HealthChoice and Acute Care Administration
Division of HealthChoice Quality Assurance

Medicaid Managed Care Organization

Systems Performance Review

Statewide Executive Summary

Calendar Year 2015

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Delmarva Foundation
A Quality Health Strategies Company

CY 2015 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) 2015, which is HealthChoice's 18th year of operation. HealthChoice served over 994,087 enrollees during this period.

COMAR 10.09.65 requires that all HealthChoice MCOs comply with the SPR standards and all applicable federal and state laws and regulations. MCOs are given an opportunity to review and comment on the SPR standards 90 days prior to the beginning of the audit process. The eight MCOs evaluated for CY 2015 were:

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

*KPMAS joined HealthChoice in July of 2014. This is the MCO's second SPR.

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.

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

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; Code of Maryland Regulations (COMAR); the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care;" Public Health Code of Federal Regulations; and Department requirements. The HealthChoice and Acute Care Administration leadership and the Division of HealthChoice Quality Assurance (DHQA) approved the MCO performance standards used in the CY 2015 review before application.

The review team that performed the annual SPRs consists of health professionals: a nurse practitioner and two masters prepared reviewers. The team has a combined experience of more than 45 years in managed care and quality improvement systems, 35 years of which are specific to HealthChoice. The team completed the reviews and provided feedback to the DHQA and each MCO with the goal of improving the care provided to HealthChoice enrollees.

Methodology

For CY 2015, 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 2015, Delmarva Foundation provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2015 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 2015 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- CY 2015 Systems Performance Review Standards and Guidelines, including specific changes

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

During the on-site reviews in January and February of 2016, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion, exit conferences were held with the MCOs. The purpose of the conferences was to provide the MCOs with preliminary findings, based on interviews and all documentation reviewed. Notification was also provided during the exit conferences that the MCOs would receive a follow-up letter describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Delmarva Foundation; documents received were subsequently reviewed against the standard(s) to which they related.

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

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

Each element or component of a standard was of equal weight. A CAP was required for each performance standard that did not meet the minimum required compliance score, as defined for the CY 2015 review.

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

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

The following eleven performance standards were included in the CY 2015 review cycle:

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

For CY 2015, all MCOs (except for KPMAS) were expected to meet the compliance score of 100% for all standards. The KPMAS compliance score was set at 90% for its second SPR. The MCOs were required to submit a CAP for any standard that did not meet the minimum compliance score.

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 must submit a CAP which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the preliminary report. CAPs are reviewed by Delmarva Foundation and determined to be adequate only if they address the following required elements and components:

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

In the event that a CAP is deemed unacceptable, Delmarva Foundation will provide technical assistance to the MCO until an acceptable CAP is submitted. Five MCOs were required to submit CAPs for the CY 2015 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

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

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2016 will determine whether the CAPs from the CY 2015 review were implemented and effective. In order to make this determination, Delmarva Foundation will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

Findings

The HealthChoice MCO annual SPR consists of 11 standards. The compliance threshold established by DHMH for all standards for CY 2015 is 100% for all MCOs, except for KPMAS for which the compliance threshold is set at 90% for its second SPR.

All eight HealthChoice MCOs participated in the SPR. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. If the MCO's score was below the minimum threshold, a CAP was required. Three MCOs (JMS, MPC, and MSFC) received perfect scores in all standards. Five MCOs (ACC, KPMAS, PPMCO, RHMD, and UHC) were required to submit CAPs for CY 2015. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Table 2 provides for a comparison of SPR results across MCOs and the MD MCO Compliance for the CY 2015 review.

Table 2. CY 2015 MCO Compliance Score

Standard	Elements Reviewed	MD MCO Compliance Score	ACC	JMS	KPMAS+	MPC	MSFC	PPMCO	RHMD	UHC
1 Systematic Process	36	100%	100%	100%	100%	100%	100%	100%	100%	100%
2 Governing Body	12	**99%***	100%	100%	100%	100%	100%	100%	**96%***	100%
3 Oversight of Delegated Entities	**7**	**93%***	100%	100%	100%	100%	100%	**90%***	**60%***	100%
4 Credentialing	42	**99%***	**99%***	100%	100%	100%	100%	100%	**96%***	**99%***
5 Enrollee Rights	25	**99%***	100%	100%	94%	100%	100%	**98%***	100%	100%
6 Availability and Access	10	**98%***	100%	100%	**80%***	100%	100%	100%	100%	100%
7 Utilization Review	24	**94%***	**84%***	100%	98%	100%	100%	**89%***	**91%***	**93%***
8 Continuity of Care	6	100%	100%	100%	100%	100%	100%	100%	100%	100%
9 Health Education Plan	12	**95%***	100%	100%	100%	100%	100%	**92%***	**92%***	**79%***
10 Outreach Plan	14	**96%***	100%	100%	**71%***	100%	100%	100%	100%	100%
11 Fraud and Abuse	19	**98%***	100%	100%	94%	100%	100%	100%	**89%***	100%
Composite Score		**98%↑**	**98%↑**	**100%**	**95%↑**	**100%**	**100%**	**98%↑**	**95%↓**	**98%↑**

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

For each standard assessed for CY 2015, the following section describes the requirements reviewed; the results, including the MD MCO compliance score; the overall MCO findings; the individual MCO opportunities for improvement and CAP requirements, if applicable; and follow up, if required.

STANDARD 1: Systematic Process of Quality Assessment/Improvement

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

Results:

- All MCOs received compliance ratings of 100%.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 90%.

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

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 2: Accountability to the Governing Body

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

Results:

- The overall MD MCO Compliance Score for CY 2015 was 99% which was an increase over the CY 2014 Compliance Score of 96%.
- ACC, JMS, KPMAS, MPC, MSFC, PPMCO, and UHC met the minimum compliance threshold for this standard.
- RHMD received a compliance score of 96%, and was required to submit a CAP.
- KPMAS received a compliance score of 100%, which was above the minimum compliance threshold of 90%.

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

MCO Opportunity/CAP Required

RHMD Opportunities/CAPs:

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

RHMD received a finding of partially met because according to the Health Services Management Program Description, the Quality Improvement Committee oversees all Health Services activities including review and approval of the Health Services Program Description. The Program Description outlines all UM activities. The Health Services Program Description was reviewed and approved by the BOD on October 26, 2015; however, the Quality Improvement Committee did not approve the Health Services Program Description.

There is evidence that Health Services Reports specific to UM activities were provided to the Quality Improvement Committee quarterly. For example, at the June 16, 2105 Quality Improvement Committee meeting, the Vice President of Health Services presented the Health Services quarterly report. It was noted that inpatient metrics are trending down for admits/1,000 members; average length of service; and days of care. The Medical Director pointed out that RHMD has enough historical data to establish a benchmark for admits/1,000 members, which will enable the Quality Improvement Committee to more effectively evaluate UM progress. The Chief Medical Officer

commented that the average length of stay for skilled nursing facilities is 17 days, which is too high; he recommended that this number be below 14 days. The reporting of various case management performance metrics also was evidenced at this Quality Improvement Committee meeting. For example, Case Management staff have not been notifying members of their right to opt out of Case Management, and this is an area needing improvement.

At the direction of the Quality Improvement Committee, a UM Committee was developed in July 2015. The committee has met monthly to address UM reporting needs and areas of under utilization of services.

In order to receive a finding of met in the next SPR, RHMD must ensure that the Quality Improvement Committee reviews and approves the Health Services Program Description within the first quarter of the year.

Follow-up:

- RHMD 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 2016.

STANDARD 3: Oversight of Delegated Entities

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

Results:

- The overall MD MCO Compliance Score was 93% for CY 2015 which was an increase over the CY 2014 Compliance Score of 90%.
- ACC, JMS, KPMAS, MPC, MSFC, and UHC met the minimum compliance threshold for this standard.
- PPMCO received a compliance score of 90%, and was required to submit a CAP.
- RHMD received a compliance score of 60%, and was required to submit a CAP.
- KPMAS received a compliance score of 100%, which was above the minimum compliance threshold of 90%.

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

PPMCO Opportunities/CAPs:

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

PPMCO received a finding of partially met because although there was evidence of quarterly review of Superior Vision complaint and grievance reports, there was inconsistent documentation of Process Management Team approval of these reports. Superior Vision reports were presented to the Process Management Team on April 9, 2015 (fourth quarter 2014); July 9, 2015 (first quarter 2015); October 8, 2015 (second quarter 2015); and December 10, 2015 (third quarter 2015). Only the minutes from April 9, 2015, and October 8, 2015, document formal acceptance/approval of the report.

Subsequent to the review, PPMCO provided the Medical Policy Committee with Executive Summaries that included a summary of Process Management Team minutes from specified meetings. The Medical Policy Committee Executive Summary from September 4, 2015, summarized minutes from the July Process Management Team meeting and noted that required delegation reports were accepted with no identified deficiencies. The specific delegate, delegated activity, and report time frame were not identified. This documentation is inadequate in demonstrating formal approval of quarterly delegate reports. The finding, therefore, remained partially met.

In order to receive a finding of met in the next SPR, PPMCO must document in the appropriate committee meeting minutes, formal quarterly review and approval of quarterly complaint, grievance, and appeal reports from all applicable delegates.

RHMD Opportunities/CAPs:

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

RHMD received a finding of unmet for this component. In response to the CY 2014 SPR findings, RHMD was required to develop a CAP to provide evidence of formal review and approval of delegate quarterly complaint, grievance, and appeal reports on a quarterly basis by the appropriate committee designated in the MCO's policy for each of the four quarters (fourth quarter of 2014 and first, second, and third quarters of 2015.) As indicated below, the CAP was not fully implemented and a continuing opportunity for improvement exists.

There was evidence of the Quality Improvement Committee's quarterly review and approval of Superior Vision reports for each quarter; however, neither the minutes nor the attached Delegated Oversight Committee report consistently reflect the specific delegated activity included in the report. Minutes are generally limited to a notation that all standards were met.

In order to receive a finding of met in the next SPR, RHMD must demonstrate evidence in the appropriate committee(s) meeting minutes of the review and approval of each delegate's complaint, grievance, and appeals report noting the specific delegated activity(ies) included in the report.

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

RHMD received a finding of unmet for this component. In response to the CY 2014 SPR findings, RHMD was required to develop a CAP to provide evidence of formal review and approval of each delegate's annual UMP and UM criteria by the appropriate committee designated in the MCO's policy. As indicated below, the CAP was not implemented and a continuing opportunity for improvement exists.

According to the Vice President of Provider Relations, Caremark's UMP was received too late for the Delegated Oversite Committee and Quality Improvement Committee to complete its review in 2015. The plan is to bring this document to the Quality Improvement Committee in the first quarter of 2016. A copy of Caremark's UMP was provided with an effective date of May 2015 through May 2016.

In order to receive a finding of met in the next SPR, RHMD must demonstrate evidence of annual approval by the appropriate committee(s) of any delegated entity's UMP and criteria if UM is delegated.

Follow-up:

- PPMCO and RHMD were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2016.

STANDARD 4: Credentialing and Recredentialing

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

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

Results:

- The overall MD MCO Compliance Score was 99% for CY 2015 which was consistent with CY 2014.
- JMS, KPMAS, MPC, MSFC, and PPMCO met the minimum compliance threshold for this standard.
- ACC received a compliance score of 99%, and was required to submit a CAP.
- RHMD received a compliance score of 96%, and was required to submit a CAP.
- UHC received a compliance score of 99%, and was required to submit a CAP.
- KPMAS received a compliance score of 100%, which was above its minimum compliance threshold of 90%.

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

MCO Opportunity/CAP Required

ACC Opportunities/CAPs:

Component 4.8e - There is evidence that recredentialing is performed at least every three years and meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements.

ACC received a finding of partially met for this component because ACC's credentialing plan and policies appropriately indicate that recredentialing is to be performed at least every 36 months; however, in a review of 10 recredentialing records, all but 1 met the 36-month time frame for a decision date. The non-compliant record was

approved for recredentialing 3 weeks after the 36-month time frame. According to credentialing staff, this particular record fell out of compliance while staff were waiting for a provider to complete his non-disclosure paperwork.

As a follow-up to the SPR, ACC provided Delmarva with a spreadsheet used for tracking the status of recredentialing time frames. In 2015, a total of 641 Maryland providers were recredentialed by the ACC Credentialing Committee. Of these 641, 27 provider records did not meet the 36-month turnaround time for recredentialing, for a total compliance rate of 95.79%. Of the 27 records, 19 were recredentialed within 37 months, 5 within 38 months, and one each at 39, 40, and 42 months, respectively. Based on this data, the one record found non-compliant during the onsite SPR was not an outlier.

In order for this standard to be considered met during the next SPR, the sample selected for recredentialing must meet 100% compliance with the 36-month recredentialing turnaround time.

RHMD Opportunities/CAPs:

Component 4.8b - There is evidence that recredentialing is performed at least every three years and that it includes a review of available performance data.

RHMD received a finding of partially met because the recredentialing records reviewed included a review of quality of care issues but did not include a review of complaint data prior to a recredentialing decision.

In order for this component to be met during the next SPR, RHMD must incorporate both quality of care and quality of service/complaint data as part of recredentialing.

Component 4.9a - There is evidence that the recredentialing process includes a review of enrollee complaints.

RHMD received a finding of unmet for this component because in a review of recredentialing records, there was no indication that quality of service data, such as enrollee grievances against a practitioner, were considered in making the recredentialing determination. According to QI staff, all grievance data against practitioners is collected centrally by the Appeal and Grievance Department and reviewed by QI monthly for quality of care issues. While quality of care issues are considered at the time of credentialing, the process for also incorporating quality of service/grievance data is not in place.

In order for this component to receive a finding of met during the next SPR, RHMD must develop a process for reviewing enrollee grievances data prior to recredentialing practitioners/providers and incorporate this process into the Credentialing Plan and Policy.

UHC Opportunities/CAPs:

Component 4.8e - There is evidence that recredentialing is performed at least every three years and meets the time frames set forth in the MCO's policies regarding recredentialing decision date requirements.

UHC received a finding of partially met for this component because of the nine records reviewed, there were two that did not meet the time frames set forth in the MCO's policies regarding recredentialing within 36 months of the last approval.

In order for this component to be met in the next SPR, UHC must demonstrate that all recredentialing records meet the time frame for recredentialing within 36 months of the prior credentialing approval date.

Follow-up:

- ACC, RHMD, and UHC were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2016.

STANDARD 5: Enrollee Rights

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

Results:

- The overall MD MCO Compliance Score was 99% for CY 2015 which was an increase over the CY 2014 Compliance Score of 96%.
- ACC, JMS, KPMAS, MPC, MSFC, RHMD, and UHC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 94%, which exceeded its minimum compliance threshold of 90%.
- PPMCO received a compliance score of 98%, and is required to submit a CAP.

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

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

MCO Opportunity/CAP Required

PPMCO Opportunities/CAPs:

Component 5.1g - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR and the MCO adheres to the time frames set forth in its policies and procedures for resolving grievances.

PPMCO received a finding of partially met for this component because 1 of 30 grievance records were reviewed did not adhere to the time frames set forth in its policies and procedures for resolving complaints and grievances. The grievance record reviewed that fell out of compliance was regarding a member inquiring about a billing issue and was considered an administrative grievance. Although the MCO had 30 days to resolve, the grievance was not resolved within the regulatory time frame.

Subsequent to the review, PPMCO provided policies and procedures to support the grievance process, but 1 of the 30 records remained out of compliance with the time frames set forth in the MCO's policies and procedures.

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

Follow-up:

- PPMCO was required to submit a CAP for the above component. Delmarva Foundation reviewed and approved the submission.
- The approved CAP will be reviewed for compliance in CY 2016.

STANDARD 6: Availability and Accessibility

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

Results:

- The overall MD MCO Compliance Score was 98% for CY 2015 which was a decrease from the CY 2014 Compliance Score of 99%.
- ACC, JMS, MPC, MSFC, PPMCO, RHMD, and UHC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 80%, and was required to submit a CAP.

Findings: Overall, MCOs have established appropriate standards for ensuring access to care and have fully implemented a system to monitor performance against these standards. All MCOs have current provider directories that list providers that are currently accepting new participants along with websites and help lines that are easily accessible to members as well. Each MCO has an effective system in place for notifying members of wellness services.

MCO Opportunity/CAP Required

KPMAS Opportunities/CAPs:

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

KPMAS received a finding of unmet for this component. In the CY 2014 SPR, KPMAS cited the following telephone performance standards:

- ASA: < 30 seconds
- Call abandonment rate: < 3%
- Service level (% of calls answered within 30 seconds): > 80%

The Appointment Access Policy outlined two of three KPMAS telephone performance standards noted above. The policy also stated that statistics were reviewed daily and shared with call center supervision to address service levels not meeting goals.

This policy did not include a detailed methodology for specific monitoring, measures, and committees responsible for oversight of the performance standards.

In order to receive a finding of met in the next SPR, KPMAS must establish policies and procedures for the operation of its customer/enrollee services and have standards/indicators to monitor, measure, and report on its performance.

Component 6.1d - 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 has documented review of the Enrollee Services Call Center performance.

KPMAS received a finding of unmet for this component because Customer Call Center reports, including call center performance for each standard, are provided to the Senior Director of Medicaid Operations. It was recommended in the CY 2014 SPR that Customer Call Center standards be included in the QMP. Upon interview, KPMAS stated that the call metrics were included in the Quality Work Plan Evaluation for 2015. In the MCO response, KPMAS stated that the metrics were cited in the work plan; however, there were no call center performance metrics in the Medicaid Work Plan document provided. Also, documentation of review of the call center performance metrics is needed through the quality committees.

In order to receive a finding of met in the next SPR, KPMAS must provide documentation of the review of enrollee services call center performance.

Follow-up:

- KPMAS was required to submit a CAP for the above components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAP will be reviewed for compliance in CY 2016.

STANDARD 7: Utilization Review

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

Results:

- The overall MD MCO Compliance Score was 94% for CY 2015 which was an increase over the CY 2014 Compliance Score of 92%.
- JAI, KPMAS, MPC, and MSFC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 98%, which exceeded its minimum compliance threshold of 90%.
- ACC, PPMCO, RHMD, and UHC received compliance scores of 84%, 89%, 91%, and 93%, respectively. These MCOs were required to submit CAPs.

Findings: Overall, MCOs have strong Utilization Management Plans that describe procedures to evaluate medical necessity criteria used, information sources, procedures for training and evaluating staff, monitoring of the timeliness and content of adverse determination notifications, and the processes used to review and approve the provision of medical services. The MCOs provided evidence that qualified medical personnel supervise pre-authorization and concurrent review decisions. The MCOs have implemented mechanisms to detect over and underutilization of services. Overall, policies and procedures are in place for providers and 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 7.3a - The written UR Plan has mechanisms in place to detect over utilization and under utilization of services. Services provided must be reviewed for over and under utilization.

ACC received a finding of unmet for this component. In response to the CY 2014 SPR findings, ACC was required to develop a CAP to demonstrate that the MCO reports utilization and evaluates opportunities for improvement in

meeting minutes of the designated committee(s) consistent with its UMP, work plan, and policies. As indicated below, an opportunity continues to exist in documenting review of services for over and under utilization.

As noted in prior reviews, the UMP Description includes as one of its goals to minimize and/or eliminate over and under utilization of medical and behavioral health services. The UM Work Plan for 2015 includes monitoring performance against the following indicators and indicator thresholds and evaluating quarterly for trends and identifying opportunities for improvement:

- Days per 1,000
- Average length of stay
- Admits per 1,000
- Readmission rate
- Emergency room visits per 1,000

The Over/Under-Utilization of Services Policy outlines the procedures for monitoring of over and under utilization of services, using aggregated data or nonidentifiable utilization reports produced on at least a quarterly basis. The results of reviews are to be reported to the Medical Advisory Committee and the Quality Management Committee. The results are used to help implement strategies to achieve utilization targets consistent with clinical and quality indicators and to identify fraud and abuse. Specific focus areas identified include:

- Acute/chronic care – readmissions, pharmaceuticals, specialty referrals, emergency room utilization, and home health and durable medical equipment utilization relative to diagnostic entity
- Preventive care – well-child/adult primary care provider visits, age-appropriate immunizations, mammograms, and blood lead level testing

According to the above policy, providers identified as having significant aberrant patterns of utilization are to be reviewed by the Medical Director and provider relations staff to determine actual utilization of services. An action plan for the provider and the health plan is to be developed by provider relations in collaboration with the Medical Director and discussed with the provider, as appropriate. Intervention strategies targeted at enhancing appropriate utilization practices are to be reviewed by Health Care Management Services and Quality Management Staff with the Medical Director. Member intervention for cases of member over utilization and under utilization is to be addressed through case management/care management and/or Health Education and outreach.

In reviewing Medical Advisory Committee minutes from seven meetings in 2015, only two meetings (March 16 and December 12) were found to have documented a review of UM metrics (IP only), which were reported by Temporary Assistance to Needy Families, Supplemental Security Income, and FAMCARE categories with notation of any trends as applicable.

In the Quality Management Committee minutes of November 4, 2015, it was reported that month-over-month emergency room visits identified as non-emergent have been monitored at the corporate level as well as locally via the emergency room work group. The Preventable Emergency Room Diagnosis list was noted as driving the data analysis. It was reported that 52% of all emergency room visits with diagnoses that met criteria did not need to be treated by the emergency room. Of these visits, 75% could have been managed by a primary care physician and 74% could have been treated at an urgent care center (overlapping denominators). The emergency room work group was assigned the task of further analysis of opportunities and reporting back to the Quality Management Committee.

In order to receive a finding of met in the next SPR, ACC must demonstrate that it reports utilization and evaluates opportunities for improvement in meeting minutes of the designated committee(s) consistent with its UMP, work plan, and policies.

Component 7.3b - The written UR Plan has mechanisms in place to detect over utilization and under utilization of services. UR reports must provide the ability to identify problems and take the appropriate corrective action.

ACC received a finding of partially met for this component. In response to the CY 2014 SPR findings, ACC was required to develop a CAP to demonstrate that the designated committee(s) consistent with its UMP, UM Work Plan, and policies addresses both over and under utilization issues and takes appropriate action to address identified opportunities for improvement based upon an analysis of those issues. As indicated below, an opportunity continues to exist to identify over and under utilization problems and take appropriate corrective action.

There was no evidence that ACC identified utilization problems and implemented corrective action in any of the seven Medical Advisory Committee meeting minutes reviewed for 2015. The Director of UM confirmed that there was no such documentation in Medical Advisory Committee meeting minutes.

In the November 4, 2015, Quality Management Committee meeting there was evidence of discussion of a number of potential/actual areas of over and under utilization. For example, in relation to outpatient sleep studies it was noted that some research studies suggest that sleep disorders are more prevalent for adults, more prevalent in adults as they become overweight, and more prevalent in the African-American population. Based on this research it was reported that the prevalence for the ACC population should be about 20% rather than the current 2%. It was suggested that ACC providers may be underutilizing sleep studies but due to other issues impacting a large number of MCO members, sleep study utilization was not being prioritized at that time. In the interim, planned interventions included:

- Exploring provider education opportunities.
- Encouraging home and freestanding sleep study facilities.
- Monitoring for trends, opportunities for improvement, and over and under utilization.

Foot and back orthotics were also discussed in the above meeting, noting that these services were being provided for diagnoses not consistent with medical necessity criteria based on an analysis of claims data for the third quarter. In response, ACC reported that it had engaged corporate partners to discuss a pre-certification requirement for these services in 2016.

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

Component 7.3c - The written UR Plan has mechanisms in place to detect over utilization and under utilization of services. Corrective measures implemented must be monitored.

ACC received a finding of partially met for this component. In response to the CY 2014 SPR findings, ACC was required to develop a CAP to demonstrate that the designated committee(s), consistent with its UMP, UM Work

Plan, and policies, routinely monitors corrective measures that have been implemented in response to both over and under utilization issues. As indicated below, an opportunity continues to exist to demonstrate that monitoring of corrective measures is occurring as documented in meeting minutes of the appropriate committees.

There was no evidence that the MCO monitored corrective measures to address areas of over and/or under utilization based on review of Medical Advisory Committee minutes from seven meetings held in 2015. The Director of UM confirmed that there was no such documentation in Medical Advisory Committee meeting minutes.

In the Quality Management Committee minutes of March 4, 2015, an update was provided on the Readmission Reduction Initiative. This initiative analyzes Chesapeake Regional Information System for Patients data to identify Group 2 members admitted to participating hospitals. These members receive social worker or Case Management intervention for 30 days post discharge in an effort to decrease readmission. A year to date decrease in the readmission rate for three of the six participating hospitals was reported. It was determined that the increase at the remaining three hospitals was due to readmission needs for complex conditions, chemotherapy, and transplants. It was further reported that this initiative would be monitored for trend and an analysis of the rates of all participating hospitals. In the Quality Management Committee minutes of June 3, 2015, it was reported that the readmission rate for the stabilization team for all of 2014 was 10.8%. ACC reached out to 471 members in 2014; 249 were enrolled into the program and 185 graduated. Only 20 were readmitted, with most readmissions to University of Maryland Medical System, Sinai, and St. Agnes facilities.

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

Component 7.4d - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that there are well publicized and readily available appeal mechanisms for both providers and enrollees.

ACC received a finding of partially met for this component. ACC continues to use an easily understandable and comprehensive two-page question-and-answer form entitled Amerigroup Appeal Process to accompany all adverse determination letters. It details the types of reviews, provides instructions for requesting each type of review, and explains the appeal process available through the HealthChoice Enrollee Help Line.

These procedures are detailed in the Member/Provider Action Appeal Process – MD Policy that also outlines the information on the appeal process to be included in the member handbook.

Detailed, easily understandable information on appeals, including an explanation of the difference between a grievance and an appeal and time frames for resolution, was found in the most recent version (2015) of the member handbook. Similar information was included in the 2015 provider manual.

As noted in the CY 2014 review, there are some inconsistencies among the documents reviewed. For expedited appeals, the member handbook identifies a time frame of three calendar days for resolution, whereas the provider manual notes three business days and the Member/Provider Action Appeal Process – MD Policy states 72 hours.

Moreover, both the member handbook and the Member/Provider Action Appeal Process – MD Policy include a filing time frame of 90 business days while the provider manual states the filing time frame as 90 days.

In order to receive a finding of met in the next SPR, ACC must resolve the inconsistencies in the time frames for appeal filing and resolution of expedited appeals in all policies and member and provider materials.

Component 7.6c - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. The MCO acts upon identified issues as a result of the review of the data.

ACC received a finding of unmet for this component. In response to the 2014 review findings, ACC was required to develop a CAP to demonstrate in the appropriate committee minutes the actions ACC has taken in response to UM-related results from the CAHPS® and Provider Satisfaction surveys. Additionally, ACC was required to demonstrate routine monitoring of these actions. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

In the Quality Management Committee minutes of February 4, 2015, provider satisfaction with the UM process was reviewed. Although ACC noted that satisfaction goals were met, the MCO conducted a barrier analysis to identify additional opportunities for improvement. In response to identified barriers, ACC noted current and ongoing initiatives to improve timeliness of authorization process completion to include:

- Close monitoring of transitions during technology and system integration for identification of "glitches" or system disruptions.
- Actively participating in change management operational meetings and work groups.
- Defining reporting needs for ongoing workload re-balance and calibration.
- Defining and implementing monitoring of reports for state-mandated and NCQA-required determination and notification.

In analyzing opportunities to improve member satisfaction with UM processes, ACC focused on results from the Child CAHPS® survey since children represent nearly 64% of the membership. Opportunities to improve satisfaction were identified in response to the following survey items:

- Easy to get an appointment for child with specialist
- Easy to get care believed necessary for child

Identified barriers included:

- Specialty network limitations exist in certain geographic areas.
- High-demand participating specialists have limited schedule openings.
- Approval of non-contracted providers requires multiple hand-offs, needing process improvement.
- Health plan initiatives may have unintended impact on member's perception of satisfaction.

Actions to improve satisfaction included:

- Identifying geographic specialty provider gaps and collaborating with provider relations to address.
- Ongoing recruitment and retention of skilled associates.
- Reassessing and rebalancing workloads and training as needed to assure best practices.

- Defining reporting needs for ongoing monitoring of workload and staff recalibration to meet turnaround times.
- Maintaining ongoing process and technology improvement.
- Closely monitoring technologic integration/upgrades to identify potential disruptions to timeliness.
- Utilizing multi-disciplinary, cross-functional work groups to evaluate potential impact of programs and initiatives on members.
- Monitoring and reporting results of actions taken to improve member and provider satisfaction with UM.

A review of subsequent Quality Management Committee meeting minutes from 2015 found no evidence of quarterly reporting to the Quality Management Committee on the status of the interventions identified above. This is not consistent with the MCO's policy.

In order to receive a finding of met in the next SPR, ACC must demonstrate quarterly reporting to the Quality Management Committee on the status of interventions implemented to improve member and provider satisfaction with UM processes consistent with the MCO's policy.

PPMCO Opportunities/CAPs:

Component 7.4c - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that the reasons for decisions are clearly documented and available to the enrollee in easy to understand language.

PPMCO received a finding of partially met for this component. In response to the CY 2014 SPR findings, PPMCO was required to develop a CAP to demonstrate that reasons for review determinations are documented in language that is clearly understandable to the member in all adverse determination letters. As indicated below, the CAP was successfully implemented; however, an opportunity exists for improvement in accurate and clear documentation of the reasons for decisions and criteria utilized in adverse determination letters.

The Clinical and Administrative Denial Notification Policy outlines the content for denial letters to include the principal reason for the determination to deny in easily understood language and a statement of the specific criteria, guideline, or benefit provision used in rendering the decision.

A review of 10 member adverse determination letters demonstrated reasons for decisions were documented in easily understandable language. One of the letters, however, identified the Summary Plan Description as the guideline used for denial of a request for an electric wheelchair when the patient record documented the rationale for the denial was based on InterQual criteria. A second letter was unclear as to the reason for the adverse determination in response to a request for genetic testing for Pompe Disease and a test for Voltage-Gated Calcium Channel Antibody. The reason for the denial was based on lack of clinical review criteria, causing the tests to be considered experimental. However, statements such as "the Medical Director must be able to access appropriate relevant resources to assist them in making their decision" could potentially be confusing to the member.

In order to receive a finding of met in the next SPR, PPMCO must demonstrate that it identifies the correct criteria or guidelines utilized in making a review determination and that the rationale for the determination is clearly stated.

Component 7.4 e - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

PPMCO received a finding of unmet for this component. In response to the CY 2014 SPR findings, PPMCO was required to develop a CAP to demonstrate consistent compliance with preauthorization determination and adverse determination notification time frames specified by the State at the 95% threshold. This includes both medical and pharmacy authorization requests. Additionally, all policies that included time frames for preauthorization determinations and adverse determination notifications were to be revised to be consistent with COMAR requirements. Tracking of compliance was also required to demonstrate COMAR time frame requirements. As documented below, inconsistent compliance with required time frames indicates that the CAP was not fully implemented. PPMCO has not fully met this component for at least the last eight review cycles, with the exception of 2011, which was scored as baseline.

Two policies were reviewed that included determination and notification time frames: the Utilization Management Determination and Notification Timeframes Policy and the Step Therapy, Prior Authorization and Quantity Limits Policy. Both have been revised to ensure consistency with COMAR requirements.

The UM Turnaround Time for Pre-certification for Inpatient, Outpatient, and Pharmacy document reported compliance with determination and notification time frames by month throughout 2015. Compliance with decision time frames varied in 2015, with a high of 68% in January and December and a low of 47% in November. According to the new Senior Director of UM, who assumed this position in late 2015, several process changes have been implemented in addition to cross training, which is demonstrating improved compliance in 2016. Compliance with notification time frames consistently exceeded the 95% threshold in 2015.

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

Component 7.4 f - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that appeal decisions are made in a timely manner as required by the exigencies of the situation.

PPMCO received a finding of unmet for this component. In response to the CY 2014 SPR findings, PPMCO was required to develop a CAP to demonstrate consistent compliance with State-required time frames for appeal resolution. This component had not been met since the CY 2012 review. As indicated below, inconsistent compliance with required time frames indicates that the CAP was not fully implemented.

PPMCO has elected to develop time frames for appeal resolution that are more stringent than required by COMAR 10.09.71.05. The Member Appeal Policy requires expedited/urgent care appeals to be resolved within 36 hours of receipt at both first and second levels rather than the 3 business days specified by regulation. Whereas COMAR specifies a time frame for resolution of non-expedited appeals within 30 days, PPMCO has established a time frame of 15 calendar days for both first- and second-level routine pre-service appeals and 30 calendar days for first- and second-level post-service appeals. The policy also provides for a 14-calendar-day extension to allow the member to submit all applicable documentation for consideration in the appeal review. In response to recommendations from the CY 2014 review, PPMCO has revised the policy to explicitly state that appeal rights are also available for adverse determinations for initial pre-service requests. It has also revised the standard time frame for processing an appeal that does not meet criteria for an expedited appeal to 15 days rather than the 30 days incorrectly cited in the previous version. The current version of this policy no longer describes the process for

monitoring compliance with resolution time frames or the process and time frame for reporting compliance to the appropriate oversight committee.

The Priority Partners Member Appeals – Compliance document identifies compliance with resolution time frames for non-urgent pre-service, expedited pre-service, and post-service by month throughout 2015. Compliance for non-urgent pre-service appeals showed steady improvement from a low of 79% in January to 100% in December. Compliance for expedited pre-service appeals was reported at 100% for four months, including the last three months of 2015. According to the new Manager of Appeals, this improvement was achieved through new hires, cross training, and outsourcing emergency room appeals.

A review of a sample of 10 appeal records from CY 2015 revealed 100% compliance for six standard appeals and 0% compliance for expedited appeals.

It is recommended that PPMCO revise the Member Appeal Policy to describe the process for monitoring compliance with the appeal resolution time frames and the time frame for reporting compliance to the appropriate oversight committee.

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

RHMD Opportunities/CAPs:

Component 7.2e - The UR Plan specifies criteria for UR/UM decisions. There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM standards.

RHMD received a finding of unmet for this component because there was no evidence that UM staff receive annual training on the interpretation and application of Milliman Care Guidelines. According to the Vice President of Health Services, annual updates to Milliman Care Guidelines are circulated to the team and discussed at stand-up meetings. There was no documentation of this requirement in the Health Services Management Program Description or in any policy.

It is recommended that RHMD develop a policy or include in the Health Services Management Program Description the requirement for annual training of UM staff on the interpretation and application of medical necessity criteria.

In order to receive a finding of met in the next SPR, RHMD must demonstrate that UM staff receive annual training on the interpretation and application of medical necessity criteria.

Component 7.4e - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

RHMD received a finding of partially met for this component. In response to the CY 2014 SPR findings, RHMD was required to develop a CAP 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. As indicated below, an opportunity continues to exist to demonstrate compliance with regulatory time frames for preservice determinations and adverse determination notifications, a documented methodology, and plan documents consistent with COMAR time frames.

The UM Program Structure and Processes Policy, effective September 1, 2015, includes a table documenting the time frames for UM decisions and notifications. The time frame for written notification to members for non-urgent preservice requests is documented as within 24 hours of the decision and no later than within 15 days of the request. Written notification for urgent preservice requests is to occur within 24 hours of the decision and no later than within 72 hours of receipt of the request. These time frames continue to be inconsistent with COMAR 10.09.71.04, which requires preservice determinations within two business days of receipt of clinical information but not later than seven calendar days from the date of the initial request. Written notification of an adverse determination is to be provided to the enrollee within 24 hours for emergency, medically related requests and within 72 hours for non-emergency, medically related requests. The Health Services Management Program Description has been revised to reflect notification of an adverse determination consistent with regulatory time frames.

The Denial of Services Policy outlines the procedures for communicating an adverse determination to a member. The policy includes the requirement for providing a member with written notice of an adverse determination of a previously authorized service at least 10 days prior to termination, suspension, or reduction of the service.

The Health Services Management Program Description states that the Timeliness of Authorization of Services Report is reviewed at the Provider Advisory Committee. It further reports that the MCO adheres to the State-specified threshold for all prior authorization review decisions of 95%. A sample of prior authorization reviews is to be completed quarterly, using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.

As evidence of tracking compliance, the MCO provided an audit spreadsheet for 2015. According to the Vice President of Health Services, all adverse preservice determinations were audited in 2015 for compliance with required turnaround times. Preservice determinations resulting in an approval were not included in this audit, so compliance with decision turnaround times could not be determined. Compliance with adverse determination notification time frames met or exceeded the 95% threshold for the first three quarters of 2015 but fell below at 93% for the fourth quarter.

Subsequent to the onsite review RHMD provided the Case Audits Desktop Procedure, which requires that all adverse determinations be audited on a monthly basis. For purposes of compliance this is inadequate. Compliance with preservice determination time frames needs to be monitored and reported for approvals as well as adverse determinations. Additionally, the desktop procedure should clearly identify the separate time frames that are monitored, such as preservice requests with and without sufficient clinical information and notification of adverse determinations for expedited versus routine requests. If a sample is to be utilized, it must reflect use of the sample size calculator approved by DHMH.

In order to receive a finding of met in the next SPR, RHMD must demonstrate compliance with regulatory time frames for all preservice determinations, including both approvals and denials, and adverse determination notifications. The methodology for determining compliance must be clearly documented to provide necessary guidance to audit staff. Additionally, all applicable plan documents must reflect determination and notification time frames consistent with COMAR.

UHC Opportunities/CAPs:

Component 7.4e - For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that preauthorization and concurrent review decisions are made in a timely manner as specified by the State.

UHC received a finding of unmet for this component. In response to the CY 2014 SPR, UHC was required to develop a CAP to address ongoing opportunities for improvement in demonstrating consistent tracking and compliance with State-required time frames for determinations and notifications for medical and pharmacy services prior authorization requests. Although UHC has demonstrated considerable improvement in complying with State-required time frames, the CAP was not fully implemented and continuing opportunities for improvement exist as noted below.

The Initial Review Timeframes Policy includes state-specific time frames at the end of the policy. Determination and adverse determination notification time frames are identified and consistent with regulation. The policy also specifies that the MCO will give an enrollee written notice of any action, except for denials of payment which do not require notice to the enrollee, within 10 days before the action for termination, suspension, or reduction of a previously authorized covered service.

UHC provided separate tracking of compliance with determination and notification time frames for medical and pharmacy services, by month, throughout 2015. Results are detailed for each area below.

In reviewing the prior authorization medical turnaround time Compliance Report for 2015, compliance was reported as follows:

- Expedited determinations – 11 out of 12 months met or exceeded the 95% compliance threshold; the outlier month was at 92%. (Of note, 8 months were at 100%.)
- Routine determinations within 2 business days – all 12 months met or exceeded the 95% threshold.
- Routine determinations within 7 calendar days – 11 out of 12 months met or exceeded the 95% compliance threshold. The outlier month fell slightly below the threshold at 94%.
- Written notification within 24 hours – 9 out of 12 months were at 100% compliance; outlier months ranged from 67% to 83%.
- Written notification within 72 hours – 10 out of 12 months met or exceeded the 95% compliance threshold; outlier months were at 78% and 94%.

In reviewing the prior authorization pharmacy turnaround time Compliance Report for 2015, compliance was reported as follows:

- Expedited determinations – 5 out of 12 months met or exceeded the 95% compliance threshold; outlier months ranged from 75% to 94%. (Of note, the last 4 months of 2015 exceeded the threshold.)
- Routine determinations within 2 business days – 5 out of 12 months met or exceeded the 95% compliance

threshold; outlier months ranged from 63% to 93%. (Of note, the last 4 months of 2015 exceeded the threshold.)

- There were no requests that required additional clinical information, so no compliance percentages were reported for the seven calendar day time frame.
- Compliance with time frames for notification of adverse determinations was consistently reported at 100%.

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

Component 7.6c - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures. The MCO acts upon identified issues as a result of the review of the data.

UHC received a finding of partially met for this component. During the onsite review, there was no evidence that UHC acted upon identified issues as a result of review of member and provider satisfaction with UM processes as documented in the appropriate oversight committee meeting minutes consistent with its policy.

Subsequent to the onsite review, UHC provided additional information to demonstrate compliance with this component. However, this component remains partially met because no new initiatives were implemented as of the end of October 2015. Additionally, continuing initiatives did not appear to be based on quantifiable data or a root cause analysis, such as a Geo Access analysis that reflects the need for specific specialists within certain geographic areas.

The CAHPS® Work Plan, updated October 30, 2015, included three UM-related measures with an identified owner, strategies, tasks, and status. The status for each of these measures was listed as “not yet started.” An example of a UM-related measure was “Got an appointment for your child to see a specialist as soon as you needed.” A strategy was identified to outreach and provide onsite education for providers concerning appointment scheduling and access and availability standards. The task was listed as “provider outreach brochure and provider and member outreach script updates to review and educate on standards.”

The undated CAHPS® UM document identified continuing initiatives to address UM-related opportunities. For example, in response to results related to the child survey item “Got an appointment with a specialist as soon as needed” actions included continuing to perform GeoAccess mapping to ensure a sufficient number of specialists are available.

As evidence that the status of interventions is monitored, UHC submitted Service Quality Improvement Subcommittee meeting minutes from October 29, 2015, as a sample. No specific UM interventions were discussed; however, it was noted that a copy of the updated CAHPS® Work Plan would be distributed for review and e-vote after the meeting.

It is recommended that UHC provide a work plan specifically related to identified UM opportunities rather than scatter different initiatives over multiple documents.

In order to receive a finding of met in the next SPR, UHC must demonstrate that it acts upon and monitors identified issues in a timely manner as a result of review of both member and provider satisfaction with UM processes as documented in the appropriate oversight committee meeting minutes consistent with its policy.
Follow-up: ➢ ACC, PPMCO, RHMD and UHC were required to submit CAPs for the above components. Delmarva Foundation reviewed and approved the submissions. ➢ The approved CAPs will be reviewed in CY 2016.

STANDARD 8: Continuity of Care

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

Results:

- The overall MD MCO Compliance Score was 100% for CY 2015 which is consistent with CY 2014.
- All MCOs met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 90%.

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

MCO Opportunity/CAP Required

No CAPs were required.

Follow-up: No follow-up is required.

STANDARD 9: Health Education Plan Review

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

Results:

- The overall MD MCO Compliance Score was 95% for CY 2015 which was an increase of the CY 2014 Compliance Score of 82%.
- ACC, JMS, KPMAS, MPC, and MSFC receive a compliance score of 100%.
- KPMAS received a compliance score of 100%, which exceeded its minimum compliance threshold of 90%.
- PPMCO, RHMD, and UHC received compliance scores of 92%, 92%, and 79% respectively. These MCOs were required to submit CAPs.

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

MCO Opportunity/CAP Required

PPMCO Opportunities/CAPs:

Element 9.4 - The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.

PPMCO received a finding of unmet for this element. According to the Manager of Health Promotion and Wellness, Health Educators are made aware of members in special need of educational efforts through their routine interaction with practice sites. However, no documentation was provided to support this process or evidence that mechanisms are in place and functioning to identify members in special need of educational efforts.

Subsequent to the review PPMCO provided evidence that members in special need of educational efforts are referred for health education. For example, two referrals for members of the same family were submitted by the primary care physician for nutritionist services and weight-loss coaching. Additional documents submitted included the Population Assessment, which focused on special needs populations not the broader population in special need of educational efforts, and a listing of community presentations on health education topics.

In order to receive a finding of met in the next SPR, PPMCO must provide documentation of the process for identifying enrollees in special need of educational efforts, including evidence that mechanisms are in place and functioning.

RHMD Opportunities/CAPs:

Component 9.3a - The MCO's Health Education Plan must have a written methodology for an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.

RHMD received a finding of unmet for this component. In the CY 2014 SPR, it was noted that in order for RHMD to receive a finding of met in the CY 2015 SPR, it must provide evidence of a formal annual evaluation of the impact of the Health Education Plan on process and/or outcome measures. As noted below, the CAP was not implemented and a continuing opportunity for improvement exists.

The Health Education Plan states that RHMD evaluates its Health Education Plan annually through the QA Evaluation. It further states that recommendations to improve the education plan are presented to the Quality Improvement Committee and Provider Advisory Committee. The Health Education Plan documents several mechanisms used to assess the impact of the MCO's educational activities through analysis of data, including:

- EPSDT compliance, well-care visits
- HEDIS® results
- Appointment compliance and adherence
- Pharmacy compliance and adherence
- Readmission reports
- Educational tracking system reports
- Member profiles for high-risk membership

The 2015 Health Education Evaluation, 4th Quarter 2015, was submitted to demonstrate evidence of the evaluation of the implementation of health education activities and their impact on health outcomes. The overview consisted of a general description of wellness and preventive services; health education/disease management targeting of certain chronic conditions; pregnancy-related resources; and notifications sent to members diagnosed with asthma, diabetes, and hypertension who have not been prescribed the correct medication or who have not filled/refilled their prescription. Additionally, it was reported that in 2015 RHMD offered six webinars to its providers to educate them on the 2015 updates to the American Diabetes Association's Standards of Medical Care in Diabetes.

In the Results section of the evaluation the MCO reported that the program is evaluated using clinical data and satisfaction surveys, including:

- Recommendations from the Provider Advisory Committee on improving health education options for patients
- Consumer Advisory Board feedback
- Member evaluations
- CAHPS® results
- HEDIS® data

Qualitative feedback from the above stakeholders was included in the evaluation; however, there was no evidence of the impact of the Health Education Plan on process and/or outcome measures as required by this component. It was noted in the evaluation that HEDIS® data has been collected monthly for CY 2015, but RHMD did not yet have final HEDIS® rates available to identify trends in the effectiveness of its Health Education Plan.

In order to receive a finding of met in the next SPR, RHMD must demonstrate evidence of an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency department utilization, avoidable admissions, utilization of preventive health services, and clinical measures.

UHC Opportunities/CAPs:

Component 9.3a - The MCO's HEP must have a written methodology for an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.

UHC received a finding of unmet for this component. According to the Health Education Plan, UHC measures program outcomes in clinical, financial, and operational categories.

Clinical Outcomes:

- Adherence to disease-specific, evidence-based guidelines for all chronic conditions, as well as preventive and curative care measures
- Clinical markers and HEDIS®, such as lead, obesity, preventive health services, and body mass index falling within normal ranges
- Member and provider satisfaction survey

Financial Outcomes:

- Improved access to care
- Reduced emergency room encounters report
- Improved use of formulary and generic drugs

Operational Outcomes:

- Consistent improved results on member satisfaction surveys – CAHPS® 5.0H
- Engagement rate by Health Educator

Subsequent to the onsite review UHC provided additional documentation to demonstrate compliance; however, this component remains unmet. Documentation submitted comprised minutes from the December 10, 2015, Provider Advisory Committee meeting minutes demonstrating review/approval of the Health Education Plan; a summary of member attendance at four health education-related events held in December 2015; and examples of member evaluations of a Diabetes Education Program.

In order to receive a finding of met in the next SPR, UHC must demonstrate implementation of its written methodology for an annual evaluation of the impact of the Health Education Plan on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.

Element 9.4 - The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.

UHC received a finding of partially met for this element. The Health Education Plan states that early identification of the MCO's special needs populations is achieved via State and HEDIS® missed opportunity reports, primary care providers and self-referrals using the Customer Service or Care/Disease Management Departments, practitioner referrals, Health Risk Assessments (at the time of enrollment), Inpatient Case Management, state flags, pharmacy data, and retrospective claims analyses. These mechanisms identify not only special needs populations but also members in special need of educational efforts.

UHC's Universal Tracking Device software compiles information from multiple sources, including claims, laboratory, and pharmacy data, to predict the future risk of members' intensity and utilization of services. A member who has been identified as needing a service receives an auto or live voice message and then is mailed health education materials related to the identified condition.

The Health Education Plan also suggests a number of tactics to use in the event that a member is not complying with the treatment plan, such as:
Continuing to invite member to community events
Sending outbound reminder notifications
Sending auto-callers
Working to identify and understand the member's barriers to success
Problem solving for alternative solutions
Reporting noncompliance to the treating provider/specialist, offering potential solutions and integrating provider feedback

No documentation was provided to support that these mechanisms are in place and functioning.

In order to receive a finding of met in the next SPR, UHC must provide documentation to support mechanisms are in place and functioning to identify enrollees in special need of educational efforts.

Component 9.5c - The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide provider evaluations of health education programs.

UHC received a finding of unmet for this component. According to the Health Education Plan providers are given the opportunity to evaluate health education programs during the Provider Advisory Committee meetings and provider onsite visits. This information is to be included in the annual QI Program evaluation. The HEP further states that UHC network providers annually review the Health Education Plan to ensure enrollee educational sessions are appropriate for the targeted population.

As evidence of compliance the MCO submitted Provider Advisory Committee meeting minutes from December 10, 2015, that reported approval of the 2015–2016 Health Education Plan via e-vote. This is insufficient in demonstrating that providers evaluated the MCO's Health Education Plan.

The MCO also submitted a completed provider evaluation form relating to an outreach scheduling appointment initiative that did not appear to address health education.

In order to receive a finding of met in the next SPR, UHC must demonstrate that providers are given the opportunity to evaluate member educational sessions and the overall Health Education Plan.

Follow-up:

- PPMCO, RHMD, and UHC were required to submit CAPs for the above elements/components. Delmarva Foundation reviewed and approved the submissions.
- The approved CAPs will be reviewed in CY 2016.

STANDARD 10: Outreach Plan Review

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

Results:

- The overall MD MCO Compliance Score was 96% for CY 2015 which was an increase over the CY 2014 Compliance Score of 89%.
- ACC, JMS, MPC, MSFC, PPMCO, RHMD, and UHC receive a compliance score of 100%.
- KPMAS received a compliance score of 71%, which was below the minimum compliance threshold of 90%, and was required to submit a CAP.

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

MCO Opportunity/CAP Required

KPMAS Opportunities/CAPs:

Component 10.1a - The MCO has developed a written Outreach Plan that describes populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership.

KPMAS received a finding of unmet for this component. KPMAS provided no evidence to support compliance with this component.

In order to receive a finding of met in the next SPR, KPMAS must describe the membership demographics including, but not limited to:

- Where the largest portion of the members reside
- Adult versus child populations
- Breakdown of the identified special needs populations as cited in COMAR (a chart by county describing this information is not sufficient)
- The most common health conditions among its Maryland HealthChoice membership
- The barriers to health care for its Maryland HealthChoice members

Component 10.1b - The MCO has developed a written Outreach Plan that describes MCO's organizational capacity to provide both broad-based and enrollee-specific outreach.

KPMAS received a finding of unmet for this component. KPMAS outreach is primarily conducted through the Medicaid Office, the centralized onboarding unit, provider health care teams, and the Case Management team. These teams and units were partially described; however, each team/unit did not have complete descriptions including number of positions, position descriptions, and educational requirements.

In order to receive a finding a met in the next review, KPMAS must:

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

Component 10.1e - The MCO has developed a written Outreach Plan that describes Role of the MCO's provider network in performing outreach.

KPMAS received a finding of unmet for this component. KPMAS provided no evidence to support compliance with this component.

In order to receive a finding of met in the next SPR, KPMAS must have a written policy on the provider's role in performing outreach. KPMAS must have a mechanism in place to deliver these policies to the providers.

Component 10.1f - The MCO has developed a written Outreach Plan that describes MCO's relationship with each of the LHDs and ACCUs.

KPMAS received a finding of unmet for this component. KPMAS provided no evidence to support compliance with this component.

In order to receive a finding of met in the next SPR, KPMAS must have a relationship with each of the LHDs/ACCUs in each county of operation. KPMAS must have policies and procedures regarding referrals for outreach to members and those referrals should be tracked by the MCO.

Follow-up:

- KPMAS was required to submit a CAP for the above components. Delmarva Foundation reviewed and approved the submission.
- The approved CAP will be reviewed in CY 2016.

STANDARD 11: Fraud and Abuse

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

Results:

- The overall MD MCO Compliance Score was 98% for CY 2015 which was consistent with CY 2014.
- ACC, JMS, KPMAS, MPC, MSFC, PPMCO, and UHC met the minimum compliance threshold for this standard.
- KPMAS received a compliance score of 94%, which exceeded its minimum compliance threshold of 90%.
- RHMD received a compliance score of 89%, and was required to submit a CAP.

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

MCO Opportunity/CAP Required

RHMD Opportunities/CAPs:

Component 11.4c - The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with.

RHMD received a finding of unmet for this component. The CRC approved the administrative and management procedures (Compliance Plan) for RHMD. However, there was no evidence of review and approval of the delegated vendors' fraud and abuse plans by the designated committees (Delegated Oversight Committee and Quality Improvement Committee).

In order to receive a finding of met in the CY 2015 SPR, RHMD must determine which committee is responsible for review and approval of the vendors' fraud and abuse plans and clearly document such review and approval in the meeting minutes.

Component 11.4d - The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.

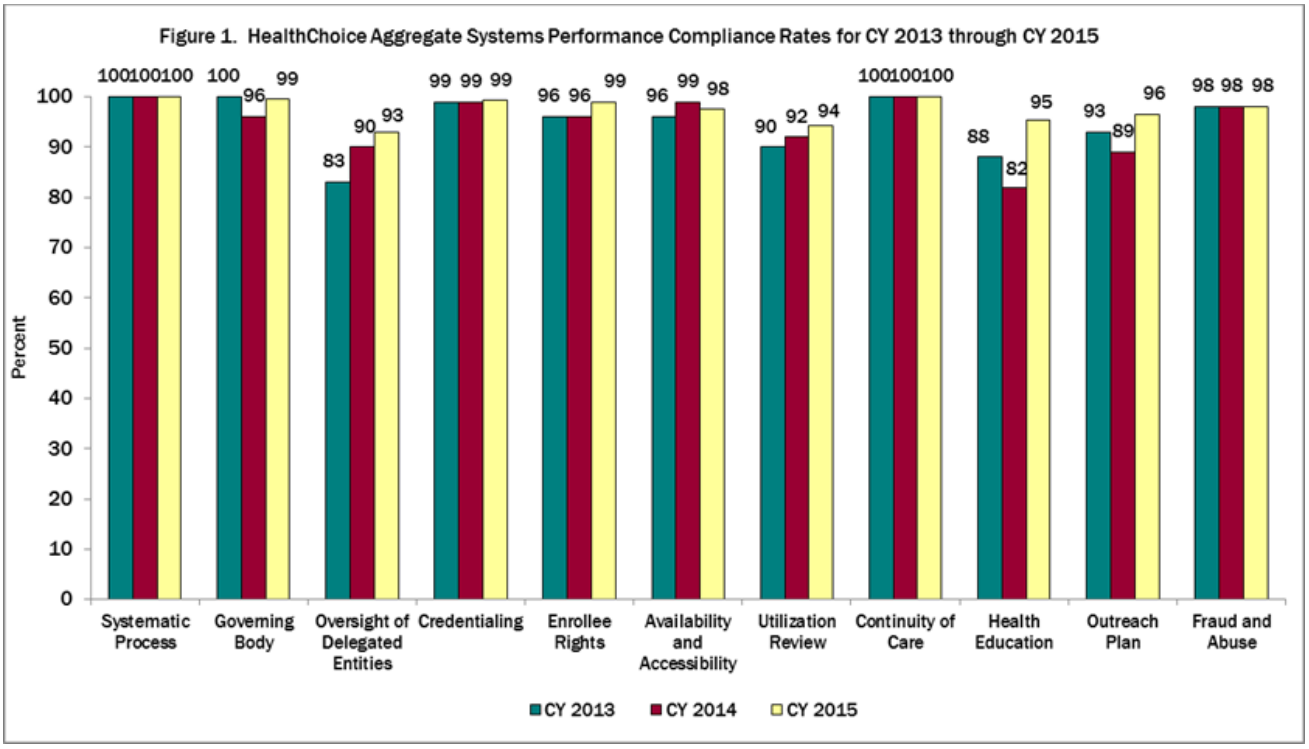
RHMD received a finding of unmet for this component. It is reported by the Director of Compliance that the delegate's fraud and abuse reports are to be reviewed by either the Delegated Oversight Committee or the Quality Improvement Committee. On review of both the Delegated Oversight Committee and the Quality Improvement Committee meeting minutes for 2015, it was determined that neither committee had noted review of these reports in the minutes.

In order to receive a finding of met in the next SPR, RHMD must provide evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities.

Follow-up:

- RHMD was required to submit a CAP for the above components. Delmarva Foundation reviewed and approved the submission.
- The approved CAP will be reviewed in CY 2016.

Figure 1 shows the HealthChoice Aggregate compliance rates from CY 2013 through CY 2015.



Between CY 2014 and CY 2015, the MD MCO compliance score increased for six standards (Governing Body, Oversight of Delegated Entities, Enrollee Rights, Utilization Review, Health Education, and Outreach Plan), remained unchanged for four standards (Systematic Process, Credentialing, Continuity of Care, and Fraud and Abuse), and decreased for one standard (Availability and Accessibility).

The overall MD MCO Composite Score increased to 98% in CY 2015 from 97% in both CY 2013 and CY 2014. It should be noted that KPMAS entered HealthChoice in mid-CY 2014, thus undergoing its second review during CY 2015.

Conclusion

Maryland has set high standards for MCO quality assurance systems. In general, 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. For example, JMS, MPC, and MSFC received scores of 100% on the annual SPR in CYs 2013-2015.

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. The CY 2015 review provided evidence of the continuing progression of the HealthChoice MCOs to ensure the delivery of quality health care for their enrollees. Two new MCOs (RHMD and KPMAS) entered the HealthChoice recently and promptly demonstrated a commitment to quality with SPR scores at 88% (RHMD) and 91% (KPMAS) in their first year reviews. A collaborative quality improvement relationship between the MCO, the Department, and the EQRO increased the scores of RHMD during their second year's review to 97% and KPMAS to 95% on the second review.

The CY 2015 SPR was the last comprehensive onsite review conducted on an annual basis. Going forward, the Department will require the EQRO to conduct comprehensive onsite SPRs every three years with exemption reviews in the interim years. CAPs will be reviewed on an annual basis. The EQRO will conduct its next comprehensive onsite SPR in CY 2019. To promote continuous quality improvement, the Department and the EQRO will identify areas for focused review.

MCOs new to HealthChoice will receive comprehensive onsite SPRs for three consecutive years after entering the program, regardless of the timing for legacy MCOs. Minimum compliance scoring for new MCOs is 80% for the first review, 90% for the second review, and 100% for the third review. Additionally, any MCO that does not meet the quality monitoring standards set forth by the Department will be required to receive a comprehensive onsite SPR.