HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

Maryland Medicaid Managed Care Organization

CY 2016 Systems Performance Review

Statewide Executive Summary Calendar Year 2016

Delmarva Foundation
A Quality Health Strategies Company

Submitted by:
Delmarva Foundation
July 2017

CY 2016 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 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) 2016, which is HealthChoice's 18th year of operation. HealthChoice served over 1,133,369 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 eight MCOs evaluated for CY 2016 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)

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 (QA) 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 DHMH to move to triennial rather than annual onsite reviews, the assessment for Calendar Year (CY) 2016 was conducted as an Interim Desktop Review. This assessment was completed by applying the systems performance standards defined for CY 2016 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 2015 review, standards that were scored as baseline in the CY 2015 review, and new standards introduced during CY 2016. Additionally, a review of a sample of credentialing and recredentialing 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 2015 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 45 years in managed care and quality improvement systems, 35 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 2016, 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 October 2016, Delmarva Foundation provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2016 and invited the MCOs to direct any questions or issues requiring clarification to Delmarva Foundation and DHQA. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2016 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- CY 2016 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, UM, delegation, credentialing, enrollee rights, coordination of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Delmarva Foundation.

During the desktop reviews conducted in January of 2017, 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 Delmarva Foundation; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the review, Delmarva Foundation 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 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" if the element or component had been found "Partially Met" for more than one consecutive year.

The CY 2016 SPR Interim Desktop Review included:

- All MCO CAPs from the CY 2015 SPR for any of the following areas:
  - Systematic Process of Quality Assessment
  - Accountability to the Governing Body
  - Oversight of Delegated Entities
  - Credentialing and Recredentialing
  - Enrollee Rights
  - Availability and Accessibility
  - Utilization Review
  - Coordination of Care
  - Health Education
  - Outreach
  - Fraud and Abuse
- Standards that were reviewed as baseline in CY 2015, were reviewed scored in the CY 2016 review:
  - 1.10
  - 3.3c and 3.3e (if 3.3e was deemed for an MCO in CY 2015, it was deemed in CY 2016)
  - 5.6d
  - 7.7
  - 8.6
- New standards introduced by the Department for CY 2016. These standards were scored as baseline:
  - 5.8
  - 7.5
  - 11.1 f
- A focused review of Credentialing and Recredentialing records included the following elements/components of Standard 4: 4.4, 4.5, 4.6, 4.7, 4.8, and 4.9.

For CY 2016, each MCO was expected to receive a finding of "Met" for all elements/components reviewed. 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 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 Plans

Each year the CAP process is discussed during the annual review meeting. This 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 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 provides technical assistance to the MCO until an acceptable CAP is submitted. Six MCOs were required to submit CAPs for the CY 2016 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 2017 will determine whether the CAPs from the CY 2016 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.

Following the CY 2016 SPR, DHMH 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. Therefore, five MCOs (ACC, KPMAS, PPMCO, RHMD and UHC) were required to submit quarterly updates of their CAPs to Delmarva Foundation. Progress will be reported quarterly to DHMH.

Findings

If the MCO's did not receive a finding of "Met", a CAP was required. Two MCOs (JMS and MPC) received findings of "Met" in all standards reviewed. Six MCOs (ACC, KPMAS, MSFC, PPMCO, RHMD, and UHC) were required to submit CAPs for CY 2016. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

Table 2 provides for a comparison of SPR results across MCOs and the MD MCO Compliance for the CY 2016 review.

Table 2. CY 2016 MCO Review Results

Standard	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	RHMD	UHC
3 - Oversight of Delegated Entities	3.3 c		3.3c		3.3 c	3.3 b 3.3 c	3.3 b 3.3 c 3.3 e	3.3 c
4 - Credentialing							4.8 e	4.4 i
5 - Enrollee Rights	5.6 d							
6 - Availability and Access			6.1 d					
7 - Utilization Review	7.4 d 7.7					7.4 e 7.4 f	7.4 e 7.6 c 7.7	7.4 e 7.7
CAPs Required	3 CAPs	0 CAPs	2 CAPs	0 CAPs	1 CAP	2 CAPs	3 CAPs	3 CAPs

For each standard assessed for CY 2016, 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:

For 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, the following two MCOs had opportunities for improvement and required CAPs:

- PPMCO – Partially Met
- RHMD - Unmet

For Component 3.3 c Review and approval of claims payment activities at least semi-annually, where applicable, the following six MCOs had opportunities for improvement and required CAPs:

- ACC - Unmet
- KPMAS – Unmet
- MSFC – Partially Met
- PPMCO – Unmet
- RHMD - Unmet
- UHC – Partially Met

For Component 3.3 e. Review and approval of over and under utilization reports, at least semi-annually, where applicable, the following MCO had an opportunity for improvement and required a CAP: RHMD - Unmet.

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

ACC Opportunities/CAPs:

Component 3.3c: ACC did not provide evidence of QMC review and approval of claims payment activities reports from Superior Vision and ESI for the fourth quarter of 2015, and the first three quarters of 2016.

Subsequent to the initial submission, ACC provided additional documentation. Review of QMC minutes from February 3, 2016, demonstrated approval of fourth quarter 2015, claims activities reports from Superior Vision and ESI. There was no evidence of approval of first, second, and third quarter 2016, claims activities reports from Superior Vision or ESI based upon review of the remainder of QMC meeting minutes submitted from 2016.

In order to receive a finding of met in the CY 2017 review, ACC must demonstrate QMC review and approval of claims activities reports from all applicable delegated entities at least on a semi-annual basis or more frequently based upon MCO policy. Documentation must specify the report being approved and the time frame such as fourth quarter 2016 Superior Vision claims activities reports.

KPMAS Opportunities/CAPs:

Component 3.3c: In response to the CY 2015 SPR findings, KPMAS was required to demonstrate that the appropriate committee reviewed and approved all delegate claims activities reports at least semi-annually in order to receive a finding of met in the CY 2016. Continued opportunities for improvement existed.

There was no evidence of RQIC review and approval of EMI claims activities reports for the fourth quarter 2015, and the second quarter, 2016. RQIC approval for first quarter reports was documented in the minutes of May 25, 2016, and third quarter in the minutes of October 19, 2016. Additionally, no evidence was submitted to support RQIC review and approval of MedImpact's claims activities on a semi-annual basis or more frequently based upon MCO policy.

Subsequent to the initial submission, KPMAS submitted additional documentation for review. RQIC minutes from February 17, 2016, demonstrated review and approval of third and fourth quarters 2015, claims activities reports from EMI. An RQIC Executive Summary was submitted dated July 29, 2016, displaying results for second quarter 2016; however, there were no RQIC minutes documenting review and approval of the second quarter EMI report.

Minutes submitted from the RQIC meeting of March 16, 2016, demonstrated review and approval of MedImpact's fourth quarter 2015, claims activities report. Second quarter 2016, claims activities reports from MedImpact were approved in the RQIC meeting of September 21, 2016. RQIC minutes from June 15, 2016, and December 21, 2016, documented approval of the consent agenda report, however, there was no documentation in the meeting minutes that MedImpact's claims activities reports were reviewed and approved.

In order to receive a finding of met in the CY 2017 review, KPMAS must demonstrate that the RQIC reviews and approves claims activities reports from all delegated entities at least on a semi-annual basis or more frequently based upon MCO policy. Minutes must reflect the specific report being approved and the associated time frame, such as EMI claims activities reports from second quarter 2016.

MSFC Opportunities/CAPs:

Component 3.3c: The QI/UMC and EOT are responsible for the review and approval of claims activities reports from all delegated entities except Vestica. Vestica's claims payment activities reports are reviewed and approved exclusively by the EOT.

There was evidence of review and approval of quarterly claims activities reports from Superior Vision by the QI/UMC on March 17, 2016, (fourth quarter 2015). In the July 21, 2016, meeting minutes it was reported that review and approval of first and second quarter 2016 reports would occur at the September 15, 2016, meeting. No additional QI/UMC meeting minutes were submitted to evidence review and approval of first, second, and third quarter 2016 reports. No EOT meeting minutes were submitted to demonstrate review and approval of claims activities reports from Superior Vision on at least a semi-annual basis consistent with the MCO's policy.

There was evidence of review and approval of semi-annual claims activities reports from Caremark by the QI/UMC on May 19, 2016, (July through December 2015.) In the July 21, 2016, meeting minutes it was reported that review and approval of first and second quarter 2016, reports would occur at the September 15, 2016, meeting. No additional QI/UMC meeting minutes were submitted. No EOT meeting minutes were submitted to demonstrate review and approval of claims activities reports from Caremark on at least a semi-annual basis consistent with the MCO's policy.

There was no evidence of at least semi-annual review and approval of claims activities reports from Vestica as no EOT meeting minutes were submitted.

Subsequent to its initial submission MSFC provided additional documentation. QI/UMC minutes from December 15, 2016, demonstrated review and approval of first and second quarter Caremark claims activities reports. EOT minutes from December 15, 2016, demonstrated review and approval of Caremark claims activities reports for third and fourth quarters 2015, and first and second quarters 2016.

In the QI/UMC minutes from December 15, 2016, there was evidence of review and approval of claims activities reports from Superior Vision for first, second, and third quarters, 2016. EOT minutes demonstrated review and approval of Superior Vision claims activities reports from fourth quarter 2015, (April 14, 2016), and first, second, and third quarters 2016, (December 15, 2016).

EOT meeting minutes evidenced approval of Vestica claims activities reports for fourth quarter 2015, (February 18, 2016), first quarter 2016, (May 17, 2016), second quarter 2016 (August 18, 2016), and third quarter 2016 (December 15, 2016).

In order to receive a finding of met in the CY 2017 review, MSFC must 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.

PPMCO Opportunities/CAPs:

Component 3.3b: In the CY 2015 SPR PPMCO was required to develop a CAP to demonstrate formal appropriate committee quarterly review and approval of quarterly complaint, grievance, and appeal reports from all applicable delegates. As indicated below, continuing opportunities for improvement exist in demonstrating compliance.

Complaints and grievances are delegated to Superior Vision. In 2016 PPMCO created the IPAD Committee which includes among its responsibilities review and approval of delegate reports.

There was evidence of IPAD Committee review and approval of Superior Vision quarterly complaint and grievance reports in the meetings of May 2, 2016, (fourth quarter 2015), and July 14, 2016 (first quarter 2016). In the draft October 2016, minutes it was reported that all goals were met but did not specify the delegated activity report that was approved. There was no evidence of third quarter IPAD Committee approval of complaint and grievance reports.

Subsequent to the initial submission, PPMCO provided additional documentation to demonstrate compliance. The finalized IPAD Committee minutes from October 13, 2016, did not specify the activity report that was approved as noted above following review of the draft minutes. The IPAD Committee minutes from the December 8, 2016, meeting demonstrated review and approval of Superior Vision's complaint and grievance report for the third quarter, 2016.

In order to receive a finding of met in the CY 2017 review, PPMCO must demonstrate in the appropriate committee meeting minute's formal quarterly review and approval of quarterly complaint, grievance, and appeal reports from all applicable delegates. Documentation must specify the report being approved and the time frame, such as third quarter 2016 Superior Vision complaint and grievance reports.

Component 3.3c: In the 2015 SPR, findings noted that in order to receive a met in the 2016 SPR, PPMCO was required to demonstrate review and approval of delegated claims activities reports from all applicable delegates no less than semi-annually in the appropriate committee meeting minutes. As indicated below, this requirement was partially met and continued opportunities for improvement exist.

Claims payment activities are delegated to both Caremark and Superior Vision. In 2016 PPMCO created the IPAD Committee which includes among its responsibilities review and approval of delegate reports.

There was evidence of IPAD Committee review and approval of Superior Vision claims activities reports in the meetings of May 2, 2016 (fourth quarter 2015), and July 14, 2016 (first quarter 2016). In the draft October 2016, minutes it was reported that all goals were met but did not specify the delegated activity report that was approved. There was no evidence of third quarter IPAD Committee approval of claims activities reports.

In the March 18, 2016, IPAD Committee meeting minutes it was reported that all Caremark delegate reports were approved but the specific delegated activity reports were not documented. First and second quarter 2016 claims activities reports were approved in the September 8, 2016, IPAD Committee meeting.

Subsequent to the initial submission, PPMCO provided additional documentation to demonstrate compliance. IPAD Committee minutes were provided for October 13, 2016; however, there was no evidence of approval of Caremark claims activities reports. IPAD Committee minutes were also submitted for the February 9, 2017, meeting which is outside of the review time frame.

The finalized IPAD Committee minutes from October 13, 2016, did not specify the activity report that was approved as noted above following review of the draft minutes. The IPAD Committee minutes from the December 8, 2016, meeting demonstrated review and approval of Superior Vision's claims activities report for the third quarter, 2016.

In order to receive a finding of met in the CY 2017 review, PPMCO must demonstrate in the appropriate committee meeting minutes specific review and approval of delegated claims activities reports from all applicable delegates no less than semi-annually or more frequently based upon the MCO's policies. Documentation must specify the report approved and time frame, such as Superior Vision's third quarter 2016 claims activities report.

RHMD Opportunities/CAPs:

Component 3.3b: The CY 2015 SPR findings noted that in order to receive a met RHMD was required to develop a CAP to demonstrate formal review and approval of delegate quarterly complaint, grievance, and appeal reports on a quarterly basis by the appropriate committee (QIC) designated in the MCO's policy for each of the four quarters (fourth quarter of 2015 and first, second, and third quarters of 2016). QIC meeting minutes must reflect the specific delegated activity included in each delegate's report being approved. The CAP was not fully implemented and a continuing opportunity for improvement existed.

Superior Vision is the only known vendor delegated complaints, grievances, and appeals. QIC meeting minutes from March 24, 2016, documented review and approval of the DOC report. It did not specify the delegated entity, the quarter being reviewed or the specific delegated activity report approved as required. The QIC minutes of June 21, 2016, documented review and approval of the DOC report. Minutes reflected the review of first quarter reports and identified each vendor, but did not specify the reports reviewed/approved, only noting where standards were not met. In the draft QIC meeting minutes of September 20, 2016, the delegated entities were identified with a note that all standards were met. There was no mention of the quarter being reviewed or the specific delegated activity report reviewed. Additionally, there was no documentation of approval of any delegate reports. There was no evidence submitted of QIC review and approval of third quarter 2016 complaint, grievance, and appeals reports.

In order to receive a finding of met in the CY 2017 review, RHMD must demonstrate evidence in the QIC meeting minutes of review and approval of each delegate's quarterly complaint, grievance, and appeal reports on a quarterly basis noting the specific delegated activity(ies) and quarter included in the report being approved.

Component 3.3c: In the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, RHMD was required to demonstrate QIC review and approval of each delegate's claims activities reports at least semi-annually noting the specific delegated activity being approved in the minutes. RHMD did not meet these requirements and continuing opportunities for improvement exist.

Superior Vision and CVS Health are the only known vendor's delegated claims payment activities. QIC meeting minutes from March 24, 2016, documented review and approval of the DOC report. It did not specify the delegated entity, the quarter being reviewed or the specific delegated activity report approved as required. The QIC minutes of June 21, 2016, documented review and approval of the DOC report. Minutes reflected the review of first quarter reports and identified each vendor, but did not specify the reports reviewed/approved, only noting where standards were not met. In the draft QIC meeting minutes of September 20, 2016, the delegated entities were identified with a note that all standards were met. There was no mention of the quarter being reviewed or the specific delegated activity report reviewed. Additionally, there was no documentation of approval of any delegate reports. There was no evidence submitted of QIC review and approval of third quarter 2016, claims payment activities reports.

In order to receive a finding of met in the CY 2017 review, RHMD must demonstrate evidence in the QIC meeting minutes of review and approval of each delegate's claims activities reports at least semi-annually noting the specific delegated activity(ies) and time frame included in the report being approved.

Component 3.3e: In the CY 2015 SPR, findings noted that in order to receive a met RHMD was required to demonstrate QIC review and approval of each delegate's over and under utilization reports at least semi-annually, noting the specific delegated activity being approved in the minutes. A continuing opportunity for improvement existed.

CVS Health is the only known UM delegated entity. QIC meeting minutes from March 24, 2016, documented review and approval of the DOC report. It did not specify the delegated entity, the quarter being reviewed or the specific delegated activity report approved as required. The QIC minutes of June 21, 2016, documented review and approval of the DOC report. Minutes reflected the review of first quarter reports and identified each vendor, but did not specify the reports reviewed/approved only noting where standards were not met. In the draft QIC meeting minutes of September 20, 2016, the delegated entities were identified with a note that all standards were met. There was no mention of the quarter being reviewed or the specific delegated activity report reviewed. Additionally, there was no documentation of approval of any delegate reports. There was no evidence submitted of QIC review and approval of third quarter 2016, over and under utilization reports.

In order to receive a finding of met in the CY 2017 review, RHMD must demonstrate evidence in the QIC meeting minutes of review and approval of each delegate's over and under utilization reports at least semi-annually, noting the specific delegated activity(ies) and time frame included in the report being approved.

UHC Opportunities/CAPs:

Component 3.3c: UHC did not provide documentation to demonstrate compliance with appropriate committee (SQIS) review and approval of delegated entities' (March Vision) claims payment activities reports at least semi-annually for the CY 2016 review. The MCO incorrectly reported in its UHC Standard 3 Narrative that this component was deemed based on CY 2015 SPR.

Subsequent to the initial submission, UHC provided additional documentation to demonstrate compliance. Review of SQIS minutes throughout 2016 documented the following:

- February 25, 2016 meeting - Review of November and December 2015, March Vision claims volume only. Approval of scorecard (monthly service levels) documented.
- April 27, 2016 meeting - Review of first quarter 2016, March Vision claims processing activities. Approval of scorecard (monthly service levels) documented.
- August 31, 2016 meeting - Review of second quarter 2016, monthly service levels, however, no specific documentation of claims activities. Approval of scorecard (monthly service levels) documented.
- December 7, 2016 - Review of third quarter 2016, March Vision claims processing activities. Approval of scorecard (monthly service levels) documented.

In order to receive a finding of met in the CY 2017 review, UHC must demonstrate that all delegates' claims activities reports are specifically reviewed and approved by the appropriate committee at least semi-annually or more frequently as required by the MCO's policies. Approvals should consistently document specific reports and time frames reviewed, such as review and approval of the third quarter 2016 March Vision claims activities report.

FOLLOW-UP:

- ACC, KPMAS, MSFC, PPMCO, RHMD, and UHC were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- PPMCO and RHMD will provide quarterly updates on the CAP for component 3.3b to Delmarva Foundation in adherence with DHMH's Quarterly Monitoring Policy.
- The approved CAPs will be reviewed in CY 2017.

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:

For Component 4.4i Adherence to the time frames set forth in the MCO's policies regarding credentialing date requirements, one MCO had an opportunity for improvement and required a CAP: UHC – Partially Met

For Component 4.8e Meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements, one MCO had an opportunity for improvement and required a CAP: RHMD – Partially Met

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 was one minor issue identified with the recredentialing process within this review; however, the MCOs evidence strong oversight in credentialing and recredentialing processes.

MCO Opportunity/CAP Required

UHC Opportunities/CAPs:

Component 4.4i: One of 10 records reviewed did not meet compliance with the time frames for processing provider applications which is required within 120 days from the date the 30-day notification letter was sent to the provider. For this record, the application was processed 138 days from the date of the 30-day notice.

An additional 20 initial credentialing records were reviewed to assess compliance with credentialing time frame requirements. Of these additional records, 1 did not meet the 120-day processing requirement; instead it took 134 days to credential the provider.

Follow-up documentation and interviews with UHC credentialing and compliance staff indicate that the NCC experienced a high inventory of providers requiring credentialing in late 2015 to early 2016. This inventory was greater than the capacity available to process the volume. As a result, the timeliness of some of the initial credentialing files fell outside of the standard timeliness requirement to process an application. In order to respond to the 2015 CAP, UHC enhanced internal credentialing monitoring processes by hiring new staff and conducting real-time tracking of all initial credentialing against required turnaround times.

Data provided by the NCC in the document, Maryland Provider Credentialing 2016 Avg Days TAT, reveals that the high inventory was addressed; all provider applications for initial credentialing, from February 2016 through December 2016, were completed within 120 days. The trends show that TAT has gone from over 120 days for nine percent of applications in January 2016 (the remaining 91% at 72 days) to an average TAT of 14 days with 100% compliance for all records.

In order to receive a finding of met in the CY 2017 review, UHC must continue tracking the timeliness of the initial credentialing application process to ensure that 100% of applications are processed within 120 days from the date the 30-day notification is sent to the provider.

RHMD Opportunities/CAPs:

Component 4.8e: In a review of 10 recredentialing records, there were 2 that did not meet the required 36-month time frame for a decision date. The first record had a prior credentialing date of July 24, 2013, and the most recent recredentialing approval was August 17, 2016. The second record had a prior credentialing date of January 24, 2013, and March 30, 2016, for the recredentialing cycle.

An additional 20 recredentialing records were requested specifically for the review of compliance with the 36-month decision date requirement. Of these 20, all were processed within 36 months of the prior credentialing date.

In order to receive a finding of met in the CY 2017 review, RHMD must implement a process for monitoring timeliness of recredentialing to ensure that all required time frames are met.

FOLLOW-UP:

- UHC and RHMD were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submission.
- RHMD will provide quarterly updates on the CAP for component 4.8e to Delmarva Foundation in adherence with DHMH's Quarterly Monitoring Policy.
- The approved CAPs will be reviewed in CY 2017.

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:

For Component 5.6d The MCO includes the Continuity of Health Care Notice in the new enrollee packet, one MCO had an opportunity for improvement and required a CAP: ACC - Unmet

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.

MCO Opportunity/CAP Required

ACC Opportunities/CAPs:

Component 5.6 d: ACC provided a draft of the member handbook that was pending DHMH approval for review; However, it was not clear whether the Continuity of Healthcare Notice was provided to enrollees or not.

In order to receive a finding of met in the CY 2017 review, ACC must provide a Continuity of Healthcare Notice in the new member packet.

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 in CY 2017.

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:

For Component 6.1d The MCO has documented review of the Enrollee Services Call Center performance, one MCO had an opportunity for improvement and required a CAP: KPMAS - Unmet

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.

MCO Opportunity/CAP Required

KPMAS Opportunities/CAPs:

Component 6.1d - In the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 review, KPMAS was required to develop a CAP to demonstrate review of Enrollee Services Call Center performance. The CAP implemented as a result of the CY 2015 SPR was not fully implemented and a continued opportunity for improvement exists.

Customer Call Center reports, including call center performance for each standard, are provided to the Senior Director of Medicaid Operations. Customer Call Center standards were included in the QMP. There was documentation that the review of call center performance metrics went through the quality committees, however, the policy states that they have an abandonment rate of 3% or less and the RQIC agenda and minutes state that they have an abandonment rate of 4% or less.

In order to receive a finding of met in the CY 2017 review, KPMAS must demonstrate consistency in the standard for abandonment rate percentage in all applicable policies, reports, and committee agendas and minutes.

FOLLOW-UP:

- KPMAS was required to submit a CAP for the above component. Delmarva Foundation reviewed and approved the submission.
- KPMAS will provide quarterly updates on the CAP for component 6.1d to Delmarva Foundation in adherence with DHMH's Quarterly Monitoring Policy.
- The approved CAP will be reviewed in CY 2017.

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:

For Component 7.4d There are well publicized and readily available appeal mechanisms for both providers and enrollees, one MCO had an opportunity for improvement and was required to submit a CAP: ACC – Unmet

For Component 7.4e Preauthorization and concurrent review decisions are made in a timely manner as specified by the State, the following three MCOs had opportunities for improvement and were required to submit CAPs:

- PPMCO - Unmet
- RHMD - Unmet
- UHC - Unmet

For Component 7.4f Appeal decisions are made in a timely manner as required by the exigencies of the situation, one MCO had an opportunity for improvement and was required to submit a CAP: PPMCO – Unmet

For Component 7.6c The MCO acts upon identified issues as a result of the review of the data, one MCO had an opportunity for improvement and was required to submit a CAP: RHMD – Unmet

For Element 7.7 The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department, the following three MCOs had opportunities for improvement and were required to submit CAPs:

- ACC – Partially Met
- RHMD – Partially Met
- UHC – Partially Met

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:

Component 7.3 d: In the CY 2015 SPR, findings noted that in order to receive a finding of met in the CY 2016 SPR, ACC was required to demonstrate that it has resolved all inconsistencies in appeal time frames for filing and resolution of expedited appeals in its policies, member handbook, and provider manual. There was no evidence that the CAP was implemented in CY 2016, therefore, continued opportunities for improvement existed.

The Member Appeals - MD Policy, last revised on November 9, 2016, states that members have 90 calendar days for filing an appeal from the date of Notice of Action. Preservice (non-emergency) appeals are to be resolved within 30 calendar days of receipt of the appeal and expedited appeals as expeditiously as the medical condition requires but no later than three business days from receipt of the request. Neither the provider manual nor the member handbook that were in place during CY 2016 was submitted for review to determine if the identified inconsistencies were resolved as planned.

Subsequent to the initial submission, ACC submitted additional documentation to demonstrate compliance. The draft 2016 provider manual included time frames for filing an appeal and resolving an expedited appeal that was consistent with the Member Appeals - MD Policy. The member handbook, revised October 2016, specified three business days for resolution of expedited appeals consistent with the above policy and draft provider manual, however, the time frame for filing an appeal was stated as 90 business days.

In order to receive a finding of met in the CY 2017 review, ACC must resolve the inconsistency in the time frame for filing an appeal which currently states 90 calendar days in the Member Appeals- MD Policy and the draft 2016

Provider Manual consistent with regulatory requirements and 90 business days in the 2016 member handbook.

Component 7.7: The Provider Payment Appeal Process Policy was updated to incorporate the IRO process available to providers who exhaust the MCO's internal appeal process. The IRO external review process outlined in this policy is consistent with all regulatory requirements with one exception. Following the stated requirement for the MCO to reimburse the provider for claims determined to be medically necessary by the IRO, including any interest, the policy further states that the MCO acknowledges that DHMH will deduct the amount from its future Medicaid payments plus the liquidated damage(s) and remit payment to the IRO. This language appears to suggest that provider payment will be deducted by DHMH from the MCO's future Medicaid payments rather than the fixed case fee in the event of non-payment by the MCO within the required time frame. In a later section the policy does include the correct requirements for MCO payment of the IRO invoice, time frame, and consequences including liquidated damages if payment is not made within the required time frame. This issue also was identified in the CY 2015 SPR.

As evidence of the establishment of an online account with the IRO and successful uploading capabilities, ACC submitted an email from the IRO requesting upload of case documentation and a final determination letter from the IRO relating to the case.

In order to receive a finding of met in the CY 2017 review, ACC must revise the Provider Payment Appeal Process Policy to eliminate language relating to provider payment that appears to imply that DHMH will deduct the amount from the MCO's future Medicaid payments in the event the IRO overturns the MCO's determination.

PPMCO Opportunities/CAPs:

Component 7.4 e: In the CY 2015 SPR, findings noted that in order to receive a finding of met in the CY 2016 SPR PPMCO was required to demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations. There was no evidence that the CAP was successfully implemented and continued opportunities for improvement existed.

No reports were submitted documenting determination and notification compliance results throughout CY 2016. The only documentation submitted was an updated CAP through September 2016.

Subsequent to the initial submission, PPMCO provided additional documentation of compliance results. Aggregate results were provided for CY 2016, which does not meet the requirement for no less than quarterly reporting of results. Additionally, results for this time frame did not meet the 95% compliance threshold. Compliance with determination time frames for urgent pre-service was reported as 46.03%, and 20.23% for non-urgent pre-service. Timeliness of notifications was reported as 100% for urgent pre-service and 99.69% for non-urgent pre-service.

In order to receive a finding of met in the CY 2017 review, PPMCO must demonstrate at least 95% compliance with COMAR time frame requirements for preauthorization determinations and notifications of adverse determinations. Compliance results must be reported on at least a quarterly basis.

Component 7.4 f: In the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, PPMCO was required to demonstrate compliance with State required time frames for appeal resolution or MCO time frames if more stringent. The CAP was partially implemented and continued opportunities for improvement existed.

The September Quarterly Update to the CAP for this component reported YTD compliance with appeal resolution time frames. Compliance with the resolution time frame for non-urgent appeals was documented as 98.2%. Compliance with expedited time frames was documented as 86.0%.

Subsequent to the initial submission, PPMCO provided additional documentation to demonstrate compliance. The Appeals Monthly Reporting Master document reported compliance with PPMCO's standard of 15 calendar days for non-urgent pre-service appeals at 98.1% overall with monthly results ranging from 95.4% to 99.5%. Compliance with PPMCO's standard of 36 hours (1 calendar day) for expedited pre-service appeals was reported as 86.7% overall with monthly results ranging from 71.4% to 100%.

In order to receive a finding of met in the CY 2017 review, PPMCO must demonstrate compliance with time frames for non-urgent and expedited appeals consistent with regulatory requirements or the time frames specified in their internal policies if more stringent.

RHMD Opportunities/CAPs:

Component 7.4 e: In the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, RHMD was required to demonstrate 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, MCO documents needed to be revised to reflect the regulatory time frames. Opportunities continue to exist to demonstrate compliance with regulatory time frames for pre-service determinations and adverse determination notifications and correct documentation of COMAR requirements within the MCO's policy.

The Turnaround Time Report Desktop Procedure outlines the process for monitoring compliance with determination and notification time frames through the Turnaround Time Report, the report fields, the compliance threshold, committee reporting, and the process for addressing opportunities for improvements. The MCO provided a sample Turnaround Time Report from October 2016, which demonstrated 93.37% compliance with the determination time frame, which is below the 95% threshold, and 97.65% compliance with notification time frames. The MCO did not submit the UM Program Structure and Processes Policy which was required to be revised to reflect notification time frames consistent with COMAR.

Subsequent to the initial submission RHMD provided additional documentation to demonstrate compliance. The UM Program Structure Policy includes a table specifying time frames for UM determinations and notifications. For non-urgent pre-service requests determination and notification time frames are consistent with regulatory requirements. For urgent pre-service requests the policy states that a notification is mailed to a member within 24 hours of the decision...and no later than 72 hours of receipt of the request. This is inconsistent with the regulatory requirement of 24 hours from the determination.

Consistent with the CAP requirements, compliance results were reported for fourth quarter 2016. The Turnaround Time Report for Q4 2016 Determinations included an overall compliance rate for the months of October, November, and December. Additional detail was provided reflecting inclusion of urgent concurrent and post service compliance results which are outside of the scope of this review. Non-urgent pre-service addressed the two business day requirement. Compliance results for the two business day requirement ranged from 83% to 92%. No results were identified for non-urgent pre-service requests which required additional clinical information. Compliance results for urgent pre-service requests ranged from 36% to 50%.

The Turnaround Time Report Q4 2016 Notifications included overall compliance results for the quarter and a breakdown which included urgent concurrent and post-service requests which are outside of the scope of this review. Compliance results for urgent pre-service was reported as 100% within two business days for the quarter. This time frame is inconsistent with the regulatory requirement of 24 hours from the determination. Compliance with non-urgent pre-service notification requirements was reported as 99.89% within two business days however, this is inconsistent with the regulatory requirement of 72 hours.

In order to receive a finding of met in the CY 2017 review, RHMC must demonstrate that it meets the 95% compliance threshold for determination and adverse determination notification time frames consistent with regulatory requirements on at least a quarterly basis. Additionally, the UM Program Structure and Processes Policy must be revised to demonstrate that the incorrect urgent pre-service notification time frame has been corrected to be in compliance with COMAR requirements.

Component 7.6 c: In the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, RHMD was required to demonstrate that the MCO acts upon UM related issues as a result of review of CAHPS® and Provider Satisfaction Survey results. As indicated below, the CAP was partially implemented.

According to the approved CAP submitted by RHMD in response to the CY 2015 findings, the CAHPS® Workgroup presented its proposed UM process interventions to the QIC on June 21, 2016, the QIC approved the interventions, and was to monitor progress at future meetings including September 20, 2016, and December 20, 2016. In reviewing the QIC minutes from the June 21, 2016, QIC meeting, it was noted that development and implementation of UM related interventions to address CAHPS®/Provider Satisfaction scores was deferred to the third quarter QIC meeting. In reviewing the draft minutes from that meeting held on September 20, 2016, and a slide from the Third Quarter Quality QIC Presentation, UM related interventions included a planned provider newsletter to include an article about what is required when submitting a formulary exception request and implementation of provider portal improvements. The minutes also mentioned a UM Satisfaction QIA. This March 2016 document included practitioner and member-related interventions with completion dates. There was no evidence that this QIA was presented to the QIC prior to the September 20, 2016, meeting.

In order to receive a finding of met in the CY 2017 review, RHMD must demonstrate that quarterly updates to the QIC are provided on the status of UM related interventions consistent with the approved CAP. Interventions should be implemented timely to have an impact on the scores in the next round of CAHPS® and Provider Satisfaction surveys.

Component 7.7: The Provider Appeals - IRO Request Policy was submitted which documents all required elements including establishment of an online account with the IRO, time frames for uploading requested case records, time frames for reimbursing the provider in the event of an overturn by the IRO, and the consequences in the event the MCO does not pay the fixed case fee if the IRO rules against the MCO. The policy also acknowledges the MCO's right to file an appeal in the event it receives an adverse decision from the IRO.

As evidence of compliance with IRO requests for case records, the MCO submitted an IRO online account screenshot that included requested date and received file date for several cases and the status of review.

In order to receive a finding of met in the CY 2017 review, RHMD must correct the apparent typo in its Provider Appeals-IRO Request Policy which states that any additional case-related documentation requested will be uploaded by the IRO rather than the MCO.

UHC Opportunities/CAPs:

Component 7.4 e: In the CY 2015 SPR, findings noted that in order to receive a met in the CY 2016 SPR, UHC was required to consistently demonstrate compliance with regulatory time frames for medical and pharmacy preservice determination and notifications. The CAP that was developed was only 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 October 2016. There were no requests which required additional clinical information; therefore compliance percentages were not reported for the seven calendar day time frame. Results are detailed for each area below.

In reviewing the PA medical TAT Compliance Report for 2016, compliance was reported as follows:

- Expedited determinations – 8 out of 10 months exceeded the 95% compliance threshold.
- Routine determinations within 2 business days – 9 out of 10 months met or exceeded the 95% threshold.
- Routine determinations within 7 calendar days – all 10 months exceeded the 95% compliance threshold.
- Written notification within 24 hours – 5 out of 10 months exceeded the 95% threshold and were at 100%; outlier months ranged from 67% to 75%.
- Written notification within 72 hours – 3 out of 10 months met or exceeded the 95% compliance threshold; outlier months ranged from 84% to 94%.

In reviewing the PA pharmacy TAT Compliance Report for 2016, compliance was reported as follows:

- Expedited determinations – all 10 months demonstrated 100% compliance.
- Routine determinations within 2 business days – all 10 months exceeded the 95% compliance threshold.
- Written notification within 24 hours – all 10 months exceeded the 95% compliance threshold (8 months at 100%).
- Written notification within 72 hours – all 10 months demonstrated 100% compliance.

UHC provided a CAP to address missed TAT compliance for letters which included actions and time frames for remediation.

Subsequent to the initial submission, UHC provided additional documentation; however, it did not provide any additional support to demonstrate compliance with regulatory time frames during CY 2016.

In order to receive a finding of met in the CY 2017 review, UHC must consistently demonstrate compliance with regulatory time frames for medical and pharmacy preservice determination and notifications at the 95% threshold.

Component 7.7: In the CY 2015 SPR, findings noted that in order to receive a finding of met in the CY 2016 SPR, UHC was required to demonstrate that the Independent Review Organization Policy includes all required components. Continued opportunities exist for demonstrating compliance with the requirements of this element.

As evidence of compliance with this element, the MCO submitted the Independent Review Organization Policy, revised December 1, 2015. As noted in the CY 2015 SPR, missing content includes the following MCO responsibilities:

- The requirement to establish an online account with the IRO and provide all required information through this account
- Upload the complete case record for each medical case review request within five business days of receipt of the request from the IRO
- Upload any additional case-related documentation requested by the IRO within two business days of receipt of notification of a request for additional information from the IRO
- Agree to pay the fixed case fee should the IRO rule against the MCO
- Acknowledge that DHMH will deduct the fixed case rate amount from the MCO's future Medicaid payments plus liquidated damaged according to the published schedule in the event the MCO does not pay the Contractor within 60 days of the release of the invoice
- Acknowledge that if the MCO receives an adverse decision from the Contractor it may file an appeal in accordance with COMAR 10.09.72.06.

As evidence of an executed agreement and compliance with IRO requirements UHC submitted a screenshot of the Active UHC Account on the IRO site showing the status and decision of specific UHC cases.

Subsequent to the initial submission, UHC submitted the MD Independent Review Organization Standard Operating Procedure which includes the time frames for submission of the case record and response to any additional documentation requests from the IRO. UHC also resubmitted the Independent Review Organization Policy with the same revision date as initially submitted and the same missing requirements.

In order to receive a finding of met in the CY 2017 review, UHC must demonstrate that it has a policy that includes all required components for supporting the IRO complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO.

FOLLOW-UP:

- ACC, PPMCO, RHMD, and UHC were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- ACC (7.4d), PPMCO (7.4e and 7.4f), RHMD (7.4e and 7.6c), and UHC (7.4e) will provide quarterly updates on the CAPs for Standard 7 to Delmarva Foundation in adherence with DHMH's Quarterly Monitoring Policy.
- The approved CAPs will be reviewed in CY 2017.

Conclusion

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. This is evident in the comparison of annual SPR results demonstrated throughout the history of HealthChoice.

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. The CY 2016 review provided evidence of the continuing progression of the HealthChoice MCOs to ensure the delivery of quality health care for their enrollees. For example, JMS, MPC, and MSFC received scores of 100% on the annual SPR in CYs 2013-2015 and JMS and MPC continued with perfect scores in the CY 2016 Interim Desktop SPR. Although numerical scores were not provided during this review, vast improvement was seen for each MCO compared to last year's performance scores in the areas of assessment where the MCOs had implemented corrective action as a result of identified opportunities for improvement.

Beginning in CY 2016, DHMH now requires that, according to its Quality Monitoring Policy, any MCO that has had a CAP for two or more consecutive years in the same element/component will be required to provide quarterly monitoring reports to Delmarva Foundation. Therefore, five MCOs (ACC, KPMAS, PPMCO, RHMD and UHC) are required to submit quarterly updates of their CAPs to Delmarva Foundation. Additionally, all CAPs will be reviewed on an annual basis.

Delmarva Foundation will conduct an Interim Desktop SPR in CY 2018 and its next comprehensive onsite SPR in CY 2019. To promote continuous quality improvement, DHMH and the EQRO may identify areas for focused review.