



MARYLAND
Department of Health

HealthChoice

Maryland's Medicaid Managed Care Program



**Medicaid Managed Care
Organization**

Systems Performance Review

**Statewide Executive Summary
Report**

Calendar Year 2018

Qlarant 

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CY 2018 Systems Performance Review Statewide Executive Summary

Maryland's HealthChoice Program (HealthChoice) is a managed care program based upon a comprehensive system of continuous quality improvement that includes problem identification, analysis, corrective action, and reevaluation. The objective is to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding the care received by HealthChoice enrollees.

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

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care provided to Maryland Medical Assistance enrollees in HealthChoice Managed Care Organizations (MCOs). MDH, pursuant to Title 42, Code of Federal Regulations, 438.204, is responsible for monitoring the QOC provided to MCO enrollees when delivered pursuant to the Code of Maryland Regulations (COMAR) 10.09.65.

Under Federal law [Section 1932(c)(2)(A)(i) of the Social Security Act], MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract to ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program. MDH contracts with Qlarant to serve as the EQRO. This executive summary describes the findings from the systems performance review (SPR) for calendar year (CY) 2018, which is HealthChoice's 20th year of operation. HealthChoice served over 1,177,051 enrollees during this period.

COMAR 10.09.65 requires that all HealthChoice MCOs comply with the SPR standards and all applicable federal and state laws and regulations. MCOs were given an opportunity to review and comment on the SPR standards 45 days prior to the beginning of the audit process. The nine MCOs evaluated for CY 2018 were:

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

*ABH joined HealthChoice in October of 2017; therefore the CY 2018 SPR was the first scored review for this MCO.

Purpose and Process

The purpose of the SPR is to provide an annual assessment of the structure, process, and outcome of each MCO's internal quality assurance programs. Through the systems review, the team is able to identify, validate, quantify, and monitor problem areas, as well as identify and promote best practices.

The CY 2018 SPR was conducted as a comprehensive onsite review at the MCO offices. This was the first onsite review subsequent to MDH's decision to transition to a triennial review process. Both CY 2016 and CY 2017 reviews were conducted as Interim Desktop Reviews focusing on standards that were not fully met in previous reviews, scored as baseline in previous reviews, or new. The CY 2018 onsite SPR applied the systems performance standards defined for CY 2018 in the Code of Maryland Regulations (COMAR) 10.09.65.03B(1). Additionally, a sample of grievance, appeal, and adverse determination records were reviewed to assess compliance with applicable standards.

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; COMAR; the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care;" Public Health Code of Federal Regulations; and Department requirements. The HealthChoice and Acute Care Administration leadership and the Division of HealthChoice Quality Assurance (DHQA) approved the MCO SPR standards and guidelines used in CY 2018.

The review team that performed the annual SPRs consisted of health care professionals: a nurse practitioner and two masters prepared reviewers. The team has a combined experience of more than 50 years in managed care and quality improvement systems, 40 years of which are specific to HealthChoice. Feedback was provided to the DHQA and each MCO with the goal of improving care provided to HealthChoice enrollees.

Methodology

For CY 2018, COMAR 10.09.65.03 required that all HealthChoice MCOs comply with the SPR standards established by the Department and all applicable federal and state laws and regulations.

In September 2018, Qlarant provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2018 and invited the MCOs to direct any questions or issues requiring clarification to Qlarant and DHQA. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2018/2019 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- CY 2018 Systems Performance Review Standards and Guidelines, including specific changes

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

During the onsite reviews conducted in January through March 2019, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion, exit conferences were held with the MCOs. The purpose of the conferences was to provide the MCOs with preliminary findings, based on interviews and all documentation reviewed. A follow-up letter was provided to each MCO describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Qlarant; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the review, Qlarant documented its findings for each standard by element and component. The level of compliance for each element and component was scored with a review determination of “Met”, “Partially Met”, or “Unmet” as follows:

Met	100%
Partially Met	50%
Unmet	0%

Each element or component of a standard was weighted equally. A CAP was required for each performance standard that did not meet the minimum required compliance score, as defined for the CY 2018 review.

If an MCO chose to have standards in their policies and procedures that were higher than what was required by MDH, the MCO was held accountable to the standards which were outlined in their policies and procedures during the SPR.

The Department had the discretion to change a review finding to “Unmet” if the element or component had been found “Partially Met” for more than one consecutive year.

The following performance standards were included in the CY 2018 SPR:

- Standard 1: Systematic Process of Quality Assessment
- Standard 2: Accountability to the Governing Body*
- Standard 3: Oversight of Delegated Entities
- Standard 4: Credentialing and Recredentialing*
- Standard 5: Enrollee Rights
- Standard 6: Availability and Accessibility
- Standard 7: Utilization Review
- Standard 8: Coordination of Care
- Standard 9: Health Education*
- Standard 10: Outreach
- Standard 11: Fraud and Abuse

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

Each MCO was expected to meet the minimum compliance rate of 100% for all standards with the exception of ABH. The minimum compliance rate was set at 80% for ABH for its first scored SPR. The CY

2017 SPR was a baseline review for ABH as the MCO joined the HealthChoice system in October 2017. The MCOs were required to submit a CAP for any element/component that did not meet the minimum compliance rate.

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

Findings

If the MCO's did not meet the minimum compliance rate of 100%, with the exception of ABH who's minimum compliance score was set at 80%, a CAP was required. One MCO (JMS) received compliance scores of 100% in all standards reviewed. Eight MCOs (ABH, ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) were required to submit CAPs for CY 2018. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

Table 1 provides a comparison of SPR results across MCOs and the MD MCO Compliance Score for CY 2018.

Table 1. CY 2018 MCO SPR Results

Standard	MD MCO Compliance Score	ABH ⁺	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
1 Systematic Process of Quality Assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2 Accountability to Governing Body	93%	93%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
3 Oversight of Delegated Entities	88%	<u>50%*</u>	<u>58%*</u>	100	<u>63%*</u>	100%	100%	100%	100%	100%
4 Credentialing and Recredentialing	99%	99%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
5 Enrollee Rights	91%	94%	<u>91%*</u>	100%	<u>69%*</u>	<u>89%*</u>	<u>97%*</u>	<u>88%*</u>	100%	<u>88%*</u>

Standard	MD MCO Compliance Score	ABH ⁺	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
6 Availability and Accessibility	86%	95%	85%*	100%	85%*	80%*	90%*	85%*	100%	55%*
7 Utilization Review	93%	93%	90%*	100%	83%*	95%*	100%	88%*	95%*	91%*
8 Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
9 Health Education	100%	100%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
10 Outreach	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
11 Fraud, Waste, and Abuse	94%	90%	90%*	100%	79%*	96%*	100%	100%	100%	88%*♦
Composite Score	97%	95%	95%	100%	90%	96%	99%	96%	99%	94%

*ABH's minimum compliance threshold was set at 80%, as this was the MCO's first scored SPR.

Underlined/Bolded/Asterisk denotes that the minimum compliance score of 100% was unmet (or 80% for ABH).

♦Quarterly updates required on CAP per MDH Performance Monitoring Policy.

For each standard assessed in the CY 2018 SPR, the following section describes:

- The requirements reviewed
- The overall MCO results and findings (where applicable, refer to Appendix A for detailed MCO findings)
- The follow up, if required

Standard 1: Systematic Process of Quality Assessment and Improvement

Requirements. The Quality Assurance Program (QAP) objectively and systematically monitors/evaluates the quality of care (QOC) and services to participants. Through QOC studies and related activities, the MCO pursues opportunities for improvement on an ongoing basis. The QAP studies monitor QOC against clinical practice guidelines which are based on reasonable evidence based practices. The QAP must have written guidelines for its QOC studies and related activities that require the analysis of clinical and related services. The QAP must include written procedures for taking appropriate corrective action whenever inappropriate or substandard services are furnished. The QAP must have written guidelines for the assessment of the corrective actions. The QAP incorporates written guidelines for evaluation of the continuity and effectiveness of the QAP. A comprehensive annual written report on the QAP must be completed, reviewed, and approved by the MCO governing body. The QAP must contain an organizational chart that includes all positions required to facilitate the QAP.

Results and Findings. All MCOs were fully compliant in the area of Systematic Process of Quality Assessment and Improvement. All MCOs' QAPs were found to be comprehensive in scope and to appropriately monitor and evaluate the quality of care and service to members using meaningful and relevant performance measures. Clinical care standards and/or practice guidelines are in place which the MCOs monitor performance against annually, and clinicians monitor and evaluate quality through review of individual cases where there are questions about care. Additionally, there was evidence of development, implementation, and monitoring of corrective actions.

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 2: Accountability to Governing Body

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

Results and Findings. All MCOs were exempt from the review of Accountability to the Governing Body except for ABH as this was the MCO's first onsite SPR. ABH received a compliance score of 93% in this area of review for CY 2018 which was above the minimum compliance score set at 80% for the MCOs first SPR. Overall, ABH was found to have appropriate oversight by their governing board. Evidence was provided of the oversight provided by the governing body, along with ongoing feedback and direction of quality improvement activities and operational activities of the MCO.

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 3: Oversight of Delegated Entities

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

Results and Findings. Three MCOs (ABH, ACC, and KPMAS) had opportunities for improvement in the area of oversight of delegated entities. These MCOs will require CAPs in the following element/components to become compliant for the CY 2019 SPR.

Element/Component	ABH	ACC	KPMAS
<u>Element 3.2:</u> Written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided.		PM	
<u>Component 3.3 a:</u> Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc.	PM		U
<u>Component 3.3 c:</u> Review and approval of claims payment activities at least semi-annually, where applicable.	PM		PM
<u>Component 3.3 d:</u> Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.	U	U	
<u>Component 3.3 e:</u> Review and approval of over and under utilization reports, at least semi-annually, where applicable.	U	U	

P=Partially Met; U=Unmet

For more detailed findings regarding MCO opportunities for improvement, refer to Appendix A.

Follow-Up:

- ABH, ACC and KPMAS were required to submit CAPs for the above elements/components. Qlarant reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2019 SPR.

Standard 5: Enrollee Rights

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

Results and Findings. Six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) had opportunities for improvement in the area of enrollee rights. These MCOs will require CAPs in the following elements/components to become compliant for the CY 2019 SPR.

Element/Component	ACC	KPMAS	MPC	MSFC	PPMCO	UMHP
<u>Component 5.1a</u> : There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.09.71.						U
<u>Component 5.1c</u> : The system ensures that the resolution of a grievance is documented according to policy and procedure.		U			PM	
<u>Component 5.1d</u> : The policy and procedure describe the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning.		U				
<u>Component 5.1f</u> : There is complete documentation of the substance of the grievances and steps taken.		PM	U			
<u>Component 5.1g</u> : The MCO adheres to the time frames set forth in its policies and procedures for resolving grievances.		PM	PM		PM	
<u>Component 5.1h</u> : The MCO has a process in place for notifying the member in writing of the grievance determination, even if the notification was previously provided verbally.	PM	U	PM	PM	U	
<u>Component 5.3d</u> : Must ensure that the release of any information in response to a court order is reported to the patient in a timely manner.						PM
<u>Element 5.4</u> : The MCO has written policies regarding the appropriate treatment of minors.			PM			
<u>Component 5.5a</u> : As a result of the enrollee satisfaction surveys, the MCO identifies and investigates sources of dissatisfaction.		U				
<u>Component 5.5b</u> : As a result of the enrollee satisfaction surveys, the MCO implements steps to follow up on the findings.		U				
<u>Component 5.5c</u> : The MCO informs practitioners and providers of assessment results.	U	U				U
<u>Component 5.5d</u> : The MCO reevaluates the interventions put in place to follow up on satisfaction surveys at least quarterly.		U			PM	

Element/Component	ACC	KPMAS	MPC	MSFC	PPMCO	UMHP
<u>Component 5.6a</u> : Policies and procedures are in place that address the content of new enrollee packets of information and specify the time frames for sending such information to the enrollee.	PM				PM	PM
<u>Component 5.7a</u> : The MCO's CAB membership must reflect the special needs population requirements.						PM
<u>Component 5.8a</u> : Materials distributed by the MCO to the enrollee will include a nondiscrimination notice and a language accessibility statement in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency of Maryland.		U				
<u>Component 5.8c</u> : Notices and Taglines must be posted in significant communications and publications.					U	
<u>Component 5.9c</u> : The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.						U

P=Partially Met; U=Unmet

For more detailed findings regarding MCO opportunities for improvement, refer to Appendix A.

Follow-up:

- All six MCOs were required to submit CAPs for the above noted elements/components. Qlarant reviewed and approved the CAP submissions.
- The approved CAPs will be reviewed in CY 2019 SPR.

Standard 6: Availability and Accessibility

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

Results and Findings. Six MCO (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) had opportunities for improvement in the area of availability and accessibility. These MCOs will require CAPs in the following components to become compliant for the CY 2019 SPR.

Element/Component	ACC	KPMAS	MPC	MSFC	PPMCO	UMHP
<u>Component 6.1b</u> : The MCO has processes in place to monitor performance against its access and availability standards at least quarterly.		U	U			PM
Component 6.1c: The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance.	PM				PM	
<u>Component 6.1d</u> : The MCO has documented review of the Enrollee Services Call Center performance.					PM	
Component 6.2b: At the time of enrollment, enrollees are provided with information about the MCO's providers that includes requirements set forth in COMAR 10.09.66.						U
<u>Component 6.2c</u> : The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities.			U			PM
Component 6.2d: The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.		PM				PM
<u>Component 6.3a</u> : The MCO must have policies and procedures in place for notifying enrollees of due dates for wellness services, IHAs, and preventive services.						U
Component 6.3c: Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	U			U	PM	U

P=Partially Met; U=Unmet

For more detailed findings regarding MCO opportunities for improvement, refer to Appendix A.

Follow-Up:

- ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2019 SPR.

Standard 7: Utilization Review

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

Results and Findings. Six MCOs (ACC, KPMAS, MPC, PPMCO, UHC, and UMHP) have opportunities for improvement in the area of Utilization Review. These MCOs will require CAPs in the following elements/components to become compliant for the CY 2019 SPR.

Element/Component	ACC	KPMAS	MPC	PPMCO	UHC	UMHP
Component 7.2d: There must be evidence that UR criteria are reviewed and updated according to MCO policies and procedures.	U				U	
Component 7.3b: UR reports must provide the ability to identify problems and take the appropriate corrective action.				PM		
Component 7.3c: Corrective measures implemented must be monitored.				U		
Element 7.6: The MCO must meet adverse determination notification timeframes in response to preauthorization requests as specified by the State.	PM	PM		U		
Component 7.7e: Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.		PM				U

Element/Component	ACC	KPMAS	MPC	PPMCO	UHC	UMHP
Component 7.9a: The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.		PM				
Component 7.9b: The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.		U				
Component 7.9c: The MCO acts upon identified issues as a result of the review of the data.		U				
Component 7.11a: The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation.	PM		U			PM

P=Partially Met; U=Unmet

For more detailed findings regarding MCO opportunities for improvement, refer to Appendix A.

Follow-Up:

- ACC, KPMAS, MPC, PPMCO, UHC, and UMHP were required to submit CAPs for the above element/components. Qlarant reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2019 SPR.

Standard 8: Continuity of Care

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

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

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 9: Health Education

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

Results and Findings. All MCOs were exempt from review of the Health Education standard except for ABH as this was the MCOs first SPR. ABH received full compliance (100%) in CY 2018. The MCO's Health Education Plans were found to be comprehensive and include policies and procedures for internal staff education, provider education and continuing education units, and enrollee health education.

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 10: Outreach Plan

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

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

Follow-Up:

- No CAPs were required.
- No follow-up is required.

Standard 11: Fraud, Waste, and Abuse

Requirements. The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.

Results and Findings. Four MCOs (ACC, KPMAS, MPC and UMHP) have opportunities for improvement in the area of Fraud and Abuse. These MCOs will require CAPs in the following components to become compliant for the CY 2019 SPR.

Element/Component	ACC	KPMAS	MPC	UMHP
<u>Component 11.1 f:</u> A documented process to ensure that services billed to the MCO were actually received by the enrollee. Due to continued opportunities from the CY 2017 SPR, UMHP requires quarterly monitoring of the CAP for 11.1f according to MDH's Performance Monitoring Policy.			U	U
Component 11.2e: A documented process for enforcement of standards through clear communication of well publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse.		U		
<u>Component 11.4a:</u> Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee.	PM	U		PM
Component 11.4b: Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP.		U		PM
<u>Component 11.4c:</u> Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with.	U	U		PM
Component 11.4d: Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.	U	U		
<u>Component 11.5d:</u> An MCO must provide evidence of initial and monthly checks of the following databases as applicable: Social Security Death				PM

Element/Component	ACC	KPMAS	MPC	UMHP
Master File; National Plan and Provider Enumeration System; List of Excluded Individuals/Entities; Excluded Parties List Systems/SAM.				

P=Partially Met; U=Unmet

For more detailed findings regarding MCO opportunities for improvement, refer to Appendix A.

Follow-Up:

- ACC, KPMAS, MPC, and UMHP were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- UMHP is required to provide quarterly updates on the CAP in CY 2018 in adherence with MDH's Quality Monitoring Policy.
- The approved CAPs will be reviewed in CY 2019 SPR.

Corrective Action Plans

The CAP process requires that each MCO submit a CAP which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the SPR results. CAPs are reviewed by Qlarant and determined to be adequate only if they address the following required elements and components:

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

In the event that a CAP is deemed unacceptable, Qlarant provides technical assistance to the MCO until an acceptable CAP is submitted. Eight MCOs (ABH, ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) were required to submit CAPs for the CY 2018 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2019 will determine whether the CAPs from the CY 2018 review were implemented and effective. In order to make this determination, Qlarant will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH will be notified for further action.

MDH implemented its Performance Monitoring Policy whereby an MCO that had a CAP for two or more consecutive years in the same element/component would require quarterly monitoring by the EQRO. As a result, four MCOs (KPMAS, MSFC, PPMCO, and UHC) were required to submit quarterly updates of their CAPs to Qlarant in the following areas of review:

MCO	Element/Component
KPMAS	<u>Component 6.1 d</u> : The MCO has documented review of the Enrollee Services Call Center performance.
MSFC	<u>Component 3.3 c</u> : Review and approval of claims payment activities at least semi-annually, where applicable.
PPMCO	<u>Component 3.3 b</u> : Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. <u>Component 7.4 e</u> : Preauthorization and concurrent review decisions are made in a timely manner as specified by the State. <u>Component 7.4 f</u> : Appeal decisions are made in a timely manner as required by the exigencies of the situation.
UHC	<u>Component 7.4 e</u> : Preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

Progress was reported on each of the above CAPs quarterly to Qlarant and MDH. One MCO's (UHC) CAP was recommended to be closed early (in May of 2018). Following the CY 2018 SPR, it was found that all MCOs could close the quarterly CAPs. However, one MCO (UMHP) was required to begin submitting quarterly CAP updates on a different area of review which is outlined in the above results section of the Executive Summary.

Conclusion

MDH works collaboratively with MCOs to identify opportunities for improvement and to initiate quality improvement activities that will impact the quality of health care services for HealthChoice participants. Maryland has set high standards for MCO quality assurance systems. JMS continued to receive a perfect score in the CY 2018 SPR for the 9th year. For its first review since joining HealthChoice, ABH's results were high at 95%, well above the 80% benchmark for new MCOs. Composite score results demonstrate improvement for one MCO (UHC) and decreases for six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP), ranging from one to five percentage points.

According to MDH's Performance Monitoring Policy, whereby any MCO that has had a CAP for two or more consecutive years in the same element/component is required to provide quarterly updates to Qlarant, one MCO (UMHP) is required to submit quarterly updates of their CAP. As part of the triennial review process, the CY 2019 review will be conducted as an Interim Desktop Review focusing on standards that were not fully met in CY 2018, scored as baseline in previous reviews, or new.

Overall, MCOs have established quality assurance systems that promote high quality care with well-organized approaches to quality improvement. HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees.

Appendix A

Included in Appendix A are detailed findings for each MCO for each standard reviewed, as applicable.

Standard 3: Oversight of Delegated Entities

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

ABH Opportunities/CAPs. For Component 3.3a, ABH received a finding of partially met. In response to the Baseline Review findings, ABH was required to provide evidence in the CY 2018 SPR of oversight and ongoing monitoring of delegated entities' performance through meeting minutes from the designated committees and an annual compliance evaluation of each delegate as required by the Delegation Oversight Responsibilities Policy. As noted below, continued opportunities for improvement exist.

Monitoring and oversight of delegates occurs through multiple committees; however, review of performance and outstanding issues is often not timely. For example, a Delegate Oversight Committee (DOC) EviCore quarterly meeting was held on October 8, 2018, to review first quarter performance which is well over six months following the end of the first quarter. The minutes addressing the agenda item of performance review and monitoring documented metrics for several areas but did not always include the goal where appropriate so it was unclear if there was a performance issue. Additionally, the majority of the minutes documented presentation of various slides with no evidence of discussion.

Superior Vision Delegation Oversight Committee minutes from meetings on April 3, 2018, and July 20, 2018, documented the same concern with Superior Vision compliance with required reporting. In the October 19, 2018, meeting Superior Vision reported the need to draft a proposal to do an updated contract when questioned regarding the status of over and under utilization reporting.

Additionally, required Quality Management Oversight Committee (QMOC) quarterly review and approval of delegate reports was often inconsistent or missing as noted in components 3.3.c, d, and e. There also was no evidence of an annual compliance evaluation of each delegate.

In order to receive a finding of met in the CY 2019 SPR, ABH must submit evidence of oversight and ongoing monitoring of delegated entities' performance through meeting minutes from the designated committees and an annual compliance evaluation of each delegate as required by the Delegation Oversight Responsibilities Policy.

For Component 3.3c, ABH received a finding of partially met. In response to the Baseline Review findings, the MCO was required to provide evidence in the CY 2018 SPR of review and approval of delegate claims payment activity reports by the designated committee at least semi-annually or more frequently as defined in ABH policies. As noted below, continued opportunities for improvement exist, as ABH did not provide evidence that claims activities reports were consistently reviewed and approved on a quarterly basis by the designated committee.

QMOC minutes demonstrated review and approval of claims activities reports from Superior Vision as follows:

- February, March, April 2018 to August 9, 2018
- Second quarter 2018 to August 28, 2018

QMOC minutes demonstrated review and approval of claims activities reports from CVS/Caremark from first quarter 2018 to August 9, 2018.

In order to receive a finding of met in the CY 2019 SPR, ABH must provide evidence of review and approval of delegate claims payment activity reports by the designated committee (QMOC) at least semi-annually or more frequently as defined in the MCO's policies.

For Component 3.3d, ABH received a finding of unmet. In response to the Baseline Review findings, ABH was required to provide evidence in the CY 2018 SPR of review and approval of delegated entities' annual UMP and criteria by the designated committee. Continued opportunities for improvement exist, as ABH did not provide evidence that annual Utilization Management Plans and criteria from Superior Vision and EviCore were reviewed and approved by the designated committee (QMOC).

In order to receive a finding of met in the CY 2019 SPR, ABH must provide evidence of review and approval of delegated entities' annual UMP and criteria by the designated committee (QMOC).

For Component 3.3e, ABH received a finding of unmet. In response to the Baseline Review findings, the MCO was required to provide evidence in the CY 2018 SPR of review and approval of delegate over and under utilization reports by the designated committee at least semi-annually or more frequently as defined in the MCO's policies. Continued opportunities for improvement exist as ABH did not provide any evidence that over and under utilization reports were reviewed and approved by the designated committee (QMOC) at the required frequency.

In order to receive a finding of met in the CY 2019 SPR, ABH must provide evidence of review and approval of delegate over and under utilization reports by the designated committee at least semi-annually or more frequently as defined in the MCO's policies.

ACC Opportunities/CAPs. For Element 3.2, ACC received a finding of partially met. The MCO continues to have overall a comprehensive set of policies and procedures that outline the process for monitoring and evaluating delegated functions and for verifying the quality of care being provided. A description of some of these policies follows.

The Delegate/Vendor Oversight and Management Program Policy describes the oversight governance committee structure and responsibilities of each committee at the corporate level as well as oversight responsibilities at the health plan level. It identifies the responsibilities of the account manager for monitoring the timely and accurate reporting of all performance measures pertaining to the contracted functions as outlined in the delegate/vendor agreement. The policy further outlines requirements for an annual assessment of each delegate's performance, CAP follow-up, and an escalation process for any delegate that meets certain criteria.

The Delegate Management Responsibilities Policy outlines the responsibilities of the vendor managers for understanding the Delegation/Vendor Oversight Management Committee (DVOMC) approval process and adequately executing contracting and oversight requirements of delegated

entities. This position is also responsible for chairing quarterly Joint Operations Meetings (JOMs) for each delegate.

The Utilization Management – Medicaid Delegation and Oversight Policy identifies the expectations of utilization management (UM) delegates and the responsibility of ACC for routine monitoring of delegates. The DVOMC is responsible for delegation oversight activities, such as pre-delegation evaluations, annual and semi-annual audit analysis, and ongoing oversight to include analysis of quarterly reports through the JOM. JOMs are held on a quarterly basis to ensure that appropriate oversight and communication occurs between corporate health plans, and its delegates.

The Claims Delegated Vendor Monthly Reporting Review Policy identifies the series of claims activities reports to be submitted on a monthly basis by claims delegation vendors. All reports are reviewed by the Claims Vendor Audit Coordinator, Senior and submitted to DVOMC within five days prior to the next standing meeting.

None of the policies identified the committee at the local health plan level responsible for review and approval of quarterly delegate reports and the annual UMP. According to the Director of Medical Management (MM), responsible for delegate oversight at the local health plan, the Quality Management Committee (QMC) has responsibility for review and approval of delegate reports.

In order to receive a finding of met in the CY 2019 SPR, ACC must revise delegation policies, as appropriate, to specify the committee at the local health plan level that has responsibility for review and approval of delegate reports on a quarterly basis.

For Component 3.3d, ACC received a finding of unmet. There was no evidence of QMC review and approval of the OrthoNet UMP. According to ACC the contract with OrthoNet was terminated at the end of 2018 and the function returned to the MCO.

In order to receive a finding of met in the CY 2019 SPR, ACC must demonstrate that the QMC reviews and approves the UMP for any entity that is delegated UM. Since the MCO no longer delegates UM to OrthoNet or any other vendor, a CAP will not be required.

For Component 3.3e, ACC received a finding of unmet. There was no evidence of QMC review and approval of OrthoNet over and under utilization reports. According to ACC the contract with OrthoNet was terminated at the end of 2018 and the function returned to the MCO.

In order to receive a finding of met in the CY 2019 SPR, ACC must demonstrate that the QMC reviews and approves over and under utilization reports for any entity that is delegated UM. Since the MCO no longer delegates UM to OrthoNet or any other vendor a CAP will not be required.

KPMAS Opportunities/CAPs. For Component 3.3a, KPMAS received a finding of unmet. The MCO provided evidence of ongoing monitoring and oversight of MedImpact, but no evidence was provided of routine monitoring and oversight of EMI at the local level. Further detail is provided below.

The Pharmacy Benefit Management (PBM) Oversight Executive Summary is submitted to the PBM Oversight Committee for review and discussion of the previous quarter's PBM performance. Reported results from the second quarter noted that MedImpact's average point of service

adjudication system availability for the quarter fell slightly below the required performance level. Results from the quarterly audit of a sample of 3% of claims were reported at 100% for the quarter. The MedImpact National PBM Delegation Oversight Audit Results Coversheet noted that MAS as referenced in the audit document was Virginia Medicaid/FAMIS and/or MD HealthChoice.

There was no evidence submitted of routine monitoring and oversight of Employers Mutual, Inc. (EMI) at the local HealthChoice level or local participation in any oversight committee at the national level. Additionally, there was no evidence of review of reports submitted by EMI. It was reported that EMI submits detailed claims listing but staff was unsure if EMI reported claims performance relative to performance guarantees.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must provide evidence of routine monitoring and oversight of EMI at the local level. Additionally, all delegate related reports need to identify results specific to MD HealthChoice.

For Component 3.3c, KPMAS received a finding of partially met. Review of RQIC meeting minutes evidenced review and approval of EMI Ambulance claims activities reports on the following dates:

- January 17, 2018 – Fourth quarter 2017 report
- April 18, 2018 – First quarter 2018 report
- July 25, 2018 – Second quarter 2018 report
- October 18, 2018 – Third quarter 2018 report

Pharmacy Delegation Reports were routinely presented at the RQIC with minutes documenting approval of the MedImpact Performance Guarantee Summary (which included processing times for paper and online claims and adjudication accuracy) on the following dates:

- June 20, 2018 – First quarter 2018 report
- October 18, 2018 – Second quarter 2018 report
- December 19, 2018 – Third quarter 2018 report

Although the RQIC minutes from the March 21, 2018, meeting noted presentation of the Pharmacy RQIC Report there was no evidence of review of claims activities reports or the MedImpact Performance Guarantee Report.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must provide evidence that the RQIC reviews and approves all claims activities reports from its vendors consistent with its policies.

Standard 5: Enrollee Rights

Findings. Overall, MCOs have policies and procedures in place that demonstrate their commitment to treating members in a manner that acknowledges their rights and responsibilities. Evidence of enrollee information was reviewed and found to be easily understood and written in Spanish as required by the Department. Additionally, all MCOs provided evidence of their complaint, grievance, and appeals processes. However, opportunities for improvement did exist regarding policies and procedures, complaints/grievances, and satisfaction surveys.

ACC Opportunities/CAPs. For Component 5.1h, ACC received a finding of partially met. The Member Grievances Policy is silent on the process for notifying the member in writing of the grievance determination when notification was provided verbally.

ACC staff stated that it is the MCO's process to send out grievance determinations for all grievances regardless of whether the notification was provided verbally or not. Once the grievance is placed into the system, it automatically requires a grievance determination.

A sample of 10 grievance records were reviewed to assess compliance with this component. All records included a copy of the resolution letter sent to the member in response to a grievance. Letters included a description of the grievance and its resolution in plain language.

In order to receive a finding of met in the CY 2019 SPR, ACC must clearly document in the Member Grievance Policy the MCO's process for notifying members in writing of the grievance determination, even if the notification was previously provided verbally.

For Component 5.5c, ACC received a finding of unmet. The MCO discussed the CAHPS® survey results during a MAC member meeting which includes several providers, but did not publish the results to all providers in CY 2018.

In order to receive a finding of met in the CY 2019 SPR, ACC must ensure that the MCO informs all providers of the CAHPS® results annually.

For Component 5.6a, ACC received a finding of partially met. The Member ID Card Policy states that all new members will receive a new member packet. The print vendor is responsible for fulfilling and mailing the packets within five days. However, the policy is silent on the contents of the new enrollee packet, who is responsible for tracking, trending, and monitoring of the mailing of the packets, what committee this information is reported to, and what corrective action is taken if the MCO fails to mail the packets timely.

In order to receive a finding of met in the CY 2019 SPR, ACC must revise the Member ID Card Policy to include the contents of the new member packet, how the mailing of the packets are tracked and trended, who is responsible for tracking, trending, and monitoring the mailing of the packets, what committee this information is reported to, and how corrective action is identified and followed up on if packets are not mailed timely.

KPMAS Opportunities/CAPs. For Component 5.1c, KPMAS received a finding of unmet. The Maryland HealthChoice Grievance and Appeal System – Medicaid Procedure states that documentation that the member was notified of the grievance resolution and notified of the right to request a second level grievance as well as their right to file an appeal as applicable will be entered into the electronic contact record. Additionally, when appropriate, written notification will be sent to the member as a follow-up to the grievance when there is information that would be valuable to impart to the member. However, according to regulations, the MCO must provide a written grievance acknowledgement and resolution letter for each grievance.

The Maryland HealthChoice Grievance and Appeal System Policy states that grievances are documented and provided in writing to the member in all cases. As demonstrated by a records review, this was not evidenced in all cases.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must revise the Maryland HealthChoice Grievance and Appeal System – Medicaid Procedure to follow regulations requiring that all member grievances will be acknowledged in writing and receive written resolutions.

For Component 5.1d, KPMAS received a finding of unmet. The Maryland HealthChoice Grievance and Appeal System Policy includes a general statement regarding how grievance data is monitored and reported. However, the policy is silent on a CAP process when there are identified issues with accuracy or timeliness.

KPMAS provided meeting minutes and a Grievance and Appeal Report for August 2018. The policy states that grievances will be measured against the time frames noted in the policy. However, neither document submitted by the MCO reported on compliance with time frames for urgent, non-urgent, and administrative grievances. The RQIC meeting minutes only discussed trending of grievances; the volume of grievances compared to similar time frames; and the types of grievances. The Grievance and Appeal Report for August 2018 only reported on cases resolved within 30 days.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must revise the Maryland HealthChoice Grievance and Appeal System Policy to include a CAP process when performance issues are identified and ensure that the MCO is able to demonstrate how it is monitoring grievance time frames, and aggregating and analyzing the grievance data.

For Component 5.1f, KPMAS received a finding of partially met. An initial sample of 10 member grievance records was reviewed for compliance. All grievances were fully described in the case record. Documentation of an appropriate resolution was available in nine of the 10 records. An additional 20 records were reviewed with 17 demonstrating compliance. Overall compliance for this component is 87%.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must demonstrate that grievance records include the steps taken to ensure an appropriate resolution. An appropriate resolution needs to be documented in the member's grievance resolution letter as well.

For Component 5.1g, KPMAS received a finding of partially met. An initial sample of 10 member grievance records was reviewed to assess compliance with resolution time frames. Six of the 10 grievances were resolved within the required time frame. An additional sample of 20 records were reviewed with 17 demonstrating compliance. The overall compliance for timeliness of grievance resolution is 77%.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must demonstrate compliance with grievance resolution time frames.

For Component 5.1h, KPMAS received a finding of unmet. The Maryland HealthChoice Grievance and Appeal System - Medicaid Procedure states that when appropriate, written notification will follow an oral grievance notification when there is information that would be valuable. The Maryland HealthChoice Grievance and Appeal System Policy states that responses to QOC grievances, whether oral or in writing, are always sent to the member in writing. However, not all grievances are classified as QOC grievances and it is required that all grievances be followed up by a written determination.

An initial sample of 10 grievance records was reviewed for compliance. One of 10 records demonstrated compliance with sending the member a written notice of grievance resolution. An additional sample of 20 records was reviewed with five records demonstrating compliance. Overall compliance with sending members written notice of a grievance resolution is 20%. Additionally, there was no evidence that an acknowledgment letter was sent for any of the 30 grievances reviewed.

By way of explanation for the absence of resolution letters, KPMAS referred this reviewer to the Maryland HealthChoice Grievance and Appeal System - Medicaid Policy to explain the lack of resolution letters for many grievances. According to the Standard Grievance Process section KPMAS contacts the member with resolution to the grievance. When appropriate written notification will be sent to the member as a follow-up to the grievance when there is information that would be valuable to impart to the member. According to COMAR 10.09.71.02 there must be a documented procedure for written notification of the MCO's determination to the enrollee who files the grievance and to those individuals and entities required to be notified of the grievance pursuant to §C (9) of this regulation.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must demonstrate that it provides written notice of resolution for each member grievance. All policies must be revised to reflect this. Additionally, there must be evidence that an acknowledgment letter is sent in response to all member grievances within the regulatory time frame.

For Component 5.5a-d, KPMAS received a finding of unmet. Documentation provided for this area of review was from the 2018 CAHPS® survey and grievance and appeal data that was reviewed in December of 2018. Information to be reviewed for this element should be the 2017 CAHPS® survey data and 2017 grievance and appeal data with work plans used throughout 2018. Additionally, RQIC meeting minutes did not demonstrate that the committee was being updated quarterly on the progress of the interventions. It was noted that KPMAS' performance declined in three CAHPS® measures in 2017 from 2016:

- Adult Rating of Specialist from 83.9% to 78.8%
- Children with Chronic Conditions Access to Prescription Medication from 94.3% to 91%
- Children with Chronic Conditions Coordination of Care from 81.4% to 72.1%

In order to receive a finding of met in the CY 2019 SPR, KPMAS must ensure that the MCO:

- Identifies and investigates sources of dissatisfaction in response to the CAHPS® surveys conducted.
- Implements steps to resolve sources of member dissatisfaction identified from the CAHPS® surveys conducted.
- Informs providers of the CAHPS® results.
- Reevaluates the action steps implemented to resolve sources of member dissatisfaction at least quarterly. Evidence of this must be provided through action plans and quarterly quality committee meeting minutes.

For Component 5.8a, KPMAS received a finding of unmet. The MCO provided examples of letters to members that did not include the correct nondiscrimination notice and language notice as follows:

- The appeal acknowledgement letter provided for review included the following enclosures: 1) Appeal and Grievance Rights; 2) Non-Discrimination Statement; 3) Language Accessibility Statement. However, KPMAS included the language accessibility statement before the appeal rights. A long version of the non-discrimination statement was included and a short version of the language accessibility statement was included. All letters going directly to the member must include the long versions of both statements/notices.
- The denial notification letter provided for review did not include a copy of the language notice.
- The sample EOB provided for review did not include a nondiscrimination rights or language statement.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must ensure that materials distributed by the MCO to the enrollee include the correct nondiscrimination notice and language accessibility statement.

MPC Opportunities/CAPs. For Component 5.1f, MPC received a finding of unmet. There is complete documentation of the substance of the grievance and action taken, as evidenced by review of case notes in a sample of grievance records. Resolution letters, however, often did not identify or describe the grievance and in most cases, the resolution was not adequately documented in the resolution letter.

In order to receive a finding of met in the CY 2019 SPR, MPC must ensure that resolution letters describe the substance of the grievance and the resolution.

For Component 5.1g, MPC received a finding of partially met. Based upon a review of 30 grievance records, 97% of resolution letters were sent within the required time frame. While 21% of grievances were inappropriately categorized as administrative rather than non-emergent medically related, only one grievance did not meet the time frame based upon the appropriate classification.

In order to receive a finding of met in the CY 2019 SPR, MPC must resolve all grievances within the required time frame based upon the appropriate classification of the grievance.

For Component 5.1h, MPC received a finding of partially met. The Member Grievances Process Policy states that MPC provides a written response to member grievances in the form of a resolution letter. The MCO also provides a verbal response of the grievance determination to the member or person acting on behalf of member. A written request to contact MPC regarding a grievance determination will be sent when MPC is unable to reach the member/designee by phone. However, the policy is silent on notifying the member in writing of the grievance determination when notification was previously provided verbally.

A review of a sample of 10 member records affirmed a written resolution was sent in response to each grievance.

In order to receive a finding of met in the CY 2019 SPR, MPC must add to the grievance policy that the MCO will notify the member in writing of the grievance determination when notification was previously provided verbally.

For Element 5.4, MPC received a finding of partially met. The Consent for Treatment of Minors or Disabled Members Under Guardianship Policy makes certain that practitioners and providers understand their obligation to comply with all applicable federal, state, and local laws, governing provision of care to minors or disabled members under guardianship as stated in the provider's contract and the provider manual.

In order to receive a finding of met in the CY 2019 SPR, MPC must revise the Treatment of Minors Policy to state under which conditions a provider can treat a minor without the consent of their guardian.

MSFC Opportunities/CAPs. For Component 5.1h, MSFC received a finding of partially met. The Member Grievance, Complaints and Inquiries Policy states that the MCO notifies members in writing of the grievance determination, even if the notification was previously provided verbally.

A review of an initial sample of 10 member grievance records demonstrated 90% compliance with providing the member notice of resolution. An additional 20 records were reviewed to assess compliance. Ten records within this second sample demonstrated compliance. The overall compliance rate was 63% for providing member with written notice of grievance resolution. Seven of the non-compliant case records were grievances submitted through MDH and four were grievances submitted through the MCO's Member Services Department.

In order to receive a finding of met in the CY 2019 SPR, MSFC must demonstrate compliance with sending a resolution letter in response to each member grievance.

For Component 5.6a, MSFC received a finding of partially met. The Welcome Call – Automated/IHAA Compliance, New Member Mailing, Newborn Coordination, and Tracking New Member Packets policies were provided for review. They describe how a new enrollee is identified, appropriate enrollment material is distributed, and the enrollee is scheduled for an IHA.

The New Member Mailing Policy and the Tracking New Member Packets have the following discrepancies regarding welcome packets:

- The New Member Mailing Policy does not list current member materials included in the packet and needs updating.
- The New Member Mailing Policy identifies new members as those with gaps in coverage of more than 120 days whereas the Tracking New Member Packets identifies new member as those with gaps in coverage of more than 90 days.
- The New Member Mailing Policy states that new member packets will be mailed within two days (however it further states on day four and five the packets are mailed). However, the Tracking New Member Packets Policy states that the packets will be mailed within 10 days. Requirements state that new member packets need to be received by the enrollee within 10 days.

In order to receive a finding of met in the CY 2019 SPR, MSFC must resolve the discrepancies within the policies and procedure in place for the content of the new enrollee packets and the mailing of the packets.

PPMCO Opportunities/CAPs. For Component 5.1c, PPMCO received a finding of partially met. The Member Complaint/Grievance Policy describes the process for ensuring that the resolution of grievances is documented and notes the appropriate resolution time frames for each type of grievance. However, the policy is silent on the monitoring of complaints/grievances to ensure timely resolution.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must include a process for the monitoring of complaints/grievances to ensure accurate and timely resolution.

For Component 5.1g, PPMCO received a finding of partially met. An initial sample of 10 member grievance records was reviewed to assess compliance with resolution time frames. All grievances were appropriately categorized; however, compliance with resolution time frames was at 60%. An additional sample of 20 records was reviewed with 17 grievances demonstrating compliance. Overall compliance with grievance resolution time frames was 77%.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must demonstrate resolution of all member grievances within the required time frame.

For Component 5.1h, PPMCO received a finding of unmet. The Member Complaint/Grievance Policy is silent on a process for notifying the member in writing of the grievance determination when notification was previously provided verbally.

A sample of 10 member grievance records was reviewed to determine compliance with the requirement for providing the member with written notice of grievance resolution. All 10 records demonstrated compliance with this requirement. All resolution letters were in plain language. One letter did not identify the grievance.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must:

- Revise the Member Complaint/Grievance Policy to include a process for notifying the member in writing of the grievance determination when notification was previously provided verbally.
- Ensure that resolution letters identify the grievance.

For Component 5.5d, PPMCO received a finding of partially met. The Member Experience Policy states that it is the responsibility of the quality committees to review, quarterly, the action steps to be taken in response to the Member Satisfaction Evaluations.

Member Survey Initiative Project Team quarterly minutes were provided throughout 2018; however, there was no evidence of quarterly monitoring of improvement initiatives by the QI team.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must ensure that there is evidence of QI committee review, discussion, and approval of the annual results of the member experience survey and quarterly monitoring of the improvement initiatives.

For Component 5.6a, PPMCO received a finding of partially met. The New Member Packets and the New Enrollee Information policies outline the information that each new enrollee receives upon enrollment in the MCO and the time frame for sending the packets to the new enrollees. Records with lists of new enrollees are forwarded to PPMCO's contracted vendor three times weekly for mailing new member enrollment materials. The vendor retrieves the lists and assembles and mails packets to each member on the file within 48 to 72 hours of receiving the records.

The ID Cards Policy describes how new enrollee ID cards and enrollment materials are produced, verified, and distributed to new enrollees. The policy states that PPMCO's ID card vendor processes the file the morning after it is received and will print and mail ID cards within three business days. The ID card(s) should arrive at the member's mailing address within four to seven business days of the ID card vendor's mail date.

Neither policy noted above included a process for monitoring, tracking, and trending nor a CAP process in response to identified issues with timeliness. Additionally, PPMCO only provided evidence of tracking ID card issuance.

Subsequent to the review, a Welcome Call Script and tracking report was provided. However, these documents did not meet the standard. Technical assistance was provided to the MCO in regards to clarification of monitoring requirements and evidence of tracking new member welcome packets going forward.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must:

- Revise policies to include a process for monitoring, tracking, and trending both new enrollee packets and ID cards.
- Include the CAP process in the policies in response to identified opportunities for improvement related to timeliness or accuracy.
- Provided evidence of monitoring, tracking, trending, and CAP activities for both new enrollee packets and ID cards.

For Component 5.8c, PPMCO received a finding of unmet. The MCO provided sample member letters which included the abbreviated nondiscrimination notice and tagline; however, the full nondiscrimination and language accessibility notices are required and were included within the grievance resolution letters and pre-service authorization letters. Sample marketing materials appropriately included the required abbreviated notices and taglines.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must ensure that all communications to members include the full nondiscrimination notice and language statement.

UMHP Opportunities/CAPs. For Component 5.1a, UMHP received a finding of unmet. The Member Grievance Policy outlines the steps taken to receive, investigate, and resolve member grievances. The policy states on page 1 that Administrative Grievances are resolved within 90 days. However, the time frame for resolving administrative grievances is 30 days. Page 2 of the policy includes the correct regulatory time frame.

Additionally, the UMHP grievance policy states that “the A&G Department will accept any information or evidence concerning the grievance orally or in writing not later than 60 calendar days after the event.” It is not clear where this requirement comes from, but per 42 CFR 438.402(c)(2), an enrollee can bring a grievance at any time after an event.

In order to receive a finding of met in the CY 2019 review, UMHP must revise the Member Grievance Policy to consistently cite the correct time frames for resolving all types of grievances and delete the restrictions on time frames for accepting grievances orally or in writing.

For Component 5.3d, UMHP received a finding of partially met. The member handbook states, “Some requests made by a court may require us to notify you.” However, regulations state that all releases of information in response to a court order must be reported to the patient in a timely manner.

In order to receive a finding of met in the CY 2019 review, UMHP must revise the member handbook to state that the release of any information in response to a court order is reported to the patient in a timely manner.

For Component 5.5c, UMHP received a finding of unmet. Subsequent to the review, UMHP submitted a PDF of its website that showed the MCO posted the 2017 CAHPS scores (rates received in 2018) to inform providers of the assessment results. The CAHPS scores are linked from the “For Providers” section of the website. UMHP states that the MCO did not receive the 2017 CAHPS results from the vendor until the middle of November 2018 and was unable to post the updated rates to the website in CY 2018. The new rates were presented to the PAC at the December meeting.

In order to receive a finding of met in the CY 2019 review, UMHP must inform providers of the CAHPS® results annually.

For Component 5.7a, UMHP received a finding of partially met. A description of the CAB and the UMHP staff that sit on the CAB is included in the QIPD. The QIPD was silent on the requirement that CAB membership must be comprised of no less than one third of the MCO's SNPs, or their representatives.

The CAB Charter was presented for review, which further detailed the required membership, but was dated in 2013.

In order to receive a finding of met in the CY 2019 review, UMHP must revise the QIPD to specify the required CAB membership. Additionally, the CAB Charter should be reviewed and updated annually as with other organizational policies.

For Component 5.9c, UMHP received a finding of unmet. The Advanced Directives Policy does not address the requirement that the MCO amend advance directive information to reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

In order to receive a finding of met in the CY 2019 review, the Advance Directives Policy must include language that UMHP will amend advance directive information to reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

Standard 6: Availability and Accessibility

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

ACC Opportunities/CAPs. For Component 6.1c, ACC received a finding of partially met. The Telephonic Access and Services Policy outlines the MCO's process to monitor and evaluate telephone access standards. ACC has set the following standards for its member services line:

- Average speed to answer: <30 seconds
- Call abandonment rate: <5%
- Service level (% answered within seconds): >72% within 30 seconds (Live Agent)

The policy states that "the health plan separately tracks and reports on State-specific standards that exceed its internal benchmark." The policy was silent on the frequency of reporting, the department responsible for monitoring, the quality committee that performance is reported to, and what action the MCO would take in response to noncompliance.

Based on a review of the QMC meeting minutes it is evident ACC is reviewing the telephone access standards quarterly.

The standard set for service level (% answered within seconds) is considered low at >72% within 30 seconds (Live Agent). Industry standard is 85%. It is recommended that ACC work with the call center to bring the standard up to at a minimum 80% within the next year and then 85% within the next two years.

In order to receive a finding of met in the CY 2019 SPR, ACC must add to the Telephonic Access and Services Policy details reflecting the current practice for the frequency of reporting, the department responsible for monitoring, the quality committee that performance is reported to, and what action the MCO would take in response to noncompliance.

For Component 6.3c, ACC received a finding of unmet. The Health Services Needs Information Policy is in place for ensuring members receive an HRA upon enrollment. However, the policy is silent on the trending and analysis of data related to the processing of HSNI/IHA data. There was no evidence related to HSNI/HRA data being reviewed by ACC in any of the quality committee minutes provided to the reviewer.

In order to receive a finding of met in the CY 2019 SPR, ACC must revise the Health Services Needs Information Policy to include a process for trending and analysis of the HSNI/IHA data. The process must include the responsible parties for trending and analyzing the data, the committees responsible for review and monitoring of the data, and a corrective action process if the HSNI/IHAs are not completed timely.

KPMAS Opportunities/CAPs. For Component 6.1b, KPMAS received a finding of unmet. The External Provider Appointment Access and Availability - Maryland HealthChoice Policy describes a quarterly

telephonic survey process used by KPMAS to monitor participating provider appointment access compliance against standards established by MDH. Several 2017 and 2018 quarterly survey results were provided for review. It was found that the surveys were not conducted telephonically as stated in the policy. In fact, they were mailed with several followed up by telephone. Additionally, it does not appear that the number of quarterly surveys followed the methodology outlined in the policy.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must revise the External Provider Appointment Access and Availability - Maryland HealthChoice Policy to include all requirements set forth in the guidelines provided in the MD standards of 6.1. Additionally, the MCO must provide evidence of quarterly telephone surveys and CAPs as appropriate.

For Component 6.2d, KPMAS received a finding of partially met. The Network Adequacy Standards – Maryland HealthChoice states that annual ratio reports will be run to ensure that members have access to PCPs and specialists according to MD requirements. The policy was silent on a monitoring process by the committee responsible for the network and developing interventions to resolve any identified issues. However, quarterly monitoring reports were provided by KPMAS, but clear quarterly review of the network and any identified opportunities by the RQIC were not provided.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must ensure that the Network Adequacy Standards – Maryland HealthChoice Policy includes a process for quarterly monitoring of the provider network, assigning a quality committee responsible for review of the network, and developing interventions to resolve any identified issues. Additionally, the MCO must provide evidence of quarterly network monitoring, quality committee review, and CAPs as appropriate.

MPC Opportunities/CAPs. For Component 6.1b, MPC received a finding of unmet. The Provider Access and Appointment Availability Standards Policy states that the Provider Services Department will monitor provider compliance with appointment standards. The policy appears to be incomplete as described below.

Each Provider Services Representative (or designee) will monitor provider appointment availability on a regular basis. Methods may include, but are not limited to, appointment availability audits. However, the policy is silent on the frequency of the audits.

Each Provider Services Representative (or designee) will document the results of their monitoring activity. However, the policy is silent on how or where they will document the results.

The Provider Services Manager will evaluate the outcome of the monitoring activity with the provider's assigned Provider Services Representative to determine if the surveyed provider is in compliance with required appointment standards. However, the policy is silent on the frequency of the evaluations or monitoring.

Corrective action is taken when providers are noncompliant with the standards. However, the policy is silent on when a CAP will be required, the types of corrective action that could be taken, what entity will monitor the CAP, and under what conditions the CAP will be closed.

Additionally, the policy states that the Provider Services Manager will forward a summary of monitoring activity to the SIC on an annual basis for review and recommendation with a formal

analysis presented to the QMOC annually. Access and availability monitoring is required quarterly, therefore, this policy needs to be revised.

MPC demonstrated evidence of completion of quarterly surveys to providers to ensure appointment availability throughout 2018. Approximately 115 calls were made each quarter to providers with from 75 to 82 successful contacts each quarter. Providers failing the survey were included in the next quarter's survey.

In order to receive a finding of met in the CY 2019 SPR, MPC must revise the Provider Access and Appointment Availability Standards Policy as follows:

- Specify the frequency of how often the Provider Service Representative or designee will monitor provider appointment availability and how they will monitor it.
- Specify how and where the Provider Service Representative will document the results of the monitoring activity.
- Specify the frequency of the Provider Services Manager's evaluation of the outcome of monitoring activities.
- Detail the CAP process for noncompliant providers.
- Detail the appropriate quarterly monitoring reporting process through the quality committees.

For Component 6.2c, MPC received a finding of unmet. As part of its annual population assessment, MPC evaluates the growth of its membership, including enrollees with disabilities and special health care needs. The quarterly Network Adequacy Report analyzes by county the number of members compared with the number of PCPs and specialists. The report also notes changes in members, PCPs, and specialists for the past four quarters. If this report reveals any shortage of providers, network management staff work to ensure adequate provider availability.

The Network Adequacy Reports are reviewed by the SIC and the QMOC quarterly. The 2018 Population Assessment was provided for review.

In order to receive a finding of met in the CY 2019 SPR, MPC must ensure that a methodology is in place to assess and monitor the network needs of its population, including individuals with disabilities that includes:

- A process of monitoring that has the ability to identify problem areas that are reported through the MCOs established structure
- Follow-up activities and progress towards resolution that are evident
- Direct access to specialists

MSFC Opportunities/CAPs. For Component 6.3c, MSFC received a finding of unmet. The Welcome Call – Automated/IHAA Compliance Policy contains a description of the processes for trending and analyzing data regarding compliance with IHA appointments. MSFC uses the CCM system to compile reports that document compliance with IHA appointments.

The policy is silent on the referral process to the LHD after three unsuccessful outreach attempts to the member; monitoring and reporting to the QI/UMC on IHA compliance; and a CAP process for any identified issues surrounding IHA compliance.

After reviewing QI/UMC meeting minutes, it was not evident that compliance with IHA data was being reviewed by the MCO. Subsequent to the review, MSFC provided evidence for this component including the Televox Welcome Call Script, the Outreach Dashboard that is submitted to the QI/UMC, and an IHAA Analysis. However, it does not appear from the QI/UMC minutes that the QI/UMC reviews the IHAA Analysis provided. Additionally, the Outreach Dashboard does not include metrics on IHA compliance, only the number of successful Televox calls.

In order to receive a finding of met in the CY 2019 SPR, MSFC must revise the Welcome Call-Automated IHAA Compliance Policy to include processes for a referral to the LHD after three unsuccessful outreach attempts to the member; monitoring and reporting to the QI/UMC on IHA compliance; and a CAP process for any identified issues surrounding IHA compliance.

PPMCO Opportunities/CAPs. For Component 6.1c, PPMCO received a finding of partially met. The Access, Availability, and Performance Standards Policy outlines the standard operating procedures for the Customer Service representatives. Standards are set in the policy for a call abandonment rate of 5%, an average speed of answer of 30 seconds, and a service level of 90%. However, the process is silent on a process for monitoring against these standards at least quarterly, reporting on performance against the standards at least quarterly to QI committees, and a CAP process when opportunities are present.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must revise the Access, Availability and Performance Standards Policy to include a process for monitoring against the call center standards at least quarterly, reporting on performance against the standards at least quarterly to QI committees, and a CAP process when opportunities are present.

For Component 6.1d, PPMCO received a finding of partially met. The MCO provided quarterly monitoring reports on the customer call center standards for 2018. However, the service level standard noted on the monitoring reports was inconsistent with the standards noted in the policy. Although monthly staff meetings were provided that reviewed the number of calls received by the center each month along with the quality statistics of the representatives, performance against standards was not documented. Additionally, there were no quality committee minutes demonstrating a review of performance against standards at least quarterly.

PPMCO also maintains a Customer Service Quality Improvement Plan Policy for monitoring the quality of service provided by their customer service representatives. It is expected that representatives reach and maintain a quality score of 96% after the six-month introductory period.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must provide evidence of the MCO's documented review of call center performance against standards in quality committee meetings at least quarterly. The meeting minutes should accurately document each standard noted in the policy and the MCO's performance.

For Component 6.3c, PPMCO received a finding of partially met. The Outreach Health Services Needs Inventories (HSNI) and Initial Appointment Schedule policies are silent on trending and

analysis of data related to outreach activities. The policies do not include development of CAPs in response to issues identified as a result of monitoring activities.

PPMCO did provide evidence that the MCO tracks and trends data quarterly on provider networks, enrollee services, and outreach activities. It also demonstrated reporting on provider networks, grievances, and complaints to the quality committees. However, reports provided on outreach activities were not clear regarding the eligible population. For example, a report was provided of how many new members received an appointment with a PCP within required time frames, but it did not indicate how many eligible new members should have received an appointment within the required time frame or a compliance rate. Therefore, the report could not offer the benefits of monitoring compliance.

The 2018 QM Evaluation and Work Plan describe objectives established to improve QOC activities. Each activity is reported through the quality committees. CAP activity is actively monitored through the work groups and reported to the quality committees.

In order to receive a finding of met in the CY 2019 SPR, the Outreach Health Services Needs Inventories (HSNI) and Initial Appointment Schedule policies must be revised to include monitoring, tracking, trending, and CAP processes. Revision also should include the committee responsible for review of outreach data. Additionally, PPMCO must provide evidence of monitoring outreach data by the quality committee.

UMHP Opportunities/CAPs. For Component 6.1b, UMHP received a finding of partially met. The Access to Appointments Policy states that UMHP's PR Department will conduct appointment access surveys (secret shopper surveys) annually to a random sample of providers. Although the policy states annually, UMHP did complete quarterly access surveys. These quarterly surveys were provided for review to demonstrate compliance. Surveys were conducted of over 100 practitioners each quarter.

In order to receive a finding of met in the CY 2019 review, UMHP must revise the MCO's policy to reflect the process undertaken by the MCO for conducting quarterly access surveys. Detail should be added to the policy regarding which quality work group and committee reviews the surveys and corrective action taken if providers fail the survey according to noted MDH guidelines.

For Component 6.2b, UMHP received a finding of unmet. The New Member Notification/Welcome Packet Policy outlines the process for contacting enrollees and mailing their welcome letter, ID card, and member handbook within 10 days of enrollment as required in COMAR 10.09.66.

The policy further describes the process for confirming member addresses and mailing welcome packets, the contents of the welcome packet, and regulatory time frames. The policy is silent on tracking, trending, and monitoring against the regulatory time frames as well as implementing corrective action to address opportunities for improvement when the MCO is not meeting those time frames.

In order to receive a finding of met in the CY 2019 review, UMHP must revise the New Member Notification/Welcome Packet Policy to include tracking, trending, and monitoring against the regulatory time frames as well as a CAP process to address opportunities for improvement when the MCO is not meeting regulatory time frames.

For Component 6.2c, UMHP received a finding of partially met. The MCO reviews the HRA data to initiate CM, care coordination, disease management, and health education to address needs indicated by analysis of the data. However, it does not appear that the demographic data collected is compared to the current network or member grievances.

It was recommended in past SPRs that the UMHP formally develop a written methodology that addresses how it assesses and monitors the network needs of its population, including individuals with disabilities.

In order to receive a finding of met in the CY 2019 review, UMHP must provide a written methodology to assess and monitor the network needs of its population, including individuals with disabilities. Additionally, the MCO must provide evidence that this monitoring process is taking place.

For Component 6.2d, UMHP received a finding of partially met. The Network Adequacy Requirements Policy states that UMHP will monitor network capacity quarterly and conduct a geographic access report annually. Although the policy states that UMHP will ensure that all services are provided in a culturally competent manner and that translator and interpreter services are available, the policy does not include a process for the annual comparison of percentages of network providers who communicate in non-English languages most common among enrollees.

UMHP provided evidence of quarterly monitoring of performance against its network capacity and assessing compliance with geographic access requirements by conducting an annual analysis. The geo access report includes an annual comparison of percentages of network providers who communicate in non-English languages most common among enrollees.

In order to receive a finding of met in the CY 2019 review, UMHP must include in the Network Adequacy Policy the process for annual comparison of the percentages of network providers who communicate in non-English languages most common among enrollees.

For Component 6.3a, UMHP received a finding of unmet. The MCO has several policies and procedures in place to notify new enrollees of benefits and services and engage them in treatment and assist with setting appointments. Policies include:

- Welcome Calls
- Health Risk Assessment
- Special Needs Populations
- Children with Special Health Care Needs

The Welcome Call Policy states that the IHA is made within 10 days of receipt of the member's assignment to UMHP. The policy states that welcome calls are reported to the QIC on a quarterly basis; however, upon review of the QIC meeting minutes, this was not evident. The policy was silent on corrective actions taken by the MCO when untimeliness is identified.

In response to the exit letter, UMHP provided a member services presentation that included the status of welcome calls completed by quarter that contain the IHA. This presentation did not identify the timeliness of the calls. Additionally, the QIC minutes do not report in detail the

discussion of the quarterly review of the trending analysis against goals for the welcome call/IHA completion or identified opportunities for corrective action.

In order to receive a finding of met in the CY 2019 review, UMHP must add to the Welcome Call Policy the monitoring and corrective action process in response to untimely performance. Additionally, the MCO must provide evidence that the QIC is monitoring timeliness of IHAs.

For Component 6.3c, UMHP received a finding of unmet. The MCO's Quality Improvement Plan Evaluation does not include tracking, trending, or analysis related to welcome calls, mailing of welcome packets, issuance of ID cards, the completion of IHAs, or any data related to outreach of noncompliant members.

In order to receive a finding of met in the CY 2019 review, UMHP must ensure that the Quality Improvement Plan and Evaluation includes tracking, trending, and analysis related to welcome calls, mailing of welcome packets, issuance of ID cards, the completion of IHAs, and data related to outreach of noncompliant members.

Standard 7: Utilization Review

Findings. Overall, MCOs have strong Utilization Management Plans that describe procedures to evaluate medical necessity criteria used, information sources, procedures for training and evaluating staff, monitoring of the timeliness and content of adverse determination notifications, and the processes used to review and approve the provision of medical services. The MCOs provided evidence that qualified medical personnel supervise pre-authorization and concurrent review decisions. The MCOs have implemented mechanisms to detect over and underutilization of services. Overall, policies and procedures are in place for providers and participants to appeal decisions. However, continued opportunities were present in the areas of monitoring compliance of UR decision.

ACC Opportunities/CAPs. For Component 7.2d, ACC received a finding of unmet. The 2018 UM criteria and guidelines as incorporated in the 2018 UMP Description were shared with members of the MAC in the meeting of May 21, 2018. There was no documentation, however, of MAC approval of the criteria or guidelines as required by the UMP Description.

In order to receive a finding of met in the CY 2019 SPR, ACC must demonstrate that the MAC reviews and approves medical necessity criteria and guidelines on an annual basis consistent with its UMP and any related policies.

For Element 7.6, ACC received a finding of partially met. The Maryland Exceptions section under the Healthcare Management Services Denial – Core Process Policy states that the health plan shall send adverse determination notices related to actions in accordance with the timing and content requirements defined by MDH. It further states that for expedited authorization decisions, the health plan shall make a determination and provide notice no later than 72 hours after receipt of the request for service. However, COMAR additionally requires that notice of an adverse determination for expedited authorization decisions be provided within 24 hours of the determination. The policy and the Maryland Exceptions section also do not include the requirement for the MCO to notify the member 10 days prior to a reduction or termination of services.

The Pharmacy Prior Authorization Policy requires letters be mailed to members and providers within three business days of the determination which is inconsistent with the 72-hour requirement.

A review of the EQRO Quarterly TAT Summary Report demonstrated compliance exceeding the threshold of 95% for adverse determination notifications for each of the four quarters in 2018.

In order to receive a finding of met in the CY 2019 SPR, ACC must revise the Healthcare Management Services Denial - Core Process Policy and the Pharmacy Prior Authorization Policy to reflect adverse determination notification time frames consistent with COMAR.

For Component 7.11a, ACC received a finding of partially met. The MCO submitted two policies to support compliance with this component for a CMCP, one addressing the prescriber and the other the pharmacy provider.

The Pharmacy Corrective Managed Care Program - MD Policy includes use of MDH criteria for identifying members for enrollment in the CMCP. The CMC Committee reviews the member's available medical claims history, provider comments, member comments, and other relevant information to determine if the member should be enrolled in the CMCP. The policy requires a 20-day notice provision to allow participants time to provide additional information, select a pharmacy, or submit an appeal. The initial lock-in period is specified as 24 months with an extended 36-month enrollment for subsequent abuse. The policy allows for designating a new pharmacy provider if the member moves out of the service area of the current selected provider. Contents of the member notification of program enrollment include tolling of the effective date until all appeal hearings have been completed. The policy further allows pharmacies to dispense a 72-hour supply of medications in an urgent or emergent situation including prescriptions resulting from an emergency room visit or a hospital discharge. Monthly reporting to MDH on program enrollments and date spans is consistent with requirements. The policy is silent on the requirement for the medical review to be performed by a medical reviewer who is a licensed health care professional. The policy also does not address the additional exception for use of a designated pharmacy to obtain specialty drugs as defined in COMAR 10.09.67.04.

The Corrective Managed Care Prescriber Program - MD Policy is focused on limiting the providers authorized to write prescriptions for members enrolled in the CMCP. Contents generally mirror what is included in the Pharmacy Corrective Managed Care Program - MD Policy with the exception of the additional designation of a new primary or specialty care provider. It also is silent on the qualifications of the medical reviewer and the exception for use of a designated pharmacy for specialty drugs as defined in COMAR 10.09.67.04.

In order to receive a finding of met in the CY 2019 SPR, ACC must revise its Corrective Managed Care Policies to include the qualifications of the medical reviewer and the exception to use of a designated pharmacy for specialty drugs as defined in COMAR 10.09.67.04.

KPMAS Opportunities/CAPs. For Element 7.6, KPMAS received a finding of partially met. The Assessing Compliance MD HealthChoice Determination and Notifications Policy includes a table, which lists the member and practitioner/provider notification requirements. For written notification in response to an expedited PA request the table specifies notice is required no later than 72 hours after receipt of the request for service. There is an additional requirement that the written notification must be provided within 24 hours of the determination (within the 72-hour time frame)

which is not included. Written notification in response to a standard PA request is required within 72 hours from the date of the determination but not later than 14 calendar days from the date of the initial request. This is inconsistent with COMAR 10.09.71.04 which requires written notification for standard authorization decisions within 72 hours from the date of determination. The policy also requires the MCO to provide the member with written notice of action within at least 10 calendar days before the action for termination, suspension, or reduction of a previously authorized covered service.

The MD HealthChoice Timeliness Report PreService Adverse Determinations identified compliance by approvals and denials with a further breakdown by urgent and routine. It appears that this report only addressed compliance with determination time frames and did not include compliance with adverse determination notifications. It also is unclear if pharmacy PA requests were included.

A sample of 10 member records were reviewed and all demonstrated compliance with the adverse determination notification time frame requirements.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must ensure that all policies include adverse determination notification time frames consistent with regulatory requirements. Additionally, KPMAS must demonstrate reporting of compliance with adverse determination notification regulatory time frames throughout 2019 for both medical and pharmacy PA requests.

For Component 7.7e, KPMAS received a finding of partially met. The Maryland HealthChoice Grievance & Appeal Systems Policy states that if a request does not meet the criteria for an expedited appeal, the member is notified verbally within 24 hours of receipt of the request followed by a written notification of the decision not to expedite the appeal within two calendar days of the decision.

A sample of 10 member appeal records was reviewed for compliance. One denial of a request for an expedited resolution was found within this sample. Case notes documented verbal notification of the denial of an expedited request to the member with written notification provided within three calendar days of the denial of the request.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must demonstrate that is in compliance with the time frame for written notification to the member of denial of an expedited resolution.

For Component 7.9a, KPMAS received a finding of partially met. The Assessing Member and Practitioner Experience with Utilization Management Process Policy outlines the mechanisms for annually assessing, collecting, and evaluating member and practitioner experience with the UM process to identify opportunities for improvement and initiate action designed to improve the member and practitioner experience. A specific section on MD HealthChoice states that KPMAS conducts a very extensive formal survey with practitioners to measure satisfaction with UM, its departments, and processes. There is no mention of the MDH coordinated annual provider satisfaction survey. The section also notes that KPMAS participates in an annual enrollee satisfaction survey using the latest version of the CAHPS® survey tool but, once again, does not identify if this survey is conducted internally or is the one coordinated by MDH. The policy states that comprehensive annual reports are written outlining the results of both practitioner and member experience surveys. The RUMC reviews results of the surveys to:

- Identify and discuss areas of dissatisfaction
- Review and revisit target goals, compare results against target goals
- Develop actionable and measurable process improvement opportunities
- Identify successful practices for dissemination
- Enforce accountability and performance standards

According to the Senior Manager of Compliance, she was unaware that KPMAS receives results from the annual MDH coordinated CAHPS® and Provider Satisfaction surveys. For this reason, the policy only addresses KPMAS administered surveys. Based upon a Qlarant interview with KPMAS Market Research staff it was confirmed that KPMAS has been receiving results from the MDH coordinated surveys.

Additional discussion with the Senior Manager of Compliance clarified the responsibilities of the RUMC and UM not accurately reflected in the policy.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must include the MDH coordinated CAHPS® and Provider Satisfaction surveys in the Assessing Member and Practitioner Experience with Utilization Management Process Policy. Additionally, the responsibilities of UM and the RUMC need to be better clarified as well as the frequency of RUMC review of results and monitoring of action plans to address identified opportunities for improvement.

For Component 7.9b, KPMAS received a finding of unmet. As evidence of compliance with this component, KPMAS submitted the RUMC Quarterly Meeting Minutes from October 17, 2018, which reflected review of comprehensive reports addressing practitioner and member satisfaction results.

Discussion of the 2018 practitioner survey noted that the questionnaire has maintained a streamlined focus on discharge planning/transition management and referral management. According to the 2018 Practitioner Experience Activity Report presented at this meeting all LOBs were included (commercial, Medicare, and Medicaid). Upon review, it was apparent that results had not been segmented by state or LOB service area, such as MD where the majority of HealthChoice members receive their care from MAPMG and network providers.

The 2018 Summary Report of Member Experience with Utilization Management Services also addressed all LOBs within the region although results were reported separately. The report noted that the target goal for UM of 82% for MD Medicaid was met in 2018 showing an average score of 83% for Getting Needed Care. This was reported as a 1% improvement from 2017. The report also presented an analysis of denial reasons for MD HealthChoice noting that denials decreased by 10% when comparing second quarter 2017 with the same quarter in 2018. However, there was a 7% increase in denials due to a non-covered service, perhaps suggesting the need for more education regarding benefits.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must demonstrate review of UM satisfaction data from members and providers specific to the HealthChoice population and/or its primary service area. Incorporating results from the MDH coordinated CAHPS® and Provider Satisfaction surveys will facilitate improved compliance with this component.

For Component 7.9c, KPMAS received a finding of unmet. Both the 2018 Practitioner Experience Activity Report and the 2018 Summary Report of Member Experience with Utilization Management Services provided a barrier analysis, interventions, and sustainability and monitoring strategies in response to identified opportunities for improvement. Although these reports were extremely comprehensive none of the planned interventions specifically addressed HealthChoice members or providers within the HealthChoice service area.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must demonstrate that it acts upon identified issues as a result of review of UM satisfaction data specific to the HealthChoice population and the providers within the HealthChoice service area.

MPC Opportunities/CAPs. For Component 7.11a, MPC received a finding of unmet. As a result of the baseline review in the CY 2017 SPR, opportunities for improvement were noted for this component, which were not fully implemented. In order to receive a finding of met in the CY 2018 SPR, MPC was required to either revise the Pharmacy Lock-in Program Policy or create a new policy that specifically addresses the requirements of a pharmacy lock-in program for Maryland HealthChoice members. Two policies were submitted for review which taken together do not address all steps outlined in the regulation.

The Maryland Physicians Care Corrective Managed Care Program Pharmacy Lock In summarizes the MCO's strategies for operationalizing the CMC Program. This document includes the criteria for enrollment in the CMC Program as well as examples of information reviewed to determine eligibility. The document addresses the opportunity for the member to express a preference for a designated pharmacy and the contents of the member notification including the time frame for providing additional information for reconsideration and the right to appeal the enrollment decision. Enrollment in the program is required for 24 months and may be extended an additional 36 months for members who continue to engage in medication abuse. Required MDH reporting requirements also are specified. The document does not address the requirement for conducting a medical review which must be performed by a licensed health care professional. It also does not address the requirement for tolling the effective date of the enrollment provided in the notice pending the MCO's review of any additional information submitted. Furthermore, it does not identify exceptions to use of a designated pharmacy for prescriptions pursuant to an ED visit or hospital IP treatment or a specialty drug as defined in COMAR 10.09.67.04.

The Member Restriction Program Policy encompasses procedures for restricting members to use of a practitioner, provider, and/or pharmacy if specified criteria is met. Under the Clinical Review section of the policy it is stated that the program is managed by MPC's CM Department and a medical director. In an earlier section the policy requires all members proposed for program enrollment be approved by an MPC medical director. Information considered in the review process includes pharmacy and utilization data and medical records, as available. Content for the member notice of program enrollment includes the right to file an appeal but does not address the right to submit additional information for a reconsideration or the accompanying time frames. The policy also does not address the tolling of the effective date of the enrollment provided in the notice pending the MCO's review of the additional information. The policy does not appear to offer the member an opportunity to suggest a specific pharmacy as it states the MCO selection will be for the entire period of the restriction unless the member is approved for a change during re-evaluation. It does provide specific criteria for a member to request a change in the designated pharmacy for cause such as member leaving the service area. Initial program enrollment is identified as 24 months

which is reevaluated at the two-year anniversary and could result in continued restriction. It does not specifically address the requirement for continued enrollment for an additional 36 months if the member is subsequently found to have abused MCO pharmacy benefits. The policy also does not address the exceptions to use of a designated pharmacy for a prescription pursuant to an ED visit, IP hospital treatment, or a specialty drug as defined in COMAR 10.09.67.04. Furthermore, it is silent on MDH reporting requirements.

In order to receive a finding of met in the CY 2019 SPR, MPC must revise the Member Restriction Program Policy to specifically address all steps outlined in COMAR 10.09.75.02.

PPMCO Opportunities/CAPs. For Component 7.3b, PPMCO received a finding of partially met. According to the Over and Under Utilization Policy, the UM/CM Work Group is responsible for analyzing potential trends and selecting one project (at a minimum) to address over or under utilization and reviewing it on a quarterly basis. There was no evidence in the UM/CM Work Group meeting minutes reviewed that at least one project related to over and/or under utilization was approved and interventions reviewed on a quarterly basis.

The Executive Summary - Monthly Health Services Utilization/Operations Report Out Meeting from March 26, 2018, identified several potential opportunities for cost savings and plans for further drill down to inform interventions. The SBU PPMCO Performance Improvement Decks provided for the last three months of 2018 reported implementation of PA requirements for several areas, such as physical therapy, imaging studies, and site of service.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must demonstrate that the UM/CM Work Group is analyzing utilization trends and selecting at least one project to address over and/or under utilization and reviewing the effectiveness of interventions at least quarterly consistent with the requirements of its Over and Under Utilization Policy.

For Component 7.3c, PPMCO received a finding of unmet. There was no evidence in the UM/CM Work Group minutes reviewed that at least one project to address over and/or under utilization was reviewed on a quarterly basis consistent with the MCO's Over and Under Utilization Policy.

The SBU PPMCO Performance Improvement Decks provided for the last three months of 2018 reported cost savings related to implementation of PA requirements for several areas, such as physical therapy, imaging studies, and site of service.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must demonstrate that the UM/CM Work Group is monitoring interventions relating to at least one project addressing over and/or under utilization on a quarterly basis consistent with the requirements of its Over and Under Utilization Policy.

For Element 7.6, PPMCO received a finding of unmet. In response to the CY 2016 Interim Review findings, PPMCO was required to develop a CAP to demonstrate at least 95% compliance with COMAR time frame requirements for PA determinations and notifications of adverse determinations. This CAP continues to be monitored quarterly since non-compliance continued throughout CY 2018. As indicated below, the CAP was partially implemented and continued opportunities for improvement exist.

Appendix A of the UM Determination and Notification Timeframes Policy identifies notification time frames for standard and expedited PA requests that are consistent with regulatory requirements. The policy also requires the MCO to give a member a written notice of any action at least 10 days before the action for termination, suspension, or reduction of a previously authorized covered service.

As evidence of compliance, PPMCO submitted the UM Turnaround Time for pre-certification for Pharmacy and Utilization Management report, which provides compliance results by month for CY 2018. Some of the time frames identified for determining compliance are inconsistent with the MCO's policies and regulatory requirements. For example, the time frame for urgent medical is stated as 96 hours with a decision to be made within 72 hours from receipt of request and notification not to exceed 24 hours from the decision rather than 72 hours for both the decision and notification (notification within 24 hours is included within the 72-hour time frame). According to PPMCO expedited requests were processed according to a total time frame of 96 rather than 72 hours. Additionally, the total days for compliance for pharmacy routine pre-service requests is stated as five calendar days from the date of the original request with complete information which includes the determination and notification. This is inconsistent with the regulatory requirement of a decision (approve, deny, request additional clinical) within 24 hours from receipt of a request and written notification to the member and prescriber within 72 hours of the determination. Although the time frame identified for tracking compliance for outpatient pharmacy is stated incorrectly, PPMCO reported they have been measuring compliance against the current requirements.

Reported compliance results for member written notification of a determination are as follows:

- Total approved- Five out of 12 months in 2018 met or exceeded the 95% compliance threshold.
- Total denied- Ten out of 12 months in 2018 met or exceeded the 95% compliance threshold.

PPMCO's reported compliance with notification time frame requirements must be viewed with caution since the MCO reported it was not measuring compliance against the required time frame for notification of an adverse determination in response to an expedited request. The MCO tracked compliance against a 96-hour time frame (72 hours for the determination and 24 hours for the notification) rather than a total of 72 hours for the determination and notification with the notification required within 24 hours of the determination and within the 72-hour time frame.

A review of a sample of 10 member adverse determination records demonstrated 100% compliance with adverse determination notification time frames based upon regulatory requirements; however, no expedited requests were included in this sample.

In order to receive a finding of met in the CY 2019 SPR, PPMCO must demonstrate consistent compliance with member notification of an adverse determination at or above the 95% threshold.

UHC Opportunities/CAPs. For Component 7.2d, UHC received a finding of unmet. As noted in the UMP Addendum for Maryland the PAC is responsible for annual evaluation of medical necessity criteria. Final approval authority rests with the CMO, which occurs after committee review.

Review of minutes from the four PAC meetings held in 2018 (March, June, September, and December), found no evidence of PAC evaluation of MCG criteria or final approval of the criteria by

the CMO. According to the CMO the annual evaluation of criteria by the PAC is included within the review of the annual UMP evaluation.

In order to receive a finding of met in the CY 2019 SPR, UHC must demonstrate that criteria are reviewed and updated on an annual basis consistent with the MCO's policies.

UMHP Opportunities/CAPs. For Component 7.7e, UMHP received a finding of unmet. As a result of the CY 2017 baseline review, opportunities for improvement were noted for this component which were not fully implemented. In order to receive a finding of met in the CY 2018 SPR, UMHP was required to revise the Appeals and Grievance Policy to require reasonable efforts be made to give the member prompt verbal notice of the denial of expedited resolution and a written notice within two calendar days of the denial of the request.

The Member Appeals Policy reviewed requires the MCO to make a reasonable effort to give the member and treating provider prompt notice that the expedited appeal is denied within two calendar days. This does not meet the requirements of this component for reasonable efforts to give the member prompt verbal notice and a written notice within two calendar days if a request for expedited resolution is denied.

There were no denials of a request for an expedited appeal resolution within the sample of 10 member appeal records reviewed.

In order to receive a finding of met in the CY 2019 review, UMHP must revise the Member Appeals Policy to include specific requirements for making reasonable efforts to give the member prompt verbal notice and a written notice within two calendar days if a request for expedited resolution is denied.

For Component 7.11a, UMHP received a finding of partially met. As a result of the CY 2017 baseline review, opportunities for improvement were noted for this component which were not fully implemented as identified below. In order to receive a finding of met in the CY 2018 SPR, UMHP was required to demonstrate inclusion of all missing components in the Corrective Managed Care Policy.

The Corrective Managed Care Policy outlines procedures for evaluating UMHP members for participation in the CMC program based upon established criteria. The policy refers to Attachment A, MDH Criteria for Lock-in, however, the attachment was not submitted for review. A Special Needs Coordinator is responsible for presenting comprehensive case information to the CMC Committee to determine if the member meets program criteria. Information provided includes lab data, medical/pharmacy claims, medical/pharmacy authorizations, and referrals from health plans or network providers. The membership of the committee is not identified in the policy, however, a sample of minutes from a committee meeting identified an RN as a committee member. The policy further describes the procedures for notifying the member of program enrollment, designating a single pharmacy provider, allowing a member to recommend a designated pharmacy subject to MCO approval, and the right of the member to provide additional information for reconsideration or file an appeal of the determination and associated time frames. Initial program enrollment is stated as 24 months which can be extended by an additional 36 months if there is evidence that the member continues to abuse pharmacy benefits. The content of the member enrollment letter is not specified within the policy; however, letter templates were provided reflecting required content. The policy outlines procedures if the member requests a change to their pharmacy including

required documentation to support the change, such as confirmation of an address change. The policy does not address exceptions to the use of a designated pharmacy if the prescription is pursuant to an ED visit, hospital IP treatment, or a specialty drug as defined in COMAR 10.09.67.04. The policy identifies the content of monthly MDH reporting consistent with regulatory requirements.

In order to receive a finding of met in the CY 2019 review, UMHP must revise the Corrective Managed Care Policy to include the following:

- A medical review must be performed by a medical reviewer who is a licensed health care professional
- Specific content to be included in the member notice of enrollment in the corrective managed care program
- Exceptions to the use of a designated pharmacy if the prescription is pursuant to an ED visit, hospital IP treatment, or a specialty drug as defined in COMAR 10.09.6

Standard 11: Fraud, Waste, and Abuse

Findings. Overall, MCOs were found to have comprehensive compliance programs designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. Fraud and abuse plans articulated the organization's commitment to comply with all applicable Federal and State laws, regulations, and standards. The MCO also demonstrated procedures for timely investigation, and tracking of reported suspected incidence of fraud and abuse. There were designated Compliance Officers and active Compliance Committees. All staff, subcontractors, and participants were clearly communicated to regarding disciplinary guidelines and sanctioning of fraud and abuse. Additionally, the MCOs demonstrated it has a process which allows employees, subcontractors, and participants to report fraud and abuse without the fear of reprisal.

ACC Opportunities/CAPs. For Component 11.4a, ACC received a finding of partially met. The SIU provides quarterly FWA reports to the Compliance Officer, which is reviewed and documented in each committee. Committee meeting minutes demonstrate that reporting occurred in 2018, however, at least in one meeting, the SIU reporting was put off and there were only three Compliance Committee meetings in CY 2018.

Per the Compliance Committee Charter, the committee is required to meet no less than four times each year.

In order to receive a finding of met in the CY 2019 SPR, ACC must ensure that there is evidence of review of routine and random reports by the Compliance Officer and Compliance Committee at each meeting.

For Component 11.4c, ACC received a finding of unmet. Evidence was not provided of review and approval by the Compliance Committee of the Antifraud Addendum for MD. Additionally, evidence was not provided of review and approval of delegate compliance plans, nor was it clear which committee was responsible for the annual review and approval of those plans.

Subsequent to the review, ACC provided March Compliance Committee minutes demonstrating a review of the Medicaid Compliance Strategic Work Plan and Compliance Committee Charter. However, there was not demonstrated review and approval by the committee in the minutes. Reviewing and approving the March meeting minutes in the July meeting minutes in no way signifies review and approval of all documents reviewed in the March meeting. Each document requiring review and approval must be signed off as reviewed and approved in the right hand column which is normally entitled the "action" column of the minutes.

Additionally, the requirement is for the committee to review and approve the administrative procedures inclusive of the mandatory plan to prevent fraud and abuse. If ACC considers this to be the work plan, then it should specifically state this in the committee charter and designate the Compliance Committee as responsible for its annual review and approval.

Furthermore, ACC provided delegate compliance plans, however, there was no evidence of review and approval of these plans in the Compliance Committee minutes for 2018.

In order to receive a finding of met in the CY 2019 SPR, ACC must define which committee is responsible for annual review and approval of both the MCO and delegate's compliance plans. Additionally, evidence must be provided of review and approval of both the MCO and delegates' compliance plans within the designated committee minutes.

For Component 11.4d, ACC received a finding of unmet. It was unclear after a discussion with MCO staff which committee is responsible for ensuring that delegates are reporting fraud and abuse activities at least quarterly. Evidence of ongoing quarterly review and approval of delegate's monitoring of fraud and abuse activities was not provided to the reviewer.

In response to the exit letter, ACC provided delegate's FWA policies, sample indicator reports, and sample overpayment reports. However, there was no evidence of these reports being reviewed by the Compliance Committee.

Additionally, the Compliance Committee must meet at least four times per year to review and approve ongoing delegate FWA reports effectively.

In order to receive a finding of met in the CY 2019 SPR, ACC must ensure that there is evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities.

KPMAS Opportunities/CAPs. For Component 11.2e, KPMAS received a finding of unmet. The MCO informs enrollees of the reporting process for fraud and abuse through the member handbook. However, the section on Fraud and Abuse is silent on sanctioning incidents of fraud and abuse.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must ensure that members are informed of how incidences of FWA are sanctioned.

For Components 11.4a-d, KPMAS received a finding of unmet. The MCO provided dashboards of MD Medicaid Compliance Standards and a Q1 Steering Committee Slide Deck with no meeting minutes. No evidence of discussions was provided of either the dashboards or the slide deck and it was unclear how any of the data related to FWA.

Evidence was not provided by KPMAS of the Compliance Officer and the compliance committee, currently designated by the 2018 Ethics and Compliance Program Description, meeting regularly (quarterly) to review routine and random reports for detecting FWA.

In order to receive a finding of met in the CY 2019 SPR, KPMAS must:

- Ensure that the designated compliance officer and committee meets quarterly to review FWA activities, including routine and random reports.
- Provide evidence of CAPs being reviewed and approved by the Compliance Committee, including committee receipt of information regarding the implementation of the approved CAP.
- Provide evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent FWA for the MCO and its delegates.
- Provide evidence of the Compliance Committee's review and approval of continuous and ongoing delegate reports regarding the monitoring of FWA.

MPC Opportunities/CAPs. For Component 11.1f, MPC received a finding of unmet. The Member Verification of Services Policy outlines MPC's process for verifying that services billed by providers were actually received by members. MPC sends explanation of benefit verifications and monitors concerns from members reported through the compliance hotline. The Fraud, Waste, and Abuse Work Group investigates all reported member compliance concerns. The policy was silent on where investigations are referred if adverse actions and/or patterns are identified, what occurs if further investigation is warranted, and if a report is completed to the State.

Response rates on member verification letters/explanation of benefit letters are typically very low and most times do not solicit responses from members at all. Using this process is not considered a best practice to ensure that services billed were actually received by the member. MDH recommends that MCOs attempt to contact members personally and target the scope of the review, such as sampling data/claims services for DME, SA, Radiology, or Pain Management. Member verification of services should be completed no less frequently than quarterly.

In order to receive a met in the CY 2018 SPR, MPC must have a documented process to ensure that services billed to the MCO were actually received by the enrollee including evidence that this is occurring.

UMHP Opportunities/CAPs. For Component 11.1f, UMHP received a finding of unmet. In response to a 2017 CAP, the MCO is in the process of implementing the Optum claims editing system where the MCO reviews claims according to the national coding guidelines for fraud and denied claims. This assists in correcting provider billing issues and ensures that there are no duplicate billings. While this is occurring, UMHP is configuring systems to pull claims data related to identified focused areas and integrate with a letter template to send to members to confirm that services were actually received. During the onsite, Qlarant discussed with staff that this could be completed as a phone survey with members quarterly.

In order to receive a finding of met in the CY 2019 review, UMHP must document a process to ensure that services billed to the MCO were actually received by the enrollee and provide evidence that this process is occurring.

For Component 11.4a, UMHP received a finding of partially met. Evidence of the compliance committee meeting on a regular basis was not provided by UMHP. Committee meeting minutes were provided for January, July, and November 2018. However, routine and random reports were submitted to the committee for review and approval.

In order to receive a finding of met in the CY 2019 review, UMHP must demonstrate that the compliance committee meets at least quarterly and documents review and approval of routine and random reports.

For Component 11.4b, UMHP received a finding of partially met. Compliance Committee minutes were provided for January, July, and November of 2018. Review and approval of CAPs were demonstrated by the committee in the minutes reviewed.

In order to receive a finding of met in the CY 2019 review, UMHP must provide evidence that CAPs are reviewed, approved, and monitored on a quarterly basis by the Compliance Committee.

For Component 11.4c, UMHP received a finding of partially met. The Compliance Committee minutes from January 31, 2018, demonstrated review and approval of the Code of Ethical Business Conduct and Compliance Program as well as the Fraud, Waste, and Abuse Program Description. However, there was no review and approval of the delegates compliance plans in either the Compliance Committee nor the DOC.

In order to receive a finding of met in the CY 2019 review, UMHP must provide evidence of review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse, from each delegated entity.

For Component 11.5d, UMHP received a finding of partially met. As evidence of compliance with this component, UMHP submitted numerous records showing monthly checks of the OIG List of Excluded Individuals/Entities database for CY 2018 to ensure that their employees and contractors are not debarred from federal agencies as defined in the Federal Acquisition Regulation.

According to CFR 455.436, MCOs are required to check the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System upon credentialing and recredentialing. The List of Excluded Individuals/Entities and the Excluded Parties List Systems /System for Award Management must be checked no less frequently than monthly.

Evidence was provided to support queries of the Excluded Parties List Systems /System for Award Management on a monthly basis. Examples of National Plan and Provider Enumeration System support compliance of required checks at the time of initial credentialing.

The Social Security Death Master File queries began in the beginning of 2019 and are being documented in the credentialing software. Qlarant will look for examples of queries to this database at the time of the 2019 review.

In order to receive a finding of met in the 2019 review, UMHP must demonstrate that it is querying the Social Security Death Master File at the time of initial credentialing and recredentialing. This process must be clearly documented in policy and implemented accordingly.