HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

Medicaid Managed Care Organization

Systems Performance Review

Statewide Executive Summary

Calendar Year 2014

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Delmarva Foundation
A Quality Health Strategies Company

CY 2014 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 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) 2014, which is HealthChoice's seventeenth year of operation. The HealthChoice program served over 1,059,300 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 eight MCOs evaluated for CY 2014 were:

- AMERIGROUP Community Care (ACC)
- 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)
- Riverside Health of Maryland, Inc. (RHMD)**
- UnitedHealthcare (UHC)

*KPMAS joined the HealthChoice Program in July of 2014. This is the MCO's first SPR.
**RHMD joined the HealthChoice Program in February 2013. This is the MCO's second 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 Foundation's 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 from the Annotated Code of Maryland; Code of Maryland 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 Quality Assurance (DHQA) approved the MCO performance standards used in the CY 2014 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, 35 years of which are specific to the HealthChoice program. The team completed the reviews and provided feedback to the DHQA and each MCO with the goal of improving the care provided to HealthChoice enrollees.

Methodology

For CY 2014, 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 2014 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 2014 review cycle for all MCOs except for KPMAS and RHMD, as this was the MCO's first and second SPRs, respectively.

For CY 2014, all MCOs (except for KPMAS and RHMD) were expected to meet the compliance score of 100% for all standards. The KPMAS compliance score was set at 80% for its first SPR, and the RHMD compliance score was set at 90% for its second SPR. The MCOs were required to submit a CAP for any standard that did not meet the minimum compliance score.

In September 2014, Delmarva Foundation provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2014 and invited the MCOs to direct any questions or issues requiring clarification to specific Delmarva Foundation and DHQA staff. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2014 Review Timeline

- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- Systems Performance Review Standards, including CY 2014 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, UM, delegation, credentialing, enrollee rights, continuity of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Delmarva Foundation prior to the on-site visit.

During the on-site reviews in January and February of 2015, 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 Foundation; documents received were subsequently reviewed against the standard(s) to which they related.

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

Met	**100%**
Partially Met	**50%**
Unmet	**0%**

Each element or component of a standard was of equal weight. A CAP was required for each performance standard that did not meet the minimum required compliance score, as defined for the CY 2014 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 Foundation 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 Foundation 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 Foundation 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. Five MCOs were required to submit CAPs for the CY 2014 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Delmarva Foundation reviewed any additional materials submitted by the MCOs, 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 2015 will determine whether the CAPs from the CY 2014 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 2014 is 100% for all MCOs, except for KPMAS for which the compliance threshold is set at 80% for its first SPR and RHMD for which the compliance threshold is set at 90% for its second SPR.

All eight 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. Three MCOs (JMS, MPC, and MSFC) received perfect scores in all standards. Five MCOs (ACC, KPMAS, PPMCO, RHMD, and UHC) were required to submit CAPs for CY 2014. 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 2014 review.

Table 2. CY 2014 MCO Compliance Score

Standard	Elements Reviewed	MD MCO Compliance Score	ACC	JMS	KPMAS+	MPC	MSFC	PPMCO	RHMD**	UHC
1 Systematic Process	33	100%	Exempt	Exempt	100%	Exempt	Exempt	Exempt	100%	Exempt
2 Governing Body	14	**96%***	100%	100%	**56%***	100%	100%	100%	100%	100%
3 Oversight of Delegated Entities	7	**90%***	100%	100%	**75%***	100%	100%	100%	**50%***	**92%***
4 Credentialing	42	**99%***	**99%***	100%	100%	100%	100%	100%	100%	100%
5 Enrollee Rights	24	**96%***	**93%***	100%	94%	100%	100%	**98%***	**85%***	100%
6 Availability and Access	10	**99%***	100%	100%	100%	100%	100%	100%	95%	100%
7 Utilization Review	23	**92%***	**89%***	100%	83%	100%	100%	**87%***	**89%***	**87%***
8 Continuity of Care	4	100%	100%	100%	100%	100%	100%	100%	100%	100%
9 Health Education Plan	12	**82%***	Exempt	Exempt	100%	Exempt	Exempt	Exempt	**67%***	Exempt
10 Outreach Plan	14	**89%***	Exempt	Exempt	**79%***	Exempt	Exempt	Exempt	100%	Exempt
11 Fraud and Abuse	19	**98%***	100%	100%	89%	100%	100%	100%	92%	100%
Composite Score		**97%**	**96%**	**100%**	**91%**	**100%**	**100%**	**97%**	**97%**	**97%**

*Denotes that the minimum compliance score of 100% was unmet.
**RHMD's minimum compliance threshold is set at 90%, as this was the MCO's second SPR.
+KPMAS's minimum compliance threshold is set at 80%, as this was the MCO's first SPR.

For each standard assessed for CY 2014, the following section describes the requirements reviewed; the results, including the MD MCO compliance score; the overall MCO 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 participants. Through QOC studies and related activities, the MCO pursues opportunities for improvement on an ongoing basis. The QAP studies monitor QOC against clinical practice guidelines which are based on reasonable evidence based practices. The QAP must have written guidelines for its QOC studies and related activities that require the analysis of clinical and related services. The QAP must include written procedures for taking appropriate corrective action whenever inappropriate or substandard services are furnished. The QAP must have written guidelines for the assessment of the corrective actions. The QAP incorporates written guidelines for evaluation of the continuity and effectiveness of the QAP. A comprehensive annual written report on the QAP must be completed, reviewed, and approved by the MCO governing body. The QAP must contain an organizational chart that includes all positions required to facilitate the QAP.

Results:

- All MCOs (except for KPMAS and RHMD) were exempt from this standard as each MCO received compliance ratings of 100% for the past three consecutive years.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- RHMD received a compliance score of 100%, which exceeded its minimum compliance threshold of 90% for its second review.

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

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 Score was 96% for CY 2014.
- ACC, JAI, MPC, MSFC, PPMCO, RHMD, and UHC met the minimum compliance threshold for this standard.
- RHMD received a compliance score of 100%, which exceeded its minimum compliance threshold of 90% for its second review.
- KPMAS received a compliance score of 56%, which was below the minimum compliance threshold of 80%, and was required to submit a CAP.

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

KPMAS Opportunities/CAPs:

<u>Element 2.3</u> - The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.

KPMAS received a finding of unmet because after a review of Regional Quality Improvement Committee (RQIC) meeting minutes for October, November, and December 2014, there was evidence of reporting on these functional areas per the RQIC Reporting Schedule for 2014; however, it was unclear which reports applied to the HealthChoice population as most reports were in the aggregate, across the tri-state region, for each service area.

In order to receive a finding of met in the CY 2015 SPR, KPMAS must ensure that reports pertaining to the Quality Management Program (QMP) Work Plan activities are clearly representative of the HealthChoice progress for the MD Medicaid population in order for this population to be monitored.

<u>Element 2.5</u> - 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.

KPMAS received a finding of unmet because this standard pertains to the RQIC's receiving regular written reports from the QAP delineating actions taken and improvements made. In the RQIC meeting minutes for October, November, and December 2014, there was evidence of reporting on functional areas as per the RQIC Reporting Schedule for 2014. However, it is unclear which reports apply to HealthChoice population as most reports were in the aggregate across the region, per service area.

In order to receive a finding of met in the CY 2015 SPR, KPMAS must document how the RQIC takes action and provides follow-up when appropriate, specifically in relation to HealthChoice initiatives. These activities should be documented in the minutes of the meetings in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to the QMP. It is unclear from a review of meeting minutes that KPMAS is addressing the full intent of this standard at this time.

Component 2.7 a - The governing body is active in UR activities. The governing body meeting minutes reflect ongoing reporting of UR activities.

KPMAS received a finding of partially met. The Regional Utilization Management Committee (RUMC) reviewed and approved the UMP by electronic vote between October 1 and October 5, 2014. Although the RQIC's role in oversight of UM activities was clearly documented in the QMP and the Utilization Management Program (UMP), it was unclear what UM reports specific to HealthChoice were provided to the RQIC.

In order to receive a finding of met in the CY 2015 SPR, KPMAS must clearly document the HealthChoice-specific UM reports in the RQIC meeting minutes.

Component 2.7 b - The governing body is active in UR activities. The governing body meeting minutes reflect ongoing reporting of UR findings.

KPMAS received a finding of unmet. In the RQIC meeting minutes for October to December 2014, review confirmed evidence of reporting of UM findings for some of the reports above, but it was unclear which findings were specific to HealthChoice.

In order to receive a finding of met in the CY 2015 SPR, KPMAS must clearly document the HealthChoice-specific UM findings in the RQIC meeting minutes.

Follow-up:

- KPMAS was 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 2015 SPR.

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 Score was 90% for CY 2014.
- ACC, JAI, MPC, MSFC, and PPMCO met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 75%, which was below its minimum compliance threshold of 80%, and was required to submit a CAP.
- RHMD received a compliance score of 50%, which was below its minimum compliance threshold of 90%, and was required to submit a CAP.
- UHC received a compliance score of 92%, which was below its minimum compliance threshold of 100%, and was required to submit a CAP.

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

KPMAS Opportunities/CAPs:

<u>Component 3.3 c</u> - There is evidence of continuous and ongoing evaluation of delegated activities, including: Review and approval of claims payment activities, where applicable.

KPMAS received a finding of unmet because the MCO began operations in mid-June 2014 and delegate claims activities reports would have been available only for the third quarter of 2014. Review of MCO policies and discussions with staff indicated that no committee had been assigned the responsibility for approval of delegate reports, including claims activities, in 2014.

In order to receive a finding of met in the CY 2015 SPR, KPMAS must provide evidence that the appropriate committee has reviewed and approved all delegate reports, including claims activities, at the stated frequency.

RHMD Opportunities/CAPs:

<u>Component 3.3 a</u> - Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc.

RHMD received a finding of partially met. Routine monitoring and oversight of delegated entities occurs at multiple levels throughout the organization. Monthly meetings with each delegate occurred throughout 2014 and focused on review of vendor performance and operational updates. The Delegate Oversight Committee (DOC) meets quarterly to review delegate-submitted quarterly reports and presents a summary of its findings to the QIC for review/approval. The Delegation of Services Policy requires an annual evaluation of each delegate, including reviews of policies and procedures, UM, credentialing, member complaints or complex CM records, as appropriate, and relevant program descriptions. If the entity is accredited or certified by NCQA, the MCO may choose to forgo the oversight functions, such as policy and record reviews. According to the Vice President of Provider Relations, no delegate audits were conducted in 2014 even though one of their vendors, Block Vision, is not NCQA accredited.

In order to receive a finding of met in the CY 2015 SPR, RHMD must provide evidence that the MCO conducts annual audits of its delegates per its Delegation of Services Policy.

<u>Component 3.3b</u> – 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. In response to the CY 2013 SPR findings, RHMD was required to develop a CAP to 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. The CAP was not fully implemented and a continuing opportunity for improvement exists.

There was evidence of Quality Improvement Committee (QIC) quarterly review and approval of Block Vision and ValueOptions complaint, grievance, and appeal reports for first, second, and third quarters of 2014. QIC meeting minutes from March 31, 2014, noted that delegate reports for fourth quarter 2013 were presented at the December 2013 QIC, even though it was not the end of the fourth quarter. This would have resulted in an incomplete QIC approval for the quarter.

In order to receive a finding of met in the CY 2015 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 for each of the four quarters (fourth quarter of 2014 and first, second, and third quarters of 2015).

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

RHMD received a partially met. In response to the CY 2013 SPR findings, RHMD was required to develop a CAP to 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. The CAP was not fully implemented and a continuing opportunity for improvement exists.

There was evidence of QIC quarterly review and approval of Block Vision, Caremark, and ValueOptions claims activities reports for first, second, and third quarters of 2014. QIC meeting minutes from March 31, 2014, noted that delegate reports for fourth quarter 2013 were presented at the December 2013 QIC, even though it was not the end of the fourth quarter. This would have resulted in an incomplete QIC approval for the quarter.

In order to receive a finding of met in the CY 2015 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. In response to the CY 2013 SPR findings, RHMD was required to develop a CAP to 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. The CAP was not implemented and a continuing opportunity for improvement exists.

There was no evidence of QIC review and approval of the annual UMP and UM criteria from CVS/Caremark and ValueOptions in 2014 meeting minutes.

In order to receive a finding of met in the CY 2015 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. In response to the CY 2013 SPR findings, RHMD was required to develop a CAP to provide evidence of formal review and approval of each delegate's over and under utilization reports by the appropriate committee designated in the MCO's policy and according to the stated frequency. The CAP was not implemented and a continuing opportunity for improvement exists.

There was no evidence of QIC review and approval of ValueOptions and CVS/Caremark over and under utilization reports in QIC meeting minutes from 2014.

In order to receive a finding of met in the CY 2015 SPR, RHMD must provide evidence of formal review and approval of each delegate's over and under utilization reports by the appropriate committee designated in the MCO's policy and according to the stated frequency.

UHC Opportunities/CAPs:

<u>Component 3.3d</u> – Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.

UHC received a finding of partially met. The 2014 Delegation Manual requires the UMP and criteria of any UM delegated entity to be reviewed and approved annually by the Healthcare Quality and Utilization Management Committee (HQUMC) and Provider Advisory Committee (PAC). Minutes from the HQUMC of September 16, 2014, included a notation that the CCN UMP Description was sent out following the meeting and approved by e-vote. Minutes from the PAC meeting of October 16, 2014, documented presentation of the Care Core National (CCN) UMP and criteria and a motion to approve, which was seconded. It was clear that the intent was to approve, but no final committee approval was documented in the meeting minutes.

In order to receive a finding of met in the CY 2015 SPR, UHC must clearly document formal approval of any delegate's UMP Description in the appropriate committee meeting minutes.

Follow-up:

- KPMAS, 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 2015 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 Score was 99% for CY 2014.
- JMS, KPMAS, MPC, MSFC, PPMCO, RHMD, and UHC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- RHMD received a compliance score of 100%, which exceeded its minimum compliance threshold 90% for its second review.
- ACC received a compliance score of 99%, which was below its minimum compliance threshold of 100%, and was required to submit a CAP.

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 score.

MCO Opportunity/CAP Required

ACC Opportunities/CAPs:

<u>Component 4.4 i</u> - Adherence to the time frames set forth in the MCO's policies regarding credentialing date requirements.

ACC received a finding of partially met because nine of the ten provider records demonstrated adherence to the time frames set forth in the MCO's policies regarding the completion of the credentialing application process within 120 days of the 30-day notification letter. One provider record was processed in over 200 days, exceeding the allowed time frame of 120 days. In discussions with credentialing staff, it was determined that this provider's record fell out of the workflow queue at Corporate, and, as soon as it was identified, the record was processed immediately. To determine if this was a pattern, aging reports were reviewed to assess the application processing time for a sample of 85 initial credentialing applications. This review demonstrated that no other records were out of compliance for processing time frames. It appears that this noncompliant record is an outlier and not customary practice.

Delmarva will assess compliance to application processing time frames in the next SPR. In the future, if ACC credentialing staff discovers that a provider application has fallen out of the work queue, the provider should be notified immediately of this fact.

Follow-up:

- ACC was required to submit a CAP for the above component. Delmarva Foundation reviewed and approved the submission.
- The approved CAP will be reviewed during the CY 2015 SPR.

STANDARD 5: Enrollee Rights

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

Results:

- The overall MD MCO Compliance Score was 96% for CY 2014.
- JMS, KPMAS, MPC, MSFC and UHC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 96%, which exceeded its minimum compliance threshold of 80% for its first review.
- RHMD received a compliance score of 85%, which was below the minimum compliance threshold of 90%, and was required to submit a CAP.
- ACC and PPMCO received compliance scores of 93% and 98%, respectively. Therefore these scores were below the compliance threshold of 100% and required CAPs.

Findings: Overall, MCOs have policies and procedures in place that demonstrate their commitment to treating members in a manner that acknowledges their rights and responsibilities. Evidence of enrollee information was reviewed and found to be easily understood and written in Spanish as required by the Department.

Additionally, all MCOs provided evidence of their complaint, grievance, and appeals processes. However, opportunities for improvement did exist regarding policies and procedures, complaints/grievances, and satisfaction surveys.

MCO Opportunity/CAP Required

ACC Opportunities/CAPs:

<u>Component 5.5 c</u> - Informs practitioners and providers of assessment results.

ACC received a finding of unmet as there was no evidence that ACC informed practitioners of 2013 CAHPS® survey results in 2014. Subsequent to the SPR, ACC provided additional documentation to support this standard. ACC stated that the third quarter 2014 provider newsletter provided a notice of ACC's QI Program stating that CAHPS® surveys were completed and results were available to providers by contacting Provider Services. The MCO stated that this allowed practitioners to determine when they wish to receive content from the MCO and provided an opportunity to obtain information in addition to CAHPS® results. The newsletter was reviewed and included the following statement after a brief sentence about the CAHPS® surveys being sent to members over the

past six months: "To review the current Quality Improvement program summary, call Provider Services at 1-800-454-3730 – we'll be glad to send you a copy."

After review of the additional documents provided by ACC, it was found that the statement noted in the provider newsletter does not meet the intent of the standard, as the standard requires the MCO to inform practitioners of the assessment results.

In order to receive a finding of met in the CY 2015 SPR, ACC must annually inform practitioners of CAHPS® survey results.

Component 5.5 d - Reevaluates the effects of b. above at least quarterly.

ACC received a finding of partially met. The member satisfaction survey results, action plans, and communication reports are evaluated by the QMC. Review of the meeting minutes revealed discussion of corrective action based on survey results. The QMC monitors at least quarterly the progress of the interventions and improvements noted in the QMP Annual Evaluation. A review of the QMC meetings of 2014 provided evidence of interventions taking place to address member satisfaction. However, clear documentation that correlates with the noted interventions in the Annual Evaluations addressing areas of the CAHPS® survey was not provided on a quarterly basis throughout 2014.

In order to receive a finding of met in the CY 2015 SPR, ACC must provide clear documentation of quarterly monitoring of the progress of the interventions implemented as a result of the CAHPS® survey.

PPMCO Opportunities/CAPs:

Component 5.1d – 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. The Member Complaint/Grievance Policy describes the process for aggregation and analysis of grievance data and the use of the data for QI. All PPMCO grievances are logged into an electronic database that tracks grievances by the type and resolution of the grievance. When trends are identified, the MCO acts to make improvements to meet the needs of its members and providers.

The policy states that grievances are reported in aggregate to the Process Management Team (PMT) and DHMH quarterly and to the Consumer Advisory Board (CAB) annually.

Review of meeting minutes found evidence of at least quarterly reporting of grievance data to the PMT. However, there is not sufficient documentation in the CAB meeting minutes for December 2014 that complaints/grievances were reported to that board.

In order to receive a finding of met in the next SPR, PPMCO must provide evidence of reporting grievance data to the CAB on an annual basis, according to policy.

RHMD Opportunities/CAPs:

Component 5.5 c - Informs practitioners and providers of assessment results.

RHMD received a finding of unmet because providers were not made aware of the CAHPS® survey results in 2014. It is recommended that the Satisfaction Surveys Policy be revised to include that RHMD annually inform providers of the assessment results.

In order to receive a finding of met in the CY 2015 SPR, RHMD must provide evidence that it informed providers of satisfaction survey results.

Component 5.6 a - 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 unmet. It is reported by the Enrollment Department that welcome packet fulfillment reports are reviewed daily. Daily reports were provided and reviewed as evidence of this activity. Health Risk Assessment and Welcome Call policies were developed and are used to confirm receipt of new enrollee packets.

However, it is required that the MCO have a policy and procedure that includes the content of new enrollee packets and the regulatory time frames for mailing such information to new enrollees.

In order to receive a finding of met in the CY 2015 SPR, RHMD must develop a policy and procedure that specifies the content of new enrollee packets and the regulatory time frames for mailing such information to new enrollees.

Component 5.6 c - The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution.

RHMD received a finding of unmet because it does not currently have a documented process for tracking timeliness of newborn enrollment that has the ability to identify issues for resolution. In the past, RHMD has provided a workflow process entitled, The In-Patient Newborn Notification Workflow Process which documented the tracking process for newborn enrollment along with the reconciliation of the DHMH 1184 form. The MCO was unable to produce this document for review this year.

In order to receive a finding of met in the CY 2015 SPR, RHMD must have a formal policy and procedure that documents its process for tracking the timeliness of newborn enrollment. The process must have the ability to identify issues for resolution. It is recommended that this policy incorporate the workflow process that was presented in the CY 2013 SPR.

Follow-up:

- ACC, RHMD, and PPMCO 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 2015 SPR.

STANDARD 6: Availability and Accessibility

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

Results:

- The overall MD MCO Compliance Score was 99% for CY 2014.
- All MCOs met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- RHMD received a compliance score of 95%, which exceeded its minimum compliance threshold 90% for its second review.

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 participants along with websites and help lines that are easily accessible to members as well. Each MCO has an effective system in place for notifying members of wellness services.

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow up is required.

STANDARD 7: Utilization Review

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

Results:

- The overall MD MCO Compliance Score was 92% in CY 2014.
- JAI, KPMAS, MPC, and MSFC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 83%, which exceeded its minimum compliance threshold of 80% for its first review.
- RHMD received a compliance score of 89%, which was below the minimum compliance threshold of 90%, and was required to submit a CAP.
- ACC, PPMCO, and UHC received compliance scores of 89%, 87%, and 87%, respectively. These scores were below the minimum compliance thresholds of 100% and required 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 participants to appeal decisions. However, continued opportunities were present in the areas of monitoring compliance of UR decision.

MCO Opportunity/CAP Required

ACC Opportunities/CAPs:

<u>Component 7.3 a</u> - Services provided must be reviewed for over and under utilization.

ACC received a finding of partially met because after reviewing MAC minutes from eight meetings in 2014, only

one meeting was found to have documented a review of UM metrics (IP only), which were displayed as directional changes in comparison to the two prior years. There was no evidence of inclusion of SA utilization metrics in this table. Reporting of UM metrics occurred more frequently in the Quality Management Committee (QMC) (three times in 2014) and often included a summary analysis. For example, in the QMC meeting of August 13, 2014, admits per 1,000 were reported by aid category (TANF, SSI, FAMCARE) and admit decreases noted as having been anticipated as the flu season ended. The top admitting diagnoses include sickle cell, diabetes, hypertension, and depression. Reported increases in days of care for FAMCARE were attributed to chronic health issues among these former Provider Advisory Committee (PAC) members. Average length of stay increased for all categories, but SSI with a plan to monitor for trend. Readmission rates were also reported.

In order to receive a finding of met in the CY 2015 SPR, there must be evidence that the MCO reports utilization and evaluates opportunities for improvement in meeting minutes of the designated committee(s) consistent with its UMP, work plan, and policies.

Component 7.3 b - UR reports must provide the ability to identify problems and take the appropriate corrective action.

ACC received a finding of partially met because Medical Advisory Committee (MAC) minutes focused primarily on interventions to improve HEDIS® and VBP measures, often including a detailed examination of barriers and opportunities, as well as recommendations from committee members. Provider barriers and opportunities also were discussed, with the observation that collaboration is important. Per the first data run of the year, the MCO reported it has tripled the controlling-HBP group and this is expected to rise. There were no interventions identified in MAC minutes to address over utilization issues; however, in the QMC minutes of July 2, 2014, there was a discussion of an Emergency Department (ED) Diversion initiative. The goal was to increase the ED Diversion rate for 2014.

Subsequent to the on-site SPR review, ACC submitted additional evidence to support compliance with this component, noting that ACC has assigned review of over and under utilization to the QMC. This is in conflict, however, with the UMP Description and the Over/Under Utilization of Services Policy, which require, at a minimum, quarterly evaluation of over/under utilization trends and opportunities for improvement with reporting to the MAC and QMC on a quarterly basis. Evidence of quarterly reporting was not consistently present in the MAC or QMC minutes, so the finding of partially met remains unchanged.

In order to receive a finding of met in the CY 2015 SPR, ACC must offer evidence that the designated committee(s) consistent with its UMP, UM Work Plan, and policies address both over and under utilization issues and take appropriate action to address identified opportunities for improvement based upon an analysis of those issues.

Component 7.3 c - Corrective measures implemented must be monitored.

ACC received a finding of partially met because there was limited evidence in review of meeting minutes that the MAC monitors corrective measures that have been implemented to address over and under utilization. MAC minutes reported almost exclusively on changes in VBP measures. There was no evidence of MAC reporting on the status of the Readmission Reduction Initiative, although there were updates provided in a number of QMC meetings. For example, in the QMC meeting of August 13, 2014, it was reported that the readmission rate from 2013 to 2014

YTD fell by an average of 4.71% for three of the six hospitals that are part of this initiative. The University of Maryland Medical System's and John Hopkins Hospital's higher readmission rates were acknowledged to be due to complex conditions, chemo, and transplants.

Subsequent to the on-site SPR review, ACC submitted additional evidence to support compliance with this component, noting that ACC has assigned review of over and under utilization to the QMC. This is in conflict, however, with the UMP Description and the Over/Under Utilization of Services Policy, which require, at a minimum, quarterly evaluation of over/under utilization trends and opportunities for improvement, with reporting to the MAC and QMC on a quarterly basis. Evidence of quarterly reporting was not consistently present in the MAC or QMC minutes, so the finding of partially met remains unchanged.

In order to receive a finding of met in the CY 2015 SPR, ACC must offer evidence that the designated committee(s), consistent with its UMP, UM Work Plan, and policies, routinely monitor(s) corrective measures that have been implemented in response to both over and under utilization issues.

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

ACC received a finding of partially met. The Utilization Management Quality Monitoring Audits – MD Policy includes the State-specified threshold for determinations using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%. The policy, however, identifies an audit of 100% of preauthorization decisions and notifications on a quarterly basis. The policy further requires analysis of a random sample of outlier cases to determine the root cause when decisions do not meet the stated time frames and CAPs for audit compliance scores below 95%. CAPs are to be logged into the UM Work Plan for monitoring and appropriate follow-up. Compliance reports are to be presented to the QMC on a quarterly basis.

The Pharmacy Prior Authorization Policy requires that prior authorization coverage requests be processed within 24 hours of receipt. If the prescribing provider has not responded to the MCO's request for additional clinical information within 24 hours, the request will be forwarded to a pharmacist for review. Coverage denial letters are generated and mailed and faxed to the provider and member within 24 hours or one business day of the decision. As noted in the CY 2013 review this latter time frame is inconsistent with state requirements for notification within 72 hours of a determination for non-emergency, medically related requests, as it could result in noncompliance as a result of a three-day holiday weekend.

Compliance with turnaround times (TATs) is reported on a quarterly basis to the QMC. The 95% threshold for compliance with pre-service determination time frames was not met throughout 2014. The 95% threshold for adverse determination notification time frames was met in the last two quarters of 2014. The decline in 2014 performance was attributed to an increase in month over month volumes. Specifically, analysis revealed an increase in PT requests from former PAC members who previously did not have the benefit. Interventions to meet the compliance threshold for both measures were documented to include recruitment efforts to increase staff, more stringent management of workflow via daily reports, investigation of external vendors for select UM functions, and staff retraining and restructuring. Another barrier identified was a delay at the clinician level. Processes were updated accordingly. UM is also working with the National Call Center (NCC) to address any delays originating at

that source.

Subsequent to the on-site review ACC submitted a revised Pharmacy Prior Authorization Policy noting that the time frames had been changed to be consistent with regulation. This policy will be reviewed as a component of the required CAP submission following the MCO's review of the draft SPR report.

In order to receive a finding of met in the CY 2015 SPR, compliance with pre-service determination and adverse determination notification time frames must be consistently met at the 95% threshold or above. Additionally, as noted in the CY 2013 review, the Pharmacy Prior Authorization Policy must be revised to include notification time frames that are consistent with regulation.

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

ACC received a finding of partially met. According to the Director of HCMS, interventions were implemented in response to UM-related results from the 2013 CAHPS® and Provider Satisfaction surveys. However, neither MAC nor QMC meeting minutes provided specific details of interventions to address UM opportunities or evidence of ongoing monitoring. The April 21, 2014, MAC meeting minutes noted an initiative to meet with providers and participate in member forums to understand and improve member and provider satisfaction with UM. The QMC meeting minutes May 4, 2014, noted that ACC met or exceeded all goals for 2013 for the member and provider satisfaction surveys. However, no action plans were identified.

Subsequent to the on-site SPR review, ACC submitted additional documentation to support compliance with this component. The QMC minutes of February 4, 2015, are outside of the CY 2014 review period and will be reviewed as a component of the CY 2015 review. Although MAC minutes from April 21, 2014, documenting a plan to continue to identify new technologies to improve workflows and communications to enhance provider satisfaction, did not appear directly related to analysis of satisfaction results, the underlying intent is recognized and as a result the finding of unmet will be changed to partially met. In future reviews ACC must clearly document corrective measures that have been implemented in response to specific opportunities for improvement in relation to analysis of results of member and provider satisfaction with the UM process.

In order to receive a finding of met in the CY 2015 SPR, there must be evidence in appropriate committee minutes of the actions the MCO has taken in response to UM-related results from the CAHPS® and Provider Satisfaction surveys. Additionally, there should be evidence of routine monitoring of these actions.

PPMCO Opportunities/CAPs:

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

PPMCO received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate that reasons for review determinations are documented in a language that is clearly understandable to the member in all adverse determination letters. The CAP was not fully implemented, and an opportunity continues to exist to improve member comprehension of adverse determination letters.

Two of the initial selection of 10 letters provided the reason for the adverse determination in clearly understandable language. The majority of letters specifically quoted InterQual or medical policy guidelines as the rationale for the decision. The remaining 10 letters for this time period were reviewed as well. Only four of those 10 letters included reasons for the determination in clearly understandable language.

In order to receive a finding of met in the 2015 SPR review, the MCO must document reasons for decisions in language that is clearly understandable to the member.

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

PPMCO received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate consistent compliance with preauthorization determination and adverse determination notification time frames specified by the State at the 95% threshold. This included medical, substance abuse (SA), and pharmacy authorization requests. Continued inconsistent compliance with required time frames indicates that the CAP was not fully implemented. PPMCO has not fully met this component for at least the last seven review cycles, with the exception of 2011, which was scored as baseline.

Both the Prospective, Concurrent and Retrospective Review Decision Timeframes and Lack of Information Policy and the Pharmacy MSR Letters Policy were inconsistent with the COMAR required time frames.

In order to receive a finding of met in the CY 2015 SPR, PPMCO must demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations. Additionally, all policies that include time frames for preauthorization determinations and adverse determination notifications must be consistent with COMAR requirements. Tracking of compliance must also demonstrate COMAR time frame requirements.

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

PPMCO received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate consistent compliance with State-required time frames for appeal resolution. Continued inconsistent compliance with required time frames indicates that the CAP was not fully implemented.

PPMCO has elected to develop time frames for appeal resolution that are more stringent than required by COMAR 10.09.71.05. The Member Appeal Policy requires expedited/urgent care appeals be resolved within 36 hours of receipt at both first and second levels rather than the three business days specified by regulation. Whereas COMAR specifies a time frame for resolution of non-expedited appeals within 30 days, the MCO has established a time frame of 15 calendar-days for both first- and second-level routine pre-service appeals and 30 calendar days for first- and second-level post-service appeals. The policy also provides for a 14-calendar-day extension to allow the member to submit all applicable documentation for consideration in the appeal review.

The policy further describes the process for monitoring compliance with the above time frames on both a weekly and monthly basis. Compliance with time frames is to be reported to the Process Management Team (PMT) on a

quarterly basis.

Minutes of the PMT demonstrate routine monitoring of compliance with appeal resolution time frames throughout 2014. For expedited pre-service appeals, the MCO met its performance goal 3 out of 11 months (one month had no expedited appeals). Compliance with the MCO standard of 36 hours ranged from 5% to 67% in the remaining 8 months. Compliance with the MCO standard for non-urgent pre-service appeals was not met in any of the 12 months in 2014. Compliance ranged from 33% to 98%.

A review of a sample of 10 appeal records from CY 2014, all standard, revealed 70% compliance with resolution time frames.

The Member Appeals Policy as written addresses appeals for claim denials and reduction, termination, or refusal to extend an approved course of treatment. Although this language would suggest that appeal rights are not available for adverse determinations for initial pre-service requests, that does not appear to be the intent of the policy. Therefore, it is recommended that PPMCO revise the language in the Member Appeal Policy to explicitly state this right as well. Additionally, the Member Appeals Policy states that, if an appeal does not meet criteria for an expedited appeal, the appeal will be transferred to the standard time frame of no longer than 30 days from the date of receipt of the appeal with a possible 14-day extension. This is inconsistent with the MCO's time frame of 15 calendar-days for pre-service routine appeals. As such, this time frame should be revised to ensure consistency with the time frame for routine appeals.

In order to receive a finding of met in the CY 2015 SPR the MCO must demonstrate consistent compliance with State-required time frames for appeal resolution.

RHMD Opportunities/CAPs:

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

RHMD received a finding of partially met because the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate 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. An opportunity continues to exist to improve member understandability of the reason for the decision in adverse determination letters.

Although there is evidence that reasons for determinations are documented in member records, one of the initial sample of 10 adverse determination letters did not provide an adequate explanation for the reason for the adverse determination. The reason for the adverse determination was stated as "Request does not meet criteria. Clinical documentation does not support the request." An additional sample of 20 letters was reviewed for this component and no further deficiencies relating to this component were found.

In order to receive a finding of met in the CY 2015 SPR, RHMD must consistently demonstrate that adverse determination letters provide a clear, full and complete explanation of the reason 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 the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate that it has a documented methodology for determining compliance with PA 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. An opportunity continues to exist to demonstrate compliance with regulatory time frames for pre-service determinations and adverse determination notifications based on a documented methodology.

The UM Program Structure and Processes Policy includes a table documenting the time frames for UM decisions and notifications. The time frame for written notification to members for non-urgent pre-service requests is documented as within 24 hours of the decision and no later than within 15 days of the request. Written notification for urgent pre-service requests is to occur within 24 hours of the decision and no later than 72 hours of receipt of the request. These time frames are inconsistent with COMAR 10.09.71.04, which requires written notification of adverse determinations within 72 hours for routine pre-service and 24 hours for urgent pre-service from the determination. The Health Services (HS) Program Description also includes notification time frames that are inconsistent with regulatory requirements.

As evidence of tracking compliance, the MCO provided a document entitled Case Audit UR CY 2014. The sample size calculator determined a need to review 370 records. Compliance results reported for CY 2014 were 88% for determinations and 84% for notifications. Based upon discussions with the VP of HS, it appears that the sample may have included concurrent as well as pre-service reviews for determinations and approvals, as well as adverse determinations for notifications.

In order to receive a finding of met in the CY 2015 review, there must be evidence of documentation of the methodology for determining compliance with determination and notification time frames, such as a desktop procedure, and evidence that the MCO meets the 95% compliance threshold for determinations and notifications on at least a quarterly basis. Additionally, all MCO documents need to be revised to reflect the regulatory time frames.

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 the MCO was required to develop a CAP in response to the CY 2013 SPR findings to demonstrate that it has copied the member's PCP on all adverse determination letters that it describes the additional information needed for reconsideration. Moreover, the letters did not consistently provide an adequate explanation of the reason for the adverse determination. Continued opportunities for improvement exist as the CAP was not fully implemented.

The Denial of Services Policy includes 12 of the 13 required letter components. The requirement to copy the member's PCP on the adverse determination letter was missing from the list of components. Additionally, the policy incorrectly identified the MCO, rather than EHL staff, as responsible for investigating the MCO decision, resolving within 10 days, or providing information about how to request a fair hearing.

A sample of 10 adverse determination letters was initially reviewed for compliance. Ten of the 13 required components were consistently present in all the letters. None of the 10 member letters evidenced that the PCP was copied. The MCO confirmed that PCPs have not been receiving a copy of the adverse determination letter unless they were the requesting provider. 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 one of the 10 letters, as reported in component 7.4c. Additionally, description of any additional information the MCO needs for reconsideration was included in only one of the initial sample of 10 letters. Another 20 adverse determination letters were reviewed for these three components. None of these letters showed evidence of the PCP being copied or documentation of additional information needed for reconsideration. An adequate explanation of the reason for the adverse determination was included in this second sample.

It is recommended that the MCO revise the Denial of Services Policy to include the requirement for copying the member's PCP on all adverse determination letters. It is also recommended that this policy be revised to correctly identify EHL staff, rather than the MCO, as responsible for investigating the MCO decision, resolving within 10 days, or providing information about how to request a fair hearing.

In order to receive a finding of met in the CY 2015 SPR, RHMD must demonstrate that it includes all required components in its adverse determination letters.

UHC Opportunities/CAPs:

<u>Component 7.2 b</u> - The UR Plan must describe the mechanism or process for the periodic updating of the criteria.

UHC received a partially met. The Clinical Review Criteria Policy, last reviewed on December 1, 2013, requires the MCO and actively practicing physicians with knowledge relevant to the clinical review criteria to evaluate criteria at least annually. The UMP Medical Director or designee is assigned responsibility for criteria approval. This is somewhat inconsistent with the State UMP Addendum, which assigns responsibility for annual review and approval of medical necessity criteria to the PAC and HQUMC. Although the Chief Medical Officer (CMO) chairs both committees, the approval authority is shared by committee members. This inconsistency was also noted in the CY 2013 SPR and required to be resolved for the CY 2014 SPR. According to the Director of HS, a representative from the national policy management team reported that the submitted policy expires December 31, 2014, and the new policy will cover 2015 activity. Because this inconsistency remains for the CY 2014 review, this component will be scored as a "partially met."

Subsequent to the on-site review, the MCO submitted additional documentation in support of compliance with this component. Although acknowledging that the UMP Description assigns annual approval authority of medical necessity criteria to both the HQUMC and PAC and the Clinical Review Criteria Policy assigns approval responsibility to the Medical Director, the MCO reported that, per UHC standard practice, final accountability for adoption of clinical review criteria rests with the Medical Director after review and approval by HQUMC and PAC. UHC reported that they did not see this as a conflict but rather a confirmation of standard practice and final accountability. It added, however, that in recognition of reviewer recommendations the MCO will ensure that the 2015 UMP Addendum will align more clearly with language in the national policy. MCO documentation needs to

clearly reflect consistent approval authority for annual review of medical necessity criteria.

In order to receive a finding of met in the CY 2015 SPR, UHC must resolve the continuing inconsistency in the annual approval authority of medical necessity criteria as documented in the 2014 State UMP Addendum and the Clinical Review Criteria Policy.

Component 7.2 d - There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures.

UHC received a partially met because there was evidence of review of the continued use of Milliman Care Guidelines (MCG) and ASAM criteria in the HQUMC minutes of June 17, 2014, but there was no evidence of approval. Although the PAC minutes of the October 16, 2014, meeting recorded a seconded motion to approve continued use of MCG and ASAM no final approval was documented.

It is recommended that the MCO clearly document appropriate committee review and approval of medical necessity criteria in meeting minutes. Seconding the motion to approve documents the intent to approve, but it is insufficient to demonstrate overall committee approval.

In order to receive a finding of met in the CY 2015 SPR, UHC must provide evidence of formal committee review and approval of medical necessity criteria consistent with the MCO's UMP Description.

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

UHC received a finding of unmet because the MCO was required to develop a CAP in response to the CY 2013 SPR review to demonstrate consistent tracking and compliance with State-required time frames for determinations and notifications for Preauthorization (PA) requests for medical, pharmacy, and SA services. The CAP was partially implemented and continued opportunities for improvement exist in demonstrating routine compliance with State-required time frames. This is the sixth year since the CY 2007 review that this component has not been met. (This component was scored as baseline for the CY 2011 review.)

The UBH UMP Description includes a table identifying PA determination and notification time frames by state. The written notification time frames are inconsistent with COMAR.

According to the Director of HS, medical PA requests are processed in the CareOne system but BH and pharmacy are processed in another system. In October UHC became aware of issues with the data reported off the CareOne system. As a result the MCO discovered that determination and notification time frames for medical PA requests were inconsistently observed and developed a CAP in response. Review of the CAP identified activities that included retraining and increased monitoring.

In reviewing the MD TAT Compliance Report for medical PA requests and adverse determination notifications, compliance was demonstrated as follows:

- Expedited determinations – 8 out of 12 months met the 95% compliance threshold; outlier months ranged from

76.5% to 92.9%.
- Routine determinations within two business days – 1 out of 12 months met the 95% threshold.
- Routine determinations within seven calendar days – all months met the 95% compliance threshold.
- Written notification within 24 hours – 3 out of 11 months met the 95% threshold; outlier months ranged from 50.0% to 90.9%.
- Written notification within 72 hours – 7 out of 12 months met the 95% compliance threshold; outlier months ranged from 84.3% to 94.4%.

Compliance with regulatory time frames for PA requests and adverse determination notifications related to pharmacy were reported as follows:
- Expedited determinations – all months met or exceeded the 95% compliance threshold.
- Routine determinations within two business days – 7 out of 12 months met the 95% compliance threshold; outlier months ranged from 72.1% to 92.3% (There were no requests that required additional clinical information.)
- Written notification within 24 hours – all months were at 100%.
- Written notification within 72 hours - all months were at 100%.

The UBH Compliance Report through November 2014 demonstrated that all approved PA requests were processed within regulatory time frames. For requests that resulted in an adverse determination, United Behavioral Health (UBH) demonstrated the following compliance:
- Expedited determinations – 9 out of 10 months were compliant, with the one outlier month reported as 75%.
- Routine determinations – 6 out of 11 months were at 100%; outlier months ranged from 78.9% to 93.3%. (There were no requests that required additional clinical information.)

In order to receive a finding of met in the CY 2015 SPR, UHC must consistently demonstrate compliance with State-required time frames for medical and pharmacy PA determinations and adverse determination notifications.

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 the MCO was required to submit a CAP as a result of the CY 2011, CY 2012, and CY 2013 SPR findings to address compliance with regulatory time frames for appeal processing on a consistent basis. The CAPs were partially implemented and continued opportunities for improvement exist in demonstrating routine compliance with State-required time frames.

The Medicaid Member Grievances and Appeals Policy includes the required 30-day resolution time frame for standard appeals and a more stringent time frame of 72 hours of receipt of appeal rather than the three business days specified per regulation.

The UBH UMP Description includes a table of state requirements identifying time frames for urgent and standard member appeals. For urgent appeals, determinations, along with verbal and written notification, are to occur within 24 hours of receipt of the request. For first- and second-level standard pre service appeals, determination and notification are to occur within 15 calendar days of receipt of the request. According to the Director of HS, the UBH

UMP Description stated the time frames in error. UBH time frames for member appeals are consistent with UHC time frames.

Compliance with State-required time frames for resolving member expedited and standard appeals were reported by month throughout 2014 in a spreadsheet entitled UHC Member Appeals. Compliance was reported separately for medical and pharmacy-related appeals. UBH compliance for SA-related appeals was tracked in a separate spreadsheet. For expedited medical appeals, compliance with the resolution time frame was met throughout 2014. For standard medical appeals, compliance was met in 7 of the 12 months, with the remaining months ranging from 90.0% to 98.1%. For expedited pharmacy appeals, one month, July, was reported as noncompliant at 95.6%. For standard pharmacy appeals, 10 of 12 months were compliant with the resolution time frames, with the 2 outlier months reported as 90.0% and 95.0%.

CAPs were initiated in response to both medical and pharmacy noncompliance and reported on the UHC Member Appeals spreadsheet. For example, in response to expedited medically-related appeals not achieving 100% compliance in July, it was reported that three triage errors in assigning priority were identified; coaching was subsequently provided to individual data entry personnel and application of performance management steps completed. It was further reported that a triage SharePoint site had been set up for continuous feedback between teams and that the urgent scrub process was still in place, but it was being reviewed for effectiveness.

The Master UBH Template January through November 2014 identified no member appeals received during this time frame.

A review of a random sample of 10 medical and pharmacy member appeals, all standard, revealed 100% compliance with the regulatory time frame for resolution.

In order to receive a finding of met in the CY 2015 SPR, UHC must provide evidence of consistently meeting regulatory resolution time frames or MCO time frames, if more stringent, for all medical and pharmacy appeals.

Follow-up:

- ACC, 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 2015 SPR.

STANDARD 8: Continuity of Care

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

Results:

- The overall MD MCO Compliance Score was 100% for CY 2014.
- All MCOs met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- RHMD received a compliance score of 100%, which exceeded its minimum compliance threshold 90% for its second review.

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 participants in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning. The MCO must make the education program available to the enrollee population and demonstrate that participants have attended.

Results:

- All MCOs (except for KPMAS and RHMD) were exempt from this standard as each MCO received compliance ratings of 100% for the past three consecutive years.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 80% for its first review.
- RHMD received a compliance score of 67%, which was below the minimum compliance threshold of 90%, and was required to submit a CAP.

Findings: This area of review was exempt for all MCOs except for KPMAS and RHMD. The Health Education Plans were found to be comprehensive and include policies and procedures for internal staff education, provider education and continuing education units, and enrollee health education. However, continued opportunities were identified regarding the health education programs.

MCO Opportunity/CAP Required

RHMD Opportunities/CAPs:

<u>Component 9.3 a</u> - 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.

RHMD received a finding of unmet because as noted in the CY 2013, the Health Education Plan (HEP) documents several mechanisms used to assess the impact of the MCO's educational activities through analysis of data. However, the MCO completed no formal evaluation of the impact of the HEP on process and/or outcome measures in CY 2014.

In order to receive a finding of met in the CY 2015 SPR, RHMD must provide evidence of a formal annual evaluation of the impact of the HEP on process and/or outcome measures.

Component 9.3 c - 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.

RHMD received a finding of unmet because it was noted in the CY 2013 SPR that in order for the MCO to receive a finding of met in the CY 2014 SPR, the MCO must provide evidence that it notifies its providers of the availability of and contact information for accessing a health educator and/or educational program for member referrals.

The HEP states that providers can access health education materials and information on CM programs by contacting an associate in the HS Department. However, it is unclear as to how providers are made aware of the HEP and to contact the CM program or the HS Department for health education materials or information.

In order to receive a finding of met in the CY 2015 SPR, RHMD must provide evidence that the MCO notifies its providers of the availability of and contact information for accessing a health educator and/or educational program for member referrals. This could be accomplished through the provider manual and also could be included in a provider newsletter.

Component 9.5 b - Attendance records and session evaluations completed by enrollees.

RHMD received a finding of unmet because there was a lack of evidence of attendance records, sign-in sheets, and evidence of completion of evaluations by embers participating in its health education programs.

The MCO provides education on health-related topics at its Consumer Advisory Board (CAB) meetings. As evidence of compliance with this component, the MCO submitted evaluations of CAB meetings completed by members in attendance. Five evaluations were submitted for the June 19, 2014, meeting, 10 from August 21, 2014, and two from October 16, 2014. Although there was evidence that educational topics were presented at two of these meetings, the meeting evaluation form did not include any questions for CAB members to specifically evaluate these presentations.

The MCO subsequently provided a sample of a member evaluation of a diabetes education program conducted by staff at Upper Chesapeake Health. The survey covered the following areas: scheduling/registration, diabetes education, endocrinologist, and overall assessment of the center. On a five-point scale (with five being “very good”) all of the areas were scored as a five in this member’s evaluation. One member’s evaluation is insufficient for demonstrating compliance.

In order to receive a finding of met in the CY 2015 SPR, RHMD must provide attendance records or sign-in sheets and evidence of completion of evaluations by members participating in its health education programs.

Component 9.5 c - Provider evaluations of health education programs.

RHMD received a finding of unmet because the MCO did not receive provider evaluations on health education programs within CY 2014.

A memo from the Manager of QI, dated December 17, 2014, was sent to all the PAC members with a request for

review of the HEP Description and a brief survey that asked for a graded response to the following statements:

- The RHMD HEP is helpful and appropriate to the needs of my patients.
- The RHMD HEP is comprehensive and addresses the needs of special needs and other vulnerable populations served.
- Provider involvement in the RHMD HEP is appropriate and effective.

Two survey responses were received, but both were dated as received in February 2015, which is outside the CY 2014 SPR review period.

As recommended in the CY 2013 SPR, the MCO may want to consider developing a survey that would offer actionable opportunities for improvement, such as soliciting provider recommendations for health education programs and obtaining feedback on the impact of their patients' participation in MCO health education programs, among other inquiries. The MCO may also want to increase its pool of potential respondents by including the survey in the provider newsletter.

In order to receive a finding of met in the CY 2015 SPR, RHMD must provide evidence of provider evaluations of the MCO's HEP. The MCO may want to begin the process of surveying its PAC members on the HEP earlier in the year so that they can meet the requirements of this component and also include any findings in the annual QAP Evaluation.

Follow-up:

- RHMD was required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed during the CY 2015 SPR.

STANDARD 10: Outreach Plan Review

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

Results:

- All MCOs (except for KPMAS and RHMD) were exempt from this standard as each MCO received compliance ratings of 100% for the past three consecutive years.
- RHMD received a compliance score of 100%, which exceeded its minimum compliance threshold 90% for its second review.
- KPMAS received a compliance score of 79%, which was below the minimum compliance threshold of 80%, and was required to submit a CAP.

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

MCO Opportunity/CAP Required

KPMAS Opportunities/CAPs:

<u>Component 10.1 a</u> - Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership.

KPMAS received a finding of unmet because the MCO's Outreach Plan was not specific regarding the populations the MCO serves and did not include an assessment of common health problems of the membership.

In order to receive a finding of met in the CY 2015 SPR, KPMAS must:

- Describe the membership demographics, including but not limited to where the largest portion of the members reside and the adult versus child populations.
- Provide a breakdown of the identified SNPs as cited in COMAR (a chart by county describing this information is not sufficient).
- Identify the most common health conditions among the HealthChoice membership.
- Identify the barriers to health care for HealthChoice members.

<u>Component 10.1 b</u> - MCO's organizational capacity to provide both broad-based and enrollee-specific outreach.

KPMAS received a finding of partially met because the Outreach Plan partially described the teams and units involved in outreach, however, a complete description that includes the number of positions, position descriptions and education requirements was not included.

In order to receive a finding a met in the CY 2015 SPR, KPMAS must:

- Describe each unit or team and how they work together to provide outreach.
- Identify the number of positions within each team or unit.
- Provide job descriptions or describe what education or qualifications are needed to hold the positions.
- Describe the data systems used to manage and monitor the outreach services to members.

Component 10.1 e - Role of the MCO's provider network in performing outreach.

KPMAS received a finding of unmet because in 2014 the MCO did not have a written policy on the provider's role in performing outreach. The KPMAS provider manual states that the MCO expects that providers will perform outreach to members and details how they should be involved in outreach efforts to members. This includes notifying members of appointments and due dates for services such as immunizations. Provider outreach also includes facilitating member referrals for specialty care, documenting outreach efforts in member medical records, notifying the KPMAS CM unit for assistance with outreach, and requesting assistance from Administrative Care Coordination Units (ACCUs) at Local Health Departments (LHDs) when members miss scheduled appointments.

Subsequently to the review, KPMAS developed a Network Provider – Outreach to Member Policy that will take effect on April 1, 2015.

In order to receive a finding of met in the CY 2015 SPR, KPMAS must implement the Network Provider – Outreach to Member Policy and ensure that there is a mechanism in place to deliver this policy to the providers.

Component 10.1 f - MCO's relationship with each of the LHDs and ACCUs.

KPMAS received a finding of partially met. KPMAS maintains collaborative relationships with the LHDs through memoranda of understanding with nine county health departments in the MCO's service area that enables KPMAS staff to work collaboratively with the LHD/ACCUs to perform outreach activities to members as needed. However, KPMAS does not have agreements with all LHDs in which the MCO has members.

The KPMAS MD Medicaid Outreach and Collaboration with Local Health Department Policy states that the MCO will refer members to ACCUs at LHDs for outreach when the MCO is unable to reach members and bring them into care. The policy indicates that KPMAS will request the assistance of a LHD after the MCO has made documented attempts to contact members. The policy is silent on the number of attempts the MCO will make before LHD assistance is requested and on how the MCO will track the referrals made and returned from the LHD.

In order to receive a finding of met in the CY 2015 SPR, KPMAS must revise the MD Medicaid Outreach and Collaboration with Local Health Department Policy to include the number of attempts the MCO will make before making a referral to the LHD and how the MCO will track referrals made and returned from the LHD. Also, KPMAS will need to establish memoranda of understanding with all LHDs in which the MCO has members.

Follow-up:

- KPMAS was required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed during the CY 2015 SPR.

STANDARD 11: Fraud and Abuse

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

Results:

- The overall MD MCO Compliance Score was 98% for CY 2014.
- All MCOs met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 89%, which exceeded its minimum compliance threshold of 80% for its first review.
- RHMD received a compliance score of 92%, which exceeded its minimum compliance threshold 90% for its second review.

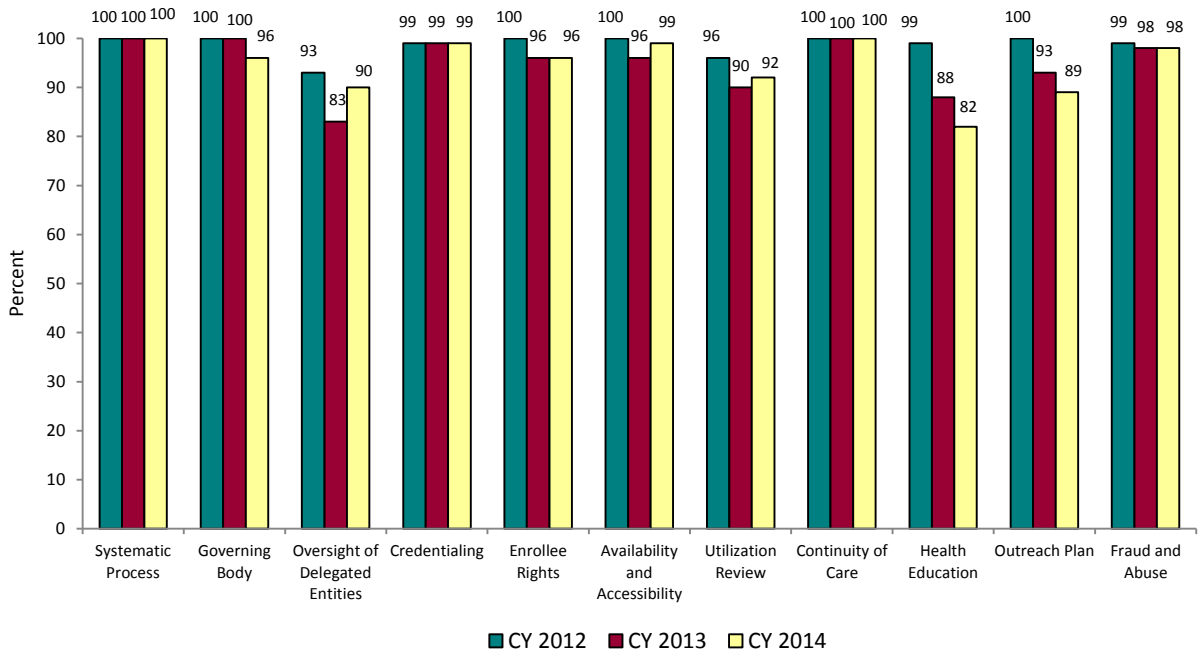
Findings: All MCOs were found to have comprehensive compliance programs designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. Fraud and abuse plans articulated the organization's commitment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

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 2012 through CY 2014



Between CY 2012 and CY 2013, the MD MCO Compliance Score 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).

Between CY 2013 and CY 2014, the MD MCO Compliance Score increased for three standards (Oversight of Delegated Entities, Availability and Accessibility, and Utilization Review), remained unchanged for five standards (Systematic Process, Credentialing, Enrollee Rights, Continuity of Care, and Fraud and Abuse), and decreased for three standards (Governing Body, Health Education, and Outreach Plan). It should be noted, however, that two new MCO's have entered the system. One in CY 2013 and one in CY 2014 thus undergoing their first and second reviews during CY 2014. The overall MD MCO Composite Score decreased from 99% in CY 2012 to 98% in both CY 2013 and CY 2014.

Conclusion

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. For example, four of the seven (ACC, JMS, MPC, and MSFC) MCOs in CY 2014 and three of the eight (JMS, MPC, and MSFC) MCOs in CY 2015 received scores of 100% on the annual SPR.

All MCOs have demonstrated the ability to design and implement effective QA systems. The CY 2014 review provided evidence of the continuing progression of the HealthChoice MCOs as each MCO provided evidence of their ability to ensure the delivery of quality health care for their enrollees. As two new MCOs (RHMD and KPMAS) entered the HealthChoice system over the past two years, they promptly demonstrated a commitment to quality with SPR scores at 88% (RHMD) and 91% (KPMAS) within their first year reviews. A collaborative quality improvement relationship between the MCO, the Department, and the EQRO increased the scores of one MCO (RHMD) into their second year's review from 88% to 97%.