HealthChoice Quality Strategy 2022-2024

Revised April 8, 2024

Mail comments to Maryland Department of Health, Attn: Managed Care Administration, 201 West Preston Street, Room 214A, Baltimore, MD 21201. Email comments to mdh.hcqa@maryland.gov.

Maryland
DEPARTMENT OF HEALTH

HealthChoice Quality Strategy

Table of Contents

Table of Figures

HealthChoice Quality Strategy

Introduction

Under 42 CFR 438.340(a) and 42 CFR 457.1240(e), the Centers for Medicare and Medicaid Services (CMS) require that state Medicaid and CHIP managed care programs develop and maintain a Medicaid and CHIP quality strategy to assess and improve the quality of healthcare and services managed care plans provide.

The purpose of Maryland's HealthChoice Quality Strategy is to describe population health and quality improvement priorities, health reform efforts, and goals and objectives to move these areas forward in the HealthChoice program. The HealthChoice Quality Strategy covers 2022 through 2024, using baseline data from measurement years 2018 through 2021.

Maryland intends to update this quality strategy every three years, with the next update scheduled for 2025. This strategy will also be updated in the event of any significant changes, including but not limited to adding or removing goals or objectives; changes that trigger public comment, tribal consultation, and input from the Maryland Medicaid Advisory Committee; and substantive changes to managed care laws and regulations during the period this strategy is designed to cover.

HealthChoice is Maryland's statewide, mandatory, Medicaid managed care program. The Maryland General Assembly passed Senate Bill 750 on April 8, 1996, which authorized the Maryland Department of Health (MDH) to require Medicaid participants to enroll in MCOs. To implement SB 750, Maryland prepared an application for waiver of certain Medicaid requirements, under Section 1115(a) of the Social Security Act (1115 Waiver). The 1115 Waiver proposed the development and implementation of a Medicaid Managed Care Program. The application was submitted to CMS, formerly the Health Care Financing Administration (HCFA), on May 3, 1996, and was approved by HCFA on October 30, 1996.

HealthChoice enables the extension of coverage and/or targeted benefits to certain participants who would otherwise be without health insurance or access to benefits tailored to the participant's specific medical needs. HealthChoice combines Medicaid and the Maryland Children's Health Program (MCHP), and Maryland's Children's Health Insurance Program (CHIP) coverage. Maryland currently contracts with nine managed care organizations (MCOs) to provide HealthChoice services and benefits.

Table 1: HealthChoice Managed Care Organizations, Authorities, and Covered Populations

Program Name	Managed Care Entity Type	Managed Care Authority	Managed Care Program Type
HealthChoice	Managed Care Organizations	Section 1115 of the Social Security Act	Combined Medicaid and CHIP
Contracted Managed Care Organizations		**Populations Covered by HealthChoice MCOs**	
• Aetna Better Health of Maryland (ABH) • CareFirst BlueCross BlueShield Community Health Plan of Maryland (CFCHP) • Jai Medical Systems (JMS) • Kaiser Permanente of the Mid-Atlantic States (KPMAS) • Maryland Physicians Care (MPC) • MedStar Family Choice (MSFC) • Priority Partners (PPMCO) • UnitedHealthcare (UHC) • Wellpoint Maryland (WPM)		• Families with low income that have children • Families receiving Temporary Assistance for Needy Families • Children younger than 19 years eligible for MCHP • Children in foster care • Former foster care adults up to age 26 • Adults under the age of 65 with income up to 138% of the federal poverty level (FPL) • Pregnant individuals with income up to 264% of the FPL or individuals who are one year postpartum • Participants receiving Supplemental Security Income (SSI) who are under 65 and ineligible for Medicare	

Currently, HealthChoice covers 86.5% of Marylanders on Medicaid and MCHP, which represents over 1.5 million participants. Eligible Medicaid participants may choose a contracted MCO along with primary care providers (PCP) in MCO networks to serve as their medical homes. HealthChoice benefits are equivalent to those provided through the Medicaid fee-for-service (FFS) program, except for certain carved out services.

Table 2: HealthChoice Covered Services and Exclusions

HealthChoice Covered Services	Services "Carved Out" of HealthChoice
● Inpatient and outpatient hospital care ● Physician care ● Clinic services ● Laboratory and x-ray services ● Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children ● Prescription drugs (see carved out column for exceptions) ● Durable medical equipment and disposable medical supplies ● Home health care ● Vision services ● Dialysis ● Skilled nursing facility or rehabilitation care up to 90 days ● Primary mental health care	● Specialty behavioral health care ● Substance use disorder treatment services ● Specialty behavioral health drugs and substance use disorder drugs ● Dental care for Medicaid participants (effective January 1, 2023) ● Health-related services and targeted case management services are provided to children through individualized Education Plans (IEPs) or individualized Family Service Plans (IFSPs) ● Occupational therapy, physical therapy, and speech therapy for children ● Personal care services ● Long-term care services after the first 90 days ● HIV/AIDS drug resistance testing, including but not limited to viral load testing, genotypic testing, phenotypic testing ● Services covered under 1915(c) home and community-based services waivers

MDH is the state agency responsible for HealthChoice and the Maryland Medical Assistance Program generally. Coordination and oversight fall under the Maryland Medicaid Administration, which includes the Office of Medical Benefits Management. Within the Office of Medical Benefits Management, the Managed Care Administration ensures that the requirements established in 42 CFR 438, Subpart D are adhered to, and that all MCOs apply these principles universally and appropriately. Quality monitoring, evaluation, and education through participant and provider feedback are integral components of the managed care program and help to ensure that health care is not compromised. The functions and infrastructure of the administration support efforts to identify and address quality issues efficiently and effectively.

Effectiveness of the Previous Quality Strategy

Maryland's previous HealthChoice Quality Strategy covered the period of 2012-2016. At that time, quality strategy guidance focused primarily on states with managed care programs demonstrating alignment and compliance with federal managed care requirements. To that end, like Maryland's current strategy, the 2012-2016 strategy aligned goals with the program goals of the Section 1115 waiver. The strategy also focused on how Maryland's quality assurance activities, regulations, and contractual agreements with the HealthChoice MCOs mapped to the federal requirements outlined in the managed care quality strategy toolkit developed by CMS.

To evaluate progress towards the goals and objectives outlined, Maryland relied upon the quality assurance activity reports developed by its quality vendors, in addition to its own oversight of HealthChoice. Preparing the strategy and performing the compliance mapping revealed several points where Maryland could strengthen its oversight, such as improving performance monitoring policies and intermediate sanctions; retooling external quality review compliance audits from being an annual process to a triennial review process; developing validation activities for primary care provider networks and provider directories; and shifting review of grievances, appeals, and denials from an internal process to performance by the external quality review vendor.

At the time, Maryland did not develop quantifiable targets and outcomes as a component of its strategy. However, quality assurance reports demonstrating the HealthChoice MCOs' continued commitment to improvement and compliance are available on the HealthChoice Quality Assurance Annual Reports site. Many of the improvements and interventions identified in the 2012-2016 strategy were implemented and evaluated during the intervening years of 2017-2021. More information about these programs may be found in our Section 1115 waiver and HealthChoice Evaluation documents on the HealthChoice website.

Quality Strategy Goals and Objectives

According to the Section 1115 waiver filing that establishes the Maryland HealthChoice Program, HealthChoice's broader program goals are:

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

To achieve these, Maryland has identified the following specific goals and measurable objectives for HealthChoice over the next three years:

Goal 1: Improve HealthChoice aggregate performance on Medicaid HEDIS measures by reaching or exceeding the pre-pandemic HealthChoice aggregate by Measurement Year (MY) 2024.

> *Objective 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.*

As reflected across the United States, the COVID-19 public health emergency significantly impacted people's ability to seek preventive care and impaired many critical business functions and industries connected to health care. As the nation collectively attempts a return to normalcy, seeking and maintaining appropriate, quality health care has become a paramount priority. Maryland observed that the public health emergency affected both healthcare outcome performance and measurement, and over the next three years, the primary focus will be ensuring that the MCOs and their network providers return to their performance trajectory prior to the pandemic to keep Marylanders in Medicaid healthy. Our goals use the highest performance in MY 2018 and MY 2019 as a baseline to set realistic targets that the HealthChoice MCOs can accomplish over the strategy period.

Objective 2: Once Objective 1 is achieved, ensure HealthChoice aggregate meets or exceeds the NCQA National HEDIS Means by MY 2024.

Once the MCOs can return to their performance prior to the public health emergency, the focus will then shift to either maintaining and improving upon the baseline to ensure the HealthChoice aggregate meets or exceeds the Medicaid National HEDIS Mean over the next three measurement years, with progressive targeting to reach higher national percentiles over time.

Goal 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.

Objective 1: Increase the HealthChoice aggregate for the HEDIS Prenatal and Postpartum Care measures by three percentage points no later than MY 2024.

Pregnant and postpartum individuals are identified as a special needs population by the HealthChoice program. HealthChoice regulations require MCOs to identify potential risks to the health of the birthing person by encouraging prenatal care providers to complete a prenatal risk assessment at the individual's first visit. The prenatal risk assessment is then shared with local health departments to connect the enrollee to community resources and assistance, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (commonly known as WIC), Maryland Medicaid's behavioral health administrative services organization for substance use disorder treatment, and home visiting programs in their county. Prenatal care providers are also encouraged to complete an enhanced maternity services form at subsequent visits to determine the enrollee's eligibility for other support that address care needs that arise during pregnancy.

In addition to these administrative efforts, Maryland Medicaid, in partnership with the Health Services Cost Review Commission (HSCRC), has identified maternal and child health as a population health priority area, specifically targeting the reduction of severe maternal morbidity. Comprehensive prenatal and postpartum care has been a cornerstone for preventing poor birth outcomes. As part of the Statewide Integrated Health Improvement Strategy (SIHIS), Maryland Medicaid has instituted multiple programs focused on improving health outcomes for pregnant and postpartum individuals, including but not limited to:

- Statewide expansion of the home visiting services pilot
- Statewide expansion of the Maternal Opioid Misuse Model pilot
- Medicaid coverage of doulas/birth workers, HealthySteps, and CenteringPregnancy

The HSCRC has committed $8 million dollars in funding annually for these initiatives, and as these efforts continue, it is anticipated that access to prenatal and postpartum care will increase over the next three years, contributing by extension to the improvement of health outcomes for pregnant and postpartum individuals through early detection, prevention, intervention, and treatment of conditions that impact the birthing person and child.

Maryland plans to institute a perinatal performance improvement project that will focus on prenatal care, postpartum care, and well-child care through the first 30 months of the baby's life to encourage MCOs to focus on maternal and child health improvement over time.

To align with these initiatives, the Population Health Incentive Program (PHIP) beginning in MY 2022 will include the HEDIS Timeliness of Prenatal Care and Postpartum Care measures to promote better performance among the HealthChoice MCOs. Incentives are set based on performance relative to the HEDIS 50th, 75th, and 90th percentiles, with rewards for superlative performance and demonstrated MCO-specific performance improvement.

Objective 2: Improve the HealthChoice aggregate for measures tracking chronic health outcomes by MY 2024.

Improving health outcomes for HealthChoice participants with chronic diseases is a key feature of Maryland's strategy. Chronic health problems, including asthma, diabetes, and substance use disorders (SUDs), impact the lives of participants in numerous ways. Maryland is committed to primary, secondary, and tertiary prevention wherever possible with the intent of limiting the impact of poor health outcomes associated with the development or lack of appropriate management of chronic disease states. Several programs have been put into place to address these issues, including but not limited to:

- Maryland Quality Innovation Program (M-QIP);
- HealthChoice Diabetes Prevention Program (DPP);
- Maternal Opioid Misuse (MOM) model;
- Doulas;
- Home Visiting Services; and
- Childhood Lead Poisoning Prevention and Environmental Case Management Program.

<u>Maryland Quality Innovation Program</u>

In partnership with the MCOs and the University of Maryland, M-QIP aims to improve health outcomes for persons with SUDs, diabetes, and asthma. Under this state directed payment authority, the University of Maryland works to reinvest in Baltimore City and Prince George's County to reduce avoidable ED utilization and preventable admissions for HealthChoice beneficiaries served by University of Maryland providers regarding SUD, diabetes, and asthma. Avoidable ED visits are measured using the New York University Center for Health and Public Service Research (NYU) ED algorithm, whereas Preventable Admissions are measured using the Agency for Healthcare Research and Quality (AHRQ) specifications. In addition to reducing preventable acute care utilization, the following metrics are also employed to gauge the quality of programming and progress toward established goals.

HealthChoice Diabetes Prevention Program

The HealthChoice Diabetes Prevention Program (DPP), which went into effect on September 1, 2019, allows MCOs to provide the National DPP Lifestyle Change Program to HealthChoice enrollees which is an evidence-based program established by the Centers for Disease Control and Prevention (CDC) to prevent or delay the onset of type 2 diabetes through healthy eating and physical activity. A healthcare professional or an MCO may refer HealthChoice participants to the program; however, enrollees may directly enroll in their MCO's in-network CDC-recognized type 2 diabetes prevention programs in certain situations.

Maternal Opioid Misuse Model

As part of a five-year Centers for Medicare and Medicaid Innovation (CMMI) demonstration waiver, the Maternal Opioid Misuse (MOM) model provides enhanced case management services through member MCOs to pregnant individuals with opioid use disorder (OUD). Through a combination of case management and prenatal care, the model works to reduce the burden of neonatal abstinence syndrome (NAS) on the participants' children.

Doulas and Home Visiting Services

Effective February 21, 2022, Maryland Medicaid provides coverage for doula services to Medicaid beneficiaries. A doula, or birth worker, is a trained professional who provides continuous physical, emotional, and informational support to birthing parents before, during, and after birth. Maryland Medicaid is also offering Home Visiting Services (HVS) as a statewide benefit as of January 2022.

Childhood Lead Poisoning Prevention and Environmental Case Management Program

Since the launch of the Childhood Lead Poisoning Prevention and Environmental Case Management program in 2017, Maryland Medicaid and the Environmental Health Bureau (EHB) have collaborated to train personnel; develop program procedures and protocols; implement budget and invoicing pathways; utilize data for outreach and enrollment; create new methods of billing for environmental assessments, and refine quality assurance mechanisms with the goal of reducing exposures to lead and asthma triggers within the homes of Medicaid/MCHP enrolled or eligible children.

Goal 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.

Objective 1: Increase the HealthChoice aggregate scores to 100% for all Systems Performance Review standards by MY 2024.

The Systems Performance Review evaluates if the MCOs have sufficient policies and procedures to comply with federal and state policies, regulations, and statutes. The minimum compliance score for this activity, therefore, is 100%, as the MCOs must meet all these requirements to operate. The 11 standards for the Systems Performance Review include:

- Systematic Process of Quality Assessment
- Accountability to the Governing Body

- Oversight of Delegated Entities
- Credentialing and Recredentialing
- Enrollee Rights
- Availability and Accessibility
- Utilization Review
- Continuity of Care
- Health Education
- Outreach
- Fraud and Abuse

Objective 2: Increase the HealthChoice aggregate scores to at least 80% for all EPSDT/Healthy Kids Medical Record Review components by MY 2024.

The EPSDT/Healthy Kids Medical Record Review measures MCO network provider compliance with the Healthy Kids periodicity schedules and requirements, which are sourced from the American Academy of Pediatrics Bright Futures program and other evidence-based practices. HealthChoice primary care providers are encouraged to receive EPSDT training through the Maryland Healthy Kids Program, which oversees compliance with the EPSDT benefit. The MCOs are expected to monitor their network providers' compliance with the EPSDT requirements. Through this objective, MDH and the MCOs will work together to monitor the five components of the EPSDT/Healthy Kids medical record review and reach a minimum compliance score of 80% in each area:

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

Objective 3: Increase the HealthChoice aggregate scores to at least 85% for all network adequacy validation activities by MY 2024.

The Network Adequacy Validation activity applies a combination of secret shopper calls to a random sample of primary care providers, MCO provider directory validation, and direct testing of routine and urgent care appointment compliance. Failure to maintain accurate directory information or ensure appointment availability could lead to participants using urgent care and emergency department care to compensate for provider availability, which may drive up costs and increase health risks for the population. Examples of areas measured by this activity include:

- Accuracy of MCOs' online provider directories for primary care providers, including but not limited to name, address, phone number, whether the provider is accepting new patients, the ages the provider serves, the languages spoken in the practice, and accommodations for individuals with disabilities

- Availability of routine and urgent appointments at the provider's practice

Objective 4: Increase the HealthChoice aggregate scores to at least 90% for encounter data validation by MY 2024.

Federal regulations require MDH to validate the accuracy and completeness of encounter data submitted by MCOs. Through the encounter data validation, encounters are reviewed in the aggregate 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. The validation and other monitoring efforts will ensure MCOs submit accurate and complete encounters for purposes of data analysis, submission to CMS through the Transformed Medicaid Statistical Information System (T-MSIS), and assessment of participant utilization for capitation rate risk adjustment.

Objective 5: Increase the HealthChoice aggregate to minimum compliance for each element of review for grievances, appeals, and pre-service determinations by MY 2024.

MCO processing and handling of grievances, appeals, and pre-service determinations have a direct impact on how participants receive care and perceive their health plan. MDH requires MCOs to submit participant and provider data related to grievances, participant appeals, and pre-service determination information. Samples of each area are evaluated through this activity and the Systems Performance Review process. Areas of noncompliance are addressed through the Systems Performance Review and other focused interventions if trends across MCOs are identified. Areas monitored include:

- Timeliness of processing member appeals, member and provider grievances, and denial determinations
- Timeliness of sending notifications after appeals, grievances, and preauthorizations are completed
- Record reviews to determine if notices included required information and were prepared for member comprehension

When MCOs receive findings for these activities, MDH requires MCOs to submit corrective action plans addressing the areas identified as opportunities for improvement. Through this objective, MDH will work collaboratively with the MCOs to ensure that the corrective action plans are fully implemented to ensure full compliance with all requirements.

HealthChoice Quality Metrics and Performance Targets

Maryland works collaboratively with MCOs and stakeholders to identify opportunities for continuous quality improvement. Through our quality assurance program, Maryland currently oversees and monitors the following activities to evaluate the effectiveness of the health care delivered by the MCOs. Please note that the HealthChoice program targets for its quality metrics that follow this activity overview are not the equivalent of the HealthChoice MCO minimum compliance scores. The targets are intended to drive continuous quality improvement on the program level.

Table 3: HealthChoice Quality Assurance Activity Overview

Activity	Description	Frequency	Authorities	Link to Webpage
Healthcare Effectiveness Data and Information Set (HEDIS)	Developed by the National Committee for Quality Assurance, HEDIS is a widely used tool that measures performance on dimensions of care and service.	Annual	COMAR 10.67.04.03	Healthcare Effectiveness Data and Information Set (HEDIS) MY 2020 Report
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Developed by the federal Agency of Healthcare Research and Quality in collaboration with NCQA, CAHPS is a survey designed to capture accurate and reliable information from Medicaid participants about their experiences with managed care organizations and their contracted network providers.	Annual	COMAR 10.67.04.03	Consumer Assessment of Healthcare Providers and Systems (CAHPS) 2021 Report
Primary Care Provider (PCP) Satisfaction Survey	The PCP Satisfaction Survey is a Maryland-developed survey tool for Medicaid PCPs to evaluate their interactions with HealthChoice MCOs in areas like claims processing, customer service, preauthorization, and more.	Annual	Md. Health-General Art. 15-103	Primary Care Provider (PCP) Satisfaction Survey 2021 Report
Performance Improvement Projects	Performance improvement projects focus on clinical and nonclinical areas, and they include measures of performance using objective quality indicators, implementation of system interventions to achieve quality improvement, evaluation of intervention	Three-year projects, with quarterly or annual reporting updates	COMAR 10.67.04.03	2021 Performance Improvement Projects Annual Report

Activity	Description	Frequency	Authorities	Link to Webpage
	effectiveness, and planning and initiation of activities to increase or sustain improvement.			
EPSDT/Healthy Kids Medical Record Review	The EPSDT/Healthy Kids Medical Record Review evaluates provider compliance with the EPSDT Healthy Kids periodicity schedule.	Annual	COMAR 10.67.04.03	**2020 EPSDT Medical Record Review Executive Summary**
Systems Performance Review	The Systems Performance Review provides an assessment of the structure, process, and outcome of each MCO's internal quality assurance programs, as well as evaluates compliance with state and federal laws and regulations.	Triennial comprehensive review, with an annual assessment of corrective action plan implementation and baseline standards	COMAR 10.67.04.03	**2020 Systems Performance Review Executive Summary**
Consumer Report Card	The Consumer Report Card assists Medicaid participants with selecting one of the participating HealthChoice MCOs. The report card compares plan performance in six domains by using performance measures from HEDIS, CAHPS, and encounter data measures from PHIP to assign a star rating.	Annual	COMAR 10.67.04.03	**2020 HealthChoice Consumer Report Card - English** **2020 HealthChoice Consumer Report Card - Spanish**
Value-Based Purchasing through MY 2021; Population Health Incentive Program (PHIP) MY 2022 and forward	For the VBP program, Maryland selects a subset of HEDIS and state-developed measures to award MCOs incentives for high performance and assess penalties for poor performance. VBP will be replaced by PHIP beginning in MY 2022. Under PHIP, Maryland selects a subset of HEDIS and state-developed measures to award MCOs incentives for high performance and improvement from the previous year.	Annual	COMAR 10.67.04.03	**2021 Value-Based Purchasing Report**

Activity	Description	Frequency	Authorities	Link to Webpage
HealthChoice Population Health Incentive Program	The HealthChoice Population Health Incentive Program is an incentive program designed to improve quality by awarding financial incentives for meeting or exceeding defined benchmarks or demonstrating significant improvement in a subset of HEDIS measures and state-developed encounter data measures.	Annual	COMAR 10.67.04.03-2	This report will be available in the calendar year 2023 for measurement year 2022.
NCQA Accreditation	Maryland requires all participating HealthChoice MCOs to maintain NCQA health plan accreditation. New plans joining HealthChoice must obtain accreditation within two years of the date they begin providing health care services.	Triennial (dependent upon the plan's original accreditation date)	COMAR 10.67.04.03	**Maryland HealthChoice MCOs Rating and Accreditation Status**
Encounter Data Validation	Maryland performs an annual encounter data validation to ensure encounter data submitted by the MCOs are accurate, complete, and valid. The review is performed collaboratively by the EQRO and Maryland Medicaid's data warehouse vendor, The Hilltop Institute of the University of Maryland Baltimore County.	Annual	42 CFR 438.242	**2021 Encounter Data Validation Report**
Grievance, Appeal, and Denial Review	Maryland engages the EQRO to review the MCO preservice determinations, enrollee grievances, and enrollee and provider appeals quarterly to analyze trends and identify anomalies.	Quarterly	COMAR 10.67.04.15	**2021 Focused Review Report on Grievances, Appeals, and Denials**
Network Adequacy Validation	Maryland's EQRO performs a direct test of the MCO's primary care provider networks to confirm the information provided in the MCOs' provider directories is accurate and complete. In addition, the EQRO verifies the availability of standard and urgent	Annual	COMAR 10.67.04.03	**2021 Network Adequacy Validation Report**

Activity	Description	Frequency	Authorities	Link to Webpage
	appointments as defined in COMAR regulations.			
MCO Performance Monitoring	The HealthChoice MCO Performance Monitoring Policies are a form of intermediate sanctions designed to hold MCOs accountable when problems arise in four quality assurance areas: network adequacy, HEDIS, EPSDT/Healthy Kids Medical Record Review, and the Systems Performance Review. MCOs may be subject to sanctions for repeated findings of noncompliance.	Annual	COMAR 10.67.10.01	See the HealthChoice Performance Monitoring and Intermediate Sanctions section of the Quality Strategy.
Performance Improvement Project Evaluation	The Performance Improvement Project Evaluation conducted by Maryland is designed to ensure MCOs are submitting projects that are accurate, understandable, and designed to implement meaningful and sustainable interventions that improve the topic area of the PIP.	Annual	COMAR 10.67.04.03	See the HealthChoice Performance Improvement Projects and Interventions section of the Quality Strategy.

The following tables are a comprehensive compilation of the quality metrics and performance targets that Maryland evaluates for HealthChoice MCOs.

Healthcare Effectiveness Data and Information Set (HEDIS)

Targets were established by evaluating the highest HealthChoice aggregate rate for MY 2018 and MY 2019. The MY 2024 targets set for measures that demonstrated a decline over MY 2019 and MY 2020 are baseline with a goal to return to those higher rates where data collection and medical record review were not impacted by the coronavirus public health emergency (pre-pandemic). For measures not impacted by the public health emergency or other data collection issues, those targets are set to improve by 2 percentage points over the three-year strategy cycle.

Table 4: HealthChoice Performance Metrics and Targets – HEDIS

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Prevention and Screening – Adult						**X**	**X**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.	N/A	52.9%	53.9%	55.9%		
Prevention and Screening – Child						**X**	**X**
Childhood Immunization Status (CIS) **Hybrid**	The percentage of children two years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B (HepB), one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotaviruses (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.						
CIS, Combo 2		79.7%	77.9%	72.4%	79.7%		
CIS, Combo 3		77.4%	75.4%	70.2%	77.4%		
CIS, Combo 4		75.7%	73.8%	68.7%	75.7%		
CIS, Combo 5		66.1%	64.4%	61.9%	66.1%		
CIS, Combo 6		50.0%	49.0%	47.8%	50.0%		
CIS, Combo 7		65.0%	63.5%	60.8%	65.0%		
CIS, Combo 8		49.3%	48.5%	47.2%	49.3%		
CIS, Combo 9		44.5%	43.8%	43.0%	44.5%		
CIS, Combo 10		43.9%	43.4%	42.5%	43.9%		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Immunizations for Adolescents (IMA) **Hybrid**	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.						
IMA, Combo 1		89.3%	87.7%	82.9%	89.3%		
IMA, Combo 2		46.2%	45.5%	42.7%	46.2%		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) **Hybrid**	The percentage of members 3 – 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. -BMI percentile documentation* -Counseling for nutrition -Counseling for physical activity						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), BMI Percentile Documentation, Total		79.0%	80.1%	76.4%	80.1%		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Nutrition, Total		80.0%	79.7%	74.3%	80.0%		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Counseling for Physical Activity, Total		76.3%	76.1%	71.0%	76.3%		
Appropriate Testing for Pharyngitis (CWP)	The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	N/A	83.7%	80.7%	85.7%		
Lead Screening in Children (LSC) **Mixed: Hybrid & Administrative**	The percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday	82.8%	82.6%	79.7%	82.8%		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)*	The percentage of adolescent females 16 – 20 years of age who were screened unnecessarily for cervical cancer.	0.8%	0.6%	0.5%	0.6%		
Respiratory Conditions						**X**	**X**
Appropriate Treatment for Upper Respiratory Infection (URI)	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.	N/A	88.0%	88.8%	90.8%		
Asthma Medication Ratio (AMR)	The percentage of members 5 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	64.0%	65.1%	68.6%	70.6%		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	The percentage of members 40 years of age and older with a new diagnosis of Chronic Obstructive Lung Disease (COPD) or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	29.8%	27.3%	28.2%	31.8%		
Pharmacotherapy Management of COPD Exacerbation (PCE)	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 – November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: 1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. 2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.						
Pharmacotherapy Management of COPD Exacerbation (PCE), Systemic Corticosteroid		70.7%	72.3%	72.5%	74.5%		
Pharmacotherapy Management of COPD Exacerbation (PCE), Bronchodilator		86.8%	86.6%	84.7%	88.8%		
Member Access						**X**	**X**

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line. -Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year. -Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.						
Adults' Access to Preventive/Ambulatory Health Services (AAP), 20-44 years		71.2%	71.8%	68.1%	73.8%		
Adults' Access to Preventive/Ambulatory Health Services (AAP), 45-64 years		82.2%	82.4%	78.7%	84.4%		
Women's Health						**X**	**X**
Breast Cancer Screening (BCS)	The percentage of women 50 – 74 years of age who had a mammogram to screen for breast cancer.	69.3%	70.6%	65.2%	72.6%		
Cervical Cancer Screening (CCS) **Hybrid**	The percentage of women 21 – 64 years of age who were screened for cervical cancer using either of the following criteria: 1. Women aged 21 – 64 who had cervical cytology performed within the last 3 years. 2. Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. 3. Women aged 30 – 64 who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.	62.2%	63.8%	57.9%	63.8%		
Chlamydia Screening in Women (CHL)	The percentage of women 16 – 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.						
Chlamydia Screening in Women (CHL), 16-20 years		65.1%	65.6%	61.4%	67.6%		
Chlamydia Screening in Women (CHL), 21-24 years		70.4%	71.5%	67.0%	73.5%		
Chlamydia Screening in Women (CHL), Total		67.8%	68.4%	64.3%	70.4%		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Prenatal and Postpartum Care						**X**	**X**
Prenatal and Postpartum Care (PPC) **Hybrid**	The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. 1. Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization. 2. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.						
Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care		N/A	88.2%	87.0%	88.2%		
Prenatal and Postpartum Care (PPC), Postpartum Care		N/A	81.3%	80.9%	81.3%		
Cardiovascular Conditions						**X**	**X**
Controlling High Blood Pressure (CBP) **Hybrid**	The percentage of members 18 – 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.	N/A	N/A	54.7%	54.7%		
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge.	69.2%	79.7%	78.4%	81.7%		
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	The percentage of members 18 – 64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement year.	80.0%	77.4%	76.7%	82.0%		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Statin Therapy for Patients with Cardiovascular Disease (SPC)	The percentage of males 21 – 75 years of age and females 40 – 75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: 1. Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. 2. Statin Adherence 80 percent. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period.						
Statin Therapy for Patients With Cardiovascular Disease (SPC), Received Statin Therapy, Total		77.5%	81.0%	81.0%	83.0%		
Statin Therapy for Patients With Cardiovascular Disease (SPC), Statin Adherence 80%, Total		56.3%	61.5%	64.7%	66.7%		
Diabetes						**X**	**X**
Comprehensive Diabetes Care (CDC) **Hybrid**	The percentage of members 18 –75 years of age with diabetes (type 1 and type 2) who had each of the following: -Hemoglobin A1c (HbA1c) testing -HbA1c poor control (>9.0%) -HbA1c control (<8.0%) -HbA1c control (<7.0%) for a selected population* -Eye exam (retinal) performed -Medical attention for nephropathy -BP control (<140/90 mm Hg)						
Comprehensive Diabetes Care (CDC), Hemoglobin A1c (HbA1c) Testing		88.8%	88.3%	82.9%	88.8%		
Comprehensive Diabetes Care (CDC), HbA1c Poor Control (>9.0%)		36.9%	34.8%	39.9%	36.9%		
Comprehensive Diabetes Care (CDC), HbA1c Control (<8.0%)		53.6%	55.6%	51.0%	55.6%		
Comprehensive Diabetes Care (CDC), Eye Exam (Retinal) Performed		54.1%	54.7%	51.7%	54.7%		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Comprehensive Diabetes Care (CDC), BP Control (<140/90 mm Hg)		N/A	N/A	55.9%	55.9%		
SMD	The percentage of members 18 – 64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.	74.0%	70.4%	63.7%	76.0%		
SSD	The percentage of members 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	N/A	91.6%	82.7%	93.6%		
SPD	The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1. Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year. 2. Statin Adherence 80 percent. Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period.						
Statin Therapy for Patients With Diabetes (SPD), Received Statin Therapy		63.9%	65.6%	65.2%	67.2%		
Statin Therapy for Patients With Diabetes (SPD), Statin Adherence 80%		53.1%	55.9%	58.6%	60.6%		
Musculoskeletal Conditions						**X**	**X**
Use of Imaging Studies for Low Back Pain (LBP)	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	76.6%	79.8%	81.7%	83.7%		
Medication Management						**X**	**X**

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Use of Opioids at High Dosage (HDO)*	The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.	N/A	8.9%	8.4%	6.4%		
Use of Opioids from Multiple Providers (UOP)*	The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. Three rates are reported. 1. Multiple Prescribers. The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year. 2. Multiple Pharmacies. The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. 3. Multiple Prescribers and Multiple Pharmacies. The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates).						
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers		27.8%	26.0%	24.3%	22.3%		
Use of Opioids From Multiple Providers (UOP), Multiple Pharmacies		8.1%	8.3%	4.7%	2.7%		
Use of Opioids From Multiple Providers (UOP), Multiple Prescribers and Multiple Pharmacies		5.2%	4.5%	2.8%	0.8%		
Risk of Continued Opioid Use (COU)*	The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported: 1. The percentage of members with at least 15 days of prescription opioids in a 30-day period. 2. The percentage of members with at least 31 days of prescription opioids in a 62-day period.						
Risk of Continued Opioid Use (COU), 15 Days, Total		10.4%	8.1%	6.5%	4.5%		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Risk of Continued Opioid Use (COU), 31 Days, Total		4.6%	4.2%	3.9%	1.9%		
Pharmacotherapy for Opioid Use Disorder (POD)	The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 days among members aged 16 and older with a diagnosis of OUD.	N/A	6.8%	3.0%	8.8%		
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. 1. Initiation Phase. The percentage of members 6–12 years of age as of the index prescription start date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. 2. Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.						
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Acute Phase		N/A	24.5%	26.4%	28.4%		
Follow-Up Care for Children Prescribed ADHD Medication (ADD), Continuation Phase		N/A	25.4%	21.2%	27.4%		
Antidepressant Medication Management (AMM)	The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported. 1. Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).						
Antidepressant Medication Management (AMM), Acute Phase		N/A	44.4%	39.6%	46.4%		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Antidepressant Medication Management (AMM), Continuation Phase		N/A	28.8%	23.2%	30.8%		
Adherence to Antipsychotic Medications for participants With Schizophrenia (SAA)	The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	N/A	55.4%	49.0%	57.4%		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: 1. The percentage of children and adolescents on antipsychotics who received blood glucose testing. 2. The percentage of children and adolescents on antipsychotics who received cholesterol testing. 3. The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.						
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Blood Glucose Total		N/A	76.1%	61.4%	78.1%		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Cholesterol Total		N/A	67.0%	51.9%	69.0%		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM), Blood Glucose and Cholesterol Total		N/A	59.9%	50.5%	61.9%		
Utilization**						**X**	**X**
Ambulatory Care (AMB)	This measure summarizes the utilization of ambulatory care in the following categories: 1. Outpatient Visits including telehealth 2. ED Visits						
Ambulatory Care (AMB), Outpatient visits per 1,000 member months		52.5	50.7	35.5	48.7		
Ambulatory Care (AMB), Emergency department (ED) visits per 1,000 member months		338	344.4	294.9	336		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Frequency of Selected Procedures (FSP)	This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.						
Frequency of Selected Procedures (FSP), Bariatric Weight Loss Surgery 45-64 F		0.14	0.18	0.15	0.14		
Frequency of Selected Procedures (FSP), Bariatric Weight Loss Surgery 45-64 M		0.03	0.03	0.03	0.03		
Frequency of Selected Procedures (FSP), Tonsillectomy 0-9		0.36	0.38	0.22	0.36		
Frequency of Selected Procedures (FSP), Tonsillectomy 10-19		0.15	0.13	0.10	0.13		
Frequency of Selected Procedures (FSP), Hysterectomy Abdominal 45-64		0.21	0.18	0.14	0.18		
Frequency of Selected Procedures (FSP), Hysterectomy Vaginal 45-64		0.09	0.1	0.11	0.09		
Frequency of Selected Procedures (FSP), Cholecystectomy Open 30-64 M		0.02	0.02	0.01	0.02		
Frequency of Selected Procedures (FSP), Cholecystectomy Open 45-64 F		0.02	0.04	0.01	0.02		
Frequency of Selected Procedures (FSP), Cholecystectomy Lap 30-64 M		0.16	0.15	0.12	0.15		
Frequency of Selected Procedures (FSP), Cholecystectomy Lap 45-64 F		0.34	0.37	0.25	0.34		
Frequency of Selected Procedures (FSP), Back Surgery 45-64F		0.53	0.5	0.42	0.5		
Frequency of Selected Procedures (FSP), Back Surgery 45-64M		0.47	0.42	0.44	0.42		
Frequency of Selected Procedures (FSP), Mastectomy 15-44		0.03	0.04	0.03	0.03		
Frequency of Selected Procedures (FSP), Mastectomy 45-64		0.11	0.12	0.13	0.11		
Frequency of Selected Procedures (FSP), Lumpectomy 15-44		0.1	0.08	0.06	0.08		
Frequency of Selected Procedures (FSP), Lumpectomy 45-64		0.34	0.27	0.24	0.27		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Inpatient Utilization—General Hospital/Acute Care (IPU)	This measure summarizes the utilization of acute inpatient care and services in the following categories: 1. Total inpatient (the sum of Maternity, Surgery, and Medicine) 2. Maternity 3. Surgery 4. Medicine						
Inpatient Utilization - General Hospital Acute Care (IPU), Total Inpatient: Total Discharges /1000 MM		4.22	4.25	4.38	4.22		
Inpatient Utilization - General Hospital Acute Care (IPU), Total Inpatient: Total Discharges /1000 MM		6.1	6.05	5.24	6.05		
Antibiotic Utilization (ABX)	This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender: - Total number of antibiotic prescriptions. - Average number of antibiotic prescriptions per member per year (PMPY). - Total days supplied for all antibiotic prescriptions. - Average days supplied per antibiotic prescription. - Total number of prescriptions for antibiotics of concern. - Average number of prescriptions PMPY for antibiotics of concern. - Percentage of antibiotics of concern for all antibiotic prescriptions. - Average number of antibiotics PMPY reported by drug class: *For selected "antibiotics of concern." *For all other antibiotics.						
Antibiotic Utilization (ABX), Average Scrips PMPY for Antibiotics		0.78	0.79	0.6	0.78		

HEDIS	NCQA's HEDIS 2020 Volume 2: Technical Specifications	MY 2018	MY 2019	MY 2020	TARGET MY 2024	Medicaid	CHIP
Antibiotic Utilization (ABX), Average Days Supplied per Antibiotic Script		9.04	9.04	9.05	9.04		
Antibiotic Utilization (ABX), Average Scrips PMPY for Antibiotics of Concern		0.30	0.30	0.22	0.30		
Antibiotic Utilization (ABX), Percentage of Antibiotics of Concern for All Antibiotic Prescriptions		38.4%	38.2%	36.9%	38.2%		
Plan All-Cause Readmissions (PCR)	For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that was followed by an unplanned acute readmission or any diagnosis within 30 days and the predicted probability of an acute readmission. Note: For commercial and Medicaid, report only members 18–64 years of age.						
Plan All-Cause Readmissions (PCR) - Observed / Expected		N/A	1.04	1.05	1.04		
Plan All-Cause Readmissions (PCR) - Observed		N/A	10.3%	10.1%	10.3%		

**Lower rate indicates better performance*

***Informational Measures only as NCQA does not view higher or lower service counts as indicating better or worse performance*

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Targets were established by evaluating the highest HealthChoice aggregate rate for MY 2019 through MY 2021 and comparing those against the 2021 Quality Compass rates. The MY 2024 targets set for Satisfaction Survey scores that demonstrated meeting or exceeding the 2021 Quality Compass rate over the prior three-year period were set using NCQA's 95th percentile rate. Satisfaction Survey scores that did not meet or exceed the 2021 Quality Compass rate over the prior three-year period are set to improve by 2 percentage points over the three-year strategy cycle.

Table 5: HealthChoice Performance Metrics and Targets – CAHPS Adult and Child

CAHPS - ADULT > NCQA 90th percentile		MY 2019	MY 2020	MY 2021	2021 Quality Compass	NCQA 95th Percentile	TARGET MY 2024
Getting Needed Care	Patient Experience Domain (Combines two survey questions that address member access to care. Both questions use a Never, Sometimes, Usually, or Always response scale, with Always being the most favorable response. This measure is included in HPR under the sub-domain of Getting Care.).	83.1%	83.5%	84.6%	83.6%	89.31%	86.6%
Getting Care Quickly	Patient Experience Domain (Combines responses to two survey questions that address the timely availability of both urgent and check-up/routine care. The questions use a Never, Sometimes, Usually, or Always scale, with Always being the most favorable response. This measure is reported in HPR under the sub-domain of Getting Care.).	83.6%	83.8%	81.9%	81.8%	88.42%	85.8%
Rating of Personal Doctor	Satisfaction with Plan Physicians (Patient Experience Domain)	65.4%	65.9%	66.3%	69.2%	77.25%	68.3%
Rating of Specialist Seen Most Often	Satisfaction with Plan Physicians (Patient Experience Domain)	65.7%	66.3%	66.0%	69.0%	76.22%	68.3%
Rating of All Health Care	Satisfaction with Plan Physicians (Patient Experience Domain)	52.0%	54.3%	55.0%	58.7%	67.53%	57%
Coordination of Care	Satisfaction with Plan Physicians (Patient Experience Domain)	83.8%	83.8%	83.1%	85.4%	92.38%	85.8%
Rating of Health Plan	Satisfaction with Plan Services (Patient Experience Domain)	54.5%	56.8%	55.0%	62.3%	72.16%	58.8%
How Well Doctors Communicate	Combines responses to four survey questions that address physician communication. Results are reported as the proportion of members responding Always or Usually.	92.2%	93.3%	92.1%	92.2%	95.69%	95.69%

Shared Decision Making	Combines responses to three survey questions that focus on decisions related to prescription medicines. Results are reported as the proportion of members responding Yes. (**Note:** NCQA retired this composite measure in 2020. The Maryland Department of Health received permission from NCQA to continue using the three Shared Decision-Making questions for tracking purposes.)	78.3%	79.3%	79.1%	N/A	N/A	81.3%
Customer Service	Combines responses to two survey questions about member experience with the health plan's customer service. Results are reported as the proportion of members responding Always or Usually.	88.0%	89.7%	88.1%	88.9%	93.27%	93.27%
CAHPS - CHILD w/CCC ≥ NCQA 90th percentile		**2019**	**2020**	**2021**	**2021 Quality Compass**	**NCQA 95th Percentile**	**TARGET MY 2024**
Getting Needed Care	Patient Experience Domain (Combines two survey questions that address member access to care. Both questions use a Never, Sometimes, Usually, or Always response scale, with Always being the most favorable response. This measure is included in HPR under the sub-domain of Getting Care.).	82.1%	85.5%	81.7%	85.7%	92.26%	92.26%
Getting Care Quickly	Patient Experience Domain (Combines responses to two survey questions that address the timely availability of both urgent and check-up/routine care. The questions use a Never, Sometimes, Usually, or Always scale, with Always being the most favorable response. This measure is reported in HPR under the sub-domain of Getting Care.).	87.4%	88.7%	82.9%	86.9%	93.64%	93.64%
Rating of Personal Doctor	Satisfaction with Plan Physicians (Patient Experience Domain)	76.4%	77.70%	76.9%	78.0%	83.89%	79.7%
Rating of Specialist Seen Most Often	Satisfaction with Plan Physicians (Patient Experience Domain)	70.0%	72.8%	69.7%	73.8%	80.92%	74.8%
Rating of All Health Care	Satisfaction with Plan Physicians (Patient Experience Domain)	70.5%	71.3%	73.9%	74.3%	81.20%	75.9%

Coordination of Care	Satisfaction with Plan Physicians (Patient Experience Domain)	80.2%	85.2%	81.5%	86.6%	91.35%	87.2%
Rating of Health Plan	Satisfaction with Plan Services (Patient Experience Domain)	70.2%	69.5%	68.3%	72.2%	81.55%	72.2%
How Well Doctors Communicate	Combines responses to four survey questions that address physician communication. Results are reported as the proportion of members responding Always or Usually.	93.5%	96.2%	92.1%	94.4%	97.94%	97.94%
Shared Decision Making	Combines responses to three survey questions that focus on decisions related to prescription medicines. Results are reported as the proportion of members responding Yes. (**Note:** NCQA retired this composite measure in 2020. The Maryland Department of Health received permission from NCQA to continue using the three Shared Decision-Making questions for tracking purposes.)	78.4%	81.3%	77.6%	N/A	N/A	83.3%
Customer Service	Combines responses to two survey questions about member experience with the health plan's customer service. Results are reported as the proportion of members responding Always or Usually.	85.5%	89.3%	86.9%	88.3%	93.01%	91.3%
Access to Prescription Medicines	Results are reported as the proportion of members responding Always or Usually.	90.0%	91.3%	91.2%	91.4%	95.82%	93.3%
Access to Specialized Services	Combines responses to three survey questions addressing the child's access to special equipment or devices, therapies, treatments, or counseling. Results are reported as the proportion of members responding Always or Usually.	75.8%	78.4%	71.6%	74.0%	83.20%	80.4%
Getting Needed Information	Results are reported as the proportion of members responding Always or Usually.	90.4%	90.9%	87.7%	90.8%	95.95%	95.95%
Personal Doctor Who Knows Child	Combines responses to three survey questions addressing the doctor's understanding of the child's health issues. Results are reported as the proportion of members responding Yes.	90.4%	90.4%	88.8%	90.8%	94.42%	92.4%

Coordination of Care for Children with Chronic Conditions	Combines responses to two survey items addressing care coordination needs related to the child's chronic condition. Results are reported as the proportion of members responding Yes.	72.8%	71.7%	71.0%	77.1%	81.37%	74.8%

Systems Performance Review

The Systems Performance Review (SPR) is an annual independent review performed by MDH's EQRO to determine whether the MCOs are delivering care in accordance with the federal and state laws, regulations, and policies governing Medicaid managed care. A comprehensive review of eleven standards is conducted every three years. During the interim years, MCOs are evaluated on any newly introduced elements or components, areas where MCOs received unmet findings that required corrective action, and areas meeting standards with additional opportunities for improvement. The minimum compliance score for all plans and all standards is 100%.

Table 6: HealthChoice Performance Metrics and Targets - Systems Performance Review

SPR Standards	MY 2015	MY 2018	MY 2021	TARGET MY 2024
Standard 1: Systematic Process of Quality Assessment	100%	100%	100%	100%
Standard 2: Accountability to the Governing Body*	99%	93%	-	100%
Standard 3: Oversight of Delegated Entities	93%	88%	95%	100%
Standard 4: Credentialing and Recredentialing*	99%	99%	99%	100%
Standard 5: Enrollee Rights	99%	91%	96%	100%
Standard 6: Availability and Access	96%	86%	99%	100%
Standard 7: Utilization Review	94%	93%	94%	100%
Standard 8: Continuity of Care	100%	100%	100%	100%
Standard 9: Health Plan Education*	95%	100%	-	100%
Standard 10: Outreach	96%	100%	99%	100%
Standard 11: Fraud and Abuse	96%	94%	98%	100%
COMPOSITE SCORE	**98%**	**97%**	**98%**	**100%**

*These standards were exempt from review for MCOs that achieved 100% in past reviews (except for new elements and/or components.

Network Adequacy Validation

The HealthChoice Network Adequacy Validation is a direct test of each MCO's primary care network. The EQRO uses a sample of primary care providers (PCPs) drawn from each plan's listing and contacts PCPs via telephone to verify demographic details, panel information, ages served, appointment availability, and more for accuracy. The EQRO then compares the information collected telephonically to the MCO's online provider network directory to determine if the information is consistent with the information from the telephonic contact and easy for HealthChoice consumers to navigate and understand. The primary metrics for the activity are identified below.

Table 7: HealthChoice Performance Metrics and Targets - Network Adequacy Validation

Network Adequacy Validation **Minimum Compliance Score: ≥ 80%** **HealthChoice Composite Target ≥ 85%**		**MY 2019**	**MY 2020**	**MY 2021**	**TARGET 2024**
Routine Care Appointment Compliance *COMAR 10.67.05.07A(3)(b)(iv)*		91.4%	100%	99.6%	100%
Urgent Care Appointment Compliance *COMAR 10.67.05.07A(3)(b)(iv)*		93.0%	88.1%	86.8%	93%
Accuracy of Provider Directory COMAR 10.67.05.02C(1)(d)	PCP Listed in Online Directory ≥ 80%	95%	97%	95.9%	97%
	PCP's Practice Location Matched Survey Response ≥ 80%	89%	98%	98.2%	98%
	PCP's Practice Telephone Number Matched Survey Response ≥ 80%	92%	95%	96.9%	96%
	Specifies that PCP Accepts New Medicaid Patients for the Listed MCO and Matches Survey Response ≥ 80%	64%	79%	80.5%	80%
	Specifies Age Specification of Patients Seen ≥ 80%	95%	100%	99.6%	100%
	Specifies Languages Spoken by PCP ≥ 80%	77%	100%	99.9%	100%
	Specifies Practice Accommodations for Patients with Disabilities (with specific details) ≥ 80%	61%	100%	95.7%	100%
HealthChoice Composite		**84.16%**	**95.23%**	**94.79%**	**≥ 85%**

Table 8: HealthChoice Performance Metrics and Targets - Network Adequacy Time and Distance Standards

	Urban[1]		Suburban[2]		Rural[3]	
Provider Type	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)	**Max Time** (min)	**Max Distance** (miles)
Primary Care	15	10	30	20	40	30
Primary Care - Pediatric	15	10	30	20	40	30
Pharmacy	15	10	30	20	40	30
Diagnostic Laboratory/X-Ray	15	10	30	20	40	30
Gynecology	15	10	30	20	40	30
Prenatal Care[4]	15	10	30	20	90	75
Acute Inpatient Hospitals	20	10	45	30	75	60
Core Specialties (Cardiology, ENT, Gastroenterology, Neurology, Ophthalmology, Orthopedics, Surgery, Urology)	30	15	60	45	90	75

[1] Urban Counties: Baltimore City

[2] Suburban Counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, Prince George's

[3] Rural Counties: Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico, Worcester

[4] Prenatal Care providers include obstetricians and certified nurse midwives. Family practitioners who provide prenatal care and deliveries may be considered in areas where there is a shortage of obstetricians.

Major Specialties (Allergy and Immunology, Dermatology, Endocrinology, Infectious Diseases, Nephrology, Pulmonology)	30	15	80	60	110	90
Pediatric Sub-Specialties (Cardiology, Gastroenterology, Neurology, Surgery)	30	15	80	60	250	200

HealthChoice Encounter Data Validation

The Encounter Data Validation (EDV) is an annual assessment of the completeness and accuracy of the encounter data submitted by the HealthChoice MCOs to MDH. This activity is conducted jointly by the EQRO and MDH's Medicaid data warehouse vendor, The Hilltop Institute, University of Maryland Baltimore County (Hilltop). Hilltop conducts an overall assessment of the encounter data collected to ensure that edit checks work properly, data is submitted timely, and there are few anomalies that could impact the validity of the information provided. The EQRO then selects a sampling of inpatient, outpatient, and office visit medical records to compare the information in the records to the information present on the encounter for accuracy. The primary metrics for the medical record review aspect of the activity are presented below.

Table 8: HealthChoice Performance Metrics and Targets - Encounter Data Validation

EDV Minimum Compliance Score: ≥ 90% **HealthChoice Composite Target ≥ 99%**	**MY 2018**	**MY 2019**	**MY 2020**	**TARGET MY 2024**
Inpatient Match Rates	94%	99%	98%	99%
Outpatient Match Rates	97%	96%	99%	99%
Office Visits Match Rates	96%	99%	98%	99%

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/Healthy Kids Medical Record Review

The EPSDT/Healthy Kids Medical Record Review is conducted annually. This review evaluates PCP adherence to the EPSDT Healthy Kids Periodicity Schedule maintained by the Maryland Healthy Kids Program. The Maryland Healthy Kids Program's primary focus is compliance with EPSDT standards, and a team of nurse consultants work with MCO PCPs to certify whether they understand the principles of EPSDT care. To conduct this activity, the EQRO receives from Hilltop a sample of children ages 0-21 who received services during the calendar year being assessed. The EQRO then reaches out to each provider's office to request a copy of the child's full medical record to determine if they received the appropriate EPSDT services for their age group. There are five principal components reviewed, and their primary metrics are listed below.

Table 9: HealthChoice Performance Metrics and Targets - EPSDT/Healthy Kids Medical Record Review

EPSDT **Minimum Compliance Score: ≥ 80%** **HealthChoice Aggregate Target ≥ 94%**		**MY 2018**	**MY 2019**	**MY 2020**	**TARGET MY 2024**
Health & Developmental History	A comprehensive medical and family history assists the provider in determining health risks and providing appropriate laboratory testing and anticipatory guidance.	94%	88%	94%	94%
Comprehensive Physical Examination	The comprehensive physical exam uses a systems review method that requires documentation of a minimum of five systems (–e.g., heart, lungs, eyes, ears, nose, throat, abdominal, genitals, skeletal-muscular, neurological, skin, head, and face) to meet EPSDT standards.	97%	93%	96%	97%
Laboratory Tests/At-Risk Screenings	The Healthy Kids Program requires assessments of risk factors associated with heart disease, tuberculosis, lead exposure, anemia, and STI/HIV.	87%	66%	77%	87%
Immunizations	Children receiving Medical Assistance must be immunized according to the current MDH Recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland State Medical Society and is based on the current recommendations of the U.S. Public Health Service's Advisory Committee of Immunization Practices and the American Academy of Pediatrics. PCPs who see Medicaid enrollees through 18 years of age must participate in the MDH's Vaccines for Children (VFC) Program.	93%	71%	86%	93%
Health Education/Anticipatory Guidance	Health education enables the patient and family to make informed healthcare decisions. Anticipatory guidance provides the family with information on what to expect in terms of the child's current and next developmental stage. Information should be provided about the benefits of healthy lifestyles and practices, as well as injury and disease prevention.	94%	92%	94%	94%
HealthChoice Aggregate Totals		**94%**	**83%**	**91%**	**≥ 94%**

HealthChoice Performance Improvement Projects and Interventions

Maryland calls for HealthChoice MCOs to develop a variety of interventions that address member, provider, and MCO based barriers to achieving the two measures. The MCOs should conduct a root cause analysis with stakeholders and frontline feedback to determine issues that create challenges for the completion of the appropriate lead screening. Upstream, equitable, and sustainable solutions are encouraged in addition to community partnerships to help implement the quality improvement process and deliver strategies that improve not only the quality measures but also contribute to the health of the communities the MCOs serve.

MCOs are required to use data-driven interventions with strategies that have a measured impact. In addition, the state looks to MCOs to explore evidence-based approaches using quality improvement tools such as Plan-Do-See-Act (PDSA) cycles and SMART goals to evaluate their test of change.

Beginning with the Lead Screening PIP in MY 2018, any new PIPs will use the Rapid Cycle PIP Process to provide MCOs with a quality improvement method that identifies, implements, and measures changes over short periods. This process aligns with the CMS EQR PIP Validation Protocol. To break the process down into manageable steps, the Rapid Cycle PIP approach is continuous and allows the MCOs to monitor their improvement efforts over short time periods (monthly or quarterly) and in real time. Frequent monitoring allows for quick modifications when necessary. The goal is for MCOs to improve performance in a short amount of time and sustain improvement resulting in a positive impact on enrollee health outcomes.

During the annual 2021 reporting period, MDH implemented an evaluation process to provide in-depth feedback to the MCOs on the quality of their improvement interventions. This evaluation is in addition to the validation performed by the EQRO to further assist the HealthChoice MCOs develop impactful and sustainable improvements and best practices. MDH assesses the MCOs' annual PIP reports for evidence that each has met the required elements for their interventions. MDH then provides insights into the strengths of the MCO's PIP and areas that might be improved. The MDH review panel includes the HealthChoice Medical Director and Quality Assurance Health Policy Analyst to assess the annual PIP reports across three major categories: ***Report Quality***, ***Intervention Planning & Design,*** and ***Intervention Evaluation*** (Appendix A). Each category is scored annually based on the categorical elements and an Evaluation Grade is assigned based on the Total Evaluation Score (Appendix B).

Table 10: Performance Improvement Projects (PIPs) and Interventions for MY 2018 - 2022

PIP Topic	PIP Aim	Performance Measure(s)	Target(s)	Examples of MCO Interventions
Childhood Lead Screening (Quarterly Rapid Cycle PIP)	For children 2 years of age, this PIP aims to increase the percentage of those who had one or more capillary or venous lead blood tests for lead poisoning. The PIP also aims to increase the percentage of children ages 12–23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year.	HEDIS Lead Screening for Children (LSC) Measure: PHIP Lead Screening for Children Ages 12-23 Months Measure	Each MCO is expected to improve its baseline measurement by 10 percentage points over the life of the project.	In-home lead testing offered by community-based home visiting programs Electronic medical record (EMR) alert reminders for timely lead screening among age-appropriate members Use of data stratification to identify and target interventions for counties with low screening rates
Asthma Medication Ratio (Annual PIP)	This PIP aims to promote and improve the use of controller medications among members 5–64 years of age who were identified as having persistent asthma.	HEDIS Asthma Medication Ratio Measure	Each MCO is expected to improve its baseline measurement by 10 percentage points over the life of the project.	Mail order program delivering 90-day prescription refills An EMR-embedded asthma report to PCPs describing prescription types and refill dates, ED visits, hospitalizations, and other demographic information for members with asthma, to prompt outreach and schedule video visits with an Allergist as appropriate. Provider notification of members over-utilizing short-acting beta-agonists with zero pharmacy claims for a longer-acting controller medication.

Beginning in calendar year 2023, MDH will roll out two new PIP topics and create additional layers to the PIP process. In addition to the Annual MDH PIP Intervention Evaluations and the Rapid Cycle PIPs as described above, the PIPs will be structured around a menu of evidence-based strategies. MDH and the EQRO have researched and considered approaches that will align the MCOs' PIP interventions with other statewide public health and Medicaid innovation initiatives. The MCOs will select which strategy is most appropriate for their membership and its available resources then develop their own interventions. They will be required to apply a health equity focus addressing health outcomes among the most disparate populations first and to meet individual process metrics for each selected strategy. This requirement is explained in more detail in the HealthChoice Disparities Plan section below.

Table 11: Performance Improvement Project Topics for MY 2023

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (Quarterly Rapid Cycle PIP)	For pregnant enrollees, this PIP aims to increase the percentage of those who enter prenatal care during the first trimester. This population should be assessed for clinical and social risk factors using Maryland's Prenatal Risk Assessment (PRA).	HEDIS PPC-CH: Prenatal and Postpartum Care: Timeliness of Prenatal Care Each MCO is expected to improve its baseline measurement on HEDIS PPC-CH by 10 percentage points over the life of the project.	**Mandatory:** *Improve completion and use of the Maryland Prenatal Risk Assessment (M-PRA)* **Process Metric:** Increase completion rate *X% above the MCO's baseline during the first measurement year (MY) then increase the goal an additional *Y% above the prior year's rate each subsequent MY. Must show the ratio of # of completed M-PRA/# of unique pregnancies for each rate. **MCO must pick 2 of the additional strategies below:** *Apply Clinical-Community linkages:* **Process Metric:** Increase the percentage of first trimester enrollment in prenatal care by *X% above the MCO's baseline during the first MY then increase the goal an additional *Y% above the prior year's rate each subsequent MY. This increase should directly result from the implementation and continuation of strategic partnerships between a clinical service organization and a non-healthcare organization that supports the needs of pregnant persons. The first trimester enrollment will be considered as defined by the HEDIS PPC measure. Must show the ratio of # of pregnant persons enrolled in the strategic partnership who also had timely prenatal care/Total # of pregnant persons enrolled in the strategic partnership.

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
			Increase engagement with Medicaid-enrolled doulas and/or home visiting services: **Process Metric:** Increase the number of pregnant persons enrolled in Medicaid doula services and/or a home visiting service by *X% every 6 months of each measurement year. Must show the ratio of # of pregnant persons enrolled in doula/home visiting services/Total # of pregnant persons currently enrolled in MCO. *Pregnancy Medical Homes or Group Prenatal Care:* **Process Metric:** Increase the number of pregnant persons enrolled in either a group prenatal care option or Pregnancy Medical Home by *X% above the MCO's baseline during the first MY then increase the goal an additional *Y% above the prior year's rate each subsequent MY. Must include the ratio of # of pregnant persons enrolled in a group prenatal care option or pregnancy medical home/Total # of pregnant persons currently enrolled in the MCO. *Identification of pregnant persons with SUD and integration of substance use management:* **Process Metrics (MUST measure BOTH listed below):** 1. Increase the number of identified pregnant persons with SUD by *X% during the first MY and by *Y% above the prior year's rate for each subsequent MY. Must include the ratio of # of identified pregnant persons with SUD/Total estimated pregnant population with SUD. 2. Improve enrollment of identified pregnant persons with SUD into enhanced case management [such as that under the Maternal Opioid Misuse (MOM) model] by *X% during the first MY and by *Y% above the prior year's rate for each subsequent MY. Must include ratio as # of those enrolled in enhanced case management/Total number of identified pregnant persons with SUD. *X, *Y - indicates that the value should be MCO

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
			determined and specific. MCO must submit a justification for why the goal was chosen including any supporting data.
Maternal Health and Infant/Toddler Care During the Postpartum Period (Quarterly Rapid Cycle PIP)	This PIP aims to maximize the benefit of expanded Medicaid coverage for 12 months postpartum by encouraging quality postpartum care including screening for postpartum depression. In addition, this PIP provides an opportunity for MCOs to re-engage families for age-appropriate well-child care visits up through 30 months of age and early childhood immunizations as the state of emergency ends.	HEDIS PPC-AD: Prenatal and Postpartum Care: Postpartum Care HEDIS WCV, W30: Well-Child Visits in the First 30 Months of Life HEDIS Childhood Immunization Status (CIS-3) Apart from CIS-3, each MCO is expected to improve its baseline for each measure by 10 percentage points over the life of the project. Each MCO will perform above the CIS-3 NCQA 90th percentile threshold by the end of the 3-year cycle.	**The MCO must choose 2 strategies from below:** *Increase engagement throughout the 12-month coverage period:* **Process Metric:** Increase the percentage of birthing persons who remain engaged with Medicaid benefits for 12 months after delivery by *X % during the first measurement year then by *Y% above the prior year's rate each subsequent MY. Through engagement, members should attend ALL the following visits: • Two (2) ACOG-recommended postpartum visits within the first 12 weeks after delivery. A postpartum depression screening and appropriate follow-up should be completed during these visits. • At least one (1) annual preventive care or a chronic condition management visit Must show the ratio using # of eligible birthing persons attending the listed visits/Total # of birthing persons eligible for the 12-month postpartum coverage period. *Implement electronic postpartum depression screening tool:* **Process Metric:** Increase performance on HEDIS Postpartum Depression Screening and Follow-up (PDS) by *X% from baseline during the first measurement year then by *Y% above the prior year's rate each subsequent MY. Must include ratios as defined by HEDIS PDS. *Apply Clinic-Community linkages on behavioral health referrals and parenting supports:* **Process Metric:** As a direct result of the implementation of strategic partnerships between a clinical service organization and a non-healthcare organization supplying family support services or

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
			behavioral healthcare, an increased percentage of at-risk birthing persons complete two (2) postpartum visits within 12 weeks after delivery by *X% from baseline for the first measurement year and increase by *Y% above the prior year's rate each subsequent MY. This strategy should focus on individuals with SUD, challenging SDOH, a positive postpartum depression screen, a history of behavioral health disorders, or a history of DV/IPV, family stressors, and other risk factors identified on the M-PRA. Must include ratio using # of birthing persons referred within the strategic partnership who complete 2 postpartum visits/Total # of birthing persons referred within the strategic partnership. *Value-added benefits for well-child care (Pick one)*: **Process Metric:** Enroll *X% pediatric members, ages birth to 30 months, in at least one option during the first measurement year then increase by *Y% above the prior year's rate each subsequent MY. Must include ratio using # of eligible children enrolled in one of the value-added options whose immunizations are up to date and attended appropriate WCV/# of eligible children enrolled in one of the value-added options. • Value-added Options: o Adverse Childhood Experiences (ACES) Screening and Trauma informed Care Implementation o Pediatric Medical Home Model *Promote WCV through engagement with home visiting services, doulas* **Process Metric:** Enroll *X % of the identified disparate populations in home visiting services and/or with a Medicaid-enrolled doula during the first MY then increase by *Y% above the prior year's rate each subsequent MY. Must include ratio using # of eligible children enrolled in home visiting service and/or parent enrolled in doula services who also attended age appropriate WCV up to first year of life/Total # of eligible children enrolled in home visiting service and/or parent enrolled in doula services.

PIP Topic	PIP Aim	Performance Measure(s) and Target(s)	Menu of Strategies and Related Process Metrics
			Improve immunization rates: **Process Metric:** Increase immunization rates under the CIS-3 measure by *X% above baseline among identified disparate populations during the first MY then by *Y% above the prior year's rate each subsequent MY. Must include ratio using the parameters of the CIS-3 measure for the selected disparate population. *X, *Y - indicates that the value should be MCO determined and specific. MCO must submit a justification for why the goal was chosen including any supporting data.

HealthChoice Transition of Care Policy

Beginning in January 2015, the Maryland General Assembly required all payers, including Medicaid, to begin including a continuity of health care notice in member communications to let them know their rights when they move from commercial plans to Medicaid MCOs and vice versa. The notice informs Marylanders of the following rights they have when transitioning to a new health plan or MCO:

- Preauthorizations from another company's plan will be honored by the new plan for 90 days or until the course of treatment is completed, whichever is sooner, so long as the participant contacts the new plan and provides a copy of the authorization.
- For HealthChoice MCOs, honoring previous preauthorizations does not apply to dental services, mental health services, substance use disorder services, or other benefits or services provided through the Maryland Medical Assistance fee-for-service program.
- Participants can request a copy of the preauthorization and receive it within 10 days of request if they do not have it beforehand.
- If the participant was receiving services from a provider that is not in the MCO's network, the participant may continue to receive services from the out-of-network provider for 90 days or until the course of treatment is completed. Conditions include acute conditions, serious chronic conditions, pregnancy, or any other condition upon which the new MCO and the out-of-network provider agree.
- The 90-day limitation is measured from the date the participant's coverage starts under the new plan. For pregnancy, the period is extended through the pregnancy and the first visit to a health care practitioner after the baby is born so long as the new plan is notified by the participant, the participant's designee, or a health care provider on behalf of the participant.
- Failure to honor the continuity of care notice is appealable by contacting the MCO, or the participant may contact MDH's HealthChoice Help Line for assistance.

In response to the federal managed care regulations update that began in 2016, Maryland began implementing a transition of care policy for participants transitioning between fee-for-service and managed care, as well as between MCOs. In 2019, Maryland partnered with Chesapeake Regional Information System for Our Patients, also known as CRISP, which serves as the regional health information exchange for Maryland and Washington, DC to develop an IT solution for better data sharing. Through this collaboration, the following systems were implemented:

- For care transition information, all MCOs were required to begin sending daily panel information to CRISP to evaluate when members were new or transitioning from other plans.
- MDH provides CRISP with historical encounter data and fee-for-service claims data for its algorithms to identify the following populations with potentially high risk:
    - Pregnant members
    - Members receiving oncology treatment
    - Members eligible for transplants or who have received transplants
    - Members with three emergency department visits, three inpatient admissions, or a combination within the past six months
    - Children with special health care needs

- If these participants are identified through historical data, CRISP sends a flag to the receiving MCO to let them know about the condition and information about the previous MCO to facilitate care coordination.
- CRISP also created a care alert system for providers and MCOs to share information about participants' care regardless of the payer accessing the data.

MDH, CRISP, and MCOs continue to explore ways to improve the continuity of care for participants through information technology as they move from plan to plan.

HealthChoice Plan to Eliminate Disparities

HealthChoice is working to minimize disparities among the HealthChoice population. NCQA will begin requiring MCOs to collect race and ethnicity data in MY 2023 to stratify HEDIS results and review measures from a health equity lens. To prepare for this change, MDH worked with the Maryland Health Connection, which manages Maryland's health benefit exchange, to improve data collection for race and ethnicity. Effective in April 2022, these changes include:

- Switching the response to race and ethnicity questions from an opt-in process to an opt-out process. Applicants now need to proactively indicate that they do not wish to respond to the race and ethnicity questions to skip providing the information.
- Creating more detailed questions to collect more race and ethnicity data. Categories are broadened to be more inclusive of different racial and ethnic identities for fuller reporting.
- Creating a location on the Medicaid eligibility file to share the information with MCOs. The eligibility file now has more robust indicators to share reported data from applicants with MCOs.

As part of the perinatal performance improvement projects (PIPs) beginning in MY 2023, MDH will ask MCOs to stratify their member data to determine racially/ethnically disparate groups and tailor interventions to address the unique needs and challenges among those populations. MCOs should seek input from these populations to determine their unique barriers and solutions tailored to their needs. MCOs are also required to apply the National Culturally and Linguistically Appropriate Services (CLAS) Standards as they develop their PIP interventions. The MCOs' application of these standards is measured as part of the EQRO's Annual PIP Validation process and additional feedback is given as part of MDH's Annual PIP Intervention Evaluation. The quality and effectiveness of their interventions will be graded as part of the PIP Intervention Evaluation process.

For 2024, Maryland is requiring MCOs to achieve the NCQA Health Equity Accreditation by the end of calendar year 2025. Obtaining and maintaining this accreditation across all MCOs helps ensure the utilization of HealthChoice population data, reinforces an internal and external organizational culture of equity, and identifies opportunities to improve care for all our members. Some MCOs are also voluntarily pursuing the Multicultural Distinction as an additional component to their NCQA Health Equity Accreditation status. Pursuit of accreditation in both of these areas will strengthen the HealthChoice program's ability to assess how well HealthChoice MCOs link individuals to needed care, especially for special needs populations like individuals with

limited English proficiency (LEP). Additionally, Maryland is working with the HealthChoice MCOs to standardize the collection of social determinants of health data through a uniform tool from all nine plans.

HealthChoice is also paying close attention to the development of a HEDIS measure that focuses on the completion of social determinants of health questionnaires and tools. Many HealthChoice special projects include completing a Social Determinants of Health tool to determine how these factors may be impacting the quality-of-care participants receive. In partnership with the HealthChoice MCOs, MDH is evaluating the various social determinants of health evaluation tools to determine the best tool to be adopted by all managed care organizations and reduce fragmentation. Once selected, the state's health information exchange, Chesapeake Regional Information System for our Patients (CRISP) may act as a central repository for responses to the tool, allowing access to community-based providers, MCOs, and social services agencies. MDH is also reviewing guidance and contracts from other states to learn how a health equity and disparities lens may be integrated into the HealthChoice framework to reach more participants and provide inclusive care.

Finally, MDH is collaborating across our Medicaid administration to develop a Health Equity Framework to define our priorities and guide our current and future steps. Based upon the CMS 2023-2033 Health Equity Framework, MDH has initially set the following:

1. Priority: Expand the Collection, Reporting, and Analysis of Standardized Data
    a. Goal: Improving Collection of Disparity-focused Data and Exploring Measure Stratification
        1. Decrease 'unknown' race/ethnicity category data and improve collection and use in quality metrics/comparisons
        2. Stratify member demographic data by county/zip code level for PHIPs
        3. Stratify member data by age group for HEDIS measures related to asthma management, preventive care, and vaccine administration
        4. Adjust the Maryland Health Connection application for benefits to enable members to further describe their sexual orientation and gender identity (SOGI)
        5. Utilize the existing PHIP measures, Ambulatory Care for SSI Adults and Ambulatory Care of SSI children, to identify disparities in access to care for those with physical, intellectual, and sensory challenges as defined by Supplemental Security Income (SSI) benefit enrollment
            a. SSI defines disabilities for children (age under 18 years) as having a medically determinable physical or mental impairment, (including an emotional or learning problem) that:
                i. Results in marked and severe functional limitations; and
                ii. Can be expected to result in death; or
                iii. Has lasted or can be expected to last for a continuous period of not less than 12 months.
            b. SSI defines disabilities for adults (age 18 years and over) as having a medically determinable physical or mental impairment, (including an emotional or learning problem) that:
                i. Results in the inability to do any substantial gainful activity; and

ii. Can be expected to result in death; or
iii. Has lasted or can be expected to last for a continuous period of not less than 12 months.

c. SSI defines blindness as having a central visual acuity for a distance of 20/200 or less with the use of a correcting lens or a visual field limitation such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

b. Goal: Identifying, Standardizing, and Prioritizing SDOH Data
   i. Determine a standardized tool for MCOs to comply with NCQA screening measures and report data to MDH by contract year 2025
   ii. By 2025, integrate SDOH data into HealthChoice Evaluation and other reporting
      1. Data may be stratified to reflect SDOH impact on pediatric members vs single adults

2. Assess Causes of Disparities Within Medicaid Programs, and Address Inequities in Policies and Operations to Close Gaps
   a. Goal: Improve MCO's performance on disparity reduction
      i. PIP Health Equity Focus
      ii. Require MCOs to have NCQA Health Equity Accreditation by contract year 2025
   b. Goal: Determine causes of barriers in MDH and MCO policies
      i. Remove sex and gender-based edits in MDH's Medicaid Management Information System (MMIS)
      ii. Implement Health Equity Index Payment as a financial incentive to MCOs based upon a percentage of membership residing in areas of social deprivation
      iii. Track data that highlights challenges in access to ambulatory care for members with SSI

Identification of HealthChoice Participants with Special Health Care Needs

In regulation[5], Maryland defines the following populations as special needs populations, and these categories are not mutually exclusive:

- Children with special health care needs
- Participants with a physical disability
- Participants with a developmental disability
- Pregnant and postpartum women
- Participants who are homeless
- Participants with HIV/AIDS
- Children in state-supervised care

[5] COMAR 10.67.04.04–10.67.04.10; 10.67.04.13.

Individuals who receive Supplemental Security Income (SSI) or Social Security Administration (SSA) benefits are part of the eligible populations to participate in HealthChoice. At the time of enrollment, applicants are asked to complete a tool called the Health Services Needs Information (HSNI) form. The HSNI is a questionnaire that assesses whether the applicant has immediate health care needs that require attention from the MCO. Examples of questions from the HSNI include whether the applicant or a member of their household is pregnant, whether the applicant or household member has immediate prescription needs, or whether the applicant or household members have a medical condition that requires an urgent appointment at the time of application completion. These answers are relayed to the MCOs with the enrollment transaction so that their care management teams and onboarding teams can follow up with the new participant.

In addition to the HSNI, if the applicant opts not to complete the tool, MCOs conduct health risk assessments as part of the onboarding process. Current Maryland regulations require the MCOs to make three attempts to contact the participant to complete the risk assessment, and at least one of the attempts must be performed after normal business hours to increase the likelihood of completion. These risk assessments also inform the MCOs of which participants in their plans belong to special needs populations.

Each MCO regularly conducts utilization review to identify participants through claims, authorizations, admissions, and other aggregated information to better target participants who could benefit from care management, enhanced care coordination, and linkage to community resources. For participants such as pregnant women and children in state-supervised care, coordination through the administrative care coordination units at each of the county local health departments assist with identification, referrals to care, and intervention if participants have risk factors requiring specialized care.

In evaluating the quality of care for individuals with special health care needs and in addition to the compendium of HEDIS measures collected for HealthChoice, Maryland developed three measures using encounter data and lead registry data to assess whether adults and children receiving SSI are being connected to ambulatory care and whether younger children between the ages of 12 to 23 months are receiving lead screenings. The measure uses HEDIS definitions for ambulatory care and stratifies this information for individuals enrolled for at least 320 continuous days in the HealthChoice program who qualify based on SSI. Ambulatory care includes visits for primary behavioral health that are reimbursed by the HealthChoice MCOs and excludes emergency department visits and inpatient admissions. Maryland is working to develop benchmarks and targets to evaluate the performance of these measures over time, and Maryland also provides financial incentives to the HealthChoice MCOs to prioritize these populations, historically through the Value-Based Purchasing Initiative (VBPI), and, beginning in MY 2022, through the Population Health Incentive Program (PHIP).

HealthChoice Clinical Practice Guidelines

MCOs are required to use valid, reliable, evidence-based clinical practice guidelines to assist practitioners in approaching healthcare issues in a systematic, appropriate manner per COMAR 10.67.09.09L and 42 CFR 438.236. All the HealthChoice MCOs use Clinical Practice Guidelines with the most common being Milliman Care Guidelines (MCG; Milliman) and InterQual. MCO guidelines are available to their provider networks via the MCO Provider Manual and their respective websites.

Table 12: HealthChoice Clinical Practice Guideline Links by MCO

MCO	Link to Clinical Practice Guidelines
ABH	https://www.mcg.com/care-guidelines/care-guidelines/ https://www.aetnabetterhealth.com/maryland/providers/clinical-guidelines-policy-bulletins.html
ACC	https://provider.amerigroup.com/maryland-provider/resources/manuals-and-guides/medical-policies-and-clinical-guidelines
CFCHP	https://www.carefirstchpmd.com/for-providers/medicaid-clinical-practice-guidelines
JMS	https://s27543.pcdn.co/wp-content/uploads/2021/01/Provider-Manual-2021_Final_With-Attachments-1.pdf
KPMAS	http://providers.kaiserpermanente.org/info_assets/cpp_mas/mas_prov_man_chap_9_Jul2020.pdf
MPC	https://www.marylandphysicianscare.com/wp-content/uploads/2020/12/2021-Medical-Practice-Guidelines.pdf
MSFC	https://www.medstarfamilychoice.com/maryland-providers/provider-support/clinical-practice-guidelines
PPMCO	https://hpo.johnshopkins.edu/doc/fetch.cfm/im8GrZkt
UHC	https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/multi/clinical-guidelines/Clinical-Practice-Guidelines-UHCCP-2021.pdf

HealthChoice Performance Monitoring and Intermediate Sanctions

In 2011, Maryland introduced an intermediate sanction framework for MCOs known as the HealthChoice MCO Performance Monitoring Policies. The policies included three levels of performance problems (minor, moderate, and major) and provided a list of recommended sanctions for failure to meet performance metrics for consecutive years or a defined number of years within a five-year period. However, MCOs were advised that Maryland has the discretion to impose sanctions without following the prescribed scheme at any time.

In 2015, Maryland revisited the policy and defined four quality assurance areas for review: network adequacy, HEDIS measures, EPSDT/Healthy Kids medical record reviews, and the Systems Performance Review. The tables below share the performance monitoring grid shared annually in the HealthChoice Managed Care Organization Agreement.

Table 13: HealthChoice MCO Performance Monitoring Enforcement Guidelines – Minor Problems

	MCO Network Adequacy	HEDIS Performance	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/ Healthy Kids Review	Systems Performance Review (SPR)
Examples of Minor Problems	Minor provider or recipient complaint.	- One year with 30% or more elements with scores below the National Medicaid HEDIS Mean (NHM). - Two consecutive years with 30% or more elements with scores below the NHM.	Receives less than 80% in one or more components for a review year.	Does not receive a "Met" in an element or component.
Enforcement	- Verbal request for clarification. - Corrective Action Plan (CAP) to prevent a future network adequacy problem. - Geo-Access Report.	Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options.	Written CAP within 45 days of presentation of the preliminary report.	- Written CAP within 45 days of presentation of the preliminary report. - Focused EQRO audit of specific elements/components on an annual basis.

Table 14: HealthChoice MCO Performance Monitoring Enforcement Guidelines – Moderate Problems

	MCO Network Adequacy	HEDIS Performance*	EPSDT/Healthy Kids Review	SPR
Examples of Moderate Problems	Persistent minor provider or recipient complaints PCP to recipient ratio appears inadequate but recipients are still able to access a PCP.	Three years in a row or three years within a five-year period with 30% or more elements with scores below the NHM.	Receives less than 80% in one or more components for two review years -- this score could be for the same component or different components.	Receives an "Unmet" score two years in a row on the same element (without components) or an "unmet" or "partially met" score on the same component.
Enforcement	- Written CAP within 30 days of finding. - Geo-Access Report. - Financial sanctions. - Required to pay for out-of-network care and transportation.	- Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options. - Freeze auto assignments in areas of the state as determined by the Department.	- Written CAP within 45 days of presentation of the preliminary report. - Focused provider education project of specific component for two calendar years.	- Second Partially Met score on the component will be changed to an Unmet score. - Written CAP within 45 days of presentation of the preliminary report. - Focused EQRO audit of specific elements or components on an annual basis. - Monitoring of CAP by EQRO on a quarterly basis, with failure to implement linked to freezing auto-assignments, freezing voluntary assignments, or financial sanctions.

*Note: For MY2022 and future reporting, HEDIS noncompliance has increased from 30% to 35% or more elements with scores below the NHM.

Table 15: HealthChoice MCO Performance Monitoring Enforcement Guidelines – Major Problems

	MCO Network Adequacy	HEDIS Performance*	EPSDT/Healthy Kids Review	SPR
Examples of Major Problems	- Persistent PCP to recipient ratio appears inadequate (greater than 1:500) but recipients are still able to access a PCP. - No access to OB/GYN and/or no choice of PCP.	- Four years in a row or four years within a five-year period with 30% or more elements with scores below the NHM. - Four years in a row or four years within a five-year period with any of the HEDIS VBP measures with scores below the NHM.	Receives less than 80% in one or more components for three consecutive years, or for three years within a five-year period – this score could be for the same component or different components.	Receives an "Unmet" score three or more years in a row on the same element (without components) or an "unmet" or "partially met" score on the same component.
Enforcement	- CAP within 10 days of finding. - Geo Access Report. - Financial Sanction. - Required to pay for out-of-network care and transportation. - Allow recipients in the problem service area(s) to voluntarily disenroll from MCO immediately. - Freeze auto assignments in problem service area(s). - Freeze voluntary enrollment in the problem service area(s). - Freeze the MCO to all future enrollment in the problem service area(s) (moving current recipients into another MCO of their choice). - Additional financial sanctions beyond paying for out-of-network care and transportation. - Contract termination/MCO closure in all affected counties.	- Letter to MCO advising of monitoring policy, measures below the NHM, and enforcement options. - Freeze auto assignments in areas of the state as determined by the Department. - Freeze voluntary enrollment in areas of the state as determined by the Department. - Financial sanctions other than enrollment freeze. - Contract termination and MCO closure in all counties.	- Written CAP within 45 days of presentation of the preliminary report. - Monitoring of CAP by EQRO on a quarterly basis, with failure to implement linked to freezing auto-assignments or financial sanctions. - Focused provider education project of specific component for three calendar years. - Freeze auto assignments in areas of the state determined by the Department.	- Second Partially Met score on the component will be changed to an Unmet score. - Written CAP within 45 days of presentation of the preliminary report. - Focused EQRO audit of specific elements or components on an annual basis. - Monitoring of CAP by EQRO on a quarterly basis, with failure to implement linked to freezing auto-assignments, freezing voluntary assignments, or financial sanctions. - MCO will be subject to full SPR review annually.

*Note: For MY2022 and future reporting, HEDIS noncompliance has increased from 30% to 35% or more elements with scores below the NHM.

Intermediate Sanctions Imposed to Date

To date, Maryland has imposed the following intermediate sanctions on the HealthChoice MCOs in accordance with the Performance Monitoring Policies:

- **HEDIS***
  *MDH and the HealthChoice MCOs agreed to waive MY 2020 sanctions for HEDIS performance monitoring and to exclude it from trending in future years due to the COVID-19 public health emergency. For MY 2022 and future reporting, HEDIS noncompliance has increased from 30% to 35% or more elements with scores below the NHM.
  - ABH: Moderate HEDIS Problem (MYs 2018, 2019, 2020)
  - ACC: Minor HEDIS Problem (MY 2020)
  - CFCHP: Major HEDIS Problem (MYs 2016, 2017, 2019, 2020)
  - JMS: Minor HEDIS Problem (MY 2020)
  - MPC: Major HEDIS Problem (MYs 2017, 2018, 2019, 2020)
  - MSFC: Minor HEDIS Problem (MY 2020)
  - PPMCO: Major HEDIS Problem (MYs 2017, 2018, 2019, 2020)
  - UHC: Moderate HEDIS Problem (MYs 2018, 2019, 2020)
- **EPSDT Healthy Kids Medical Record Reviews**
  - ACC: Major Problem (MY 2018 - 2020; Laboratory Tests/At-Risk Screenings Component) - Quarterly monitoring of corrective action plan along with a focused provider education project specific to the area of noncompliance for 3 calendar years.
- **Systems Performance Review**
  - ABH: Moderate SPR Problem (MY 2019 - 2020; Standard 6: Availability and Access and Standard 7: Utilization Review) - Quarterly review of corrective action plan by EQRO.
  - ACC: Moderate SPR Problem (MY 2019 - 2020; Standard 7: Utilization Review) - Quarterly review of corrective action plan by EQRO.
  - CFCHP: Moderate SPR Problem (MY 2019 - 2020; Standard 5: Enrollee Rights and Standard 7: Utilization Review) - Quarterly review of corrective action plan by EQRO.
  - KPMAS: Major SPR Problem (MY 2018-2020; Standard 11: Fraud and Abuse) - $42,000 Fine
  - PPMCO: Major SPR Problem (MY 2015-2017, 2018 [baseline], 2019, 2020; Standard 7: Utilization Review) - $200,000 Fine

MDH evaluates the HealthChoice Performance Monitoring Policies regularly to ensure its areas of focus align with current priorities and improve its implementation over time. The Performance Monitoring Policies are also tied to an incentive-only quality initiative known as the Population Health Improvement Program (PHIP), which will begin in measurement year 2022. The ability to collect certain funds in PHIP is conditioned upon plans having no moderate or major performance monitoring findings.

HealthChoice External Quality Review Arrangements and Non-Duplication Option

Maryland contracts with three vendors for its quality assurance activities:

- Qlarant Quality Solutions, Inc. (Qlarant) is the EQRO. Qlarant is responsible for performance improvement project validation; performance measure validation for the Value-Based Purchasing Initiative; compliance reviews to ensure MCOs comply with 42 CFR 438, Subpart D and 42 CFR 438.330; MCO network adequacy validation; encounter data validation; clinical quality studies focused on MCO appeals, grievances, and pre-service denials; and development of an annual consumer report card to assist HealthChoice enrollees with MCO selection.
- MetaStar, Inc. (MetaStar) is the HEDIS Compliance Auditor. MetaStar is responsible for ensuring compliance with the National Committee for Quality Assurance (NCQA) guidelines for reporting HEDIS measures, including onsite audits of MCO systems and processes to report data. MetaStar also reviews and approves the CAHPS survey sample frame. At the end of the audit cycle, MetaStar compiles a comprehensive report with trending MCO performance on the HEDIS measures.
- Center for the Study of Services, Inc. (CSS) is the survey administration vendor. CSS administers the CAHPS surveys for adults and children, as well as the Primary Care Provider (PCP) Satisfaction Survey. CSS monitors compliance with survey protocols and compiles reporting on the results of both survey efforts.

CMS permits the opportunity for states 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 the opportunity for non-duplication deeming.

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

MDH initiated this process for the CY 2021 SPR. To qualify for deeming, MDH established the following criteria:

- The MCO must be NCQA accredited—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 in the applicable standards.

Using this information and the NCQA Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards (Effective July 1, 2020 – June 30, 2021), Qlarant evaluated whether the MCO qualified for deeming of further review for the Systems Performance Review activity.

Table 16: Systems Performance Review MY 2021 Non-Duplication Deeming Standards Crosswalk

Standard 1: Systematic Process of Quality Assessment and Improvement											
1.1 N	1.2 N	1.3 6/7	1.4 N	1.5 N	1.6 N/A	1.7 N	1.8 Y	1.9 N	1.10 N		
Standard 2: Accountability to the Governing Body											
2.1 N	2.2 N	2.3 N	2.4 N	2.5 N	2.6 N/A	2.7 N					
Standard 3: Oversight of Delegated Entities and Subcontractors											
3.1 N	3.2 N	3.3 N	3.4 N								
Standard 4: Credentialing and Recredentialing											
4.1 3/4	4.2 N	4.3 Y	4.4 N	4.5 Y	4.6 Y	4.7 N	4.8 4/5	4.9 2/3	4.10 N	4.11 N	4.12 N
Standard 5: Enrollee Rights											
5.1 N	5.2 Y	5.3 1/5	5.4 N	5.5 N	5.6 N	5.7 N	**5.8 1/5**	5.9 N	5.10 N	5.11 N	
Standard 6: Availability and Accessibility											
6.1 1/4	6.2 2/4	6.3 N	6.4 N								
Standard 7: Utilization Review											
7.1 2/3	7.2 5/6	7.3 1/3	7.4 1/3	7.5 N	7.6 N	7.7 2/7	7.8 N	7.9 N	7.10 N	7.11 N	7.12 N/A
Standard 8: Coordination 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							

*Deemed Standards with fractions indicate the number of components available for deeming within the identified element.

Legend
Y - Standard Deemable
N - Standard is Not Deemable
Standard is Partially Deemable (# of Components Indicated)
Not Applicable - Standards Deleted

HealthChoice External Quality Review Recommendations

In Maryland's 2021 Annual Technical Report, the external quality review organization recommended various actions for MDH to take. Responses to those recommendations are outlined below in Table 17.

Table 17: Responses to MDH Recommendations from External Quality Review Activities, 2021

Activity	EQRO Recommendation	MDH Response
Performance Improvement Projects	Provide a forum for MCOs to discuss barriers and share best practices to improve rates among all HealthChoice MCOs	MDH hosts quarterly quality assurance liaison committee meetings with MCOs and the quality assurance vendors. During these meetings, MDH will explore hosting discussions about best practices and common barriers faced during the performance improvement project implementation, in addition to providing technical assistance to improve MCOs' proposed interventions and evaluation. Because the PIPs are moving to rapid cycle evaluation each quarter, MDH has more opportunities to identify common barriers and best practices in alignment with the quarterly meetings.
Encounter Data Validation	Continue to work with MCOs to resolve provider data problems	MDH, in partnership with its data warehouse vendor, is reviewing reports more frequently to determine each MCO's encounter data error rate and identify issues that may impact multiple plans.
	Encourage MCOs to ensure providers are enrolled on the date of service and verify their status to address the rise in rejected encounters	MDH and MCOs continue to encourage providers to enroll with fee-for-service, maintain active status, and use the tools available online to verify a provider's active enrollment.
	Continue to monitor monthly encounter submissions to ensure MCOs submit data timely	MDH is adopting this recommendation.
	Continue to monitor PCP visits by MCO in future validations	MDH will continue to incorporate monitoring PCP visits as part of its validation.

Activity	EQRO Recommendation	MDH Response
	Continue to review inpatient visit, ED visit, and observation stay data in encounters and compare trends to look for consistency	MDH will continue to monitor these trends as part of its encounter data validation activities.
	Continue to review and audit participant-level reports for delivery, dementia, participants over age 65, pediatric dental, and missing age outliers in encounter data	MDH will continue to check encounter anomalies and outliers to verify accuracy.
	Instruct MCOs to direct providers to update and maintain accurate billing/claims address information to reduce returned mail for medical record reviews	MCOs will continue their ongoing efforts to keep provider billing and claims addresses up to date. MDH is exploring asking the EQRO to share a report with each MCO informing them of providers with incorrect addresses in the provider sample.
	Communicate with provider offices and hospitals to reinforce sending all supporting medical record documentation for encounter data review to achieve minimum samples in a timely manner	MDH will continue to work with the MCOs and the EQRO to encourage responsiveness to medical record documentation requests for this activity.
Focused Review of Grievances, Appeals, and Denials	Require MCOs to implement routine quality oversight of report submissions and explore supporting ongoing data quality of reports	MDH and the EQRO have begun sharing resubmission data with the MCOs. In addition, MDH continues to adjust the submission templates to include formulas and macros that promote accurate reporting.
Focused Review of Grievances, Appeals, and Denials	Cross-check MCO-reported provider grievances with grievances submitted to MDH to ensure all grievances are counted in MCO reports	MDH is working on an internal process to compare self-reported MCO data to complaint data through its customer service lines.
Focused Review of Grievances, Appeals, and Denials	Clarify requirements of Hepatitis C preauthorization and appeal reporting requirements to ensure consistent understanding among MCOs	Hepatitis C medication costs are managed through a separate risk pool and reconciliation process, as outlined in the 2022 HealthChoice MCO Agreement in Appendix L-2. Now that MCOs are responsible for the preauthorization process, the statistics may be reported through the preauthorization template.

Activity	EQRO Recommendation	MDH Response
Focused Review of Grievances, Appeals, and Denials	Consider conducting focused record reviews of pharmacy-related denials and appeals to determine key drivers of consistently high volume among MCOs	MDH is working on an internal process to review preauthorization denials more closely on at least a semiannual basis.
Focused Review of Grievances, Appeals, and Denials	Consider including compliance with timeframes for sending written acknowledgment of grievance receipt, a written resolution of the grievance, and written acknowledgment of appeal receipt in quarterly reporting	MDH will work with the EQRO to determine what would be an appropriate metric to measure compliance with this requirement, as the element is already captured in the Systems Performance Review process.
Focused Review of Grievances, Appeals, and Denials	Assess the need for additional grievance service categories	MDH will evaluate including additional grievance categories to MCO reporting.
Network Adequacy Validation	Promote standards/best practices for MCO online provider directory information, including: ● Use of consistent lexicon for provider detail information ● Use of placeholders with consistent descriptions for provider details that are missing, such as “none” or “none specified” rather than blanks ● Require all directories to state the date the information was last updated for easy monitoring	MDH will use feedback from the EQRO’s provider directory assessments to develop online provider directory best practices for MCOs.
Network Adequacy Validation	Continue to monitor MCO complaints regarding the use of urgent care and emergency department services and review utilization trends to ensure members are not accessing these services due to an inability to identify or access PCPs	MDH will evaluate the availability of resources and data for this recommendation.

Conclusion

As demonstrated in this quality strategy, while Maryland has implemented numerous initiatives to improve health outcomes for adults, children, individuals with chronic illnesses, and pregnant individuals, the impact of the COVID-19 pandemic on healthcare quality is evident in Maryland Medicaid's quality performance, as well as performance nationally.

Through quality oversight, collaboration with MCOs and stakeholders, data analysis, health equity initiatives, and performance monitoring, Maryland's quality strategy embraces the principles of continuous quality improvement to contribute to overall improved public health for Marylanders.

The objectives and goals identified in our strategy align with HealthChoice's aims to provide healthcare to low-income Marylanders that is patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. MDH will continue its commitment to customer service, high quality care, and stewardship through the implementation and reevaluation of this strategy over time.

Appendix A: Reports and Publications

Current and historical quality assurance reports for the following activities may be found on the Maryland Department of Health's **HealthChoice Quality Assurance website**:

- Systems Performance Review
- Performance Improvement Projects
- Encounter Data Validation
- Value-Based Purchasing
- Early and Periodic Screening, Diagnosis, and Treatment Healthy Kids Medical Record Review
- Consumer Report Card
- Focused Review of Grievances, Appeals, & Denials
- Network Adequacy Validation
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Section 1115 waiver renewal documents may be found here. The Section 1115 HealthChoice evaluations may be found here.