Qlarant

Maryland HealthChoice Program

Comprehensive Systems Performance Review

Statewide Executive Summary Report

Measurement Year 2024

Revised October 2025

Maryland
DEPARTMENT OF HEALTH

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Acronym List

Abbreviation	Definition	Specific to MCO?
ABH	Aetna Better Health of Maryland	MCO name
ACCU	Administrative care coordination unit	No
ADA	Americans with Disabilities Act	No
B	Baseline	No
BHO	Behavioral health organization	No
BNDD	Bureau of Narcotics and Dangerous Drugs	No
BOD	Board of Directors	No
CAB	Consumer Advisory Board	No
CAHPS	Consumer Assessment of Healthcare Providers and Systems®	No
CAP	Corrective action plan	No
CBO	Community-based organization	No
CDS	Controlled dangerous substances	No
CFCHP	CareFirst Community Health Plan	MCO name
CFR	Code of Federal Regulations	No
CM	Care or Case Management	No
CMS	Centers for Medicare & Medicaid Services	No
COMAR	Code of Maryland Regulations	No
CVS	Consumer Value Store became CVS in 1964/ CVS Health	CFCHP and PPMCO
D	Deemed	No
DC	District of Columbia	KPMAS, MSFC, and UHC*
DEA	Drug Enforcement Administration	No
EPIC	EPIC from Epic Systems Corporation	No
EQR	External quality review	No
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment	No
ER	Emergency room	No
FWA	Fraud, waste, and abuse	No
HbA1c or A1c	Hemoglobin A1c Control	No
HealthChoice	Maryland's Medicaid Managed Care Program	No
HEDIS	Healthcare Effectiveness Data and Information Set®	No
HEP	Health education plan	No

Abbreviation	Definition	Specific to MCO?
HIPAA	Health Insurance Portability and Accountability Act	No
HSNI	Health Services Needs Information	No
IA	Iowa	WPM*
ICM	Integrated Care Management	KPMAS
IN	Indiana	WPM*
IRO	Independent review organization	No
JMS	Jai Medical Systems, Inc.	MCO name
KFHP-MAS	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	KPMAS
KPMAS	Kaiser Permanente of the Mid-Atlantic States, Inc.	MCO name
LHD	Local health department	No
M	Met	No
MBP	Maryland Board of Physicians	No
MCHAC	Member and Consumer Health Advisory Committee	WPM
MCO	Managed care organization	No
MD or Md.	Maryland	No
MDH	Maryland Department of Health	No
MFC	MedStar Family Choice	MSFC
MIA	Maryland Insurance Administration	No
MPC	Maryland Physicians Care	MCO name
MSFC	MedStar Family Choice, Inc.	MCO name
MwO	Met with Opportunity	No
MY	Measurement year	No
NA	Not applicable	No
NCQA	National Committee for Quality Assurance	No
NPDB	National Practitioner Data Bank	No
PA	Preauthorization or Prior authorization	ABH
PCP	Primary care provider	No
PHI	Protected health information	No
PM	Partially met	No
PPMCO	Priority Partners	MCO name
Q	Quarter	No
QA	Quality assurance	No

Abbreviation	Definition	Specific to MCO?
QAP	Quality assessment program, Quality assurance program, or Quality assessment and performance improvement plan	No
QI	Quality improvement	No
QIC	Quality Improvement Council or Committee	MSFC
QIP	Quality improvement plan	MSFC
QI/UMC	Quality Improvement Utilization Management Committee	MSFC
QMC	Quality Management Committee	UHC and WPM
QMOC	Quality Oversight Management Committee or Quality Management Oversight Committee	ABH and MPC
QOC	Quality of care	No
SAM	System for Award Management	No
SPR	Systems performance review	No
TAT	Turnaround time	No
TCC	The Coordinating Center	WPM
TX	Texas	WPM*
UHC	UnitedHealthcare Community Plan	MCO name
UM	Unmet or Utilization management	No
UR	Utilization review	No
WPM	Wellpoint Maryland	MCO name

* For those acronyms with an asterisk, the word itself is not specific to MCOs, but the context is specific to identified MCOs.

Maryland HealthChoice Program

Comprehensive Systems Performance Review

Executive Summary

Introduction

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

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

The Maryland Department of Health (MDH) is responsible for evaluating the quality of care provided to eligible HealthChoice enrollees by contracted managed care organizations (MCOs). MDH contracts with Qlarant to conduct external quality reviews (EQRs) and to annually evaluate the quality assurance program and activities of each MCO. Qlarant's annual independent reviews assess compliance with standards governing the HealthChoice program in the Code of Maryland Regulations (COMAR) 10.67.04 and the Code of Federal Regulations (CFR) Title 42, §438.204 through the Centers for Medicare & Medicaid Services (CMS) protocols.

This executive summary report describes findings from the measurement year (MY) 2024's systems performance review (SPR). No MCOs were exempt from the SPR for MY 2024. The nine MCOs evaluated for MY 2024 were:

- Aetna Better Health of Maryland (ABH)
- CareFirst Community Health Plan (CFCHP)
- Jai Medical Systems, Inc. (JMS)
- Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)
- Maryland Physicians Care (MPC)

- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- UnitedHealthcare Community Plan (UHC)
- Wellpoint Maryland (WPM)

Purpose and Process

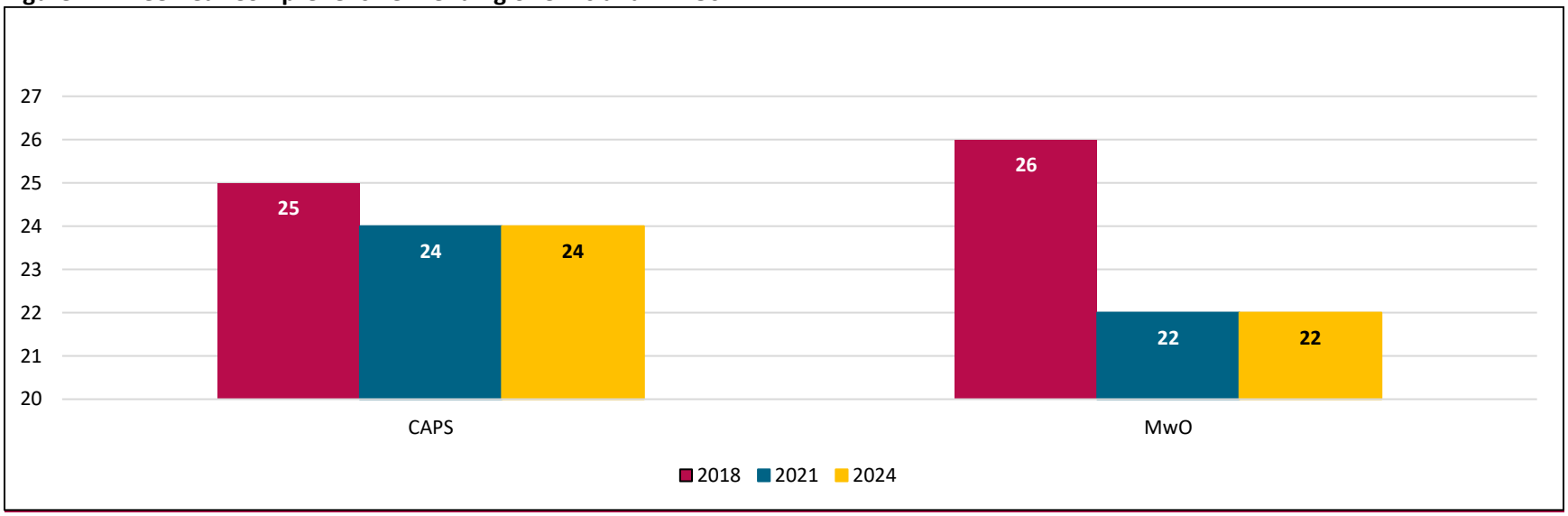
Conducting the SPR provides an annual assessment of the structures, processes, and outcomes of each MCO's internal quality assurance program. Qlarant's review team identifies, validates, quantifies, and monitors problem areas; and distinguishes and promotes best practices through compliance, or systems, review. Healthcare professionals with experience in managed care and quality improvement systems performed the annual SPR. Team members utilized a combined experience of more than 50 years in managed care and quality improvement systems, 40 years of which are specific to HealthChoice.

COMAR 10.67.04 requires all HealthChoice MCOs to comply with SPR standards and all applicable federal and state laws and regulations. MY 2024's SPR applied the system performance standards defined for MY 2024, and reviewed a sample of appeal, grievance, adverse determination, and credentialing records to assess compliance with applicable standards. Performance standards used to assess the MCOs' operational systems were developed through a review of COMAR 10.67.04.03B(1), federal regulations, and guidelines from other quality assurance accrediting bodies, such as the National Committee for Quality Assurance (NCQA).

Key Findings

Trended results for the last three comprehensive reviews (MY 2018, MY 2021, and MY 2024) illustrate that the number of corrective action plans (CAPs), decreased from 25 to 24 CAPs across the MCOs. It should be noted that while the number of CAPs decreased, the amount of *Met with Opportunity (MwO)* findings remained consistent across the MCOs (22), when MY 2024 is compared to MY 2021; and decreased by four when compared to MY 2018.

Figure 1. Three-Year Comprehensive Trending of CAPs and MwOs



Quality Strategy Highlights

Per the *HealthChoice Quality Strategy 2022-2024*[1], MDH set a goal to *ensure HealthChoice MCOs are complying with all state and federal requirements by meeting or exceeding the minimum compliance scores for all administrative quality assurance activities* and an objective to *increase the HealthChoice aggregate scores to 100% for all Systems Performance Review standards by MY 2024.* Results of MY 2024 demonstrate that the HealthChoice aggregate met MDH's goal/objective in six of the eleven standards. The remaining five standards scored just below the compliance threshold, between 95% to 98%.

Strengths. All MCOs demonstrated the ability to design and implement effective quality assurance systems. JMS was the only MCO to receive a finding of *Met* or *Met with Opportunity* for all standards reviewed during MY 2024.

Improvements. All MCOs continue to make improvements in quality assurance monitoring policies, procedures, and processes while working to provide appropriate levels and types of healthcare services to managed care enrollees.

Recommendations. All MCOs requiring a CAP received recommendations that, if implemented, should improve performance for future reviews.

[1] HealthChoice Quality Strategy 2022-2024

Statewide Executive Summary Report

Measurement Year 2024

Methodology

MCOs received the MY 2024 SPR orientation manual, "Medicaid Managed Care Organization Systems Performance Review Orientation Manual," prior to the comprehensive review. Contents included:

- Overview of HealthChoice program and SPR
- MY 2024 Review Timeline
- External Quality Review Contacts
- Pre-audit Visit Overview and Survey
- Pre-audit SPR Document List
- SPR Standards and Guidelines, including MY 2024 revisions
- Maryland Standards Eligible for Deeming (NCQA Crosswalk)

Review Activities

MY 2024's comprehensive review activities included a pre-audit overview and survey, a comprehensive review, exit letters, reporting, and CAPs.

Pre-audit Overview and Survey. Each MCO received a draft of the standards in advance for the opportunity to review and comment. Qlarant finalized the SPR standards for the orientation manual after considering all MCO comments and MDH's review and approval. MCOs were required to submit a completed pre-audit survey form and provide documentation, written plans, and policies and procedures for various processes, such as quality assurance and governance, delegation of activities, credentialing and recredentialing, enrollee rights, availability and accessibility, utilization review, continuity of care, health education, outreach, and fraud and abuse. MCOs demonstrated efficiency of their healthcare systems by providing written documentation, committee minutes, work plans, reports, and other procedures identifying continuous quality improvement efforts undertaken by each MCO for these processes. Qlarant's SPR team reviewed documents provided prior to the comprehensive site review.

Comprehensive Reviews. Comprehensive reviews are conducted as site reviews. Virtual reviews were an optional choice to in-person visits to each MCO's office of choice. Structured interviews with key MCO staff and review of all relevant documentation needed to assess the standards occurred during the site visit. An exit conference with the MCO concluded the site visit to provide preliminary findings based on interviews and all

documentation reviewed. Qlarant notified each MCO that an exit letter was forthcoming for all elements and components not meeting minimum compliance. Exit letters identified potential issues that could be addressed by supplemental documents, if available.

Exit Letters. Each MCO received finalized exit letters sharing areas of noncompliance based on initial conclusions of Qlarant's SPR review team, and indicates, as necessary, a request for additional information not provided during the comprehensive review. After receiving the exit letter, the MCOs had the opportunity to submit any additional documentation to Qlarant.

Reports. Additional documents received from the MCO in response to the exit letter were reviewed against the standard(s) to which they related. Qlarant made appropriate revisions to each MCO's draft report, documented findings and levels of compliance for each standard by element and component, and submitted draft results of the SPR to MDH for review. Upon MDH's approval, the MCOs received a final report containing individual review findings and any required CAPs. Feedback provided to MDH and the MCOs sought to improve the care provided to HealthChoice enrollees.

CAPs. After receiving the final report, each MCO responded to Qlarant with the required CAP(s). Each MCO had the opportunity to respond to any other issues contained in the report, request a consultation to clarify issues, or ask for technical assistance in preparing a CAP. Qlarant evaluates the content of all CAPs and determines a CAP adequate only if it addressed all required elements and components (such as timelines, action steps, or documented evidence).

Data Collection and Review

Documentation provided by the MCOs included policies and procedures; meeting minutes; program descriptions; annual evaluations; work plans; tracking and monitoring reports; focused studies; delegate reports; population assessments; Healthcare Effectiveness Data and Information Set (HEDIS)® and Consumer Assessment of Healthcare Providers and Systems (CAHPS)® results; operational performance reports; enrollee handbooks and materials; provider manuals, directories, and newsletters; and grievance, appeal, and adverse determination records.

Each element and component received a review determination for meeting compliance with performance standards (*Met* or *Met with Opportunity*) or for required CAPs because of not meeting compliance with performance standards (*Partially Met* or *Unmet*). Each element or component was provided equal weight. MCOs were held accountable for standards in their policies and procedures that were more restrictive than what was required by MDH. MDH had the discretion to change a finding to *Unmet* if the element or component received a *Partially Met* finding for more than one consecutive year.

Elements or components receiving a review determination of *Met with Opportunities* should be remedied by the MCO and will be reviewed during the next SPR. MCOs identified as requiring corrective action submitted a CAP with proposed detailed actions to correct any identified deficiencies from the review process. Specific details include:

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

Non-duplication Deeming

CMS permits states the opportunity to use information from a private accreditation review, such as an NCQA audit, to meet comparable federal regulations. Using results from a comparable audit allows an opportunity for non-duplication deeming.

Non-duplication, as described in EQR protocols and 42 CFR §438.360, is intended to reduce the administrative burden on the MCOs. This process eliminates the need to review the regulation as part of the SPR, thus reducing the administrative burden on the MCO.

To qualify for deeming, MDH established the following criteria:

- The MCO must be NCQA accredited with Health Plan Accreditation.
- The NCQA accreditation review standards were comparable to applicable standards established through EQR protocols.
- The MCO must provide evidence of the most recent NCQA audit, which includes a 100% assessment in the applicable standards.

To determine qualifications for deeming, Qlarant used the following resource:

- NCQA *Medicaid Managed Care Toolkit: Standards Crosswalk, 2023 Health Plan Standards*[2] (Effective July 1, 2023 – June 30, 2024),

Standards in which MDH permitted deeming are identified below.

[2] National Committee for Quality Assurance. (2023). *Medicaid Managed Care Toolkit: Standards Crosswalk, 2023 Health Plan Standards.* Retrieved from https://store.ncqa.org/index.php/catalog/product/view/id/5224

Table 1. Non-Duplication Deeming Standards Crosswalk

Systems Performance Review Standards	Elements and Components Eligible for Deeming
Standard 1: Systematic Process of Quality Assessment and Improvement	1.3b, 1.3c, 1.3d, 1.3e, 1.3g, 1.3h, 1.8
Standard 2: Accountability to the Governing Body	No elements/components are eligible for deeming.
Standard 3: Oversight of Delegated Entities and Subcontractors	No elements/components are eligible for deeming.
Standard 4: Credentialing and Recredentialing	4.1, 4.7
Standard 5: Enrollee Rights	5.3a, 5.6a, 5.8a
Standard 6: Availability and Accessibility	6.1b, 6.2a, 6.2b, 6.2c, 6.2d
Standard 7: Utilization Review	7.1a, 7.1b, 7.1c, 7.2a, 7.2b, 7.2c, 7.2d, 7.2f, 7.4a, 7.7b, 7.7c, 7.7d, 7.7f, 7.7g
Standard 8: Continuity of Care	8.4
Standard 9: Health Education Plan	No elements/components are eligible for deeming.
Standard 10: Outreach Plan	No elements/components are eligible for deeming.
Standard 11: Fraud and Abuse	No elements/components are eligible for deeming.
Standard 12: Disenrollment	No elements/components are eligible for deeming.

Timeline

MY 2024's SPR timeline started in August 2024 by providing MCOs an opportunity to review and comment on standards, laws, and regulations applying to the upcoming review. Any comments forwarded from MCOs during their 45-day comment period were considered before submission of the "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" in September 2024. Site visits occurred from January through March 2025. After receiving exit letters at the conclusion of the site visits, MCOs had 10 business days to submit any additional information. MCOs received final reports after MDH approved Qlarant's draft reports. Any required CAPs were due within 45 days of receiving final reports. Continued technical assistance occurred until the MCO submitted an acceptable CAP, if necessary.

Results

Results from the last three comprehensive SPR reviews are provided at-a-glance in Table 2 for MY 2018, MY 2021, and MY 2024.

Table 2. SPR Aggregate Scores At-A-Glance

Standard	MY 2018	MY 2021	MY 2024
1: Systematic Process of Quality Assessment and Performance Improvement	100%	100%	100%
2: Accountability to the Governing Body*	93%	NA	97%
3: Oversight of Delegated Entities and Subcontractors	88%	95%	100%
4: Credentialing and Recredentialing	99%	99%	100%
5: Enrollee Rights	91%	96%	98%
6: Availability and Accessibility	86%	99%	100%
7: Utilization Review	93%	94%	95%
8: Continuity of Care	100%	100%	100%
9: Health Education Plan*	100%	NA	97%
10: Outreach Plan	100%	99%	100%
11: Fraud and Abuse	94%	98%	99%
12: Disenrollment Requirements and Limitations	NA	NA	BASELINE REVIEW
Composite Score	**97%**	**98%**	**99%**

NA – Not Applicable
*Standards 2 and 9 were exempt from the MY 2021 SPR due to 100% MCO compliance in previous SPRs and were reviewed in the MY 2022 SPR.
Standard 12 (Disenrollment) was previously monitored by the State of Maryland and introduced to Qlarant's EQR review as a Baseline Review in MY 2024.

For each standard assessed for MY 2024, the following section describes:

- Overall MCO results and findings; and
- Follow-up, if required.

Table 3. SPR Validation Review Determination

Determination Category	Review Determination and Criteria
Performance Evaluation Status	**Met (M)** MCO achieved compliance with all requirements and scored minimum compliance with performance standards relating to grievances, appeals, and denials (95%) or minimum compliance for all other performance standards (100%).
	Met with Opportunity (MwO) MCO achieved compliance with requirements, but demonstrated an opportunity to improve; CAP is not required
	Partially Met (PM) Qlarant required a CAP from MCO.
	Unmet (UM) Qlarant required a CAP from MCO.
Review Inclusion Status	**Baseline (B)** Qlarant reviewed, but did not score the component, element, or standard.
	Deemed (D) Qlarant did not review the component, element, or standard as the MCO scored minimum compliance (100%) on the applicable NCQA[3] standards.
	Not Applicable (NA) Qlarant did not review, as the component was not applicable.

Appendices provide detailed assessments of the SPR findings (Appendix A) and standard descriptions with compliance score requirements (Appendix B).

Standard 1: Systematic Process of Quality Assessment and Performance Improvement

Results and Findings: All MCOs met the compliance threshold for Standard 1; however, Qlarant identified recommendations for improvement within the standard for PPMCO.

Table 4. MY 2024 MCO Opportunities Findings for Standard 1

MCO	PM	UM	MwO
PPMCO	**NA**	**NA**	**1.2b**

NA – Not Applicable

Follow up: The standards listed above will be reviewed during the interim SPR for MY 2025.

[3] National Committee for Quality Assurance (NCQA)

Standard 2: Accountability to the Governing Body

Results and Findings: Eight MCOs met the compliance threshold for Standard 2. MSFC has opportunities for improvement in Accountability to the Governing Body and is required to submit corrective action.

Table 5. MY 2024 MCO Opportunities Findings for Standard 2

MCO	PM	UM	MwO
MSFC	NA	2.1, 2.5	NA

NA – Not Applicable

Follow up: Qlarant reviewed and approved MCO CAP submissions. The standards listed above will be reviewed during the interim SPR for MY 2025.

Standard 3: Oversight of Delegated Entities

Results and Findings: All the MCOs met the compliance threshold for Standard 3; however, Qlarant identified recommendations for improvement within the standard for PPMCO.

Table 6. MY 2024 MCO Opportunities Findings for Standard 3

MCO	PM	UM	MwO
PPMCO	NA	NA	3.3a

NA – Not Applicable

Follow up: The standards listed above will be reviewed during the interim SPR for MY 2025.

Standard 4: Credentialing and Recredentialing

Results and Findings: Eight MCOs met the compliance threshold for Standard 4. ABH has opportunities for improvement in Credentialing and Recredentialing and is required to submit corrective action.

Table 7. MY 2024 MCO Opportunities Findings for Standard 4

MCO	PM	UM	MwO
ABH	4.4j	NA	NA

NA – Not Applicable

Follow up: Qlarant reviewed and approved MCO CAP submissions. The standard listed above will be reviewed during the interim SPR for MY 2025.

Standard 5: Enrollee Rights

Results and Findings: JMS demonstrated full compliance for Standard 5. Eight MCOs have opportunities for improvement in Enrollee Rights and are required to submit corrective action. In addition, five MCOs (JMS, KPMAS, MPC, UHC, and WPM) demonstrated an area in which Qlarant identified recommendations for improvement within the standard.

Table 8. MY 2024 MCO Opportunities Findings for Standard 5

MCO	PM	UM	MwO
ABH	5.1d	NA	NA
CFCHP	5.1g	NA	NA
JMS	NA	NA	5.8d
KPMAS	5.1d	NA	5.7a
MPC	5.1g	NA	5.1a
MSFC	5.1g	NA	NA
PPMCO	5.1d, 5.1g, 5.1h	NA	NA
UHC	5.1g, 5.1h	NA	5.1d
WPM	5.1d	NA	5.1c, 5.1g

NA – Not Applicable

Follow up: Qlarant reviewed and approved MCO CAP submissions. The standards listed above will be reviewed during the interim SPR for MY 2025.

Standard 6: Availability and Accessibility

Results and Findings: All MCOs met the compliance threshold of 100% for Standard 6; therefore, CAPs were not required.

Follow up: There is no follow up required for Standard 6.

Standard 7: Utilization Review

Results and Findings: Eight MCOs have opportunities for improvement in Utilization Review, however seven are required to submit corrective action. Two MCOs (CFCHP and WPM) are required to submit quarterly CAPs due to not meeting compliance through consecutive review years. In addition, seven MCOs demonstrated an area in which Qlarant identified recommendations for improvement within the standard.

Table 9. MY 2024 MCO Opportunities Findings for Standard 7

MCO	PM	UM	MwO
ABH	7.4c	NA	7.2e, 7.7a, 7.8a, 7.9c, 7.10
CFCHP	7.1c, 7.3a, 7.3b, 7.5b, 7.7a	7.3c, 7.7c, 7.7e	7.4c, 7.6a
KPMAS	7.10	NA	7.4c, 7.6a, 7.8b, 7.9c
MPC	NA	NA	7.4c, 7.6a, 7.11a
MSFC	7.8c, 7.9b	NA	7.4c
PPMCO	7.4c, 7.6b, 7.9b	NA	7.3c, 7.5b, 7.8c, 7.9a
UHC	7.4c, 7.7e, 7.8b, 7.8c	NA	NA
WPM	7.2e, 7.3c, 7.4c, 7.6b, 7.8a, 7.9c	7.7c	7.3a, 7.3b, 7.6a, 7.8c

NA – Not Applicable
Red indicates quarterly updates on the CAP are required per MDH's Performance Monitoring Policy

Follow up: Qlarant reviewed and approved MCO CAP submissions. The standards listed above will be reviewed during the interim SPR for MY 2025.

In accordance with MDH's Performance Monitoring Policy:

- CFCHP is required to submit quarterly updates on its CAP for Components 7.7c and 7.7e.
- WPM is required to submit quarterly updates on its CAP for Component 7.7c.

Standard 8: Continuity of Care

Results and Findings: All MCOs met the compliance threshold for Standard 8. Qlarant identified recommendations for improvement within the standard for two MCOs (MPC and PPMCO).

Table 10. MY 2024 MCO Opportunities Findings for Standard 8

MCO	PM	UM	MwO
MPC	NA	NA	8.6
PPMCO	NA	NA	8.6

NA – Not Applicable

Follow up: The standards listed above will be reviewed during the interim SPR for MY 2025.

Standard 9: Health Education Plan

Results and Findings: Five MCOs have opportunities for improvement in Standard 9, however four are required to submit corrective action. Qlarant identified recommendations for improvement within the standard for three MCOs (ABH, MPC, and PPMCO).

Table 11. MY 2024 MCO Opportunities Findings for Standard 9

MCO	PM	UM	MwO
ABH	NA	NA	9.5c
KPMAS	9.3a	NA	NA
MPC	NA	NA	9.3a
MSFC	9.3a	9.1a	NA
PPMCO	NA	NA	9.3a
UHC	9.3a	NA	NA
WPM	9.3a	NA	NA

NA – Not Applicable

Follow up: Qlarant reviewed and approved MCO CAP submissions. The standards listed above will be reviewed during the interim SPR for MY 2025.

Standard 10: Outreach Plan

Results and Findings: All MCOs met the compliance threshold of 100% for Standard 10; therefore, CAPs were not required.

Follow up: There is no follow up required for Standard 10.

Standard 11: Fraud and Abuse

Results and Findings: Three MCOs have opportunities for improvement in Standard 11 and are required to submit corrective action (KPMAS, UHC, and WPM). Qlarant identified recommendations for improvement within the standard for three MCOs (CFCHP, UHC, and WPM).

Table 12. MY 2024 MCO Opportunities Findings for Standard 11

MCO	PM	UM	MwO
CFCHP	NA	NA	11.4c
KPMAS	11.4c	NA	NA
UHC	11.4d	NA	11.4c
WPM	11.4c	NA	11.4d

NA – Not Applicable

Follow up: Qlarant reviewed and approved MCO CAP submissions. The standards listed above will be reviewed during the interim SPR for MY 2025.

Standard 12: Disenrollment Requirements and Limitations

Results and Findings: Standard 12 was reviewed as a baseline year for all MCOs; therefore, CAPs are not required.

Follow up: Standard 12 will be reviewed and scored during the interim SPR for MY 2025.

Conclusion

MDH has set high standards for MCO quality assurance systems. In response, all MCOs have demonstrated the ability to design and implement effective quality assurance systems. 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 healthcare services to managed care enrollees.

This section identifies all required CAPs and any findings scored as *MwO*, based on results from the MY 2024 SPR. In areas where deficiencies were noted in MCO CAP submissions, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. A comparison of SPR results across MCOs and the HealthChoice Aggregate follows. MY 2024's compliance score requirement rate is 100%.

Table 13. MY 2024 MCO and HealthChoice Aggregate SPR Results

Standard	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM	HealthChoice Aggregate
1: Systematic Process of Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
2: Accountability to the Governing Body	100%	100%	100%	100%	100%	**71%**	100%	100%	100%	**97%**
3: Oversight of Delegated Entities	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
4: Credentialing and Recredentialing	**99%**	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
5: Enrollee Rights	**99%**	**99%**	100%	**99%**	**99%**	**99%**	**96%**	**97%**	**99%**	**98%**
6: Availability and Accessibility	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
7: Utilization Review	**99%**	**84%**	100%	**99%**	100%	**97%**	**96%**	**94%**	**89%**	**95%**
8: Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
9: Health Education Plan	100%	100%	100%	**96%**	100%	**88%**	100%	**96%**	**96%**	**97%**
10: Outreach Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
11: Fraud and Abuse	100%	100%	100%	**98%**	100%	100%	100%	**98%**	**98%**	**99%**
12: Disenrollment Requirements and Limitations	B	B	B	B	B	B	B	B	B	**B**
Composite Score	99%	97%	100%	99%	100%	98%	99%	98%	98%	**99%**
CAPs Required	**3**	**2**	**0**	**4**	**1**	**4**	**2**	**4**	**4**	**25**

Red represents a score below the required threshold and requires CAP
B – Baseline Standard; score was not calculated.
All scores are rounded to the nearest whole number.

Corrective Action Plans

SPR CAPs can be directly linked to specific elements, components, or standards. The comprehensive SPR for MY 2024 determined whether the CAPs from the MY 2023 review were implemented and effective. In order to make this determination, Qlarant evaluated 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. In the event that a CAP is deemed unacceptable, Qlarant provides technical assistance to the MCO until an acceptable CAP is submitted.

Qlarant recommends CAP closures for the following CAPs, as compliance was achieved during the MY 2024 review:

Table 14. Recommended CAP Closures

MCO	Standard	Element/Component	SPR Requirements
CFCHP	7	8c	Turnaround timeframe compliance for written acknowledgment and written resolution of provider appeals, at or above the MDH-established compliance score of 95%.
KPMAS	7	8c	Demonstrate compliance with written acknowledgment of provider appeals, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the review period.
MPC	7	7c	Compliance with expedited appeal resolution notification at or above the MDH-established score of 95% on at least a quarterly basis throughout the MY.

MDH updated its Performance Monitoring Policies following the MY 2016 SPR, whereby an MCO that had a CAP for two or more consecutive years in the same element/component would require quarterly monitoring by Qlarant. As a result of the MY 2024 SPR, two MCOs were placed on quarterly CAP monitoring and were required to submit quarterly updates of their CAPs to Qlarant:

- CFCHP is required to submit a quarterly CAP due to multiple years of not meeting the requirement to improve Utilization Review (Components 7.7c and 7.7e).
- WPM is required to submit a quarterly CAP due to multiple years of not meeting the requirement to improve Utilization Review (Component 7.7c).

The following tables identify MCOs with continued quarterly CAP monitoring.

Table 15. Continued CAP Monitoring

MCO	Standards	Consecutive Years
CFCHP	7.7c	2
CFCHP	7.7e	3
WPM	7.7c	3

Met with Opportunities

Elements/components scored as *MwO* have been found compliant with the requirement(s), but with an opportunity to improve. While *MwO* findings do not require a CAP, those improvements will need to be addressed in order to receive a *Met* finding in the next review period. Each of the nine MCOs received a finding of *MwO* in one or more standards and need to address the following opportunities for improvement:

ABH should improve:

- Documentation of the requirement for annual training of Utilization Management staff on the interpretation and application of medical necessity criteria/guidelines. (Component 7.2e)
- The Enrollee Appeals Policy to specify the timeframe for filing an appeal is within 60 calendar days from "the date on the MCO's adverse determination letter." (Component 7.7a)
- The Provider Appeals Policy to require written notice of appeal resolution be sent to the provider, regardless of whether the appeal is filed verbally or in writing. (Component 7.8a)
- Documentation in meeting minutes to explain its criteria for selecting opportunities for improvement related to utilization management, identified from the CAHPS and Provider Satisfaction survey results. (Component 7.9c)
- The final step in the job aid for timely payment of independent review organization invoices to identify the process for follow-up with Accounts Payable to ensure payment is issued within the designated timeframe and cross-reference this job aid in the Provider Appeals Policy. (Element 7.10)
- Documentation of provider feedback related to evaluation of its health education plan (HEP). (Component 9.5c)

CFCHP should improve:

- The Pharmacy Prior Authorizations Standard Operating Procedure to include information from the MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe for a determination about a covered outpatient drug, if additional clinical information is requested. (Component 7.4c)
- The Pharmacy Prior Authorizations Standard Operating Procedure to require notification of an enrollee of an adverse determination within 24 hours of the preauthorization determination request. This change from receipt to determination is required to support the additional time allowed for a provider to submit requested clinical information, as outlined in the MCO transmittal dated October 3, 2024. (Component 7.6a)
- Monitoring by the CFCHP Compliance Officer to ensure the Compliance Committee annually reviews and approves delegated entities' Compliance Plans. This review and approval must be clearly documented in the Compliance Committee meeting minutes. (Component 11.4c)

JMS should improve:

- Evidence of notice and tagline postings when the MCO interacts with the public during community events (e.g., pictures during enrollee health fairs, baby showers). (Component 5.8d)

KPMAS should improve:

- The language requirements for written policies and delete "strive to" within the operating protocol for required standards. (Component 5.7a)
- The MD HealthChoice Pharmacy Service Authorizations Policy to include up to 14 calendar days from receipt of the initial preauthorization request for a determination about a covered outpatient drug, if additional clinical information is requested. (Component 7.4c)
- The adverse determination notification timeframe in the MD HealthChoice Pharmacy Service Authorizations Policy by revising from 24 hours from receipt of the preauthorization request to the date of determination. (Component 7.6a)
- The Provider Claims Appeals Policy - Maryland by revising the timeframe for resolving subsequent levels of provider appeals beyond the initial appeal. (Component 7.8b)
- Documentation demonstrating specific initiatives have been implemented to address opportunities for improvement related to results from the CAHPS survey. (Component 7.9c)

MPC should improve:

- The Member Grievance Process Policy by identifying the timeframe for acknowledgment of receipt of an enrollee grievance. (Component 5.1a)
- The Pharmacy Prior Authorization Policy includes providing up to 14 calendar days for providers to submit additional information, if needed to make an authorization decision. (Component 7.4c)
- The Pharmacy Prior Authorization Policy timeframe for enrollee written notice of the determination by replacing “from 24 hours of receipt of request” to” 24 hours from the decision” to reflect MCO Transmittal No. 225’s 14-calendar day extension. (Component 7.6a)
- The Corrective Managed Care Program Description to provide for the designation of a new pharmacy provider, if the enrollee moves out of the service area of the current pharmacy. (Component 7.11a)
- Revise the Corrective Managed Care Program Description’s stated timeframe for submitting additional information 20 days from the date of the notice for consistency with COMAR 10.67.12.02. (Component 7.11a)
- Education of providers on the Screening, Brief Intervention, and Referral to Treatment Program and Release of Information for Substance Use Disorder, at a minimum, in the provider newsletter and directly on the MPC provider website. Other options for education include presentations at the time of the new provider’s orientation. (Component 8.6)
- Evaluations of the effectiveness of its various health education programs on process and outcome measures, based upon pre and post enrollee participation on relevant outcome measures or comparisons to non-participants on selected measures. (Component 9.3a)

MSFC should improve:

- The Utilization Management Process Policy to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a decision about a covered outpatient drug, if additional clinical information is requested. (Component 7.4c)

PPMCO should improve:

- Timing of review of the Quality Assurance Program (QAPI) Description and Work Plan and the QAPI Program Evaluation to the first quarter of the year. This allows for more timely analysis to detect the need for program change. (Component 1.2b)
- Its quarterly oversight of delegates as written in policy and the QAPI Committee Charter, as evidenced by committee meeting minutes. (Component 3.3a)
- Identification of the specific overutilization and underutilization measures is addressed through the development of its interventions and monitor not only the progress of its interventions but also how those interventions are having an impact on those measures that they are designed to address. For example, to address overutilization of services and resources for enrollees with diabetes, emergency room and inpatient utilization metrics could be assessed to determine the impact of interventions. (Component 7.3c)
- Language in its adverse determination letters by removing reference to the assumption of a five-day timeframe for mailing in the appeal filing timeframe. (Component 7.5b)
- Reporting of compliance with provider claims appeals timeframes by eliminating the “expedited” category, which is inconsistent with administrative appeals. (Component 7.8c)
- The Member and Provider Experience with the Utilization Management Process Policy to identify the "appropriate oversight committee" referenced in this policy. (Component 7.9a)
- Education of its providers on the Screening, Brief Intervention, and Referral to Treatment process and Release of Information procedures in any of the following sources: the provider manual, new provider orientation program, the provider website, or in provider newsletters. (Element 8.6)
- Analysis of negative outcomes, such as the increase in emergency room visits following class attendance, to understand the root cause(s) and determine any needed enhancements to class offerings. (Component 9.3a)

UHC should improve:

- The MD Member Appeal, Grievance, and State Fair Hearing Policy to specify the appropriate quality committee(s) responsible for analyzing grievance data to identify opportunities for improvement and develop and monitor action plans in response to identified opportunities. (Component 5.1d)

- Meeting minutes of the appropriate quality committee(s) for grievances to reflect identified opportunities and actions taken to address opportunities. (Component 5.1d)
- Documentation of the Compliance Committee's annual review and approval of fraud, waste, and abuse (FWA) policies and procedures and Compliance Plan for each of its delegates. The Compliance Committee Charter and Compliance Program Policy must include the role of the Compliance Committee in this oversight of delegate Compliance Plans/FWA policies. (Component 11.4c)

WPM should improve:

- The Member Grievances - MD Policy to explicitly address the requirement for documentation of the resolution of a grievance in the enrollee's case record. (Component 5.1c)
- Staff understanding of what constitutes an emergency medically related or non-emergency medically related grievance. Routine audits of categorization should be conducted until compliance with appropriate categorization is achieved in three consecutive quarters. (Component 5.1g)
- Inclusion of the role and responsibilities of the Clinical Services Committee in its Over/Under-Utilization of Services Policy. (Component 7.3a)
- Presentation of action plans to address areas of overutilization and underutilization to the identified committees, consistent with its Over/Under-Utilization of Services Policy. (Component 7.3b)
- The timeframe of enrollee notification of an approval or denial from "closed date" to "date of determination." (Component 7.6a)
- The Provider Claim Payment Dispute Process Policy to specify the MCO's timeframe for sending the provider a written appeal resolution for each level of appeal, which would allow sufficient time for a second level of appeal if the provider so chooses. (Component 7.8c)
- Documentation in Compliance Committee meeting minutes of quarterly review and approval of the delegate's FWA activity. If a Special Investigations Unit Report is given that addresses delegate oversight of their Special Investigations Unit FWA activity, the name of the delegate and the date of that oversight should be documented in Compliance Committee meeting minutes. (Component 11.4d)

Appendix A: MCO Detailed Findings

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

1.0 – Systematic Process of Quality Assessment and Improvement

Findings

Priority Partners (PPMCO)

1.2 b. Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.
This component is Met with Opportunity.

There are several PPMCO committees involved in assessing the quality of care and services for the enrollee population. Committees, such as the Quality Management & Medical Management, meet a minimum of ten times per year to identify opportunities for program change.

On a quarterly basis, an executive summary of the deliberations from three preceding months of meeting minutes is presented to the QAPI Committee from relevant committees and workgroups. These reports align with Quality Improvement Work Plan activities and allow for effective oversight of the QAPI. In addition to this committee oversight, annual population analyses are performed to determine any changes in the demographics or epidemiological characteristics of the enrollee population. These data help PPMCO identify the need for a change in quality improvement initiatives.

The QAPI Charter and Reporting Calendar were reviewed and approved at the February 1, 2024, QAPI Committee meeting. The 2024 QAPI Program Description and Work Plan were reviewed and approved at the April 18, 2024, Quality Management/Medical Management Committee meeting and by the QAPI Committee at the May 2, 2024, meeting. The 2023 QAPI Program Evaluation was not reviewed by the QAPI Committee until the September 5, 2024, meeting. This late review limits the QAPI Committee from making recommendations for improvements in quality improvement programs and services at the beginning of the subsequent year.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must review the QAPI Program Description, Work Plan, and the QAPI Program Evaluation in the first quarter of the year. This allows for more timely analysis to detect the need for program change.

2.0 – Accountability to Governing Body

Findings

MedStar Family Choice, Inc. (MSFC)

2.1 - There is documentation that the governing body has oversight of the quality assessment program (QAP) and approves the annual quality assurance (QA) Plan/Description and QA Work Plan.
This element is Unmet.

In 2024, MSFC made changes to the health plan's organizational structure. MSFC outlined its 2024 operational objectives for the Quality Improvement Committee in the 2024 Quality Improvement Plan:

- Redesign the Quality Department to align with new goals, priorities objectives, and initiatives to achieve better outcomes.
- Promote a culture of continuous quality improvement within the organization. Infuse a health equity lens in all programs to ensure that all individuals, regardless of their socioeconomic status, race, ethnicity, gender, or other factors, have fair and equal access to healthcare resources and services.
- Identify and address disparities in healthcare access, quality, and outcomes among different population groups.
- Monitor healthcare utilization patterns and identify opportunities to optimize resource allocation and utilization management.
- Meet all regulatory requirements and accreditation standards.
- Conduct quarterly meetings and one ad-hoc meeting to review the clinical operations and quality plans and assessments.
- Monitor key performance indicators on quality of care, quality of service, and enrollee satisfaction.
- Evaluate the effectiveness of quality improvement initiatives and adjust activities, as needed, to achieve desired outcomes.

The Functional Organization Chart Maryland illustrates the resources assigned to MSFC. These include several new positions: an Executive Director and a Vice President Maryland Operations, each with a direct report to the President of MSFC; a new Population Health & Equity Department led by a Director Population Health & Equity, who oversees two Maryland Health Equity coordinators and a Health Equity Educator; and two additional quality positions that report to the Director of Quality, a Manager of Outreach and a Manager, HEDIS & Quality Analytics.

According to the 2024 Quality Improvement Plan, overall responsibility and authority for MSFC quality improvement lies with the MSFC Board of Directors, which has delegated the oversight of quality to MSFC's Executive Operations Committee. This committee oversees both MSFC's Maryland and the District of Columbia health plans. Currently, the Executive Operations Committee has the following responsibilities:

- Review and discuss state regulatory requirements.
- Develop plans for implementing state requirements.
- Review operational issues/problems discussed at MSFC internal meetings.
- Provide oversight of the MSFC quality improvement, Utilization Management, and Outreach plans.
- Review credentialing activities.
- Provide oversight of the Compliance Program and all its components.
- Review reports/minutes from the Quality Improvement Committee and make recommendations and act, as appropriate.
- Ensure the operational Quality Improvement Plan is updated at least annually to accommodate review of findings, issues of concern, changes in regulations, and modifications from MDH.

As written in the list of functions above, the Executive Operations Committee is not reviewing all operational areas affecting enrollees' quality of care. These include, for example, case management (CM), Network Access, Grievances and Appeals, Delegation Oversight, Member Services, and Pharmacy and Therapeutics. The 2024 Executive Operations Committee meeting minutes do document review of these operational areas, especially in December 2024 when meeting minutes show more robust reporting on quality, case management, Utilization Management, delegated oversight, and Provider Relations. Also, in the Executive Operations Committee list of responsibilities, there is no requirement for the committee to review and approve the quality trilogy documents: Quality Improvement Plan, Quality Improvement Plan Workplan, and Quality Improvement Plan Evaluation as well as the Utilization Management trilogy documents, which is a requirement in Element 2.7. of this report.

The Quality Improvement Committee, formerly the Quality Improvement Utilization Management Committee (QI/UMC), functions more like a governing body. Its role and functions, as outlined in the QIP, are more aligned with what Qlarant would identify as a governing body with authority. Membership includes senior leadership, participating physicians, and representatives from internal departments. Quality Improvement Committee meeting minutes reflect this broader scope of oversight of the Quality Improvement Plan.

Minutes from the April 9, 2024, QIC meeting state the "Clinical Operations and QAPI plans and appraisals were reviewed, approved and submitted." At the June 13, 2024, Executive Operations Committee meeting the Chief Medical Officer provided a Quality Update report on the QIC deliberations from the April 9, 2024, meeting. The Executive Operations Committee meeting minutes indicate the committee approved the QIC Maryland report. It is not clear if the QIP and QIP Workplan were both approved. The terminology in the 2024 QIP vacillates between the role of the old Executive Operations Committee and the current role. Names of positions also are not consistent with the 2024 Organization Chart.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MSFC must clearly identify which committee, the Executive Operations Committee or the Quality Improvement Committee, serves as the governing body with authority to make decisions regarding the Quality improvement Plan. In 2024, the Quality Improvement Committee functioned more as a governing body. The governing body must comply with all elements (2.1 through 2.7b) of this standard. For example, the governing body must be made up of senior leadership with the authority to make decisions on strategy and resource assignments; review and approve the quality and Utilization Management Program descriptions, workplans, and

annual evaluations; receive and approve reports from quality committees, as outlined in the Quality Improvement Plan committee structure; ensure committee descriptions are clear on accountability and approval authority; and comprehensively and accurately describe the functions the committee is assigned.

2.5 - 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.
This element is Unmet.

While quality updates are provided at each Executive Operations Committee meeting, there is little if any committee discourse on achievements, barriers to improvement, or action steps to address barriers to improvement until the end of 2024. The Quality Improvement Committee meeting minutes October 22, 2024; however, provide the best example of the role this committee plays in reviewing achievements of quality improvement initiatives; identifying barriers to improvement when performance is not meeting goals; and establishing action plans for remediation.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MSFC must show, in meeting minutes, that the governing body is taking an active part in monitoring Quality Improvement Plan initiatives, establishing priorities, assessing performance barriers, and developing action plans for improvement.

3.0 – Oversight of Delegated Entities

Findings

Priority Partners (PPMCO)

3.3 a. 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.
This component is Met with Opportunity.

PPMCO has procedures in place for ongoing monitoring and oversight of delegated entities, Superior Vision, CVS/Caremark, and eviCore. PPMCO assigns vendor managers with subject matter expertise to serve as liaisons to each vendor, based upon delegated functions. The vendor manager is accountable for review and analysis of vendor-submitted reports, ongoing monitoring and oversight, feedback to each delegate of any identified opportunities for improvement, and quarterly delegate performance reporting to the Delegation Oversight Committee. Per the Delegation Policy, the Delegation Oversight Committee submits quarterly reports to the QAPI Committee for review and approval.

Vendor-specific Delegation Oversight Reports offer a detailed snapshot of each delegate's performance for the reporting period. For example, the Superior Vision Delegation Oversight Report for quarter 1, 2024, lists performance against metrics identified in the delegation agreement with PPMCO. For Superior Vision, the vendor manager reviews call center and claims data, appeals timeliness, and network adequacy. The findings include whether a CAP is needed to address identified deficiencies. Additionally, the report includes an Action Plan section, which provides an update on existing CAPs and MCO-planned activities, such as follow-up file audits. Delegation Oversight Committee meeting minutes document the completion of annual audits for eviCore in March 2024 and for Superior Vision and Caremark in December. Minutes from 2024 Delegation Oversight Committee meetings reflect a review of vendor-specific Delegation Oversight Reports. The Delegation Oversight Committee met quarterly to review delegate reports in March, June, September, and December 2024. The QAPI received Delegation Oversight Committee reports twice in 2024 as follows:

- Q4 2023 delegate report - no review
- Q1 2024 delegate report reviewed by QAPI in August 2024
- Q2 2024 delegate report reviewed by QAPI in October 2024
- Q3 2024 QAPI meeting scheduled for February 2025

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must ensure the QAPI Committee reviews, approves, and documents, in meeting minutes, its quarterly oversight of delegates, as written in policy, and the QAPI Committee Charter.

4.0 – Credentialing and Recredentialing

Findings

Aetna Better Health of Maryland (ABH)

4.4 j. Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the time frames specified in Insurance Article Section 15-112(d).
This component is Partially Met.

ABH's Practitioner Credentialing, Recredentialing Policy stipulates the requirements of the Maryland Insurance Administration Article Section 15-112(d) for communicating with providers regarding the status of their credentialing application. ABH notifies providers of receipt of completed applications, or if the application is incomplete or has missing information, within ten days. Providers also receive a 30-day notification letter (letter of intent) advising that the credentialing process will proceed. The policy also indicates that the application process must be completed within 120 days of informing the provider of the intent to process the application.

In a review of ten initial credentialing records, only three had the required 30-day notification letter.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, ABH must ensure that all initial credentialing records include a notice of intent to continue or reject the application process. This letter must be sent to the provider within 30 days of receipt of the initial application.

5.0 – Enrollee Rights

Findings

Aetna Better Health of Maryland (ABH)

5.1 d. 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.
This component is Partially Met.

The Enrollee Complaint/Grievance Process Policy affirms that all grievance data will be tracked, trended, and reported to the Service Improvement Committee and Quality Management Oversight Committee, at least quarterly, summarizing the frequency and resolution of all grievances.

Minutes from five Service Improvement Committee meetings from MY 2024 were reviewed. Reporting through September was limited to the number of grievances received and compliance with timeframes for acknowledgment letters and grievances.

A review of minutes from four Grievance and Appeal Committee meetings held in March, May, June, and August found reporting of the top three grievance drivers for the month prior and year-to-date. Billing/claims issues were consistently reported as the top grievance category, followed by communication/relationships, and access/availability. There was no evidence of either a root cause analysis or interventions to address opportunities for improvement in any of these top categories. Additionally, ABH grievance staff did not identify any actions taken in response to grievance opportunities.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* in the MY 2025 review, ABH must demonstrate that it is tracking and trending grievances by category, identifying opportunities for improvement, and taking appropriate action to address identified opportunities, consistent with its Enrollee Complaint/Grievance Process Policy.

CareFirst Community Health Plan (CFCHP)

5.1 g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.
This component is Partially Met.

According to CFCHP, compliance results, by quarter, for MY 2024 were reported as follows:

- Grievance Acknowledgment Letters: Q1 (85%), Q2 (96%), Q3 (90%), and Q4 (100%)
- Grievance Resolutions: Q1 (100%), Q2 (96%), Q3 (100%), and Q4 (100%)

An initial sample review of ten enrollee grievance records found that nine met the timeframe for written acknowledgment. Review of an additional 20 records found that 18 met the acknowledgment letter timeframe. Overall, compliance for timeliness of the acknowledgment letter is 90% (27/20). Case notes indicated that one of the grievances missing the timeframe was received late from the Compliance Department.

All grievances in the sample review met the 30-calendar day timeframe for grievance resolution. All were appropriately categorized as administrative.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must demonstrate consistent compliance with acknowledgment letter timeliness, on at least a quarterly basis, at or above the MDH compliance score of 95%.

***RECOMMENDATION*:** Qlarant recommends CFCHP consider convening a cross-functional workgroup to discuss how processing delays may be eliminated as a result of grievances being incorrectly routed or received by an area other than the Grievance and Appeals Department.

Jai Medical Systems, Inc. (JMS)

5.8 d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.
This component is Met with Opportunity.

The Member Materials Policy indicates that if JMS interacts with the public, the Non-Discrimination Notice and Taglines for Language Accessibility shall be posted in a conspicuous location. For evidence, JMS provided pictures of notices and taglines postings on a bulletin board. During review, it was discussed with JMS that these postings also should be made available during community interactions, such as health fairs.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 SPR review, JMS must provide evidence of notice and tagline postings when the MCO interacts with the public during community events (e.g., pictures during enrollee health fairs, baby showers).

Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)

5.1 d. 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.
This component is Partially Met.

According to the Mid-Atlantic States Non-Medicare Grievance and Appeals Policy, grievance data is routinely monitored and analyzed for trends as a component of KPMAS' quality assurance/improvement program. Member Relations is responsible for reporting grievance data and any recommended action plans that will be implemented and monitored for improvement by the Regional Quality Improvement Committee at least quarterly.

KPMAS submitted minutes from the September 11, 2024, Regional Quality Improvement Committee to demonstrate its tracks and trends grievances, identifies opportunities for improvement, and develops action plans, as indicated. The information provided was extremely comprehensive, demonstrating a review of multi-year trends, key drivers, and key areas of focus; however, analysis was based on either the overall Mid-Atlantic States region or specific lines of business, such as commercial, Medicare, and Medicaid, which includes Virginia and Maryland combined. There was no evidence of analysis of grievance trends, opportunities for improvement, or action plans specifically related to Maryland HealthChoice. However, in the Follow Up/Actions column, it was reported that the Regional Quality Improvement Committee reviewed and approved the Maryland Medicaid HealthChoice (specific) reporting for Q4 2022 to Q1 2024.

A review of this semi-annual report, entitled "Member Experience Annual Assessment of Non-Behavioral Health" for the fourth quarter 2022 through the first quarter 2024, found Maryland HealthChoice-specific enrollee grievance data which identified rates per 1000 for each of the five NCQA categories (access, attitude/service, billing and financial issues, quality of care, and quality of practitioner office site). Attitude/service grievances represented 60% of all grievances from fourth quarter of 2022 through first quarter of 2023. This same category represented 58% of all grievances from the fourth quarter of 2023 through the first quarter of 2024. It was noted that the target goal for each grievance category was met, therefore no opportunities for improvement were identified.

According to KPMAS staff, the absence of routine reporting and analysis of grievance data for Maryland HealthChoice has been limited, as data is pulled only by line of business (Medicare, Medicaid, commercial) and by service area (DC/Suburban, Baltimore, Northern Virginia). Work is currently underway to split out grievance data by product line, which would support specific reporting for Maryland HealthChoice grievance data.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding of in the MY 2025 review, KPMAS must:

- Demonstrate reporting and analysis of Maryland HealthChoice grievance data to the Regional Quality Improvement Committee on a quarterly basis, consistent with its Mid-Atlantic States Non-Medicare Grievance and Appeals Policy. Reporting should include any identified opportunities for improvement and associated action plans.

- Eliminate the sole use of goals to determine if an opportunity for improvement exists. For example, it was noted the majority of grievances for the timeframes reported were related to attitude/service. This would clearly represent an opportunity for improvement.

5.7 a. The MCO's Consumer Advisory Board (CAB) membership must reflect the special needs population requirements.
This component is Met with Opportunity.

KPMAS' Maryland Consumer Advisory Board Policy under the “Procedures/Provisions” section states, "To ensure diversity, KFHP-MAS will strive to include at least one third of special needs members (or their representatives).”

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025, KPMAS must eliminate "strive to” (include special needs enrollees) within the Maryland Consumer Advisory Board Policy.

Maryland Physicians Care (MPC)

5.1 a. There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09.
This component is Met with Opportunity.

The Member Grievance Process Policy describes how MPC registers, responds, monitors, tracks, and trends enrollee grievances, including compliance with any required timeframes, consistent with COMAR 10.67.09.

Missing from the Member Grievance Process Policy; however, was the specific timeframe for providing written acknowledgment of enrollee grievances.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MPC must revise the Member Grievance Process Policy to identify the timeframe for acknowledgment of receipt of an enrollee grievance.

5.1 g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.
This component is Partially Met.

The 2024 Key Indicator Report provided quarterly compliance results for timeliness of grievance resolution by category, which exceeded the MDH compliance score of 95% for all four quarters of the MY. No compliance results were provided for the timeliness of written grievance acknowledgments.

An initial sample review of enrollee grievance records found nine that met the five-calendar day timeframe for written grievance acknowledgment. Review of an additional 20 records found 17 met the required timeframe. Overall compliance was 87% (26/30).

A review of ten records from the same sample noted above found that the resolution timeframe was met for each grievance, according to the assigned category.

After initial review, MPC presented additional information; however, compliance was not demonstrated, and the *Partially Met* finding remains unchanged.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MPC must demonstrate compliance with the timeframe for written grievance acknowledgment, at or above the MDH compliance score of 95%, on at least a quarterly basis throughout the MY.

RECOMMENDATION: Qlarant recommends that MPC consider including timeliness of grievance acknowledgment letter on its Key Indicator Report to ensure consistent monitoring of compliance.

MedStar Family Choice, Inc. (MSFC)

5.1 g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.
This component is Partially Met.

As evidence of compliance, MSFC submitted quarterly Appeals and Grievances reports presented at Quality Improvement Committee meetings, which identified compliance with written acknowledgment and resolution timeframes. Compliance with the timeframe for written grievance acknowledgment exceeded the MDH compliance score of 95% for the first, second, and fourth quarters. Timeframe compliance fell below the compliance score in the third quarter to 84%. Compliance with the timeframes for resolution exceeded the MDH compliance score of 95% in all four quarters of the MY. According to MSFC, non-compliance with written acknowledgment experienced in the third quarter was the result of some changes designed to improve grievance processes.

An initial sample review of ten enrollee grievance records found all written acknowledgments met the required timeframe. Nine records met the grievance resolution regulatory timeframes. The one outlier was related to escalation of the grievance to the Provider Relations team within MSFC for further investigation, which was inappropriately identified as the resolution. There was no evidence of follow-up by the Provider Relations team in case notes. Review of an additional 20 records found all met the grievance resolution timeframes. Overall compliance was 97% (29/30).

According to MSFC staff, they have already identified provider-related grievances as an opportunity for improvement. As a result, provider-related grievances are now resolved by the Grievance team. The only time a provider grievance would be escalated to Provider Relations would be if grievances continued to be filed related to the same provider.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MSFC must demonstrate consistent compliance with the timeframe for grievance acknowledgment letters, at or above the MDH compliance score of 95%, on at least a quarterly basis throughout the MY.

Priority Partners (PPMCO)

5.1 d. 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.
This component is Partially Met.

The Member Complaint/Grievance Policy assigns responsibility to the Complaint & Grievance Department for analyzing trends and determining the form of intervention most appropriate to promote improvements in complaints and grievances throughout the organization. Data and analysis related to complaints and grievances are required to be reported in the aggregate to the designated quality committees on a quarterly basis. Additionally, the policy also identifies other committees and departments that receive an analysis of grievance data and the frequency, as applicable.

Minutes from four Member Survey Work Group meetings, held in 2024, included reporting of grievances by category and subcategory and identification of subcategories trending in a negative direction. Balance billing was consistently identified as the top subcategory. There was no evidence that grievance data was utilized to identify opportunities for improvement or develop action plans, as needed, in response to findings.

According to Grievance staff, the Grievance Team tracks and trends grievances according to the top five NCQA categories. Action plans are developed and implemented to resolve any identified opportunities for improvement outside of the Member Survey Work Group. For example, in response to balance billing issues, Provider Relations is working with providers to educate them on proper claims submission, and enrollees are being educated by Member Services on the importance of submitting their identification card at the time of service. PPMCO is currently exploring providing the enrollee with the ability to easily access their identification card on the enrollee website at the time of service.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must:

- Identify the specific quality committees required to receive complaint and grievance data on a quarterly basis.
- Demonstrate identification of opportunities for improvement, based upon analysis of grievance data, and interventions to address identified opportunities.

5.1 g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.
This component is Partially Met.

According to the Priority Partners Member Complaints/Grievances Policy, written acknowledgment of grievance receipt is sent to the enrollee within 72 hours of grievance receipt.

Member Survey Work Group meeting minutes reported timeframe compliance for written grievance acknowledgment exceeded the MDH score of 95% for the first three quarters of 2024. No results were provided for the fourth quarter of 2024.

An initial sample review of ten enrollee grievance records found an acknowledgment letter was sent within the MCO's timeframe of 72 hours in nine of the cases. Review of an additional 20 records found all met the timeframe. Overall compliance was 97%, which is above MDH's compliance score of 95%.

Timeframes for resolution by assigned grievance category, emergency, medically related, non-emergency medically related, and administrative, identified in the Priority Partners Member Complaints/Grievances Policy are consistent with regulatory requirements.

As evidence of compliance with grievance resolution timeframes, PPMCO submitted quarterly Grievance, Appeal, and Denial Reports for the first three quarters of 2024, which indicated results were above the MDH score of 95% for all three quarters. No results were provided for the fourth quarter of 2024.

Based upon the same initial sample review of ten grievance records, compliance with resolution timeframes according to the assigned category was met in five of the cases. The remaining five cases did not include a resolution. Case notes indicated the cases were forwarded to Provider Relations for resolution. Review of 20 additional records found 17 met the resolution timeframe. Overall compliance was 73%.

After the initial review, PPMCO submitted its response to the Exit Letter, which stated: "PPMCO does not dispute that the grievance written acknowledgement and resolution turnaround time were not within MDH-established thresholds (>95%) for the full year. PPMCO will review processes and procedures to ensure that grievance written acknowledgment and resolutions are completed within required timeframes in CY2025."

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must:

- Demonstrate compliance with the timeframes for acknowledgement letters and resolution, by grievance category, at or above the MDH score of 95% for all four quarters of the MY.
- Document appropriate grievance resolutions in case notes.

5.1 h. The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and within the MDH-established threshold of 95%.
This component is Partially Met.

The Member Complaints/Grievances Policy identifies the timeframe for written notice to the enrollee of grievance resolution as within 72 hours of the resolution, even if the resolution was provided verbally.

Member Survey Work Group meeting minutes reported timeframe compliance for written grievance resolution notifications exceeded the MDH score of 95% for the first three quarters of 2024. No results were provided for the fourth quarter of 2024.

An initial sample review of ten enrollee grievances found that compliance with resolution letter timeliness was met in five of the cases. The other five cases did not include an appropriate resolution in the letter sent to the enrollee. These were cases referred to Provider Relations for resolution. Letters stated "...the investigation is ongoing, and we are actively working toward a resolution...will keep you informed of any development." Identical language was found in three of the additional 20 records reviewed. Overall compliance with the timeframe for providing the enrollee with written notification of the resolution was 73% (22/30).

According to Grievance staff, a final resolution letter was sent in those cases where a grievance was referred to Provider Relations. This occurred after Provider Relations completed their follow-up with the provider identified as the subject of the grievance. No final resolution letters were found in the case notes reviewed. Staff subsequently reported that a review of final resolution letters found they were outside of the required timeframe. Staff reported that the practice of sending both an interim and final resolution letter was discontinued in the latter half of 2024, possibly in August.

After the initial review, PPMCO submitted its response to the Exit Letter, which stated: "PPMCO does not dispute that the grievance written notification turnaround time were not within the MDH-established thresholds (>95%) for the full year. PPMCO will review processes and procedures to ensure that grievance written notification of resolutions is completed within required timeframes in CY2025."

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must:

- Demonstrate compliance with the MCO's timeframe for grievance resolution letters, at or above the MDH score of 95%, for all four quarters of the MY.
- Document appropriate resolutions in grievance resolution letters.

UnitedHealthcare Community Plan (UHC)

5.1 d. 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.
This component is Met with Opportunity.

The MD Member Appeal, Grievance, and State Fair Hearing Policy specifies UHC will aggregate and analyze grievance data and use the data for quality improvement. It further indicates that records are used, as applicable, for reporting to the provider involved, appropriate quality improvement committees, Consumer Advisory Board, and MDH.

Information provided by UHC in the Standard 05 Narrative noted complaint activity is compiled and analyzed at Service Quality Improvement Subcommittee meetings and via the Quality Improvement Plan Evaluation. This subcommittee identifies opportunities for improvement and works with relevant departments to develop appropriate action plans.

Review of minutes from four Service Quality Improvement Subcommittee meetings held in 2024 found review of grievance turnaround timeframe compliance reports for fourth quarter 2023, and first and second quarters 2024. In the February 21, 2024, meeting top grievances by service and reason code were identified in the 2023 Member Complaint Analysis presentation. Billing/financial was the top grievance category for 2023; it was noted there were no trends related to balance billing by practice/provider/facility. In the April and August meetings, a continuing trend of balance billing by Quest Lab was identified; however, no actions to address the issue were identified in either meeting.

According to UHC staff, monthly meetings are held with appeals and grievances cross-functional staff to identify grievance-related opportunities for improvement and develop action plans in response. No minutes are taken during these meetings. However, minutes from Consumer Advisory Board meetings demonstrated reporting of grievance trends, opportunities, and action plans. For example, in the October 17, 2024, meeting, it was reported that a meeting was held with subject matter experts to review top complaint drivers impacting access to care.

In the December 12, 2024, CAB meeting top enrollee grievances and action items reported included:

- Quality of Care (15) – A specialized Quality of Care clinical team reviews grievances and determines if it is substantiated or unsubstantiated. The team implements appropriate improvement actions when warranted.
- Attitude/Services: MCO Customer Service (13) – The Member Services leadership team reviews the situations and pulls the audio of the call. Substantiated grievances result in coaching of the advocate, re-training, or performance management if there are repeat occurrences.
- Billing/Financial (8) – Balance billing concerns are investigated to determine if the bill is valid. If determined that the enrollee is not liable, then UHC researches to ensure they have a billed claim on file from the provider and that there are no obvious errors. If the claim is processed

correctly and the provider is wrongly billing, UHC actively makes verbal outreach to the provider and sends them a letter to cease and desist to resolve the billing matter.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must:

- Revise the MD Member Appeal, Grievance, and State Fair Hearing Policy to specify the appropriate quality committee(s) responsible for analyzing grievance data to identify opportunities for improvement and developing and monitoring action plans in response to identified opportunities.
- Ensure meeting minutes of the appropriate quality committee(s) reflect identified opportunities and actions taken to address opportunities.

5.1 g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.
This component is Partially Met.

The MD Member Appeal, Grievance, and State Fair Hearing Policy requires a grievance acknowledgment letter to be sent to the enrollee within five calendar days of grievance receipt, if any grievance takes longer than the regulatory timeframe or five calendar days, whichever is sooner. Resolution timeframes are consistent with regulatory requirements and include notification.

The Maryland Appeal Compliance Report provided timeframe compliance by month and by quarter for written grievance acknowledgments and resolutions by grievance category. Compliance with the timeframe for written grievance acknowledgment was reported as 98.15% first quarter, 98.46% second quarter, 90.2% third quarter, and 100% fourth quarter.

Compliance with resolution timeframes by grievance category was reported as follows:

- Emergency, medically related - none received first and fourth quarters, 50% second quarter, and 25% third quarter.
- Non-emergency, medically related - 100% first quarter, 83% second quarter, 36.4% third quarter, and 37.5% fourth quarter.
- Administrative - 100% first quarter, 96.43% second quarter, 96.8% third quarter, and 86.4% fourth quarter.

According to UHC staff, results below the 95% compliance score for both acknowledgment letters and resolutions by category were related to implementation issues associated with a new grievance and appeal system and overly optimistic expectations of increased efficiency with the new system.

A sample review of ten enrollee grievance records, all administrative, found all met the timeframes for written grievance acknowledgment and resolution.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must demonstrate compliance with required timeframes for written grievance acknowledgment and resolutions, by category, at or above the MDH compliance score of 95% on at least a quarterly basis for all four quarters of the MY.

RECOMMENDATION: Qlarant recommends UHC consider indicating "revised" and identifying the revision when sending a revised letter to a enrollee. In the sample reviewed, a revised acknowledgment letter was sent to the enrollee after the category and the resulting timeframe for resolution were changed.

5.1 h. The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and within the MDH-established threshold of 95%.
This component is Partially Met.

The MD Member Appeal, Grievance, and State Fair Hearing Policy requires that written grievance resolutions be provided to enrollees within the grievance resolution timeframes.

As written resolution is incorporated in the resolution timeframes by grievance category, this component was *Partially Met*, as noted in component 5.1g. Overall, UHC fell below the MDH compliance score in the second, third, and fourth quarters in one or more grievance category.

According to UHC staff, results below the 95% compliance score were related to implementation issues associated with a new grievance and appeal system and overly optimistic expectations of increased efficiency with the new system.

A sample review of ten enrollee grievances, all administrative, found that all met the timeframes for written grievance resolution. One administrative grievance was immediately resolved; however, the resolution letter was not sent until 28 days later. Further investigation of this grievance by UHC staff found this delay was due to the health plan's ongoing transition from its Escalated Tracking System to the new Appeals Tracking System. The migration to Appeals Tracking System for enrollee appeals and grievances began in August 2024. Staff have noted it takes three to six months for staff to be fully proficient in a new system. This new Appeals Tracking System offers advanced features for staff that will help reduce case processing times and minimize delays and escalations.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must demonstrate compliance with required timeframes for written grievance resolutions, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY.

Wellpoint Maryland (WPM)

5.1 c. The system ensures that the resolution of a grievance is documented according to policy and procedure.
This component is Met with Opportunity.

The Member Grievances - MD Policy does not directly address documentation of grievance resolution in the case record; however, it does require WPM to maintain a grievance log that includes the disposition of each grievance. Furthermore, the Grievance Manager is required to provide a written summary analyzing the category of grievances, brief statements of the problem, resolutions, and resulting corrective actions, as required on a monthly, quarterly, and annual basis.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must revise the Member Grievances - MD Policy to explicitly address the requirement for documentation of the resolution of a grievance in the enrollee's case record.

5.1 d. 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.
This component is Partially Met.

The Member Grievances - MD Policy indicates the Quality Management Committee reviews grievance reports quarterly and annually to identify patterns of grievances.

As evidence of QMC review of enrollee grievances, minutes were reviewed from five Quality Management Committee meetings held in 2024. In the meeting of March 27, 2024, it was reported that grievances increased by 20% compared to the third quarter of 2023. The top three grievance categories were access, attitude/service, and financial/billing. In the May 8, 2024, Quality Management Committee meeting, it was reported grievances increased by 22% compared to the fourth quarter of 2023. The top three grievance categories identified were access, attitude/service, and billing/financial. There was no evidence of analysis of the root causes of the ongoing increases in grievances, opportunities for improvement, or action plans to address identified opportunities.

According to WPM staff, a root cause analysis has occurred for the top three grievance categories. The predominant cause for all three grievance categories was lack of enrollee knowledge/understanding, such as the need to present both the WPM and any other health insurance identification cards at the time of service to prevent billing issues and how to access the WPM system to locate an in-network provider. In addition to providing education to individual enrollees in response to their specific grievance issue, education to address top grievance categories also is provided during Member and Consumer Health Advisory Committee meetings. These meetings include between ten and 20 enrollees. Use of enrollee newsletters was presented as a more effective, proactive approach to educating WPM's membership on a larger scale; however, staff reported that WPM no longer publishes enrollee newsletters.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must demonstrate it conducts an analysis of grievance data to identify opportunities for improvement and develops action plans to address identified opportunities, consistent with the Member Grievances - MD Policy.

RECOMMENDATION: Qlarant recommends WPM consider exploring opportunities to educate its membership on a much broader scale to address top grievance categories related to lack of enrollee knowledge/understanding.

5.1 g. The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.
This component is Met with Opportunity.

The Member Grievances - MD Policy outlines the regulatory and MDH timeframes for resolution of a grievance, based on the assigned category (emergency medically related, non-emergency medically related, and administrative). The policy requires an acknowledgment letter to be sent to the enrollee by the Member Advocate but does not identify a timeframe. According to WPM Grievance staff, an acknowledgment letter is sent for all enrollee grievances within five calendar days of grievance receipt.

Compliance with grievance acknowledgment and resolution/notification timeframes was routinely reported in Quality Management Committee minutes as exceeding the MDH score of 95% for the first three quarters of 2024. The Q4 2024 Grievance turnaround time report prepared for the WPM Compliance Committee meeting indicated compliance with the timeframes for grievance acknowledgment and resolution was 100% for the fourth quarter.

A sample review of ten enrollee grievance records found 100% compliance with written grievance acknowledgment and resolution. Four of 30 cases were incorrectly categorized as administrative rather than non-emergency medically related; however, the resolution timeframe for the appropriate categorization was met.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must revise the timeframe for written grievance acknowledgment within its Member Grievances - MD Policy to be consistent with the MDH requirement, which allows waiver of the acknowledgment letter only if a grievance is resolved within the regulatory timeframe or within five calendar days, whichever is less; or its own policy, if more stringent.

***RECOMMENDATION*:** Qlarant recommends WPM consider retraining staff on what constitutes an emergency, medically related or non-emergency medically related grievance. Routine audits of categorization should be conducted until compliance with appropriate categorization is achieved in three consecutive quarters.

7.0 – Utilization Review

Findings

Aetna Better Health of Maryland (ABH)

7.2 e. There is evidence that utilization review (UR)/utilization management staff receive annual training on the interpretation and application of UR/utilization management criteria/guidelines.
This component is Met with Opportunity.

The Approving and Applying Medical Necessity Criteria - Maryland Amendment Policy indicates staff who make medical necessity determinations are trained on medical necessity criteria; however, it does not address the requirement for annual training. The Utilization Management Program Description also includes training without specifying a timeframe.

According to ABH, ongoing and annual updates to medical necessity criteria are regularly reviewed in Utilization Management team meetings. As evidence of annual training, minutes from the Utilization Management team meeting held on April 11, 2024, and attended by seven staff, included a review and discussion of updated criteria in the new Milliman Care Guidelines 28th edition.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, ABH must include a requirement for annual training of Utilization Management staff on the interpretation and application of medical necessity criteria/guidelines in either the Utilization Management Program Description or an appropriate Utilization Management policy.

7.4 c. Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is Partially Met.

An amendment to the Utilization Management Timeliness Standards and Decision Notification Policy includes a table with one column labeled "Legislation" and the other labeled "Policy/Procedure Language Change." The latter column specifies prior authorization determination timeframes for standard and expedited requests, which are consistent with regulatory requirements. If additional clinical information is required, the policy states, "it must be requested within two business days of receipt of the request."

The Pharmacy Prior Authorization and Formulary Exceptions Policy, "Decisions and Notifications" section, requires an approval, denial, or request for information for urgent and non-urgent preauthorization requests within 24 hours of receipt. The policy does not specify that the prescriber must be notified of the outcome (approval, denial, or request for additional information) of a preauthorization request by telephone or other

telecommunication device within 24 hours of request receipt. The policy provides for a 14-calendar day extension if additional information is requested to process the request.

Based upon a discussion with the Pharmacy Director, it was discovered that reporting of compliance with 24-hour prescriber notification, following receipt of the preauthorization request, encompassed compliance with both the 24-hour notification following receipt of the request and the 24-hour decision timeframe following receipt of requested additional information.

According to the 2024 Monthly Monitoring PA Tracking Report – Medical, ABH exceeded MDH's compliance score of 95% for preauthorization determinations in all months. Additionally, the 2024 Monthly Monitoring PA Tracking Report - Pharmacy indicated the 95% compliance score for timeliness of determinations was exceeded in each of the months.

No results were provided on compliance with 24-hour prescriber telephonic notifications since ABH report specifications were incorrect, as noted above.

A sample review of ten adverse determination records (five medical and five pharmacy) found 100% compliance with preauthorization determination timeframes and 24-hour prescriber notifications, following receipt of a preauthorization request.

After the initial review, ABH submitted two documents to demonstrate it had fully operationalized the process for prescriber fax notification of the outcome of a preauthorization request (approve, deny, and request additional information) within 24 hours of receipt of the preauthorization request.

The Pharmacy Preauthorization Pharmacist review Workflow requires a fax to be sent to the prescriber if the information provided is not enough to complete the review. It does not include the timeframe for sending a fax, and there is no mention of 24-hour fax notification for approvals and denials.

Additionally, ABH submitted a spreadsheet of pharmacy preauthorization requests pended for additional information. Fields included request date and time, and date the response was sent to the prescriber. This spreadsheet does not address the requirement for notification of an approval, denial, or request for additional information by telephone or other telecommunication device within 24 hours of receipt of the request.

The finding of *Partially Met,* therefore, remains unchanged.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, ABH must:

- Revise the Pharmacy Prior Authorization and Formulary Exceptions Policy to include the requirement for notifying the prescriber of the outcome (approve, deny, or request additional information) of the preauthorization request for a covered outpatient drug, by telephone or other telecommunication device, within 24 hours of receipt of the request.

- Remove reference to urgent and non-urgent, as all outpatient drug requests are subject to the same requirements. There is no separate classification based on the level of urgency.
- Provide reports of compliance with the timeframe for notifying the prescriber of the outcome of a preauthorization request within 24 hours of receipt, on at least a quarterly basis.

7.7 a. The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05.
This component is Met with Opportunity.

The Member Appeals Policy is comprehensive in scope and includes the following:

- Timeframe for filing, processing, and representation
- Acknowledgment and resolution letter timeframes
- Availability of timeframe extension and notification requirements
- Oral and written requirements for denial of an expedited request
- Enrollee rights during the appeal process
- Availability of continuation of benefits
- Requirements of appeal decision-makers
- Parties to the appeal
- Prohibition of any punitive action against a provider for filing on behalf of an enrollee

All of the above were consistent with regulatory requirements, with one exception. The policy identifies the timeframe for appeal filing as 60 calendar days from the postmark on the notice of adverse benefit determination, rather than from the date on the notice of the adverse benefit determination.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, ABH must revise the Enrollee Appeals Policy to specify the timeframe for filing an appeal as within 60 calendar days from "the date on the MCO's adverse determination letter."

7.8 a. The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.
This component is Met with Opportunity.

The Provider Appeals Policy outlines the process for resolving provider appeals and includes the following:

- The appeal process available to providers for claims disputes
- Timeframes for filing and acknowledgment of appeal receipt
- Timeframe between subsequent levels of appeal

- Resolution of all appeals within 90 business days of receipt of the initial appeal
- Decision timeframe
- Opportunity for provider to be heard by ABH's Chief Executive Officer or designee at the final level of appeal
- Timeframe for claims payment, when a claim denial is overturned

According to the policy, decisions on verbal appeal requests will be communicated to the provider, via telephone, no later than three business days after the decision is made. For all written requests, or requests where the provider requested a written response, ABH will generate a written decision notice to the provider via electronic mail, fax, or surface mail within three business days from the date of the decision.

Lack of written notification of resolution of appeals filed verbally is inconsistent with regulatory requirements. Regardless of the method of submission, notice of the results of the appeal must be communicated to the provider in writing.

According to ABH staff, written appeal resolutions are sent to all providers, regardless of whether the appeal was filed verbally or in writing.

After the initial review, ABH submitted several documents that indicate written notification of resolution is sent for all provider appeals. The MD Provider Appeals - Staff Cheat Sheet includes a requirement for sending the provider an appeal resolution letter within three business days of the decision and within the original 30 business days processing timeframe. The MD Provider Appeal - Job Aid Screenshot requires staff to send a decision letter once they have completed the resolution notes and saved the case. Guidance on how to generate an appeal resolution letter is also included. None of the additional documents reviewed includes an option for a verbal resolution.

It is clear that ABH's practice is to send a written resolution for all provider appeals. This component is therefore met; however, ABH must revise its Provider Appeals Policy, as indicated, in order to receive a finding of *Met* in the MY 2025 review.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025, ABH must revise the Provider Appeals Policy to require written notice of appeal resolution to be sent to the provider, regardless of whether the appeal is filed verbally or in writing.

7.9 c. The MCO acts upon identified issues as a result of the review of the data.
This component is Met with Opportunity.

Review of Service Improvement Committee minutes throughout MY 2024 found routine updates of Member and Provider Internal Action Plans developed to address opportunities identified from the 2023 CAHPS and Provider Satisfaction surveys.
Among the initiatives identified in the Member Internal Action Plan was promoting knowledge of the transportation benefit to address the issue of *Getting Needed Care*. In response to opportunities related to *Getting Care Quickly,* ABH expanded its network to include providers with extended hours and multiple locations throughout Maryland.

The Provider Internal Action Plan did not address any utilization management-related opportunities for improvement. According to the Director of QM, overall responses to the Provider Satisfaction Survey were below the 100-respondent requirement to ensure validity of findings. Furthermore, only half of respondents completed survey items related to preauthorization. In view of these and other factors, ABH implemented initiatives to focus on claims processing and customer service, which were more prevalent issues of dissatisfaction based on survey results.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, ABH must improve its meeting minutes documentation to explain its criteria for selection of utilization management-related opportunities for improvement identified from the CAHPS and Provider Satisfaction survey results.

7.10 - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.
This element is Met with Opportunity.

If a provider requests an Independent Review Organization appeal, the Provider Appeals Policy requires ABH to submit a complete case file to the Independent Review Organization within five business days from receipt of the request. If the Independent Review Organization requests additional information, it will be uploaded within two business days from the request. ABH will pay the fixed-case fee in the event the Independent Review Organization overturns the appeal decision and will process the provider's claim within 60 calendar days of the Independent Review Organization's notification, including any interest owed.

While the policy did not specifically address the requirement for establishment of an online account with the Independent Review Organization, the executed Medical Necessity Case Review Agreement between Maximus and ABH affirms this requirement was met. Additionally, a screenshot of a Registration-Request for a Portal Account initiated by ABH and acknowledged by the Independent Review Organization on August 13, 2024, supports this requirement.

The policy did not include a documented process to ensure Independent Review Organization invoices are paid within 60 days of receipt per COMAR; however, a job aid was submitted, which documented the process as follows:

- Appeals and Grievance staff submit the Independent Review Organization invoice within two business days of receipt to the director's administrative assistant for processing.
- Within two business days, the administrative assistant loads the Independent Review Organization invoice into the system for payment.
- The Director approves the invoice for payment within one business day of receipt.

- The administrative assistant forwards the invoice to Accounts Payable for payment within 24 hours.
- Accounts Payable issues payment no later than 45 days from invoice date.

A log was submitted that listed three provider appeal cases, indicating one was paid but did not include either the date of the receipt of the Independent Review Organization invoice or paid date.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, ABH must:

- Include a final step in the job aid for timely payment of Independent Review Organization invoices to identify the process for follow-up with Accounts Payable to ensure payment is issued within the designated timeframe.
- Cross reference this job aid in the Provider Appeals Policy.

CareFirst Community Health Plan (CFCHP)

7.1 c. There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.
This component is Partially Met.

The Affirmative Statement Policy requires each utilization management decision-maker, upon hire and on an annual basis thereafter, to sign an affirmative statement that includes the following:

- Utilization management decision-making is based solely on the appropriateness of care and services and the existence of coverage.
- CFCHP does not reward providers or other individuals for issuing denials of coverage.
- Financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization.

As evidence of compliance, CFCHP submitted the 2024 New Hire and Annual Conflict of Interest Training spreadsheet that included the names of employees and dates of completion of the Conflict of Interest form. Review of this form found no reference to the content required by CFCHP's Affirmative Statement Policy.

The policy further notes that the Affirmative Statement is included in the provider manual and enrollee handbook and published on the CFCHP website. Review of "Attachment J" of the enrollee handbook found an affirmative statement about the absence of financial incentives for utilization management decision-makers that result in underutilization, consistent with the policy.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must provide evidence that all Utilization Management staff members sign an Affirmative Statement that includes the required content identified in the Affirmative Statement Policy, on an annual basis.

7.3 a. Services provided must be reviewed for over and underutilization.
This component is Partially Met.

The 2024 Health Services Program Description requires the following measures to be monitored to identify potential areas of overutilization and underutilization of medical services:

- Admissions per 1000 enrollees
- Bed days per 1000 enrollees
- Length of stay
- Readmissions
- Underutilization of wellness and prevention services (for example annual preventive screenings)
- Quality, utilization, and risk management indicators

The following measurable goals of Health Services programs for 2024 include:

- Increasing primary care utilization
- Increasing well-patient visits
- Lower emergency room utilization
- Lower inpatient admissions and decrease length of stay
- Reduction in 30-day readmissions
- Increasing care coordination between behavioral and physical health
- Track utilization patterns for both inpatient and outpatient services

According to the Health Services Program Description, the Quality Improvement Committee is responsible for reviewing data and responding to utilization issues. The Quality Improvement Committee leadership team identifies, prioritizes, and implements opportunities for improvement in Health Services activities, when indicated. Reports from various quality committees are reviewed and approved by the Quality Improvement Committee, which meets on a quarterly basis.

Review of minutes from all six Quality Improvement Committee meetings held in 2024 revealed inconsistent and incomplete quarterly reporting of utilization management metrics identified in the Health Services Program description.

According to CFCHP, utilization metrics are reported based on paid claims data, which results in a lag in reporting. Admits per thousand, days per thousand, and average length of stay were reported for the first and second quarters of 2024 in the Quality Improvement Committee meetings of April 25, 2024, and September 20, 2024. There was no evidence of reporting of other key metrics, such as emergency room utilization and readmissions, which were both identified as focus areas for reduction in MY 2024.

For the measures reported, there was evidence of analysis to determine potential areas of overutilization and underutilization. For example, in the April 25, 2024, Quality Improvement Committee meeting, it was noted that admits per thousand, average length of stay, and days per thousand vary based on the subpopulations of Medicaid enrollees: adults without children, Supplemental Social Security Income adult and child, and temporary assistance for needy families. In comparing the fourth quarter of 2023 to the first quarter of 2024, it was reported there were declines in all categories (except for denied days for inpatient requests, which is an inverse measure). It was explained that the increase in denied days is not a good sign, as it indicates enrollees are in the hospital when they don't need to be, which could be because of discharge disposition issues, such as finding a skilled nursing facility. This was identified as an area to monitor.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must demonstrate consistent reporting of identified metrics to the Quality Improvement Committee, consistent with the Health Services Program Description.

7.3 b. UR reports must provide the ability to identify problems and take the appropriate corrective action.
This component is Partially Met.

Review of all six Quality Improvement Committee meetings held in 2024 found no action plans to address identified opportunities to address overutilization and underutilization, specifically in response to the focused areas identified in the 2024 HS Program Description.

Discussion with CFCHP staff indicated there are interventions in place to address these key areas, such as emergency room overutilization and underutilization of primary care. As an example, CFCHP submitted a presentation entitled "Increasing Primary Care Utilization." This was an extremely comprehensive study of utilization of various sites of care by enrollees, with evidence of PCP utilization and those without, based on data from 2021, 2022, and 2023. Identified challenges and barriers were cited as: a shortage of PCPs, self-referrals to specialists, availability of alternate sites of care, social determinants of health, and distrust of the healthcare system.

A summary of findings found:

- 49% of CFCHP enrollees did not visit a PCP in 2023.
- PCP visit gaps for young children and adults over 50 are concerning.
- Low PCP usage occurs in various parts of Maryland, but the highest concentration is in Baltimore City and County.

- Federally Qualified Health Centers make up a large part of the Primary Care infrastructure.
- PCP visits have the potential to improve quality and reduce costs.

It was concluded that PCP visits have the potential to improve quality and reduce costs and that increasing PCP visit rates is difficult and will require a multi-pronged approach.

Next steps identified the need for:

- Further Data Analysis
- Determination of a scaling model
- Implementation of promising models
- Monitoring and evaluating existing and new activities
- Expanding successful interventions

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must demonstrate it takes appropriate action, based on identified opportunities to improve overutilization and underutilization of healthcare services, as evidenced by reporting to the appropriate committee(s) identified in its Health Services Program Description and/or applicable policies.

RECOMMENDATION: Qlarant recommends that CFCHP consider revisiting its current reporting structure to bring together all initiatives to address identified overutilization and underutilization to ensure appropriate monitoring and oversight. For example, workgroups could be established to address each of the key focus areas identified in its Health Services Program Description. An overutilization and underutilization workplan would support consolidated reporting from the workgroups, with coordination at the Health Services Department level. This department would then be responsible for providing updates to the Quality Improvement Committee on a regular basis. Alternatively, the current role of the corporate Utilization Management Committee, which oversees all lines of business, could be revisited. The Quality Improvement Committee should serve as an oversight body rather than a working committee.

7.3 c. Corrective measures implemented must be monitored.
This component is Unmet.

Review of all six Quality Improvement Committee meetings held in 2024 found no monitoring of action plans to address identified opportunities to address overutilization and underutilization, specifically in response to the focused areas identified in the 2024 Health Services Program Description.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must demonstrate routine monitoring of action plans implemented to address areas of overutilization and underutilization by the appropriate committee(s), as identified in its Health Services Program Description and/or applicable policies.

7.4 c. Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is Met with Opportunity.

The Timeliness of Utilization Management Decisions Standard Operating Procedure identifies determination timeframes for standard and expedited preauthorization requests that are consistent with regulatory requirements. Additionally, requests for additional clinical information, if necessary, must be made within two business days of receipt of the preauthorization request.

The Pharmacy Prior Authorizations Policy asserts that CVS will approve, deny, or request additional information by telephone or other telecommunication device within 24 hours of the preauthorization request for all covered outpatient drugs.

The Pharmacy Prior Authorizations Standard Operating Procedure indicates if additional clinical information is not received within 24 hours of the initial receipt of the requested preauthorization, an adverse determination is made, and the enrollee is notified within 24 hours of receipt of the request. The availability of a 14-calendar day extension is to allow a provider additional time to submit requested clinical information, as communicated in the MCO Transmittal No. 225, dated October 3, 2024, which was not found in either the policy or standard operating procedure. Pharmacy staff were unaware of this transmittal.

As evidence of compliance, CFCHP submitted the Medical Pre-Service Denial Turnaround Time Compliance report, which indicated compliance with preauthorization determination timeframes was above the MDH compliance score of 95% for all four quarters of MY 2024.

The CVS Health - Pharmacy Preauthorization Timeliness report indicated compliance with the preauthorization determination timeframe for covered outpatient drugs exceeded the MDH compliance score of 95% for all four quarters of the MY. Additionally, compliance with 24-hour prescriber notification was above the compliance score for all four quarters.

A sample review of ten adverse determination records (all standard medical) found that all demonstrated compliance with determination timeframes.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must update the Pharmacy Prior Authorizations Standard Operating Procedure to include information from the MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a determination about a covered outpatient drug, if additional clinical information is requested.

7.5 b. Adverse determination letters include all required components.
This component is Partially Met.

The Timeliness of Utilization Management Decisions Policy lists the content to be included in the adverse determination letter but is missing several required components.

Despite the Timeliness of Utilization Management Decisions Policy missing several required components, a sample review of ten adverse determination records found that adverse determination letters included all requirements.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must include all required adverse determination letter components in the Timeliness of Utilization Management Decisions Policy, or in a policy/standard operating procedure of its choice.

7.6 a. The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.
This component is Met with Opportunity.

The Timeliness of Utilization Management Decisions SOP and the Timeliness of Utilization Management Decisions Policy include regulatory timeframes for sending an enrollee notice of an adverse determination in response to a standard or expedited preauthorization request. Additionally, written notice to an enrollee is required at least ten days prior to reducing, suspending, or terminating a covered service.

The Pharmacy Prior Authorizations Standard Operating Procedure requires notifying the enrollee of an adverse determination within 24 hours of the preauthorization request.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must revise the Pharmacy Prior Authorizations Standard Operating Procedure to require notification of an enrollee of an adverse determination within 24 hours of the preauthorization determination. This change from receipt to determination is required to support the additional time allowed for a provider to submit requested clinical information, as outlined in the October 3, 2024, MCO transmittal.

7.7 a. The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05.
This component is Partially Met.

The Medicaid Member Appeals Policy allows an enrollee, or their authorized representative with written consent, to file an appeal "within 60 days from the initial denial notice." This timeframe description does not specifically indicate the date of the adverse determination notice beginning the 60-day timeframe. Appeals are accepted orally or in writing. Timeframes specified for written acknowledgment and written resolution of standard and expedited appeals are consistent with regulatory requirements. The policy also indicates that CFCHP will not take punitive action against a provider for supporting an enrollee's appeal or requesting expedited resolution of an enrollee's appeal.

The Appeals and Grievances Desktop Procedures provide additional details relating to the processing of appeals and enrollee rights. Responsibilities of the appeals and grievances coordinators include logging the appeal into the appeals and grievances database while appeals and grievances investigators document the substance of the appeal, including the reason for the appeal and any aspects of clinical care involved; and any actions taken. The appeals and grievances investigator takes into account information provided by the enrollee or their authorized representative, without regard to whether such information was submitted or considered in the initial action. The enrollee, or their authorized representative, is provided with the opportunity to examine the enrollee's case file, including medical records and any other documents and records before and during the appeal process, free of charge. Review procedures are documented for both clinical and administrative appeals. Additionally, the contents of the notice of resolution are listed.

The appeal filing timeframe noted above was also identified as an opportunity for improvement in the MY 2021 review, resulting in a CAP, which was successfully resolved at the time of the MY 2022 review.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must revise the Medicaid Member Appeals Policy to clarify the appeal filing timeframe is 60 calendar days from the date on the notice of adverse benefit determination. This also should be clarified in the standard operating procedure.

7.7 c. The MCO must adhere to appeal timeframes.
This component is Unmet.

In response to the MY 2023 review, CFCHP was required to demonstrate compliance with timeframes for written appeal acknowledgement at or above the MDH compliance score of 95%, on at least a quarterly basis, for all four quarters of the review period. As indicated below, continued opportunities for improvement exist.

The Member Appeals Policy includes timeframes for written acknowledgment of an appeal and written resolution for standard and expedited appeals that are consistent with regulatory requirements.
As evidence of compliance, CFCHP submitted the Member Appeals 2024 report that identified compliance for each of the four quarters of MY 2024 as follows:

- Acknowledgment letter: Q1 (93%), Q2(99%), Q3 (98%), and Q4 (100%)
- Expedited appeals resolution/notification: Q1 (100%), Q2 (82%), Q3 (83%), and Q4 (91%)
- Standard appeals resolution/notification: Q1 (100%), Q2 (98%), Q3 (100%), and Q4 (100%)

A sample review of ten appeal records, two expedited and eight standard, found 100% compliance with the timeframe for enrollee written notification of appeal resolution.

According to staff, CFCHP had been strictly using a 24-hour timeframe for notification of resolution of an expedited appeal, rather than the one-calendar day equivalent in assessing timeframe compliance.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must demonstrate consistent compliance with timeframes for written enrollee appeal acknowledgment and resolution/notification for expedited appeals, at or above the MDH score of 95%, for all four quarters of the MY.

7.7 e. 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.
This component is Unmet.

In response to the MY 2023 review, CFCHP was required to demonstrate a reasonable attempt to provide the enrollee with oral notification of the denial of a request for an expedited appeal resolution. As indicated below, continued opportunities for improvement exist.

The Member Appeals Policy requires CFCHP to make a reasonable effort to give the enrollee and treating provider prompt verbal notice and written notice, within two calendar days of a denial of a request for an expedited appeal resolution.

The Member Appeals Q1-Q4 report documented compliance for all four quarters of MY 2024 as follows:

- Reasonable attempt to provide verbal notification of the denial: Q1 (85%), Q2 (94%), Q3 (100%), and Q4 (100%)
- Written notification within two calendar days of the denial decision: Q1 (74%), Q2 (88%), Q3 (92%), and Q4 (100%)

A sample review of ten enrollee appeal records found three denials of a request for an expedited resolution. Case notes demonstrated an attempt to provide oral notification of the denial to the enrollee and written notification within two calendar days of the denial decision.
OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, CFCHP must demonstrate a reasonable attempt to provide the enrollee with oral notification of the denial of a request for an expedited appeal resolution and written notification within two calendar days of the denial decision, at or above the MDH score of 95%, on at least a quarterly basis throughout the MY.

Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)

7.4 c. Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is Met with Opportunity.

The Managing Referrals for Maryland HealthChoice Members Policy includes a table that identifies the decision timeframe for expedited and standard preauthorization requests. For expedited requests, determination and written notification to the enrollee is required within 72 hours from receipt of the request. For standard authorization requests, determinations are required within two business days of receipt of clinical information, but not later than 14 calendar days from the date of the initial request. Requests for additional clinical information, if necessary, must be made within two business days of receipt of the preauthorization request.

The MD HealthChoice Pharmacy Service Authorizations Policy requires a response to pharmacy service requests of either an approval, denial, or request for additional clinical information to the prescriber within 24 hours of the request, by telephone or other telecommunication device. It does not include the availability of a 14-day extension if additional clinical information is requested. According to KPMAS staff, they have been allowing a seven-day extension, as needed.

The Maryland HealthChoice Medical TAT Report identified quarterly turnaround time compliance for determinations by approvals and denials. The MDH compliance score of 95% was exceeded in all four quarters of the MY.

The Maryland HealthChoice Pharmacy TAT Report identified compliance with the determination timeframe and the 24-hour prescriber notification by quarter. The MDH compliance score of 95% was exceeded in all four quarters of 2024.

A sample review of ten adverse determination records (nine standard medical, one pharmacy) found 100% compliance with the determination timeframe and 24-hour prescriber notification.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, KPMAS must update the MD HealthChoice Pharmacy Service Authorizations Policy to include information from the MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe for a determination about a covered outpatient drug, if additional clinical information is requested.

7.6 a. The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.
This component is Met with Opportunity.

The Assessing Compliance MD HealthChoice Determination and Notifications Policy includes a table listing enrollee and practitioner/provider notification requirements compliant with regulatory requirements. For expedited requests, written notification of an adverse determination is required within 24 hours of the determination and within the 72-hour timeframe from receipt of the request. Notice of an adverse determination is required within 72 hours of the determination for standard requests.

The MD HealthChoice Pharmacy Service Authorizations Policy requires an adverse determination notification letter be sent to the enrollee and the prescribing provider within 24 hours of a preauthorization request for a covered outpatient drug.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, KPMAS must revise the adverse determination notification timeframe in the MD HealthChoice Pharmacy Service Authorizations Policy from 24 hours from receipt of the preauthorization request to the date of determination. This is consistent with the availability of a 14-calendar day extension communicated in MCO Transmittal no. 225 dated October 3, 2024.

7.8 b. The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. This component is limited to provider administrative appeals. Provider medical necessity appeals are always post-payment. Pre-service medical necessity reviews are enrollee appeals.
This component is Met with Opportunity.

The Provider Claims Appeals Policy - Maryland requires KPMAS to resolve initial appeals within 30 business days of receipt. It does not identify the timeframe for resolution of subsequent appeal levels; however, according to KPMAS staff, the 30-business day timeframe applies to all appeal levels.

A written determination will be provided for each level of appeal and will be sent at the time of the appeal decision.

The policy further requires all provider appeals, regardless of the number of levels, to be resolved within 90 business days from the initial appeal.

After the initial review, KPMAS submitted the Provider Claims Appeals Disputes/Appeals Policy - Maryland, which included an update date of February 6, 2025. This document is outside of the MY 2024 review period; however, it will be reviewed as a component of the MY 2025 interim review.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, KPMAS must revise the Provider Claims Appeals Policy - Maryland to specify the timeframe for resolving subsequent levels of provider appeals beyond the initial appeal.

7.9 c. The MCO acts upon identified issues as a result of the review of the data.
This component is Met with Opportunity.

KPMAS developed an action plan based on an analysis of opportunities for improvement, which identified the opportunity, action steps, materials or resources needed, the goal, findings/outcomes, next steps, and the timeframe for completing action steps. Getting Care Quickly was identified as an opportunity for improvement as CAHPS results showed a large gap from the Maryland Medicaid Plan Average of ten percentage points for the adult survey and nine percentage points for the Child survey. In response to this opportunity and one for care coordination from the Provider Satisfaction Survey, KPMAS realigned case and care management into a consolidated Integrated Care Management Department, effective January 2024, to better coordinate care, particularly for high-risk enrollees. Activities completed or underway for the first three quarters included forming this new department; hiring an Executive Director and ICM staff; developing an Integrated Care Management Department playbook/team guide; forming an oversight committee; conducting staff development; and developing goals, workflows and an action plan for 2025 with a particular focus on Supplemental Security Income enrollees.

Although documentation submitted did not appear to address how the action plan addressed the Getting Care Quickly CAHPS survey result, KPMAS staff reported improvement has occurred in the referral timeframe as a result of the realignment of case and care management into a consolidated department.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025, KPMAS must provide documentation that demonstrates specific initiatives have been implemented to address opportunities for improvement related to results from the CAHPS survey.

7.10 - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.
This element is Partially Met.

The Provider Claims Appeals Policy - Maryland includes a brief reference to the availability of additional provider appeal rights to the Independent Review Organization once all appeals have been exhausted with KPMAS.

According to KPMAS staff, the Maryland HealthChoice Provider Appeals Procedure Policy reviewed to demonstrate compliance with this element in MY 2021 has been retired. KPMAS is currently in the process of incorporating content from this policy into the Provider Claims Appeal Policy - Maryland.

After the initial review, KPMAS submitted the Provider Claims Appeals Disputes/Appeals Policy - Maryland, which included an update date of February 6, 2025. This document is outside of the MY 2024 review period; however, it may be submitted for review at the time KPMAS' CAP is due to Qlarant.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025, KPMAS must revise the Provider Claims Appeals Policy - Maryland to be consistent with the requirements of COMAR 10.67.13.

Maryland Physicians Care (MPC)

7.4 c. Time frames for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is Met with Opportunity.

The Prior Authorization Policy includes a table outlining the decision and notification timeframes for urgent and non-urgent pre-service authorization requests. Urgent preservice decisions/notifications are required within 72 hours of receipt of the request. Nonurgent decisions are required within two business days of receipt of necessary clinical information, but no later than 14 calendar days from the date of the initial request. If additional clinical information is required for review, it must be requested within two business days of receipt of the request. The table also includes the availability of a 14-calendar day extension for authorization decisions for both urgent and non-urgent requests.

The Pharmacy Prior Authorization Policy requires notice to the prescriber, by telephone or other telecommunication device, of all covered outpatient pharmacy decisions (approve, deny, or request additional clinical) within 24 hours of receipt of the request. The Pharmacy Benefit Manager is required to provide written notice of a decision to the enrollee with a copy to the requesting provider within 24 hours of the request. According to MDH Transmittal No. 225, dated October 3, 2024, the MCO may allow the provider up to 14 calendar days to submit additional information, if requested, to make an authorization decision. This 14-calendar day timeframe includes the original 24-hour decision timeframe.

MPC exceeded the MDH compliance score of 95% for standard and expedited non-pharmacy and outpatient pharmacy preauthorization determinations in all four quarters of MY 2024, based on the key indicator reports. Compliance with prescriber notification within 24 hours of receipt of an outpatient pharmacy preauthorization request was reported as 100% for all four quarters of MY 2024.

A sample review of ten enrollee adverse determination records (nine medical and one pharmacy) found 100% compliance with timeframes for medical and pharmacy preauthorization determinations and 24-hour prescriber notification of the outcome of a preauthorization request for a covered outpatient drug.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the CY 2025 review, MPC must revise the Pharmacy Prior Authorization Policy to include providing up to 14-calendar days for providers to submit additional information if needed to make an authorization decision.

7.6 a. The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.
This component is Met with Opportunity.

The Prior Authorization Policy includes a table that identifies the notification timeframes for urgent and non-urgent adverse determinations, which is consistent with regulatory requirements. Specifically, for urgent pre-service adverse determinations, notification is required within 24 hours of the decision, but no later than 72 hours from receipt of the request. For non-urgent pre-service adverse determinations, notification is required within 72 hours of the decision. Additionally, the policy requires MPC to provide the enrollee with at least a ten-day notice before the date of action whenever the action is termination, suspension, or reduction of previously authorized services.

As noted in component 7.4c, the Pharmacy Prior Authorization Policy requires the Pharmacy Benefit Manager to provide written notice of a decision to the enrollee with a copy to the requesting provider within 24 hours of the request. The policy does not differentiate between approvals and adverse determinations. According to MDH Transmittal No. 225, dated October 3, 2024, the MCO may allow the provider up to 14 calendar days to submit additional information, if requested, to make an authorization decision.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the CY 2025 review, MPC must revise the Pharmacy Prior Authorization Policy timeframe for enrollee written notice of the determination from 24 hours of receipt of request to 24 hours from the decision in view of the MCO Transmittal No. 225 allowing for this 14-calendar day extension.

7.11 a. The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation.
This component is Met with Opportunity.

The Corrective Managed Care Program Description requires the use of approved criteria for evaluating an enrollee for initial enrollment in the Corrective Managed Care Program; specifies the requirement for a licensed healthcare professional to review enrollees proposed for the program and identifies the timeframe for initial restriction; and an additional enrollment period for any enrollee who continues to engage in medication abuse. MPC allows the enrollee an opportunity to identify a preference for a single assigned pharmacy provider. Pharmacy changes may be requested in the event of an emergency department visit, hospital inpatient treatment, or inability of the designated pharmacy to provide specific specialty medications prescribed for the enrollee. The policy allows enrollees 20 days from the date of the decision to provide additional information for reconsideration of the enrollment decision. The enrollee, or provider acting on the enrollee's behalf, may file an appeal within 20 days from the date of receipt of the MCO’s notice of action. Lastly, the policy outlines required monthly reporting to MDH of all enrollees who have been enrolled in the program, with beginning and end dates and reconciliation of the files created by MDH, on a monthly basis.

Missing from the Corrective Managed Care Program description was the provision for designating a new pharmacy provider, if the enrollee moves out of the service area of the current pharmacy. Additionally, the timeframe for providing additional information stated as 20 days from the "date of decision" is inconsistent with the COMAR timeframe of 20 days from the "date of the notice."

The Corrective Managed Care Policy includes all requirements consistent with COMAR 10.67.12.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MPC must:

- Revise the Corrective Managed Care Program Description to provide for the designation of a new pharmacy provider, if the enrollee moves out of the service area of the current pharmacy.
- Revise the timeframe for submitting additional information to 20 days from the date of the notice to be consistent with COMAR 10.67.12.02.

MedStar Family Choice, Inc. (MSFC)

7.4 c. Time frames for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is Met with Opportunity.

The UM Process Policy identifies preauthorization determination timeframes in compliance with regulatory requirements. For urgent pre-service requests, a determination is required within 72 hours of receipt of the request. For standard pre-service requests, a determination is required within two business days of receipt of the information necessary to make a determination, but no longer than 14 calendar days from the date of the initial request. If additional clinical information is required, it must be requested within two business days of receipt of the request. The policy also provides for an extension of the timeframe for a determination and outlines the requirements for enrollee notification of the extension, the reason for the extension, and the right to file a grievance if they disagree with the decision.

For outpatient drug preauthorization requests, MSFC will approve, deny, or request further information within 24 hours of receipt of the request and make a determination within that timeframe, even if requested clinical information is not yet received. This is inconsistent with MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a decision about a covered outpatient drug if additional clinical information is requested. MSFC explained they have not updated their processes to be consistent with the October 3, 2024, MCO Transmittal in view of the NCQA requirement, which only allows 24 hours from receipt of the request for a determination of an approval or denial.

As evidence of compliance, MSFC submitted the Utilization Management Trends Summary through December 2024, which indicated that MSFC exceeded the MDH compliance score of 95% for preauthorization determination timeframes for pharmacy and non-pharmacy requests and 24-hour prescriber notification of the outcome of a preauthorization request for all four quarters of the MY.

A sample review of ten enrollee adverse determination records found 100% compliance with determination timeframes for both medical and pharmacy preauthorization requests. Additionally, all applicable records demonstrated compliance with notifying the prescriber of the determination within 24 hours of receipt of the request.

OPPORTUNITY FOR IMPROVEMENT: In order to receive *Met* finding in the MY 2025 review, MSFC must update the Utilization Management Process Policy to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a decision about a covered outpatient drug if additional clinical information is requested.

RECOMMENDATION: Qlarant recommends MSFC consider revising the Prior Authorization/Non-Formulary Medication Request form to eliminate the statement "MFC-Maryland must render a decision within 24 hours. If medical records are incomplete, the request is subject to denial." This is inconsistent with MCO Transmittal No. 225.

7.8 c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
This component is Partially Met.

The Appeal and Grievance Dashboard indicates MSFC exceeded the MDH compliance score of 95% for compliance with the timeframe for written acknowledgment of provider appeal receipt in the first and second quarters of the MY. Compliance fell to 91.3% in the third quarter and 94.4% in the fourth quarter. Compliance exceeded the MDH compliance score for written resolution in the first three quarters of the MY. Compliance with written resolution fell to 93.2% in the fourth quarter.

According to MSFC staff, compliance was impacted in the latter half of 2024 due to an unexpected surge of emergency room appeals, training of new hires to support the increased volume, and cross-training of existing staff to provide more flexibility in resource utilization.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MSFC must demonstrate compliance with provider appeal acknowledgment letters and written resolution, at or above the MDH compliance score, on at least a quarterly basis throughout the MY.

7.9 b. The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.
This component is Partially Met.

Quality Improvement Committee minutes from the November 26, 2024, meeting demonstrated presentation of results from both the Adult and Child versions of the CAHPs survey. Detailed summaries of results also were provided. No utilization management-related opportunities were identified from the Adult survey; however, Ease of Getting Care was identified as an opportunity from the Child survey.

According to MSFC staff, Provider Satisfaction Survey results were not presented at any of the Quality Improvement Committee meetings held in MY 2024.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MSFC must present results of the annual Provider Satisfaction Survey to the appropriate oversight committee identified in its policy.

Priority Partners (PPMCO)

7.3 c. Corrective measures implemented must be monitored.
This component is Met with Opportunity.

Minutes from QAPI Committee meetings demonstrated ongoing monitoring of implementation of interventions to address identified overutilization and underutilization issues and reported progress. For example, minutes from the October 3, 2024, QAPI Committee meeting identified members enrolled year-to-date in the Diabetes Prevention Program, noting that ten percent of enrollees had at least one virtual session, and ten of 83 enrollees completed the program. There was no evidence of the impact of this and other interventions on specific measures related to overutilization of services and resources by enrollees with diabetes, such as emergency room visits or inpatient admissions.

While not found in any of the QAPI Committee meeting minutes reviewed, PPMCO staff reported that HbA1c, one of the process measures selected that could have a potential impact on overutilization of acute services, demonstrated a statistically significant improvement for those enrollees engaged in care management versus those who were unengaged.

Updates also were provided on the Teladoc program, indicating that annualized utilization remained stable at 0.8% and noting that discussions with Johns Hopkins Medicine were continuing on opportunities to increase utilization. There was no evidence of reporting of the impact of this intervention on overutilization of emergency room and urgent care services.

Under the "Continuity and Coordination of Care" section of these minutes, results of interventions to address various HEDIS measures were identified comparing performance to a benchmark and rates for enrollees engaged in care management versus those unengaged. For example, the rate for timeliness of postpartum care for enrollees engaged in care management was slightly better than those not engaged at 78.05% versus 77.65%, respectively.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must identify the specific overutilization, and underutilization measures it is addressing through the development of its interventions and monitor not only the progress of its interventions, but also how those interventions are having an impact on those measures which they are designed to address. For example, to address overutilization of services and resources for enrollees with diabetes, emergency room and inpatient utilization metrics could be assessed to determine impact of interventions.

7.4 c. Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is Partially Met.

Appendix A of the UM Determination and Notifications Timeframes Policy specifies the determination timeframes for standard and expedited preauthorization requests, consistent with COMAR. If additional clinical information is needed, it must be requested within two business days of receipt of the request and a decision must be rendered within two business days of receipt of any necessary clinical information. The policy also allows for a 14-calendar day extension under certain circumstances.

The Prior Authorization, Quantity Limits, and Step Therapy Exceptions Policy requires decision and notification by telephone or other telecommunication device to the requesting provider within 24 hours from receipt of the original preauthorization request. If additional information is needed, the provider will have up to 14 calendar days from the date of the original request to submit it. Written enrollee notification, with a copy to the requesting provider, shall be provided within 72 hours from the date of the decision.

The Utilization Management Turnaround Time Report indicated PPMCO exceeded the MDH compliance score of 95% for determination timeframes for approved preauthorization requests in eight of the nine months reported. Compliance for May was reported as 94.15%. Determination timeframe compliance exceeded the 95% score for denied preauthorization requests in four of the nine months. Compliance fell short of the 95% score for the months of May through September. According to PPMCO staff, the MCO changed platforms from Arial to EPIC in April and experienced system implementation issues, which impacted turnaround times. The issues were finally resolved in September 2024. No compliance results for determination timeframes were provided for the fourth quarter of the MY.

As evidence of compliance with 24-hour prescriber notification of the outcome of a preauthorization request for a covered outpatient drug, PPMCO submitted quarterly Grievance Appeal and Denial Reports for the first three quarters of 2024, which demonstrated compliance as exceeding the MDH score. No reports were provided for the fourth quarter of 2024.

A sample review of ten enrollee adverse determination records (eight medical and two pharmacy) found 100% compliance with determination timeframes and 24-hour prescriber notifications.

After the initial review, PPMCO submitted its response to the Exit Letter, which stated "PPMCO does not dispute that the timeframes for prior authorization decisions were not within MDH-established thresholds (>95%) for the full year. PPMCO will review processes and procedures to ensure that preauthorization decisions are completed within required timeframes in CY2025."

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must demonstrate consistent compliance, at or above the MDH score of 95%, for preauthorization determination timeframes and 24-hour prescriber notification no less than quarterly for the entire MY.

7.5 b. Adverse determination letters include all required components.
This component is Met with Opportunity.

The Clinical and Administrative Denial Notification Policy lists all required content for enrollee adverse determination letters.

A sample review of ten enrollee adverse determination letters found all required components were included.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025, PPMCO must remove reference to the assumption of a five-day timeframe for mailing in the appeal filing timeframe in adverse determination notices.

7.6 b. The MCO demonstrates compliance with adverse determination notification time frames in response to preauthorization requests as specified by the State.
This component is Partially Met.

The Utilization Management Turnaround Time Report indicated PPMCO exceeded the MDH compliance score of 95% for adverse determination notification timeframes in four of the nine months reported. Compliance fell short of the 95% score for the months of May through September. According to PPMCO staff, the MCO changed platforms from Arial to EPIC in April and experienced system implementation issues, which impacted turnaround times. The issues were finally resolved in September 2024. No compliance results for determination timeframes were provided for the fourth quarter of the MY.

A sample review of ten enrollee adverse determination records found 100% compliance with adverse determination notification timeframes.

After the initial review, PPMCO submitted its response to the Exit Letter, which stated, "PPMCO does not dispute the findings that the timeframes for adverse determination notification were not within MDH-established thresholds (>95%) for the full year. PPMCO will review processes and procedures to ensure that adverse determination notifications are completed within required timeframes in CY2025."

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must demonstrate compliance with the timeframes for adverse determination notifications, at or above the MDH score of 95%, on at least a quarterly basis for the entire MY.

7.8 c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
This component is Met with Opportunity.

According to the Priority Partners Provider Appeals Policy, a written acknowledgment is to be sent to the provider within five business days of receipt of the appeal. Providers are to be notified of the determination in writing within 30 calendar days of receipt of the request for either a first or second level appeal.

The Provider Appeals Report for the first three quarters of 2024 demonstrated that PPMCO exceeded the MDH compliance score of 95% for timeliness of written acknowledgment and written resolution of provider appeals. The Provider Appeals Turnaround Time Report for the fourth quarter of MY 2024 demonstrated PPMCO exceeded the MDH compliance score for written resolution; however, written acknowledgment fell below the compliance threshold at 60.78% for non-emergency appeals. PPMCO also reported acknowledgment letter timeliness for expedited appeals; however, there is no expedited category for provider administrative (claims) appeals.

After the initial review, PPMCO's response to the Exit Letter stated, "There was an error in the provider appeals data submitted on January 31, 2025. PPMCO has included the corrected report [File: Qlarant Quarterly Provider Appeals Turnaround Time Report_Q4 2024_REVISED] to reflect the written acknowledgement of provider appeals was 96.31% not the 60.78% shown in the original reporting." Review of the revised report found that PPMCO exceeded the MDH compliance score for written acknowledgment of provider appeals for the fourth quarter of the MY.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must eliminate the "expedited" category for provider administrative (claims) appeals.

7.9 a. The MCO has a process in place to evaluate the effects of the utilization review program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.
This component is Met with Opportunity.

The Member and Provider Experience with the Utilization Management Process Policy assigns responsibility to the Utilization Management Department for an annual analysis of Utilization Management-related satisfaction results from the MDH-coordinated CAHPS and Provider Satisfaction surveys. An evaluation of these findings is reported to the appropriate oversight committee on an annual basis. When opportunities are identified to improve enrollee and practitioner experience with the Utilization Management process, the Utilization Management Department develops an action plan based on trends identified or areas in need of improvement. The Utilization Management Department is also responsible for evaluating the effectiveness of improvement interventions and making changes, as necessary. Progress reports related to improvement initiatives are reported to the Enrollee Survey Workgroup and Utilization Management/Care Management Workgroup on a quarterly basis.

According to PPMCO staff, the "appropriate oversight committee" mentioned in the Enrollee and Provider Experience with the Utilization Management Process Policy is the QAPI Committee.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must revise the Member and Provider Experience with the Utilization Management Process Policy to identify the "appropriate oversight committee" referenced in this policy.

7.9 b. The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.
This component is Partially Met.

The Member and Provider Experience with the Utilization Management Process Policy indicates that an evaluation of survey findings related to enrollee and practitioner experience with the Utilization Management process be reported to the appropriate oversight committees on an annual basis. According to PPMCO staff, the appropriate oversight committee is the QAPI Committee.

Review of minutes from eight QAPI Committee meetings from MY 2024 found no evidence that annual CAHPS and Provider Satisfaction Survey results were reported.

After the initial review, PPMCO submitted its response to the Exit Letter which stated, "PPMCO does not dispute these findings. PPMCO instituted actions/initiatives to improve enrollee and provider satisfaction and those initiatives were shared during appropriate oversight committees. PPMCO will work to improve the reporting of the data and results of provider and enrollee satisfaction surveys to the governance structure during CY2025."

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must demonstrate that annual CAHPS and Provider Satisfaction Survey results are reviewed annually by the appropriate oversight committee, as specified in its Member and Provider Experience with the Utilization Management Process Policy.

UnitedHealthcare Community Plan (UHC)

7.4 c. Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is Partially Met.

The Initial Review Timeframes Policy includes state-specific timeframes at the end of the policy. Preauthorization determination timeframes are identified and consistent with the regulations for standard and expedited requests. The policy also includes a provision for up to a 14-day calendar extension for authorization decisions under certain conditions and the requirement that if additional clinical information is required, it must be requested within two business days of receipt of the request. Additionally, the requirement for prescriber notification of all covered outpatient drug authorization decisions, by telephone or another telecommunication device, within 24 hours of a preauthorization request is included.

The policy does not address the content found in MCO Transmittal No. 225, dated October 3, 2024, which allows up to 14 calendar days, including the original 24-hour decision timeframe, when additional information is requested in response to a preauthorization request for a covered outpatient drug. According to UHC staff, this is being incorporated in the next policy revision.

Review of the MD Medical Turnaround Time Report identified compliance with determination timeframes, at or above the MDH compliance score of 95%, for all four quarters of the MY. The Pharmacy Preauthorization Turnaround Report - revised indicated 100% compliance with the determination timeframe and 24-hour prescriber notification of the outcome of preauthorization request for a covered outpatient drug for all four quarters of the MY.

An initial sample review of ten enrollee adverse determination records (five standard medical and five pharmacy) demonstrated compliance with the required timeframes for preauthorization determinations. Compliance with prescriber notifications within 24 hours of receipt of a preauthorization request for a covered outpatient drug was not found in case notes. Review of an additional 20 records for compliance found no evidence of prescriber notification for the 12 outpatient pharmacy requests. Overall compliance was 0% (0/17). According to UHC, the provider notification letter included in case records is faxed to prescribers within 24 hours of receipt of the preauthorization request.

After the initial review, UHC provided additional information to address the finding of *Partially Met* by noting it added fax notification to the case files via case notes for a covered outpatient drug within 24 hours of receipt. This cannot be accepted as changes to case records already reviewed cannot be accepted. Compliance with this requirement will be assessed during the MY 2025 record review.

UHC also reported that requested updates were made to the Pharmacy Policy, Pharmacy TAT report, and the MD Medical TAT report. These documents will need to be submitted with UHC's CAP and will be reviewed at that time.

The findings for this component remain unchanged.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must:

- Revise appropriate policy to include content found in MCO Transmittal No. 225, dated October 3, 2024, which allows up to 14 calendar days, including the original 24-hour decision timeframe, when additional information is requested in response to a preauthorization request for a covered outpatient drug.
- Provide evidence in case notes of fax notification of the outcome of a preauthorization request for a covered outpatient drug within 24 hours of receipt.
- Revise the Pharmacy Turnaround Time report to replace "final determination within 24 hours of receipt of preauthorization request" to "final determination within 24 hours of the decision" and add "determination within 24 hours of receipt of additional information not to exceed 14 calendar days from date of receipt"; and change faxed notification from "24 hours from the determination" to "24 hours from receipt of the preauthorization request."
- Revise the MD Medical TAT Report to replace "case closure" with "determination," and clarify the written notification of expedited request is "within 72 hours of receipt of the preauthorization request."

7.7 e. 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.
This component is Partially Met.

The MD Member Appeal, Grievance, and State Hearing Policy requires UHC to make reasonable efforts to give the enrollee prompt verbal notice of the denial of a request for an expedited resolution and provide a written notice within two calendar days of the denial.

An initial sample review of ten enrollee appeal records found two denials of a request for an expedited resolution, with one meeting the requirements for oral and written notice of the denial. For the second record, oral notice was documented in the case record; however, it did not occur until 12 days after the decision was made to deny the request for an expedited resolution. The written notice of the denial was also not provided until 12 days after the decision to deny the request. Review of an additional 20 records found one denial of an expedited request, which met the requirements for oral and written notification of the denial. Overall compliance was 67% (2/3).

According to UHC Appeals staff, the appeal case noted above experienced a problem when both the urgency of the request was reclassified, and the request was reviewed for medical necessity by the pharmacist on the same day. As both tasks were in progress, this caused the system to glitch, and the appeal to get stuck. This issue was identified as a combination of a system issue and human error. To address this defect, the appeals and grievance team initiated a manual process to review each reclassified appeal to ensure a decision is not populated until a full evaluation of the system is completed.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must demonstrate compliance with providing an enrollee timely oral notice and written notice of denial of a request for an expedited appeal resolution within two calendar days of the denial.

7.8 b. The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. This component is limited to provider administrative appeals. Provider medical necessity appeals are always post-payment. Pre-service medical necessity reviews are member appeals.
This component is Partially Met.

The Provider Grievance and Appeal Policy requires resolution of the first level appeal determination within 40 calendar days of receipt of the appeal, and the final level of determination within 35 days of receipt of the request for reconsideration of the appeal.

According to the Provider Appeals Turnaround Time 2024 FINAL report submitted by UHC, compliance with the health plan's resolution timeframe for the first level appeal exceeded the MDH compliance score of 95% for all four quarters of the MY. The timeframe for second level appeals was met in three of the four quarters. Compliance fell to 93.8% in the third quarter of the MY.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must demonstrate compliance with resolution timeframes for provider appeals, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY.

7.8 c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
This component is Partially Met.

According to the Provider Grievance and Appeal Policy, an appeal acknowledgment letter for each level is to be sent within five business days of appeal receipt. The timeframe for written notification of appeal resolution is included within the resolution timeframes for each level of appeal. A first level appeal is to be resolved, including notice, within 40 calendar days of receipt; and a second level appeal is to be resolved, including notice, within 35 calendar days of receipt.

Review of the Provider Appeals Turnaround Time 2024 FINAL report found UHC met the timeframe for written acknowledgment of receipt of a provider appeal as exceeding the MDH compliance score of 95% for the first and second quarters of the MY. Compliance for the third quarter was reported as 94.1% and as 88.2% for the fourth quarter of the MY.

Compliance with UHC's written resolution timeframe for the first level appeal exceeded the MDH compliance score of 95% for all four quarters of the MY. The timeframe for second level appeals was met in three of the four quarters. Compliance fell to 93.8% in the third quarter of the MY.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must demonstrate compliance with timeframes for acknowledgment and written resolution of provider appeals, at or above the MDH compliance score of 95%, on at least a quarterly basis for all four quarters of the MY.

Wellpoint Maryland (WPM)

7.2 e. There is evidence that UR/Utilization Management staff receive annual training on the interpretation and application of UR/UM criteria/guidelines.
This component is Partially Met.

The Health Care Management - Clinical Training Compliance Policy requires all Utilization Review/Utilization Management staff to receive annual training on the interpretation and application of utilization review/utilization management criteria and guidelines used to make clinical decisions.

As evidence of compliance, WPM submitted the 2024 Clinical Staff Training Log. IRR GB Medical Policy-Clinical Guidelines 2024 (inactive) was highlighted, with enrollment limited to seven managers.

After the initial review, WPM submitted the Region 5 Short Length of Stay Initiative Inter-Rater Reliability document that described the monthly medical directors and review nurses meeting as a structured forum to engage in collaborative case analysis and guideline interpretation. Three cases were presented for discussion in the November 21, 2024, meeting. This does not meet the requirement that Utilization Management staff participate in annual training on the interpretation and application of utilization management criteria/guidelines, which includes training content addressing updated medical necessity criteria.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must demonstrate that Utilization Management staff participated in annual training on the interpretation and application of utilization management criteria/guidelines, which includes training content and attendees.

7.3 a. Services provided must be reviewed for over and underutilization.
This component is Met with Opportunity.

The Over/Under-Utilization of Services Policy indicates that overutilization and underutilization of services are reviewed by the Health Care Management and Quality Management departments. Results of reviews are reported to the Medical Advisory Committee and Quality Management Committee. The reviews are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and identify fraud and abuse.

Specific focused areas of quarterly review include:

- Acute/chronic care - readmissions, pharmaceuticals, specialty referrals, emergency room, home health, durable medical equipment, and behavioral health.
- Preventive care - well-child/adult PCP visits, age-appropriate immunizations, mammograms, and blood-level testing.

Providers identified as having significant aberrant patterns of utilization are reviewed by the Medical Director and Provider Relations representatives to determine the actual utilization of services.

Representatives from Health Care Management and Quality Management collaborate with the Medical Director to review intervention strategies targeted at enhancing appropriate utilization practices and provide enrollee intervention for cases of overutilization and underutilization through case/care management and/or health education and outreach.

Utilization patterns of identified enrollees/providers are monitored and trended and a review of the provider's performance is performed by the Medical Director or designee after a six-month period or earlier, as indicated.

Minutes from the Clinical Services Committee meeting of May 15, 2024, provided a comprehensive snapshot of key utilization metrics, including days per thousand, average length of stay, admits per thousand, readmission rates, emergency room visits per thousand, and outpatient services per thousand by aid category. Results were displayed by line and bar graphs, followed by a discussion of results and action plans. For example, it was reported that days per thousand increased across all categories in comparison to the prior quarter. It was noted that conditions such as sickle cell anemia, pneumonia, asthma, and cellulitis contributed to the increase.

While the Clinical Services Committee appears to have a major role in reviewing services for overutilization and underutilization of services, there is no mention of it in the Over/Under-Utilization of Services Policy. According to minutes from the Health Care Management meeting of February 22, 2023, the Health Care Management was renamed the Clinical Services Committee.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must include the role and responsibilities of the Clinical Services Committee in its Over/Under-Utilization of Services Policy.

7.3 b. UR reports must provide the ability to identify problems and take the appropriate corrective action.
This component is Met with Opportunity.

The UM Work Plan: Utilization Trends Q3 was presented at the October 30, 2024, Clinical Strategy meeting. Action plans to address opportunities for improvement in utilization metrics were reported as follows:

- Implemented the Integrated Transitional Care Program in May, aimed at identifying enrollees with a chronic diagnosis of diabetes, heart failure, asthma, and chronic obstructive pulmonary disease; enrollees with high emergency room utilization at risk for readmission; barriers to care; and social determinants of health care needs.
- Actively assessing discharge readiness and facilitating safe transition to lower levels of care.
- Implemented Home Health Rounds in July to address the overutilization and underutilization of post-acute care services.
- Implemented Discharge Planning Pilot on September 24, 2024, to reduce readmissions and the average length of stay.

There was no evidence that any of these action plans were presented, based on the review of minutes from six Quality Management Committee and three Medical Advisory Committee meetings consistent with its Over/Under-Utilization of Services Policy.

After the initial review, WPM submitted draft Quality Management Committee minutes from the December 4, 2024, meeting, which demonstrated review of utilization and HEDIS metrics; however, there was no evidence that action plans to address areas of overutilization and underutilization were reviewed. Additionally, the Quality Management Committee meeting packet for the July 17, 2024, meeting demonstrated review of the Health Care Management Q1 2024 Executive Summary, which contained first quarter 2024 utilization trends with no evidence of action plans to address utilization opportunities.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must demonstrate that action plans to address areas of overutilization and underutilization are presented to the identified committees consistent with its Over/Under-Utilization of Services Policy.

7.3 c. Corrective measures implemented must be monitored.
This component is Partially Met.

Although several action plans to address specific utilization metrics were identified in the Clinical Services Committee meeting of October, there was no evidence in the November meeting of discussion of the effectiveness of these interventions. For example, while Home Health Rounds were implemented in July, there was no evidence of the impact of this initiative on utilization of post-acute services. Additionally, there was no evidence in review of the minutes from the December Quality Management Committee meeting.

After the initial review, WPM submitted draft Quality Management Committee minutes from the December 4, 2024, meeting, which demonstrated review of utilization and HEDIS metrics; however, there was no evidence that action plans to address areas of overutilization and underutilization were monitored, as noted in the initial review.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must demonstrate that action plans to address overutilization and underutilization of services are routinely monitored to determine their effectiveness and reported to the committee(s) specified in its Over/Under-Utilization of Services Policy.

RECOMMENDATION: Qlarant recommends that WPM consider developing an Overutilization and Underutilization workplan, which identifies the areas of overutilization/underutilization, the root causes/barriers, action plans, responsible parties (departments), and quarterly status updates. This may facilitate routine reporting and also provide a vehicle for other departments to contribute their initiatives, such as Population Health and Care Management.

7.4 c. Time frames for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
This component is Partially Met.

Under the "Maryland" specific section of the Health Care Management Denial - Core Process Policy, determination timeframes for standard and expedited preauthorization requests are consistent with regular requirements. If additional clinical information is required to make a determination, it must be requested within two business days of receipt of the preauthorization request. An extension of up to 14 calendar days is available if the enrollee or provider requests the extension or WPM justifies a need for additional information and how the extension is in the enrollee's best interest.

The Pharmacy Prior Authorization Policy requires all preauthorization requests to be processed with either a decision or a request for additional information within 24 hours of receipt of the request. When additional clinical information is needed to make a determination, prescribers are sent a fax noting the specific information required. If the prescriber's office has not responded within 24 hours of receipt of the original preauthorization request, the request is forwarded to a clinical pharmacist for review. Under the "Maryland" specific section, the policy requires prescriber notification by telephone or other telecommunication device within 24 hours of a preauthorization request. Although not included within the policy, MCO staff were aware of the 14-calendar day extension if additional information is requested from the prescriber as outlined in MCO Transmittal No. 225, dated October 3, 2024.

The Preauthorization Turnaround Time Approvals and Denials document identified WPM compliance with determination timeframes, by quarter, for medical and pharmacy preauthorization requests, which exceeded the MDH score of 95% throughout MY 2024. Compliance with the 24-hour prescriber notification of the outcome of a preauthorization request (approval, denial, or request for additional information) by telephone or other telecommunication device exceeded the compliance score for the first three quarters of the MY, as reported in the MD quarterly grievance, appeal, and denial reports. No report was provided for the fourth quarter of the MY.

A sample review of ten adverse determination records (six medical and four pharmacy) found 100% compliance with determination timeframes and required 24-hour prescriber notification of the outcome of the review.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must:

- Provide compliance results for prescriber notifications of the review outcome (approval, denial, or request for additional information), by telephone or other telecommunication device, within 24 hours of receipt of a preauthorization request for a covered outpatient drug on at least a quarterly basis for the entire MY.
- Update the Pharmacy Prior Authorization Policy to include information from MCO Transmittal No. 225, dated October 3, 2024, which provides up to 14 calendar days, including the original 24-hour decision timeframe, for a determination about a covered outpatient drug if additional clinical information is requested.

7.6 a. The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.
This component is Met with Opportunity.

Timeframes for enrollee written notification of an adverse determination in the “Maryland Exceptions" section within the Healthcare Management Services Denial – Core Process Policy are consistent with regulatory requirements. The policy requires WPM to provide notice of an adverse benefit determination to the enrollee and the requesting provider within 72 hours of the determination for standard requests. For expedited requests, WPM must make a determination and provide notice within 72 hours of receipt of the request. Additionally, the policy specifies that WPM must provide notice of an adverse determination at least ten days before the action for termination, suspension, or reduction of a previously authorized covered service.

According to the Pharmacy Prior Authorization Policy, enrollees and prescribers will be sent a denial or approval notification within 24 hours of the case being closed. According to staff, the closed date is the date of an approval or adverse determination decision.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must change the timeframe of enrollee notification of an approval or denial from "closed date" to "date of determination."

7.6 b. The MCO demonstrates compliance with adverse determination notification time frames in response to preauthorization requests as specified by the State.
This component is Partially Met.

According to the TAT Report - Pharmacy, compliance with the timeframe for adverse determination notifications was met in the first three quarters of MY 2024. No results were provided for the fourth quarter.

Compliance with adverse determination timeframes for medical preauthorization requests, as reported in Clinical Strategy meetings, was found to have exceeded the MDH compliance score of 95% for the first three quarters of MY 2024. No results were provided for the fourth quarter.

A sample review of ten adverse determination records (six medical and four pharmacy) found 100% compliance with adverse determination notification timeframes.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must demonstrate compliance with adverse determination notification timeframes for medical and pharmacy preauthorization requests no less than quarterly throughout the MY.

7.7 c. The MCO must adhere to appeal timeframes.
This component is Unmet.

In response to the MY 2023 review, WPM was required to demonstrate compliance with timeframes for written appeal resolution, at or above the MDH score of 95%, on at least a quarterly basis for all four quarters of the review period. As indicated below, continued opportunities for improvement exist.

WPM submitted Service Quality Committee appeal timeframe compliance reports for the first three quarters of 2024. Three measures were reported: written appeal acknowledgment, standard resolution notification, and expedited resolution notification. Timeframe compliance was demonstrated in all nine months for written appeal acknowledgment and written notification of standard resolution. Expedited notice of resolution fell below the MDH compliance score of 95% in the first three months of the year at 62%, 93%, and 92% respectively. Additionally, the Appeal Turnaround Time Results document included fourth quarter results, which exceeded the MDH compliance score of 95% for written acknowledgment and written notice of resolution for both standard and expedited appeals.

A sample review of ten enrollee appeal records found 100% compliance with appeal acknowledgment and resolution letters.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must demonstrate compliance with the timeframe for written expedited appeal resolution, at or above the MDH score of 95%, on at least a quarterly basis for all four quarters of the MY.

7.8 a. The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.
This component is Partially Met.

The Provider Claim Payment Dispute Process Policy, the "Maryland Exceptions" section, outlines a two-level appeal process when a provider is dissatisfied with the denial, in whole or in part, of payment for services included on a clean claim. The first level of appeal was referred to as a "Reconsideration" in the policy; however, WPM staff indicated this is the first level of appeal. The policy includes the following:

- Allows the provider 90 business days from the date of denial to file an appeal.
- Timeframe for written acknowledgment of appeal is within five business days of appeal receipt.
- Timeframe for resolution of each level of appeal is within 30 business days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional business days.
- Providers have at least 15 business days from the date of denial to file a second-level appeal, but no more than 30 business days from the date on the reconsideration (first-level appeal) letter.
- Resolves all levels of appeal within 90 business days of receipt of the initial appeal by the MCO.

The policy does not include the following:

- The MCO's timeframe for written resolution of each level of appeal (The policy states the timeframe for written notice of resolution is "within State specified guidelines".)
- The opportunity for the provider to have their final level of appeal heard by the MCO's Chief Executive Officer, or the Chief Executive Officer's designee.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must revise the Provider Claim Payment Dispute Process Policy to include the following:

- The MCO's timeframe for sending written notice of appeal resolution to the provider.
- The opportunity for the provider to have their final level of appeal heard by the MCO's Chief Executive Officer, or the Chief Executive Officer's designee.
- Recategorize "Reconsideration" as "Appeal" which, according to WPM staff, is the first level of a provider claim appeal to be consistent with COMAR 10.67.09.03 language.

7.8 c. The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
This component is Met with Opportunity.

The Provider Claim Payment Dispute Process Policy requires written acknowledgment of receipt of a provider appeal within five business days of the provider's request. It does not specify the MCO's timeframe for written resolution for each level of appeal.

Compliance with written appeal acknowledgment exceeded the MDH compliance score of 95% throughout the MY.

According to the 2024 Provider Claims Payment Dispute Turnaround Time Report, WPM tracks compliance with written appeal resolution within 30 business days of the decision. Results by month through MY 2024 were reported as exceeding the MDH compliance score of 95%. It is unlikely this

timeframe is accurate as only 15 business days at most would be available for processing a second level appeal (30 business days for the decision plus 30 business days following the decision for a written resolution, and a minimum of 15 days from the initial decision for the provider to file a second level appeal).

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must revise the Provider Claim Payment Dispute Process Policy to specify the MCO's timeframe for sending the provider a written appeal resolution for each level of appeal, which would allow sufficient time for a second level of appeal if the provider chooses.

7.9 c. The MCO acts upon identified issues as a result of the review of the data.
This component is Partially Met.

Limited documentation was provided to support WPM implementing action plans to address utilization management opportunities based on results from the CAHPS and Provider Satisfaction surveys. According to the Member Satisfaction Survey Policy, progress reports are to be presented to the Quality Management Committee on a quarterly basis and to the corporate Quality Improvement Committee on a semi-annual basis. According to the Practitioner/Provider Satisfaction Survey Policy, the Quality Management Committee is responsible for monitoring the development and re-evaluation of improvement action plan progress and generating progress reports, as appropriate, as well as presenting results to the Quality Improvement Committee semi-annually. Review of QMC minutes from the March, May, and August meetings did not include any action plans related to CAHPS or Provider Satisfaction Survey results. The minutes from the July 17, 2024, Quality Management Committee meeting included a report from the Service Quality Committee advising:

- "The MD new Member Welcome Guide was posted to the Member website.
- Access to care topics were added to the MCHAC meeting to educate its enrollees.
- A CAHPS® proxy survey was utilized to reach out to enrollees to gather feedback after a recent visit to a provider. This scorecard to select providers will be reviewed quarterly for any opportunities for targeted interventions."

Review of the 2024 Annual Assessment of Member Experience documented results, opportunities for improvement, and action plans relating to the 2023 CAHPS child and adult surveys. Activities identified in response to utilization management-related opportunities from the CAHPS survey included:

- Adding the MD New Welcome Guide to the enrollee website in an area that is easy to review, which orients enrollees to their benefits and how to set up routine and urgent care appointments.
- Educating enrollees during Member and Consumer Health Advisory Committee meetings on available resources when care is needed urgently.

Medical Advisory Committee minutes from March 18, 2024, included discussion of Provider Satisfaction Survey results by noting that preauthorization had declined due to a change in the prior authorization process. In response, a workgroup has been convened to focus on this issue and additional training may be planned with the Availity platform.

None of the additional documents submitted provided further detail on action plans to address utilization management-related provider satisfaction. The 2023 Utilization Management Program Evaluation included results, barriers, and opportunities for improvement; however, they were based on an analysis of responses to the MY 2022 CAHPS and Provider Satisfaction surveys. The MD Network Management Analysis, dated December 6, 2023, is outside of the MY 2024 review period. The Provider Satisfaction Improvement Planning and Execution Dashboard did not address utilization management improvement opportunities related to 2023 Provider Satisfaction Survey results.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must demonstrate development and implementation of action plans to address utilization management-related opportunities to improve satisfaction based on CAHPS and Provider Satisfaction Survey results and provide updates to the quality committees at the frequency identified in its Member Satisfaction Survey Policy and Practitioner/Provider Satisfaction Survey Policy.

8.0 – Continuity of Care

Findings

Maryland Physicians Care (MPC)

8.6 - The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.
This element is Met with Opportunity.

Documents and staff interviews indicate that MPC is coordinating care with the Maryland's behavioral health vendor, Optum Health. The following evidence was provided for review:

- Desktop Procedure for Referring Enrollees for Behavioral Health Services, which outlines the role of Care Management staff in identifying and referring enrollees for behavioral health/substance use disorder services.
- A Sample Optum Referral Log documents evidence of the referral process.
- The Collaboration with Behavioral Health Report lists the various interventions in place to demonstrate coordination with Optum. For example, Optum staff (specific for Maryland) participate in monthly interdisciplinary rounds with MPC quality staff and theCare

Management department. Optum staff offer behavioral health resources and guidance, as appropriate, during these rounds. Rounds include MPC quality and utilization management staff, the pharmacy services director, and directors of Medical Management.

Individual case collaboration occurs during complex case presentations with Optum and MPC medical directors, case managers, and facility-based personnel.

MPC sends representatives to the quarterly Local Health Department/MCO Coordination of Care Meetings, which include updates from the local health departments and Optum. Optumholds monthly discussions to clarify referral criteria and promote appropriate referrals to the Optum Care Coordination Department.

At the guidance of MDH, Optum developed the Maryland Medicaid Care Coordination Tool, a referral tool to provide a uniform mechanism for MPC and Optum to review, report, determine interventions for, and evaluate the outcomes of interventions to improve enrollees' state of health.
In the October 2024 QMOC meeting minutes, a summary documents barriers and opportunities to improve behavioral health collaboration and coordination.

Sample Care Management screenshots from the Care Management database, Identify, and sample meeting minutes from case rounds evidence that coordination of care efforts are in place.

Educating providers on the Screening, Brief Intervention, and Referral to Treatment Program and Release of Information for substance use disorder is managed by a link from the MPC provider website to the Optum behavioral health Website. There is no specific information pertaining to Screening, Brief Intervention, and Referral to Treatment Program or Release of Information for substance use disorder on the MPC provider portal.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MPC must add education on Screening, Brief Intervention, and Referral to Treatment Program and Release of Information for Substance Use Disorder, at a minimum, in the provider newsletter and directly on the MPC provider website. Other options for education include presentations at the time of the new provider's orientation.

Priority Partners (PPMCO)

8.6 - The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.
This element is Met with Opportunity.

The MDH and BHO Transmittal/Communication, Tracking, and Distribution Policy specifies that it is the role of the PPMCO Special Needs Coordinator to serve as the liaison with Optum to ensure that enrollees with behavioral health/substance use disorder issues have care that is coordinated and meets the needs of the enrollee.

Once an enrollee is identified as having a behavioral health/substance use disorder concern, the enrollee is referred to Care Management. PPMCO has several key processes designed for coordinating with the behavioral health vendor, Optum.

PPMCO's Behavioral Health Triage and Referral Policy describes Johns Hopkins Health Plans' commitment to work with providers to assess the enrollee's needs; establish the urgency of the enrollee's clinical condition/presentation; determine the appropriate level of service indicated; and facilitate all enrollees with behavioral health needs with the most appropriate level of care in a timely manner within the benefit coverage.

According to care management staff interviewed, PPMCO participates in monthly rounds with Optum. Rounds is a dedicated time for integrated, interdisciplinary review of PPMCO enrollees with identified behavioral health conditions and determined to be at-risk for experiencing a greater impact on health and wellbeing. The intention of the rounding process is to improve the quality of care, care coordination, and enrollee experience through:

- Review of case history, barriers, needs, interventions
- Multidisciplinary discussion of cases currently open in care management
- Discussion of alternatives, next steps, additions to care team

A document referred to as the "Daily Tool" is circulated back and forth between PPMCO and Optum care management. This document lists enrollees receiving services from PPMCO and Optum. Based upon the level of intensity of the enrollee's needs, communication with Optum may be daily, weekly, or at the monthly case rounds session.

At the time of the MY 2021 SPR, the provider manual included information to educate providers on the Screening, Brief Intervention, and Referral to Treatment process and the release of information for enrollees with substance use disorders issues. For MY 2024, this information is not in the provider manual, the provider website, or the provider newsletter.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must educate providers on the Screening, Brief Intervention, and Referral to Treatment process and Release of Information procedures in any of the following sources: the provider manual, new provider orientation program, the provider website, or in provider newsletters.

9.0 – Health Education

Findings

Aetna Better Health of Maryland (ABH)

9.5 c. Provider evaluations of health education programs.
This component is Met with Opportunity.

There is evidence that ABH obtains provider feedback on both specific educational presentations and the overall HEP.

Review of three Quality Management/Utilization Management Committee meetings from 2024 affirmed presentation of the annual HEP, Annual HEP Evaluation, HEP workplan updates, and video vignettes addressing health related topics. Minimal provider feedback was documented per meeting notes shared from the Director of Quality Management regarding the evaluation of the HEP.

Additionally, provider evaluations from two enrollee educational events, one unnamed held on October 26, 2024, and one on Women's Health held on November 7, 2024, were submitted, both reflecting a positive review.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025, ABH must demonstrate provider feedback related to the evaluation of its HEP.

Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)

9.3 a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is Partially Met.

According to the HEP, KPMAS' impact methodology and reporting encompasses:

- Quarterly tracking and analysis of the utilization of programs and printed health education materials.
- Bi-annual tracking and analysis of satisfaction from both enrollees and healthcare teams on healthy living programs.
- Annual outcome analysis that compares use of preventive care services of program "users" to "non-users."

According to the Evaluation of Health Education Program Usage by MD HealthChoice Members (2024), the Health Engagement team assessed the effectiveness of coaching in helping to reduce the number of extra physician visits that instead could be supported by programs that offer strategies to help with behavior change. The evaluation focused on Maryland HealthChoice enrollees who participated in Wellness Coaching compared to those who did not. The timeframe was six weeks prior to starting Wellness Coaching and six weeks afterward to see if there was a change in appointment utilization. This same timeframe was tracked for those enrollees who did not use Wellness Coaching services. After six weeks post Wellness Coaching, HealthChoice participants had an average 21.74% reduction in visits to Family Medicine and Internal Medicine. Within that same timeframe, non-participants saw an average 31.25% reduction in visits to Family Medicine and Internal Medicine. KPMAS cited some factors potentially impacting results, noting the volume of participating enrollees was significantly higher than the control group and that these enrollees may be currently more involved in their care and not visiting their physician as often.

After the initial review, KPMAS submitted the Health Education Program Outcomes - Weight Control Health Education Class Overview and a spreadsheet of participating enrollees. According to the program outcome document, enrollees that participated in the single session Weight Control class averaged a 1.23-pound loss when comparing weight pre and post class participation.

This additional evidence does not address the opportunity for improvement, which requires KPMAS to include evaluation measures that are more indicative of the health of the enrollee population, such as the impact of health education on emergency room utilization, hospital admissions, utilization of preventive health services, and/or clinical measures, such as HbA1c for enrollees with diabetes.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, KPMAS must include evaluation measures that are more indicative of the health of the enrollee population, such as the impact of health education on emergency room utilization, hospital admissions, utilization of preventive health services, and/or clinical measures, such as HbA1c for enrollees with diabetes.

Maryland Physicians Care (MPC)

9.3 a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is Met with Opportunity.

The Prevention and Wellness Program Policy requires MPC to evaluate the effectiveness and goals of the Prevention and Wellness Program at least annually and incorporate opportunities into the annual workplan development. Benchmarks and goals are based on national standards and/or MPC thresholds. Progress on each prevention and wellness goal is updated quarterly with barriers and opportunities/recommendations noted as needed when goals are not met within the quarter.

As evidence of compliance, MPC submitted the 2022 Prevention and Wellness Evaluation, which was presented in table format with five major topic areas: Prevention and Wellness Communication, Child Preventive Care, Adult Preventive Care, Pregnancy/Post Partum Care, and Provider Prevention and Wellness. The following table headings included content for each of the identified subtopics: Scope, Goal/Benchmark, Methodology, Responsible Party, Committee(s), Due Dates, Barriers from 2022, Goals Met/Not Met, Continue Goals for 2024, 2023 Barriers, and Opportunities and Recommendations. For example, the overall goal of the Adult Access to Preventive/Ambulatory Health Services HEDIS measure was to meet or exceed the Medicaid Health Maintenance Organization National HEDIS Mean by providing outreach and health education. According to MPC, the MY 2023 result was 74.7%, which exceeded the National HEDIS Mean of 72.7%. MPC also established goals to improve HEDIS prenatal and postpartum rates by providing outreach and education to pregnant enrollees. According to MPC, the MY 2022 Timeliness of Prenatal Care rate of 89.1 and Postpartum Care rate of 83.5 exceeded the NCQA Medicaid Health Maintenance Organization 50th percentile rates of 84.2 and 78.1, respectively. These rates also exceeded the 75th percentile rates of 88.3 and 82.0, respectively. While MPC demonstrated success in not only meeting but also exceeding its goals, there was no comparison of results pre and post educational intervention or with a control group that would suggest a positive relationship between health education and health outcomes.

In addition to the above, MPC submitted an evaluation of the effectiveness of health education delivered during baby showers on receipt of prenatal and postpartum care. Two enrollees (100%) attended the shower prior to delivery within the prenatal period and were compliant with care. Five enrollees (100%) attended the shower within the postpartum period (one to 12 weeks after delivery) and became compliant with postpartum care. The remaining nine enrollees attending the baby shower were seen three and one-half to eight months after delivery, which was outside of the prenatal and postpartum timeframes. Overall, of the 17 enrollees who attended baby showers and received health education on perinatal care, 100% of those eligible for pre and postpartum care appear to have received timely perinatal care as advised by the health educator. The remaining enrollees were outside of the perinatal timeframes. According to MPC, it can be reasonably concluded that the health education had an impact on the enrollees' health and well-being.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MPC must further explore opportunities to evaluate the effectiveness of its various health education programs on process and outcome measures based upon pre and post enrollee participation in relevant outcome measures or comparisons to non-participants on selected measures.

RECOMMENDATION: Qlarant recommends that MPC revise the methodology for evaluating the effectiveness of health education delivered during baby showers on perinatal measures, as the majority of baby shower attendees were outside of the perinatal measure timeframes. Perhaps a baby shower or similar event could be held prior to delivery to more clearly evaluate the impact of health education on timely receipt of postpartum care and compare the rate to those pregnant enrollees who did not attend the baby shower.

MedStar Family Choice, Inc. (MSFC)

9.1 a. The education plan's purpose and objectives.
This component is Unmet.

MSFC did not submit the HEP in the presite documentation upload to the Qlarant portal. In response to a follow-up from Qlarant, MSFC reported they were unable to locate a copy of the HEP and appraisal when gathering documents for submission. According to MSFC, historically, the HEP was completed by the previous Quality Improvement Director and created by pulling education elements from the annual Outreach Plan. Upon discovery of the missing HEP, an education plan was created using the outreach plan education elements and taken to the Quality Improvement Committee for review and approval on November 26, 2024. MSFC also provided a CAP to prevent this from recurring in the future.

The purpose of MSFC's HEP is to guide the process for the development, implementation, and evaluation of health education activities.

MSFC identified seven major HEP objectives for 2024:

- Develop health education programs that increase knowledge, develop positive attitudes towards health, and promote informed decision-making related to health and self-care.
- Develop health education strategies and materials to meet the needs of special populations, including obstetrics, diabetes, cardiovascular disease, and asthma.
- Evaluate and identify population needs and community interests, while developing new programs designed to meet these needs on an ongoing basis.
- Maintain the availability of high-quality programs that are accessible to the community.
- Provide enrollees with information about when, where, and what health education programs are available.
- Utilize a broad range of communication technologies, such as text messaging, online education platforms, and virtual education/check-in sessions to aid in the accessibility of educational materials.
- Establish MSFC structures/committees to locate, evaluate, develop, and implement enrollee and staff education/training to standardize processes and educational offerings/trainings.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MSFC must demonstrate that the HEP is in place for the MY. The approved HEP was in place for MY 2024 only since late November.

9.3 a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is Partially Met.

The HEP identified the overall goals for 2024 to include evaluation of the impact of health education on process and outcome measures, as described below:

- Encourage long-standing physical/behavioral/mental health and enrollee wellbeing as evidenced by decreased admissions, emergency room utilization, and increased medication adherence.
- Evaluate the effectiveness of the new asthma medication adherence program by reducing emergency room visits and hospitalizations post program and adherence with controller medications.
- Evaluate the effectiveness of care management interventions by reduction of admissions and emergency room visits post intervention and education.

The 2023 Health Education Appraisal included a mix of activity-based and HEDIS measures as a means of evaluating the impact of health education through its various outreach efforts. As an example, MSFC continued to target enrollees with diabetes to ensure appropriate care for their condition. HEDIS rates for HbA1c under 8% and the rate of eye exams were selected to assess the impact of education on enrollees with diabetes. For HEDIS MY 2022, the rate for HbA1c below 8% for enrollees with diabetes was 61.56%. This was an increase of 4.97 percentage points compared to HEDIS MY 2021 and was in the HEDIS MY 2022 90th percentile nationally. For the same measure, the poor control greater than 9% rate was 30.66%, a decrease of 3.97%. This was viewed as a positive outcome and was in the HEDIS MY 2022 75th percentile nationally. There was no comparison of results pre and post educational intervention or with a control group that would suggest a positive relationship between health education and health outcomes.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, MSFC must demonstrate it has a written methodology for evaluating the impact of its HEP on process and outcome measures using either comparison groups or comparing individual process or outcome measures pre and post participation in health education activities.

Priority Partners (PPMCO)

9.3 a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is Met with Opportunity.

According to the HEP, biometric and clinical outcomes data from quarterly six-week-long series programs are included in the annual evaluation. These six-week programs include: Winter Weight Loss Challenge, Spring into Healthy Eating Challenge, Summer Weight Loss Challenge, and Fall Weight Loss Challenge. For these programs, enrollees are asked to complete a pre-test survey on week one of the program and a post-test survey on week six of the program so that the results could be compared. Surveys include questions related to the enrollee's knowledge of the topic and their personal behavior change. There also are questions asking enrollees to self-report biometric data, such as their weight, waist circumference, and average daily step counts. Program registrants are mailed a tape measure and instructions on how to measure their waist circumference prior to starting the

program. In addition to the self-reported data on changes in knowledge of the topic, confidence to make behavior changes, waist circumference, weight, and step counts, the Analytics Department pulls and analyzes claims-based baseline emergency room visit and outpatient provider visit data from three months prior to starting the challenge and three months after completing the challenge for comparison purposes. The goal is to decrease emergency room utilization in favor of increased outpatient utilization due to healthier lifestyle changes.

According to the PPMCO Health Education Impact Evaluation for MY 2023, enrollees participating in the Winter Weight Loss Challenge experienced a slight decrease in average waist circumference from week one (41.3 inches) to week six (40.5 inches), but there was no improvement in average weight. Emergency room visits decreased from one visit pre-program to zero post-program. During this same timeframe, outpatient visits increased from 27 pre-program to 30 post-program. There was no self-reported data for the Spring into Healthy Eating Challenge or change in emergency room visits pre and post program completion; however, outpatient visits increased from 30 to 46 during this six-week timeframe.

PPMCO also offers several educational programs to target other prevalent conditions within its membership, such as hypertension, anxiety disorder, depression, and diabetes. There did not appear to be any outcome data provided to specifically address enrollees with any of these prevalent conditions, many of which often result in high emergency room usage and avoidable hospital admissions.

According to HEP staff, a dashboard is currently under development, which will measure process and outcome measures by class/program offering. These outcome measures have the potential to serve as an effective marketing tool for increasing provider referrals and enrollee attendance in HEP classes and programs.

After the initial review, PPMCO reported that in response to feedback following the MY 2023 Interim SPR, a dashboard was developed to evaluate the impact of health education program offerings on enrollees with specific prevalent health conditions, including diabetes. This dashboard and data were utilized in the review and evaluation of the MY 2024 Health Education Program, which was submitted for review.

According to the MY 2024 Health Education and Impact Evaluation, the evaluation design is based on a set of pre/post comparisons of multiple outcome metrics. For each period, the latest possible value is recorded. Pre/post comparisons are then presented in tables and graphs for each class and topic (a group of classes on the same health issue).

The outcome metrics to be monitored include:

- Weight
- A1c level
- Blood pressure
- A new diagnosis of diabetes, obesity, or hypertension in the six months following the class
- Any emergency room visits in the 6 months before and after class

- For Baby Basics class only: adherence with the HEDIS measure of a timely postpartum visit

The Health Education Dashboard by Condition displays outcome metrics by selected conditions both pre and post class attendance. For example, average A1c was reported for three diabetes-related classes. For Diabetes: A Healthier You, the average A1c remained unchanged. For Managing Diabetes, the value decreased from 8.3 to 7.9. For Pre-diabetes & Me, the average decreased from 6.5 to 6.06.

Another example included a comparison of the percentage of enrollees with an emergency room visit within six months pre and post class attendance. Overall, the percentage of enrollees with an ER visit during this timeframe increased from 18% to 28%. Enrollees attending classes on diabetes, heart, stress, other conditions, and one-on-one education showed the greatest increases.

Specific findings, based upon analysis of dashboard results, were included in the Health Education Impact Evaluation report. In the "Action Plan" section of the report, it was noted that this newly developed dashboard can be used for evaluation purposes going forward and positive outcomes may be used in promoting registration and attendance at future classes.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, PPMCO must demonstrate that it analyzes negative outcomes, such as the increase in emergency room visits following class attendance, to understand the root cause(s) and determine any needed enhancements to class offerings.

UnitedHealthcare Community Plan (UHC)

9.3 a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is Partially Met.

According to the HEP, UHC measures program outcomes in four categories:

- Clinical
  - Adherence to disease-specific, evidence-based guidelines for all chronic conditions, as well as preventive measures
  - Clinical markers and HEDIS measures, such as lead, asthma, preventive health services, childhood immunizations, and well-child visits

- Financial
  - Improved access to care
  - Reduced emergency room visits
  - Improved use of formulary and generic drugs

- Operational
  - Medical and Pharmacy Turn-Around Times
  - New Enrollee Welcome Calls
  - Delegated entities (March Vision, eviCore)
  - Accessibility of services (telephonic appointment scheduling audit)

- Performance
  - CAHPS
  - Enrollee Engagement Survey - meet or exceed Quality Compass Percentile and year-over-year trending
  - Provider Satisfaction Survey - meet or exceed HealthChoice Aggregate Rating and year-over-year trending

No evaluation of the HEP on process and/or outcome measures was submitted for MY 2024. Data reported was previously submitted for MY 2023. According to UHC staff, evaluation of HEP activities for MY 2024 was included in the 2025 HEP that was presented at the December 12, 2024, QMC meeting; however, it was not provided for review.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must demonstrate it evaluates the effectiveness of its HEP on process and/or outcome measures.

Wellpoint Maryland (WPM)

9.3 a. Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
This component is Partially Met.

The HEP describes the methodology for annually measuring and analyzing the performance and outcomes of all programs including:

- Program descriptions, work plans, and overall program evaluation
- Outcome measures - such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures
- Participation rates
- Enrollee and provider feedback
- Gaps in care
- Social determinants of health

Reports are summarized and presented at one of the Quality Management Committee meetings for review.

Evaluation of the impact of the HEP is to be measured with quantitative methodologies; have a benchmark or performance goal; and provide a year-over-year comparison that includes the data displayed and reporting of results or conclusions.

No annual evaluation of the HEP's impact on process and/or outcome measures was submitted based on this written methodology.

After the initial review, WPM submitted the 2024 Health Education Program Evaluation. This document was very comprehensive in identifying the health education needs of WPM's population, targeting subpopulations based on identified health disparities, and reporting on the results of various health education-related events. For example, WPM reported that the Well Child/Adolescent Preventative Healthcare presentation, in partnership with the University of Maryland School of Medicine, was attended by fewer than 10 enrollees of the 5,000 invited. WPM attributed the low turnout to the weather that reached temperatures above 90 degrees.

WPM also partnered with Total Health Care to improve access to preventive care through breast cancer screening and education. Two onsite clinic events were held in Baltimore City with digital and live outbound calls providing breast health education and confirmation of attendance. Total Health Care identified and outreached to 59 WPM enrollees due for mammograms, resulting in a 38% success rate with 29 participants receiving a mammogram.

Neither of these programs nor any of the additional programs included in the Health Education Program Evaluation provided evidence of the effectiveness of health education. For example, there was no comparison of breast cancer screening compliance rates for enrollees participating in the Total Health Care onsite clinic events versus those enrollees not attending.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must provide an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures that demonstrate the effectiveness of health education by comparing individual rates pre and post receipt of health education or comparing rates of those who received health education versus those who did not on process and/or outcome measures.

11.0 – Fraud and Abuse

Findings

CareFirst Community Health Plan (CFCHP)

11.4 c. 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.
This component is Met with Opportunity.

CFCHP's Compliance Committee routinely reviews CFCHP's compliance and FWA policies and procedures. This review is evident in the Compliance Committee meeting minutes of August 6, 2024. At this meeting, the Compliance Officer informed business areas to start preparing for the calendar year 2024 policy review cycle. The deadline for the calendar year 2024 policy review cycle is September 30, 2024. The committee also reminded participants that all new or revised policies and standard operating procedures need to go through Stage Gate for review and approval by Legal and Compliance. Additionally, all training materials, enrollee and provider materials, both internal and vendor, need to go through Stage Gate.

CFCHP submitted documentation to support annual review and approval of Superior Vision and CVS FWA and Compliance Plans:

CFCHP submitted documentation from an October 2024 joint CVS pharmacy and CFCHP monthly meeting. During this meeting, the Annual Audit of CVS included review of Compliance and Special Investigations Unit documentation.

Superior Vision submitted it FWA Policy and Plan to CFCHP's Delegation Oversight Committee on February 15, 2024, and its Corporate Compliance Plan on November 17, 2024.

According to Compliance staff, CFCHP's Compliance Officer annually reviews all delegated entities Compliance Plans to prevent FWA. If concerns arise with any of the plans, the Compliance Officer submits a report to the Compliance Committee. As there were none in 2024, delegate Compliance Plans were not addressed at any Compliance Committee meeting in MY 2024.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, the CFCHP Compliance Officer, (in addition to reading the delegates' compliance documents ahead of time), must ensure the Compliance Committee annually reviews and approves delegated entities' Compliance Plans. This review and approval must be clearly documented in the Compliance Committee meeting minutes.

Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)

11.4 c. 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.
This component is Partially Met.

According to the Ethics and Compliance Program Description, KPMAS' Compliance Committee receives routine reports on ethics and compliance-related issues such as FWA, privacy and security of protected health information (PHI), health plan operations, billing and coding, overpayments for services rendered, and behavior potentially in violation of guidelines, policies, regulations, and/or laws. These oversight activities also apply to KPMAS' delegated entities, Relations Insurance and MedImpact.

The quarterly Compliance Committee meeting minutes for 2024 show review and approval of both delegate's FWA program activities. Minutes from the January 10, 2024, Regional Quality Improvement Committee meeting affirm the annual audit of Relations Insurance and MedImpact Compliance Plans.

Through the delegation oversight process, there is evidence to show that delegation oversight includes annual review of each delegate's Compliance Plan, in November 2024 for Relations Insurance and in December 2024 for MedImpact.

In addition, as part of its pre-site document upload, KPMAS submitted numerous Relations Insurance and MedImpact policies and procedures reflecting each delegate's processes in place for compliance monitoring.

For this component, it is unclear if the Compliance Committee reviewed Relations Insurance and MedImpact delegates' Compliance Plans and FWA policies and procedures; the 2024 meeting minutes are significantly redacted.

After the initial review, KPMAS submitted Annual Review of MedImpact Policies and Procedures. This document is a table listing six MedImpact FWA policies and procedures. It also includes Relations Insurance FWA policies and procedures.

The table shows the following MedImpact FWA and Compliance documents that were reviewed by the KPMAS Pharmacy Compliance Review team and by the National Pharmacy Benefit Manager Vendor Management Review team.

- Corporate Compliance Program 2023
- Code of Conduct 2023
- Pharmacy Compliance FWA - Pre-Pay Claim Review
- Pharmacy Compliance, FWA - On Site Audits

- Pharmacy Compliance FWA - Desk Audits
- 2024 MedImpact Network Compliance and FWA Program Description – Medicaid

Another document, Annual Review of Relation Insurance Services FWA Policies and Procedures, is also in table format. This table includes two Relations Insurance policies, Relations Insurance FWA Policy and Procedure, updated August 7, 2023, and Upcoding Guidelines, updated November 9, 2023.

The review of MedImpact Compliance and FWA policies and procedures (many dated in 2023) were reviewed in September 2024. Relations Insurance FWA policies and procedures were also dated in 2023 and were reviewed by an individual (no reference to a committee) in November 2024.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, KPMAS must show evidence of Compliance Committee's review and approval of each delegates Compliance Plans and FWA policies and procedures. The delegates FWA and Compliance Plans must be dated in the measurement year under review.

UnitedHealthcare Community Plan (UHC)

11.4 c. 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.
This component is Met with Opportunity

As written in UHC's Delegation Manual, the Compliance Committee is accountable for the review and approval of the following delegate reports:

- Corrective Action Plan Monitoring
- Fraud and Abuse Plan
- Fraud and Abuse Policies
- Audits

The annual Delegation Assessment for eviCore conducted in 2024 documents the review of Health Insurance Portability and Accountability Act (HIPAA) privacy policies. It is unclear in the assessment report whether FWA policies and Compliance Plans were reviewed.

The Compliance Program Policy and the Compliance Committee Charter do not indicate the role of the Compliance Committee in the annual review of delegates' FWA policies and procedures and Compliance Plans.

After the initial review, UHC submitted a "Summary of eviCore Annual Monitoring Oversight."

The eviCore Annual Monitoring Oversight was conducted on November 13, 2024, by the UHC Clinical Delegation Oversight team. The period reviewed was June 1, 2024– August 31, 2024. The scope of monitoring oversight covered all programs (Radiology or Cardiology, as applicable to each health plan).

The Utilization Management Program Description, as well as supporting policies and procedures, were reviewed and found to meet UHC standards. The monitoring oversight also covered policies and procedures for the following:

- Privacy Controls, HIPAA Regulation, and PHI Handling Compliance
- Quality Assurance
- Delegation Agreements
- Training
- Office of the Inspector General/General Services Administration Exclusion Checks
- Disaster Recovery
- Systems Controls

UHC also submitted Compliance Committee minutes from the November 8, 2024, meeting. Under the heading "Health Plan Updates," a report was given on the 2024 national audit of eviCore. The report concluded there were no findings found specific to Maryland or the District of Columbia.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must clearly document the Compliance Committee's annual review and approval of FWA policies and procedures and Compliance Plan for each of its delegates. The Compliance Committee Charter and Compliance Program Policy must clearly outline the role of the Compliance Committee in overseeing delegate Compliance Plans and FWA policies.

11.4 d. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.
This component is Partially Met.

UHC did not provide evidence in 2024 Compliance Committee meeting minutes of quarterly reporting, review, and approval of eviCore's FWA/Special Investigations Unit activities. Compliance Program policies and procedures also do not include the review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities.

After the initial review, UHC submitted feedback and documentation that it does monitor and review fraud, waste, and abuse activity of its delegates. This occurs during the Program Integrity FWA Reporting update, which is recorded under Health Plan Updates in the Compliance Committee meeting minutes.

Additionally, there is oversight of delegate operations that occurs regularly and includes an annual assessment. UHC pays claims associated with the clinical review conducted by the delegate; accordingly, claims are a part of UHC's comprehensive FWA reviews, investigations, and reporting prepared/conducted by the Special Investigations Unit and program integrity.

UHC also submitted a Maryland Q3 2024 FWA Activities Report to the Compliance Committee, presented at the November 8, 2024, meeting. The report includes data from three quarters (July, August, and September 2024) on Financials, Tips, Investigations, Provider Flags, and the number of Provider Educations and Reeducations.

Compliance Committee meeting minutes pertaining to the above-referenced Program Integrity reports, as part of Health Plan Updates and the FWA Activities Report (PowerPoint slide), do not clearly specify that this is a Delegate FWA Report. Delegate FWA Reports should include information on the vendors' own internal FWA activities.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, UHC must review and approve each delegate's FWA/Special Investigations Unit activities on a quarterly basis. This review must be clearly documented in Compliance Committee meeting minutes and in relevant Compliance Program policies and procedures.

Wellpoint Maryland (WPM)

11.4 c. 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.
This component is Partially Met.

WPM's Compliance Department presents policies, procedures, and reports on compliance risks to the Compliance Committee as part of its quarterly reporting. As a component of Superior Vision's Annual Audit, EDOM reviews the vendor's compliance with the following:

> "Evidence to demonstrate the Compliance Officer and/or the Compliance Committee periodically report activities and status of the compliance program to the Governing Body (e.g., BOD) or delegated oversight committee. This evidence must include review of compliance program description/plan, any issues of non-compliance identified, investigated, and resolved by the compliance program specifically including FWA reports reviewed and addressed."

Superior Vision's Annual Audit was completed December 31, 2024. The delegate scored 100% in meeting the compliance review referenced above. WPM's Q3 and Q4 Compliance Committee meeting minutes have a section dedicated to Vendor Management. There is no evidence to support the Compliance Committee review of Superior Vision's Annual Audit results, or review of Superior Vision's Compliance/Anti-Fraud Plans or FWA policies and procedures.

An Annual Audit for The Coordinating Center was completed on October 30, 2024. The delegate scored 100% in meeting the compliance review referenced above. WPM's Q3 and Q4 Compliance Committee meeting minutes have a section dedicated to Vendor Management. There is no evidence to support the Compliance Committee review of The Coordinating Center's Annual Audit results, or review of The Coordinating Center's Compliance/Anti-Fraud Plans or FWA policies and procedures.

After the initial review, WPM submitted the Joint Operations Committee meeting minutes for Q3 2024 held on November 20, 2024, and the Maryland Special Investigations Unit Monthly Dashboard. Neither of these documents indicate the Compliance Committee reviewed Superior Vision's Compliance/Anti-Fraud Plans.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must ensure the Compliance Committee reviews and approves each delegate's FWA policies and procedures and Compliance/Anti-Fraud Plans at a minimum annually. Evidence must be clearly documented in the Compliance Committee meeting minutes.

11.4 d. Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.
This component is Met with Opportunity.

Excel spreadsheets reflect Performance Indicator Reports for Superior Vision and The Coordinating Center and month-to-month monitoring of performance metrics for each delegate. Data are rolled up into a quarterly report of performance data. Superior Vision's quarterly Joint Operations Committee meeting minutes include a section on the delegate's Special Investigations Unit activity; however, reporting is generic for Medicaid, and there is no distinction made for Maryland Special Investigations Unit reporting.

For example, a Joint Operations Committee meeting with Superior Vision on May 15, 2024, included this report in the meeting minutes:

Special Investigation Activity Q1 2024. (Name of reporter) "overviews Special Investigation activity for the quarter. The individual says they are continuously reviewing and discussing investigations with professionals who are identified for potential fraud, waste, and abuse. The reporter reviews markets IA, IN, and TX, and there is one open investigation."

After the initial review, WPM submitted two additional documents to support compliance: Superior Vision Joint Operations Committee meeting minutes for November 20, 2024, and the Q3 2024 Maryland Special Investigations Unit Monthly Dashboard. These support the quarterly review of the delegate's FWA activity. While delegate oversight reports are submitted to the Compliance Committee as part of the Compliance Program Updates report, the meeting minutes should clearly document the quarterly review and approval of the delegates' name and FWA activity reviewed.

OPPORTUNITY FOR IMPROVEMENT: In order to receive a *Met* finding in the MY 2025 review, WPM must clearly document in the Compliance Committee meeting minutes, quarterly review, and approval of the delegate's FWA activity. If a Special Investigations Unit Report is given that addresses delegate oversight of their Special Investigations Unit FWA activity, the name of the delegate and the date of that oversight should be documented in the Compliance Committee meeting minutes, per component 11.4d.

Appendix B: Compliance Score Requirements and Standard Descriptions

Appendix B displays each of the SPR standards and the minimum compliance score requirement rate for the MY 2024 review.

Table 16. MY 2024 Standards and Guidelines

Element/Component Reviewed	Standard Description
Compliance Score Requirement Rate: 100%	**1.0: Systematic Process of Quality Assessment and Improvement**
1.1	**The Quality Assessment and Performance Improvement Plan (QAP) ensures monitoring and evaluation of the enrolled population and areas of concern for the enrolled population.**
1.1a	The monitoring and evaluation of care reflects the population served by the MCO in terms of age, disease categories, and special risk status.
1.1b	The QAP monitors and evaluates priority areas of concern selected by the State and any additional areas of concern identified by the MCO.
1.2	**The QAP's written guidelines for the MCO's Quality of Care (QOC) studies and related activities require the use of quality indicators.**
1.2a	The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.
1.2b	Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.
1.3	**The QAP has written guidelines for its QOC studies and related activities must include the use of clinical practice guidelines.**
1.3a	*Deleted in MY 2018.*
1.3b	Clinical practice guidelines are based on evidence-based practices or professional standards of practice and are developed or reviewed by MCO providers.
1.3c	The guidelines focus on the process and outcomes of health care delivery and access to care.
1.3d	A mechanism is in place for continuously updating the guidelines as appropriate. There is evidence that this occurs.
1.3e	The guidelines are included in the provider manuals or disseminated to the providers (electronically or faxed) as they are adopted.
1.3f	There are guidelines to address preventive health services for children and adults.
1.3g	The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a.
1.3h	The MCO's clinical guidelines policies and procedures must reflect how the guidelines are used for utilization management decisions, enrollee education, and coverage of services.

Element/Component Reviewed	Standard Description
1.4	**The QAP has written guidelines for its QOC studies and related activities that require the analysis of clinical and related services.**
1.4a	The QAP has written guidelines to evaluate the quality of care provided by the MCO's providers.
1.4b	Appropriate clinicians monitor and evaluate quality through the review of individual cases and through studies analyzing patterns of clinical care.
1.4c	Multidisciplinary teams are used to analyze, identify, and address systems issues.
1.4d	Clinical and related service areas requiring improvements are identified through activities described in a. and b. above.
1.4e	*Deleted in MY 2023.*
1.4f	Mechanisms to assess the quality and appropriateness of the care provided to enrollees with special health care needs.
1.5	**The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The remedial/corrective action procedures specifically include:**
1.5a	Performance thresholds to identify when actual or potential problems may exist that require remedial/corrective action.
1.5b	The individual(s) or department(s) responsible for making the final determinations regarding quality problems.
1.5c	The specific actions to be taken.
1.5d	The provision of feedback to the appropriate health professionals, providers, and staff (as appropriate).
1.5e	The schedule and accountability for implementing corrective actions.
1.5f	The approach to modifying the corrective action if improvements do not occur.
1.5g	The procedures for terminating health professionals, providers, or staff (as appropriate).
1.6	***Deleted in MY 2017.***
1.7	**The Quality Assurance (QA) Plan incorporates written guidelines for evaluation of the status of QAP activities and the continuity and effectiveness of the QAP.**
1.7a	The MCO reviews the status of QAP activities against the QA Work Plan on a quarterly basis.
1.7b	There is evidence that QA activities are assessed to determine if they have contributed to improvements in the care and services delivered to enrollees.
1.8	**A comprehensive annual written report on the QAP is completed. The annual report on the QAP must include:**
1.8a	QA studies and other activities undertaken, results, and subsequent actions.
1.8b	Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results.
1.8c	Analysis of aggregate data on utilization and quality of services rendered.
1.8d	Demonstrated improvements in quality.

Element/Component Reviewed	Standard Description
1.8e	Areas of deficiency.
1.8f	Recommendations for improvement to be included in the subsequent year's QA Work Plan.
1.8g	An evaluation of the overall effectiveness of the QAP.
1.9	**The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.**
1.10	**The MCO must have a Continuity of Operations Plan and a Disaster Recovery Plan that is updated on an annual basis.**
Compliance Score Requirement Rate: 100%	**2.0: Accountability to the Governing Body**
2.1	**There is documentation that the governing body has oversight of the QAP and approves the annual QA Plan/Description and QA Work Plan.**
2.2	**The governing body formally designates an accountable entity or entities within the organization to provide oversight of QA or has formally decided to provide oversight as a committee.**
2.3	**The governing body routinely receives written reports on the QAP that describes actions taken, progress in meeting QA objectives, and improvements made.**
2.4	**The governing body formally reviews, at least annually, a written report on the QAP Evaluation.**
2.5	**The governing body takes action when appropriate and directs that the operational QAP be modified to accommodate a review of findings and issues of concern within the MCO.**
2.6	***Deleted in MY 2019***
2.7	**The governing body is active in utilization management activities. The governing body meeting minutes reflect ongoing reporting of:**
2.7a	Utilization management activities and findings, and
2.7b	Evaluation of utilization management progress.
Compliance Score Requirement Rate: 100%	**3.0: Oversight of Delegated Entities and Subcontractors**
3.1	**The MCO must ensure that delegates have detailed agreements and are notified of the grievance and appeal system.**
3.1a	The MCO must ensure that there is a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO.
3.1b	The MCO must provide evidence of informing delegates and subcontractors of the grievance and appeal system.
3.2	**The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided.**
3.3	**There is evidence of continuous and ongoing evaluation of delegated activities, including:**

Element/Component Reviewed	Standard Description
3.3a	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.
3.3b	Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable.
3.3c	Review and approval of claims payment activities at least semi-annually, where applicable.
3.3d	Review and approval of the delegated entities' utilization management plan, which must include evidence of review and approval of utilization management criteria by the delegated entity, where applicable.
3.3e	Review and approval of overutilization and underutilization reports, at least semi-annually, where applicable.
3.4	**The MCO has written policies and procedures for subcontractor termination that impacts the MCO's operations, services, or enrollees.**
Compliance Score Requirement Rate: 100%	**4.0: Credentialing and Recredentialing**
4.1	**The MCO has written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing.**
4.1a	The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process.
4.1b	The Credentialing Plan designates a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions.
4.1c	The Credentialing Plan must identify the practitioners who fall under its scope of authority and action.
4.1d	The Credentialing Plan must include policies and procedures for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d).
4.2	**There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. Documentation includes:**
4.2a	Written policies and procedures for the suspension, reduction, or termination of practitioner privileges.
4.2b	A documented process for and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner.
4.2c	*Deleted in MY 2019.*
4.3	**If the MCO delegates credentialing/recredentialing activities, the following must be present:**
4.3a	A written description of the delegated activities.
4.3b	A description of the delegate's accountability for designated activities.
4.3c	Evidence that the delegate accomplished the credentialing activities.

Element/Component Reviewed	Standard Description
4.4	**The credentialing process must be ongoing and current. At a minimum, the credentialing process must include:**
4.4a	A review of a current valid license to practice.
4.4b	A review of a valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, if applicable.
4.4c	A review of graduation from medical/ancillary (nurse practitioner, physical therapy, occupational therapy, speech/language pathology, etc.) school and completed residency or post-graduate training, as applicable.
4.4d	A review of work history.
4.4e	A review of a professional and liability claims history.
4.4f	A review of current adequate malpractice insurance according to the MCO's policy.
4.4g	*Deleted in 2017.*
4.4h	A review of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) certification.
4.4i	Adherence to the timeframes set forth in the MCO's policies regarding credentialing date requirements.
4.4j	Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d).
4.4k	Verification that the provider is actively enrolled in Medicaid at the time of credentialing.
4.5	**The MCO should request and review information from recognized monitoring organizations regarding practitioners. The evidence must include:**
4.5a	Any revocation or suspension of a state license or a DEA/Bureau of Narcotics and Dangerous Drugs (BNDD) number.
4.5b	Any curtailment or suspension of medical staff privileges (other than for incomplete medical records).
4.5c	Any sanctions imposed by Medicare and/or Medicaid.
4.5d	Information about the practitioner from the National Practitioner Data Bank (NPDB) and the Maryland Board of Physicians (MBP).
4.6	**The credentialing application includes the following:**
4.6a	The use of illegal drugs.
4.6b	Any history of loss of license.
4.6c	Any history of loss or limitation of privileges or disciplinary activity.
4.6d	Attestation to the correctness and completeness of the application.
4.7	**There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the Americans with Disabilities Act (ADA) and the MCO's standards.**
4.8	**There is evidence that recredentialing is performed at least every three years and:**

Element/Component Reviewed	Standard Description
4.8a	Includes a review of information from the NPDB.
4.8b	*Deleted in MY 2019.*
4.8c	Includes all items contained in element 4.4 a–h, except 4.4 d (work history).
4.8d	Includes all items contained in 4.6 a–d.
4.8e	Meets the timeframes set forth in the MCO's policies regarding recredentialing decision date requirements.
4.8f	Ensures the MCO is verifying that the provider is actively enrolled in Medicaid at the time of recredentialing.
4.9	**There is evidence that the recredentialing process includes a review of the following:**
4.9a	Enrollee complaints/grievances.
4.9b	Results of quality reviews.
4.9c	*Deleted in MY 2018.*
4.9d	Office site compliance with ADA standards, if applicable.
4.10	**The MCO must have policies and procedures regarding the selection and retention of providers.**
4.10a	The MCO must have written policies and procedures for selection and recruitment of providers in the HealthChoice Program.
4.10b	The MCO must have written policies and procedures for the retention of providers in the HealthChoice Program.
4.11	**The MCO must ensure that enrollees' parents/guardians are notified if they have chosen for their child to be treated by a non-EPSDT certified PCP.**
4.11a	The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.
4.11b	The MCO must provide evidence of notification to parents/guardians that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.
4.12	**The MCO must have written policies and procedures for notifying the Department of provider terminations.**
Compliance Score Requirement Rate: 100%	**5.0: Enrollee Rights**
5.1	**The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.**
5.1a	There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09.
5.1b	The system requires documentation of the substance of the grievances and steps taken.
5.1c	The system ensures that the resolution of a grievance is documented according to policy and procedure.

Element/Component Reviewed	Standard Description
5.1d	The policy and procedure describe the process for aggregation and analysis of grievance data and the use of the data for quality improvement. There is documented evidence that this process is in place and is functioning.
5.1e	*Deleted in MY 2018.*
5.1f	There is complete documentation of the substance of the grievance, steps taken to resolve, and the resolution in the case record.
5.1g	The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances within the MDH-established threshold of 95%.
5.1h	The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy and within the MDH-established threshold of 95%.
5.1i	Written resolution letters describe the grievance and the resolution in easy-to-understand language.
5.2	The MCO shall provide access to health care services and information in a manner consistent with the formatting and special access requirements of COMAR 10.67.05.01C.
5.3	The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO:
5.3a	Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data.
5.3b	Ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.
5.3c	Must hold confidential all information obtained by its personnel about enrollees related to their care and shall not divulge it without the enrollee's authorization unless: (1) it is required by law, (2) it is necessary to coordinate the patient's care, or (3) it is necessary in compelling circumstances to protect the health or safety of an individual.
5.3d	*Deleted in MY 2023.*
5.3e	May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.
5.4	**The MCO has written policies and procedures regarding the appropriate treatment of minors, including minor consent to treatment and confidentiality requirements. Without the consent of or over the express objection of a minor, a licensed health care practitioner may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor under this section, except information about an abortion.**
5.5	**As a result of the enrollee satisfaction surveys, the MCO:**

Element/Component Reviewed	Standard Description
5.5a	Identifies and investigates sources of dissatisfaction.
5.5b	Implements steps to follow up on the findings.
5.5c	Informs practitioners and providers of assessment results.
5.5d	Reevaluates the effects of b. above at least quarterly.
5.6	**The MCO has systems in place to assure that new enrollees receive required information within established timeframes.**
5.6a	Policies and procedures are in place that address the content of new enrollee packets of information and specify the timeframes for sending such information to the enrollee.
5.6b	Policies and procedures are in place for newborn enrollments, including issuance of the MCO's identification card.
5.6c	The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution.
5.6d	The MCO includes the Continuity of Health Care Notice in the new enrollee packet.
5.6e	The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.
5.7	**The MCO must have an active Consumer Advisory Board (CAB).**
5.7a	The MCO's CAB membership must reflect the special needs population requirements.
5.7b	The CAB must meet at least six times a year.
5.7c	The MCO must have a mechanism for tracking enrollee feedback from the meetings.
5.7d	The MCO provides a report on enrollee grievances to the CAB on at least an annual basis, including actions taken to address identified opportunities for improvement.
5.8	**The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights.**
5.8a	Materials critical to obtaining services that are 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 in Maryland.
5.8b	Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page.
5.8c	Notices and Taglines must be posted in significant communications and publications.
5.8d	Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.
5.8e	MCO's electronic information provided to enrollees must meet requirements set forth in COMAR.
5.9	**The MCO must maintain written policies and procedures for advance directives.**
5.9a	The MCO must educate staff regarding advance directives policies and procedures.

Element/Component Reviewed	Standard Description
5.9b	The MCO must provide adult enrollees with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618).
5.9c	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.
5.10	**MCO must comply with the marketing requirements of COMAR 10.67.04.23.**
5.10a	An MCO may not have face-to-face contact with a recipient who is not an enrollee of the MCO unless contact is authorized by the Department or contact is initiated by the recipient.
5.10b	An MCO cannot engage in marketing activities without prior approval of the Department.
5.10c	*Deleted in MY 2018.*
5.11	**The MCO has implemented policies and procedures to ensure that the MCO does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.**
Compliance Score Requirement Rate: 100%	**6.0: Availability and Accessibility**
6.1	**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.**
6.1a	The MCO has developed and disseminated written access and availability standards.
6.1b	The MCO has processes in place to monitor performance against its access and availability standards at least quarterly.
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.
6.1d	The MCO has documented a review of the Enrollee Services Call Center performance.
6.2	**The MCO has a list of providers that are currently accepting new enrollees.**
6.2a	The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population.
6.2b	At the time of enrollment, enrollees are provided with information about the MCO's providers.
6.2c	The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities.
6.2d	The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.
6.3	**The MCO has implemented policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services.**
6.3a	*Deleted in MY 2019.*

Element/Component Reviewed	Standard Description
6.3b	*Deleted in MY 2019.*
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.
6.4	**The MCO has implemented policies and procedures to ensure coverage and payment of emergency services and post-stabilization care services for enrollees.**
Compliance Score Requirement Rate: 100%	**7.0: Utilization Review (UR)**
7.1	**There is a comprehensive written UR Plan.**
7.1a	This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.
7.1b	The scope of the UR Plan includes a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services.
7.1c	There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.
7.2	**The UR Plan specifies criteria for UR/utilization management decisions.**
7.2a	The criteria used to make UR/utilization management decisions must be based on acceptable medical practice.
7.2b	The UR Plan must describe the mechanism or process for the periodic updating of the criteria.
7.2c	The UR Plan must describe the involvement of participating providers in the review and updating of criteria.
7.2d	There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures.
7.2e	There is evidence that UR/utilization management staff receive annual training on the interpretation and application of UR/utilization management criteria/guidelines.
7.2f	There is evidence that the MCO evaluates the consistency with which all staff involved apply UR/utilization management criteria on at least an annual basis.
7.3	**The written UR Plan has mechanisms in place to detect overutilization and underutilization of services.**
7.3a	Services provided must be reviewed for overutilization and underutilization.
7.3b	UR reports must provide the ability to identify problems and take the appropriate corrective action.
7.3c	Corrective measures implemented must be monitored.
7.4	**The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation.**

Element/Component Reviewed	Standard Description
7.4a	Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
7.4b	Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate.
7.4c	Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.
7.5	**Adverse determination letters include a description of how to file an appeal.**
7.5a	All adverse determination letters are written in easy-to-understand language.
7.5b	Adverse determination letters include all required components.
7.6	**The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials.**
7.6a	The MCO maintains policies and procedures pertaining to the timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.
7.6b	The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.
7.7	**The MCO must have written policies and procedures pertaining to enrollee appeals.**
7.7a	The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05.
7.7b	The MCO's appeals policies and procedures must include staffing safeguards to avoid conflicts of interest when reviewing appeals.
7.7c	The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes.
7.7d	The MCO's appeal policies must include procedures for how the MCO will assist enrollees with the appeal process.
7.7e	Reasonable efforts are made to give the enrollee prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.
7.7f	Written notifications to enrollees include appeal decisions that are documented in easy-to-understand language.
7.7g	The MCO's appeal policies and procedures must include oral inquiries seeking to appeal are treated as appeals.
7.8	**The MCO must have written policies and procedures pertaining to provider administrative appeals, including but not limited to claims appeals.**
7.8a	The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.

Element/Component Reviewed	Standard Description
7.8b	The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely. This component is limited to provider administrative appeals. Provider medical necessity appeals are always post-payment. Pre-service medical necessity reviews are enrollee appeal.
7.8c	The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
7.9 *(formerly 7.6)*	**There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.**
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.
7.9b	The MCO demonstrates a review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.
7.9c	The MCO acts upon identified issues as a result of the review of the data.
7.10 *(formerly 7.7)*	**The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.**
7.11 *(formerly 7.8)*	**The MCO must have written policies and procedures for establishing a corrective managed care plan for enrollee abuse of medical assistance pharmacy benefits consistent with the Department's corrective managed care plan.**
7.11a	The MCO's policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation.
7.11b	The MCOs must provide evidence of implementation of the corrective managed care plan.
7.12	***Deleted in MY 2019.***
Compliance Score Requirement Rate: 100%	**8.0: Continuity of Care**
8.1	**Enrollees with special needs and/or those with complex health care needs must have access to case management (CM) according to established criteria and must receive the appropriate services.**
8.2	**The MCO must ensure appropriate initiation of care based on the results of Health Services Needs Information (HSNI) data supplied to the MCO. This must include a process for gathering HSNI data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.**
8.3	**The MCO must have policies and procedures in place to coordinate care with primary care, Local Health Departments (LHDs), school health programs, and other frequently involved community-based organizations (CBOs).**

Element/Component Reviewed	Standard Description
8.4	**The MCO must monitor continuity of care across all services and treatment modalities including discharges or admissions to inpatient setting to home. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).**
8.5	**The MCO must monitor the effectiveness of the CM Program.**
8.6	**The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.**
8.7	**The MCO must comply with providing the Continuity of Health Care Notice to enrollees and have policies and procedures in place to provide services in accordance with the Maryland Insurance Administration (MIA) requirements when requested by enrollees.**
Compliance Score Requirement Rate: 100%	**9.0: Health Education Plan**
9.1	**The MCO has a comprehensive written Health Education Plan (HEP), which must include:**
9.1a	The education plan's purpose and objectives.
9.1b	Outlines of the educational activities such as seminars and distribution of brochures and calendars of events.
9.1c	A methodology for notifying enrollees and providers of available educational activities.
9.1d	A description of group and individual educational activities targeted at both providers and enrollees.
9.2	**The HEP incorporates activities that address needs identified through the analysis of enrollee data.**
9.3	**The MCO's HEP must:**
9.3a	Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.
9.3b	Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the enrollees.
9.3c	Contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for enrollee referrals.
9.4	**The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.** **Note:** This component is not limited to individuals in a special needs population.
9.5	**The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide:**
9.5a	Samples of notifications, brochures, and mailings.
9.5b	Attendance records and session evaluations completed by enrollees.

Element/Component Reviewed	Standard Description
9.5c	Provider evaluations of health education programs.
Compliance Score Requirement Rate: 100%	**10.0: Outreach Plan (OP)**
10.1	**The MCO has developed a written OP that describes the following:**
10.1a	Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership.
10.1b	MCO's organizational capacity to provide both broad-based and enrollee-specific outreach.
10.1c	Unique features of the MCO's enrollee outreach initiatives.
10.1d	Community partnerships.
10.1e	Role of the MCO's provider network in performing outreach.
10.1f	MCO's relationship with each of the LHDs and Administrative Care Coordination Units (ACCUs).
10.2	**The MCO has implemented policies and procedures for:**
10.2a	The provision of outreach services for new and existing enrollees for wellness/preventive health services.
10.2b	*Deleted in MY 2019.*
10.2c	The provision of outreach via telephone, written materials, and face-to-face contact.
10.2d	Monitoring of all outreach activities, including those delegated or subcontracted to other entities.
10.3	**The MCO has implemented strategies:**
10.3a	*Deleted in MY 2019.*
10.3b	*Deleted in MY 2019.*
10.3c	To promote the provision of EPSDT services and respond to no-shows and non-compliant behavior related to children in need of EPSDT services.
10.3d	To bring enrollees into care who are difficult to reach or who miss appointments.
Compliance Score Requirement Rate: 100%	**11.0: Fraud and Abuse**
11.1	**The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include:**
11.1a	Documentation that articulates the organization's commitment to comply with all applicable Federal and State laws, regulations, and standards.
11.1b	Designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and is responsible for ongoing monitoring of the MCO's mandatory compliance plan.

Element/Component Reviewed	Standard Description
11.1c	Designation of a Compliance Officer to serve as the liaison between the MCO and the Department.
11.1d	A documented process for internal monitoring and auditing, both routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and abuse education of MCO staff, enrollees, and providers.
11.1e	A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation.
11.1f	A documented process to ensure that services billed to the MCO were actually received by the enrollee.
11.2	**The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include:**
11.2a	Education and training for the Compliance Officer and the MCO's employees on detection of fraud and abuse.
11.2b	A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO's employees.
11.2c	A documented process for enforcing standards by means of clear communication to employees, in well-publicized guidelines, to sanction incidents of fraud and abuse.
11.2d	A documented process for enforcement of standards through clear communication of well-publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse.
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.
11.2f	A documented process for the reporting by employees of suspected fraud and abuse within the organization, without fear of reprisal.
11.2g	A documented process for reporting by subcontractors of the MCO suspected fraud and abuse within the organization, without fear of reprisal.
11.2h	A documented process for reporting by enrollees of the MCO suspected fraud and abuse within the organization without fear of reprisal.
11.3	**The MCO maintains administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. It must include:**
11.3a	A documented process for reporting all suspected cases of provider fraud and abuse to the MDH Office of the Inspector General and the Medicaid Fraud Control Unit within 30 calendar days of the initial report.

Element/Component Reviewed	Standard Description
11.3b	A documented process for cooperating with the MDH Office of the Inspector General and the State Medicaid Fraud Control Unit when suspected fraud and abuse is investigated.
11.4	**The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address:**
11.4a	Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee.
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.
11.4c	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.
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.
11.5 *(formerly 2.8)*	**An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies.**
11.5a	An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals or entities debarred by Federal Agencies.
11.5b	An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO's equity.
11.5c	An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with an employment, consulting, or other arrangement with the MCO.
11.5d	An MCO must provide evidence of initial and monthly checks of the following databases as applicable: National Plan and Provider Enumeration System; List of Excluded Individuals/Entities; Excluded Parties List Systems/System for Award Management (SAM).
11.5e	An MCO must have written policies and procedures for providing written disclosure of any prohibited affiliation and/or termination to MDH.
Compliance Score Requirement Rate: Baseline	**12.0: Disenrollment Requirements and Limitations**
12.1	**The MCO may request disenrollment for an enrollee from the HealthChoice program in accordance with federal and state regulations.**
12.1a	MCO policies and procedures specify the reasons for which the MCO and the Department may request enrollee disenrollment.

Element/Component Reviewed	Standard Description
12.1b	The MCO submits to the Department, within thirty (30) days of discovering a discrepancy, a list of enrollees who are known to the MCO to have reasons to be disenrolled for any reason listed in the referenced COMAR regulations from the HealthChoice Program.
12.2	**MCO policies and procedures specify the reasons the MCO is prohibited from requesting enrollee disenrollment.**
12.3	**The MCO policies and procedures specify the methods by which the MCO assures the state that it does not request disenrollment for reasons other than those permitted under the contract.**
12.4	**The MCO must have policies and procedures for notifying enrollees when, (1) the MCO terminates its contract with the state, and (2) when the MCO is acquired by another entity. In these instances, the MCO must:**
12.4a	Provide written notice to the enrollee at least 60 days before the date on which the MCO will exit the HealthChoice Program, or when the MCO is acquired by another entity.
12.4b	Include in the written notice to the enrollee, the name and provider number of the PCP assigned to the recipient and the telephone number of the enrollment broker.