findings and comprehensive details associated with the MY 2022 GAD focused study, please access the link to the GAD Annual Report in **Appendix E**. The **MCO Quality, Access, and Timeliness Assessment section** includes informed conclusions from the GAD activity related to quality, access, and timeliness for the HealthChoice program.

MCO Quality, Access, Timeliness Assessment

Quality, Access, Timeliness

Qlarant identified strengths, improvements, and recommendations summarizing aggregate performance across MCOs, based on the results of the EQR activities. These strengths, improvements, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for these domains:

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

MCO Aggregate Strengths, Improvements, and Recommendations

Tables 92 through 98 highlight strengths, improvements, and recommendations summarizing aggregate performance across MCOs. Identified strengths, improvements, and recommendations correspond to the quality, access, and/or timeliness of services delivered to MCO enrollees. Applicable domains for each strength, improvement, or weakness are identified with a (↑) or (↓), indicating a positive or negative impact. Not all domains were impacted by each strength, improvement, or recommendation. Where appropriate, recommendations include opportunities.

Table 92. MY 2022 MCO PIP Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↑	**Performance Improvement Project**

Strength:

- All MCOs performed at confidence levels of *Confidence* and *High Confidence*.

Improvement:

- No formal improvements due to MY 2022 being a baseline measurement year.

Recommendation:

- Review prenatal and postpartum care enrollee data and identify how the PIP topics are relevant to the MCO's enrollees. MCOs must provide MCO-specific data to support the relevant justification.
- Ensure SMART objectives identify the details as outlined in the Quality Assurance and Performance Improvement (QAPI) "Goal Setting Worksheet" by answering the following: What do we want to accomplish? Who will be involved and/or affected? Where will it take place? What is the measure you will use? What is the current data figure for that measure? What do you want to increase/decrease that number to? Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark? Is the goal measure set so low that it is not challenging enough? Does the goal measure require a stretch without being too unreasonable? Briefly describe how the goal will address the problem. What is the target date for achieving this goal?
- Ensure that interventions incorporate each component of the National Culturally and Linguistically Appropriate Services (CLAS) standards and describe how each component specifically relates to each intervention. Ensure that feedback from enrollees and providers serving those enrollees is included in the identification of barriers to timeliness of prenatal and postpartum-related care as well as included in the solutions to overcome those barriers.
- Conduct barrier analyses at least on an annual basis. MCOs should consider enrollee, provider, and MCO barriers relevant to the PIP topics, the interventions, and the disparate populations. Identify the tool utilized to conduct the barrier analysis and identify the quality improvement process, such as PDSA.
- Utilize evidence-based research to support interventions. Evidence-based research should identify a proven-successful plan to improve policies, processes, and protocols, address social determinants of health, and improve or implement community partnerships, or overcome cultural barriers related to the desired outcome of the intervention.
- Accurately identify the HEDIS rates that align with the selected strategies. Review process metric data and ensure that the intervention is designed to improve the appropriate HEDIS rate.

Table 93. MY 2022 MCO PHIP Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↑	**Performance Measure Validation**

Strength:

- MCO commitment to quality, access, and timeliness standards positively impacted desired health outcomes for enrollees during the measurement period. MCOs demonstrated improved performance for the following PHIP measures in MY 2022: Asthma Medication Ratio, Poor HbA1c Control, Lead, Postpartum Care, and Timeliness of Prenatal Care.
- Results of PHIP activities demonstrate steady improvement across MCOs in meeting or exceeding the current measurement year's benchmarks and improving year over year.
- The COVID-19 public health emergency waxed and waned in its effects on MCOs during MY 2022. Across MCOs, HEDIS rates normalized somewhat to performance prior to the COVID-19 public health emergency.
- Several HEDIS measures or indicators demonstrated above or better performance than the NHM for eight out of the nine MCOs: BCS, CIS Combo 10, CWP, PCE Bronchodilator, POD, PPC-Postpartum Care, WCC Nutrition Counseling, and WCC Physical Activity.
- All nine MCOs demonstrated performance above or better than the NHM for the following measures: CHL, HBD Hemoglobin A1c control <8, HBD Hemoglobin A1c poor control >9, CIS Combo 3, COU 15 days, KED, LSC, and PPC – Timeliness of Prenatal Care.
- All nine MCOs demonstrated continued commitment to the HEDIS reporting process and their efforts to improve enrollee outcomes. The MCOs' HEDIS team members were responsive to all requests for information and worked with their auditors to comply with HEDIS audit requirements.
- All MCOs were fully engaged in fine-tuning their quality improvement programs and enrollee outreach activities.
- Five (ABH, CFCHP, JMS, PPMCO, and UHC) of the nine MCOs successfully reported at least one ECDS measure (beyond the accreditation-required PRS-E measure). Although exempt from reporting, these measures are certainly important for the MCOs to get comfortable with as NCQA has expanded the ECDS measure domain significantly, and is continuing to transition traditional HEDIS clinical measures to ECDS-only reporting.
- Each MCO worked collaboratively with MDH to obtain complete and accurate race and ethnicity data in order to meet NCQA's MY 2022 reporting requirements. All nine MCOs were able to report race/ethnicity stratifications for applicable MY 2022 measures.

Improvement:

- No formal improvements due to MY 2022 being the first year of implementation for the PHIP.

Recommendation:

- MetaStar recommends that MDH explore allowing MCOs to contract directly with behavioral health vendors to provide better coordination of care between physical and mental health providers to potentially improve outcomes.
- MetaStar recommends MDH explore ways to improve the completeness of the race and ethnicity data it provides to the MCOs to meet expected completeness thresholds NCQA may implement in years to come.

Table 94. MY 2022 MCO SPR Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↑	**Systems Performance Review**
Strength: • MCOs have demonstrated the ability to design and implement effective quality assurance systems. **Improvement:** • MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of healthcare services to managed care enrollees. The overall amount of CAPs decreased from 25 in MY 2021 to 17 in MY 2022. The number of *Met with Opportunity* scores reduced from 22 in MY 2021 to 11 in MY 2022. **Recommendation:** • MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.			

Table 95. MY 2023 MCO NAV Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↓	**Network Adequacy Validation**
Strength: • The online provider directory validation results are consistent from MYs 2021 to 2023 for accuracy with PCP addresses, phone numbers, ADA specifications, accepting new patients, specified age ranges, and specified languages spoken by the PCP. **Improvement:** • MCOs demonstrated an increase in the ability for enrollees to filter options for patient age requirements, gender, or language preferences. • MCOs demonstrated an increase in the likelihood that enrollees will be able to schedule a routine care appointment within 30 days. • Overall compliance with routine and urgent care appointments has improved from MY 2022 to MY 2023, scoring approximately 90% for compliance in both categories. **Recommendation:** • MCOs demonstrated a decrease in the likelihood that enrollees will be able to schedule an urgent care appointment within 48 hours. • MCOs should consider the availability of network PCPs in neighboring states, such as Delaware, Pennsylvania, DC, Virginia, and West Virginia. • Provide complete and accurate PCP information for MCO internal listings and online provider directories to continue to improve successful contact with the intended PCP office. MCOs demonstrated an increase in the likelihood that enrollees will not reach the intended PCP due to no answer or having reached a voicemail. MCOs demonstrated an increase in the likelihood that enrollees will not receive the accurate phone number or address for PCPs. • Provide the customer service department's telephone number or a scheduling assistance telephone number on each directory page for enrollee reference.			

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↓	**Network Adequacy Validation**
• Review and address root causes for the increase in unsuccessful surveys due to "No Contact," such as incorrect PCP phone numbers and limited staffing availability to answer calls. • Notify PCPs of the Maryland NAV survey timeframe and promote participation one month before the surveys begin to increase the likelihood of successful contacts. • Refrain from completing any MCO-specific provider surveys within the same timeframe as the Maryland NAV survey 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. MCOs demonstrated a decrease in the likelihood that enrollees will be able to successfully identify and access providers that are accepting new Medicaid patients. • Review and address root causes of the decline in PCP acceptance of new Medicaid patients to ensure access and timeliness of care. • Provide education to provider staff members to ensure staff responses match the online directory regarding accepting new Medicaid patients. • Consistently provide ADA-specific details when the provider identifies as being handicap accessible in online provider directories. MCOs demonstrated a decrease in the likelihood that enrollees will be able to view specific ADA accommodations in MCO online provider directories. • Ensure the glossary is easily located. • Use placeholders with consistent descriptions for provider details that are missing, such as "none" or "none specified," rather than blanks.			

Table 96. MY 2022 MCO EDV Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↑	**Encounter Data Validation**
Strength: • All MCOs maintained high performance. **Improvement:** • The percentage of inpatient match rates has steadily improved and the percentage for outpatient match rates has remained consistent at 99% from MY 2020 to MY 2022. **Recommendation:** • All MCOs should investigate reasons for declines in match rates for office visit encounters. With MDH's MY 2024 target of 99% match rates, any decline should be investigated to determine the reasons for the decline. • The MCOs should continue to encourage enrollees to change or update their "assigned" PCP to improve selection rates through MCO New Member Welcome packet and in the member handbook (The Hilltop Institute, 2024).			

Table 97. MY 2022 MCO EPSDT Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↑	**Early and Periodic, Screening, Diagnostic, and Treatment**

Strength:

- All MCOs met the MDH-established minimum compliance threshold (80%) for total composite scores.
- All nine MCOs scored above minimum compliance (80%) for the component score and all elements comprising the Health Education/Anticipatory Guidance component. Specifically, component scores ranged from 94% (WPM) to 100% (JMS and KPMAS).
- All nine MCO component scores and the HeathChoice Aggregate score for each element comprising the Immunizations component exceeded minimum compliance (80%).

Improvement:

- The HealthChoice Aggregate total score has steadily increased from MY 2020 (91%) to MY 2022 (95%).
- The Laboratory Test/At-Risk Screenings component continues to display a substantial increase across MYs, improving two percentage points compared to MY 2021 and eight percentage points compared to MY 2020.
- All component scores in MY 2022 demonstrated sustained improvement from MY 2020, with a total increase of four percentage points to the HealthChoice Aggregate component score.
- The HealthChoice Aggregate score for the Immunizations component increased by nine percentage points from MY 2020 (86%) to MY 2022 (95%).
- The Immunizations component displays the most substantial increase, improving four percentage points compared to MY 2021, and nine percentage points compared to MY 2020.

Recommendation:

- Collaborate with the assigned state Healthy Kids/EPSDT Nurses to assist in re-educating providers on the Healthy Kids/EPSDT Program requirements and develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards.
- Prepare and encourage provider cooperation and assistance with audit review scheduling and supplying of records.
- Continue to 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.
- Continue to 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.
- Continue to reinforce preventive care standards as they apply to adolescents and young adults assigned to family practice and internal medicine PCPs.
- Continue to 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.

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↑	**Early and Periodic, Screening, Diagnostic, and Treatment**
• Continue to facilitate the transfer of medical, immunization, and laboratory records when a child is transferred to a newly assigned PCP within the MCO network. • Continue to 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. • Continue to refer to the local health department for assistance in bringing children in for missed healthcare appointments when other outreach efforts have been unsuccessful. • Continue to 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.			

Table 98. MY 2022 MCO GAD Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	Strengths, Improvements, and Recommendations
↑	↑	↑	**Grievances, Appeals, and Pre-Service Adverse Determinations**
Strength: • The level of compliance for all MCOs is helping to ensure the delivery of quality care and services to HealthChoice enrollees. • Timeliness of written acknowledgment of receipt of enrollee grievances and timely resolution, written notification of pre-service adverse determinations, and resolution of enrollee grievances and resolution letters. • Grievance resolution letters written in easy-to-understand language. • Appeals processed based on the level of urgency of enrollee appeal resolutions **Improvement:** • MCOs have shown improvement in reporting and regulatory compliance over the course of MY 2022. **Recommendation:** • Provide a greater explanation of data variances when submitting GAD quarterly reports. The reports have a place for this and not all MCOs use this section to aid in the analysis of data. All "Other" reason and service categories in the top five should clearly describe what "Other" issues are. • The number of provider grievances continues to be underreported 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, such as Provider Relations, Customer Service, Utilization Management, and Care Management. MCOs need to establish a cross-functional workgroup to address the various points of entry and develop a process for aggregating all grievances to support accurate reporting.			

Assessment of Previous Recommendations

During the course of conducting 2023 EQR activities, Qlarant evaluated MCO compliance in addressing previous annual recommendations.[18] Assessment outcomes, included in Tables 99-107, identify if the MCO adequately addressed 2021 recommendations. NAV is the only task that has MY 2022 recommendations and an MY 2023 assessment. Color-coded symbols specify the degree to which the MCOs addressed recommendations.

ABH

Table 99. ABH Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Actions(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Project Validation		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for ABH.		
Performance Measure Validation		
There were no formal MY 2021 recommendations for ABH.		
Systems Performance Review		
Add quarterly status update columns to the Internal Action Plan documents to more clearly document and track quarterly re-evaluation of the effects of steps taken to follow up on sources of enrollee dissatisfaction.	Component 5.5d met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Revise the timeframe for obtaining additional clinical information for standard preauthorization requests specified in the Desktop: (UM) Clinical Request for Additional Information and Extension from 2 calendar days to 2 business days to better accommodate weekends and holidays.	ABH revised and submitted Aetna Medicaid Administrators LLC Utilization Management Timeliness Standards and Decision Notification - Maryland Policy "Attachment A" which indicates if additional clinical information is required, it must be requested within two business days of receipt of the request. This additional information satisfies the requirements of component 7.4c.	↑
Enhance documentation of Special Investigations Unit investigations within the Compliance Committee meeting minutes.	Component 11.1e met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	

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

MY 2021 Recommendation	MY 2022 Assessment and Actions(s) Taken	Plan Addressed Recommendation(s)
Network Adequacy Validation		
ABH's score for urgent care compliance in MY 2022 was 80.1% - a 15 point decline since MY 2021 and just above the compliance threshold. ABH should address this area to ensure their compliance remains above 80%.	ABH's score for urgent care compliance in MY 2023 was 14.4 percentage points above (94.5%) its MY 2022 score (80.1%).	↑
Encounter Data Validation		
There were no formal MY 2021 recommendations for ABH.		
Early and Periodic Screening, Diagnosis, and Treatment		
Monitor the Laboratory Tests/At-Risk Screenings component for root causes in scoring below the MDH-established minimum compliance threshold of 80%.	ABH's score for the Laboratory Tests/At-Risk Screenings component remained consistent during MY 2022; however, there are continued opportunities for ABH to monitor low performance for specific elements that make up the component: Recorded Cholesterol Risk Assessment, 9-11 Year Dyslipidemia Lab Test, 18-21 Year Dyslipidemia Lab Test, Conducted Anemia Risk Assessment, 24 Month Anemia Test, 3-5 Year Anemia Test.	●
Monitor the Hearing Assessment element and Rotavirus (RV) element for root causes in significant declines in scoring.	ABH's scores for the Hearing Assessment element and Rotavirus element both demonstrated improvement from MY 2021 to MY 2022.	↑
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		
Retrain grievance staff on appropriate documentation requirements and grievance resolution.	ABH met compliance for both the record review and the quarterly/annual self-reported GAD data: • All grievance and appeal timeframes met for acknowledgment, resolution, and notification. • All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.	↑

MY 2021 Recommendation	MY 2022 Assessment and Actions(s) Taken	Plan Addressed Recommendation(s)
Audit case notes on a routine basis to ensure compliance with documentation standards and appropriate grievance resolution.	ABH met compliance for both the record review and the quarterly/annual self-reported GAD data: • All grievance and appeal timeframes met for acknowledgment, resolution, and notification. All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.	↑
Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for grievance acknowledgment letters, provider grievance resolutions, appeal resolution/notifications, and pre-service determinations. Increase the frequency and scope of monitoring until consistent compliance is demonstrated.	ABH met compliance for both the record review and the quarterly/annual self-reported GAD data: • All grievance and appeal timeframes met for acknowledgment, resolution, and notification. All timeframes met for pre-service determinations, prescriber notifications, and adverse determination notifications.	↑
Routinely audit a sample of appeal acknowledgment and resolution/notification letters, including those issues by delegated entities, to ensure the completeness and accuracy of content and ease of understanding.	Appeal acknowledgment and resolution letters are written in plain language, include required and correct content in all fields, and use proper grammar; however, continued recommendations exist for appeal acknowledgment letters. It is recommended that the statement that the enrollee has requested to continue receiving services while their appeal is being reviewed should be revised to reflect the right of the enrollee to continuation of benefits and potential member liability if the denial is upheld.	⊙

↑ MCO addressed the recommendation; ⊙ MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

CFCHP

Table 100. CFCHP Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Project Validation		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for CFCHP.		

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Measure Validation		
There were no formal MY 2021 recommendations for CFCHP.		
Systems Performance Review		
Revise the section of the Disaster Recovery Plan at the end of document, "Version Information & Changes," to reflect the need for an annual update of the plan. Also, it should be clarified in the Disaster Recovery Plan, which CFCHP committee is accountable for the review and approval of the document.	Element 1.10 met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Place taglines on the Nondiscrimination Notice displayed at events when CFCHP interacts with the public.	CFCHP did not adequately adhere to the recommendation for component 5.8d during MY 2022 and continued opportunities exist. CFCHP must provide evidence of notices and taglines being posted in conspicuous physical locations, where appropriate, when interacting with the public.	↓
Revise the Emergency Services Policy to state that coverage and payment provisions for emergency and post-stabilization services are communicated within the enrollee handbook and the provider manual.	Element 6.4 met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Include in the Member Appeals Policy that no punitive action will be taken against a provider for supporting an enrollee's appeal or for requesting expedited resolution for an enrollee's appeal.	CFCHP adequately adhered to the recommendation for component 7.7a by revising the Member Appeals Policy.	↑
Include information about fraud detection and reporting in provider newsletters, new provider orientation, and subcontractor Business Associate Agreements, if it is not included.	Component 11.2d met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Use a consistent format for reporting delegate fraud, waste, and abuse activities. This may alleviate confusion and prevent underreporting.	CFCHP did not adhere to the recommendation for component 11.4d. This recommendation remains for MY 2022.	↓
Include information about fraud detection and reporting in enrollee newsletters.	Component 11.2e met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Network Adequacy Validation		
The phone number listed in CFCHP's online provider directory does not align with the phone number obtained during the telephone survey (70.9%). CFCHP must submit a CAP to achieve compliance in the MY 2023 validations and ensure staff responses regarding the PCP's phone number align with information provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.	After expanding its contract with Atlas, CFCHP implemented continuous validation of online provider directory information. This best practice resulted in significant improvement by 21.7 percentage points (70.9% in MY 2022 to 92.6% in MY 2023) in the accuracy of provider telephone numbers in the online provider directory.	↑
Encounter Data Validation		
There were no formal MY 2021 recommendations for CFCHP.		
Early and Periodic Screening, Diagnosis, and Treatment		
Monitor the Laboratory Tests/At-Risk Screenings component for root causes in the declining scores that are below the MDH-established minimum compliance threshold of 80%.	CFCHP's score for the Laboratory Tests/At-Risk Screenings component remained consistent during MY 2022 at 80%; however, there are continued opportunities for CFCHP to monitor low performance for various elements that make up the component.	⊙
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		
Revise the Member Grievances Policy to specify a timeframe for providing the enrollee with a written resolution of their grievance.	CFCHP revised the Member Grievances Policy to specify a timeframe for providing the enrollee with a written grievance resolution following the resolution of the grievance.	↑
Monitor timeliness of mailing of grievance and appeal acknowledgment letters on a routine basis.	CFCHP did not demonstrate compliance during the record review for timeliness of grievance and appeal acknowledgment letters.	↓
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.	No denials of a request for an expedited appeal resolution were found in the sample review of ten appeal records. Additionally, no denials were found within the additional 20 records reviewed. This component will be reviewed again in the next annual review since there were no cases found in the MY 2022 sample.	

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Ensure an effective process is in place for monitoring compliance with regulatory timeframes for provider grievances and pre-service determinations. Increase the frequency and scope of monitoring until consistent compliance is demonstrated.	Although CFCHP demonstrated consistent compliance with regulatory timeframes for pre-service determinations during MY 2022, opportunities still exist for grievances.	◎

↑ MCO addressed the recommendation; ◎ MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

JMS

Table 101. JMS Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Project Validation		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for JMS.		
Performance Measure Validation		
There were no formal MY 2021 recommendations for JMS.		
Systems Performance Review		
There were no formal MY 2021 recommendations for JMS.		
Network Adequacy Validation		
JMS was required to submit a CAP to address findings in the MY 2021 validations and ensure staff responses regarding accepting new Medicaid patients for the MCO align with the information provided in the online directory. Results from the MY 2022 online directory validation did not demonstrate that JMS met compliance with this requirement. Alignment of responses regarding acceptance of new Medicaid patients with information provided in the online directory further declined from MY 2021 (79%) to MY 2022 (75.5%). JMS must submit a CAP to achieve compliance in the MY 2023 validations and ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory.	Due to multiple years of not meeting this requirement, JMS must submit a quarterly CAP to achieve compliance in the MY 2024 validations to address the following: • Ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. JMS should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.	↓

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
The percentage of JMS PCPs with information in the online directory regarding their practice's accommodations for patients with disabilities fell below the MY 2022 compliance threshold of 80% (70.9%). JMS must submit a CAP to achieve compliance in the CY 2023 validations and ensure PCP's online provider directories include information regarding their practice's accommodations for patients with disabilities.	After implementing corrective action for MY 2022, JMS significantly improved "Practice has Accommodations for Patients with Disabilities (with specific details)" by 28.2 percentage points (70.9% in MY 2022 to 99.1% in MY 2023).	↑
Encounter Data Validation		
There were no formal MY 2021 recommendations for JMS.		
Early and Periodic Screening, Diagnosis, and Treatment		
There were no formal MY 2021 recommendations for JMS.		
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		
Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.	JMS met compliance for all pre-service determinations, prescriber notifications, and adverse determination notifications timeframes.	↑

↑ MCO addressed the recommendation; ⊙ MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

KPMAS

Table 102. KPMAS Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Project Validation		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for KPMAS.		
Performance Measure Validation		
There were no formal MY 2021 recommendations for KPMAS.		
Systems Performance Review		
Retrain grievance staff on correct categorization of grievances and establish regular audits to ensure grievances are being correctly categorized.	KPMAS did not provide evidence that it adequately addressed the recommendation during MY 2022 for component 5.1g as continued opportunities exist. KPMAS must demonstrate compliance with timeframes for grievance acknowledgment and	⊙

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
	resolution at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.	
Outline in writing and demonstrate how KPMAS tracks enrollee feedback from consumer advisory board (CAB) meetings.	Component 5.7c met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Include fraud, waste, and abuse reporting in the member newsletter and investigate options for placing information in the clinic sites.	Component 11.2e met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Network Adequacy Validation		
KPMAS was required to submit a CAP to address findings in the MY 2021 validations and ensure staff responses regarding accepting new Medicaid patients for the assigned MCO aligned with information provided in the online directory. The MY 2022 validation demonstrated that although KPMAS' MY 2021 CAP proposed solutions to address the above issues, the online directory still does not reflect the required changes to staff awareness with accepting new Medicaid patients for the assigned MCO; thus, KPMAS did not score above the 80% compliance threshold for this category for CY 2022 (74.1%). KPMAS must submit a CAP to achieve compliance in the MY 2023 validations and ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with information provided in the online directory.	After implementing corrective action for MY 2022, KPMAS improved acceptance for new Medicaid patients by 6.5 percentage points (74.1% in MY 2022 to 80.6% in MY 2023).	↑
Encounter Data Validation		
There were no formal MY 2021 recommendations for KPMAS.		
Early and Periodic Screening, Diagnosis, and Treatment		
Monitor the Recorded Maternal Depression Screening element and the Recorded Developmental Screening Tool element for root causes in the significant decline in scoring from MY 2020 to MY 2021.	Compared to MY 2021, KPMAS' MY 2022 scores for the Recorded Maternal Depression Screening (100%) and the Recorded Developmental Screening Tool (100%) elements demonstrated significant improvements in scores by 32 and 19 percentage points, respectively.	↑

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		
Consider conducting a root cause analysis of service/attitude-related enrollee grievances to identify opportunities for improvement.	Service/attitude-related enrollee grievances continues to be a top reason code for KPMAS, which differs from other MCOs.	↓
Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for grievance resolutions, appeal acknowledgment letters, appeal resolutions/notifications, and adverse determination notifications. Increase the frequency and scope of monitoring until consistent compliance is demonstrated.	KPMAS demonstrated compliance with all regulatory timeframes for grievance resolutions, appeal acknowledgment letters, appeal resolutions/notifications, and adverse determination notifications.	↑
Retrain grievance staff on the assignment of enrollment grievances to the appropriate category (emergency medically-related, non-emergency medically-related, and administrative).	KPMAS demonstrated appropriate categorization of grievances.	↑

↑ MCO addressed the recommendation; ○ MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

MPC

Table 103. MPC Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Project Validation		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for MPC.		
Performance Measure Validation		
There were no formal MY 2021 recommendations for MPC.		
Systems Performance Review		
Use the Key Indicator Report for tracking and monitoring compliance with turnaround times for written grievance acknowledgment and resolution.	Component 5.1g met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Revise the timeframes for sending a written resolution for urgent and routine administrative grievances, in the Member Grievance Process Policy, to clarify the timeframe is from the receipt of the grievance. Additionally, it is recommended that	MPC adequately adhered to MY 2021's recommendation for component 5.1h. Enrollee Grievance Process Policy	↑

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
MPC consider the use of the Key Indicator Report for tracking and monitoring compliance with timeframes established by MPC for written grievance resolution.	indicates MPC provides a written response to enrollee grievances in the form of a resolution letter within the required timeframes. The Key Indicator Reports tracks the compliance timeframes and a sample review of ten member grievances affirmed compliance.	
Include the grievance resolution within the requirement for providing a description of the grievance in easily understood language in the Member Grievance Process Policy.	Component 5.1i met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Network Adequacy Validation		
MPC was required to submit a CAP to address findings in the MY 2021 validations and ensure staff responses regarding accepting new Medicaid patients for the assigned MCO aligned with information provided in the online directory. The MY 2022 validation demonstrated that the online directory still does not reflect the required changes to staff awareness with accepting new Medicaid patients for the assigned MCO; thus, MPC did not score above the 80% compliance threshold for this category in MY 2022 (70.3%). MPC must submit a CAP to achieve compliance in the MY 2023 validations and ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with information provided in the online directory.	After implementing corrective action for MY 2022, MPC significantly improved acceptance for new Medicaid patients by 15.2 percentage points (70.3% in MY 2022 to 85.5% in MY 2023). MPC's provider directory easily identified the phone number for member services at the top of the web page.	↑
Encounter Data Validation		
There were no formal MY 2021 recommendations for MPC.		
Early and Periodic Screening, Diagnosis, and Treatment		
Monitor the Recorded Maternal Depression Screening for root causes in scoring not meeting the MDH-established minimum compliance threshold of 80%.	The Maternal Depression Screening element remained below the MDH-established threshold; therefore, the recommendation for this element remains.	↓

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Monitor the Conducted Lead Risk Assessment element for root causes in the significant decrease of seven percentage points from MY 2020 (90%) to MY 2021 (86%).	MPC's score for the Conducted Lead Risk Assessment element remained the same from MY 2021 to MY 2022.	◉
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		
Ensure an effective process is in place for monitoring compliance with all regulatory timeframes for written appeal acknowledgments and appeal resolutions/notifications. Increase the frequency and scope of monitoring until consistent compliance is demonstrated.	MPC demonstrated compliance with appeal timeframes for acknowledgment, resolution, and notification.	↑

↑ MCO addressed the recommendation; ◉ MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

MSFC

Table 104. MSFC Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Project Validation		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for MSFC.		
Performance Measure Validation		
There were no formal MY 2021 recommendations for MSFC.		
Systems Performance Review		
Update policies and procedures supporting compliance monitoring in order to reference the Corrective Action Policy for guidance.	Component 6.3c met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Network Adequacy Validation		
Results from the MY 2022 telephone survey indicate MSFC did not meet the compliance threshold of 80% for providing routine care appointments within 30 days. Furthermore, the percentage of MSFC PCPs meeting this requirement declined by ten percentage points from MY 2021 (88.4%) to MY 2022 (78.4%). MSFC must submit a CAP to achieve compliance in the MY 2023 validations and ensure routine care appointments are made with the requested provider, or another provider, within the 30-day timeframe.	MSFC has implemented an internal secret shopper campaign requiring corrective action for provider offices found to be noncompliant with routine care appointment timeframes. This best practice resulted in a significant improvement by 13.3 percentage points (78.4% in MY 2022 to 91.7% in MY 2023)	↑

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
	in compliance with the routine care appointment timeframe.	
Encounter Data Validation		
There were no formal MY 2021 recommendations for MSFC.		
Early and Periodic Screening, Diagnosis, and Treatment		
Monitor the Conducted Anemia Risk Assessment element, Recorded Maternal Depression Screening element, and Documented Referral to Dentist element for root causes in decreases in scoring.	MSFC's scores for each component improved significantly from MY 2021 to MY 2022.	↑
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		
Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with enrollee appeal resolution/notification timeframes and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.	MSFC demonstrated compliance for enrollee appeal resolution/notification timeframes and adverse determination notifications.	↑

↑ MCO addressed the recommendation; ◌ MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

PPMCO

Table 105. PPMCO Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Project Validation		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for PPMCO.		
Performance Measure Validation		
There were no formal MY 2021 recommendations for PPMCO.		
Systems Performance Review		
Update the COMAR reference for the definition of a specialty drug to 10.67.06.04 in the MDH Unified Corrective Managed Care Program Policy.	Component 7.11a met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Include information about the Screening, Brief Intervention, and Referral to Treatment process and Release of Information procedures in new provider orientation programs and in provider newsletters.	Element 8.6 met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Review the method used for reporting on homeless individuals to ensure accuracy.	PPMCO's outreach plan sufficiently included the total amount of homeless individuals, homeless member outreach events, and plans to bring homeless members into care, which satisfies the recommendation for component 10.1a.	↑
Network Adequacy Validation		
PPMCO was required to submit a CAP to address findings in the MY 2021 validations and ensure staff responses regarding accepting new Medicaid patients for the assigned MCO aligned with information provided in the online directory. The MY 2022 validation demonstrated that PPMCO's online provider directory still does not reflect the required changes to staff awareness with accepting new Medicaid patients for the assigned MCO; thus PPMCO did not score above the 80% compliance threshold for this category in MY 2022. PPMCO must submit a CAP to achieve compliance in the CY 2023 validations and ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with responses provided in the online directory.	Due to multiple years of not meeting this requirement, PPMCO must submit a quarterly CAP to achieve compliance in the MY 2024 validations to ensure staff responses regarding accepting new Medicaid patients for the assigned MCO are aligned with information provided in the online directory.	↓
Encounter Data Validation		
There were no formal MY 2021 recommendations for PPMCO.		
Early and Periodic Screening, Diagnosis, and Treatment		
Monitor the Vision and Hearing Assessment elements in the Comprehensive Physical Exam component for root causes for decrease in performance.	PPMCO's scores for the Vision and Hearing Assessment elements improved by four and five percentage points respectively.	↑
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		
Retrain staff on the appropriate categorization of grievances.	PPMCO demonstrated appropriate categorization of grievances.	↑
Conduct a root cause analysis and implement associated action plans to ensure compliance with enrollee grievance resolution timeframes.	All grievance timeframes were met for acknowledgment, resolution, and notification.	↑

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Retrain appeal staff and conduct routine audits on appeal case documentation requirements, including verbal notification of an expedited resolution.	Although timeframes for expedited appeal resolution/notification were 100% and 96% for standard appeal resolution/notification, continued opportunities exist for PPMCO to demonstrate consistent compliance with oral notifications to enrollees of expedited appeal resolutions.	

↑ MCO addressed the recommendation;  MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

UHC

Table 106. UHC Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Projects		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for UHC.		
Performance Measure Validation		
There were no formal MY 2021 recommendations for UHC.		
Systems Performance Review		
Establish one independent review organization (IRO) policy and procedure that addresses all aspects of the IRO process. This may eliminate the inconsistencies with having more than one policy and procedure.	UHC did not adhere adequately to the recommendation in MY 2021 for element 7.10, and a continued opportunity still exists. UHC must provide a documented process that is designed to assure IRO invoices are paid within the 60-day timeframe required by COMAR. This could be added to either the Provider Grievance and Appeal Policy or a desktop procedure and include, for example, communication and follow-up on a routine basis with the Accounts Payable Department to ensure all IRO invoices are paid within 60 days of receipt.	↓
Network Adequacy Validation		

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Findings from MY 2022's validations identified that UHC's online provider directory did not appropriately demonstrate compliance with indicating the providers who are accepting new Medicaid patients for the assigned MCO (76.8%). UHC must submit a CAP to achieve compliance in the MY 2023 validations and ensure staff responses regarding accepting new Medicaid patients for the assigned MCO align with information provided in the online directory.	Due to multiple years of not meeting this requirement, UHC must submit a quarterly CAP to achieve compliance in the MY 2024 validations to ensure staff responses regarding accepting new Medicaid patients for the assigned MCO are aligned with information provided in the online directory.	↓
Encounter Data Validation		
There were no formal MY 2021 recommendations for UHC.		
Early and Periodic Screening, Diagnosis, and Treatment		
Monitor Laboratory Tests/At-Risk Screenings for root causes in the decrease of performance from MY 2020 to MY 2021 to improve the overall component score to be above the MDH-established minimum compliance threshold (80%). UHC should also focus on the Recorded STI/HIV Risk Assessment element for root causes for the significant decline of 21 percentage points from MY 2020 to MY 2021.	UHC's score for Laboratory Tests/At-Risk Screenings improved by six percentage points to 83% (three points above the MDH-established minimum compliance threshold). The Recorded STI/HIV Risk Assessment element (93%) demonstrated significant improvement compared to MY 2021 with an increase of 15 percentage points.	↑
Monitor the Health and Developmental History component's Depression Screening element for root causes in the significant decline from MY 2020 to MY 2021.	The Depression Screening element had the most significant improvement for the Health and Developmental History component of 17 percentage points from MY 2021 (72%) to MY 2022 (89%).	↑
Monitor the Comprehensive Physical Exam component's Vision Assessment element score for root causes in the significant decline from MY 2020 to MY 2021.	The Vision Assessment element (93%) improved by four percentage points when compared to MY 2021.	↑
Monitor the Health Education/Anticipatory Guidance element, Documented Referral to Dentist, for root causes for the significant decline from MY 2020 to MY 2021.	The Documented Referral to Dentist element demonstrated a significant increase of 17 percentage points from MY 2021 (74%) to MY 2022 (91%).	↑
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Conduct a root cause analysis and implement associated action plans to ensure consistent compliance with grievance acknowledgment letters, appeal acknowledgment letters, and appeal resolution/notification timeframes. Increase the frequency and scope of monitoring until consistent compliance is demonstrated.	UHC demonstrated improvement with consistent compliance in meeting the timeframe for written acknowledgment of receipt of enrollee grievance.	↑
Consider including a more detailed description of the grievance in the enrollee acknowledgment letters.	UHC demonstrated strength by appropriately categorizing and resolving all grievances. Comprehensive case notes document grievance, investigation, and resolution. Letters were written in easy-to-understand language and described grievance and resolution. In particular, paraphrasing the member's grievances in his or her own words reflects member's concern is heard and understood.	↑
Educate appeal staff on dating appeal receipt as the date the provider filed on behalf of the enrollee.	UHC demonstrated improvement during MY 2022 for the date of appeal is the date the provider filed on behalf of the enrollee, not the date of enrollee consent.	↑

↑ MCO addressed the recommendation; ◎ MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

WPM

Table 107. WPM Assessment of Previous Annual Recommendations

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Performance Improvement Project Validation		
Due to a change in MY 2022 PIP topics, there are no formal MY 2021 PIP recommendations for WPM.		
Performance Measure Validation		
There were no formal MY 2021 recommendations for WPM.		
Systems Performance Review		
Establish a performance threshold for the provider site visit scoring tool. This will facilitate performance improvements,	Element met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
should an office not comply with the required performance level.		
Revise the Member Grievances – MD Policy to explicitly address the requirement for documentation of the resolution of a grievance in the enrollee's case record.	Component 5.1c met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Include in its report of grievances to the Quality Management Committee (QMC) compliance with grievance acknowledgment and grievance resolution letters, in addition to its reporting of grievance resolution.	Component 5.1g met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Post notices and taglines, where appropriate, in conspicuous physical locations when WPM interacts with the public.	WPM did not meet compliance for component 5.8d and opportunities for improvement still exist. WPM must provide evidence of posted notices and taglines during public interactions, in conspicuous physical locations.	↓
Update WPM's policies to remove Maryland Market Watch, as WPM stated this no longer exists.	Component 6.1d met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Revise the Member Satisfaction Survey and the Practitioner/Provider Satisfaction Survey, policies to clarify the process for analyzing and responding to opportunities for improvement from the MDH-coordinated surveys, including reporting of results, development of action plans, and ongoing monitoring of improvement initiatives and its frequency, by the appropriate department(s) and quality committee(s) at the health plan level.	Component 7.9a met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Conduct a more timely review of CAHPS® and Provider Satisfaction Survey results, and development of action plans, to potentially impact subsequent years' results.	Component 7.9b met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Include more recent data regarding the number of enrollees in each of the special populations in the Outreach Plan.	Component 10.1a met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Include methods for provider referrals of potential fraud, waste, and abuse (FWA) in provider newsletters, at least semi-annually.	Component 11.2c met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Add an easy-to-access section on FWA to the provider website.	Component 11.2d met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Add information on FWA to member newsletters at least semi-annually.	Component 11.2e met compliance during MY 2021. This recommendation will be reviewed during the next comprehensive review.	
Network Adequacy Validation		
WPM's online provider directory does not appropriately demonstrate compliance with indicating the providers who are accepting new Medicaid patients for the assigned MCO (77.9%). WPM must submit a CAP to achieve compliance in the MY 2023 validations and 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.	WPM has implemented a Provider Self-Service Tool that allows providers to directly update demographic information. This best practice resulted in an improvement of 3.9 percentage points (77.9% in MY 2022 to 81.8% in MY 2023) in compliance with "Specifies PCP Accepts New Medicaid Patients & Matches Survey Response."	↑
Encounter Data Validation		
There were no formal MY 2021 recommendations for WPM.		
Early and Periodic Screening, Diagnosis, and Treatment		
Monitor Recorded Maternal Depression Screening, 18-21 Year Dyslipidemia Lab Test Score, HPV, Vision Assessment, and Hearing Assessment elements for root causes in the significant decline from MY 2020 to MY 2021.	WPM demonstrated improvements in scoring for the 18-21 Year Dyslipidemia Lab Test Score, HPV, Vision Assessment, and Hearing Assessment elements; however, findings demonstrate a further decline in performance for Recorded Maternal Depression Screening.	⊙
Monitor the Health and Developmental History, Laboratory Tests/At-Risk Screenings, and Immunizations components for elements that scored below the MDH-established minimum compliance threshold for root causes.	Component scores for Health and Developmental History, Laboratory Tests/At-Risk Screenings, and Immunizations demonstrated improvements from MY 2021 to MY 2022.	↑
Grievances, Appeals, and Denials Focused Study		
Grievance Acknowledgement and Resolution Notification		
Revise the Member Grievances – MD Policy to specify a timeframe for providing the enrollee with a written resolution of their grievance.	This recommendation continues to be an opportunity for improvement for WPM.	↓

MY 2021 Recommendation	MY 2022 Assessment and Action(s) Taken	Plan Addressed Recommendation(s)
Retrain grievance staff on the appropriate categorization of grievances (emergency medically-related, non-emergency medically-related, and administrative).	Appropriate categorization of grievances continues to be an opportunity for improvement.	↓
Conduct a barrier analysis and implement associated action plans to ensure compliance with all regulatory timeframes for enrollee appeals, pre-service determinations, and adverse determination notifications. Increase frequency and scope of monitoring until consistent compliance is demonstrated.	WPM demonstrated the following: • Initial, then consistent compliance with expedited appeals resolution timeframes. • Consistent compliance with timeframes for resolution/notification of enrollee appeals. • Consistent compliance with timeframes for adverse determination notifications.	↑
Work with the pharmacy vendor to ensure the use of plain language and the most recent adverse determination letter template in letters. Routinely audit a sample of adverse determination letters to ensure compliance.	WPM demonstrated improvement in the use of the current letter template and easy-to-understand language in pharmacy adverse determination letters.	↑

↑ MCO addressed the recommendation; ◎ MCO did not fully address the recommendation; ↓ MCO did not address the recommendation.

State Recommendations

As identified in the introduction of this report, the State aims to deliver high quality, accessible care to managed care members. To achieve this goal, MDH developed a framework to focus quality improvement efforts for the managed care programs. Table 108 identifies goals and objectives described in the *HealthChoice Quality Strategy*.

Table 108. HealthChoice Program Goals and Objectives

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

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

Source: *HealthChoice Quality Strategy*

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

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

Performance Improvement Project Validation

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

Performance Measure Validation

The following are MetaStar's recommendations for HEDIS MYs 2023 and 2024:

- MetaStar advises to keep the impact of the pandemic in focus with any year-over-year comparisons of HEDIS data for the foreseeable future. Challenges related to the COVID variants that continue to pop up did not have the impact on healthcare delivery as was observed during HEDIS MYs 2020 and 2021. Normalization of measure rates have been observed for some performance measures.

- MetaStar continues to encourage MCOs to work towards reporting ECDS measures voluntarily, even if they are not yet required to do so. Starting in HEDIS MY 2023, some HEDIS measures will only have an ECDS reporting option, and NCQA is expected to continue a transition to ECDS-only reporting. If MCOs choose to report ECDS measures voluntarily, MCOs will gain a level of comfort in reporting these measures prior to any requirement to do so, or when ECDS is the only option for reporting certain measures moving forward.
- MetaStar recommends that MDH explore allowing MCOs to contract directly with behavioral health vendors to enable better coordination of care between physical and mental health providers and potentially improve outcomes. Utilizing this approach would enable the MCOs to more directly enforce contract requirements for providing the data needed for HEDIS reporting efforts, as the MCOs hold the contract with the vendor.
- MetaStar encourages MDH to explore ways to improve the completeness of race and ethnicity data provided to the MCOs to meet expected completeness thresholds that NCQA may implement in years to come. NCQA's intention is to enable the evaluation of race and ethnicity strata for screening/prevention, behavioral health, and respiratory conditions in order to identify social determinants of health and their impact on these groups. The stratification reporting measure set continues to expand, making it even more important for the MCOs to obtain complete and accurate race and ethnicity data to the extent possible. MY 2023 specifications require race and ethnicity stratification reporting for the following measures:
    - Controlling High Blood Pressure (CBP)
    - Hemoglobin A1c Control for Patients with Diabetes (HBD)
    - Prenatal and Postpartum Care (PPC)
    - Child and Adolescent Well Care Visits (WCV)
    - Immunizations for Adolescents (including IMA-E)
    - Colorectal Cancer Screening (including COL-E)
    - Asthma Medication Ratio (AMR)
    - Follow-Up After Emergency Department Visit for Substance Use (FUA)
    - Pharmacotherapy for Opioid Use Disorder (POD)
    - Initiation and Engagement of Substance Use Disorder Treatment (IET)
    - Well-Child Visits in the First 30 Months of Life (W30)
    - Breast Cancer Screening (BCS-E)
    - Adult Immunization Status (AIS-E)

Network Adequacy Validation

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

Encounter Data Validation

- Encourage MCOs to conduct internal investigations/audits in order to determine the cause of office visit encounter match rate decline and monitor the MCO root causes. Although MDH has achieved its Objective 4 goal of increasing the HealthChoice aggregate scores to at least 90% by MY 2024, MDH has set a specific EDV target goal at 99% match rates. At this time, office visit encounters are not meeting that target goal.
- Work with the MCOs to instill best practices to improve their numbers of rejected encounters (The Hilltop Institute, 2024).
- Consider evaluating each MCO's sub-capitation arrangements with other organizations and comparing those arrangements with the MCO's use of the sub-capitation indicator (The Hilltop Institute, 2024).
- Monitor the MCOs' TPL-reported amounts (The Hilltop Institute, 2024).
- Continue to monitor and work with the MCOs to resolve the provider enrollment data problems as the volume of rejected encounters remains high (The Hilltop Institute, 2024).
- Continue to work with the MCOs to ensure appropriate utilization and improvement in the accuracy of the payment field on accepted encounters (The Hilltop Institute, 2024).
- Continue to encourage MCOs to work with their providers to ensure that they are enrolled on the date of service and that they know how to check their current status to address the high volume of rejected encounters (The Hilltop Institute, 2024).
- Continue to monitor monthly submissions to evaluate consistency and ensure that the MCOs submit data in a timely manner (The Hilltop Institute, 2024).
- Continue to monitor PCP visits by MCOs in future encounter data validations. (The Hilltop Institute, 2024).

- Continue to review the service type analysis data and compare trends in future annual encounter data validations to ensure consistency (The Hilltop Institute, 2024).
- Continue to review and audit the participant-level, MCO-specific reports that Hilltop generated for delivery, dementia, individuals over age 65, pediatric dental, and missing age outlier data measures (The Hilltop Institute, 2024).

Early and Periodic Screening, Diagnosis, and Treatment

- Consider an alternate methodology to improve the medical record review process.
- Encourage MCOs performing below the MDH-established compliance threshold to perform frequent monitoring of the quality of clinical care provided to all children younger than 21 years old enrolled in the HealthChoice program.
- Consider resuming implementation of corrective action at the provider level in addition to MCO level for underperformance in accordance with COMAR 10.67.04.03.5b.
- Consider monitoring the Laboratory Tests/At-Risk Screenings component for root causes in performance as it is still scoring below MDH's quality strategy target goal percentage of 87%.

Grievance, Appeal, and Denial Focused Study

- Continue to explore options with Qlarant and the MCOs to reduce the complexity/redundancy of the GAD data collection process.

  Examples to consider:
  - Conduct a crosswalk of SPR standards with quarterly GAD reporting data to determine where redundancies can be eliminated.
  - Consider eliminating the annual GAD record review currently performed as part of the SPR. Align the record review with the quarterly GAD review to provide more real time results.
  - Identify the most relevant GAD metrics to monitor on a quarterly and annual basis. These should be meaningful data that the MCOs and MDH can act upon to make improvements (i.e., those required by regulatory bodies and those that may adversely affect enrollee access to medically necessary services). These could include, for example, all clinically related grievances, appeals, and denials, timeliness metrics, denial and appeal rates, decisions to uphold or overturn as well as monitoring appeals and denials. Performance thresholds should be developed for each metric and should be evidence-based or based on historical MCO data.
- Convene a meeting with Qlarant and the MCOs to obtain feedback on the GAD process. Identify systemic barriers hindering the accuracy of data entry and aspects of the process that are working well. Clarify all performance requirements and expectations.
- Initiate a more real time corrective action plan process for GAD. Corrective action plans (CAPs) must be based upon clearly defined performance metrics, such as the 95% threshold MDH currently has in place, to monitor GAD timeliness metrics.

- Consider making GAD a PIP that can be structured and consistent in its implementation. The process is familiar to the MCOs and requires ongoing monitoring by the EQRO and MDH.

Conclusion

As Maryland's contracted EQRO, Qlarant evaluated the HealthChoice managed care program to assess compliance with federal and state-specific requirements. Review and validation activities occurred over the course of 2023 and assessed MY 2022 and MY 2023 performance, as applicable.

The MCOs provided evidence of meeting almost all federal, state, and quality strategy requirements. Overall, the MCOs are performing well. MCOs are actively working to address deficiencies identified during the review. The MCOs can trend performance to gauge where it meets and exceeds requirements and to identify opportunities for improvement. By implementing interventions and addressing these opportunities, the MCOs will improve in the areas of quality, access, and timeliness of care for the Maryland HealthChoice Program population.

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

Appendices Introduction

MCO-Specific Summaries

MCO profiles and summary findings are based on the quality assurance activities that took place in MYs 2022 to 2023 for the Maryland HealthChoice program. Tables 107 to 115 of **Appendix A** serve as a profile summary for each MCO and identify strengths, improvements, and recommendations, as applicable. Each table also identifies positive or negative impacts on quality, access, and timeliness as strengths, improvements, or recommendations. These profiles are extensions of content from the **MCO Quality, Access, and Timeliness Assessment** section.

SPR Standards and Guidelines

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

Hilltop's MY 2022 Encounter Data Validation Report

MDH has an interagency governmental agreement with the Hilltop Institute at the University of Baltimore County (Hilltop) to serve as the data warehouse for its encounters. MDH elected to contract with Hilltop to analyze and evaluate the validity of encounter data in order to complete Activity 3 (analyzing MCO electronic encounter data for accuracy and completeness). Hilltop performed an evaluation of all electronic encounter data submitted by the MCOs for MYs 2020 to 2022 to determine the validity of the encounter data and ensure the data are complete, accurate, and of high quality. The full report of Hilltop's encounter data validation can be found in **Appendix C**.

2023 Final IRS and Methodology

Appendix D explains the reporting strategy and analytic methods Qlarant used in developing the report card that MDH released in 2023, based on data reported from the MCOs in MY 2021. The information reporting strategy explains the criteria used to determine the most appropriate and effective methods of reporting quality information to Medicaid enrollees, the intended target audience. The analytic method provides a statistical basis and the analysis method used for reporting comparative MCO performance.

Report Reference Page

Appendix E identifies task-specific reports provided by Qlarant and provides webpage links to access additional findings and comprehensive details associated with these reports.

Appendix A: MCO-Specific Summaries

Tables 109 through 117 highlight strengths, improvements, and recommendations summarizing performance per MCO. Identified strengths, improvements, and recommendations correspond to the quality, access, and/or timeliness of services delivered to MCO enrollees. Applicable domains for each strength, improvement, or recommendation are identified with a (↑) or (↓), indicating a positive or negative impact. Not all domains were impacted by each strength, improvement, or recommendation. Where appropriate, recommendations include opportunities.

Table 109. ABH Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	ABH Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	NA	**Strengths:** • ABH's performance score of 88% resulted in a confidence level of *Confidence* for the prenatal care PIP and a performance score of 91% resulted in a confidence level of *High Confidence* for the postpartum care-related PIP. • Continues to demonstrate and enhance efforts toward incorporating a health equity focus within its interventions. Interventions are assessed following the PDSA cycle and barriers have been identified on the member, provider, and MCO levels. • Conducted a disparity analysis stratified by race/ethnicity and by geographic data for each strategy. Data was reviewed on a quarterly basis. • Identified the planned activities for calendar year 2024.
NA	NA	NA	**Improvements:** • ABH did not demonstrate improvement from the previous MY.
↓	↓	NA	**Recommendations:** • Accurately identify whether a sample was studied versus the entire population for each strategy. The sampling methodology must identify if sampling was used. • Describe how each component of CLAS standards has been incorporated in the development of each intervention.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	NA	↑	**Strengths:** ***MetaStar observed the following strengths:*** • Provided a standardized and well-document HEDIS MY 2022 Roadmap on time, which greatly facilitated both offsite and virtual phases of the HEDIS Compliance Audit. No issues were identified with ABH's completion of the Roadmap General Information or Appendix sections. • Provided all required documents, databases, and rate files on or before the required deadlines. ABH also provided all requested audit follow-up items in a timely manner.

Quality	Access	Timeliness	ABH Strengths, Improvements, and Recommendations
			• Utilized a software vendor with NCQA-certified measures. The auditor confirmed that the certified version of the software was used for each measure by ensuring the IDSS did not produce any warnings regarding the GUIDs. • NCQA did not identify any Tier 4 warnings for ABH. • Maintained excellent communication with the auditor throughout the audit process, and alerted the auditor with any concerns that could potentially impact the audit.
NA	**NA**	**NA**	**Improvements:** • ABH did not demonstrate improvement from the previous MY.
↓	↓	**NA**	**Recommendations:** ***MetaStar recommends the following actions:*** • Continue working with MDH to obtain better race and ethnicity data. ABH's race and ethnicity data appeared better than in previous years; however, there is still a large percentage of enrollees with unknown race and ethnicity. • Continue exploring reasons for any low-reported rates to improve future HEDIS reporting. The auditor solicited further explanation for rates that fell below the 10th percentile or that changed by more than five percentage points from the previous MY.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
↑	**NA**	**NA**	**Strengths:** • Annual evaluation of ABH's Health Education Program is extremely comprehensive in scope and includes an assessment of its success in achieving goals, both activity and process-based, and identification of barriers to success and opportunities for improvement in the coming year.
↑	**NA**	↑	**Improvements:** • Turnaround time (TAT) compliance for grievance acknowledgment and resolution exceeded the 95% threshold throughout 2022. • A sample review of ten enrollee grievance resolution letters found all were written in easy-to-understand language.
↓	↓	↓	**Recommendations:** • Review Member Services call records and written grievances to ensure grievances are appropriately categorized. It is highly unlikely that no emergency medically-related or non-emergency medically-related grievances were received in an entire year. • Document the specific language utilized within the provider manual in other documents provided as evidence of compliance, such as the Practitioner and Provider Performance Data Policy.

Quality	Access	Timeliness	ABH Strengths, Improvements, and Recommendations
			• Promote positive health outcomes for enrollees receiving health education services as a means to facilitate provider referrals for health education, such as pre- and post-utilization of emergency room and inpatient care for enrollees receiving health education related to a diagnosis of diabetes.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	↑	**Strengths:** • ABH's scores for compliance with routine and urgent care appointment timeframes were approximately 14 to 17 percentage points above the 80% threshold established by MDH. • ABH scored above the 80% threshold in all online validation categories for MY 2023.
NA	**NA**	**NA**	**Improvements:** • ABH did not demonstrate improvement from the previous MY.
↓	↓	**NA**	**Recommendations:** • ABH should consider reviewing the root causes for the decline in performance compared to MY 2022 and address the identified issues to improve MY 2024 performance: o ABH's performance has declined in the following provider directory requirements: ▪ *PCP's Practice Location Matched Survey Response* (86.6%) declined by 6.6 percentage points from MY 2022 and by 10.4 percentage points from MY 2021 (97.0%). ▪ *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* (81.9%) declined by 6.8 percentage points from MY 2022 and by 9 percentage points from MY 2021 (90.9%).
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for ABH exceeded the compliance standard of 90%. • ABH's MY 2022 match rates achieved 100% across all code types for inpatient encounters and for revenue code types for outpatient encounters. • ABH's match rate for outpatient diagnosis and procedure codes achieved 98% and 99%, respectively. • Trended results reveal high-performing match rates across MYs. Inpatient encounters achieved 100% match rates for all three MYs (2020 through 2022).
↑	**NA**	**NA**	**Improvements:** • Outpatient encounters achieved a 98% match rate in MY 2021, and 99% match rates in MYs 2020 and 2022.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for ABH.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:** • The Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components exceeded the MDH-established compliance threshold (80%) for MY 2022.

Quality	Access	Timeliness	ABH Strengths, Improvements, and Recommendations
↑	↑	↑	**Improvements:** • Compared to MY 2021, all component scores in MY 2022 have sustained or improved in ratings. • All elements for the Immunizations and Health Education/Anticipatory Guidance components met or exceeded scores compared to MY 2021.
↓	↓	↓	**Recommendations:** • ABH should consider monitoring the root cause of low performance and implement strategic initiatives to improve scoring for the following elements: o Recorded Maternal Depression Screening o Measured Head Circumference o Graphed Head Circumference o Recorded Cholesterol Risk Assessment o 9-11 Year Dyslipidemia Lab Test o 18-21 Year Dyslipidemia Lab Test o Conducted Anemia Risk Assessment o 24 Month Anemia Test o 3-5 Year Anemia Test
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	↑	↑	**Strengths:** • Consistently exceed compliance thresholds for all record reviews and quarterly/annual GAD self-report data. • Consistently meets all appeals resolution timeframes for expedited and non-emergency appeals. • Consistently meets enrollee and provider grievance metrics at 100% for the year. • Both grievance acknowledgment and resolution letters provided a detailed description of the enrollee grievance.
↑	↑	↑	**Improvements:** • Consistent compliance in meeting timeframes for appeal resolution/notification. • Consistent compliance with enrollee verbal notification of an expedited appeal decision. • Appeal acknowledgment and resolution letters are written in plain language, include required and correct content in all fields, and use proper grammar. • Consistent compliance in meeting timeframes for pre-service determinations.
↓	**NA**	**NA**	**Recommendations:** • Routinely audit a sample of adverse determination notifications to ensure the use of easy-to-understand language. • All appeal acknowledgment letters included a statement that the enrollee has requested to continue receiving services while their appeal is being reviewed. In most cases, this statement is inappropriate, as the

Quality	Access	Timeliness	ABH Strengths, Improvements, and Recommendations
			service, being appealed is a discrete one-time service, such as a magnetic resonance imaging. This statement should only be used when an enrollee specifically requests continuation of benefits; otherwise, the statement should be revised to reflect the right of the enrollee to continuation of benefits and potential enrollee liability if the denial is upheld.

Table 110. CFCHP Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	CFCHP Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	**NA**	**Strengths:** • CFCHP's performance score of 78% resulted in a *Confidence* level for the prenatal care PIP and a performance score of 90% resulted in a *High Confidence* level for the postpartum care-related PIP. • Conducted a disparity analysis stratified by race/ethnicity data for each strategy and reviewed data quarterly. • Identified barriers on the member, provider, and MCO levels. • Identified the planned activities for calendar year 2024.
NA	**NA**	**NA**	**Improvements:** • CFCHP did not demonstrate improvement from the previous MY.
↓	↓	**NA**	**Recommendations:** • Identify the tool used to conduct barrier analyses and identify the quality improvement process utilized, such as the PDSA cycle. • Describe how each component of the CLAS standards has been incorporated into the development of each intervention. • Review selected strategies and report the HEDIS rate that aligns with each postpartum-care related strategy. • Identify the project population according to HEDIS specifications for each measure.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	**NA**	↑	**Strengths:** ***MetaStar observed the following strengths:*** • CFCHP's HEDIS team was extremely responsive to auditor requests and provided information or documentation in a timely manner. Additionally, the team served as subject matter experts for all organization functions and demonstrated a commitment to ensuring successful reporting. Robust oversight of data was evident in HEDIS reporting.
NA	**NA**	**NA**	**Improvements:** • CFCHP did not demonstrate improvement from the previous MY.
↓	↓	**NA**	**Recommendations:** ***MetaStar recommends the following actions:***

Quality	Access	Timeliness	CFCHP Strengths, Improvements, and Recommendations
			• Implement a more robust claims audit process that validates corrections and audits all claim types. Part of the claims data validation included validation of a small portion of high-dollar claims. • Incorporate steps to evaluate these data to determine enrollees with dual coverage and report enrollee enrollments based on HEDIS reporting requirements. CFCHP did not evaluate the coordination of benefits data provided by MDH or CMS to determine dual eligibility of enrollees.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
NA	**NA**	**NA**	**Strengths:** • CFCHP did not demonstrate any strengths in performance in this MY.
↑	↑	↑	**Improvements:** • Reviewed overutilization and underutilization reports from each of the Delegation Oversight Committee's delegates, which were subsequently reviewed and approved at the following Quality Improvement Committee meeting. • Revised the Member Grievances Policy to state the correct timeframe for sending a written acknowledgment of a grievance, eliminating the timeframe requirement for filing a grievance, and requiring an acknowledgment letter be sent for non-emergency medically related grievances that are not anticipated to be resolved within five calendar days. • Informed practitioners and providers of the availability of CAHPS assessment results on the provider portal, through the provider newsletter within the period under review. • The Consistency in Application of Decision-Making Criteria Policy specifies the requirement for annual training of utilization management staff on the interpretation and application of utilization management criteria.
↓	↓	**NA**	**Recommendations:** • Clearly state the frequency in which the process for locating and contacting enrollees for needed healthcare services is reviewed and updated. • Consult with the plan's Quality Improvement Department to use meeting minute formats similar to the Quality Improvement Committee for the Compliance & Regulatory Committee. Fraud, waste, and abuse reports should be consistent in every meeting, such as documenting the quarter under review and the names of the delegates, so that it is easy to identify gaps in oversight. The format of the Compliance & Regulatory Committee meeting minutes reviewed changes from meeting to meeting, making task accountability and consistency in reporting difficult to follow. In some meetings, the documents presented are embedded in the meeting minutes and the reviewer was not provided with the actual report.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	↑	**Strengths:**

Quality	Access	Timeliness	CFCHP Strengths, Improvements, and Recommendations
			• CFCHP's scores for compliance with routine and urgent care appointment timeframes were 11.3 percentage points above the 80% minimum compliance threshold established by MDH.
↑	↑	NA	**Improvements:** • ***Best Practice:*** After expanding its contract with Atlas, CFCHP implemented continuous validation of online provider directory information. This best practice resulted in significant improvement by 21.7 percentage points (70.9% in MY 2022 to 92.6% in MY 2023) in the accuracy of provider telephone numbers in the online provider directory.
↓	↓	NA	**Recommendations:** • CFCHP should consider reviewing the root causes for the decline in performance compared to MY 2022 and address the identified issues to improve MY 2024 performance. o CFCHP's performance has declined in the following provider directory requirements: ▪ *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* (65.1%) declined by 21.2 percentage points from MY 2022 (86.3%). • CFCHP must ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory through provider staff education. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly.
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for CFCHP exceeded the compliance standard of 90%. • CFCHP's MY 2022 match rates achieved 100% across all code types for inpatient and outpatient encounters. • Trended results reveal high-performing match rates across MYs. Inpatient and outpatient encounters achieved 100% match rates for both MYs 2021 and 2022.
↑	↑	NA	**Improvements:** • CFCHP showed steady improvement from MYs 2020 to 2021 for both inpatient and outpatient encounters and maintained a 100% match rate from MY 2021 and for MY 2022 in both encounter types.
NA	NA	NA	**Recommendations:** • There are no formal recommendations for CFCHP.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:** • All of the elements comprising the Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components exceeded the MDH-established minimum compliance threshold (80%).
↑	↑	↑	**Improvements:**

Quality	Access	Timeliness	CFCHP Strengths, Improvements, and Recommendations
			• CFCHP met or exceeded the MDH-established minimum compliance threshold (80%) for all five components and sustained or improved each component score compared to MY 2021. • All of the elements comprising the Health Education/Anticipatory Guidance component met or exceeded scores compared to MY 2021.
↓	↓	↓	**Recommendations:** • CFCHP should monitor the following elements for root causes in scoring for MY 2022, as these elements did not meet the MDH-established compliance score of 80%, and implement strategic initiatives to improve scoring: o Recorded Cholesterol Risk Assessment o 9-11 Year Dyslipidemia Lab Test o 18-21 Year Dyslipidemia Lab Test o 3-5 Year (Baseline) Blood Lead Test o Conducted Anemia Risk Assessment o 12 Month Anemia Test o 24 Month Anemia Test o 3-5 Year Anemia Test o HIV Test Per Schedule o 3-5 Year (Baseline) Blood Lead Test o HIV Test Per Schedule o 3-5 Year Anemia Test
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	**NA**	↑	**Strengths:** • All grievances are appropriately categorized and resolved. • Enrollee resolution timeframes exceeded the threshold for both standard and expedited appeals in all three quarters and the year. • Met compliance for determination/notification timeframes in all three quarters and the year for pre-service denials. • CFCHP routinely reaches out for technical assistance to improve processes.
NA	**NA**	↑	**Improvements:** • Consistent compliance with pre-service determination timeframes.
↓	**NA**	↓	**Recommendations:** • Increase monitoring of timeframe compliance for written acknowledgment of grievance and appeal receipt, grievance resolution, and grievance and appeal resolution notifications until consistent compliance is demonstrated over multiple measurement periods.

Quality	Access	Timeliness	CFCHP Strengths, Improvements, and Recommendations
			• Conduct routine audits of grievance resolution and adverse determination letters to ensure the use of correct letter templates and content in easy-to-understand language. • In view of the number of opportunities related to grievances, retrain grievance staff on procedures and timeframes for processing grievances.

Table 111. JMS Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	JMS Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	**NA**	**Strengths:** • JMS' performance score of 93% for both the prenatal care and postpartum care-related PIPs resulted in a *High Confidence* level for both PIP topics. • Continued to demonstrate efforts in incorporating a health equity focus. • Conducted a disparity analysis stratified by race/ethnicity for each strategy and reviewed data quarterly. • Identified member, provider, and MCO barriers for the PIP topics and its interventions. • Identified the planned activities for calendar year 2024.
NA	**NA**	**NA**	**Improvements:** • JMS did not demonstrate improvement from the previous MY.
↓	↓	**NA**	**Recommendations:** • Describe how each component of the CLAS standards has been incorporated into the development of each intervention.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	**NA**	↑	**Strengths:** ***MetaStar observed the following strengths:*** • JMS' HEDIS team was extremely responsive to auditor requests and provided information or documentation in a timely manner. Additionally, the team served as subject matter experts for all organization functions and demonstrated a commitment to ensuring successful reporting. Robust oversight of data was evident in HEDIS reporting.
NA	**NA**	**NA**	**Improvements:** • JMS did not demonstrate improvement from the previous MY.
↓	↓	**NA**	**Recommendations:** ***MetaStar recommends the following actions:*** • Incorporate additional supplemental data sources for future reporting periods, including the lead registry data. Another example of additional supplemental data sources is to explore obtaining and incorporating

Quality	Access	Timeliness	JMS Strengths, Improvements, and Recommendations
			electronic medical record data from various provider groups. These data sources would reduce the burden of MRR and possibly improve data completeness. • Incorporate JMS' behavioral health pharmacy data, provided by MDH, as encounter data for future HEDIS reporting. • Investigate data sources to enable the reporting of other ECDS measures, after JMS expanded the reporting of these measures to include the Breast Cancer Screening (BCS-E) measure and the required Prenatal Immunization Status (PRS-E) measure.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
↑	↑	**NA**	**Strengths:** • Wrote all adverse determination letters in plain language, and provided detailed information as to the reason for the adverse determination and any additional information needed for reconsideration. • Invested considerable resources in developing comprehensive educational programs for its enrollees, based on the health needs of its population.
↑	↑	↑	**Improvements:** • Revised the Member Grievance and Appeals Policy to eliminate the requirement for written confirmation of an oral appeal. • Provided the total number of enrollees comprising the special needs population categories, as defined in COMAR 10.67.04.04B, including individuals with developmental disabilities and postpartum women. • Provided further detail in the Outreach Plan regarding how the MCO tracks and monitors referrals to the local health department.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for JMS.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	↑	**Strengths:** • JMS' scores for compliance with routine and urgent care appointment timeframes were between 5 to 8 percentage points above the 80% minimum compliance threshold established by MDH.
↑	↑	**NA**	**Improvements:** • After implementing corrective action for MY 2022, JMS significantly improved *Practice has Accommodations for Patients with Disabilities (with specific details*) by 28.2 percentage points (70.9% in MY 2022 to 99.1% in MY 2023). • Despite falling below the compliance threshold for *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response*, JMS demonstrated a slight increase of 0.4 percentage points for MY 2023 (75.9%) from MY 2022 (75.5%).
↓	↓	**NA**	**Recommendations:**

Quality	Access	Timeliness	JMS Strengths, Improvements, and Recommendations
			• ***CAP:*** Due to multiple years of not meeting this requirement, JMS must submit a quarterly CAP to achieve compliance in the MY 2024 validations: o JMS must ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. o JMS has remained below the 80% compliance threshold in the following provider directory requirements: *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* (75.9%). JMS should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for JMS exceeded the compliance standard of 90%. • JMS' MY 2022 match rates achieved 100% across all code types for inpatient encounters and for procedure and revenue code types for outpatient encounters. • Diagnosis codes for outpatient encounters were also high-performing, with a match rate of 98%. • Trended results reveal high-performing match rates across MYs.
↑	**NA**	**NA**	**Improvements:** • JMS achieved a 100% match rate for MY 2022's inpatient encounters, an improvement year over year from MY 2020's 92% match rate to MY 2021's 96% match rate.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for JMS.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:** • JMS' total composite score (99%) was four percentage points above the HealthChoice Aggregate composite score (95%). • JMS exceeded the MDH-established minimum compliance threshold (80%) for all five components. • All of the elements comprising each of the five components met or exceeded the MDH-established minimum compliance threshold (80%). • All of the elements comprising the Health and Developmental History, Laboratory Tests/At-Risk Screenings, and Health Education/Anticipatory Guidance components met or exceeded the HealthChoice Aggregate scores.
↑	↑	↑	**Improvements:** • JMS sustained or improved all element scores for the Health and Developmental History and the Laboratory Tests/At-Risk Screenings components compared to MY 2021.

Quality	Access	Timeliness	JMS Strengths, Improvements, and Recommendations
			• The Newborn Metabolic Screen element had the most significant increase of 22 percentage points from MY 2021 (70%) to MY 2022 (92%).
↓	↓	↓	**Recommendations:** • JMS should consider monitoring the root cause of the decline in scoring and implement strategic initiatives to improve scoring for the following elements: o Vision Assessment o Hearing Assessment o Influenza (Flu) o Specified Requirements for Return Visit
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	**NA**	↑	**Strengths:** • Consistently met enrollee and provider grievance resolution metrics and appeal resolution timeframes. • Met all pre-service denial determination and notification timeframes for the year. • Appropriately categorized and resolved all grievances. Case notes fully document grievance, interventions, and resolution. • Wrote all adverse determination letters in easy-to-understand language and provided detailed information describing the reason for the adverse determination and any additional information needed for reconsideration.
NA	**NA**	↑	**Improvements:** • Consistent compliance with adverse determination notification timeframes.
↓	**NA**	**NA**	**Recommendations:** • Consider strategies for improving the completeness of outpatient pharmacy prior authorization requests submitted by providers. It was observed in the sample record review that all appeals were overturned due to the prescriber submitting additional information upon appeal.

Table 112. KPMAS Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	KPMAS Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	**NA**	**Strengths:** • KPMAS' performance score of 79% resulted in a *Confidence* level for the prenatal care PIP and a performance score of 76% resulted in a *Confidence* level for the postpartum care-related PIP. • Continued to incorporate quarterly feedback and recommendations to enhance efforts towards a health equity focus. • Conducted a disparity analysis stratified by race/ethnicity and data was reviewed on a quarterly basis. KPMAS provided further information on rates specific to race/ethnicity. • Identified the planned activities for calendar year 2024.
NA	**NA**	**NA**	**Improvements:** • KPMAS did not demonstrate improvement from the previous MY.
↓	↓	↓	**Recommendations:** • Provide MCO-specific data to support how the PIP topics are relevant to KPMAS' enrollee population. • Review selected strategies and report the HEDIS rate that aligns with each strategy for the postpartum care-related PIP. • Identify member, provider, and MCO barriers related to the PIP topic, interventions, and the disparate population. • Review SMART (Specific, Measureable, Attainable, Relevant, Timebound) objectives to ensure they are measurable and specific.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	**NA**	↑	**Strengths:** ***MetaStar observed the following strengths:*** • Reported valid rates for all relevant measures to meet accreditation and MDH-reporting requirements. • Stratified applicable measures by race and ethnicity, as required by NCQA for MY 2022 reporting. KPMAS developed methodology for mapping and data source hierarchy. Additionally, KPMAS' race and ethnicity data were captured at a high rate of completion; therefore, the stratified data results may lend itself to more meaningful results to inform future programming decisions.
NA	**NA**	**NA**	**Improvements:** • KPMAS did not demonstrate improvement from the previous MY.
NA	↓	**NA**	**Recommendations:** ***MetaStar recommends the following actions:*** • Obtain encounter data from MDH's behavioral health vendor, Optum, which could be used as a supplemental data source in future reporting years since some measures may be impacted by integrating

Quality	Access	Timeliness	KPMAS Strengths, Improvements, and Recommendations
			these data. Behavioral health measures were carved-out for HEDIS reporting due to MDH's carve-out of these benefits.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
↑	↑	**NA**	**Strengths:** • Maintains a comprehensive health education program that includes the development of educational materials, based upon evidence-based guidelines and identified enrollee needs; and actively promotes these programs to its provider network and enrollee population.
↑	↑	↑	**Improvements:** • Reported utilization rates specific to the Maryland HealthChoice population. • Reported barriers and interventions relating to identified overutilization and underutilization of services specific to the Maryland HealthChoice population. • Compliance with the timeframe for written resolution of provider appeals exceeded the MDH threshold of 95% throughout 2022. • The Outreach Plan describes its community partnerships and their role in supporting outreach activities to bring enrollees into care. • Provided further detail in the Outreach Plan, regarding how referrals to the local health department are tracked and monitored. • Developed a process for verifying that services billed to enrollees were actually received.
↓	↓	**NA**	**Recommendations:** • Consider evaluating emergency room usage and hospital admissions of enrollees who participate in Wellness Coaching to determine if a reduction in physician visits may have shifted utilization to more intensive levels of care. • Respond to identified opportunities from the Health Education Resources Survey to further promote the resources of the Health Engagement Department and explore how the usefulness of health education resources could be increased.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	**NA**	**Strengths:** • KPMAS had 99% accuracy for provider addresses. • 100% of KPMAS providers accepted the MCO, which matched the provider directory.
↑	↑	**NA**	**Improvements:** • After implementing corrective action for MY 2022, KPMAS improved acceptance for new Medicaid patients by 6.5 percentage points (74.1% in MY 2022 to 80.6% in MY 2023).
↓	↓	↓	**Recommendations:** • ***CAP:*** KPMAS must submit a CAP to achieve compliance in the MY 2024 validations:

Quality	Access	Timeliness	KPMAS Strengths, Improvements, and Recommendations
			o KPMAS must ensure provider offices are able to accommodate requirements for routine care appointment scheduling within 30 days of the call date and urgent care appointment scheduling within 48 hours of the call date at the same location with either the requested provider, an alternate provider, or telemedicine. o KPMAS' scores for compliance with routine and urgent care appointment timeframes both fell below the 80% compliance threshold at 68.0% and 77.7%, respectively. Compliance with routine care appointment timeframes decreased by 27.5% from MY 2022 (95.5%). KPMAS should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for KPMAS exceeded the compliance standard of 90%. • KPMAS' MY 2022 match rates achieved 100% across all code types for inpatient and outpatient encounters. • KPMAS' office visit match rate was also high-performing, with a MY 2022 match rate of 99% for all code types. • Notably, KPMAS achieved the highest match rate for MY 2022 office visit encounters, including all code types. • Outpatient results also achieved match rates of 100% for all MY 2022 code types. • Comparatively, KPMAS was one of three MCOs with 100% match rates for diagnosis codes in outpatient encounters.
↑	**NA**	**NA**	**Improvements:** • Inpatient trended performance shows KPMAS improved performance by one percentage point in inpatient encounters (MY 2020 to MY 2021), and maintained the 100% match rate in MY 2021 to MY 2022.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for KPMAS.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:** • KPMAS' total composite score of 99% was four percentage points above the HealthChoice Aggregate composite score of 95%. • All five components exceeded the MDH-established compliance threshold (80%) for MY 2022. • All of the individual elements comprising each of the five components exceeded the MDH-established minimum compliance threshold (80%). • The Health and Developmental History, Laboratory Tests/At-Risk Screenings, and Health Education/Anticipatory Guidance components exceeded the HealthChoice Aggregate scores.

Quality	Access	Timeliness	KPMAS Strengths, Improvements, and Recommendations
↑	↑	↑	**Improvements:** • The Recorded Maternal Depression Screening, Recorded Developmental Screening Tool, Recorded Cholesterol Risk Assessment, and 9-11 Year Dyslipidemia Lab Test elements had the most significant improvement from MY 2021 to MY 2022 ranging in increases from ten to 32 percentage points.
↓	↓	↓	**Recommendations:** • There are no formal recommendations for KPMAS.
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	**NA**	↑	**Strengths:** • Appropriately categorized and resolved grievances. • Met compliance with appeal acknowledgment letters, appeal resolutions, and pre-service denials determination/notification timeframes in all categories but one.
↑	**NA**	↑	**Improvements:** • Appropriately categorized grievances. • Consistent compliance in meeting resolution timeframes for enrollee grievances. • Consistent compliance in meeting the timeframe for written acknowledgment of enrollee appeal receipt. • Consistent compliance in meeting the timeframes for adverse determination notifications.
↓	**NA**	↓	**Recommendations:** • Routinely audit a sample of grievance acknowledgment and resolution letters. Mandatory fields were left blank in one of the acknowledgment letters and the date of grievance receipt identified in a resolution letter was different from the date in the case notes. • It was observed that many grievances were the result of adult members having received (or attempted to receive) more than one routine vision service during the 24 month time period. The benefit allows for one routine eye exam every two years. While stated in the enrollee handbook, a process should be established to advise enrollees of their eligibility at the time an appointment is made. • Routinely audit a sample of case notes to ensure that enrollees are notified, both verbally and in writing, of any denial of a request for an expedited appeal resolution. • Increase monitoring of compliance with determination timeframes, until consistent compliance is demonstrated over multiple measurement periods.

Table 113. MPC Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	MPC Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	**NA**	**Strengths:** • MPC's performance score of 93% for both the prenatal care and postpartum care-related PIPs resulted in *High Confidence* levels for both PIP topics. • Continued to incorporate quarterly feedback and recommendations to enhance efforts towards a health equity focus. • Conducted a disparity analysis stratified by race/ethnicity and geographic data for each strategy and reviewed data on a quarterly basis. • Developed a plan in quarter three to incorporate CLAS standards specific to each intervention.
NA	**NA**	**NA**	**Improvements:** • MPC did not demonstrate improvement from the previous MY.
↓	↓	↓	**Recommendations:** • Identify member, provider, and MCO barriers relevant to the PIP topic, interventions, and the disparate population. • Describe how each component of the CLAS standards has been incorporated in the development of each intervention.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	↑	**NA**	**Strengths:** ***MetaStar observed the following strengths:*** • Reported valid rates for all relevant measures to meet accreditation and MDH-reporting requirements. • Stratified applicable measures by race and ethnicity, as required by NCQA for MY 2022 reporting. MPC developed a methodology for mapping and data source hierarchy.
NA	**NA**	**NA**	**Improvements:** • MPC did not demonstrate improvement from the previous MY.
↓	↓	**NA**	**Recommendations:** ***MetaStar recommends the following actions:*** • Consider exploring the number of years that medical record data is loaded by Inovalon from previous MRR projects, as there may be an opportunity to capture historical exclusions identified via MRR for supplemental data use in future years. • Pursue MPC's plan to use behavioral health pharmacy claims data from MDH's carve-out as a future supplemental data source. • Develop a methodology for how MPC identifies dual-enrollment, including the start date; and ensure that MPC has the capability to identify ongoing dual-coverage. During the HEDIS MY 2022 audit, MPC did not

Quality	Access	Timeliness	MPC Strengths, Improvements, and Recommendations
			exclude any Medicaid enrollees from reporting but did note the potential to exclude enrollees with dual-enrollment in future years. MPC will work on its proposed approach for potential use in MY 2023.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
↑	**NA**	**NA**	**Strengths:** • All adverse determination letters within the sample reviewed provided a detailed explanation of the requested services and the reason(s) for the adverse determination in plain language.
↑	↑	↑	**Improvements:** • Analyzed top grievance trends to determine any opportunities for improvement and action initiated, as indicated. • Revised the Prior Authorization Policy to include the availability of a 14 calendar-day extension for standard preauthorization requests. • Compliance with the timeframes for sending the enrollee written acknowledgment of appeal receipt and notification of standard appeal resolution exceeded the 95% compliance threshold for all four quarters of 2022. • Revised the Member Appeal Policy to require the MCO to make reasonable efforts to give an enrollee or their representative, a prompt verbal notice of the denial of a request for an expedited resolution and written notice of the denial within two calendar days of the initial appeal request. • Revised the Member Appeals Policy to eliminate the requirement for written confirmation of an oral appeal. • Compliance with timeframes for written appeal acknowledgment and written resolution of provider appeals exceeded the 95% compliance threshold for all four quarters of MY 2022.
↓	↓	↓	**Recommendations:** • Increase the frequency of monitoring compliance with the 24-hour timeframe for prescriber notification to address any noncompliance issues before it impacts overall compliance results for the quarter. • Revise the Provider Appeal Policy to clarify a written resolution is sent to providers within five business days of the decision for both initial and subsequent appeals. It is clear this is the intent of the policy, based on the review of the Key Indicator Report, which tracks MPC's compliance with this requirement. • Compare process or outcome measures between program participants and non-participants to determine the impact of health education. For example, the timeliness of prenatal care and postpartum care rates could be compared between program participants (those participating in the Pregnancy Care Program) with non-participants to assess the effectiveness of its educational efforts.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	↑	**Strengths:**

Quality	Access	Timeliness	MPC Strengths, Improvements, and Recommendations
			• MPC's score for compliance with routine and urgent care appointment timeframes was 94.3% and 89.9%, respectively, which are above the 80% threshold established by MDH by approximately ten to 14 percentage points. • MPC had the third highest percentage of the nine MCOs for successful contacts and 100% of MPC's successful contacts accepted MPC enrollees. • MPC scored above the compliance threshold for all online provider directory requirements.
↑	↑	NA	**Improvements:** • After implementing corrective action for MY 2022, MPC significantly improved *Acceptance for new Medicaid patients* by 15.2 percentage points (70.3% in MY 2022 to 85.5% in MY 2023). MPC's provider directory easily identified the phone number for enrollee services at the top of the web page.
NA	NA	NA	**Recommendations:** • There are no formal recommendations for MPC.
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for MPC exceeded the compliance standard of 90%. • MPC's MY 2022 match rates achieved 100% for diagnosis and procedure code types for inpatient encounters, and procedure and revenue code types for outpatient encounters. • Revenue codes for inpatient encounters were also high-performing, with a match rate of 98%. • Diagnosis codes for outpatient encounters achieved a match rate of 99%.
NA	NA	NA	**Improvements:** • MPC maintained high performance in all encounter types. There was no demonstration of improvement.
NA	NA	NA	**Recommendations:** • There are no formal recommendations for MPC.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:** • MPC met or exceeded the MDH-established minimum compliance threshold (80%) for all five components. • All elements for the Comprehensive Physical Exam and Health Education/Anticipatory Guidance components exceeded the MDH-established minimum compliance threshold (80%).
↑	↑	↑	**Improvements:** • MPC's total composite score has steadily improved from MY 2020 (89%) to MY 2022 (94%). • The most significant improvement in element scores was for the Graphed Head Circumference (93%) and the 18-21 Year Dyslipidemia Lab Test (94%) elements, which increased by 21 and 23 percentage points, respectively.
↓	↓	↓	**Recommendations:**

Quality	Access	Timeliness	MPC Strengths, Improvements, and Recommendations
			• MPC should consider monitoring the root causes for low performance and implement strategic initiatives to improve scoring for the following elements: o Recorded Perinatal History o Recorded Maternal Depression Screening o Newborn Metabolic Screen o 9-11 Year Dyslipidemia Lab Test o 24 Month Blood Lead Test o Conducted Anemia Risk Assessment o 24 Month Anemia Test o HIV Test Per Schedule o Influenza (Flu)
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	**NA**	**NA**	**Strengths:** • Minimal compliance issues for the year. • Met all applicable grievance and pre-service denial metrics for the year. • Comprehensive case notes document grievance, investigation, and resolution. All are appropriately categorized and resolved. Resolution letters in plain language and fully describe the grievance and resolution. • Wrote all appeal resolution letters in easy-to-understand language and provided detailed explanations of the enrollee's needs and reason for the decision. • Wrote all adverse determination letters in easy-to-understand language and provided a detailed explanation of the requested services and the reason(s) for the determination.
NA	**NA**	↑	**Improvements:** • Compliance with the self-reported timeframe for expedited appeals fell below the threshold for the year, though there is a noticeable improvement from Q3 2022 to the end of the year. • Consistent compliance with the timeframe for sending enrollee acknowledgment of appeal receipt. • Consistent compliance with the timeframes for appeal resolution/notification in record review.
↓	**NA**	↓	**Recommendations:** • Increase routine monitoring of case notes until consistent compliance is demonstrated with the timeframe for prescriber notification of review outcomes over multiple measurement periods.

Table 114. MSFC Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	MSFC Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	**NA**	**Strengths:** • MSFC's performance score of 93% resulted in a *High Confidence* level for the prenatal care PIP and the performance score of 79% resulted in a *Confidence* level for the postpartum care-related PIP. • Incorporated quarterly feedback to clarify the disparate population and identify barriers specific to the disparate population for the prenatal care PIP topic. • Provided follow up activities for calendar year 2024, which included obtaining its NCQA Health Equity certification.
NA	**NA**	**NA**	**Improvements:** • MSFC did not demonstrate improvement from the previous MY.
↓	↓	↓	**Recommendations:** • Describe how each component of the CLAS standards has been incorporated in the development of each intervention. • Identify member, provider, and MCO barriers relevant to the PIP topic, interventions, and the disparate population. • Develop SMART objectives that are specific and measurable. • Ensure all interventions are impactful, systemic, and sustainable. • Ensure each intervention identifies the disparate population. • Identify the quality improvement process, such as the PDSA cycle.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	**NA**	↑	**Strengths:** ***MetaStar observed the following strengths:*** • Provided a standardized and well-documented HEDIS MY 2022 Roadmap on time, which greatly facilitated both offsite and virtual phases of the HEDIS Compliance Audit. No issues were identified with MSFC's completion of the Roadmap General Information or Appendix sections. • Provided all required documents, databases, and rate files on or before the required deadlines. MSFC also provided all requested audit follow-up items in a timely manner. • Utilized a software vendor with NCQA-certified measures. The auditor confirmed that the certified version of the software was used for each measure by ensuring the IDSS did not produce any warnings regarding the GUIDs. • NCQA did not identify any Tier 4 warnings for MSFC. • Maintained excellent communication with the auditor throughout the audit process and alerted the auditor when there were concerns that could potentially impact the audit.

Quality	Access	Timeliness	MSFC Strengths, Improvements, and Recommendations
NA	NA	NA	**Improvements:** • MSFC did not demonstrate improvement from the previous MY.
↓	↓	NA	**Recommendations:** ***MetaStar recommends the following actions:*** • Continue working with MDH to obtain better race and ethnicity data. MSFC's race and ethnicity data appeared better than in previous years; however, there is still a large percentage of enrollees with unknown race and ethnicity. • Continue exploring potential additional supplemental data sources, such as increased use of EMR data, for future reporting years. • Continue exploring reasons for any low-reported rates to improve future HEDIS reporting. The auditor solicited further explanation for rates that fell below the 10th percentile or that changed by more than five percentage points from the previous MY.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
↑	↑	↑	**Strengths:** • MSFC made noticeable improvements to reach compliance with the Maryland Insurance Administration requirements for the timeliness of the initial credentialing process. Sent all required 30-day letters as required and, on average, completed the credentialing process within 30 days of receipt of the application, when the credentialing process timeliness threshold is 120 days from sending the 30-day notice of intent to proceed. • Adverse determination letters and appeals resolution notification letters provide one of the best examples of the use of plain language. For example, acronyms were spelled out and explained, such as COMAR (Code of Maryland Regulations), and even ordinary terms explained, such as "authorization," were described as "permission."
↑	NA	↑	**Improvements:** • Initial credentialing records showed that the provider was given written notice of the MCO's intent to continue or discontinue processing the application. This written notice was sent within 30 days from receipt of the Council for Affordable Quality Healthcare credentialing application. • Achieved compliance with the MDH-established threshold of 95% for written appeal acknowledgment in all four quarters of the period under review. • Revised the Member Appeals Policy to eliminate the requirement for written confirmation of any enrollee appeal that was filed orally. • Documented the process for ensuring timely payment of Independent Review Organization (IRO) invoices in the External Appeals and IRO Process Policy.
↓	NA	↓	**Recommendations:**

Quality	Access	Timeliness	MSFC Strengths, Improvements, and Recommendations
			• Measure the impact of educational interventions associated with programs, such as *Momma & Me* and the *Diabetes Boot Camp*, on utilization measures that could include emergency room visits and inpatient utilization. Studies could address pre- and post-utilization for program participants or a comparison of program participant utilization rates with non-participants. • Promote the effectiveness of MSFC's health education programs by including process and outcome results in provider newsletters to increase provider referrals.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	↑	**Strengths:** • MSFC's scores for routine and urgent care appointment timeframes were 91.7% and 89.1%, respectively, which are above the 80% threshold established by MDH by approximately 9 to 11 percentage points. • MSFC had the second highest percentage of the 9 MCOs for successful contacts and 100% of MSFC's successful contacts accepted MSFC enrollees. • MSFC remained above the compliance threshold for all provider directory requirements. MSFC's provider directory clearly has a link at the bottom of the web page for "Contact Us" that leads to useful enrollee phone numbers including enrollee services.
↑	↑	↑	**Improvements:** • ***Best Practice:*** MSFC has implemented an internal secret shopper campaign requiring corrective action for provider offices found to be noncompliant with routine care appointment timeframes. This best practice resulted in a significant improvement of 13.3 percentage points (78.4% in MY 2022 to 91.7% in MY 2023) in compliance with the routine care appointment timeframe.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for MSFC.
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for MSFC exceeded the compliance standard of 90%. • MSFC's MY 2022 match rates achieved 100% for diagnosis and procedure code types for inpatient encounters, and procedure and revenue code types for outpatient encounters. • Revenue codes for inpatient encounters were also high-performing, with a match rate of 99%. • Diagnosis codes achieved a match rate of 98% for outpatient encounters. • MSFC achieved the highest match rate for MY 2022 office visit encounters (99%), with match rates of 98% for procedure codes and 99% for diagnosis codes. • Comparatively, MSFC achieved the highest match rate for total and diagnosis codes (99%) within office visit encounters.
NA	**NA**	**NA**	**Improvements:**

Quality	Access	Timeliness	MSFC Strengths, Improvements, and Recommendations
			• MSFC maintained high performance in all encounter types. There was no demonstration of improvement.
NA	NA	NA	**Recommendations:** • There are no formal recommendations for MSFC.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:** • MSFC exceeded the MDH-established minimum compliance threshold (80%) for all five components. • All elements for the Health and Developmental History, Comprehensive Physical Exam, and Health Education/Anticipatory Guidance components exceeded the MDH-established minimum threshold (80%).
↑	↑	↑	**Improvements:** • Compared to MY 2021, MSFC sustained or improved in four out of the five components. • The Recorded Maternal Depression Screening element score improved significantly by 27 percentage points from MY 2021 (54%) to MY 2022 (81%). • The Documented Referral to Dentist element improved by 13 percentage points in MY 2022 (92%), surpassing MY 2020's score by 5 percentage points.
↓	↓	↓	**Recommendations:** • MSFC should consider monitoring the following elements for root causes in scoring for MY 2022, as these elements did not meet the MDH-established compliance score of 80%, and implement strategic initiatives to improve scoring: o Newborn Metabolic Screen o 9-11 Year Dyslipidemia Lab Test o 18-21 Year Dyslipidemia Lab Test o Conducted Anemia Risk Assessment o 12 Month Anemia Test o 24 Month Anemia Test o Influenza (Flu)
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	NA	NA	**Strengths:** • Consistently met all appeals and pre-service denial metrics. • Appropriately categorized and resolved all grievances. Case notes fully document the grievance, investigation, and resolution. • ***Best Practice:*** Adverse determination and appeal resolution letters provide one of the best examples of the use of easy-to-understand language.
↑	NA	↑	**Improvements:** • Consistent compliance with adverse determination notification timeframes.

Quality	Access	Timeliness	MSFC Strengths, Improvements, and Recommendations
NA	NA	NA	**Recommendations:** • There are no formal recommendations for MSFC.

Table 115. PPMCO Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	PPMCO Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	NA	**Strengths:** • PPMCO's performance score of 90% resulted in a *High Confidence* level for the prenatal care PIP and a performance score of 82% resulted in a *Confidence* level for the postpartum care-related PIP. • Continued to demonstrate and enhance efforts towards the health equity focus. • Conducted a disparity analysis stratified by race/ethnicity data for each strategy and reviewed data quarterly. • Identified the planned activities for calendar year 2024.
NA	NA	NA	**Improvements:** • PPMCO did not demonstrate improvement from the previous MY.
↓	↓	↓	**Recommendations:** • Describe how each component of the CLAS standards has been incorporated into the development of each intervention. • Identify member, provider, and MCO barriers relevant to the PIP topic, interventions, and the disparate population. • Develop SMART objectives that are specific and measurable.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	NA	↑	**Strengths:** ***MetaStar observed the following strengths:*** • PPMCO's HEDIS team was extremely responsive to auditor requests and provided information or documentation in a timely manner. Additionally, the team served as subject matter experts for all organization functions and demonstrated a commitment to ensuring successful reporting. Robust oversight of data was evident in HEDIS reporting. • Processes for transactional systems, that underwent changes during the MY, were well managed to ensure all data were appropriately incorporated for HEDIS reporting.
↑	NA	NA	**Improvements:** ***MetaStar observed the following improvement from the previous MY:*** • Expanded the scope of reporting from the previous MY to include additional ECDS measures.
↓	↓	NA	**Recommendations:** ***MetaStar recommends the following actions:***

Quality	Access	Timeliness	PPMCO Strengths, Improvements, and Recommendations
			• Investigate and incorporate additional supplemental data sources for future reporting periods, including the lead registry data and health information exchange data. These data sources would reduce the burden of MRR and possibly improve data completeness. • Incorporate PPMCO's behavioral health pharmacy data, provided by the State of Maryland, as encounter data for future HEDIS reporting.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
↑	↑	**NA**	**Strengths:** • A comprehensive plan is utilized for notifying enrollees and providers of health education activities using multiple means of communication, such as enrollee email alerts and provider and enrollee website advertising. • Utilizes specific Healthy People 2030 recommendations in designing health education programs by targeting identified areas of need. This effort/initiative supports the development of measurable goals to determine program effectiveness.
↑	↑	↑	**Improvements:** • Analyzed grievance data for trends and developed interventions to address opportunities for improvement. • Achieved compliance with grievance resolution timeframes within the MDH-established threshold of 95% on at least a quarterly basis. • Maintained consistency with PPMCO's Utilization Management: Over and Under Utilization Policy by routinely reviewing utilization data to assess for potential overutilization and underutilization of services.
↓	**NA**	**NA**	**Recommendations:** • Remove any reference to "expedited" appeals for administrative (claims) issues in provider appeal reports, as its continuing presence may prompt MCO staff to miscategorize an administrative appeal as expedited. • Consider other avenues for obtaining more specificity in feedback from providers regarding the Health Education Plan. The survey, as written, is too general and does not support identifying specific opportunities for improvement. • Review the method used for reporting on homeless individuals to ensure accuracy.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	↑	**Strengths:** • PPMCO scored above the 80% compliance threshold for routine and urgent care appointment timeframes at 94.7% and 89.5%, respectively.
↑	↑	**NA**	**Improvements:** • PPMCO's performance increased for *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* by 13.8 percentage points from MY 2022 (54.6%).
↓	↓	**NA**	**Recommendations:**

Quality	Access	Timeliness	PPMCO Strengths, Improvements, and Recommendations
			• ***CAP:*** Due to multiple years of not meeting this requirement, PPMCO must submit a quarterly CAP to achieve compliance in the MY 2024 validations: o PPMCO must ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. o *Practice has Accommodations for Patients with Disabilities (with specific details)* (77.2%) declined by 6.1 percentage points from MY 2022 (83.3%). PPMCO's performance has declined in this provider directory requirement compared to MY 2022. PPMCO should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance • ***CAP:*** PPMCO must submit a CAP to achieve compliance in the MY 2024 validations: o PPMCO must ensure PCP's online provider directories include information regarding their practice's accommodations for patients with disabilities. o Despite demonstrated improvement for *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* (68.4%), PPMCO remains under the 80% compliance threshold. PPMCO's performance has declined in this provider directory requirement compared to MY 2022. PPMCO should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for PPMCO exceeded the compliance standard of 90%. • PPMCO's MY 2022 match rates achieved 100% across all code types for inpatient encounters. • Match rates per code type for outpatient encounters were high performing, with 96% for diagnosis codes, 97% for revenue codes, and 98% for procedure codes. • Code types for MY 2022 office visit encounters achieved match rates of 97% for procedure codes and 98% for diagnosis codes.
↑	**NA**	**NA**	**Improvements:** • PPMCO achieved a match rate of 100% for inpatient encounters after a decline of one percentage point from MY 2020's 99% match rate to MY 2021's 98% match rate, demonstrating an increase of two percentage points to MY 2022.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for PPMCO.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:**

Quality	Access	Timeliness	PPMCO Strengths, Improvements, and Recommendations
			• All elements comprising the Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components scored above the MDH-established minimum compliance threshold of 80%. • The Comprehensive Physical Exam, Measured Weight, BMI Percentile, and Rotavirus elements scored 100% compliance for MY 2022.
↑	↑	↑	**Improvements:** • The Recorded Maternal Depression Screening element had the most significant improvement from MY 2021 (75%) to MY 2022 (92%) by 17 percentage points and has an overall increase in score by 49 percentage points from MY 2020 (43%).
↓	↓	↓	**Recommendations:** • PPMCO should monitor the following component and element for root causes in performance for MY 2022, as scores did not meet the MDH-established compliance score of 80%, and implement strategic initiatives to improve scoring: o Recorded Autism Screening Tool Element o Laboratory Tests/At-Risk Screenings Component • ***CAP:*** PPMCO must submit a CAP for the Laboratory/At-Risk Screenings component to achieve compliance in MY 2023.
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	**NA**	↑	**Strengths:** • Met administrative grievance resolution in all 3 quarters and the year. • Standard, expedited, and pharmacy pre-service denial determination and notification timeframes consistently met compliance in MY 2022. • Appropriately categorized and resolved all grievances. • Grievances, investigation, and resolution are well documented in case notes.
↑	**NA**	↑	**Improvements:** • PPMCO made improvements to the TAT for enrollee administrative grievances and non-emergency medically related grievances moving from non-compliance in the first three quarters to a compliance rate of 100% for the year. • Appropriate categorization of grievances (emergency-medically related, non-emergency medically related, and administrative). • Consistent compliance with enrollee grievance resolution timeframes.
↓	**NA**	↓	**Recommendations:** • Continue efforts to identify causes for non-compliance in emergency and non-emergency grievance resolution timeframes.

Quality	Access	Timeliness	PPMCO Strengths, Improvements, and Recommendations
			• Retrain the appeals team on documentation standards for expedited appeals and use of easy-to-understand language in enrollee appeal letters. • Routinely audit appeal case notes to ensure compliance with documentation standards. • Routinely audit appeal resolution letters to ensure the use of easy-to-understand language. • Increase monitoring of timeframe compliance for appeal acknowledgment letters until consistent compliance is demonstrated over multiple measurement periods.

Table 116. UHC Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	UHC Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	**NA**	**Strengths:** • UHC's performance score of 75% for the prenatal care PIP and 86% for the postpartum care-related PIP resulted in *Confidence* levels for both PIP topics. • Continued to demonstrate and enhance efforts towards the health equity focus. • Conducted a disparity analysis stratified by race/ethnicity data for each strategy and reviewed data quarterly. • Identified the planned activities for calendar year 2024.
NA	**NA**	**NA**	**Improvements:** • UHC did not demonstrate improvement from the previous MY.
↓	↓	↓	**Recommendations:** • Identify the quality improvement process, such as the PDSA cycle. • Describe how each component of the CLAS standards has been incorporated into the development of each intervention. • Ensure that all interventions are impactful, systemic, and sustainable.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	↑	↑	**Strengths:** ***MetaStar observed the following strengths:*** • UHC's HEDIS team was extremely responsive to auditor requests and provided information or documentation in a timely manner. Additionally, the team served as subject matter experts for all organization functions and demonstrated a commitment to ensuring successful reporting. Robust oversight of data was evident in HEDIS reporting. • Continued to utilize a process to incorporate coordination of benefits data, based on data collected from various sources (including data from the State of Maryland), as part of UHC's corporate processes. These data were used to identify enrollment segments for Medicaid enrollees that overlapped with commercial coverage for exclusion from Maryland Medicaid reporting, consistent with HEDIS specifications.

Quality	Access	Timeliness	UHC Strengths, Improvements, and Recommendations
NA	NA	NA	**Improvements:** • UHC did not demonstrate improvement from the previous MY.
↓	↓	↓	**Recommendations:** ***MetaStar recommends the following actions:*** • Ensure that the data identifies the accurate date of the pharmacy fill to incorporate for future reporting. UHC utilized Chart Finder as a supplemental data source and submitted three file types from medical, lab, and pharmacy data sources. The pharmacy file did not pass primary source validation due to issues with pharmacy fill dates and as a result, the pharmacy data component was not approved.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
NA	NA	NA	**Strengths:** • UHC did not demonstrate any strengths in performance in this MY.
NA	NA	↑	**Improvement:** • Reported compliance with timeframes for written grievance acknowledgment and resolution as exceeding the 95% compliance threshold throughout 2022. • Reported compliance with timeframes for written enrollee appeal acknowledgments and written enrollee appeal resolutions as exceeding the 95% compliance threshold throughout 2022. • Removed the requirement for written confirmation of an oral appeal from the Member Appeal and Grievance Policy. • Revised the Provider Grievance and Appeal Policy to specify the timeframe it has established for providing written notice of appeal resolution for both the first and second levels. • The Outreach Plan described how local health department enrollee referrals are tracked and monitored.
↓	↓	NA	**Recommendation:** • Specify in all applicable policies and compliance reports that written appeal notifications are inclusive of the timeframe for resolution. • Include contact information for accessing a health educator (senior health coach) in either the provider manual or a provider newsletter for referrals that may not be related to specific programs highlighted in various provider communications.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	↑	**Strengths:** • UHC scored above the 80% compliance threshold for routine and urgent care appointment timeframes at 91.7% and 93.5%, respectively.
NA	NA	NA	**Improvements:** • UHC did not demonstrate improvement from the previous MY.
↓	↓	NA	**Recommendations:**

Quality	Access	Timeliness	UHC Strengths, Improvements, and Recommendations
			• UHC declined in performance from MY 2022 to MY 2023 for *PCP's Practice Locations Matched Survey Response* (83.9%) and *PCP's Practice Telephone Number Matched Survey Response* (86.3%). • ***CAP:*** Due to multiple years of not meeting this requirement, UHC must submit a quarterly CAP to achieve compliance in the MY 2024 validations: o UHC's performance declined by 4.8 percentage points from MY 2022 (76.8%) in the following provider directory requirement: *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response* (72.0%). o UHC must ensure staff responses regarding accepting new Medicaid patients for the MCO align with responses provided in the online directory. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. UHC should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for UHC exceeded the compliance standard of 90%. • UHC's MY 2022 match rates achieved 100% for procedure and revenue code types for inpatient encounters, and diagnosis and revenue code types for outpatient encounters. • Diagnosis codes for inpatient encounters in MY 2022 were high-performing, with a match rate of 98%. • Procedure codes achieved a MY 2022 match rate of 99% for outpatient encounters. • Outpatient match rates for revenue and diagnosis codes achieved 100%. • UHC was one of three MCOs to achieve match rates of 100% for diagnosis codes in outpatient encounters.
NA	**NA**	**NA**	**Improvements:** • UHC maintained high performance in all encounter types. There was no demonstration of improvement.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for UHC.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:** • UHC scored above the MDH-established minimum compliance threshold of 80% for all five EPSDT components. • All of the elements comprising the Health and Developmental History, Comprehensive Physical Exam, Immunizations, and Health Education/Anticipatory Guidance components met or exceeded the minimum compliance threshold (80%).
↑	↑	↑	**Improvements:**

Quality	Access	Timeliness	UHC Strengths, Improvements, and Recommendations
			• Compared to MY 2021, UHC improved all component scores for MY 2022. The Laboratory Test/At-Risk Screenings component had the most significant improvement by seven percentage points from MY 2021 (77%) to MY 2022 (83%). • The Health and Developmental History and Laboratory Tests/At-Risk Screenings component scores have steadily increased from MY 2020 to MY 2022. • The Depression Screening, 9-11 Year Dyslipidemia Lab Test, 24 Month Anemia Test, Recorded STI/HIV Risk Assessment, and Documented Referral to Dentist elements had the most significant improvements from MY 2021 to MY 2022 ranging from 14 to 17 percentage points.
↓	↓	↓	**Recommendations:** • UHC should monitor the following elements for root causes in scoring for MY 2022, as these elements did not meet the MDH-established compliance score of 80%, and implement strategic initiatives to improve scoring: o Newborn Metabolic Screening o 9-11 Year Dyslipidemia Lab Test o 18-21 Year Dyslipidemia Lab Test
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	**NA**	↑	**Strengths:** • In quarterly GAD reports, UHC consistently provides explanations for data variances and documents its own improvement strategy to include, for example, staff training, process modification, and increased oversight. • Met 100% of grievance and denial TAT metrics in all applicable categories during each review period. • All grievances are appropriately categorized and resolved. Comprehensive case notes document grievance, investigation, and resolution. Letters were written in easy-to-understand language and described grievance and resolution. In particular, paraphrasing the member's grievances in his or her own words reflects member's concern is heard and understood. • Thorough documentation of enrollee appeals in case notes.
↑	**NA**	↑	**Improvements:** • Appropriate categorization of grievances. • Consistent compliance in meeting timeframe for written acknowledgment of receipt of enrollee grievance. • Consistent compliance in meeting the timeframe for written acknowledgment of receipt of enrollee appeal. • Consistent compliance with appeal resolution/notification timeframes. • Date of appeal is the date the provider filed on behalf of the enrollee, not the date of enrollee consent.
↓	**NA**	**NA**	**Recommendations:** • Incorrectly identified several pharmacy requests as expedited. Based upon COMAR, there is no expedited category for pharmacy prior authorization requests.

Table 117. WPM Strengths, Improvements, and Recommendations

Quality	Access	Timeliness	WPM Strengths, Improvements, and Recommendations
Quality	**Access**	**Timeliness**	**Performance Improvement Project Validation**
↑	↑	NA	**Strengths:** • WPM's performance score of 81% for the prenatal care PIP and 86% for the postpartum care-related PIP resulted in *Confidence* levels for both PIP topics. • Continued to demonstrate and enhance efforts towards the health equity focus. • Conducted a disparity analysis stratified by race/ethnicity data for each strategy and reviewed data quarterly. • Identified the planned activities for calendar year 2024.
NA	NA	NA	**Improvements:** • WPM did not demonstrate improvement from the previous MY.
↓	↓	↓	**Recommendations:** • Develop interventions utilizing evidence-based literature that will indicate that the tests of change would likely lead to the desired outcome. • Identify the quality improvement process, such as the PDSA cycle. • Develop SMART objectives that are specific and measurable. • Identify member, provider, and MCO barriers relevant to the PIP topic, interventions, and the disparate population.
Quality	**Access**	**Timeliness**	**Performance Measure Validation**
↑	NA	NA	**Strengths:** ***MetaStar observed the following strengths:*** • Continued to employ a coordinated effort between regional and corporate teams to ensure that all regional reporting requirements are managed appropriately. This endeavor from WPM, from previous years, is due to its large corporate structure and multiple national markets, data sources, and systems. • Maintained an established and centralized process across all corporate markets for MRR, which included oversight of abstraction, as well as conducting training and ongoing quality checks. • Proactively explored and incorporated various supplemental data sources, including use of a validated, NCQA data aggregation source.
↑	NA	NA	**Improvements:** ***MetaStar observed the following improvement from the previous MY:*** • Proactively addressed, for MY 2022 reporting, the issue with the export file from WPM's MRR tool, Reveeler, since MY 2021's correction and continued to ensure that data files were consistent with HEDIS measure requirements. This issue specifically concerned the two/three dose Rotavirus vaccine in MY 2021 reporting.
↓	NA	NA	**Recommendations:** ***MetaStar recommends the following actions:***

Quality	Access	Timeliness	WPM Strengths, Improvements, and Recommendations
			• Develop a supplemental data flow chart, or other such documentation, to outline the different methods of data incorporation for HEDIS. Ensuring that the Roadmap responses comprehensively reflect the processes of the sources is necessary for the audit process. • Use a consistent naming convention for WPM's supplemental data sources across the documentation provided for the audit. • Investigate methods to incorporate supplemental data sources early in the audit process; this will eliminate the review of sources not applicable to the scope of the audit and ensure that data sources requiring primary source verification have the available proof-of-service documentation.
Quality	**Access**	**Timeliness**	**Systems Performance Review**
NA	**NA**	**NA**	**Strengths:** • WPM did not demonstrate any strengths in performance in this MY.
↑	↑	↑	**Improvements:** • Included the requirement for annual training of utilization management staff on the interpretation and application of utilization management criteria/guidelines in the Utilization Management Plan Description. • The sample of records reviewed demonstrated that all adverse determination letters were written in easy-to-understand language and included all required components. • Demonstrated compliance with the MCO's timeframe for sending the provider a written resolution of its administrative appeal within the MDH threshold of 95%. • Numerous documents support the implementation of provider education on and promotion of the Screening, Brief Intervention, and Referral to Treatment process and the substance use release of information process under 42 CFR, Part 2.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for WPM.
Quality	**Access**	**Timeliness**	**Network Adequacy Validation**
↑	↑	↑	**Strengths:** • WPM scored above the 80% compliance threshold for routine and urgent care appointment timeframes at 93.4% and 89.1%, respectively.
↑	↑	**NA**	**Improvements:** • ***Best Practice:*** WPM has implemented a Provider Self Service Tool that allows providers to directly update demographic information. This best practice resulted in an improvement by 3.9 percentage points (77.9% in MY 2022 to 81.8% in MY 2023) in compliance with *Specifies PCP Accepts New Medicaid Patients & Matches Survey Response*.
↓	↓	**NA**	**Recommendations:** • ***CAP:*** WPM must submit a CAP to achieve compliance in the MY 2024 validations:

Quality	Access	Timeliness	WPM Strengths, Improvements, and Recommendations
			o WPM must ensure staff responses regarding practice location match the online provider directory accurately. Enrollees use the online directory to search for new PCPs and should receive the same information when calling the provider directly. o WPM's performance has declined in the following provider directory requirement compared to MY 2022: *PCP's Practice Location Matched Survey Response* (79.6%). This is a decline of 15.3 percentage points from MY 2022 (94.9%). WPM should consider reviewing the root causes for the decline in performance and address the identified issues to improve MY 2024 performance.
Quality	**Access**	**Timeliness**	**Encounter Data Validation**
↑	↑	↑	**Strengths:** • All encounter match rates for WPM exceeded the compliance standard of 90%. • WPM's MY 2022 match rates achieved 100% across all code types for inpatient encounters. • Match rates for outpatient encounters were also high-performing, with 98% for diagnosis codes and 99% for procedure and revenue codes.
↑	**NA**	**NA**	**Improvements:** • Trended results reveal high-performing match rates across MYs, and demonstrate WPM's capacity for achieving and maintaining improvement. o Inpatient encounters achieved and maintained a 100% match rate in MY 2021 and MY 2022, after increasing one percentage point from MY 2020's 99%. o Outpatient encounters also had an increase of two percentage points from MY 2020's 97%, maintaining MY 2021's 99% match rate in MY 2022.
NA	**NA**	**NA**	**Recommendations:** • There are no formal recommendations for WPM.
Quality	**Access**	**Timeliness**	**Early and Periodic Screening, Diagnosis, and Treatment**
↑	↑	↑	**Strengths:** • WPM met the MDH-established minimum compliance threshold (80%) for all five component scores. • WPM achieved full compliance (100%) for the elements Documentation of Minimum 5 Systems Examined, Measured Weight, and Rotavirus (RV). • All elements comprising both the Immunizations component and Comprehensive Physician Exam component scored at or above 90%.
↑	↑	↑	**Improvements:** • All component scores improved from MY 2021 to MY 2022, ranging from one to five percentage points above. • The 12 Month Blood Lead Test element displays the most significant improvement for the Laboratory Tests/At-Risk Screenings component from MY 2021 (77%) to MY 2022 (89%).

Quality	Access	Timeliness	WPM Strengths, Improvements, and Recommendations
↓	↓	↓	**Recommendations:** • WPM should monitor the following elements for root causes in performance for MY 2022, as these elements did not meet the MDH-established compliance score of 80%, and implement strategic initiatives to improve scoring: o Recorded Maternal Depression Screening o Recorded Autism Screening Tool o Recorded Cholesterol Risk Assessment o 9-11 Year Dyslipidemia Lab Test o 18-21 Year Dyslipidemia Lab Test o Conducted Anemia Risk Assessment
Quality	**Access**	**Timeliness**	**Grievance, Appeal, and Denial Focused Study**
↑	**NA**	↑	**Strengths:** • WPM requests team meetings with Qlarant to remedy non-compliant metrics. • Consistently met compliance at 100% for all applicable enrollee and provider grievance categories in all three quarters and the year. • Consistently met the non-emergency appeals resolution timeliness threshold in all three quarters and the year. • Appropriately resolved all grievances.
↑	**NA**	↑	**Improvements:** • Initial, then consistent compliance with expedited appeals resolution timeframes. • Consistent compliance with timeframes for resolution/notification of enrollee appeals. • Consistent compliance with timeframes for adverse determination notifications. • Use of the current letter template and easy-to-understand language in pharmacy adverse determination letters.
↓	**NA**	↓	**Recommendations:** • Provide training to the grievance team focused on the appropriate categorization of grievances and associated resolution timeframes. Routinely conduct audits of case notes to ensure appropriate categorization and compliance with resolution timeframes. • Increase monitoring of timeframe compliance for grievance resolution, appeal acknowledgment letters, and pre-service determinations, until consistent compliance is demonstrated over multiple measurement periods. • Conduct routine audits of appeal case notes for documentation of reasonable attempts to provide enrollee verbal notice of expedited appeal resolution.

Quality	Access	Timeliness	WPM Strengths, Improvements, and Recommendations
			• Audit a random sample of enrollee appeal letters to ensure the correct template is used. One acknowledgment letter was for a provider rather than an enrollee appeal.

Appendix B: MY 2022 Maryland Standards Crosswalks and Guidelines

*Rows highlighted in blue identify NCQA deemable elements/components. Within the highlighted sections, italicized elements/components are eligible for deeming.

SPR 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 Quality Assurance Plan (QAP) objectively and systematically monitors and evaluates the Quality of Care (QOC) and services to enrollees, through QOC studies and related activities, and pursues opportunities for improvement on an ongoing basis.**			
1.1	The QAP ensures monitoring and evaluation of the enrolled population and areas of concern for the enrolled population. a. The monitoring and evaluation of care reflect the population served by the MCO in terms of age, disease categories, and special risk status. b. The QAP monitors and evaluates priority areas of concern selected by the State and any additional areas of concern identified by the MCO.	The MCO demonstrates the ability to capture and analyze data that describe the demographic, health status, and utilization patterns of the enrolled population. The MCO documents processes used to prioritize problems and develop a timeframe for QAP studies and projects.	• Quality Assurance (QA) Plan • Policies & Procedures • Data Analysis • Population Assessment Data • Enrollee Profiles (demographic; medical; pharmacy; and utilization data) • Quality Assurance Committee (QAC) Meeting Minutes • QA Timeline/Work Plan • Outreach Plan	42 CFR §438.330 42 CFR §438.330(b)(4) COMAR 10.67.04.03A(3)(c)
1.2	The QAP's written guidelines for the MCO's QOC studies and related activities require the use of quality indicators.	QOC study designs or project plans contain indicators based on sound clinical evidence or guidelines. The methodology and frequency of data collection will be evaluated to determine if they are sufficient to detect change.	• QA Plan • Policies & Procedures • QOC Study Designs • QOC Project Plans	42 CFR §438.330 42 CFR §438.330(c) COMAR 10.67.04.03B(2)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience. b. Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.		• Quality Indicators, including HEDIS and CAHPS reports • Data Analysis	
1.3	The QAP has written guidelines for its QOC studies and related activities must include the use of clinical practice guidelines. *a.* Deleted in measurement year (MY) 2018. *b. Clinical practice guidelines are based on evidence-based practices or professional standards of practice and are developed or reviewed by MCO providers.* *c. The guidelines focus on the process and outcomes of health care delivery and access to care.*	There must be a comprehensive set of guidelines that address preventive care and the range of the populations enrolled in the MCO. Clinical practice guidelines provide the basis for QOC studies and related QA activities. There is evidence that these guidelines are based on reasonable evidence-based practice and have been developed or reviewed by plan providers. The guidelines in use allow for the assessment of the process and outcomes of care. The MCO must have a mechanism in place for reviewing the guidelines at least every two years and updating them as appropriate. There must be evidence that the MCO disseminated guidelines to providers and, upon request, to enrollees and potential enrollees.	• QA Plan • Policies & Procedures • Practice Guidelines • Proof of Guidelines Disseminated to Providers • QA/Quality Improvement Committee (QIC)/MCO's Internal Provider/Medical Advisory Committee (MAC) Meeting Minutes • Clinical Care Standards • QOC Study Designs • QOC Study Tools • QOC Project Plans • Quality Indicators • Data Analysis	42 CFR §438.236 NCQA: MED 2 Element A-C UM 2 Element C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 (electronically or faxed) as they are adopted.* *f.* There are guidelines to address preventive health services for children and adults. *g. The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a.* *h. The MCO's clinical guidelines policies and procedures must reflect how the guidelines are used for utilization management (UM) decisions, enrollee education, and coverage of services.*	Decisions for UM, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the clinical guidelines.	• Population Assessment Results	
1.4	The QAP has written guidelines for its QOC studies and related activities that require the	The QA Plan and/or related documents describe the methodology for monitoring the quality of care provided by the MCO's	• QA Plan • Data Analysis • Policies & Procedures	42 CFR §438.330b(3)-b(4)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	analysis of clinical and related services. a. The QAP has written guidelines to evaluate the quality of care provided by the MCO's providers. b. Appropriate clinicians monitor and evaluate quality through the review of individual cases and through studies analyzing patterns of clinical care. c. Multidisciplinary teams are used to analyze, identify, and address systems issues. d. Clinical and related service areas requiring improvements are identified through activities described in a. and b. above. e. Deleted for MY 2023. f. Mechanisms to assess the quality and appropriateness of the care provided to enrollees with special health care needs.	providers. This may be through a study of clinical care and services through individual case reviews, 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/QIC/MCO's internal Provider/Medical Advisory Committee (MAC) Meeting Minutes • QA/QIC/MAC Membership • QA/QIC/MAC Attendance Records	
1.5	The QAP includes written procedures for taking	The QA Plan specifies the process for identifying problems and taking appropriate	• QA Plan • Policies & Procedures	HCQIS II.E.1-7

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 professionals, providers, and staff (as appropriate). e. The schedule and accountability for implementing corrective actions. f. The approach to modifying the corrective	corrective actions. Documentation must be provided to ensure that policies and procedures are in place that support the process and address all components of this element. This would include the identification, development, implementation, and monitoring of Corrective Action Plans (CAPs).	• Data Analysis • Provider Feedback • CAPs	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	action if improvements do not occur. g. The procedures for terminating health professionals, providers, or staff (as appropriate).			
1.6 Deleted in MY 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 ensure that the QAP is routinely reviewed to assess its scope and content. Documentation must be provided to substantiate that QA activities have resulted in improvements to care. And if not, what is being done to address areas of opportunity for improvement. QOC study data, analysis, reports and findings may support these improvements.	• QA Plan • Policies and Procedures • QAC Meeting Minutes • QOC Studies • QAP Annual Report	42 CFR §438.330(e)
1.8	*A comprehensive annual written report on the QAP is completed. The annual report on the QAP must include:* *a. QA studies and other activities undertaken, results, and subsequent actions.*	The annual report on the QAP must include all required components. **Note:** Element 2.1 requires this report to be reviewed and approved by the governing body to assess the QAP's continuity, effectiveness, and current acceptability.	• Annual QAP Evaluation Report • QAC Meeting Minutes • Governing Body Meeting Minutes	42 CFR §438.330(e) NCQA: QI 1 Element C and D

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.*			
1.9	The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.	The organizational chart must be comprehensive, indicating all appropriate positions and their relationships to one another.	• QAP Organizational Chart	42 CFR §438.330
1.10	The MCO must have a Continuity of Operations Plan and a Disaster Recovery Plan that is updated on an annual basis.	The MCO and its subcontractor(s) shall have robust continuity of operations and disaster recovery plans in place to ensure that the services provided will be maintained in the event of disruption to the MCO/subcontractor's operations (including, but not limited to, disruption to information technology systems), however caused.	• Disaster Recovery Plan • Continuity of Operations Plan • Evidence that subcontractor disaster recovery plans are in place.	COMAR 10.67.04.15(I) MCO Agreement: Section II.A.5 https://health.maryland.gov/mmcp/healthchoice/Documents/CY%202022%20HealthChoice%20MCO%20Agreement%20%28Ma

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
				ster%20-%20Combined%29.pdf
2.0	**Accountability to the Governing Body – The governing body of the MCO is the Board of Directors (BOD) or, where the Board's participation with the quality improvement (QI) issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care.**			
2.1	There is documentation that the governing body has oversight of the QAP and approves the annual QA Plan/Description and QA Work Plan.	The governing body is the BOD or the designated entity of senior management that has accountability and oversight of the operations of the MCO, including but not limited to the QAP. The QA Plan/Description must specify that the governing body has oversight of the QAP. The governing body meeting minutes must reflect the review and approval of the annual QA Plan/Description and the annual QA Work Plan.	• 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 management does not choose to provide direct oversight of the day-to-day operations of the QAP, it must formally designate in writing a committee or other entity to provide such oversight. For example, this may be the MCO's Quality Committee. However, the governing body must continue to perform all of the responsibilities noted in Standard 2.0.	• Governing Body Meeting Minutes • QA Plan • QAC Meeting Minutes • QA Organizational Chart	HCQIS III.B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
2.3	The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.	There must be evidence that the governing body receives written reports from the QAC. Reporting to the governing body should occur according to the timeframes documented in the QA Plan (e.g., monthly, quarterly, etc.).	• Governing Body Meeting Minutes • QA Plan	HCQIS III.C
2.4	The governing body formally reviews, at least annually, a written report on the QAP Evaluation.	There must be evidence in the governing body meeting minutes that this document was reviewed and approved by the governing body.	• QAP Annual Evaluation Report • Governing Body Meeting Minutes	HCQIS III.D
2.5	The governing body takes action when appropriate and directs that the operational QAP be modified to accommodate a 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 followed up on necessary actions pertaining to the QAP.	• QA Plan • Governing Body Meeting Minutes • QAC Meeting Minutes	HCQIS III.E
2.6 Deleted in MY 2019.				
2.7	The governing body is active in UM activities. The governing body meeting minutes reflect ongoing reporting of: a. UM activities and findings, and b. Evaluation of UM progress.	The UM Plan provides a clear definition of the overall authority and responsibility of the governing body.	• Governing Body Meeting Minutes • UR Plan	HCQIS XIII
3.0	**Oversight of Delegated Entities and Subcontractors – The MCO remains accountable for all functions, even if certain functions are delegated to other entities.**			
3.1	The MCO must ensure that delegates have detailed	Delegates are subcontractors that administer a critical benefit on behalf of the	• Delegation Contract	HCQIS VIIL A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.	MCO that impacts enrollees directly (e.g., vision, claims, UM, pharmacy). Subcontractors are individuals or entities that have a contract with an MCO that relates directly or indirectly to the performance of the MOC's obligations under its contract with the state related to Medicaid (e.g., contractors providing outreach services, call center activities, or mobile laboratory vendors). Vendors are subcontractors that administer a function that does not directly impact enrollee services or benefits (e.g. mail room, print services, and janitorial services). The contract for delegated activities contains all items listed in component a. The MCO must provide evidence that it has provided information about the grievance and appeal system to all delegates and subcontractors. For new delegates, the evidence must be provided at the time that they entered into a contract with the MCO. For existing delegates, the MCO must provide evidence of an amendment to the agreement with the grievance and appeal system information or documentation it has shared with the delegate, and the delegate's acknowledgment of receipt.	• Delegation Policies & Procedures	COMAR 10.67.04.17.A3

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		The only delegates required for Standard 3 are those who are delegated UM, claims, and/or appeals and grievances for mandatory services, such as vision, drug, radiology, and physical therapy (PT).		
3.2	The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided.	The MCO has policies and procedures in place to monitor and evaluate the delegated functions and for verifying the care provided.	• Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities	HCQIS VIIL B COMAR 10.67.04.17.D
3.3	There is evidence of continuous and ongoing evaluation of delegated activities, including: a. Oversight of delegated entities' performance to ensure the quality of the care and/or service 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-	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 10.67.04.17D COMAR 31.10.11 COMAR 31.10.23.01 Ins. Art. §15-1004 Ins. Art. §15-1005

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	annually, where applicable. d. Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable. e. Review and approval of overutilization and underutilization reports, at least semi-annually, where applicable.			
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.**			
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*	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 42 CFR §438.214 NCQA: CR 1 Element A-B CR 2 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	credentialing and subsequent recredentialing process. b. *The Credentialing Plan designates a CC or other peer review body that makes recommendations regarding credentialing decisions.* c. *The Credentialing Plan must identify the practitioners who fall under its scope of authority and action.* d. The Credentialing Plan must include policies and procedures for communication with providers regarding 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 timeframes for completed application processing. When an "online credentialing system" is utilized by the MCO the following applies:		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• 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 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	There are policies and procedures in place for the suspension, reduction, or termination of practitioner privileges. There is evidence that these policies and procedures have been implemented. The policies and procedures must identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place.	• Credentialing Plan • Recredentialing Plan • Credentialing Policies & Procedures • Provider Appeal Policy & Procedure • Provider Appeals Files • Facility Site Reviews (completed forms/files)	HCQIS IX H-J

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner. c. Deleted in MY 2019.			
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 42 CFR §438.214 NCQA: CR 8 Element A-D
4.4	The credentialing process must be ongoing and current. At a minimum, the credentialing process must include: a. A review of a current valid license to practice. b. A review of a valid Drug Enforcement Administration (DEA) or	The credentialing plan and policies and procedures require, at a minimum, that the MCO obtain the information required in components a-k for the credentialing process. **Note:** (h) is applicable to those primary care providers (PCPs) who deliver preventive health care services to enrollees less than 21 years of age. The reviewer will assess the	• Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Written correspondence to providers • Screenshots from ePREP showing	HCQIS IX E.1-7 42 CFR §438.214 (c-e) COMAR 10.67.04.02N Ins. Art. §15-112 (a)(4)(ii)(9) Ins. Art. §15-112 (d) MCO Transmittal PT 10-19

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	Controlled Dangerous Substances (CDS) certificate, if applicable. c. A review of graduation from medical/ancillary (NP, PT, OT, SLP, etc.) school and completed residency or post-graduate training, as applicable. d. A review of work history. e. A review of a professional and liability claims history. f. A review of current adequate malpractice insurance according to the MCO's policy. g. Deleted as of the MY 2017 SPR. h. A review of Early and Periodic Screening Diagnosis and Treatment (EPSDT) certification. i. Adherence to the timeframes set forth in the MCO's policies regarding credentialing date requirements. j. Adherence to the timeframes set forth in the MCO's policies for	MCO's methodology for verifying whether PCPs in the MCO's network that see patients under age 21 are EPSDT certified.	validation of provider enrollment in Medicaid • Provider agreement (for new contracts)	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d). k. Verification that the provider is actively enrolled in Medicaid at the time of credentialing.			
4.5	*The MCO should request and review information from recognized monitoring organizations regarding practitioners. The evidence must include:* *a. Any revocation or suspension of a State license or a DEA/Bureau of Narcotics and Dangerous Drugs (BNDD) number.* *b. Any curtailment or suspension of medical staff privileges (other than for incomplete medical records).* *c. Any sanctions imposed by Medicare and/or Medicaid.*	The credentialing plan and policies and procedures require that the MCO request information required in components a-d from recognized monitoring organizations.	• Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Credentialing Committee Meeting Minutes	HCQIS IX E.8-12 42 CFR §438.214 (d) NCQA: CR 1 Element A CR 3 Element B CR 5 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. *Information about the practitioner from the National Practitioner Data Bank (NPDB) and the Maryland Board of Physicians (MBP).*			
4.6	*The credentialing application includes the following:* *a. The use of illegal drugs.* *b. Any history of loss of license.* *c. Any history of loss or limitation of privileges or disciplinary activity.* d. *Attestation to the correctness and completeness of the application.*	The credentialing plan and policies and procedures describe the application process. This process includes the requirement that the applicant must provide a statement that includes components a-d. There must be evidence in the credentialing files that this statement is completed. Type of credentialing application must be reviewed and in compliance with Maryland Insurance Administration (MIA) regulatory requirements noted.	• Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Completed Application • Completed Uniform Credentialing Form	HCQIS IX E.13.a-e COMAR 31.10.26.03 42 CFR §438.214 NCQA: CR 3 Element C
4.7	There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the Americans with Disabilities Act (ADA) and the MCO's standards.	The credentialing plan and policies and procedures must require an initial visit to each potential primary care practitioner's office. There must be documentation that a review of the site includes both an evaluation of ADA compliance and medical record keeping and that these practices are in conformance with the MCO's standards. Such standards should consider: • Handicapped designated parking clearly marked and close to the entrance. • Ramps for wheelchair access.	• 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

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Door openings to the practice and restroom and hallways should facilitate access for disabled individuals. • Elevator availability for practices above ground level.		
4.8	There is evidence that recredentialing is performed at least every three years and: *a. Includes a review of information from the NPDB.* b. Deleted in MY 2019. c. Includes all items contained in element 4.4 a–h, except 4.4 d (work history). *d. Includes all items contained in 4.6 a–d.* *e. Meets the timeframes set forth in the MCO's policies regarding recredentialing decision date requirements.* f. *Ensures the MCO is verifying that the provider is actively enrolled in Medicaid at the time of recredentialing.*	The credentialing plan and policies and procedures indicate that recredentialing is performed at least every three years. The recredentialing process requires a review of components contained in a-f. There is evidence in individual provider credentialing files that this has occurred. This information is used to decide whether or not to renew the participating physician agreement.	• Credentialing Plan • Recredentialing Policies & Procedures • Sample Credentialing Records • Credentialing Committee Meeting Minutes	HCQIS IX F.1-2 COMAR 10.67.04.02N Ins. Art. §15-112 (d) MCO Transmittal PT-10-19 42 CFR §438.214 NCQA: CR 1 Elements A - B CR 3 Elements A - C CR 4 Element A
4.9	There is evidence that the recredentialing process includes a review of the following:	There is evidence in provider recredentialing records in which complaints, grievances, and the results of quality reviews were reviewed	• Credentialing Plan • Recredentialing Policies & Procedures	HCQIS IX F.3 a – e 42 CFR §438.214

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	a. Enrollee complaints/grievances. *b. Results of quality reviews.* c. Deleted in MY 2018. d. Office site compliance with ADA standards, if applicable.	prior to the MCO's recredentialing of providers. There is a process in place to re-assess provider site ADA compliance when: • Provider relocates to a site that has not previously been evaluated and approved as being ADA-compliant, or • There is evidence of ADA non-compliance issues with a particular site of care delivery.	• Sample Recredentialing Records	NCQA: CR 5 Element A
4.10	The MCO must have policies and procedures regarding the selection and retention of providers. a. The MCO must have written policies and procedures for selection and recruitment of providers in the HealthChoice Program. b. The MCO must have written policies and procedures for the retention of providers in the HealthChoice Program.	Policies and procedures should be directed at ensuring that recipient choice is enhanced by providers participating in multiple MCOs. Also, ensuring that providers are retained within the Medicaid network.	• Credentialing Plan • Credentialing Policies and Procedures	42 CFR §438.214 42 CFR §438.207
4.11	The MCO must ensure that enrollees' parents/guardians are notified if they have chosen for	The MCO must include in the notification: • An explanation of the EPSDT preventive screening services to	• Policies and Procedures • Letters to Parents/Guardians	COMAR 10.67.05.05

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	their child to be treated by a non-EPSDT certified PCP. a. The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired. b. The MCO must provide evidence of notification to parents/guardians that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.	which an enrollee is entitled according to the EPSDT periodicity schedule (only a summary is necessary if the periodicity schedule was included in the MCO's welcome packet); • Importance of accessing the EPSDT preventive screening services; and • Process for requesting a change to an EPSDT-certified PCP to obtain preventive screening services.		
4.12	The MCO must have written policies and procedures for notifying the Department of provider terminations.	MCO must be compliant with the following COMAR 10.67.04.17B(4) requirements for notifying and reporting provider terminations: a. When an MCO and provider terminate their contract, the MCO shall provide the Department with a	• Network Provider Termination Policies and Procedures • Network Provider Termination Notices to MDH • Examples of completed MDH-required forms	COMAR 10.67.04.17B 42 CFR § 438.10

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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 at the later of: i. 30 calendar days before the effective date of the termination; or ii. 15 calendar days after receipt or issuance of the termination notice. c. If the provider is terminating the contract, the notice required in §B(4)(a) of this regulation shall be provided within 15 days after the MCO receives the notice from the terminating provider. d. If 50 to 99 enrollees are affected, the notice shall contain the: i. Date of termination; ii. Name or names of providers or subcontractors terminating; iii. Number of enrollees affected; and iv. MCO's plan for transitioning enrollees to other providers. e. If more than 99 enrollees are affected, the MCO shall provide the Department with a Department-approved termination survey.	• Evidence of terminated provider notices to enrollees.	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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 have had an encounter with the provider in the previous 12 months. Additionally, per 42 CFR § 438.10, the MCO must make a good faith effort to give written notice of termination of contracted providers to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. The MCO must provide notice to enrollees by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt of issuance of the termination notice.		
5.0	**Enrollee Rights – The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.**			
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.	Timeframes for resolving grievances in the policy and procedure must be in accordance with the following: • Emergency medically related grievances not > 24 hours.	• Grievance Policies & Procedures • Grievance Form • Grievance Logs • Grievance Reports • Grievances Files	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)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 the data for QI. There is documented evidence that this process is in place and is functioning. e. Deleted in MY 2018. f. There is complete documentation of the substance of the grievance, steps taken to resolve, and the	• 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. The MCO must have a documented procedure for written notification of the MCO's determination: • To the enrollee who filed the grievance • To those individuals and entities required to be notified of the grievance • To the Department's complaint unit for complaints referred to the MCO by the Department's complaint unit or ombudsman program If closing the grievance case due to not being able to contact the enrollee via phone, the MCO must notify the enrollee in writing that their grievance is being closed. The policies and procedures must describe	• TAT Grievance Compliance Reports for acknowledgment letters, resolution, and resolution letters monthly or quarterly for the entire review period. • Grievance Committee meeting minutes • QAC/QIC Meeting Minutes • Consumer Advisory Board (CAB) Meeting Minutes • Quarterly Complaints/Grievances • Sample Grievance Letters to Enrollees	42 CFR §438.406 (a & b) 42 CFR §438.408 (a-f)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	resolution in the case record. g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%. h. The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and within the MDH established threshold of 95%. i. Written resolution letters describe the grievance and the resolution in easy-to-understand language.	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. A sample of selected grievances is reviewed to assure that the process is complete and is being followed. The policies and procedures describe the process to be used for data collection and analysis. This must include timeframes for collection and reporting. (e.g., collected and analyzed quarterly, reported to the QAC quarterly). The policies and procedures must include the notification of results to the provider involved, if applicable, the Consumer Advisory Board, and the QACs as required by COMAR. If problems are identified, the reviewer will track the progress of problem resolution. The state specified threshold for timeliness of all grievance acknowledgment letters, resolutions, and resolution letter decisions is 95%. A sample of grievance files must be reviewed for compliance with state and		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		MCO (for resolution letter) specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
5.2	*The MCO shall provide access to health care services and 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 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.	• Enrollee Informational Materials	COMAR 10.67.04.02H COMAR 10.67.05.01 42 CFR §438.10 42 CFR §438.206 (c)(2) NCQA: MED 12
5.3	The organization acts to ensure that the confidentiality of specified patient information	The policies and procedures address all required components described in a-e. The MCO must provide evidence that these	• Medical Records Policies & Procedures • Confidentiality Policies & Procedures	HCQIS X.1 42 CFR §438.100 (d) 42 CFR §438.224 HIPAA

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 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	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.	• 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 Confidentiality Statement • Signed MCO Employee Confidentiality Statements • Sample Vendor Contracts	Health-General §§ 4-301 NCQA: MED 4 Elements A - C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	the health or safety of an individual. d. Deleted in 2023. e. May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.			
5.4	The MCO has written policies and procedures regarding the appropriate treatment of minors, including minor consent to treatment and confidentiality requirements. Without the consent of or over the express objection of a minor, a licensed health care practitioner may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor under this section, except information about an abortion.	The MCO has a written policy addressing the appropriate treatment of minors. This policy must address the minor's right to receive treatment without parental consent in cases of sexual abuse, rape, family planning, and sexually transmitted diseases.	• Treatment of Minors Policy and associated procedures	HCQIS X.J Health General 20-102 HIPAA

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
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 pro vide follow-up. There must be documentation (e.g. meeting minutes, CAPs) to demonstrate that policies and procedures are in place and are being followed. There is a mechanism in place to provide survey information to providers as a group, and to an individual provider(s) if warranted.	• Patient Satisfaction Evaluation Policies and Procedures • Patient Satisfaction Evaluation Tool • Patient Satisfaction Survey Data Analysis • Corrective Action Plans • Appropriate Committee Meeting Minutes Showing CAHPS Results Review	HCQIS X.K.3 a-c HCQIS X.K.4 42 CFR §438.206 (c)
5.6	The MCO has systems in place to assure that new enrollees receive required information within established timeframes. a. Policies and procedures are in place that address the content of new enrollee packets of information and specify the time timeframes for sending such information to the enrollee. b. Policies and procedures are in place for newborn enrollments, including issuance of the MCO's ID card.	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 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	• Enrollee Handbook • Enrollee Notices • Sample New Enrollee Information Packet • New Enrollee Policies & Procedures • Committee Meeting Minutes • ID Card Fulfillment Reports • ID Card Fulfillment Tracking and Trending Analysis	COMAR 10.67.05.02 COMAR 10.67.04.02.G(3) COMAR 10.67.02.02 Ins. Art. §15-140 42 CFR 438.10

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.	required by § 15-140(f) of the Insurance Article. The MCO has written procedures that track and monitor timeliness of receipt of ID cards (including newborns). Such monitoring is analyzed and if timelines are not met, there is evidence of corrective action and evaluation of progress. Performance is reported through a committee or the MCO's administrative structure. There is a documented process for newborn enrollment that includes timeframes. The MCO has a documented internal mechanism for processing and follow-up on the Daily MCO Newborn Enrollment Report from the Department.		
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	• Policies and Procedures • Committee Charter • CAB Meeting Minutes • CAB Annual Summary	COMAR 10.67.04.12 and 10.67.04.15

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Mission/Vision Statement for the CAB • Goals for the CAB • Structure of and member composition of the CAB • Dates, times, and locations for each CAB meeting • Summary of topics/issues discussed • Enrollee feedback/concerns • Accomplishments/Resolutions • Opportunities for Improvement/Follow-up		
5.8	The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights. a. *Materials critical to obtaining services that are distributed by the MCO to the enrollee will include a 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	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	• Enrollee Handbook • Provider Directory • Enrollee Information/ Material • Screen Shot of the MCO Website • Pictures of Notices and Taglines posted at enrollee events • Websites • Online Directories	45 CFR §92.101 42 CFR §438.10 COMAR 10.67.05.01 NCQA: MED 12 Element D-H MED 13 Element B-C NET 5 Element J ME 7 A-B ME 2 Element A-B UM 3 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	accessible from the home page. c. Notices and Taglines must be posted in significant communications and publications. d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public. e. MCO's electronic information provided to enrollees must meet requirements set forth in COMAR.	understand the information provided; and 2. Provide the toll-free and TTY/TTD telephone number of the MCO's customer service unit. MCOs must take steps to notify enrollees and prospective enrollees about their rights under Section 1557 of the ACA. Specifically, MCOs must post a nondiscrimination Notice in English and in at least the top 15 non-English languages spoken by the individuals with limited English proficiency of the relevant State or States. MCOs may combine the content of the Notice with other notices as long as the combined notice clearly informs individuals of their rights under Section 1557. Small-size material (trifold brochures) must have statements and taglines in at least the top 2 non-English languages. MCOs may use the Sample "Discrimination is Against the Law" statement to meet this requirement. The Notice and Taglines must be posted in a conspicuously-visible font size in a conspicuous location of covered entity websites accessible from the home page, in written materials critical to obtaining services, in significant communications and significant publications, and, where appropriate, in conspicuous physical locations where the entity interacts with the public.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		This applies to, but is not limited to: Marketing materials, enrollee communications related to health coverage, benefits, and prescription drug coverage, provider/pharmacy directories, formularies, enrollment forms, a summary of benefits, and appeal and grievance notices. COMAR 10.67.05.01.D states that if the MCO provides enrollee information electronically (provider directory, EOB, enrollee handbook), the following requirements must be met: 1. The format is readily accessible; 2. The information is placed in a location on the MCO's website that is prominent and readily accessible; 3. The information is provided in an electronic form which can be electronically retained and printed; 4. The information is consistent with the content and language requirements of this section; 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.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		MCOs should be prepared to provide evidence of materials referring enrollees to online information that advises them how to request printed material free of charge; evidence that the online information provided is downloadable and printable; and information/reports that are uploaded to the MCO website should be 508c accessible.		
5.9	The MCO must maintain written policies and procedures for advance directives. a. The MCO must educate staff regarding advance directives policies and procedures. b. The MCO must provide adult enrollees with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618). c. The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.	The MCO must have written policies and procedures for advance directives. Advance directives are written instructions, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. MCOs must educate staff on advance directives. Staff should include clinical staff, case management, enrollee services, and outreach staff that would interact with enrollees and advance directives. Additionally, network management staff should be educated since they have contact with the provider network. MCO must provide examples of completed staff training such as signed attestations and rosters of staff showing dates of annual training completed.	• Policies and Procedures • Enrollee Handbook • Enrollee Notices • Staff Notices • Evidence of staff training	42 CFR §422.128 42 CFR §438.3(j)(1) 42 CFR §489.100 Hlth Gen Art §5-601-618 COMAR 10.67.04.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
5.10	MCO must comply with the marketing requirements of COMAR 10.67.04.23. a. An MCO may not have face-to-face contact with a recipient who is not an enrollee of the MCO unless contact is authorized by the Department or contact is initiated by the recipient. b. An MCO cannot engage in marketing activities without prior approval of the Department. c. Deleted in MY 2018.	The MCO's marketing policies and procedures comply with the requirements of COMAR 10.67.04.23. An MCO may not have face-to-face or telephone contact with a recipient, or otherwise solicit a recipient who is not an enrollee of the MCO, unless authorized by the Department or the recipient initiates the contact. Subject to prior approval by the Department, an MCO may engage in marketing activities designed to make recipients aware of their availability, as well as any special services they offer. These marketing activities may involve campaigns using but not limited to Television; Radio; Newspaper; Informational booths at public events; Billboards and other public displays; Addressee-blind informational mailings, but only when mailed to the MCO's entire service area; Magazines; Airborne marketing displays; or Public conveyances.	• Marketing Policies and Procedures • Marketing Requests and Approvals from the Department	42 CFR §438.104 COMAR 10.67.04.23
5.11	The MCO has implemented policies and procedures to ensure that the MCO does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.	The MCO has written policies and procedure to ensure: a. that it does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:	• Policies and Procedures • Provider Manual • Enrollee handbook	42 CFR §438.102

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		i. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. ii. Any information the enrollee needs to decide among all relevant treatment options. iii. The risks, benefits, and consequences of treatment or non-treatment. iv. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. b. that if the MCO objects to providing, reimbursing for, or providing coverage of a counseling of referral service on moral or religious grounds for the requirements in 5.11, section a, then the MCO must furnish information about the services it does not cover to MDH consistent with the requirements in § 438.102 (b)(1)(i)(A)(B) c. enrollees are informed how they can obtain information from the		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		State to access the service(s) excluded in 5.11, section a.		
6.0	**Availability and Accessibility – The MCO has established measurable standards for access and availability.**			
6.1	The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services. *a. The MCO has developed and disseminated written access and availability standards.* b. The MCO has processes in place to monitor performance against its access and availability standards at least quarterly. c. The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance. d. The MCO has documented a review of the Enrollee Services	The MCO has established access and availability standards that comply with HCQIS and COMAR requirements and demonstrates that these standards have been disseminated to providers. These standards must include: • routine appointments • urgent appointments • emergency care/services • telephone appointments • advice • enrollee service lines • outreach • clinical and pharmacy access The MCO must monitor against the above standards. The following should be included to ensure compliance with standards: • Quarterly calls to be conducted to a sample of providers to ensure compliance with all access and availability standards including but not limited to the validation of provider directory information, compliance with appointment availability, and after hour requirements.	• Access and Availability Standards • Access and Availability Policies & Procedures • Provider Manual • Newsletters • Monitoring and Evaluation Processes • Committee Meeting Minutes • Monitoring Reports • Performance Trends • Evidence of Quarterly Monitoring of Access and Availability Standards	HCQIS XI COMAR 10.67.05.03-08 42 CFR §438.206(c)(1) 42 CFR §438.210 COMAR 10.67.05.07.B(2) 42 CFR §438.68(c)(1)(vii) 42 CFR §438.68(c)(1)(viii) 42 CFR §438.206(c)(2) 42 CFR §438.206(c)(3) CMS's Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	Call Center performance.	• Quarterly survey results should be reviewed, reported, and trended by the MCO. • Providers failing the survey for not meeting access standards will be provided education and included in a survey within the next 6th months to ensure compliance. If the provider fails the following survey, they will be placed on a Corrective Action Plan by the MCO. The MCO has also established policies and procedures for the operations of its internal customer/enrollee services. Performance standards have been developed, such as telephone answering time, wait time, abandoned call rates, and timeframes for response to enrollees' inquiries. Such standards are measured for performance and identification of issues that affect enrollee services and are reported through established channels, such as committees.		NCQA: NET 1 Element B-C
6.2	The MCO has a list of providers that are currently accepting new enrollees. a. The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population.	The MCO must conduct annual geo mapping to calculate the average distance to ensure compliance with geographic access requirements. Specific network capacity and geographic access requirements are defined in COMAR 10.67.05.05.B and COMAR 10.67.05.06.B-D. Some of these are listed below: • Enrollee to physician ratio for local access area = 200:1	• Provider Directory • Provider Manual • New Enrollee Packet • New Enrollee Orientation Materials • Availability & Access Standards • Access and Availability Policies & Procedures	HCQIS XI COMAR 10.67.05.02C COMAR 10.67.05.05B COMAR 10.67.05.06B-D COMAR 10.67.05.01A (3) 42 CFR §438.10 (f) (2-6)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 and geographic access requirements at least annually by conducting geo mapping.*	• Travel distance (urban) - 10-mile radius • Travel distance (suburban) – 20-mile radius • Travel distance (rural) - 30-mile radius. Annually compare percentages of network providers who communicate in non-English languages most common among enrollees. As defined in COMAR, the MCO must make available a listing of individual practitioners who are the MCO's primary and specialty care providers. Information must include: • Name as well as any group affiliation • Street address • Telephone number • Website URL, as appropriate • Specialty, as appropriate • An indication of whether or not the provider is accepting new Medicaid patients • The provider's cultural and linguistic capabilities (including American Sign Language) • An indication of whether or not access to the provider is otherwise limited (e.g. by age of patient or number of enrollees the provider will serve)	• Monitoring Methodology • Monitoring Reports • Committee Meeting Minutes • Top Ten Diagnoses for all Care Settings • Enrollee Complaint Reports • Documentation of any CAPs • Online Provider Directories • Provider Directory Machine Readable Format and File • Link to Online Provider Directory • Screenshots of Online Provider Directory	42 CFR §438.206 (b) 42 CFR §438.207 42 CFR §438.10 (h) (1) (i-viii) 42 CFR §438.236 NCQA: NET 1 Elements A-C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• 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. Hardcopy provider directory updates must be made quarterly if the MCO has a mobile-enabled electronic provider directory. Hardcopy provider directory updates must be made monthly if the MCO does not have a mobile-enabled electronic provider directory. Electronic provider directories must be updated no later than 30 calendar days after		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		the MCO receives updated provider information. The MCO has a methodology in place to assess and monitor the network needs of its Medicaid population. The methodology substantiates how the MCO determines that it has sufficient numbers and the types of specialists, as well as PCPs, within its network to meet the care and service needs of its population in all care settings. The methodology includes: • A process of monitoring that has the ability to identify problem areas that are reported through the MCO's established structure. • Follow-up activities and progress toward resolution that are evident. • Direct access to specialists. Each MCO must have a mechanism in place to allow enrollees with special health care needs who have been determined to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the enrollee's condition and identified needs. This is determined through an assessment by appropriate health care professionals and can be provided for example, through a standing referral or an approved number of visits.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		"An MCO shall provide access to health care services and information in a manner that addresses the individualized needs of its enrollees, including, but not limited to, the delivery of services and information to enrollees: In a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it."		
6.3	The MCO has implemented policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services. a. Deleted in MY 2019. b. Deleted in MY 2019. c. Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	Policies and procedures must be in place and address trending and analysis of wellness services. The analysis must be included in the QAP with CAPs developed as appropriate. Documentation must be provided to substantiate that timeframes are adhered to and that tracking procedures are in place. The MCO has a written procedure/methodology that tracks and monitors timeliness of Initial Health Assessments (IHAs). Such monitoring is analyzed and if un-timeliness is identified, there is evidence of corrective action and evaluation of progress. Performance is reported through a committee or the MCO's administrative structure.	• Scheduling of IHA Policies & Procedures • IHA completion analysis • QAP	HCQIS XI COMAR 10.67.03.06 COMAR 10.67.05.03 COMAR 10.67.05.07
6.4	The MCO has implemented policies and procedures to ensure coverage and payment of	Policies and procedures must be in place to ensure payment is not denied for	• Availability & Access Standards	42 CFR §438.114 10.67.05.08B 10.67.06.28

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	emergency services and post-stabilization care services for enrollees.	emergency and post-stabilization treatment obtained under the following circumstances: a. An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in §438.114(a)(b)(c)(1)(i)(ii). b. A representative of the MCO instructs the enrollee to seek emergency services. c. Emergency services obtained outside of the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services. d. Regardless of whether the servicing provider has a contract with the MCO. Documentation must be provided to indicate that the MCO does not: a. Limit what constitutes an emergency medical condition. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or MCO of the enrollee's screening and treatment within 10 calendar days of	• Access and Availability Policies & Procedures • Claims Payment Policies & Procedures • Emergency Department (ED) Policies & Procedures • Enrollee handbook • Provider Manual	10.67.04.20B

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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 (UR) – The MCO has a comprehensive UM program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement.**			
7.1	There is a comprehensive written UR Plan. *a. This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.* *b. The scope of the UR Plan includes a review of all covered services in all settings, admissions in*	The UR Plan is comprehensive and addresses components a-c. Component 7.1(c) requires that the MCO documentation reflect that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.	• UR Plan • UR Meeting Minutes • Governing Body Meeting Minutes • Enrollee Handbook • Provider Manual • UR Staff signed affirmations	HCQIS XIII A 42 CFR §438.236 NCQA: UM 1 Element A UM 2 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.			
7.2	The UR Plan specifies criteria for UR/UM decisions. *a. The criteria used to make UR/UM decisions must be based on acceptable medical practice.* *b. The UR Plan must describe the mechanism or process for the periodic updating of the criteria.* *c. The UR Plan must describe the involvement of participating providers in the review and updating of criteria.* *d. There must be evidence that the criteria are reviewed and updated*	There is evidence that UR criteria are based on acceptable medical practice. The UR Plan must describe the process for reviewing and updating the criteria and for involving providers. There must be evidence that criteria are reviewed and updated per the policies and procedures. The MCO must use an appropriate mechanism to assess the consistency with which physician and non-physician reviewers apply medical necessity criteria.	• UR Plan • Documentation of review/approval of new medical necessity criteria/updates • Policies & Procedures for Criteria Review/Revision, annual IRR assessment, and annual training on UM criteria • UR Committee Meeting Minutes • Sign-in sheets, training logs, certificates of completion of annual training on UM criteria • Documentation of annual assessment of IRR among UM staff/physicians	HCQIS XIII A COMAR 10.67.04.11 S 2 42 CFR §438.210(a) NCQA: UM 1 Element A UM 2 Element A and C

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.*			
7.3	The written UR Plan has mechanisms in place to detect overutilization and underutilization of services. a. Services provided must be reviewed for overutilization and underutilization. b. UR reports must provide the ability to identify problems and take the appropriate corrective action. c. Corrective measures implemented must be monitored.	The UR Plan describes the process to be used for detecting overutilization and underutilization of services. UR reports and data analysis must be available and should demonstrate the ability to identify problems. There must be documentation to support that the MCO has developed, implemented, and provided follow-up of corrective actions for the identified issues.	• UR Plan • UR Policies & Procedures • Data Reports and Analysis • CAPs • UR Committee Meeting Minutes • Provider Profiles	HCQIS XIII 42 CFR §438.330 (b) NCQA: MED 7 Element A
7.4	The MCO maintains policies and procedures pertaining to	MCO policies and procedures must be compliant with the requirements of COMAR 10.67.09.04. The MCO must demonstrate	• UR Plan • UR Policies & Procedures	HCQIS XIII.C 1-7 COMAR 10.67.09.04

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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.	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. If additional clinical information is required, it must be requested within 2 business days of receipt of the request. For expedited authorization requests, the MCO shall make a preauthorization determination and provide notice in a timely manner so as not to adversely affect the health of the enrollee and no later than 72 hours after receipt if the provider indicates or the MCO determines following the standard timeframe could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. For outpatient drug preauthorization decisions, the MCO shall approve, deny, or request additional information by telephone or other telecommunication device to the	• UR Organizational Charts • UM Position Descriptions • UM Staffing Plan • UR Committee Meeting Minutes • Delegate Reports to MCO • MCO Monitoring of Delegate Reports • TAT Compliance Reports monthly or quarterly for the entire review period.	42 CFR §438.210 (c & d) 42 CFR §438.236 NCQA: UM 4 Element A-B, F

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		requesting provider within 24 hours of request. The enrollee, enrollee's representative, or the MCO may request an extension of the authorization timeframe of up to 14 calendar days. If the MCO extends the authorization timeframe, the MCO must provide evidence it notified enrollees in writing of the extension and the reason, as well as enrollees' right to file a grievance if they disagree with the MCO's decision. The state-specified threshold for all preauthorization review decisions is 95%. A sample of preauthorization reviews must be reviewed for compliance with state-specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.5	Adverse determination letters include a description of how to file an appeal. a. All adverse determination letters are written in easy-to-understand language. b. Adverse determination letters include all required components.	There must be documented policies and procedures for appeals. Such policies and procedures must comply with the requirements stated in COMAR 10.67.09.04F. The required adverse determination letter components include: 1. Explanation of the requested care, treatment, or service. 2. Clear, full and complete factual explanation of the reasons for the	• Enrollee Adverse Determination Letter Policies and Procedure documenting required letter components • Sample Enrollee Adverse Determination Letters • Selected UR Cases	HCQIS XIII.C 1-7 COMAR 10.67.09.02 COMAR 10.67.09.04F 42 CFR §438.404 45 CFR §92.7 45 CFR §92.8 42 CFR §438.406

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		denial, reduction or termination in understandable language. • Conclusive statements such as “services included under another procedure” and “not medically necessary” are not legally sufficient. 3. Use of the phrase “nationally recognized medical standards” is acceptable; however, the exact clinical guideline reference must be included. 4. Availability of a free copy of any guideline, code, or similar information MCO used to decide and the MCO contact number including TTY/TTD. 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.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		8. Direction to the enrollee to call the HealthChoice Help Line for assistance. 9. The enrollee may also appeal to the MCO directly by contacting the MCO (phone # or address) within 60 days from the date of the adverse determination notice. 10. Explanation to the enrollee that if he/she is currently receiving ongoing services that are being denied or reduced, he/she may be able to continue receiving these services during the appeal process by calling the MCO or the HealthChoice Help Line within 10 days from receipt of this letter. If the enrollee's appeal is denied, he/she may be required to pay for the cost of the services received during the appeal process. 11. Statement that the enrollee may represent themselves or use legal counsel, a relative, a friend, or another spokesperson. 12. There is evidence that the letter is copied to the requesting provider with copying the PCP optional. 13. A statement explaining the availability of the expedited review process, MCO phone number, and timeframe for making a determination.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		14. A statement that the enrollee or their representative may request an extension of the timeframe for appeals by up to 14 calendar days. 15. A statement of availability of the letter in other languages and alternate formats. 16. Notice of Nondiscrimination and Appeals and Grievance Rights document.		
7.6	The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials. a. The MCO maintains policies and procedures pertaining to the timeliness of adverse determination notifications in response 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 the decision to deny initial services must be provided to the enrollee: • within 24 hours of the expedited authorization determination, **and** • within 72 hours of receipt of the request, **and** • within 72 hours for standard requests and outpatient drug decisions. For any previously authorized service, written notice to the enrollee must be provided at least 10 days prior to reducing, suspending, or terminating a covered service. The state-specified threshold for all adverse determination notifications is 95%. A sample	• UR Plan • UR Policies & Procedures • UR Committee Meeting Minutes • Selected UR Cases • Enrollee Notices • Turnaround Time (TAT) Compliance Reports monthly or quarterly for the entire review period.	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
		of adverse determination notifications must be reviewed for compliance with state-specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.7	The MCO must have written policies and procedures pertaining to enrollee appeals. a. The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05. *b. The MCO's appeals policies and procedures must include staffing safeguards to avoid conflicts of interest when reviewing appeals.* c. The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes. d. The MCO's appeal policies must include procedures for how the MCO will assist enrollees with the appeal process.	There is evidence that appeals are resolved, and notification is provided within the timeframes established by the State. Timeframes for resolving and providing notification of appeal decisions in the policy and procedure must be in accordance with the following: • Expedited Appeals must be resolved and written notification of the decision provided within 72 hours of receipt. The MCO must also make reasonable efforts to provide oral notice of the decision. • Standard Appeals must be resolved and written notice provided within 30 days unless extended pursuant to 438.408 b & c. • Appeals may be extended up to 14 days. The MCO must ensure that decision-makers on an appeal were not involved in previous levels of review or decision-making, were not subordinates of decision-makers	• UR Organizational Charts • UM Position Descriptions • QM Committee Meeting Minutes • Enrollee Appeals Policies & Procedures • Contract • Appeals Forms & Logs • Appeals Reports including TAT compliance monthly or quarterly for the entire review period. • Appeal Records • Enrollee Notices	HCQIS XIII.C 1-7 COMAR 10.67.09.02 COMAR 10.67.09.05 42 CFR §438.404 (b) 42 CFR §438.406 (a & b) 42 CFR §438.408 (a-f) 42 CFR §438.402 (c)(3)(ii) NCQA: UM 8 Element A UM 9 Element A MED 10 Element A

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	e. Reasonable efforts are made to give the enrollee prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request. f. Written notifications to enrollees include appeal decisions that are documented in easy-to-understand language. *g. The MCO's appeal policies and procedures must include oral inquiries seeking to appeal are treated as appeals.*	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. The state-specified threshold for all enrollee appeal acknowledgment and resolution letters is 95%. A sample of enrollee appeals must be reviewed for compliance with state-specified timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.		
7.8	The MCO must have written policies and procedures pertaining to provider administrative appeals, including but not limited to claims appeals. a. The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.	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, resolution at each level, and written resolution timeframes through routine reports (i.e. weekly, monthly, or quarterly) consistent with the MCO's policies that includes the compliance percentage for each	• Provider Administrative 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	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
	b. The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. This component is limited to provider administrative appeals. Provider medical necessity appeals are always post-payment. Pre-service medical necessity reviews are member appeals. c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	of the regulatory timeframes. The MCO can include either all provider appeals or a statistically valid sample in reporting compliance. If using a sample, the MCO must use a statistically valid sample size with a confidence level of 95% and a sampling error of 5%. The MCO must include in its provider complaint process at least the following elements: An appeal process which: • Is available when the provider's appeal or grievance is not resolved to the provider's satisfaction; • Acknowledges receipt of provider appeals within 5 business days of receipt by the MCO; • Allows providers 90 business days from the date of a denial to file an initial appeal; • Allows providers at least 15 business days from the date of denial to file each subsequent level of appeal; • 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;	written resolution monthly or quarterly for the entire review period.	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Pays claim within 30 days of the appeal decision when a claim denial is overturned; • Provides at its final level an opportunity for the provider to be heard by the MCO's chief executive officer or the chief executive officer's designee; • Provides timely written notice to the provider of the results of the internal appeal consistent with the timeframe documented in its policies.		
7.9 (Formerly 7.6)	There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. a. The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures. b. The MCO demonstrates a review of the data on enrollee satisfaction, provider satisfaction, and/or other	The intent of this element is to provide a mechanism for enrollees and providers to offer opinions on the UR process in place at the MCO and assure that the MCO is reviewing and acting upon identified issues. There must be evidence these processes are in place and functioning. There must be evidence that these policies and procedures have been followed. The policies and procedures must describe the process to evaluate the effects of the program using data on enrollee and provider satisfaction and/or other appropriate measures. **If the MCO conducts any independent surveys, data sources must include both the MCO's independent survey results and MDH-coordinated enrollee and provider satisfaction survey results.**	• Enrollee & Provider Satisfaction Policies and Procedures Relating to UR Program • Enrollee and Provider Satisfaction Surveys Evaluating UR Program • Data Reports Evidencing Review of enrollee and provider satisfaction with UR survey results • Trending Reports • Action Plans to specifically address UR satisfaction opportunities for improvement • Committee Meeting Minutes demonstrating	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	appropriate data by the appropriate oversight committee. c. The MCO acts upon identified issues as a result of the review of the data.	It is expected that the MCO will review the results of enrollee and provider satisfaction surveys and develop and implement action plans to address identified opportunities for improvement timely in order to have some impact on subsequent survey results.	review of enrollee and provider satisfaction survey results, identification of opportunities for improvement, and action plans to address	
7.10 (Formerly 7.7)	The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.	"Independent review organization" means an entity that contracts with the Department to conduct independent review of managed care organizations' adverse decisions. The MCO's specific responsibilities under the Maryland Medicaid Managed Care Independent Review Services process are as follows and should be included in the policy and procedure: 1. Establish an online account with the IRO and provide all required information through this account. 2. Upload the complete case record for each medical case review request within five (5) business days of receipt of the request from the IRO. 3. Upload any additional, case-related documentation requested by the IRO within two (2) business days of receipt of notification of a request for additional information from the IRO.	• Complaint Resolution/IRO Policy and Procedure • MCO Independent Review Organization Agreement • Online Account • Sample Case Record • Logs documenting IRO invoices are paid within 60 days. • Documented process for ensuring IRO invoices are paid within 60 days, such as a policy or desktop procedure	COMAR 10.67.13

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		4. Agree to pay the fixed case fee should the IRO rule against the MCO and has a documented process to assure IRO invoices are paid within 60 days per COMAR 10.67.13.07C(2).		
7.11 (Formerly 7.8)	The MCO must have written policies and procedures for establishing a corrective managed care plan for enrollee abuse of medical assistance pharmacy benefits consistent with the Department's corrective managed care plan. a. The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation. b. The MCOs must provide evidence of implementation of the corrective managed care plan.	The MCO must have documented policies and procedures for a corrective managed care plan for abuse of pharmacy benefits consistent with COMAR 10.67.12. An MCO's corrective managed care plan shall cover enrollee abuse of medical assistance pharmacy benefits. For all pharmacy benefit abuse covered by an MCO's corrective managed care plan, the plan shall: • Use the criteria as described in Regulation .01B of this regulation to determine if enrollees have abused benefits; • Provide for a medical review of the alleged abuse consistent with §C of this regulation; • Provide that an enrollee found to have abused pharmacy benefits will be enrolled in the program for 24 months; • Provide that an enrollee who has been enrolled in a 24-month plan and is subsequently found to have abused MCO pharmacy benefits	• 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
		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; 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		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		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; • Provide for the designation of a new pharmacy provider if the enrollee moves out of the service area of the current pharmacy provider; • Provide for prompt reporting to the Department the name of any enrollee enrolled in the MCO's program, the duration of enrollment, or any change in the duration of enrollment; and • Be submitted to the Department for review and approval: a) Within 60 days of the effective date of this regulation; and b) Before the implementation of any modification.		
7.12 Deleted in MY 2019.				
8.0	**Continuity of Care – The MCO has put a basic system in place that promotes continuity of care and case management (CM).**			
8.1	Enrollees with special needs and/or those with complex health care needs must have access to CM according to	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-	• CM Plan • CM Criteria/ • Standards	HCQIS XIV COMAR 10.67.03.06 COMAR 10.67.04.04-11

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	established criteria and must receive the appropriate services.	risk pregnancy, and to enroll them into CM according to the MCOs established criteria. This system must allow the enrollee to access the appropriate services provided by the MCO. 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: o Identification of children and adult enrollees with special needs o Assessments o Plans of care o Caseload • Committee reporting structure.	• CM Policies & Procedures • CM Cases • Committee Meeting Minutes (e.g., QA/UR) • Job Descriptions • Reports and Analysis • Orientation/ • Training Materials	42 CFR §438.208(c)(1,2)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• 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 Health Services Needs Information (HSNI) data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.	There is documented evidence of HSNI: • data collection methodology • data analysis activities, and • evidence that follow-up based on the results of the analysis is occurring in a timely manner. If MDH does not transmit HSNI for an enrollee to the MCO within 10 calendar days of enrollment, the MCO shall make at least two attempts to conduct an initial screening of the enrollee's needs, within 90 calendar days of the effective date of enrollment. At least one of these attempts shall be during non-working hours. If the MCO does not receive the HSNI within the 10-day window, the MCO should attempt to perform the screening. **NOTE:** The HSNI is completed at the time of enrollment into HealthChoice and this data is sent to the MCO from the state. The HSNI is NOT the Health Risk Assessment (HRA) performed by CM.	• HSNI Policies and Procedures • Reports and Analysis of TATs	COMAR 10.67.02.03 COMAR 10.67.05.07
8.3	The MCO must have policies and procedures in place to coordinate care with primary	The MCO must have policies and procedures in place to assure the coordination of services for its enrollees, including	• Continuity of Care Policies & Procedures	HCQIS XIV

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	care, Local Health Departments (LHDs), school health programs, and other frequently involved community-based organizations (CBOs).	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.		
8.4	*The MCO must monitor continuity of care across all services and treatment modalities including discharges or admissions to inpatient setting to home. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).*	There is documented evidence of monitoring activities. This includes the collection and analysis of data.	• Continuity of Care Policies & Procedures (e.g. hospitalizations, prenatal care) • Data Analysis • QA & UR Committee Meeting Minutes	HCQIS XI NCQA: QI 3 Element A
8.5	The MCO must monitor the effectiveness of the CM Program.	• Methodology to evaluate the effectiveness of the CM program. • Methodology for monitoring the plans of care. • Methodology for evaluating plans of care.	• CM Evaluation Studies • Analysis and Reports • Computer Screen Shots of CM Software or Actual Demonstration of CM System • Case Records	HCQIS XIV COMAR 10.67.03.06 COMAR 10.67.04.04-11
8.6	The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and	The MCO has policies and procedures for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation through	• Coordination with Behavioral Health and Substance Use Vendors Policy and Procedures • Enrollee Records	COMAR 10.67.04.14E MCO Agreement: Section II.G

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	demonstrates implementation of these procedures.	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, d. Provider education about the substance use release of information (ROI) process under 42 CFR, Part 2, and e. Provider education for Enrollee identification and referrals to the Administrative Services Organization (ASO) or core service agencies for behavioral health services.	• Provider Education Materials • Provider Newsletters • Screenshots of the MCO's website • Provider Manual	
8.7	The MCO must comply with providing the Continuity of Health Care Notice to enrollees and have policies and procedures in place to provide services in accordance with the MIA requirements when requested by enrollees.	The MCO has policies and procedures for complying with the Continuity of Health Care Notice and provides documentation of compliance. Evidence of compliance is not showing the Continuity of Health Care Notice in the Enrollee Handbook. Examples of evidence	• Policies and Procedures • Care management notes, single case agreements with out-of-network providers, enrollee letters	Ins. Art. §15-140(f)

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		may be derived from care management notes, documentation of single case agreements with out-of-network providers, enrollee letters to show continued approval of a service received through an out-of-network provider, etc.		
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.**			
9.1	The MCO has a comprehensive written Health Education Plan (HEP), which must include: a. The education plan's purpose and objectives. b. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events. c. A methodology for notifying enrollees and providers of available educational activities. d. A description of group and individual educational activities targeted at both providers and enrollees.	The MCO's HEP must contain all of the components listed in a-d. There must be an indication of how the objectives were established.	• HEP Description • Health Education Schedule of Events • Health Education Work Plan • Health Education Materials • Enrollee/Provider Notification Methodology • Samples of enrollee and provider notifications of available educational activities. • Descriptions of group and individual educational activities targeted at both enrollees and providers	COMAR 10.67.04.03
9.2	The HEP incorporates activities that address needs identified through the analysis of enrollee data.	The MCO must provide evidence that enrollee data were analyzed to determine the need for certain health education programs.	• HEP • Enrollee Data Analysis • Health Education Calendar of Events	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
9.3	The MCO's HEP must: a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room (ER) utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures. b. Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the enrollees. c. Contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for enrollee referrals.	The HEP must describe the qualifications of the staff or external providers that will conduct the educational sessions (e.g., certified diabetes instructor, registered dietician, or certified mental health provider). The education plan must describe how a provider can access a health educator/ educational program through the MCO (e.g., the MCO may designate a contact person to assist the provider in connecting the enrollee to a health educator or program).	• Data Analysis and Studies • HEP and Work Plan • Impact Evaluation Methodology that includes process and outcome measures • Annual evaluation of the impact of the HEP on process and/or outcome measures • Provider Manual • Provider newsletters • Sample of provider referrals of enrollees for health education • Job descriptions of health education staff • Brochures of health education programs from external organizations demonstrating qualifications of program presenters.	COMAR 10.67.04.03
9.4	The MCO must have mechanisms in place to identify enrollees in special need of educational	Mechanisms to identify enrollees in special need of educational efforts may include CM, outreach, or PCP referral for one-on-one	• Special Educational Need Identification Mechanisms	COMAR 10.67.04.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	efforts. Documentation must support that these mechanisms are in place and functioning. **Note:** This component is not limited to individuals in a special needs population.	education of the enrollee with complex medical needs, the homebound enrollee, and the noncompliant enrollee with health issues.	• Evidence that mechanisms are in place and functioning to identify enrollees in special need of education efforts	
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. b. Attendance records and session evaluations completed by enrollees. c. Provider evaluations of health education programs.	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 educational sessions and the overall health education program.	• Enrollee Mailings such as brochures, postcards, flyers • Enrollee attendance records • Completed Session Evaluations by individual attendees • Program Evaluations • Completed Provider Evaluations of the MCO's health education programs.	COMAR 10.67.04.03
10.0	**Outreach Plan (OP) – The MCO has developed a comprehensive written outreach services plan to assist enrollees in overcoming barriers in accessing health care services. The OP adequately describes the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.**			
10.1	The MCO has developed a written OP that describes the following: a. Populations to be served through the outreach activities and an assessment of common	Each of the MCOs participating in HealthChoice is unique in the manner in which it facilitates the outreach requirements. The OP must describe the individual MCO's approach to providing outreach. This written plan must provide an overview of outreach activities that include components 10.1a through 10.1f.	• Educational Materials • DM and CM Program Descriptions • MOUs • Community Event Calendars or Education Program Schedules • Provider Manual	COMAR 10.67.04.02

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 Administrative Care Coordination Units (ACCUs).	Supporting policies and procedures must be in place to provide details regarding how these activities are carried out. The OP must include an overview of the populations to be served. At a minimum, the populations must include: • Those in need of wellness/ preventive services. • Those children eligible for EPSDT services. • Those enrollees (both adults and children) who are difficult to reach or miss appointments. • 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.,	• Provider Contracts	

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		diabetes, HIV/AIDS, pediatric asthma) and any identified barriers or specific areas where outreach has been or is anticipated to be particularly challenging (i.e., rural population, non-English speaking populations). The OP must provide an overview of how the MCO's internal and external resources are organized to provide an effective outreach program. For example, the OP briefly describes the roles of various departments such as provider relations, enrollee services, CM, DM, health education, and delegated entities in the performance of outreach activities. The OP must briefly describe data management systems to be utilized in performing outreach activities. This may include data systems or software used to identify, track, and report outreach activities. The OP briefly describes any unique educational activities related to the populations served, such as: • Languages in which materials are printed and availability of interpreter services. TTD/TTY services for those who are hearing impaired.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		• Any unique educational activities such as CM or DM programs related to special populations (e.g., mother/baby programs, substance abuse programs for pregnant women, asthma management programs, etc.). • Any other unique services related to education. The OP briefly describes any community partners and their role in providing outreach activities to assist the MCO in bringing enrollees into care (e.g., church groups, YMCA, homeless shelters, community-based school programs, parks and recreation programs, medical societies and/or associations such as the American Diabetes Assoc., etc.). The community partner may provide educational health fairs or screenings, educational materials, speakers, personnel who assist the enrollee in completing necessary medical paperwork or who assist the enrollee in locating special services to facilitate bringing the enrollee into care, etc. (Do not include the role of the local health departments, since they are addressed in 10.1f) The OP must include a brief description of the role and responsibilities of providers for participating in outreach activities.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
		The OP must demonstrate the MCO's relationship with the LHD/ACCU regarding collaborative efforts being undertaken (i.e. methods of referral). The description must include: • The LHD's responsibilities in outreach. • How results of the LHD's efforts are conveyed to the MCO.		
10.2	The MCO has implemented policies and procedures for: a. The provision of outreach services for new and existing enrollees for wellness/preventive health services. b. Deleted in MY 2019. 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.	There must be evidence that the MCO has policies and procedures implemented for each of the activities in 10.2 a-d. The MCO identifies those enrollees in need of wellness/ preventive services and initiates activities to encourage the utilization of these services. There is evidence that the MCO implements a system to track and monitor access to these services. For example, the MCO identifies and notifies 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.	• 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
		There must be evidence that the MCO utilizes a systematic process to provide outreach services that employ: • Telephone contact. • Written materials. • Face-to-face contact. There must be evidence that outreach activities are monitored. There must be evidence that the MCO monitors any delegated activities to assure that contracted or delegated activities are carried out. For example, if the MCO has an agreement with the LHD to perform specific outreach activities such as face-to-face contact with enrollees, the MCO must have a mechanism for monitoring outcomes of these activities (i.e., number of enrollees referred for LHD outreach and number successfully reached).		
10.3	The MCO has implemented strategies: a. Deleted in MY 2019. b. Deleted in MY 2019. c. To promote the provision of EPSDT services and respond to no-shows and non-compliant behavior related to children in need of EPSDT services.	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	• Outreach Work Plan • Data Reports • Tracking/Referral logs • Enrollee Mailings • Provider Mailings	COMAR 10.67.05.03

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	d. To bring enrollees into care who are difficult to reach or who miss appointments.	and/or to bring those children who miss appointments into care.		
11.0	**Fraud and Abuse - The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.**			
11.1	The MCO maintains administrative and management procedures, including a mandatory compliance plan, 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	The MCO demonstrates the ability to detect and identify inappropriate and unlawful conduct, fraudulent activities, and abusive patterns through detailed policies, procedures, education, and training. The MCO demonstrates the ability to internally monitor and audit for potential fraud and abuse in such areas as encounter data, claims submission, claims processing, billing procedures, underutilization, customer service, enrollment and disenrollment, marketing, and provider/enrollee education materials. The MCO documents its processes used to detect and identify incidences of fraud and abuse. 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.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Compliance Officer Job Description and Qualifications • Compliance Committee Membership • Compliance Committee Meeting Minutes • Communication Between Compliance Officer & Compliance Committee • Routine and Random Audit Reports for Fraud and Abuse • Reports tracking the receipt and dispensation of all incidences of reported suspected fraud and abuse	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf CMS Resource Handout- "Medicaid Managed Care: Compliance Program Requirements https://www.cms.gov/files/document/mc

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	responsible for ongoing monitoring of the MCO's mandatory compliance plan. c. Designation of a Compliance Officer to serve as the liaison between the MCO and the Department. d. A documented process for internal monitoring and auditing, both routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and abuse education of MCO staff, enrollees, and providers. e. A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of			presourcehandout011416pdf

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation. f. A documented process to ensure that services billed to the MCO were actually received by the enrollee.			
11.2	The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include: a. Education and training for the Compliance Officer and the MCO's employees on detection of fraud and abuse. b. A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the	The MCO demonstrates clear and well-publicized communication of disciplinary guidelines to employees, subcontractors of the MCO, and enrollees to sanction fraud and abuse offenses. The MCO demonstrates its process exists, e.g. a hotline, which allows employees, subcontractors of the MCO, and enrollees to report suspected fraud and abuse without fear of reprisal. The MCO will also demonstrate its procedures for timely investigation, dispensation, and tracking of reported suspected incidences of fraud and abuse.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Staff orientation, education, and training protocols pertaining to fraud and abuse • Sign-in rosters for employee training sessions regarding fraud and abuse	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf CMS Resource Handout- "Medicaid Managed Care: Compliance Program Requirements

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	organization between the Compliance Officer and the MCO's employees. c. A documented process for enforcing standards by means of clear communication to employees, in well-publicized guidelines, to sanction incidents of fraud and abuse. d. A documented process for enforcement of standards through clear communication of well-publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse. e. A documented process for enforcement of standards through clear communication of well-publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse. f. A documented process for the reporting by employees of suspected fraud and abuse within			https://www.cms.gov/files/document/mcpresourcehandout011416pdf

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	the organization, without fear of reprisal. g. A documented process for reporting by subcontractors of the MCO suspected fraud and abuse within the organization, without fear of reprisal. h. A documented process for reporting by enrollees of the MCO suspected fraud and abuse within the organization without fear of reprisal.			
11.3	The MCO maintains administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. It must include: a. A documented process for reporting all suspected cases of provider fraud and abuse to the MDH Office of the Inspector General and the Medicaid Fraud Control Unit within 30	The MCO documents its processes for reporting and tracking suspected incidences of fraud and abuse to the appropriate State and Federal agencies within the appropriate timeframes and its cooperation with those agencies investigating those alleged incidents.	• Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Documentation of reported incidences of fraud and abuse to State Medicaid Agency • Documentation of collaboration and cooperation with the State Medicaid Fraud Control Unit	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	calendar days of the initial report. b. A documented process for cooperating with the MDH Office of the Inspector General and the State Medicaid Fraud Control Unit when suspected fraud and abuse are investigated.			CMS Resource Handout- "Medicaid Managed Care: Compliance Program Requirements https://www.cms.gov/files/document/mcpresourcehandout011416pdf
11.4	The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address: a. Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee. b. Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP. c. Evidence of the Compliance Committee's review and approval of	The MCO documents the mechanisms that evaluate the effectiveness of its fraud and abuse compliance plan through routine and random reports, CAPs and their implementation, administrative and management procedures. The MCO documents oversight of fraud and abuse activities for each delegate, including delegate compliance plans and fraud and abuse activity reports.	• Compliance Committee Minutes • Routine and Random Fraud and Abuse Reports • CAPs • CAP Implementation Reports • Delegate Fraud and Abuse Reports	42 CFR §438.608 COMAR 10.67.07 COMAR 31.04.15 CMS Publication – "Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Health Plans" https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mccomplan.pdf CMS Resource Handout- "Medicaid Managed Care: Compliance Program Requirements

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with. d. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.			https://www.cms.gov/files/document/mcpresourcehandout011416pdf
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	An MCO may not have a relationship with an individual or entities who are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. An MCO may not have an affiliation with an individual or entities who have been debarred by Federal Agencies, as defined in the Federal Acquisition Regulation. Checks of all databases are required at the time of initial credentialing and recredentialing.	• Governance Policies and Procedures • Subcontracting and Employment Policies and Procedures • Evidence of database checks	42 CFR §438.610(a) 42 CFR §438.610(b) 42 CFR §438.610(c) COMAR 10.67.03.03 42 CFR §455.436 COMAR 10.67.07.03G

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	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 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	Monthly checks of the following databases are required: List of Excluded Individuals/Entities and Excluded Parties List Systems/SAM.		

Standard	Description	Review Guidelines	Documents to be Reviewed	Cite(s) and References
	and/or termination to MDH.			

Deeming Eligibility

Deemed Elements and Components by Standard												
Standard 1 Systematic Process of Quality Assessment and Improvement	1.1 N	1.2 N	1.3 6/7	1.4 N	1.5 N	1.6 NA	1.7 N	1.8 Y	1.9 N	1.10 N		
Standard 2 Accountability to the Governing Body	2.1 N	2.2 N	2.3 N	2.4 N	2.5 N	2.6 NA	2.7 N					
Standard 3 Oversight of Delegated Entities and Subcontractors	3.1 N	3.2 N	3.3 N	3.4 N								
Standard 4 Credentialing and Recredentialing	4.1 3/4	4.2 N	4.3 Y	4.4 N	4.5 Y	4.6 Y	4.7 N	4.8 4/5	4.9 2/3	4.10 N	4.11 N	4.12 N
Standard 5 Enrollee Rights	5.1 N	5.2 Y	5.3 1/5	5.4 N	5.5 N	5.6 N	5.7 N	5.8 1/5	5.9 N	5.10 N	5.11 N	
Standard 6 Availability and Accessibility	6.1 1/4	6.2 2/4	6.3 N	6.4 N								
Standard 7 Utilization Review	7.1 2/3	7.2 5/6	7.3 N	7.4 1/3	7.5 N	7.6 N	7.7 2/7	7.8 N	7.9 N	7.10 N	7.11 N	7.12 NA
Standard 8 Continuity of Care	8.1 N	8.2 N	8.3 N	8.4 Y	8.5 N	8.6 N	8.7 N					
Standard 9 Health Education Plan	9.1 N	9.2 N	9.3 N	9.4 N	9.5 N							
Standard 10 Outreach Plan	10.1 N	10.2 N	10.3 N									
Standard 11 Fraud and Abuse	11.1 N	11.2 N	11.3 N	11.4 N	11.5 N							

Standards are evaluated and compared to NCQA health plan accreditation standards and MCO performance to identify qualifications for deeming.
Green Y = Standard is deemable; Red N = Standard is not deemable; Yellow = Standard is partially deemable; Gray = Not applicable as standards have been deleted

SPR Standards to Part 438 Subpart D and QAPI Standards Crosswalk

Standards	Availability of Services	Assurances of Adequate Capability and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Provider Selection	Confidentiality	Grievance and Appeal Systems	Subcontractual Relationships and Delegation	Practice Guidelines	Health Information Systems	Quality Assessment and Performance Improvement Project
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: MY 2022 Validation of Encounter Data

Completed by the Hilltop Institute, University of Maryland Baltimore County (Hilltop)

The Hilltop Institute
UMBC

report

EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2020 to CY 2022

January 31, 2024

Qlarant

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EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2020 to CY 2022

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EQR Protocol 5, Activity 3: Validation of Encounter Data, CY 2020 to CY 2022

Introduction

HealthChoice—Maryland's statewide mandatory Medicaid and Children's Health Insurance Program (CHIP) managed care system—was implemented in 1997 under the Social Security Act's §1115 waiver authority and provides participants with access to a wide range of health care services arranged or provided by managed care organizations (MCOs). In calendar year (CY) 2022, nearly 90% of the state's Medicaid and Maryland Children's Health Program (MCHP) populations were enrolled in HealthChoice. HealthChoice participants are given the opportunity to select an MCO and primary care provider (PCP) from their MCO's network to oversee their medical care. Participants who do not select an MCO or PCP are automatically assigned to one. HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid (including MCHP participants) through the fee-for-service (FFS) system.

In addition to providing a wide range of services, one of the goals of the HealthChoice program is to improve the access to and quality of health care services delivered to participants by the MCOs. The Maryland Department of Health (MDH) contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to analyze and evaluate the validity of encounter data submitted by the HealthChoice MCOs. Hilltop has conducted the annual encounter data evaluations and assisted MDH with improving the quality and integrity of encounter data submissions since the inception of the HealthChoice program.

In 2012, the Centers for Medicare & Medicaid Services (CMS) issued a set of external quality review (EQR) protocols to states receiving encounter data from contracted MCOs. The EQR process included eight protocols—three mandatory and five optional—used to analyze and evaluate state encounter data for quality, timeliness, and access to health care services (CMS, 2012). In April 2016, CMS released its final rule on managed care,[19] which included a new regulation that states must require contracted MCOs to submit encounter data that comply with specified standards, formatting, and criteria for accuracy and completeness.[20] This final rule required substantive changes to the EQR protocols[21] and provided an opportunity to revise the protocol design. In October 2019, CMS released updated protocols for the EQR to help states and external quality review organizations (EQROs) improve reporting in EQR technical reports. Hilltop evaluated the new managed care final rule released in November 2020 and found that it did not include substantive changes to the EQR regulations.[22]

[19] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,498 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).
[20] 42 CFR § 438.818.
[21] 42 CFR § 438.350–438.370; 457.1250.
[22] Medicaid and CHIP Managed Care Final Rule. 85 Fed. Reg. 72,574 (November 13, 2020) (to be codified at 42 CFR Parts 438 and 457).

In 2018, MDH asked Hilltop to work with Qlarant, Maryland's EQRO, to evaluate all electronic encounter data submitted by the MCOs on an annual basis as part of the encounter data validation activity. Hilltop serves as MDH's data warehouse and currently stores and evaluates all Maryland Medicaid encounter data, providing data-driven policy consultation, research, and analytics. This specific analysis—Activity 3 of the CMS EQR Protocol 5 for encounter data validation—is the core function used to determine the validity of encounter data and ensure the data are complete, accurate, and of high quality. MDH can use the results of the evaluation to monitor and collaborate with the MCOs to improve the quality and usefulness of their data submissions.

Hilltop evaluated all electronic encounter data submitted by the MCOs for CY 2020 through CY 2022. The two primary validation areas are 1) MDH's encounter data processing before acceptance of data and 2) the accepted encounter data review. Documentation of the data processing involves an overview of the electronic data interchange (EDI) and the Medicaid Management Information System (MMIS2), as well as the validation process for submitted encounters before acceptance. For this analysis, Hilltop obtained information from MDH about encounter data that failed/were denied during the edit checks (referred to as rejected records) and the reasons for failure. Hilltop conducted a review of accepted encounters and analyzed the volume and consistency of encounters submitted over time, utilization rates, data accuracy and completeness of identified fields, appropriateness of diagnosis and procedure codes, and the timeliness of MCOs' submissions to MDH.

Methodology

The following methodology was designed to address the five required activities of CMS EQR Protocol 5:

- Activity 1: Review state requirements
- Activity 2: Review MCO's capability
- Activity 3: Analyze electronic encounter data
- Activity 4: Review of medical records
- Activity 5: Submission of findings

Information from Activities 1 and 2 is necessary to evaluate Activity 3. The primary focus of Activity 3 is to analyze the electronic encounter data submitted by the MCOs, and this analysis composes a substantive portion of this report. Activity 1 is necessary to develop the plan for encounter analysis given that its directive is to ensure the EQRO has a complete understanding of state requirements for collecting and submitting encounter data (CMS, 2023).

MDH required the MCOs to submit all CY 2022 encounters by June 16, 2023. In July 2023, Hilltop reviewed the 2023 release of the CMS Protocol 5 requirements and encounter data validation activities and found that no changes were required to the procedures for data validation. Hilltop also participated in Encounter Data Workgroup meetings with MDH and MCOs regarding the quality of encounter data. Hilltop then confirmed the proposed procedures for data validation with MDH and reviewed and finalized the methodology prior to performing this encounter data

validation analysis. Next, Hilltop analyzed encounter data as of August 2023, including both rejected encounters and accepted encounters with 2022 dates of service. The review and audit processes for CY 2022 encounters concluded in October 2023.

Activity 3. Analysis of Electronic Encounter Data

In accordance with Hilltop's interagency governmental agreement with MDH to host a secure data warehouse for its encounters and provide data-driven policy consultation, research, and analytics, Hilltop completed Activity 3 of the encounter data validation.

Activity 3 requires the following four steps for analyses:

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

Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements

Hilltop incorporated information in Activities 1 and 2 to develop a data quality test plan. This plan accounts for the EDI (front-end) edits built into the state's data system so that it pursues data problems that the state may have inadvertently missed or allowed (CMS, 2023).

Hilltop first met with MDH in August 2018 to obtain pertinent information regarding the processes and procedures used to receive, evaluate, and report on the validity of MCO encounter data. Hilltop also interviewed MDH staff to document state processes for accepting and validating the completeness and accuracy of encounter data; this information was used to investigate and determine the magnitude and types of missing encounter data and identify potential data quality and MCO submission issues. Information provided included, but was not limited to, the following:

- MCO submission of encounter data in a X12 data standard (837), via a secure EDI system, to MDH; the transfer of those data to MDH's mainframe for processing and validation checks; generation of exception (error) reports (8ER and 835); and the uploading of the accepted data to MMIS2.
    - The 837 transaction set contains patient claim information, and the 835 system contains the claim payment and/or explanation of benefits data.
    - MDH receives, via an EDI system, encounter data from the MCOs in a format that is HIPAA EDI X12 837-compliant. Once it confirms that the 837 compliance is sound, it then translates the data for MMIS to adjudicate. The results of the adjudication are then given back to EDI to generate exception (error) reports that

are in HIPAA X12 835-compliant file format, as well as a summarized version known to MDH as the "8ER" report.

- Encounter data fields validated through MMIS process include recipient ID, sex, age, diagnosis codes, and procedure codes.
    - Beyond checking for numeric characters, the MMIS does not perform validation checks on the completeness or accuracy of payment fields submitted by the MCOs.
- After the data have been validated by the MMIS, MDH processes incoming data from the MCOs within one to two business days.
- Error code (exception) reports (835 and 8ER) are generated by the validation process and sent to the MCOs.

Hilltop receives the daily EDI error report data (the 8ER report) and analyzes the number, types, and reasons for failed encounter submissions for each MCO. This report includes an analysis of the frequency of different error types and rejection categories. The 8ER error descriptions were used to develop a comprehensive overview of the validation process.

Successfully processed encounters receive additional code validation that identifies the criteria each encounter must meet to be accepted into MMIS2. In addition, Hilltop reviews the accepted encounter data for accuracy, completeness, and timeliness of MCO data submission.

Hilltop meets with MDH annually to discuss encounter data analysis, strategize efforts for improvement, and coordinate messaging on these topics. Major topics of discussion have included the completion of payment fields, the use of sub-indicators in payment fields, provider enrollment edits, and rejected encounter error rates. Hilltop also discussed with MDH the provider enrollment edits that took effect in January 2020. These edits were a response to the 2016 Medicaid managed care final rule, which required states to screen and enroll all managed care network providers who are not already enrolled in FFS.[23] Hilltop met with MDH regarding the increase in provider-related encounter rejections in May 2021, October 2022, and July 2023 to coordinate a further investigation of the issue. In consultation with MDH, Hilltop developed and maintains the categorization of provider-related rejection codes to distinguish the provider-related issues tied to enrollment from all other provider-related rejection codes.

The CY 2023 MCO contract initially established potential penalties for MCOs for submitting a high volume of rejected encounters. This penalty was intended to improve the accuracy and quality of encounter data used for risk adjustment of capitated rates and to maintain compliance with the federal rule strengthening the requirements for data, transparency, and accountability.

During 2023, in response to concerns about the increased number of rejected encounters impacting rate setting and risk adjustment, MDH requested that Hilltop collect rejected

[23] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,890 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).

encounters from the MCOs. Hilltop was able to identify rejected encounters (or encounters with a claim type 'X') in its data warehouse that were previously unknown and therefore did not need to separately collect these encounters from the MCOs directly. Hilltop analyzed these rejected encounters and found they may provide a more complete picture of the final adjudication status of encounters than using the 8ER reports alone. This analysis uses a methodology developed by Hilltop to de-duplicate the encounter submissions, which is not done when generating the 8ER reports. Additional workgroup meetings will be held with the MCOs to further refine the appropriateness of these rejections. The universe of encounters that were appropriately rejected will then be sent to the state's auditor. The auditor will ensure that these encounters are not included in MCO HealthChoice Financial Monitoring Report (HFMR) costs, which are used to set MCO capitation for future calendar years. The rejected encounter de-duplication and error identification method is described in Appendix A. Claim type 'X' encounters were not analyzed in this report. Our next report will analyze 8ER and claim type 'X' encounters.

MDH re-established the technical Encounter Data Workgroup with the MCOs in 2018 to ensure the submission of data that are complete, accurate, high-quality, and compliant with the new requirements for pay fields. The Workgroup also provides an opportunity to review the new structure in which CMS requires states to submit data: the Transformed Medicaid Statistical Information System (T-MSIS). States must comply with T-MSIS requirements and follow all guidance for managed care data submitted to CMS.[24]

Due to the COVID-19 public health emergency, the Workgroup paused its in-person meetings and reconvened virtually in July 2021. During these meetings, the Workgroup addressed the issues of exception errors, encounter denials, provider enrollment, and provider enrollment edit exceptions ("free agent") usage and monitoring. MDH also provided updates on T-MSIS, procedure codes, diagnosis codes, duplicate rejections, and encounter processing resolutions, including a solution for avoiding duplicate rejected encounters with instructions on how to bill for specific modifiers. Hilltop also presented the rejected encounter error rate and de-duplication methodology, and MDH explained that the de-duplication process is designed to help define the encounters that should be excluded from the HFMR.

To conduct the analysis, Hilltop used MDH's information regarding encounter data that failed the edit checks (rejected encounters), reasons for failure by the EDI, and comparisons with CY 2020 through CY 2022 rejection results. Hilltop also used these data and knowledge of the MCOs' relationships with providers to identify specific areas to investigate for missing services; data quality problems, such as the inability to process or retain certain fields; and problems MCOs might have compiling their encounter data and submitting the data files.

[24] See August 10, 2018 letter to State Health Officials (SHO# 18-008) providing guidance to states regarding expectations for Medicaid and CHIP data and ongoing T-MSIS implementation at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO18008.pdf

Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity

Hilltop reviewed encounter data for accuracy and completeness by conducting integrity checks of the data files and automating the analyses. The analysis includes verifying that the state's identifiers (IDs) are accurately incorporated into the MCO information system; applying other consistency checks, such as verifying critical fields containing non-missing data; and inspecting the data fields for quality and general validity. Hilltop evaluated the ratio of participants to total accepted encounters by MCO to assess whether the distribution was similar across MCOs. Selected fields not verified by MDH during the EDI process in Step 1 were assessed for completeness and accuracy. Hilltop investigated how completely and accurately the MCOs populated payment fields when submitting encounter data to MDH following the new mandate effective January 1, 2018.

Hilltop then assessed how many medical encounters with a paid amount of $0 were identified as sub-capitated payments or denied payments and compared the amount entered in the pay field with the amount listed in the FFS fee schedule. In addition, Hilltop analyzed the completion of the institutional paid amounts. Hilltop investigated the third-party liability (TPL) variable in MCO encounters to determine whether MCOs are reporting these encounters appropriately. Finally, Hilltop assessed the MCO provider numbers to ensure that encounters received and accepted only included providers currently active within the HealthChoice program. Encounters received and accepted with MCO provider numbers that were not active within the HealthChoice program were excluded from the analysis.

Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports

Hilltop analyzed and interpreted data based on the submitted fields, volume and consistency of the encounter data, and utilization rates. Hilltop specifically conducted analyses for other volume/consistency dimensions in four primary areas: time, provider type, service type, and appropriateness of diagnosis and procedure codes based on patient age and sex. MDH helped identify several specific analyses for each primary area related to policy interests; the results can inform the development of long-term strategies for monitoring and assessing the quality of encounter data.

Hilltop conducted an analysis of encounter data by time dimensions (i.e., service date and processing date) to show trends and evaluate data consistency. After establishing the length of time between service dates and processing dates, Hilltop compared these dimensions with state standards or benchmarks for data submission and processing. Hilltop also compared time dimension data between MCOs to determine whether they process data within similar time frames.

Hilltop analyzed encounter data by provider type to identify missing data. This analysis evaluates trends in provider services and seeks to determine any fluctuation in visits between CY 2020 and CY 2022. Provider analysis is focused on primary care visits—specifically the number of participants who had a visit with their PCPs within the calendar year. The service type analysis

concentrated on three main service areas: inpatient hospitalizations, emergency department (ED) visits, and observation stays. The CY 2020 analysis provides baseline data and would typically allow MDH to identify any inconsistencies in utilization patterns for these types of services in CY 2021 and CY 2022. The public health emergency, however, resulted in declines in health care service utilization across the board in CY 2020, limiting the usefulness of the comparison.

Finally, Hilltop analyzed the age and sex appropriateness of diagnosis and procedure codes. Specifically, Hilltop conducted analyses of enrollees aged 66 years or older, deliveries (births), the presence of a dementia diagnosis, and dental services. Hilltop conducted a sex analysis for delivery diagnosis codes. Participants older than 65 are ineligible for HealthChoice; therefore, any encounters for this population were noted, which could indicate an error in a participant's date of birth. Hilltop also conducted an analysis of dental encounters for enrollees aged 0 to 20 years whose dental services should have been paid through the FFS system.

Step 4. Compare Findings to State-Identified Benchmarks

In Steps 2 and 3, Hilltop compared the encounter data submitted by each MCO with benchmarks identified by MDH. Hilltop performed the analyses by MCO and calendar year to benchmark each MCO against its own performance over time, as well as against other MCOs. Hilltop also identified and compared outlier data with overall trends noted among the MCOs.

Results of Activity 3: Analysis of Electronic Encounter Data

Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements

MDH began evaluating the MCO electronic encounter data by performing a series of validation checks on the EDI data. This process included analysis of critical data fields, consistency between data points, duplication, and validity. Encounters that failed to meet these standards were reported to the MCOs, and the 835 and the 8ER reports were returned to the MCOs for possible correction and resubmission.

MDH sent Hilltop the 8ER reports for CY 2020 through CY 2022, which included encounters that failed initial EDI edits (rejected encounters). Hilltop classified these rejected encounters into five categories: missing data, participant not eligible for service, value not valid for the field, inconsistent data, and duplicates.

Hilltop performed checks on critical fields for missing, invalid, and inconsistent data, including provider number, units of service, drug number, drug quantity, revenue code, procedure code, and diagnosis code. Hilltop identified eligibility issues for participants who were not eligible for MCO services at the time of the service. Examples of inconsistent data include discrepancies between dates, inconsistencies between diagnosis and age or sex, and inconsistencies between original and resubmitted encounters.

Table 1 presents the distribution of rejected encounters submitted by all MCOs, by category, for CY 2020 to CY 2022.

Table 1. Distribution of Rejected Encounter Submissions by EDI Rejection Category, CY 2019–CY 2022

Rejection Category	CY 2019 (Baseline)		CY 2020		CY 2021		CY 2022	
	Number of Rejected	Percentage of Total	Number of Rejected	Percentage of Total	Number of Rejected	Percentage of Total	Number of Rejected	Percentage of Total
Duplicate	103,108	5.4%	480,007	7.1%	77,347	1.8%	60,723	1.6%
Inconsistent	46,438	2.5%	78,017	1.1%	40,841*	0.9%	123,034	3.2%
Missing	595,697	31.5%	1,053,540	15.5%	753,586	17.1%	533,411	13.8%
Not Eligible	814,451	43.0%	450,374	6.6%	321,135	7.3%	529,468	13.7%
Not Valid	334,314	17.7%	4,737,893	69.7%	3,224,378*	73.0%	2,613,590	67.7%
Total	1,894,008	100%	**6,799,831**	**100%**	**4,417,287**	**100%**	**3,860,226**	**100%**

*The number of "Inconsistent" and "Not Valid" rejected encounters in CY 2021 were revised due to recategorizing a rejection code in prior years' reports.

Overall, the number of rejected encounters decreased by 43.2% from CY 2020 to CY 2022. However, the number of rejected encounters increased from 1,894,008 in CY 2019 to 6,799,831 in CY 2020; an increase of 259%. While the rejected encounters from the 8ER reports are not de-duplicated, the number of rejected encounters in CY 2022 is still much higher as compared to CY 2019. In 2023, MDH required via MCO contracts that less than 5% of total encounters be rejected. MDH asked Hilltop to analyze rejected encounters for purposes of capitated rate risk adjustment. To determine the total number of rejected encounters that were potentially missing from the base data used for risk adjustment, Hilltop developed a process to identify and de-duplicate rejected encounters using data received via MMIS2 rather than the 8ER reports. Once de-duplicated, all MCOs would have met the 5% threshold in CY 2022 had it been in effect. This indicates that the 8ER reports include many duplicate encounters. See Appendix A for a description of the de-duplication methodology.

Most of the rejected encounters were due to invalid data, and this can largely be attributed to the addition of provider enrollment encounter edits that went live on January 1, 2020 (see Provider Enrollment-Related Encounter Data Validation section below for details). MDH worked with the MCOs for two years prior to the provider enrollment edits becoming effective to ensure that their providers were enrolled in FFS via the electronic provider revalidation and enrollment portal (ePREP). However, many providers failed to enroll by January 1, 2020, or submitted enrollment information that was inconsistent with the encounter data submitted to MDH. The total number of rejected encounters due to invalid data decreased by 44.8% during the evaluation period, but the share of all rejected encounters attributed to invalid data only experienced a slight decrease by 2.0 percentage points between CY 2020 and CY 2022.

The two primary reasons encounters were rejected in CY 2020 and CY 2021 were missing data and invalid data for MCO services. In CY 2022, a third top reason arose. The share of rejected encounters due to participants ineligible for MCO services increased by 7.1 percentage points between CY 2020 and CY 2022, with a 17.6% increase from 450,374 in CY 2020 to 529,468 in CY

2022. The following categories of rejections decreased in number: duplicate encounters, missing encounters, and invalid encounters.

Analyzing rejected encounters by MCO is useful for assessing trends and identifying issues that are specific to each MCO. This allows MDH to monitor and follow up with the MCOs on potential problem areas. Table 2 presents the distribution of rejected and accepted encounter submissions across MCOs for CY 2020 through CY 2022.

Table 2. Distribution of Rejected and Accepted Encounter Submissions by MCO, CY 2020–CY 2022

Rejected Encounters						
MCO	CY 2020		CY 2021		CY 2022	
	Number of Rejected Encounters	Percentage of All Rejected Encounters	Number of Rejected Encounters	Percentage of All Rejected Encounters	Number of Rejected Encounters	Percentage of All Rejected Encounters
ABH	100,444	1.5%	432,360	9.8%	105,659	2.7%
ACC*	1,217,777	17.9%	595,665	13.5%	380,019	9.8%
CFCHP	1,569,819	23.1%	323,604	7.3%	342,384	8.9%
JMS	97,575	1.4%	197,734	4.5%	252,155	6.5%
KPMAS	119,369	1.8%	286,174	6.5%	218,981	5.7%
MPC	1,053,040	15.5%	768,064	17.4%	585,477	15.2%
MSFC	361,709	5.3%	170,138	3.9%	70,142	1.8%
PPMCO	1,450,364	21.3%	977,473	22.1%	1,346,750	34.9%
UHC	829,734	12.2%	666,075	15.1%	558,659	14.5%
Total	**6,799,831**	**100%**	**4,417,287**	**100%**	**3,860,226**	**100%**
Accepted Encounters						
MCO	CY 2020		CY 2021		CY 2022	
	Number of Accepted Encounters	Percentage of All Accepted Encounters	Number of Accepted Encounters	Percentage of All Accepted Encounters	Number of Accepted Encounters	Percentage of All Accepted Encounters
ABH	989,996	2.5%	1,312,880	3.0%	1,465,995	3.2%
ACC*	7,708,937	19.5%	8,399,279	19.0%	8,614,423	18.9%
CFCHP	2,237,433	5.7%	1,892,492	4.3%	2,393,506	5.3%
JMS	1,168,449	3.0%	1,235,612	2.8%	1,141,684	2.5%
KPMAS	2,080,743	5.3%	2,914,875	6.6%	3,059,397	6.7%
MPC	7,386,436	18.7%	8,250,416	18.6%	8,240,573	18.1%
MSFC	3,231,387	8.2%	3,413,822	7.7%	3,340,877	7.3%
PPMCO	9,906,093	25.0%	11,472,685	25.9%	12,115,262	26.6%
UHC	4,838,602	12.2%	5,390,628	12.2%	5,195,084	11.4%
Total	**39,548,076**	**100%**	**44,282,689**	**100%**	**45,566,801**	**100%**

* ACC's name changed to Wellpoint Maryland, effective January 1, 2023, and will be reflected in measurement year (MY) 2023's report.

The volume of rejected encounters decreased across many MCOs between CY 2020 and CY 2022, largely due to improvements in provider data, explained in greater detail below. While there was an overall increase for Aetna Better Health of Maryland (ABH), Jai Medical Systems (JMS), and Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS), there was a dramatic decrease for Amerigroup Community Care (ACC) and CareFirst Community Health Plan (CFCHP), followed by Maryland Physicians Care (MPC), MedStar Family Choice, Inc. (MSFC), Priority Partners (PPMCO), and UnitedHealthcare Community Plan (UHC).

PPMCO had the highest share (34.9%) of all rejections in CY 2022—a notable increase from 22.1% in CY 2021, and an increase of 13.6 percentage points since CY 2020. MPC had 15.2% of all rejections in CY 2022—a decrease of 2.2 percentage points from CY 2021 and a decrease of 0.3 percentage points from CY 2020. UHC submitted 14.5% of the total rejected encounters in CY 2022—a decrease of 0.6 percentage points from CY 2021, and an increase of 2.3 percentage points from CY 2020. ACC had 9.8% of all rejections in CY 2022, which was a decrease of 3.7 percentage points from CY 2021 and a decrease of 8.1 percentage points from CY 2020.

ABH, CFCHP, JMS, KPMAS, and MSFC each had less than 9% of the rejected encounters in CY 2022. MSFC decreased its share of rejections by 3.5 percentage points from CY 2020 to CY 2022, while ABH's, JMS's, and KPMAS's share of rejections fluctuated during the evaluation period.

Although there was some variation among MCOs in the distribution of the total rejected encounters from CY 2020 to CY 2022, there was very little variation in the distribution of accepted encounters among MCOs, except for KPMAS and PPMCO, whose shares increased by 1.4 and 1.6 percentage points, respectively. All the other MCOs had less than 1.0 percentage points change during the evaluation period.

Tables 3 and 4 show the rate of encounters rejected by the EDI by category and MCO. Specifically, Table 3 presents the percentage of rejected encounters by EDI rejection category and MCO for CY 2022. See Appendix B for a graphical representation of Table 3.

Table 3. Percentage of Rejected Encounters by EDI Rejection Category by MCO, CY 2022

Rejection Category	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Duplicate	0.0%	1.0%	2.6%	0.4%	0.4%	4.7%	0.9%	0.3%	2.6%
Inconsistent	4.9%	1.5%	18.3%	0.0%	1.6%	0.3%	1.1%	0.1%	7.6%
Missing	13.5%	13.9%	8.3%	29.0%	19.7%	9.4%	14.3%	14.4%	11.2%
Not Eligible	1.8%	6.6%	6.8%	4.9%	9.1%	14.3%	12.5%	22.6%	9.0%
Not Valid	79.8%	76.9%	64.0%	65.7%	69.2%	71.4%	71.3%	62.6%	69.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

For all MCOs, the primary reasons for rejection of encounters in CY 2022 were categorized as "Not Valid" (from 62.6% to 79.8%). The second most common rejection category for most MCOs was "Missing"—except for CFCHP, which was "Inconsistent," and MPC and PPMCO, which was "Not Eligible." For all MCOs, encounters rejected for reasons grouped under the "Duplicate" category remained below 5.0%. Encounters rejected as "Not Eligible" showed mixed performance across MCOs, ranging from 1.8% to 22.6%.

Table 4 presents the distribution of the rejection reason category and how it changed for each MCO between CY 2020 and CY 2022. Table 4. Number and Percentage of Rejected Encounters by EDI Rejection Category and MCO, CY 2020–CY 2022

Rejection Category	Year	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	Total
Duplicate	CY 2020	1,165	9,206	440,785	325	342	8,703	499	2,408	16,574	**480,007**
		1.2%	0.8%	28.1%	0.3%	0.3%	0.8%	0.1%	0.2%	2.0%	**7.1%**
	CY 2021	2,054	1,521	39,546	665	3,790	11,082	45	2,439	16,205	**77,347**
		0.5%	0.3%	12.2%	0.3%	1.3%	1.4%	0.0%	0.2%	2.4%	**1.8%**
	CY 2022	16	3,982	8,759	957	823	27,283	607	3,738	14,558	**60,723**
		0.0%	1.0%	2.6%	0.4%	0.4%	4.7%	0.9%	0.3%	2.6%	**1.6%**
Inconsistent	CY 2020	271	5,110	41,135	125	562	14,243	1,493	737	14,341	**78,017**
		0.3%	0.4%	2.6%	0.1%	0.5%	1.4%	0.4%	0.1%	1.7%	**1.1%**
	CY 2021	6,386*	7,689	2,399	209	3,771	6,792	3,000	1,145	9,450	**40,841**
		1.5%	1.3%	0.7%	0.1%	1.3%	0.9%	1.8%	0.1%	1.4%	**0.9%**
	CY 2022	5,162	5,698	62,819	75	3,523	1,501	741	1,253	42,262	**123,034**
		4.9%	1.5%	18.3%	0.0%	1.6%	0.3%	1.1%	0.1%	7.6%	**3.2%**
Missing	CY 2020	12,980	241,554	102,409	35,798	16,126	136,058	100,515	289,479	118,621	**1,053,540**
		12.9%	19.8%	6.5%	36.7%	13.5%	12.9%	27.8%	20.0%	14.3%	**15.5%**
	CY 2021	82,627	91,105	31,378	78,907	55,501	89,383	52,811	189,734	82,140	**753,586**
		19.1%	15.3%	9.7%	39.9%	19.4%	11.6%	31.0%	19.4%	12.3%	**17.1%**
	CY 2022	14,259	52,708	28,442	73,168	43,191	55,069	9,998	193,751	62,825	**533,411**
		13.5%	13.9%	8.3%	29.0%	19.7%	9.4%	14.3%	14.4%	11.2%	**13.8%**
Not Eligible	CY 2020	2,839	50,198	52,338	10,800	8,502	54,866	10,956	175,366	84,509	**450,374**
		2.8%	4.1%	3.3%	11.1%	7.1%	5.2%	3.0%	12.1%	10.2%	**6.6%**
	CY 2021	2,201	19,531	36,708	12,929	13,326	37,778	8,609	129,848	60,205	**321,135**
		0.5%	3.3%	11.3%	6.5%	4.7%	4.9%	5.1%	13.3%	9.0%	**7.3%**
	CY 2022	1,887	25,258	23,185	12,291	19,887	83,513	8,762	304,498	50,187	**529,468**
		1.8%	6.6%	6.8%	4.9%	9.1%	14.3%	12.5%	22.6%	9.0%	**13.7%**
Not Valid	CY 2020	83,189	911,709	933,152	50,527	93,837	839,170	248,246	982,374	595,689	**4,737,893**
		82.8%	74.9%	59.4%	51.8%	78.6%	79.7%	68.6%	67.7%	71.8%	**69.7%**
	CY 2021	339,092*	475,819	213,573	105,024	209,786	623,029	105,673	654,307	498,075	**3,224,378**
		78.4%	79.9%	66.0%	53.1%	73.3%	81.1%	62.1%	66.9%	74.8%	**73.0%**
	CY 2022	84,335	292,373	219,179	165,664	151,557	418,111	50,034	843,510	388,827	**2,613,590**
		79.8%	76.9%	64.0%	65.7%	69.2%	71.4%	71.3%	62.6%	69.6%	**67.7%**
Total (100%)	**CY 2020**	**100,444**	**1,217,777**	**1,569,819**	**97,575**	**119,369**	**1,053,040**	**361,709**	**1,450,364**	**829,734**	**6,799,831**
	CY 2021	**432,360**	**595,665**	**323,604**	**197,734**	**286,174**	**768,064**	**170,138**	**977,473**	**666,075**	**4,417,287**
	CY 2022	**105,659**	**380,019**	**342,384**	**252,155**	**218,981**	**585,477**	**70,142**	**1,346,750**	**558,659**	**3,860,226**

* The number of "Inconsistent" and "Not Valid" rejected encounters in CY 2021 for ABH were revised due to recategorizing a rejection code from prior years' reports.

The greatest number of rejected encounters during the evaluation period were in the "Not Valid" category. The total number of "Not Valid" encounters decreased from 4,737,893 to 2,613,590 between CY 2020 and CY 2022, but the proportion of all rejected encounters categorized as "Not Valid" remained fairly stable throughout the evaluation period. The impact of invalid data was not spread evenly across MCOs. In CY 2022, more than one-half (62.6%) of PPMCO's rejections were in this category on the low end, with ABH closer to 80.0% on the high end.

The second most common rejection category for all MCOs during the evaluation period was "Missing." The number of rejections categorized as "Missing" decreased for the majority of MCOs: ACC, CFCHP, MPC, MSFC, PPMCO, and UHC. However, there was an increase in missing encounters for ABH, JMS, and KPMAS.

MCOs showed varied results in the numbers and percentages of rejected encounters in the "Inconsistent" category. The total number of rejections categorized as "Inconsistent" fluctuated for all MCOs during the evaluation period, except for MPC, which decreased throughout the evaluation period from 14,243 in CY 2020 to 1,501 in CY 2022. Notable outliers include the steep increases for UHC between CY 2021 and CY 2022 (1.4% to 7.6%) and CFCHP between CY 2021 and CY 2022 (0.7% to 18.3%). CFCHP had the highest percentage of rejections for inconsistency in CY 2022, followed by UHC at 7.6%.

While the number of encounter rejections categorized as "Duplicate" increased for five of the nine MCOs (JMS, KPMAS, MPC, MSFC, and PPMCO), the remaining MCOs (ABH, ACC, CFCHP, and UHC) decreased in the number of these rejections, with CFCHP having the greatest decline from 440,785 in CY 2020 to 8,759 in CY 2022. In CY 2022, PPMCO had the largest percentage of encounters rejected in the "Not Eligible" category (22.6%), and ABH had the lowest (1.8%).

Overall, there was a decrease in rejections marked "Duplicate," "Missing," and "Not Valid," while there was an increase in rejections marked "Inconsistent" and "Not Eligible" between CY 2020 and CY 2022. In CY 2022, the greatest decrease in share of rejections was in the "Duplicate" category, which decreased by 5.5 percentage points.

Provider Enrollment-Related Encounter Data Validation

Hilltop conducted an additional review of the 8ER reports to analyze the high rates of encounters that failed initial EDI edits—particularly for invalid data. Further research revealed that the 8ER high rejection rates were related to provider enrollment issues. The provider data, which are collected via ePREP, underwent changes that affected data beginning January 1, 2020. After two years of collaborative preparation with the MCOs, the provider system implemented new rules that require the National Provider Identifier (NPI) on any encounter to match the active NPI under which the provider enrolled with Medicaid for both the billing and rendering fields.[25] To remain actively enrolled with Medicaid, providers must perform actions such as updating their

[25] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,890 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).

licensure on the ePREP portal. Failure to do so can affect a provider's active status and thus jeopardize the successful submission of encounters.

Prior to 2020, a provider could use any NPI on the encounter in the billing and rendering fields; as long as it matched any active NPI in MMIS2, the encounter linked with that provider/claim was accepted. The provider enrollment edits—intended to improve the accuracy of provider details—were implemented in response to CMS requirements. See Appendix C for a list of rejection codes divided into those relating to provider data and all others, and then subdivided by rejection category for CY 2022 encounters.

Table 5 presents rejected encounters by MCO, divided into provider enrollment-related and all other rejections for CY 2020 to CY 2022. See Appendix D for more specific information about the top three most common MCO-specific EDI rejection codes (errors) for CY 2022.

Table 5. Number of Rejected Encounters for Provider Enrollment-Related and Other Rejection Types by MCO, CY 2020–CY 2022

Rejection Type	MCO	CY 2020	CY 2021	CY 2022
Provider Enrollment-Related	ABH	62,852	213,977	61,134
	ACC	581,764	358,314	221,095
	CFCHP	792,889	171,835	167,242
	JMS	39,849	87,223	79,497
	KPMAS	58,026	161,576	101,865
	MPC	655,323	462,622	316,131
	MSFC	165,243	44,877	29,275
	PPMCO	690,775	428,998	605,207
	UHC	410,302	323,994	250,417
	Subtotal	**3,457,023**	**2,253,416**	**1,831,863**
Other	ABH	37,592	218,383	44,525
	ACC	636,013	237,351	158,924
	CFCHP	776,930	151,769	175,142
	JMS	57,726	110,511	172,658
	KPMAS	61,343	124,598	117,116
	MPC	397,717	305,442	269,346
	MSFC	196,466	125,261	40,867
	PPMCO	759,589	548,475	741,543
	UHC	419,432	342,081	308,242
	Subtotal	**3,342,808**	**2,163,871**	**2,028,363**
Total		**6,799,831**	**4,417,287**	**3,860,226**

The number of provider enrollment-related rejections decreased for all MCOs from CY 2020 to CY 2022, except for JMS and KPMAS. The decline was lowest for ABH (2.7%) and highest for MSFC (82.3%). Almost all MCOs had a notable decrease in the number of rejections due to provider enrollment-related encounters from CY 2021 to CY 2022, except for PPMCO (increased by 41.1%).

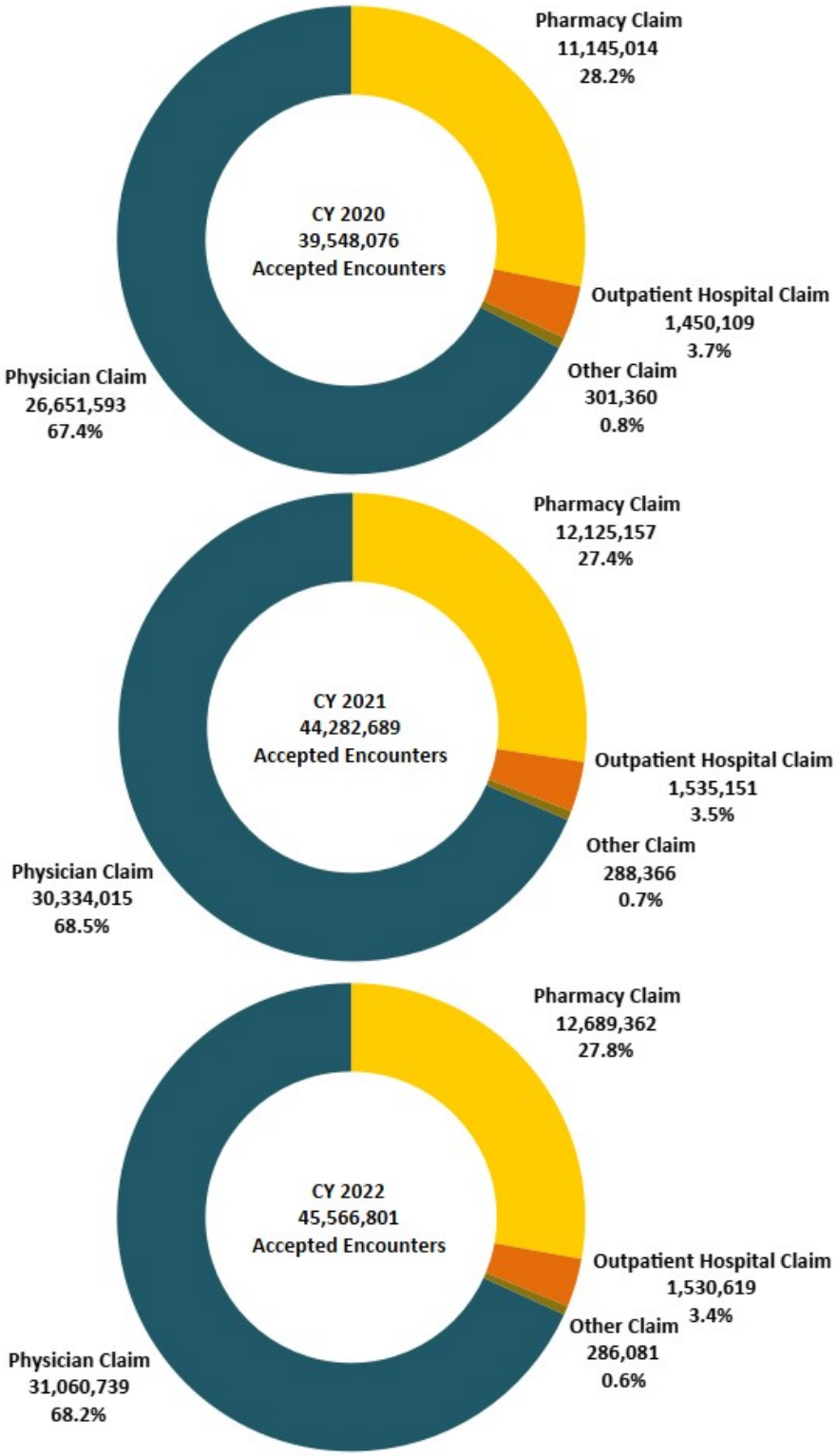
Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity

During CY 2022, the MCOs submitted a total of 45.6 million accepted encounters (records), which was an increase from 39.5 million in CY 2020 and 44.3 million in CY 2021. Despite increased enrollment in CY 2020, overall utilization decreased across all MCOs due to the COVID-19 pandemic. However, utilization started to rebound in CY 2021. Because the 8ER data received do not include dates of service, Hilltop estimated the total number of encounters submitted by adding the number of EDI rejected encounters to the number of accepted encounters. Using that method, a total of approximately 46.3 million encounters were submitted in CY 2020. This number increased to 48.7 million encounters in CY 2021 and 49.4 million encounters in CY 2022. Approximately 92% of the CY 2022 encounters were accepted into MMIS2, which is higher than the 91% acceptance rate during CY 2021 and the 85% acceptance rate during CY 2020.

Hilltop received a monthly copy of all encounters accepted by MMIS2. Upon receipt of the accepted encounters, Hilltop performed several validation assessments and integrity checks of the fields to analyze and interpret the accuracy and completeness of the data. These assessments included determining whether there was an invalid end date of service or other errors. The files with errors were excluded before being imported into Hilltop's data warehouse.

Figure 1 shows the distribution of accepted encounter submissions by claim type (physician claim, pharmacy claim, outpatient hospital claim, and other claims) from CY 2020 to CY 2022.

Figure 1. Number and Percentage of Accepted Encounters by Claim Type, CY 2020–CY 2022



The distribution of accepted encounters by claim type changed slightly from CY 2020 to CY 2022. Physician claims represented most of the encounters during the evaluation period (roughly two-thirds), followed by pharmacy claims. Across the evaluation period, other encounters—including inpatient hospital stays, community-based services, and long-term care services—accounted for less than 1% of services.

Table 6 displays the percentage and number of accepted encounters by claim type for each MCO from CY 2020 to CY 2022.

Table 6. Distribution of Accepted Encounters by Claim Type and MCO, CY 2020–CY 2022

Claim Type	Year	ABH	ACC*	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
Physician Claim	CY 2020	71.7%	66.4%	77.4%	62.6%	74.0%	65.9%	67.0%	64.3%	70.7%
		709,927	5,115,977	1,731,798	731,706	1,540,478	4,866,194	2,163,553	6,369,837	3,422,123
	CY 2021	71.8%	67.2%	67.5%	62.6%	75.9%	66.8%	67.7%	67.2%	73.3%
		943,246	5,646,100	1,277,419	773,641	2,212,349	5,510,114	2,311,286	7,710,525	3,949,335
	CY 2022	69.1%	67.5%	68.7%	59.8%	74.5%	66.3%	66.5%	67.6%	72.1%
		1,013,129	5,817,693	1,644,307	682,602	2,280,214	5,463,440	2,222,432	8,191,130	3,745,792
Pharmacy Claim	CY 2020	23.9%	28.1%	18.5%	33.6%	24.5%	29.7%	28.6%	31.2%	25.2%
		236,632	2,162,803	412,828	392,016	509,958	2,195,708	924,461	3,093,170	1,217,438
	CY 2021	24.4%	28.0%	27.4%	33.1%	22.4%	28.3%	28.4%	29.0%	22.9%
		319,923	2,355,627	517,959	408,946	653,626	2,333,598	969,219	3,330,404	1,235,855
	CY 2022	26.4%	28.3%	27.5%	36.2%	23.7%	29.2%	29.2%	28.5%	23.9%
		386,874	2,435,990	657,020	413,751	726,213	2,406,846	973,973	3,447,617	1,241,078
Outpatient Hospital Claim	CY 2020	3.4%	4.9%	3.3%	3.4%	0.8%	3.4%	3.6%	3.9%	3.4%
		33,887	373,886	73,827	39,863	17,162	251,207	115,213	382,663	162,401
	CY 2021	3.0%	4.1%	4.2%	3.9%	1.0%	4.0%	3.1%	3.3%	3.2%
		39,698	344,237	79,830	47,750	30,602	332,752	106,394	381,918	171,970
	CY 2022	3.7%	3.6%	3.1%	3.6%	1.1%	3.7%	3.5%	3.5%	3.3%
		54,446	308,844	74,166	40,800	34,086	306,000	115,292	425,008	171,977
Other	CY 2020	1.0%	0.7%	0.8%	0.4%	0.6%	1.0%	0.9%	0.6%	0.8%
		9,550	56,271	18,980	4,864	13,145	73,327	28,160	60,423	36,640
	CY 2021	0.8%	0.6%	0.9%	0.4%	0.6%	0.9%	0.8%	0.4%	0.6%
		10,013	53,315	17,284	5,275	18,298	73,952	26,923	49,838	33,468
	CY 2022	0.8%	0.6%	0.8%	0.4%	0.6%	0.8%	0.9%	0.4%	0.7%
		11,546	51,896	18,013	4,531	18,884	64,287	29,180	51,507	36,237
Total (100%)	**CY 2020**	**989,996**	**7,708,937**	**2,237,433**	**1,168,449**	**2,080,743**	**7,386,436**	**3,231,387**	**9,906,093**	**4,838,602**
	CY 2021	**1,312,880**	**8,399,279**	**1,892,492**	**1,235,612**	**2,914,875**	**8,250,416**	**3,413,822**	**11,472,685**	**5,390,628**
	CY 2022	**1,465,995**	**8,614,423**	**2,393,506**	**1,141,684**	**3,059,397**	**8,240,573**	**3,340,877**	**12,115,262**	**5,195,084**

* ACC's name changed to Wellpoint Maryland, effective January 1, 2023, and will be reflected in MY 2023's report.

The distribution of accepted encounters remained relatively consistent across MCOs and calendar years. In CY 2022, physician encounters ranged from 59.8% of encounters (JMS) to 74.5% of encounters (KPMAS). JMS had the largest percentage of CY 2022 pharmacy encounters (36.2%), while KPMAS had the lowest percentage (23.7%). Outpatient hospital encounters ranged from a low of 1.1% for KPMAS to a high of 3.7% for ABH and MPC.

See Appendix E for a visual display of the number and percentage of accepted encounters by claim type and MCO in CY 2022.

Table 7 illustrates the distribution of HealthChoice participants and the volume of accepted encounters for each MCO during CY 2020 through CY 2022.

Table 7. Percentage of HealthChoice Participants and Accepted Encounters by MCO, CY 2020–CY 2022

MCO	CY 2020		CY 2021		CY 2022	
	Percentage of Total Participants	Percentage of Total Encounters	Percentage of Total Participants	Percentage of Total Encounters	Percentage of Total Participants	Percentage of Total Encounters
ABH	3.8%	2.5%	4.0%	3.0%	4.1%	3.2%
ACC	22.8%	19.5%	22.3%	19.0%	21.9%	18.9%
CFCHP	4.3%	5.7%	5.0%	4.3%	5.8%	5.3%
JMS	2.3%	3.0%	2.2%	2.8%	2.1%	2.5%
KPMAS	7.3%	5.3%	7.9%	6.6%	8.1%	6.7%
MPC	17.5%	18.7%	17.1%	18.6%	16.8%	18.1%
MSFC	7.8%	8.2%	7.6%	7.7%	7.4%	7.3%
PPMCO	24.7%	25.0%	24.1%	25.9%	23.7%	26.6%
UHC	12.3%	12.2%	11.9%	12.2%	11.7%	11.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

PPMCO and ACC were the largest MCOs in CY 2022, followed by MPC, UHC, KPMAS, MSFC, CFCHP, ABH, and JMS. The distribution of accepted encounters among MCOs in CY 2020 through CY 2022 was nearly proportional to the participant distribution. For example, in CY 2022, MPC had 16.8% of all HealthChoice participants and 18.1% of all MMIS2 encounters.

Managed Care Regulations: Accurate and Complete Encounter Data

In 2016, CMS issued its final rule, updating Medicaid managed care regulations.[26] One of the requirements specified that MCOs must submit encounter data that are accurate and complete by January 2018.[27] To address this requirement, MDH notified Maryland MCOs in September 2017 that all encounter data submitted to MDH on or after January 1, 2018, must include allowed amounts and paid amounts on each encounter (Maryland Department of Health, 2017).

[26] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,498 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).
[27] 42 CFR § 438.818(a)(2).

In November 2020, CMS released a new final rule on managed care[28] that included technical modifications; however, it did not include changes to the EQR or encounter data reporting regulations.

In 2010, MDH and the MCOs worked together to ensure complete and accurate submission of paid amounts on pharmacy encounters. Pharmacy encounter data flow through a point of sale (POS) system, which ensures data accuracy at the time of submission. For nearly a decade, pharmacy encounters have been reliable, and MDH has confidence in the integrity and quality of the payment amounts. Beginning in October 2017, MDH used the pharmacy paid encounter process as a framework to begin receiving payment data for all encounters.

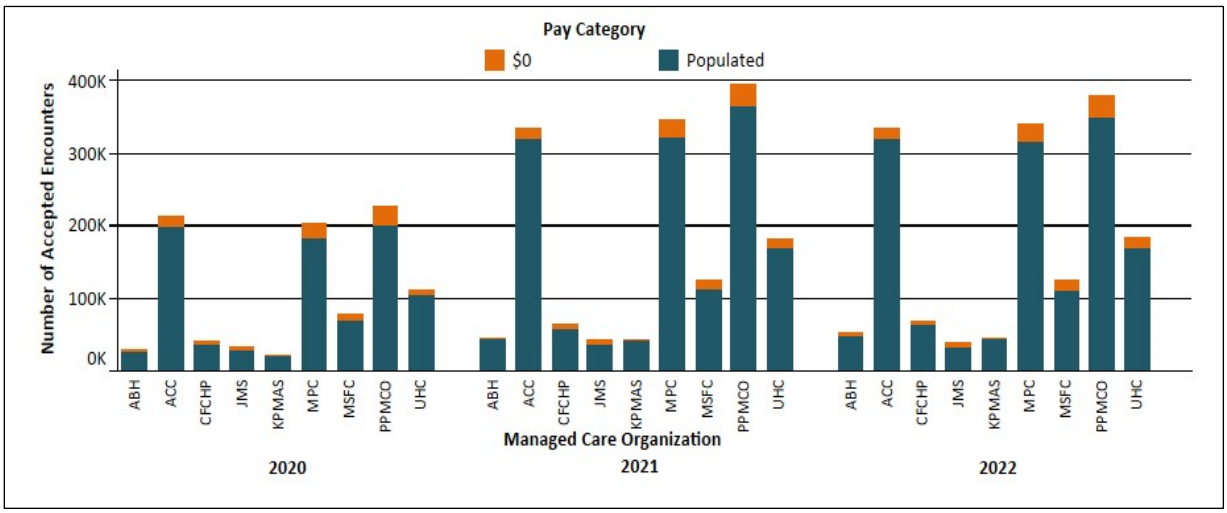
MDH staff prepared MMIS2 to accept payment data for all encounters in the fall of 2017, convened technical MCO workgroups, and updated the 837 Companion Guides for professional (medical) and institutional encounters. Soon after MCOs began submitting payment data for all encounters in January 2018, MDH staff identified errors in processing the paid amount for medical and institutional encounters. In February 2018, MDH reviewed MCO paid submissions to determine how many encounters had missing paid amounts, how many were $0 (separated by denied ('09' on CN1 segment) and sub-capitated ('05' on CN1 segment)), and how many were populated. MDH shared its findings and met with MCOs individually to improve their submission processes. By August 2018, MMIS2 had received populated payment data for all medical encounters.

In Fall 2018, MDH staff discovered that only the paid amount for the first service line of each institutional encounter was being recorded, which underreported the total amount paid. This issue was corrected in mid-2020; MMIS2 now stores the correct sum for all the total paid institutional service lines. MDH continues to work with the MCOs to ensure the validity of institutional and medical encounter data.

Figure 2 displays the distribution of pay category for accepted institutional encounter data by MCO in CY 2022.

[28] Medicaid and CHIP Managed Care Final Rule. 85 Fed. Reg. 72,574 (November 13, 2020) (to be codified at 42 CFR Parts 438 and 457).

Figure 2. Number of Accepted Institutional Encounters by MCO and Pay Category, CY 2020–CY 2022

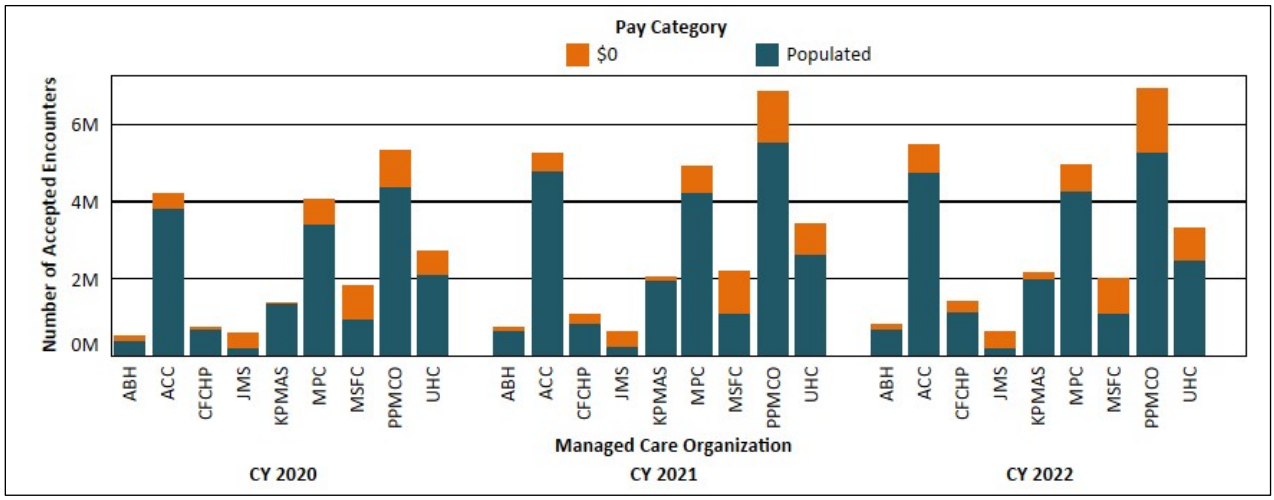


Year	Pay Category	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
CY 2020	Populated	86.1%	92.4%	87.6%	78.7%	93.9%	89.5%	86.5%	88.2%	91.3%
		26,802	197,517	36,627	27,573	20,770	183,970	69,681	201,121	102,668
	$0	13.9%	7.6%	12.4%	21.3%	6.1%	10.5%	13.5%	11.8%	8.7%
		4,312	16,142	5,179	7,472	1,352	21,595	10,852	26,916	9,724
	Subtotal	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		31,114	**213,659**	**41,806**	**35,045**	**22,122**	**205,565**	**80,533**	**228,037**	**112,392**
CY 2021	Populated	95.1%	94.7%	90.0%	84.6%	93.8%	92.7%	89.4%	92.0%	91.0%
		42,079	318,900	57,983	36,632	39,840	320,922	111,588	364,217	167,132
	$0	4.9%	5.3%	10.0%	15.4%	6.2%	7.3%	10.6%	8.0%	9.0%
		2,178	17,700	6,451	6,648	2,638	25,219	13,300	31,556	16,432
	Subtotal	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		44,257	**336,600**	**64,434**	**43,280**	**42,478**	**346,141**	**124,888**	**395,773**	**183,564**
CY 2022	Populated	90.0%	95.1%	91.6%	83.1%	94.0%	92.8%	88.9%	91.4%	90.7%
		48,316	319,452	62,241	32,292	42,532	316,808	110,643	348,593	168,690
	$0	10.0%	4.9%	8.4%	16.9%	6.0%	7.2%	11.1%	8.6%	9.3%
		5,367	16,372	5,695	6,562	2,691	24,422	13,816	32,885	17,318
	Subtotal	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		53,683	**335,824**	**67,936**	**38,854**	**45,223**	**341,230**	**124,459**	**381,478**	**186,008**

All MCOs except for UHC increased the percentage of institutional encounters with a populated pay amount during the evaluation period. In CY 2022, the percentage of institutional encounters with a populated amount ranged from 83.1% (JMS) to 95.1% (ACC). The MCOs showed mixed results from CY 2021 to CY 2022: ACC, CFCHP, KPMAS, and MPC increased the percentage of populated pay amounts, while ABH, JMS, MSFC, PPMCO, and UHC decreased.

Figure 3 displays the number and percentage of accepted medical encounters by MCO and pay category for CY 2020 through CY 2022. Appendix F displays the number of accepted medical encounters by MCO and pay category for CY 2020 to CY 2022.

Figure 3. Number of Accepted Medical Encounters by MCO and Pay Category, CY 2020–CY 2022



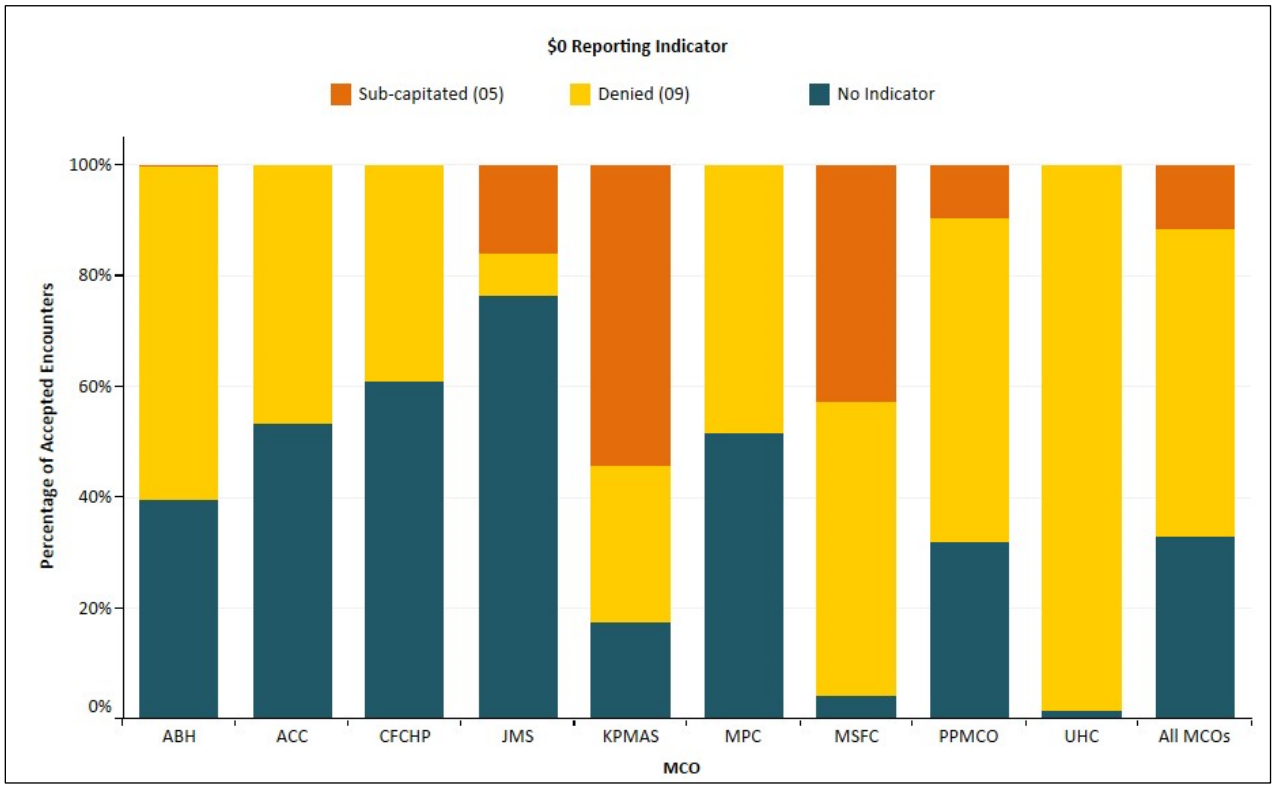
Year	Pay Category	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
CY 2020	Populated	81.3%	91.1%	85.6%	34.0%	96.6%	83.0%	50.9%	81.9%	78.5%
		427,437	3,813,960	680,020	209,224	1,332,909	3,384,552	936,837	4,381,528	2,132,482
	$0	18.7%	8.9%	14.4%	66.0%	3.4%	17.0%	49.1%	18.1%	21.5%
		98,213	374,433	114,605	405,416	47,118	691,817	904,435	970,711	585,247
	Subtotal	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		525,650	**4,188,393**	**794,625**	**614,640**	**1,380,027**	**4,076,369**	**1,841,272**	**5,352,239**	**2,717,729**
CY 2021	Populated	82.0%	90.8%	78.6%	37.5%	94.3%	85.5%	51.0%	80.5%	76.3%
		639,721	4,789,407	869,961	247,332	1,973,718	4,217,329	1,117,795	5,531,945	2,622,037
	$0	18.0%	9.2%	21.4%	62.5%	5.7%	14.5%	49.0%	19.5%	23.7%
		140,020	488,070	237,519	412,501	118,827	717,480	1,074,314	1,341,220	814,233
	Subtotal	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		779,741	**5,277,477**	**1,107,480**	**659,833**	**2,092,545**	**4,934,809**	**2,192,109**	**6,873,165**	**3,436,270**
CY 2022	Populated	80.8%	86.2%	79.8%	34.2%	93.7%	84.7%	55.2%	76.3%	74.8%
		697,565	4,729,467	1,151,967	222,651	2,021,446	4,230,981	1,117,555	5,284,443	2,511,339
	$0	19.2%	13.8%	20.2%	65.8%	6.3%	15.3%	44.8%	23.7%	25.2%
		165,635	757,248	290,813	428,663	136,943	766,411	907,070	1,641,938	845,955
	Subtotal	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		863,200	**5,486,715**	**1,442,780**	**651,314**	**2,158,389**	**4,997,392**	**2,024,625**	**6,926,381**	**3,357,294**

During CY 2022, JMS submitted 65.8% of its medical encounters with a $0 pay amount, and MSFC submitted nearly half of its medical encounters the same way. All other MCOs ranged from 6.3% (KPMAS) to 25.2% (UHC) of accepted medical encounters with $0 pay. Only JMS, MPC, and

MSFC among all the MCOs had a lower share of encounters with $0 pay during CY 2022 than in CY 2020.

Figure 4 displays the percentage of accepted medical encounters with a $0 pay field with the sub-capitated reporting indicator (05), the denied reporting indicator (09), and no indicator by MCO.

Figure 4. Accepted Medical Encounters with $0 Pay Data by Reporting Indicator (05/09) and MCO, CY 2022



$0 Reporting Indicator	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	All MCOs
Sub-capitated (05)	0.1%	0.0%	0.0%	16.0%	54.4%	0.0%	42.8%	9.7%	0.0%	**11.6%**
Denied (09)	60.5%	46.8%	39.2%	7.6%	28.3%	48.4%	53.2%	58.3%	98.6%	**55.3%**
No Indicator	39.4%	53.2%	60.8%	76.4%	17.4%	51.6%	4.0%	32.0%	1.4%	**33.1%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Adherence to the requirement that encounters with $0 pay include a reporting indicator varied significantly among the MCOs during CY 2022. MSFC and UHC submitted nearly all their $0 encounters with an indicator. By contrast, ACC, CFCHP, and MPC submitted more than one-half and JMS more than three-quarters of their $0 pay medical encounters without an indicator. The percentage of $0 pay medical encounters without an indicator submitted by the remaining MCOs ranged from 17.4% (KPMAS), 32% (PPMCO), to 39.4% (ABH).

Hilltop also analyzed the accepted medical encounters during CY 2022 by comparing the price paid against the price listed for the same service on the FFS fee schedule. Of the almost 28 million medical encounters in this analysis, around 20% of the encounters were reported with a $0 pay amount. Approximately 40% of these were laboratory procedures. The proportion of encounters with $0 ranged greatly by MCO from less than 10% to over half. Of the encounters matched to the fee schedule with a non-zero payment amount, nearly 50% of encounters had some degree of difference between the amount paid by MCOs and the amount specified in the fee schedule. Of those encounters matched to the FFS fee schedule with a non-zero payment amount, 75% were greater than the fee schedule payment amount and 25% were less; a third of these encounters were more than 20% greater than the FFS payment amount. The range by MCO of the percentage of encounters matched to the FFS fee schedule with a non-zero payment that was greater than the FFS fee schedule was from 54% to 99%. The overall utilization of the pay field has not changed significantly in CY 2022 as compared to previous years. MDH should continue to work with the MCOs to ensure that appropriate utilization and accuracy of the pay field on accepted encounters improves.

In CY 2019, Hilltop determined that TPL was reported inconsistently in MMIS2 across MCOs. Some MCOs had up to 95% of their encounters with a positive TPL amount in a sample of trauma encounters from CY 2019, whereas others had no encounters with a positive TPL amount during the same time period. FFS claims generally had positive TPL amounts in 1% to 3% of cases. Further analysis of a sample of trauma encounters from CY 2021 showed that the inconsistencies remained; three MCOs had no TPL for any encounters, and six MCOs had positive TPL in 85% to 99% of the encounters.

MDH reported that TPL for professional encounters was corrected in MMIS2 as of May 1, 2022. Analysis of trauma encounters pulled from the professional file found that the two MCOs who previously had no TPL still had no TPL after May 1, 2022. Four MCOs had TPL on the majority of their claims before May 1, 2022, and no TPL at all after May 1, 2022. Two MCOs had TPL on the majority of their encounters before May 1, 2022, and TPL on a small number of encounters after May 1, 2022. Finally, one MCO had TPL on a majority of their encounters before and after May 1, 2022. through the end of CY 2022. This suggests that only two MCOs have TPL properly recorded in professional files in CY 2022. Hilltop will continue to investigate TPL on all encounters and will review the results with MDH to develop a resolution.

Hilltop has not used the MCO-reported TPL amount in any analyses since CY 2018.

Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports

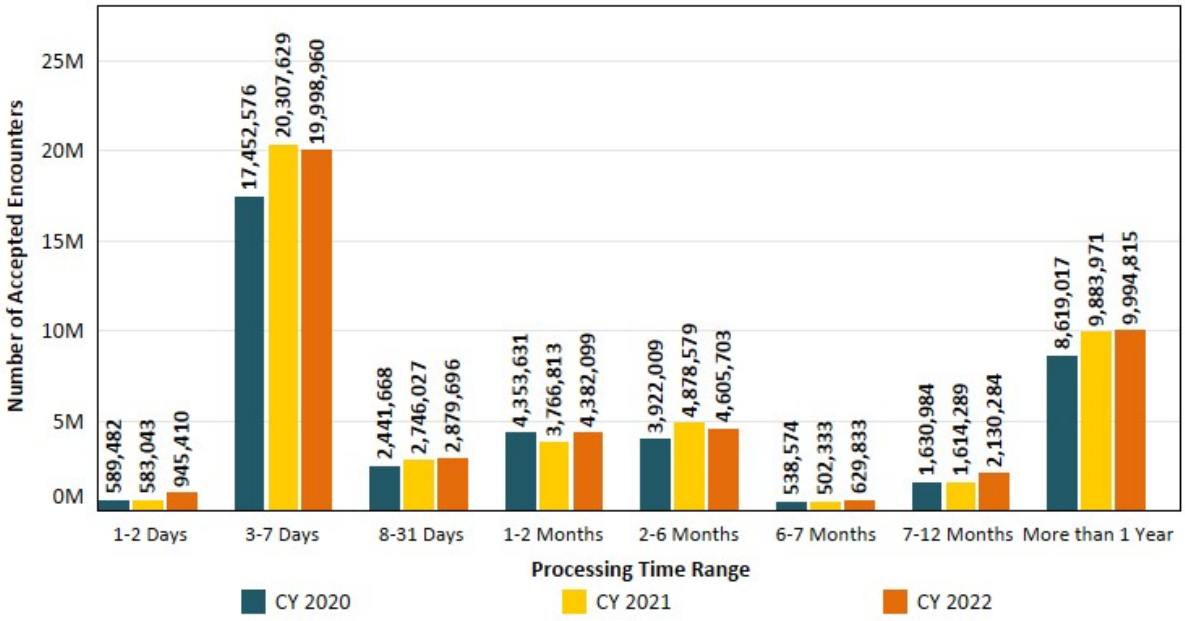
Time Dimension Analysis

Effective analysis of the Medicaid program requires complete, accurate, and timely processing of encounter data. Encounter processing time spans the interval between the end date of service and the date on which the encounter is submitted to MDH. After providers render a service, they are required to invoice the MCO within six months. The MCO must then adjudicate the

encounter within 30 days of invoice submission.[29] Maryland regulations require MCOs to submit encounter data to MDH "within 60 calendar days after receipt of the claim from the provider."[30] Therefore, the maximum acceptable processing time allotted for an encounter between the end date of service and the date of submission to MDH is eight months.

The Medicaid program requires MCOs to submit encounters in a timely fashion; however, delays in submission occur, and some variation from month to month is expected. Noticeable changes related to timeliness may indicate irregular submission of encounter data. Figure 5 shows the timeliness of processing accepted encounter submissions from the end date of service for CY 2020 through CY 2022.

Figure 5. Number of Accepted Encounters Submitted by Processing Time, CY 2020–CY 2022



Note for Figure 5 and Tables 8-10: An encounter is labeled as "1-2 months" if the encounter was submitted between 32 and 60 days after the date of service; "2-6 months" if the encounter was submitted between 61 and 182 days after the date of service; "6-7 months" if the encounter was submitted between 183 and 212 days after the date of service; and "7-12 months" if the encounter was submitted between 213 and 364 days after the date of service.

Overall, timelines of encounter submissions improved during the evaluation period, with more MCOs submitting encounters within 1 to 2 days in CY 2022, and an increase in encounters submitted between 8 days and 2 months.

[29] Md. Code Ann., Health-Gen. § 15-102.3; § 15-1005.
[30] COMAR 10.09.65.15(B)(4).

Table 8 shows the processing times for encounters submitted by claim type for CY 2020 through CY 2022.

Table 8. Distribution of the Total Number of Accepted Encounters Submitted, by Claim Type and Processing Time, CY 2020–CY 2022

Processing Time Range	Pharmacy Claims			Physician Claims			Outpatient Hospital Claims*			Other**		
	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022
1-2 Days	83.3%	82.7%	82.8%	29.4%	32.6%	29.4%	20.0%	22.6%	20.3%	16.3%	17.0%	15.2%
	9,284,451	10,026,380	10,510,053	7,829,006	9,884,739	9,135,115	290,059	347,471	310,346	49,060	49,039	43,446
3-7 Days	11.0%	11.5%	11.1%	9.6%	11.0%	9.9%	7.7%	8.8%	7.7%	7.7%	8.0%	6.7%
	1,229,931	1,392,401	1,407,027	2,557,495	3,327,402	3,061,363	111,235	135,723	118,118	23,348	23,053	19,195
8-31 Days	5.3%	5.4%	5.4%	28.3%	28.8%	28.4%	27.2%	26.9%	26.7%	32.5%	30.8%	27.4%
	596,126	650,512	680,381	7,530,801	8,731,435	8,826,893	394,196	413,259	409,013	97,894	88,765	78,528
1-2 Months	0.2%	0.3%	0.2%	8.1%	8.2%	8.3%	14.5%	12.9%	14.6%	14.3%	12.6%	14.9%
	25,139	32,578	26,697	2,163,246	2,478,225	2,587,218	210,294	198,767	223,184	42,989	36,457	42,597
2-6 Months	0.1%	0.2%	0.3%	14.9%	11.3%	12.7%	21.2%	17.6%	21.1%	19.1%	18.2%	23.0%
	8,798	21,363	39,678	3,979,681	3,423,369	3,953,948	307,591	269,617	322,630	57,561	52,464	65,843
More than 6 Months	0.0%	0.0%	0.2%	9.7%	8.2%	11.3%	9.4%	11.1%	9.6%	10.1%	13.4%	12.7%
	569	1,923	25,526	2,591,238	2,488,840	3,496,201	136,730	170,314	147,328	30,503	38,588	36,472
Total (100%)	**11,145,014**	**12,125,157**	**12,689,362**	**26,651,467**	**30,334,010**	**31,060,738**	**1,450,105**	**1,535,151**	**1,530,619**	**301,355**	**288,366**	**286,081**

*"Outpatient hospital claims" include emergency department (ED) visits. **"Other" includes inpatient hospital stays, community-based services, and long-term care services.

Most pharmacy encounters were submitted within 1 to 2 days throughout the evaluation period (over 80%), and more than 65% of all physician encounters were submitted within 31 days. Over 50% of outpatient hospital encounters were submitted within 31 days during the evaluation period. See Appendix G for a visual display of the number and percentage of encounters submitted by time processing range and claim type in CY 2020 through CY 2022.

Table 9 displays the monthly processing time for accepted encounters in CY 2020 through CY 2022.

Table 9. Percentage of Accepted Encounters Submitted, by Month and Processing Time, CY 2020–CY 2022

Processing Time Range	Year	January	February	March	April	May	June	July	August	September	October	November	December	Annual Total
1-2 Days	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%**
	CY 2021	35.9%	41.0%	47.1%	41.9%	44.5%	51.4%	47.1%	50.9%	46.6%	45.5%	51.4%	45.6%	**45.9%**
	CY 2022	40.9%	42.4%	45.4%	45.8%	45.2%	43.9%	43.2%	48.0%	35.2%	44.6%	44.5%	47.4%	**43.9%**
3-7 Days	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%**
	CY 2021	11.9%	15.1%	9.9%	11.7%	12.4%	10.7%	10.6%	10.2%	11.6%	12.9%	5.8%	10.2%	**11.0%**
	CY 2022	10.6%	11.7%	10.7%	10.9%	9.6%	10.5%	13.1%	9.4%	10.9%	10.0%	6.7%	7.7%	**10.1%**
8-31 Days	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%**
	CY 2021	23.8%	22.3%	22.0%	24.8%	24.2%	19.0%	21.6%	19.7%	22.5%	22.2%	22.0%	23.9%	**22.3%**
	CY 2022	23.0%	21.4%	23.5%	21.1%	23.4%	23.4%	20.7%	18.4%	24.9%	17.5%	24.4%	21.6%	**21.9%**
1-2 Months	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%**
	CY 2021	9.8%	6.1%	5.5%	6.4%	4.7%	6.0%	5.0%	5.1%	6.3%	5.9%	7.3%	6.5%	**6.2%**
	CY 2022	6.9%	7.5%	4.8%	5.9%	4.6%	6.0%	4.6%	5.7%	8.0%	10.3%	5.7%	5.7%	**6.3%**
2-6 Months	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%**
	CY 2021	9.1%	7.5%	7.6%	7.5%	7.0%	5.5%	5.6%	6.9%	8.9%	9.7%	13.0%	13.3%	**8.5%**
	CY 2022	8.2%	7.4%	6.9%	7.2%	6.7%	7.4%	7.8%	9.1%	12.0%	9.7%	16.0%	16.4%	**9.6%**
6-7 Months	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%**
	CY 2021	1.2%	1.2%	0.7%	0.5%	0.5%	0.5%	2.3%	1.7%	0.9%	3.3%	0.3%	0.5%	**1.1%**
	CY 2022	1.5%	0.8%	0.9%	0.8%	0.8%	0.4%	1.2%	1.2%	1.3%	5.2%	1.6%	0.6%	**1.4%**
7-12 Months	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%**
	CY 2021	2.8%	3.1%	3.3%	4.1%	6.4%	6.9%	7.8%	5.5%	3.3%	0.5%	0.3%	0.0%	**3.6%**
	CY 2022	3.0%	3.7%	2.8%	3.4%	8.4%	7.4%	7.1%	8.2%	7.9%	2.6%	1.0%	0.7%	**4.7%**
More than 1 Year	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%**
	CY 2021	5.5%	3.7%	3.8%	3.0%	0.3%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.3%**
	CY 2022	5.9%	5.1%	5.1%	5.0%	1.3%	0.9%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%	**2.1%**
Total		**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

The timeliness of encounter submissions remained relatively consistent across all months. An average of 43.9% of CY 2022 encounters were processed by MDH within 1 to 2 days of the end date of service—a decrease from 44.1% in CY 2020 and 45.9% in CY 2021.

Table 10 displays processing times for accepted encounters submitted to MDH by MCO from CY 2020 to CY 2022.

Table 10. Percentage of Accepted Encounters Submitted by MCO and Processing Time, CY 2020–CY 2022

MCO	1-2 Days			3-7 Days			8-31 Days			1-2 Months		
	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022
ABH	33.2%	35.7%	33.3%	7.0%	8.9%	7.3%	17.4%	21.7%	17.1%	6.8%	7.7%	5.1%
ACC	45.4%	49.5%	47.5%	10.3%	11.9%	10.9%	21.0%	21.6%	20.5%	6.2%	5.0%	4.4%
CFCHP	37.1%	42.2%	54.0%	7.1%	9.3%	10.7%	10.9%	17.4%	16.6%	4.3%	8.4%	5.8%
JMS	28.3%	27.9%	30.6%	3.7%	4.1%	4.0%	9.4%	15.9%	16.7%	12.7%	17.4%	14.8%
KPMAS	51.1%	60.0%	57.5%	12.1%	14.0%	13.4%	20.5%	18.8%	21.2%	7.2%	2.1%	2.1%
MPC	44.4%	46.4%	47.1%	10.0%	10.2%	9.9%	22.1%	16.9%	17.5%	5.1%	4.9%	4.7%
MSFC	30.4%	28.0%	25.3%	8.2%	8.6%	5.7%	32.0%	35.5%	23.4%	9.2%	11.3%	17.4%
PPMCO	53.7%	56.2%	46.2%	11.5%	12.5%	10.7%	21.4%	19.0%	22.4%	4.7%	4.2%	5.8%
UHC	37.7%	28.8%	32.7%	9.7%	10.4%	10.5%	25.9%	35.7%	34.6%	7.6%	9.7%	7.4%
MCO	**2-6 Months**			**More than 1 Year**			**6-7 Months**			**7-12 Months**		
	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022
ABH	13.3%	12.1%	16.5%	7.7%	4.0%	6.5%	3.3%	1.7%	3.9%	11.3%	8.1%	10.3%
ACC	12.5%	6.7%	7.6%	1.0%	2.0%	2.8%	0.9%	0.6%	1.0%	2.8%	2.8%	5.2%
CFCHP	15.6%	15.8%	9.5%	1.3%	1.1%	0.6%	3.9%	1.4%	0.6%	19.8%	4.3%	2.3%
JMS	31.0%	11.8%	14.6%	6.1%	4.9%	3.8%	3.7%	2.6%	2.4%	5.0%	15.5%	13.1%
KPMAS	5.1%	3.8%	3.2%	0.4%	0.1%	0.5%	0.7%	0.5%	0.5%	2.9%	0.7%	1.7%
MPC	11.0%	10.6%	10.2%	1.8%	1.7%	3.2%	1.3%	2.0%	1.6%	4.3%	7.3%	5.8%
MSFC	14.1%	12.1%	17.3%	1.4%	0.5%	1.9%	2.0%	1.7%	1.9%	2.7%	2.2%	6.9%
PPMCO	6.5%	5.2%	8.6%	0.5%	0.9%	1.3%	0.6%	0.6%	1.4%	1.2%	1.5%	3.6%
UHC	10.9%	11.2%	10.3%	2.1%	0.4%	0.9%	1.5%	1.2%	1.1%	4.5%	2.5%	2.4%

While six MCOs (ABH, ACC, CFCHP, JMS, KPMAS, MPC) submitted a higher percentage of their encounters within 1 to 2 days in CY 2022 than in CY 2020, half of these MCOs (ABH, ACC, KPMAS) experienced a decrease in the percentage of encounters submitted within 1 to 2 days from CY 2021 to CY 2022. In CY 2022, the percentage of encounters submitted by MCOs within 1 to 2 days ranged from 25.3% (MSFC) to 57.5% (KPMAS). The percentage of encounters submitted within 3 to 7 days increased slightly for ABH, ACC, CFCHP, JMS, KPMAS, and UHC, and decreased for MPC, MSFC, and PPMCO. JMS had the lowest (4.0%) percentage of encounters submitted within 3 to 7 days in CY 2022.

See Appendix H for a stacked bar chart displaying the number and percentage of encounters within each claim type from CY 2020 to CY 2022 by processing time. Appendix I provides a table outlining the number and percentage of encounters submitted by MCOs by processing time in CY 2022. See Appendix J for a stacked bar chart displaying the percentage of encounters submitted by MCO by processing time in CY 2020 through CY 2022.

Provider Analysis

Evaluating encounters by provider type for fluctuations across MCOs contributes to the assessment of encounter data volume and consistency. The following provider analysis examines encounter data for PCPs and establishes a comparison rate of PCP visits in HealthChoice. For this analysis, Hilltop matched the Medicaid identification numbers the MCOs provided for their members to eligibility data in MMIS2. Only participants listed in an MCO's files and enrolled in MMIS2 were included in the analysis. Table 11 shows the distribution of all HealthChoice participants enrolled for any length of time who received a PCP visit by an MCO during CY 2020 through CY 2022.

Table 11. Number and Percentage of HealthChoice Participants (Any Period of Enrollment) with a PCP Visit by MCO, CY 2020–CY 2022

	Year	ABH	ACC*	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	Total
Number of Participants (any period of enrollment)	CY 2020	51,501	317,912	59,073	32,184	101,834	243,944	108,468	344,584	170,640	**1,430,140**
	CY 2021	59,058	332,173	73,931	32,367	117,044	255,039	113,288	359,863	177,570	**1,520,333**
	CY 2022	64,730	346,723	92,054	32,823	128,331	266,005	117,398	374,444	184,917	**1,607,425**
Percentage of participants with a visit with any PCP in any MCO network	CY 2020	16.9%	75.8%	65.3%	73.5%	70.3%	73.8%	71.3%	74.7%	67.8%	**70.9%**
	CY 2021	61.8%	80.8%	64.4%	75.2%	79.1%	77.4%	74.7%	78.0%	69.2%	**76.0%**
	CY 2022	62.6%	78.6%	66.2%	73.9%	75.9%	75.4%	73.6%	77.8%	73.5%	**75.3%**
Percentage of participants with a visit with their assigned PCP	CY 2020	1.6%	42.5%	24.6%	25.8%	47.3%	31.6%	26.1%	32.7%	28.6%	**33.1%**
	CY 2021	21.4%	44.1%	23.5%	27.0%	54.4%	31.5%	26.2%	38.1%	24.7%	**35.5%**
	CY 2022	23.2%	42.0%	23.2%	29.6%	50.5%	31.8%	25.7%	38.3%	31.6%	**35.7%**
Percentage of participants with a visit with their assigned PCP, group practice, or partner PCPs	CY 2020	2.4%	60.4%	37.1%	52.5%	67.3%	48.8%	43.3%	35.5%	41.4%	**46.1%**
	CY 2021	31.0%	62.8%	35.6%	54.0%	74.8%	50.2%	44.3%	40.8%	38.5%	**49.4%**
	CY 2022	34.7%	59.7%	34.8%	55.3%	71.5%	49.9%	43.4%	40.3%	45.2%	**49.1%**

Notes: Because a participant can be enrolled in multiple MCOs during the year, the total number of participants shown above is not a unique count. Counts do not include FFS claims. Please read ABH's results with caution: the MCO only began providing acceptable files in 2021. The methodology was updated in 2021 to account for changes in the rendering vs. billing provider fields in MMIS2, so the CY 2020 numbers have changed significantly in some cases.
* ACC's name changed to Wellpoint Maryland, effective January 1, 2023, and will be reflected in MY 2023's report.

The CY 2022 PCP visit rate (defined as a visit to the assigned PCP, group practice, or partner PCP) ranged from 34.7% (ABH) to 71.5% (KPMAS). Using the broadest definition of a PCP visit—that is, a visit to any PCP within any MCO's network—the PCP visit rate ranged from 62.6% (ABH) to 78.6% (ACC). The PCP visit rate increased across all measures between CY 2020 and CY 2022, but

the percentage of participants with a visit to any PCP in any MCO network and a visit with their assigned PCP, group practice, or partner PCPs decreased slightly from CY 2021 to CY 2022.

Service Type Analysis

Table 12 shows the number and percentage of encounter visits for inpatient hospitalizations, ED visits, and observation stays by MCO for CY 2020 to CY 2022.

Table 12. Number and Percentage of Inpatient Visits, ED Visits, and Observation Stays by MCO, CY 2020–CY 2022

Visits	Year	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	Total
Number of Visits	CY 2020	432,167	3,604,824	671,679	461,007	797,758	3,564,836	1,495,891	4,718,567	2,131,056	**17,877,785**
	CY 2021	613,502	4,296,251	887,454	502,290	1,144,056	4,035,993	1,699,091	5,534,477	2,470,312	**21,183,426**
	CY 2022	672,857	4,316,397	1,093,093	469,075	1,143,675	4,048,013	1,666,516	5,512,901	2,393,716	**21,316,243**
Percentage of All Visits	CY 2020	2.4%	20.2%	3.8%	2.6%	4.5%	19.9%	8.4%	26.4%	11.9%	**100%**
	CY 2021	2.9%	20.3%	4.2%	2.4%	5.4%	19.1%	8.0%	26.1%	11.7%	**100%**
	CY 2022	3.2%	20.2%	5.1%	2.2%	5.4%	19.0%	7.8%	25.9%	11.2%	**100%**
Number of Inpatient Visits	CY 2020	3,792	21,966	5,009	3,510	6,603	21,181	8,590	28,685	12,717	**112,053**
	CY 2021	4,047	22,569	6,080	3,556	7,609	22,247	9,141	29,423	13,042	**117,714**
	CY 2022	4,176	22,277	6,923	3,086	7,679	20,100	9,272	28,102	12,816	**114,431**
Percentage of Visits that were Inpatient	CY 2020	0.9%	0.6%	0.7%	0.8%	0.8%	0.6%	0.6%	0.6%	0.6%	**0.6%**
	CY 2021	0.7%	0.5%	0.7%	0.7%	0.7%	0.6%	0.5%	0.5%	0.5%	**0.6%**
	CY 2022	0.6%	0.5%	0.6%	0.7%	0.7%	0.5%	0.6%	0.5%	0.5%	**0.5%**
Number of ED Visits	CY 2020	15,762	109,255	23,287	18,740	13,001	110,516	43,988	138,115	62,984	**535,648**
	CY 2021	21,509	131,335	30,394	20,795	23,246	125,517	51,392	165,869	73,567	**643,624**
	CY 2022	23,569	135,907	33,155	18,701	25,341	127,470	54,528	170,435	75,401	**664,507**
Percentage of Visits that were ED	CY 2020	3.6%	3.0%	3.5%	4.1%	1.6%	3.1%	2.9%	2.9%	3.0%	**3.0%**
	CY 2021	3.5%	3.1%	3.4%	4.1%	2.0%	3.1%	3.0%	3.0%	3.0%	**3.0%**
	CY 2022	3.5%	3.1%	3.0%	4.0%	2.2%	3.1%	3.3%	3.1%	3.1%	**3.1%**
Number of Observation Stays	CY 2020	1,074	7,426	1,552	1,182	928	8,232	2,901	8,740	5,469	**37,504**
	CY 2021	1,239	8,115	1,994	1,173	1,472	8,926	3,134	10,698	6,789	**43,540**
	CY 2022	1,430	6,928	1,811	979	1,623	8,416	2,738	9,413	7,951	**41,289**
Percentage of All Visits that were Observation Stays	CY 2020	0.2%	0.2%	0.2%	0.3%	0.1%	0.2%	0.2%	0.2%	0.3%	**0.2%**
	CY 2021	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%	0.3%	**0.2%**
	CY 2022	0.2%	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.2%	0.3%	**0.2%**

Note: Visits were duplicated between inpatient visits, ED visits, and observation stays.

For this analysis, a visit was defined as one encounter per person per provider per day. MCOs reported a consistent distribution of visits by service type for all years of the evaluation period. The percentages for both the total inpatient hospitalizations and observation stays combined were less than 1.0% of visits each year. ED visits, which were 3.1% of all visits in CY 2022, ranged from 2.2% of all visits (KPMAS) to 4.0% of all visits (JMS). Overall, during the evaluation period, the percentage of inpatient visits decreased slightly, and ED visits increased slightly. As shown in

the annual HealthChoice evaluation, the overall percentage of HealthChoice participants with an outpatient ED visit and inpatient admission decreased between CY 2017 and CY 2021 (The Hilltop Institute, 2023).

Analysis by Age and Sex

Hilltop conducted an analysis of encounter data submitted by MCOs to determine the effectiveness of encounter data edit checks between CY 2020 and CY 2022. The following areas were analyzed: 1) individuals over age 65 with encounters, 2) individuals with a service date before their date of birth, 3) age-appropriate and sex-appropriate diagnoses for delivery, 4) age-appropriate dementia diagnoses, and 5) children aged 0 to 20 years with dental encounters.

Because participants older than 65 are ineligible for HealthChoice, Hilltop searched for any encounters for those aged 66 or older. Between CY 2020 and 2021, the number of encounters for MCO participants aged 66 or older fell before rising again in CY 2022.[31] The number of individuals with a service date before their date of birth decreased between CY 2020 and CY 2022, although the number of such individuals fell to its lowest point during CY 2021. The MCOs and MDH improved the quality of reporting encounter data for age-appropriate diagnoses in CY 2021.

The Maryland Healthy Smiles Dental Program (Healthy Smiles) provides dental coverage for children under the age of 21. The program is paid on an FFS basis—not through the MCO service package. Hilltop found very few dental encounters for children under the age of 21 covered by an MCO in CY 2020 through CY 2022. As of January 1, 2023, Healthy Smiles is available to adults who receive full Medicaid benefits[32] and will be included in the analysis for MY 2023's report.

Hilltop analyzed the volume of participants who had a diagnosis for delivery (births) by age group between CY 2020 and CY 2022. Participants aged 0 to 11 and 51 or older are typically considered to be outside of the expected age range for delivery. This analysis only considers female participants with a delivery diagnosis.[33] Across all MCOs, the number of female participants identified as delivering outside of the expected age ranges was 118 in CY 2020, 122 in CY 2021, and 136 in CY 2022. The data substantiate that, overall, the encounters submitted are age-appropriate for delivery. See Appendix K for delivery codes.

Hilltop also validated encounter data for sex-appropriate delivery diagnoses. A diagnosis for delivery should typically be present only on encounters for female participants.[34] All MCOs had a similar distribution, with nearly 100% of deliveries being reported for females. Delivery diagnoses for male participants in the encounter data are negligible, totaling 45 reported deliveries across all MCOs in CY 2020, 52 deliveries in CY 2021, and 48 deliveries in CY 2022.[35]

[31] Data not shown due to small cell sizes.
[32] 2022 MD Laws Ch. 303.
[33] In MMIS2, male or female are the only two options.
[34] In MMIS2, male or female are the only two options.
[35] Data not shown by MCO due to small cell sizes.

The final analysis focused on age-appropriate diagnoses of dementia (see Appendix L for dementia codes) from CY 2020 to CY 2022. Although dementia is a disease generally associated with older age, onset can occur as early as 30 years of age. Thus, the prevalence of dementia diagnoses should increase with age after 30. Hilltop identified the number of participants under the age of 30 with an encounter with a dementia diagnosis. While each MCO had participants under the age of 30 with a dementia diagnosis, the total numbers were relatively small (298 participants were reported across all MCOs in CY 2022).[36]

Recommendations

Step 1. Develop a Data Quality Test Plan Based on Data Element Validity Requirements

In Step 1, Hilltop reviewed 8ER reports and found that, out of approximately 49.4 million overall encounters, more than 3.8 million encounters (approximately 7.8%) were rejected through the EDI process in CY 2022. This represents a decrease from 4.4 million rejected encounters in CY 2021 and 6.8 million in CY 2020. The main cause of this decrease in rejected encounters is an improvement in invalid encounters related to provider information, which indicates a positive trend. However, in CY 2019—before the provider enrollment edits were implemented—the number of rejected encounters was 1.9 million, which increased by 259% in CY 2020. When Hilltop applied the de-duplication method, all MCOs' rate of rejected encounters remained below the 5% threshold. The volume of rejected encounters remains high, so MDH should continue to monitor and work with the MCOs to resolve the provider enrollment data problems.

From CY 2020 to CY 2022, all MCOs except for JMS and KPMAS experienced a decrease in the incidence of provider enrollment-related rejected encounters. From CY 2021 to CY 2022, all MCOs except for PPMCO (which increased by 41.1%) experienced a decrease. CFCHP, JMS, and PPMCO are the only MCOs to have an increase in non-provider enrollment-related rejected encounters from CY 2021 to CY 2022, with PPMCO increasing by 35.2%.

There was an increase in PPMCO's rejected encounters for both provider enrollment-related and other from CY 2021 to CY 2022, while there was a decrease in its share of all HealthChoice enrollees (from 24.1% in CY 2021 to 23.7% in CY 2022). This may indicate problems with PPMCO's encounter submission processes. It is also possible that the duplicate encounters in the 8ER reports are contributing to the increase in rejected encounters. MDH should work with the MCOs to instill best practices to improve their numbers of rejected encounters.

The variance between an MCO's share of all rejections and its share of all accepted encounters might warrant further attention. If an MCO's share of rejections is much higher than its share of accepted encounters, then the organization might have a specific problem. If, on the other hand, the share of accepted encounters is greater than the share of rejections, the MCO might have some best practices to share. PPMCO had 34.9% of all rejected encounters in CY 2022, but only

[36] Data not shown by MCO due to small cell sizes.

26.6% of accepted encounters. Conversely, ACC's share of accepted encounters (18.9%) exceeded its share of rejections (9.8%) during the same period. In CY 2022, when Hilltop applied the de-duplication method, the error rate for submissions for all MCOs was below the 5% threshold.

Step 2. Encounter Data Macro-Analysis—Verification of Data Integrity

Hilltop analyzed and interpreted the encounter data and found that, during CY 2022, the MCOs submitted a total of 45.6 million accepted encounters (records), an increase from 39.5 million in CY 2020 and 44.3 million in CY 2021, respectively. Hilltop reviewed encounters by claim type and found the distribution to be similar among MCOs. Each MCO's distribution of encounters across claim types remained stable and consistent throughout the years. Hilltop also compared the proportion of HealthChoice participants by MCO with the proportion of accepted encounters by MCO and found similar trends.

Hilltop conducted an analysis of payment data on medical encounters and found that all HealthChoice MCOs continued to submit their medical encounters with populated payment fields from CY 2020 to CY 2022, as required. However, all MCOs except for JMS, MPC, and MSFC increased the share of encounters with $0 pay over the evaluation period, which could indicate that the MCOs are not accurately populating the pay field. During CY 2022, JMS submitted 65.8% of its medical encounters with a $0 pay amount, and MSFC submitted nearly half of its medical encounters the same way. All other MCOs ranged from 6.3% (KPMAS) to 25.2% (UHC) of accepted medical encounters with $0 pay. The MCOs with unusually high volumes of $0 encounters should provide an explanation to MDH and ensure accuracy with future submissions.

Hilltop further analyzed the MCOs' use of the 05/09 indicator on medical encounters with $0 in the pay field. Adherence to this requirement is uneven across MCOs, and none demonstrated full compliance in CY 2022, although MSFC and UHC submitted the majority of their $0 encounters with an indicator. The issue was particularly pronounced with JMS, who had no indicator for over three quarters of $0 encounters. MDH should consider evaluating each MCO's sub-capitation arrangements with other organizations and comparing those arrangements with the MCO's use of the sub-capitation indicator.

Hilltop also analyzed the variance between the pay amounts included in accepted encounters and the FFS fee schedule. The overall utilization of the pay field had not changed significantly in CY 2022 as compared to previous years. MDH should continue to work with the MCOs to ensure appropriate utilization and improvement in the accuracy of the payment field on accepted encounters. MDH also resolved an MMIS2 issue, which allowed institutional pay to be captured more accurately in July 2020. This field is now populated for all MCOs. Hilltop determined that the TPL was not captured consistently across MCOs, so the MCO TPL amount is not used in any analyses. Hilltop will continue to investigate TPL and will work with MDH to develop a resolution.

To address the high volume of rejected encounters, MDH should continue to encourage MCOs to work with their providers to ensure that they are enrolled on the date of service and that they

know how to check their current status. MDH should also monitor the MCOs' TPL-reported amounts.

Step 3. Encounter Data Micro-Analysis—Generate and Review Analytic Reports

Time Dimension Analysis

Hilltop compared dates of service with MCO encounter submission dates and found that most encounters in CY 2022 were submitted to MDH within one month of the end date of service, which is consistent with CY 2021 and CY 2020 findings. Nearly all (82.8%) pharmacy encounters were submitted within one to two days of the date of service. All MCOs except for MSFC, PPMCO, and UHC showed improvement in the submission of accepted encounters within two days of the end date of service. JMS's proportion of accepted encounters submitted more than seven months after the service date increased significantly from 5% in CY 2020 to 13.1% in CY 2022, while CFCHP's decreased from 19.8% to 2.3%. PPMCO's rate of encounters processed within one to two days fell by 7.5 percentage points over the evaluation period. MDH should continue to monitor monthly submissions to evaluate consistency and ensure that the MCOs submit data in a timely manner. MCOs that submit encounters more than eight months after the date of service—the maximum time allotted for an encounter to be submitted to MDH—should be flagged for improvement.

Provider Analysis

Hilltop compared the percentage of participants with a PCP visit by MCO between CY 2020 and CY 2022 and found that all categories of PCP visits increased from CY 2020 to CY 2022. However, the percentage of participants with a visit to any PCP in any MCO network and the percentage of participants with a visit with their assigned PCP, group practice, or partner PCPs decreased slightly from CY 2021 to CY 2022. MDH should continue to monitor PCP visits by MCOs in future encounter data validations. In addition, the MCOs should continue to encourage enrollees to change or update their "assigned" PCP to improve selection rates through MCO New Member Welcome packet and in the member handbook.

Service Type Analysis

Hilltop reviewed the volume of inpatient visits, ED visits, and observation stays by MCO. Trends in service type were consistent across MCOs and years. There was a slight increase in ED visits between CY 2020 and CY 2022. MDH should continue to review these data and compare trends in future annual encounter data validations to ensure consistency.

Analysis by Age and Sex

The MCOs and MDH continued to improve the quality of reporting encounter data for age-appropriate and sex-appropriate diagnoses in CY 2022. MDH should continue to review and audit the participant-level, MCO-specific reports that Hilltop generated for delivery, dementia, individuals over age 65, pediatric dental, and missing age outlier data measures. MCOs that

submit the encounter outliers should be notified, demographic information should be updated, and adjustments should be made, as needed.

Conclusion

HealthChoice is a mature managed care program and, overall, analysis of the CY 2022 electronic encounter data submitted indicates that, while there have been improvements in provider-related rejected encounters, MCOs continue to struggle with the changes in encounter editing logic, despite having had two years' lead time to prepare for the change. In many other respects, however, MDH and the MCOs have continued to strengthen gains made in recent years.

The most concerning issue arising in CY 2022 data is the continued volume of encounter rejections, largely due to the aforementioned change in encounter editing logic. Although MDH did not use encounter data from CY 2020 for rate setting because of the COVID-19 health emergency, it should continue to work with the MCOs to resolve their provider enrollment issues, which will allow for more accurate rate setting in the future. The CY 2023 MCO Agreement initially included penalties for MCOs whose total number of rejected encounters exceeds 5% of their total encounters. This penalty was intended to improve the accuracy and quality of encounter data to better support rate setting and maintain compliance with the federal rule strengthening requirements for data, transparency, and accountability.[37] Once de-duplicated, the error rate for CY 2022 submissions for all MCOs was below the 5% threshold (see Appendix A). In the MCO CY 2024 contract, workgroup meetings with MCOs will continue to refine encounters that should be removed from the HFMR. Hilltop will continue to use the methodology outlined in Appendix A to identify and de-duplicate rejected encounters. MDH will work with the MCOs to ensure that appropriately rejected encounters will not be reported on the HFMR. In addition, of concern is that some of the MCOs had unusually high volumes of $0 encounters, which should not be reported on the HFMRs. MDH will also work with the MCOs to provide an explanation and ensure the accuracy of the pay field with future submissions.

In general, the MCOs have similar distributions of rejections, types of encounters, types of visits, and outliers, except where specifically noted in the results. This analysis identified minor outliers that merit further monitoring and investigation, although the MCOs made progress. Hilltop generated recipient-level reports for MDH staff to discuss with the MCOs. MDH should review the content standards and criteria for accuracy and completeness with the MCOs. Continued work with each MCO to address identified discrepancies will improve the quality and integrity of encounter submissions and increase MDH's ability to assess the efficiency and effectiveness of the Medicaid program.

Hilltop found that the volume of accepted encounters was generally consistent with MCO enrollment. Although the time dimension analysis showed some variation among MCOs regarding the timeliness of encounter submissions, most encounters were submitted within the eight-month maximum time frame allotted by MDH. The slight decrease in encounters

[37] Medicaid and CHIP Managed Care Final Rule. 81 Fed. Reg. 27,498 (May 6, 2016) (to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495).

submitted within one to two days that was observed for CY 2020 to CY 2021 rebounded in CY 2022. MDH should work with MCOs to continue improving the timeliness of encounter submissions, especially for MCOs with high rates of submissions occurring more than six months after the end date of service.

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Appendix A. Rejected Encounters Error Rate Methodology

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memorandum

To: Tricia Roddy, Alyssa Brown, Monchel Pridget, and Jennifer McIlvaine
CC: Cynthia Woodcock
From: Jim Clavin, Laura Spicer, Todd Switzer, and Alice Middleton
Date: November 7, 2023
Re: Rejected Encounters Error Rate Methodology

Introduction

Effective calendar year (CY) 2020, the Maryland Department of Health (MDH) implemented changes to the electronic provider revalidation and enrollment portal (ePREP) in response to Centers for Medicare & Medicaid Services (CMS) requirements. The changes require the national provider identifier (NPI) on any encounter to match the active NPI under which the provider enrolled with Medicaid for both the billing and rendering provider fields. To remain actively enrolled with Medicaid, providers had to perform such actions as updating their licensure within ePREP. Failure to do so causes the Medicaid Management Information System (MMIS2) to reject these encounters. MDH worked with the Medicaid managed care organizations (MCOs) for two years prior to the implementation of this change to help ensure a seamless transition. Despite these planning efforts, provider-related encounter rejections increased significantly in CY 2020. While the data improved slightly for CY 2021, the number of provider-related rejected encounters remained above pre-2020 levels.[38]

Concerned that this increase in rejected encounters would affect the validity of the base data for setting the MCO payment rates, MDH added the following language to the MCO contracts for CY 2023 that would have established a penalty for submitting rejected encounters.

> *The Department will require MCOs to submit all unreconciled encounters rejected by the Department's Medicaid Management Information System (MMIS) to its data warehouse vendor, The Hilltop Institute at University of Maryland Baltimore County (Hilltop), for the period covered by this Agreement to determine enrollee utilization for risk adjustment during the capitation rate setting process.*

[38] See the 2021 *Encounter Data Validation Report*.

The MCO is expected to submit less than five (5) percent of its total encounters for the calendar year using the rejected encounter submission process developed by the Department and Hilltop, beginning in calendar year 2023 for 2021, 2022, and 2023 encounters submitted for capitation rate risk adjustment.

Penalties will be assessed for rejected encounters at or exceeding five (5) percent of total encounters for failing to submit accurate and complete encounter data. Penalties will follow the scheme on the following page as a percentage of the MCO's total capitation for the period covered by this Agreement.[39]

% of Encounters Accepted in MMIS	% of Encounters Submitted to Hilltop after Encounter Deadline	Revenue Penalty %
> 95%	≤ 5%	0.0%
≥ 94.0% - ≤ 95.0%	≥ 5.0% - ≤ 6.0%	0.5%
≥ 93.0% - ≤ 94.0%	≥ 6.0% - ≤ 7.0%	0.6%
≥ 92.0% - ≤ 93.0%	≥ 7.0% - ≤ 8.0%	0.7%
≥ 91.0% - ≤ 92.0%	≥ 8.0% - ≤ 9.0%	0.8%
≥ 90.0% - ≤ 91.0%	≥ 9.0% - ≤ 10.0%	0.9%
≤ 90.0%	≤ 10.0%	1.0%

Upon further investigation, after the MCO contracts were signed, Hilltop determined that the data necessary to evaluate rejected encounters are present in Hilltop's monthly MMIS2 data feeds, eliminating the need for a separate encounter submission process. As a result, MDH determined any penalties for rejected encounters exceeding 5% of total encounters would not be assessed. The purpose of this memorandum is to explain Hilltop's methodology for identifying rejected encounters that would have been subject to the policy and for calculating the penalty.

Methodology

Step 1: Identifying Rejected Encounters

MDH provides Hilltop with monthly feeds of MMIS2 data. As part of the production process, Hilltop filters out rejected encounters based upon CLMSTAT = 'X' and stores them in a separate file. These rejected encounters have historically been excluded from rate setting and other analyses.

Hilltop pulled these rejected encounters and identified those as provider-related using the following codes from Table 1. Encounters with multiple denial reasons are only counted once. If an encounter has multiple denial reasons, if any of them are provider-related, the encounter is categorized as provider-related. Pharmacy encounters were removed from the calculation.

[39] 2023 Contract Requirement

Table 1. Provider-Related Code Categorization

Category	Error Code
Provider Enrollment	122, 412, 951, 961, 962, 963, 964, 965, 971, 975, 976
Provider but Not Enrollment	000, 100, 200, 300, 367, 400, 500, 531, 600, 700, 800, 900, 922, 937, 950, 952
Not Provider-Related	All else

Step 2: De-Duplication and Identifying Whether a Rejected Encounter was Ultimately Accepted

Because new ICNs are generated upon re-submission, creating a complete history of an encounter's rejection to acceptance pathway is impossible to trace. Therefore, a fuzzy match algorithm was developed to de-duplicate encounter submissions (i.e., match a rejected encounter to an encounter that was ultimately accepted). From the universe of accepted and denied encounters, Hilltop identifies rejected encounters that were eventually accepted by using Medicaid ID (RECIPNO), beginning date of service (BEGDOS), and Revenue code or Procedure code (REVCODE/PROCODE). Medicaid provider number (PROV) is also used for de-duplication only if there are no provider-related error codes on the rejected encounter. Rejected encounters that were never accepted are then merged into the set of accepted encounters to form "submitted encounters," or the denominator. Hilltop categorizes the rejected encounter into Provider-Related – Enrollment, Provider-Related – Not Enrollment, and Not Provider-Related as described in Step 1. Hilltop validated the rejection identification algorithm against samples from the MCOs. Scenarios validated included:

- An encounter is rejected after it was accepted. In this case, the encounter is not included in the numerator and does not count against the rejection rate.
- Encounters with $0 payment with CN1 = '09' are not included in the numerator and do not count against the rejection rate.
- Encounters rejected for NPI, including exceptions 961, 962, 971, and 975, are used in both the rejection rate calculation and risk adjustment.
- Submitted and resubmitted encounters from a two-day period totaling over 200,000 unique ICNs were tested. Of these, approximately 9,000 were rejected, of which 23% had a CN01 segment of '09'; therefore, around 77% (6,990) of the sample's rejected encounters would be included in the numerator.
- A procedure that is rejected for being a duplicate of a previously paid claim is never included in the numerator.

Step 3: Calculating the Error Rate

The calculation for the error rate is as follows, noting that pharmacy encounters are excluded:

$$Error\ Rate\ = \frac{Rejected\ Encounters\ (excluding\ CN1\ '09')}{Submitted\ Encounters}$$

$Rejected\ Encounter$ = Encounter with CLMSTAT 'X' that was never accepted

$Accepted\ Encounter$ = Encounter with CLMSTAT not equal to 'X' that may have been rejected one or more times

$Submitted\ Encounters$ = Rejected Encounters + Accepted Encounters

All rejected encounters have a CN1 segment that is "used to identify a denied claim between the MCO and the Provider or a sub-capitated agreement between the MCO and Provider;" valid values are "05 – Sub-capitated," "09 – Denied", or blank.[40] For the error rate, those rejected encounters with the CN1 segment not equal to "09" are included in the numerator. Note that, separately, both "05" and "09" were included in the ACG model and used for RAC assignment.

Table 2 presents the number and percentage of rejected encounters for each MCO for CY 2022, reflecting the MMIS as of August 2023. The statewide average was 2.1% with a range of 0.3% to 4.0%. Overall, the data show a 0.2% improvement over CY 2021.

Table 2. Numerator and Denominator by MCO for CY 2022

MCO	Rejected Encounters (excluding CN1 "09") [Error Rate Numerator]	Submitted Encounters [Error Rate Denominator]	Error Rate [Numerator/ Denominator]
1	11,017	1,152,191	1.0%
2	50,359	1,766,454	2.9%
3	18,291	737,083	2.5%
4	61,304	2,346,267	2.6%
5	50,031	6,118,912	0.8%
6	45,091	2,563,262	1.8%
7	362,888	9,038,359	4.0%
8	11,533	4,228,569	0.3%
9	99,806	6,469,491	1.5%

Conclusion

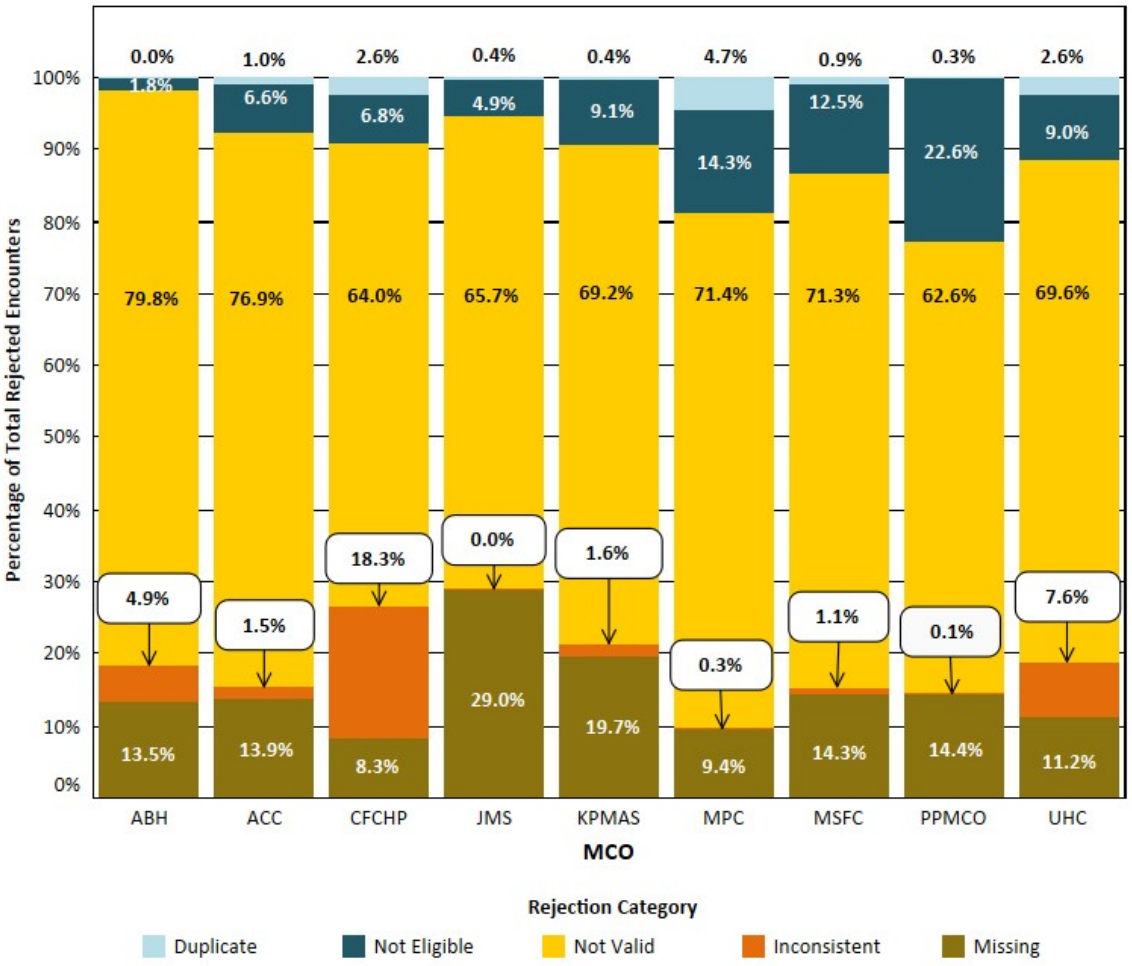
Pursuant to the MCO 2023 contracts' inclusion of improving encounter submission error rates with a target of error rates below 5%, Hilltop identified denied encounters in its MMIS data warehouse. In collaboration with MDH, Hilltop developed a method to calculate the error rate of submitted encounters and to categorize errors into provider and non-provider related. Hilltop validated the methodology by testing samples provided by the MCOs against various scenarios of

[40] 837 Companion Guide

accepted and rejected encounter history. The error rate for CY 2022 submissions for all MCOs is below the 5% threshold.

Applying this methodology going forward, all encounters for a given calendar year will be accepted up until the mid-June encounter cutoff date the following year. As noted in the MCO CY 2024 contract, MDH will convene a workgroup to define which encounters should be removed from the HFMR. Hilltop will use the methodology outlined above to identify and de-duplicate rejected encounters. Hilltop will also apply any additional business rules as agreed to by the encounter data workgroup to define the universe of encounters that should not be included in the HFMR. These data will be shared with MDH's contracted independent accounting firm (currently Myers & Stauffer) to perform procedures to verify that these encounters have been excluded from the HFMR.

Appendix B. Percentage of Encounters Rejected by EDI Rejection Category, by MCO, CY 2022



Appendix C. Rejection Codes, Errors, by Category with Provider-Related and Other Rejection Codes, CY 2022

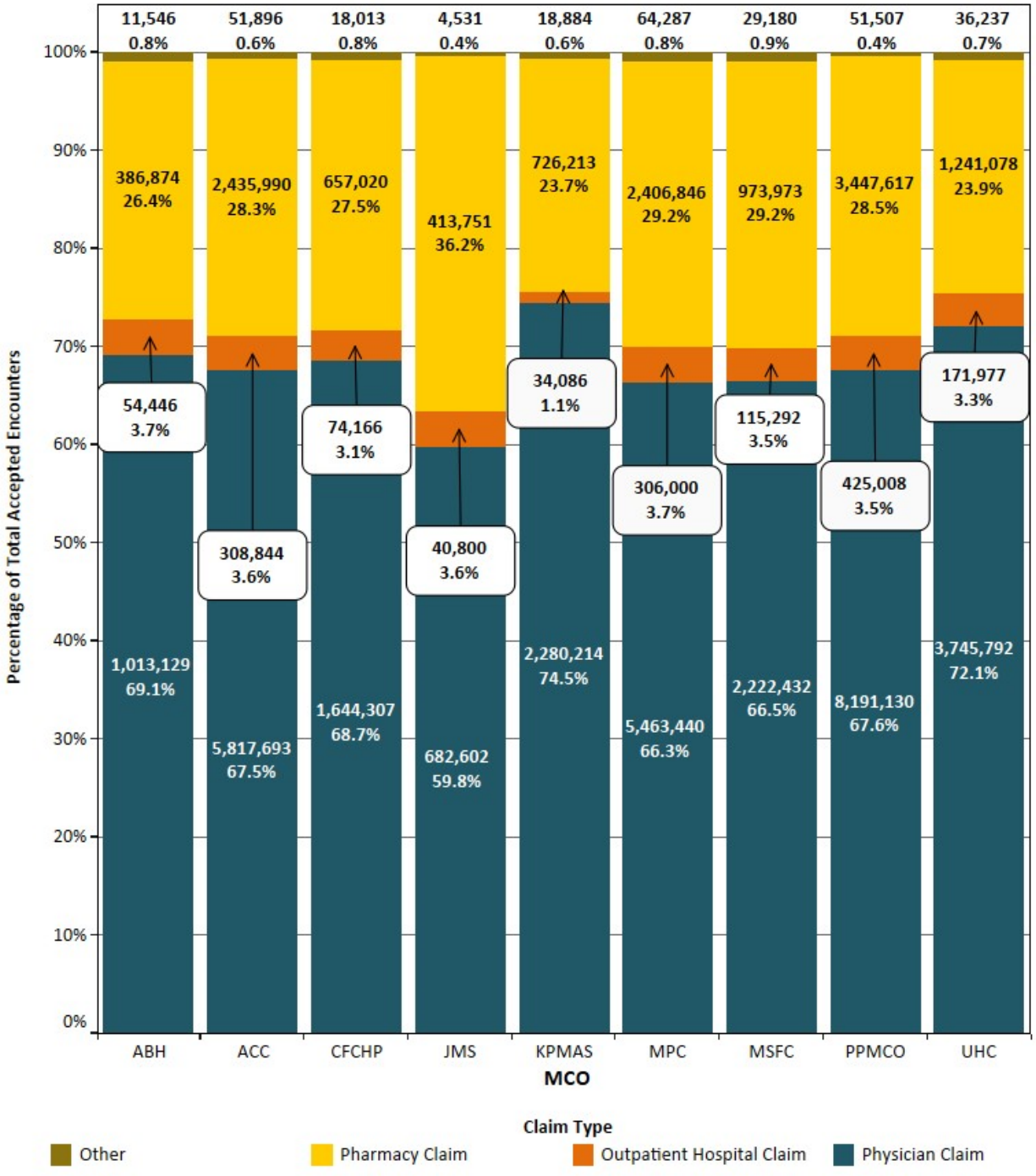
Rejection Type	Rejection Category	Last 3 of ICN	Error Description
Provider-Related	Provider Enrollment	122	INVALID RENDERING PROV NUMBER
		412	REND PROV NOT ON FILE
		961	PAY-TO/FAC PROVIDER SUSPENDED
		962	RENDERING PROVIDER SUSPENDED
		963	PAY-TO/FAC PROV NOT ACT DOS
		964	REND PROV NOT ACT ON DOS
		965	BILL/PAY2 PROV NPI <> MA ID
		971	NPI NUMBER INVLD FR PYTOPROV
		975	NPI#NFDONPROVFLFRENREFFACLTY
		976	REND PROV NPI NO MATCH FFS ID
	Not Valid	367	PRO TYP RENDPROV N/ATH REP PRO
		531	SVC/REND PROV# N/9 NUM DIGITS
		922	INVLD DEFAULT PROVIDER NUMBER
		950	SUB PROV NOT ON MASTER FILE
Other	Inconsistent	113	ADMIT DATE AFTER 1ST DATE SER
		126	THRU DOS PRIOR TO BEGIN DOS
		182	PAT STAT CD DISCHRG DTE CNFLT
		190	FIRST SURG DOS W/IN SVC PERIOD
		290	ORIG ENC TP A/RES DN AGREE
		435	SEX RECIP N/VALD F/REPT PROC
		454	FIRST DIAGNOSIS AGE CONFLICT
		455	FIRST DIAGNOSIS SEX CONFLICT
		464	2ND DIAGNOSIS AGE CONFLICT
		465	2ND DIAG SEX CONFLICT
		474	3RD DIAGNOSIS AGE CONFLICT
		484	4TH DIAGNOSIS AGE CONFLICT
		485	4TH DIAGNOSIS SEX CONFLICT
		589	FRM DOS PRIOR TO RECIP DOB
		901	ORIG ICN N/FOUND ON HISTORY
		912	VD/RESB MCO# NOT EQL HISTORY
		913	VOID RESUBMIT RECPT NOT = HIST

Rejection Type	Rejection Category	Last 3 of ICN	Error Description
Other (cont.)	Missing	135	BILLING PROV NUM MISSING
		170	INV/MISS PLACE OF SERVICE
		172	INVLD OR MISS REV/HCPCS CODE
		249	UNITS OF SERVICE EQUAL ZERO
		259	PROC CODE REQ DIAG CODE
		361	TOOTH # REQD FOR PROC IS MISS
		362	TOOTH SURF REQ F/PROC IS MISS
		970	NPI NUMBER IS MISSING
		971	NPI ON ENC NOT FOUND IN MMIS
		982	NDC MISSING OR NOT VALID
		985	NDC QUANTITY MISSING
	Not Eligible	250	RECPT NOT ON ELIGIBILITY FILE
		271	RECIP NOT ENRLD W/RPT MCO DOS
		437	PROC/REV CODE NOT COVD DOS
		961	EXCEPTION 961
		962	EXCEPTION 962
		963	EXCEPTION 963
		964	EXCEPTION 964
	Not Valid	124	FIRST DOS NOT STRUCTURED PROP
		129	RECPT NUMBER NOT 11 NUM DIGITS
		138	UB92 TYPE OF BILL INVALID
		144	LAST DOS AFTER BATCH PROC DATE
		153	NDC NOT VALID STRUCTURE
		167	ADMIT DATE NOT STRUCTURED PROP
		197	1ST SURG PROC DATE INVALID
		207	PATIENT DISCHARGE STATUS INVAL
		213	CHARGE EXCEEDS EXCESS AMOUNT
		217	FACILITY NUMBER NOT VALID
		430	PROC/REV CODE NOT ON FILE
		450	FIRST DIAGNOSIS NOT ON FILE
		460	2ND DIAG NOT ON FILE
		470	3RD DIAG NOT ON FILE
		480	4TH DIAG NOT ON FILE
		550	FIRST PROC NOT ON FILE
		560	SECOND PROC NOT ON FILE
		600	CLAIM EXCEEDS 50 SERVICE LINES
		896	RELATED HISTORY REC MAX EXCEED
		898	RECIP CLAIM OVERFLOW
		900	VD/RESB RECD WOUT/ORIG ICN.
		925	PROC BLD N/VLD F CLMTYP
		926	DENTAL CODE NOT VALID FOR DOS.
		951	PROVIDER NUMBER NOT VALID
		973	NPI/MA# NOT MATCHED IN MMIS
	Duplicate	902	ORIG ICN FD ON HIST ALRD VOID
		986	NDC CODE IS DUPLICATE

Appendix D. Top Three EDI Rejection Descriptions by Number of Rejected Encounters by MCO, CY 2022

MCO	Error Description	CY 2020	Error Description	CY 2021	Error Description	CY 2022
ABH	INVALID RENDERING PROV NUMBER	25,063	PROVIDER NUMBER NOT VALID	95,559	PROVIDER NUMBER NOT VALID	20,227
	PROVIDER NUMBER NOT VALID	18,862	BILLING PROV NUM MISSING	81,186	INVALID RENDERING PROV NUMBER	14,422
	NPI NUMBER INVLD FR PYTOPROV	13,486	INVALID RENDERING PROV NUMBER	75,487	BILLING PROV NUM MISSING	13,144
ACC	PROVIDER NUMBER NOT VALID	296,648	PAY-TO/FAC PROV NOT ACT DOS	148,131	PAY-TO/FAC PROV NOT ACT DOS	96,012
	BILLING PROV NUM MISSING	201,778	PROVIDER NUMBER NOT VALID	103,159	PROVIDER NUMBER NOT VALID	62,768
	INVALID RENDERING PROV NUMBER	180,265	BILLING PROV NUM MISSING	85,744	NPI NUMBER INVLD FR PYTOPROV	48,722
CFCHP	ORIG ICN FD ON HIST ALRD VOID	439,756	INVALID RENDERING PROV NUMBER	71,050	INVALID RENDERING PROV NUMBER	70,336
	INVALID RENDERING PROV NUMBER	352,329	ORIG ICN FD ON HIST ALRD VOID	38,922	ORIG ICN N/FOUND ON HISTORY	62,413
	REND PROV NOT ACT ON DOS	126,315	BILLING PROV NUM MISSING	30,250	PROVIDER NUMBER NOT VALID	40,799
JMS	BILLING PROV NUM MISSING	35,694	BILLING PROV NUM MISSING	78,790	PROVIDER NUMBER NOT VALID	73,311
	NPI NUMBER INVLD FR PYTOPROV	35,244	NPI NUMBER INVLD FR PYTOPROV	78,619	BILLING PROV NUM MISSING	72,728
	RECIP NOT ENRLD W/RPT MCO DOS	5,422	PROC/REV CODE NOT COVD DOS	7,333	NPI NUMBER INVLD FR PYTOPROV	72,713
KPMAS	PROVIDER NUMBER NOT VALID	34,533	REND PROV NOT ACT ON DOS	65,188	PROVIDER NUMBER NOT VALID	45,888
	INVALID RENDERING PROV NUMBER	15,026	NPI NUMBER INVLD FR PYTOPROV	50,865	NPI NUMBER INVLD FR PYTOPROV	43,197
	NPI NUMBER INVLD FR PYTOPROV	14,761	BILLING PROV NUM MISSING	49,696	BILLING PROV NUM MISSING	41,877
MPC	INVALID RENDERING PROV NUMBER	177,630	INVALID RENDERING PROV NUMBER	189,825	PAY-TO/FAC PROV NOT ACT DOS	119,963
	PROVIDER NUMBER NOT VALID	146,992	PAY-TO/FAC PROV NOT ACT DOS	125,802	PROVIDER NUMBER NOT VALID	85,691
	BILLING PROV NUM MISSING	126,517	PROVIDER NUMBER NOT VALID	124,747	RECIP NOT ENRLD W/RPT MCO DOS	67,711
MSFC	BILLING PROV NUM MISSING	93,903	BILLING PROV NUM MISSING	47,996	PAY-TO/FAC PROV NOT ACT DOS	20,532
	PROVIDER NUMBER NOT VALID	79,936	PAY-TO/FAC PROV NOT ACT DOS	30,791	PROVIDER NUMBER NOT VALID	11,300
	NPI NUMBER INVLD FR PYTOPROV	73,427	PROVIDER NUMBER NOT VALID	30,182	BILLING PROV NUM MISSING	6,398
PPMCO	PROVIDER NUMBER NOT VALID	259,111	PROVIDER NUMBER NOT VALID	199,364	RECIP NOT ENRLD W/RPT MCO DOS	227,772
	BILLING PROV NUM MISSING	243,694	BILLING PROV NUM MISSING	180,024	PROVIDER NUMBER NOT VALID	225,291
	NPI NUMBER INVLD FR PYTOPROV	185,075	NPI NUMBER INVLD FR PYTOPROV	122,306	BILLING PROV NUM MISSING	159,157
UHC	PROVIDER NUMBER NOT VALID	176,208	PROVIDER NUMBER NOT VALID	157,534	PROVIDER NUMBER NOT VALID	131,176
	INVALID RENDERING PROV NUMBER	143,864	PAY-TO/FAC PROV NOT ACT DOS	125,534	NPI#NFDONPROVFLFRENREFFACLTY	86,177
	BILLING PROV NUM MISSING	106,311	INVALID RENDERING PROV NUMBER	72,331	PAY-TO/FAC PROV NOT ACT DOS	55,829

Appendix E. Number and Percentage of Accepted Encounters by Claim Type and MCO, CY 2022

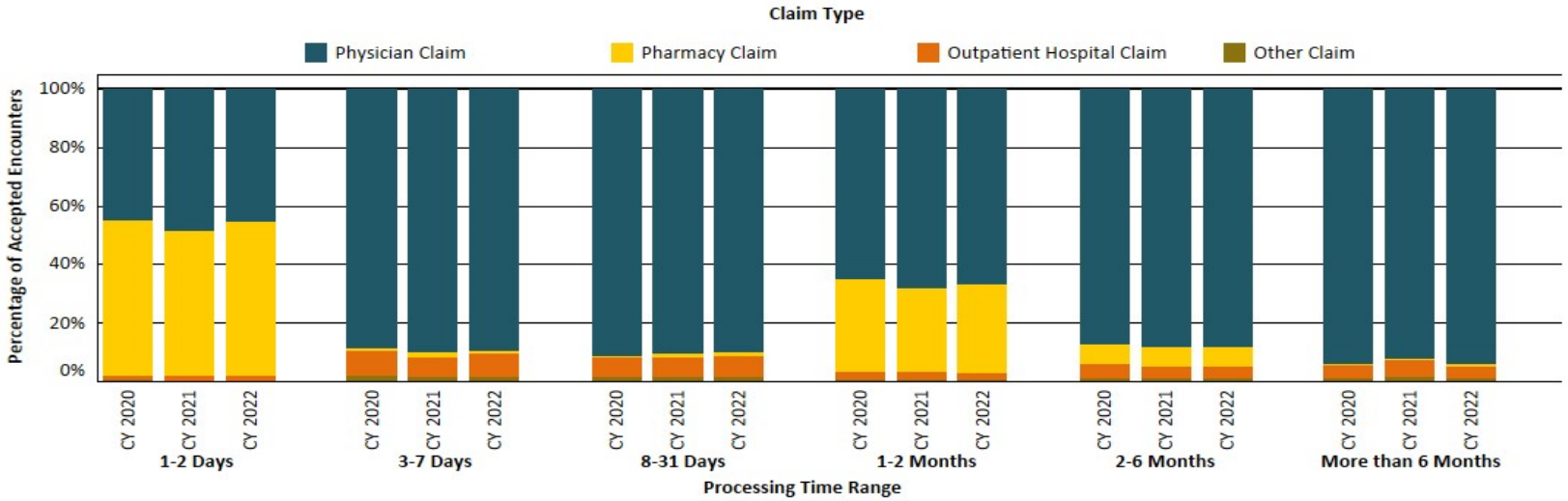


Note: "Other" is a combination of inpatient hospital claims, community-based services claims, and long-term care claims.

Appendix F. Number of Accepted Medical Encounters by MCO and Pay Category, CY 2020–CY 2022

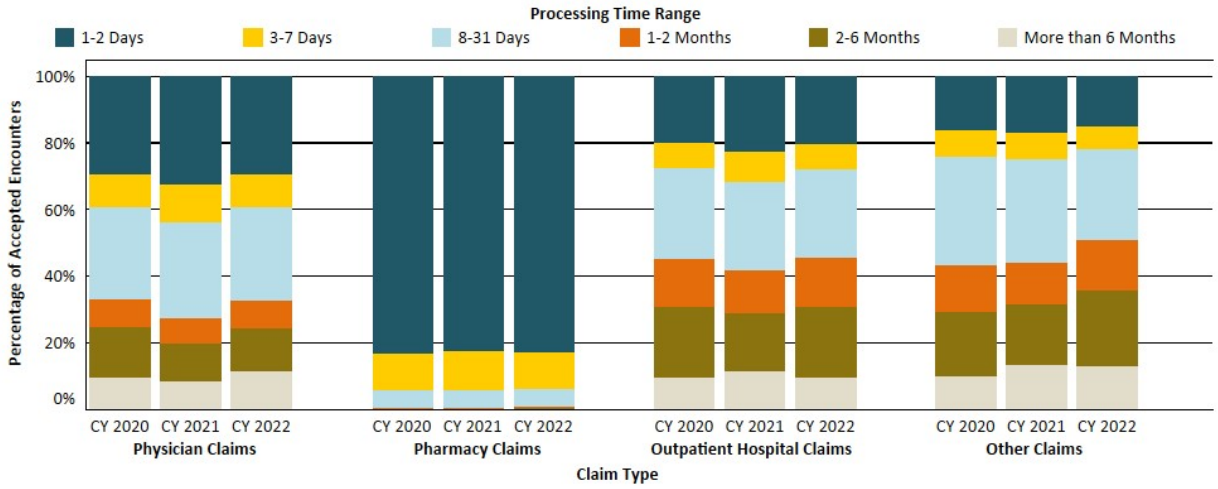
MCO	Populated			$0		
	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022
ABH	427,437	639,721	697,565	98,213	140,020	165,635
ACC	3,813,960	4,789,407	4,729,467	374,433	488,070	757,248
CFCHP	680,020	869,961	1,151,967	114,605	237,519	290,813
JMS	209,224	247,332	222,651	405,416	412,501	428,663
KPMAS	1,332,909	1,973,718	2,021,446	47,118	118,827	136,943
MPC	3,384,552	4,217,329	4,230,981	691,817	717,480	766,411
MSFC	936,837	1,117,795	1,117,555	904,435	1,074,314	907,070
PPMCO	4,381,528	5,531,945	5,284,443	970,711	1,341,220	1,641,938
UHC	2,132,482	2,622,037	2,511,339	585,247	814,233	845,955
Total	**17,298,949**	**22,009,245**	**21,967,414**	**4,191,995**	**5,344,184**	**5,940,676**

Appendix G. Distribution of Accepted Encounters by Processing Time and Claim Type, CY 2020–CY 2022



Processing Time Range	CY 2020				CY 2021				CY 2022			
	Physician Claim	Outpatient Hospital Claim	Pharmacy Claim	Other Claim	Physician Claim	Outpatient Hospital Claim	Pharmacy Claim	Other Claim	Physician Claim	Outpatient Hospital Claim	Pharmacy Claim	Other Claim
1-2 Days	44.9%	1.7%	53.2%	0.3%	48.7%	1.7%	49.4%	0.2%	45.7%	1.6%	52.6%	0.2%
	7,829,006	290,059	9,284,451	49,060	9,884,739	347,471	10,026,380	49,039	9,135,115	310,346	10,510,053	43,446
3-7 Days	65.2%	2.8%	31.4%	0.6%	68.2%	2.8%	28.5%	0.5%	66.5%	2.6%	30.5%	0.4%
	2,557,495	111,235	1,229,931	23,348	3,327,402	135,723	1,392,401	23,053	3,061,363	118,118	1,407,027	19,195
8-31 Days	87.4%	4.6%	6.9%	1.1%	88.3%	4.2%	6.6%	0.9%	88.3%	4.1%	6.8%	0.8%
	7,530,801	394,196	596,126	97,894	8,731,435	413,259	650,512	88,765	8,826,893	409,013	680,381	78,528
1-2 Months	88.6%	8.6%	1.0%	1.8%	90.2%	7.2%	1.2%	1.3%	89.8%	7.8%	0.9%	1.5%
	2,163,246	210,294	25,139	42,989	2,478,225	198,767	32,578	36,457	2,587,218	223,184	26,697	42,597
2-6 Months	91.4%	7.1%	0.2%	1.3%	90.9%	7.2%	0.6%	1.4%	90.2%	7.4%	0.9%	1.5%
	3,979,681	307,591	8,798	57,561	3,423,369	269,617	21,363	52,464	3,953,948	322,630	39,678	65,843
More than 6 Months	93.9%	5.0%	0.0%	1.1%	92.2%	6.3%	0.1%	1.4%	94.4%	4.0%	0.7%	1.0%
	2,591,238	136,730	569	30,503	2,488,840	170,314	1,923	38,588	3,496,201	147,328	25,526	36,472
Total	**67.4%**	**3.7%**	**28.2%**	**0.8%**	**68.5%**	**3.5%**	**27.4%**	**0.7%**	**68.2%**	**3.4%**	**27.8%**	**0.6%**
	26,651,467	**1,450,105**	**11,145,014**	**301,355**	**30,334,010**	**1,535,151**	**12,125,157**	**288,366**	**31,060,738**	**1,530,619**	**12,689,362**	**286,081**

Appendix H. Percentage of the Total Number of Accepted Encounters Submitted by Claim Type and Processing Time, CY 2020–CY 2022

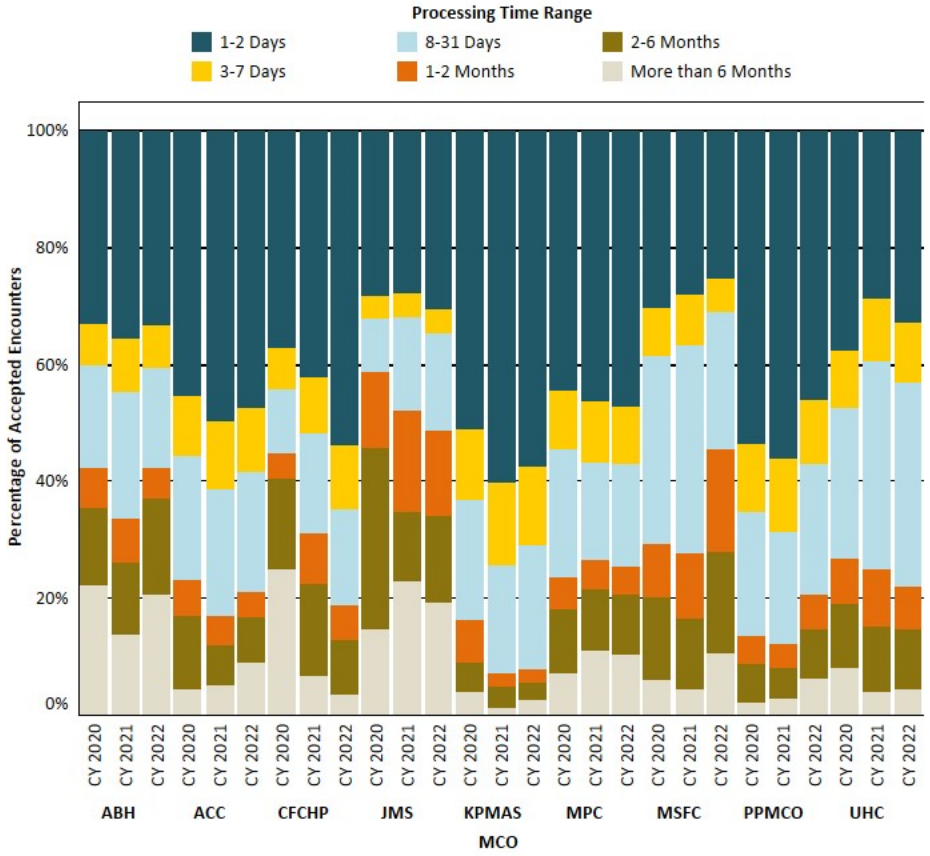


Processing Time Range	Physician Claim			Pharmacy Claim			Outpatient Hospital Claim			Other Claim		
	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022	CY 2020	CY 2021	CY 2022
1-2 Days	29.4%	32.6%	29.4%	83.3%	82.7%	82.8%	20.0%	22.6%	20.3%	16.3%	17.0%	15.2%
	7,829,006	9,884,739	9,135,115	9,284,451	10,026,380	10,510,053	290,059	347,471	310,346	49,060	49,039	43,446
3-7 Days	9.6%	11.0%	9.9%	11.0%	11.5%	11.1%	7.7%	8.8%	7.7%	7.7%	8.0%	6.7%
	2,557,495	3,327,402	3,061,363	1,229,931	1,392,401	1,407,027	111,235	135,723	118,118	23,348	23,053	19,195
8-31 Days	28.3%	28.8%	28.4%	5.3%	5.4%	5.4%	27.2%	26.9%	26.7%	32.5%	30.8%	27.4%
	7,530,801	8,731,435	8,826,893	596,126	650,512	680,381	394,196	413,259	409,013	97,894	88,765	78,528
1-2 Months	8.1%	8.2%	8.3%	0.2%	0.3%	0.2%	14.5%	12.9%	14.6%	14.3%	12.6%	14.9%
	2,163,246	2,478,225	2,587,218	25,139	32,578	26,697	210,294	198,767	223,184	42,989	36,457	42,597
2-6 Months	14.9%	11.3%	12.7%	0.1%	0.2%	0.3%	21.2%	17.6%	21.1%	19.1%	18.2%	23.0%
	3,979,681	3,423,369	3,953,948	8,798	21,363	39,678	307,591	269,617	322,630	57,561	52,464	65,843
More than 6 Months	9.7%	8.2%	11.3%	0.0%	0.0%	0.2%	9.4%	11.1%	9.6%	10.1%	13.4%	12.7%
	2,591,238	2,488,840	3,496,201	569	1,923	25,526	136,730	170,314	147,328	30,503	38,588	36,472
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	26,651,467	**30,334,010**	**31,060,738**	**11,145,014**	**12,125,157**	**12,689,362**	**1,450,105**	**1,535,151**	**1,530,619**	**301,355**	**288,366**	**286,081**

Appendix I. Distribution of Accepted Encounters Submitted by MCO and Processing Time, CY 2022

Processing Time Range	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	Total
1-2 Days	33.3%	47.5%	54.0%	30.6%	57.5%	47.1%	25.3%	46.2%	32.7%	**43.9%**
	487,509	4,091,315	1,292,233	348,967	1,759,690	3,879,689	846,462	5,592,468	1,700,627	**19,998,960**
3-7 Days	7.3%	10.9%	10.7%	4.0%	13.4%	9.9%	5.7%	10.7%	10.5%	**10.1%**
	107,111	938,817	255,441	46,089	408,538	817,168	190,869	1,296,341	545,329	**4,605,703**
8-31 Days	17.1%	20.5%	16.6%	16.7%	21.2%	17.5%	23.4%	22.4%	34.6%	**21.9%**
	250,583	1,767,395	396,159	190,298	648,137	1,441,499	782,908	2,719,358	1,798,478	**9,994,815**
1-2 Months	5.1%	4.4%	5.8%	14.8%	2.1%	4.7%	17.4%	5.8%	7.4%	**6.3%**
	75,281	380,594	138,808	168,487	64,619	383,584	581,766	704,562	381,995	**2,879,696**
2-6 Months	16.5%	7.6%	9.5%	14.6%	3.2%	10.2%	17.3%	8.6%	10.3%	**9.6%**
	241,981	654,923	227,331	166,282	97,091	843,801	579,281	1,036,417	534,992	**4,382,099**
6-7 Months	3.9%	1.0%	0.6%	2.4%	0.5%	1.6%	1.9%	1.4%	1.1%	**1.4%**
	56,975	89,146	14,474	27,832	14,978	134,212	63,008	169,653	59,555	**629,833**
7-12 Months	10.3%	5.2%	2.3%	13.1%	1.7%	5.8%	6.9%	3.6%	2.4%	**4.7%**
	151,565	447,272	55,176	150,127	52,034	474,105	231,563	441,632	126,810	**2,130,284**
More than 1 Year	6.5%	2.8%	0.6%	3.8%	0.5%	3.2%	1.9%	1.3%	0.9%	**2.1%**
	94,990	244,961	13,884	43,602	14,310	266,514	65,020	154,831	47,298	**945,410**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	1,465,995	**8,614,423**	**2,393,506**	**1,141,684**	**3,059,397**	**8,240,572**	**3,340,877**	**12,115,262**	**5,195,084**	**45,566,800**

Appendix J. Percentage of Accepted Encounters Submitted by MCO and Processing Time, CY 2020–CY 2022



MCO	Year	1-2 Days	3-7 Days	8-31 Days	1-2 Months	2-6 Months	More than 6 Months
ABH	CY 2020	33.2%	7.0%	17.4%	6.8%	13.3%	22.3%
	CY 2021	35.7%	8.9%	21.7%	7.7%	12.1%	13.9%
	CY 2022	33.3%	7.3%	17.1%	5.1%	16.5%	20.7%
ACC	CY 2020	45.4%	10.3%	21.0%	6.2%	12.5%	4.6%
	CY 2021	49.5%	11.9%	21.6%	5.0%	6.7%	5.4%
	CY 2022	47.5%	10.9%	20.5%	4.4%	7.6%	9.1%
CFCHP	CY 2020	37.1%	7.1%	10.9%	4.3%	15.6%	24.9%
	CY 2021	42.2%	9.3%	17.4%	8.4%	15.8%	6.8%
	CY 2022	54.0%	10.7%	16.6%	5.8%	9.5%	3.5%
JMS	CY 2020	28.3%	3.7%	9.4%	12.7%	31.0%	14.8%
	CY 2021	27.9%	4.1%	15.9%	17.4%	11.8%	23.0%
	CY 2022	30.6%	4.0%	16.7%	14.8%	14.6%	19.4%
KPMAS	CY 2020	51.1%	12.1%	20.5%	7.2%	5.1%	4.0%
	CY 2021	60.0%	14.0%	18.8%	2.1%	3.8%	1.3%
	CY 2022	57.5%	13.4%	21.2%	2.1%	3.2%	2.7%
MPC	CY 2020	44.4%	10.0%	22.1%	5.1%	11.0%	7.4%
	CY 2021	46.4%	10.2%	16.9%	4.9%	10.6%	11.0%
	CY 2022	47.1%	9.9%	17.5%	4.7%	10.2%	10.6%
MSFC	CY 2020	30.4%	8.2%	32.0%	9.2%	14.1%	6.1%
	CY 2021	28.0%	8.6%	35.5%	11.3%	12.1%	4.4%
	CY 2022	25.3%	5.7%	23.4%	17.4%	17.3%	10.8%
PPMCO	CY 2020	53.7%	11.5%	21.4%	4.7%	6.5%	2.3%
	CY 2021	56.2%	12.5%	19.0%	4.2%	5.2%	3.0%
	CY 2022	46.2%	10.7%	22.4%	5.8%	8.6%	6.3%
UHC	CY 2020	37.7%	9.7%	25.9%	7.6%	10.9%	8.2%
	CY 2021	28.8%	10.4%	35.7%	9.7%	11.2%	4.1%
	CY 2022	32.7%	10.5%	34.6%	7.4%	10.3%	4.5%

Appendix K. Delivery Codes

Delivery services were identified as any encounter that had one of the ICD-10 diagnosis codes listed in the table below during CY 2020 through CY 2022.

Code Type	Codes Used in Analysis
ICD-10 Diagnosis Codes	O60.1x, O60.2x, O61.x, O64.x, O65.x, O66.x, O67.x, O68*, O69.x, O70.x, O71.x, O72.x, O73.x, O74.x, O75.x, O76*, O77.x, O80*, O82*, Z37.x

*Only the three-character code listed in the table (e.g., 068, 076, and O80) was included as a valid diagnosis. For all other diagnosis codes, the analysis included all other codes that began with the diagnosis code listed in the table (e.g., O61.x), where x equals any number of digits after the decimal. For example, O61.x, the "x" can represent any number of digits after the decimal (e.g., 061.1 or 061.14) or no digits after the decimal (e.g., O61).

Appendix L. Dementia Codes

Dementia-related services in CY 2022 were identified as any encounter that had one of the ICD-10 diagnosis codes listed in the table below. These codes indicate services for Alzheimer's disease and other types of dementia.

Code Type	Codes Used in Analysis
ICD-10 Diagnosis Codes*	F01, F02, F03, G30, G31

*The three-character codes can include any number of additional digits, such as F02.81.

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Appendix D: 2023 Maryland HealthChoice Consumer Report Card Information Reporting Strategy and Analytic Methodology

Introduction

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 enrollees select a HealthChoice managed care organization (MCO). Information in the report card includes performance measures from the Healthcare Effectiveness Data and Information Set (HEDIS®[1]), the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]) survey, and Maryland's encounter data measures.

This report explains the reporting strategy and analytic methods Qlarant will use in developing the report card MDH will release in 2023, based on data reported from the MCOs in calendar year (CY) 2022. This report is organized as follows:

- Section II
  - **The Information Reporting Strategy** explains the criteria used to determine the most appropriate and effective methods of reporting quality information to Medicaid enrollees, the intended target audience.
- Section III
  - **The Analytic Method** provides a statistical basis and the analysis method used for reporting comparative MCO performance.
- Appendices
  - Reporting Categories and Measures
  - Questions Comprising CAHPS Measures for the Medicaid Product Line

Information Reporting Strategy

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

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

the available HEDIS and CAHPS measures, Qlarant recommends the following reporting categories, outlined with associated measures in the tables that follow:

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

The recommended categories are based on measures reported by HealthChoice MCOs in 2022 and are 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 enrollees; the remaining categories are relevant to specific Maryland HealthChoice enrollees: children, children with chronic illness, women, and adults with chronic illness. Reporting measures individually (in addition to the reporting categories listed above) is not recommended. Comparing the performance of a category composed of many measures with the performance of individual measures may give undue weight to the individual measures.

Measure Selection

The measures considered for inclusion in the report card are derived from those required by MDH for MCOs to report. Those measures include HEDIS measures, the CAHPS results from both the Adult Questionnaire and the Child Questionnaire, and MDH's encounter data measures.

The Reporting Categories and Measures section of this report includes the complete list of HEDIS, CAHPS, and Maryland encounter data measures recommended for inclusion in each reporting category.

HEDIS Measures

The following table identifies Measure Specification and HEDIS® General Updates. For detailed changes, refer to *HEDIS Measurement Year 2022, Volume 2: Technical Specifications for Health Plans.*

Table 1. Measure Specific Updates

Performance Measures	Changes for 2023 report card
Adults' Access to Preventive/Ambulatory Health Services	• Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion.
Appropriate Testing for Children With Pharyngitis	• Added 8th step to the event/diagnosis. *Step 8 Deduplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.* *Note: The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or deduplicated remain in the denominator*.
Appropriate Treatment Upper Respiratory Infection	• Replaced all references to "CWP Antibiotic Medications List" with "AAB Antibiotic Medications List." • Standardized medication names in the medication tables (this change does not impact drugs that are included in the Medication List Directory).
Avoidance of Antibiotic Treatment For Acute Bronchitis/Bronchiolitis	• Clarified that members in hospice or using hospice services anytime during the measurement year are a required exclusion. • Standardized medication names in the medication tables (this change does not impact drugs that are included in the Medication List Directory).
Controlling High Blood Pressure	• Clarified in the numerator of the Hybrid Specification that BP readings taken by the member are eligible for use in reporting. • Clarified in the numerator of the Hybrid Specification that ranges and thresholds do not meet the criteria. • Clarified in the numerator of the Hybrid Specification that a BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.
Comprehensive Diabetes Care	• Clarified the telehealth requirements. • Retired the "Medical Attention for Nephropathy" indicator and replaced it with BP Control <140/90 mm Hg.
Prenatal and Postpartum Visits	• Clarified that services provided during a telephone visit, e-visit, or virtual check-in may be used for Administrative and Hybrid collection methods.
Childhood Immunization Status	• Revised optional exclusions for immunocompromising conditions (e.g., immunodeficiency) to be required exclusions. • Revised optional exclusions for anaphylaxis due to vaccine to be numerator compliant. • Single antigen MMR vaccines are no longer used.

Performance Measures	Changes for 2023 report card
Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	• Added a note in the description to clarify that the Guidelines for Effectiveness of Care Measures should be used when calculating this measure.
Immunization for Adolescents	• Clarified in the example for the two-dose HPV vaccination series that the second vaccine must be on or after July 25.

CAHPS Patient Experience Survey Measures

Consistent with the 2022 Consumer Report Card, it is recommended that results of both the CAHPS Health Plan Survey 5.1H, Adult Version, and the CAHPS Health Plan Survey 5.1H, Child Version with the Children with Chronic Conditions (CCC) measures be included.

The sampling protocol for the CAHPS 5.1H Child Questionnaire allows reporting of two separate sets of results: one for the general population of children and one for the population of children with chronic illness. For each population, results include the same ratings, composites, and individual question summary rates. In addition, five CCC measures are reported for the population of children with chronic conditions.

The CAHPS 5.1H Measures for the Medicaid Product Line section of this report shows the questions comprising the CAHPS 5.1H measures recommended for the report card and their score values.

Summary of CAHPS Measure Changes for the 2023 report card:

- The only change in the CAHPS measure specification is the addition of language to cover telehealth visits; some questions were revised to include phone and video visits.

Format

The following considerations are important when designing report cards:

Table 2. Formatting Elements

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

Recommendation

Create an 11 x 18-inch, one-page document with English on one side and Spanish on the opposite side. This one-page document allows for the 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 the 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 enrollees had difficulty associating data in charts with explanations if they were presented elsewhere in the report card. Consumers prefer a format that groups related data on a single page. Given the number of MCOs whose information is being presented in Maryland's HealthChoice Consumer 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 as "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 enrollees 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 the Analytic Method section below). 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 enrollees 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.[41]

This analysis aims to generate reliable and useful information Medicaid enrollees can use to compare the quality of health care provided by Maryland's HealthChoice MCOs. A statistically reliable index of differences should compare MCO-to-MCO quality performance directly, allowing consumers to detect differences in MCO performance easily.

Handling Missing Values

Missing values are addressed in the following ways:

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

1. Analysts need to first decide which pool of observed (non-missing) MCOs should be used to derive replacement values for missing data and then decide how imputed values will be chosen. Imputed values may be fixed values (i.e., "zero," "25th percentile for all MCOs in the nation"), calculated values (i.e., means or regression estimates), or probable selected values (i.e., multiplying imputed values).

2. Analysts determine which method should be used to replace missing values, 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.

3. Commercial plan data is not an appropriate replacement for missing data because the characteristics of Medicaid populations differ from those of commercial populations. This restricts the potential group to national Medicaid plans, regional Medicaid MCOs, or Maryland HealthChoice MCOs. Analyses conducted by NCQA for the annual State of Health Care Quality Report have consistently shown substantial regional differences in the performance of commercial managed care plans. 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.

4. Further, utilizing regional MCOs to derive missing values is also inappropriate because of the substantial differences in Medicaid program administration across states. In other words, reporting of Medicaid data is skewed to a few large states with large Medicaid managed care enrollment.

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

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

- For HEDIS, health plans that followed the specifications but had too small a denominator (<30) to report a valid rate were assigned a result of NA.
- For CAHPS, MCOs who do not meet the minimum denominator of at least 100 responses are assigned a result of NA.

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

1. If fewer than 50% of the MCOs report a measure, the measure is dropped from the report card category.

2. If an MCO has reported at least 50% of the measures in a reporting category, the missing values are replaced with the mean or minimum values based on the reasons for the missing value.

3. MCOs missing more than 50% of the measures composing a reporting category are given a designation of "Insufficient Data" for the measurement category.

Calculations in each category are based on the remaining reportable measures versus reportable MCOs. "NA" and "BR/NR" designations will be treated differently when values are missing. "NA" values will be replaced with the mean of non-missing observations, and "BR/NR" values will be replaced with the minimum value of non-missing observations. This minimizes any disadvantage to MCOs that are willing to report data but are unable to. Variances for replaced rates are calculated differently for CAHPS survey measures and for non-survey measures (HEDIS, Maryland encounter data).

Handling New MCOs

MCOs are eligible for inclusion in the report card when they are able to report more than half the required HEDIS and CAHPS measures used in the report card category.

Members Who Switch Products/Product Lines

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

Case-Mix Adjustment of CAHPS Data

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

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

Statistical Methodology

Qlarant's statistical methodology includes the following steps:

1. Create standardized versions (z-scores) of all measures for each MCO so that all component measures contributing to the summary scores for each reporting category are on the same scale. Standardized scores are determined by subtracting the overall mean for all MCOs from the mean value of individual MCOs and dividing by the standard deviation of all MCOs.

2. Combine the standardized measures into summary scores for each reporting category and MCO.

3. Calculate standard errors for individual MCO summary scores and for the mean summary scores for all MCOs.

4. Calculate difference scores for each reporting category by subtracting the mean summary score for all MCOs from the individual MCO summary score values.

5. Use the standard errors to calculate 95% confidence intervals (CI) for the difference scores.

6. Categorize MCOs into three categories based on these CIs:

    - Above Average: 95% CI is in the positive range
    - Average: MCO's 95% CI includes zero
    - Below Average: 95% CI is in the negative range

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

Quality Control

Qlarant includes quality control processes 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 and discuss and resolve any

discrepancies in the 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 (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Getting Care Quickly (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Customer Service (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/12 1/12
Adults' Access to Preventive/Ambulatory Health Services - 20-44 years	HEDIS	1/6
Adults' Access to Preventive/Ambulatory Health Services - 45-64 years		
Access to Care - SSI Adult - 21 years or older*	MDH Encounter Data	1/6
Access to Care - SSI Children - ages 0-20*	MDH Encounter Data	1/6
Category: Doctor Communication & Service	**Data Source**	**Weight**
Rating of All Health Care (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Rating of Personal Doctor (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Rating of Specialist Seen Most Often (Rating Mean)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
How Well Doctors Communicate (Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Shared Decision Making ("Yes" Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Health Promotion and Education ("Yes" summary rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Coordination of Care ("Usually" & "Always" Question Summary Rate)	CAHPS 5.1H MA CAHPS 5.1H MC	1/14 1/14
Category: Keeping Kids Healthy	**Data Source**	**Weight**
Childhood Immunization Status (Combo 3)*	HEDIS	1/8
Appropriate Treatment for Upper Respiratory Infections - 3 months - 18 years	HEDIS	1/8
Appropriate Testing for Pharyngitis - 2-18 years	HEDIS	1/8

Category: Keeping Kids Healthy *continued…*	Data Source	Weight
Well-Child Visits in the First 30 Months of Life- Well-Child Visits in the First 15 Months	HEDIS	1/8
Child and Adolescent Well-Care Visits- Ages 3-11	HEDIS	1/8
Child and Adolescent Well-Care Visits- Ages 12-17 and Ages 18-21*	HEDIS	1/8
Lead Screening - 12-23 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 (Rating Mean)	CAHPS 5.1H MC	1/6
Access to Specialized Services: Special Medical Equipment or Devices (Summary Rate)	CAHPS 5.1H MC	1/6
Family Centered Care: Personal Doctor or Nurse Who Knows Child ('Yes" Summary Rate)	CAHPS 5.1H MC	1/6
Family Centered Care: Getting Needed Information (Rating Mean)	CAHPS 5.1H MC	1/6
Coordination of Care for Children with Chronic Conditions ("Yes" Summary Rate)	CAHPS 5.1H MC	1/6
Asthma Medication Ratio - 5-11 years*	HEDIS	1/6
Asthma Medication Ratio - 12-18 years*		
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%)**	HEDIS	1/8
CDC: Eye Exam (Retinal) Performed	HEDIS	1/8
CDC: BP Control <140/90 mm Hg	HEDIS	1/8
Avoidance of Antibiotic Treatment Acute Bronchitis/Bronchiolitis- 18-64 years	HEDIS	1/8
Use of Imaging Studies for Low Back Pain	HEDIS	1/8
Asthma Medication Ratio - 19-50 years*	HEDIS	1/8
Asthma Medication Ratio - 51-64 years*		
Controlling High Blood Pressure*	HEDIS	1/8

*Maryland Value-Based Purchasing Measure

**Note: MCO rate used in the analysis is the inverse score in order to provide consistency with other measures (i.e., higher % is better).

CAHPS 5.1H Measures for the Medicaid Product Line

The table below displays the questions, response choices, and corresponding score values used to calculate results for the CAHPS 5.1H 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
Q20=MA Q41=MC	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	Never Sometimes Usually Always
Q9=MA Q10=MC	In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?	Never Sometimes Usually Always
Question	**Getting Care Quickly**	**Response Choices**
Q4=MA Q4=MC	In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	Never Sometimes Usually Always
Q6=MA Q6=MC	In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	Never Sometimes Usually Always
Question	**How Well Doctors Communicate**	**Response Choices**
Q12=MA Q27=MC	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	Never Sometimes Usually Always
Q13=MA Q28=MC	In the last 6 months, how often did your personal doctor listen carefully to you?	Never Sometimes Usually Always

Question	How Well Doctors Communicate *continued…*	Response Choices
Q14=MA Q29=MC	In the last 6 months, how often did your personal doctor show respect for what you had to say?	Never Sometimes Usually Always
Q15=MA Q32=MC	In the last 6 months, how often did your personal doctor spend enough time with you?	Never Sometimes Usually Always
Question	**Customer Service**	**Response Choices**
Q24=MA Q45=MC	In the last 6 months, how often did your health plan's customer service give you the information or help you needed?	Never Sometimes Usually Always
Q25=MA Q46=MC	In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?	Never Sometimes Usually Always
Question	**Coordination of Care**	**Response Choices**
Q17=MA Q35=MC	In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?	Never Sometimes Usually Always
Question	**Rating of All Health Care**	**Response Choices**
Q8=MA Q9=MC	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	1 (worst) through 10 (best)
Question	**Rating of Personal Doctor**	**Response Choices**
Q18=MA Q36=MC	Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?	1 (worst) through 10 (best)
Question	**Rating of Specialist Seen Most Often**	**Response Choices**
Q22=MA Q43=MC	We want to know your rating of the specialist you 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?	1 (worst) through 10 (best)

Question	Shared Decision Making	Response Choices
Q43=MA Q79-MC	Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?	Yes No
Q44=MA Q80=MC	Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?	Yes No
Q45=MA Q81=MC	When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?	Yes No
Question	**Health Promotion and Education**	**Response Choices**
Q41=MA Q77=MC	In the last 6 months, did you and a doctor, or other health provider, talk about specific things you could do to prevent illness?	Yes No

MA = CAHPS 5.1H Medicaid Adult Questionnaire; MC = CAHPS 5.1H Medicaid Child Questionnaire (With CCC Measure)

CAHPS 5.1H Child Questionnaire Measures

The following questions from the CAHPS 5.1H 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 (other than vitamins) for a medical, behavioral, or other health condition lasting/expected to last 12 months or more.
- Child needs/uses more medical, mental health, or educational services than is usual for most children the same age due to a medical, behavioral, or other health condition lasting/ expected to last 12 months or more.
- Child is limited or prevented in any way in his or her ability to do the things most children of the same age can do because of a medical, behavioral, or other health condition lasting/expected to last 12 months or more.
- Child needs to get special therapy, such as physical, occupational, or speech therapy for a medical, behavioral, or other health condition lasting/expected to last 12 months or more.
- Child has any kind of emotional, developmental, or behavioral problem lasting/expected to last 12 months or more for which he or she needs or gets treatment or counseling.

Question	Access to Prescription Medicines	Response Choices
Q51	In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?	Never Sometimes Usually Always
Question	**Access to Specialized Services**	**Response Choices**
Q15	In the last 6 months, how often was it easy to get special medical equipment or devices for your child?	Never Sometimes Usually Always
Q18	In the last 6 months, how often was it easy to get this therapy for your child?	Never Sometimes Usually Always
Q21	In the last 6 months, how often was it easy to get this treatment or counseling for your child?	Never Sometimes Usually Always
Question	**Family-Centered Care: Personal Doctor Who Knows Child**	**Response Choices**
Q33	In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?	Yes No
Q38	Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	Yes No
Q39	Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?	Yes No
Question	**Family-Centered Care: Getting Needed Information**	**Response Choices**
Q8	In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?	Never Sometimes Usually Always
Question	**Coordination of Care for Children with Chronic Conditions**	**Response Choices**
Q13	In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	Yes No
Q24	In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	Yes No

Appendix E: Report Reference Page

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

Performance Improvement Projects

MY 2022 PIP Report

Performance Measure Validation

Population Health Incentive Program: **MY 2022 PHIP Report**

Healthcare Effectiveness Data and Information Set:
MetaStar's Statewide Executive Summary Report for HealthChoice Participating Organizations' HEDIS MY 2022 Results

Systems Performance Review

MY 2022 SPR Statewide Executive Summary Report

Network Adequacy Validation

MY 2023 NAV Report

Encounter Data Validation

MY 2022 EDV Report

Early and Periodic, Screening, Diagnosis, and Treatment

MY 2022 EPSDT Statewide Executive Summary Report

Consumer Report Card

MY 2023 Consumer Report Card in **English** and **Spanish**

Grievances, Appeals, and Denials Focused Study

MY 2022 GAD Annual Report

Consumer Assessment of Healthcare Providers and Systems

State of Maryland Executive Summary Report for HealthChoice Managed Care Organizations' Adult and Child Populations 2022 CAHPS 5.0H Member Experience Survey