HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

MARYLAND Department of Health

HealthChoice
Maryland's Medicaid Managed Care Program

Qlarant

Maryland Medicaid Managed Care Organization

Systems Performance Review

Statewide Executive Summary Report

Calendar Year 2017

Submitted: July 2018

CY 2017 Statewide Executive Summary

HealthChoice Overview and Introduction

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

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

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

Under Federal law [Section 1932(c)(2)(A)(i) of the Social Security Act], MDH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract to ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program. MDH contracts with Qlarant to serve as the EQRO. This executive summary describes the findings from the systems performance review (SPR) for calendar year (CY) 2017, which is HealthChoice's 19th year of operation. HealthChoice served over 1,182,879 enrollees during this period.

COMAR 10.09.65 requires that all HealthChoice MCOs comply with the SPR standards and all applicable federal and state laws and regulations. MCOs were given an opportunity to review and comment on the

SPR standards 45 days prior to the beginning of the audit process. The nine MCOs evaluated for CY 2017 were:

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

*ABH joined HealthChoice in October of 2017, therefore the CY 2017 SPR was a baseline review for this MCO.

Purpose and Process

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

In view of the decision by MDH to move to triennial review from an annual onsite review in CY 2016, the assessment for Calendar Year (CY) 2017 was conducted as the second Interim Desktop Review. This assessment was completed by applying the systems performance standards defined for CY 2017 in the Code of Maryland Regulations (COMAR) 10.09.65.03B(1). The focus of the review was primarily on three areas: standards that were not fully met in the CY 2016 review, standards that were scored as baseline in the CY 2016 review, and new standards introduced during CY 2017. Additionally, a review of a sample of appeal and notice of determination records was conducted to assess compliance with applicable standards.

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; 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 2017 review before application.

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

Feedback was provided to the DHQA and each MCO with the goal of improving the care provided to HealthChoice enrollees.

Methodology

For CY 2017, COMAR 10.09.65.03 required that all HealthChoice MCOs comply with the SPR standards established by the Department and all applicable federal and state laws and regulations.

In September 2017, Qlarant provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2017 and invited the MCOs to direct any questions or issues requiring clarification to Qlarant and DHQA. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2017 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- CY 2017 Systems Performance Review Standards and Guidelines, including specific changes

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

During the desktop reviews conducted in January of 2018, the team reviewed all relevant documentation needed to assess the standards. A follow-up letter was provided to each MCO describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Qlarant; documents received were subsequently reviewed against the standard(s) to which they related.

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

A corrective action plan (CAP) was required for each performance standard that did not receive a finding of "Met".

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

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

The CY 2017 SPR Interim Desktop Review included:

- All MCO CAPs from the CY 2016 SPR within any of the following areas:
  - Standard 1: Systematic Process of Quality Assessment
  - Standard 2: Accountability to the Governing Body
  - Standard 3: Oversight of Delegated Entities
  - Standard 4: Credentialing and Recredentialing
  - Standard 5: Enrollee Rights
  - Standard 6: Availability and Accessibility
  - Standard 7: Utilization Review
  - Standard 8: Coordination of Care
  - Standard 9: Health Education
  - Standard 10: Outreach
  - Standard 11: Fraud and Abuse
- Standards that were reviewed as baseline in CY 2016, were scored in the CY 2017 review:
  - Standard 5: Enrollee Rights – Element 5.8
  - Standard 7: Utilization Review – Component 7.4i and Element 7.5
  - Standard 11: Fraud and Abuse – Component 11.1f
- New standards introduced by MDH in CY 2017, were reviewed and scored as baseline:
  - Standard 5: Enrollee Rights – Element 5.9 and Element 5.10
  - Standard 6: Availability and Accessibility – Component 6.1b
  - Standard 7: Utilization Review – Component 7.4h and Element 7.8
  - Standard 8: Coordination of Care – Element 8.6 and Element 8.7
  - Standard 11: Fraud and Abuse – Component 11.5d

Each MCO was expected to receive a finding of "Met" for all elements/components reviewed with the exception of ABH. The CY 2017 SPR was a baseline review for this MCO as ABH joined the HealthChoice system in October 2017. The MCOs were required to submit a CAP for any element/component that did not receive a finding of "Met".

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

Corrective Action Plans

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

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

In the event that a CAP is deemed unacceptable, Qlarant provides technical assistance to the MCO until an acceptable CAP is submitted. Seven MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) were required to submit CAPs for the CY 2017 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2018 will determine whether the CAPs from the CY 2017 review were implemented and effective. In order to make this determination, Qlarant will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH will be notified for further action.

Following the CY 2016 SPR, MDH implemented its Quality Monitoring Policy whereby an MCO that had a CAP for two or more consecutive years in the same element/component would require quarterly monitoring by the EQRO. As a result, five MCOs (ACC, KPMAS, PPMCO, UMHP and UHC) were required to submit quarterly updates of their CAPs to Qlarant. Progress was reported quarterly to MDH. Two MCO's (ACC and UMHP) CAPs were recommended to be closed. However, after the CY 2017 SPR, it was

found that three MCOs (KPMAS, PPMCO, and UHC) continue to require quarterly updates on the CAPs. Additionally, one MCO (MSFC) is required to begin submitting quarterly updates on the CAPs.

Findings

If the MCO's did not receive a finding of "Met", a CAP was required. One MCO (JMS) received findings of "Met" in all standards reviewed. Seven MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, UMHP, and UHC) were required to submit CAPs for CY 2017. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. As the review for ABH was a baseline review, all areas were scored as baseline with recommendations provided as applicable in order for the MCO to become compliant for the CY 2018 SPR.

Table 1 provides the required CAPs for each of the MCOs as a result of the CY 2017 review.

Table 1. CY 2017 MCO CAP Requirements

	Standard	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
3	Oversight of Delegated Entities					3.3c*	3.3b*		
5	Enrollee Rights	5.8 c		5.8c 5.8d	5.8a 5.8d	5.8d	5.8d		5.8b 5.8d
6	Availability and Access			6.1d*					
7	Utilization Review				7.5	7.4i	7.4e* 7.4f* 7.5	7.4e* 7.5	7.5
11	Fraud, Waste, and Abuse	11.1f		11.1f					11.1f
	CAPs Required	**2 CAPs**	**0 CAPs**	**3 CAPs**	**2 CAPs**	**3 CAP**	**3 CAPs**	**1 CAPs**	**2 CAPs**

*Quarterly updates required on CAP per MDH Quality Monitoring Policy

For each standard assessed for CY 2017, the following section describes:

- The requirements reviewed
- The overall MCO findings
- The individual MCO opportunities for improvement and CAP requirements, if applicable
- The follow up, if required

Standard 3: Oversight of Delegated Entities

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

Results. Two MCOs (PPMCO and MSFC) had opportunities for improvement in the area of oversight of delegated entities. These MCOs will require quarterly updates on the CAPs as these are continued opportunities from CY 2016.

> Component 3.3 b. Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. PPMCO received a finding of Unmet and is required to provide quarterly updates on the CAPs.
>
> Component 3.3 c. Review and approval of claims payment activities at least semi-annually, where applicable. MSFC received a finding of Unmet and is required to provide quarterly updates on the CAPs.

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

> **PPMCO Opportunities/CAPs:** For Component 3.3b, in response to the CY 2016 SPR findings, PPMCO was required to develop a CAP and submit quarterly updates to demonstrate compliance that the appropriate committee meeting minutes formal quarterly review and approval of quarterly grievance and appeal reports from all applicable delegates. Continued opportunities for improvement exist in demonstrating compliance.
>
> Grievances and appeals are delegated to Superior Vision. In 2016 PPMCO created the Interdepartmental Policy and Delegation Committee which includes among its responsibilities review and approval of delegate reports.
>
> There was evidence of Interdepartmental Policy and Delegation Committee review and approval of Superior Vision quarterly grievance and appeal reports in the meetings of May 11, 2017, (fourth quarter 2016), and September 7, 2017, (first and second quarter 2017). There was no

evidence of Interdepartmental Policy and Delegation Committee approval of third quarter grievance and appeal reports.

Subsequent to the CY 2017 Interim Desktop Review, PPMCO submitted additional documentation to support review and approval of the third quarter grievance and appeal report from Superior Vision. This component, however, remains partially met as delegate quarterly grievance and appeal reports must be reviewed on a quarterly basis. Quarterly review did not occur as the first and second quarterly reports were not reviewed quarterly, but rather were presented together at the September 7, 2017, IPAD meeting.

In order to receive a finding of met in the CY 2018 Review, PPMCO must demonstrate in the appropriate committee meeting minutes formal review and approval of quarterly grievance and appeal reports from all applicable delegates on a quarterly basis. Superior Vision first and second quarter reports were reviewed and approved by the Interdepartmental Policy and Delegation Committee on September 7, 2017, which does not meet the requirement for review of quarterly reports on a quarterly basis. Documentation must specify the report being approved and the time frame, such as third quarter 2017 Superior Vision grievance and appeal reports.

MSFC Opportunities/CAPs: For Component 3.3 c, in response to the CY 2016 Interim Desktop Review, MSFC was required to develop a CAP to demonstrate that claims activities reports from all applicable vendors are reviewed and approved on at least a semi-annual basis by the specific committee(s) identified in its policies. Continuing opportunities for improvement exist.

As documented in past reviews, the Quality Improvement/Utilization Management Committee and Executive Operations Team are responsible for the review and approval of claims activities reports from all delegated entities except Vestica. Vestica claims payment activities reports are reviewed and approved exclusively by the EOT. According to the CY 2017 MCO Pre-Site Visit Survey MSFC reported there were no changes to the committee(s) that review and approve delegate reports in the CY 2017 review year.

There was evidence of review and approval of quarterly claims activities reports from Superior Vision by the Quality Improvement/Utilization Management Committee on April 20, 2017, (fourth quarter 2016). The approval authority of the Quality Improvement/Utilization Management Committee appeared to change mid-year as minutes for July 20, 2017, (first quarter 2017), and October 19, 2017, (second quarter 2017) stated “reviewed and recommended for approval at the Executive Operations Team”. First and second quarter 2017,

Caremark reports were reviewed in the October 19, 2017, Quality Improvement/Utilization Management Committee with a recommendation for approval at the Executive Operations Team. The December 7, 2017, Quality Improvement/Utilization Management Committee minutes noted that the Superior Vision and Caremark meetings for third quarter 2017 were pending and would be reported at the next Quality Improvement/Utilization Management Committee in 2018.

Superior Vision claims activities reports were reviewed and approved by the Executive Operations Team as follows:

- April 24, 2017- Fourth quarter 2016
- October 16, 2017- First quarter 2017
- November 3, 2017- Second quarter 2017

Caremark claims activities reports were reviewed and approved by the Executive Operations Team as follows:

- April 24, 2017- Third and fourth quarters 2016
- There was no evidence that Caremark claims activities reports for first and second quarters 2017, were reviewed and approved.

There was evidence of Executive Operations Team review and approval of Vestica claims activities reports in 2017 meeting minutes as follows:

- February 14, 2017- It was reported that the January Vestica report was not complete and would be available at the next meeting.
- March 24, 2017- February claims activities report was reviewed and approved. No mention of the January Vestica report was found.
- April 24, 2017- March claims activities report was reviewed and approved.
- July 17, 2017- June claims activities report was reviewed and approved.
- August 17, 2017- July claims activities report was reviewed and approved.
- September 21, 2017- August claims activities report was reviewed and approved.
- October 16, 2017- September claims activities report was reviewed and approved.
- December 12, 2017- October claims activities report was reviewed and approved.

No Executive Operations Team minutes were submitted for May and June 2017, and there was no evidence that the Executive Operations Team reviewed and approved Vestica claims activities report for April and May 2017, in any subsequent Executive Operations Team meetings. Additionally, there was no evidence that the Executive Operations Team reviewed and approved the delayed January 2017, Vestica claims report.

Subsequent to the interim review, MSFC submitted additional documentation to support compliance. It noted that its Contracted Delegated Quality Improvement Functions Policy states "delegated entities summary reports are presented to the Quality Improvement/Utilization Management Committee for review and approval at least semi-annually. The reports will then be submitted to the Executive Operation Team Meeting for review and approval". It argued that the Quality Improvement/Utilization Management Committee minutes noting "review and recommended for approval at the Executive Operations Team" indicate the action to be taken per policy, as the Quality Improvement/Utilization Management Committee would not recommend approval if in fact the reports were not reviewed and approved. The wording, however, in the Quality Improvement/Utilization Management Committee minutes implies that the Quality Improvement/Utilization Management Committee does not have separate approval authority from the Executive Operations Team. The wording "review and recommend for approval" is used by lower level committees that do not have approval authority which is not the case for MSFC as noted in their policy.

MSFC reported that Superior Vision's third quarter 2016 claims activities report was reviewed and approved by the Quality Improvement/Utilization Management Committee and the Executive Operation Team on December 15, 2016, which is outside of the 2017 review period. There was evidence of review and approval of third and fourth quarter Caremark claims activities reports by the Quality Improvement/Utilization Management Committee on April 20, 2017. Additionally, MSFC reported that the Executive Operations Team reviewed and approved the first and second quarter 2017 Caremark claims activities reports on November 13, 2017, however, review of the redacted minutes from this meeting was unsuccessful in finding any reference to this review and approval.

In order to receive a finding of met in the CY 2018 SPR, MSFC must demonstrate that the Quality Improvement/Utilization Management Committee and Executive Operations Team reviews and approves all delegate claims activities reports consistent with its policies. Minutes must clearly document the delegate report being reviewed and the time frame such as Superior Vision claims activities report for third quarter 2017. Additionally, the approval authority of the Quality Improvement/Utilization Management Committee needs to be clearly documented by noting the "review and approval" of all delegate reports.

Follow-Up:

- PPMCO and MSFC were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.

- PPMCO and MSFC are required to provide quarterly updates on the CAPs in CY 2018 in adherence with MDH's Quality Monitoring Policy.
- The approved CAPs will be reviewed in CY 2018 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 Quality Assurance Program for resolving participants' grievances. This system must meet all requirements in COMAR 10.09.71.02 and 10.09.71.04. Enrollee information must be written to be readable and easily understood. This information must be available in the prevalent non-English languages identified by the Department. The MCO must act to ensure that the confidentiality of specified patient information and records are protected. The MCO must have written policies regarding the appropriate treatment of minors. The MCO must, as a result of the enrollee satisfaction surveys, identify and investigate sources of enrollee dissatisfaction, implement steps to follow-up on the findings, inform practitioners and providers of assessment results, and reevaluate the effectiveness of the implementation steps at least quarterly. The MCO must have systems in place to assure that new participants receive required information within established time frames.

Results. Six MCOs (ACC, KPMAS, MPC, MSFC, PPMCO, and UMHP) had opportunities for improvement in the area of enrollee rights. These MCOs will require CAPs to become compliant for the CY 2018 SPR.

MPC requires a CAP for Component 5.8 a. Materials distributed by the MCO to the enrollee will include a nondiscrimination notice in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency of Maryland.

UMHP requires a CAP for Component 5.8 b. Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page.

ACC and KPMAS require CAPs for Component 5.8 c. Notices and Taglines must be posted in significant communications and publications.

Five MCOs (KPMAS, MPC, MSFC, PPMCO, and UMHP) require CAPs for Component 5.8 d. Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

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.

MCOs continue to demonstrate opportunities for improvement in this standard regarding notifying enrollees and prospective enrollees about their nondiscrimination rights.

ACC Opportunities/CAPs: For Component 5.8c, in the CY 2016 Interim Desktop Review, ACC provided a copy of its fourth quarter 2016 newsletter and its proposed member handbook with changes submitted to MDH as evidence of enrollee material distributed with nondiscrimination notices. The member handbook appeared to have the required notice with translation information in the required languages. However, the newsletter included interpreter services in the required languages, but the nondiscrimination notice was not included. It was required as a result of the review that ACC provide evidence of posting notices and taglines in all significant communications and publications.

For the CY 2017 Interim Desktop Review, ACC provided the Spring and Fall Member Newsletter and the provider directory. The provider directory included the required notices and taglines, however, the newsletter again failed to include the appropriate nondiscrimination notice. It did include interpreter services in the required languages.

In order to receive a finding of met in the CY 2018 SPR, ACC must provide evidence of posting notices and taglines in all significant communications and publications.

KPMAS Opportunities/CAPs: For Component 5.8c, KPMAS provided a sample of marketing material mailed to members, however, the mailer did not meet the requirements for a small publication which follow:

- A "Statement of Nondiscrimination" informing persons that the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities; and
- Taglines in at least the top two languages spoken by individuals with limited English proficiency in the relevant state, presumably Spanish and one other non-English language.

A sample tagline informs individuals with limited English proficiency of language assistance services. An example follows:

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx).

Subsequent to the interim review, KPMAS provided a brochure on 24/7 supports that included the appropriate notices and taglines.

In order to receive a finding of met in the CY 2018 SPR, KPMAS must ensure that all significant member communications and publications include the required notices and taglines.

For Component 5.8d, KPMAS did not provide evidence of notices and taglines being posted in conspicuous physical locations where the MCO interacts with the public.

Subsequent to the interim review, KPMAS provided a snapshot of Federal Nondiscrimination Information, however, the MCO did not explain where this information was located or posted. An example of evidence that would demonstrate compliance with the requirement would be a picture of notices and taglines posted during community events that the MCO facilitates.

In order to receive a finding of met in the CY 2018 SPR, KPMAS must provide evidence of posting notices and taglines, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

MPC Opportunities/CAPs: For Component 5.8a, MPC provided several samples of member materials that were distributed to enrollees, however, not all consistently included the appropriate nondiscrimination notice and notice of translation services in the required languages. Both the member handbook and a telemedicine flyer included the required information. The member newsletter only included information regarding language services. This information was not in the required languages and there was no nondiscrimination notice. The dental and vision flyer provided for review included a nondiscrimination notice and information regarding translation services but not in all of the required languages.

In order to receive a finding of met in the CY 2018 SPR, MPC must ensure that all enrollee materials include a nondiscrimination notice and information regarding translation services in English and at least the top 15 non-English languages spoken by individuals with limited English proficiency as required by the state of Maryland.

For Component 5.8d, MPC did not provide evidence of notices and taglines being posted in conspicuous physical locations where the MCO interacts with the public.

In order to receive a finding of met in the CY 2018 SPR, MPC must provide evidence of notices and taglines being posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public. Notices and taglines must be in English and in at least the top 15 non-English languages spoken by individuals with limited English proficiency in Maryland.

MSFC Opportunities/CAPs: For Component 5.8d, MSFC provided a photograph of the posting of the nondiscrimination and language accessibility notices, however, the MCO did not provide an explanation as to where these were posted. It is necessary to know this information in order to evaluate compliance with this component.

In order to receive a finding of met in the CY 2018 SPR, MSFC must provide evidence of Notices and Taglines being posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

PPMCO Opportunities/CAPs: For Component 5.8d, PPMCO did not provide evidence of notices and taglines being posted in conspicuous physical locations where the MCO interacts with the public, for example, during community events, education events, health fairs, etc.

Subsequent to the interim review, PPMCO provided a screenshot of the MCO's member website showing a link to the Notice of Nondiscrimination and a brochure that the MCO states is shared at health education and redetermination events. However, the reviewer needs evidence that this is occurring, such as a photograph of notices and taglines being posted during the events.

In order to receive a finding of met in the CY 2018 SPR, PPMCO must provide evidence of notices and taglines being posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

UMHP Opportunities/CAPs: For Component 5.8b, UMHP did not provide any documentation to support compliance with this element.

In order to receive a finding of met in the CY 2018 SPR, UMHP must provide evidence that notices and taglines are posted in a conspicuously visible location on websites accessible from the home page.

For Component 5.8d, UMHP provided a "community event material" which was a flyer stating that enrollment is always open and included the notice and tagline. It is not clear how this flyer is used.

In order to receive a finding of met in the CY 2018 SPR, UMHP must provide evidence of the nondiscrimination notice and taglines being posted, where appropriate, in conspicuous locations where the MCO interacts with the public. Evidence could include a picture of the outreach staff at community events with the community event materials displayed on a table.

Follow-up:

- All six MCOs were required to submit CAPs for the above noted components. Qlarant reviewed and approved the CAP submissions.
- The approved CAPs will be reviewed in CY 2018 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. One MCO (KPMAS) had a continuing opportunities for improvement in the area of availability and accessibility. This MCO will require quarterly updates on the CAP as this is a continued opportunity from the CY 2016 SPR.

KPMAS requires a CAP for Component 6.1d. The MCO has documented review of the Enrollee Services Call Center performance.

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. Each MCO has an effective system in place for notifying members of wellness services.

KPMAS Opportunities/CAPs: For Component 6.1d, as a result of the CY 2017 Interim Desktop Review, KPMAS was required to submit a CAP along with quarterly monitoring to correct the inconsistency between the Achieving Call Metrics Policy that indicated an abandonment rate of 3% or less and the RQIC minutes that were monitoring an abandonment rate of 4% or less. KPMAS submitted a revised policy in November 2017 that noted a 5% abandonment rate which

was not in alignment with industry standards. Therefore, the MCO was requested to revise the policy. A second revision was made to the policy and accepted in December of 2017.

Since Regional Quality Improvement Committee meetings to monitor the call standards have not taken place to date, this CAP with quarterly monitoring will continue for the next two quarters to ensure consistent monitoring of the revised abandonment rate.

In order to receive a finding of met in the CY 2018 SPR, KPMAS must ensure consistent monitoring against accurate Enrollee Services Call Center performance standards.

Follow-Up:

- KPMAS was required to submit a CAP for Component 6.1d. Qlarant reviewed and approved the submission.
- KPMAS is required to provide quarterly updates on the CAP in CY 2018 in adherence with MDH's Quality Monitoring Policy.
- The approved CAP will be reviewed in CY 2018 SPR.

STANDARD 7: Utilization Review

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

Management Program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

Results. Five MCOs (MPC, MSFC, PPMCO, UHC, and UMHP) have opportunities for improvement in the area of Utilization Review. Two MCOs (PPMCO and UHC) will require quarterly updates on the CAP as these are continued opportunities from the CY 2016 SPR.

PPMCO and UHC require CAPs for Component 7.4 e. Preauthorization and concurrent review decisions are made in a timely manner as specified by the State. These CAPs require quarterly updates.

PPMCO requires a CAP for Component 7.4 f. Appeal decisions are made in a timely manner as required by the exigencies of the situation. This CAP requires quarterly updates.

MSFC requires a CAP for Component 7.4 i. Appeal decisions are made by health care professionals who have the appropriate clinical expertise in treating the member's condition or disease consistent with the MCO's policies and procedures.

Four MCOs (MPC, PPMCO, UHC, and UMHP) require CAPs for Element 7.5 - Adverse determination letters include a description of how to file an appeal and all other required components.

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.

MPC Opportunities/CAPs: Element 7.5 was scored as baseline for the CY 2016 review as a result of the requirement to include a notice of nondiscrimination in all adverse determination letters. The Prior Authorization Policy lists the content to be included in the Notice of Action (adverse determination letter) which does not address all of the 16 components required for Maryland HealthChoice members. For example, the list does not include member access to his/her medical records, an explanation that it is assumed the member received the letter five

days after it was dated, a notice of nondiscrimination, and the availability of a free copy of any guideline, code or similar information used in making the determination. The member pre-service letter template included 15 of the required components. The last component, a notice of nondiscrimination, was provided separately.

A sample of 10 adverse determination letters were reviewed for compliance. The notice of nondiscrimination was included in eight of the 10 letters. An additional 20 letters were reviewed with 10 demonstrating compliance. Overall compliance for the 30 letters reviewed was 60% for the nondiscrimination notice requirement.

Additionally, the PCP was not copied in all of the letters. In the initial sample of 10, eight letters evidenced that the PCP was copied. An additional sample of 20 letters were reviewed with 16 demonstrating compliance with this component. Overall, for the component requiring that the letter is copied to the PCP compliance was at 80%. Five of the six non-compliant letters were related to National Imaging Associates reviews. In reviewing the case notes it was documented that PCP notification was not required and that PCP information was not available. In addition to these missing components, letters did not always reflect the current HealthChoice Help Line that replaced the former Enrollee Help Line.

Subsequent to the review, MPC provided additional documentation to support compliance. It reported that the Prior Authorization Policy was revised to include all missing components and was approved by the policy committee on February 14, 2018. It also noted that the letter template was revised to include the HealthChoice Help Line effective February 1, 2018. Since these changes are outside of the CY 2017 review period the revised policy and letter template will be reviewed in the CY 2018 SPR.

In order to receive a finding of met in the CY 2018 review, MPC must revise the Prior Authorization Policy to reflect the 16 required components in all adverse determination letters. Additionally, all adverse determination letters must demonstrate compliance with all 16 required components. Any references to the former Enrollee Help Line in policies or letter templates must be updated to reflect the current HealthChoice Help Line.

MSFC Opportunities/CAPs: For Component 7.4i, the Appeals - Member Policy requires that when necessary for clinical appeals, the Appeal Reviewer will be someone in the same or a similar specialty on the second level who typically treats the medical condition, performs the procedure or provides the treatment under review. This requirement is insufficient in demonstrating compliance with this component.

A review of a sample of 10 member appeal records demonstrated compliance with the requirement for appeal decisions to be made by health care professionals with appropriate clinical expertise.

Subsequent to the interim review, MSFC submitted additional documentation to support compliance. It referenced the same section of the policy previously reviewed. This policy statement is inadequate as it only addresses the requirement for the appeal reviewer to be someone in the same or a similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment under review for second level appeals.

In order to receive a finding of met in the CY 2018 review, the Appeals - Member Policy needs to be revised to require appeal decisions be made by health care professionals who have the appropriate clinical expertise in treating the member's condition or disease at any level of appeal.

PPMCO Opportunities/CAPs: For Component 7.4e, in response to the CY 2016 Interim Desktop Review findings, PPMCO was required to develop a CAP to demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations. This CAP is being monitored quarterly since non-compliance has occurred for two consecutive review periods. The CAP was partially implemented and continued opportunities for improvement exist.

The Preservice Turnaround Time for Pharmacy and Utilization Management spreadsheet identified monthly compliance with decision and notification time frames for routine and urgent preservice requests by approval status. Overall compliance rate was combined for both determinations and notifications and reported separately for routine and urgent requests. Individual results for determinations and adverse determination notifications reported for routine and urgent requests are as follows:

- For routine approvals compliance with decision time frames was not met in any of the 12 months with rates ranging from 25.2% in April to 67.5% in August.
- For routine denials compliance with decision time frames was met in one of 12 months. Compliance rates ranged from 88% in February to 95% in December.
- For routine denials compliance with the adverse determination notification time frame was met in 11 out of 12 months with May the only outlier at 93.7%.
- For urgent approvals compliance with decision time frames was met in three of the 12 months. Compliance rates ranged from 76.2% in October to 98.5% in July.

- For urgent denials compliance with decision time frames was met in two of 12 months. Compliance rates ranged from 88.8% in February and June to 99.1% in December.
- For urgent denials compliance with the adverse determination notification time frame was met in 11 of the 12 months. The one outlier month was May at 92.9%.

PPMCO provided an updated CAP and multiple documents to demonstrate completion of CAP deliverables. Interim solutions have been implemented in response to ongoing delays in implementation of the new utilization management platform due to configuration issues. PPMCO attributed high employee turnover as the cause of productivity and turnaround issues in 2017. It noted that the business continuity plan to address staff turnover was completed on November 27, 2017. In view of ongoing non-compliance with determination and notification time frames quarterly CAP review will continue until PPMCO demonstrates compliance for three consecutive quarters.

In order to receive a finding of met in the CY 2018 SPR, PPMCO must consistently demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations.

For Component 7.4f, in response to the CY 2016 Interim Desktop Review findings, PPMCO was required to develop a CAP to demonstrate compliance with State required time frames for appeal resolution or MCO time frames if more stringent. This CAP is being monitored quarterly since non-compliance has occurred for two consecutive review periods. The CAP was partially implemented and continued opportunities for improvement exist.

The Standard and Expedited Appeal Compliance- CY 2017 spreadsheet identifies monthly compliance with resolution time frames for standard and expedited appeals. Standard appeals demonstrated compliance with the resolution time frame in 10 of the 12 months in 2017. Outlier months were February at 97.7% and September at 97.5%. Requests for an expedited appeal were submitted in only four of the 12 months in 2017. All expedited appeals were resolved within the resolution time frame.

PPMCO provided an updated CAP to demonstrate completion of CAP deliverables. Two deliverables, tracking appeals volume by sources and comparing appeal turnaround time among appeals received through different sources, had an initial completion date of August 15, 2017, which was later revised to October 30, 2017. No update was provided for either deliverable in the latest CAP submission.

While PPMCO has demonstrated improvement in 2017, the CAP will remain in place with quarterly reporting until PPMCO demonstrates compliance for three consecutive quarters.

In order to receive a finding of met in the CY 2018 SPR, PPMCO must demonstrate consistent compliance with appeal resolution time frames. The resolution time frame for standard appeals was not met for the months of February and September in 2017.

Element 7.5 was scored as baseline for the CY 2016 Interim Desktop Review as a result of the requirement to include a notice of nondiscrimination in all adverse determination letters. A sample outpatient adverse determination letter submitted for the CY 2017 review included this and the additional 15 required components.

The Clinical and Administrative Denial Policy includes some, but not all, of the required components for member adverse determination letters. The policy notes that additional elements may be included in letter templates to meet requirements for each line of business or governing agency. The Step Therapy, Prior Authorization and Quantity Limits Policy requires the denial letter to include the reason for the denial, information regarding the member's appeal rights, including information on how to initiate an appeal, and information on obtaining criteria used in making the denial decision.

A sample of 10 adverse determination letters was reviewed for compliance. In the initial sample of 10 only five letters included the notice of nondiscrimination. Additionally, none of the letters included evidence that both the requesting provider and the PCP were copied. An additional 20 letters were reviewed for compliance. Twelve of the 20 letters included the notice of nondiscrimination. Three of the 20 letters evidenced that both the PCP and requesting provider were copied. The overall compliance rate for the notice of nondiscrimination was 53% and for evidence that the PCP and requesting provider were copied the overall compliance rate was 10%. Additionally, letters referenced the former Enrollee Help Line which was replaced by the HealthChoice Help Line.

In order to receive a finding of met in the CY 2018 SPR, PPMCO must demonstrate that member adverse determination letters include all required components. Additionally, PPMCO must either list the letter components in the appropriate policies or attach a letter template to the policy. All references to the former Enrollee Help Line need to be replaced by the current HealthChoice Help Line.

UHC Opportunities/CAPs: For Component 7.4e, in response to the CY 2016 Interim Desktop Review findings, UHC was required to develop a CAP to demonstrate consistent compliance with regulatory time frames for medical and pharmacy preservice determination and notifications. This CAP is being monitored quarterly since non-compliance has occurred for two consecutive review periods. The CAP was partially implemented and continued opportunities for improvement exist.

UHC provided separate tracking of compliance with determination and notification time frames for medical and pharmacy, by month, from January through December 2017. Results are detailed for each area below.

In reviewing the Priorauthorization Medical Turnaround Time Compliance Report for 2017, compliance was reported as follows:

- Determinations (emergent and non-emergent) – All 12 months in 2017 met or exceeded the 95% threshold.
- Notifications (emergent and non-emergent) – The last seven months of 2017 met or exceeded the 95% threshold.

In reviewing the Priorauthorization Pharmacy Turnaround Time Compliance Report for 2017, compliance was reported as follows:

- Expedited determinations – Eleven out of 12 months met or exceeded the 95% threshold. The outlier month was May 2017, at 93.3%.
- Routine determinations within two business days – Nine out of 12 months met or exceeded the 95% compliance threshold. Outlier months were April, May, and October 2017.
- Written notification within 24 hours – Seven out of 12 months met or exceeded the 95% compliance threshold. Outlier months were April, May, June, July, and October 2017.
- Written notification within 72 hours – Eleven out of 12 months met or exceeded the 95% threshold. Outlier month was May 2017, at 89%.

There were no pharmacy requests which required additional clinical information so no compliance percentages were reported for the seven-calendar day time frame.

Updated CAPs were provided for both medical and pharmacy compliance which included increased staffing and oversight and some process changes. One of the contributing factors to pharmacy non-compliance was cited as the additional opioid review that is now required. While UHC has demonstrated improvement in 2017, the CAP will remain in place for 2018 with

quarterly monitoring until UHC demonstrates consistent compliance over at least three quarters.

In order to receive a finding of met in the CY 2018 SPR, UHC must consistently demonstrate compliance with regulatory time frames for medical and pharmacy preservice determination and notifications at the 95% threshold.

Element 7.5 was scored as baseline for the CY 2016 Interim Desktop Review as a result of the requirement to include a notice of nondiscrimination in all adverse determination letters. The sample enrollee adverse determination letter submitted for the CY 2017 review included this and the additional 15 required components, however, this notice was not included in all of the letters within the sample reviewed.

The Initial Adverse Determination Notices Policy which references UnitedHealthcare Community Plan- Maryland in its title includes some, but not all, of the components required in adverse determination letters for HealthChoice members. The policy states that letters specifically required by state/federal law, contract, or government programs will be accepted as meeting the written notice elements required by this policy. The Member Pre-Services Denial letter template was provided and included all 16 required components.

A sample of ten adverse determination letters was reviewed for compliance. The notice of nondiscrimination was included in five of the 10 letters within the initial sample. An additional 20 letters were reviewed with 11 demonstrating compliance with inclusion of the nondiscrimination notice. Overall compliance for this component in the 30 letters reviewed was 53%.

It is recommended that UHC include the list of required components for member adverse determination letters in the Initial Adverse Determination Notices Policy.

In order to receive a finding of met in the CY 2018 SPR, UHC must demonstrate that member adverse determination letters consistently include the notice of nondiscrimination. Additionally, all references to the former Enrollee Help Line need to be replaced with the current HealthChoice Help Line.

UMHP Opportunities/CAPs: Element 7.5 was scored as baseline for the CY 2016 Interim Desktop Review as a result of the requirement to include a notice of nondiscrimination in all

adverse determination letters. UMHP did not submit any policy that identified the 16 required components for the member adverse determination letters.

An initial sample of 10 adverse determination letters was reviewed for compliance. Fifteen of the 16 components were included within this sample. The notice of non-discrimination was not found within any of the 10 letters reviewed. An additional sample of 20 adverse determination letters was reviewed for compliance. Thirteen of the 20 letters included the notice of nondiscrimination. The overall compliance rate for the sample of 30 adverse determination letters is 43% for this component. Additionally, letters reflected inconsistent reference to the HealthChoice Help Line which has replaced the former Enrollee Help Line.

Subsequent to the review, UMHP submitted additional documentation to support its compliance. In the 2017 Qlarant System Performance Review Narrative Summary, UMHP explained that it utilizes a filler form process, noting that the template format was tested successfully with the addition of the nondiscrimination language. UMHP's quality assurance process included an registered nurse reviewing the adverse determination letters on the SharePoint site for release to print and mail. It was discovered during a mid-year audit that the printed letters did not include the nondiscrimination notice. It immediately performed a root cause analysis of the printing discrepancy and included in its process manual review of the printed letter on an ongoing basis. It also reported that it could find no reference to the change in the language replacing the Enrollee Help Line with the HealthChoice Help Line which was revised by MDH on March 31, 2016. This oversight, however, had no impact on the scoring. Although UMHP has identified and corrected the letters to include the nondiscrimination notice this element remains partially met for the CY 2017 review.

In order to receive a finding of met in the CY 2018 SPR, UMHP must demonstrate that all adverse determination letters include all required 16 components. Additionally, if UMHP does not have a policy addressing the required adverse determination letter components one needs to be developed. All references to the former Enrollee Help Line need to be replaced by the current HealthChoice Help Line.

Follow-Up:

- All five MCOs were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- PPMCO (7.4e and 7.4f) and UHC (7.4e) will provide quarterly updates on the CAPs for Standard 7 to Qlarant in adherence with MDH's Quality Monitoring Policy.

- The approved CAPs will be reviewed in CY 2018 SPR.

STANDARD 11: Fraud, Waste, and Abuse

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

Results. Three MCOs (ACC, KPMAS, and UMHP) have opportunities for improvement in the area of Fraud and Abuse.

ACC, KPMAS, and UMHP require CAPs for Component 11.1 f. A documented process to ensure that services billed to the MCO were actually received by the enrollee.

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.

ACC Opportunities/CAPs: Component 11.1f was scored as baseline in the CY 2016 Interim Desktop Review. ACC was required to provide documentation of the Member Verification of Service or Explanation of Medical Benefits process and evidence that the process is being executed. ACC provided the Member Verification of Services Process - MD Policy which was dated November 21, 2017, and a template of a letter to a member (Explanation of Benefits). However, there was no evidence presented of members actually being mailed these letters to date.

Additionally, the policy states that a random sample and the type of claims will be pulled quarterly, but it does not state how many claims will be included in the sample.

Subsequent to the interim review, ACC provided a revised Member Verification of Services Process - MD Policy which included the number of Explanation of Benefits included in the quarterly sample.

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

In order to receive a finding of met in the CY 2018 SPR, ACC must provide evidence that explanation of benefits were actually mailed to members and that the process is actually being monitored through the quality workgroups.

KPMAS Opportunities/CAPs: For Component 11.1f, KPMAS stated that Maryland Medicaid will be added to the Health Information Management Services audit scope in the second quarter of 2018. The MCO states that the audit will take place annually to ensure that services billed to the MCO were actually received by the enrollee.

KPMAS did not provide an explanation of the "audit scope". Should this include member explanation of benefit letters, it should be noted that response rates on member verification letters or explanation of benefit letters are typically very low and most times do not solicit responses from members at all. Using this process is not considered a best practice to ensure that services billed were actually received by the member. It is recommended that MCOs attempt to contact members personally and target the scope of the review, such as sampling data/claims for services such as durable medical equipment, substance use, radiology, or pain management. Member verification of services should be completed no less frequently than quarterly.

In order to receive a finding of met in the CY 2018 SPR, KPMAS must provide a written process for ensuring that services billed to the MCO were actually received by the enrollee. Additionally, KPMAS must provide evidence that this process was implemented.

UMHP Opportunities/CAPs: For Component 11.1f, UMHP was notified in the CY 2016 SPR that the MCO was required to document its process to ensure that services billed to the MCO were

actually received by the member. UMHP submitted its Fraud, Waste, and Abuse Reporting Policy that was not revised until December of 2017 which states that members with recent claims are to be provided verification letters. A copy of the letter template was provided for review. It requests that members verify they received the services. The first letters were not anticipated to be distributed until April 2018.

The policy is silent on how many members will receive the letters, at which interval the letters will be mailed to members, a goal for survey response rate, what action will be taken if the response rates do not meet the goal, and corrective actions. Response rates on member verification letters are typically very low and using this type of member verification to document if services were received is not a best practice.

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

In order to receive a finding of met in the CY 2018 SPR, UMHP must provide evidence of a complete documented process to ensure that services billed to the MCO were actually received by the member and evidence that the process has been implemented.

Follow-Up:

- ACC, KPMAS, and UMHP were required to submit CAPs for the above component. Qlarant reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2018 SPR.

Conclusion

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. Although numerical scores were not provided in CY 2017, improvement was seen for three MCOs (ACC, UHC, and UMHP) and a slight decrease in performance was seen for four MCOs (MPC, MSFC, PPMCO, and KPMAS). JMS continued to receive a perfect score in the CY 2017 SPR.

Beginning in CY 2016, MDH implemented its Quality Monitoring Policy whereby any MCO that has had a CAP for two or more consecutive years in the same element/component is required to provide quarterly updates to Qlarant. In following with this policy, four MCOs (KPMAS, PPMCO, UHC, and UMHP) are required to submit quarterly updates of their CAPs to Qlarant. Additionally, all CAPs will be reviewed during the CY 2018 SPR.

Maryland has set high standards for MCO quality assurance systems. HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees.

Qlarant will conduct a comprehensive SPR for CY 2018 onsite at the MCO facilities in January and February of 2019.