HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

MARYLAND Department of Health

HealthChoice
Maryland's Medicaid Managed Care Program

Qlarant

Medicaid Managed Care Organization

EPSDT Medical Record Review

Statewide Executive Summary Report

Calendar Year 2017

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CY 2017 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review Executive Summary Report

Introduction

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is the federally mandated Medicaid program for screening, prevention, diagnosis, and treatment of physical and mental health conditions in children and adolescents 0 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 primary care provider (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 participants be provided health education and outreach services.

As the Maryland Department of Health's (MDH's) contracted External Quality Review Organization (EQRO), Qlarant annually completes an EPSDT medical record review. The medical record review findings assist MDH in evaluating the degree to which HealthChoice children and adolescents 0 through 20 years of age are receiving timely screening and preventive care in accordance with the Maryland Preventive Health Schedule.

This report summarizes the findings from the EPSDT medical record review for Calendar Year (CY) 2017. Approximately 628,954 children were enrolled in the HealthChoice Program during this period. The eight Managed Care Organizations (MCOs) evaluated for CY 2017 were:

- AMERIGROUP Community Care (ACC)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid–Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- University of Maryland Health Partners (UMHP)

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 evaluation and includes documentation of:

- Medical, family, and psychosocial histories with annual updates.
- Perinatal history 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 11 years of age, younger if indicated.
- Developmental screening using a standardized screening tool at the 9, 18, and 24-30 month visits.
- Autism screening required at the 18 and 24-30 month visits.
- Depression screening beginning at 11 years of age.

Comprehensive, unclothed, physical exam requires evaluation and includes documentation of:

- A complete assessment of no fewer than five body systems.
- Age-appropriate vision and hearing assessments (subjective or objective) at every visit.
- Assessment of nutritional status 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 beginning at 2 years of age.
- Blood pressure measurement beginning at 3 years of age.

Laboratory tests/at-risk screenings requires evaluation and includes documentation of:

- Newborn metabolic screening test results at birth and again by 8 weeks of age.
- Age-appropriate tuberculosis and cholesterol risk assessment results with appropriate follow up for positive or at risk results.
- Dyslipidemia lab test results for 9-11 and 18-21 years of age.
- Anemia risk assessment beginning at 11 years of age.
- Anemia test results at 1, 2, and 3-5 years of age.
- Lead risk assessment beginning at 6 months through 6 years of age.

- Referral to the lab for blood lead testing or follow up at appropriate ages.
- Blood lead test results at 1 and 2 years of age.
- Baseline blood lead test results at 3 to 5 years of age when not done at 24 months of age.
- STI/HIV risk assessment beginning at 11 years of age, or younger if indicated.

Immunizations require assessment of need and documentation that:

- The MDH Immunization Schedule is being followed in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.
- Age-appropriate vaccines are not postponed for inappropriate reasons.
- Children and/or adolescents who are delayed in their immunizations are brought current with the MDH Immunization Schedule.

Health education and anticipatory guidance requires documentation that the following were provided:

- Age appropriate anticipatory guidance.
- Counseling and/or referrals for health issues identified by the parent(s) or provider.
- Referral to dentist beginning at 12 months of age.
- Requirements for return visit specified.

CY 2017 EPSDT Review Process

Sampling Methodology

The sample frame was drawn from preventive care encounters occurring during calendar year 2017 for children from birth through 20 years of age. The sampling methodology includes the following criteria:

- A random sample is drawn from preventive care encounters per MCO, including a 10% over sample.
- Sample size per MCO provides a 90% confidence level and 5% margin of error.
- Sample includes only recipients through 20 years of age as of the last day of the measurement year.
- Sample includes EPSDT recipients enrolled on last day of measurement year, 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 (CPT 99381-85 or 99391-95). 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, or general practice.

Scoring Methodology

Data from the medical record reviews were entered into Qlarant's EPSDT Evaluation Tool. The analysis of the data was organized by the following age groupings:

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

Scoring reflects the percentage of possible points obtained in each component, for each age group, and for each MCO. The minimum compliance score is 80% for each component. If the minimum compliance score is not met, a Corrective Action Plan (CAP) will be required.

New elements and elements with revised criteria are scored as baseline.

The following should be considered when assessing results based on the random sampling methodology:

- Randomized record sampling does not assure that all providers and practices within the MCO network are included in the sample.

- Conclusions about individual provider performance in meeting program requirements cannot be made if the sample size per provider is too small (less than 10 charts) or the case mix does not include all ages.
- A randomized sample of preventive encounters may include both EPSDT-certified and non-certified providers. Providers who have not been certified by the program may not be familiar with the preventive care requirements. However, MCOs are still required by regulation to assure that preventive services are rendered to Medicaid recipients through 20 years of age.
- MCOs with low membership are likely to have the same providers reviewed every year to meet the minimum record sampling requirement.

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 child in the sample. These providers were given the option to mail or fax a complete copy of the medical record to Qlarant for review. A total of 2,350 medical records were reviewed in CY 2017.

The review criteria used by Qlarant's review nurses were the same as those developed and used by MDH's Healthy Kids Program nurse consultants. The review nurses successfully completed annual training and conducted inter-rater reliability (IRR) prior to the EPSDT review.

EPSDT Review Results

EPSDT review indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance score of 80% for each of the five components. If an MCO did not achieve the minimum compliance score, the MCO was required to submit a CAP. Each MCO met the minimum compliance score of 80% for all five component areas in CY 2017 (Table 1).

Table 1. CY 2017 EPSDT Component Results by MCO

Component	CY 2017 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2015	CY 2016	CY 2017
Health & Developmental History	94%	99%	98%	91%	93%	94%	92%	92%	92%	92%	92%
Comprehensive Physical Examination	96%	99%	97%	93%	96%	96%	92%	93%	93%	96%	96%
Laboratory Tests/At Risk Screenings	81%	99%	92%	82%	82%	81%	80%	81%	78%	85%	82%
Immunizations	89%	95%	96%	86%	93%	89%	87%	87%	84%	85%	90%
Health Education/ Anticipatory Guidance	93%	99%	97%	91%	93%	94%	90%	92%	92%	95%	94%
Total Score	**91%**	**98%**	**96%**	**88%**	**92%**	**92%**	**88%**	**89%**	**89%**	**91%**	**92%**

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

Health and Developmental History

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

Components: Medical history includes personal, family, perinatal, psychosocial, developmental, and mental health information. Psychosocial history assesses support systems and exposure to family and/or community violence, which may adversely affect the child's mental health. Developmental, autism, and depression 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. The substance abuse assessment identifies children who should be referred for counselling and/or treatment.

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 is recommended. While the CRAFFT assessment tool and those used for developmental and autism screening are suggested, the PHQ-9 or HEAD screen is mandatory for the depression screening.

Table 2. CY 2017 Health and Developmental History Element Results

CY 2017 Health and Development History Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Recorded Medical history	97%	100%	98%	96%	98%	99%	96%	96%
Recorded Family History	91%	99%	94%	88%	84%	92%	88%	88%
Recorded Perinatal History	92%	100%	94%	79%	86%	86%	80%	83%
Recorded Psychosocial History	95%	100%	97%	94%	94%	94%	94%	93%
Recorded Developmental Surveillance/History (0-5 years of age)	96%	98%	100%	94%	98%	97%	96%	97%
Recorded Developmental Surveillance/History (6-20 years of age)	95%	98%	100%	89%	95%	96%	91%	94%
Recorded Developmental Screening Tool	83%	100%	100%	81%	84%	86%	88%	88%
Recorded Autism Screening Tool	85%	100%	100%	67%	74%	68%	65%	83%
Recorded Mental/Behavioral Health Assessment	95%	100%	99%	94%	95%	94%	94%	92%
Recorded Substance Abuse Assessment[1]	80%	99%	99%	81%	87%	87%	83%	81%
Depression Screening[2]	48%	69%	92%	67%	58%	72%	59%	56%
MCO Component Score	**94%**	**99%**	**98%**	**91%**	**93%**	**94%**	**92%**	**92%**

Underlined scores denote scores below the 80% minimum compliance requirement.
[1]Baseline score for CY 2017; element criteria revised.
[2]Baseline score for CY 2017; new element.

Health and Developmental History Results

- All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.
- The HealthChoice Aggregate score remains stable at 92% since CY 2014.

Comprehensive Physical Examination

Rationale: The comprehensive physical exam uses a systems review method that requires documentation of a minimum of five systems (example - heart, lungs, eyes, ears, nose, throat, abdominal, genitals, skeletal-muscular, neurological, skin, head, and face) 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 beginning at 3 years of age.
- Oral assessment at each well-child visit, 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 a growth chart.
- Calculating and graphing Body Mass Index (BMI) beginning at 2 years of age.

Table 3. CY 2017 Comprehensive Physical Examination Element Results

CY 2017 Comprhensive Physical Exam Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Documentation of Minimum 5 Systems Examined	100%	99%	100%	97%	99%	99%	97%	97%
Vision Assessment	93%	100%	89%	92%	95%	93%	91%	94%
Hearing Assessment	90%	100%	91%	91%	92%	92%	87%	93%
Nutritional Assessment	96%	100%	100%	94%	97%	97%	93%	96%
Conducted Oral Assessment	98%	99%	99%	94%	95%	98%	93%	95%
Measured Height	99%	100%	100%	97%	99%	99%	97%	97%
Graphed Height	95%	99%	99%	90%	95%	96%	91%	89%
Measured Weight	99%	100%	100%	97%	99%	99%	97%	97%
Graphed Weight	95%	99%	99%	91%	96%	96%	90%	90%
BMI Percentile	94%	99%	100%	89%	93%	96%	90%	87%
BMI Graphing	94%	99%	99%	88%	93%	96%	89%	87%
Measured Head Circumference	100%	100%	97%	95%	86%	95%	91%	97%
Graphed Head Circumference	87%	94%	97%	91%	83%	95%	82%	92%
Measured Blood Pressure	97%	100%	97%	96%	99%	97%	95%	96%
MCO Component Score	**96%**	**99%**	**97%**	**93%**	**96%**	**96%**	**92%**	**93%**

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

Comprehensive Physical Examination Results

- All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.
- The HealthChoice Aggregate score remains consistent at 96% in CY 2017 after an increase of 3 percentage points in CY 2016.

Laboratory Tests/At-Risk Screenings

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

Components: Assessment of risk factors includes:

- A second newborn metabolic screen (lab test) by 8 weeks of age.
- Tuberculosis risk assessment annually beginning at 1 month of age.
- Cholesterol risk assessment annually beginning at 2 years of age.
- Dyslipidemia lab test results at 9-11 and 18-21 years of age.
- Lead risk assessment at every well-child visit from 6 months through 6 years of age with appropriate testing if positive or at risk.
- Blood lead test at 12 and 24 months of age.
- Baseline/3-5 year blood lead test if the 24 month test is not documented.
- Documented referral to lab for age appropriate blood lead test.
- Anemia risk assessment annually beginning at 11 years of age.
- Anemia test results at 1, 2, and 3-5 years of age.
- STI/HIV risk assessment annually beginning at 11 years of age.

Table 4. CY 2017 Laboratory Test/At–Risk Screenings Element Results

CY 2017 Laboratory Test/At-Risk Screenings Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Newborn Metabolic Screen	100%	88%	100%	100%	NA	100%	100%	75%
Recorded TB Risk Assessment	82%	99%	95%	81%	80%	82%	80%	75%
Recorded Cholesterol Risk Assessment	85%	100%	85%	83%	78%	80%	81%	79%
Dyslipidemia Lab Test[1]	59%	79%	55%	35%	44%	54%	48%	50%
Conducted Lead Risk Assessment	87%	100%	97%	92%	91%	89%	92%	92%
12 Month Blood Lead Test	64%	100%	97%	80%	92%	64%	75%	98%
24 Month Blood Lead Test	80%	100%	100%	82%	64%	93%	79%	79%
3 – 5 Year (Baseline) Blood Lead Test	70%	96%	88%	76%	85%	75%	71%	77%
Referral to Lab for Blood Lead Test	76%	97%	90%	77%	85%	75%	71%	85%
Conducted Anemia Risk Assessment[1]	72%	96%	55%	52%	62%	77%	65%	73%
Anemia Test[2]	71%	94%	84%	74%	77%	72%	74%	82%
Recorded STI/HIV Risk Assessment[1]	83%	99%	96%	78%	95%	84%	88%	85%
MCO Component Score	**81%**	**99%**	**92%**	**82%**	**82%**	**81%**	**80%**	**81%**

Underlined scores denote scores below the 80% minimum compliance requirement.
[1]Baseline score for CY 2017; element criteria revised.
[2]Baseline score for CY 2017; new element.
NA – Not applicable as there were no records included in the sample requiring a review of this element.

Laboratory/At-Risk Screening Results

All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.After a significant 7 percentage point increase from 78% in CY 2015 to 85% in CY 2016, the HealthChoice Aggregate score decreased by 3 percentage points to 82% in CY 2017.

Immunizations

Rationale: Children on Medical Assistance must be immunized according to the current MDH Recommended Childhood Immunization Schedule. The immunization schedule is endorsed by The Maryland State Medical Society and is based on the current recommendations of the U.S. Public Health Service's Advisory Committee of Immunization Practices (ACIP) and the American Academy of Pediatrics. Primary care providers who see Medicaid recipients through 18 years of age must participate in the Department's Vaccines for Children (VFC) Program.

Documentation: The VFC Program requires completion of the VFC 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 (VIS), and name/location of provider. Immunization components are listed in the table below.

Table 5. CY 2017 Immunizations Element Results

CY 2017 Immunization Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Hepatitis B	90%	98%	97%	88%	95%	91%	88%	86%
Diphtheria/tetanus/acellular pertussis (DTaP)	92%	99%	100%	91%	94%	93%	91%	92%
Haemophilus influenza type B (HIB)	91%	99%	99%	91%	96%	91%	92%	90%
Pneumococcal (PCV-7 or PCV-13 [Prevnar])	93%	99%	98%	91%	94%	91%	92%	91%
Polio (IPV)	92%	97%	97%	88%	95%	91%	89%	88%
Measles/Mumps/Rubella (MMR)	92%	98%	97%	88%	95%	90%	89%	88%
Varicella (VAR)	91%	98%	97%	87%	93%	91%	91%	88%
Tetanus/diphtheria/acellular pertussis (TDAP)	88%	99%	95%	84%	96%	89%	88%	86%
Influenza (Flu)	82%	88%	98%	75%	85%	86%	78%	84%
Meningococcal (MCV4)	93%	98%	95%	88%	97%	87%	82%	83%
Hepatitis A	89%	94%	94%	84%	93%	86%	87%	83%
Rotavirus	82%	92%	100%	100%	100%	100%	85%	87%
Human Papillomavirus (HPV)[1]*	84%	97%	95%	78%	92%	82%	83%	71%
Assessed Immunizations Up-to-Date	88%	89%	91%	84%	88%	90%	82%	87%
MCO Component Score	**89%**	**95%**	**96%**	**86%**	**93%**	**89%**	**87%**	**87%**

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

[1]Element criteria revised.

*Data collected for informational purposes only; not used in the calculation of the overall component score.

Immunizations Results

- All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.
- The HealthChoice Aggregate score for this component continues to improve. After an increase of 1 percentage point in CY 2016, the Immunization component aggregate score continued to rise another 5 percentage points in CY 2017 to 90%.

Health Education/Anticipatory Guidance

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

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. Beginning at 2 years of age, annual routine dental referrals are required 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. Educating the family about the preventive care schedule and scheduling the next preventive care visit increases the chances of having the child or 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 or 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 6. CY 2017 Health Education/Anticipatory Guidance Element Results

CY 2017 Health Education/Anticipatory Guidance Element Results								
Element	**ACC**	**JMS**	**KPMAS**	**MPC**	**MSFC**	**PPMCO**	**UHC**	**UMHP**
Documented Age Appropriate Anticipatory Guidance	97%	100%	100%	96%	96%	98%	94%	97%
Documented Health Education/ Referral for Identified Problems/Tests	98%	100%	99%	97%	99%	98%	96%	96%
Documented Referral to Dentist	84%	99%	88%	79%	88%	87%	81%	82%
Specified Requirements for Return Visit	92%	98%	100%	90%	89%	93%	89%	90%
MCO Component Score	**93%**	**99%**	**97%**	**91%**	**93%**	**94%**	**90%**	**92%**

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

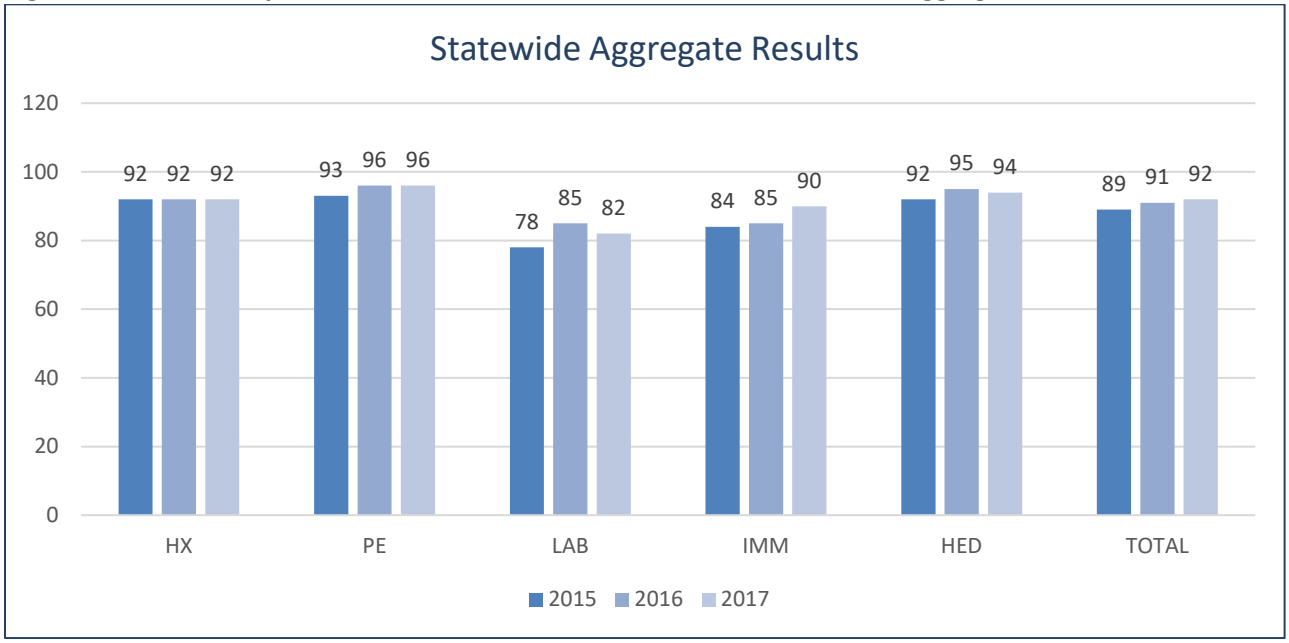
Health Education/Anticipatory Guidance Results

- All MCO scores exceeded the minimum compliance score of 80% for this component in CY 2017.
- The HealthChoice Aggregate score for this component decreased slightly by 1 percentage point in CY 2017 to 94% after the 3 percentage point increase demonstrated in CY 2016.

Trending Analysis of Aggregate Compliance Scores

The purpose of a trend analysis is to demonstrate changes in patterns of care at multiple points in time. Score variation is to be expected; not all increases or decreases from CY 2015 through CY 2017 can be interpreted as reflecting differences in quality of care. Potential effects of demographic factors or changes in case mix must also be considered. One must evaluate both the magnitude and pattern of the change in terms of potential clinical impact in order to determine whether the results reflect a change in the quality of care being delivered to enrollees.

Figure I-1. Trend analysis for CY 2015, CY 2016, and CY 2017 HealthChoice Aggregate scores.



The Total HealthChoice Aggregate scores demonstrate continuous improvement with increases in the total score by 2 percentage points (89% to 91%) from CY 2015 to CY 2016, and 1 percentage point (91% to 92%) from CY 2016 to CY 2017.

In CY 2017, the IMM – Immunizations component score demonstrated a significant improvement of five percentage points. Two component scores (HX – Health and Developmental History and PE – Comprehensive Physical Exam) remained the same and two component scores (LAB – Laboratory Tests/At Risk Screenings and HED – Health Education/Anticipatory Guidance) decreased. The Total score increased by one percentage point and all Statewide Aggregate Component scores continued to remain above the 80% minimum compliance threshold in CY 2017.

Corrective Action Plan Process

MDH sets high performance standards for the Healthy Kids/EPSDT Program. In the event the minimum compliance score is not met, MCOs are required to submit a CAP. The CAPs are evaluated by Qlarant to determine whether the plans are acceptable. In the event that a CAP is deemed unacceptable, Qlarant provides recommendations to the MCOs until an acceptable CAP is submitted.

Required Contents of EPSDT CAPs

Each required CAP must 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 Process

The review team evaluates 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 determines whether the CAPs were implemented and effective. In order to make this determination, Qlarant evaluates 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, MDH may take further action.

Conclusions

HealthChoice Aggregate scores for each of the five components were above the 80% minimum threshold for compliance. After a significant 7 percentage point increase from 78% in CY 2015 to 85% in CY 2016, the Laboratory Test/At-Risk Screenings Component demonstrated a 3 percentage point decrease to 82% in CY 2017. It is recommended that MCOs continue their concerted efforts in this area so that the component scores do not drop below the minimum compliance score of 80% in CY 2018. Scores for each component area except for the Laboratory Test/At-Risk Screenings Component increased or remained unchanged from CY 2016 to CY 2017. This resulted in an increase of 1 percentage point in the CY 2017 HealthChoice Aggregate Total Composite Score from 91% to 92%.

Each MCO met the minimum compliance score of 80% for all five components; therefore, no CAPs are required for CY 2017. However, it should be noted that the scores for the Laboratory Test/At-Risk Screenings Component for six out of the eight MCOs are within two percentage points of the minimum compliance score. MCOs should continue to monitor the elements of this component closely.

The MCO results of the EPSDT review demonstrate strong compliance with the timely screening and preventive care requirements of the Healthy Kids/EPSDT Program. Overall scores indicate that the MCOs, in collaboration with PCPs, are committed to the Department's goals to provide care that is patient focused, prevention oriented, and follows the Maryland Schedule of Preventive Health Care.