



Maryland
DEPARTMENT OF HEALTH



Maryland HealthChoice Program

**Early and Periodic Screening, Diagnosis, and
Treatment (EPSDT) Medical Record Review**

Statewide Executive Summary Report

Measurement Year 2024

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Maryland HealthChoice Program

Early and Periodic Screening, Diagnosis, and Treatment Medical Record Review

Executive Summary

HealthChoice Program Overview

Maryland’s Medicaid Managed Care Program, known as HealthChoice, is a comprehensive system of continuous quality improvement, which includes problem identification, analysis, corrective action, and re-evaluation, to identify and address areas for improvement. HealthChoice serves Marylanders on Medicaid by developing processes and systems capable of profiling and tracking information regarding the care received by enrollees.

Guiding principles for HealthChoice’s operations are to provide quality healthcare that is equitable, patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. HealthChoice emphasizes health promotion and disease prevention and requires enrollees to receive health education and outreach services. Utilization of a “medical home” connects each enrollee with a primary care provider (PCP) of their choice and identifies a PCP responsible for overseeing their medical care by providing preventive and primary care services, managing referrals, and coordinating all necessary care.

External Quality Review

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible HealthChoice enrollees by contracted managed care organizations (MCOs). MDH contracts with Qlarant to conduct external quality reviews (EQRs) and to annually evaluate the quality assurance program and activities of each MCO. Qlarant’s annual, independent reviews assess compliance with standards governing the HealthChoice Program in the Code of Federal Regulations and Code of Maryland Regulations through the Centers for Medicare & Medicaid protocols.

EPSDT Medical Record Review

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated Medicaid program that monitors physical and mental health conditions in children and adolescents through 20 years of age, as defined by the Omnibus Budget Reconciliation Act of 1989. Each state determines its own periodicity schedule for services, including periodic physical and mental health screening, vision, dental, and hearing services.

Since 2007, MDH has conducted an EPSDT program named *Healthy Kids*, which requires all PCPs to provide services to eligible HealthChoice children and adolescents with timely screening and preventive care. Each year, Qlarant completes an annual EPSDT medical record review (MRR) to assess compliance with the Maryland Healthy Kids Program guidelines defined in the Maryland Schedule of Preventive Health Care standards.

This report summarizes the EPSDT MRR results, describes sample sizes, compares and trends performance per component, and identifies required corrective action plans (CAPs) for measurement year (MY) 2024, defined as January 1 to December 31, 2024. No MCOs were exempt from this task; therefore, Qlarant evaluated and assessed the following nine MCOs contracted to provide services in this report:

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

Key Findings

Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs provided by The Hilltop Institute of the University of Maryland, Baltimore County (Hilltop). For MY 2024, there was a total sample of 2,651 preventive care encounters across all MCOs.

MDH established the minimum compliance score for MY 2024 as 80% for the following components:

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

Two MCOs (MPC and UHC) are required to submit CAPs along with a focused provider education project for two years per MDH’s Performance Monitoring Policy, to address noncompliance in the *Laboratory Tests/At-Risk Screenings* component, which should improve compliance rates if successfully implemented. Qlarant calculated CAPs by component instead of individual elements.

Quality Strategy Highlights

MDH set a task goal of increasing all EPSDT requirements to 80% or above by MY 2024 in the HealthChoice Quality Strategy for 2022-2024, based on pre-Covid public health emergency aggregate performance. Specific HealthChoice performance metrics and targets are displayed in the table below.

All components met or exceeded the MDH minimum threshold (80%) in MY 2024. All components fell below MDH’s Quality Strategy Targets for MY 2024 by one percentage point (*Immunizations*) to four percentage points (*Laboratory Tests/At-Risk Screenings*). The HealthChoice aggregate total fell below the MY 2024 target by two percentage points. Results within this report include sample size, performance per component, trended results per component, and required CAPs.

Table 1. MY 2024 HealthChoice Aggregate Performance Against Quality Strategy Targets

Requirement: Minimum Compliance Score: ≥80%	HealthChoice Aggregate MY 2024	MDH Quality Strategy Targets for MY 2024
HX	92%	94%
PE	95%	97%
LAB	83%	87%
IMM	92%	93%
HED	92%	94%
HealthChoice Aggregate Totals	92%	≥94%

Source: [HealthChoice Quality Strategy](#)

Measurement Year (MY) 2024's Statewide Executive Summary Report

EPSDT Objective and Methodology

Objective. Maryland's EPSDT/Healthy Kids Program mission is to improve accessibility and ensure the availability of quality healthcare for HealthChoice children and adolescents through 20 years of age. The EPSDT MRR supports this mission and assesses the timely delivery of EPSDT services to children and adolescents enrolled in an MCO. HealthChoice MCOs are responsible for providing or arranging the full range of healthcare services for Maryland Medicaid enrollees. MCOs contract with providers to deliver covered health services to their enrollees. At its core, the Healthy Kids program is a partnership between healthcare providers, MCOs, public health officials, local health departments, and families.

Description of Data Obtained. MDH has an interagency governmental agreement with Hilltop to serve as the data warehouse for its encounters. Upon receiving Hilltop's full MY 2024 preventive care encounters sample frame, Qlarant selected a sample of medical records from the pool of EPSDT-certified and non-EPSDT certified PCPs. Sample size per MCO included a 10% oversample and provided a 90% confidence level (CL) with a 5% margin of error (error). A total sample of 2,651 medical records was included in the review for MY 2024 across all HealthChoice MCOs. Abstracted data from the MRRs was entered into Qlarant's EPSDT evaluation tool. Data was organized and analyzed in the following age groups:

- Birth through 11 months of age
- 12 through 35 months of age
- 3 through 5 years of age
- 6 through 11 years of age
- 12 through 20 years of age

Qlarant's methodology included selecting samples, defining exclusion and inclusion within samples, scheduling onsite reviews, gathering updated fax numbers, faxing medical record requests, securely storing and receiving medical records, and conducting outreach attempts for missing information.

- **Selecting Samples.** Qlarant used random sampling for MY 2024's MRR, which does not ensure all providers and practices within the MCO network are included in the sample and may include both EPSDT-certified and non-EPSDT-certified providers. MCOs are still required by regulation to ensure preventive services are rendered to Medicaid enrollees through 20 years of age, even if providers without certification by the EPSDT program are unfamiliar with the preventive care requirements. MCOs with low memberships are likely to have the same providers reviewed every year to meet the minimum record sampling requirements. Conclusions about individual provider performance in meeting program requirements cannot be made if the sample size per provider is too small (less than ten charts) or the case-mix does not include all ages.

- **Defining Exclusion and Inclusion within Samples.** Enrollees were eligible through 20 years of age, as of the last day of the measurement year, and with qualifying preventive care encounters (CPT 99381-85 or 99391-95). Only one date of service was selected from the sample for children less than two years of age who may have had four to six preventive visits within a 12-month period. EPSDT services were included for enrollees enrolled on the last day of the measurement year, and for at least 320 days in the same MCO. If the enrollee's age on the last day of the selected period was less than 365 days, the criteria was modified to read the same MCO for 180 days, with no break in eligibility. The following specialty codes were included in the sample: 16 (pediatrics), 28 (general practice), 29 (family practice), 30 (internal medicine), and 171 (nurse practitioner). The specialty code 007 (OBGYN) is excluded from the MRR. Telehealth visits were flagged and excluded from the MRR.
- **Scheduling Onsite Reviews.** For MY 2024, nurse reviewers conducted MRRs onsite at the provider offices or MCO headquarters, except for providers with five or fewer patients in the sample (singles). Qlarant's contracted administrative scheduler worked with the respective offices to determine the date and time of the review. If unsuccessful in initiating contact for scheduling after three attempts, Qlarant contacted the MCOs for assistance with solidifying provider contact and scheduling onsite MRR(s). In the event a provider office had more than one MCO identified, the MCO with the most patients on the listing was contacted first for assistance, with other MCOs contacted as needed. The administrative scheduler sent a copy of the patient listing to the provider office at the time of scheduling via fax. The nurse reviewers then confirmed the patient list with the provider office via telephone 48 hours prior to the onsite review. Qlarant required access to the entire medical record to ensure adequate information was available to evaluate compliance with the EPSDT program guidelines. All documentation needed to be present at the time of the record review, as no documentation was accepted after the nurse left the practice site office.
- **Gathering Updated Fax Numbers.** Providers with five or fewer patients in the sample (singles) were initially contacted to obtain updated office fax numbers to submit the MY 2024 medical record request. Providers were notified that the fax request for medical records would be submitted to the fax number provided.
- **Faxing Medical Record Requests.** Qlarant directly faxed each sampled billing provider a letter with their specific medical record request.
- **Singles Medical Record Reviews:**
 - **Securely Storing and Receiving Medical Records.** Providers were asked to securely submit complete medical record information for specific dates of service to Qlarant via secure fax or Kiteworks.
 - **Outreach Attempts for Missing Information.** Upon receipt of medical records via secure fax or Kiteworks, Qlarant reviewed each record for completeness and outreached providers for any missing documentation. Qlarant conducted two outreach attempts for missing documentation. MCOs were notified when outreach attempts were exhausted for specific medical records and

provided an opportunity to obtain this information. Any medical records with missing information not received by the conclusion of the EPSDT MRR activity were reviewed “as is” and scored accordingly.

- **MCO-Provided Records:** Some MCOs provide medical records, and nurse reviewers conduct onsite reviews at the MCOs’ headquarters, instead of onsite at provider offices. For MY 2024, three MCOs used this approach (JMS, KPMAS, and MSFC).
- Each record was reviewed for validity and completeness at the time of the onsite or desktop review. In the event a record was classified as invalid (incorrect date of birth, incorrect gender, incorrect date of service, patient not seen by provider, not an EPSDT record, or no record), the review for that medical record stopped, and it did not count against the total score.
- MRR samples contained total samples, completed reviews, and invalid records. Five invalid records were identified within the MY 2024 sample. During onsite or desktop reviews, nurse reviewers verified that all medical records matched the patient listing. Medical records were only considered valid if the reviewer successfully verified:
 - Patient name
 - Date of birth
 - Gender
 - Date of service
 - EPSDT record

Table 2. MY 2024 MCO and HealthChoice Sample Size Summary

MY 2024 Sample Size	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	Total
Minimum (90% CL with 5% Error)	265	267	261	269	270	267	270	269	270	2,408
Maximum (10% Oversample)	292	294	288	296	297	294	297	296	297	2,651
Total Valid Sample Reviewed	277	273	281	293	283	273	288	272	257	2,497
Invalid Record Total	0	0	3	1	0	0	0	1	0	5

Technical Methods of Data Collection and Analysis. Qlarant’s medical record data reviewers are trained nurses and experienced MDH Healthy Kids Program nurse consultants. Prior to reviewing medical records, these nurses were required to complete Qlarant’s EPSDT annual training and achieve an inter-rater reliability rate of 90% or above. The MY 2024 EPSDT MRR was conducted by six nurses who completed the EPSDT training and achieved a 90% or higher inter-rater reliability rate. One of the six nurses was a HEDIS nurse, three of the six nurses had experience completing a prior EPSDT MRR, and the two remaining nurses completed their first EPSDT MRR with Qlarant this year.

Abstracted data from the MRRs were organized and analyzed within the five age groups identified previously. Within each age group, specific elements were scored based on medical record documentation. Elements within each component are weighted equally, scored, and added together to calculate the final component score. Similarly, elements’ composite (overall) scores follow the same methodology. CAPs for MCOs are required if the minimum compliance score for each component (80%) is not met. New elements or elements with revised criteria are scored as baseline for the MY.

Table 3. MY 2024 Validation Review Determinations and Scoring

Review Determination	Score
Complete	2
Incomplete	1
Missing	0
Not Applicable*	NA
Compliance Score	MDH established the minimum compliance for MY 2024 at 80%.

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

Corrective Action Plan Process. MCOs are required to submit CAPs for elements or components not meeting the minimum compliance score. Qlarant evaluates CAPs to determine whether they are acceptable and provides recommendations to the MCOs until an acceptable CAP is submitted. CAPs are determined adequate only if they address the following required elements and components:

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

Qlarant evaluates the effectiveness of any CAPs initiated because of the prior year’s review. A review of all required EPSDT components is completed annually for each MCO. Since CAPs related to the review can be directly linked to specific components, the annual EPSDT MRR determines whether the CAPs were implemented and effective. To make this determination, Qlarant evaluates all data collected or trended by the MCO through the monitoring mechanism established in the CAP. If an MCO has not implemented or followed through with the tasks identified in the CAP, MDH may take further action according to their Performance Monitoring Policy.

Timeline. Qlarant conducted EPSDT activities from July 2025 to October 2025 to assess MCOs' MY 2024 compliance with EPSDT and Healthy Kids requirements. MCOs upload required CAPs to their respective portals, with an email notification to Qlarant, within 45 calendar days of receiving their final report.

EPSDT Medical Record Review Results

EPSDT MRR indicators are based on current pediatric preventive care guidelines and MDH-identified priority areas. Guidelines and criteria are divided into five component areas: Health and Developmental History (HX), Comprehensive Physical Examination (PE), Laboratory Tests/At-Risk Screenings (LAB), Immunizations (IMM), and Health Education/Anticipatory Guidance (HED). The following sections describe each component, summarize and trend results of MCO performance, and describe aggregate performance scores with HealthChoice aggregate and total composite scores.

EPSDT Component Results

MY 2024's EPSDT MRR observed the following about aggregate MCO performance across all components:

- All MCOs' total composite scores exceeded the 80% minimum compliance score.
- All MCOs exceeded the 80% minimum compliance score for four of the five component scores.
- Two of the nine MCOs (MPC and UHC) fell below the 80% minimum compliance score for the *Laboratory Tests/At-Risk Screenings* component, requiring CAP submissions along with a focused provider education project for two years per MDH's Performance Monitoring Policy, due to multiple years of not meeting the requirement.
- The HealthChoice aggregate component scores ranged from 83% (*Laboratory Tests/At-Risk Screenings*) to 95% (*Comprehensive Physical Examination*).
- The HealthChoice aggregate *Health and Developmental History*, *Comprehensive Physical Examination*, and *Health Education/Anticipatory Guidance* component scores decreased from MY 2023 to MY 2024, with the most significant decrease of four percentage points for the *Health Education/Anticipatory Guidance* component score.
- The total HealthChoice aggregate composite score has consistently declined from MY 2022 (95%) to MY 2024 (92%).

Table 4. MY 2024 Component Results by MCO and Measurement Year Aggregates

Component	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
HX	92%	90%	94%	95%	93%	93%	93%	85%	90%	96%	93%	92%
PE	95%	94%	98%	97%	94%	96%	96%	86%	94%	98%	97%	95%
LAB	80%	82%	94%	93%	79%*	82%	81%	74%*	80%	85%	80%	83%
IMM	90%	88%	96%	97%	90%	91%	92%	89%	91%	95%	92%	92%
HED	92%	90%	98%	98%	92%	94%	91%	85%	89%	97%	96%	92%
Total Composite Score	91%	90%	97%	96%	91%	92%	92%	85%	91%	95%	93%	92%

Red font denotes a CAP requirement for components scoring below the 80% minimum compliance score.

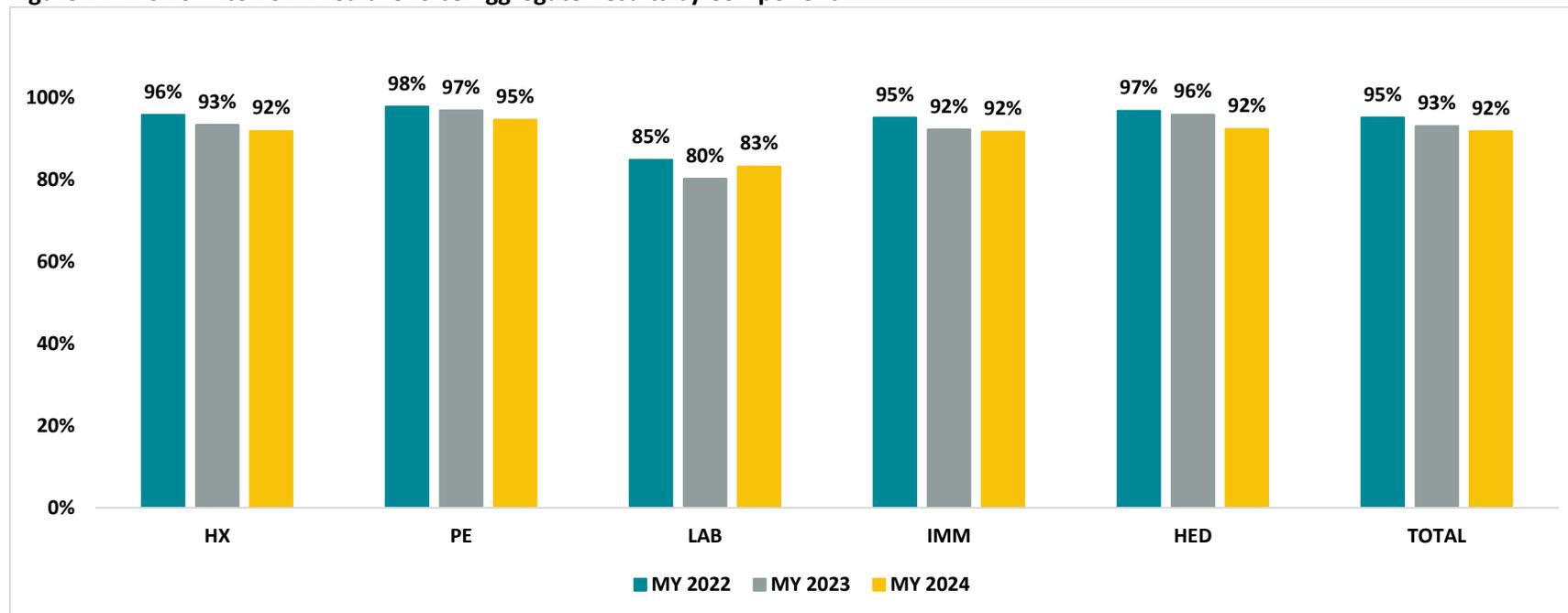
*Score fell below the minimum compliance score for multiple years and requires a CAP along with a focused provider education project per MDH’s Performance Monitoring Policy.

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 MY 2022 through MY 2024 can be interpreted as reflecting differences in quality of care.

MY 2024’s EPSDT MRR observed the following about MCO performance trends across all component scores:

- All component scores remained consistent from MY 2022 to MY 2024.
- Though minimal, the *Health and Developmental History, Comprehensive Physical Examination, Health Education/Anticipatory Guidance* components scores, and total composite scores have consistently declined from MY 2022 to MY 2024.
- There was an increase of three percentage points for *Laboratory Tests/At-Risk Screenings* from MY 2023 (80%) to MY 2024 (83%).
- All five component scores have met or exceeded the 80% minimum compliance score from MY 2022 to MY 2024.

Figure 1. MYs 2022 to 2024 HealthChoice Aggregate Results by Component



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.

Requirements. PCPs evaluated and documented:

- Medical, family, and psychosocial histories with annual updates
- Perinatal history through 2 years of age
- Maternal depression screening at child’s 1, 2, 4, and 6-month visits
- Developmental history/surveillance through 20 years of age
- Mental health assessment beginning at 3 years of age
- Substance use screening beginning at 11 years of age, younger if indicated

- Developmental screening using an approved, 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

Documentation. Initial personal, family, and psychosocial histories, with annual updates, are required to ensure the most current information is available. 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. An approved screening tool is required for substance abuse, developmental, autism, depression, and maternal depression screenings.

Results. MY 2024's EPSDT MRR observed the following about aggregate MCO performance across the *Health and Developmental History* component:

- All MCOs exceeded the 80% minimum compliance score for the *Health and Developmental History* component, ranging from 85% (UHC) to 95% (KPMAS).
- ABH, JMS, KPMAS, MPC, MSFC, and PPMCO met or exceeded the HealthChoice aggregate component score, ranging from 92% (ABH) to 95% (KPMAS).
- Ten of the eleven HealthChoice aggregate element scores exceeded the 80% minimum compliance score, except for the *Recorded Maternal Depression Screening* element, which fell below compliance by three percentage points (77%).
- Two of the nine MCOs (ABH and JMS) exceeded the 80% minimum compliance score for all elements.
- All MCOs exceeded the 80% minimum compliance score for the *Recorded Medical History, Recorded Psychological History, Recorded Developmental Surveillance/History, Recorded Mental/Behavioral Health Assessment, and Recorded Substance Use Assessment* elements.
- UHC was the only MCO to score below the 80% minimum compliance score for the *Recorded Family History* element (79%).
- MPC, UHC, and WPM scored below the 80% minimum compliance score for the *Recorded Perinatal History* element at 76%, 75%, and 78%, respectively.
- CFCHP, KPMAS, MPC, PPMCO, and UHC scored below the 80% minimum compliance score for the *Recorded Maternal Depression Screening* element, ranging from 9% (KPMAS) to 79% (CFCHP).
- WPM was the only MCO to score below the 80% minimum compliance score by six percentage points for the *Recorded Developmental Screening Tool* element (74%).
- MSFC and WPM scored below the 80% minimum compliance score for the *Recorded Autism Screening Tool* element at 76%.
- KPMAS was the only MCO to score below the 80% minimum compliance score for the *Depression Screening* element at 57%.
- Despite an increase of nine percentage points from MY 2023 to MY 2024, the HealthChoice aggregate score for the *Recorded Maternal Depression Screening* element remains below the 80% minimum compliance score (68% to 77%).

- All HealthChoice aggregate scores for each element have declined from MY 2022 to MY 2024, with the most significant decrease of eight percentage points for the *Recorded Family History* element (93% to 85%).

Table 5. MY 2024 Health and Developmental History Element Results and Measurement Year Aggregates

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Recorded Medical History	94%	93%	89%	97%	95%	94%	94%	86%	94%	97%	95%	93%
Recorded Family History	86%	82%	85%	92%	87%	89%	87%	79%	82%	93%	89%	85%
Recorded Perinatal History	91%	85%	88%	100%	76%	85%	85%	75%	78%	90%	86%	86%
Recorded Maternal Depression Screening	84%	79%	92%	9%	73%	88%	77%	78%	92%	82%	68%	77%
Recorded Psychological History	95%	93%	99%	96%	95%	97%	96%	87%	96%	99%	96%	95%
Recorded Developmental Surveillance/History	95%	93%	95%	100%	96%	97%	97%	88%	95%	98%	96%	95%
Recorded Developmental Screening Tool	93%	82%	100%	100%	89%	88%	94%	84%	74%	93%	84%	90%
Recorded Autism Screening Tool	81%	87%	100%	100%	84%	76%	100%	80%	76%	88%	82%	87%
Recorded Mental/Behavioral Health Assessment	95%	95%	100%	100%	97%	96%	99%	90%	97%	98%	97%	96%
Recorded Substance Use Assessment	89%	89%	99%	96%	95%	93%	89%	85%	88%	93%	94%	91%
Depression Screening	85%	80%	100%	57%	88%	84%	85%	82%	83%	89%	87%	83%
Total Composite Score	92%	90%	94%	95%	93%	93%	93%	85%	90%	96%	93%	92%

Bold font denotes scores below the 80% minimum compliance score.

Comprehensive Physical Examination

Rationale. The comprehensive physical examination uses a systems review method that requires documentation of a minimum of five systems (e.g., heart, lungs, eyes, ears, nose, throat, abdominal, genitals, skeletal-muscular, neurological, skin, head, and face) to meet EPSDT standards.

Requirements. PCPs evaluated and documented:

- 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
- Body mass index (BMI) calculation and graphing beginning at 2 years of age
- Blood pressure measurement beginning at 3 years of age

Documentation. A comprehensive physical examination 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 examination 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 BMI beginning at 2 years of age.

Results. MY 2024's EPSDT MRR observed the following about aggregate MCO performance across the *Comprehensive Physical Examination* component:

- All MCOs exceeded the 80% minimum compliance score for the *Comprehensive Physical Examination* component.
- ABH, JMS, KPMAS, MSFC, and PPMCO met or exceeded the HealthChoice aggregate component score, ranging from 95% (ABH) to 98% (JMS).
- All HealthChoice aggregate element scores exceeded the 80% minimum compliance score.
- Two of the nine MCOs (MPC and UHC) met or exceeded the 80% minimum compliance score for all elements.
- MPC scored below the minimum compliance score for the *Graphed Head Circumference* element at 68%.
- UHC scored below the minimum compliance score for the *Hearing Assessment*, *BMI Graphing*, and *Graphed Head Circumference* elements at 77%, 77%, and 79%, respectively.

- All HealthChoice aggregate scores for each element have declined from MY 2022 to MY 2024, with the most significant decrease of ten percentage points for the *BMI Graphing* element (99% to 89%).

Table 6. MY 2024 Comprehensive Physical Examination Element Results and Measurement Year Aggregates

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Documentation of Minimum 5 Systems Examined	98%	97%	99%	100%	97%	99%	99%	90%	97%	99%	99%	97%
Vision Assessment	89%	89%	97%	87%	88%	86%	93%	81%	90%	94%	91%	89%
Hearing Assessment	86%	87%	97%	88%	84%	84%	93%	77%	88%	93%	90%	87%
Nutritional Assessment	96%	94%	100%	98%	96%	97%	97%	87%	95%	98%	98%	96%
Conducted Oral Assessment	95%	94%	95%	100%	94%	94%	97%	85%	94%	96%	98%	94%
Measured Height	99%	97%	100%	99%	99%	100%	99%	92%	98%	100%	99%	98%
Graphed Height	97%	96%	99%	99%	96%	100%	98%	89%	97%	99%	99%	97%
Measured Weight	99%	99%	100%	100%	100%	100%	100%	92%	99%	100%	100%	99%
Graphed Weight	98%	96%	99%	100%	96%	99%	98%	89%	97%	99%	99%	97%
BMI Percentile	97%	98%	100%	99%	98%	99%	98%	90%	96%	100%	98%	97%
BMI Graphing	87%	89%	97%	99%	88%	94%	86%	77%	83%	99%	95%	89%
Measured Head Circumference	98%	84%	98%	93%	85%	95%	97%	82%	95%	94%	95%	92%
Graphed Head Circumference	95%	80%	92%	93%	68%	95%	89%	79%	80%	92%	93%	86%
Measured Blood Pressure	97%	95%	99%	96%	98%	98%	95%	89%	97%	97%	95%	96%
Total Composite Score	95%	94%	98%	97%	94%	96%	96%	86%	94%	98%	97%	95%

Bold font denotes scores below the 80% minimum compliance score.

Laboratory Tests/At-Risk Screenings

Rationale. The Healthy Kids Program requires assessments of risk factors associated with heart disease, tuberculosis (TB), lead exposure, anemia, and STI/HIV.

Requirements. PCPs evaluated and documented:

- Newborn metabolic screening test results at birth and again by 8 weeks of age
- TB assessment required at 1, 6, and 12 months, and annually thereafter with appropriate follow-up for positive or at-risk results

- Cholesterol risk assessment beginning at 2 years of age, and annually thereafter 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, and annually thereafter with appropriate follow-up for positive or at-risk results
- Anemia test results at 12 months, 24 months, and 3-5 years of age
- Lead risk assessment beginning at 6 months through 5 years of age, with appropriate follow-up for positive or at-risk results
- Referral to the lab for blood lead testing or follow up at appropriate ages
- Blood lead test results at 12 and 24 months of age
- Baseline blood lead test results at 3 to 5 years of age, when not done at 24 months of age
- Sexually transmitted infection/human immunodeficiency virus (STI/HIV) risk assessment beginning at 11 years of age, or younger, if indicated; and annually thereafter with appropriate follow up for positive or at-risk results
- Human immunodeficiency virus (HIV) lab test required between the ages of 15 and 18

Documentation. Assessment results, Preventive Screen Questionnaires, documented lab test results, and completed risk assessments should include:

- A second newborn metabolic screen (lab test) by 8 weeks of age
- TB risk assessment beginning at 1, 6, and 12 months of age and annually thereafter
- Cholesterol risk assessment beginning at 2 years of age and annually thereafter
- 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 5 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 beginning at 11 years of age and annually thereafter
- Anemia test results at 1, 2, and 3-5 years of age
- STI/HIV risk assessment beginning at 11 years of age and annually thereafter
- HIV lab test required between the ages of 15 and 18

Results. MY 2024's EPSDT MRR observed the following about aggregate MCO performance across the *Laboratory Tests/At-Risk Screenings* component:

- Two of the nine MCOs, MPC and UHC, fell below the minimum compliance score for the *Laboratory Tests/At-Risk Screenings* component at 79% and 74%, respectively.

- JMS and KPMAS exceeded the HealthChoice aggregate component score (83%) at 94% and 93%, respectively.
- The *Conducted Lead Risk Assessment* element was the only element that all MCOs have exceeded the 80% minimum compliance score.
- The *9-11 Year Dyslipidemia Lab Test* element had the most MCOs (all MCOs except for JMS) score below the 80% minimum compliance score, ranging from 53% (ABH and UHC) to 75% (KPMAS).
- UHC had the most element scores that fell below the 80% minimum compliance score for twelve of the sixteen elements, ranging from 53% for the *9-11 Year Dyslipidemia Lab Test* element to 79% for the *Recorded Cholesterol Risk Assessment* and *Referral to Lab for Blood Test* elements.
- The *9-11 Year Dyslipidemia Lab Test*, *18-21 Year Dyslipidemia Lab Test*, *12 Month Blood Lead Test*, *12 Month Anemia Test*, and *24 Month Anemia Test* element HealthChoice aggregate scores fell below the 80% minimum compliance score.
- The *12 Month Blood Lead Test* and *12 Month Anemia Test* element scores have consistently declined from MY 2022 to MY 2024.

Table 7. MY 2024 Laboratory Tests/At-Risk Screenings Element Results and Measurement Year Aggregates

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Newborn Metabolic Screen	84%	83%	71%	100%	69%	73%	91%	75%	77%	81%	81%	80%
Recorded TB Risk Assessment	84%	86%	96%	75%	80%	86%	86%	77%	84%	89%	83%	84%
Recorded Cholesterol Risk Assessment	80%	83%	97%	88%	79%	88%	90%	79%	80%	85%	83%	85%
9-11 Year Dyslipidemia Lab Test	53%	55%	87%	75%	54%	65%	68%	53%	66%	72%	59%	65%
18-21 Year Dyslipidemia Lab Test	50%	80%	100%	100%	71%	44%	86%	71%	73%	80%	75%	76%
Conducted Lead Risk Assessment	95%	95%	98%	92%	88%	93%	87%	86%	89%	91%	90%	92%
12 Month Blood Lead Test	76%	74%	91%	95%	73%	74%	74%	66%	78%	86%	80%	79%
24 Month Blood Lead Test	72%	84%	88%	95%	83%	70%	71%	72%	84%	84%	75%	81%
3-5 Year (Baseline) Blood Lead Test	100%	93%	100%	99%	91%	97%	78%	87%	93%	95%	78%	95%
Referral to Lab for Blood Test	85%	90%	96%	100%	87%	87%	84%	79%	86%	90%	87%	89%
Conducted Anemia Risk Assessment	87%	85%	98%	99%	86%	84%	76%	73%	77%	81%	81%	84%
12 Month Anemia Test	73%	73%	88%	94%	71%	72%	74%	66%	77%	85%	78%	77%
24 Month Anemia Test	70%	78%	89%	94%	86%	67%	69%	70%	88%	82%	73%	79%
3-5 Year Anemia Test	95%	94%	100%	99%	88%	100%	78%	88%	100%	90%	76%	95%

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Recorded STI/HIV Risk Assessment	89%	86%	98%	95%	93%	92%	92%	79%	83%	89%	91%	90%
HIV Test Per Schedule	100%	75%	100%	100%	64%	70%	90%	89%	90%	89%	91%	91%
Total Composite Score	80%	82%	94%	93%	79%	82%	81%	74%	80%	85%	80%	83%

Bold font denotes scores below the 80% minimum compliance score.

Immunizations

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

Requirements. Encounters must demonstrate assessment of need and documentation that:

- The MDH Immunization Schedule is being followed in accordance with the Advisory Committee on Immunization Practices 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 Recommended Childhood Immunization Schedule

Documentation. The VFC Program requires completion of the VFC Patient Eligibility Screening Record for each enrollee receiving free vaccines. Additionally, federal law requires documentation of the date, dosage, site of administration, manufacturer, lot number, publication date of the Vaccine Information Statement, and name/location of the provider. Immunization components are listed in the table below.

Results. MY 2024’s EPSDT MRR observed the following about aggregate MCO performance across the *Immunizations* component:

- All MCOs exceeded the 80% minimum compliance score for the *Immunizations* component, ranging from 88% (CFCHP) to 97% (KPMAS).
- JMS, KPMAS, and PPMCO met or exceeded the HealthChoice aggregate component score at 96%, 97%, and 92%, respectively.
- Thirteen of the 14 HealthChoice aggregate element scores exceeded the 80% minimum compliance score, except for the *Influenza* element, which remained below compliance by nine percentage points (71%).
- All MCOs exceeded the 80% minimum compliance score for 11 of the 14 elements.
- CFCHP was the only MCO to score below the 80% minimum compliance score for the *Human Papillomavirus (HPV)* (79%) element.

- CFCHP and UHC were the only MCOs to score below the 80% minimum compliance score for the *Assessed Immunizations Up to Date* element at 77% and 78%, respectively.
- Seven of the nine MCOs (ABH, CFCHP, MPC, MSFCS, PPMCO, UHC, and WPM) scored below the 80% minimum compliance score for the *Influenza* element, ranging from 56% (UHC) to 71% (MPC and MSFC).
- Thirteen of the 14 HealthChoice aggregate element scores have declined from MY 2022 to MY 2024, with the most significant decline of ten percentage points for the *Influenza* element (81% to 71%) and seven percentage points for the *Assessed Immunizations Up to Date* element (90% to 83%).

Table 8. MY 2024 Immunizations Element Results and Measurement Year Aggregates

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Hepatitis B	94%	93%	98%	99%	92%	95%	95%	92%	94%	97%	96%	95%
Diphtheria/Tetanus/Acellular Pertussis (DTaP)	96%	96%	98%	100%	94%	99%	94%	92%	98%	99%	98%	96%
Haemophilus Influenzae Type B (Hib)	96%	95%	98%	99%	93%	99%	93%	91%	97%	98%	96%	96%
Pneumococcal (PCV-7 or PCV-13) [Prevnar]	95%	94%	98%	99%	94%	99%	94%	91%	97%	99%	97%	96%
Polio (IPV)	93%	92%	97%	98%	94%	95%	95%	93%	96%	97%	96%	95%
Measles/Mumps/Rubella (MMR)	92%	92%	98%	98%	95%	95%	96%	93%	96%	97%	96%	95%
Varicella (VAR)	92%	92%	99%	98%	94%	94%	96%	94%	96%	97%	96%	95%
Tetanus/Diphtheria/Acellular Pertussis (Tdap)	93%	85%	98%	98%	94%	95%	97%	96%	97%	95%	96%	95%
Influenza (Flu)	64%	61%	85%	95%	71%	71%	64%	56%	62%	81%	69%	71%
Meningococcal (MCV4)	91%	86%	97%	98%	94%	93%	96%	95%	94%	95%	96%	94%
Hepatitis A	90%	90%	98%	98%	93%	92%	96%	91%	93%	96%	94%	94%
Rotavirus (RV)	100%	88%	92%	100%	83%	93%	100%	100%	96%	100%	94%	94%
Human Papillomavirus (HPV)*	88%	79%	97%	95%	83%	92%	93%	91%	90%	93%	92%	90%
Assessed Immunizations Up to Date	82%	77%	92%	92%	82%	82%	82%	78%	80%	90%	81%	83%
Total Composite Score	90%	88%	96%	97%	90%	91%	92%	89%	91%	95%	92%	92%

Bold font denotes scores below the 80% minimum compliance score.

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

Health Education/Anticipatory Guidance

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

Requirements. Documentation supports that PCPs provided the following:

- 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

Documentation. At least three anticipatory guidance items or two major topics must be discussed and documented 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 12 months 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 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.” The PCP must specifically document whenever 2-year intervals for preventive care are the usual and customary schedule of the practice instead of annual visits.

Results. MY 2024’s EPSDT MRR observed the following about aggregate MCO performance across the *Health Education/Anticipatory Guidance* component:

- All MCOs exceeded the 80% minimum compliance score for the *Health Education/Anticipatory Guidance* component, ranging from 85% (UHC) to 98% (JMS and KPMAS).
- ABH, JMS, KPMAS, MPC, and MSFC met or exceeded the HealthChoice aggregate component score, ranging from 92% (ABH and MPC) to 98% (JMS and KPMAS).
- All MCOs exceeded the 80% minimum compliance score for the *Documents Age – Appropriate Anticipatory Guidance, Documented Health Education/Referral for Identified Problems/Tests, and Specified Requirements for Return Visit* elements.
- JMS, KPMAS, MPC, and MSFC exceeded the 80% minimum compliance score for all elements.
- ABH, CFCHP, PPMCO, UHC, and WPM scored below the 80% minimum compliance score for the Documented Referral to Dentist element, ranging from 71% (PPMCO) to 78% (ABH).

- All HealthChoice Aggregate scores for each element have declined from MY 2022 to MY 2024, with the most significant decrease of 12 percentage points for the *Documented Referral to Dentist* element (93% to 81%).

Table 9. MY 2024 Health Education/Anticipatory Guidance Element Results and Measurement Year Aggregates

Element	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	MY 2022	MY 2023	MY 2024
Documented Age – Appropriate Anticipatory Guidance	96%	95%	99%	100%	96%	97%	98%	88%	95%	99%	98%	96%
Documented Health Education/Referral for Identified Problems/Tests	98%	96%	99%	94%	97%	98%	99%	91%	95%	99%	99%	96%
Documented Referral to Dentist	78%	75%	95%	99%	80%	85%	71%	72%	76%	93%	91%	81%
Specified Requirements for Return Visit	94%	91%	98%	100%	93%	97%	97%	88%	91%	96%	95%	94%
Total Composite Score	92%	90%	98%	98%	92%	94%	91%	85%	89%	97%	96%	92%

Bold font denotes scores below the 80% minimum compliance score.

Conclusion

The analysis of the EPSDT MRR results ensures the MCOs’ providers are delivering timely access to healthcare services according to EPSDT standards for its population of children and adolescents through 20 years of age. For MY 2024, all component scores fell below MDH’s Quality Strategy Targets for MY 2024. However, the MY 2024 EPSDT MRR demonstrates steady compliance in the HealthChoice aggregate scores and MCO total composite scores from MY 2022 to MY 2024. All MCOs’ total composite scores performed well above the 80% minimum compliance score, ranging from 85% (UHC) to 97% (JMS). Despite an increase of three percentage points from MY 2023 (80%) to MY 2024 (83%), the HealthChoice aggregate score for the *Laboratory Tests/At-Risk Screenings* component remains an opportunity for improvement, as it is the only component that results in CAPs for two MCOs (MPC and UHC) for MY 2024.

Process Analysis

The following are areas Qlarant noted as most challenging during the MY 2024 MRR completion:

- Providers not reviewing or accurately confirming patient listings sent at the time of scheduling.

- Receiving requested medical records in a timely manner in compliance with initial requests to providers.
- Request for MCOs to obtain and submit the requested medical record; however, providers not complying with the MCO request.

Quality, Access, and Timeliness

Qlarant identified strengths, improvements, opportunities, and recommendations summarizing aggregate performance across MCOs, based on the results of the MY 2024 EPSDT MRR. These strengths, improvements, opportunities, and recommendations correspond to the quality, access, and timeliness of services provided to enrollees. Qlarant adopted the following definitions for MY 2024’s EPSDT MRR:

- Providers, and by extension the MCOs, demonstrate **quality** by increasing the likelihood of desired health outcomes of timely screening and preventive care by maintaining compliance with the Maryland Schedule of Preventive Health Care standards.
- Providers demonstrate **access (or accessibility)** by incorporating the timely use of services to achieve optimal outcomes.
- Providers demonstrate **timeliness** by ensuring children and adolescents up to age 20 are receiving timely screenings and preventive care, according to guidelines specified in the Maryland Schedule of Preventive Health Care Standards.

Applicable domains in the quality, access, or timeliness correspond to areas of impact during the MY 2024 EPSDT MRR and identify positive (↑), negative (↓), or NA assessments of aggregate MCO performance.

Table 10. MY 2024 EPSDT Strengths, Improvements, and Recommendations

Domain	Strengths, Improvements, and Recommendations	Assessment
Quality, Access, Timeliness	Strengths: <ul style="list-style-type: none"> • All MCOs exceeded the 80% minimum compliance score for the <i>Health and Developmental History, Comprehensive Physical Examination, Immunizations, and Health Education/Anticipatory Guidance</i> components. • All HealthChoice aggregate element scores exceeded the 80% minimum compliance score. 	↑
Quality, Access, Timeliness	Improvements: <ul style="list-style-type: none"> • ABH, CFCHP, MSFC, PPMCO, and WPM improved performance for the Laboratory Tests/At-Risk Screenings component and were found to be in compliance for MY 2024, no longer requiring corrective action. 	↑
Quality, Access, Timeliness	Recommendations: <ul style="list-style-type: none"> • Review and address root causes for all HealthChoice aggregate component scores falling below MDH’s Quality Strategy Targets for MY 2024. Consider extending the quality strategy targets for additional MYs. 	↓

Domain	Strengths, Improvements, and Recommendations	Assessment
	<ul style="list-style-type: none"> • Monitor MCO performance for elements comprising the <i>Health and Developmental History, Comprehensive Physical Examination, and Health Education/Anticipatory Guidance</i> components, as all HealthChoice aggregate element scores have declined from MY 2022 to MY 2024. • Monitor MCOs to ensure <i>Recorded Maternal Depression Screenings</i> are being tracked, appropriately documented within the medical record, and that MCOs are working towards improved performance to bring the HealthChoice aggregate element score (77%) within compliance for the <i>Health and Developmental History</i> component. • Monitor the <i>Laboratory Tests/At-Risk Screenings</i> component elements to ensure MCOs are working towards improved performance for the <i>9-11 Year Dyslipidemia Lab Test is 65%, 18-21 Year Dyslipidemia Lab Test is 76%, 12 Month Blood Lead Test 79%, 12 Month Anemia Test is 77%, and 24 Month Anemia Test is 79%</i> elements. • Monitor MCO performance for elements comprising the <i>Immunizations</i> component, as 13 of the 14 HealthChoice aggregate element scores have declined from MY 2022 to MY 2024, with the most significant decline in the <i>Influenza and Assessed Immunizations Up to Date</i> element. Ensure MCOs are following influenza immunization protocols and processes, influenza immunizations are appropriately documented within the medical record, and that MCOs are working towards improved performance. • Monitor MCOs to ensure <i>Documented Referral to Dentist</i> is appropriately documented within the medical record, as five of the nine MCOs (ABH, CFCHP, PPMCO, UHC, and WPM) fell below the 80% minimum compliance score for this element in the <i>Health Education/Anticipatory Guidance</i> component. 	

Continued Improvement Summary

Results of the MY 2024 EPSDT MRR indicate required CAPs along with a focused provider education project for two calendar years per MDH’s Performance Monitoring Policy, for two MCOs (MPC and UHC) for the *Laboratory Tests/At-Risk Screenings* component, as demonstrated in the table below.

Table 11. MY 2024 and Trended CAP Summary per MCO

MCO CAP Requirements	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Total # of MY 2022 CAPs	0	0	0	0	0	0	1	0	0
Total # of MY 2023 CAPs	1	1	0	0	1	1	1*	1	1
Total # of MY 2024 CAPs	0	0	0	0	1*	0	0	1*	0
MY 2023 to MY 2024 CAP Comparison	↓	↓	∅	∅	↑	↓	↓	↑	↓

*Score fell below the minimum compliance score for multiple years and requires a CAP along with a focused provider education project per MDH's Performance Monitoring Policy.

Green and ↓ = positive improvement (decrease in CAPs); Pink and ↑ = negative increase in CAPs; White and ∅ = no change in required CAPs.

MCO Recommendations

To improve the quality of healthcare provided to Maryland's Medicaid enrollees who are less than 21 years of age, the following program recommendations are directed toward all participating HealthChoice MCOs:

- Collaborate with the assigned state Healthy Kids/EPSDT Nurse Consultants to assist in re-educating providers on the Healthy Kids/EPSDT Program requirements and develop a plan to bring underperforming practices into compliance with the Maryland Healthy Kids Program standards.
- Prepare and encourage provider cooperation and assistance with audit review scheduling, confirming the enrollee list to be reviewed, adherence to review start times, and demonstration of compliance or the supplying of records, including enrollee immunizations.
- Educate the MCO provider network regarding revisions and new standards to the Maryland Schedule of Preventive Health Care, using the MCO provider newsletter and/or practice visits by MCO staff.
- Encourage network providers to use the Maryland Healthy Kids Program's age-appropriate encounter forms, risk assessment forms, and questionnaires that are designed to assist with documenting preventive services, according to the Maryland Schedule of Preventive Health Care.
- Reinforce preventive care standards as they apply to adolescents and young adults assigned to family practice and internal medicine PCPs.
- Assist practices to improve electronic medical records to ensure all Maryland Healthy Kids Program requirements are incorporated into these tools and records are accessible for demonstration by provider offices during audit requests.
- Facilitate the transfer of medical, immunization, and laboratory records when a child is transferred to a newly assigned PCP within the MCO network.
- Utilize MCO data to identify children who are not up to date with EPSDT visits according to the Maryland Schedule of Preventive Health Care, check if children received services from a previous PCP or MCO to prevent duplication, and assist the PCP by scheduling a preventive care visit based on this information.

- Refer to the local health department for assistance in bringing children in for missed healthcare appointments when other outreach efforts have been unsuccessful.
- Remind providers that they are required to enroll in the VFC program. Encourage and refer physicians to the Maryland immunization registry (ImmuNet) as a resource to check a child's immunization history.
- MCOs should review and address root causes for decreases in element and component scores from MY 2023 to MY 2024 to ensure continued compliance in MY 2025.
- Ensure practices are documenting parent/guardian refusals for services within patient records.