HealthChoice and Acute Care Administration
Division of HealthChoice Management
and Quality Assurance

Medicaid Managed Care Organization

Systems Performance Review

Statewide Executive Summary

Calendar Year 2013

Delmarva Foundation

A Quality Health Strategies Company

Submitted by:
Delmarva Foundation
August 2014

CY 2013 Statewide Executive Summary

HealthChoice Program Overview

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

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

Introduction

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

Under Federal law [Section 1932(c)(2)(A)(i) of the Social Security Act], DHMH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract. To ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program, DHMH contracts with Delmarva Foundation to serve as the EQRO. This executive summary describes the findings from the systems performance review (SPR) for calendar year (CY) 2013, which is HealthChoice's sixteenth year of operation. The HealthChoice program served over 832,500 enrollees during this period.

COMAR 10.09.65 requires that all HealthChoice MCOs comply with the SPR standards and all applicable federal and state laws and regulations. MCOs are given an opportunity to review and comment on the SPR standards 90 days prior to the beginning of the audit process. The seven MCOs evaluated for CY 2012 were:

- AMERIGROUP Community Care (ACC)
- Jai Medical Systems, Inc. (JMS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- Priority Partners (PPMCO)
- Riverside Health of Maryland, Inc. (RHMD)*
- UnitedHealthcare (UHC)

*Riverside Health of Maryland, Inc. joined the HealthChoice Program in February 2013. This is the MCO's first SPR.

Purpose

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

The SPRs were conducted at the MCO's corporate offices and performed by a team of health care professionals. Prior to the on-site reviews, MCOs were required to submit a pre-site survey form and supply documentation for various processes such as quality management, utilization management (UM), credentialing and recredentialing, enrollee rights, and fraud and abuse identification. Delmarva staff reviews these documents prior to the on-site visit.

The on-site component provides the MCOs with an opportunity to demonstrate the efficacy of their health care system. Policies, committee minutes, work plans, reports, and other written procedures were presented to the reviewers that demonstrate the continuous quality improvement efforts undertaken by the MCOs. Key staff interfaced with the team to further define their organization's operational protocols. In addition, the team evaluated the effectiveness of any Corrective Action Plans (CAPs) initiated as a result of the prior year's review.

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes and Code of Maryland Annotated Regulations (COMAR), the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care," Public Health Code of Federal Regulations, and Department requirements. The HealthChoice and Acute Care Administration leadership and the Division of HealthChoice Management and Quality Assurance (DHMQA) approved the MCO performance standards used in the CY 2013 review before application.

The review team that performed the annual SPRs consists of health professionals: a nurse practitioner and two masters prepared reviewers. The team has a combined experience of more than 45 years in managed care and quality improvement systems, 33 years of which are specific to the HealthChoice program. The team completed the reviews and provided feedback to the DHMQA and each MCO with the goal of improving the care provided to HealthChoice enrollees.

Methodology

For CY 2013, COMAR 10.09.65.03 required that all HealthChoice MCOs comply with the SPR standards established by the Department and all applicable federal and state laws and regulations.

The following eleven performance standards were included in the CY 2013 review cycle:

- Systematic Process of Quality Assessment*
- Accountability to the Governing Body
- Oversight of Delegated Entities
- Credentialing and Recredentialing
- Enrollee Rights
- Availability and Accessibility
- Utilization Review (UR)
- Continuity of Care
- Health Education*
- Outreach*
- Fraud and Abuse

*Note: These standards were exempt from the CY 2013 review cycle for all MCOs except for RHMD, as this was the MCO's first SPR.

For CY 2013, all MCOs (except for RHMD as this was the MCOs first SPR) were expected to meet the compliance rate of 100% for all standards. The RHMD compliance rate was set at 80% for its first SPR. The MCOs were required to submit a CAP for any standard that did not meet the minimum compliance rate.

In September 2013, Delmarva provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for Calendar Year 2013 and invited the MCOs to direct any questions or issues requiring clarification to specific Delmarva and DHMQA staff. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2013 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey

- Pre-site SPR Document List
- Systems Performance Review Standards, including CY 2013 changes
- System Performance Standards and Guidelines

Prior to the on-site review, the MCOs were required to submit a completed pre-site survey form and provide documentation for various processes such as quality and UM, delegation, credentialing, enrollee rights, continuity of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Delmarva staff prior to the on-site visit.

During the on-site reviews in January and February of 2014, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion, exit conferences were held with the MCOs. The purpose of the conferences was to provide the MCOs with preliminary findings, based on interviews and all documentation reviewed. Notification was also provided during the exit conferences that the MCOs would receive a follow-up letter describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Delmarva; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the on-site review, Delmarva documented its findings for each standard by element and component. The level of compliance for each element and component was rated with a review determination of met, partially met, or unmet, as follows:

Met	100%
Partially Met	50%
Unmet	0%

Each element or component of a standard was of equal weight. A CAP was required for each performance standard that did not meet the minimum required compliance rate, as defined for the CY 2013 review.

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

The Department had the discretion to change a review finding to “Unmet” based on the fact that it has been found “Partially Met” for more than one consecutive year.

Preliminary results of the SPR were compiled and submitted to DHMH for review. Upon the Department’s approval, the MCOs received a report containing individual review findings. After receiving the preliminary

reports, the MCOs were given 45 calendar days to respond to Delmarva with required CAPs. The MCOs could have also responded to any other issues contained in the report at its discretion within this same time frame, and/or requested a consultation with DHMH and Delmarva to clarify issues or ask for assistance in preparing a CAP.

Corrective Action Plan Process

Each year the CAP process is discussed during the annual review meeting. This process requires that each MCO must submit a CAP which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the preliminary report. CAPs are reviewed by Delmarva and determined to be adequate only if they address the following required elements and components:

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

In the event that a CAP is deemed unacceptable, Delmarva Foundation will provide technical assistance to the MCO until an acceptable CAP is submitted. Three MCOs were required to submit CAPs for the CY 2013 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Delmarva reviewed any additional materials submitted by the MCO, made appropriate revisions to the MCO's final report, and submitted the report to the DHMH for review and approval. The Final MCO Annual System Performance Review Reports were mailed to the MCOs.

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2014 will determine whether the CAPs from the CY 2013 review were implemented and effective. In order to make this determination, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

Findings

The HealthChoice MCO annual SPR consists of 8 to 11 standards, depending on the MCO. The compliance threshold established by DHMH for all standards for CY 2013 is 100% for all MCOs, except for RHMD for which the compliance threshold is set at 80% for its first SPR.

All seven HealthChoice MCOs participated in the SPR. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. If the MCO's score was below the minimum threshold, a CAP was required. Four MCOs (ACC, JMS, MPC, and MSFC) received perfect scores in all standards. Three MCOs (PPMCO, RHMD, and UHC) were required to submit CAPs for CY 2013. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Table 2 provides for a comparison of SPR results across MCOs and the MD MCO Compliance for the CY 2013 review.

Table 2. CY 2013 MCO Compliance Rates

Standard	Description	Elements Reviewed	MD MCO Compliance Rate	ACC	JMS	MPC	MSFC	PPMCO	RHMD**	UHC
1	Systematic Process	33	100%	Exempt	Exempt	Exempt	Exempt	Exempt	100%	Exempt
2	Governing Body	10	100%	100%	100%	100%	100%	100%	100%	100%
3	Oversight of Delegated Entities	7	**83%***	100%	100%	100%	100%	100%	**36%***	**71%***
4	Credentialing	38	**98%***	100%	100%	100%	100%	100%	**98%***	100%
5	Enrollee Rights	21	**96%***	100%	100%	100%	100%	**90%***	**94%***	**90%***
6	Availability and Access	10	**96%***	100%	100%	100%	100%	**95%***	**80%***	100%
7	Utilization Review	24	**90%***	100%	100%	100%	100%	**80%***	**67%***	**85%***
8	Continuity of Care	4	100%	100%	100%	100%	100%	100%	100%	100%
9	Health Education Plan	12	**88%***	Exempt	Exempt	Exempt	Exempt	Exempt	**88%***	Exempt
10	Outreach Plan	14	**93%***	Exempt	Exempt	Exempt	Exempt	Exempt	**93%***	Exempt
11	Fraud and Abuse	19	**98%***	100%	100%	100%	100%	100%	**89%***	100%

*Denotes that the minimum compliance rate of 100% was unmet.
**RHMD's minimum compliance threshold is set at 80%, as this was the MCO's first SPR.

The following section describes for each standard assessed in CY 2013: the requirements assessed for the standard; the results and MD MCO compliance rate; the findings; the individual MCO opportunities for improvement and CAP requirements, if applicable; and follow up, if required.

STANDARD 1: Systematic Process of Quality Assessment/Improvement

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

Results:
- The overall MD MCO Compliance Rate was 100% in CY 2013.
- All MCOs were exempt from this standard except for RHMD.
- RHMD met the minimum compliance threshold for this standard.

Findings: This area of review was exempt for all MCOs except for RHMD. This was RHMD's first review of their QAP. It was found to be comprehensive in scope and to appropriately monitor and evaluate the quality of care and service to members using meaningful and relevant performance measures. Clinical care standards and/or practice guidelines are in place which the MCOs monitor performance against annually, and clinicians monitor and evaluate quality through review of individual cases where there are questions about care. Additionally, there is evidence of development, implementation, and monitoring of corrective actions.

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 2: Accountability to the Governing Body

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

Results:
- The overall MD MCO Compliance Rate was 100% for CY 2013.
- All MCOs met the minimum compliance threshold for this standard.

Findings: Overall, MCOs continue to have appropriate oversight by their governing boards. Evidence was provided of the oversight provided by the governing body, along with ongoing feedback and direction of quality improvement activities and operational activities of the MCO.

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 3: Oversight of Delegated Entities

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

Results:

- The overall MD MCO Compliance Rate was 83% for CY 2013.
- ACC, JAI, MPC, MSFC, and PPMCO met the minimum compliance threshold for this standard.
- RHMD and UHC were required to submit CAPs.

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

MCO Opportunity/CAP Required

RHMD Opportunities/CAPs:

Element 3.1 – There is a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO.

RHMD received a finding of partially met because the delegated agreements provided a detailed listing of specific delegated claims processing activities and procedures; however, no specific performance measures or reporting requirements were identified. Additionally, formalized responsibilities, which had been delegated to the vendor and clearly outlined in amendments, were not found for functions such as complaints, grievances, and appeals.

In order to receive a finding of met in the CY 2014 SPR, RHMD must ensure that all delegation agreements accurately reflect responsibility for specific delegated activities. Additionally, specific reporting requirements and performance measures need to be included in all delegation agreements.

Component 3.3b – There is evidence of continuous and ongoing evaluation of delegated activities, including quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable.

RHMD received a finding of unmet because there was no evidence of QIC quarterly review and approval of two delegated vendors' quarterly complaint, grievance, and appeal reports for the first, second, or third quarter of 2013. The MCO did not commence operations until February of 2013, therefore there were no delegated activities for the fourth quarter of 2012.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence of formal review and approval of delegate quarterly complaint, grievance, and appeal reports on a quarterly basis by the appropriate committee designated in the MCO's policy.

Component 3.3c - There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of claims payment activities, where applicable.

RHMD received a finding of unmet because there was no evidence of the Quality Improvement Committee's review and approval of three delegated vendors' claims activities reports since the MCO's commencement of operations in mid-February 2013.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence of formal review and approval of delegate claims activities reports by the appropriate committee designated in the MCO's policy and according to the stated frequency.

Component 3.3d - There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.

RHMD received a finding of unmet because there was no evidence of QIC review and approval of the annual UMP and UM criteria from two of the delegated vendors in 2013.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence of formal review and approval of each delegate's annual UMP and UM criteria by the appropriate committee designated in the MCO's policy.

Component 3.3e - There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of over and underutilization reports, where applicable.

RHMD received a finding of unmet because there was no evidence of QIC review and approval for two delegated vendors over and underutilization reports since the MCO's commencement of operations in mid-February 2013.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence of formal review and approval of each delegate's over/under utilization report(s) by the appropriate committee designated in the MCO's policy and according to the stated frequency.

UHC Opportunities/CAPs:

Component 3.3a – There is evidence of continuous and ongoing evaluation of delegated activities, including 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.

UHC received a finding of unmet because this was the second year that there were opportunities for improvement identified in this area of review. As a result of the CY 2012 SPR finding, UHC was required to submit a CAP to provide evidence of ongoing oversight and monitoring of delegated entities. The CAP was not fully implemented and continuing opportunities for improvement exist. According to the Director of Marketing, routine monitoring of delegated entities occurred informally through ad hoc meetings convened in response to identified issues. There was no documentation of these meetings. There was no evidence of review of delegated vendors' annual audit findings. Evidence was provided supporting an annual credentialing audit; however, there was no evidence of a claims audit, which is also a delegated activity.

In order to receive a finding of met in the CY 2014 SPR, UHC must provide ongoing evidence of routine monitoring and oversight of each delegated entity that includes documented review of annual audit findings of delegated activities and monitoring of any CAPs.

Component 3.3e - There is evidence of continuous and ongoing evaluation of delegated activities, including review and approval of over and underutilization reports, where applicable.

UHC received a finding of unmet because the QMC did not review over and underutilization comparisons on an annual basis.

In order to receive a finding of met in the CY 2014 SPR, UHC must provide evidence of review/approval of any UM delegated entity's over/under utilization report(s) by the appropriate committee at intervals consistent with the MCO's policy.

Follow-up: RHMD and UHC were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions. The approved CAPs will be reviewed during the CY 2014 SPR.

STANDARD 4: Credentialing and Recredentialing

Requirements: The QAP must contain all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services. The MCO must have written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. The MCO may delegate credentialing/recredentialing activities with a written description of the delegated activities, a description of the delegate's accountability for designated activities, and evidence that the delegate accomplished the credentialing activities. The credentialing process must be ongoing and current. There must be evidence that the MCO requests information from recognized monitoring organizations about the practitioner. The credentialing application must include information regarding the use of illegal drugs, a history of loss of license and loss or limitation of privileges or disciplinary activity, and an attestation to the correctness and completeness of the application. There must be 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 American's with Disabilities Act and the MCO's standards.

There must be evidence that recredentialing is performed at least every three years and includes a review of enrollee complaints, results of quality reviews, hospital privileges, current licensure, and office site compliance with Americans with Disabilities Act of 1990 (ADA) standards, if applicable.

Results:

- The overall MD MCO Compliance Rate was 99% for CY 2013.
- All MCOs met the minimum compliance threshold for this standard.

Findings: Overall, MCOs have appropriate policies and procedures in place to determine whether physicians and other health care professionals, licensed by the State and under contract to the MCO, are qualified to perform their services. Evidence in credentialing and recredentialing records demonstrated that those policies and procedures are functioning effectively. There were issues identified with the recredentialing process over the past year which represented the slight decline in the overall MCO compliance rate.

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 5: Enrollee Rights

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

Results:

- The overall MD MCO Compliance Rate was 96% for CY 2013.
- ACC, JAI, MPC, and MSFC met the minimum compliance threshold for this standard.
- PPMCO, RHMD and UHC were required to submit CAPs.

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

MCO Opportunity/CAP Required

PPMCO Opportunities/CAPs:

<u>Component 5.1d</u> – The grievance policy and procedure describes 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.

PPMCO received a finding of partially met because its Member Complaint/Grievance Policy did not reflect the correct committee reporting structure.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must revise the Member Complaint/Grievance Policy to reflect the correct reporting structure.

<u>Component 5.1f</u> - There is complete documentation of the substance of the grievances and steps taken.

PPMCO received a finding of partially met because after a review of 35 complaint/grievance records, it was found that the documentation of the substance of the complaint/grievance in the electronic system, along with the letters to members regarding the complaint/grievance and its resolution, was not complete in several records. Additionally, the documentation in the complaint/grievance records did not match up to the dates noted in the system: start dates, completion dates, dates on customer service call notes, and response letter dates.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must provide complete and clear documentation of the substance of the grievances and steps taken in each record.

Component 5.1g – The MCO adheres to the time frames set forth in its policies and procedures for resolving grievances.

PPMCO received a finding of unmet because a review of 35 complaint/grievance records found that the current electronic system did not clearly track the dates of resolution activity for all records.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must adhere to the time frames set forth in its policies and procedures for resolving grievances in all records.

RHMD Opportunities/CAPs:

Component 5.6a - Policies and procedures are in place that address the content of new enrollee packets of information and specify the time frames for sending such information to the enrollee.

RHMD received a finding of partially met because the MCO does not have a formal written policy and procedure that includes the content of new enrollee packets and the regulatory time frames for mailing such information to new enrollees. Currently, welcome packet fulfillment reports are reviewed daily, along with the use of Health Risk Assessments and Welcome Calls to confirm receipt of new enrollee packets.

In order to receive a finding of met in the CY 2014 SPR, RHMD must develop a policy and procedure that includes the content of new enrollee packets and the regulatory time frames for mailing such information to new enrollees.

UHC Opportunities/CAPs:

Component 5.1g – The MCO adheres to the time frames set forth in its policies and procedures for resolving grievances.

UHC received a finding of unmet because grievance records demonstrated that resolution letters were absent from almost all case records due to staffing changes and training issues during 2013. Therefore, the reviewer was unable to determine whether or not resolutions met the required time frames. UHC proactively developed a CAP prior to the review to rectify the noncompliant situation, including a new tracking grid, implementation of weekly and quarterly audits, and secured electronic record keeping. These activities will begin in February 2014.

In order to receive a finding of met in the CY 2014 SPR, UHC must adhere to the time frames set forth in the MCO's policies and procedures for resolving grievances.

Component 5.5c - As a result of the enrollee satisfaction surveys, the MCO informs practitioners and providers of assessment results.

UHC received a finding of unmet because the MCO did not notify providers of the annual satisfaction survey results. UHC would normally publish the results and analysis of the 2013 CAHPS® survey (measuring data from CY 2012) in the fourth quarter 2013 provider newsletter.

In order to receive a finding of met in the CY 2014 SPR, UHC must inform practitioners and providers of assessment results.

Follow-up: PPMCO, RHMD, and UHC were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions. The approved CAPs will be reviewed for compliance during the CY 2014 SPR.

STANDARD 6: Availability and Accessibility

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

Results:

- The overall MD MCO Compliance Rate was 96% for CY 2013.
- ACC, JAI, MPC, MSFC, RHMD, and UHC met the minimum compliance threshold for this standard.
- PPMCO was required to submit a CAP.

Findings: Overall, MCOs have established appropriate standards for ensuring access to care and have fully implemented a system to monitor performance against these standards. All MCOs have current provider directories that list providers that are currently accepting new enrollees along with websites and helplines that are easily accessible to members as well. Each MCO has an effective system in place for notifying members of wellness services. However, opportunities exist regarding consistency in policies and procedures and corrective action planning.

MCO Opportunity/CAP Required

Component 6.1c - The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance.

PPMCO received a finding of partially met because the MCO's Access, Availability and Performance Standards Policy cited performance standards that were inconsistent with their call center metrics. Additionally, the policy was silent as to how to rectify ongoing noncompliance of call center performance.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must revise either the Access, Availability and Performance Standards Policy or the Call Center Metric goal so that both documents state the same calls answered within 30 seconds (availability rate for customer service representatives) goal. Currently, the policy states 90% and the matrix spreadsheet states 85%.

Follow-up: PPMCO was required to submit a CAP for the above element/component. Delmarva Foundation reviewed and approved the submission. The approved CAP will be reviewed for compliance during the CY 2014 SPR.

STANDARD 7: Utilization Review

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

Results:

- The overall MD MCO Compliance Rate was 90% in CY 2013.
- ACC, JAI, MPC, and MSFC met the minimum compliance threshold for this standard.
- PPMCO, RHMD and UHC were required to submit CAPs.

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

MCO Opportunity/CAP Required

PPMCO Opportunities/CAPs:

Component 7.3a - Services provided must be reviewed for over and underutilization.

PPMCO received a finding of partially met because the Over and Under Utilization Policy outlines procedures for monitoring of potential over and underutilization and development of interventions, as indicated. Monitoring is to

occur on a quarterly basis with results reported to the QIWG. Although it is evident that the UM Close Committee was reviewing utilization trends for some IP services, this component was only partially met as there was no evidence that the UM Close Committee reported results to the QIWG in a manner consistent with the MCO's policy. Additionally, there was no evidence of follow-up on action items requiring further investigation of identified trends to assess for over or under utilization.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must provide evidence that the MCO is following its policies for monitoring and reporting of potential over and underutilization. There must also be evidence of follow-up on identified action plans requiring further investigation of potential over and underutilization.

Component 7.3b – Utilization review reports must provide the ability to identify problems and take the appropriate corrective action.

PPMCO received a finding of unmet because there was no evidence that the MCO identified problems of over/under utilization and implemented corrective action based upon review of QIWG meeting minutes from 2013. The MCO did provide two examples of BH meeting minutes that primarily focused on the State-required SA performance improvement project and noted that reports had been presented to the QIWG. Use of a State-required performance improvement project does not meet the intent of this standard/component.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must provide evidence that the MCO takes corrective action in response to identified over/under utilization problems as documented in the appropriate committee meeting minutes.

Component 7.3c - Corrective measures implemented must be monitored.

PPMCO received a finding of unmet because there was no documentation in appropriate committee meeting minutes that corrective measures to address over/under utilization were monitored in 2013.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must provide evidence that corrective measures have been implemented to address over/under utilization problems are monitored by the appropriate committee.

Component 7.4c - The reasons for decisions are clearly documented and available to the enrollee.

PPMCO received a finding of partially met because a review of a sample of member adverse determination letters demonstrated unclear language from the criteria used to make the determination included in the letters. For example, the letters included the use of standard medical terminology such as "functional plateau" and "decline in speech intelligibility," terms. These terms could not be easily understood and are inappropriate in a letter to a member.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must document the reasons for decisions in clearly understandable language for the member.

Component 7.4e - Preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

In response to the CY 2012 SPR findings, **PPMCO** was required to develop a CAP to demonstrate consistent compliance with determination and notification time frames specified by the State. In CY 2013, continued opportunities for improvement exist, therefore PPMCO received a finding of unmet in that component. The Inpatient Preauthorizations document identified compliance with turnaround times by month throughout 2013. Compliance exceeded the 95% threshold with the exception of June, which was slightly below at 94.8%.

In order to receive a finding of met in the CY 2014 SPR, PPMCO must consistently demonstrate compliance at the 95% threshold in response to State-required time frames for preauthorization determinations and adverse determination notifications for medical, pharmacy, and SA.

Component 7.4f - Appeal decisions are made in a timely manner as required by the exigencies of the situation.

PPMCO received a finding of partially met because the MCO failed to meet the required resolution time frames throughout 2013. The Appeals Process Management Team Report evidences tracking of compliance by month for expedited pre-service, non-urgent pre-service, and post-service appeals. For expedited pre-service appeals, compliance was consistently reported as 100%. For non-urgent pre-service appeals, compliance ranged from 91% to 100%, with four months out of compliance (June, July, August, and September).

In order to receive a finding of met in the CY 2014 SPR, PPMCO must consistently demonstrate compliance with State-required time frames for appeal resolution.

RHMD Opportunities/CAPs:

Component 7.1a – The comprehensive Utilization Review Plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

RHMD received a finding of partially met because there was there was no description of the data and information the MCO uses to make determinations regarding SA and there was no evidence that the UMP was approved by the QIC in 2013.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence of the processes the MCO follows and the information it uses to make determinations in response to requests for preauthorization, concurrent, and retrospective reviews for SA. This can be included in the UMP or in specific PA, Concurrent, and Retrospective Review policies. Additionally, the UMP must be approved by the QIC annually.

Component 7.1b - The scope of the Utilization Review Plan includes a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services.

RHMD received a finding of unmet because the UMP did not state that its review activities included all covered services in all settings, admissions in all settings, and collateral and ancillary services.

In order to receive a finding of met in the CY 2014 SPR, RHMD must ensure that the UMP explicitly includes the scope of its review activities.

__Component 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.**

RHMD received a finding of partially met because there was no evidence that the Affirmative Statement regarding UM decision making that is required at initial hire and annually thereafter was included in the December 2012 edition of the RHMD Provider Manual.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence that the MCO fully implements its Affirmative Statement Policy, which requires inclusion of the affirmative statement in the Provider Manual as well as annual publication in the provider newsletter.

__Component 7.2d__ **- There must be evidence that the criteria for UR/UM decisions are reviewed and updated according to MCO policies and procedures.**

RHMD received a finding of unmet because there was no evidence of PAC review and approval of Milliman Care Guidelines found, from the time the MCO commenced operations to the SPR review.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence of PAC annual review and approval of all medical necessity criteria used by the MCO, consistent with its policy.

__Component 7.4c__ **- The reasons for decisions are clearly documented and available to the enrollee.**

RHMD received a finding of partially met because adverse determination letters did not consistently provide a clear, full, complete explanation of the reason for the adverse determination in easily understandable language. Seven out of the 30 letters reviewed (23%) provided an inadequate explanation for the reason for the adverse determination.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence that reasons for adverse determinations are communicated in writing to the member and provide a clear, full, and complete explanation for the decision in easily understandable language.

__Component 7.4e__ **- Preauthorization and concurrent review decisions are made in a timely manner as specified by the State.**

RHMD received a finding of unmet because there was no documented process that describes the methodology for reporting compliance with preauthorization determination and adverse determination notification time frames. However, compliance was tracked on a routine basis and reported to the QIC. Although sampling was used, the required sample size calculator was not used to ensure a statistically valid sample size. Compliance with the 95% threshold could, therefore, not be assessed.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence that the MCO has a documented methodology for determining compliance with preauthorization determination and adverse determination notification time frames consistent with state requirements, including use of the sample size calculator to ensure a statistically valid sample size if the total population is not used.

Component 7.4g - The MCO maintains policies and procedures pertaining to provider appeals as outlined in COMAR 10.09.71.03.

RHMD received a finding of partially met because the Provider Appeals Policy includes some, but not all, requirements as outlined in COMAR 10.09.71.03.

In order to receive a finding of met in the CY 2014 SPR, RHMD must revise the Provider Appeal Policy to be consistent with the requirements outlined in COMAR 10.09.71.03.

Element 7.5 - Adverse determination letters include a description of how to file an appeal and all other required components.

RHMD received a finding of unmet because none of the sample adverse determination letters reviewed evidenced that the PCP was copied, although there was evidence that the PCP was copied on the requesting provider letter. The component that requires a clear, full, complete factual explanation for the reasons for denial, reduction or termination in understandable language was not met in two (20%) of the 10 letters. Additionally, the component requiring description of any additional information the MCO needs for reconsideration was stated as N/A in each of these letters. Another 20 adverse determination letters were reviewed for these two components. Five of the 20 (25%) additional letters reviewed for compliance with these components were found to provide an inadequate explanation of the reason for the adverse determination and were also lacking a description of additional information needed for reconsideration.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence that the PCP is copied on all member adverse determination letters. Additionally, all adverse determination letters must include a clear, full, complete factual explanation of the reasons for denial, reduction, or termination in understandable language and describe any additional information the MCO needs for reconsideration.

Component 7.6a - 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.

RHMD received a finding of unmet because there was no policy that addresses member and provider satisfaction with the UMP.

In order to receive a finding of met in the CY 2014 SPR, RHMD must provide evidence that the MCO has developed a comprehensive policy that addresses the process for evaluating member and provider satisfaction with the UMP on an annual basis.

UHC Opportunities/CAPs:

Component 7.4c - The reasons for decisions are clearly documented and available to the enrollee.
UHC received a finding of unmet as it has not met compliance with State required time frames for determinations and notifications for preauthorization requests since 2007 with the exception of 2011 when the component was scored as baseline. The CAPs that have been implemented to date have left continued opportunities for improvement.

In order to receive a finding of met in the CY 2014 SPR, UHC must demonstrate consistent tracking and compliance with State-required time frames for determinations and notifications for preauthorization requests for medical, pharmacy, and SA services.

Component 7.4f – Appeal decisions are made in a timely manner as required by the exigencies of the situation.

UHC received a finding of unmet because as a result of the CY 2011 and 2012 SPR findings, the MCO was required to submit a CAP each year to address compliance with regulatory time frames for appeal processing on a consistent basis. These CAPs were partially implemented and continued opportunities for improvement exist in demonstrating routine compliance with State-required time frames.

In order to receive a finding of met in the CY 2014 review, there must be evidence that the MCO consistently meets the State required resolution time frames for all medical, pharmacy, and SA appeals.

Element 7.5 - Adverse determination letters include a description of how to file an appeal and all other required components.

UHC received a finding of partially met because in seven of the 10 denial letters reviewed, the requesting provider rather than the PCP was copied at the bottom of the letter.

In order to receive a finding of met in the CY 2014 SPR, UHC must consistently demonstrate inclusion of all 13 required components in adverse determination letters. Specifically, all letters must include evidence that a copy was sent to the member's PCP.

Component 7.6c - The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.

UHC received a finding of partially met because there was no evidence of review of 2013 Provider Satisfaction Survey results related to UMP satisfaction by the appropriate oversight committee.

In order to receive a finding of met in the CY 2014 SPR, UHC must provide evidence of committee review of 2014 Provider Satisfaction Survey results, specifically in relation to UM processes. Additionally, there needs to be a more detailed review of CAHPS® satisfaction results relating specifically to the UMP.

Component 7.6d - The MCO acts upon identified issues as a result of the review of the data.

UHC received a finding of partially met because there were no specific interventions related to specific UM-related Provider Satisfaction issues.

In order to receive a finding of met in the CY 2014 SPR, UHC must provide evidence that the MCO acts upon identified issues in response to both the 2014 CAHPS® and the provider satisfaction surveys, specifically relating to the UMP.

Follow-up: PPMCO, RHMD and UHC were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions. The approved CAPs will be reviewed during the CY 2014 SPR.

STANDARD 8: Continuity of Care

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

Results:

- The overall MD MCO Compliance Rate was 100% for CY 2013.
- All MCOs met the minimum compliance threshold for this standard.

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

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 9: Health Education Plan Review

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

Results:

- The overall MD MCO Compliance was 88% for CY 2013.
- All MCOs were exempt from this standard except for RHMD.
- RHMD met the minimum compliance threshold for this standard.

Findings: This area of review was exempt for all MCOs except for RHMD. This was RHMD's first review of their Health Education Plan. It was found to be comprehensive and include policies and procedures for internal staff education, provider education and continuing education units, and enrollee health education.

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 10: Outreach Plan Review

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

Results:

- The overall MD MCO Compliance Rate was 93% for CY 2013.
- All MCOs were exempt from this standard except for RHMD.
- RHMD met the minimum compliance threshold for this standard.

Findings: This area of review was exempt for all MCOs except for RHMD. This was RHMD's first review of their Outreach Plan. Overall, it was found to have adequately described their populations served, an assessment of common health problems, and barriers to outreach within the MCO's membership. RHMD described the organizational capacity to provide both broad-based and enrollee specific outreach in the plan. The unique features of the MCO's enrollee education initiatives, community partnerships, and the roles of the provider network and local health departments were also included in the Outreach Plan. Appropriate supporting evidence of the outreach activities was also provided.

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

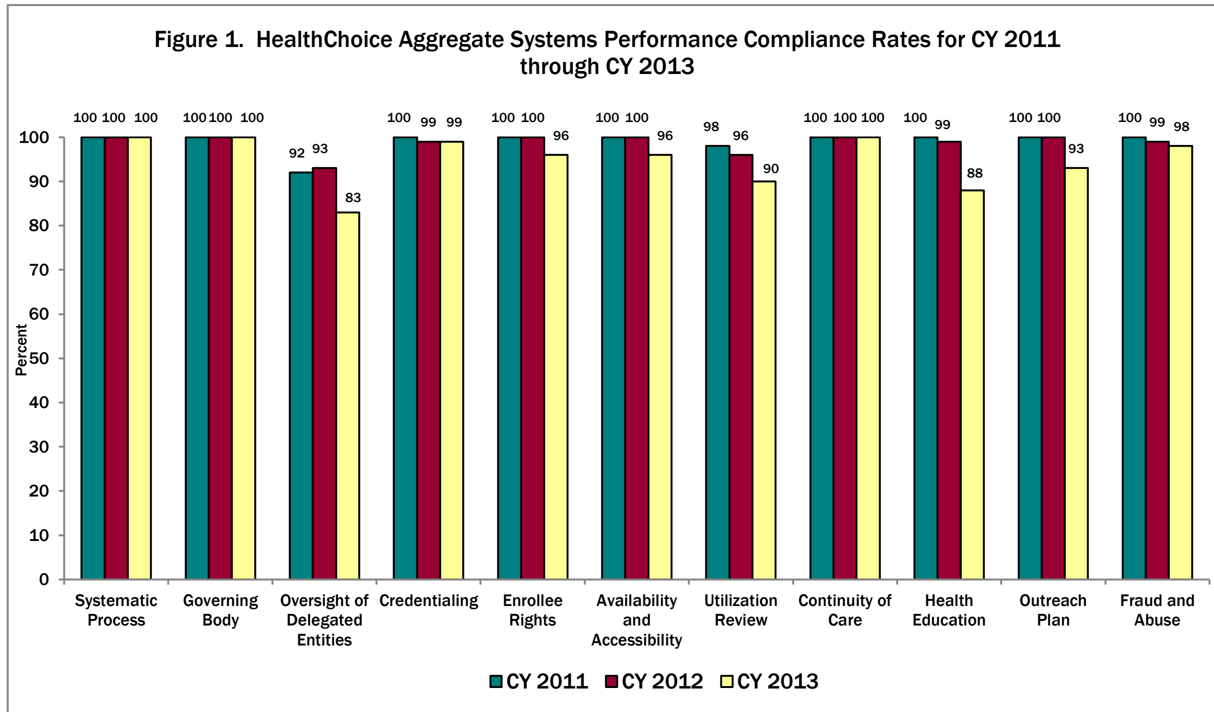

Figure 1. HealthChoice Aggregate Systems Performance Compliance Rates for CY 2011 through CY 2013

Between CY 2011 and CY 2012, the MD MCO Compliance Rate remained unchanged for six standards (Systematic Process, Governing Body, Enrollee Rights, Availability and Accessibility, Continuity of Care, and Outreach Plan), increased for one standard (Oversight of Delegated Entities), and decreased for four standards (Credentialing, Utilization Review, Health Education, and Fraud and Abuse). Between CY 2012 and CY 2013, the MD MCO Compliance Rate remained unchanged for four standards (Systematic Process, Governing Body, Credentialing, and Continuity of Care), and decreased for seven standards (Oversight of Delegated Entities, Enrollee Rights, Availability and Accessibility, Utilization Review, Health Education, Outreach Plan, and Fraud and Abuse). It should be noted, however, that a new MCO entered the system during this review year. The overall MD MCO Composite Score remained unchanged from CY 2011 to CY 2012 at a rate of 99% and decreased to 97% in CY 2013.

Conclusions

All MCOs have demonstrated the ability to design and implement effective QA systems. The CY 2013 review provided evidence of the continuing progression of the HealthChoice MCOs as each MCO demonstrated their ability to ensure the delivery of quality health care for their enrollees.

Maryland has set high standards for MCO QA systems. In general, HealthChoice MCOs continue to make improvements in their QA monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. This is evident in the comparison of annual SPR results demonstrated throughout the history of the HealthChoice Program.