

**MEDSTAR FAMILY CHOICE**  
**2026 QUALITY IMPROVEMENT PLAN**

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## **INTRODUCTION**

MFC is wholly owned by MedStar Health, Inc., and has been operating as an MCO in Maryland since the inception of HealthChoice in 1997. HealthChoice is the designation given to the 1115 Waiver that allows the State to enroll Medicaid eligible individuals in managed care. The MDH administers the Maryland Medicaid program and is the oversight body for the Maryland Medicaid MCO program.

MFC, with the full support of its not-for-profit parent organization, is committed to providing high quality clinical care and administrative services. There were 91,765 active MFC Maryland members as of January 1, 2025. MFC pursues an active and aggressive agenda of quality improvement projects and outreach initiatives.

## **VISION, MISSION, AND VALUES**

### *Vision*

To be the trusted leader in caring for people and advancing health.

### *Mission*

To serve patients, those who care for them, and the community.

### *Values*

- Service – Strive to anticipate and meet the needs of patients, physicians, and coworkers.
- Patient First – Strive to deliver the best to every patient every day. The patient is the first priority in everything MFC does.
- Integrity – Communicate openly and honestly, build trust, and act according to the highest ethical standards.
- Respect – Treat each individual, those served, and coworkers, with the highest professionalism and dignity.
- Innovation – Embrace change and work to improve in a fiscally responsible manner.
- Teamwork – System effectiveness is built on the collective strength and cultural diversity of everyone, working with open communication and mutual respect.

## **GOAL**

MFC's goal is to provide the highest quality of care and deliver the best outcomes for members.

## OBJECTIVES

### **Provider Network**

1. Provide a systematic approach for monitoring the quality, safety, appropriateness, and effectiveness of member care and services through a consistent review process throughout the MFC provider and practitioner community.
2. Provide support and education to practitioners and providers to improve the safety of their practices and include participating network practitioners in the Quality Improvement Plan, policy decisions, and quality improvement process.

### **Member Community**

3. Perform a comprehensive population assessment of the member population to improve the quality of healthcare received by members, identify SDOH, reduce health care disparities, and ensure members receive culturally and linguistically appropriate health care services and education.
4. Identify and remove barriers to health care services and resources including, but not limited to, cultural and linguistic barriers.

### **Regulatory/Accreditation**

5. Develop, implement, and monitor CAPs and QIAs based on identified deficiencies/opportunities.
6. Incorporate Federal, State, and local public health organizations goals and coordinate activities with the development of the Quality Improvement Plan.
7. Comply with the quality of care, access to care, documentation, and performance standards of Federal and State agencies for the treatment of members, especially those with special needs.
8. Prevent fraud, waste, and abuse and ensure compliance with all associated Federal and State laws and regulations.
9. Meet or exceed the standards for: the Maryland SPR, NCQA accreditation, PHIP, and EPSDT and MDH screening criteria.

### **MFC Operations**

10. Support/enhance a culture of quality at MFC by using benchmarks representing best practice outcomes to trend and analyze data for improvement opportunities, implementing strategies designed to address quality indicators and goals across departments, and coordinating data collection to evaluate opportunities and improvement efforts.
11. Advance the use of quality management principles and evidence-based practice through education, resource sharing, and analysis.
12. Provide integration, coordination, and continuity of medical and behavioral health.
13. Coordinate monitoring of MFC's performance with internal and external parties.
14. Improve oversight of activities of delegated entities and the quality of care they provide.
15. Support the MSH effort to become a high reliability organization by applying the principles of preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience, and deference to expertise

## **PROGRAM STRUCTURE**

### **Delegation from the Board**

The overall responsibility and authority for MFC quality improvement has been delegated from the MFC Board of Directors to the Quality Improvement Committee. The QIC Committee delegates data collection and analysis to the Quality Improvement and Clinical Operations departments. Data gathered by other sources will be submitted to the Quality Improvement or Clinical Operations departments and then analyzed and evaluated by the QIC Committee. The Chief Medical Officer oversees all functions of the QIC Committee and may delegate certain activities to other medical directors, as needed.

All practitioner contracts stipulate that the practitioner will abide by the policies and procedures of the organization including, but not limited to, medical record access and participation in both the Quality Improvement and Clinical Operations plans.

### **Provision of Resources**

MFC devotes substantial resources to the quality improvement program. There is one full-time Chief Medical Officer who oversees the program. Additionally, there are five physicians consisting of four full-time Medical Directors and one Consulting Medical Director. The Chief Medical Officer and Medical Directors are involved in the day-to-day operations of MFC Care Management, which includes Quality Improvement, Clinical Operations, Member Experience, and Provider Relations.

### **Quality Improvement Department**

In the Quality Improvement Department there are a full-time Manager of Quality Improvement, a full-time NCQA Accreditation Manager, and a Manager of Clinical Support Services and Clinical Effectiveness, who report to the Director of Quality Improvement. The Director of Quality Improvement reports to the AVP of Quality and Outreach, who reports to the Chief Medical Officer. Reporting to the Manager of Quality Improvement are two full-time Quality Improvement Coordinators and three full-time Quality Improvement Specialists. Reporting to the Manager of Clinical Support Services and Clinical Effectiveness are 6 Wellness Preventive Care Coordinators (WPCC), one Senior Wellness Preventive Care Coordinator, and two EPSDT Coordinators. Reporting to the NCQA Accreditation Manager are two NCQA Accreditation Coordinators.

### **Member Services and Customer Services**

Overall member services and customer services are delegated to UST where Customer Service Representatives, Customer Care Supervisors, and Team Leads are dedicated to all MFC plans.

The Complaints, Grievances, and Appeals department at MFC also handle member services and customer services inquiries and complaints. More details on the Denials, Appeals, and Grievances Department can be found in the attached Clinical Operations Department Plan for 2026.

## **Clinical Operations Department**

The Clinical Operations Department is responsible for utilization management related to inpatient concurrent, precertification (including pharmacy management), retrospective reviews, appeals and grievances, catastrophic care, comprehensive complex care, complex care pediatrics, condition care, transition care, and emergent care management. More details on the activities of the Clinical Operations Department can be found in the attached Clinical Operations Department Plan for 2026.

## **Provider Relations Department**

The Provider Relations Department includes one Director of Provider Networks, one Manager of Provider Relations, two Senior Provider Relations Associates, two Provider Relations Associates, and one Provider Network Support Specialist. The Provider Relations Department ultimately reports to the Executive Director/Vice President of Operations. The Provider Relations Department works with the provider network ensuring the communication of the Quality Improvement Plan.

## **Credentialing Department**

The Credentialing Department is comprised of the Director of Credentialing, the Manager of Credentialing, one Sr. Credentialing Associate, two Credentialing Associates, one Sr. Credentialing QA & Delegation Oversight Coordinator and one Provider Delegation Credentialing Coordinator. The Credentialing Department is responsible for credentialing activities including, but not limited to, initial credentialing, recredentialing, ongoing monitoring, and delegated oversight activities to ensure compliance with state, federal and regulatory requirements.

## **Community Relations Department**

The Regional Community Relations Coordinator reports to the AVP Growth and Member Experience. The Community Relations Department focuses its efforts on educating the communities served about the benefits and services offered by MFC. The department's grassroots efforts of building relationships and partnerships within the communities served and contribute to improving health outcomes for members. The Regional Community Relations Coordinators devote a large portion of their time to community outreach by participating in community events, planning community and wellness events, and assisting the Outreach Department and Clinical Operations Department. Community and Wellness events focus on providing health screenings, and health services, health education and health resources to MFC members and members of the communities served. Community Relations also coordinates the Consumer Advisory Board Meeting, which is a forum allowing MFC members and staff to collaborate in improving the services offered to members multiple times throughout the year.

## **Executive Leadership – Roles and Responsibilities**

### **President, MFC**

- Responsible for the overall execution of MFC.
- Creates, delivers, and oversees MFC's annual objectives, long-term strategic plan, and regulatory requirements under the Medicaid programs.

- Responsible for developing and executing the overall annual and long-term fiscal plan for the Health Plan Company.
- Responsible for the profit and loss outcomes of MFC.
- Represents MFC across MSH and coordinates to ensure best possible member service and clinical outcomes.
- Chair of the MFC Board of Directors.

### **Chief Medical Officer**

- Contributes to the achievement of established MFC goals and objectives and ensures adherence to department policies, procedures, quality standards, and safety standards.
- Complies with governmental and accreditation regulations including Maryland COMAR, SPR Standards, Maryland Annual Evaluation of Drug Use Management Programs, and NCQA Accreditation.
- Acts as Chairperson or designates appropriate person to act as Chairperson for the QIC Committee, QOC/Peer Review, and Pharmacy and Therapeutics committees.
- Participates or designates appropriate physician to participate in Ambulatory Best Practices Committee and Pediatric Subcommittee.
- Acts as the designated physician and has substantial involvement in the organization's quality improvement and case management programs and may designate additional physicians to address specific areas within the overall quality and case management programs.
- Serves as an active member of the MFC Credentialing Committee.
- Oversees physician functions and compliance with SPR and NCQA standards.
- Acts in the capacity of a Medical Director for UM decisions.
- Makes UM decisions based only on appropriateness of care and service and the existence of coverage.
- Participates in the development of medical policy, utilization review, and quality improvement programs.
- Works to assure physician commitment to and delivery of high-quality health care to MFC members.
- Reviews member and provider appeals as appropriate to the appeals process.
- Collaborates with the Quality Director regarding the Quality Improvement Plan, and provides recommendations, organization performance evaluations, progress, and goals.
- Acts as liaison to various groups and initiatives across MSH.
- Contributes and develops strategic planning.
- Member of the MFC MD Quality Improvement Committee.
- In the absence of the Chief Medical Officer, the roles and responsibilities will be delegated to a Medical Director.

### **Chief Financial Officer, MedStar Family Choice**

- Responsible for internal and external reporting of financial position and results.
- Responsible for short-term and long-range budgeting and forecasting for membership, operating results, and capital.
- Responsible for the annual budget and financial forecasting for MFC including allocation of resources and capital expenditures.

- Serves as liaison to Maryland Insurance Administration (MIA) regarding financial monitoring and compliance.
- Staff to the MFC Board of Directors.

#### **VP/Executive Director Maryland Operations**

- Serves as the Executive Director for MFC-MD.
- Serves as MFC Executive for Maryland operational meetings between MFC and MDH.
- Manages relationships with Maryland government officials.
- Provides leadership and maintains oversight of all Maryland operations including Clinical Operations for Case Management and Utilization Management; Quality; Outreach; Health Plan Communications; Marketing; Provider Network Management; Contract Oversight; shared oversight with the Chief Medical Officer; and Finance shared oversight with the Chief Financial Officer.
- Works to implement and manage a strategic plan for MFC-MD and defines specific operational strategies that aligns with the organizational goals and objectives.
- Contribute and develops strategic planning.
- Staff to the MFC Board of Directors.
- Member of the MFC MD Quality Improvement Committee.

#### **Vice President Centralized Operations Maryland and District of Columbia**

- Responsible for the leadership and execution of all administrative operational components of the organization.
- Provides leadership for shared services including enrollment, benefit operations, vendor oversight, claims, member appeals and grievances.
- Work collaboratively with Chief Medical Officer with contract relation of pharmacy benefit manager, and oversee policies related to medical management that results in optimum cost and benefit for MFC.
- Collaborate with Executive Leadership team to oversee development and implementation of strategies to support network cost and quality performance, P4P incentives, care management and utilization management.
- Member of the MFC MD Quality Improvement Committee.

#### **Vice President, Medical Economics, Reporting and Analytics**

- Liaison between the Medical Economics Department and the clinical areas for reporting medical expenditures, utilization data, and reporting of clinical information from the MFC data warehouse.
- Responsible for encounter data and provider data management
- Responsible for office administration and real estate.
- Member of the MFC MD Quality Improvement Committee.

#### **Vice President, Physician, Ambulatory Contracting, and Credentialing, Managed Care**

- Responsible for the Credentialing Department
- Acts as primary liaison between MFC and MSH provider entities and facilitate operational communication among entities.
- Assists in strategic planning.

- Staff to the Credentialing Committee.

#### **Assistant Vice President, Clinical Operations**

- Responsible for the implementation, integration, leadership, and operation of the Clinical Operations Department.
- Responsible for the day-to-day operations of Clinical Operations including inpatient concurrent utilization review, precertification, pharmacy utilization, case management, retrospective review, and over- and under-utilization.
- Functions as the system level representative to assure case management and population health meet established quality objectives and deliver cost-effective outcomes.
- Assists with strategic planning.
- Member of the MFC MD Quality Improvement Committee.

#### **Assistant Vice President, Information Services**

- Consults with and advises President on operational issues and makes recommendations to carry out objectives more effectively.
- Manages the IT Department's operational and strategic planning, including business requirements, project planning and organizing, and negotiating the allocation of resources.
- Develops and implements all IT policies and procedures, including those for architecture, security, recovery, standards, purchasing, and service provisions.
- Responsible for the preparation and maintenance of reports for senior leadership.
- Ensures the efficient, economic, and quality performance of assigned areas.
- Member of the MFC MD Quality Improvement Committee.

#### **Executive Director District of Columbia Operations (does not function in MD operations)**

- Serves as the Executive Director for MFC-DC.
- Serves as MFC Executive for District operational meetings between MFC and DHCF.
- Manages relationships with District government officials.
- Member of the MFC Executive Operations Team.
- Provides leadership and maintains oversight of all District operations including Clinical Operations for Case Management and Utilization Management; Community Relations; Quality; Outreach; Health Plan Communications; Marketing; Provider Network Management; Contract Oversight; shared oversight with the Chief Medical Officer; and Finance shared oversight with the Chief Financial Officer.
- Works to implement and manage a strategic plan for MFC-DC and defines specific operational strategies that aligns with the organizational goals and objectives.

#### **Assistant Vice President Growth and Member Experience**

- Develop and execute comprehensive marketing strategies align with organizations' goals and objectives to maintain and grow membership.
- Shape and enhance MFC brand by developing compelling brand strategy, messaging, and visual identity.
- Build a differentiated member experience that strengthen existing relationships and create new ones.
- Member of the MFC MD Quality Improvement Committee.

## Quality Improvement Committee (QIC)

### *Role*

This committee is responsible for integrating the MFC Quality Improvement, Outreach, and Clinical Operations Department plans throughout the entire organization and across all levels of care. It advises the Chief Medical Officer of plans that relate to the continuous process of evaluating and improving the quality and the appropriateness of patient care and services. The Committee coordinates with the Chief Medical Officer, along with other relevant committees, to develop a method to monitor and evaluate patient care and services. The Committee ensures that policies and procedures are in place to monitor ongoing utilization management processes, reviews and recommends revisions or additions to processes, and monitors and responds to trends in utilization. The Committee is responsible for ensuring continuity and coordination of patient care throughout the health care system. Membership of the committee includes senior management, participating physicians, and representatives from internal departments. The chairman of the QIC is the Chief Medical Officer, or designated physician, who has substantial involvement in the implementation of the Quality Improvement, Outreach, and Clinical Operations Department plans.

### *Membership Structure*

Participants include:

- Chief Medical Officer, serving as chairman
- Medical Directors
- Executive Director Maryland Operations
- Assistant Vice President of Clinical Operations
- Director Population Health Equity
- Director of Credentialing
- Director Contract Oversight
- Director Vendor Delegation
- Director of Provider Networks
- Director of Quality Improvement
- Manager of Appeals, Customer Service, and Emergency Room Review
- Manager of Case Management
- Manager of Clinical Support Services
- Manager of Delegated Oversight
- Manager of HEDIS and Quality Analytics
- Manager of Utilization Management
- Manager of Quality Improvement
- Manager of NCQA Accreditation
- Delegated Oversight Coordinator

Optional and ad hoc participants include:

- Chief Financial Officer
- VP Centralized Operations, Maryland and District of Columbia

- AVP Growth and Member Experience
- AVP Quality and Outreach
- Representatives from Community Relations
- Additional representatives from the Quality Improvement, Case Management, Utilization Management, Provider Relations, and Outreach departments
- Additional physicians at the discretion of the QIC.

#### *Committee Structure and Reporting Relationships*

MFC performs a comprehensive review of all aspects of its committees including committee structure, roles, functions, reports, and reporting relationships. The departments and committees that report to QIC are:

- Utilization Management
- Case Management
- Complaints, Grievances, and Appeals
- Quality Improvement Department
- Quality of Care and Peer Review Committee
- Delegated Oversight
- Outreach Department
- Pharmacy and Therapeutics Committee
- Ambulatory Best Practice Committee
- Credentialing Committee
- Member Experience Department
- Provider Relations Department

#### *Frequency/Minutes*

The QIC shall meet at least quarterly each year and maintains electronic minutes.

#### *Functions*

- Reviews the Quality Improvement, Clinical Operations Department, Health Education, and Outreach plans annually For final approval.
- Reviews the annual Quality Improvement Workplan for final approval.
- Reviews the Quality Improvement, Clinical Operations, Health Education, and Outreach appraisals annually ensuring detailed analysis on the assessed performance and demonstrated improvements in quality of care for final approval.
- Manages all functions related to the implementation, maintenance, and evaluation of the Quality Improvement, Clinical Operations, Health Education, and Outreach plans.
- Evaluates the overall effectiveness of the Quality Improvement, Clinical Operations, Health Education, and Outreach plans and makes changes and recommendations for future activities.
- Receives and acts on all issues or trends felt to have an impact on quality of care.
- Monitors utilization across all care settings.
- Reviews patterns of over- and under-utilization.
- Monitors oversight of and reports for delegated entities for medical claims, member services, vision, 24-hour nurse triage line, and pharmacy benefit services which take place at Delegated Oversight Committees.

- Reviews and approves the regularly reported activities of the Quality Improvement Department, QOC/Peer Review Committee, Utilization Management Department, Case Management Department, Complaints, Grievances, and Appeals Department, Delegated Oversight Committees, Outreach Department, Credentialing Committee, P&T Committee, Clinical Practice Guidelines and Ambulatory Best Practices Committees, Community Relations Department, Consumer Advisory Board, and Provider Relations Department.
- Reports the results of projects to practitioners with the assistance of the Provider Relations Department.
- Communicates an outline of the Quality Improvement Plan to practitioners and members annually and ensures orientation of new primary care practitioners includes an introduction to the Quality Improvement Plan by the Provider Relations Department.
- Participates, when appropriate, in the development and monitoring of internal corrective action plans and the corrective action plans of outside vendors and delegates.
- Reports information about quality projects and performance through the Chief Medical Officer's Annual Report to the Consumer Advisory Board.
- Ensures that the goals and objectives of Care Management are met and makes recommendations for continued improvement.
- Reviews protocols, procedures, and utilization management criteria at least annually.
- Assesses new technology at least annually.

*Plans for 2026:*

- Infuse health equity lens in all programs with a primary goal to ensure that all individuals, regardless of their socioeconomic status, race, ethnicity, gender, or other factors, have fair and equal access to healthcare resources and services.
- Identify and address disparities in healthcare access, quality and outcomes among different population groups.
- Monitor healthcare utilization patterns and identify opportunities to optimize resource allocation and utilization management.
- Implement strategies to reduce unnecessary utilization, minimize overutilization and ensure appropriate use of healthcare services.
- Promote a culture of continuous quality improvement within the organization.
- Regularly evaluate effectiveness of quality improvement initiatives and make adjustments as needed to achieve desired outcomes.
- Ensure health plan meets regulatory requirements and accreditation standards.
- Conduct quarterly meetings and one ad hoc meeting to review the clinical operation and quality plans and assessments.
- Identify key performance indicators that reflect member care and service quality, e.g. clinical outcomes, member satisfaction.

## **Quality of Care (QOC)/Peer Review Committee**

### *Role*

This committee supports credentialing activities by performing formal peer review of all quality-of-care concerns, referred from any source, to determine if an MFC-credentialed provider or practitioner deviated from the standard of care. QOC/Peer Review Committee findings are reported to MFC's Credentialing Department.

### *Membership Structure*

Participants include:

- Chief Medical Officer
- QOC Committee Chair designated by Chief Medical Officer
- Medical Directors designated by the Chief Medical Officer
- Quality Improvement Coordinator(s)
- Specialty practitioners invited as necessary by content of review
- Other members at the discretion of the Committee

Optional and ad hoc participants:

- Director of Quality Improvement
- Manager of Quality Improvement

### *Function*

The QOC/Peer Review Committee functions as an advisory board providing the medical expertise necessary for quality-of-care case reviews and physician oversight. Its responsibilities include acting as an advisory board on clinical matters to the Compliance Department, performing quality-of-care case peer-review, reporting findings to the Credentialing Department and escalating cases to the Credentialing Committee when appropriate. This Committee also supports the QIC in monitoring physician corrective action plans when necessary. Quality-of-care concerns referred to the Quality Improvement Department for review are researched by Quality Improvement Coordinators and in-network cases are prepared for formal review at the QOC/Peer Review Committee meetings. QOC concerns involving out-of-network providers and facilities are addressed by sending a referral letter to the provider or facility requesting that they perform their own review of the QOC issue and follow up per their policy. Quality improvement staff track, and trend QOC/Peer Review Committee case review data and report results to the Credentialing Department for upload to MFC's internal credentialing database (ECHO).

### *Frequency/Minutes*

The QOC/Peer Review Committee convenes monthly and maintains electronic minutes. Minutes are maintained in a secure folder on an internal share drive and are accessible by committee members only. All materials pertaining to the QOC/Peer Review Committee are protected by all applicable peer review confidentiality and non-discoverability policy and laws.

### *Plans for 2026*

- Continue to perform case review in support of the Quality Improvement and Credentialing departments.
- Continue to formally incorporate Compliance Department concerns as appropriate.

- Continue to analyze the quality-of-care module in Guiding Care for potential enhancements that improve data gathering, categorizing, reporting and workflow.
- Continue to complete Provider lookbacks biannually to trend patterns.
- Use available technology to improve efficiency and optimize workflows for all members of the QOC/Peer Review Committee.

## **HEDIS Proactive Workgroup**

### *Role*

This workgroup monitors performance for HEDIS and PHIP measures in real time. The workgroup meets after a proactive run of claims and internal data through the HEDIS engine has occurred.

### Membership Structure

Participants include:

- Representative of Information Services
- Assistant Vice President of Clinical Operations
- Director and/or Manger of Population Health
- Director and/or Manager of Quality Improvement
- Manager of Case Management
- Manager of HEDIS Business Information
- Manager and/or Representative of Outreach
- Manager of Community Relations and Engagement
- Assistant Vice President of Growth and Member Experience
- Manager of Marketing Member Experience
- Manager of Community Assistance and Resources
- Members of improvement teams designated by the workgroup
- Other representatives may include members from Quality Improvement, Outreach, Clinical Operations, Provider Relations, Delegated Oversight, Community Relations, and Finance departments at the discretion of the workgroup

### *Function*

The workgroup reviews collaborative efforts and activities of internal departments, efforts of external vendors, and other reports to identify any trends and identify opportunities for improvement. Presents and discusses proactive rates for HEDIS and Population Health Incentive Program (PHIP) measures in the categories of diabetes care, asthma, childhood wellness, pregnancy, well-woman care, state-run PIPs, and medication adherence. The rates are trended against previous performance and appropriate goals for impact evaluation and identification of areas requiring additional intervention. The multi-disciplinary team performs all evaluations and develops new interventions in real-time.

### *Frequency of Meeting and Minutes*

The committee meets at least monthly during the months of May through December and maintains electronic minutes.

### *Plans for 2026*

- Enhance use of provider data and bi-directional data sharing for HEDIS.
- Identify and address underutilization projects related to HEDIS and Population Health Incentive Program measures.
- Ensure we meet the minimum requirements of 65% of HEDIS metrics better than the NCQA mean.
- Use trends from MY2025 to start on interventions to improve rates that were lower.

## **Policy Workgroup**

### *Role*

This workgroup reviews, revises, and maintains all MFC policies in following series: Care Management (Case Management and Utilization Management); Member Services, Appeals, Grievances, and ER Reviews; Outreach; Quality Improvement; Provider Relations; General Administration; Medical Non-Pharmacy Protocols; Enrollee Materials; Enrollment; Delegated Oversight; and Member Experience.

### *Membership Structure*

Participants include:

- Quality Improvement Accreditation Project Manager, serving as chairman
- Chief Medical Officer
- Medical Directors
- Executive Director/Vice President of Operations
- Assistant Vice President, Clinical Operations
- Director of Provider Relations
- Manager of Appeals, Customer Service, and Emergency Room Review
- Manager of Case Management
- Manager of Clinical Support Services
- Manager of Delegated Oversight
- Manager of Health Plan Communications
- Manager of Provider Relations
- Director of Quality Improvement
- Manager of Utilization Management
- Manager of Quality Improvement

### *Frequency/Minutes:*

The Policy Workgroup meets at least annually to conduct an in-depth review of all policy series within the scope of the workgroup's purview. Additional meetings are held on an as-needed basis. The workgroup maintains electronic minutes.

### *Functions*

- Reviews, revises, and recommends approval at the QIC for all MFC policies in the following series: Care Management; Case Management, Utilization Management, Member Services, Appeals, Grievances, and ER Reviews; Outreach; Quality Improvement; Provider Relations;

General Administration; Medical Non-Pharmacy Protocols; Enrollee Materials; Enrollment; Delegated Oversight; and Member Connections.

- Ensures all policies and procedures comply with NCQA, COMAR, and SPR requirements.
- Assists in the review and implementation of all new MFC policies in series under the purview of the Policy Workgroup.
- Collaborates with the Compliance, Pharmacy & Therapeutics, and Credentialing Committees to ensure all MFC policies outside of the workgroup's purview comply with NCQA, COMAR, and SPR requirements.

#### *Plans for 2026*

- Continue e-mail process with ad hoc voting options for minor policy changes while continuing to conduct meetings based on the magnitude of policy revisions.
- Maintain policy inventory on MS Teams.

## **NCQA Workgroup**

### *Role*

The NCQA Workgroup provides ongoing oversight and support to ensure adherence to NCQA requirements across all applicable departments within MedStar Family Choice. Although considered a workgroup, the process is intentionally collaborative and less formal in design.

The NCQA Accreditation Manager and Coordinators meet with each applicable department on a regular monthly cadence to:

- Communicate new or updated NCQA standards and guidelines
- Confirm that processes and workflows align with current NCQA requirements
- Assist departments in developing or updating procedures to meet emerging standards
- Track required annual and cycle-based deliverables
- Monitor readiness activities in preparation for survey submission

While the group may convene collectively when appropriate, most work is accomplished through focused departmental meetings.

A project plan is developed and maintained for each accreditation cycle. This plan tracks all standards, required documentation, evidence of compliance, and the progress of materials needed for survey submission.

### *Membership Structure*

Participation may include:

- Manager of NCQA Accreditation
- NCQA Accreditation Coordinators
- Applicable departmental leaders and subject matter experts
- External accreditation consultants (as needed)

Monthly accreditation-focused meetings occur with departmental representatives from:

- Quality Improvement
- Utilization Management
- Population Health Management / Case Management
- Grievances and Appeals
- Provider Relations
- Credentialing
- Delegation Oversight

#### *Meeting Frequency and Documentation*

- Monthly meetings are held with each applicable department.
- Additional meetings occur as needed based on survey timelines, deliverables, or changes in requirements.
- Collective workgroup meetings may occur but are not required.
- Documentation is maintained within the accreditation project plan and supporting tracking tools

#### *Functions*

- Provides ongoing guidance and oversight to ensure departmental compliance with NCQA requirements
- Ensures all policies and procedures remain compliant with NCQA requirements by reviewing annual updates and refining documentation as new or revised standards are released.
- Communicates new or revised NCQA standards to affected departments
- Supports departments in designing, refining, or validating processes to meet accreditation expectations
- Tracks progress on documentation, reports, and evidence needed for accreditation
- Identifies potential risks or gaps early and partners with departments to resolve them
- Monitors survey preparedness, including documentation accuracy and process validation
- Maintains and updates the accreditation project plan
- Coordinates with external consultants to review materials and incorporate recommended improvements
- Shares key updates, risks, and concerns with senior leadership to ensure visibility, alignment, and timely decision-making

#### *Plans for 2026*

- Collect and review required documents, reports, and evidence for upcoming survey cycles.
- Participate in internal or consultant-led mock reviews to assess readiness and identify improvement opportunities.
- Support departments with training needs related to NCQA standards, documentation expectations, writing quality, and relevant tools or systems.
- Implement corrective actions and process enhancements to ensure compliance prior to submission.

### **Ambulatory Best Practices Committees**

The MedStar Health Ambulatory Adult Best Practice Committee and Pediatric Ambulatory Best Practice Work Group develop clinical practice guidelines to help practitioners make decisions about appropriate health care for both medical and certain behavioral health circumstances. Guidelines will be evidenced-based, and outcomes will be measurable to determine effectiveness of care. Standardized guidelines are intended to help reduce inter-practitioner variation in diagnosis and treatment. MedStar Family Choice (MFC) will have representation on both the adult committee and the pediatric workgroup. The MedStar Health clinical practice guidelines will be the clinical basis for the medical care provided to members of MFC. The committee meets monthly.

Plans for 2026:

- Revise existing guidelines and develop new guidelines as needed.
- Continue communication initiatives to improve guidelines incorporation with MSH Clinical Practice Councils.
- Continue collaboration and open discussion with MedConnect teams to enhance functionality related to best practices.
- Collaborate with MMG medical experts to assist with guideline revisions, updates, or development as needed.
- Continue to have the Adult Ambulatory Best Practice Committee function as a subcommittee of the Primary Care Clinical Council under the MMG structure.
- Continue to have the Pediatric Ambulatory Committee under the Pediatric Clinical Council as the committee responsible for the clinical practice guidelines for children and adolescents.

## **Credentialing Committee**

### *Role*

This committee performs peer-review of practitioners applying for participation in the networks.

### *Membership Structure*

Participants include:

- Committee Chairperson, as appointed
- Chief Medical Officer
- Practitioners from the MFC network

Staff Members include:

- VP, Physician, Ambulatory Contracting & Credentialing
- Director of Credentialing
- Manager of Credentialing
- Sr. Credentialing Associate

Committee membership includes a range of medical and surgical specialty representation. The Chief Medical Officer or designated physician initially appoints physicians for two years and may reappoint them for additional two-year terms. During the term of appointment, committee

members must maintain active status in the MFC network. Physician members have voting rights while the Credentialing staff members do not.

Credentialing staff complete all credentialing and recredentialing activities leading up to the Credentialing Committee meeting and prepare, coordinate, and facilitate the meeting schedule, agenda, and reports.

#### *Functions*

- Conducts peer-review as it relates to the credentialing and recredentialing processes and render credentialing decisions on behalf of the MFC network, which includes practitioners and organizational providers.
- Makes recommendations to the MFC President for escalated cases.
- Acts in accordance with MFC's written credentialing policies, NCQA standards, federal regulations, Maryland state and District of Columbia laws/regulations.
- Reviews practitioner cases for adverse events referred by the QOC/Peer Review Committee.
- Reviews all new practitioners and organizational providers for initial credentialing and review existing practitioners and organizational providers at least every three years for recredentialing.
- Reviews, approves, or makes recommendations regarding the following credentialing decisions:
  - Practitioners who do not meet MFC's credentialing criteria.
  - Adverse actions, events, sanctions, or limitations on licensure including reprimands.
  - Practitioners who terminate from the MedStar Family Choice network.
  - Material updates to the credentialing policies, including annual review.
  - Delegated entities' annual oversight audit results and pre-delegation evaluation of potential delegates.

#### *Frequency of Meeting and Minutes*

The Credentialing Committee meets at least quarterly, or more frequently as needed, and maintains electronic minutes.

#### *Plans for 2026:*

- Continue to enhance the provider delegation roster audit function.

## **Pharmacy and Therapeutics Committee**

#### *Role*

The committee reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence. It is responsible for analyzing drug utilization patterns and making recommendations for projects to address issues as they arise. The committee reviews and manages the MedStar Family Choice (MFC) closed formulary and oversees reporting to the Maryland Department of Health (MDH).

#### *Membership Structure*

Participants include:

- Chief Medical Officer

- Health Plan Pharmacist
- Medical Directors
- Executive Director/Vice President of Operations
- Assistant Vice President, Clinical Operations
- Director of Medicaid Contract Oversight and Vendor Delegation
- Manager of Delegated Entity Oversight
- Manager of Utilization Management
- Representatives from CVS Caremark
- Representatives from the Case Management Department
- Practitioners and pharmacists

#### *Functions*

- Provides oversight for all modifications to the formulary using clinical evidence from appropriate external organizations including, but not limited to, CVS Caremark, Drug Review Monographs, current clinical practice guidelines, and Medical Society guidelines.
- Assesses and monitors all matters related to the MFC closed formulary.
- Reviews the MFC closed formulary at least annually and evaluates new medications and requests for changes to the formulary.
- Analyzes patterns of utilization for evidence of over- and under-utilization.
- Designs projects to address issues of concern in areas of utilization and drug safety.
- Reviews practitioner profiles, which are given as feedback to improve care management.
- Reports all quality concerns to the Chief Medical Officer.
- Reviews and approves materials for DUR programs.
- Oversees DUR functions.
- Reviews and approves all DUR activities that occur within MFC, including the following programs:
  - MDH Opioid DUR.
  - MDH Corrective Managed Care.
  - Top 5 Opioid Prescriber.
  - Red Flags.
- Performs annual reviews of MFC prior authorization protocols, step therapy protocols, managed drug limitations, and pharmacy policies and procedures.
- Publishes the closed formulary list quarterly and whenever changes are made.
- Complies with all regulatory pharmacy guidelines.
- Ensures that all Food and Drug Administration level I and II recalls are communicated to the appropriate practitioners.

#### *Frequency/Minutes*

This Committee meets at least five times per year and maintains electronic minutes.

#### *Plans for 2026*

Continue management of the MFC closed formulary including:

- An annual formulary review,
- Evaluation of new-to-market medications for formulary inclusion,
- Review of policies and procedures,

- Protocol review, and other functions.

Complete all necessary monthly and annual reporting to MDH including:

- Quarterly formulary updates,
- Annual Pharmacy Report, and
- Annual CMS MCO-DUR Survey.
- Continue distribution of physician profiles highlighting and comparing individual practitioner utilization patterns.
- Execute a complete review and update of opioid prescription management to reduce inappropriate utilization which includes policy review and updates to align with the Federal Support Act and updated CDC prescribing guidance, provider outreach and education, refreshed web resources, prior authorization criteria and form refresh. This will also leverage internal communications with the pre-cert team and medical directors to improve standardization of opioid review and increase comfort level with opioid therapy evaluation.
- Continue to evaluate opioid prescribing trends by
  - total number of opioid prescriptions by provider, and
  - total number of members receiving opioids by prescriber, number of members receiving therapy > 90 MME/day by provider, and number of patients receiving chronic pain treatment (> 3 months) with only short-acting opioid treatment.
- Support and contribute to achieving successful HEDIS measures by focusing on patient-centric medication utilization practices. This includes identifying and mitigating clinical inertia by applying managed drug quantity limitations.
  - preventing the continued use of starter doses of GLP-1 medications, encouraging appropriate dose escalation, and supporting medication-guided glycemic control, and
  - Review asthma related HEDIS measures and assess the need for updates to rescue inhalers quantity limits
- Update the MedStar Family Choice pharmacy website and forms to allow for a better user experience for our members and providers.

## **Consumer Advisory Board**

### *Role*

Provide an avenue for direct feedback from MFC members on the plan and to inform members of updates to the plan and how to navigate the different services provided by MFC.

### *Membership Structure*

Participants include:

- President, MFC or designee
- AVP Growth and Member Experience
- Medical Director or designee
- Manager, Community Relations and Member Engagement

- Director Population Health Equity
- Special Needs Coordinator
- Representation from the Outreach Team and Case Management departments
- Invited MFC enrollees and enrollee family members, guardians, or caregivers
- Local special guest presenter

#### *Function*

The Consumer Advisory Board reviews issues identified through grievance reports, special needs issues, health education, and issues that an enrollee identifies for consideration. It also serves to inform MFC members of quality and supported initiatives throughout MFC. Members can ask questions and participate in anonymous polls to provide valuable feedback and data to MFC to improve services.

#### *Frequency/Minutes*

The Consumer Advisory Board meets at least six times per year and maintains electronic minutes. An annual report is prepared and presented to the QIC for review and approval and then submitted to the MFC Executive Operations Team.

#### *Plans for 2026:*

- Continue efforts to increase member attendance with a focus on the special-needs populations, new members, and members who are overdue for their preventative health visits.
- Continue to review benefits and proper utilization of benefits with members.
- Continue to function as a forum for member input.
- Continue to provide education to members on health issues with special emphasis on the importance of nutrition and how to build a healthy plate, which leads to improved health.
- Continue to provide representation from the Outreach, QI, Appeals and Grievances, Case Management, and Community Relations departments at CAB meetings to improve members' engagement and utilization of available services.
- Complete the implementation of the CAB Complaint Tracking system in coordination with the Case Management Department.
- Improve the ability of attendees to receive preventive care incentives in collaboration with the Outreach Department.
- Provide guest speakers based on chronic conditions of our members.

## **Delegation Oversight Committees**

#### *Role*

The committee reviews and approves the performance of the contracted, delegated entities against the written delegation agreements and quality and performance goals, develops strategies to improve the quality of the delegated care to members, provides input into the quality, safety, and coordination of care for members, provides input into the development of guidelines and programs relevant to the membership of MFC, and develops annual over-and under- utilization projects.

### *Membership Structure*

Participants include:

- Chief Medical Officer or designee
- Medical Directors
- Executive Director
- Executive Director/Vice President of Operations
- Assistant Vice President, Clinical Operations
- Director of Ancillary Contracting
- Director of Credentialing
- Director of Medicaid Contract Oversight ~~and Vendor Delegation~~
- Director of Quality Improvement or designee
- Manager, Appeals and Grievances
- Manager of Case Management
- Manager of Credentialing
- Manager of Utilization Management
- Delegated Oversight Coordinator
- Manager of NCQA Accreditation
- Additional representatives as needed from departments within MFC
- Representatives from the Delegated Entities

### *Functions*

To monitor the performance of the Delegated Entities in, at a minimum, these general areas:

- Quality assurance and improvement
- Claims payment and timeliness
- Credentialing
- Utilization management
- Member and provider services including call center, complaints, appeals, and grievances
- Network development and management
- Compliance, fraud, waste, and abuse
- Encounter data submission
- Pharmacy network adequacy
- Pharmacy pricing appeals
- Member experience standards

### *Frequency/Minutes*

The committees meet at assigned cadences based on individualized contracts and maintain electronic minutes. The Manager of Delegated Oversight, or designee, summarizes the work of the committee and reports to the QIC.

## **Navigate Committee**

### *Role*

To review and approve the performance of Navigate against the written delegation agreement for providing an online health and wellness portal. The MedStar Family Choice HealthyLife Portal

allows adult members to identify and manage health risks through evidence-based tools focused on preventing illness and injury, promoting health and productivity while reducing risk.

#### *Membership Structure*

MFC participants include:

- Director of Quality Improvement or designee
- Manager of NCQA
- Manager of Health Plan Communications
- Manager of Community Assistance and Resources or designee
- Other representatives as needed from MFC departments, including but not limited to, CM, Outreach, and QI.

Navigate participants include:

- Client Results Analyst, Client, and Performance Management Organization
- Population Health Management Strategist

#### *Function*

To monitor the performance of Navigate in at least the areas related to Wellness and Prevention in the Population Health Management Standards:

- Health appraisals
- Self-management tools
- Support for healthy living

#### *Frequency/Minutes*

This committee meets monthly with vendor to discuss issues/changes.

### **Quality Improvement Advisory Committee**

#### *Role*

Reviews and discusses current and new information with, receives collaborative input from, and presents processes and proposals to practitioners within the MFC network.

#### *Membership Structure*

Participants include:

- Chief Medical Officer or designee
- Clinical Operations representative(s)
- Director of Quality and Outreach
- MFC network practitioners
- Assistant Vice President of Clinical Operations

#### *Function*

The Quality Improvement Advisory Committee (QIAC) collaborates with practitioners in the MFC network to address complaints, concerns, and new technology. It educates those practitioners on MFC information, programs, processes, authorization rules and changes, quality scores, and plans.

### *Frequency/Minutes*

The sub-committee meets at least quarterly and maintains electronic minutes. The Chief Medical Officer or designee summarizes the work of the committee and reports to the QIC.

## **QUALITY IMPROVEMENT ACTIVITIES**

### **Enrolled Members and QI Activities**

MFC is committed to providing safe, high-quality care to every member. An annual summary of the Quality Improvement Plan for the year is posted on the MFC website. Results and analyses of major quality initiatives, such as HEDIS and CAHPS, are communicated to members in language understandable to the broad audience of MFC members. Results are posted for members to the MFC website and communicated to members through the MFC Member Newsletter. Paper copies of any information posted to the website are available upon request. The Chief Medical Officer or designee presents quality results at least annually at a Consumer Advisory Board meeting.

### **Contracted Practitioners and QI Activities**

MFC expects network practitioners to participate and cooperate in all aspects of the quality program, including providing access to medical records to the extent permitted by State and Federal law while maintaining the confidentiality of member information and records as outlined in the practitioner's contract with MFC.

MFC affirms that practitioners may freely communicate with patients about their treatment regardless of benefit coverage.

Practitioners are introduced to the quality improvement program by the Provider Relations staff during the practitioner's orientation session. MFC posts an annual summary of the Quality Improvement Plan for practitioners on the MFC website. Results and analyses of major quality initiatives including HEDIS, CAHPS, Population Health Incentive Program (PHIP), and Provider Satisfaction Surveys are posted for practitioners on the MFC website. Practitioners are notified annually of the availability of the Quality Improvement Plan and performance information on the MFC website. Paper copies of any information posted to the website are available upon request.

Practitioners are invited to participate in the QIC and the various subcommittees under the QIC.

### **Practitioner Satisfaction**

Two different Practitioner Satisfaction Surveys are conducted annually. One is performed by a vendor who is contracted by the State of Maryland and the other is completed internally by MFC's Provider Relations Department. The results of both are reviewed and analyzed to identify opportunities for improvement and appropriate interventions.

### **Access Standards: Addressing Members' Individualized Needs- Geographical Access Requirements**

The Maryland Department of Health requires Managed Care Organizations (MCO's) to provide access to health care services and information in a manner that addresses the individualized needs of its members, regardless of gender, sexual orientation, or gender identity, including, but not limited to, the delivery of service and information to members. Access Standards are based on the Maryland Department of Health (MDH) COMAR regulation 10.67.05.05 through 10.67.05.08. MFC is required to develop and maintain a complete network of adult and pediatric primary care, specialty care, ancillary services, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of benefits. In accordance with COMAR regulation 10.67.05.05 an MCO may include, as appropriate, any of the following provider types to serve as the primary care provider:

- General practitioners;
- Family practitioners;
- Internists;
- Pediatrician;
- OB/GYN;
- Physician assistant;
- Certified nurse midwife;
- Nurse practitioners certified in any of the following areas of specialization:
  - Adult;
  - Pediatric;
  - Geriatric;
  - OB/GYN;
  - School nurse; or
  - Family.

MFC is required to ensure adequate capacity and services in compliance with 42 CFR §438.206(b)(1)(i), as amended. Based on full-time equivalency, per COMAR 10.67.05.05 B 8(c), MCOs will be assigned no more than the number of members that is consistent with a 200:1 ratio of members-to-practitioner in the local access area. Per COMAR 10.67.05.05 B(d) MDH may not approve a member-to-Primary Care Physician (PCP) ratio that is higher than 2,000:1.

In accordance with COMAR regulation 10.67.05.05-1 the MDH will review an MCO's specialty provider network for core, major, and pediatric specialties:

- Core specialties include:
  - Cardiology;
  - Otolaryngology;
  - Gastroenterology;
  - Neurology;
  - Ophthalmology;
  - Orthopedics;
  - Surgery; and
  - Urology.
- Major specialties include:
  - Allergy and immunology;
  - Dermatology;
  - Endocrinology;

- Infectious disease;
- Nephrology; and
- Pulmonology.
- Pediatric subspecialties:
  - Cardiology;
  - Gastroenterology;
  - Neurology; and
  - Surgery.

MFC shall follow, analyze, measure its performance, and adjust the network as required, in accordance with COMAR 10.67.05.06 requirements and shall report MFC’s performance against COMAR regulations, quarterly as required by MDH.

- MFC shall meet or exceed the following adult and pediatric primary care, pharmacy, diagnostic laboratory and x-ray, and gynecology geographical access time and distance requirements;

Area	Standard
Urban	10 miles or 15 minutes
Suburban	20 miles or 30 minutes
Rural	30 miles or 40 minutes

- MFC shall meet or exceed the following prenatal care (obstetricians, certified nurse midwives, and family practitioners who provide prenatal care and perform deliveries) geographical access time and distance requirements;

Area	Standard
Urban	10 miles or 15 minutes
Suburban	20 miles or 30 minutes
Rural	75 miles or 90 minutes

- MFC shall meet or exceed the following acute inpatient hospital geographical access time and distance requirements;

Area	Standard
Urban	10 miles or 20 minutes
Suburban	30 miles or 45 minutes
Rural	60 miles or 75 minutes

- MFC shall meet or exceed the following core specialties geographical access time and distance requirements;

Area	Standard
Urban	15 miles or 30 minutes
Suburban	45 miles or 60 minutes
Rural	75 miles or 90 minutes

- MFC shall meet or exceed the following major specialties geographical access time and distance requirements; and

Area	Standard
Urban	15 miles or 30 minutes
Suburban	60 miles or 80 minutes
Rural	90 miles or 110 minutes

Area	Standard
Urban	15 miles or 30 minutes
Suburban	60 miles or 80 minutes
Rural	200 miles or 250 minutes

- MFC shall meet or exceed the following pediatric subspecialties geographical access time and distance requirements.

Urban, Suburban, and Rural areas are defined in accordance with COMAR regulation 10.67.05.06 E 1., 2. (a) through (p), and 3. (a) through (g).

### **Access Standards: Clinical and Pharmacy Access – Appointment Wait Times**

MFC shall ensure it provides and maintains access to primary care services and specialty care services for its membership in a timely manner and in accordance with the following COMAR 10.67.05.07 requirements:

Appointment Request Type	Appointment Wait Time
Newborns – initial office visit	3-5 days post birth of newborn
Adults (Healthy) – initial office visit	Within 90 days of enrollment
Adults (High Risk) – initial office visit	Within 15 days of enrollment
Children – initial office visit	Within 30 days of enrollment/request
Routine office visits, physicals, lab and x-ray	Within 30 days of request
OB/Post-partum and family planning – initial visit	Within 10 days of request
Additional requirements	<ul style="list-style-type: none"> <li>• 24 hours phone coverage with emergency directions.</li> <li>• Members waiting room time should not exceed 30 minutes.</li> <li>• Office hours for MFC members must be equivalent to office hours offered to commercial or other Medicaid patients.</li> </ul>

Appointment Request Type	Appointment Wait Time
	<ul style="list-style-type: none"> <li>Urgent care shall be scheduled to be seen within 48 hours of request.</li> </ul>

**Member Services Telephone Line**

MFC establishes goals for average speed of answer and call abandonment rate for member services lines, delegated to UST HealthProof, and for the vendors who field member services calls. The goal is for the average speed of answer to be under 30 seconds, the call abandonment rate to be under 5%, and for the service level of 85% of calls to be answered within 30 seconds. Vendor performance is assessed against these standards and monitored by Delegation Oversight Committees.

**Serving the Culturally and Linguistically Diverse Population**

MFC assesses the member population to improve the quality of healthcare received, reduce health care disparity, and ensure members receive health care services that are culturally and linguistically appropriate. In 2025 these efforts will include, but not be limited to, the following.

- Providing member materials in languages and formats that are easily understood.
- Ensuring written materials are available in alternative formats and through the provision of auxiliary aids and services.
- Ensuring written materials are available in a format that takes into consideration the special needs of the member population, including disabilities and limited English proficiency.
- Offering members or providers with translation services for members who are sight impaired, hearing impaired, or have limited English proficiency to improve their healthcare experience.
- Providing members with information on practitioner cultural and linguistic capabilities and accommodations for people with disabilities.
- Continuing mandatory cultural competency training for all MFC staff.
- Promoting provider cultural competency training for network providers.
- Analyzing healthcare outcomes by race, ethnicity, and language to identify and address healthcare disparities.
- Analyzing member complaints to identify membership needs, trends, or health care disparities.

**Member Satisfaction**

MFC will evaluate member satisfaction to identify areas for improvement and implement interventions as indicated.

**The CAHPS Survey**

MDH contracts with an outside vendor to conduct a CAHPS survey for the Maryland Medicaid MCOs. The CAHPS 2026 survey will be conducted by the Center for the Study of Services, a certified survey vendor. The CAHPS survey is analyzed annually, and findings are presented to the QIC. They are also published on the MFC website and in newsletter articles for both members and practitioners. A summary of the CAHPS results will be shared with delegated entities.

**Member Safety**

- MFC will continue to demonstrate its commitment to improving safe clinical practice in 2026.
- MFC continues to monitor the safety of its network providers and practitioners through review of quality-of-care cases and through ongoing monitoring in the Credentialing operations.
- MFC collaborates with network providers and practitioners to educate them on improving their knowledge of safe practices.
- MFC evaluates practitioner offices for patient safety and accessibility standards.
- MFC will continue to enforce stronger controls on the prescribing and dispensing of controlled substances, as outlined in the MDH Opioid DUR and Corrective Managed Care programs.
- MFC publishes articles in the member newsletter regarding safe use of medications and advice on choosing an appropriate practitioner.

## **Confidentiality and Privacy**

MFC places a high priority on the privacy and confidentiality of enrollee information. MFC maintains a Compliance Plan that is reviewed annually and describes the Compliance Program structure, reporting, monitoring, auditing, and investigation conducted by the Compliance department. Education and training are conducted by the Office of Corporate Business Integrity and through MedStar Health's SiTEL (learning management system) online modules. In addition to the Compliance Plan, MFC maintains a robust and comprehensive set of compliance and privacy policies that serve as guiding principles as they relate to the organization's quality activities. Topics covered in MFC's privacy policies include, but are not limited to:

- Access to PHI for Research
- Authorization
- Business Associates
- Communication with Friends, Family Members and Others
- Complaints to the Department of Health and Human Services
- De-Identification of Individually Identifiable Health Information, Limited Data Set and Data Use Agreement
- General Privacy Requirements
- Incidental Disclosures
- Marketing
- Member Rights Related to PHI
- Minimum Necessary
- Notice of Privacy Practices
- Notification of Breaches of Unsecured Protected Health Information
- Treatment, Payment, and Healthcare Operations
- Breach Reporting, Mitigation, Sanctions and Non-Retaliation
- Privacy Complaints, Investigations and Compliance Reviews
- Protecting PHI of High-Profile Individuals
- Release of Data to the Media
- Role Based Internal Data Access
- Uses and Disclosures of PHI Not Requiring Permission
- Verification
- Digital Copy/Scanner Security
- Confidentiality and Security

- System Access

MFC has mechanisms in place to guard against unauthorized or inadvertent disclosure of confidential information. MFC's Information Security and Information Services employees coordinate with department leaders to manage employee access to electronic data systems and physical locations. MFC policies, the Compliance Plan, and additional documentation describe further confidentiality and security mechanisms at MFC.

MFC publishes articles in the Provider Newsletter that cover privacy topics including tips for ensuring patient privacy and notice of privacy practices.

MFC publishes articles in the Member Newsletter that cover privacy topics including education for parents on PHI rules and for enrollees on protecting the privacy of their health information.

New MFC employees are trained on HIPAA Privacy and Security. All MFC employees additionally are trained annually on HIPAA Privacy and Security via the corporate SiTEL on-line modules.

The Manager of Delegated Oversight will share the following with delegated entities annually:

- MedStar Health Code of Conduct.
- MFC HIPAA privacy and security policies.
- MFC Compliance Plan and policies.

## **Continuity and Coordination of Medical Care**

MFC will monitor and act as necessary to improve the continuity and coordination of care across its delivery system. MFC will conduct an at least annual analysis to identify opportunities to improve the coordination of medical care and perform a quantitative and causal analysis. Areas of opportunity will be identified, and action plans developed and implemented, when indicated.

In 2026, MFC will continue to collaborate with CVS Caremark on continuity and coordination of care. MFC will collaborate to perform DUR for patient safety regarding narcotic medications. CVS Caremark uses an adherence program to notify prescribers by fax if a member fails to obtain a first refill of a new chronic medication or a member fails to obtain a refill of a chronic medication. CVS Caremark also uses a point of service drug-drug interaction tool that alerts the pharmacist and stratifies the level of interaction. The alert prompts the pharmacist to take a series of possible actions including contacting the prescribing physician. CVS Caremark provides key safety information to members and prescribers if and when there is a level 1 and level 2 recall, or voluntary recall from the market.

As part of the termination process for PCPs and specialists, members are notified 30 calendar days in advance or within 30 calendar days of notification of MFC of the termination of a general practitioner, internist, family medicine practitioner or pediatrician from the network who are assigned members. Members are assisted with selecting a new practitioner.

MFC allows continued access to the care when a practitioner's contract is discontinued through the lesser of the current period of active treatment or 90 calendar days for members undergoing active treatment for a chronic or acute medical condition. This is part of the quality-of-care statement and is included in the member letter. With prior authorization, members who are pregnant and in their second or third trimester of pregnancy are allowed continued access to a practitioner with a discontinued contract through the postpartum period.

MFC will abide by the member's right to self-refer for obstetrical care as outlined in COMAR 10.67.06.28.A.3(a,b,c). This regulation mandates access for services related to pregnancy for women who are pregnant and, at the time of initial enrollment, have received prenatal care during their current pregnancy from a non-participating provider. Pre-enrollment care consists of at least a full prenatal examination, a risk assessment, and appropriate laboratory services.

In 2026, the MFC Quality Improvement Department will be gathering the necessary data needed for the Quality Improvement Activity Analysis review process.

### **Delegation of QI**

MFC delegates quality activities to several subcontractors. Delegation of quality activities range from the very specific delegation of drug safety related issues to CVS Caremark for pharmacy services to broader over- and under-utilization and quality studies delegated to Avēsis for routine vision services. Delegation details are laid out in the individual written delegation agreements for each entity.

MFC maintains a robust oversight process that includes mutually agreed upon and written delegation agreements with each of its delegated entities or subcontractors that outline the specific activities that are delegated, the responsibilities of each party, the required reporting or performance against predetermined goals, and the remedies available to MFC if the delegated entity does not fulfill their obligations. The remedies include termination of the contract if the delegated entity or subcontractor cannot rectify deficiencies to the satisfaction of MFC.

The exchange of PHI is an expected part of the collaborative work that takes place between MFC and its delegated vendors. Delegation agreements include language designed to safeguard PHI from inappropriate use or further disclosure.

MFC will meet at least 10 times per year with UST HealthProof, at least semi-annually with CVS Caremark and Carenet, and at least quarterly with Avēsis. The content of Delegation Oversight Committee meetings will be summarized and presented to the QIC by the Manager of Delegated Oversight. MFC reviews annual quality and utilization management programs when delegated, and confirms that they meet SPR and NCQA standards, where appropriate. All necessary oversight reports are reviewed and approved on an ongoing basis. MFC annually evaluates a delegate's performance against NCQA and SPR standards for delegated activities, where appropriate. Opportunities for improvement are identified through the evaluation process, causal analyses performed, and actions to improve performance will be identified and implemented collaboratively by MFC and the delegate when identified.

MFC provides member experience data, if applicable, and clinical performance data to its delegates. The delegates may collect experience data directly from members. MFC will share relevant experience data, including CAHPS results, with delegated entities annually. Delegates may have access to clinical performance data through the claims system. MFC will provide the delegates with the opportunity to attend QIC Meetings when results of relevant clinical performance measures are scheduled for review. The delegates may request member experience and clinical performance data at any time by contacting the Manager of Delegated Oversight. Over- and under-utilization projects will be included in the delegate's annual efforts, as appropriate. In addition, MFC fulfills its obligation to prevent fraud and abuse by including oversight of the delegate's work in this area

## **COLLABORATIVE QUALITY INITIATIVES**

All activities are reviewed for over-utilization, under-utilization, safety, and quality of care issues. In the development of the plans for quality improvement and health education, federal, state, and local public health goals have been considered, including Medicaid areas of interests. It remains a priority of the QIC that MFC design, implement, and improve projects to proactively identify members with specified conditions or those in need of services and improve compliance or access with those services. The conditions or services identified are based on regulations, requirements, and identified opportunities for improvements.

The proposed activities for calendar year 2026 are in the following sections. The MFC Quality Improvement Committee recognizes that the coordination of outreach efforts and quality improvement projects represent an opportunity to create synergies. Many projects will be joint efforts between the Outreach, Case Management, Provider Relations, and Quality Improvement departments.

### **Asthma Medication Compliance QI Program**

A program in the Quality Improvement Department works to improve compliance for members with persistent asthma with their use of controller medications. The program is staffed by a full-time Quality Improvement Specialist. Members are identified per the Asthma Medication Ratio (AMR) HEDIS measure, which determines whether members identified as having persistent asthma receive at least as many controller medications as relievers during the measured year, and through extracts from CRISP to determine which of these members who received a recent ED visit. The QI Specialist then uses that report to outreach these members and assist them with scheduling follow up care with their PCP or a specialist as needed. The QI Specialist also uses this opportunity to educate the member on the importance of regular follow-ups with their PCP.

To increase compliance and access to medications, the program educates members and providers about opportunities to receive 90-day supplies of controller medications for members with persistent asthma. Members without the appropriate controller medications for the year and those who are not being followed on an outpatient basis for asthma are identified using claim and pharmacy data. The Quality Improvement Specialist performs outreach to members by telephone, mail, and text to assist them with access to appropriate controller medications and collaborates with provider offices to obtain long-term prescriptions for members. Where appropriate, MFC Medical Directors are incorporated into the process to work directly with provider offices on

education and peer-to-peer reviews of a member's case. These physician-to-physician outreach attempts are most often used in cases where reliever medications are being prescribed and filled excessively.

In 2026, the AMR measure is turning to focus on 30 day follow up PCP visits for members who had a recent emergency department, urgent care, inpatient stay, or observation stay with an asthma diagnosis. MFC QI will collaborate with MFC CM and Outreach as needed to help utilize the similar process for AMR but to get members into PCP visits timely.

Goals for 2026:

- Review data for asthma-related hospital visits and stay to ensure members are having their PCP follow up visit within 30 days.
- Continue the process for AMR to identify potential members who are non-compliant on medications to help avoid hospital stays and emergency department visits proactively.

## **HIV/AIDS QI Program**

A program in the Quality Improvement Department works to ensure that members with HIV or AIDS are appropriately identified, that external agencies have the same diagnosis, that reimbursement rates are appropriate to member diagnosis, and that members are outreached annually and those with a potential need for case management are referred with care coordination needs addressed. The program is staffed by a full-time Quality Improvement Specialist. Members are identified by eligibility code from reimbursement, referrals, diagnoses, and medications. For members with a potential diagnosis who are not receiving correct reimbursement, the Quality Improvement Specialist and a medical director manually research available systems to verify and collect proof of diagnosis. Then, the Quality Improvement Specialist coordinates with external agencies to provide proof of diagnosis and correct the reimbursement rate. Members who are identified with potential gaps in their treatment, such as a lack of outpatient claims or a gap in medication events, are outreached by mail, telephone, and text by the Quality Improvement Specialist. These members are outreached to ensure that they are in care, able to receive their medications, have access to case management, and to address any barriers to receiving any service to which the member is entitled.

Goals for 2026:

- Increase engagement with our HIV/AIDS members.
- Establish relationships with community partners.

## **MSH POD Meetings**

The Quality Improvement Department represents MFC during MSH POD meetings. These meetings are opportunities to communicate health plan data with providers and practitioners about their attributed members, information about MFC's quality initiatives, MFC's resources, and member needs. Quarterly practice-specific HEDIS measure summaries and gaps-in-care reports will be shared around the time of the MSH POD meetings. The long-term goals of the collaboration and data sharing are to improve quality outcomes for members and to achieve population health

objectives. The meeting also allows practitioners to collaborate with MFC on achieving strategic goals.

Goals for 2026:

- MFC will continue attendance at MMG POD meetings to improve collaboration and member health care outcomes. The QI team will also work with practices outside of MMG POD meetings to improve collaboration and data sharing opportunities.

## **Provider Data Sharing**

To improve quality of care for members, MFC produces provider reports related to their panels. These reports are designed to show the compliance of members who are assigned or are engaged in a practitioner's practice. The reports use claims data, supplemented by laboratory results files, pharmacy data, and supplemental medical records where appropriate. The reports provide compliance metrics for HEDIS and PHIP measures specific to members in the practice. The reports are provided to share information on members who are non-adherent with care, identify barriers, and promote wellness and preventive services. GIC reports are provided to offices at least annually. Scorecard frequency and delivery methods are determined by practice size and MFC policy, which dictates more frequent delivery for larger practices with more members.

In 2026, MFC is also participating in the Achieving Healthcare Efficiency through Accountable Design (AHEAD) model, which is a program created through the state to help improve the primary care system. The focus is on helping primary care providers delivery quality care over volume of care to help expand the primary care role to include care management, integrated behavioral health, and data-informed care. MFC will help meet these needs by proving the gaps in the measures covered by this program to provider offices to identify members that need care.

Goals for 2026:

- Continue the frequency of provider scorecard delivery established per policy.
- Evaluate the impact of provider scorecards on quality initiatives.
- Initiate the gaps in care related to the AHEAD model.

## **EXTERNAL MEASURES OF EFFECTIVENESS**

### **Early Periodic Screening, Diagnosis, and Treatment Audit**

MDH monitors preventative services for children through its EPSDT Program. Annual reviews assess the components of health and developmental history, comprehensive physical examination, laboratory tests/at risk screenings, immunizations, and health education/anticipatory guidance. MFC will continue work to exceed the goals of 80% compliance on the audit. Data obtained from MDH will be reviewed based on 2024 EPSDT audits for services provided in calendar year 2023.

Staff from the Quality Improvement and Provider Relations departments will collaborate to educate practitioners and provider offices. Articles will be placed in the provider newsletters reminding the practices of the importance of ordering and following up on laboratory tests, a component which continues to be an opportunity improvement for the MFC provider network. Quality Improvement Coordinators and Provider Relations Representatives will collaborate to ensure that all practitioners who treat members below the age of 21 are EPSDT-certified and are informed of changes in EPSDT policies and forms. The Quality Improvement and Provider Relations Departments will pursue CAPs with practices that do not maintain the standards required to remain active in the EPSDT program.

Goals for 2026:

- Meet and exceed the 80% threshold for compliance in the overall score and for each of the components.
- Improve the Laboratory/At-risk Screening component by implementing internal audits and create provider education if necessary.
- Improve completion of depression screenings and autism screening to maintain compliance.
- Complete the 2026 EPSDT audit without a CAP being required by the results.

## **HEDIS Compliance Audit**

MFC uses HEDIS technical specifications to design sound studies and apply statistical analysis to all data for projects involving HEDIS measures. An independent auditor is used to validate the data and results annually. Data sources include, but are not limited to, medical claims, encounters, enrollment, medical record review, pharmacy, laboratory, and HIEs. The Director of Quality Improvement, Manager of HEDIS and Quality Analytics, Quality Improvement Analyst, Quality Improvement Accreditation Project Manager, and all Quality Improvement Coordinators and Quality Improvement Specialists assist with these studies.

Audited HEDIS measurements will be performed and reported to NCQA by MFC as part of MY 2025. MFC will use the Quality Intelligence platform from Cotiviti to calculate and submit MY 2025 results. IS will compile all required and supporting data into files in the vendor's format and upload them to Cotiviti, who will host the data, manage software updates, and perform all HEDIS calculations. MFC will report all measures required by the MDH and all measures required for NCQA Health Plan Rating, except for those measures where benefits are carved out to the State in Maryland and the result will be "no benefit."

Active Quality Improvement, Outreach, and Clinical Operations projects for 2026 will address HEDIS measures in the following categories:

- PCP follow up visits for members with an inpatient admission, observation stay, emergency department or urgent care visit with diagnosis of asthma.
- Appropriate and continuous use of chronic medications, especially statins and medications for diabetes.
- Appropriate use and avoidance of abuse for opioid medications.
- Prenatal care timeliness.
- Postpartum care.
- Breast cancer screening.

- Cervical cancer screening.
- Child, adolescent, and adult access to primary care services.
- Childhood and adolescent immunizations.
- Lead screening in children.
- Wellness visits for children.
- Comprehensive diabetes care with a focus on A1C control, retinal eye examinations, and kidney health evaluation.
- Controlling high blood pressure.
- Use of imaging studies for low back pain.
- Prenatal immunizations and adult immunizations of Tdap and Influenza.

Goals for 2026:

- Submit HEDIS rates according to the NCQA schedule.
- Report all measures required of MFC with no rates reported with bias.
- Achieving at least the 50<sup>th</sup> percentile for all measures.

## **NCQA Accreditation**

MFC recognizes that NCQA Accreditation programs reflect a health plan’s dedication to providing high-quality care and service to its members. Therefore, MFC is committed to maintaining a continual state of accreditation readiness. To uphold its NCQA Health Plan Accreditation (HPA) status, MFC participates in a triennial survey. The current HPA status is valid through 2027, with the next renewal survey scheduled for that year.

The Manager of NCQA Accreditation at MFC oversees the accreditation process and survey submissions, supported by the Accreditation team and internal contributors from various departments across the organization.

Goals for 2026:

- Maintain continual state of accreditation readiness

## **Performance Improvement Projects (PIP)**

Beginning in CY 2023, MDH has assigned two new PIP topics with additional layers to the PIP process. The PIPs are structured around a menu of evidence-based strategies. PIP interventions are aligned with other statewide public health and Medicaid innovation initiatives.

MFC will continue to implement interventions that satisfy the previously selected strategies that are most appropriate for our membership and available. MFC will utilize SMART goals using a health equity focus for all interventions to address health outcomes among the most disparate populations. MFC will determine specific process metrics for each selected strategy and monitor progress over each quarter.

## **Timeliness of Prenatal Care and Identification of High-Risk Pregnancies (HEDIS PPC-CH)**

Goals for 2026:

- Continue the rapid-cycle PDSA process on PIP interventions and implement initiatives.
- Submit quarterly PIP reports on schedule.
- Achieve highest marks from the new point scoring methodology per the EQRO PIP Project Validation process.
- Progress toward MDN goal of 5% improvement above the MCO's baseline measure during the life of the project for specified outcome measure(s).

### **Maternal Health and Infant/Toddler Care During the Postpartum Period (HEDIS PPC-AD, HEDIS W30, and HEDIS CIS-3)**

Goals for 2026:

- Continue the rapid-cycle PDSA process on PIP interventions and implement initiatives.
- Submit quarterly PIP reports on schedule.
- Achieve highest marks from the new point scoring methodology per the EQRO PIP Project Validation process.
- Progress toward MDN goal of 5% improvement above the MCO's baseline measure during the life of the project for specified outcome measure(s).

### **System Performance Review**

MFC will participate in the triannual, full, desktop SPR audit and the interim, focused, desktop SPR audits performed by the EQRO contracted by MDH. MFC seeks 100% compliance with all standards and will review and implement all suggestions made by the EQRO as necessary.

Goals for 2026:

- Complete the interim audit by submitting all required documentation in a timely manner.
- Meet all standards in the SPR avoiding the need for any corrective action plans.

### **Population Health Incentive Program**

The Population Health Incentive Program is an MDH system of incentives for MCOs based on their performance. All plans are eligible for up to 1% of total capitation if they meet exceptional thresholds of performance nationally or if they improve and perform better than most plans nationally. MFC's goal is to receive incentives on as many measures as possible by exceeding the 90<sup>th</sup>, 75<sup>th</sup>, and 50<sup>th</sup> percentiles and improving results for measures year-over-year.

The results for measurement year 2025 will be reported in 2026. The measures are:

- Colorectal Cancer Screening (COL)- Total Rate
- Glycemic Status Assessment for Patients with Diabetes (GSD): Glycemic Status >9/0%
- Controlling High Blood Pressure (CBP)
- Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care
- Child and Adolescent Well-Care Visits (WCV)- Total Rate
- Well-Child Visits in the First 30 Months of Life (W30)- Ages 0-15 Months and Ages 15-30 Months
- Immunizations for Adolescents (IMA-E): Combination 2
- Child Immunization Status (CIS): Combination 3

Starting in MY 2022, incentive payments were based on improvements year-over-year and national percentiles and there were not disincentives or penalties to plans. As a result, there are no prospective benchmarks for performance available until the year after the measurement year ends. Instead, MFC strives to show exemplary performance among national plans and to improve over previous results wherever results are not exemplary.

Goals for 2026:

- Continue to work toward improvement of the multiple PHIP metrics.
- Proactively assess progress at the HEDIS Proactive meetings compared to CY 2025. Adjust or add initiatives as needed to improve performance.
- Improve the percentage of total capitation received as incentives for MY 2026 compared to MY 2025.

## **NEW INITIATIVES FOR 2026**

1. Infuse health equity lens in all programs with a primary goal to ensure that all individuals, regardless of their socioeconomic status, race, ethnicity, gender, or other factors, have fair and equal access to healthcare resources and services.
2. Enhance member demographic information to increase successful contacts to close gaps in care.
3. Evaluate member engagement initiatives by HEDIS measure to determine efficacy and fiscal impact while exploring additional evidence-based initiatives that may provide greater ROI.
4. Explore new interventions to improve provider engagement and satisfaction with MFC.

## **INITIATIVES CONTINUED THROUGH 2026**

1. Continue quality assurance reviews for any reports submitted to the EQRO.
2. Expand existing practitioner incentive programs where efficacy is demonstrated.
3. Enhance processes that establish relationships with provider offices, deliver gaps in care reports, and help close gaps in care through the collaboration of departments within MFC.
4. Submit HEDIS rates according to the NCQA schedule and have no rates reported with bias.
5. Educate practitioners on EPSDT guidelines, HEDIS requirements, MFC pharmacy benefits, HEDIS results, CAHPS survey results, provider satisfaction survey results, and other initiatives as appropriate.
6. Continue to implement evidence-based PIP initiatives on “Timeliness of Prenatal Care” and “Postpartum Care”.
7. Increase utilization and access to mobile and community-based services to improve member access to care.
8. Participate in MSH POD meetings to educate and support practitioners and providers in achieving population health management goals.
9. Standardize data presentation and educate MFC staff on interpreting/analyzing data to support their ability to evaluate initiatives and efforts. Develop standardized reporting of efforts and outcomes for quality initiatives.

10. Increase member input into quality initiatives through expanded use of the Consumer Advisory Board and targeted member surveys.
11. Integrate internal, EPSDT audits to improve the rates for the thresholds for each component and offer provider education in real-time.