



## Medicaid Managed Care Organization

## 2013 Annual Technical Report



**Health Choice**



Delmarva Foundation

*A Quality Health Strategies Company*

Submitted by:  
Delmarva Foundation  
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## Executive Summary

### Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is responsible for evaluating the quality of care provided to eligible enrollees in contracted Managed Care Organizations (MCOs) through the Maryland Medicaid Managed Care Program, known as HealthChoice. HealthChoice has been operational since June 1997 and operates pursuant to the Code of Federal Regulations (CFR), Title 42.438.204 and the Code of Maryland Annotated Regulations (COMAR) 10.09.65. HealthChoice's philosophy is based on providing quality health care that is patient-focused, prevention-oriented, comprehensive, coordinated, accessible, and cost-effective.

DHMH's HealthChoice and Acute Care Administration (HACA) is responsible for coordination and oversight of the HealthChoice program. HACA ensures that the initiatives established in 42 CFR 438, Subpart D are adhered to and that all MCOs that participate in the HealthChoice program apply these principles universally and appropriately. The mission of HACA is to continuously improve both the clinical and administrative aspects of the HealthChoice Program. The functions and infrastructure of HACA support efforts to efficiently and effectively identify and address quality issues. There is a systematic process where DHMH identifies both positive and negative trends in service delivery and outcomes. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care process and help to ensure that health care is not compromised.

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

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

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

The HealthChoice program served over 790,600 enrollees as of December 31, 2012, and contracted with seven MCOs during this evaluation period. The seven MCOs evaluated during this period were:

- AMERIGROUP Community Care (ACC)
- Diamond Plan from Coventry Health Care, Inc. (DIA)
- Jai Medical Systems, Inc. (JMS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare (UHC)

Pursuant to 42 CFR 438.364, this Annual Technical Report describes the findings from Delmarva Foundation's External Quality Review activities for years 2012-2013. The report includes each review activity conducted by Delmarva Foundation, the methods used to aggregate and analyze information from the review activities, and conclusions drawn regarding the quality, access, and timeliness of healthcare services provided by the HealthChoice MCO. This is the first year that Delmarva Foundation has prepared this report for the HealthChoice program.

### **HACA Quality Strategy**

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

- Ensure compliance with changes in Federal/State law and regulation;
- Improve performance over time;
- Allow comparisons to national and state benchmarks;
- Reduce unnecessary administrative burden on MCOs; and,
- Assist the Department with setting priorities and responding to identified areas of concern such as children, pregnant women, children with special healthcare needs, adults with disabilities, and adults with chronic conditions.

HACA works collaboratively with MCOs and stakeholders to identify opportunities for improvement and to initiate quality improvement activities that will impact the quality of healthcare services for HealthChoice enrollees.

## EQRO Program Assessment Activities

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

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

Delmarva Foundation also conducted an optional activity - validation of encounter data reported by the MCO. As the EQRO, Delmarva Foundation conducted each of the mandatory activities and the optional activity in a manner consistent with the CMS protocols during calendar year (CY) 2013.

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

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

In aggregating and analyzing the data from each activity, Delmarva Foundation allocated standards and/or measures to domains indicative of quality, access, and timeliness to care and services. Separate report sections address each review activity and describe the methodology and data sources used to draw conclusions for the particular area of focus. The final report section summarizes findings and recommendations to HACCA and the MCOs to further improve the quality of, timeliness of, and access to health care services for HealthChoice enrollees.

## General Overview of Findings

### Assessment of Access, Quality, and Timeliness

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

- **Quality**, as it pertains to external quality review, is defined as “the degree to which an MCO or Prepaid Inpatient Health Plan increases the likelihood of desired health outcomes of its enrollees (as defined in 42 CFR 438.320[2]) through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.” ([CMS], *Final Rule: Medicaid Managed Care; 42 CFR Part 400, et. al. Subpart D- Quality Assessment and Performance Improvement*, [June 2002]).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is “the extent to which a patient can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment, if applicable. The intent is that each organization provides and maintains appropriate access to primary care, behavioral health care, and member services.” (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*).
- **Timeliness**, as it relates to utilization management decisions and as defined by NCQA, is whether “the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care.” (*2006 Standards and Guidelines for the Accreditation of Managed Care Organizations*). An additional definition of timeliness given in the Institute of Medicine National Health Care Quality Report refers to “obtaining needed care and minimizing unnecessary delays in getting that care.” (*Envisioning the National Health Care Quality Report, 2001*).

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

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

Annual Review Activities that Assess Quality, Access, and Timeliness			
Systems Performance Review	Quality	Access	Timeliness
Standard 1 - Systematic Process of Quality Assessment and Improvement	√		
Standard 2 - Accountability to the Governing Body	√		
Standard 3 - Oversight of Delegated Entities	√		
Standard 4 - Credentialing and Recredentialing	√	√	√
Standard 5 - Enrollee Rights	√	√	√
Standard 6 - Availability and Accessibility		√	√
Standard 7 - Utilization Review	√	√	√
Standard 8 - Continuity of Care	√	√	√
Standard 9 - Health Education Plan	√	√	
Standard 10 - Outreach Plan	√	√	
Standard 11 - Fraud and Abuse	√		√
Value Based Purchasing	Quality	Access	Timeliness
Adolescent Well Care	√	√	√
Ambulatory Care Services for SSI Adults Ages 21–64 Years	√	√	
Ambulatory Care Services for SSI Children Ages 0–20 Years	√	√	
Cervical Cancer Screening for Women Ages 21–64 Years	√		√
Childhood Immunization Status (Combo 3)	√		√
Eye Exams for Diabetics	√		√
Lead Screenings for Children Ages 12–23 Months	√		√

Value Based Purchasing	Quality	Access	Timeliness
Postpartum Care	√	√	√
Use of Appropriate Meds for Asthma	√		
Well-Child Visits for Children Ages 3 – 6 Years	√	√	√
Performance Improvement Project	Quality	Access	Timeliness
Adolescent Well Care PIP	√	√	√
Substance Abuse PIP	√	√	√
EPSDT Medical Record Review	Quality	Access	Timeliness
Health and Developmental History	√		√
Comprehensive physical examination	√		√
Laboratory tests/at risk screenings		√	√
Immunizations	√		√
Health education and anticipatory guidance	√		√
Encounter Data Validation	Quality	Access	Timeliness
Inpatient, Outpatient, Office Visit Medical Record Review	√		
HEDIS®	Quality	Access	Timeliness
Childhood Immunization Status	√		√
Immunizations for Adolescents	√		√
Appropriate Treatment for Children with Upper Respiratory Infection	√		
Appropriate Testing for Children with Pharyngitis	√		
Breast Cancer Screening	√		√
Cervical Cancer Screening	√		√
Chlamydia Screening in Women	√		√
Comprehensive Diabetes Care	√		√
Use of Appropriate Medications for People with Asthma	√		
Use of Imaging Studies for Low Back Pain	√		
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	√		
Adult BMI Assessment	√		√
Controlling High Blood Pressure	√		√
Annual Monitoring for Patients on Persistent Medications	√		√
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	√		
Medication Management for People with Asthma	√		
Adults' Access to Preventive/Ambulatory Health Services		√	√
Children and Adolescents' Access to Primary Care Practitioners		√	√
Prenatal and Postpartum Care		√	√
Call Answer Timeliness		√	√

HEDIS	Quality	Access	Timeliness
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	√	√	
Frequency of Ongoing Prenatal Care	√	√	√
Well-Child Visits in the First 15 Months of Life	√	√	√
Well-Child Visits in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> and 6 <sup>th</sup> Years of Life	√	√	√
Adolescent Well-Care Visits	√	√	√
Ambulatory Care		√	
Identification of Alcohol and Other Drug Services	√	√	
CAHPS®	Quality	Access	Timeliness
Getting Needed Care		√	
Getting Care Quickly			√
How Well Doctors Communicate	√		
Customer Service	√	√	
Shared Decision Making	√		
Health Promotion and Education	√		
Coordination of Care	√		
Access to Prescription Medication*		√	
Access to Specialized Services*		√	
Family Centered Care: Personal Doctor Who Knows Your Child*	√		
Family Centered Care: Getting Needed Information*	√		
Coordination of Care for Children with Chronic Conditions*	√		

\*Additional Composite Measures for Children with Chronic Conditions

## Recommendations and Corrective Action Plans for MCOs Prior Year Review Activities

### Systems Performance Review

Although the Maryland (MD) MCO Aggregate rate was 99% in CY 2011, MCOs were required to submit systems performance review Corrective Action Plans (CAPs) in areas where opportunities for improvement were identified or in areas where non-conformance with federal and contractual operational systems were noted.

The following CAPs from the last review period (January 1, 2011 – December 31, 2011) were implemented by the MCOs:

- UHC provided evidence of the MCO’s quality committee’s review and approval of all delegated entity’s quarterly complaint, grievance, and appeal reports.
- ACC provided evidence of the MCO’s quality committee’s review and approval of all delegated entity’s claims payment activities.

- ACC, DIA, and UHC provided evidence of the MCO's quality committee's review and approval of over and under utilization reports submitted from each entity to which utilization management activities have been delegated.
- PPMCO adhered to the time frames set forth in the MCO's policies for recredentialing decision date requirements.
- UHC adhered to the time frames set forth in the MCO's policies and procedures for resolving grievances.
- PPMCO reviewed services provided for over and under utilization.
- ACC, DIA, and UHC ensured that appeal decisions are being made in a timely manner as required by the exigencies of the situation.
- PPMCO acted upon identified issues as a result of the review of the data.

Overall, the MCOs demonstrated a commitment to providing quality and comprehensive health care to HealthChoice members. Although these CAPs were followed up on in CY 2012, opportunities still remain in the areas of utilization management and recredentialing.

### **Performance Improvement Projects**

Multiple recommendations were made to the MCOs as a result of the CY 2011 PIP review activities:

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

Although these recommendations were addressed by the MCOs in the CY 2012 PIPs, continued opportunities for improvements remain for MCOs to improve both qualitative and quantitative analyses of the study populations.

### **EPSDT Medical Record Review**

The result of the EPSDT review demonstrates strong compliance with the timely screening and preventive care requirements of the HealthChoice/EPSDT Program. The results of the CY 2011 demonstrated that improvements were needed in the following areas:

- Immunizations - this component showed a slight one percentage point decline.
- Laboratory Tests/At Risk Screenings - this component showed a three percentage point decline. Historically the Laboratory Tests/At Risk Screenings component score has represented an area in most

need of improvement. MCO specific recommendations for quality improvement continue to be shared with MCOs annually.

Two MCOs (PPMCO and UHC) required CAPs in CY 2011 for the Laboratory Tests/At Risk Screening component. Although these CAPs were followed up on in CY 2012, continued opportunities were seen in the area of Laboratory Tests/At Risk Screenings. Overall scores demonstrated that the Primary Care Physicians (PCPs) and MCOs are committed to providing care that is patient focused and prevention oriented.

### **Best and Emerging Practice Strategies**

The MCOs effectively addressed quality, timeliness and access to care issues in their respective managed care populations. The MCOs implemented the following best practice strategies:

- ACC provides clear, easily understandable, detailed explanations of the rationale for the determination in the adverse determination letters.
- ACC sponsors an ongoing Latino Forum to better understand the needs of its Spanish-speaking members which provides a venue for its Latino community partners to share issues, successes and challenges as well as offer opportunities and solutions for issues facing the Latino community. The quarterly meetings consists of community-based organizations, faith based organizations, schools and school-based programs and local health departments.
- DIA began using a new software program, Verisk Health, which is used to manage and predict potential fraud on a pre-payment basis in addition to programs currently being used to identify potential fraud on a post-payment basis.
- DIA keeps employees up-to-date on current fraud and abuse issues, the State Investigations Unit publishes a quarterly fraud, waste and abuse newsletter entitled The Sentinel that includes section on announcements, fraud in the news, and coding issues.
- JMS ensures that its PCPs serving members under the age of 21 are EPSDT certified by conducting an internal audit and developing a CAP for internal tracking. Any provider not EPSDT certified is not permitted to see members under the age of 21.
- JMS provides a very detailed description of any additional information needed for reconsideration in all adverse determination letters.
- JMS has a robust Health Education Plan as evidenced by the number and diversity of health education offerings and the high number of PCP referrals of its members for educational interventions. Classes/programs reflect the needs of the population based upon data analysis and provider recommendations.
- MPC includes language in all adverse determination letters documenting the rationale for the determination which is very clear and easy to understand for a layperson. Letters explain in detail the

reason for the determination, any authorization requirements, and any additional information needed for reconsideration.

- MPC consistently performed well above the State performance threshold for both determination and notification time frames.
- MPC completed an effective evaluation of its member mailings using a control and an experimental group.
- MSFC conducts extremely comprehensive annual evaluations of each delegated entity which are presented for committee review and approval.
- MSFC provides a very detailed, easily understandable explanation for the adverse determination as well as additional information needed for reconsideration.
- MSFC conducts outcome studies that clearly demonstrate the effectiveness of health education activities on utilization of services.
- PPMCO developed a unique method for evaluating and prioritizing clinical outcome measures for quality improvement planning. The new process will enable PPMCO to determine what HEDIS® and other quality measures have the greatest impact in cost reduction, Value Based Purchasing (VBP) incentives, member satisfaction and quality improvement using a statistically valid research methodology.
- PPMCO's Conceptual Model for a Substance Abuse (SA) Program is focused on categorizing and matching members with SA issues with the appropriate providers to maximize the likelihood of treatment success has the potential to become a best practice.
- UHC has a very engaged Provider Advisory Committee lead by the MCO's Chief Medical Officer. Meeting minutes reflect active provider discussion on operational issues that affect both members and providers.
- UHC targeted communities with high numbers of Hispanic members for Farmers' Market Nutrition Education events in response to its growing Hispanic population. Nutrition education was focused on local dietary preferences and recipe cards. Additionally, cooking demonstrations were provided in Spanish.

## Section I Systems Performance Review

### Introduction

As the EQRO, Delmarva Foundation performed an independent annual review of services provided under each MCO contract in order to ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program. COMAR 10.09.65 requires that all HealthChoice MCOs comply with the SPR standards and all applicable federal and state laws and regulations. This section describes the findings from the SPR for CY 2012, conducted in January and February of 2013. All seven MCOs were evaluated during this review period.

The SPRs were conducted at the MCO's corporate offices and performed by a review team consisting of health professionals, a nurse practitioner and two masters prepared reviewers. The team has a combined experience of more than 45 years in managed care and quality improvement systems, 33 years of which are specific to the HealthChoice program.

### Purpose

The purpose of the SPR is to provide an annual assessment of the structure, process, and outcome of each MCO's internal quality assurance programs. Through the systems review, the team is able to identify, validate, quantify, and monitor problem areas. The team completed the reviews and provided feedback to the Division of Health Choice Management and Quality Assurance (DHMQA) and each MCO with the goal of improving the care provided to HealthChoice enrollees.

### Methodology

For CY 2012, COMAR 10.09.65.03 required that all HealthChoice MCOs comply with the SPR standards established by the Department and all applicable federal and state laws and regulations. The performance standards used to assess the MCO's operational systems were developed from applicable Health General Statutes and COMAR, the CMS document, "A Health Care Quality Improvement System for Medicaid Managed Care", Public Health Code of Federal Regulations, and Departmental requirements. The HACA leadership and the DHMQA approved the MCO performance standards used in the CY 2012 review before application.

The following eleven performance standards were included in the CY 2012 review cycle:

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

For CY 2012, the MCOs were expected to meet the compliance rate of 100% for all standards. The MCOs were required to submit a CAP for any standard that did not meet the minimum compliance rate.

In September 2012, Delmarva Foundation provided the MCOs with a “Medicaid Managed Care Organization Systems Performance Review Orientation Manual” for Calendar Year 2012 and invited the MCOs to direct any questions or issues requiring clarification to specific Delmarva Foundation and DHMQA staff. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2012 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- Systems Performance Review Standards, including CY 2012 changes
- System Performance Standards and Guidelines

Prior to the onsite review, the MCOs were required to submit a completed pre-site survey form and provide documentation for various processes such as quality and utilization management, delegation, credentialing, enrollee rights, continuity of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Delmarva Foundation staff prior to the onsite visit.

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

During the onsite review, the team conducted interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion, exit conferences were held with the MCOs. The purpose of the conferences was to provide the MCOs with preliminary findings, based on interviews and all documentation reviewed. Notification was also provided during the exit conferences that the MCOs would receive a follow-up letter describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Delmarva Foundation; documents received were subsequently reviewed against the standard(s) to which they related.

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

<b>Met</b>	<b>100%</b>
<b>Partially Met</b>	<b>50%</b>
<b>Unmet</b>	<b>0%</b>

Each element or component of a standard was of equal weight. A CAP was required for each performance standard that did not meet the 100% minimum required compliance rate, as defined for the CY 2012 review.

If an MCO chooses to have standards in their policies and procedures that are higher than required by DHMH, the MCO will be held accountable to the standards which are outlined in their policies and procedures during the SPR.

The Department may change a reviewing finding to “Unmet” based on the fact that it has been found “Partially Met” for more than one consecutive year.

Preliminary results of the SPR were compiled and submitted to the DHMH for review. Upon the Department’s approval, the MCOs received a report containing its individual review findings. After receiving the preliminary reports, the MCOs were given 45 calendar days to respond to Delmarva Foundation with required CAPs. The MCOs could have also responded to any other issues contained in the report at its discretion within this same time frame, and/or requested a consultation with DHMH and Delmarva Foundation to clarify issues or ask for assistance in preparing a CAP.

## Corrective Action Plan Process

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

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

In the event that a CAP is deemed unacceptable, Delmarva Foundation provides technical assistance to the MCO until an acceptable CAP is submitted.

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

## Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2013 will determine whether the CAPs from the CY 2012 review were implemented and effective. In order to make this determination, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

## Findings

The HealthChoice MCO annual SPR consists of 11 standards. The compliance threshold established by DHMH for all standards for CY 2012 is 100%.

All seven HealthChoice MCOs participated in the SPR. In areas where deficiencies were noted, the MCOs were provided recommendations that if implemented, should improve their performance for future reviews. If the MCO's score was below the 100% threshold, a CAP was required. Two MCOs (MPC and MSFC) received perfect scores in all standards. Five MCOs (ACC, DIA, JMS, PPMCO, and UHC) were required to submit CAPs for CY 2012. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Table 2 provides for a comparison of SPR results across MCOs and the MD MCO Compliance for the CY 2012 review.

Table 2. CY 2012 MCO Compliance Rates

Standard	Description	Elements Reviewed CY 2012	MD MCO Compliance Rate CY 2012	ACC CY 2012	DIA CY 2012	JMS CY 2012	MPC CY 2012	MSFC CY 2012	PPMCO CY 2012	UHC CY 2012
1	Systematic Process	33	100%	100%	100%	100%	100%	100%	100%	100%
2	Governing Body	10	100%	100%	100%	100%	100%	100%	100%	100%
3	Oversight of Delegated Entities	7	93%*	100%	100%	100%	100%	100%	79%*	79%*
4	Credentialing	38	99%*	100%	100%	99%*	100%	100%	97%*	100%
5	Enrollee Rights	21	100%	100%	100%	100%	100%	100%	100%	100%
6	Availability and Access	10	100%	100%	100%	100%	100%	100%	100%	100%
7	Utilization Review	24	96%*	96%*	98%*	100%	100%	100%	89%*	91%*
8	Continuity of Care	4	100%	100%	100%	100%	100%	100%	100%	100%
9	Health Education Plan	12	99%*	100%	96%*	100%	100%	100%	100%	100%
10	Outreach Plan	14	100%	100%	100%	100%	100%	100%	100%	100%
11	Fraud and Abuse	19	99%*	100%	100%	100%	100%	100%	100%	97%*

\*Denotes that the minimum compliance rate of 100% was unmet.

The following section describes for each standard: the requirements assessed for the standard; the CY 2012 results for the standard, the MD MCO Compliance score for CY 2012, and opportunities for improvement, if applicable.

**STANDARD 1: Systematic Process of Quality Assessment/Improvement**

**Requirements:** The Quality Assurance Program (QAP) objectively and systematically monitors and evaluates the quality of care and services to enrollees. Through quality of care studies and related activities, the MCO pursues opportunities for improvement on an ongoing basis. The QAP studies monitor quality of care against clinical practice guidelines which are based on reasonable evidence based practices. The QAP must have written guidelines for its quality of care studies and related activities that require the analysis of clinical and related services. The QAP must include written procedures for taking appropriate corrective action whenever inappropriate or substandard services are furnished. The QAP must have written guidelines for the assessment of the corrective actions. The QAP incorporates written guidelines for evaluation of the

continuity and effectiveness of the QAP. A comprehensive annual written report on the QAP must be completed, reviewed, and approved by the MCO governing body. The QAP must contain an organizational chart that includes all positions required to facilitate the QAP.

**Findings:** Overall, MCOs continue to maintain comprehensive QAPs that appropriately monitor and evaluate the quality of care and service to members using meaningful and relevant performance measures. Clinical care standards and/or practice guidelines are in place which the MCOs monitor performance against annually, and clinicians monitor and evaluate quality through review of individual cases where there are questions about care. Additionally, there is evidence of development, implementation, and monitoring of corrective actions.

- The overall MD MCO Compliance Rate was 100% in CY 2012. No CAPs were required.

**STANDARD 2: Accountability to the Governing Body**

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

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

- The overall MD MCO Compliance Rate was 100% for CY 2012. No CAPs were required.

**STANDARD 3: Oversight of Delegated Entities**

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

being provided. The MCO must also provide evidence of continuous and ongoing evaluation of delegated activities.

**Findings:** MCOs continue to demonstrate opportunities for improvement in this standard regarding delegation policies and procedures and in the monitoring and evaluation of delegated functions.

- The overall MD MCO Compliance Rate was 93% for CY 2012. PPMCO and UHC were required to submit CAPs for validation.

**Opportunities for Improvement:**

PPMCO received a partially met finding because a revision to the Delegation policy was required regarding the frequency of Process Management Team review and approval of complaints, grievances, and appeals.

In order to meet this element in the CY 2013 review, PPMCO was required to revise its Delegation Policy to ensure that it is in compliance with committee review and approval of delegated complaint, grievance, and appeal reports on a quarterly basis.

PPMCO also received a partially met finding because there was no evidence of Process Management Team review and approval of Block Vision's annual UM Plan and UM criteria in 2012.

In order to meet this standard in the CY 2013 review, PPMCO was required to provide evidence of the appropriate committee's review and approval of all the annual utilization management plans and utilization management criteria for each entity that has been delegated utilization management.

UHC received a partially met finding because CAPs are not monitored by any of the MCO committees, included on the Open Issues Log, or discussed during monthly conference calls with the vendor.

In order to receive a finding of met in the CY 2013 review, UHC was required to provide evidence of ongoing monitoring of vendor CAPs specific to the MCO, with documentation to support progress and resolution or recommendation for termination.

UHC also received a partially met finding because the CAP that was required to be implemented from the CY 2011 review was not fully implemented, and continued opportunities for improvement existed regarding the review and approval of provider complaints and grievances by the appropriate designated committee.

In order to receive a finding of met in the CY 2013 review, UHC was required to complete the following:

- Clarify in the Delegation Manual which committee was responsible for review and approval of delegate quarterly complaints and grievance reports.
- Provide evidence that the appropriate committee reviewed and approved quarterly complaint and grievance reports on a quarterly basis.
- Clearly document committee review and approval of delegate reports to identify the time period being reviewed.

PPMCO and UHC were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions. The approved CAPs will be reviewed during the CY 2013 SPR.

**STANDARD 4: Credentialing and Recredentialing**

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

There must be evidence that recredentialing is performed at least every three years and includes a review of enrollee complaints, results of quality reviews, hospital privileges, current licensure, and office site compliance with Americans with Disabilities Act of 1990 (ADA) standards, if applicable.

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

- The overall MD MCO Compliance Rate was 99% for CY 2012. JMS and PPMCO were required to submit CAPs for validation.

**Opportunities for Improvement:**

JMS received a partially met finding because recredentialing time frames were not met in 15 of 30 records reviewed.

In order to receive a finding of met in the CY 2013 review, JMS was required to meet the time frames set forth in its policies regarding recredentialing decision date requirements.

PPMCO received a partially met finding because 7 of the 30 records reviewed did not meet the time frame for recredentialing within the 36-month time period. Additionally, this component received a partially met the year before.

In order to receive a finding of met in the CY 2013 review, PPMCO was required to meet the time frames set forth in the MCO's policies regarding recredentialing decision date requirements.

JMS and PPMCO were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions. The approved CAPs will be reviewed during the CY 2013 SPR.

**STANDARD 5: Enrollee Rights**

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

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

- The overall MD MCO Compliance Rate was 100% for CY 2012. No CAPs were required.

**STANDARD 6: Availability and Accessibility**

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

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

➤ The overall MD MCO Compliance Rate was 100% for CY 2012. No CAPs were required.

**STANDARD 7: Utilization Review**

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

**Findings:** Overall, MCOs have strong Utilization Management Plans that describe procedures to evaluate medical necessity criteria used, information sources, procedures for training and evaluating staff, monitoring of the timeliness and content of adverse determination notifications, and the processes used to review and approve the provision of medical services. The MCOs provided evidence that qualified medical personnel

supervise pre-authorization and concurrent review decisions. The MCOs have implemented mechanisms to detect over and under utilization of services. Overall, policies and procedures are in place for providers and enrollees to appeal decisions.

- The overall MD MCO Compliance Rate was 96% in CY 2012. ACC, DIA, PPMCO, and UHC were required to submit CAPs for validation.

**Opportunities for Improvement:**

ACC received a finding of partially met because continued opportunities for improvement exist in demonstrating compliance with State-required determination and notification time frames. In order to receive a finding of met in the CY 2013 review, ACC was required to demonstrate compliance with preauthorization determination and adverse determination notification time frames including the process for reporting compliance with notification time frames. Additionally, the Utilization Management Timeliness Audit Policy needed to be revised to incorporate the process for monitoring and reporting compliance with State-required notification time frames.

DIA received a finding of partially met because after a review of all four quarters' compliance with the 30-day turnaround time (TAT) for appeal decisions made within the State-required time frames, the reviewer found that the first quarter was out of compliance with 67%. This represented only one of four appeals that were resolved outside of the required time frame.

In order to receive a finding of met in the CY 2013 review, DIA was required to provide evidence of resolution of clinical member appeals within the State-required time frames on a consistent basis. However, DIA did not receive a follow-up review because they discontinued doing business with the State in September 2013.

PPMCO received a finding of partially met because the MCO had an inconsistency in two of their policies as it pertains to the responsibility for the development of internal criteria. In order to receive a finding of met in the CY 2013 review, PPMCO was required to resolve the inconsistency in the policies.

PPMCO received a finding of partially met because pharmacy compliance with required TAT was reported separately and did not meet the required time frames. There were no data reported for the percentage of determinations with insufficient clinical information that were completed after two business days or within seven calendar days. Additionally, the one-business-day notification requirement is inconsistent with the 24-hour time frame for emergency or 72 hours for non-emergency requests, as required by the State.

In order to receive a finding of met in the CY 2013 review, PPMCO was required to demonstrate compliance with determination and notification time frames for all preauthorization requests consistent with State regulation or MCO standards if the latter were more stringent than State regulation.

PPMCO received a finding of unmet because of inconsistencies in compliance with two of the required 13 adverse determination letter components were noted. Six of the 10 letters stated a time frame of 15 rather than 10 days of receiving an adverse action letter for requesting continuation of ongoing services during the appeal process. Another six of the 10 letters was missing a component requiring that the letter explain that receipt of the letter within five days of its date is assumed unless the recipient can show otherwise. Additionally, the letters did not include the option for the member to call the MCO if requesting a continuation of ongoing services; it only referenced the State Enrollee Help Line.

In order to receive a finding of met in the CY 2013 review, PPMCO was required to demonstrate that it consistently includes all 13 required components in all adverse determination letters.

UHC received a finding of partially met because the Utilization Management Work Plan's goal was inconsistent with State-required time frames for processing routine and expedited requests. State-required time frames were not met. Although this component was scored as baseline in CY 2011, UHC did not meet this component for the previous four years (2007, 2008, 2009, and 2010).

In order to receive a finding of met in the CY 2013 review, UHC was required to:

- Demonstrate compliance with the 95% threshold for meeting regulatory time frames for preauthorization determinations and for adverse determination notifications for any service requiring pre-authorization, regardless of which unit conducts the review
- Provide documentation to support how compliance is measured and evidence of corrective action when time frames are not met
- Meet minimum thresholds for compliance consistent with those established by the State

UHC received a finding of partially met because the required CAP from CY 2011 was not fully implemented and opportunities for improvement existed regarding demonstrating routing compliance with State-required time frames for appeal decisions. Additionally, the Utilization Management Work Plan's goal for processing of routine and expedited requests was inconsistent with the State-required time frame.

In order to receive a finding of met in the CY 2013 review, UHC was required to demonstrate compliance with the 100% threshold for meeting regulatory time frames for resolution of all expedited and routine appeals, including medical, SA, and pharmacy. Additionally, MCO minimum thresholds for compliance must be consistent with those established by the State.

ACC, DIA, PPMCO, and UHC were required to submit CAPs for the above elements/components.

Delmarva Foundation reviewed and approved the submissions. The approved CAPs will be reviewed during the CY 2013 SPR.

**STANDARD 8: Continuity of Care**

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

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

➤ The overall MD MCO Compliance Rate was 100% for CY 2012. No CAPs were required.

**STANDARD 9: Health Education Plan Review**

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

**Findings:** Overall, the MCOs were found to have comprehensive Health Education Plans which included policies and procedures for internal staff education, provider education and continuing education units, and enrollee health education.

- The overall MD MCO Compliance was 99% for CY 2012. DIA was required to submit a CAP for validation.

**Opportunities for Improvement:**

DIA received a finding of partially met because there was no evidence of a written methodology for conducting an annual evaluation of the Health Education Plan on process and/or outcome measures.

In order to receive a finding of met in the CY 2013 review, DIA was required to provide evidence of a written methodology for evaluation the impact of the Health Education Plan on process and/or outcome measures. Although it is acknowledged that multiple areas within the MCO deliver educational interventions focused on improving the health of the member, the scope of the evaluation should also include some health education specific activities/interventions.

DIA was required to submit a CAP for the above component. Delmarva Foundation reviewed and approved the submission. However, DIA did not receive a follow-up review because they discontinued doing business with the State in September 2013.

**STANDARD 10: Outreach Plan Review**

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

**Findings:** Overall, MCO's were found to have adequately described their populations served, an assessment of common health problems, and barriers to outreach within the MCO's membership. MCOs described the organizational capacity to provide both broad-based and enrollee specific outreach in the plan. The unique features of the MCO's enrollee education initiatives, community partnerships, and the roles of the provider networks and local health departments are also included in the Outreach Plan. Appropriate supporting evidence of the outreach activities was also provided.

- The overall MD MCO Compliance Rate was 100% for CY 2012. No CAPs were required.

**STANDARD 11: Fraud and Abuse**

**Requirements:** The MCO must maintain a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program must include guidelines for defining failure to comply with these standards. The MCO must maintain administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The MCO must maintain administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The MCO must maintain administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The MCO must utilize various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan.

**Findings:** Overall, the MCOs have strong compliance programs with internal policies and procedures that define failure to comply that are adherent to all Federal and State laws and regulations. The MCOs programs maintain administrative and management procedures for identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. MCOs also have programs and policies and procedures to train employees, subcontractors, and enrollees to detect and report fraud and abuse.

- The overall MD MCO Compliance Rate was 99% for CY 2012. UHC was required to submit a CAP for validation

**Opportunities for Improvement:**

UHC received a partially met for Element 11.4 because component (c) was partially met. The Compliance Committee did not review March Vision's compliance plan to prevent fraud and abuse for 2012. In order to receive a finding of met in the CY 2013 review, UHC was required to provide evidence of the Compliance Committee's review and approval of each delegate's administrative and management procures, including mandatory compliance plans to prevent fraud and abuse.

UHC was required to submit a CAP for the above component. Delmarva Foundation reviewed and approved the submission. The approved CAP will be reviewed during the CY 2013 SPR.

## **Conclusions**

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. The CY 2012 review provided evidence of the continuing progression of the HealthChoice MCOs as each MCO demonstrated their ability to ensure the delivery of quality health care for their enrollees.

Maryland has set high standards for MCO quality assurance systems. In general, HealthChoice MCOs continue to make improvements in their QA monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. This is evident in the comparison of annual SPR results demonstrated throughout the history of the HealthChoice Program.

## SECTION II Value Based Purchasing

### Introduction

DHMH began working with the Center for Health Care Strategies in 1999 to develop a Value Based Purchasing Initiative (VBPI) for HealthChoice, Maryland's Medicaid managed care program. VBP improves quality by awarding business and incentives to contractors based on their performance along a range of dimensions. The goal of Maryland's purchasing strategy is to achieve better enrollee health through improved MCO performance. Appropriate service delivery is promoted by aligning MCO incentives with the provision of high-quality care, increased access, and administrative efficiency. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice. In addition, the state's strategy meets the requirements of the Balanced Budget Act of 1997 (BBA).

Delmarva Foundation and HealthcareData Company, LLC (HDC), a National Committee for Quality Assurance (NCQA)-Licensed Organization, were contracted by DHMH to perform a validation of the CY 2012 VBP measurement data. Validation is the process by which an independent entity evaluates the accuracy of reported performance measure data by or on behalf of, another entity and determines the extent to which specific performance measures calculated by an entity (or one acting on behalf of another) followed established calculation specifications. A validation (or audit) determination is assigned to each measure, indicating whether the measure and its result is fully compliant, substantially compliant, or not valid. DHMH contracted with HDC to perform the validation of HEDIS® measures for the HealthChoice MCOs. HDC performed the validation of the HEDIS®-based VBP measurement data for all seven of the HealthChoice MCOs using the NCQA's *HEDIS® Volume 5: HEDIS® Compliance Audit: Standards, Policies, and Procedures*.

### Performance Measure Selection Process

DHMH solicits input from stakeholders, including MCOs and the Maryland Medicaid Advisory Committee. Together, they identified legislative priorities in selecting the performance measures. Measures may be added or removed, based upon evolving DHMH priorities and enrollee health care needs.

The measures address several aspects of plan performance which fall into one of the following three categories:

- Access to Care: The ability of patients to get access to needed services.
- Quality of Care: The ability to deliver services to improve health outcomes.
- Timeliness of Care: The ability of patients to get needed services in a timely manner.

DHMH selects measures that are:

- 1) relevant to the core populations served by HealthChoice, including children, pregnant women, special needs children, adults with disabilities, and adults with chronic conditions;
- 2) prevention-oriented and associated with improved outcomes;
- 3) measurable with available data;
- 4) comparable to national performance measures for benchmarking;
- 5) consistent with how CMS is developing a national set of performance measures for Medicaid MCOs; and
- 6) possible for MCOs to affect change.

### Value Based Purchasing Validation

Several sources of measures (Table 3) are included in the CY 2012 VBP program. They are chosen from NCQA’s HEDIS® data set, encounter data, and data supplied by the HealthChoice MCOs, and subsequently validated by Delmarva Foundation. The measure type and the presence of an existing audit or validation process determined the validation activities undertaken.

Table 3. CY 2012 VBP Measures

Performance Measure	HEDIS® Domain	Measure	Reporting Entity
Adolescent Well Care	Use of Services	HEDIS®	MCO
Ambulatory Care Services for SSI Adults Ages 21-64	Access to Care	Encounter Data	DHMH
Ambulatory Care Services for SSI Children Ages 0-20	Access to Care	Encounter Data	DHMH
Cervical Cancer Screening for Women Ages 21–64	Effectiveness of Care	HEDIS®	MCO
Childhood Immunization Status (Combo 3)	Effectiveness of Care	HEDIS®	MCO
Eye Exams for Diabetics Ages 18-75	Effectiveness of Care	HEDIS®	MCO
Lead Screenings for Children Ages 12–23 Months	Effectiveness of Care	Encounter , Lead Registry, & Fee For Service Data	DHMH
Postpartum Care	Access to Care	HEDIS®	MCO
Appropriate Meds for Asthma (Comb.)	Effectiveness of Care	HEDIS®	MCO
Well Child Visits for Children Ages 3–6	Use of Services	HEDIS®	MCO

## HEDIS® Measure Validation

HealthChoice MCOs are required to produce and report audited HEDIS® data under COMAR 10.09.65.03.B(2). Seven of the CY 2012 VBP measures are HEDIS® measures and are validated under the provisions of the HEDIS® Compliance Audit. The goal of the HEDIS® audit is to ensure accurate, reliable, and publicly reportable data.

HDC completed the HEDIS® audits in three phases: offsite, onsite, and post onsite (reporting). The offsite audit phase includes a review of each MCO’s HEDIS® Roadmap. The Roadmap is used to supply information about an MCO’s data systems and HEDIS® data reporting structure and processes. Other activities of the offsite audit process include the selection of HEDIS® measures to audit in detail (results are then extrapolated to the rest of the HEDIS® measures), investigation of measure rotation strategies, and validation of the medical record review process by the certified audit firm.

Prior to the onsite phase, HDC holds annual auditor conference calls with all MCOs for the purpose of addressing any NCQA changes or updates to the audit guidelines. HDC also responds to each MCO’s questions.

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

The post onsite and reporting phase of the HEDIS® Compliance Audit includes the issuance of a follow-up letter to the MCO that lists any items the auditors still require to complete the audit, a list of corrective actions for problems found in the roadmap or onsite as well as the necessary completion dates, and preliminary audit findings specifically indicating the measures at risk for a *Not Report* designation. When the MCO has provided all requested documents and performed the recommended corrective actions, the auditor completes a final audit report and assigns audit designations indicating the suitability of measures for public reporting. The four possible audit designations are explained in Table 4. The final activity of the post onsite phase of the audit consists of the MCO submitting data to NCQA, using NCQA’s Interactive Data Submission System (IDSS).

**Table 4. HEDIS® Compliance Audit Designations**

Audit Findings	Description	Rate/Result
Reportable rate or numeric result for HEDIS® measures.	Reportable Measure	0-XXX
The MCO followed the specifications but the denominator was too small to report a valid rate.	Denominator <30.	NA
The MCO did not offer the health benefits required by the measure (e.g., specialty mental health).	No Benefit	NB
The MCO calculated the measure but the rate was materially biased, or The MCO was not required to report the measure.	Not Reportable	NR

In order to avoid duplicating efforts and placing undue administrative burden on the HealthChoice MCOs, DHMH used seven of the HEDIS® audit measure determinations as VBP measure determinations. The HEDIS® measures in the VBP program are:

- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well Care
- Childhood Immunization Status (Combo 3)
- Cervical Cancer Screening
- Postpartum Care
- Use of Appropriate Medications for People With Asthma
- Comprehensive Diabetes Care (eye exam indicator only)

### EQRO’s Data Measure Validation

Three CY 2012 VBP measures were calculated by DHMH, using encounter data submitted by the MCOs for January 1 – December 31, 2011, Maryland Department of the Environment’s Lead Registry data, and Fee-for-Service data. The measures calculated utilizing encounter data are:

- Ambulatory Care Services for SSI Adults
- Ambulatory Care Services for SSI Children
- Lead Screenings for Children Ages 12–23 Months

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

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

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

Validation Determination	Definition
Fully Compliant (FC)	Measure was fully compliant with State specifications and reportable.
Substantially Compliant (SC)	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid (NV)	Measure deviated from state specifications such that the reported rate was significantly biased. This designation is also assigned to measures where no rate was reported, although reporting of the rate was required.
Not Applicable (NA)	Measure was not reported because the entity did not have any Medicaid enrollees that qualified for the denominator.

## Validation Results

Validation of the methodologies, criteria, and processes employed in creating the VBP measures results in a determination of the effect of bias on the resulting statistic. Validation determinations by HDC are reported using the audit designations and rationales outlined by NCQA as part of the HEDIS® Compliance Audit.

All of the VBP measures audited by HDC were determined to be reportable for all MCOs.

Table 6 shows the results of the EQRO-led validation activities related to the VBP measures. DHMH was responsible for producing these VBP measures at the MCO level and working with the EQRO to validate the measurement data. During the validation process undertaken by Delmarva Foundation, no issues were identified that could have introduced bias to the resulting statistics.

**Table 6. EQRO VBP Measure Validation Determinations**

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

## **CY 2012 VBP Incentive/Disincentive Target Setting Methodology**

The Hilltop Institute of University of Maryland Baltimore County (Hilltop) developed a target setting methodology at the request of DHMH for VBP.

The incentive target is calculated as follows:

- Determine the mean of the highest score for the measure in CY 2010 and the overall average of all MCOs
- Add 15 percent of the difference between the new mean determined above and 100 percent

The disincentive target is calculated as follows:

- Determine the mean of the highest score for the measure in CY 2010 and the overall average of all MCOs
- Subtract 15 percent of the difference between the new mean determined above and 100 percent

The neutral range includes all scores following between the incentive and disincentive targets.

Table 7 shows the CY 2012 VBP measures and their targets.

Table 7. CY 2012 VBP Measures

Performance Measure	Data Source	2012 Target
<p><b>Adolescent Well Care:</b> % of adolescents ages 12-21 (enrolled 320 or more days) receiving at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year</p>	HEDIS®	<p>Incentive: ≥ 76% Neutral: 68%–75% Disincentive: ≤ 67%</p>
<p><b>Ambulatory Care Services for SSI Adults Ages 21–64 Years:</b> % of SSI adults (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year</p>	Encounter Data	<p>Incentive: ≥ 86% Neutral: 82%–85% Disincentive: ≤ 81%</p>
<p><b>Ambulatory Care Services for SSI Children Ages 0–20 Years:</b> % of SSI children (enrolled 320 or more days) receiving at least one ambulatory care service during the measurement year</p>	Encounter Data	<p>Incentive: ≥ 83% Neutral: 78%–82% Disincentive: ≤ 77%</p>
<p><b>Cervical Cancer Screening for Women Ages 21–64 Years:</b> % of women ages 21–64 (continuously enrolled during reporting year) receiving at least one PAP test during the last 3 years, consistent with U.S. Preventive Services Task Force recommendations</p>	HEDIS®	<p>Incentive: ≥ 80% Neutral: 74%–79% Disincentive: ≤ 73%</p>
<p><b>Childhood Immunization Status (Combo 3):</b> % of children who turned 2 years old during the measurement year who were continuously enrolled for 12 months immediately preceding their second birthday and who had 4 DTaP, 3 IPV, 1 MMR, 2 H influenza type B, 3 hepatitis B, 1 chicken pox vaccine (VZV), and pneumococcal conjugate by the time period specified and by the child's second birthday</p>	HEDIS®	<p>Incentive: ≥ 84% Neutral: 79%–83% Disincentive: ≤ 78%</p>
<p><b>Eye Exams for Diabetics:</b> % of diabetics ages 18-75 (continuously enrolled during measurement year) receiving a retinal or dilated eye exam during the measurement year, consistent with American Diabetes Association recommendations</p>	HEDIS®	<p>Incentive: ≥ 78% Neutral: 71%–77% Disincentive: ≤ 70%</p>
<p><b>Lead Screenings for Children Ages 12–23 Months:</b> % of children ages 12–23 months (enrolled 90 or more days) who receive a lead test during the current or prior calendar year</p>	Lead Registry, Encounter & Fee for Service Data	<p>Incentive: ≥ 68% Neutral: 58%–67% Disincentive: ≤ 57%</p>
<p><b>Postpartum Care:</b> % of deliveries that had a postpartum visit on or between 21 and 56 days after delivery</p>	HEDIS®	<p>Incentive: ≥ 78% Neutral: 72%–77% Disincentive: ≤ 71%</p>
<p><b>Use of Appropriate Meds for Asthma:</b> % of members 5–50 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year</p>	HEDIS®	<p>Incentive: ≥ 93% Neutral: 92% Disincentive: ≤ 91%</p>
<p><b>Well-Child Visits for Children Ages 3 – 6 Years:</b> % of children ages 3–6 (enrolled 320 or more days) receiving at least one well-child visit during the measurement year, consistent with American Academy of Pediatrics &amp; EPSDT recommended number of visits</p>	HEDIS®	<p>Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%</p>

## 2012 Value Based Purchasing Results

The CY 2012 performance results presented in Table 8 were validated by Delmarva Foundation and DHMH's contracted HEDIS® Compliance Audit™ firm, HDC. The contractors determined the validity and the accuracy of the performance measure results. All measures were calculated in a manner that did not introduce bias, allowing the results to be used for public reporting and the VBP program. In CY 2012, there were seven HealthChoice MCOs:

- AMERIGROUP Community Care (ACC)
- Diamond Plan from Coventry Health Care, Inc. (DIA)
- Jai Medical Systems (JMS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare (UHC)

**Table 8. MCO CY 2012 VBP Performance Summary**

Performance Measure	CY 2012 Target	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
		Incentive (I); Neutral (N); Disincentive (D)						
Adolescent Well Care	Incentive: ≥ 76% Neutral: 68%–75% Disincentive: ≤ 67%	68% (N)	56% (D)	77% (I)	60% (D)	69% (N)	68% (N)	60% (D)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 86% Neutral: 82%–85% Disincentive: ≤ 81%	80% (D)	74% (D)	86% (I)	83% (N)	81% (D)	84% (N)	81% (D)
Ambulatory Care Services for SSI Children	Incentive: ≥ 83% Neutral: 78%–82% Disincentive: ≤ 77%	79% (N)	75% (D)	85% (I)	79% (N)	81% (N)	83% (I)	76% (D)
Cervical Cancer Screening for Women Ages 21–64	Incentive: ≥ 80% Neutral: 74%–79% Disincentive: ≤ 73%	74% (N)	72% (D)	81% (I)	74% (N)	71% (D)	75% (N)	70% (D)
Childhood Immunization Status—Combo 3	Incentive: ≥ 84% Neutral: 79%–83% Disincentive: ≤ 78%	84% (I)	68% (D)	84% (I)	74% (D)	84% (I)	84% (I)	67% (D)
Eye Exams for Diabetics Ages 18-75	Incentive: ≥ 78% Neutral: 71%–77% Disincentive: ≤ 70%	69% (D)	65% (D)	80% (I)	65% (D)	73% (N)	78% (I)	58% (D)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 68% Neutral: 58%–67% Disincentive: ≤ 57%	61% (N)	52% (D)	75% (I)	56% (D)	62% (N)	59% (N)	51% (D)
Postpartum Care	Incentive: ≥ 78% Neutral: 72%–77% Disincentive: ≤ 71%	72% (N)	59% (D)	84% (I)	68% (D)	74% (N)	73% (N)	60% (D)
Use of Appropriate Meds for Asthma	Incentive: ≥ 93% Neutral: 92% Disincentive: ≤ 91%	87% (D)	88% (D)	93% (I)	89% (D)	89% (D)	89% (D)	94% (I)
Well-Child Visits for Children Ages 3–6	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	84% (N)	72% (D)	88% (I)	88% (I)	80% (D)	81% (D)	84% (N)

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## 2012 VBP Financial Incentive and Disincentive Methodology

As described in COMAR 10.09.65.03, DHMH uses financial incentives and disincentives to promote performance improvement. There are three levels of performance for all measures: incentive, neutral and disincentive. Financial incentives are earned when performance meets or exceeds the incentive target for a measure. Conversely, disincentives are assessed when performance is at or below the minimum target. All measures are evaluated separately and are of equal weight in the methodology. For any measure that the MCO does not meet the minimum target, a disincentive of 1/10 of 1 percent of the total capitation amount paid to the MCO during the measurement year shall be collected. For any measure that the MCO meets or exceeds the incentive target, the MCO shall be paid an incentive payment of up to 1/10 of 1 percent of the total capitation amount paid to the MCO during the measurement year. The amounts are calculated for each measure and the total incentive payments made to the MCOs each year may not exceed the total amount of disincentives collected from the MCOs in the same year plus any additional funds allocated by the DHMH for a quality initiative. MCOs' CY 2012 performance is shown in Table 9.

**Table 9. MCO CY 2012 VBP Incentive/Disincentive Amounts**

Performance Measure	MCO						
	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Adolescent Well Care	\$0	(\$52,989.46)	\$86,499.50	(\$677,900.71)	\$0	\$0	(\$545,102.82)
Ambulatory Care Services for SSI Adults	(\$658,530.83)	(\$52,989.46)	\$86,499.50	\$0	(\$115,485.82)	\$0	(\$545,102.82)
Ambulatory Care Services for SSI Children	\$0	(\$52,989.46)	\$86,499.50	\$0	\$0	\$875,279.40	(\$545,102.82)
Cervical Cancer Screening for Women Ages 21-64	\$0	(\$52,989.46)	\$86,499.50	\$0	(\$115,485.82)	\$0	(\$545,102.82)
Childhood Immunization Status—Combo 3	\$658,530.83	(\$52,989.46)	\$86,499.50	(\$677,900.71)	\$115,485.82	\$875,279.40	(\$545,102.82)
Eye Exams for Diabetics Ages 18-75	(\$658,530.83)	(\$52,989.46)	\$86,499.50	(\$677,900.71)	\$0	\$875,279.40	(\$545,102.82)
Lead Screenings for Children Ages 12-23 Months	\$0	(\$52,989.46)	\$86,499.50	(\$677,900.71)	\$0	\$0	(\$545,102.82)
Postpartum Care	\$0	(\$52,989.46)	\$86,499.50	(\$677,900.71)	\$0	\$0	(\$545,102.82)
Use of Appropriate Meds for Asthma	(\$658,530.83)	(\$52,989.46)	\$86,499.50	(\$677,900.71)	(\$115,485.82)	(\$875,279.40)	\$545,102.82
Well-Child Visits for Children Ages 3-6	\$0	(\$52,989.46)	\$86,499.50	\$677,900.71	(\$115,485.82)	(\$875,279.40)	\$0
<b>Total Incentive/Disincentive Amount</b>	<b>(\$1,317,061.66)</b>	<b>(\$529,894.60)</b>	<b>\$864,995.00</b>	<b>(\$3,389,503.55)</b>	<b>(\$346,457.46)</b>	<b>\$875,279.40</b>	<b>(\$3,815,719.74)</b>

## Conclusion

The HealthChoice VBP program emphasizes continuous quality improvement and evidence-based medicine, making it consistent with trends in the larger health care market. The program increases the comparability of Maryland's performance to that of other states, enabling the sharing of best practices. In addition, performance evaluation based on administrative and encounter data rather than on the review of a small sample of medical records means that the quality indicators are representative of more enrollees.

In future years, measures may be added, removed, or rotated. This flexibility allows DHMH to meet the changing needs and priorities of its population. In years when DHMH is unable to provide monetary incentives, other methods of providing incentives, such as offsetting disincentives or reducing administrative burdens, will be explored.

## SECTION III Performance Improvement Projects

### Introduction

COMAR 10.09.65.03 requires that all HealthChoice MCOs conduct PIPs that focus on clinical or nonclinical areas. As the EQRO, Delmarva Foundation is responsible for evaluating the two PIPs from each of the HealthChoice MCOs according to CMS' *External Quality Review Protocol 3: Validating Performance Improvement Projects*. The PIPs are designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care or non-clinical care areas that are expected to have a favorable effect on health outcomes. The PIPs include measurements of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of activities for increasing or sustaining improvement.

In addition to improving the quality, access, or timeliness of service delivery, the process of completing a PIP functions as a learning opportunity for the MCO. The processes and skills required in PIPs, such as indicator development, root cause analysis, and intervention development, are transferable to other projects that can lead to improvement in other health areas.

As designated by DHMH, the MCOs continued the Substance Abuse PIPs and the Adolescent Well Care PIPs CY 2013. Six MCOs submitted PIPs in September 2013, which included CY 2012 data and results. The Diamond Plan from Coventry Health Care, Inc. concluded their business with the HealthChoice Program in September 2013 and did not submit PIPs.

### Topics Selected

DHMH initiated the Substance Abuse PIP in March 2009 using HEDIS® 2009 measurement rates as the baseline measurement for MCOs in developing interventions due in fall 2009. The measure seeks to increase the timeliness of treatment initiation following a new episode of identified dependency, and continued engagement in treatment. According to a study completed in 2007 by Maryland's Alcohol and Drug Abuse Administration, persons remaining in treatment for 90 or more days resulted in lower drug use upon discharge from treatment. When longevity increased to at least 180 days, the use of drugs following discharge fell more than 50%. Therefore, the Department aimed at building upon those statistics through this project.

DHMH initiated the Adolescent Well Care PIP in March 2012 using HEDIS® 2012 measurement rates as the baseline measurement for MCOs in developing interventions due in fall 2012. The measure seeks to increase the percentage of adolescents 12-21 years of age in receiving at least one comprehensive well-care visit with a

PCP or OB/GYN practitioner during the measurement year. Maryland's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review program measures health and developmental history; comprehensive physical exam; laboratory tests/at risk screening; immunizations; and health education and anticipatory guidance for children and adolescents through age 20. The EPSDT 12-20 year age group consistently scores lower than the other four age groups in each of these categories. In addition, the underutilization of an adolescent well-care visit yields missed opportunities for prevention, early detection, and treatment; therefore, increasing routine adolescent utilization is an important health care objective for the Department.

Delmarva Foundation was responsible for providing technical assistance, validation of results, education, and oversight of the MCOs' PIPs. All PIP submissions were made using an approved project submission tool.

### Methodology

The guidelines utilized for PIP review activities were CMS' *External Quality Review Protocol 3: Validating Performance Improvement Projects (PIPs)*. The protocol assists in evaluating whether or not the PIP was designed, conducted, and reported in a sound manner and the degree of confidence a state agency could have in the reported results.

Each MCO was required to provide the study framework and project description for each PIP. This information was reviewed to ensure that each MCO was using relevant and valid study techniques. The MCOs were required to provide annual PIP submissions in September 2013. The submissions included results of measurement activities, a status report of intervention implementations, analysis of the measurement results using the defined data analysis plan, as well as information concerning any modifications to (or removal of) intervention strategies that may not be yielding anticipated improvement. If an MCO decided to modify other portions of the project, updates to the submissions were permitted in consultation with Delmarva Foundation and the Department.

Reviewers evaluated each project submitted using a standard validation tool that employed the CMS validation methodology, which included assessing each project in the following ten critical areas:

- Step 1: Review of the selected study topics.
- Step 2: Review of the study questions.
- Step 3: Review of the selected study indicator(s).
- Step 4: Review of the identified study population.
- Step 5: Review of sampling methods.

- Step 6: Review of the MCO’s data collection procedures.
- Step 7: Assessment of the MCO’s improvement strategies.
- Step 8: Review of data analysis and interpretation of study results.
- Step 9: Assessment of the likelihood that reported improvement is *real* improvement.
- Step 10: Assessment of whether the MCO has *sustained* its documented improvement.

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

Table 10 describes the criteria for reaching a determination in the scoring methodology.

**Table 10. Rating Scale for PIP Validation**

Determination	Criteria
Met	All required components were present.
Partially Met	One but not all components were present.
Unmet	None of the required components were present.
Not Applicable	None of the required components are applicable.

## Findings

This section presents an overview of the findings from the validation activities completed for each PIP submitted by the MCOs. Each MCO’s PIP was reviewed against all components contained within the 10 steps.

### Substance Abuse PIPs

All Substance Abuse PIPs focused on increasing the number of individuals who initiated alcohol and other drug dependence treatment, along with increasing the number of individuals who engaged in alcohol and other drug dependence treatment, according to HEDIS® technical specifications.

Table 11 represents the PIP Validation Results for all Substance Abuse PIPs for CY 2012.

Table 11. Substance Abuse PIP Validation Results for CY 2012

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

In 2013, all Substance Abuse PIPs received a rating of “Not Applicable” for Step 5 (Review Sampling Methods) because sampling was not utilized. The entire eligible population was used for this study.

A rating of “Partially Met” was received by all MCOs for Step 9 (Assess Whether Improvement Is Real Improvement) because there was no documented improvement noted for either indicator of the PIP. Measurement rates for both indicators decreased during this remeasurement year.

A rating of “Unmet” was received by six of the seven MCOs for Step 10 (Assess Sustained Improvement) because there was no sustained improvement demonstrated through repeated remeasurements over comparable time periods. UHC received a “Partially Met” for Step 10, as the MCO was able to demonstrate sustained improvement for one of the two indicators through repeated remeasurements over comparable time periods. Therefore, UHC was able to maintain a higher measurement rate over their baseline measurement throughout the life of the project for one of the measures.

The following are examples of interventions which were implemented by the HealthChoice MCOs for the Substance Abuse PIPs:

- Provider, member, and MCO staff education
- ER Diversion Project
- Patient Centered Medical Home implementation
- Revised SA provider contracts and SA provider visits
- MCO representation at DHMH Stakeholder Meetings
- Collaboration with the behavioral health (BH) provider for better continuity of care for members

- BH and Pharmacy providers identify pregnant members on Suboxone or Methadone to engage members in group or individual counseling
- HEDIS® data review to ensure data accuracy
- Implement and expand use of social media
- Coordination of care with PCP Initiative implemented
- Provider Relations pursuing additional provider contracts for SA in underserved areas
- Initiated a Follow-Up After Hospitalization Best Practices Workgroup focused on improving follow up after hospitalization
- Gold Card Suboxone Prescribers - reevaluated the need to increase access to Suboxone at initial visits, increasing access to prescribers and medication during initiation and requesting engagement visits
- Create contract with Chesapeake Regional Information System for our Patients (CRISP) to receive information regarding SA related ER visits within a day of the incident
- Implemented a written feedback system from the SA Coordinator to the Utilization Review nurses with updates regarding members beginning and/or ongoing SA treatment
- Perform in-depth analysis on members failing the HEDIS® measure to see if they are in SA treatment
- Addition of SA Consultant/ Medical Director to perform peer to peer discussions with providers
- Instituted prior authorization requirement for use of Suboxone
- Daily and weekly reports provided to outreach of members admitted to ER with SA diagnosis
- A pilot was developed for a behavioral health and PCP collaborative
- Partners for Moms Johns Hopkins Health Care (JHHC) Case Management Program coordinates referrals to the Centers of Addictions for Pregnancy Program
- Substance use screening tool is posted on the web as a reference for physicians
- Added HEDIS® Subject Matter Expert to clinical material review committee process

### **Adolescent Well Care PIPs**

All Adolescent Well Care PIPs focused on increasing the number of adolescents ages 12-21 who receive at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, according to HEDIS® technical specifications.

Table 12 represents the PIP Validation Results for all Adolescent Well Care PIPs.

Table 12. Adolescent Well Care PIP Validation Results

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

In 2013, JMS received a rating of “Not Applicable” for Step 5 (Review Sampling Methods) because sampling was not utilized. JMS’s entire eligible population was used for this study.

Additionally, a rating of “Not Applicable” was received for all MCOs for Steps 9 and 10 as this was a baseline year of data collection, and neither real improvement nor sustained improvement could be assessed.

Three MCOs received a rating of “Partially Met” For Step 7 (Assess Improvement Strategies). JMS and MPC received this rating because only one new system level intervention was implemented in this calendar year. In order to receive a met, more than one system level intervention is required to be implemented. PPMCO received this rating because the interventions that were implemented did not appear to address the member, provider, or MCO barriers identified in its barrier analysis.

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

- Nurse Medical Record Reviews to confirm that well child visits did not occur for non compliant members
- Provider visits to top 20 high volume PCPs to share non compliance member reports
- Home visits offered to SSI population

- Onsite appointment scheduling
- Birthday card reminders sent to members
- Wellness letter sent to members
- Automated telephone call reminders to non compliant members
- Member incentives
- Provider pay for performance program/provider incentives
- School based clinic collaboration
- Back to school flyers
- Hiring of outreach representative
- Piloting use of Facebook to communicate need for Adolescent Well Care (AWC) visits
- Offer pediatric health fairs, with entertainment, games, food, and gifts at pediatric offices
- Provider focus groups

### Substance Abuse Indicator Results

CY 2012 is the third and final remeasurement year for the Substance Abuse PIP. Tables 13 and 14 represent the Substance Abuse PIP indicator rates for all MCOs for each measurement year of the PIP.

**Table 13. Substance Abuse PIP Indicator 1 Rates**

Measurement Year	Indicator 1: Initiation of Alcohol and Other Drug Dependence Treatment					
	ACC	JMS	MPC	MSFC	PPMCO	UHC
Baseline Year 1/1/09 - 12/31/09	49.38%	44.39%	44.68%	35.60%	46.82%	49.75%
Measurement Year 1 1/1/10 - 12/31/10	50.94%	48.84%	50.61%	32.21%	48.61%	50.30%
Remeasurement Year 2 1/1/11 - 12/31/11	46.43%	46.48%	47.93%	35.49%	43.38%	47.60%
Remeasurement Year 3 1/1/12 - 12/31/12	41.87%	36.75%	43.03%	27.36%	36.46%	47.32%

All MCO's indicator rates declined for indicator one over baseline measurement. The average decline in rates across all MCOs for the HEDIS® Initiation of Alcohol and Other Drug Dependence Treatment measure was 5.55 percentage points. However, it should be noted that the measure rate for the HEDIS® Medicaid 90th Percentile for this indicator declined 9.07 percentage points from 2010 to 2013 as well.

**Table 14. Substance Abuse PIP Indicator 2 Rates**

Measurement Year	Indicator 2: Engagement of Alcohol and Other Drug Dependence Treatment					
	ACC	JMS	MPC	MSFC	PPMCO	UHC
Baseline Year 1/1/09 - 12/31/09	21.42%	15.98%	12.70%	7.20%	17.93%	10.78%
Measurement Year 1 1/1/10 - 12/31/10	25.27%	22.05%	25.89%	10.27%	23.61%	15.99%
Remeasurement Year 2 1/1/11 - 12/31/11	21.55%	19.41%	24.95%	8.43%	19.92%	18.75%
Remeasurement Year 3 1/1/12 - 12/31/12	19.71%	15.41%	21.02%	5.28%	17.63%	18.46%

MPC and UHC's indicator rates increased for indicator two over baseline measurement. The average increase across all MCOs for the HEDIS® Engagement of Alcohol and Other Drug Dependence Treatment measure was 1.47 percentage points. This increase is due to the fact that MPC and UHC saw large increases in rates (8.32 and 7.68 percentage points over baselines, respectively). However, it should be noted that the measure rate for the HEDIS® Medicaid 90th Percentile for this indicator declined 1.58 percentage points from 2010 to 2013 as well.

### **Substance Abuse PIP Barriers**

The inability to sustain improvement in rates for the Substance Abuse PIP may be due to how substance abuse treatment is provided and billed in Maryland. The behavioral health system in Maryland operates separately from medical health, meaning that while members were being seen for SA treatment, the services were being billed through the behavioral health system and not through the members' MCO. Also, members in the Maryland Medicaid program can receive substance abuse treatment from providers who may not be in the Medicaid network, as a result of Maryland permitting member self-referrals. These discrepancies are not accounted for in HEDIS® and have caused MCO claims data for members who may have received treatment within the correct time frame to fail to meet the measure specifications.

Specific systems issues reported by the MCOs that impacted the indicator rates for the Substance Abuse PIP include but are not limited to:

- Members on buprenorphine who are receiving the proper treatment in the correct time frame and still failing the measure because the mental health provider is billing ValueOptions instead of the MCO.
- Substance Abuse coordinator is aware that the members are receiving treatment, but there is no way to get the information into the billing system to pass the members based on the HEDIS® specifications.
- Some Substance Abuse providers do not file claims because they are working with grants. This leads to incomplete information in the database used to identify member's conditions and used to calculate the HEDIS® score used as the measurement for this project.
- Some members are being seen by medical practitioners who may be reluctant to bill Substance Abuse codes for fear that they will not get paid.
- Some members are paying cash for visits to the office but are filling buprenorphine through the pharmacy benefit. These encounters would not qualify for the HEDIS® measure because they would not be in the system.

Please also refer to the SA Project Summaries (Appendix A3-1) for specific barriers and interventions identified by each MCO.

### **Adolescent Well Care Indicator Results**

This is a baseline year measurement for the Adolescent Well Care PIP. Table 15 represents the indicator rates for all MCOs for the PIP.

Table 15. Adolescent Well Care PIP

Measurement Year	Indicator 1: Adolescent Well Care					
	ACC	JMS	MPC	MSFC	PPMCO	UHC
Baseline Year 1/1/11-12/31/11	68.06%	76.85%	60.20%	69.40%	67.59%	59.71%
Measurement Year 1 1/1/12-12/31/12	N/A	N/A	N/A	N/A	N/A	N/A
Remeasurement Year 2 1/1/13-12/31/13	N/A	N/A	N/A	N/A	N/A	N/A
Remeasurement Year 3 1/1/14-12/31/14	N/A	N/A	N/A	N/A	N/A	N/A

The rate for the 2011 HEDIS® Medicaid 90th Percentile measure for Adolescent Well Care was 64.72%. MPC and UHC are performing below the 90th percentile, and the remaining four MCOs are performing above the 90th percentile.

## Recommendations

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

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

## Section IV Encounter Data Validation

### Introduction

The Medicaid Managed Care Provisions of the BBA directed the U.S. Department of Health and Human Services to develop protocols to serve as guidelines for conducting EQRO activities. In 1995, CMS began developing a series of tools to help State Medicaid agencies collect, validate, and use encounter data for managed care program management and oversight. Among the functions that Delmarva Foundation performs as EQRO for the Maryland HealthChoice Program is the medical record review component for encounter data validation (EDV). Delmarva Foundation completes encounter data validation according to CMS' EQR Protocol 4: Validation of Encounter Data Reported by the MCO. The Department required all HealthChoice MCOs to submit CY 2012 encounter data by June 2013.

### Encounter Data Validation Process

The CMS approach to EDV<sup>1</sup> includes the following three core activities:

- Assessment of MCO information system (IS).
- Analysis of MCO electronic encounter data for accuracy and completeness.
- Review of medical records for additional confirmation of findings.

The EDV protocol also makes the following assumptions:

- An encounter refers to the electronic record of a service provided to an MCO enrollee by both institutional and non-institutional providers.
- The State specifies the types of encounters (e.g., physician, hospital, dental, vision, laboratory) for which encounter data are to be provided. In addition, the type of data selected for review (e.g., inpatient, outpatient, office visits) is directly proportionate to the total percent of encounter types per calendar year.
- Encounter data is considered “complete” when the data can be used to describe the majority of services that have been provided to Medicaid beneficiaries who are MCO enrollees.
- Encounter data completeness and accuracy requires continued monitoring and improvement. States need to develop encounter data standards and monitor for accuracy and completeness. Ultimately, it is the State that establishes standards for encounter data accuracy and completeness.

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

The EDV protocol consists of five sequential activities:

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

## Medical Record Review Procedure

### Medical Record Validation

Medical record documentation for services provided from January 2012 through December 2012 was compared to the encounter data for the same time period. The medical record was validated as the correct medical record requested by verifying the patient name, date of birth (DOB), and gender.

### Encounter Data Validation

After completing medical record reviewer training and achieving an inter-rater reliability score of 94%, reviewers entered data from the medical record reviews into the Delmarva Foundation EDV Tool/Database. The medical record was reviewed by either a certified coder or a nurse with coding experience to determine if the submitted encounter data (diagnosis, procedure, or revenue codes) could be validated against the findings in the medical record (see Table 16 for definition of terms). Where the diagnosis, procedure, and revenue codes could be substantiated by the medical record, the review decision was “yes” or “a match.” Conversely, if the medical record could not support the encounter data, the review decision was “no” or “no match.” For inpatient encounters, the medical record reviewers also matched the principal diagnosis code to the primary sequenced diagnosis. The review included validation of a maximum of 9 diagnosis codes, 6 procedure codes, and 23 revenue codes per record.

Table 16. EDV Definition of Terms

Term	Definition
Encounter	A unique date of service with coded diagnoses and procedures for a single provider or care/service provided on a unique date of service by the provider.
Review element	Specific element in the encounter data which is being compared to the medical record; elements in this review include diagnosis, procedure, and revenue codes.
Match rate	Rate of correct record elements to the total elements presented as a percent.

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

- As directed by the CMS Protocol, medical record reviewers could not infer a diagnosis from the medical record documentation. Reviewers were required to use the diagnosis listed by the provider. For example, if the provider recorded “fever and chills” in the medical record, and the diagnosis in the encounter data was “upper respiratory infection,” the record did not match for diagnosis even if the medical record documentation would support the use of that diagnosis.
- For inpatient encounters with multiple diagnoses listed, the medical record reviewers were instructed to match the first listed diagnosis (as the principal diagnosis) with the primary diagnosis in the encounter data.
- Procedure data was matched to the medical record regardless of sequencing.

### **Analysis Methodology**

Data from the EDV Tool/Database were used to analyze the consistency between submitted encounter data and corresponding medical records. Results were analyzed and presented separately by encounter type and review element. Match rates and reasons for “no match” errors for diagnosis code, procedure code, and revenue code elements are presented for Inpatient, Outpatient, and Office Visit encounter types in the results. Delmarva Foundation recommended that DHMH set the standard for accuracy of match rates between encounter data and medical records at 90% based on rates obtained in previous years.

### **Exclusion Criteria**

Cases where a match between the medical record and encounter data could not be verified by date of birth, gender, and name were excluded from analyses. If information for date of birth, gender, or name were missing, the record could not be validated and was excluded from analyses.

## Medical Record Sampling

Delmarva Foundation received a random sample of HealthChoice encounter data for hospital inpatient, hospital outpatient, and physician office services that occurred in CY 2012 from The Hilltop Institute at University of Maryland Baltimore County (Hilltop). The sample size, determined to achieve a 95% confidence interval, was 384 medical records (Table 1). Oversampling for CY 2012 continued in order to ensure adequate numbers of medical records were received to meet the required sample size. The hospital inpatient encounter types were oversampled by 500%, while the hospital outpatient and office visit encounter types were oversampled by 200%.

**Table 17. Maryland EDV Sample Size by Encounter Type, CY 2010 – CY 2012**

Encounter Type	CY 2010			CY 2011			CY 2012		
	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size	Total Encounters	% of Encounters	Sample Size
Inpatient	116,498	1.80%	7	107,202	1.00%	4	116,434	1.60%	6
Outpatient	1,046,201	15.80%	61	1,030,121	9.50%	36	1,117,949	15.30%	59
Office Visit	5,449,215	82.40%	316	9,702,064	89.50%	344	6,090,237	83.10%	319
<b>Total</b>	<b>6,611,914</b>	<b>100.00%</b>	<b>384</b>	<b>10,839,387</b>	<b>100.00%</b>	<b>384</b>	<b>7,324,620</b>	<b>100.00%</b>	<b>384</b>

The shift in the proportion of encounter types of the random sample as seen in Table 17:

- Office Visit increased 7.1 percentage points from 82.4% in CY 2010 to 89.5% in CY 2011 and then declined by 6.4 percentage points to 83.1% in CY 2012.
- Outpatient decreased 6.3 percentage points from 15.8% in CY 2010 to 9.5% in CY 2011 and increased by 5.8 percentage points to 15.3% in CY 2012.
- Inpatient decreased .8 percentage points from 1.8% in CY 2010 to 1.0% in CY 2011 and increased again in CY 2012 by .6 percentage points to 1.6%.

From the information provided in Table 17, the following conclusions can be drawn:

- Office Visit encounters make up the majority of the random sample of encounter data in all three years.
- Inpatient encounters comprise a very small part of the random sample at less than 2 percent in all three years.
- Office Visit encounters share of the random sample increased from CY 2010 to CY 2011 and then declined nearly to CY 2010 levels again in CY 2012.
- The increase in Office Visit encounters share of the random sample in CY 2011 was offset by a decline in the share of the random sample of inpatient and outpatient encounters. Inpatient and Outpatient encounters' share of the total random sample also returned nearly to CY 2010 levels in CY 2012.

With the approval of DHMH, Delmarva Foundation mailed requests for medical records to the providers of service. Non-responders were contacted by telephone and fax. The efforts to obtain adequate records to meet the minimum sample in CY 2012 were impacted by:

- Many outpatient records were submitted without the patient’s DOB included (7%). Since DOB was one of the critical elements needed to determine a record to be valid, these records either were not included in the review or required additional follow-up to obtain the missing information.
- There continued to be an issue with outpatient and office visit requests being returned due to bad addresses (8%).

Response rates by encounter type are outlined in Table 18.

**Table 18. Maryland EDV Medical Record Response Rates by Encounter Type, CY 2010 - CY 2012**

<b>Encounter Type</b>	<b>CY 2010 Total Records Received and Reviewed</b>	<b>CY 2010 Sample Size Achieved? Yes/No</b>	<b>CY 2011 Total Records Received and Reviewed</b>	<b>CY 2011 Sample Size Achieved? Yes/No</b>	<b>CY 2012 Total Records Received and Reviewed</b>	<b>CY 2012 Sample Size Achieved? Yes/No</b>
<b>Inpatient</b>	<b>7</b>	<b>Yes</b>	<b>4</b>	<b>Yes</b>	<b>7</b>	<b>Yes</b>
<b>Outpatient</b>	<b>66</b>	<b>Yes</b>	<b>38</b>	<b>Yes</b>	<b>60</b>	<b>Yes</b>
<b>Office Visit</b>	<b>328</b>	<b>Yes</b>	<b>352</b>	<b>Yes</b>	<b>326</b>	<b>Yes</b>
<b>Total</b>	<b>401</b>		<b>394</b>		<b>393</b>	

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

## Results

The analysis of the data was organized by review elements including diagnosis, procedure, and revenue codes. A total of 393 medical records were reviewed. The overall element match rate (medical record review supporting the encounter data submitted) decreased in CY 2012 as compared to CY 2011, but remained higher than the CY 2010 percentage. The results for CY 2010 - CY 2012 EDV are displayed in Tables 18 through 19 below and the findings are discussed in the following section.

**Table 19. Maryland EDV Results by Encounter Type, CY 2010 – CY 2012**

Encounter Type	Records Received & Reviewed			Total Elements Possible*			Total Matched Elements			Percentage of Matched Elements		
	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012
Inpatient	7	4	7	147	67	152	145	66	147	98.6%	98.5%	96.7%
Outpatient	66	38	60	636	435	614	569	394	588	89.5%	90.6%	95.8%
Office Visit	328	352	326	944	1,075	1,084	894	1,063	1,018	94.7%	98.9%	93.9%
<b>TOTAL</b>	<b>401</b>	<b>394</b>	<b>393</b>	<b>1,727</b>	<b>1,577</b>	<b>1,850</b>	<b>1,608</b>	<b>1,523</b>	<b>1,753</b>	<b>93.1%</b>	<b>96.6%</b>	<b>94.8%</b>

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

The overall element match rate in CY 2011 was 96.6%, which represents an increase of 3.5 percentage points from CY 2010. However, the overall element match rate declined from 96.6% in CY 2011 to 94.8% in CY 2012 – a decrease of 1.8 percentage points.

The inpatient encounter data match rate for CY 2011 was 98.5%, which represents a decrease of one-tenth of a percentage point (0.1%) from the CY 2010 match rate. From CY 2011 to CY 2012, the inpatient encounter data match rate decreased 1.8 percentage points to 96.7%.

The outpatient encounter data match rate was 90.6% for CY 2011, representing an increase of just over 1 percentage point compared to CY 2010. In CY 2012, the outpatient encounter data match rate increased another 5.2 percentage points to 95.8%.

An increase of over 4 percentage points in match rate was observed in CY 2011 office visit encounters compared to CY 2010. In CY 2012, the office visit match rate declined to 93.9% - a decrease of 5.0 percentage points from CY 2011.

## Results by Review Element

Tables 20 through 22 illustrate EDV results by review element for each encounter type. The elements reviewed were diagnosis codes, procedure codes, and revenue codes. (Note: Revenue codes are not applicable for office visit encounters.)

### Inpatient Encounters

Table 20. Maryland EDV Results by Element by Inpatient Encounter Type, CY 2010 – CY 2012

Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012
Match	54	17	43	7	5	15	84	44	89	145	66	147
No Match	2	1	4	0	0	0	0	0	1	2	1	5
Total Elements	56	18	47	7	5	15	84	44	90	147	67	152
Match Percent	96.4	94.4	91.5	100	100	100	100	100	98.9	98.6	98.5	96.7

In CY 2012, inpatient procedure codes maintained a 100% match rate when compared to inpatient medical records. One revenue code failed to match in the CY 2012 review, resulting in a match rate of 98.9%. The match rate for diagnosis codes in CY 2012 was 91.5%. In CY 2011, inpatient revenue and procedure codes were matched at a 100% rate when compared to the content of the inpatient medical record. Meanwhile, only one diagnosis code failed to match in the CY 2011 review, resulting in a rate of 94.4%. The total match rate for the elements in the inpatient encounter review have been stable from CY 2010 to CY 2011, and declined slightly from CY 2011 to CY 2012.

### Outpatient Encounters

Table 21. Maryland EDV Results by Element by Outpatient Encounter Type, CY 2010 – CY 2012

Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012
Match	161	91	162	121	101	171	287	202	255	569	394	588
No Match	1	5	17	57	35	7	9	1	2	67	41	26
Total Elements	162	96	179	178	136	178	296	203	257	636	435	614
Match Percent	99.4	94.8	90.5	68.0	74.3	96.1	97.0	99.5	99.2	89.5	90.6	95.8

In CY 2012, the total match rate for outpatient encounters across all of the element types rose to 95.8%, an increase of 5.2 percentage points. The procedure code element had the lowest match rate of all elements in CY 2011 at 74.3%. This represents an increase of 6.3 percentage points from the CY 2010 match rate for the

procedure code element of 68%. In CY 2012, the procedure code match rate rose 21.8 percentage points to 96.1%. In CY 2012, the diagnosis code element had the lowest match rate of all elements at 90.5%. This represents a decline of 4.3 percentage points from CY 2011. In CY 2012 the match rate for revenue codes was virtually the same as in CY 2011 at 99.2% (see Table 22).

Table 22. Maryland EDV Results by Element by Physician Office Encounter Type, CY 2010 – CY 2012

Encounter Type	Diagnosis Codes			Procedure Codes			Revenue Codes			Total		
	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012	CY 2010	CY 2011	CY 2012
Match	589	714	707	305	349	311	NA	NA	NA	894	1,063	1,018
No Match	27	9	29	23	3	37	NA	NA	NA	50	12	66
Total Elements	616	723	736	328	352	348	NA	NA	NA	944	1,075	1,084
Match Percent	95.6	98.8	96.1	93.0	99.1	89.4	NA	NA	NA	94.7	98.9	93.9

In CY 2012, the match rate dropped 5.0 percentage points from CY 2011 to 93.9%. The overall office visit encounter match rate was 98.9% in CY 2011. This rate represents a 4.2 percentage point increase from the 94.7% match rate for CY 2010. Diagnosis code and procedure code match rates both fell from CY 2011 to CY 2012, declining by 2.7 percentage points for diagnosis codes and 9.7 percentage points for procedure codes. The CY 2011 match rate for diagnosis codes and procedure codes elements increased relative to their CY 2010 match rate, with a 3.2 percentage point increase for the diagnosis code match rate and a 6.1 percentage point increase for the procedure code match rate.

**“No Match” Results by Element and Reason**

Tables 23 through 25 illustrate the principal reasons for “no match” errors. The reasons for determining a “no match” for the diagnosis code element were:

- Lack of medical record documentation
- Incorrect principal diagnosis (inpatient encounters) or incorrect diagnosis codes

**Table 23. Maryland EDV CY 2012 “No Match” Results for Diagnosis Code Element**

CY 2012 “No Match” for Diagnosis Code Element			
Encounter Type	Total Elements	Lack of Medical Record Documentation	Incorrect Principal Diagnosis (Inpatient) or Incorrect Diagnosis Codes
<b>Inpatient</b>	<b>4</b>	<b>0</b>	<b>4</b>
% of Total		<b>0</b>	<b>100</b>
<b>Outpatient</b>	<b>17</b>	<b>2</b>	<b>15</b>
% of Total		<b>11.8</b>	<b>88.2</b>
<b>Office Visit</b>	<b>29</b>	<b>8</b>	<b>21</b>
% of Total		<b>27.6</b>	<b>72.4</b>

All diagnosis code “no match” errors for inpatient encounters were due to incorrect diagnosis codes. Two of the 17 “no match” errors for outpatient encounters resulted from a lack of medical record documentation.

For office visit encounters, 8 of the 29 “no match” errors in resulted from a lack of medical record documentation. Also for office visit encounters, 21 of the 29 “no match” errors (72.4%) were the result of incorrect diagnosis codes.

The reasons for determining a “no match” for the procedure code element were:

- Lack of medical record documentation
- Incorrect procedure codes

**Table 24. Maryland EDV CY 2012 “No Match” Results for Procedure Code Element**

CY 2012 “No Match” for Procedure Code Element			
Encounter Type	Total Elements	Lack of Medical Record Documentation	Incorrect Procedure Code
<b>Inpatient</b>	<b>0</b>	<b>0</b>	<b>0</b>
% of Total		<b>0</b>	<b>0</b>
<b>Outpatient</b>	<b>7</b>	<b>0</b>	<b>7</b>
% of Total		<b>0</b>	<b>100</b>
<b>Office Visit</b>	<b>37</b>	<b>21</b>	<b>16</b>
% of Total		<b>56.8</b>	<b>43.2</b>

All “no match” errors for outpatient encounters were due to incorrect procedure codes. The “no match” errors for office visits were split between the lack of medical record documentation which represented 56.8% of the errors and incorrect procedure codes which represented 43.2% of the errors.

The reasons for determining a “no match” for the revenue code element were:

- Lack of medical record documentation
- Incorrect revenue codes

**Table 25. Maryland EDV CY 2012 “No Match” Results for Revenue Code Element**

CY 2012 “No Match” for Revenue Code Element *			
Encounter Type*	Total Elements	Lack of Medical Record Documentation	Incorrect Revenue Code
Inpatient	1	0	1
% of Total		0	100
Outpatient	2	1	1
% of Total		50.0	50.0

\*Note – Revenue Codes do not apply to Office Visit encounters.

The one inpatient revenue code “no match” error was the result of an incorrect revenue code. The outpatient revenue code “no match” errors were split with one of each error, a lack of medical record documentation and an incorrect revenue code error.

### Conclusions/Recommendations

For CY 2012, overall encounters matched the medical records 94.8% of the time. This match rate exceeds Delmarva Foundation’s recommended standard of 90% for accuracy of match rates between encounter data and medical records. However, the CY 2012 match rate decreased 1.8 percentage points from CY 2011, but is 1.7 percentage points higher than CY 2010. Therefore, although the encounter data submitted for CY 2012 is slightly less reliable than that for CY 2011, CY 2012 encounter data can be considered reliable for reporting purposes.

The match rates for inpatient encounters were 96.7% and outpatient encounters were 95.8%. Office visit encounters had the lowest match rate of all encounter types at 93.9%. Amongst all office visit encounters, the procedure code element had the lowest match rate of all elements at 89.4% as compared to the highest match rate of all elements at 96.1% for diagnosis codes.

Based on our encounter data validation, we concluded that the primary reason for “no match” results in the inpatient encounter data, outpatient encounter data, and office visit encounters for the diagnosis code

element was due to incorrect diagnosis codes (Table 23). Only 2 of the 17 “no match” errors for outpatient encounters for the diagnosis code element were due to a lack of medical record documentation. Only 8 of the 29 “no match” errors for office visit encounters for the diagnosis code element were due to a lack of medical record documentation.

The primary reason for all of the “no match” results in the outpatient encounter data (see Table 24) for the procedure code element was due to incorrect procedure codes. The reason for “no match” results in office visit encounters for the procedure code element was more evenly split. Just under half (16 of 37) of all “no match” errors were due to an incorrect procedure code. As represented in Table 24, all inpatient encounter data procedure code elements were matched.

It is recommended that the current rate of oversampling be continued in order to ensure adequate numbers of medical records are received to meet the required sample size. We recognize the need to continue instructing provider offices to supply all supporting medical record documentation for the encounter data, including the patient’s DOB.

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

### Introduction

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

This section summarizes the findings from the EPSDT medical record review for CY 2012. Approximately 605,263 children were enrolled in the HealthChoice Program during this period.

The seven MCOs evaluated for CY 2012 were:

- AMERIGROUP Community Care (ACC)
- Diamond Plan from Coventry Health Care, Inc. (DIA)
- MedStar Family Choice, Inc. (MSFC)
- Jai Medical Systems (JMS)
- Maryland Physicians Care (MPC)
- Priority Partners (PPMCO)
- UnitedHealthcare (UHC)

### Program Overview

The EPSDT Program is the federally mandated Medicaid program for screening, prevention, diagnosis, and treatment of physical and mental health conditions in children and adolescents through 20 years of age (as defined by Omnibus Budget Reconciliation Act [OBRA] 1989). Each State determines its own periodicity schedule for services, including periodic physical and mental health screening, vision, dental, and hearing services.

The Program's philosophy is to provide quality health care that is patient focused, prevention oriented, coordinated, accessible, and cost effective. The foundation of this philosophy is based on providing a "medical home" for each enrollee, by connecting each enrollee with a PCP who is responsible for providing preventive and primary care services, managing referrals, and coordinating all necessary preventive care for the enrollee. The Program emphasizes health promotion and disease prevention, and requires that enrollees be provided health education and outreach services.

## Program Objectives

The Maryland EPSDT Program's mission is to promote access to and assure availability of quality health care for Medical Assistance children, and adolescents through 20 years of age. In support of the program's mission, the primary objective of the EPSDT medical record review is to collect and analyze data to assess the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. The review includes an assessment of MCO performance for the following EPSDT components and their respective subcategories:

**Health and developmental history** requires a comprehensive evaluation and includes documentation of:

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

**Comprehensive physical examination** requires evaluation and includes documentation of:

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

**Laboratory tests/at risk screenings** require documentation of:

- Hereditary/metabolic screening test results at birth and again by 1 month\* of age.
- Age appropriate risk assessment results for tuberculosis, cholesterol, and sexually transmitted diseases.
- Counseling and/or laboratory test results for at risk recipients.
- Anemia tests at 12\*\* and 24\*\*\* months of age.
- Lead risk assessment for 6 months through 6 years of age.
- Referral to the lab for lead testing at appropriate ages.
- Blood lead tests results at 12\*\* and 24\*\*\* months of age.
- Baseline Blood lead test results for ages 3 through 5 years of age when not done at 12 or 24 months of age.

**NOTES:** \*accepted until 8 weeks of age, \*\*accepted from 9-23 months of age, \*\*\*accepted from 24-35 months of age.

**Immunizations** require assessment of need and documented administration that:

- The DHMH Immunization Schedule is being implemented in accordance with the Advisory Committee on Immunization Practices guidelines.
- Age-appropriate vaccines are not postponed for inappropriate reasons.
- Children/Adolescents who are delayed in their immunizations are brought current with the Maryland DHMH Immunization Schedule.

**Health education and anticipatory guidance** requires documentation of:

- Age-appropriate guidance with a minimum of three anticipatory guidance items or two major topics documented per visit.
- Counseling/referrals for health issues identified by parent or provider during the visit.
- Oral health assessment following eruption of teeth; yearly dental education and referrals beginning at 2 years of age.
- Educating recipient and/or parent regarding schedule of preventive care visits.
- Return appointments documented according to the Maryland Schedule of Preventive Health Care.

## CY 2012 EPSDT Review Process

### Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during calendar year 2012 for children from birth through 20 years of age. The sampling methodology includes the following criteria:

- A random sample of preventive care encounters per MCO including a 10% over sample.
- Sample size per MCO provides a 95% confidence level and 5% margin of error.
- Sample includes only recipients through 20 years of age as of the last day of CY 2012.
- Sample includes encounter data for recipients enrolled on last day of CY 2012, and for at least 320 days in the same MCO.

**Exception** – If the recipient’s age on the last day of selected period is less than 365 days, the criteria is modified to read same MCO for 180 days, with no break in eligibility.

- Sample includes recipients who had a preventive care encounter (Current Procedural Terminology [CPT] 99381-85 or 99391-95) with a diagnostic code of V20 or V70 (For children less than 2 years of age who may have had 4-6 preventive visits within a 12-month period, only one date of service was selected.)
- Sample includes recipients when visits with CPT 99381-85 or 99391-95 were provided by primary care providers and clinics with the following specialties:
  - Pediatrics

- Family Practice
- Internal Medicine
- Nurse Practitioner
- General Practice
- Federally Qualified Health Center

### Medical Record Review Process

Medical records were randomly selected in order to assess compliance with the program standards. Nurse reviewers conducted all medical record reviews in the provider offices, with the exception of providers with only one or two children in the sample. These providers were given the option to mail or fax a complete copy of the medical record to Delmarva Foundation for review. In total, 2,693 medical records were reviewed for CY 2012.

The review criteria used by Delmarva Foundation’s review nurses were the same as those developed and used by the Department’s EPSDT review nurses. Delmarva Foundation review nurses completed annual training and conducted Inter-Rater Reliability (IRR). The review nurses achieved a score of 90.3% prior to the beginning of the CY 2012 EPSDT Medical Record Review.

### Scoring Methodology

Data from the medical record reviews were entered into Delmarva Foundation’s EPSDT Evaluation Tool.

The analysis of the data was organized by the following age groupings:

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

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

Score	Finding
2	Complete
1	Incomplete
0	Missing

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

Elements, each weighted equally, within a component were scored and added together to derive the final component score. Similarly, the composite score (or overall score) follows the same methodology. The scoring methodology produced a result that reflected the percentage of possible points obtained in each component, for each age group, and for each MCO. The minimum per component compliance score is 75%. If the minimum compliance score is not met, a CAP is required.

## Findings

EPSDT review indicators are based on current pediatric preventive care guidelines and DHMH-identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance rate of 75% for each of the five components. If an MCO did not achieve the minimum compliance rate, the MCO was required to submit a CAP. Five of the seven MCOs (ACC, DIA, JMS, MSFC, and UHC) met the minimum compliance rate of 75% in each of the five component areas for the CY 2012 review. CAPs for the Laboratory Tests/At Risk Screenings component were required from two MCOs (MPC and PPMCO).

Findings for the CY 2012 EPSDT review by component area are described in Table 26.

**Table 26. CY 2012 EPSDT Component Results by MCO**

Component	Number of Elements Reviewed	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC	HealthChoice Aggregate CY 2012
Health & Developmental History	9	83%	90%	98%	85%	93%	86%	86%	89%
Comprehensive Physical Examination	14	90%	94%	98%	91%	96%	91%	92%	93%
Laboratory Tests/At Risk Screenings	10	77%	78%	96%	<u>73%*</u>	86%	<u>71%*</u>	78%	80%
Immunizations	13	85%	83%	88%	87%	86%	86%	85%	86%
Health Education/Anticipatory Guidance	4	91%	90%	97%	89%	94%	93%	91%	92%

\*Denotes that the minimum compliance score of 75% was unmet and a CAP was required

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

## Health and Developmental History

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

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

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

Table 27. CY 2012 Health and Developmental History Element Scores

Maryland Schedule of Preventive Health Care Health and Development History Elements	ACC CY 2012	DIA CY 2012	JMS CY 2012	MPC CY 2012	MSFC CY 2012	PPMCO CY 2012	UHC CY 2012
Substance Abuse Assessment	80%	83%	99%	81%	95%	84%	87%
Psychosocial History	88%	92%	100%	89%	96%	90%	89%
Mental Health Assessment	83%	89%	98%	84%	94%	87%	86%
Family History	77%	87%	98%	76%	86%	79%	84%
Peri-natal History	85%	84%	95%	88%	93%	87%	86%
Health History	89%	95%	99%	90%	96%	89%	88%
Developmental Assessment/History/Surveillance (0-5 yrs)	91%	95%	99%	94%	97%	91%	92%
Developmental Assessment/History/Surveillance (6-20 yrs)	95%	94%	97%	93%	98%	93%	94%
Developmental Screening Using Standardized Tool at 9, 18, 24-30 Month Visits	<u>56%</u>	80%	83%	<u>72%</u>	<u>68%</u>	<u>65%</u>	<u>56%</u>
Recorded Autism Screening using Standardized Tool*	<u>20%</u>	<u>46%</u>	<u>61%</u>	<u>36%</u>	<u>50%</u>	<u>48%</u>	<u>29%</u>
Aggregate Element Rate	83%	90%	98%	85%	93%	86%	86%

\_\_ Denotes that the element score is below 75% which may impact the minimum level compliance score for the component.

\*Baseline for CY 2012

## Findings

- All MCO scores exceeded the minimum compliance rate of 75% for the Health and Developmental History component in CY 2012.
- The current CY 2012 HealthChoice Aggregate score for the Health and Developmental History component is 89%. No CAPs were required.

## Comprehensive Physical Examination

**Rationale:** The comprehensive physical exam by a review of systems method requires documentation of a minimum of five systems to meet EPSDT standards.

**Components & Documentation:** A comprehensive physical exam includes documentation of:

- Subjective or objective vision and hearing assessments at every well-child visit.
- Measuring and graphing head circumference through 2 years of age.
- Recording blood pressure annually for children 3 years of age and older.
- Oral assessment including a visual exam of the mouth, gums, and teeth.
- Nutritional assessment including typical diet, physical activity, and education provided with graphing of weight and height through 20 years of age on the growth chart.
- Calculating and graphing BMI for 2 years of age through 20 years of age.
- Appropriate referrals for nutrition services and/or counseling due to identified nutrition or growth problems.

Table 28. CY 2012 Comprehensive Physical Examination Element Scores

Maryland Schedule of Preventive Health Care Comprehensive Physical Examination	ACC CY 2012	DIA CY 2012	JMS CY 2012	MPC CY 2012	MSFC CY 2012	PPMCO CY 2012	UHC CY 2012
Graphed Height	84%	90%	98%	87%	95%	85%	89%
Measured Height	99%	99%	99%	99%	99%	98%	99%
Graphed Weight	84%	91%	99%	88%	95%	86%	91%
Measured Weight	99%	99%	99%	100%	99%	99%	100%
Graphed Head Circumference	77%	84%	89%	79%	88%	78%	80%
Measured Head Circumference	92%	94%	91%	90%	93%	85%	89%
Measured Blood Pressure	94%	96%	99%	97%	98%	94%	97%
Documentation Of Minimum 5 Systems	98%	99%	99%	99%	99%	99%	98%
Assessed Hearing	96%	96%	99%	91%	98%	96%	95%
Assessed Vision	97%	97%	99%	94%	98%	97%	96%
Assessed Nutritional Status	95%	94%	95%	92%	97%	94%	96%
Conducted Oral Screening	98%	99%	99%	99%	99%	99%	97%
Calculated BMI	<u>73%</u>	87%	99%	81%	92%	77%	<u>73%</u>
Graphed BMI	<u>63%</u>	75%	98%	<u>68%</u>	87%	<u>64%</u>	<u>65%</u>
Aggregate Element Rate	90%	94%	98%	91%	96%	91%	92%

— Denotes that the element score is below 75% which may impact the minimum level compliance score for the component.

## Findings

- All MCO scores exceeded the minimum compliance rate of 75% for the Comprehensive Physical Exam component for CY 2012.
- Calculation and graphing of BMI was included in the scoring of this component for the first time in CY 2010. The CY 2012 HealthChoice Aggregate score for the Comprehensive Physical Exam component is 93%.

## Laboratory Tests/At Risk Screenings

**Rationale:** The Healthy Kids Program requires assessments of risk factors associated with heart disease, anemia, tuberculosis, lead exposure, and sexually transmitted infection/human immunodeficiency virus (STI/HIV).

**Components:** Assessment of risk factors includes:

- Tuberculosis risk assessment beginning at one year of age. Beginning in CY 2012 this risk assessment requirement will begin at one month of age.
- Heart disease/cholesterol risk assessment beginning at two years of age.
- STI/HIV risk assessment beginning at 12 years of age.
- Lead risk assessment at six months – six years of age (A positive lead risk assessment necessitates blood lead testing at any age. In addition, blood lead levels must be obtained at 12\*\* and 24\*\*\* months.)
- Blood testing of hematocrit or hemoglobin at 12\*\* and 24\*\*\* months of age, at the same time as the blood lead test (On the initial visit for all children two through five years of age, unless previous test results are available, a hematocrit or hemoglobin is required.)
- A second hereditary/metabolic screen (lab test) by two–four weeks\* of age.

**Notes:** \*accepted until 8 weeks of age; \*\*accepted from 9-23 months of age; \*\*\*accepted from 24-35 months of age

Table 29. CY 2012 Laboratory Test/At Risk Screenings Element Scores

Maryland Schedule of Preventive Health Care Laboratory Test/At Risk Screenings	ACC CY 2012	DIA CY 2012	JMS CY 2012	MPC CY 2012	MSFC CY 2012	PPMCO CY 2012	UHC CY 2012
Cholesterol Risk Assessment per Schedule	<u>74%</u>	<u>74%</u>	97%	76%	81%	<u>68%</u>	75%
STI/HIV Risk Assessment per Schedule	81%	78%	97%	82%	90%	84%	83%
Referred for Lead Test	79%	<u>74%</u>	95%	<u>70%</u>	90%	<u>70%</u>	77%
12 Month Lead Test Result per Schedule	<u>73%</u>	80%	92%	<u>65%</u>	88%	75%	<u>73%</u>
24 Month Lead Test Result per Schedule	<u>62%</u>	<u>64%</u>	86%	<u>46%</u>	<u>71%</u>	<u>69%</u>	<u>67%</u>
Lead Risk Assessment	86%	91%	97%	85%	94%	86%	89%
Anemia Screening per Schedule	80%	77%	96%	<u>67%</u>	90%	<u>72%</u>	78%
Conducted Second Hereditary/Metabolic Screening by 2-4 weeks	<u>61%</u>	<u>70%</u>	90%	<u>52%</u>	80%	<u>73%</u>	86%
Baseline Lead Testing Completed	85%	77%	95%	<u>62%</u>	94%	<u>65%</u>	84%
Tb Risk Assessment (1 mth-20yrs)	<u>74%</u>	79%	96%	<u>73%</u>	84%	<u>64%</u>	<u>74%</u>
Aggregate Element Rate	77%	78%	96%	<u>73%</u>	86%	<u>71%</u>	78%

— Denotes that the element score is below 75% which may impact the minimum level compliance score for the component.

## Findings

- MPC and PPMCO scored below the minimum compliance rate and were required to submit CAPs. Historically, this component score has represented an area in need of improvement and MCO specific recommendations for quality improvement focus at the element level are shared with each MCO each year in the EPSDT Medical Record Review Report.
- The current CY 2012 HealthChoice Aggregate score for the Laboratory Tests/At Risk Screenings component is 80%.

## Immunizations

**Rationale:** Children must be immunized according to the Maryland DHMH Recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland State Medical Society, and is based on the current recommendations of the U.S. Public Health Service’s Advisory Committee on Immunization Practices and the American Academy of Pediatrics. Primary care providers who see Medicaid recipients up to 19 years of age must participate in the Department’s Vaccine for Children Program.

**Documentation:** The Vaccine for Children Program requires completion of the Patient Eligibility Screening Record for each patient receiving free vaccines. Additionally, federal law requires documentation of date, dosage, site of administration, manufacturer, lot number, publication date of Vaccine Information Statement, and name/location of provider.

Table 30. CY 2012 Immunizations Element Scores

Maryland Schedule of Preventive Health Care Immunizations	ACC CY 2012	DIA CY 2012	JMS CY 2012	MPC CY 2012	MSFC CY 2012	PPMCO CY 2012	UHC CY 2012
TD Vaccine(s) per Schedule	78%	77%	89%	88%	<u>69%</u>	88%	84%
Hepatitis B Vaccine(s) per Schedule	88%	84%	93%	90%	92%	88%	90%
MMR Vaccine(s) per Schedule	96%	94%	98%	96%	97%	95%	96%
Polio Vaccine(s) per Schedule	91%	<u>90%</u>	95%	90%	93%	94%	93%
Hib Vaccine(s) per Schedule	88%	92%	92%	90%	94%	90%	91%
DTP/DTaP (DT) Vaccine(s) per Schedule	90%	87%	92%	93%	92%	91%	90%
Hepatitis A Vaccine(s) per Schedule (2 dose requirement)	<u>73%</u>	84%	96%	92%	87%	83%	82%
Influenza Vaccine(s) (Beginning at 6 months of age per schedule)	<u>71%</u>	<u>67%</u>	75%	<u>71%</u>	<u>72%</u>	<u>68%</u>	<u>66%</u>
Meningococcal (MCV4) Vaccine(s) per Schedule	80%	<u>73%</u>	86%	88%	85%	81%	81%
Varicella Vaccine(s) per Schedule (2 dose requirement)	85%	83%	88%	88%	92%	86%	85%
Rotavirus Vaccine(s) per Schedule	83%	<u>74%</u>	78%	80%	89%	94%	75%
Assessed if Immunizations are Up to Date	83%	83%	85%	87%	85%	85%	83%
PCV-13 Vaccine(s) per Schedule	91%	91%	95%	93%	94%	91%	89%
Human Papillomavirus Vaccine(s)*	<u>63%</u>	<u>52%</u>	<u>71%</u>	<u>58%</u>	<u>53%</u>	<u>52%</u>	<u>53%</u>
<b>Aggregate Element Rate</b>	<b>85%</b>	<b>83%</b>	<b>88%</b>	<b>87%</b>	<b>86%</b>	<b>86%</b>	<b>85%</b>

     Denotes that the element score is below 75% which may impact the minimum level compliance score for the component.

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

## Findings

- All MCO's scores exceeded the minimum compliance rate of 75% for this component for CY 2012.
- The HealthChoice Aggregate score for this component decreased one percentage point from CY 2010 to CY 2011. The current CY 2012 aggregate score of 86% represents a two percentage point decrease from the previous year. MCOs were encouraged to continue efforts to improve administration immunizations according to the DHMH Recommended Childhood and Adolescent Immunization Schedule.

## Health Education/Anticipatory Guidance

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

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

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

Table 31. CY 2012 Health Education/Anticipatory Guidance Element Scores

Maryland Schedule of Preventive Health Care Health Education/Anticipatory Guidance	ACC CY 2012	DIA CY 2012	JMS CY 2012	MPC CY 2012	MSFC CY 2012	PPMCO CY 2012	UHC CY 2012
Provided Education and Referral to Dentist	83%	82%	98%	79%	92%	86%	84%
Provided Age Appropriate Guidance	94%	96%	99%	96%	98%	96%	95%
Specified Requirements for Return Visit	87%	82%	91%	81%	86%	89%	88%
Provided Ed/Referral for Identified Problems/Tests	99%	98%	100%	98%	99%	99%	97%
Aggregate Element Rate	91%	90%	97%	89%	94%	93%	91%

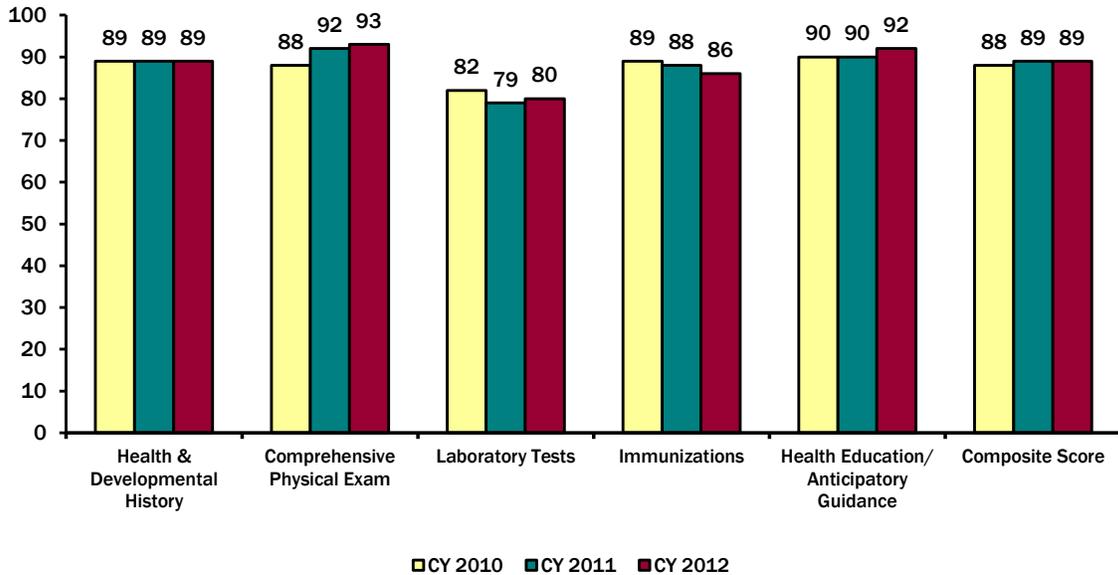
— Denotes that the element score is below 75% which may impact the minimum level compliance score for the component.

## Findings

- All MCO’s scores exceeded the minimum compliance rate for the Health Education/Anticipatory Guidance component for CY 2012.
- The HealthChoice Aggregate score for this component in CY 2012 is 92%.

Figure 1 compares the HealthChoice Aggregate Rates for three reporting periods: January 1 – December 31, 2010 (CY 2010), January 1 – December 31, 2011 (CY 2011), and January 1 – December 31, 2012 (CY 2012).

**Figure 1. HealthChoice Aggregate Rates for EPSDT Program Review Components for CY 2010 through CY 2012**



From CY 2010 to CY 2011, the HealthChoice Aggregate rates increased for the Comprehensive Physical Exam component and decreased for the Laboratory Tests and Immunizations component. This resulted in a 1 percentage point increase to the total Composite Score for CY 2011.

From CY 2011 to CY 2012, the HealthChoice Aggregate rates increased for Comprehensive Physical Exam, Laboratory Tests, and Health Education/Anticipatory Guidance components, and decreased or remained the same for Health & Developmental History and Immunizations components. The Composite Score from CY 2011 to CY 2012 remains the same.

## Corrective Action Plan Process

DHMH sets high performance standards for the Healthy Kids Program. Five of the seven MCOs scored above the 75% minimum compliance score for all five components. MPC and PPMCO scored below the 75% minimum compliance score for the Laboratory Tests/At Risk Screenings component and were required to submit CAPs. The CAPs were evaluated by Delmarva Foundation to determine whether the plans were acceptable. In the event that a CAP is deemed unacceptable, Delmarva Foundation provides technical assistance to the MCO until an acceptable CAP is submitted. MPC and PPMCO have submitted adequate CAPs for the areas where deficiencies occurred for CY 2012.

### Required Contents of EPSDT CAPs

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

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

### EPSDT CAP Evaluation

The review team will evaluate the effectiveness of any CAPs initiated as a result of the prior year's review. A review of all required EPSDT components are completed annually for each MCO. Since CAPs related to the review can be directly linked to specific components, the annual EPSDT review will determine whether the CAPs were implemented and effective. In order to make this determination, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

## Conclusions

The result of the EPSDT review demonstrated strong compliance with the timely screening and preventive care requirements of the HealthChoice/ EPSDT Program. Aggregate scores for four of the five components increased or remained unchanged from CY 2011 to CY 2012. Only the aggregate score for the Immunizations component declined in CY 2012. MPC and PPMCO submitted CAPs for Laboratory/At Risk Screenings.

The total Composite Score of 89% remained unchanged in CY 2012. Overall scores demonstrate that the MCOs, in collaboration with PCPs, are committed to the Department's goals to provide care that is patient focused and prevention oriented.

## Section VI Healthcare Effectiveness Data and Information Set®

### Introduction

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

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

In July 2006, DHMH combined two of its programs, Maryland Pharmacy Assistance and Maryland Primary Care, to form a new Medical Assistance program called Primary Adult Care (PAC). PAC offers healthcare services to low-income Maryland residents, 19 years of age and older, who are not eligible for full Medicaid benefits. Five MCOs participated in PAC.

Within DHMH, the HACA is responsible for the quality oversight of the HealthChoice and PAC programs. DHMH continues to measure HealthChoice program clinical quality performance and enrollee satisfaction using initiatives including HEDIS® reporting. Performance is measured at both the organization level and on a statewide basis. In 2007, DHMH announced its intention to collect HEDIS® results from each organization offering PAC for a subset of the HEDIS® measures already being reported by HealthChoice MCOs. All seven HealthChoice MCOs submitted CY 2012 data for HEDIS® 2013. Five PAC MCOs reported CY 2012 data for HEDIS® 2013.

MCO	HealthChoice	PAC
AMERIGROUP Community Care	X	X
Diamond Plan	X	
Jai Medical Systems	X	X
Maryland Physicians Care	X	X
MedStar Family Choice, Inc.	X	
Priority Partners	X	X
UnitedHealthcare	X	X

## Measures Designated for Reporting

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

## Measures Selected by DHMH for HealthChoice Performance Reporting

DHMH required HealthChoice MCOs to report 27 HEDIS® measures for services rendered in CY 2012. One previously required measure was retired by NCQA and as such was removed from HEDIS® 2013: Call Abandonment (CAB).

The HEDIS® Performance Measures are:

- Effectiveness of Care
  - Childhood Immunization Status (CIS)
  - Immunizations for Adolescents (IMA)
  - Breast Cancer Screening (BCS)
  - Cervical Cancer Screening (CCS)
  - Comprehensive Diabetes Care, all indicators except HbA1c <7.0% (CDC)
  - Use of Appropriate Medications for People with Asthma (ASM)
  - Appropriate Treatment for Children with Upper Respiratory Infection (URI)
  - Appropriate Testing for Children with Pharyngitis (CWP)
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
  - Chlamydia Screening in Women (CHL)
  - Use of Imaging Studies for Low Back Pain (LBP)
  - Annual Monitoring for Patients on Persistent Medications (MPM)
  - Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
  - Medication Management for People with Asthma (MMA)
  - Controlling High Blood Pressure (CBP)
  - Adult BMI Assessment (ABA)
- Access/Availability of Care
  - Adults' Access to Preventive/Ambulatory Health Services (AAP)
  - Children and Adolescents' Access to Primary Care Practitioners (CAP)
  - Prenatal and Postpartum Care (PPC)
  - Call Answer Timeliness (CAT)
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Utilization and Relative Resource Use
  - Frequency of Ongoing Prenatal Care (FPC)
  - Well-Child Visits in the First 15 Months of Life (W15)

- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Ambulatory Care (AMB)
- Identification of Alcohol and Other Drug Services (IAD)

**Measures Selected by DHMH for PAC Performance Reporting**

DHMH required PAC MCOs to report 5 HEDIS® measures for services rendered in CY 2012:

- Effectiveness of Care
  - Breast Cancer Screening (BCS)
  - Cervical Cancer Screening (CCS)
  - Comprehensive Diabetes Care, all indicators except HbA1c <7.0% (CDC)
  - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)
- Access/Availability of Care
  - Adults' Access to Preventive/Ambulatory Health Services (AAP)

**HEDIS® Measures Reporting History**

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

NCQA Domain	Measure Name	Indicators <i>(Indicators reported for HEDIS but not included in this report are italicized.)</i>	HealthChoice reporting history	PAC reporting history
<b>Prevention and Screening – Adult and Child</b>				
EOC	Childhood Immunization Status (CIS)	<i>DTaP; IPV; MMR; HiB; Hepatitis B; VZV</i> Combination 2 <sup>1</sup> <i>Pneumococcal conjugate</i> Combination 3 <sup>1</sup> <i>Hepatitis A; Rotavirus; Influenza</i> Combinations 4,5,6,7,8,9, and 10 <sup>1</sup>	≤ 2005  2006  2010	
EOC	Immunizations for Adolescents (IMA)	<i>Meningococcal; Tdap/Td</i> Combination 1 (Meningococcal, Tdap/Td)	2010	
URR	Well-Child Visits in the First 15 Months of Life (W15)	No visits; <i>One visit; Two visits; Three visits; Four visits; Five visits; Six or more visits</i> DHMH non-HEDIS measure: Five or six-or-more visits (additive percentage of HEDIS five visits and six-or-more)	≤ 2005	
URR	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)		≤ 2005	
URR	Adolescent Well-Care Visits (AWC)		≤ 2005	
EOC	Adult BMI Assessment (ABA)		2013	
<b>Respiratory Conditions</b>				
EOC	Appropriate Testing for Children with Pharyngitis (CWP)		2007	

\*Domain abbreviations: EOC: Effectiveness of Care, AAC: Access/Availability of Care, URR: Utilization and Relative Resource Use.

1. Please refer to the table on page 12 for delineation of antigens included in each combination.

The table is continued on the next page

* NCQA Domain	Measure Name	Indicators <i>(Indicators reported for HEDIS but not included in this report are italicized.)</i>	HealthChoice reporting history	PAC reporting history
<b>Prevention and Screening – Adult and Child</b>				
EOC	Appropriate Treatment for Children with Upper Respiratory Infection (URI)		2007	
EOC	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)		2012	2012
EOC	Use of Appropriate Medications for People with Asthma (ASM)	<2009: 5-9 years of age; 10-17 years of age; 18-56 years of age; Total (5-56 years of age) 2010: 5-11 years of age; 12-50 years of age; Total (5-50 years of age) 2012: 5-11 years of age; 12-18 years of age; 19-50 years of age; 51-64 years of age; Total (5-64 years of age); DHMH non-HEDIS measure: Total (5-50 years of age) – additive percentage of HEDIS 5-11 yrs, 12-18 yrs, 19-50 yrs.	2006	
EOC	Medication Management for People With Asthma (MMA)	Percentage of members who remained on an asthma controller medication for at least 50% of their treatment period Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period	2013	
<b>Member Access</b>				
AAC	Children and Adolescents' Access to Primary Care Practitioners (CAP)	12-24 months of age 25 months-6 years of age 7-11 years of age 12-19 years of age	2007	
AAC	Adults' Access to Preventive/ Ambulatory Health Services	20-44 years of age 45-65 years of age	2007	2009
<b>Women's Health</b>				
EOC	Breast Cancer Screening (BCS)		2007	2009
EOC	Cervical Cancer Screening (CCS)		2007	2009
EOC	Chlamydia Screening in Women (CHL)	16-20 years of age 2009: 21-25 years of age 2007-2008: 21-24 years of age 2009: Total (16-24 years of age) 2007-2008: Total (16-25 years of age)	2007	
<b>Prenatal &amp; Postpartum Care</b>				
AAC	Prenatal and Postpartum Care (PPC)	Timeliness of prenatal care Postpartum care	< 2005 < 2005	
URR	Frequency of Ongoing Prenatal Care (FPC)	<21 percent of expected visits 21 percent of expected visits 41 percent of expected visits 61 percent of expected visits >81 percent of expected visits	< 2005	

\*Domain abbreviations: EOC: Effectiveness of Care, AAC: Access/Availability of Care, URR: Utilization and Relative Resource Use

* NCQA Domain	Measure Name	Indicators <i>(Indicators reported for HEDIS but not included in this report are italicized.)</i>	HealthChoice reporting history	PAC reporting history
<b>Cardiovascular Conditions</b>				
EOC	Controlling High Blood Pressure (CBP)		2013	
<b>Diabetes</b>				
EOC	Comprehensive Diabetes Care (CDC)	HbA1c testing	< 2005	2009
		HbA1c poor control (>9.0%)	< 2005	2009
		HbA1c control (<8.0%)	2009	2009
		Eye exam (retinal) performed	< 2005	2009
		LDL-C screening		
		LDL-C control (<100mg/dL)	2007	2009
		Medical attention for nephropathy		
		Blood pressure control (<140/80 mm Hg)	2011	2011
Blood pressure control (<140/90 mm Hg)	2007	2009		
<b>Musculoskeletal Conditions</b>				
EOC	Use of Imaging Studies for Low Back Pain (LBP)		2012	
EOC	Disease-Modifying Anti- Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)		2013	
<b>Medication Management</b>				
EOC	Annual Monitoring for Patients on Persistent Medications(MPM)	Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) Digoxin Diuretics Anticonvulsants Total Rate	2013	
<b>Behavioral Health</b>				
AAC	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Initiation: 13-17 years of age 18+ years of age Total (ages 13-65) Engagement: 13-17 years of age 18+ years of age Total (ages 13-65)	2009	
URR	Identification of Alcohol and Other Drug Services (IAD)	Any services Inpatient services Intensive Outpatient/Partial Hospitalization Outpatient/ED	2009	
<b>Ambulatory Care (Utilization)</b>				
URR	Ambulatory Care (AMB)	Outpatient visits ED visits <i>Note: Ambulatory Surgery/Procedures and Observation Room Stays categories were retired in 2011</i>	2007	
<b>Call Services</b>				
AAC	Call Answer Timeliness (CAT)		2006	

\* Domain abbreviations: EOC: Effectiveness of Care, AAC: Access/Availability of Care, URR: Utilization and Relative Resource Use

## HEDIS® Methodology

The HEDIS®-reporting organization follows guidelines for data collection and specifications for measure calculation described in *HEDIS® 2013 Volume 2: Technical Specifications*.

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

**Administrative data:** Data from transaction systems (claims, encounters, enrollment, practitioner) provide the majority of administrative data. Organizations may receive encounter files from pharmacy, laboratory, vision, and behavioral health vendors.

**Supplemental data:** NCQA defines supplemental data as atypical administrative data, i.e., not claims or encounters. Sources include immunization registry files, laboratory results files, case management databases, and medical record-derived databases.

**Medical record data:** Data abstracted from paper or electronic medical records may be applied to certain measures, using the NCQA-defined hybrid method. HEDIS® specifications describe statistically sound methods of sampling, so that only a subset of the eligible population's medical records needs to be chased.

NCQA specifies hybrid calculation methods, in addition to administrative methods, for several measures selected by DHMH for HEDIS® reporting:

- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC)—HbA1c testing; poor control >9.0; control <8.0\*
- Comprehensive Diabetes Care (CDC)—Eye exam (retinal) performed
- Comprehensive Diabetes Care (CDC)—LDL-C screening; LDL-C control <100mg/dL\*
- Comprehensive Diabetes Care (CDC)—Medical attention for nephropathy
- Comprehensive Diabetes Care (CDC)—Blood pressure control <140/90 mm Hg;
- Comprehensive Diabetes Care (CDC)—Blood pressure control <140/80 mm Hg\*
- Prenatal and Postpartum Care (PPC)
- Frequency of Ongoing Prenatal Care (FPC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)
- Adult BMI Assessment (ABA)
- Controlling High Blood Pressure (CBP)

Use of the hybrid method is optional. NCQA maintains that no one approach to measure calculation or data collection is considered superior to another. From organization to organization, the percentages of data obtained from one data source versus another are highly variable, making it inappropriate to make across-the-board statements about the need for, or positive impact of, one method versus another. In fact, an organization's yield from the hybrid method may impact the final rate by only a few percentage points, an impact that is also achievable through improvement of administrative data systems.

\* An organization must use the same method for the group of indicators.

The following table shows actual HEDIS 2013 use of the administrative or hybrid method. The choice of using the administrative vs. hybrid method is usually one of available resources. The hybrid method takes significant resources to perform.

Measure	ACC HC	DIA HC	JMS HC	MPC HC	MSFC HC	PP HC	UHC HC	ACC PAC	JMS PAC	MPC PAC	PP PAC	UHC PAC
CIS	H	H	H	H	H	H	H					
IMA	H	H	A	H	H	H	H					
W15	H	H	H	H	H	A	H					
W34	H	H	A	H	H	H	H					
AWC	H	H	A	H	H	H	H					
CCS	H	H	A	H	H	H	H	A	A	A	A	A
PPC Pre	H	H	H	H	H	H	H					
PPC Post	H	H	H	H	H	H	H					
FPC	H	H	H	A	H	H	H					
CDC - HbA1c testing	H	H	H	H	H	H	H	A	H	H	A	A
CDC - HbA1c Poor Control	H	H	H	H	H	H	H	A	H	H	A	A
CDC HbA1c Control (<8.0%)	H	H	H	H	H	H	H	A	H	H	A	A
CDC - Eye exam (retinal) performed	H	H	H	H	H	H	H	A	H	H	A	A
CDC - LDL-C screening and control	H	H	H	H	H	H	H	A	H	H	A	A
CDC - Medical attention for nephropathy	H	H	H	H	H	H	H	A	H	H	A	A
CDC - Blood pressure control 140/80	H	H	H	H	H	H	H	A	H	H	A	A
CDC - Blood pressure control 140/90	H	H	H	H	H	H	H	A	H	H	A	A
ABA	H	H	H	H	H	H	H					
CBP	H	H	H	H	H	H	H					

H - Hybrid  
A - Administrative  
HC - HealthChoice  
PAC - Primary Adult Care

## HEDIS® Audit Protocol

The HEDIS® auditor follows NCQA's *Volume 5: HEDIS® Compliance Audit™: Standards, Policies, and Procedures* described briefly below:

- **Offsite preparation for the onsite audit:** To prepare the MCOs for the upcoming audit, HDC takes the following steps:
  - **Conference call:** A conference call is held to introduce key personnel, review the onsite agenda, identify session participants, and determine a plan to audit data sources used for HEDIS®.
  - **HEDIS® Roadmap review:** Each MCO must complete the HEDIS Record of Administration, Data Management, and Processes (ROADMAP). The Roadmap includes detailed questions about all audit standards and describes the operational and organizational structure of the organization. The auditor reviews the HEDIS® Roadmap to make preliminary assessments regarding information systems compliance and to identify areas requiring follow-up at the onsite audit.
- **Information Systems (IS) standards compliance:** The onsite portion of the HEDIS® Audit that expands upon information gleaned from the HEDIS® Roadmap to enable the auditor to make conclusions about the organization's compliance with IS standards. IS standards, describing the minimum requirements for information systems and processes used in HEDIS® data collection, are the foundation on which the auditor assesses the organization's ability to report HEDIS® data accurately and reliably. The auditor reviews data collection and management processes, including the monitoring of vendors, and makes a determination regarding the soundness and completeness of data to be used for HEDIS® reporting.
- **HEDIS® Measure Determination (HD) standards compliance:** The auditor uses both onsite and offsite activities to determine compliance with HD standards and to assess the organization's adherence to HEDIS® Technical Specifications and report-production protocols. The auditor confirms the use of NCQA certified software. (All Maryland Medicaid organizations continue to use certified software to produce HEDIS® reports.) The auditor reviews the organization's sampling protocols for the hybrid method. Later in the audit season, the auditor reviews HEDIS® results for algorithmic compliance and performs benchmarking against NCQA-published means and percentiles.
- **Medical record review validation (MRRV):** The HEDIS® audit includes a protocol to validate the integrity of data obtained from medical record review (MRR) for any measures calculated using the hybrid method. The audit team compares its medical record findings to the organization's abstraction forms for a sample of positive numerator events. Part one of the validation may also include review of a *convenience sample* of medical records for the purpose of finding procedural errors early in the medical record abstraction process so that timely corrective action can be made. This is optional based on NCQA standards and auditor opinion. MRRV is an important component of the HEDIS® Compliance Audit. It ensures that medical records reviews performed by the organization, or by its contracted vendor, meet audit standards for sound processes and that abstracted medical data are accurate. In part two of the MRRV, the auditor selects hybrid measures from like-measure groupings for measure validation. MRRV tests medical records and appropriate application of the HEDIS® hybrid specifications (i.e., the member

is a numerator negative, a numerator positive or an exclusion for the measure). NCQA uses an acceptable quality level of 2.5 percent for the sampling process, which translates to a sample of 16 medical records for each selected measure.

- **Audit designations:** The auditor approves the rate/result of each measure included in the HEDIS® report, as shown in the table of audit results in the Appendix XX, excerpted from *Volume 5: HEDIS® Compliance Audit™: Standards, Policies, and Procedures*.

Rate/Result	Comment
O-XXX	Reportable rate or numeric result for HEDIS® measures
NR	Not Reported: <ol style="list-style-type: none"> <li>1. Plan chose not to report. *</li> <li>2. Calculated rate was materially biased.</li> </ol>
NA	Small Denominator: The organization followed the specifications but the denominator was too small to report a valid rate.

\* An organization may exercise this option only for those measures not included in the measurement set required by DHMH.

- **Bias Determination:** If the auditor determines that a measure is biased, the organization cannot report a rate for that measure and the auditor assigns the designation of NR. Bias is based on the degree of error or data completeness for the data collection method used. NCQA defines four bias determination rules, applied to specific measures. These are explained in Appendix 10 of *Volume 5: HEDIS® Compliance Audit™: Standards, Policies and Procedures*.
- **Final Audit Opinion:** At the close of the audit, the auditor renders the Final Audit Opinion, containing a Final Audit Statement along with measure-specific rates/results and comments housed in the Audit Review Table.

**Measure-specific Findings – Explanation**

Two metrics are calculated to accompany the MCO-specific scores:

- **Maryland Average Reportable Rate (MARR):** The MARR is an average of HealthChoice MCO’s rates as reported to NCQA. In most cases, all seven MCOs contributed a rate to the average. Where one or more organizations reported NA or NR instead of a rate, the average consisted of fewer than seven component rates.
- **National HEDIS® Mean (NHM):** The mean value is taken from NCQA’s *HEDIS® Audit Means, Percentiles and Ratios – Medicaid*, released each year to HEDIS® auditors and reporting organizations. The NCQA data set gives prior-year rates for each measure displayed as the mean rate and the rate at the 5th, 10th, 25th, 50th, 75th, 90th and 95th percentiles. *HEDIS® 2012 Means, Percentiles, and Ratios* pertinent to this report, as well as additional rates for measure components not published in this report, can be found in the Appendix A2-1. NCQA averages the rates of all organizations submitting HEDIS® results,

regardless of the method of calculation (administrative or hybrid). NCQA's method is the same as that used for the MARR, but on a larger scale.

**Year-to-year trending:** Year-to-year trending is possible when specifications remain consistent from year to year. (Expected updates to industry-wide coding systems are not considered specification changes.) For each measure, the tables display up to five-years of results, where available.

Prior year results are retained in the trending tables, regardless of specification changes. Text in italics notes when prior-year results fall under different specifications. Performance trends at the organization level are juxtaposed with the trends for the MARR and the NHM for the same measurement year.

**Rounding of figures:** Rates are rounded to one decimal point from the rate/ratio reported to NCQA. This rounding corresponds to the rounding used by NCQA for the NHM. Where any two or more rates are identical at this level of detail, an additional decimal place of detail is provided.

**Audit designation other than a rate/ratio:** According to NCQA reporting protocols, *NA* or *NR* may replace a rate. Please see page 9 for defined uses of these audit designations.

**Organization of data:** The following pages contain the comparative results for HEDIS 2013. This report does group and sequence measures by like populations or functions.

- Prevention and Screening-Adult and Child: CIS, IMA, W15, W34, AWC, ABA
- Respiratory Conditions: CWP, URI, AAB, ASM, MMA
- Member Access: CAP, AAP
- Women's Health: BCS, CCS, CHL
- Prenatal and Postpartum Care: PPC, FPC
- Cardiovascular Conditions: CBP
- Diabetes: CDC
- Musculoskeletal Conditions: LBP, ART
- Medication Management: MPM
- Behavioral Health: IET, IAD
- Ambulatory Care (utilization): AMB
- Call Services: CAT

**Sources of accompanying information:**

- Description – The source of the information is NCQA's HEDIS 2013 Volume 2: Technical Specifications.
- Rationale – For all measures, except Call Answer Timeliness (CAT) the source of the information is the Agency for Healthcare Research and Quality (AHRQ) citations of NCQA as of 2013. These citations appear under the Brief Abstract on the Web site of the National Quality Measures Clearinghouse, <http://www.qualitymeasures.ahrq.gov/>. For CAT the rationale was adapted from HEDIS 2004 Vol. 2: Technical Specifications.

- Summary of Changes for HEDIS 2013 – The source of the text, is the HEDIS 2013 Volume 2: Technical Specifications, incorporating additional changes published in the HEDIS 2013 Volume 2: “October” Technical Update.

### Year-to-year changes

Table 32 shows the numbers of organizations that experienced a lower or higher change in HEDIS rates from 2012 to 2013. The change in the MARR (2013 rate minus 2012 rate) and the change in the NHM (2012 rate minus 2011 rate) place Maryland HealthChoice organization trends in perspective. For measures where a lower rate indicates better performance (single asterisk), the number of lower performing organizations appears in the higher column and the number of higher performing organizations appear in the lower column. New measures or indicators with no trendable history are not included in this analysis of change. HEDIS 2013 results of *NA* are not included in tallies. Rates that stayed the same from last year and did not increase or decrease are not included in this table.

Table 32. Changes in HEDIS Rates from 2012 to 2013

HEDIS Measure	Lower	Higher	MARR change	NHM change
Childhood Immunization Status (CIS) – Combination 2	4	3	-2.3	+0.4
Childhood Immunization Status (CIS) – Combination 3	3	4	-2.0	+0.7
Childhood Immunization Status (CIS) – Combination 4	0	7	+35.6	+2.6
Childhood Immunization Status (CIS) – Combination 5	2	5	+0.1	+4.7
Childhood Immunization Status (CIS) – Combination 6	2	5	+1.7	+1.5
Childhood Immunization Status (CIS) – Combination 7	0	7	+27.3	+3.3
Childhood Immunization Status (CIS) – Combination 8	0	7	+21.2	+1.9
Childhood Immunization Status (CIS) – Combination 9	2	5	+1.7	+2.7
Childhood Immunization Status (CIS) – Combination 10	0	7	+16.5	+2.1
Immunizations for Adolescents (IMA) – Combination 1	1	5	+6.4	+8.3
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*	4	2	+0.1	-0.3
Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or Six-or-more visits rates**	3	3	-1.1	NA
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	6	1	-2.8	+0.1
Adolescent Well-Care Visits (AWC)	3	4	-1.6	+1.6
Appropriate Testing for Children with Pharyngitis (CWP)	1	6	+4.2	+1.8
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	7	0	-1.8	-1.9
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	5	2	-0.1	+24.3
Use of Appropriate Medications for People With Asthma (ASM) – Ages 5-11	4	3	-1.0	-1.3
Use of Appropriate Medications for People With Asthma (ASM) – Ages 12-18	5	1	-1.7	NA
Use of Appropriate Medications for People With Asthma (ASM) – Ages 19-50	4	3	-1.5	NA
Use of Appropriate Medications for People With Asthma (ASM) – Ages 51-64	3	2	+1.0	NA
Use of Appropriate Medications for People With Asthma (ASM) – Ages 5-64	7	0	-3.7	NA
Use of Appropriate Medications for People With Asthma (ASM) – Total combined ages 5-50**	5	2	-1.3	NA

HEDIS Measure	Lower	Higher	MARR change	NHM change
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12-24 months	4	2	-0.5	0.0
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months-6 years	6	1	-0.6	-0.1
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7-11 years	4	3	-0.2	-0.7
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12-19 years	3	4	0.0	-0.2
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 20-44	4	3	-0.1	-1.2
Adults' Access to Preventive/Ambulatory Health Services (AAP) – Age 45-64	3	3	-0.1	0.0
Breast Cancer Screening (BCS)	1	6	+0.7	-0.9
Cervical Cancer Screening (CCS)	2	5	+0.6	-0.5
Chlamydia Screening in Women (CHL) – Age 16-20 years	4	3	+1.0	+0.3
Chlamydia Screening in Women (CHL) – Age 21-24 years	3	4	-1.0	+1.1
Chlamydia Screening in Women (CHL) – Total, 16-24 years of age	3	4	+0.1	+0.5
Prenatal and Postpartum Care (PPC) – Timeliness of prenatal care	4	3	-0.5	-1.0
Prenatal and Postpartum Care (PPC) – Postpartum care	4	3	-0.6	-0.3
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*	2	5	+1.4	-1.4
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	6	1	-2.9	-0.2
Comprehensive Diabetes (CDC) – HbA1c testing	3	4	+0.2	+0.5
Comprehensive Diabetes (CDC) – HbA1c poor control (>9.0%)*	1	6	+1.9	-1.0
Comprehensive Diabetes (CDC) – HbA1c control (< 8.0%)	5	2	-0.5	+1.2
Comprehensive Diabetes (CDC) – Eye exam (retinal) performed	5	2	-1.4	+0.3
Comprehensive Diabetes (CDC) – LDL-C screening	5	2	-0.7	+0.3
Comprehensive Diabetes (CDC) – LDL-C control (<100 mg/dL)	4	3	-0.9	+0.6
Comprehensive Diabetes (CDC) – Medical attention for nephropathy	5	2	-2.0	+0.1
Comprehensive Diabetes (CDC) – Blood pressure control (<140/80 mm Hg)	3	4	+0.6	+0.7
Comprehensive Diabetes (CDC) – Blood pressure control (<140/90 mm Hg)	4	3	-1.6	+0.6
Use of Imaging Studies for Low Back Pain (LBP)	5	2	-1.7	+0.3
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 13-17 years	4	1	-7.4	-4.2
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 18+ years	5	2	-3.6	-3.3
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation overall ages	6	1	-3.8	-3.7
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 13-17 years	4	1	-5.4	-2.5
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 18+ years	6	1	-2.2	-2.1
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement overall ages	7	0	-2.4	-2.3
Identification of Alcohol and Other Drug Services (IAD) – Any	3	3	-0.2	+0.3
Identification of Alcohol and Other Drug Services (IAD) – Inpatient	4	0	-0.3	+0.2
Identification of Alcohol and Other Drug Services (IAD) – Intensive outpatient/partial hospitalization	6	0	-0.2	+0.1

HEDIS Measure	Lower	Higher	MARR change	NHM change
Identification of Alcohol and Other Drug Services (IAD) – Outpatient/ED	2	4	0.0	+0.1
Ambulatory Care (AMB) – Outpatient visits	5	2	-0.6	-3.5
Ambulatory Care (AMB) – Emergency department*	4	3	0.0	+0.4
Call Answer Timeliness (CAT)	2	5	+1.9	+0.5

\* A lower rate indicates better performance.

\*\* Not a HEDIS sub-measure; HDC is calculating for DHMH trending purposes.

NA – NHM change cannot be calculated since these age groups first started in 2012

Three-year trends: The following table shows organizations that demonstrated incremental increases in performance scores over the past three years. The analysis only shows a trend toward improvement. It does not indicate superior performance. For a comparison of one organization against another, please refer to the measure-specific tables in this report. For measures where a lower rate indicates better performance (single asterisk), the table shows organizations having a decrease in performance score over the past three years.

Table 33. HEDIS Measures Incremental Increases in Performance

HEDIS Measure	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Childhood Immunization Status (CIS) – Combination 2 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV)		X				X	
Childhood Immunization Status (CIS) – Combination 3 (DTaP/DT, IPV, MMR, HiB, Hep B, VZV, pneumococcal conjugate)	X	X				X	
Childhood Immunization Status (CIS) – Combination 4 (DTaP/DT, IPV, MMR, HiB, Hep B, VZV, PCV, Hepatitis A)	X	X		X	X	X	X
Childhood Immunization Status (CIS) – Combination 5 (DTaP/DT, IPV, MMR, HiB, Hep B, VZV, PCV, Rotavirus)	X	X				X	
Childhood Immunization Status (CIS) – Combination 6 (DTaP/DT, IPV, MMR, HiB, Hep B, VZV, PCV, Influenza)	X	X		X		X	
Childhood Immunization Status (CIS) – Combination 7 (DTaP/DT, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	X	X			X	X	X
Childhood Immunization Status (CIS) – Combination 8 (DTaP/DT, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, Influenza)	X	X	X	X	X	X	
Childhood Immunization Status (CIS) – Combination 9 (DTaP/DT, IPV, MMR, HiB, Hep B, VZV, PCV, RV, Influenza)	X	X		X		X	
Childhood Immunization Status (CIS) – Combination 10 (DTaP/DT, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	X	X	X	X	X	X	X
Immunizations for Adolescents (IMA) – Combination 1 (Meningococcal, Tdap/Td)	X	X					X
Well-Child Visits in the First 15 months of Life (W15) – No well-child visits*	X	X	X	X	X	X	X
Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or Six-or-more visits rates (additive)**		X	X		X		
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)							X
Adolescent Well-Care Visits (AWC)					X	X	X
Appropriate Testing for Children with Pharyngitis (CWP)	X	X		X		X	X

HEDIS Measure	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Appropriate Treatment for Children with Upper Respiratory Infection (URI)							
Use of Appropriate Medications for People with Asthma (ASM) – Ages 5-11							X
Use of Appropriate Medications for People with Asthma (ASM) – Total combined ages 5-50**							
Children and Adolescents’ Access to Primary Care Practitioners (CAP) – Age 12-24 months				X			
Children and Adolescents’ Access to Primary Care Practitioners (CAP) – Age 25 months-6 years							
Children and Adolescents’ Access to Primary Care Practitioners (CAP) – Age 7-11 years	X						
Children and Adolescents’ Access to Primary Care Practitioners (CAP) – Age 12-19 years	X					X	
Adults’ Access to Preventive/Ambulatory Health Services (AAP) – Age 20-44		X		X	X		
Adults’ Access to Preventive/Ambulatory Health Services (AAP) – Age 45-64		X			X		X
Breast Cancer Screening (BCS)	X	X		X		X	X
Cervical Cancer Screening (CCS)				X		X	
Chlamydia Screening in Women (CHL) – Age 16-20 years		X			X		
Chlamydia Screening in Women (CHL) – Age 21-24 years	X			X	X		
Chlamydia Screening in Women (CHL) – Age 16-24 years		X			X		
Prenatal and Postpartum Care (PPC) – Timeliness of prenatal care							
Prenatal and Postpartum Care (PPC) – Postpartum care	X				X		
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits*	X	X			X	X	
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits							
Comprehensive Diabetes (CDC) – Hemoglobin A1c testing	X	X				X	X
Comprehensive Diabetes (CDC) – Hemoglobin A1c poor control (>9.0%)*	X	X	X	X	X	X	X
Comprehensive Diabetes (CDC) – Hemoglobin A1c control (<8.0%)					X		
Comprehensive Diabetes (CDC) – Eye exam (retinal) performed						X	
Comprehensive Diabetes (CDC) – LDL-C screening		X					X
Comprehensive Diabetes (CDC) – LDL-C control (<100 mg/dL)							
Comprehensive Diabetes (CDC) – Medical attention for nephropathy							
Comprehensive Diabetes (CDC) – Blood pressure control (<140/80 mm Hg)			X		X	X	
Comprehensive Diabetes (CDC) – Blood pressure control (<140/90 mm Hg)			X		X		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 13-17 years							
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation 18+ years							
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Initiation overall ages							
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 13-17 years							
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement 18+ years							X

HEDIS Measure	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) – Engagement overall ages							
Identification of Alcohol and Other Drug Services (IAD) – Any				X			
Identification of Alcohol and Other Drug Services (IAD) – Inpatient							
Identification of Alcohol and Other Drug Services (IAD) – Intensive Outpatient / Partial Hospitalization							
Identification of Alcohol and Other Drug Services (IAD) – Outpatient / ED	X			X		X	
Call Answer Timeliness (CAT)	X		X				
<b>TOTALS (of 53 above)</b>	<b>21</b>	<b>22</b>	<b>9</b>	<b>15</b>	<b>18</b>	<b>21</b>	<b>16</b>

\* A lower rate indicates better performance. \*\* Not a HEDIS sub-measure; HDC is calculating for DHMH trending purposes.

## Findings

### Implications

HEDIS® rates are widely used and respected standardized quality indicators. As with any measurement tool, it is important to understand uses and limitations. HEDIS® results can be used as markers of care, but cannot be used, on their own, to draw conclusions about the quality of care. A comparison among organizations on the basis of HEDIS® rates alone would not take into account population differences, such as age, health status, or catchment area (urban vs. rural). For example, Maryland Medicaid organizations are dissimilar in location served: two organizations operate statewide (ACC and UHC), four are regional (DIA, MPC, MSFC, and PPMCO), and one operates in Baltimore City and parts of Baltimore County (JMS). The effect of these geographic locations on HEDIS® rates is unknown.

Year-to-year trends: Trends in rates, as shown in the tables provided in Appendix A5-1, can indicate genuine improvement or can indicate something else, e.g., familiarity with HEDIS® reporting or improved data systems. Significant changes (up or down) from HEDIS® 2012 to HEDIS® 2013 include:

- The MARR for all CIS combo rates, except Combo 2 and 3, increased
- The MARR for the ASM (5-50) measure decreased 1.3 percentage points
- The MARR FPC, 81%+ of expected visits measure, decreased 2.9 percentage points
- The MARR for the CIS measure, Combo 2, decreased 2.3 percentage points
- The MARR for the ASM measure overall 5-64 decreased 3.7 percentage points
- The MARR for Retinal Eye Exam, CDC measure, decreased 1.4 percentage points
- The MARR for the IMA measure, Combo 1) increased 6.4 percentage points
- The MARR for the CAT measure increased 1.9 percentage points

HC MARR comparison to NHM: The HealthChoice MARR is above the NHM for all measures except in ten areas. Differences of less than .5 percentage points are not listed.

- URI measure – the MARR is 0.9 percentage points below the NHM
- AAB measure – the MARR is 3.9 percentage points below the NHM
- MMA measures – the MARR is 6 percentage points below the NHM
- FPC measure (Less than 21%) – the MARR is 3.7 percentage points below the NHM
- CBP measure – the MARR is 7 percentage points below the NHM
- CDC measure (HbA1c testing) – the MARR is 1.3 percentage points below the NHM
- CDC measure (BP < 140/80) – the MARR is 3 percentage points below the NHM
- CDC measure (BP < 140/90) – the MARR is 3.7 percentage points below the NHM
- LBP measure – the MARR is 0.9 percentage points below the NHM
- IET measure (Initiation age 13-17) – the MARR is 6.4 percentage points below the NHM

## HealthChoice Maryland Average Reportable Rate Highlights

Some changes in performance rates from HEDIS® 2012 are highlighted below:

- Childhood Immunization Status
  - The MARR for every CIS Combo rate increased except Combo 2 and 3. Some of the increases were significant with Combo 4 increasing 35.6 percentage points and Combo 7 increasing 27.3 percentage points. Plans took the time to extract information from the state immunization registry and also improved upon their supplemental data capture.
- Immunizations for Adolescents
  - The MARR for IMA, Combo 1, increased by 6.4 percentage points.
- Well-Child Visits
  - The MARR for the W15 (5 or more visits) measure decreased 1.1 percentage points even with higher performance scores from MedStar, Jai, and the Diamond plan.
  - The MARR for the Well Child Visits in the 3rd, 4th, 5th, or 6th Year of Life decreased 2.8 percentage points even with a slightly higher performance scores from United.
- Appropriate Testing of Children with Pharyngitis (CWP)
  - The MARR for CWP increased 4.2 percentage points. This was due to a strong performance score increase across all health plans.
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
  - In the second year of reporting the AAB measure, rates for the HealthChoice plans showed no improvement in the number of individuals who were not given antibiotics after diagnosis for bronchitis. Interestingly the PAC had a 2.9 percentage point increase in this measure. HC is below the NHM for this measure.
- Use of Appropriate Medications for People with Asthma
  - The special report of age groups 5-50 for the ASM measures shows the MARR had a slight decrease of 1.3 percentage points. Only PP showed a slight increase in this measure.
- Prenatal and Postpartum Care
  - There was a decrease 2.9 percentage points in the MARR for women who received more than 81% of prenatal care visits. There was also a decrease in the performance score for Timeliness of Prenatal Care (- .5 points).
- Call Answer Timeliness
  - There was an increase in the MARR for the CAT measure of 1.9 percentage points, which indicates more attention to customer service metrics.
- Comprehensive Diabetes Care
  - Overall, the changes for the CDC indicators were mixed (some went up while others went down).
  - The biggest change was a decrease in the MARR for the nephropathy indicator, which dropped 2 percentage points.

## Section VII Consumer Assessment of Healthcare Providers and Systems®

### Introduction

COMAR 10.09.65.03 C (4) requires that all HealthChoice MCOs participate in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey. DHMH has contracted with WBA Market Research (WBA), an NCQA-certified survey vendor, since 2008 to conduct its survey. WBA administers this survey to a random sample of eligible adult and child members enrolled in HealthChoice and eligible adult members enrolled in PAC, via mixed methodology (mail with telephone follow-up), per NCQA protocol. Seven MCOs participated in the HealthChoice CAHPS® 2013 survey, and five MCOs participated in the PAC CAHPS® 2013 survey, based on services provided in CY 2012:

MCO	HealthChoice	PAC
AMERIGROUP Community Care	X	X
Diamond Plan	X	
Jai Medical Systems	X	X
Maryland Physicians Care	X	X
MedStar Family Choice, Inc.	X	
Priority Partners	X	X
UnitedHealthcare	X	X

### 2013 CAHPS® 5.0H Medicaid Survey Methodology

In 2013, NCQA released the 5.0H version of the CAHPS® Adult and Child Medicaid Satisfaction Surveys, which DHMH adopted. The CAHPS® 5.0H survey measures those aspects of care for which members are the best and/or the only source of information. From this survey, members' ratings of and experiences with the medical care they receive can be determined. Based on members' health care experiences, potential opportunities for improvement can be identified. Specifically, the results obtained from this consumer survey will allow DHMH to:

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

Results from the CAHPS® 5.0H survey summarize member satisfaction with their health care through ratings, composites, and question summary rates. In general, summary rates represent the percentage of respondents who chose the most positive response categories as specified by NCQA. Ratings and composite measures in the CAHPS® 5.0H Adult and Child Medicaid Survey include:

- Overall Ratings of Personal Doctor, Specialist, Health Care, and Health Plan
- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision-Making
- Health Promotion and Education
- Coordination of Care

Five additional composite measures are calculated for the Children with Chronic Conditions (CCC) population:

- Access to Prescription Medicine
- Family Centered Care: Getting Needed Information
- Family Centered Care: Personal Doctor Who Knows Child
- Access to Specialized Services
- Coordination of Care for CCC

### **Research Approach**

Eligible adult and child members from each of the seven HealthChoice MCOs that provide Medicaid services participated in this research. WBA administered a mixed methodology including mailing the CAHPS survey along with a telephonic survey follow-up. Two questionnaire packages and follow-up reminder postcards were sent to random samples of eligible adult and child members from each of the seven HealthChoice MCOs with “Return Service Requested” with WBA’s toll-free number included. The mailed materials also included a toll-free number for Spanish-speaking members to complete the survey over the telephone. Those who did not respond by mail were contacted by phone to complete the survey. During the telephone follow-up, members had the option to complete the survey in either English or Spanish. The child surveys were conducted by proxy, that is, with the parent/guardian who knows the most about the sampled child’s health care.

### **Sampling Methodology**

The NCQA required sample size is 1,350 for each of the adult Medicaid plans. In addition to the required sample size, NCQA allows oversampling of up to 30%. DHMH elected to use this option. To qualify, adult Medicaid members had to be 18 years of age or older, as well as continuously enrolled in the HealthChoice MCO for five of the last six months as of the last day of the measurement year (December 31, 2012).

Following this sampling methodology, WBA mailed 1,755 surveys for each HealthChoice MCO, for a total of 12,285 surveys in CAHPS® 2013.

A total of 3,704 valid surveys were completed between February and May 2013 for the adult HealthChoice population, 13 of which were completed in Spanish. Specifically, 2,284 were returned by mail and 1,420 were conducted over the phone. The overall response rate from the eligible Medicaid adult population for CAHPS® 2013 was 31%.

A total of 3,280 valid surveys were completed between February and May 2013 for the PAC population. Specifically 2,590 were returned by mail and 690 were conducted over the phone. The overall response rate for CAHPS® 2013 was 39%.

The NCQA required sample size is 1,650 for child Medicaid plans (General Population/Sample A). In addition to the required sample size, NCQA allows over-sampling up to 30%. DHMH elected to use this option. To qualify, child Medicaid members had to be 17 years of age or younger. Furthermore, members had to be continuously enrolled in the HealthChoice MCO for five of the last six months as of the last day of the measurement year (December 31, 2012).

Among the child population, an additional over-sample of up to 1,840 child members with diagnoses indicative of a probable chronic condition was also pulled (CCC Over-sample/Sample B). This is standard procedure when the CAHPS® 5.0H Child Medicaid Survey (with CCC Measurement Set) is administered, to ensure the validity of the information collected.

The CCC population is identified based on child members' responses to the CCC survey-based screening tool (questions 60 to 73), which contains five questions representing five different health consequences; four are three-part questions and one is a two-part question. A child member is identified as having a chronic condition if all parts of the question for at least one of the specific health consequences are answered "Yes".

It's important to note that the General Population data set (Sample A) and CCC Over-sample data set (Sample B) are not mutually exclusive groups. For example, if a child member is randomly selected for the CAHPS® Child Survey sample (General Population/Sample A) and is identified as having a chronic condition based on responses to the CCC survey-based screening tool, the member is included in both General and CCC Population results.

Between February and May 2013, WBA collected 4,720 valid surveys, 306 of which were completed in Spanish. Specifically, 4,436 were completed by mail and 2,573 were completed by phone. The overall response rate from the eligible Medicaid child population was 32%. Of the responses, 2,211 child members

across all HealthChoice MCOs qualified as being children with chronic conditions based on the parent's/guardian's responses to the CCC survey-based screening tool.

Ineligible adult and child members included those who were deceased, did not meet eligible population criteria (indicated non-membership in the specified health plan), or had a language barrier (non-English or Spanish). In addition, adult members who were mentally or physically incapacitated and unable to complete the survey themselves were also considered ineligible. Non-respondents included those who had refused to participate, could not be reached due to a bad address or telephone number, or were unable to be contacted during the survey time period. Ineligible surveys are subtracted from the sample size when computing a response rate.

Table 34 shows the total number of adult members in the sample that fell into each disposition category.

**Table 34. Adult Dispositions**

Disposition Group	Disposition Category	Number
Ineligible	Deceased	11
	Does not meet eligibility criteria	197
	Language barrier	48
	Mentally/Physically incapacitated	46
	Total Ineligible	302
Non-Response	Bad address/phone	831
	Refusal	451
	Maximum attempts made	6997
	Total Non-Response	8279

Table 35 show the number of mail and phone completes as well as the response rate for each Health Choice MCO.

**Table 35. MCO Response Rate**

HealthChoice MCO	Mail and Phone Completes*	Response Rate
AMERIGROUP Community Care	464	27%
Diamond Plan	440	26%
Jai Medical Systems	553	32%
Maryland Physicians Care	566	33%
MedStar Family Choice, Inc.	547	32%
Priority Partners	579	34%
UnitedHealthcare	555	33%
Total HealthChoice MCOs	3704	31%

## Findings

### Key Findings from the 2013 CAHPS® 5.0H Adult Medicaid Survey

There were four Overall Rating questions asked in the CAHPS® 5.0H Adult Medicaid Survey that used a scale of “0 to 10”, where a “0” represented the worst possible rating and a “10” represented the best possible rating. Table 36 shows each of the four Overall Rating questions and the Summary Rate for these questions from CAHPS® 2011 through CAHPS® 2013. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

**Table 36. CAHPS® 2011 - CAHPS® 2013 Adult Summary Rates for Overall Rating Questions**

Overall Ratings	2011 (Summary Rate – 8,9,10)	2012 (Summary Rate – 8,9,10)	2013 (Summary Rate – 8,9,10)
Health Care	66%	68%	69%
Personal Doctor	74%	75%	76%
Specialist Seen Most Often	73%	73%	77%↑
Health Plan	67%	70%	69%

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

Consistent with CAHPS® 2012, HealthChoice adult members give their highest satisfaction ratings to their Specialist (77% giving a rating of 8, 9, or 10; which is up from 73% in 2012) and/or their Personal Doctor (76%). Additionally, HealthChoice adult members continued to give slightly lower satisfaction ratings to their Health Plan (69%) and/or Health Care (69%) overall.

### Overall Ratings

In order to assess how the HealthChoice MCOs overall ratings compared with other Medicaid adult and child plans nationwide, national benchmarks are provided. Specifically, the adult and child data are compared to the Quality Compass® benchmarks (Reporting Year 2012). Quality Compass® is a national database created by the NCQA to provide health plans with comparative information on the quality of the nation’s managed care plans.

Table 37 shows a plan comparison of Adult Summary Ratings of the four Overall Rating questions for the seven participating HealthChoice MCOs. Additionally, it indicates the Quality Compass® and the HealthChoice Aggregate for each question.

Table 37. CAHPS® 2013 MCO Adult Summary Rates for Overall Rating Questions

2013 Adult Overall Ratings (Summary Rate – 8,9,10)				
	Health Care	Personal Doctor	Specialist Seen Most Often	Health Plan
Quality Compass® <sup>1</sup>	71%	78%	79%	74%
HealthChoice Aggregate	69%	76%	77%	69%
AMERIGROUP Community Care	71%	73%	76%	73%
Diamond Plan	67%	69%	81%	66%
Jai Medical Systems	63%	81%*	76%	66%
Maryland Physicians Care	70%	75%	84%*	70%
MedStar Family Choice, Inc.	78%*	79%	71%	77%*
Priority Partners	65%	73%	74%	66%
UnitedHealthcare	72%	78%	81%	68%

\*MCO with the highest Summary Rate.

<sup>1</sup>Quality Compass® is a registered trademark of NCQA.

Composite measures assess results for main issues/areas of concern. The following composite measures were derived by combining survey results of similar CAHPS® questions:

- **How Well Doctors Communicate** – Measures how well personal doctor explains things, listens to them, shows respect for what they have to say and spends enough time with them.
- **Customer Service** – Measures members’ experiences with getting the information needed and treatment by Customer Service staff.
- **Getting Care Quickly** – Measures members’ experiences with receiving care and getting appointments as soon as they needed.
- **Getting Needed Care** – Measures members’ experiences in the last six months when trying to get care from specialists and through health plan.
- **Coordination of Care** – Measures members’ perception of whether their doctor is up-to-date about the care he/she received from other doctors or health providers.
- **Health Promotion and Education** – Measures members’ experience with their doctor discussing specific things to do to prevent illness.
- **Shared Decision Making** – Measures members’ experiences with doctors discussing the pros and cons of starting or stopping a prescription medicine and asking the member what they thought was best for them.

Table 38 shows the adult composite measure results from CAHPS® 2011 to CAHPS® 2013.

Table 38. CAHPS® 2011 - CAHPS® 2013 Adult Composite Measure Results

Composite Measure	CY 2011 (Summary Rate– Always/Usually)	CY 2012 (Summary Rate– Always/Usually)	CY 2013 (Yes or A lot/ Some/Yes)
How Well Doctors Communicate	87%	87%	89%
Customer Service	78%	79%	81%
Getting Care Quickly	80%	79%	80%
Getting Needed Care	72%	71%	79%↑
Coordination of Care	76%	75%	78%
Health Promotion and Education	N/A	N/A	75%
Shared Decision-Making	N/A	N/A	74%

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

Consistent with CAHPS® 2012, HealthChoice MCOs continued to receive the highest ratings among their members on the “How Well Doctors Communicate” composite (89%). Notably, the “Getting Needed Care” composite is up from 2012 (79%, up from 71% in 2012). Research shows that HealthChoice MCOs receive the lowest ratings among their members on the following composite measures:

- Health Promotion and Education (75% Summary Rate – *Yes*); and/or
- Shared Decision-Making (74% Summary Rate – *A lot/Some or Yes*).

**Key Findings from the 2013 PAC Enrollee Satisfaction Survey**

There are four Overall Ratings questions asked in the PAC Survey that used a scale of “0 to 10”, where a “0” represents the worst possible and a “10” represents the best possible: Rating of “Health Care”, “Primary Care Provider”, “Pharmacy Coverage” and “Health Plan”. The Summary Rate for these questions represents the percentage of members who rated the question an 8, 9 or 10.

PAC enrollees continued to give the highest satisfaction ratings to their Pharmacy Coverage (70%) and their Primary Care Provider (64%).

- At the same time, PAC enrollees gave lower satisfaction ratings to their Health Plan (54%, down from 57% in 2012) and Health Care (54%, down from 57% in 2012) overall.

Table 39 shows each of the four Overall Rating questions and the Summary Rate for these questions from CAHPS® 2011 through CAHPS® 2013. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

**Table 39. CAHPS® 2011 - CAHPS® 2013 PAC Summary Rates for Overall Rating Questions**

Overall Ratings	2011 (Summary Rate – 8,9,10)	2012 (Summary Rate – 8,9,10)	2013 (Summary Rate – 8,9,10)
Health Care	54%	57%	54%↓
Primary Care Provider	56%	57%	54%↓
Pharmacy Coverage	72%	72%	70%
Health Plan	56%	57%	54%

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

Table 40 shows a comparison of the five PAC MCOs.

**Table 40. CAHPS® 2013 MCO Adult Summary Rates for Overall Rating Questions**

2013 PAC Overall Ratings (Summary Rate – 8,9,10)				
	Health Care	Primary Care Provider	Pharmacy Coverage	Health Plan
<b>PAC Aggregate</b>	54%	64%	70%	54%
AMERIGROUP Community Care	56%	69%	74%	58%
Jai Medical Systems	56%	61%	66%	56%
Maryland Physicians Care	52%	61%	67%	54%
Priority Partners	53%	63%	71%	51%
UnitedHealthcare	53%	66%	71%	50%

Composite measures assess results for main issues/areas of concern. The following composite measures were derived by combining survey results of similar questions:

- **Getting Needed Care** – Measures members’ experiences in the last six months when trying to get care from their PCP and through their health Plan.
- **Getting Care Quickly** – Measures members’ experiences with receiving care as soon as they needed.
- **How Well Primary Care Provider Communicates** – Measures how well their PCP explained things, listened to them and spent enough time with them.
- **Customer Service** – measures members’ experiences with getting the information needed and treatment by Customer Service staff.

Table 41 shows the PAC composite measure results from the CAHPS® 2011 to CAHPS® 2013.

**Table 41. CAHPS® 2011 - CAHPS® 2013 PAC Composite Measure Results**

Composite Measure	CY 2011 (Summary Rate– Always/Usually)	CY 2012 (Summary Rate– Always/Usually)	CY 2013 (Yes or A lot/ Some/Yes)
How Well Doctors Communicate	83%	84%	83%
Customer Service	73%	74%	74%
Getting Care Quickly	76%	78%	73%↓
Getting Needed Care	69%	70%	69%

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

The PAC MCOs received the highest ratings among members on the following composite measures: “How Well Primary Care Provider Communicates” (83% Summary Rate – *Always/Usually*), “Customer Service” (74% Summary Rate – *Always/Usually*) and “Getting Care Quickly” (73% Summary Rate – *Always/Usually*, down from 78% in 2012).

On the other hand, the research shows that the PAC MCOs continue to receive somewhat lower ratings among members on the “Getting Needed Care” composite (69% Summary Rate – *Always/Usually*).

**Key Findings from the 2013 CAHPS® 5.0H Child Medicaid Survey**

The results from the four Overall Ratings questions asked in the CAHPS® 5.0H Child Medicaid Survey that are represented in Table 42. The summary rate represents the percentage of members who rated the question an 8, 9, or 10.

**Table 42. CAHPS® 2011 - CAHPS® 2013 Child Summary Rates for Overall Rating Questions**

Overall Ratings	2011 (Summary Rate – 8,9,10)		2012 (Summary Rate – 8,9,10)		2013 (Summary Rate – 8,9,10)	
	General	CCC	General	CCC	General	CCC
Health Care	83%	80%	85%	82%	85%	82%
Personal Doctor	87%	87%	89%	87%	87%	86%
Specialist Seen Most Often	81%	81%	80%	83%	82%	82%
Health Plan	83%	80%	84%	81%	83%	80%

HealthChoice MCOs continued to receive high satisfaction ratings from both parents/guardians of the general children’s population group and the parents/guardians of the children with chronic conditions population group for each overall rating question.

Table 43 shows a plan comparison of Child Summary Ratings of the four Overall Rating questions for the seven participating HealthChoice MCOs. Additionally, it indicates the Quality Compass® and HealthChoice Aggregate for each question.

Table 43. CAHPS® 2013 MCO Child Summary Rates for Overall Rating Questions

2013 Adult Overall Ratings (Summary Rate – 8,9,10)								
	Health Care		Personal Doctor		Specialist Seen Most Often		Health Plan	
	General	CCC	General	CCC	General	CCC	General	CCC
<b>Quality Compass®<sup>1</sup></b>	<b>83%</b>	<b>82%</b>	<b>87%</b>	<b>86%</b>	<b>85%</b>	<b>85%</b>	<b>83%</b>	<b>81%</b>
<b>HC Aggregate</b>	<b>85%</b>	<b>82%</b>	<b>87%</b>	<b>86%</b>	<b>82%</b>	<b>82%</b>	<b>83%</b>	<b>80%</b>
<b>ACC</b>	<b>83%</b>	<b>79%</b>	<b>86%</b>	<b>85%</b>	<b>74%</b>	<b>80%</b>	<b>86%*</b>	<b>79%</b>
<b>DIA</b>	<b>84%</b>	<b>83%</b>	<b>85%</b>	<b>85%</b>	<b>84%</b>	<b>87%</b>	<b>77%</b>	<b>74%</b>
<b>JMS</b>	<b>86%</b>	<b>85%</b>	<b>93%*</b>	<b>93%</b>	<b>78%</b>	<b>78%</b>	<b>81%</b>	<b>80%</b>
<b>MPC</b>	<b>84%</b>	<b>79%</b>	<b>86%</b>	<b>83%</b>	<b>84%</b>	<b>78%</b>	<b>82%</b>	<b>78%</b>
<b>MSFC</b>	<b>88%*</b>	<b>87%</b>	<b>87%</b>	<b>88%</b>	<b>86%</b>	<b>79%</b>	<b>84%</b>	<b>83%</b>
<b>PPMCO</b>	<b>86%</b>	<b>83%</b>	<b>90%</b>	<b>88%</b>	<b>79%</b>	<b>84%</b>	<b>86%*</b>	<b>83%</b>
<b>UHC</b>	<b>86%</b>	<b>83%</b>	<b>86%</b>	<b>86%</b>	<b>87%*</b>	<b>86%</b>	<b>83%</b>	<b>78%</b>

<sup>1</sup>MCO with the highest Summary Rate.

<sup>2</sup>Quality Compass® is a registered trademark of NCQA.

In 2013, HealthChoice MCOs received the highest ratings among both the general child population members and the child members with chronic conditions on the following composite measures:

- **How Well Doctors Communicate** – Measures how well personal doctor explains things, listens to them, shows respect for what they have to say and spends enough time with them.
- **Getting Care Quickly** – Measures member’s experiences with receiving care and getting appointments as soon as they needed.
- **Customer Service** – Measures member’s experiences with getting the information needed and treatment by Customer Service staff.

Table 44 shows the child composite measure results from CY 2011 to CY 2013.

Table 44. CAHPS® 2011 - CAHPS® 2013 Adult Composite Measure Results

Composite Measure	2011 (Summary Rate- Always/Usually)		2012 (Summary Rate- Always/Usually)		2013 (Yes or A lot/ Some/Yes)	
	General	CCC	General	CCC	General	CCC
How Well Doctors Communicate	92%	93%	94%	93%	94%	93%
Getting Care Quickly	88%	91%	87%	90%	91%↑	93%↑
Customer Service	79%	77%	82%	81%	87%↑	87%↑
Getting Needed Care	77%	78%	79%	80%	82%	84%↑
Coordination of Care	80%	80%	81%	80%	80%	79%
Shared Decision-Making <sup>1</sup>	N/A	N/A	N/A	N/A	73%	80%
Health Promotion and Education <sup>2</sup>	N/A	N/A	N/A	N/A	73%	78%

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

<sup>1</sup>Shared Decision-Making composite revised in 2013. Added one question and significantly altered the existing questions and response choices. Trending impacted.

<sup>2</sup>Health Promotion and Education composite revised in 2013. Question wording and response choices altered. Trending impacted.

Research shows that for the general population, HealthChoice MCOs received the lowest ratings among their child members on the “Shared Decision-Making” (73%) and “Health Promotion and Education” composites (73%). Notably, the “Getting Needed Care” and “Customer Service” composites saw increases for both population surveys.

### Key Drivers of Satisfaction

In an effort to identify the underlying components of adult and child members’ ratings of their Health Plan and Health Care, advanced statistical techniques were employed.

- Regression analysis is a statistical technique used to determine which influences or “independent variables” (composite measures) have the greatest impact on an overall attribute or “dependent variable” (overall rating of Health Plan or Health Care).
- In addition, correlation analyses were conducted between each composite measure attribute and overall rating of Health Plan and Health Care in order to ascertain which attributes have the greatest impact.

### Adult Medicaid Members – Key Drivers of Satisfaction with Health Plan

Based on the 2013 findings, the “Customer Service” composite measure has the most significant impact on adult members’ overall rating of their Health Plan.

- The attribute listed below is identified as an unmet need and should be considered a priority area for the HealthChoice MCOs. If performance on this attributes is improved, it could have a positive impact on adult members’ overall rating of their Health Plan.
  - Received information or help needed from health plan’s Customer Service

### Adult Medicaid Members – Key Drivers of Satisfaction with Health Care

Based on the 2013 findings, the “Getting Needed Care” composite measure has the most significant impact on adult members’ overall rating of their Health Care.

- There were no attributes identified as unmet needs that should be considered priority areas for improving adult members’ overall rating of their Health Care.

- The attribute listed below is identified as a driving strength and performance in this area should be maintained. If performance on this attribute is decreased, it could have a negative impact on adult members' overall rating of their Health Care.
  - Doctor explained things in a way that was easy to understand

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

Based on the 2013 findings, there are two composite measures that have the most significant impact on child members' overall rating of their Health Plan: “Customer Service” and “Getting Needed Care”.

- There were no attributes identified as unmet needs that should be considered priority areas for improving child members' overall rating of their Health Plan.
- The attributes listed below are identified as driving strengths and performance in these areas should be maintained. If performance on these attributes is decreased, it could have a negative impact on child members' overall rating of their Health Plan.
  - Treated with courtesy and respect by child's health plan's Customer Service
  - Got the care, tests or treatment your child needed

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

Based on the 2013 findings, the “How Well Doctors Communicate” and “Getting Needed Care” composite measures are identified as having the most significant impact on child members' overall rating of their Health Care.

- Given some of the high ratings received, there were no attributes identified as unmet needs<sup>1</sup> that should be considered priority areas for improving child members' overall rating of their Health Care.
- Instead, the attributes listed below are identified as driving strengths and performance in these areas should be maintained. If performance on these attributes is decreased, it could have a negative impact on child members' overall rating of their Health Care.
  - Got the care, tests or treatment your child needed
  - Child's doctor listened carefully to you
  - Child's doctor showed respect for what you had to say
  - Child's doctor explained things about your child's health in a way that was easy to understand

## Section VIII Consumer Report Card

### Introduction

DHMH contracted with Delmarva Foundation to develop a Medicaid Consumer Report Card (Report Card). Delmarva Foundation collaborated with the NCQA to assist in the Report Card development and production.

The Report Card assists Medicaid beneficiaries in selecting one of the participating HealthChoice MCOs. Information in the Report Card includes performance measures from HEDIS<sup>®</sup>, the CAHPS<sup>®</sup> survey, and DHMH's VBPI.

### Information Report Strategy

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

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

Based on a review of the measures available for the Report Card (HEDIS<sup>®</sup>, CAHPS and DHMH's VBPI), the team recommended the following reporting categories and their descriptions:

- Access to Care
  - Appointments are scheduled without a long wait
  - The MCO has good customer service
  - Everyone sees a doctor at least once a year

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HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

- Doctor Communication and Service
  - Doctors explain things clearly and answer questions
  - The doctor's office staff is helpful
  - Doctors provide good care
- Keeping Kids Healthy
  - Kids get shots to protect them from serious illness
  - Kids see a doctor and dentist regularly
  - Kids get tested for lead
- Care for Kids With Chronic Illness
  - Doctors give personal attention
  - Kids get the medicine they need
  - A doctor or nurse knows the child's needs
  - Doctors involve parents in decision making
- Taking Care of Women
  - Women are tested for breast cancer and cervical cancer
  - Moms are taken care of when they are pregnant and after they have their baby
- Diabetes Care
  - Blood sugar levels are monitored and controlled
  - Cholesterol levels are tested and controlled
  - Eyes are examined for loss of vision
  - Kidneys are healthy and working properly

The first two categories are relevant to all beneficiaries. The remaining categories are focused on more specific populations that are relevant to Maryland HealthChoice beneficiaries: children, children with chronic illness, women, and people with diabetes.

In accordance with its research, NCQA did not recommend reporting specific measures individually, in addition to the above reporting categories. Consumers comparing the performance of a category composed of many measures to individual measures may give undue weight to the performance on the individual measures.

### **Measure Selection**

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

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

Recent revisions to the CAHPS survey and re-evaluations of HEDIS® measures influence NCQA's recommendations for the 2013 reporting strategy.

### Reporting Category Changes:

Access to Care

- No changes

Doctor Communication and Service

- No changes

Keeping Kids Healthy

- NCQA completed the analytic assessment and have determined that we will include the VBP measure Immunization for Adolescents in this Report Card category.

Care for Kids with Chronic Illness

- At DHMH's request, NCQA will remove 2 of 3 questions (Q21 and Q24) from the Access to Specialized Services (composite) and rename the composite to Access to Specialized Services: Special Medical Equipment or Devices.

Taking Care of Women

- No changes

Diabetes Care

- No changes

### Format

The following principles are important when designing report cards:

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

The Report Card was printed as a 24 x 9.75 inch pamphlet folded in thirds, with English on one side and Spanish on the opposite side. Pamphlets allow one-page presentation of all performance information.

Additionally, measure explanations can be integrated on the same page as the performance results, facilitating a reader's ability to match the explanation to actual data.

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

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

### **Rating Scale**

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

A tri-level rating scale in a matrix that displays performance across a select number of salient performance categories provides beneficiaries with an easy-to-read "picture" of quality performance across plans and presents data in a manner that emphasizes meaningful differences between plans that are available to them. (The tri-level rating method is explained in Section III, Analytic Methods.) This methodology differs from similar methodologies that compare plan performance to ideal targets or national percentiles. The team's recommended approach is more useful in an environment where consumers must choose from a group of available plans.

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

## Analytic Methodology

NCQA and Delmarva Foundation recommend that the Report Card compare each MCO's actual score to the unweighted, statewide plan average for a particular reporting category. An icon or symbol would denote whether a plan performed "above," "the same as," or "below" the statewide Medicaid plan average.<sup>2</sup> The goal of the analysis is to generate reliable and useful information that can be used by Medicaid consumers to make relative comparisons of the quality of health care provided by Maryland's HealthChoice MCOs. This information should allow consumers to easily detect substantial differences in MCO performance. This means that the index of difference should compare plan-to-plan quality performance directly and that differences between MCOs should be statistically reliable.

### Handling Missing Values

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

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

The third issue is that the method used to replace missing values should not provide an incentive for plans that perform poorly to purposefully fail to report data. For example, if missing values are replaced with the mean of non-missing cases, scores for plans that perform below the mean would be increased if they fail to report.

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

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<sup>2</sup> For state performance reports directed at consumers, NCQA believes it is most appropriate to compare a plan's performance to the average of all plans serving the state. NCQA does not recommend comparing plans to a statewide average that has been weighted proportionally to the enrollment size of each plan. A weighted average emphasizes plans with higher enrollments and is used to measure the overall, statewide average. Report cards compare a plan's performance relative to other plans, rather than presenting how well the state's Medicaid managed care plans serve beneficiaries *overall*. In a Report Card, each plan represents an equally valid option to the reader, regardless of its enrollment size.

generalize to Medicaid plans, it would be inappropriate to use the entire group of national Medicaid plans to replace missing values for Maryland HealthChoice plans.

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

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

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

For Report Card purposes, missing values will be replaced where a plan has reported data for at least 50 percent of the indicators in a reporting category. A plan that is missing more than 50 percent of the indicators that compose a reporting category will be given a designation of “insufficient data” for that measurement category. If fewer than 50 percent of the plans report a measure, the measure is dropped from the report card category. Therefore, the calculations in that category are based upon the remaining reportable measures. “N/A” and “NR” designations will be treated differently where values are missing. “N/A” values will be replaced with the mean of “non-missing observations” and “NR” values will be replaced with the minimum value of the “non-missing observations.” This procedure minimizes any disadvantage to plans that are willing but unable to report data.

### **Case-Mix Adjustment of CAHPS Data**

Several field tests indicate that there is a tendency for CAHPS survey respondents who are in poor health to have lower satisfaction scores. It is not clear whether this is because members in poor health experience lower quality health care or because they are generally predisposed to give more negative responses (halo effect).

It is believed that respondents in poor health receive more intensive health care services, and their CAHPS survey responses do contain meaningful information about the quality of care delivered in this more intensive environment. Therefore, case-mix adjusting is not planned for the CAHPS survey data used in this analysis.

### **Statistical Methodology**

The statistical methodology includes the following steps:

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

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

### CY 2013 Report Card Results

HealthChoice MCOs	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Diabetes Care
ACC	★★	★★	★★	★★	★★★	★
DIA	★	★★	★	★★	★	★
JMS	★	★★	★★★	Not Rated by Researchers*	★★★	★★★
MPC	★★	★★	★★★	★★	★	★
MSFC	★★★	★★	★★★	★★	★★★	★★★
PPMCO	★★★	★★	★	★★	★★	★★
UHC	★★	★★	★	★★	★	★

★ Below HealthChoice Average

★★ HealthChoice Average

★★★ Above HealthChoice Average

\*“Not Rated By Researchers” does not describe the performance or quality of care provided by the health plan.

## Section IX Review of Compliance with Quality Strategy

Table 45 below describes HACA’s progress against the Quality Strategy’s goal.

Table 45. Quality Strategy Evaluation

Department’s Quality Strategy Goal	Performance Against Goal	Met
Ensure compliance with changes in Federal/State law and regulation	The Department consistently reviews all new Federal and State laws and regulations. Any new laws and regulations are immediately put into the standards and guidelines for review and communicated to the MCOs.	√
Improve performance over time	The Department continually strives to improve performance, which is evident through the high standards it sets for the MCOs in the Annual Systems Performance Review, Value Based Purchasing Initiative, Performance Improvement Projects, and other review activities. It continually monitors the progress of MCO performance in multiple areas as demonstrated throughout this report.	√
Allow comparisons to national and state benchmarks	In almost every area of review, comparisons to national and state benchmarks can be found to mark progress and delineate performance against goals.	√
Reduce unnecessary administrative burden on MCOs	The Department has attempted to reduce unnecessary administrative burden to the MCOs in any way possible. Delmarva Foundation has assisted with this goal in streamlining the Annual Systems Review Process so that documentation can be submitted electronically.	√
Assist the Department with setting priorities and responding to identified areas of concern such as children, pregnant women, children with special healthcare needs, adults with a disability, and adults with chronic conditions.	<p>The HealthChoice and Acute Care Administration has assisted the Department by:</p> <ul style="list-style-type: none"> <li>➤ Selecting performance measures to monitor compliance with quality of care and access standards for enrollees.</li> <li>➤ Selecting the initial Adult and Child CORE health care quality measures for Medicaid and CHIP. Maryland Volunteered to collect Medicaid Adult and Child CORE Measures which will assist CMS to better understand the quality of health care that adults enrolled in Medicaid receive.</li> <li>➤ Designing supplemental CAHPS survey questions to address pregnant women and children to provide data input for the Deputy Secretary of Health Care Financing –Medical Care Programs Administration’s annual Managing for Results report that includes key goals, objectives, and performance measures’ results for calendar year.</li> </ul>	√

√ - Goal Met

## EQRO Recommendations for MCOs

Although each MCO is committed to delivering high quality care and services to its enrollees, opportunities exist for continued performance improvement. Based upon the evaluation of CY 2012 activities, Delmarva Foundation has developed several recommendations for all MCOs which are identified within each section of the Annual Technical Report.

## EQRO Recommendations for HACA

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

- Considering Health Care Reform activities will begin in 2014 and Maryland Medicaid enrollment will increase, the Department may want to consider revising the layout of the MD Consumer Report Card. The Information Reporting Strategy may continue to be relevant, but the format of the report card may need to be revised, including different information displayed in a different manner. This update would include funding for consumer focus groups to test the understanding/ease of language and layout.
- Given the issues encountered when conducting the Substance Abuse Performance Improvement Project, which appears to be linked to how SA treatment is provided and billed in Maryland, the Department may want to consider taking the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) HEDIS® measure off of the list of required measures for reporting.

## Conclusions

This report is a representation of all EQRO, HEDIS®, and CAHPS® activities that took place in calendar years 2012-2013 for the Maryland HealthChoice program. Opportunities for improvement and best practices of the MCOs are noted in the executive summary and within each individual review activity.

The MCOs have quality systems and procedures in place to promote high quality care with well-organized approaches to quality improvement. The CY 2013 review provided evidence of the continuing progression of the HealthChoice MCOs as each MCO demonstrated their ability to ensure the delivery of quality health care for their enrollees.

Maryland has set high standards for MCO QA systems. In general, HealthChoice MCOs continue to make improvements in their QA monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. This is evident in the various review activities conducted and demonstrated throughout the history of the HealthChoice Program.

## Acronym List

ACC	AMERIGROUP Community Care
ADA	Americans with Disabilities Act of 1990
AWC	Adolescent Well Care
BBA	Balanced Budget Act of 1997
BH	Behavioral Health
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COMAR	Code of Maryland Annotated Regulations
CPT	Current Procedural Terminology
CRISP	Chesapeake Regional Information System for our Patients
CY	Calendar Year
DHMH	Department of Health and Mental Hygiene
DIA	Diamond Plan from Coventry Health Care, Inc.
DOB	Date of Birth
EDV	Encounter Data Validation
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
HACA	HealthChoice and Acute Care Administration
HDC	HealthcareData Company, LLC
HEDIS	Healthcare Effectiveness Data and Information Set
HIV	Human Immunodeficiency Virus
HRA	Health Risk Assessment
IDSS	Interactive Data Submission System
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
IRR	Inter-Rater Reliability
IS	Information System
JHHC	Johns Hopkins Health Care
JMS	Jai Medical Systems
MARR	Maryland Average Reportable Rate
MCO	Managed Care Organization
MD	Maryland
MPC	Maryland Physicians Care
MSFC	MedStar Family Choice, Inc.

## Acronym List

NCQA	National Committee for Quality Assurance
NHM	National HEDIS® Mean
OB/GYN	Obstetrician/Gynecology
PCP	Primary Care Physician
PIP	Performance Improvement Project
PPMCO	Priority Partners
QAP	Quality Assurance Program
SA	Substance Abuse
SSI	Supplemental Security Income
STI	Sexually Transmitted Infection
TAT	Turn Around Time
UHC	UnitedHealthcare
VBP	Value Based Purchasing
VBPI	Value Based Purchasing Initiative
WBA	WBA Market Research

## ***Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)***

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### **SUMMARY OF CHANGES TO HEDIS 2013**

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Added HCPCS code G0443 to Table IET-B.

#### **Description**

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

*Initiation of AOD Treatment.* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

*Engagement of AOD Treatment.* The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

#### **Definitions**

<b>Intake Period</b>	January 1–November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.
<b>Index Episode</b>	The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD.  <i>For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.</i>
<b>IESD</b>	Index Episode Start Date. The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD.  <i>For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED (not resulting in an inpatient stay) claim/encounter, the IESD is the date of service.</i> <i>For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge.</i> <i>For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge.</i> <i>For direct transfers, the IESD is the discharge date from the second admission.</i>
<b>Negative Diagnosis History</b>	A period of 60 days (2 months) before the IESD when the member had no claims/encounters with a diagnosis of AOD dependence.  <i>For an inpatient claim/encounter, use the admission date to determine the Negative Diagnosis History.</i> <i>For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.</i> <i>For direct transfers, use the first admission to determine the Negative Diagnosis History.</i>

## Eligible Population

<b>Product lines</b>	Commercial, Medicaid, Medicare (report each product line separately).
<b>Age</b>	13 years and older as of the December 31 of the measurement year. Report two age stratifications and a total rate. 13–17 years. 18+ years. Total. The total is the sum of the age stratifications.
<b>Continuous enrollment</b>	60 days (2 months) prior to the IESD through 44 days after the IESD (inclusive).
<b>Allowable gap</b>	None.
<b>Anchor date</b>	None.
<b>Benefits</b>	Medical and chemical dependency (inpatient and outpatient). <b>Note:</b> <i>Members with detoxification-only chemical dependency benefits do not meet these criteria.</i>
<b>Event/ diagnosis</b>	New episode of AOD during the Intake Period. Follow the steps below to identify the eligible population, which is the denominator for both rates.
<b>Step 1</b>	Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following. <ul style="list-style-type: none"> <li>An outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with a diagnosis of AOD (Table IET-A).</li> <li>A detoxification visit (Table IET-C).</li> <li>An ED visit (Table IET-D) with a diagnosis of AOD (Table IET-A).</li> <li>An inpatient discharge with a diagnosis of AOD as identified by either of the following: <ul style="list-style-type: none"> <li>An inpatient facility code in conjunction with a diagnosis of AOD (IET-A).</li> <li>An inpatient facility code in conjunction with an AOD procedure code (IET-E).</li> </ul> </li> </ul> <p><i>For members with more than one episode of AOD, use the first episode.</i></p> <p><i>For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.</i></p> <p>Select the IESD.</p>

**Table IET-A: Codes to Identify AOD Dependence**

ICD-9-CM Diagnosis
291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1

**Table IET-B: Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization Visits**

CPT	HCPCS	UB Revenue
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983
CPT		POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	<i>WITH</i>	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72
90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	<i>WITH</i>	52, 53

**Table IET-C: Codes to Identify Detoxification Visits**

HCPCS	ICD-9-CM Procedure	UB Revenue
H0008-H0014	94.62, 94.65, 94.68	0116, 0126, 0136, 0146, 0156

**Table IET-D: Codes to Identify ED Visits**

CPT	UB Revenue
99281-99285	045x, 0981

**Table IET-E: Codes to Identify AOD Procedures**

ICD-9-CM Procedure
94.61, 94.63, 94.64, 94.66, 94.67, 94.69

**Step 2** Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD (Table IET-A) during the 60 days (2 months) before the IESD.

*For an inpatient IESD, use the admission date to determine the Negative Diagnosis History.*

*For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.*

**Step 3** Calculate continuous enrollment. Members must be continuously enrolled without any gaps 60 days (2 months) before the IESD through 44 days after the IESD.

## Administrative Specification

**Denominator** The eligible population.

### Numerator

**Initiation of AOD Treatment** Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

*If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant.*

*If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET-B) with an AOD diagnosis (Table IET-A) within 14 days of the IESD (inclusive).*

*If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive).*

Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment.

Exclude members from the denominator whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

**Engagement of AOD Treatment** Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

*For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period.*

*If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).*

Do not count engagement encounters that include detoxification codes (including inpatient detoxification).

### Note

*Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate (e.g., within 14 days of the IESD or within 30 days after the date of the initiation encounter).*

## Data Elements for Reporting

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

**Table IET-1/2/3: Data Elements for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>Each rate, for each age stratification and total</i>
Reported rate	<i>Each rate, for each age stratification and total</i>
Lower 95% confidence interval	<i>Each rate, for each age stratification and total</i>
Upper 95% confidence interval	<i>Each rate, for each age stratification and total</i>

Table 1. Project Summary for AMERIGROUP Community Care

ACC Substance Abuse PIP			
Indicator 1: Initiation of Alcohol and Other Drug Dependence Treatment			
Time Period	Measurement	Goal	Rate/Results
1/1/09 – 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 57.31%	49.38%
1/1/10 – 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 60.70%	50.94%
1/1/11 – 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 49.44%	46.43%
1/1/12 – 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 48.24%	41.87%
Indicator 2: Engagement of Alcohol and Other Drug Dependence Treatment			
Time Period	Measurement	Goal	Rate/Results
1/1/09 – 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.42%	21.42%
1/1/10 – 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 25.90%	25.27%
1/1/11 – 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.24%	21.55%
1/1/12 – 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 19.84%	19.71%
<b>Identified Barriers to Care</b>	<p><b>Member Barriers:</b></p> <ul style="list-style-type: none"> <li>• Adherence to treatment recommendations</li> <li>• Attendance at scheduled follow up appointments</li> <li>• Diverted to the justice system</li> <li>• Ability to obtain multiple opiate prescriptions from multiple prescribers</li> <li>• Limited Inpatient benefit and lack of housing options limiting a safe recovery environment</li> </ul> <p><b>Provider Barriers:</b></p> <ul style="list-style-type: none"> <li>• Awareness of self-referral protocols</li> <li>• Referral to MH services for SA Diagnosis (Carve out, no claims data)</li> <li>• Inability to monitor member prescriptions, lack of awareness of emergency room (ER) visits and specialty providers prescriptions</li> <li>• Inability to reach members</li> <li>• Awareness of billing process for SA diagnosis, especially in Primary Care Setting</li> <li>• Concerns related to claims payment issues</li> </ul> <p><b>MCO Barriers:</b></p> <ul style="list-style-type: none"> <li>• Unable to identify behavioral health (BH) encounters</li> <li>• Credentialing process not beneficial to providers</li> <li>• System lag in identifying admission to higher levels of care, members discharged prior to case management (CM) intervention</li> <li>• Difficulties locating and engaging patients in order to provide follow up assistance</li> <li>• Lack of communication with BH providers due to no agreement, carve out network, Health Insurance Portability and Accountability Act regulations</li> </ul>		
	<p><b>Interventions</b></p> <ul style="list-style-type: none"> <li>• Follow-Up After Hospitalization Best Practices Workgroup Meeting- Join workgroup focused on improving follow up after hospitalization</li> <li>• Medical CM Training</li> <li>• Integrated medical home recruitment continuation</li> <li>• Contracted with ValueOptions to educate on SA follow up</li> <li>• BH presence at Community Outreach Day</li> <li>• SA provider visits</li> <li>• BH brochures distributed and mailed to all providers</li> <li>• Amerigroup representation at DHMH Stakeholder Meetings</li> <li>• Gold Card Suboxone Prescribers - reevaluated need to increase access to Suboxone at initial visit, increasing access to prescribers and medication during initiation and requesting engagement visit</li> <li>• Attendance at Maryland Addiction Directors Committee Meeting</li> <li>• ER Diversion Project</li> <li>• Community Outreach Implementation</li> </ul>		

Table 2. Project Summary for DIA Plan from Coventry Health Care, Inc.

<b>DIA Substance Abuse PIP</b>			
<b>Indicator 1: Initiation of Alcohol and Other Drug Dependence Treatment</b>			
<b>Time Period</b>	<b>Measurement</b>	<b>Goal</b>	<b>Rate/Results</b>
1/1/09 – 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 57.31%	40.89%
1/1/10 – 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 60.70%	40.81%
1/1/11 – 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 49.44%	40.32%
1/1/12 – 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 48.24%	N/A
<b>Indicator 2: Engagement of Alcohol and Other Drug Dependence Treatment</b>			
<b>Time Period</b>	<b>Measurement</b>	<b>Goal</b>	<b>Rate/Results</b>
1/1/09 – 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.42%	21.05%
1/1/10 – 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 25.90%	25.55%
1/1/11 – 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.24%	22.28%
1/1/12 – 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 19.84%	N/A
<b>Identified Barriers to Care</b>	<b>Member Barriers:</b>		
	<ul style="list-style-type: none"> <li>• Denial of disease</li> <li>• Stigma associated with addiction and treatment</li> <li>• Lack of education on SA</li> <li>• Care not with assigned Primary Care Provider (PCP) or at all</li> <li>• Low literacy</li> <li>• Psychosocial factors- Homelessness</li> <li>• Lack of available resources</li> <li>• Failure to respond to MHNNet's attempt at outreach</li> </ul>		
	<b>Provider Barriers:</b>		
<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Limited SA knowledge/ability to recognize signs and symptoms</li> <li>• Limited resources to ensure follow up with members</li> <li>• Inability to enforce compliance with members</li> <li>• Lack of contact with SA member</li> <li>• Limited knowledge of SA guidelines</li> <li>• Lack of medical home approach in most practices</li> </ul>		
	<b>MCO Barriers:</b>		
	<ul style="list-style-type: none"> <li>• Limited communication between ERs, PCPs, and MHNNet</li> <li>• Inability to maintain correct demographics due to transitory population</li> <li>• Opportunities for continued collaboration between MCO and MHNNet</li> <li>• Non-par providers are seeing members due to self referral process: claims not received due to grant monies</li> <li>• Separation of MH and SA vendors; ValueOptions can be difficult to work with</li> </ul>		
<ul style="list-style-type: none"> <li>• Provider and member education</li> <li>• Patient Centered Medical Home implementation</li> <li>• MHNNet and pharmacy providers identify pregnant members on Suboxone or Methadone to engage members in group or individual counseling</li> <li>• HEDIS® data review to ensure data accuracy</li> <li>• Collaboration with ValueOptions for better continuity of care for members</li> </ul>			

Table 3. Project Summary for Jai Medical Systems

<b>JMS Substance Abuse PIP</b>			
<b>Indicator 1: Initiation of Alcohol and Other Drug Dependence Treatment</b>			
<b>Time Period</b>	<b>Measurement</b>	<b>Goal</b>	<b>Rate/Results</b>
1/1/09 – 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 57.31%	44.39%
1/1/10 – 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 60.70%	48.84%
1/1/11 – 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 49.44%	46.48%
1/1/12 – 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 48.24%	36.75%
<b>Indicator 2: Engagement of Alcohol and Other Drug Dependence Treatment</b>			
<b>Time Period</b>	<b>Measurement</b>	<b>Goal</b>	<b>Rate/Results</b>
1/1/09 – 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.42%	15.98%
1/1/10 – 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 25.90%	22.05%
1/1/11 – 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.24%	19.41%
1/1/12 – 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 19.84%	15.41%
<b>Identified Barriers to Care</b>	<p><b>Member Barriers:</b></p> <ul style="list-style-type: none"> <li>• Member refusal</li> <li>• Member motivation</li> <li>• Lack of referral</li> </ul> <p><b>Provider Barriers:</b></p> <ul style="list-style-type: none"> <li>• Providers unaware if referral is followed up on by member</li> <li>• Providers are still unaware of the time frames outlined in the measures for initiation of treatment</li> </ul> <p><b>MCO Barriers:</b></p> <ul style="list-style-type: none"> <li>• Members receive ongoing SA treatment through their MH provider</li> <li>• Members on buprenorphine who are receiving the proper treatment in the correct time frame and still failing the measure because the MH provider is billing ValueOptions instead of the MCO</li> <li>• SA coordinator is aware that the members are receiving treatment, but there is no way to get the information into the billing system to pass the members based on the HEDIS® specifications</li> <li>• If a member receives their initial diagnosis while in the ER, the MCO is not able to help the member receive treatment in a timely manner as the MCO is unaware of the visit until after the claim is received, usually 30 days to 6 months later</li> <li>• The member may get into SA treatment based on the claim data, but it won't be within the short timeframe required by HEDIS®</li> <li>• The MCO is aware of members who are inpatient due to concurrent review. Our Utilization Review (UR) Nurses report all members with a SA diagnosis to the SA Coordinator. This has been an ongoing process. The Task Force chose to re-emphasize this process with the UR Nurses and to stress the importance of the required timeframes to ensure that this communication was happening while the member was still inpatient.</li> </ul>		
	<p><b>Interventions</b></p> <ul style="list-style-type: none"> <li>• Create contract with database contractor to receive information regarding SA-related ER visits within a day of the incident</li> <li>• Implemented a written feedback system from the SA Coordinator to the UR nurses with updates regarding members beginning and /or ongoing SA treatment</li> <li>• Increase involvement of the SA Coordinator with the UR nurses by having her attend each weekly utilization management (UM) meeting, in addition to the quarterly UM meetings</li> <li>• Perform in-depth analysis on members failing the measure to see if they are indeed in SA treatment</li> <li>• Create and implement tracking sheet for all members referred to SA treatment</li> <li>• Continue to educate providers through the HEDIS® education mailing</li> </ul>		

Table 4. Project Summary for Maryland Physicians Care

<b>MPC Substance Abuse PIP</b>			
<b>Indicator 1: Initiation of Alcohol and Other Drug Dependence Treatment</b>			
<b>Time Period</b>	<b>Measurement</b>	<b>Goal</b>	<b>Rate/Results</b>
1/1/09 - 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 57.31%	44.68%
1/1/10 - 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 60.70%	50.61%
1/1/11 - 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 49.44%	47.93%
1/1/12 - 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 48.24%	43.03%
<b>Indicator 2: Engagement of Alcohol and Other Drug Dependence Treatment</b>			
<b>Time Period</b>	<b>Measurement</b>	<b>Goal</b>	<b>Rate/Results</b>
1/1/09 - 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.42%	12.70%
1/1/10 - 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 25.90%	25.89%
1/1/11 - 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.24%	24.95%
1/1/12 - 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 19.84%	21.02%
<b>Identified Barriers to Care</b>	<p><b>Member Barriers:</b></p> <ul style="list-style-type: none"> <li>• Lack of member knowledge regarding treatment/resources available</li> <li>• Responsibility for care of family members</li> <li>• Transient living arrangements</li> <li>• Access to illicit drugs</li> <li>• Member non-compliance</li> <li>• Lack of member/PCP relationship</li> <li>• Dual Diagnoses (complicated by 2 disorders)</li> <li>• Homelessness</li> <li>• Lack of transportation</li> <li>• Low literacy</li> <li>• Lack of trust of MCO/CM staff due to concerns of prosecution for illegal activities</li> </ul> <p><b>Provider Barriers:</b></p> <ul style="list-style-type: none"> <li>• Limited resources for management of SA patients in provider offices</li> <li>• Lack of knowledge regarding available treatment/community resources</li> <li>• Lack of member compliance</li> <li>• Inadequate/inaccurate member contact information</li> <li>• Staffing resources</li> <li>• Lack of knowledge/expertise and adherence to American Society of Addictions Medicine (ASAM) criteria</li> <li>• Limited coordination of care between ER and other SA treatment</li> <li>• Inadequate SA screening tools</li> <li>• Inadequate reimbursement</li> <li>• Lack of knowledge of appropriate prescribing guidelines for Suboxone</li> </ul>		
	<p><b>MCO Barriers:</b></p> <ul style="list-style-type: none"> <li>• Limited staffing resources</li> <li>• Inadequate screening by provider offices</li> <li>• Inadequate training of staff to interact with members with SA</li> <li>• Need for coordinated care between SA and MH (carve out)</li> <li>• Inadequate/inaccurate member contact information</li> <li>• Difficulty in accurately identifying members with a SA problem</li> <li>• Increased membership</li> <li>• Lack of coordination with other agencies</li> <li>• Need for SA expert to evaluate and enhance program policies and structure and to communicate with the providers in the community</li> </ul>		
<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Implement and expand use of social media</li> <li>• Addition of SA Consultant/Medical Director to perform peer to peer discussions with providers</li> <li>• Instituted prior authorization requirement for use of Suboxone</li> <li>• Revised SA provider contracts</li> </ul>		

Table 5. Project Summary for MedStar Family Choice

<b>MSFC Substance Abuse PIP</b>			
<b>Indicator 1: Initiation of Alcohol and Other Drug Dependence Treatment</b>			
<b>Time Period</b>	<b>Measurement</b>	<b>Goal</b>	<b>Rate/Results</b>
1/1/09 – 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 57.31%	35.60%
1/1/10 – 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 60.70%	32.21%
1/1/11 – 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 49.44%	35.49%
1/1/12 – 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 48.24%	27.36%
<b>Indicator 2: Engagement of Alcohol and Other Drug Dependence Treatment</b>			
<b>Time Period</b>	<b>Measurement</b>	<b>Goal</b>	<b>Rate/Results</b>
1/1/09 – 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.42%	7.20%
1/1/10 – 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 25.90%	10.27%
1/1/11 – 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.24%	8.43%
1/1/12 – 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 19.84%	5.28%
<b>Identified Barriers to Care</b>	<p><b>Member Barriers:</b></p> <ul style="list-style-type: none"> <li>• Refusal to admit there is a problem</li> <li>• Does not follow through with counseling</li> <li>• Lack of awareness of benefits and where to get assistance</li> <li>• Co-existing psychiatric illness</li> <li>• Co-existing medical and/or socioeconomic problems</li> </ul> <p><b>Provider Barriers:</b></p> <ul style="list-style-type: none"> <li>• Difficulty motivating member to adhere with treatment plan</li> <li>• Untimely discharge instructions from ER's or discharge notes from hospitalizations</li> <li>• Lack of understanding of the resources and benefits available to members</li> <li>• Lack of knowledge of SA resources in their service area</li> <li>• Lack of training and expertise among PCPs to work with the SA population</li> <li>• Lack of communication between SA Providers and Medical practitioners</li> <li>• Time constraints of busy office schedule</li> </ul> <p><b>MCO Barriers:</b></p> <ul style="list-style-type: none"> <li>• Difficulty identifying members in a timely manner due to claims delay</li> <li>• Outreach and CM efforts are hampered by poor contact information</li> <li>• Collaborating coordination of care with a new vendor outside the MCO system</li> <li>• Some SA providers do not file claims because they are working with grants which leads to incomplete information in the database used to identify member's conditions and used to calculate the HEDIS® score used as the measurement for this project</li> <li>• Claims may not be correctly transferring into the HEDIS® data repository</li> <li>• New vendors original network did not include some of the historical provider sites</li> </ul>		
	<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Daily and weekly reports of members admitted to ER w/ SA diagnosis were provided outreach by ValueOptions</li> <li>• Coordination of care with PCP Initiative implemented</li> <li>• Provider and member education</li> <li>• MedStar Family Choice Annual Youth Fitness &amp; Health Expo</li> </ul>	

Table 6. Project Summary for Priority Partners

PPMCO Substance Abuse PIP			
Indicator 1: Initiation of Alcohol and Other Drug Dependence Treatment			
Time Period	Measurement	Goal	Rate/Results
1/1/09 - 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 57.31%	46.82%
1/1/10 - 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 60.70%	48.61%
1/1/11 - 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 49.44%	43.38%
1/1/12 - 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 48.24%	36.46%
Indicator 2: Engagement of Alcohol and Other Drug Dependence Treatment			
Time Period	Measurement	Goal	Rate/Results
1/1/09 - 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.42%	17.93%
1/1/10 - 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 25.90%	23.61%
1/1/11 - 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.24%	19.92%
1/1/12 - 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 19.84%	17.63%
<b>Identified Barriers to Care</b>	<p><b>Member Barriers:</b></p> <ul style="list-style-type: none"> <li>Maryland HealthChoice Program allows member self-referral to substance treatment. The self-referral process creates a continuity of care issue and this is considered a barrier.</li> <li>Members have limited knowledge regarding appropriate levels of treatment</li> </ul> <p><b>Provider Barriers:</b></p> <ul style="list-style-type: none"> <li>Many substance treatment providers do not accept insurance payment and requires cash payment from members</li> <li>Practice patterns for providers are not consistent with standards</li> <li>Limited number of SA providers in specific areas</li> </ul> <p><b>MCO Barriers:</b></p> <ul style="list-style-type: none"> <li>Quality of substance treatment does not meet the Johns Hopkins Standards</li> <li>Continuity of care barriers due to member self-referral to non-network providers</li> <li>Limited substance treatment providers identified in Charles County</li> <li>Data reporting gaps related to PCP providers have no specific codes for Suboxone treatment</li> </ul>		
	<p><b>Interventions</b></p> <ul style="list-style-type: none"> <li>Participation in DHMH Meetings to review SA policies including self referrals and payment unbundling</li> <li>Provider Relations pursuing additional provider contracts for substance treatment in Charles County and Eastern Shore</li> <li>BH coaches actively monitor substance use treatment plans using practice standards and Johns Hopkins treatment model as a benchmark</li> <li>Restructured the Intensive Outpatient Program to be in alignment with substance treatment practice standards. This included BH coaches implementing care transition member support moving members into appropriate outpatient maintenance levels of care.</li> <li>Suboxone medication pharmacy protocol assures adequate monitoring of substance treatment regime and appropriate referrals to Corrective Managed Care</li> <li>A pilot was developed for a BH and PCP collaborative</li> <li>Partners for Moms CM Program coordinates referrals to the Centers of Addictions for Pregnancy Program</li> <li>Substance use screening tool is posted on the web as a reference for physicians</li> </ul>		

Table 7. Project Summary for UnitedHealthcare

UHC Substance Abuse PIP			
<b>Indicator 1: Initiation of Alcohol and Other Drug Dependence Treatment</b>			
Time Period	Measurement	Goal	Rate/Results
1/1/09 - 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 57.31%	49.75%
1/1/10 - 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 60.70%	50.30%
1/1/11 - 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 49.44%	47.60%
1/1/12 - 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 48.24%	47.32%
<b>Indicator 2: Engagement of Alcohol and Other Drug Dependence Treatment</b>			
Time Period	Measurement	Goal	Rate/Results
1/1/09 - 12/31/09	Baseline	2010 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.42%	10.78%
1/1/10 - 12/31/10	Remeasurement 1	2011 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 25.90%	15.99%
1/1/11 - 12/31/11	Remeasurement 2	2012 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 21.24%	18.75%
1/1/12 - 12/31/12	Remeasurement 3	2013 HEDIS® Medicaid 90 <sup>th</sup> Percentile - 19.84%	18.46%
<b>Identified Barriers to Care</b>	<p><b>Member Barriers:</b></p> <ul style="list-style-type: none"> <li>• Lack of member knowledge on the importance of SA follow up diagnosis</li> <li>• Lack of member knowledge of and adherence with aftercare recommendations</li> <li>• Lack of enrollee motivation to seek SA treatment</li> <li>• Lack of enrollee engagement due housing issues</li> <li>• Multiple complex life issues that keep members from seeking care</li> <li>• Lack of member acceptance of the alcohol or other drug dependency as a problem</li> </ul> <p><b>Provider Barriers:</b></p> <ul style="list-style-type: none"> <li>• Practitioners are not aware of SA treatment recommendations HEDIS® guidelines pertaining to the SA measures</li> <li>• Lack of care coordination between medical practitioners and BH practitioners when treating enrollees with SA issues</li> <li>• Lack of knowledge of facility and outpatient practitioners regarding importance of timely discharge appointments and enrollee participation in aftercare</li> <li>• Lack of awareness of referral sources to address complex member needs</li> <li>• Lack of identification, outreach, and education programs</li> <li>• Lack of concurrent review and follow-up for weekend discharges</li> </ul> <p><b>MCO Barriers:</b></p> <ul style="list-style-type: none"> <li>▪ Staff may not be aware of HEDIS® SA guidelines relating to treatment.</li> <li>▪ Insufficient internal staff knowledge of performance related to discharge planning of enrollees diagnosed with a SA disorder</li> <li>▪ Lack of specialized services and/or resources that may be external to the health care services offered by the MCO for enrollees with complex treatment needs</li> <li>▪ Lack of accurate demographic information relative to the affected member population</li> </ul>		
	<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Provider and member education</li> <li>• Added HEDIS® Subject Matter Expert to clinical material review committee process</li> <li>• Director of Consumer Affairs for SA hosted a webinar that was available to internal UBH clinicians to talk about supporting enrollees with drug abuse issues</li> </ul>	

## **Adolescent Well-Care Visits (AWC)**

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### **SUMMARY OF CHANGES TO HEDIS 2013**

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No changes to this measure.

#### **Description**

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

**Note:** *This measure has the same structure as measures in the Effectiveness of Care domain. Organizations should follow the Guidelines for Effectiveness of Care Measures when calculating this measure. Only the Administrative Method of data collection may be used when reporting this measure for the commercial population.*

#### **Eligible Population**

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

#### **Administrative Specification**

<b>Denominator</b>	The eligible population.
<b>Numerator</b>	At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.  The PCP does not have to be assigned to the member. Adolescents who had a claim/encounter with a code listed in Table AWC-A are considered to have had a comprehensive well-care visit.

**Table AWC-A: Codes to Identify Adolescent Well-Care Visits**

CPT	HCPCS	ICD-9-CM Diagnosis
99383-99385, 99393-99395	G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

**Hybrid Specification**

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

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

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

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

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

A health and developmental history (physical and mental).

A physical exam.

Health education/anticipatory guidance.

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

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

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

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

**Note**

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

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

## Data Elements for Reporting

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

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

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

HealthChoice Organizations HEDIS 2013 Results, page one of four	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2013	HEDIS 2012
	ACC			DIA			JMS			MPC			MSFC			PP			UHC			MARR	NHM
<b>Prevention and Screening - Adult and Child</b>																							
Childhood Immunization Status (CIS) – Combination 2 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV)	79.4%	85.6%	<b>84.7%</b>	65.7%	71.1%	<b>71.3%</b>	88.4%	80.6%	<b>86.1%</b>	84.9%	81.8%	<b>76.9%</b>	86.6%	89.5%	<b>85.4%</b>	83.0%	86.0%	<b>86.8%</b>	71.0%	82.7%	<b>70.3%</b>	80.2%	74.5%
Childhood Immunization Status (CIS) – Combination 3 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV, pneumococcal conjugate)	73.8%	81.9%	<b>83.5%</b>	62.2%	66.1%	<b>68.0%</b>	85.9%	78.7%	<b>83.7%</b>	81.3%	80.8%	<b>74.3%</b>	84.7%	87.6%	<b>83.7%</b>	79.8%	83.7%	<b>83.8%</b>	66.7%	78.8%	<b>66.7%</b>	77.7%	70.6%
Childhood Immunization Status (CIS) – Combination 4 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV, pneumococcal conjugate, Hepatitis A)	28.9%	39.1%	<b>75.9%</b>	29.9%	30.7%	<b>65.2%</b>	36.1%	33.3%	<b>80.9%</b>	30.2%	32.8%	<b>67.4%</b>	29.2%	41.6%	<b>80.3%</b>	25.8%	38.8%	<b>73.8%</b>	34.3%	37.2%	<b>58.9%</b>	71.8%	34.2%
Childhood Immunization Status (CIS) – Combination 5 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV, pneumococcal conjugate, rotavirus)	54.4%	59.7%	<b>61.3%</b>	40.2%	46.9%	<b>51.1%</b>	58.9%	57.9%	<b>59.4%</b>	53.8%	53.5%	<b>55.3%</b>	53.5%	63.3%	<b>56.0%</b>	37.5%	55.1%	<b>59.6%</b>	47.4%	57.2%	<b>52.0%</b>	56.3%	51.9%
Childhood Immunization Status (CIS) – Combination 6 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV, pneumococcal conjugate, influenza)	40.5%	48.6%	<b>49.7%</b>	34.6%	36.5%	<b>44.1%</b>	40.2%	33.3%	<b>39.0%</b>	37.5%	39.2%	<b>42.4%</b>	49.1%	57.4%	<b>55.2%</b>	47.4%	51.4%	<b>51.5%</b>	36.5%	41.8%	<b>38.2%</b>	45.7%	37.9%
Childhood Immunization Status (CIS) – Combination 7 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV, pneumococcal conjugate, Hepatitis A, rotavirus)	23.1%	30.1%	<b>57.8%</b>	20.9%	23.5%	<b>49.2%</b>	28.6%	25.5%	<b>59.0%</b>	21.2%	20.2%	<b>51.4%</b>	21.9%	31.1%	<b>54.3%</b>	14.6%	25.3%	<b>56.2%</b>	24.6%	28.2%	<b>47.2%</b>	53.6%	27.1%
Childhood Immunization Status (CIS) – Combination 8 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV, pneumococcal conjugate, Hepatitis A, influenza)	17.8%	25.7%	<b>47.3%</b>	17.32%	18.8%	<b>43.1%</b>	20.7%	21.3%	<b>39.0%</b>	16.3%	17.0%	<b>38.7%</b>	18.0%	28.2%	<b>53.5%</b>	17.27%	24.2%	<b>48.3%</b>	21.7%	21.7%	<b>35.3%</b>	43.6%	20.9%
Childhood Immunization Status (CIS) – Combination 9 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV, pneumococcal conjugate, rotavirus, influenza)	32.4%	38.2%	<b>38.5%</b>	25.2%	28.5%	<b>35.5%</b>	27.8%	25.0%	<b>29.5%</b>	25.1%	29.2%	<b>33.8%</b>	33.1%	43.8%	<b>38.7%</b>	25.5%	38.8%	<b>41.1%</b>	27.7%	32.8%	<b>31.6%</b>	35.5%	30.5%
Childhood Immunization Status (CIS) – Combination 10 (DTaP/DT, IPV, MMR, HiB, Hepatitis B, VZV, pneumococcal conjugate, Hepatitis A, rotavirus, and influenza)	15.5%	20.6%	<b>37.1%</b>	13.78%	15.5%	<b>34.8%</b>	17.0%	18.1%	<b>29.5%</b>	10.9%	12.2%	<b>31.0%</b>	13.87%	22.1%	<b>37.7%</b>	10.7%	17.9%	<b>39.7%</b>	15.8%	17.5%	<b>29.2%</b>	34.2%	17.3%
Immunizations for Adolescents (IMA) – Combination 1 (Meningococcal, Tdap/Td)	46.1%	56.7%	<b>65.0%</b>	40.0%	49.5%	<b>58.9%</b>	71.6%	73.2%	<b>70.66%</b>	52.1%	51.1%	<b>57.6%</b>	57.2%	70.7%	<b>70.69%</b>	56.9%	52.0%	<b>67.4%</b>	38.6%	48.4%	<b>56.4%</b>	63.8%	60.5%
Well-Child Visits in the First 15 months of Life (W15) – Zero visits <sup>1</sup>	0.8%	1.6%	<b>1.01%</b>	4.3%	3.1%	<b>2.1%</b>	2.4%	0.87%	<b>2.7%</b>	1.1%	1.4%	<b>1.11%</b>	2.2%	1.3%	<b>1.01%</b>	0.9%	1.1%	<b>1.14%</b>	1.95%	0.88%	<b>2.2%</b>	1.6%	1.95%
Well-Child Visits in the First 15 months of Life (W15) – DHMH Five or Six-or-more visits rates (additive)	87.2%	87.3%	<b>86.1%</b>	64.7%	74.6%	<b>81.7%</b>	83.4%	84.0%	<b>85.9%</b>	86.0%	89.9%	<b>77.8%</b>	84.7%	88.2%	<b>89.2%</b>	87.1%	84.3%	<b>84.3%</b>	83.6%	86.8%	<b>82.1%</b>	83.9%	77.9%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	86.6%	86.4%	<b>83.6%</b>	75.9%	82.9%	<b>72.2%</b>	89.3%	88.9%	<b>87.7%</b>	86.3%	89.1%	<b>87.5%</b>	73.5%	82.3%	<b>79.6%</b>	78.3%	82.4%	<b>80.7%</b>	75.2%	83.1%	<b>83.8%</b>	82.2%	72.0%
Adolescent Well-Care Visits (AWC)	63.1%	61.9%	<b>68.1%</b>	51.4%	61.8%	<b>55.8%</b>	79.7%	79.9%	<b>76.9%</b>	72.1%	75.8%	<b>60.2%</b>	63.5%	67.7%	<b>69.4%</b>	60.0%	66.1%	<b>67.6%</b>	49.8%	55.7%	<b>59.7%</b>	65.4%	49.7%
Adult BMI Assessment (ABA)	<sup>2</sup>	<sup>2</sup>	<b>61.3%</b>	<sup>2</sup>	<sup>2</sup>	<b>69.4%</b>	<sup>2</sup>	<sup>2</sup>	<b>90.7%</b>	<sup>2</sup>	<sup>2</sup>	<b>48.7%</b>	<sup>2</sup>	<sup>2</sup>	<b>76.4%</b>	<sup>2</sup>	<sup>2</sup>	<b>59.9%</b>	<sup>2</sup>	<sup>2</sup>	<b>49.1%</b>	65.1%	52.6%

<sup>1</sup> A lower rate indicates better performance.

<sup>2</sup> New measure for HEDIS 2013.

MARR = Maryland Average Reportable Rate    NHM = National HEDIS Mean

ACC = AMERIGROUP Community Care    DIA = Diamond Plan    JMS = Jai Medical Systems    MPC = Maryland Physicians Care    MSFC = MedStar Family Choice    PP = Priority Partners    UHC = UnitedHealthcare

Table A – HealthChoice Organizations HEDIS 2012 Results, page two of four	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2013	HEDIS 2012
	ACC			DIA			JMS			MPC			MSFC			PP			UHC			MARR	NHM
<b>Respiratory Conditions</b>																							
Appropriate Testing for Children with Pharyngitis (CWP)	61.5%	68.8%	75.9%	64.7%	72.8%	87.6%	76.3%	74.51%	75.3%	74.0%	76.9%	77.4%	81.0%	85.9%	85.2%	69.5%	74.46%	78.2%	70.8%	76.4%	79.8%	79.9%	66.7%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	87.0%	86.13%	85.1%	85.3%	86.16%	83.3%	93.8%	89.8%	85.2%	85.6%	86.08%	86.06%	88.6%	89.0%	86.13%	88.5%	86.01%	85.0%	83.3%	80.2%	80.1%	84.4%	85.3%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	3	23.7%	20.6%	3	21.3%	17.5%	3	21.9%	35.5%	3	19.7%	19.9%	3	16.1%	14.1%	3	21.1%	18.9%	3	19.6%	16.0%	20.4%	24.3%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 5-11	91.90%	91.4%	88.7%	87.5%	86.7%	88.0%	91.94%	94.2%	91.4%	93.1%	93.0%	92.3%	92.8%	96.7%	93.7%	93.6%	91.7%	92.3%	93.2%	95.7%	96.1%	91.8%	90.5%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 12-18	4	88.2%	86.2%	4	NA <sup>4</sup>	96.8%	4	100%	92.9%	4	91.1%	92.3%	4	93.3%	90.2%	4	90.8%	89.6%	4	96.6%	93.4%	91.6%	86.6%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 19-50	4	78.0%	79.5%	4	85.0%	84.7%	4	91.3%	93.3%	4	82.8%	81.8%	4	85.2%	76.8%	4	77.9%	80.7%	4	95.1%	88.0%	83.5%	74.7%
Use of Appropriate Medications for People With Asthma (ASM) – Ages 51-64	4	71.2%	77.7%	4	NA <sup>4</sup>	NA <sup>4</sup>	4	83.7%	82.0%	4	81.7%	78.5%	4	NA <sup>4</sup>	77.1%	4	69.2%	77.0%	4	95.0%	94.1%	81.1%	72.9%
Use of Appropriate Medications for People With Asthma (ASM) – Total Combined Ages 5-64	4	89.1%	86.5%	4	95.0%	88.0%	4	95.7%	90.7%	4	90.7%	88.7%	4	95.5%	88.8%	4	89.3%	88.9%	4	96.7%	94.0%	89.4%	85.0%
Use of Appropriate Medications for People With Asthma (ASM) – Total combined ages 5-50 (Note: Additive for HEDIS 2013 – DHMH only)	90.1%	88.5%	86.7%	89.8%	88.1%	88.2%	93.3%	93.9%	92.5%	90.6%	89.8%	89.2%	91.1%	93.6%	89.4%	90.4%	88.9%	89.3%	90.2%	95.9%	94.0%	89.9%	
Medication Management for People with Asthma (MMA) - Total 50% of treatment period	2	2	44.8%	2	2	36.9%	2	2	53.2%	2	2	49.4%	2	2	52.4%	2	2	40.3%	2	2	47.3%	46.3%	52.3%
Medication Management for People with Asthma (MMA) - Total 75% of treatment period	2	2	24.1%	2	2	15.5%	2	2	28.9%	2	2	26.6%	2	2	28.7%	2	2	19.7%	2	2	26.7%	24.3%	30.3%
<b>Member Access</b>																							
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12-24 months	97.7%	97.45%	97.5%	94.4%	93.1%	92.3%	94.3%	92.9%	91.1%	96.5%	96.8%	97.1%	95.2%	96.6%	96.6%	97.9%	98.1%	97.8%	96.8%	97.41%	96.7%	95.6%	96.1%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 25 months to 6 years	92.7%	92.8%	92.6%	88.1%	86.8%	85.9%	90.6%	89.3%	90.4%	89.8%	90.7%	89.0%	88.9%	91.4%	90.3%	92.3%	93.0%	92.8%	91.7%	92.1%	91.1%	90.3%	88.2%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 7-11 years	93.6%	93.6%	93.9%	86.7%	90.6%	90.1%	94.5%	94.0%	93.3%	92.8%	92.0%	91.5%	93.4%	92.9%	92.5%	94.1%	93.9%	94.3%	93.1%	93.0%	93.3%	92.7%	89.5%
Children and Adolescents' Access to Primary Care Practitioners (CAP) – Age 12-19 years	88.6%	89.3%	89.5%	86.1%	87.8%	86.0%	92.02%	92.4%	91.7%	89.5%	88.4%	87.7%	91.98%	90.9%	92.5%	90.8%	91.6%	92.0%	89.9%	88.5%	89.2%	89.8%	87.9%
Adults' Access to Preventive/ Ambulatory Health Services (AAP) – Age 20-44	79.6%	80.4%	79.7%	76.9%	79.2%	79.8%	79.0%	75.5%	74.8%	80.9%	81.2%	81.4%	79.22%	79.6%	79.9%	83.0%	83.7%	83.5%	79.23%	80.3%	80.2%	79.9%	80.0%
Adults' Access to Preventive/ Ambulatory Health Services (AAP) – Age 45-64	85.0%	87.0%	86.4%	76.4%	80.0%	80.4%	89.2%	88.8%	87.8%	87.4%	87.28%	86.8%	84.6%	85.9%	86.2%	88.5%	89.4%	89.4%	85.9%	87.31%	87.5%	86.4%	86.1%
<b>Women's Health</b>																							
Breast Cancer Screening (BCS)	46.0%	48.5%	49.1%	39.3%	45.3%	46.2%	62.3%	63.9%	60.8%	42.8%	43.6%	43.9%	54.6%	54.5%	56.8%	48.0%	49.9%	51.5%	45.3%	46.6%	48.4%	51.0%	50.4%
Cervical Cancer Screening (CCS)	76.6%	75.71%	73.6%	70.2%	64.7%	72.0%	79.7%	78.5%	80.9%	69.7%	73.6%	74.0%	76.4%	75.74%	70.9%	69.4%	73.9%	75.0%	70.3%	69.5%	69.8%	73.7%	66.7%
Chlamydia Screening in Women (CHL) – Age 16-20 years of age	62.8%	61.1%	62.6%	54.4%	58.6%	66.6%	89.2%	84.0%	81.1%	60.6%	58.5%	58.1%	56.2%	57.4%	59.6%	62.1%	62.6%	61.8%	55.9%	57.1%	56.9%	63.8%	54.9%
Chlamydia Screening in Women (CHL) – Age 21-24 years of age	69.8%	70.6%	72.5%	71.1%	71.0%	73.2%	78.6%	77.4%	63.9%	65.1%	66.6%	67.6%	67.2%	70.5%	74.0%	68.8%	69.8%	68.9%	62.1%	64.8%	63.7%	69.1%	63.4%
Chlamydia Screening in Women (CHL) – Total, 16-24 years of age	65.5%	64.8%	66.4%	63.1%	65.3%	70.4%	85.3%	81.3%	74.2%	62.4%	62.0%	62.3%	60.1%	62.5%	65.0%	64.6%	65.4%	64.6%	58.2%	60.0%	59.5%	66.1%	58.0%

<sup>2</sup> New measure for HEDIS 2013.

<sup>3</sup> New measure for DHMH reporting in 2012.

<sup>4</sup> New measure for HEDIS 2012.

<sup>5</sup> When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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Table A – HealthChoice Organizations HEDIS 2012 Results page three of four	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2013	HEDIS 2012
	ACC			DIA			JMS			MPC			MSFC			PP			UHC			MARR	NHM
<b>Prenatal and Postpartum Care</b>																							
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	87.7%	90.4%	87.8%	83.1%	86.6%	83.4%	89.2%	86.2%	82.9%	83.9%	82.1%	86.28%	90.7%	87.7%	86.28%	87.9%	87.1%	89.3%	85.7%	83.8%	84.7%	85.8%	82.8%
Prenatal and Postpartum Care (PPC) – Postpartum Care	66.3%	70.7%	71.5%	59.4%	62.0%	59.3%	80.2%	78.1%	83.7%	75.2%	71.3%	68.4%	71.7%	74.0%	74.4%	68.2%	73.0%	72.5%	62.5%	64.7%	60.3%	70.0%	64.1%
Frequency of Ongoing Prenatal Care (FPC) – Less than 21% of expected visits <sup>1</sup>	3.49%	3.4%	4.2%	7.9%	5.9%	6.7%	1.4%	2.8%	3.6%	4.2%	5.7%	10.6%	1.8%	2.9%	2.7%	3.50%	7.7%	4.4%	3.6%	5.4%	12.1%	6.3%	10.0%
Frequency of Ongoing Prenatal Care (FPC) – Greater than or equal to 81% of expected visits	71.4%	80.3%	72.2%	58.3%	74.2%	63.5%	82.4%	76.9%	75.8%	74.0%	69.6%	60.1%	79.6%	82.7%	79.3%	77.9%	64.7%	78.8%	75.8%	72.2%	70.8%	71.5%	60.9%
<b>Cardiovascular Conditions</b>																							
Controlling High Blood Pressure (CBP)	<sup>2</sup>	<sup>2</sup>	47.0%	<sup>2</sup>	<sup>2</sup>	52.4%	<sup>2</sup>	<sup>2</sup>	52.3%	<sup>2</sup>	<sup>2</sup>	23.9%	<sup>2</sup>	<sup>2</sup>	70.5%	<sup>2</sup>	<sup>2</sup>	59.1%	<sup>2</sup>	<sup>2</sup>	43.1%	49.8%	56.8%
Comprehensive Diabetes Care (CDC) - Hemoglobin A1c (HbA1c) Testing	76.2%	78.8%	81.1%	62.9%	74.9%	77.7%	89.4%	90.5%	89.8%	79.6%	77.1%	76.0%	83.7%	88.1%	83.5%	78.5%	81.9%	82.4%	73.2%	75.9%	78.1%	81.2%	82.5%
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%) <sup>1</sup>	49.3%	43.3%	44.0%	55.9%	46.2%	46.8%	38.0%	33.6%	35.4%	51.1%	56.7%	52.6%	37.0%	27.5%	35.3%	46.0%	38.3%	41.7%	56.2%	51.1%	54.3%	44.3%	43.0%
Comprehensive Diabetes Care (CDC) - HbA1c Control (<8.0%)	41.1%	48.4%	47.1%	37.1%	46.2%	45.7%	52.7%	56.2%	54.7%	41.6%	37.0%	39.9%	52.8%	57.7%	58.9%	46.2%	50.8%	49.1%	37.5%	42.1%	38.9%	47.8%	48.1%
Comprehensive Diabetes Care (CDC) - Eye Exam (Retinal) Performed	62.3%	62.2%	69.3%	55.9%	69.6%	64.8%	79.7%	80.8%	80.1%	74.5%	76.2%	64.6%	73.7%	75.7%	72.8%	62.2%	71.6%	78.1%	66.7%	60.8%	57.7%	69.6%	53.4%
Comprehensive Diabetes Care (CDC) - LDL-C Screening	71.6%	77.4%	76.0%	61.8%	67.6%	71.2%	91.2%	89.4%	88.5%	74.9%	71.3%	69.2%	79.3%	81.7%	77.4%	70.4%	74.9%	73.1%	71.0%	72.3%	74.2%	75.7%	75.0%
Comprehensive Diabetes Care (CDC) - LDL-C Control (<100 mg/dL)	38.2%	35.9%	36.2%	24.7%	30.8%	27.7%	47.8%	48.7%	44.2%	32.4%	27.0%	28.0%	39.2%	44.6%	41.1%	37.2%	36.1%	44.5%	27.0%	35.0%	30.7%	36.1%	35.2%
Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy	78.8%	79.7%	73.6%	67.1%	66.8%	71.9%	93.6%	94.7%	93.6%	77.6%	75.2%	74.4%	85.6%	89.6%	78.8%	80.1%	79.0%	77.6%	73.5%	72.7%	74.2%	77.7%	77.8%
Comprehensive Diabetes Care (CDC) - Blood Pressure Control (<140/80 mm Hg)	41.3%	31.1%	29.1%	28.8%	38.9%	33.5%	27.4%	34.1%	38.0%	31.1%	24.1%	30.3%	37.7%	46.3%	55.7%	37.6%	42.2%	42.6%	19.2%	33.8%	25.3%	36.4%	39.4%
Comprehensive Diabetes Care (CDC) - Blood Pressure Control (<140/90 mm Hg)	63.0%	54.6%	48.4%	51.8%	64.4%	62.6%	43.2%	54.74%	59.1%	51.3%	45.7%	47.1%	59.6%	73.3%	73.7%	59.1%	65.1%	63.3%	32.8%	54.74%	47.0%	57.3%	61.0%
<b>Musculoskeletal Conditions</b>																							
Use of Imaging Studies for Low Back Pain (LBP)	<sup>3</sup>	78.5%	77.8%	<sup>3</sup>	74.8%	77.7%	<sup>3</sup>	81.6%	70.9%	<sup>3</sup>	76.8%	75.2%	<sup>3</sup>	74.5%	73.1%	<sup>3</sup>	74.7%	75.0%	<sup>3</sup>	75.5%	74.8%	74.9%	75.8%
Disease- Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)	<sup>2</sup>	<sup>2</sup>	61.8%	<sup>2</sup>	<sup>2</sup>	NA <sup>5</sup>	<sup>2</sup>	<sup>2</sup>	NA <sup>5</sup>	<sup>2</sup>	<sup>2</sup>	71.9%	<sup>2</sup>	<sup>2</sup>	NA <sup>5</sup>	<sup>2</sup>	<sup>2</sup>	69.5%	<sup>2</sup>	<sup>2</sup>	73.3%	69.1%	68.9%
Annual Monitoring for Patients on Persistent Medications (MPM) - Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)	<sup>2</sup>	<sup>2</sup>	90.1%	<sup>2</sup>	<sup>2</sup>	87.7%	<sup>2</sup>	<sup>2</sup>	95.8%	<sup>2</sup>	<sup>2</sup>	88.9%	<sup>2</sup>	<sup>2</sup>	87.6%	<sup>2</sup>	<sup>2</sup>	88.22%	<sup>2</sup>	<sup>2</sup>	88.22%	89.5%	85.9%
Annual Monitoring for Patients on Persistent Medications (MPM) - Members on Digoxin	<sup>2</sup>	<sup>2</sup>	95.8%	<sup>2</sup>	<sup>2</sup>	NA <sup>5</sup>	<sup>2</sup>	<sup>2</sup>	NA <sup>5</sup>	<sup>2</sup>	<sup>2</sup>	91.4%	<sup>2</sup>	<sup>2</sup>	NA <sup>5</sup>	<sup>2</sup>	<sup>2</sup>	91.5%	<sup>2</sup>	<sup>2</sup>	93.4%	93.1%	90.3%
Annual Monitoring for Patients on Persistent Medications (MPM) - Members on diuretics	<sup>2</sup>	<sup>2</sup>	88.2%	<sup>2</sup>	<sup>2</sup>	83.1%	<sup>2</sup>	<sup>2</sup>	94.3%	<sup>2</sup>	<sup>2</sup>	88.04%	<sup>2</sup>	<sup>2</sup>	88.02%	<sup>2</sup>	<sup>2</sup>	87.2%	<sup>2</sup>	<sup>2</sup>	87.8%	88.1%	85.4%
Annual Monitoring for Patients on Persistent Medications (MPM) - Members on anticonvulsants	<sup>2</sup>	<sup>2</sup>	66.0%	<sup>2</sup>	<sup>2</sup>	68.3%	<sup>2</sup>	<sup>2</sup>	64.8%	<sup>2</sup>	<sup>2</sup>	69.9%	<sup>2</sup>	<sup>2</sup>	58.1%	<sup>2</sup>	<sup>2</sup>	73.3%	<sup>2</sup>	<sup>2</sup>	72.4%	67.5%	65.2%
Annual Monitoring for Patients on Persistent Medications (MPM) - Total rate	<sup>2</sup>	<sup>2</sup>	86.2%	<sup>2</sup>	<sup>2</sup>	83.5%	<sup>2</sup>	<sup>2</sup>	93.1%	<sup>2</sup>	<sup>2</sup>	88.0%	<sup>2</sup>	<sup>2</sup>	84.1%	<sup>2</sup>	<sup>2</sup>	87.3%	<sup>2</sup>	<sup>2</sup>	87.5%	87.1%	83.9%

<sup>1</sup> A lower rate indicates better performance.

<sup>2</sup> New measure for HEDIS 2013.

<sup>3</sup> New measure for DHMH reporting in 2012.

<sup>5</sup> When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

MARR = Maryland Average Reportable Rate    NHM = National HEDIS Mean

ACC = AMERIGROUP Community Care    DIA = Diamond Plan    JMS = Jai Medical Systems    MPC = Maryland Physicians Care    MSFC = MedStar Family Choice    PP = Priority Partners    UHC = UnitedHealthcare

Table A – HealthChoice Organizations HEDIS 2012 Results – page four of four	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2013	HEDIS 2012
	ACC			DIA			JMS			MPC			MSFC			PP			UHC			MARR	NHM
<b>Behavioral Health</b>																							
Initiation and Engagement of Alcohol and other Drug Dependence (IET) – Initiation 13-17 Years	47.6%	41.0%	42.0%	NA <sup>5</sup>	49.5%	49.7%	42.3%	19.6%	19.5%	5.0%	50.0%	47.4%	38.4%	52.0%	49.8%	42.9%	34.1%	40.5%					
Initiation and Engagement of Alcohol and other Drug Dependence (IET) – Initiation 18+ Years	51.5%	47.4%	41.9%	41.1%	40.3%	45.8%	48.9%	46.7%	37.1%	50.8%	47.7%	43.1%	33.1%	36.6%	29.2%	48.4%	42.8%	38.5%	50.1%	47.3%	47.9%	40.5%	39.4%
Initiation and Engagement of Alcohol and other Drug Dependence (IET) – Initiation Overall	50.9%	46.4%	41.9%	40.8%	40.3%	45.8%	48.8%	46.5%	36.8%	50.6%	47.9%	43.0%	32.2%	35.5%	27.4%	48.6%	43.4%	38.5%	50.3%	47.6%	47.3%	40.1%	39.2%
Initiation and Engagement of Alcohol and other Drug Dependence (IET) – Engagement 13-17 Years	33.3%	26.5%	27.7%	NA <sup>5</sup>	33.6%	33.2%	26.5%	8.7%	9.8%	2.5%	32.4%	29.2%	22.6%	25.4%	31.5%	24.0%	20.7%	17.4%					
Initiation and Engagement of Alcohol and other Drug Dependence (IET) – Engagement 18+ Years	23.8%	20.7%	18.2%	25.2%	21.8%	20.3%	21.7%	19.5%	15.4%	25.0%	24.0%	20.5%	10.4%	8.3%	5.5%	22.3%	18.7%	17.0%	14.7%	17.0%	17.8%	16.4%	11.5%
Initiation and Engagement of Alcohol and other Drug Dependence (IET) – Engagement Overall	25.3%	21.6%	19.7%	25.5%	22.3%	21.1%	22.0%	19.4%	15.4%	25.9%	24.9%	21.0%	10.3%	8.4%	5.3%	23.6%	19.9%	17.6%	16.0%	18.8%	18.5%	16.9%	11.9%
Identification of Alcohol and Other Drug Services (IAD) – Any	2.5%	2.5%	2.6%	5.9%	5.4%	5.6%	17.1%	16.7%	15.8%	6.0%	6.2%	6.3%	4.4%	3.3%	3.1%	5.3%	5.2%	5.2%	3.9%	4.0%	3.6%	6.0%	3.6%
Identification of Alcohol and Other Drug Services (IAD) – Inpatient	0.6%	0.6%	0.6%	1.1%	1.0%	0.92%	4.4%	4.1%	3.8%	1.4%	1.3%	1.3%	1.5%	2.2%	0.90%	1.2%	1.1%	0.94%	0.9%	0.9%	0.94%	1.3%	1.1%
Identification of Alcohol and Other Drug Services (IAD) – Intensive	0.3%	0.33%	0.3%	0.5%	0.40%	0.4%	3.1%	2.9%	2.5%	0.9%	0.94%	0.82%	0.4%	0.34%	0.18%	0.9%	0.8%	0.7%	0.6%	0.43%	0.22%	0.7%	0.3%
Identification of Alcohol and Other Drug Services (IAD) – Outpatient/ED	2.2%	2.2%	2.4%	5.44%	4.9%	5.2%	15.4%	15.2%	14.5%	5.37%	5.7%	5.8%	3.9%	2.5%	2.5%	4.7%	4.8%	4.9%	3.4%	3.5%	3.0%	5.5%	3.4%
<b>Ambulatory Care (Utilization)</b>																							
Ambulatory Care (AMB) – Outpatient Visits	366.8	370.9	363.6	321.5	324.4	325.7	347.4	347.4	373.9	373.9	386.8	385.3	364.4	370.0	361.6	395.0	415.9	407.8	361.1	381.0	374.2	370.3	353.7
Ambulatory Care (AMB) – Emergency Department	59.0	60.7	59.8	84.3	85.1	84.7	88.8	91.3	93.4	72.5	78.8	79.3	70.3	72.3	70.8	64.0	65.7	66.0	63.7	65.8	65.2	74.2	62.4
<b>Call Services</b>																							
Call Answer Timeliness (CAT)	76.1%	78.9%	81.9%	92.3%	88.2%	81.3%	86.6%	93.1%	95.0%	85.7%	91.1%	87.7%	94.8%	89.2%	89.4%	84.4%	73.1%	84.9%	79.6%	85.5%	92.4%	87.5%	83.2%
Call Abandonment (CAB) <sup>1</sup>	6.0%	1.4%	<sup>6</sup>	2.6%	1.3%	<sup>6</sup>	3.8%	3.0%	<sup>6</sup>	1.3%	0.8%	<sup>6</sup>	1.2%	2.8%	<sup>6</sup>	1.5%	3.3%	<sup>6</sup>	3.1%	2.6%	<sup>6</sup>	<sup>6</sup>	<sup>6</sup>

<sup>1</sup> A lower rate indicates better performance.

<sup>5</sup> When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

<sup>6</sup> Effective HEDIS 2013, the measure is no longer reported.

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Table A1 – HealthChoice Organizations Reporting PAC HEDIS 2013 Results – page one of one	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011 MARR	2012 MARR	2013 MARR
	ACC PAC			JMS PAC			MPC PAC			PP PAC			UHC PAC					
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	<sup>2</sup>	32.6%	23.2%	<sup>2</sup>	15.2%	NA <sup>3</sup>	<sup>2</sup>	23.7%	23.4%	<sup>2</sup>	30.7%	39.7%	<sup>2</sup>	19.9%	22.8%	<sup>2</sup>	24.4%	27.3%
Adults' Access to Preventive/ Ambulatory Health Services (AAP) – Age 20-44	77.1%	70.6%	71.5%	74.9%	72.8%	71.8%	67.6%	62.3%	54.6%	65.1%	65.2%	64.0%	68.5%	69.8%	71.4%	70.6%	68.1%	66.7%
Adults' Access to Preventive/ Ambulatory Health Services (AAP) – Age 45-64	82.9%	80.5%	81.1%	82.1%	82.1%	82.6%	78.0%	72.8%	60.2%	75.7%	76.8%	78.2%	79.3%	81.4%	82.5%	79.6%	78.7%	76.9%
Breast Cancer Screening (BCS)	NA <sup>3</sup>	41.2%	42.5%	55.6%	52.6%	52.5%	40.7%	38.03%	27.7%	33.8%	34.4%	37.5%	36.7%	38.02%	41.1%	41.7%	40.8%	40.3%
Cervical Cancer Screening (CCS)	33.8%	37.8%	39.8%	62.6%	66.1%	61.7%	38.8%	39.4%	33.2%	38.1%	40.3%	40.2%	40.2%	38.9%	39.0%	42.7%	44.5%	42.8%
Comprehensive Diabetes (CDC) – Hemoglobin A1c Testing	71.4%	80.9%	82.0%	87.4%	91.5%	86.6%	75.4%	79.8%	73.6%	76.70%	78.5%	78.6%	72.7%	77.4%	78.8%	76.72%	81.6%	79.9%
Comprehensive Diabetes (CDC) – HbA1c Poor Control (>9.0%) <sup>1</sup>	55.4%	49.8%	50.3%	39.0%	32.1%	38.1%	47.9%	49.4%	54.9%	58.4%	52.2%	58.2%	59.9%	44.0%	57.5%	52.1%	45.5%	51.8%
Comprehensive Diabetes (CDC) – HbA1c Control (<8.0%)	33.0%	44.0%	42.5%	49.2%	58.6%	52.2%	43.3%	43.3%	37.7%	35.5%	40.3%	35.8%	32.4%	47.4%	36.6%	38.7%	46.7%	41.0%
Comprehensive Diabetes (CDC) – Eye Exam (Retinal) Performed	36.6%	34.9%	31.7%	60.5%	66.2%	62.1%	42.3%	29.0%	25.6%	30.8%	31.0%	33.4%	32.4%	42.3%	35.1%	40.5%	40.7%	37.6%
Comprehensive Diabetes (CDC) – LDL-C Screening	70.5%	74.6%	74.5%	87.1%	90.5%	87.3%	69.3%	74.7%	65.6%	68.1%	68.1%	70.2%	69.2%	73.2%	75.0%	72.8%	76.2%	74.5%
Comprehensive Diabetes (CDC) – LDL-C Control (<100 mg/dL)	29.5%	29.7%	30.4%	43.5%	45.7%	44.9%	31.6%	30.7%	26.4%	25.1%	26.3%	45.9%	24.3%	40.1%	28.1%	30.8%	34.5%	35.1%
Comprehensive Diabetes (CDC) – Medical Attention for Nephropathy	72.3%	80.4%	76.1%	91.9%	94.4%	90.7%	79.1%	79.8%	73.8%	74.9%	73.5%	77.3%	74.6%	79.5%	79.1%	78.6%	81.5%	79.4%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/80 mm Hg)	0.0%	0.0%	0.0%	26.1%	33.8%	34.2%	25.8%	26.5%	17.8%	3.2%	2.4%	0.0%	0.0%	24.8%	0.2%	11.0%	17.5%	8.6%
Comprehensive Diabetes (CDC) – Blood Pressure Control (<140/90 mm Hg)	0.0%	0.0%	0.0%	48.4%	56.4%	53.5%	46.0%	44.5%	31.5%	6.5%	4.4%	0.0%	0.0%	42.8%	0.2%	20.2%	29.6%	17.0%

<sup>1</sup> A lower rate indicates better performance.

<sup>2</sup> New measure for DHMH reporting in 2012.

<sup>3</sup> When denominator is less than 30 eligible members, NA is automatically assigned as the performance score.

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# A PERFORMANCE REPORT CARD

for Consumers

2013



Printed  
2/2013

## LOOKING AT HEALTH PLAN PERFORMANCE

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

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

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

### Key

- ☆☆☆ Above HealthChoice Average
- ☆☆ HealthChoice Average
- ☆ Below HealthChoice Average

PERFORMANCE AREAS						
HEALTH PLANS	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Diabetes Care
AMERIGROUP MARYLAND, INC.	☆☆	☆☆	☆☆	☆☆	☆☆☆	☆
COVENTRY HEALTH CARE OF DELAWARE, INC.	☆	☆☆	☆	☆☆	☆	☆
JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.	☆	☆☆	☆☆☆	Not Rated by Researchers	☆☆☆	☆☆☆
MARYLAND PHYSICIANS CARE	☆☆	☆☆	☆☆☆	☆☆	☆	☆
MEDSTAR FAMILY CHOICE, INC.	☆☆☆	☆☆	☆☆☆	☆☆	☆☆☆	☆☆☆
PRIORITY PARTNERS	☆☆☆	☆☆	☆	☆☆	☆☆	☆☆
UNITED HEALTHCARE OF THE MID-ATLANTIC, INC.	☆☆	☆☆	☆	☆☆	☆	☆

This information was collected from health plans and their members and is the most current performance data available. The information reported was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member composition. "Not Rated by Researchers" does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan.

### Performance Area Descriptions

#### Access to Care

- Appointments are scheduled without a long wait
- The health plan has good customer service
- Everyone sees a doctor at least once a year

#### Doctor Communication and Service

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

#### Keeping Kids Healthy

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

#### Care for Kids with Chronic Illness

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

#### Taking Care of Women

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

#### Diabetes Care

- Blood sugar levels are monitored and controlled
- Cholesterol levels are tested and controlled
- Eyes are examined for loss of vision
- Kidneys are healthy and working properly

### Services Covered by Each Health Plan

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

Every HealthChoice health plan offers some additional services.

### DO YOU WANT TO ASK THE HEALTH PLANS QUESTIONS?

AMERIGROUP MARYLAND	1-800-600-4441
COVENTRY HEALTH CARE OF DE	1-866-533-5154
JAI MEDICAL SYSTEMS	1-888-524-1999
MARYLAND PHYSICIANS CARE	1-800-953-8852
MEDSTAR FAMILY CHOICE	1-888-404-3549
PRIORITY PARTNERS	1-800-654-9728
UNITED HEALTHCARE	1-800-318-8821

For more information visit the HealthChoice website  
[www.dbmb.state.md.us/mma/](http://www.dbmb.state.md.us/mma/)

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

# INFORME CALIFICATIVO SOBRE DESEMPEÑO

para Consumidores

2013



Impresión  
2/2013

## EVALUACION DEL DESEMPEÑO DEL PLAN DE SALUD

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

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

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

Clave

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

### ÁREAS DEL FUNCIONAMIENTO

PLANES DE SALUD	Acceso a la Atención	Comunicación con el Médico y sus Servicios	Mantenimiento de la Salud de los Niños	Atención de Niños con Enfermedades Crónicas	Atención de la Mujer	Cuidado de la Diabetes
 AMERIGROUP MARYLAND, INC.	☆☆	☆☆	☆☆	☆☆	☆☆☆	☆
COVENTRY HEALTH CARE OF DELAWARE, INC.	☆	☆☆	☆	☆☆	☆	☆
JAI MEDICAL SYSTEMS MANAGED CARE ORGANIZATION, INC.	☆	☆☆	☆☆☆	No calificado por los investigadores	☆☆☆	☆☆☆
MARYLAND PHYSICIANS CARE	☆☆	☆☆	☆☆☆	☆☆	☆	☆
MEDSTAR FAMILY CHOICE, INC.	☆☆☆	☆☆	☆☆☆	☆☆	☆☆☆	☆☆☆
PRIORITY PARTNERS	☆☆☆	☆☆	☆	☆☆	☆☆	☆☆
UNITED HEALTHCARE OF THE MID-ATLANTIC, INC.	☆☆	☆☆	☆	☆☆	☆	☆

Esta información proviene de los planes de salud y de sus miembros y son los datos de desempeño más actualizados disponibles. La veracidad de la información recabada fue analizada por organizaciones independientes. Los puntajes de desempeño de los planes de salud no han sido ajustados para reflejar las diferencias en regiones de servicio o la composición del grupo de afiliados. 'No calificada por investigadores' no describe el desempeño o calidad de atención que proporciona este plan de salud; por lo tanto, no debería afectar su opción de plan de salud.

### Descripción de las Áreas de Desempeño

#### Acceso a la Atención

- Se otorgan citas sin demoras prolongadas
- El plan de salud tiene buena atención al cliente
- Todos ven al doctor por lo menos una vez por año

#### Comunicación con el Médico y sus Servicios

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

#### Mantenimiento de la Salud de los Niños

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

#### Atención de Niños con Enfermedades Crónicas

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

#### Atención de la Mujer

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

#### Cuidado de la Diabetes

- Se observan y controlan los niveles de azúcar en sangre
- Se analizan y controlan los niveles de colesterol
- Se examinan los ojos para ver si hay pérdida de la visión
- Los riñones están saludables y en buen funcionamiento

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

### Servicios Cubiertos por Cada Plan de Salud

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

Cada plan de salud HealthChoice ofrece algunos servicios adicionales.

### ¿TIENE PREGUNTAS PARA LOS PLANES DE SALUD?

AMERIGROUP MARYLAND	1-800-600-4441
COVENTRY HEALTH CARE OF DE	1-866-533-5154
JAI MEDICAL SYSTEMS	1-888-524-1999
MARYLAND PHYSICIANS CARE	1-800-953-8852
MEDSTAR FAMILY CHOICE	1-888-404-3549
PRIORITY PARTNERS	1-800-654-9728
UNITED HEALTHCARE	1-800-318-8821

Para obtener mayor información visite el sitio web de HealthChoice, [www.dhmb.state.md.us/mma/](http://www.dhmb.state.md.us/mma/)