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Qlarant®



**Maryland**

DEPARTMENT OF HEALTH

**HealthChoice**

Maryland's Medicaid Managed Care Program

**Medicaid Managed Care  
Organization**

**Interim Systems Performance  
Review**

**Statewide Executive Summary  
Report**

**Calendar Year 2019**

**Submitted August 2020**

# Maryland HealthChoice

## 2019 Interim Systems Performance Review

### Executive Summary

#### Overview and Introduction

Maryland's HealthChoice Program (HealthChoice) is a managed care program based upon a comprehensive system of continuous quality improvement including 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) 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 enrollees be provided health education and outreach services.

The Maryland Department of Health (MDH) is required annually to evaluate the quality of care provided to Maryland Medical Assistance enrollees in HealthChoice managed care organizations (MCOs). MDH, pursuant to Title 42, Code of Federal Regulations, 438.204, is responsible for monitoring the quality of care provided to MCO enrollees when delivered pursuant to the Code of Maryland Regulations (COMAR) 10.67.04.

Under Federal law<sup>1</sup>, MDH is required to contract with an external quality review organization (EQRO) to perform an independent annual review of services provided under each MCO contract to ensure the services provided to enrollees meet standards set forth in the regulations governing the HealthChoice Program. MDH contracts with Qlarant to serve as the EQRO. This executive summary report describes findings from calendar year (CY) 2019's systems performance review (SPR). HealthChoice served over 1,187,270 enrollees during its 21<sup>st</sup> year of operation.

COMAR 10.67.04 requires all HealthChoice MCOs to comply with SPR standards and all applicable federal and state laws and regulations. MCOs were given an opportunity to review and comment on the SPR standards 45 days prior to the beginning of the audit process. The nine MCOs evaluated for CY 2019 were:

- Aetna Better Health of Maryland (ABH)
- 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)
- UnitedHealthcare Community Plan (UHC)
- University of Maryland Health Partners (UMHP)

<sup>1</sup> Federal law - Section 1932(c)(2)(A)(i) of the Social Security Act

## Purpose and Process

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

Qlarant conducted CY 2019's assessment as an interim desktop review in response to MDH's decision to move to triennial rather than annual onsite reviews. Reviewers completed this assessment by applying the systems performance standards defined for CY 2019 in COMAR 10.67.04.03B(1). Standards requiring a corrective action plan (CAP) or scored as baseline in the CY 2018 review were the focus of CY 2019's SPR. Additionally, a sample review of appeal, grievance, adverse determination, and recredentialing (ABH only) records was conducted to assess compliance with applicable standards.

Performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; 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 before inclusion in the CY 2019 review.

The review team that performed the annual SPRs consisted of three masters prepared health care professionals. The team has a combined experience of more than 50 years in managed care and quality improvement systems, 40 years of which are specific to HealthChoice. Feedback was provided to the DHQA and each MCO with the goal of improving the care provided to HealthChoice enrollees.

## Methodology

For CY 2019, COMAR 10.67.04.03 required all HealthChoice MCOs to comply with SPR standards established by the Department and all applicable federal and state laws and regulations.

In September 2019, Qlarant provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for CY 2019 and invited the MCOs to direct any questions or issues requiring clarification to Qlarant and DHQA. The manual included the following information:

- Overview of HealthChoice Program
- SPR process
- CY 2019/2020 Review Timeline
- Qlarant Contact Listing
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- CY 2019 Systems Performance Review Standards and Guidelines, including specific revisions

Prior to the review, the MCOs were required to submit a completed pre-site survey form and provide documentation, written plans, and policies and procedure for various processes such as quality assurance and governance, delegation of activities, credentialing and recredentialing, enrollee rights, availability and accessibility, utilization review, continuity of care, health education, outreach, and fraud and abuse. Documents provided were reviewed by Qlarant.

During the desktop reviews conducted in January and February of 2020, the team reviewed all relevant documentation needed to assess the standards. A follow-up letter was provided to each MCO describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Qlarant; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the review, Qlarant documented its findings for each standard by element and component. The level of compliance for each element and component was documented with a review determination. A CAP was required for each performance standard that received a finding of “partially met” or “unmet.”

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

MDH had the discretion to change a review finding to “unmet” if the element or component had been found “partially met” for more than one consecutive year.

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

## Corrective Action Plans and Met Findings with Opportunities

The CAP process requires each MCO to submit a CAP which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the SPR final results. CAPs are reviewed by Qlarant and determined 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 evaluating each action item, including plans for evaluation
- Responsible party for each action item

In the event that a CAP is deemed unacceptable, Qlarant provides technical assistance to the MCO until an acceptable CAP is submitted. Eight MCOs (ABH, ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) were required to submit CAPs for the CY 2019 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Elements/components scored as “met with opportunity” (MwO) have been found compliant with the requirement(s) but with an opportunity to improve. While MwO findings do not require a CAP, those improvements will need to be addressed in order to receive a met finding in the next review period. This section also identifies areas that were met with an opportunity for improvement.

## Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The interim SPR for CY 2019 will determine whether the CAPs from the CY 2018 review were implemented and effective. In order to make this determination, Qlarant will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, MDH will be notified for further action.

MDH implemented its Performance Monitoring Policies following the 2016 SPR, whereby an MCO that had a CAP for two or more consecutive years in the same element/component would require quarterly monitoring by the EQRO. As a result of the CY 2018 SPR, one MCO (UMHP) was required to submit quarterly updates of their CAP to Qlarant. Progress was reported quarterly to MDH and after the CY 2019 SPR was conducted, Qlarant recommended that UMHP's quarterly CAP from CY 2018 be closed. Five MCOs (ABH, KPMAS, MPC, PPMCO, and UMHP) are required to begin submitting quarterly updates on the CAPs.

## Findings

If the MCOs did not receive a finding of "met" or "met with opportunity," for each standard, a CAP was required. One MCO (JMS) received findings of "met" or "met with opportunity" in all standards reviewed. Eight MCOs (ABH, ACC, KPMAS, MPC, MSFC, PPMCO, UMHP, and UHC) were required to submit CAPs for CY 2019. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

**Table 1. Elements/Components Requiring CAPs and Met with Opportunities**

Standard	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
<b>3</b> Oversight of Delegated Entities	3.3c 3.3e	3.1b	-	3.2 3.3a 3.3c	-	-	-	-	-
<b>5</b> Enrollee Rights	5.6c 5.6e	5.1h 5.6a	-	5.1g 5.1h 5.2 5.3d 5.5b	5.3d	-	5.1c 5.1g 5.6a	-	5.8e
<b>6</b> Availability and Access	6.1b 6.2a	-	-	-	6.1b 6.2a	-	6.2a 6.3c	-	6.1c 6.2a 6.3c
<b>7</b> Utilization Review	7.4c 7.5b 7.6a 7.6b 7.7c 7.7e 7.8c 7.11 a	7.4c 7.5b 7.6a 7.6b 7.7a 7.7c 7.8a 7.8c	7.5b 7.7a 7.7c	7.4c 7.5b 7.6a 7.6b 7.7a 7.7c 7.8c 7.9c	7.4c 7.6a 7.6b 7.7a 7.7c	7.7a 7.7c 7.8a	7.3c 7.4c 7.7a 7.7c 7.8a 7.8c 7.9c	7.4c 7.6 b 7.7c 7.8c 7.9 a	7.2f 7.4c 7.5b 7.7a 7.7c 7.8a 7.8c

Standard	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
<b>9</b> Health Plan Education	<b>9.3a</b>	-	-	-	-	-	-	-	-
<b>11</b> Fraud, Waste, and Abuse	11.1 f	-	-	11.4c	-	-	-	-	11.4c
	11.4 c	-	-	11.4d	-	-	-	-	-
<b>CAPs Required</b>	<b>5</b>	<b>3</b>	<b>0</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>1</b>	<b>4</b>
<b>MWOs</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>0</b>	<b>0</b>

Red represents quarterly updates are required on CAP per MDH Quality Monitoring Policy

Green represents MWO

For each standard assessed for CY 2019, the following section describes:

- Requirements reviewed
- Overall MCO results and findings (where applicable, refer to Appendix A for detailed MCO findings)
- Individual MCO improvement opportunities, CAP requirements, and met findings with opportunities, if applicable
- Follow-up, if required

### Standard 3: Oversight of Delegated Entities

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

**Results and Findings:** Three MCOs (ABH, ACC, and KPMAS) have improvement opportunities in the area of oversight of delegated entities. These MCOs require CAPs to become compliant for the CY 2020 SPR. One MCO (ABH) requires quarterly updates on a CAP as a continued opportunity from CY 2018.

**Table 2. Standard 3 Interim Desktop Review Results for CY 2019**

Element/ Component Reviewed	Element/Component Description	ABH	ACC	KPMAS
3.1b	The MCO must provide evidence of informing delegates and subcontractors of the grievance and appeal system.	-	PM	-
3.2	Written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided.	-	-	PM
3.3a	Oversight of delegated entities' performance to ensure quality of the care and/or service provided, through review of regular reports, annual reviews, site visits, etc.	-	-	UM
3.3c	Review and approval of claims payment activities at least semi-annually, where applicable.	PM	-	UM
3.3e	Review and approval of overutilization and underutilization reports, at least semi-annually, where applicable.	UM	-	-

PM=partially met, UM=unmet

Red represents quarterly updates are required on CAP per MDH Quality Monitoring Policy

#### Follow Up:

- ABH, ACC, and KPMAS were required to submit CAPs for the above components. Qlarant reviewed and approved the submissions.
- Approved CAPs will be reviewed in the CY 2020 SPR.

ABH will provide quarterly updates on the CAPs in CY 2019 for 3.3c and 3.3e, in adherence with MDH's Quality Monitoring Policy.

## Standard 5: Enrollee Rights

**Requirements:** MCOs must demonstrate a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities. The MCO must have a system linked to the Quality Assurance Program for resolving enrollees' grievances. This system must meet all requirements in COMAR 10.67.09.02 and 10.67.09.04. Enrollee information must be written to be readable and easily understood. This information must be available in prevalent non-English languages identified by MDH. The MCO must act to ensure 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 new enrollees receive required information within established time frames.

**Results and Findings:** Five MCOs (ABH, ACC, KPMAS, PPMCO, and UMHP) have improvement opportunities in the area of enrollee rights. These MCOs require CAPs to become compliant for the CY 2020 SPR. Two MCOs (KPMAS and PPMCO) require quarterly updates on the CAPs as a continued opportunity from CY 2018. Additionally, four MCOs (ACC, KPMAS, MPC, and PPMCO) received a finding of met with opportunities for improvement in the following elements/components to address for the CY 2020 SPR.

**Table 3. Standard 5 Interim Desktop Review Results for CY 2019**

Element/ Component Reviewed	Element/Component Description	ABH	ACC	KPMAS	MPC	PPMCO	UMHP
5.1c	The system ensures the resolution of a grievance is documented according to policy and procedure.	-	-	-	-	MwO	-
5.1g	The MCO adheres to regulatory timeframes for written acknowledgment and written resolution of all grievances, even if the resolution was previously provided verbally.	-	-	UM	-	UM	-
5.1h	The MCO ensures written resolution letters describe the grievance and the resolution in easy to understand language.	-	MwO	UM	-	-	-
5.2	The MCO shall provide access to health care services and information in a manner consistent with the formatting and special access requirements of COMAR 10.67.05.01C.	-	-	PM	-	-	-
5.3d	Must ensure the release of any information in response to a court order is reported to the patient in a timely manner.	-	-	PM	MwO	-	-
5.5b	As a result of the enrollee satisfaction surveys, the MCO: Implements steps to follow up on the findings.	-	-	MwO	-	-	-
5.6a	Policies and procedures are in place that address the content of new enrollee packets of information and specify the timeframes for sending such information to the enrollee.	-	UM	-	-	PM	-
5.6c	The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution.	PM	-	-	-	-	-
5.6e	The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.	PM	-	-	-	-	-

Element/ Component Reviewed	Element/Component Description	ABH	ACC	KPMAS	MPC	PPMCO	UMHP
5.8e	MCO's electronic information provided to members must meet requirements set forth in COMAR.	-	-	-	-	-	PM

MwO=met with opportunity, PM=partially met, UM=unmet

Red represents quarterly updates are required on CAP per MDH Quality Monitoring Policy

Green represents MwO

#### Follow up:

- Five MCOs were required to submit CAPs for the above noted components. Qlarant reviewed and approved the CAP submissions.
- The approved CAPs will be reviewed in CY 2020 SPR.

In accordance with MDH's Quality Monitoring Policy, KPMAS will provide quarterly updates on the CAPs in CY 2019 for 5.1g and 5.1h; PPMCO will provide quarterly updates on the CAPs in CY 2019 for 5.1g and 5.6a.

## Standard 6: Availability and Accessibility

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

**Results and Findings:** Four MCOs (ABH, MPC, PPMCO, and UMHP) have improvement opportunities in the area of availability and accessibility. These MCOs require CAPs to become compliant for the CY 2020 SPR. Two MCOs (MPC and UMHP) require quarterly updates on the CAPs as these are continued opportunities from CY 2018.

**Table 4. Standard 6 Interim Desktop Review Results for CY 2019**

Element/ Component Reviewed	Element/ Component Description	ABH	MPC	PPMCO	UMHP
6.1b	The MCO has processes in place to monitor performance against its access and availability standards at least quarterly.	PM	UM	-	-
6.1c	The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance.	-	-	-	UM
6.2a	The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population as specified in COMAR.	PM	PM	PM	PM

Element/ Component Reviewed	Element/ Component Description	ABH	MPC	PPMCO	UMHP
6.3c	Trending and analysis of data are included in the Quality Assurance Plan (QAP) and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.	-	-	UM	UM

PM=partially met, UM=unmet

Red represents quarterly updates are required on CAP per MDH Quality Monitoring Policy

#### Follow up:

- All four MCOs were required to submit CAPs for the above noted components. Qlarant reviewed and approved the CAP submissions.
- The approved CAPs will be reviewed in CY 2020 SPR.

In accordance with MDH's Quality Monitoring Policy, MPC will provide a quarterly update on the CAP in CY 2019 for 6.1b; UMHP will provide a quarterly update on the CAP in CY 2019 for 6.3c.

## 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 MCO has a comprehensive Utilization Review (UR) Plan that specifies criteria for UR/UM decisions. The UR Plan must have mechanisms in place to detect overutilization and underutilization of services. The MCO must also have policies and procedures pertaining to preauthorization decisions and demonstrates implementation. Adverse determination letters include a description of how to file an appeal. The MCO must be compliant with the requirements outlined in COMAR 10.67.09.04 pursuant to notification requirement for preauthorization denials. There must be written policies and procedure pertaining to enrollee appeals and provider appeals; 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; written policy and procedure outlining the compliant resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO including the process for explaining how providers receiving an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization designated by MDH. The MCO must have written policies and procedures for establishing a corrective managed care place for enrollee abuse of medical assistance pharmacy benefits consistent with MDH's corrective managed care plan.

**Results and Findings:** Eight MCOs (ABH, ACC, KPMAS, MPC, MSFC, PPMCO, UHC, and UMHP) have improvement opportunities in the area of Utilization Review. These MCOs require CAPs to become compliant for the CY 2020 SPR. One MCO (KPMAS) requires quarterly updates on the CAP as a continued opportunity from CY 2018. Six MCOs (ACC, JMS, KPMAS, MPC, MSFC, and PPMCO) received a finding of met with opportunities for improvement in the following elements/components to address for the CY 2020 SPR.

Table 5. Standard 7 Interim Desktop Review Results for CY 2019

Element/ Component Reviewed	Element/Component Description	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
7.2f	There is evidence that the MCO evaluates the consistency with which all staff involved apply UR/utilization management (UM) criteria on at least an annual basis.	-	-	-	-	-	-	-	-	PM
7.3c	Corrective measures implemented must be monitored.	-	-	-	-	-	-	MwO	-	-
7.4c	Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.	UM	PM	-	PM	PM	-	UM	PM	UM
7.5b	Adverse determination letters include all required components.	PM	PM	MwO	MwO	-	-	-	-	UM
7.6a	The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.	UM	MwO	-	UM	PM	-	-	-	-
7.6b	The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.	UM	UM	-	MwO	MwO	-	-	PM	-
7.7a	The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and 10.67.09.05.	-	PM	MwO	UM	UM	MwO	PM	-	UM
7.7c	The MCO must adhere to appeal timeframes.	PM	PM	MwO	PM	MwO	PM	PM	PM	UM
7.7e	Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.	UM	-	-	-	-	-	-	-	-

Element/ Component Reviewed	Element/Component Description	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
7.8a	The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.	-	PM	-	-	-	MwO	MwO	-	UM
7.8c	The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	UM	UM	-	UM	-	-	UM	PM	UM
7.9a	The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.	-	-	-	-	-	-	-	PM	-
7.9c	The MCO acts upon identified issues as a result of the review of the data.	-	-	-	UM	-	-	MwO	-	-
7.11a	The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation.	UM	-	-	-	-	-	-	-	-

MwO= met with opportunity, PM=partially met, UM=unmet

Red represents quarterly updates are required on CAP per MDH Quality Monitoring Policy

Green represents MwO

#### Follow up:

- Eight MCOs were required to submit CAPs for the above noted components. Qlarant reviewed and approved the CAP submissions.
- Approved CAPs will be reviewed in CY 2020 SPR.
- KPMAS (7.9c) will provide quarterly updates on the CAPs in CY 2019 in adherence with MDH's Quality Monitoring Policy.

In accordance with MDH's Quality Monitoring Policy, KPMAS will provide a quarterly update on the CAP in CY 2019 for 7.9c.

## Standard 9: Health Plan Education

**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. Educational activities must include health education on subjects affecting the health status of the enrollee population. The Health Education Plan must incorporate activities addressing the 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 and Findings.** All MCOs were exempt from review of the Health Education standard except for ABH. ABH received a finding of MwO for 9.3a to address for the CY 2020 SPR.

**Table 6. Standard 9 Interim Desktop Review Results for CY 2019**

Element/ Component Reviewed	Element/Component Description	ABH
9.3a	Have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.	MwO

MwO= met with opportunity  
Green represents MwO

### Follow Up:

- No CAPs were required.
- No follow up is required.

## Standard 11: Fraud and Abuse

**Requirements.** The MCO maintains a Medicaid Managed Care Compliance Program outline in 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 and Findings.** Three MCOs (ABH, KPMAS, and UMHP) have opportunities for improvement in the area of Fraud and Abuse. These MCOs will require CAPs in the following components to become compliant for the CY 2020 SPR.

**Table 7. Standard 11 Interim Desktop Review Results for CY 2019**

Element/ Component Reviewed	Element/ Component Description	ABH	KPMAS	UMHP
11.1f	A documented process to ensure services billed to the MCO were actually received by the enrollee.	PM	-	-
11.4c	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 the MCO contracts with.	PM	UM	PM
11.4d	Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.	-	UM	-

PM=partially met, UM=unmet

Red represents quarterly updates are required on CAP per MDH Quality Monitoring Policy

#### Follow-up:

- All three MCOs were required to submit CAPs for the above noted components. Qlarant reviewed and approved the CAP submissions.
- Approved CAPs will be reviewed in CY 2020 SPR.

In accordance with MDH's Quality Monitoring Policy, KPMAS will provide quarterly updates on the CAPs in CY 2019 for 11.4c and 11.4d; UMHP will provide a quarterly update on the CAP in CY 2019 for 11.4c.

## Conclusion

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. Although numerical scores were not provided in CY 2019, improvement was seen for three MCOs (ACC, KPMAS, MPC, and MSFC) and a slight decrease in performance was seen for one MCO (ABH). Three MCOs had findings that resulted in the same number of CAPs from the previous reporting year (PPMCO, UHC, and UMHP). JMS continued to receive a perfect score in the CY 2019 SPR.

Beginning in CY 2016, MDH implemented its Quality Monitoring Policy whereby any MCO that has had a CAP for two or more consecutive years in the same element/component is required to provide quarterly updates to Qlarant. In accordance with this policy, five MCOs (ABH, KPMAS, MPC, PPMCO, and UMHP) are required to submit quarterly updates of their CAPs to Qlarant. Additionally, all CAPs will be reviewed during the CY 2020 SPR.

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

Qlarant will conduct an interim desktop SPR for CY 2020 in January and February of 2021 with the next full onsite SPR review scheduled for January and February of 2022 (for SPR CY 2021).

## Appendix A

Included in Appendix A are detailed findings for each MCO for each standard reviewed, as applicable.

### Standard 3: Oversight of Delegated Entities

#### Findings

##### Aetna Better Health of Maryland (ABH)

**Component 3.3c:** In response to the CY 2018 review, ABH was required to provide evidence of review and approval of delegate claims payment activity reports by the designated committee (QMOC) at least semi-annually or more frequently as defined in the MCO's policies. As indicated below, the CAP was not fully implemented and a continued opportunity for improvement exists. Quarterly updates have been required as a result of noncompliance.

Quality Management Oversight Committee (QMOC) minutes demonstrated review and approval of claims activities reports from Superior Vision as follows:

- Fourth quarter 2018 - March 28, 2019
- First quarter 2019 - May 23, 2019
- Second quarter 2019 - September 30, 2019

QMOC minutes demonstrated review and approval of claims activities reports from CVS/Caremark as follows:

- Third and fourth quarter 2018 - March 28, 2019
- First quarter 2019 - July 25, 2019
- Second quarter 2019 - September 30, 2019
- Third quarter 2019 - November 21, 2019

Subsequent to the initial review, ABH reported that review and approval of the third quarter Superior Vision claims activities report occurred in the QMOC meeting of January 23, 2020. In practice, QMOC has been reviewing claims activities reports on a quarterly basis. As a result of the timing of the QMOC meetings, only three Superior Vision quarterly claims activities reports were reviewed and approved by QMOC in the calendar year under review.

In order to receive a finding of met in the CY 2020 review, ABH must provide evidence of review and approval of delegate claims payment activity reports by the designated committee (QMOC) at least semi-annually or more frequently as defined in the MCO's policies. There was no evidence that the QMOC reviewed and approved the third quarter 2019 claims activities report from Superior Vision in the calendar year under review.

Qlarant recommends that ABH consider revising the schedule of QMOC meetings to ensure four quarterly claims activities reports are reviewed and approved within the calendar year under review.

**Component 3.3e:** In response to the CY 2018 review, ABH was required to provide evidence of review and approval of delegate overutilization and underutilization reports by the designated committee at least semi-annually or more frequently as defined in the MCO's policies. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist. QMOC minutes demonstrated review and approval of overutilization and underutilization reports from EviCore as follows:

- Fourth quarter 2018 - March 28, 2019
- First quarter 2019 - July 25, 2019
- Second quarter 2019 - September 30, 2019

Subsequent to the initial review, ABH reported that review and approval of the third quarter EviCore overutilization and underutilization report occurred in the QMOC meeting of January 23, 2020. In practice, QMOC has been reviewing overutilization and underutilization reports on a quarterly basis. As a result of the timing of the QMOC meetings, only three EviCore quarterly overutilization and underutilization reports were reviewed and approved by QMOC in the calendar year under review.

In order to receive a finding of met in the CY 2020 review, ABH must provide evidence of review and approval of overutilization and underutilization reports from each UM delegate by the designated committee at least semi-annually or more frequently as defined in the MCO's policies. No evidence was provided of QMOC review and approval of the third quarter 2019 overutilization and underutilization reports from EviCore in the calendar year under review. Qlarant recommends that ABH consider revising the schedule of QMOC meetings to ensure four quarterly overutilization and underutilization reports are reviewed and approved within the calendar year under review.

## AMERIGROUP Community Care (ACC)

**Component 3.1b:** In response to the CY 2018 review, ACC was required to provide evidence that it informs delegates and subcontractors of the MCO's grievance and appeal system. As indicated below, continued opportunities for improvement exist.

ACC reportedly delegates services to the following entities:

- Superior Vision
- IngenioRx
- The Coordinating Center

ACC submitted Agreements/Amendments for each of these entities as evidence of compliance.

Exhibit F of the Amendment to the Superior Vision Agreement, effective December 1, 2019 (not fully executed), pertains to "Provider Complaints, Grievances, and Appeals Services Delegated Responsibilities." This exhibit outlines responsibilities of ACC and of the delegate. ACC's accountability for the grievance and appeal system and each step in the process is clearly listed within this exhibit.

The Amended Restated Pharmacy Benefit Management Services Agreement with Express Scripts, Inc. (ESI), effective January 1, 2012, does not contain any requirement for notifying the delegate of ACC's grievance and appeals system. Follow-up with ACC indicates that ACC no longer contracts with ESI. ACC submitted a copy of a letter to MDH indicating that it was transitioning from ESI to IngenioRX in May 2019. The document "Memorandum of Understanding Related to the Wellpoint, Inc. Amended and

Restated Master Administrative Services Agreement and IngenioRx, Inc. Services” effective May 1, 2019, includes a section which specifies that IngenioRx must comply with the federal and ACC's grievance and appeal system. There is no indication of what this system is.

Section 2.4 of The Coordinating Center's original agreement with ACC (November 2003) indicates that ACC will inform The Coordinating Center of grievance and appeal policies through the provider manual. ACC did not submit a copy of the relevant section of the provider manual to the delegate; there was no indication the delegate was made aware of or acknowledged receipt of current grievance and appeals procedures.

In order to receive a finding of met in the CY 2020 SPR, ACC must provide evidence of informing the Coordinating Center and IngenioRx of the MCO's grievance and appeal system. Specifically, ACC must do one of the following or both:

- Amend the Memorandum of Understanding with IngenioRx and the provider agreement with The Coordinating Center to outline ACC's grievance and appeal procedures. ACC's agreement with Superior Vision should serve as a model for what should be communicated to a delegate/subcontractor.
- Send an email to IngenioRx and The Coordinating Center attaching ACC's grievance and appeal policies or the relevant section of the provider manual or member handbook on grievance and appeal procedures. The delegate must acknowledge receipt of these documents.

### **Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)**

**Element 3.2:** In response to the CY 2018 review, KPMAS was required to clarify the responsibility of the Regional Quality Improvement Committee (RQIC) for quarterly review and approval of delegate reports consistent with the MCO's practice. As indicated below, a continued opportunity for improvement exists.

The KP Mid-Atlantic Medicaid Delegation and Monitoring Policy provides guidance for reviewing and monitoring various delegated subcontractual partners and on placing and remediating any CAPs needed as a result of failing to meet contractual requirements. The policy includes required content for delegation agreements, the process for delegation oversight, and CAP issuance and monitoring. Specifically, the policy states that the KPMAS Medicaid Oversight Review Board has final responsibility for oversight and CAP activities. The responsible functional area performs ongoing monitoring of all subcontractors and ensures compliance with subcontractual requirements. The responsible functional area also is required to perform a formal review of all subcontracts at least annually. As a result of monitoring activities conducted by the responsible functional area, subcontractor deficiencies or areas for improvement shall be identified and require the subcontractor to take appropriate corrective action. The policy further states that the Medicaid Oversight Review Board monitors Service Level Agreement compliance based on monthly and quarterly reports supplied by the delegated subcontractor. It is responsible for issuing CAPs and verifying when remediation is complete. The policy does not specify that the KPMAS committee has formal approval authority for required delegate reports including claims, complaints, grievances, and appeals, overutilization and underutilization reports, and annual Utilization Management Program (UMP) and criteria, as applicable.

The MD HealthChoice PBM Oversight Functions Policy outlines MCO processes to ensure appropriate oversight of its pharmacy benefit manager (PBM), which requires KPMAS to:

- Perform a pre-delegation assessment of the delegate prior to delegating any activities for the Maryland (MD) HealthChoice Program.
- Enter into a delegation agreement with the PBM prior to delegating any activities for the MD HealthChoice Program.
- At least annually, conduct a formal audit of the PBM to ensure compliance with MCO expectations and NCQA requirements.

The PBM Vendor Management business functional area, which lies within the Kaiser Foundation Health Plan of Southern California Pharmacy Benefits and Business Development Department, leads the PBM Oversight Committee. KPMAS Pharmacy Benefits and Quality representatives are members of this committee. PBM Oversight Committee findings should be reported to the KPMAS RQIC at least quarterly.

Specific responsibilities of the KPMAS Team include:

- Holding weekly account meetings with the PBM to assess and address areas of opportunities including, but not limited to, MD HealthChoice claims processing.
- Reviewing the PBM's performance guarantees and reports to assess compliance with delegated activities quarterly.
- Reporting any identified opportunities for improvement at the weekly account meetings with the PBM and escalating, as needed, to the National PBM Oversight Committee for resolution.
- Submitting findings and recommendations of the quarterly PBM Oversight Committee to the KPMAS RQIC Committee quarterly for regional review and approval.

In order to receive a finding of met in the CY 2020 review, KPMAS must specify in all delegation policies which KPMAS committee has responsibility for review and approval of required delegate reports and the frequency of review.

**Component 3.3a:** In response to the CY 2018 review, KPMAS was required to provide evidence of routine monitoring and oversight of all vendors at the local level with results specific to Maryland HealthChoice. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

KPMAS provided evidence of ongoing monitoring and oversight of Employers Mutual Inc. (EMI) and MedImpact in quarterly Medicaid Oversight Review Committee meetings. PowerPoint decks presented at these meetings provided a table that included the delegate name, performance standard/target, current status, reporting period, and comments. For example, in the Medicaid Oversight Review Committee meeting of June 18, 2019, it was reported that EMI did not meet financial accuracy and payment incidence accuracy for the first quarter. Additionally, further detail was provided on the root cause and follow-up, which included working with the RQIC to determine if a CAP was needed. This same information was included in the First Quarter RQIC Executive Summary with no decision noted as to the need for a CAP. Subsequent RQIC Executive Summaries for the second and third quarters did not address the need for a CAP. In the September 17, 2019, Medicaid Oversight Review Committee, second quarter results were provided for EMI; however, there was no mention of follow up with the RQIC regarding a needed CAP. Additionally, it is unclear if the EMI reported results in these meetings are specific to MD HealthChoice. In the Medicaid Oversight Review Committee meeting of September 17, 2019, MedImpact results for the second quarter were reported separately for MD HealthChoice.

According to the KP Mid-Atlantic Medicaid Delegation and Monitoring Policy, the responsible functional area is required to perform a formal review of all subcontracts at least annually. No evidence was provided of an annual review of either EMI or MedImpact.

In order to receive a finding of met in the CY 2020 review, KPMAS must demonstrate that it follows up on identified issues, provides MD specific results for EMI, and presents evidence of formal reviews of each delegate by the responsible functional area on an annual basis.

**Component 3.3c:** In response to the CY 2018 review, KPMAS was required to provide evidence that the RQIC reviews and approves all claims activities reports from its vendors consistent with its policies. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

Review of RQIC Executive Summaries for three quarters evidenced only review of EMI Ambulance claims activities reports for the first and second quarters. RQIC Executive Summaries evidenced only review of Pharmacy/MedImpact claims reports for first and second quarters. Executive Summaries did not identify the calendar date of the RQIC meeting but only referenced the quarter under review, which was not always consistent with the quarter addressed by the specific reports reviewed.

In order to receive a finding of met in the CY 2020 review, KPMAS must provide evidence that the RQIC reviews and approves all claims activities reports from its vendors consistent with its policies through RQIC meeting minutes. For example, if the MCO's policies require quarterly review and approval, there must be evidence for four quarters.

## Standard 5: Enrollee Rights

### Findings

#### Aetna Better Health of Maryland (ABH)

**Component 5.6c:** In response to the CY 2018 review, ABH was required to add language either to the Member Enrollment Policy or the New, Existing, and Reinstated Member Information Policy, identifying a process to document the tracking of timeliness of newborn enrollment and identify issues for resolution. As indicated below, continued opportunities for improvement exist.

The Member Enrollment Policy states that the tracking of timeliness of newborn enrollment is conducted through review of reports from the monthly enrollment data file. Data and trends are then reported to the Service Improvement Committee (SIC). Additionally, the Member Enrollment Policy states that newborn identification (ID) cards are distributed to members within 10 days of enrollment after the receipt of the newborn's individual Medicaid number. The policy does not include resolution for any identified issues.

In order to receive a finding of met in the CY 2020 SPR, ABH must include a process for resolving any issues identified from the tracking and trending of newborn enrollment data.

**Component 5.6e:** The member handbook and all of the member notice templates were submitted for review.

ABH did not submit evidence of MDH approval of the member handbook.

In order to receive a finding of met in the CY 2020 review, ABH must provide evidence that the member handbook was approved by MDH. For example, approval might come from MDH via an email to ABH staff.

### **AMERIGROUP Community Care (ACC)**

**Component 5.6a:** In response to the CY 2018 review, ACC was required to revise the Member ID Card Policy to include content of the new member packet; identify how the mailing of the packets are tracked and trended; identify who is responsible for tracking, trending, and monitoring the mailing of the packets; identify what committee this information is reported to; and describe how corrective action is identified and followed up on if packets are not mailed timely. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

The revised Member ID Card/Member Information Packet Policy includes content of the new member packet, the turnaround time (TAT) for sending out the packets, and the responsibility of the QMC for monitoring the fulfillment tracking of member ID cards and member information packets. QMC meeting minutes reflect presentation of the New Member Packets and New Member ID Reports, which identify the percentage of new member ID cards and packets mailed within 10 days of enrollment. Corrective action is requested when member ID cards and/or packets are not sent within required timeframes. The policy does not include the process for corrective action follow-up.

In order to receive a finding of met in the CY 2020 SPR, ACC must revise the Member ID Card/Member Information Packet Policy to indicate the process for corrective action follow-up if packets are not mailed timely.

### **Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)**

**Component 5.1g:** In response to the CY 2018 review, KPMAS was required to demonstrate compliance with grievance resolution timeframes. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

Based upon a review of 30 grievance records, 93% of grievances were resolved within the required timeframe; however, only 43% of grievances received a resolution letter. Additionally, only 59% of grievances received an acknowledgment letter within the regulatory timeframe. There was no evidence that an acknowledgment letter was sent for seven of the grievances.

In order to receive a finding of met in the CY 2020 review, KPMAS must demonstrate compliance at the 100% threshold for sending a written acknowledgment of each grievance and a written resolution within regulatory timeframes.

**Component 5.1h:** In response to the CY 2018 review, KPMAS was required to demonstrate that it provides written notice of resolution for each member grievance. All policies must be revised to reflect this. Additionally, there must be evidence that an acknowledgment letter is sent in response to all member grievances within the regulatory timeframe. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

The Maryland HealthChoice Grievance and Appeal System Policy states that grievance responses are provided in writing, regardless of how the grievance was received. KPMAS will issue written grievance resolution notices/letters to the member in clear and concise language in a tone that is culturally and linguistically appropriate.

Based upon a review of 30 grievance records for compliance, 43% received a resolution letter. Additionally, KPMAS achieved a 59% compliance with mailing acknowledgement letters within the required turnaround times. Seventeen cases missing resolution letters were related to a grievance that was initially submitted to the Complaint Resolution Unit at MDH. Three resolution letters did not include the grievance or the resolution. Two of the letters were for the commercial product line and differed in content from the HealthChoice required letter. Fields in letter templates were frequently not replaced with required information, such as member name or description of grievance.

In order to receive a finding of met in the CY 2020 SPR, KPMAS must demonstrate that it provides written notice of resolution for each member grievance. Additionally, there must be evidence that an acknowledgment letter is sent in response to all member grievances within the regulatory timeframe.

**Element 5.2:** The member handbook and samples of outreach materials were reviewed and demonstrated readability. Additionally, member materials are made available in Spanish; however, policies or procedures were unavailable as evidence to document regulatory compliance.

In order to receive a finding of met in the CY 2020 SPR, KPMAS must demonstrate policies and procedures for member communications and materials meet defined objective(s), are appropriate for the target audience, and comply with regulatory requirements.

**Component 5.3d:** In response to the CY 2018 review, KPMAS was required to ensure members are notified in a timely manner upon release of information in response to a court order.

The Legal and Risk Management Requests for Protected Health Information Policy was provided for review. This policy refers to having documentation acknowledging that both legal parties have been notified; however, it does not include a process that ensures release of any information in response to a court order is reported to the patient in a timely manner.

In order to receive a finding of met in the CY 2020 SPR, KPMAS must revise the Legal and Risk Management Requests for Protected Health Information Policy to include a process for notifying members in a timely manner upon release of information in response to a court order.

Qlarant recommends that the MCO review the guidelines for establishing timeframes.

## Priority Partners (PPMCO)

**Component 5.1g:** In response to the CY 2018 review, PPMCO was required to demonstrate compliance with member grievance resolution timeframes. As indicated below, the CAP was partially implemented and continued opportunities for improvement exist.

A total of 10 member grievance records were submitted to assess compliance with resolution timeframes; however, one record was an inquiry and one record was a duplicate. Therefore, only eight records were reviewed. Three out of the eight grievances were medically related but inappropriately categorized as administrative. No grievances were resolved within the required timeframes.

In order to receive a finding of met in the CY 2020 SPR, PPMCO must demonstrate resolution of all member grievances within the required timeframe.

**Component 5.6a:** In response to the CY 2018 review, PPMCO was required to:

- Revise applicable policies to include a process for monitoring, tracking, and trending both new member packets and ID cards;
- Include within applicable policies a CAP process for responding to identified opportunities for improvement related to timeliness or accuracy; and
- Provide evidence of monitoring, tracking, trending, and CAP activities for both new member packets and ID cards.

As indicated below, the CAP was partially implemented and continued opportunities for improvement exist.

The ID Card Process Policy describes how new member ID cards are produced and distributed to new members. Timeframes also are identified in the policy. The policy states that once a new member is added to the enrollment database, the member is flagged for generation of a new ID card. Production Control generates a card file three times weekly, which are then sent to the vendor. The vendor processes the file and will print and mail ID cards within three business days. The ID card(s) should arrive at the member's mailing address within 10 calendar days of the ID card vendor's mail date. The policy additionally identifies PPMCO's process for ensuring timeliness and accuracy, indicating that the information will be presented at the Quality Improvement Committee (QIC) on a quarterly basis. If issues are identified, the CAP policy will be followed. PPMCO provided the following documentation as evidence that this process is being implemented:

- 2019 ID Card Tracking Log
- 2019 DOC Minutes for June, August, and November

Information regarding how and when new member packets are created and distributed to new members also was provided. Appendix A of the Member Communications Policy indicates its vendor, Tray Incorporated, is responsible for retrieving the new member file once it is added to the claims system and mailing out new member packets within two to three business days of the file being retrieved. The policy additionally states, "Monitoring of tracking of the new member welcome packets will be reported at the appropriate Quality Improvement Committee on a quarterly basis." While the New Member Packet Tracking Log for 2019 and Delegation Oversight Committee (DOC) meeting minutes showed evidence of monitoring and tracking of new member packet TATs, the indicated TAT is listed as 10 business days, which contradicts Appendix A of the Member Communications Policy. Additionally, the Standard Operating Procedure for New Member Handbooks document states, "Vendor completes preparations for mailings within 5 working days of receiving client data file."

In order to receive a finding of met in the CY 2020 SPR, PPMCO must align all new member packet policies and related documents to include the same TAT expectation for the mailing of new member packets.

## University of Maryland Health Partners (UMHP)

**Component 5.8e:** In the CY 2018 review, UMHP submitted the Accuracy of Information Provided to Medicaid Members Policy to describe how UMHP develops electronic information for members that meet requirements set forth in COMAR relating to 508c requirements for individuals with disabilities. The policy was not submitted for the CY 2019 SPR. The Languages Services Policy that was submitted only addresses compliance with Americans with Disabilities Act (ADA) requirements for written materials.

Although UMHP's 2019 policy does not reflect 508 compliance, UMHP uploaded email communications with the certified 508 compliance vendor to demonstrate that electronic information on the UMHP website is 508 compliant. Examples include 508 compliance with the UMHP formulary, the fall member newsletter, Healthy Partners, and Advance Directives communication via the website.

In order to receive a finding of met in the CY 2020 review, UMHP must update all applicable policies to include the requirement that all electronic information provided to members will be 508 compliant.

## Standard 6: Availability and Accessibility

### Findings

#### Aetna Better Health of Maryland (ABH)

**Component 6.1b:** In response to the CY 2018 review, ABH was required to revise the Practitioner Appointment Availability Study Policy to reflect quarterly monitoring against performance standards. Additionally, ABH must provide evidence this process is taking place. As indicated below, a continued opportunity for improvement exists.

The Practitioner Appointment Availability Study Policy was revised to reflect quarterly monitoring of availability and accessibility. Additionally, the Primary Care Practitioner After-Hour Accessibility Study Policy also was revised to reflect quarterly monitoring of after-hours accessibility. However, evidence of quarterly monitoring of performance was not provided.

In order to receive a finding of met in the CY 2020 SPR, ABH must provide evidence of quarterly performance monitoring as indicated in both the Practitioner Appointment Availability Study Policy and the PCP After-Hour Accessibility Study Policy.

**Component 6.2a:** In response to the CY 2018 review, ABH was required to ensure the online provider directories specify whether the office practice has ADA accommodations. Additionally, ABH was required to ensure online provider directories include specifics regarding ADA accommodations for patients with disabilities, including offices, exam room(s), and equipment.

As outlined in the Practitioner Directory Updates, Access to Care Plan, and Practitioner and Provider Availability Network Composition and Contracting Plan policies, ABH maintains a complete and up-to-date paper, electronic, and provider search feature directory that is organized geographically and evaluated regularly to ensure network adequacy. The provider directory was reviewed and lists providers geographically.

ABH's online provider directory is easy to navigate and complete with designated placeholders for each of the components required by regulation; although during the validation process, reviewers discovered that specific ADA accessibility accommodations for patients with disabilities including offices, exam room(s), and equipment were not provided.

In order to receive a finding of met in the CY 2020 SPR, ABH must ensure the online provider directories specify whether the office practice has ADA accommodations including specifics regarding offices, exam room(s), and equipment accessibility for patients with disabilities.

## Maryland Physicians Care (MPC)

**Component 6.1b:** In response to the CY 2018 review, MPC was required to revise the Provider Access and Appointment Availability Standards Policy as follows:

- Specify the frequency of how often the Provider Service (PS) representative or designee will monitor provider appointment availability and identify processes for how they will monitor it.
- Specify how and where the PS representative will document the results of the monitoring activity.
- Specify the frequency of the PS manager's evaluation of the outcome of monitoring activities.
- Detail the CAP process for noncompliant providers.
- Detail the appropriate quarterly monitoring reporting process through the quality committees.

As indicated below, the CAP was partially implemented and continued opportunities for improvement exist.

The Provider Access and Appointment Availability Standards Policy states that the PS Department will monitor provider compliance with appointment standards.

Each PS representative (or designee) will monitor provider appointment availability on a quarterly basis. Methods may include, but are not limited to, appointment availability audits.

Each PS representative (or designee) will document the results of their monitoring activity. Those results will be recorded on MPC's Primary Care Access Survey log for quarterly evaluation and trending by the PS manager.

The PS manager will submit a quarterly report to identify providers who are noncompliant with access standards to the SIC. All identified trends will also be submitted to the QMOC for review. A formal analysis will be presented to the Quality Management/Utilization Management Committee (QM/UMC) annually.

Corrective action is taken when providers are noncompliant with the standards, which may include, but are not limited to, education on required access standards, subsequent survey of MPC's site, credentialing, and/or termination of agreement. Desktop procedures outline the process for identifying when a CAP will be required and what entity will monitor the CAP but does not include conditions under which the CAP will be closed. The policy does not acknowledge or cross reference associated desktop procedures.

In order to receive a finding of met in the CY 2020 SPR, MPC must revise the Provider Access and Appointment Availability Standards Policy to include detailed information about the CAP process for noncompliant providers.

**Component 6.2a:** In response to the CY 2018 review, MPC was required to ensure online provider directories consistently include responses for languages spoken by the PCP and include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.

The MPC provider directory identifies languages spoken by the PCP and includes specifics regarding ADA accommodations for patients with disabilities, including offices, exam room(s), and equipment. The directory also lists primary, specialty, and ancillary providers by local access area.

MPC's online provider directory is easy to read, available on one page, and includes placeholders for all components required by regulation. The placeholder for languages spoken is presented to identify additional practitioner languages. Qlarant discovered during the validation process that this information was not consistently identified. The placeholder for ADA accessibility provides a response including an icon for more information. When the icon is accessed, a table appears with an accessibility legend listing accommodations available at the provider site, such as Braille signage, accessible exam rooms, ramps, and equipment. Reviewers further discovered during the validation process that when accessing the icon placed next to a "yes" response for some PCPs, the table appeared, but information pertaining to the specific accessibility accommodations of the practice location was not included. Additionally, the validation process revealed inconsistencies in the following:

- Provider phone numbers and addresses
- Office staff responses pertaining to the acceptance of new Medicaid patients
- Ages the provider serves

In order to receive a finding of met in the CY 2020 SPR, MPC must ensure online provider directory placeholders consistently include accurate provider phone numbers and addresses, languages spoken by the PCP, and specifics regarding ADA accommodations for patients with disabilities, including offices, exam room(s), and equipment.

## Priority Partners (PPMCO)

**Component 6.2a:** PPMCO's online provider directory is searchable by provider; clinic, hospital, or other facility; location; and/or service type. Provider information is on three pages named "Details," "Contact Information," and "Locations." The directory is complete with designated placeholders for all components required by regulation. However, while some responses communicate that the information is "not specified" or "not available" when information is not available, there are other fields left blank, such as information for office hours, website, and fax number. Although the ADA accessibility responses are shown by an icon and a "yes" or "no" response on the "details" page, specifics regarding accommodations for patients with disabilities including offices, exam room(s), and equipment were not identified within the directory. A screenshot of the website provided by PPMCO stated that the MCO has sent a request to have this changed by the vendor.

In order to receive a finding of met in the CY 2020 SPR, PPMCO must ensure the online provider directory includes specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment. It also is recommended that PPMCO remain consistent in their language when indicating information is not available within the provider directory.

**Component 6.3c:** In response to the CY 2018 review, PPMCO was required to revise the appropriate policies to include monitoring, tracking, trending, and CAP processes and provide evidence of monitoring outreach data by the quality committee. As indicated below, the CAP was partially implemented and continued opportunities for improvement exist.

In addition to outlining the processes for contacting new members, the Outreach Health Services Needs Inventories (HSNI) and Initial Appointment Scheduling policies include “Monitoring, Tracking, and Trending” and “Corrective Action Plan (CAP)” sections. These sections detail the goals for each process; how performance will be monitored, tracked, and reported to the appropriate quality improvement (QI) committee; and what constitutes the need for a CAP.

PPMCO provided evidence that the MCO tracks outreach data and submits this information to the QI Outreach Data Work Group on a quarterly basis. Minutes from the workgroup meetings do not indicate that performance was evaluated based on the goals identified within the policies. Additionally, based on the workgroup meeting minutes, there is a lack of follow up or explanation of decisions made within the workgroup. For example, meeting minutes from the first quarter state, “Optum is only outreaching to 17% of new members which is why we are discontinuing our contract with Optum for poor performance;” however, the third quarter document and meeting minutes identify Optum as continuing to make new member outreach calls.

In order to receive a finding of met in the CY 2020 SPR, PPMCO must compare and evaluate outreach performance results to goals identified within policies and develop and implement CAPs, if needed.

## University of Maryland Health Partners (UMHP)

**Component 6.1c:** In response to the CY 2018 review, UMHP was required to revise the Call Center Requirements – Member Services Policy to reflect how the MCO will correct issues relating to call statistics that do not meet set standards. As indicated below, the CAP was not fully implemented. No evidence was submitted to review compliance for this component.

In order to receive a finding of met in the CY 2020 review, UMHP must submit documentation of established policies and procedures including a revised Call Center Requirements – Member Services Policy to reflect how the MCO will correct issues relating to call statistics that do not meet set standards.

**Component 6.2a:** In response to the CY 2018 review, UMHP was required to ensure that the online provider directory:

- Specifies ages served by the provider
- Specifies ADA accessibility responses for the provider
- Specifies ADA accommodations for patients with disabilities including offices, exam room(s), and equipment

The 2018 provider directory lists providers geographically and in alphabetical order, including hospitals, PCPs, clinics, OB/GYNs, specialists, pharmacies, and ancillary, mental health, substance abuse, dental, and vision services providers.

UMHP's online provider directory contains components required by regulation. Screenshots of the online directory show that UMHP leaves placeholders blank if information is not received by the providers. It was found during the validation process that specifics regarding ADA accommodations for patients with disabilities, including offices, exam room(s), and equipment, were missing. Additionally, the validation process revealed inconsistencies in the following:

- Staff responses regarding accepting new Medicaid patients
- Ages the provider serves
- ADA accessibility and specific ADA accommodations for patients with disabilities including offices, exam room(s), and equipment

In order to receive a finding of met in the CY 2020 review, UMHP must ensure online provider directory open and closed panel information is kept up to date, that placeholders consistently include ages the provider serves and specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.

**Component 6.3c:** In response to the CY 2018 review, UMHP was required to ensure the Quality Improvement Plan and Evaluation includes tracking, trending, and analysis related to welcome calls, mailing of welcome packets, issuance of ID cards, completion of initial health assessments (IHAs), and data related to outreach of noncompliant members. As indicated below, the CAP was not fully implemented.

The UMHP Quality Assurance Plan (QAP) was not submitted for review of compliance with this component.

The UMHP Health Risk Assessment Policy outlines the process of using HRA data to initiate case management (CM), care coordination, disease management, and health education to address needs identified during analysis of the data.

The New Member Notification/Welcome Packet Policy tracks the timeliness of mailing the New Member Welcome Packets and ID cards. Member Services makes and receives new member calls and can identify when a welcome packet needs to be sent in the Health Rules System. Additionally, the policy outlines the mechanisms in place to ensure the MCO's fulfillment process is working properly. The Vice President (VP) of Operations or designee reviews reports and addresses any follow-up actions required. Compliance rates are reported to the QIC on a quarterly basis.

In order to receive a finding of met in the CY 2020 review, UMHP must ensure the QAP includes tracking, trending, and analysis related to welcome calls, mailing of welcome packets, issuance of ID cards, completion of IHAs, and data related to outreach of noncompliant members.

## Standard 7: Utilization Review

### Findings

#### ABH

**Component 7.4c:** In response to the CY 2018 review, ABH was required to demonstrate consistent compliance with the 95% threshold for all PA determinations. As indicated below, continued opportunities for improvement exist.

The Prior Authorization Policy includes a table that identifies decision and notification timeframe requirements for urgent and non-urgent pre-service approvals and denials which are consistent with regulatory requirements. The decision/notification timeframe for urgent pre-service approvals and denials is stated as within 72 hours from receipt of the request. For non-urgent pre-service approvals and denials, a decision is required within two business days from receipt of request when no additional information is needed and within 14 calendar days if additional information is required. The policy also provides for an extension of the decision timeframe up to 14 additional calendar days under certain circumstances.

The Pharmacy Prior Authorization Policy in the Decision and Notification Standards section states that the MCO makes decisions or requests additional information for urgent or non-urgent pre-service authorization requests within 24 calendar hours of receipt of a request.

As evidence of compliance with this component, ABH provided their UM Authorizations TAT Dashboard, which identifies compliance by month for both expedited and standard PA determinations. For expedited requests, compliance with the decision TAT was met in only three of the nine applicable months. The months of April, May, July, August, September, and October demonstrated compliance ranging from 0% to 75%. For standard authorization requests, compliance with the determination timeframe was met in seven of the 10 months. Outlier months were April, May, and July with compliance ranging from 85% to 87%.

An initial review of 10 adverse determination records (five standard, one expedited, and four outpatient drug) found that nine of 10 records demonstrated compliance with determination timeframes. An additional 20 records were reviewed for compliance. Overall, the compliance percentage was 97% for the 30 records reviewed.

In order to receive a finding of met in the CY 2020 review, ABH must demonstrate consistent compliance with determination timeframes at the 95% threshold at least quarterly for the entire CY under review.

**Component 7.5b:** In response to the CY 2018 review, ABH was required to include all 17 components in adverse determination letters. As indicated below, continued opportunities for improvement exist.

The Prior Authorization Policy lists required contents of the notice of action. Fifteen of the required components were listed. Missing were a statement that the member or their representative may request an extension of the timeframe for appeals by up to 14 calendar days and the Appeals and Grievance Rights document. Additionally, one component did not specifically include the member's right to be provided a copy of their medical record upon request, free of charge.

A sample of 10 adverse determination letters were reviewed for compliance with this component. Five of 10 letters demonstrated compliance with all 17 required components. The five outliers did not include the member's right to be provided, upon request, a copy of the member's medical record, free of charge.

Subsequent to the initial review, ABH reported that the Prior Authorization Policy includes, within the list of required adverse determination letter components, the member's right to a free copy of their medical record which was found in the policy. ABH also stated that member adverse determination letters include a statement advising the member of the right to request a free copy of any guideline, codes, records, benefit provision, protocol, or any document the MCO used to make the decision. This is insufficient in meeting the requirement. Adverse determination letters must specifically include the member's right to a copy of their medical record, provided free of charge.

In order to receive a finding of met in the CY 2020 review, ABH must include all required components in adverse determination letters and in the Prior Authorization Policy.

**Component 7.6a:** In response to the CY 2018 review, ABH was required to revise PA policies to reflect specific notification timeframes consistent with COMAR. As indicated below, a continued opportunity for improvement exists.

The Prior Authorization Policy includes a table that identifies notification timeframes for urgent and non-urgent pre-service approvals and denials, which are consistent with regulatory requirements. The decision/notification timeframe for urgent pre-service approvals and denials is stated as within 72 hours from receipt of the request. Notification is required within 24 hours of the decision; however, this notification must occur within the 72-hour timeframe based upon MDH requirements. For non-urgent pre-service denials, notification of the determination is required within 72 hours of the decision. For termination, suspension, or reduction of a PA, the MCO is required to provide notice to the member and practitioner/provider at least 10 calendar days before the date of the action.

The Pharmacy Prior Authorization Policy requires notification of requesting providers of approved decisions by fax, phone, or other electronic communication within 24 hours of receiving all necessary information. If an authorization is denied, the MCO is required to give requesting practitioners/providers and members electronic or written confirmation of the reason for the decisions within 24 calendar hours. Notification requirements are not completely consistent with the requirement to provide the member with written notice of the adverse determination within 72 hours of the decision with a copy to the requesting provider. The policy also does not address the requirement for providing a request for additional information to the prescriber by fax or other telecommunication device within 24 hours. Additionally, there are no expedited requests for covered outpatient PA requests.

Subsequent to the initial review, ABH reported that the Pharmacy Prior Authorization Policy supports compliance with COMAR notification requirements. As noted above, the Pharmacy Prior Authorization Policy is missing the requirement for notifying the prescriber within 24 hours of a PA request of the need for additional information by telephone or other telecommunication device. The policy only addresses approval and denial decisions. Additionally, as stated above, members must receive written notification of an adverse determination within 72 hours of the determination. Electronic communication to the member does not meet this requirement.

In order to receive a finding of met in the CY 2020 review, ABH must revise the Pharmacy Prior Authorization Policy to specify notification timeframes consistent with COMAR/MDH requirements.

Specifically, the MCO must include in the policy prescriber notice of a request for additional information by telephone or telecommunication device within 24 hours of receipt of a PA request. Additionally, members must be notified in writing of an adverse determination within 72 hours of the decision with a copy to the requesting provider. The Prior Authorization Policy also must be revised to specify that for expedited PA requests, both the determination and the notice must be provided within 72 hours of receipt of the request.

**Component 7.6b:** In response to the CY 2018 review, ABH was required to demonstrate compliance with adverse determination notification timeframes at the 95% threshold. As indicated below, continued opportunities for improvement exist.

The ABHMD UM Authorizations TAT Dashboard provided monthly compliance with notification TATs for expedited and standard requests for the first 10 months of 2019. For expedited requests, compliance with TAT notification was met in only three of the nine applicable months. The months of April, May, July, August, September, and October demonstrated compliance ranging from 0% to 75%. For standard requests, compliance with TAT was met in seven of the ten months. The months of April, May, and July demonstrated compliance ranging from 80% to 85%. There was no evidence that the MCO tracks compliance with the 24-hour timeframe for prescriber notification of the PA determination.

An initial review of 10 records demonstrated nine of 10 adverse determination notifications met the required TAT. An additional 20 records were reviewed demonstrating 19 out of 20 met the TAT requirement. The overall compliance for member adverse determination notification was 93% for the 30 records reviewed. Four of the initial 10 records were PA requests for covered outpatient drugs. In each case, the prescriber was notified of the determination within 24 hours of receipt of the PA request by telephone or other telecommunication device.

In order to receive a finding of met in the CY 2020 SPR, ABH must demonstrate consistent compliance with all notification TATs at the 95% threshold on at least a quarterly basis for the entire year under review.

**Component 7.7c:** In response to the CY 2018 review, ABH was required to demonstrate consistent compliance with appeal resolution/notification timeframes. As indicated below, a continued opportunity for improvement exists.

The Member Appeals Policy requires ABH to resolve an expedited appeal within 72 hours and make reasonable efforts to communicate the decision orally, followed by written notification within 24 hours of the decision and within the original 72 hours. A standard appeal is to be resolved and written notification provided to the member as expeditiously as the member's health condition requires, not exceeding 30 calendar days from the date the MCO receives the appeal. A 14-day extension for both standard and expedited appeals is provided if the member requests the extension or the MCO demonstrates (to MDH, upon its request) that there is a need for additional information and how the delay is in the member's interest. If the member did not request the extension, the MCO must make reasonable attempts to give oral notification of the delay and written notice of the delay within two calendar days of the decision to extend the timeframe, including the member's right to file a grievance if they disagree with the decision. The policy includes measurement of the total volume of appeals adjudicated within regulatory timeframes and submission of reports to Medical Management (MM) and QMOC.

Year-to-date appeal timeframe compliance was reported in the SIC minutes from the November 14, 2019, meeting. Compliance for both expedited and standard appeals was reported, as applicable, from January through September 2019. Expedited appeals for the four applicable months were reported at 100% compliance. For seven of the eight applicable months, ABH demonstrated compliance with the standard resolution/notification timeframe. January, the one outlier month, was reported at 50% compliance.

There appears to be some confusion over the compliance threshold for appeals. In the June 26, 2019 meeting, it was reported that resolution timeliness is 93.2%, which is below the 95% threshold. The threshold for member appeals, however, is 100%, not 95%.

A sample of 10 appeals was reviewed for compliance (one expedited and nine standard). All timeframes met the 100% compliance threshold.

In order to receive a finding of met in the CY 2020 review, ABH must demonstrate compliance with appeal timeframes throughout the calendar year at the 100% compliance threshold.

**Component 7.7e:** In response to the CY 2018 review, ABH was required to provide evidence of a reasonable attempt to give the member prompt verbal notice of denial of expedited resolution. As indicated below, a continued opportunity for improvement exists.

The Member Appeals Policy requires the MCO to provide the member and/or practitioner prompt oral notice of the denial of a request for an expedited appeal resolution and written notice within two calendar days of receipt of the request that the appeal will be handled through the non-expedited standard process.

ABH also provided the Expedited Member Appeal MD Workflow Process, which outlines the process for handling an expedited appeal request. It includes the requirement for making a reasonable attempt to notify a member verbally of the denial of an expedited request and to send a written letter within two calendar days, which includes the member's right to file an expedited grievance if they disagree with the decision to process the request as a standard appeal.

Two denials of an expedited request were found in the sample of the ten member appeal records reviewed. There was no documentation in the case record of a reasonable attempt to give the member prompt verbal notice of the denial of an expedited resolution. In both cases, written notice of the denial of an expedited resolution was provided to the member within the required timeframe.

In order to receive a finding of met in the CY 2020 review, ABH must provide evidence of a reasonable attempt to give the member prompt verbal notice of denial of expedited resolution.

**Component 7.8c:** In response to the CY 2018 review, ABH was required to demonstrate compliance with timeframe requirements for providing both a written acknowledgment and written resolution for all provider appeals. As indicated below, continued opportunities for improvement exist.

The Provider Acknowledgment Letters Report documents compliance with the TAT for sending written acknowledgment of a provider appeal and resolution of the appeal within 30 business days. Reported compliance with written acknowledgment did not meet the 95% compliance threshold for any of the four quarters for CY 2019. Compliance results by quarter ranged from 6% to 47%. Compliance with provider notification of appeal resolution within the 30 business days was reported as 95.4%; however,

the timeframe was not specified. Compliance with the 95% threshold must be reported at least quarterly.

In order to receive a finding of met in the CY 2020 SPR, ABH must demonstrate compliance with timeframe requirements at the 95% threshold for written acknowledgment and written resolution of provider appeals on at least a quarterly basis.

**Component 7.11a:** In response to the CY 2018 review, ABH was required to revise the Corrective Managed Care Plan Policy to include all missing components. As indicated below, continued opportunities for improvement exist.

The Corrective Managed Care Plan Policy lists required criteria to identify potential members for participation in the Corrective Managed Care Program (CMCP) as well as additional member data to be reviewed to identify members for potential case management intervention. The MCO's CMCP is managed by the CM Department. A clinical review is done by a licensed health care professional in collaboration with a medical director. Twelve months of emails from a bachelor's prepared registered nurse to MDH listing members meeting the criteria for the CMCP were provided as supporting evidence.

The policy includes a section on responsibilities of the CM staff in conducting the medical review process and considering all information that is relevant and available to the MCO, such as the need to perform a review of appropriate clinical records, claims, complaints, and information from providers, family or other agencies.

The policy restricts a member to a single designated pharmacy in the network for a period of 24 months, which may be extended an additional 36 months if subsequent abuse is identified. In the CY 2018 SPR, the policy allowed exceptions to this restriction in the event of an emergency or need for a specialty drug not available at the designated pharmacy. The policy does not include these requirements. Instead, new language was added to the Definitions section of the policy to define a restriction as follows: "Limitation of utilization such that a member cannot choose to utilize multiple pharmacies, providers and/or institutions. The restriction can be to a pharmacy, physician, dentist, and/or hospital, but may not apply to emergency services." The policy and implementation of the policy should be clear about requiring an enrollee to obtain prescribed drugs only from a single designated pharmacy provider, which may be any pharmacy or any single branch of a pharmacy chain that participates in the MCO and meets the requirements of COMAR unless the prescription is pursuant to an emergency department (ED) visit; hospital inpatient treatment; or a specialty drug as defined in COMAR 10.67.06.04.

The policy provides for the designation of a new pharmacy provider if the member moves out of the service area of the current pharmacy provider. Content of the required member notice includes the reason for the restriction; the duration of the restriction; the pharmacy selected; the opportunity for the member to identify a preference for a designated pharmacy; an offer of CM; and the right to file an appeal or request a reconsideration upon providing additional information. Members who appeal the decision will not be locked in while the appeal is in process. All members are to be advised in writing of the outcome of the appeal. Responsibilities of the staff involved in the CMCP include submitting to the HealthChoice staff a spreadsheet with information on all ABH members that were locked-in in the previous month with beginning and end dates by the close of business on the eighth business day of the month. Additionally, staff are responsible for reconciling the file created by MDH on a monthly basis.

In order to receive a finding of met in the CY 2020 review, the Corrective Managed Care Policy and implementation of the policy should include the following restriction language: "Require a member to

obtain prescribed drugs only from a single designated pharmacy provider, which may be any pharmacy or any single branch of a pharmacy chain that participates in the MCO and meets the requirements of COMAR 10.67.05.06 unless the prescription is: (a) Pursuant to an emergency department visit; (b) Pursuant to hospital inpatient treatment; or (c) A specialty drug as defined in COMAR 10.67.06.04.”

## AMERIGROUP Community Care (ACC)

**Component 7.4c:** The Healthcare Management Denial – Core Process Policy includes preauthorization determination (PA) timeframes for standard and expedited authorization requests that are consistent with regulatory requirements for Maryland. Specifically, the policy requires decision and notification within 72 hours of receipt of request for an expedited pre-service review. For standard authorization decisions, the MCO is required to make a determination within two business days of receipt of clinical information but no later than 14 calendar days from the date of the initial request. The policy includes an extension of the authorization timeframe under certain conditions and member notice and determination requirements.

The Pharmacy Prior Authorization Policy in the Exceptions section includes PA requirements for Maryland that are consistent with current regulations. The policy states that notice by telephone or other telecommunication device will be provided within 24 hours of receipt of the PA request.

As evidence of compliance, ACC submitted the minutes from the May 15, 2019, meeting of the Health Care Management (HCM) Committee. A table labeled Prospective Request Decision Turn Around Time provided determination TATs by quarter for CY 2018. This is insufficient in demonstrating compliance for CY 2019.

A Pharmacy Department Report for the first quarter of 2019 also was provided that identified compliance with the 24-hour PA decision timeframe for outpatient drug requests. Compliance was reported at 99.15%. Additionally, compliance with PA TAT for drugs covered under the MCO's medical benefit was reported at 99.79% for the first quarter of 2019. This is insufficient in demonstrating compliance as all four quarters for 2019 are required.

A sample of 10 member adverse determination records were reviewed to assess compliance with PA determination timeframes with six of 10 records demonstrating compliance. An additional 20 records were reviewed with an overall compliance rate of 77% based upon 30 records reviewed.

Subsequent to the initial review, ACC submitted additional documentation to support compliance. Maryland HCM Committee meeting minutes from September 18, 2019, included a report of PA determination timeframe compliance for the first two quarters of 2019. Compliance with the timeframe for expedited requests was reported as 97% for the first quarter and 100% for the second quarter. Timeframe compliance for standard PA requests was reported as 90% for the first quarter and 97% for the second quarter.

Maryland HCM Committee meeting minutes from November 20, 2019, included a report on decision timeframes for pharmacy for the first three quarters of 2019. All three quarters exceeded 99% compliance. Compliance with the standard PA determination timeframe was also reported for the first three quarters of 2019. The compliance rate for the third quarter was reported as 98%. Compliance with the PA TAT for expedited requests was not reported for the third quarter. No TAT compliance results were reported for the fourth quarter for pharmacy and medical determinations.

In order to receive a finding of met in the CY 2020 review, ACC must provide evidence of compliance with PA determination timeframes for at least each quarter of the calendar year under review for both medical and outpatient pharmacy requests.

**Component 7.5b:** The Healthcare Management Denial – Core Process Policy lists some, but not all, of the 17 required components to be included in the adverse determination letter. Additionally, components referencing the Enrollee Help Line were not replaced by the HealthChoice Help Line, a change that was made several years ago.

Missing were the following components:

- The member's right to be provided upon request and free of charge, reasonable access and copies of all documents, records, and other information relevant to the MCO's action. This includes a copy of the member's medical record, provided free of charge.
- A statement that the member or their representative may request an extension of the timeframe for appeals by up to 14 calendar days.
- Appeals and Grievance Rights document.

A sample of 10 denial files were reviewed for compliance. All adverse determination letters included the 17 required components.

Subsequent to the initial review, ACC submitted the following documents to support compliance: Model Enrollee Notices, Model Notices Workflow, and Member Appeals-MD Policy. These documents are insufficient in demonstrating compliance.

In order to receive a finding of met in the CY 2020 review, ACC must revise the Healthcare Management Denial – Core Process Policy to include all current adverse determination letter components.

**Component 7.6b:** As evidence of compliance, ACC submitted the minutes from the May 15, 2019, Maryland HCM meeting, which included a table labeled Prospective/Member Adverse Determination Notification Turnaround. Results were provided for each of the four quarters of CY 2018. This is insufficient in demonstrating compliance for CY 2019.

A sample of 10 adverse determination records were reviewed for compliance with notification TATs. All 10 records demonstrated TAT compliance for prescriber notifications of an outpatient drug PA determination, as applicable, and member notification of an adverse determination.

Subsequent to the initial review, ACC submitted additional documentation to support compliance. Maryland HCM Committee meeting minutes from September 18, 2019, included a report of adverse determination notification timeframe compliance for the first two quarters of 2019. TAT compliance was reported as 90% for the first quarter and 82% for the second quarter. No other compliance results for adverse determination notifications were provided.

In order to receive a finding of met in the CY 2020 review, ACC must provide compliance results for notification TATs for adverse determinations for medical and outpatient drug PA requests and for prescriber notification of the determination by telephone or telecommunication device within 24 hours of the PA request for the entire year under review.

**Component 7.7a:** The Member Appeals - Maryland Policy is comprehensive in scope. It allows the member or an authorized representative or a provider with the member's written consent to file an appeal, standard or expedited, within 60 calendar days from the date of receipt of the notice of action. This is inconsistent with the COMAR appeal filing timeframe of 60 calendar days from the date on the MCO's notice of action. An appeal may be requested verbally or in writing. Unless an expedited appeal is requested, a verbal appeal must be followed by a signed, written appeal. Verbal filings will be treated as appeals to establish the earliest possible filing date. All appeals must be acknowledged in writing within five calendar days of receipt. This is more stringent than the COMAR standard which requires acknowledgment of an appeal within five business days of receipt. No punitive action is taken against a provider who requests an expedited resolution or supports the member's appeal. The policy identifies the sources and information collected during the appeal investigation, including the requirement to take into account all comments, records, and other information submitted by the member or their representative without regard as to whether such information was submitted or considered in the initial action. During the appeal process, the member will be provided a reasonable opportunity to present evidence and testimony and make legal/ factual arguments in person as well as in writing. Furthermore, the member will be informed of the limited time available to exercise this right. Additionally, the member or authorized representative has the right, before and during the appeals process, to examine the member's case file, including medical records, other documents, and new or additional evidence considered or generated by the MCO during the appeal process, free of charge. Parties to the appeal include the member, authorized representative, or the legal representative of a deceased member's estate.

In order to receive a finding of met in the CY 2020 review, ACC must revise the Member Appeals - Maryland Policy to reflect the regulatory timeframe for appeal filing which is 60 calendar days from the date on the MCO's notice of action.

**Component 7.7c:** The Member Appeals - MD Policy states that appeals must be resolved and notice provided to the member within the following regulatory timeframes:

- Standard and pre-service appeals within 30 calendar days of receipt of the appeal request.
- Expedited appeals within 72 hours of receipt of the appeal request.

The policy also provides for a 14-calendar day extension for appeal resolution under certain circumstances.

MCO Appeal Quarterly Reports for the first three quarters of 2019 identified compliance with appeal resolution and notification timeframes as follows:

- Q1 2019 - Expedited 100%; Standard 100%
- Q2 2019 - Expedited 86%; Standard 98%
- Q3 2019 - Expedited 83%; Standard 98%

A sample review of 10 member appeal records, all standard, demonstrated compliance with the resolution/notification timeframe.

Subsequent to the initial review, ACC provided a copy of the MCO Member Appeals Quarterly Report for the fourth quarter of 2019. Compliance with TATs for expedited appeals was reported as 72.2% and for non-emergency appeals as 98.6%

In order to receive a finding of met in the CY 2020 review, ACC must demonstrate consistent compliance with appeal resolution/notification timeframes at the 100% threshold for all 12 months of the year under review.

**Component 7.8a:** Review of the Provider Claim Payment Dispute Process Policy affirmed compliance with all but one required element as specified in COMAR 10.67.09.03. The policy requires the MCO to acknowledge a provider's appeal within five business days of receipt by the MCO. Providers are afforded 90 business days from the date of the denial to file an initial appeal (reconsideration) and 30 calendar days for the second level of appeal (claim payment appeal). If the decision is to uphold a previous decision at either level, the provider must receive written communication of the decision within 30 calendar days of the decision. If a denial is overturned upon appeal, the claim is to be paid within 30 calendar days of the appeal decision. The policy also affords the provider an opportunity to have the final level of appeal heard by the MCO's Chief Executive Officer (CEO) or the CEO's designee. Missing from the policy is the requirement to resolve all appeals, regardless of the number of levels, within 90 business days of receipt of the initial appeal.

In order to receive a finding of met in the CY 2020 review, ACC must revise the Provider Claims Payment Dispute Process Policy to include the requirement to resolve all appeals, regardless of the number of levels, within 90 business days of receipt of the initial appeal.

**Component 7.8c:** In response to the CY 2018 review, ACC was required to provide evidence of compliance with timeframes for acknowledgment and resolution of provider administrative appeals. As indicated below, continued opportunities for improvement exist.

ACC did not provide evidence of compliance with timeframes for sending written acknowledgment and resolution letters in response to a provider administrative (claims) appeal.

Subsequent to the initial review, ACC submitted a sample claims dispute acknowledgment letter. This is insufficient in demonstrating compliance with timeframes for providing written acknowledgement of provider appeals and written resolution.

In order to receive a finding of met in the CY 2020 review, ACC must provide evidence of compliance with timeframes for written acknowledgment and written resolution of provider administrative appeals consistent with the MCO's policies.

### **Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)**

**Component 7.4c:** In response to the CY 2018 review, KPMAS was required to update all applicable policies to reflect determination timeframes consistent with COMAR 10.67.09.04 and demonstrate compliance with determination timeframes for all PA requests (medical and pharmacy). As indicated below, continued opportunities for improvement exist.

The Assessing Compliance MD HealthChoice Determination and Notifications Policy includes a table which lists the determination timeframe requirements. For expedited PA requests, a determination is to be made no later than 72 hours after receipt of the request. For standard authorization requests, a determination is required within two business days of receipt of clinical information but not later than 14 calendar days from the date of the initial request. The policy also includes the availability of up to a 14-calendar day extension for decisions under certain conditions.

The MD HealthChoice Pharmacy Service Authorizations Policy provides determination timeframes for both standard and expedited PA requests for covered outpatient drugs. The policy states that for standard authorization decisions, the determination will be made within two business days of receipt of necessary clinical information, but no later than 14 calendar days from the date of the initial request. For expedited authorization requests, a decision will be made within 24 hours of receiving the request. Both timeframes are inconsistent with COMAR. The timeframe for outpatient drug PA decisions (approve, deny, or request additional clinical information) is within 24 hours of the request. This applies to all outpatient drug PA requests. There is no expedited category for outpatient drug PA requests.

The MCO did not submit evidence of compliance with determination TATs for CY 2019 for either medical or pharmacy PA requests.

A sample of 10 adverse determination member records (all medical) were reviewed and all demonstrated compliance with PA determination timeframe requirements.

In order to receive a finding of met in the CY 2020 review, KPMAS must update all applicable policies to reflect determination timeframes consistent with COMAR 10.67.09.04. Additionally, there must be evidence that KPMAS reports compliance with determination timeframes for all PA requests, medical and pharmacy, for the entire year under review.

**Component 7.6a:** In response to the CY 2018 review, KPMAS was required to ensure all policies include adverse determination notification timeframes consistent with regulatory requirements. As indicated below, the CAP was only partially implemented and continued opportunities for improvement exist.

The Assessing Compliance MD HealthChoice Determination and Notifications Policy includes a table that lists the member and practitioner/provider notification requirements. For written notification in response to an expedited PA request, the table specifies notice is required no later than 72 hours after receipt of the request for service. Written notification in response to a standard PA request is required within 72 hours from the date of the determination. The policy also requires the MCO to provide the member with written notice of action within at least 10 calendar days before the action for termination, suspension, or reduction of a previously authorized covered service.

The MD HealthChoice Pharmacy Service Authorizations Policy provides notification timeframes for emergency and standard pharmacy service PA requests. For emergency pharmacy service authorizations, the notice is required to be issued within 24 hours following receipt of the request or as expeditiously as the member's health condition requires. For standard pharmacy service PA requests, the denial notice will be issued within 72 hours of making the determination but no later than 14 calendar days. The policy also requires notice to the prescriber or designee by telephone or other telecommunication device, but the timeframe is not specified. As noted in component 7.4c, there is no expedited category for outpatient drug PA requests. Requesting providers must be notified within 24 hours of receipt of a PA request for a covered outpatient drug of the decision to either approve, deny, or request additional information. Additionally, members must receive written notice of an adverse determination within 72 hours of the determination with a copy to the requesting provider.

In order to receive a finding of met in the CY 2020 review, KPMAS must ensure all policies include notification timeframes consistent with regulatory requirements.

**Component 7.7a:** In response to the CY 2018 review, KPMAS was required to revise all member appeal policies to be consistent with COMAR 10.67.09.05 and MDH requirements. As indicated below, a continued opportunity for improvement exists.

The Maryland HealthChoice Grievance & Appeal Systems Policy provides timeframes for filing an appeal, acknowledging receipt in writing, resolving standard and expedited appeals, and requesting continuation of benefits. The policy allows members, their authorized representatives, or their providers acting on the member's behalf to appeal an adverse action. It identifies the parties to the appeal and the member's/member representative's right to review the information being used for the appeal decision before, during, and after the appeal process, and the right to provide additional information. It specifies the content of the appeal resolution letter and the availability of a State Fair Hearing if the member disagrees with the decision.

Among the missing COMAR requirements in the MCO's policy are the following:

- Written consent of the member allowing a provider or authorized representative acting on behalf of a member to file an appeal.
- An oral request for an appeal must be considered the initiation of the appeal to establish the earliest possible filing date.
- Confirmation of appeals in writing unless there is an expedited request for resolution.
- In the case of an expedited appeal, the MCO shall inform the member of the limited time available for the member to present evidence.
- The MCO must ensure punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

Subsequent to the initial review, KPMAS resubmitted the MD HealthChoice Grievance and Appeal System Policy in which was found a statement that "members, providers, authorized representatives, or an attorney ("Members"), are assured of the right to file a grievance or an appeal of an Adverse Action or receive and attend a State Fair Hearing without concern that the member's care or service will be affected, and without punitive action." A new document also was submitted to support compliance. The MD HealthChoice Grievance and Appeal System Procedure- Medicaid document included all the remaining missing elements except the requirement to inform the member of the limited time available for the member to present evidence in the case of an expedited appeal. This requirement also was not found in the MD HealthChoice Grievance and Appeal System Policy. This component, therefore, remains unmet.

In order to receive a finding of met in the CY 2020 review, KPMAS must revise all member appeal policies to be consistent with COMAR 10.67.09.05 and MDH requirements.

**Component 7.7c:** The Maryland HealthChoice Grievance and Appeal System Policy requires resolution of a standard appeal within 30 calendar days of receipt. The policy further states the requirement of written notice to the member of the resolution, but a timeframe is not specified. According to COMAR, an MCO is required to resolve each standard appeal and provide notice of resolution as expeditiously as the member's health condition requires, and unless extended, within 30 days from MCO receipt of the appeal. For expedited appeals, the policy requires the MCO to notify the member of the decision verbally within 72 hours of receiving the request and in writing in the form of a resolution letter within 24 hours of the verbal notification. This is inconsistent with MDH's requirement for resolution and notification within 72 hours following receipt of the expedited appeal request.

The Maryland Medicaid Appeals and Grievances Dashboard Report provides compliance results with an appeal resolution for the first 11 months of 2019. Expedited appeals were received in five of the 11 months and were all reported as 100% compliant with the 72-hour resolution TAT. It did not specify that this also included notification, so compliance cannot be accurately determined based upon the information provided. Compliance with the resolution/notification TAT of 30 calendar days from receipt of the appeal was met in all 11 months.

The MCO submitted only five records for review: four standard and one expedited appeal. All appeals demonstrated compliance with resolution/written notification TATs. For the one expedited appeal, however, there was no evidence in case notes that the MCO made a reasonable attempt to provide oral notification of the resolution.

In order to receive a finding of met in the CY 2020 review, KPMAS must revise the Maryland HealthChoice Grievance and Appeal System Policy to reflect the resolution/notification timeframes for standard and expedited appeals. Additionally, the Maryland Medicaid Appeals and Grievances Dashboard Report needs to specify that compliance with the timeframe for expedited appeals includes resolution/notification. There should also be evidence in member case notes of a reasonable attempt to provide the member with oral notification of the resolution of an expedited appeal.

**Component 7.8c:** In response to the CY 2018 review, KPMAS was required to demonstrate compliance with timeframes for written acknowledgment of receipt of a provider appeal and written resolution by each level of appeal. As indicated below, continued opportunities for improvement exist.

The MD Medicaid Provider Appeal Report provides monthly TAT compliance results for written acknowledgment of a provider appeal and written resolution for both first and second level appeals. At the first level, KPMAS did not meet the 95% compliance threshold for either acknowledgment or resolution letter TATs. Compliance results for acknowledgment letter TATs ranged from 0% to 14%, with an annual compliance rate of 3%. Written resolution TAT was reported at 0% compliance throughout the year.

For second level appeals compliance results for written acknowledgment, TAT ranged from 0% to 50% for the six applicable months with a reported annual compliance rate of 14%. Compliance with written resolution TAT was reported at 0% for the applicable six months.

No TAT compliance results were provided for the third level appeal.

In order to receive a finding of met in the CY 2020 review, KPMAS must provide evidence of compliance with timeframes for written acknowledgment of receipt of a provider appeal and written resolution by each level of appeal on at least a quarterly basis at the 95% threshold.

**Component 7.9c:** In response to the CY 2018 review, KPMAS was required to demonstrate that it acts upon identified issues as a result of review of UM satisfaction data specific to the HealthChoice population and the providers within the HealthChoice service area. As indicated below, the CAP was not implemented and continued opportunities for improvement exist.

KPMAS did not submit any evidence of action plans developed to address UM-related opportunities identified from review of results from the MD HealthChoice CAHPS®<sup>1</sup> and Provider Satisfaction Surveys.

In order to receive a finding of met in the CY 2020 review, KPMAS must demonstrate that it acts upon identified issues as a result of review of UM satisfaction data specific to the HealthChoice population and the providers within the HealthChoice service area.

## Maryland Physicians Care (MPC)

**Component 7.4c:** The Prior Authorization Policy includes a table which outlines decision timeframes for urgent and non-urgent pre-service authorization requests consistent with regulatory requirements. Urgent pre-service decisions and notifications are required within 72 hours of receipt of request. Non-urgent decisions are required within two business days of receipt of necessary clinical information but no later than 14 calendar days from the date of the initial request. The policy further states that a 14-calendar day extension is available for both urgent and non-urgent requests if the member or provider requests an extension or additional information is needed.

The Pharmacy Prior Authorization Policy requires all covered outpatient pharmacy decisions be made within 24 hours of receipt of the request, consistent with regulatory requirements.

The Key Indicator Report (KIR) identified overall compliance with determination TATs by month through November 2019; however, it was limited to standard requests. It did not include TAT compliance for determinations in response to an expedited medical or covered outpatient drug PA requests. The overall reported compliance rate for standard PA requests exceeded the 95% threshold by month throughout this timeframe.

Based upon a sample review of 30 adverse determination records, MPC demonstrated 97% compliance with determination timeframes. Three of the 30 records were outpatient drug PA requests, which all met the 24-hour determination TAT.

Subsequent to the initial review, MPC provided the KIR Monthly, Quarterly, and Annual Report which included compliance results for December for standard requests (two business days, not to exceed 14 calendar days). Based upon a review of this updated report, MPC exceeded the 95% compliance threshold for PA determinations for each quarter in 2019 for standard requests. Compliance with determination timeframes for expedited and outpatient drug requests was not provided; therefore, this component remains partially met.

In order to receive a finding of met in the CY 2020 review, MPC must provide evidence of TAT compliance for PA determinations for the entire period under review that includes expedited PA requests, outpatient drug requests, and standard PA requests.

It is recommended that MPC consider deleting non-outpatient pharmacy determination and notification timeframes from the Pharmacy Prior Authorization Policy to prevent confusion for pharmacy PA staff.

**Component 7.6a:** The Prior Authorization Policy includes a table which identifies notification timeframes for urgent and non-urgent adverse determinations consistent with regulatory requirements. For urgent

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<sup>1</sup> CAHPS® – Consumer Assessment of Healthcare Providers and Systems. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, U. S. Department of Health and Human Services.

pre-service adverse determinations, notification is required within 24 hours of the decision but no later than 72 hours from the date of the request. For non-urgent pre-service adverse determination, notification is required within 72 hours of the decision. Additionally, the policy requires MPC to provide the member with at least 10 calendar days' notice before the date of action whenever the action is a termination, suspension, or reduction of previously authorized services.

The Pharmacy Prior Authorization Policy requires determination and notification in response to all covered outpatient pharmacy requests within 24 hours of receipt of the request. Notification of the member and prescriber is required by telephone or other telecommunication device. The policy does not include the requirement to provide the member with written notice of the decision to deny an outpatient pharmacy request within 72 hours of the determination.

In order to receive a finding of met in the CY 2020 review, MPC must revise the Pharmacy Prior Authorization Policy to require written notification of the member of any adverse determination in response to a PA request for a covered outpatient drug within 72 hours of the decision.

**Component 7.7a:** In response to the CY 2018 findings, the MCO was required to revise the Member Appeals Policy to include all required elements. As identified below, a continued opportunity for improvement exists.

The Member Appeal Policy is comprehensive in scope and is compliant with regulatory requirements with two exceptions regarding omission of the parties to the appeal as noted in the prior year's review and the appeal filing timeframe. The appeal filing timeframe is incorrectly stated as within 60 days from the date of receipt of the notice of an adverse determination rather than 60 days from the date on the notice of action.

Additional timeframes for providing a written acknowledgment of appeal receipt and sending notice of resolution for both standard and expedited appeals are included within the policy. According to the policy, a member may assign a representative to act on their behalf with written authorization. Appeals may be filed verbally or submitted in writing. All oral requests are considered the initiation of the appeal to establish the earliest possible filing date and are confirmed in writing unless the member, their authorized representative, or the provider requests an expedited resolution. The MCO provides the member or their authorized representative the opportunity to submit written comments, documents, records, or other information relevant to the appeal before or during the appeal process without regard to whether such information was submitted or considered in the initial action. For expedited appeals, the MCO is required to inform the member of the limited timeframe for providing additional information. The policy also states the right of the member or member representative to request copies of all documents relevant to the appeal before, during, or after the appeal, free of charge. The policy identifies examples of information, which is included in the documentation and investigation process. The policy also states that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

The policy further requires all appeals clinical in nature be reviewed by an appropriately licensed practitioner who is board eligible or certified as required and has clinical expertise in the same or similar specialty as typically treats the medical condition, performs the procedure, or provides the treatment. The policy further defines "same specialty" as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A similar specialty is defined as a practitioner with experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

An initial review of 10 appeal records revealed all appeal determinations were made by a pediatric emergency medicine physician, even for cases involving adults. An additional 20 records were reviewed for compliance. Overall, 23 of the appeals were for adults, and all were reviewed by a pediatric emergency room physician, which is inconsistent with the MCO's policy requiring a same or similar specialty reviewer.

Subsequent to the initial review, MPC provided additional documentation to support the use of a pediatric emergency room physician as a reviewer for the adult as well as child appeals. A letter from MPC's Chief Medical Officer was presented which summarized the reviewing practitioner's adult training and experience. The letter noted the following:

- Pediatric care and emergency medicine are the reviewer's primary clinical practice.
- The reviewer is recognized as an emergency department physician and as a pediatrician.
- The reviewer engaged in adult practice from 1985-1989 through an adult emergency medicine position and outpatient internal medicine practice role.
- The reviewer met the grandfather criteria in emergency medicine which qualifies him as an emergency medicine specialist.

The reviewer's resume also was provided with clinical experience documented from 1987 through 2007 as follows:

- 2005-2007 Pediatric Emergency Medicine
- 2004-2006 Pediatric Emergency Medicine
- 2002-2004 Pediatric Emergency Medicine
- 1989-2001 Pediatric Emergency Medicine
- 1988-1989 General Pediatrics
- 1987-1993 General Pediatrics

No evidence of direct clinical experience treating an adult population in any setting was found in reviewing this practitioner's resume. As a result, this component remains unmet.

In order to receive a finding of met in the CY 2020 review, MPC must demonstrate all appeal decisions are made by an appropriately licensed practitioner who is board eligible or certified as required. The practitioner must have clinical expertise in the same or similar specialty as typically treats the medical condition, performs the procedure, or provides the treatment that is the subject of the appeal. Additionally, the Member Appeal Policy must be revised to include the correct appeal filing timeframe and the parties to the appeal.

### **Medstar Family Choice, Inc. (MSFC)**

**Component 7.7c:** The Member Appeals Policy requires MSFC to provide written notice of an expedited resolution within 24 hours of resolution, not to exceed 72 hours from receipt of the request. For standard appeals, resolution and notification are required within 30 calendar days of receipt of the request. The policy also allows for an extension of the resolution timeframe and member notice requirements.

The Complaints, Appeals, and Grievances Dashboard tracks MSFC's compliance with timeframes for determination and member notice of resolution by month and quarter through October 2019. Compliance was reported at 100% for all 10 months.

A sample review of 10 member records demonstrated compliance with all appeal resolution/notification timeframe requirements.

Subsequent to the initial review, MSFC provided the Dashboard: Complaints, Appeals, and Grievances Q1 - Q4 for 2019 to demonstrate compliance. Compliance with regulatory timeframes was demonstrated for the first three quarters of 2019. Timeliness of notification for one of two expedited appeal resolutions was not met in the fourth quarter, resulting in an overall compliance of 96.2% for resolution notification.

In order to receive a finding of met in the CY 2020 review, MSFC must provide evidence of compliance with resolution/notification timeframes for standard and expedited appeals at the 100% threshold for the entire 12 months of the calendar year.

### Priority Partners (PPMCO)

**Component 7.4c:** In response to the CY 2018 review, PPMCO was required to demonstrate consistent compliance with regulatory timeframes for determinations at the 95% threshold. As indicated below, a continued opportunity for improvement exists.

Appendix A of the UM Determination and Notification Timeframes Policy identifies decision timeframes for standard and expedited PA requests that are consistent with regulatory requirements. The policy also provides for up to a 14-calendar day extension for decision-making under certain conditions.

The Prior Authorization, Quantity Limits, and Step Therapy Policy requires for outpatient drug PA requests, a decision and notification by telephone or other telecommunication device to the requesting provider within 24 hours from the receipt date of the original request, which is consistent with regulatory requirements.

As evidence of compliance, PPMCO submitted the UM Turnaround Time for Pre-certification for Utilization Management report, which provides compliance results by month from January through September 2019. Compliance with determinations by individual reporting categories are as follows:

- Total approved-Determinations exceeded the 95% compliance threshold for all nine reported months.
- Total denied-Seven of the nine reported months exceeded the 95% compliance threshold. Outlier months were August and September at 87.02% and 88.32%, respectively.

A sample review of 10 member adverse determination records demonstrated 50% compliance with determination timeframes. An additional 20 records were reviewed for compliance resulting in an overall compliance rate of 73% for the 30 total records reviewed. Requests for additional clinical information frequently occurred well after receipt of the PA request. For example, four of seven requests for additional clinical information did not occur until 11 to 14 days after the PA request was received. Two of the four requests were denied the same day as the request for additional clinical information. All requests for additional clinical information must be submitted within two business days of receipt of the PA request.

Subsequent to the initial review, PPMCO submitted additional documentation to support compliance. The UM Turnaround Time for Pre-certification for UM/Pharmacy spreadsheet documented determination compliance rates by month for approvals and denials. For approvals, PPMCO reported meeting the 95% compliance threshold in 11 of 12 months. November was an outlier at 94.6%. For denials, PPMCO reported compliance in nine of 12 months. Outlier months demonstrated compliance ranging from 93.7% to 94.9%.

In order to receive a finding of met in the CY 2020 SPR, PPMCO must demonstrate consistent compliance with regulatory timeframes for determinations at the 95% threshold on at least a quarterly basis throughout the entire calendar year. This includes requesting additional clinical information, if needed, within two business days of receipt of the PA request.

**Component 7.7a:** In response to the CY 2018 review, PPMCO was required to revise the Member Appeals Policy to include missing or incorrect information. As indicated below, continued opportunities for improvement exist.

The Priority Partners Member Appeals Policy provides for one level of appeal which may be submitted orally or in writing by a member or their authorized representative with the member's written permission. Oral requests for an appeal are considered to be the initiation of the appeal and are to be confirmed in writing unless an expedited resolution is requested. The timeframe for filing is stated as 60 days from the date of receipt of the notice of action rather than 60 days from the date of the notice of action. Members are provided a reasonable opportunity, in person or in writing, to present evidence and testimony and to make legal and factual arguments. As part of the appeal process, members and/or their authorized representatives have the right to submit written comments, documents, or other information relating to the appeal that will be considered without regard to whether such information was submitted or considered in the initial action. Additionally, the member or their authorized representative is entitled to access and copies of the member's case file free of charge, and sufficiently in advance of the resolution timeframe for the appeal.

The policy also provides for continuation of benefits under certain circumstances. Timeframes for written acknowledgement of appeal receipt and written notice of resolution are provided for both standard and expedited requests. The policy requires the MCO to make reasonable efforts to provide oral notice of the decision in response to an expedited request. An extension timeframe for a determination of up to 14 calendar days is included. The policy states that it "is silent on the parties to the appeal and ensuring that no punitive action is taken against a provider who requests an expedited resolution or supports a member's appeal."

Subsequent to the initial review, PPMCO submitted a revised Member Appeals Policy with a revision date of January 29, 2020. This is outside of the CY 2019 review period. It may be resubmitted as part of the formal CAP process once the final report is issued.

In order to receive a finding of met in the CY 2020 SPR, PPMCO must revise the Member Appeals Policy to include the regulatory timeframe for filing an appeal, parties to the appeal, and a statement that no punitive action is taken against a provider who requests an expedited resolution or supports a member's appeal.

**Component 7.7c:** In response to the CY 2018 review, PPMCO was required to demonstrate consistent compliance with appeal timeframes. As indicated below, a continued opportunity for improvement exists.

The Priority Partners Member Appeals Policy requires the MCO to resolve each appeal and provide notice of the resolution within 72 hours of receipt of an expedited request and within 30 days of receipt of a standard request. This is consistent with regulatory requirements.

As evidence of compliance, PPMCO submitted MCO Member Appeal Quarterly Reports for the first three quarters of 2019. These reports are submitted to Qlarant on a quarterly basis. TAT Compliance results are as follows:

- Q1 2019 - standard 90% (there were no expedited reported for this quarter)
- Q2 2019 - standard 94.12% (there were no expedited reported for this quarter)
- Q3 2019 - standard 100%, expedited 100%

All 10 member appeal records submitted by the MCO were reviewed to assess compliance. An expedited resolution was requested for two of the 10 appeals reviewed. For one expedited request, the appeal acknowledgment letter stated that the member would receive an appeal resolution in 30 days; however, case notes stated "EXPEDITED." There was no evidence of denial of an expedited resolution or an appeal resolution letter. The other expedited appeal demonstrated compliance with the timeframe for written notice of resolution. Seven of the eight standard appeals demonstrated compliance with the timeframe for written resolution. There was no evidence of a resolution letter for the remaining standard appeal. Overall compliance with written appeal resolution is 80% (8/10).

In order to receive a finding of met in the CY 2020 review, PPMCO must demonstrate 100% compliance with timeframes for written resolution of standard and expedited appeals throughout 2020.

**Component 7.8c:** In response to the CY 2018 review, PPMCO was required to demonstrate compliance with timeframes for providing written acknowledgment of appeal receipt and resolution in response to provider submitted appeals. As indicated below, continued opportunities for improvement exist.

Provider Appeals TAT Reports were submitted for the first three quarters of 2019. Compliance with timeliness of written acknowledgment of provider appeals by quarter is as follows:

- Q1 2019 - 100% expedited, 10.03% non-emergency
- Q2 2019 - 97.65% expedited, 13.10% non-emergency
- Q3 2019 - 95% expedited, 13.89% non-emergency

Compliance with timeliness of resolution of the provider appeal by quarter is as follows:

- Q1 2019 - 83.3% expedited, 91.01% non-emergency
- Q2 2019 - 84.71% expedited, 89.7% non-emergency
- Q3 2019 - 83.33% expedited, 90.91% non-emergency

In these TAT reports, the top heading was incorrectly stated as "Member Appeal Outcomes." Additionally, there should be no expedited provider appeals as noted in component 7.8a. Furthermore, TAT compliance must be reported for written provider notification of appeal resolution not the resolution of the appeal.

Subsequent to the initial review, PPMCO submitted the Provider Appeals TAT Report (PPMCO) for the fourth quarter of 2019. Timeliness of the acknowledgment letter was reported at 94.6% for expedited and 37.5% for non-emergency. Compliance with written notification of the resolution was reported as 67.3% for expedited and 75.2% for non-emergency.

In order to receive a finding of met in the 2020 review, PPMCO must demonstrate TAT compliance with written acknowledgment and written resolution of provider appeals. Expedited resolution is not applicable for provider appeals.

## UnitedHealthcare Community Plan (UHC)

**Component 7.4c:** The Initial Review Timeframes Policy includes state-specific timeframes at the end of the policy. Preauthorization (PA) determination timeframes are identified and consistent with regulation for standard and expedited medically related PA requests and PA requests for covered outpatient drugs. The policy also includes a provision for up to a 14-calendar day extension for authorization decisions under certain conditions.

The Clinical Coverage Review Oversight Policy details the decision timeframe for outpatient drug PA requests consistent with COMAR. It specifically states that notice to approve, deny, or request additional information will be sent by fax/telephone to the requesting provider within 24 hours of the request.

The MD Medical TAT Report provided monthly compliance results for standard and expedited PA determination timeframes through mid-November 2019. All expedited and standard PA requests exceeded the 95% compliance threshold for the months reported. The Pharmacy PA TAT Report documented compliance with determination timeframes for routine and expedited PA requests for outpatient drugs. Based upon UHC's PA determination timeframe of 24 hours for expedited requests, compliance was reported at 100%. For routine cases, UHC met or exceeded the 95% threshold for PA determination within 24 hours for all months reported. In future reporting of compliance with PA determination TAT, only one category should be reported as there is no distinction between expedited and standard PA requests for outpatient drugs.

A sample review of 10 member adverse determination records, consisting of both medical and outpatient drug requests, demonstrated compliance with the required timeframes for determination.

In order to receive a finding of met in the CY 2020 review, UHC must provide evidence of compliance at the 95% threshold for PA determination TATs for the entire calendar year under review.

**Component 7.6b:** As evidence of compliance, UHC submitted reports of TATs for both medical and pharmacy adverse determination notifications. The MD Medical TAT Report provides compliance results through mid-November 2019. For expedited requests, 100% compliance with the adverse determination notification TAT was reported for all but three of the 10.5 months reported. Outlier months ranged from 60% to 85.71%. For standard requests, all reported months met or exceeded the 95% threshold for compliance.

The Pharmacy PA TAT report provided adverse determination notification TAT compliance for expedited and standard PA requests for the first 10 months of 2019. Compliance with notification within 24 hours from the date of determination was reported at 100% for expedited and between 99% and 100% for standard requests. UHC also tracked compliance with a 48- and 72-hour timeframe for both categories.

For the 72-hour regulatory timeframe, full compliance was reported for standard notifications. As noted in component 7.4c, only one category should be reported, as there is no distinction between expedited and standard PA requests for outpatient drugs.

A sample review of 10 member adverse determination records (four medical and six pharmacy) demonstrated 100% compliance with adverse determination notification timeframes based upon regulatory requirements. Additionally, all pharmacy denials demonstrated faxed notification of the determination to the prescriber within 24 hours of receipt of the PA request.

In order to receive a finding of met in the CY 2020 review, UHC must demonstrate compliance with adverse determination notification timeframes throughout the CY under review. Additionally, UHC must report compliance with provider notification of a determination for PA of a covered outpatient drug by telephone or other telecommunication device within 24 hours of receipt of the request.

**Component 7.7c:** The Member Grievance and Appeal Policy identifies the timeframe for resolution/notification of a standard appeal as 30 calendar days from the date of receipt, or as expeditiously as the member's health condition requires. For an expedited appeal, the resolution timeframe is within 72 hours from receipt of the appeal or as expeditiously as the member's health condition requires. Additionally, the resolution analyst makes reasonable efforts to provide oral and written notice of the decision to the member within 24 hours of the decision. This is inconsistent with the MDH requirement of resolution and notification within 72 hours of receipt of an expedited appeal.

The Member Appeal Compliance Report documented TAT compliance with resolution and notification of member appeal decisions for the first ten months of 2019 by month and by quarter. Compliance results are identified below.

- Expedited - 100% for eight out of 10 months. Outlier months ranged from 75% to 89%.
- Standard - 100% for all 10 months.

A sample of 10 member records (four expedited and six standard) was reviewed to assess compliance with written resolution/notification timeframes. All appeals demonstrated full compliance with required timeframes. Additionally, a reasonable attempt to provide oral notification of an expedited appeal decision was documented in case notes for all four applicable appeals.

Subsequent to the initial review, UHC submitted a revised draft of the Member Appeal and Grievance Policy which states that the MCO makes reasonable efforts to provide oral and written notice of the appeal decision to the member, and if applicable, other affected parties, within 24 hours of the decision. This revised language remains inconsistent with the MDH requirement for sending resolution notice of an expedited appeal within 24 hours of the date the MCO makes a determination and within the 72-hour timeframe for expedited appeal decisions. This requirement, however, did not impact UHC's score for 2019, but it will in the 2020 review if not revised to demonstrate compliance.

In order to receive a finding of met in the CY 2020 review, UHC must demonstrate compliance with resolution/notification timeframes for all member appeals for the entire calendar year under review. Additionally, the Member Grievance and Appeal Policy must be revised to reflect the MDH required resolution/notification timeframe for expedited appeals.

**Component 7.8c:** The Provider Appeal Compliance Report documented compliance with written acknowledgement and written resolution of provider appeals for 2019 by month through October. Compliance results are as follows:

- Written acknowledgment of appeal receipt - The 95% compliance threshold was met or exceeded in all 10 months reported.
- First level appeal resolution - 100% compliance for all 10 months reported.
- Second level appeal resolution - 100% compliance for all 10 months reported.

In order to receive a finding of met in the CY 2020 review, UHC must demonstrate TAT compliance at the 95% threshold for all written acknowledgment and resolution of provider appeals for the entire calendar year under review.

**Component 7.9a:** The Consumer and Provider Satisfaction and Concerns Policy requires UHC Clinical Services Management to confer with appropriate UHC quality and accreditation staff on the annual analysis of consumer and practitioner satisfaction surveys in order to identify and pursue opportunities and report findings to the quality oversight committee. Actions are taken to improve consumer and provider experience in accordance with quality committee recommendations. The policy addresses both internal surveys of members through the CAHPS survey tool and providers through the physician/practice manager survey, and the MDH coordinated CAHPS and Provider Satisfaction Survey. The policy does not identify the appropriate quality committee(s) for reporting CAHPS and Provider Satisfaction Survey results and updates on actions taken in response to identified opportunities for improvement.

In order to receive a finding of met in the CY 2020 review, UHC must revise the Consumer and Provider Satisfaction and Concerns Policy to identify the UHC quality oversight committee that receives CAHPS and Provider Satisfaction Survey results and updates on actions taken in response to identified opportunities for improvement. Reporting should occur at least quarterly.

## University of Maryland Health Partners (UMHP)

**Component 7.2f:** In response to the CY 2018 review, UMHP was required to resolve the inconsistency in the Consistency in Application of Decision-Making Criteria Policy, which allows two retests of an individual before they are released from their responsibilities as a UM nurse or physician in the policy section, while the procedure section allows only one retest before an individual is released if they score below the 90% threshold. As indicated below, a continued opportunity for improvement exists.

The Consistency in Application of Decision-Making Criteria Policy describes the process for conducting formal inter-rater reliability (IRR) testing of all licensed staff responsible for application of criteria, including UM nurses and physicians. The procedure section of the policy states that if a UM reviewer receives a score of less than 90%, another review is to be conducted within three months following reeducation. If the minimum threshold is not reached upon retesting, the individual is released of their responsibility as UM staff. However, under the Policy section, if an individual scores below the 90% threshold upon retest, they are prohibited from reviewing cases unsupervised until such time as the management staff is comfortable with the judgment being displayed. At that time, another retest is administered. If the individual scores below the 90% threshold, they are released from their responsibilities as a UM nurse or physician. IRR testing results are presented to the Provider Advisory Committee (PAC) with a CAP, as needed.

Average IRR scores for 18 UM reviewers, both nurses and physicians, evidence all scores above the 90% threshold.

In order to receive a finding of met in the CY 2020 review, UMHP must resolve the inconsistency in the Consistency in Application of Decision-Making Criteria Policy which allows two retests of an individual before they are released from their responsibilities as a UM nurse or physician in the policy section, while the procedure section allows only one retest before an individual is released if they score below the 90% threshold.

**Component 7.4c:** The UM Program Structure and Processes Policy includes a table documenting timeframes for non-urgent and urgent pre-service decisions. Both timeframes specified for determination in response to standard (non-urgent) and urgent (expedited) PA requests are consistent with COMAR.

The Pharmacy Prior Authorization Policy requires responses to PA requests be made within 24 hours of the request.

As evidence of compliance, UMHP submitted the MDH Quarterly Report for the first quarter of 2019, which is insufficient in demonstrating compliance, as it only addresses determination TATs for denials and is only for one quarter.

An initial review of a sample of 10 adverse determination records (all medical) demonstrated TAT compliance for four of the 10 records. An additional 20 records were reviewed, with overall compliance at 60% for all 30 records. While reviewing case notes, Qlarant's reviewer observed that the determination due date was always documented as 14 days after MCO receipt of the request. This would be the maximum timeframe if additional clinical information is requested within two business days of receipt and the provider is either slow in responding or does not respond at all. If there is no need to request additional clinical information, the timeframe for a determination is within two business days of receipt.

Subsequent to the initial review, UMHP submitted additional evidence to support compliance with TATs. The UM Approvals Timeliness Summary report provided UM TAT results for each quarter of 2019 for urgent and non-urgent pre-service approvals. The folder labeled Pharmacy was empty.

UM results reported are as follows:

- First quarter - 86.84% urgent and 99.62% non-urgent
- Second quarter - 100% urgent and 99.67% non-urgent
- Third quarter - 94.29% urgent and 99.81% non-urgent
- Fourth quarter - 100% urgent and 99.89% non-urgent

Compliance with determination timeframes for pre-service denials for all PA categories (expedited, outpatient pharmacy, and non-emergency) was reported for the third and fourth quarters of 2019, utilizing the MCO Pre-Service Denial Quarterly Reports. Compliance with TATs was reported as 100% for all categories for both quarters.

In order to receive a finding of met in the CY 2020 review, UMHP must demonstrate compliance with determination TATs for both medical and pharmacy PA requests at the 95% threshold throughout the CY under review. Either an internal report, which tracks compliance with determination TATs for expedited,

standard, and outpatient pharmacy PA requests by month or quarter needs to be submitted or appropriate committee meeting minutes need to evidence review of this information with specific TAT compliance by the month/quarter documented.

**Component 7.5b:** The UM Approval/Denial Process Policy includes a list of 12 of the 17 required components to be included in the adverse determination letter. Partially or completely missing components are as follows:

- The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the MCO's action. This includes a copy of the member's medical record, provided free of charge.
- Direction to the member to call the HealthChoice Help Line for assistance.
- Explanation to the member that if she/he is currently receiving ongoing services that are being denied or reduced, he/she may be able to continue receiving these services during the appeal process by calling the MCO or the HealthChoice Help Line within 10 days from receipt of this letter. If the member's appeal is denied, he/she may be required to pay the cost of the services received during the appeal process.
- A statement that the member or their representative may request an extension of the timeframe for appeals by up to 14 calendar days.
- Appeals and Grievance Rights document.

A sample of 10 adverse determination letters were reviewed for compliance and found to contain 16 of the 17 required letter components. Missing from all letters was the right of the member to request continuation of benefits, the process and timeframe for requesting, and potential member liability for the cost of services received during the appeal process.

Subsequent to the initial review, UMHP submitted additional evidence to support compliance, including a sample adverse determination letter from November 25, 2019, which reflected required language on continuation of benefits. The MCO also submitted a draft of a policy revised in 2020 which lists the required contents of an adverse determination letter. This is outside of the CY 2019 review period and may be resubmitted in response to a required CAP.

In order to receive a finding of met in the CY 2020 review, UMHP must revise all applicable policies that list the required adverse determination letter components and ensure the adverse determination letter template is updated accordingly.

**Component 7.7a:** In response to the CY 2018 review, UMHP was required to revise its Member Appeals Policy to include the requirement for considering oral requests for an appeal as the initiation of the appeal for establishing the earliest possible filing date; taking into account information provided by the member or their authorized representative without regard to whether such information was submitted or considered in the initial action; and specifying parties to the appeal to include the member, the member's representative, and the estate representative of a deceased member. As indicated below, continued opportunities for improvement exist.

The Member Appeals Policy allows a member or their authorized representative with written consent to file an appeal within 60 days from the initial notice of denial. Appeals are accepted orally or in writing; however, an oral appeal must be followed by a written, signed appeal unless an expedited appeal is requested. The policy does not address the requirement for considering oral requests for an appeal as the initiation of the appeal for establishing the earliest possible filing date. The procedures include the

requirement for sending a written acknowledgment of the appeal within five business days of receipt. The policy also requires the member be provided with an opportunity to submit written comments, documents, or other information or present evidence and allegations of fact or law relating to the appeal in person as well as in writing. The responsibilities of the Appeal & Grievance Coordinator for researching the case and gathering all the facts are addressed under procedures; however, the policy does not explicitly state that the MCO takes into account information provided by the member or their authorized representative without regard to whether such information was submitted or considered in the initial action. The policy requires the MCO to permit the member, or their authorized representative, the opportunity before and during the appeals process, to examine the member's case file, including medical records and any other documents and records free of charge and upon request. The policy does not address the parties to the appeal. The Provider Appeals Policy states that UMHP will not take any punitive action against a provider for supporting a member's appeal or for requesting expedited resolution for a member's appeal.

In order to receive a finding of met in the CY 2020 review, UMHP must revise its Member Appeals Policy to include the missing elements and the expedited appeal resolution/notification timeframe as noted in component 7.7c.

**Component 7.7c:** In response to the CY 2018 review, UMHP was required to demonstrate 100% compliance with appeal resolution/notification timeframes. As indicated below, continued opportunities for improvement exist.

The Member Appeals Policy requires expedited appeals be resolved within 72 hours of receipt. Written notification of the outcome is to be mailed within three calendar days of the decision. This is inconsistent with the MDH requirement for resolution/written notification within 72 hours of receipt of an expedited appeal. Resolution and notification for standard appeals are required within 30 calendar days of receipt.

In its statement of compliance, UMHP reported that appeal TATs are reviewed in quarterly QIC meetings. Review of QIC minutes submitted from six meetings in 2019 evidenced no reporting of compliance with appeal TATs in five of the meetings. In the December 12, 2019, meeting it was reported that appeal TAT metrics were currently at 100%. This is insufficient in demonstrating compliance.

A sample of 10 member appeal records were reviewed for compliance. All records reviewed were standard appeals and met the resolution/notification timeframe.

In order to receive a finding of met in the CY 2020 review, UMHP must demonstrate 100% compliance with appeal resolution/notification timeframes throughout the calendar year under review. Either a monthly or quarterly internal report which tracks compliance with expedited and standard appeal resolution/notification needs to be submitted or QIC meeting minutes need to provide more detail in documenting compliance including the timeframe being reported and TAT results for both expedited and standard appeals. Additionally, UMHP must revise the Member Appeals Policy to include the MDH required timeframe for expedited appeal resolution/notification.

**Component 7.8a:** In response to the CY 2018 review, UMHP was required to revise its Provider Appeals Policy to include the requirement for sending a written acknowledgement of the appeal within five business days of receipt by the MCO. Additionally, the filing timeframe for an initial appeal was required to be revised to 90 business days from the date of denial to be consistent with COMAR 10.67.09.03. As indicated below, continued opportunities for improvement exist.

The Provider Appeals Policy allows providers 15 business days from the date of denial to file each subsequent level of appeal and requires resolution of appeals, regardless of the number of appeal levels, within 90 business days of receipt of the initial appeal by the MCO. If the appeal is overturned, the MCO is required to pay the claim within 30 days of appeal closure. The policy provides a second level appeal review with the MCO's Chief Executive Officer or designee. A resolution letter is to be sent to the provider within 30 calendar days of appeal receipt. There is no requirement for sending a written acknowledgement of the appeal within five business days of receipt by the MCO. Additionally, the filing timeframe for an initial appeal is stated as 180 calendar days from the date of denial rather than 90 business days from the date of denial.

In order to receive a finding of met in the CY 2020 review, UMHP must revise its Provider Appeals Policy to include the requirement for sending a written acknowledgement of the appeal within five business days of receipt by the MCO. Additionally, the filing timeframe for an initial appeal must be revised to 90 business days from the date of denial.

**Component 7.8c:** In response to the CY 2018 review, UMHP was required to demonstrate compliance with acknowledgement and resolution timeframes for provider appeals. As indicated below, continued opportunities for improvement exist.

According to UMHP's Statement of Compliance, the MCO reviews compliance with provider appeal timeframes during quarterly QIC meetings. A review of all QIC minutes submitted from six 2019 meetings provided no evidence of reporting compliance with acknowledgement and resolution timeframes for provider appeals.

In order to receive a finding of met in the CY 2020 review, UMHP must demonstrate compliance with TATs for sending providers a written appeal acknowledgement and written resolution within required timeframes at the 95% threshold. Reports of compliance must be no less than quarterly.

## Standard 11: Fraud, Waste, and Abuse

### Findings

#### Aetna Better Health of Maryland (ABH)

**Component 11.1f:** In response to the CY 2018 review, ABH was required to revise the MD Plan Verification of Services Desktop Procedure to include the following: (1) the number of surveys to be conducted and at what intervals, as member verification of services is required to be completed no less frequently than quarterly; and (2) which quality committee is responsible for reviewing the data. As indicated below, continued opportunities for improvement exist.

No policies reviewed indicate the frequency of oversight activities. These requirements were outlined only in a PowerPoint presentation to the SIC in November 2019.

According to ABH, the relevant policy was not updated as required, however, for all four quarters in 2019 the requirement to ensure that services billed to members were actually received, was met.

The MD Plan Verification of Services Program Integrity Desktop Procedure specifies how ABH verifies that services billed by the MCO are actually received by its members. This procedure states that the plan Special Investigations Unit (SIU) investigator will perform telephonic surveys and/or other mechanisms when necessary to verify that services or supplies paid by the MCO were received by the beneficiaries. This desktop procedure does not indicate the frequency of the telephonic surveys. It does outline the sample size of 20 members.

ABH submitted a Verification of Service Satisfaction Survey Results report for the first three quarters of 2019. The report was presented to the SIC on November 14, 2019. This document indicates the goal of this process is to "establish a process to randomly select members to verify that services were rendered and billed appropriately." This document further indicates that these surveys would be performed quarterly via telephone calls to members.

ABH has a SIU Committee to review all suspected instances of suspected fraud, waste, and abuse (FWA), review case investigations, and audit and monitor reports to include verifying services billed to members.

In order to receive a finding of met in the CY 2020 SPR, ABH must revise the MD Plan Verification of Services Desktop Procedure to include the survey intervals (monthly or quarterly). Compliance plans and policies should be clearer on the frequency of oversight and reporting. The SIU Committee and its roles and responsibilities should be included in relevant policies, plans, and desktop procedures.

Qlarant recommends the new SIU Committee and its roles and responsibilities be included in relevant policies, plans, and desktop procedures.

**Component 11.4c:** In response to the CY 2018 review, ABH was required to provide evidence of annual review of all delegate's plans to prevent FWA. Additionally, ABH was required to ensure the committee annually reviews and approves the ABH Anti-Fraud Plan and Compliance Plan. As indicated below, continued opportunities for improvement exist.

The second quarter 2019, Compliance Committee meeting minutes show review and approval of the following delegates' programs/plans:

- Avesis Anti-Fraud Plan
- CVS Health Compliance Review Program
- EviCore Compliance Program
- Versant Health Corporate Compliance Program
- Avesis Program Integrity for UM/Utilization Review (UR) and FWA Audits

Meeting minutes do not show evidence that the ABH Anti-Fraud Plan and Compliance Plan were reviewed and approved by the Compliance Committee.

Subsequent to the initial review, ABH indicated that its Compliance Department completed the review of the ABH Medicaid Compliance and Anti-Fraud plans; however, this was not reported in the Compliance Committee.

In order to receive a finding of met in the CY 2020 SPR, ABH must provide evidence of the Compliance Committee's annual review of the ABH Anti-Fraud Plan and Compliance Plan.

## Kaiser Permanente of the Mid-Atlantic States, Inc. (KPMAS)

**Component 11.4c:** In response to the CY 2018 review, KPMAS was required to provide evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent FWA for the MCO and its delegates. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

According to the KPMAS Maryland Medicaid – CY 2018 SPR CAP of August 9, 2019, "the Compliance Department will share with the Compliance Leadership Committee (CLC) for review and/or approval: (i) the Compliance Program Description; and (ii) workplans and activities to prevent FWA, including those activities of delegates that KPMAS contracts with. The Compliance Department will share this information at the Q3 Compliance Leadership Committee meeting."

Based upon review of the CLC October and December 2019 meetings, it is not clear that the CLC reviewed the Compliance Program Description. In the December 19, 2019, CLC meeting minutes, a compliance report indicated that KPMAS is working with its National Compliance Office to determine the process for overseeing FWA activities for delegated entities.

In order to receive a finding of met in the CY 2020 SPR, KPMAS must provide evidence that it conducts an annual review of its own Compliance Program Plan and that of its delegates.

**Component 11.4d:** In response to the CY 2018 review, KPMAS was required to provide evidence of the Compliance Committee's review and approval of continuous and ongoing delegate reports regarding the monitoring of FWA. As indicated below, the CAP was not fully implemented and continued opportunities for improvement exist.

In late 2019, KPMAS documented in CAP reports and in CLC meeting minutes, evidence of monitoring delegate FWA activities. This oversight is just beginning.

According to the pre-site survey submitted to Qlarant, KPMAS specifies that it has the following delegates:

- MedImpact for pharmacy benefits and pharmacy claims
- EMI for emergency transport claims

In December 2019, the KPMAS Compliance Department submitted its Quarter 4 2019, Medicaid Compliance Update. This document includes embedded files for MedImpact and EMI's Compliance Plans and for their 3rd Quarter FWA monitoring activities. These embedded documents were not submitted for review.

Minutes from the December 2019 CLC meeting reveal that "work continues for KPMAS to refine oversight of subcontractors to ensure their compliance."

In order to receive a finding of met in the CY 2020 SPR, KPMAS must show ongoing efforts to review and monitor FWA activities of its delegated entities. This monitoring must include an annual review of each delegate's Compliance Plan, and a quarterly review of the delegate's FWA activities. Monitoring oversight must address requirements specified in component 11.1d, such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, and marketing.

## University of Maryland Health Partners (UMHP)

**Component 11.4c:** In response to the CY 2018 review, UMHP was required to provide evidence of review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse, from each delegated entity. As indicated below, the CAP was partially implemented and continued opportunities for improvement exist.

UMHP provided Qlarant with the Caremark Compliance Plan, Employee Handbook, and Code of Conduct. Corporate Compliance Review Committee (CCRC) meeting minutes for January, May, July, and October 2019, and CCRC ad hoc meeting minutes from February, April, May, June, and July 2019, also were submitted to Qlarant for review. While it is evident that UMHP is carrying out its quarterly FWA oversight responsibilities, it was not clear if Caremark compliance documents were reviewed and approved by the CCRC.

QIC meeting minutes from March, June, and December 2019 along with CCRC minutes from May, July, and October 2019 show evidence of oversight of Superior Vision.

In order to receive a finding of met in the CY 2020 review, UMHP must submit evidence of CCRC review and approval of Caremark's Compliance Plan documents.