



**Qlarant** 



**Medicaid Managed Care  
Organization**



**Comprehensive Systems  
Performance Review**

**Statewide Executive Summary  
Final Report**

**Calendar Year 2021**

**Submitted September 2022**



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# Maryland HealthChoice Program

## CY 2021 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 to 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. This independent annual review ensures 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 the calendar year (CY) 2021's systems performance review (SPR). HealthChoice served over 1,337,796<sup>2</sup> enrollees during its 23rd 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 2021 were:

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

<sup>2</sup> Source: [https://md-medicaid.org/mco/mco-enrollment\\_action.cfm](https://md-medicaid.org/mco/mco-enrollment_action.cfm)

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- CareFirst Community Health Plan (CFCHP)
- 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)

## Purpose and Process

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

Qlarant conducted CY 2021's assessment as a comprehensive onsite review. Due to the COVID-19 public health emergency, virtual onsite reviews were offered to each MCO. Reviewers completed this assessment by applying systems performance standards. Performance standards used to assess the MCOs' operational systems were developed through a review of COMAR, federal regulations, and guidelines from other quality assurance accrediting bodies such as the National Committee for Quality Assurance (NCQA). Additionally, a sample review of appeal, grievance, and adverse determination records was conducted to assess compliance with applicable standards.

Each MCO received a draft of the standards in advance for review and comment within 45 days from receipt. All comments were taken into consideration prior to finalizing standards. SPR standards were finalized after review and approval by the Division of HealthChoice Quality Assurance (DHQA).

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

## Methodology

### Review Activities

In September 2021, Qlarant provided the MCOs with an SPR orientation manual, "Medicaid Managed Care Organization Systems Performance Review Orientation Manual," for CY 2021 and invited the MCOs to direct any questions or issues requiring clarification to specific Qlarant and DHQA staff. The manual included the following information:

- Overview of HealthChoice program and Systems Performance Review
- CY 2021 Review Timeline
- External Quality Review Contacts
- Pre-audit Visit Overview and Survey
- Pre-audit SPR Document List
- Systems Performance Review Standards and Guidelines, including CY 2021 revisions
- Maryland Standards Eligible for Deeming

Prior to the review, the MCO was required to submit a completed pre-audit survey form and provide documentation for various processes, such as quality and utilization management (UM), delegation, credentialing, enrollee rights, continuity of care, outreach, and fraud and abuse policies. Documents provided were reviewed by Qlarant's review team prior to the desktop review.

During the onsite or virtual onsite review, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion, an exit conference was held with the MCO. The purpose of this conference was to provide the MCO with preliminary findings, based on interviews and all documentation reviewed. Notification was also provided during the exit conference that the MCO would receive a follow-up letter describing potential issues that could be addressed by supplemental documents, if available.

After completing the review, Qlarant documented its findings and level of compliance for each standard by element and component. Levels of compliance for each element and component received a review determination of Met, Met with Opportunity, Partially Met, or Unmet. Each element or component reviewed was provided equal weight. Each element or component that received a finding of Met with Opportunity does not require a CAP but should be remedied by the MCO and will be reviewed during the next SPR. Each element or component not receiving a finding of Met required a CAP.

Preliminary results of the SPR were compiled and submitted to DHQA for review. 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. Upon MDH approval, the MCO received an exit letter containing its individual review findings of elements/components not fully met. MCOs then had 10 business days to submit any additional documentation for review. Qlarant reviewed any additional materials submitted by the MCO, made appropriate revisions to the MCO's final report, and submitted the report to DHQA for review and approval.

- After receiving the final report, the MCO is given 45 calendar days to respond to Qlarant with its required CAPs. The MCO could have also responded to any other issues contained in the report, at its discretion, within this same timeframe, and/or requested a consultation with DHQA and Qlarant to clarify issues or ask for assistance in preparing a CAP.
- Qlarant evaluates the content of all CAPs and determines adequacy of compliance. A CAP is determined adequate only if it addresses all required elements and components (such as timelines, action steps, or documented evidence).

## Non-duplication Deeming

CMS permits states the opportunity to use information from a private accreditation review, such as a NCQA audit, to meet comparable federal regulations. Using results from a comparable audit allows an opportunity for non-duplication deeming.

Non-duplication, as described in EQRO protocols and 42 CFR §438.360, is intended to reduce the administrative burden on the MCOs. When NCQA standards are comparable to federal regulations, and the MCO scored 100% on the applicable NCQA standards, there is an opportunity to “deem” or consider the federal regulation as meeting requirements. This process eliminates the need to review the regulation as part of the SPR, thus reducing the administrative burden on the MCO.

MDH initiated this process for the CY 2021 SPR. To qualify for deeming, MDH established the following criteria:

- The MCO must be NCQA accredited with Health Plan Accreditation.
- For applicable standards, the NCQA accreditation review standards were comparable to standards established through the EQR protocols.
- The MCO must provide evidence of the most recent NCQA audit, which includes a 100% assessment in the applicable standards.

Using this information and the NCQA *Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards*<sup>3</sup> (Effective July 1, 2020 – June 30, 2021), Qlarant evaluated whether the MCO qualified for deeming of federal regulations.

Standards in which MDH permitted deeming of are detailed in Table 1.

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<sup>3</sup> National Committee for Quality Assurance. (2020). *Medicaid Managed Care Toolkit: Standards Crosswalk, 2020 Health Plan Standards*. Retrieved from <https://store.ncqa.org/2020-medicaid-managed-care-toolkit.html>

**Table 1. Non-Duplication Deeming Standards Crosswalk**

<b>Standard 1</b> Systematic Process of Quality Assessment and Improvement	1.1 N	1.2 N	1.3 6/7	1.4 N	1.5 N	1.6 N/A	1.7 N	1.8 Y	1.9 N	1.10 N		
<b>Standard 2</b> Accountability to the Governing Body	2.1 N	2.2 N	2.3 N	2.4 N	2.5 N	2.6 N/A	2.7 N					
<b>Standard 3</b> Oversight of Delegated Entities and Subcontractors	3.1 N	3.2 N	3.3 N	3.4 N								
<b>Standard 4</b> Credentialing and Recredentialing	4.1 3/4	4.2 N	4.3 Y	4.4 N	4.5 Y	4.6 Y	4.7 N	4.8 4/5	4.9 2/3	4.10 N	4.11 N	4.12 N
<b>Standard 5</b> Enrollee Rights	5.1 N	5.2 Y	5.3 1/5	5.4 N	5.5 N	5.6 N	5.7 N	5.8 1/5	5.9 N	5.10 N	5.11 N	
<b>Standard 6</b> Availability and Accessibility	6.1 1/4	6.2 2/4	6.3 N	6.4 N								
<b>Standard 7</b> Utilization Review	7.1 2/3	7.2 5/6	7.3 1/3	7.4 1/3	7.5 N	7.6 N	7.7 2/7	7.8 N	7.9 N	7.10 N	7.11 N	7.12 N/A
<b>Standard 8</b> Continuity of Care	8.1 N	8.2 N	8.3 N	8.4 Y	8.5 N	8.6 N	8.7 N					
<b>Standard 9</b> Health Education Plan	9.1 N	9.2 N	9.3 N	9.4 N	9.5 N							
<b>Standard 10</b> Outreach Plan	10.1 N	10.2 N	10.3 N									
<b>Standard 11</b> Fraud and Abuse	11.1 N	11.2 N	11.3 N	11.4 N	11.5 N							

Green Y = Standard is deemable  
 Red N = Standard is not deemable  
 Yellow = Standard is partially deemable  
 Gray = Not applicable as standards have been deleted



## Findings

If the MCOs did not meet the minimum compliance rate of 100%, a CAP was required. One MCO (JMS) received compliance scores of 100% in all standards reviewed. Eight MCOs (ABH, ACC, CFCHP, KPMAS, MPC, MSFC, PPMCO, and UHC) were required to submit CAPs for CY 2021. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

Table 2 provides a composite review of the last three comprehensive SPR reviews at a glance for CY 2015, CY 2018, and CY 2021.

**Table 2. SPR Aggregate Scores At-A-Glance**

Standard	CY 2015	CY 2018	CY 2021
1: Systematic Process of Quality	100%	100%	100%
2: Accountability to the Governing Body*	99%	93%	-
3: Oversight of Delegated Entities	93%	88%	95%
4: Credentialing and Recredentialing	99%	99%	99%
5: Enrollee Rights	99%	91%	96%
6: Availability and Accessibility	96%	86%	99%
7: Utilization Review	94%	93%	94%
8: Continuity of Care	100%	100%	100%
9: Health Education Plan*	95%	100%	-
10: Outreach Plan	96%	100%	99%
11: Fraud, and Abuse	96%	94%	98%
<b>Composite Score</b>	<b>98%</b>	<b>97%</b>	<b>98%</b>

\*Standards 2 and 9 were exempt from the CY 2021 SPR due to 100% MCO compliance in previous SPRs and will be reviewed in the CY 2022 SPR.

Table 3 provides a comparison of SPR results across MCOs and the MD MCO Compliance Score for CY 2021.

**Table 3. Elements/Components Requiring CAPs and Met with Opportunities**

Standard	MD MCO Compliance Score	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
1: Systematic Process of Quality	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
2: Accountability to the Governing Body	Exempt	-	-	-	-	-	-	-	-	-
3: Oversight of Delegated Entities	100%	100%	100%	61%	100%	100%	100%	100%	94%	100%
4: Credentialing and Recredentialing	100%	100%	100%	99%	100%	100%	96%	99%	100%	100%
5: Enrollee Rights	100%	89%	93%	93%	100%	97%	99%	100%	96%	99%
6: Availability and Accessibility	100%	100%	100%	100%	100%	100%	100%	100%	100%	89%
7: Utilization Review	100%	94%	94%	77%	100%	90%	97%	100%	97%	97%
8: Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
9: Health Education Plan	Exempt	-	-	-	-	-	-	-	-	-
10: Outreach Plan	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%
11: Fraud, and Abuse	100%	92%	100%	94%	100%	98%	100%	100%	100%	100%
Composite Score	100%	97%	99%	92%	100%	98%	99%	100%	99%	98%
<b>CAPs Required</b>	-	<b>3</b>	<b>2</b>	<b>5</b>	<b>0</b>	<b>4</b>	<b>3</b>	<b>1</b>	<b>3</b>	<b>3</b>

Red represents score below required threshold and required CAP

For each standard assessed for CY 2021, the following section describes:

- Overall MCO results and findings (where applicable, refer to Appendix A for detailed MCO findings); and
- Follow-up, if required.

Detailed information regarding each standard's requirements can be found in Appendix B.

## Standard 1: Systematic Process of Quality

**Results and Findings:** All nine of the MCOs met the compliance score of 100% for Standard 1. CAPs were not required, due to each MCO meeting the required compliance score.

## Standard 2: Accountability to the Governing Body

Standard 2 was exempt from the SPR for CY 2021. Qlarant will review Standard 2 in the upcoming CY 2022 SPR.

## Standard 3: Oversight of Delegated Entities

**Results and Findings:** Two MCOs (CFCHP and PPMCO) have opportunities for improvement in the area of Oversight of Delegated Entities and are required to submit CAPs. Seven MCOs met the compliance score of 100%.

**Table 4. Standard 3 Comprehensive Review Results for CY 2021**

Element/Component Reviewed	CFCHP	PPMCO
3.3a	PM	-
3.3b	PM	-
3.3c	PM	-
3.3d	UM	PM
3.3e	UM	-

Yellow = Partially Met (PM), Red = Unmet (UM)

### Follow up:

- Qlarant reviewed and approved the MCO CAP submissions.
- The approved CAPs will be reviewed during the Interim CY 2022 SPR.

## Standard 4: Credentialing and Recredentialing

**Results and Findings:** Six of the nine MCOs met the compliance threshold for Standard 4. Three MCOs (CFCHP, MPC, and MSFC) have opportunities for improvement in the area of Credentialing and Recredentialing and are required to submit CAPs.

**Table 5. Standard 4 Comprehensive Review Results for CY 2021**

Element/Component Reviewed	CFCHP	MPC	MSFC
4.4h	-	PM	-
4.4i	-	PM	-
4.4j	PM	PM	PM

Yellow = PM

### Follow up:

- Qlarant reviewed and approved the MCO CAP submissions.
- The approved CAPs will be reviewed during the Interim CY 2022 SPR.

## Standard 5: Enrollee Rights

**Results and Findings:** Seven MCOs (ABH, ACC, CFCHP, KPMAS, MPC, PPMCO, and UHC) have opportunities for improvement in the area of Enrollee Rights and are required to submit CAPs.

**Table 6. Standard 5 Comprehensive Review Results for CY 2021**

Element/Component Reviewed	ABH	ACC	CFCHP	KPMAS	MPC	PPMCO	UHC
5.1a	-	-	PM	-	-	-	-
5.1c	-	-	-	-	-	-	-
5.1d	-	-	-	PM	PM	PM	-
5.1f	PM	-	-	-	-	-	-
5.1g	PM	-	PM	PM	-	PM	PM
5.1i	PM	-	-	-	-	-	-
5.2	-	-	-	-	-	PM	-
5.3e	-	-	UM	-	-	-	-
5.5c	PM	UM	PM	-	-	-	-
5.6c	PM	-	-	-	-	-	-
5.7b	-	PM	-	-	-	-	-
5.7c	PM	-	-	-	-	-	-
5.9c	-	UM	-	-	-	-	-
5.11	PM	-	-	-	-	-	-

Yellow = PM, Red = UM

### Follow up:

- Qlarant reviewed and approved the MCO CAP submissions.
- The approved CAPs will be reviewed during the Interim CY 2022 SPR.

## Standard 6: Availability and Accessibility

**Results and Findings:** UHC is the only MCO to not meet the compliance threshold of 100% for Standard 6. Due to having an opportunity for improvement in the area of Availability and Accessibility, UHC is required to submit a CAP in order to address the CY 2021 SPR component finding.

**Table 7. Standard 6 Comprehensive Review Results for CY 2021**

Element/Component Reviewed	UHC
6.1c	UM

Red = UM

### Follow up:

- Qlarant reviewed and approved the MCO CAP submission.
- The approved CAPs will be reviewed during the Interim CY 2022 SPR.

## Standard 7: Utilization Review

**Results and Findings:** Seven MCOs (ABH, ACC, CFCHP, KPMAS, MPC, PPMCO and UHC) have improvement opportunities in the area of Utilization Review and require CAPs to address the CY 2021 SPR component finding. Four MCOs (ABH, ACC, CFCHP, and KPMAS) also require quarterly updates on their CAPs as continued opportunities from the CY 2020 SPR.

**Table 8. Standard 7 Comprehensive Review Results for CY 2021**

Element/Component Reviewed	ABH	ACC	CFCHP	KPMAS	MPC	PPMCO	UHC
7.3a	-	-	PM	PM	-	PM	-
7.3b	-	-	UM	-	-	-	-
7.3c	-	-	UM	PM	-	-	-
7.6a	-	-	PM	PM	-	-	-
7.6b	-	PM	-	-	-	-	-
7.7a	-	-	PM	PM	-	-	-
7.7e	-	-	PM	-	PM	PM	-
7.7f	PM	-	-	-	-	-	-
7.8a	PM	-	-	-	-	-	-
7.8c	UM	UM	UM	UM	PM	-	-
7.9b	-	-	PM	-	-	-	-
7.9c	-	-	UM	UM	-	-	PM
7.10	-	PM	PM	-	-	-	PM

Yellow = PM, Red = UM

Red font represents quarterly updates that are required on the CAP per MDH's Performance Monitoring Policy

**Follow up:**

- Qlarant reviewed and approved the CAP submissions.
- Approved CAPs will be reviewed in CY 2022 SPR.

**In accordance with MDH's Performance Monitoring Policy:**

- ABH will provide a quarterly update on the CAP in CY 2021 for 7.8c;
- ACC will provide a quarterly update on the CAP in CY 2021 for 7.8c;
- CFCHP will provide a quarterly update on the CAP in CY 2021 for 7.8c; and
- KPMAS will provide a quarterly update on the CAP in CY 2021 for 7.8c.

**Standard 8: Continuity of Care**

**Results and Findings:** All nine of the MCOs met the compliance score of 100% for Standard 8. CAPs were not required, due to each MCO meeting the required compliance score.

**Standard 9: Health Education Plan**

Standard 9 was exempt from the SPR for CY 2021. Qlarant will review Standard 9 during the upcoming CY 2022 SPR.

**Standard 10: Outreach Plan**

**Results and Findings:** KPMAS had opportunities for improvement in the area of Outreach Plan and required the plan to submit a CAP.

**Table 9. Standard 10 Comprehensive Review Results for CY 2021**

Element/Component Reviewed	KPMAS
10.1d	PM

Yellow = PM

**Follow up:**

- Qlarant reviewed and approved the MCO CAP submission.
- The approved CAP will be reviewed during the Interim CY 2022 SPR.

**Standard 11: Fraud and Abuse**

**Results and Findings.** Three MCOs (ABH, CFCHP, and KPMAS) have opportunities for improvement and require CAP submissions.

**Table 10. Standard 11 Comprehensive Review Results for CY 2021**

Element/Component Reviewed	ABH	CFCHP	KPMAS
11.1f	UM	-	PM
11.4a	PM	-	-
11.4c	-	UM	-
11.4d	PM	PM	-

Yellow = PM, Red = UM

**Follow-up:**

- Qlarant reviewed and approved the CAP submissions.
- The approved CAP will be reviewed in CY 2022 SPR.

## 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
- Timeframe 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, CFCHP, KPMAS, MPC, MSFC, PPMCO, and UHC) were required to submit CAPs for the CY 2021 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

### Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific elements, components, or standards. The comprehensive SPR for CY 2021 determined whether the CAPs from the CY 2020 review were implemented and effective. In order to make this determination, Qlarant evaluated 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 updated its Performance Monitoring Policies following the CY 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 2020 SPR, five MCOs (ABH, ACC, CFCHP, KPMAS, and PPMCO) were required to submit quarterly updates of their CAPs to Qlarant.

Progress was reported quarterly to MDH and after the CY 2021 SPR was conducted, Qlarant recommended the following quarterly CAP closures as represented in Table 11.

**Table 11. Quarterly CAP Closures**

MCO	Standards
ABH	6.2a, 7.5b, 7.7c, 7.7e
ACC	7.4c, 7.7a, 7.7c
CFCHP	5.8e
KPMAS	7.7c, 11.4c, 11.4d
PPMCO	7.4c, 7.7c

As a result of the CY 2021 SPR, four MCOs (ABH, ACC, CFCHP, and KPMAS) have continued quarterly CAP monitoring for component 7.8c.

### Met with Opportunity Review

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 MwO. Each of the nine MCOs received a finding of MwO in one or more standards as represented in Table 12.

**Table 12. Met with Opportunities**

MCO	Standards
ABH	7.10, 10.1f, 11.5b
ACC	7.2e, 8.6, 11.1f
CFCHP	5.1c, 7.2e, 8.2, 10.1d, 10.1f
JMS	5.1a, 7.10, 10.1a, 10.1f
KPMAS	10.1f
MPC	7.8b, 10.1f
MSFC	7.10, 10.1f
PPMCO	7.3b, 7.8c, 7.10, 10.1a
UHC	7.3c, 7.8a, 10.1f

## Conclusion

The CY 2021 SPR was a comprehensive onsite/virtual onsite review. The minimum compliance rate for each standard was 100%. If an MCO did not meet the required compliance rate, then a CAP submission was required in order to meet compliance. In areas where deficiencies were noted in their CAP submissions, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews. One MCO (JMS) received compliance scores of 100% in all standards reviewed. Eight MCOs (ABH, ACC, CFCHP, KPMAS, MPC, MSFC, PPMCO, and UHC) were required to submit CAPs for CY 2021. As a result of the CY 2021 SPR, four MCOs (ABH, ACC, CFCHP, and KPMAS) have continued quarterly CAP monitoring for component 7.8c.

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. 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.



## Appendix A: MCO Detailed Findings

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

### 3.0 - Oversight of Delegated Entities and Subcontractors

#### Findings

##### CareFirst Community Health Plan (CFCHP)

**3.3** - There is evidence of continuous and ongoing evaluation of delegated activities, including:

**This element is Partially Met.**

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

**This component is Partially Met.**

Routine monitoring and oversight of delegated entity's performance occurs at several levels throughout CFCHP. The content of this oversight depends upon what each delegate's service level agreement dictates. Once this content is determined, performance monitoring becomes a function of specific CFCHP departments and of certain committees within the Quality Improvement Program (QIP) structure.

At the department level, subject matter experts conduct oversight of delegate performance for the service area delegated. For example, if utilization management (UM) activity is delegated, the Health Services (HS) Department reports on UM performance, including grievance and appeal data through the MMRC. The Pharmacy & Therapeutics Committee is responsible for the review of pharmacy utilization, and the Compliance Committee reviews delegate's fraud, waste, and abuse (FWA) reports.

The outcomes of these initial assessments are tracked and monitored using tools such as Excel spreadsheets and committee meeting minutes. This data is subsequently reported to the Delegated Oversight Committee (DOC) and the Quality Improvement Committee (QIC) for approval. The DOC meets quarterly to review delegate-submitted reports. DOC meeting outcomes are presented quarterly to the QIC for review and approval.

Interviews with CFCHP leadership and a review of 2021 committee meeting minutes for DOC and QIC support an oversight process still in development. In 2021, there was continued discussion on what delegation oversight will look like, the processes for reporting through committees at the health plan level, and what department would take ownership of these committee activities.

This partially developed structure resulted in an inconsistency in the quarterly reporting of delegated oversight activities for Versant Health (vision) and CVS/Caremark (pharmacy) in 2021. In some instances, a delegate did not provide required reports, while in others, a committee did not meet quarterly or did not always report to the QIC for final review and approval. Examples of these inconsistencies are documented below.

Meeting minutes from the DOC indicate it met four times (but not quarterly) in 2021: March, July, October, and December. QIC meetings were held in March, June, August, and December 2021.

At the March 2021 QIC meeting, no DOC report was given as the DOC did not meet in the fourth quarter of 2020.

At the June 9, 2021 QIC meeting, there was a discussion on what department would take responsibility for DOC activities. No report from DOC was given at this time.

In 2021, CVS/Caremark metrics were monitored through the Delegation Oversight Tracker, an Excel spreadsheet that includes monthly and quarterly roll-ups of performance against metrics outlined in the service level agreement. This same tracking report is intended for oversight of Versant Health; however, documentation of performance did not occur until the last two quarters of 2021 since Versant Health did not submit any data on performance until the third quarter of 2021, when it submitted the entire first eight months of metrics in August 2021.

An ad hoc meeting of the QIC was held on August 2, 2021, where first and second quarter 2021 CVS/Caremark metrics were reported. Metrics for the first half of CY 2021 included Call Stats, Claims Activity, Gaps in Care Reporting, OIG Exclusions, Provider Network, FWA (cases opened and closed audits), Safety & Monitoring Activity, and Interpreter stats, which were reviewed and approved by the ad hoc QIC. At this same meeting, CFCHP discussed the vision vendor, Versant Health.

The September 8, 2021 QIC meeting, minutes reflect reporting from the MMRC on Versant Health and CVS/Caremark PA denials. No DOC oversight report was provided.

Two QIC meetings were held in December 2021. One of these was an ad hoc meeting on December 16, 2021, which focused solely on delegated oversight. Reports from the December 10, 2021 DOC were provided at this meeting. This meeting documented oversight of all relevant metrics from Versant Health and CVS/Caremark.

Evidence of annual oversight audits of the two delegates was not provided.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must show evidence of consistent quarterly reporting of performance metrics for service level agreements with each delegated vendor. These metrics must be reviewed quarterly by the DOC and reviewed and approved by the QIC at each of its quarterly meetings. If this committee structure should change, quarterly reporting and approval should go to the appropriate committee. In addition, the DOC must conduct annual oversight audits of delegates, according to CFCHP's Delegation of Quality Improvement and Services Policy.

**3.3 b.** Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable.

**This component is Partially Met.**

As reflected in component 3.3 a., CFCHP had inconsistencies in delegate performance oversight in 2021, including quarterly review and approval of Versant Health complaints, grievances, and appeals. Delegation oversight of Versant Health complaints, grievances, and appeals oversight did not begin until August 2021, and DOC reporting to the QIC did not occur until December 2021.

CFCHP submitted the following Versant Health complaint, grievance, and appeal reports to show evidence of oversight:

- August 2021 - Appeals Summary Report for Versant Health. This report indicated there were no appeals for this time period.
- August 2021 - Complaint Log Report documenting no enrollee complaints for this time period.
- A 2021 Superior Vision Monthly Oversight Dashboard showing tracking of provider, enrollee, clinical, and administrative appeals, and complaints for the first three quarters of 2021.
- December 2021- Versant Health Dashboard Review documents CFCHP discussion noting Versant Health receives minimal to no appeals each month, and complaints, whether unsubstantiated or not, need to reflect the nature of follow-up action taken.

Improvements in this oversight process were beginning to take shape in December 2021, based on more detailed reporting in two December QIC meetings. In the December 12, 2021 DOC meeting minutes, the committee reviewed the Versant Health Remediation Plan (CAP). It was noted that regular meetings were initiated with the delegate in October 2021 to discuss necessary reporting, the cadence of reporting, quality monitoring, and oversight of performance metrics.

At the December 8, 2021 QIC meeting, a quality program manager reported that Versant Health provided CFCHP with ten months of reporting for 2021, and this data will be reviewed at the December 10, 2021 DOC meeting.

At the December 16, 2021 QIC meeting, a DOC report was presented on delegation oversight, and Versant Health reports were reviewed and approved; however, there was no detail as to what complaint, grievance, and appeal data was reviewed and approved.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must show evidence of quarterly oversight of complaints/grievances and appeals for any entity for whom CFCHP delegates these functions. In 2021, this delegate was Versant Health. Oversight must include a quarterly review of these delegated functions by the DOC and review and approval of these findings by the QIC. Documentation in DOC and QIC meeting minutes must include the detail of the complaints/grievance and appeals activity being reviewed.

**3.3 c.** Review and approval of claims payment activities at least semi-annually, where applicable. **This component is Partially Met.**

Versant Health and CVS/Caremark are delegated claims payment activities.

As per component 3.3a, there was inconsistency in reporting delegation oversight activities to the DOC and the QIC in 2021.

Consistent documentation and reporting of CVS/Caremark claims activities were included on the Delegation Oversight Tracker spreadsheet for all four quarters in 2021. These reports were given to the QIC in the August and December QIC meetings.

Monitoring of claims payment activities for Versant Health did not begin until the third quarter of 2021.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must show evidence in the QIC of semi-annual (at minimum) review and approval of claims payment activities for each vendor delegated claims payment.

**3.3 d.** Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.

**This component is Unmet.**

CFCHP provided no evidence of review and approval of either the Versant Health or CVS/Caremark's UM plan and approval of UM criteria used by the delegates.

Versant Health provided CFCHP with ten months of reporting for 2021, which was reviewed at the December 10, 2021 meeting. This lag in reports prevents CFCHP from doing more real-time oversight of the vendor in order to ensure enrollees are getting the appropriate vision benefit.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must provide evidence of QIC review and approval of the UM Plan and UM criteria for each vendor delegated to perform UM activities.

**3.3 e.** Review and approval of over and underutilization reports, at least semi-annually, where applicable.

**This component is Unmet.**

Based on a review of DOC and QIC 2021 meeting minutes and delegate oversight dashboards for Versant Health and CVS/Caremark, monitoring of utilization data has been more consistent with CVS/Caremark than with Versant Health. It is unclear if there has been discussion and approval of overutilization/underutilization from either delegate in CY 2021.

CFCHP tracks CVS/Caremark's utilization data monthly on the Delegation Oversight Tracker spreadsheet and on the CVS/Caremark Ops Log.

In August 2021, Versant Health submitted to CFCHP its Utilization Report for Age and Type of Service for the first eight months of the year. CFCHP created a Versant Health Monthly Oversight Dashboard that includes this utilization data for the same time period.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must document evidence of QIC review and approval of overutilization/underutilization reports for each entity delegated UM activity at least semi-annually.

### Priority Partners (PPMCO)

**3.3** - There is evidence of continuous and ongoing evaluation of delegated activities, including:

**This element is Partially Met.**

**3.3 d.** Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.

**This component is Partially Met.**

Meeting minutes from the November 30, 2021 DOC meeting indicate all annual UM plans, policies, and procedures were reviewed and approved for CVS/Caremark, TCC, and eviCore.

Meeting minutes from the same DOC meeting indicate Superior Vision's annual review is on hold due to Superior Vision's CAP; PPMCO is awaiting further input in response to the CAP.

In response to the CY 2021 exit letter, PPMCO indicated that it is increasing staffing to successfully complete all delegation oversight functions. The Superior Vision annual review, including a review of the UM Plan and related policies and procedures, is under review and will be presented to the DOC and reported up to the Quality Assurance and Performance Improvement (QAPI) governing body for final review and approval in CY 2022.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, PPMCO must show evidence that the DOC has reviewed Superior Vision's UM plan and UM criteria at least annually and reported findings to the QAPI Committee for review and approval.

## 4.0 - Credentialing and Recredentialing

### Findings

#### CareFirst Community Health Plan (CFCHP)

**4.4** - The credentialing process must be ongoing and current. At a minimum, the credentialing process must include:

**This element is Partially Met.**

**4.4 j.** Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d).

**This component is Partially Met.**

The Credentialing Policy indicates that practitioners will receive a Receipt of a Completed Application letter within 30 days of receipt of the Council for Affordable Quality Healthcare (CAQH) application.

A review of 10 initial credentialing records found five were missing the 30-day notification letter. An additional 20 records were reviewed specifically for evidence of the 30-day notice of intent to credential. A total of 16 more records did not include the required 30-day letter. A final total of 21 out of 30 records, or 70%, were non-compliant.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, initial credentialing records must show evidence that the provider was given written notice of the intent to continue or not continue processing the application. This written notice must be sent within 30 days from receipt of the CAQH credentialing application. This notice is referred to as the 30-day letter.

#### Maryland Physicians Care (MPC)

**4.4** - The credentialing process must be ongoing and current. At a minimum, the credentialing process must include:

**This element is Partially Met.**

**4.4 h.** A review of EPSDT certification.

**This component is Partially Met.**

In a review of 10 initial credentialing records, followed by a review of an additional 20, three out of 30 records did not show evidence of verifying EPSDT certification. Overall compliance was 90%.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MPC must show evidence of verifying EPSDT certification for relevant PCPs.

**4.4 i.** Adherence to the timeframes set forth in the MCO's policies regarding credentialing date requirements.

**This component is Partially Met.**

In a review of 10 initial credentialing records, followed by an additional 20, two out of 30 records exceeded the required turn-around-time (TAT) for processing the application from receipt to 150 days total. Overall compliance was 93%.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MPC must demonstrate consistent compliance with the required TAT for processing the credentialing application in less than or equal to 150 days from the receipt of the application.

**4.4 j.** Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d).

**This component is Partially Met.**

In a review of 10 initial credentialing records, followed by an additional 20, four out of 30 records did not include the 30-day notice to inform the practitioner of the intent to move forward with the initial credentialing process. Overall compliance was 87%.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MPC must show consistent evidence of sending the practitioner the 30-day notice that informs the practitioner of the intent to move forward with the initial credentialing process.

### MedStar Family Care (MSFC)

**4.4 -** The credentialing process must be ongoing and current. At a minimum, the credentialing process must include:

**This element is Partially Met.**

**4.4 j.** Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d).

**This component is Partially Met.**

Per the timeframes specified in Insurance Article Section 15- 112(d), MCOs are required to send a letter of intent to proceed with the initial credentialing review process within 30-days of receipt of the provider's application.

A review of 10 initial credentialing records found two were missing the 30-day notification letter. An additional 20 records were reviewed specifically for evidence of the 30-day notice of intent to credential. A total of four more records did not include the required 30-day letter. Overall compliance was 80% (24 out of 30 records).

Interviews with credentialing management revealed that two of the senior staff responsible for credentialing were out of the office at the same time due to serious illness and death in the family. This led to gaps in credentialing operations for several months in 2021.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, initial credentialing records must show evidence the provider was given written notice of the intent to continue or discontinue processing the application. This written notice must be sent within 30 days from receipt of the Council for Affordable Quality Healthcare credentialing application. This notice is referred to as the 30-day letter.

## 5.0 - Enrollee Rights

### Findings

#### Aetna Better Health (ABH)

**5.1** - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

**This element is Partially Met.**

**5.1 f.** There is complete documentation of the substance of the grievance, steps taken to resolve, and the resolution in the case record.

**This component is Partially Met.**

A sample review of 10 grievance records found inconsistent documentation of the grievance, steps to resolve, and/or a resolution in 4 of the records. For example, an enrollee filed multiple grievances against a previous provider relating to quality of care. Case notes did not document an investigation. An additional 20 records were reviewed for compliance. The majority of cases did not document an investigation in response to a grievance filed against a provider or pharmacy. Additionally, documentation did not identify a resolution in some cases. For example, an apology is not a resolution. Overall compliance with documentation of the substance of a grievance, steps taken to resolve, and the resolution, was 83% (25 out of 30 records reviewed).

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must demonstrate complete documentation of the substance of a grievance, steps to resolve, and the resolution in the case record.

**5.1 g.** The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances.

**This component is Partially Met.**

The Enrollee Complaint/Grievance Policy requires verbal acknowledgment for all verbal grievances at the time of receipt and written acknowledgment for all written grievances within five business days. This is inconsistent with the MDH requirement for written acknowledgment of enrollee grievances within five calendar days of receipt, with the exception of emergency, medically related grievances. Timeframes for grievance resolution are consistent with regulatory requirements for emergency medically related, non-emergency medically related, and administrative grievances.



The 2021 Member Grievance TAT Report identified TAT compliance with written grievance acknowledgment and resolution by grievance category. Written acknowledgment of a grievance was reported as 100% for all months. The difference between this number and the 93% compliance found in the record review may be related to ABH's policy to only acknowledge written grievances in writing. Resolution timeframes met or exceeded the compliance threshold for emergency medically related in 0 out of 1 applicable month, non-emergency, medically related in all 12 months, and administrative in 9 out of 12 months.

A sample review of 10 grievance records found 9 out of 10 grievances demonstrating timeframe compliance with an acknowledgment letter. An additional 20 records were reviewed, with 19 grievances demonstrating compliance. Overall compliance with the grievance acknowledgment letter was 93% (28 out of 30 records). All grievances within the initial sample were resolved within the required timeframe.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must revise the Enrollee Complaint/Grievance Policy to require written acknowledgment of grievance receipt for all non-emergency medically related and all administrative grievances, whether received verbally or in writing. Additionally, ABH must demonstrate TAT compliance for grievance acknowledgment and resolution consistent with regulatory requirements.

**5.1 i.** Written resolution letters describe the grievance and the resolution in easy to understand language.

**This component is Partially Met.**

An initial sample of 10 grievance records were reviewed for compliance. While resolution letters were generally written in easily understandable language, grievance resolutions were appropriate in only five records. An additional sample of 20 resolution letters were reviewed for compliance, with 19 of those demonstrating an appropriate resolution. Overall compliance was 80% (24 out of 30 records). Examples of missing or inappropriate resolutions were offers of an apology only, confirmation that the enrollee's grievance was substantiated as the plan also was unable to establish phone contact with the provider, and a statement of "after further review, grievance found unsubstantiated" as the resolution.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must describe the resolution in easily understandable language (e.g., eliminating the use of substantiated/unsubstantiated) and provide an appropriate resolution of the grievance.

**5.5 -** As a result of the enrollee satisfaction surveys, the MCO:

**This element is Partially Met.**

**5.5 c.** Informs practitioners and providers of assessment results.

**This component is Partially Met.**

The ABH CAHPS/Member Satisfaction Surveys Policy explains that the Chief Operating Officer (COO), with the assistance of the Chief Medical Officer (CMO) and the Director of Quality Management (QM) or designee, is responsible for notifying the provider network of CAHPS® performance results, with results posted on the website, and notification of the posting placed in the provider newsletter. ABH provided evidence that the results were posted on the website via a screenshot sample.



However, none of the four available 2021 provider newsletters appeared to include notification to providers of the availability of CAHPS® performance results on the website, as stated in the ABH CAHPS®/Member Satisfaction Surveys Policy.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must provide evidence of provider notification in the provider newsletter that CAHPS® assessment results were posted on the website.

5.6 - The MCO has systems in place to assure that new enrollees receive required information within established timeframes.

**This element is Partially Met.**

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

**This component is Partially Met.**

The statement in Policy & Procedure 4500.15 under the section “Member Identification Cards” that reads, “Returned ID cards are tracked in the ABH business application system,” is not sufficient to meet this component. ABH’s Member Enrollment Policy and Procedure addresses a tracking mechanism, but does not address an ability to resolve any issues identified with newborn enrollment.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must provide evidence of performing the Enrollment Discrepancy Notifications Desktop Procedure, which describes ABH’s six-step identification and reconciliation process when ABH identifies an enrollee with discrepant eligibility or demographic information, including newborn enrollment.

5.7 - The MCO must have an active Consumer Advisory Board (CAB).

**This element is Partially Met.**

5.7 c. The MCO must have a mechanism for tracking enrollee feedback from the meetings.

**This component is Partially Met.**

The Member Advisory Committee (MAC) Policy does not explain the mechanism of tracking enrollee feedback. In reviewing the minutes for the MAC, there was no attendance from an enrollee of ABH. The meeting minutes did not include any enrollee concerns.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must provide evidence of a) enrollee attendance in MAC meetings, b) enrollee feedback, and c) MAC quorum being met.

5.11 - The MCO has implemented policies and procedures to ensure that the MCO does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his or her patient.

**This element is Partially Met.**

In 2021, ABH’s provider manual asserted that ABH does not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is the provider’s patient.

However, in the policies that ABH provided, Practitioner and Provider Performance Data and Member Rights and Responsibilities, ABH did not offer evidence of how the MCO validates that a provider, acting within the lawful scope of practice, is not restricted from advising or advocating on behalf of an enrollee who is their patient.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must provide evidence of the method(s) for determining that a provider, acting within the lawful scope of practice, is not restricted from advising or advocating on behalf of an enrollee who is their patient.

### Amerigroup (ACC)

**5.5** - As a result of the enrollee satisfaction surveys, the MCO:  
**This element is Partially Met.**

**5.5 c.** Informs practitioners and providers of assessment results.  
**This component is Unmet.**

For this standard, ACC provided evidence of a draft article informing providers about CAHPS® results. During the review, provider newsletters with notification of assessment results were requested; however, ACC stated that provider notification of CAHPS® results was not present in the provider newsletter until 2022. ACC provided a sample of their January 2022 provider newsletter with notification of assessment results. ACC also provided their Member Satisfaction Survey Policy, which includes a section on informing providers of results.

In response to Qlarant's request for additional evidence demonstrating that providers were informed of assessment results, ACC provided two sets of MAC minutes; however, with under 15 providers attending each of the two MAC meetings, this would not serve as sufficient evidence of informing ACC's provider network of assessment results.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ACC must provide evidence that providers were notified of assessment results within the CY being reviewed via both the provider newsletter and any additional means by which providers were informed of assessment results, such as an online provider portal.

**5.7** - The MCO must have an active Consumer Advisory Board (CAB).  
**This element is Partially Met.**

**5.7 b.** The CAB must meet at least six times a year.  
**This component is Partially Met.**

The MCO's CAB did not meet six times in 2021. The CAB met one time in 2021.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ACC must demonstrate that a minimum of six CAB meetings are held in the period under review.

**5.9** - The MCO must maintain written policies and procedures for advance directives.  
**This element is Partially Met.**

**5.9 c.** The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.

**This component is Unmet.**

ACC provided their enrollee handbook as evidence to meet this component; however, ACC did not include any verbiage that advance directive information should reflect changes in state law as soon as possible but no later than 90 days after the effective date of the change.

**OPPORTUNITY FOR IMPROVEMENT:** In order for ACC to receive a finding of Met in the CY 2022 review, ACC must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change and include this requirement in applicable policies and procedures.

### CareFirst Community Health Plan (CFCHP)

**5.1** - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

**This element is Partially Met.**

**5.1 a.** There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09.

**This component is Partially Met.**

The Member Grievance Policy outlines the steps taken to receive, investigate, and resolve enrollee grievances. Several requirements identified in this policy and the desktop procedure are inconsistent with regulatory or the MDH requirements and are as follows:

- The timeframe for sending a written acknowledgment of grievance receipt is five calendar days, not five business days, from receipt of the grievance.
- Grievance acknowledgment letters must be sent for all administrative grievances, as stated, but also for any non-emergency medically related grievances that are not anticipated to be resolved within five calendar days.
- The grievance filing timeframe is identified as not later than 60 calendar days after the event. COMAR 10.67.09.62 states a grievance may be submitted orally or in writing at any time.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must revise the Member Grievances Policy and desktop procedures to state the correct timeframe for sending a written acknowledgment of a grievance, eliminate the timeframe requirement for filing a grievance, and require an acknowledgment letter be sent for non-emergency medically related grievances that are not anticipated to be resolved within five calendar days.

**5.1 c.** The system ensures that the resolution of a grievance is documented according to policy and procedure.

**This component is Met with Opportunity.**

The Member Grievances Desktop Procedure Policy contains a list of items to be documented in the Appeal & Grievance (A&G) systems. The policy includes the date of the grievance resolution but not the resolution. The desktop procedure later indicates that when the investigation is complete,

documentation of results and any pertinent information are forwarded to the A&G Department. The A&G Investigator generates a letter notifying the enrollee of the disposition of the grievance.

CFCHP indicates that resolution timeframes are determined by the type of grievance. The A&G Investigator reviews the issue, determines the grievance type and codes, and categorizes the grievance.

**OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the CY 2022 review, CFCHP must explicitly state in either the Member Grievances Policy or the desktop procedures that grievance resolutions are documented in the case record.**

**5.1 g.** The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances.

**This component is Partially Met.**

As evidence of compliance, CFCHP submitted the quarterly MDH Grievance Report for each of the four quarters of 2021. Overall compliance with grievance resolution timeframes was reported as 100% for the first, second, and fourth quarters and 80% for the third quarter. No reports were submitted demonstrating TAT compliance for grievance acknowledgment letters.

A sample review of 10 enrollee grievance records found 65% compliance with the timeframe for written grievance acknowledgment and 100% compliance with the resolution timeframes.

**OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate compliance with timeframes for written grievance acknowledgment and resolution at the MDH-established threshold.**

**5.3** - The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO:

**This element is Partially Met.**

**5.3 e.** May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.

**This component is Unmet.**

CFCHP provided their Privacy Policy, Minimum Necessary & De-Identification Standard Operating Procedures, and numerous desktop procedures related to confidentiality to demonstrate compliance with this component. However, these policies, the standard operating procedures, and desktop procedures do not appear to specifically address disclosing enrollee records with or without the enrollee's authorization and the need to ensure the enrollee is not identifiable in such a disclosure. During the virtual review, the Use and Disclosure of PHI Policy was requested for review as it was provided in a previous review. However, this policy also did not appear to specifically address disclosure for the purpose of conducting scientific research with or without the enrollee's authorization and the need to ensure the enrollee is not identifiable in such a disclosure.

**OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the CY 2022 review, CFCHP must include in their privacy policy a section that addresses disclosure of enrollee records for research purposes with or without the enrollee's authorization and the need to ensure the enrollee is not identifiable in such a disclosure.**

**5.5** - As a result of the enrollee satisfaction surveys, the MCO:  
**This element is Partially Met.**

**5.5 c.** Informs practitioners and providers of assessment results.  
**This component is Partially Met.**

CFCHP provided a screenshot of their website as evidence that practitioners and providers were informed of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) assessment results. However, while CFCHP provided the Summer/Fall 2021 provider newsletter upon request during the virtual review, the content of the newsletter did not appear to demonstrate evidence that all network practitioners and providers were informed of CAHPS assessment results within the period under review.

The Code of Federal Regulations 42 CFR § 438.66(c)(5) indicates that the State must use results from satisfaction surveys to improve the performance of its managed care program. As one of the primary drivers of satisfaction in the care delivered by the provider network, it is critical that the provider network be fully aware of and encouraged to review updated CAHPS results in order to be able to improve performance. While the website and provider manual are areas where the MCO may have some ability to inform the provider of assessment results, these areas are likely not areas providers would regularly review for general provider news, unlike the provider newsletter. Incorporating information about the review of updated CAHPS results in the provider newsletter, therefore, offers the MCO a greater opportunity to notify providers of common areas where improvement is needed. Greater provider exposure to CAHPS results likely will result in greater provider awareness of, and timely integration of feedback from CAHPS results than a more passive approach might offer and likely impact a larger percentage of the provider network than if the information was not included in the provider newsletter.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must provide evidence of a provider newsletter that informs practitioners and providers of CAHPS assessment results within the period under review in addition to the provided website screenshot.

### **Jai Medical Systems, Inc. (JMS)**

**5.1** - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.  
**This element is Met.**

**5.1 a.** There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09.  
**This component is Met with Opportunity.**

The Member Grievance and Appeal Policy includes all required components for operationalizing a grievance system available to enrollees; however, the TAT for written grievance acknowledgment is incorrectly stated as five business days rather than five calendar days. Additionally, the policy states that if JMS resolves the grievance expeditiously, a Combined Grievance Acknowledgement and Resolution Notice will be sent to the enrollee within two business days. This is not specific enough to demonstrate compliance with requirements. According to MDH, acknowledgment letters are waived if the MCO resolves the grievance within five calendar days or within the regulatory requirement, whichever is less. Furthermore, the specified two business days timeframe for providing a Combined Grievance

Acknowledgment and Resolution Notice is in conflict with the timeframes established by JMS for written resolution and may be confusing to staff.

JMS commented that the MCO's Member Grievance and Appeal Policy procedure for sending a grievance acknowledgment complies with the MDH's guidance from 2019, which states that acknowledgment letters are waived if the MCO resolves the grievance within five calendar days or within the regulatory requirement, whichever is less. JMS' Grievance and Appeals Policy and implementation of the policy indicate that JMS resolves the grievance more expeditiously than the MDH requirement through a Combined Grievance Acknowledgement and Resolution Notice sent to the enrollee within two business days.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, JMS must revise the timeframe for sending the enrollee a written acknowledgment of grievance receipt from five business days to five calendar days of grievance receipt. Additionally, JMS must revise the exception noted for sending a written grievance acknowledgment to be consistent with MDH requirements.

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

**5.1** - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

**This element is Partially Met.**

**5.1 d.** The policy and procedure describe the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning.

**This component is Partially Met.**

The Mid-Atlantic States Non-Medicare Grievances and Appeals Policy indicates that grievance data will be routinely monitored and analyzed for trends, as a component of the MCO's QI program. According to the policy, action plans will be implemented and monitored for improvement.

As evidence of compliance, KPMAS submitted RQIC Medicaid Updates for the third and fourth quarters of 2020 and the first and second quarters of 2021. Each of these updates included reporting of compliance with grievance TATs. There was no evidence that grievance trends were identified and analyzed for opportunities for improvement, or action plans developed and monitored, in response to any identified opportunities.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must demonstrate that it tracks and trends grievance data to identify opportunities for improvement and implements action plans, as indicated. Additionally, the Mid-Atlantic States Non-Medicare Grievances and Appeals Policy needs to be revised to identify the responsible party for reporting grievance data, including trends, opportunities for improvement, and action plans to the appropriate quality committee, at least quarterly.

**5.1 g.** The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances.

**This component is Partially Met.**

The Mid-Atlantic States Non-Medicare Grievance and Appeals Policy identifies the timeframes for written acknowledgment of each grievance within five calendar days and written resolution of each category of grievance, which is inclusive of the resolution and consistent with regulatory timeframes for resolution.

KPMAS submitted TAT reports indicating monthly compliance, by grievance category, throughout 2021. One emergency medically related grievance was submitted and was not resolved within the required timeframe. For non-emergency medically related grievances, the compliance threshold met or exceeded compliance in eight of 12 months. For administrative grievances, the compliance threshold met or exceeded compliance in 11 of 12 months. Compliance with the timeframe for written grievance acknowledgment for non-emergency medically related grievances met or exceeded the compliance threshold in all 12 months of 2021. Administrative grievances met or exceeded the threshold in six of the 12 months.

A sample review of 10 enrollee grievance records found 100% TAT compliance with written grievances. Seven of 10 records met or exceeded the TAT compliance threshold for resolution. An additional 20 records were reviewed with 17 out of the 20 records demonstrating compliance. Overall compliance was 80% (24 out of 30 records).

Incorrect categorization was the major cause of noncompliance in eight of 30 grievances. The most frequent error was categorizing a grievance as administrative when it should have been categorized as non-emergency medically related, such as difficulty obtaining a prescription or receiving the wrong medication.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must demonstrate TAT compliance with written acknowledgment and resolution of grievances at or above MDH's threshold.

**RECOMMENDATION:** Qlarant recommends that KPMAS consider retraining its grievance staff on correct categorization of grievances and institute regular audits to ensure grievances are being correctly categorized.

## Maryland Physicians Care (MPC)

**5.1** - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

**This element is Partially Met.**

**5.1 d.** The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning.

**This component is Partially Met.**

The Enrollee Grievance Process Policy requires the Grievance Manager to review grievances on a monthly basis to determine if any trends exist. If any trends are identified, they are referred to the appropriate department for review, education, training, and/or corrective action, as indicated. The Grievance Manager is required to submit a quarterly report of enrollee grievances to the Service Improvement Committee (SIC). All identified trends also are submitted to Quality Management Oversight Committee (QMOC) for review. Action plans are initiated under the direction of the SIC.



A review of SIC minutes from five meetings held in 2021 found that the top enrollee grievances were reported in three of the five meetings. Billing was identified as the top service category and represented 40.5%, 35%, and 63% for the months of March, June, and September, respectively. Access-related grievances occupied the second spot, ranging from 13% to 34%. There was no evidence that MPC analyzed these top categories, in particular the financial one, to identify any opportunities for improvement.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MPC must demonstrate that it analyzes top grievance trends to determine any opportunities for improvement and initiates action, as indicated.

**5.3** - The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO:

**This element is Met.**

**5.3 e.** May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.

**This component is Met with Opportunity.**

The Use and Disclosure of Protected Health Information (PHI) Policy explains that MPC releases the minimum amount of information necessary to carry out a function or purpose. Compliance with this component was affirmed by MPC's policy for research-related disclosures during the virtual onsite review. While this policy does protect enrollee information to an extent, it does not explicitly outline what elements MPC will not ultimately disclose to qualified personnel for the purpose of conducting scientific research.

**OPPORTUNITY FOR IMPROVEMENT:** To receive a finding of Met for the CY 2022 review, MPC must enhance the language surrounding research-related disclosures to specifically address the prevention of the disclosure of enrollee identity to qualified personnel for the purpose of conducting scientific research.

### Priority Partners (PPMCO)

**5.1** - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

**This element is Partially Met.**

**5.1 d.** The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning.

**This component is Partially Met.**

The Member Complaint/Grievance Policy requires data and analysis related to complaints and grievances to be reported to the designated quality committee on a quarterly basis. The QI Department is responsible for analyzing trends and determining the form of intervention most appropriate to promote improvements in QI relating to complaints and grievances throughout the organization. The



policy also identifies other committees and departments that receive an analysis of grievance data and the frequency, as applicable.

As evidence of compliance, PPMCO submitted minutes from four 2021 Member Survey Workgroup meetings. Minutes from each meeting noted that attitude/service continued to be the top service category for complaints; however, there was no evidence of analysis of the root causes or development of interventions to address identified opportunities for improvement.

PPMCO responded to the CY 2021 exit letter agreeing with these findings and reporting improvements to the grievance analysis process are underway. These improvements will need to be detailed in the CAP submission.

**OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the CY 2022 review, PPMCO must demonstrate that it analyzes grievance data based on identified trends and develops interventions to address opportunities for improvement. Additionally, the Member Complaint/Grievance Policy should be modified to reflect the transfer of responsibility for trending and analysis of grievance data from the QI Department to the Appeals, Complaints, and Grievances Department.**

**5.1 g.** The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances.

**This component is Partially Met.**

As noted in component 5.1a, the Priority Partners Member Complaint/Grievance Policy indicates that acknowledgment of grievance receipt will be sent to the enrollee within 72 hours of receipt, with the exception of emergency medically related grievances. Resolution timeframes are consistent with regulations.

PPMCO submitted a TAT Compliance Report that indicated monthly compliance for acknowledgment letters, which consistently exceeded the threshold for all 12 months of 2021. PPMCO did not submit any reports of TAT compliance with grievance resolution. The TAT report provided was for written resolution within 72 hours of grievance resolution, which does not satisfy this requirement.

A sample review of 10 enrollee grievance records found 100% compliance with the timeframe for written grievance acknowledgment and 93% with the resolution, which meets the MDH relaxed compliance threshold in place during the first three quarters of 2021.

PPMCO responded to the exit letter indicating agreement with these findings.

**OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the CY 2022 review, PPMCO must demonstrate compliance with grievance resolution timeframes at the MDH-established threshold on at least a quarterly basis.**

**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.

**This element is Partially Met.**

PPMCO provided a few examples of written enrollee materials that demonstrate access to health care services and information in a manner consistent with the formatting and special access requirements of COMAR 10.67.05.01C. However, PPMCO did not provide a policy on written materials demonstrating a

standard for written materials to globally meet these requirements. PPMCO did provide the JHHC Member Communications Policy upon request, but this policy does not appear to address the special access requirements of COMAR 10.67.05.01C.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, PPMCO must provide a policy that demonstrates written materials are developed in a manner consistent with the formatting and special access requirements of COMAR 10.67.05.01C.

## UnitedHealthcare (UHC)

**5.1** - The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.

**This element is Partially Met.**

**5.1 g.** The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances.

**This component is Partially Met.**

As evidence of compliance, UHC submitted MCO Grievance Quarterly Reports for the first through the third quarter of 2021, which demonstrated resolution timeframes exceeded the compliance threshold. No evidence was provided of compliance with written grievance acknowledgments. UHC subsequently submitted the Maryland Appeal Compliance Report Q4 2021, which included compliance with grievance timeframes by month and by quarter throughout 2021. In all quarters, UHC exceeded the TAT compliance threshold for written acknowledgment and grievance resolution.

An initial sample review of 10 enrollee grievances found that nine met the five—calendar-day timeframe for written grievance acknowledgment. An additional 20 records were reviewed for compliance, with 14 of the 20 records meeting the timeframe. Overall compliance with written grievance acknowledgment was 77% (23 out of 30 records).

This same sample was reviewed for compliance with resolution timeframes, with nine of 10 records meeting the regulatory timeframe. A review of an additional 20 records found 18 out of the 20 in compliance. Overall compliance with resolution timeframes was 90% (27 out of 30 records), which met the 90% threshold in place through September 2021. No records were reviewed for the fourth quarter.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, UHC must demonstrate compliance with the timeframe for written grievance acknowledgment within the MDH-established threshold.

## 6.0 - Availability and Accessibility

### Findings

#### UnitedHealthcare (UHC)

**6.1** - 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.

**This element is Partially Met.**

**6.1 c.** 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. **This component is Unmet.**

UHC did not demonstrate that it has developed standards/indicators to monitor, measure, and report on its performance within the established policies and procedures for the operations of its customer/enrollee services. UHC provided the Accessibility of Services Policy, which outlines the types of access standards and measures. It describes that measures must reflect the standards used to assess performance. However, the "Member Service Telephone Access" section does not specify the performance standards, leaving this section blank.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a score of Met in the CY 2022 review, UHC must demonstrate the development of call center performance standards, including methodologies for measurement of the standards and consistent processes for monitoring, evaluating, and improving performance.

## 7.0 - Utilization Review

### Findings

#### Aetna Better Health (ABH)

**7.7** - The MCO must have written policies and procedures pertaining to enrollee appeals. **This element is Partially Met.**

**7.7 f.** Written notifications to enrollees include appeal decisions that are documented in easy to understand language. **This component is Partially Met.**

The Enrollee Appeals Policy requires ABH to provide the enrollee with written notice of the appeal resolution, which includes the specific reasons for the decision in easily understandable language.

A sample of 10 appeal resolution letters was reviewed to determine if appeal decisions were documented in easily understandable language. Two letters did not satisfy this requirement. For example, one letter stated the reason for appeal as "Denial of HT Muscle Image Spect Mult," and the other stated the reason for the upheld decision as "records do not show procedure met criteria for diagnosis and condition of member," which is an inadequate explanation. An additional 20 records were reviewed, with two providing reasons for the decision in language that was not easily understandable, such as "provided documentation that GFR is over 45." Overall compliance was 87% (26 out of 30 records). Additionally, the majority of the resolution letters were of extremely poor quality, with field descriptions not replaced with required content, multiple grammatical errors, and consistently incorrect dates for requesting a state fair hearing (e.g., 5/1/1900) and requesting continuation of benefits (e.g., 1/11/1900).

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must demonstrate that its enrollee-appeal resolution letters are written in easily understandable language, include all required content and accurate dates, and are grammatically correct.

**7.8** - The MCO must have written policies and procedures pertaining to provider appeals.

**This element is Partially Met.**

**7.8 a.** The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.

**This component is Partially Met.**

The Provider Appeals Policy outlines procedures and timeframes for resolving provider requests to reconsider a decision. The policy requires verbal acknowledgment of all verbal requests at the time of receipt and either written or verbal acknowledgment of written requests within five business days. This is inconsistent with COMAR 10.67.09.03, which requires a written acknowledgment of all provider appeals within five business days of receipt by the MCO. The policy allows appeal levels within 90 days from receipt of the initial appeal received by ABH. This is also inconsistent with COMAR 10.67.09.03, which specifies a timeframe of 90 business days from receipt of the initial appeal by the MCO for resolution of appeals, regardless of the number of appeal levels. The policy further notes that providers are allowed 15 business days from the date of denial to file each subsequent level of appeal. Providers appealing a first-level decision are allowed to appeal directly to ABH's Chief Executive Officer.

The policy requires the review and resolution of all provider appeals within 30 business days of receipt for each level of appeal. For all requests, ABH will generate a written decision notice to the provider via electronic mail, fax, or surface mail within 10 calendar days from the date of the decision, or as promptly as the enrollee's health requires. Additionally, the policy specifies that ABH will pay the claim within 30 days of the appeal decision when a claim denial is overturned.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must revise the Provider Appeals Policy to require written acknowledgment of appeal receipt for all provider appeals, whether requested verbally or in writing. Additionally, all appeals, regardless of the number of levels, must be resolved within 90 business days, not 90 calendar days, from receipt of the initial appeal.

**7.8 c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.

**This component is Unmet.**

In response to the CY 2020 review, ABH was required to demonstrate compliance with providing written acknowledgment of a provider appeal, and written resolution, within the required timeframes. As indicated below, a continued opportunity for improvement exists.

The 2021 Monthly Provider Appeals TAT report identifies the monthly percentage of compliance for written acknowledgment and written resolution of provider appeals from January through December 2021. Compliance with a written acknowledgment of appeal receipt was met in eight of 12 months (67%), with the first four months ranging from 21.9% to 73.1%. Compliance with appeal resolution timeliness was met in nine of 12 months (75%), with the first three months ranging from 54.7% to 82.7%. Compliance with ABH's timeframe for providing written notification of an appeal resolution within three business days of the decision met or exceeded the threshold in all 12 months.

According to the Provider Appeal Policy, ABH is required to generate a written decision notice to the provider via electronic mail, fax, or surface mail within 10 calendar days from the date of the decision, or

as promptly as the enrollee's health requires. As reported above, TAT compliance is measured using a three business day standard.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must demonstrate compliance with the timeframe for sending a written acknowledgment of receipt of a provider appeal and resolution for all 12 months of the year under review. ABH also must resolve the inconsistency in the timeframe for providing written notice of appeal resolution, which is identified as 10 calendar days from the decision in policy and 3 business days for compliance tracking.

**7.10** - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.

**This element is Met with Opportunity.**

The Provider Appeals Policy describes the specific responsibilities of ABH in relation to the IRO complaint resolution process for disputes between the MCO and providers regarding MCO adverse medical necessity decisions. Missing from this list is the establishment of an online account with the IRO that is to be used to provide all information; however, a completed agreement between ABH and the IRO includes this requirement. The policy requires the MCO to submit a complete case file to the IRO within five business days of the request, and to upload any additional information requested within two business days of the request. It indicates that the MCO will pay the fixed-case fee in the event the IRO overturns the appeal decision, and will process the provider's claim to pay within 60 calendar days of the date on the IRO's notification, including any interest owed under Health Insurance Article § 15-1005(f). The policy also identifies MCO penalties based on the number of delinquencies resulting from failure to pay the IRO fee within 60 calendar days of the date of the invoice.

According to ABH, it has not had any providers submit an appeal to the IRO, so no online account has been established and no invoices submitted by the IRO for payment if the IRO overturns the MCO's appeal decision.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must provide documentation of a process to ensure IRO invoices are paid within 60 days and logs documenting payment of any IRO invoices within 60 days. The process for monitoring timely payment of IRO invoices could be documented in either a policy or desktop procedure. Additionally, ABH must demonstrate that it has established an online account with the IRO, which is required regardless of whether the MCO receives any cases.

### Amerigroup (ACC)

**7.2** - The UR Plan specifies criteria for UR/UM decisions.

**This element is Met.**

**7.2 e.** There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM criteria/guidelines.

**This component is Met with Opportunity.**

The Utilization Management Program (UMP) Description identified the UMP's objectives. One objective is to establish and maintain education and training for health care professionals to foster expertise that corresponds with the UM reviews they conduct. The Health Care Management - Clinical Training Compliance Policy primarily addressed the orientation and training of new hires. There is no mention of the required annual training of UM staff on the interpretation and application of UM criteria/guidelines.

As evidence of training, ACC provided a table that included the name of five UM staff enrollees, their position, the Milliman Care Guidelines (MCG) course taken, and the date of completion.

In response to the CY 2021 SPR exit letter, ACC resubmitted the 2021 UMP Description with a modification date of February 24, 2022. This version includes, as one of the program objectives, "the need to ensure that all Clinical UM staff receive annual training on the interpretation and application of UM criteria and guidelines." Since this revision is outside of the CY 2021 review period, the policy in place at the time of the CY 2022 SPR will be reviewed for compliance.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ACC must include, in policy or the UMP Description, the requirement for annual training of UM staff on the interpretation and application of UM criteria/guidelines.

**7.6** - The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials.

**This element is Partially Met.**

**7.6 b.** The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.

**This component is Partially Met.**

A review of the Health Care Management Pharmacy report for the first and second quarters of 2021 found that ACC met or exceeded the TAT compliance threshold for adverse determination notifications. HCM meeting minutes for the first and second quarters of 2021 also affirmed compliance with adverse determination notification timeframes for medical preauthorization (PA) requests. MCO Quarterly Pre-Service Denial Reports were submitted for the third and fourth quarters of 2021, demonstrating compliance with the MDH threshold in all categories for the third quarter and in all categories, except expedited, in the fourth quarter.

A sample review of 10 adverse determination records (4 medical and 6 pharmacy) found 100% compliance with adverse determination notification timeframes.

As part of the CY 2021 SPR exit letter response, ACC documented its progress in coming into compliance with adverse determination notification timeframes, which needs to be included in the CAP at the time of submission.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ACC must demonstrate compliance with adverse determination notification timeframes at or above the threshold established by MDH for all four quarters.

**7.8** - The MCO must have written policies and procedures pertaining to provider appeals.

**This element is Partially Met.**



**7.8 c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.

**This component is Unmet.**

In response to the CY 2020 review, ACC was required to provide evidence of compliance with timeframes for written resolution of all upheld and overturned provider administrative (claims) appeals, consistent with the MCO's policies for the entire CY under review. As indicated below, continued opportunities for improvement exist.

As evidence of compliance, ACC provided a Maryland-Metrics Provider Appeals Report. This report is an excel spreadsheet documenting monthly TAT compliance with a written acknowledgment of provider appeals and resolution of overturned decisions within 30 business days and resolution of overturned and upheld decisions within 90 business days.

Based upon a review of the Maryland-Metrics Provider Appeals Report, ACC met MDH's threshold for written appeal acknowledgment in all months of CY 2021, except February, when the TAT compliance rate was 83.8%. ACC did not track compliance with the 30-calendar-day timeframe from the appeal decision for providing a written resolution.

In discussions with ACC Compliance and Quality Department staff, Qlarant also identified that ACC was considering appeals submitted by a provider, on behalf of an enrollee, as provider appeals rather than enrollee appeals. ACC acknowledged this and is developing action steps to address this error with applicable MCO staff.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ACC must demonstrate TAT compliance with written appeal acknowledgment letters at the MDH-established threshold and written resolution with the MCO's timeframe for each appeal level. In addition, ACC must document in policy and procedure and appropriately distinguish in tracking documents that pre-service appeals submitted by a provider on behalf of an enrollee are considered enrollee appeals.

**7.10** - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.

**This element is Partially Met.**

The Provider Claim Payment Dispute Process Policy submitted to demonstrate compliance with this component does not address the IRO dispute resolution process available to providers regarding adverse medical necessity decisions made by the MCO. ACC did submit a Maximus Medical Necessity Case Review Agreement; however, it was neither signed nor executed.

ACC provided additional feedback in response to the CY 2021 SPR exit letter, including a fully executed Medical Necessity Case Review Agreement between Maximus Federal Services Inc. and ACC, dated June 13, 2014. According to this agreement, ACC has established an online account for IRO cases through Maximus. A screenshot of this database illustrates a Maximus password-protected portal for reporting medical-necessity review cases under the heading, Independent Review Organization for MDH.

ACC confirmed there were no IRO services required in CY 2021 and, therefore, no invoices in CY 2021 to provide as evidence. ACC updated the Provider Claim Payment Dispute Process Policy with the IRO language on February 25, 2022. This policy and procedure will need to be resubmitted for review as part of the CAP required in response to this finding.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ACC must demonstrate that it has a documented policy and procedure for supporting the provider complaint resolution process through the IRO.

### CareFirst Community Health Plan (CFCHP)

**7.2** - The UR Plan specifies criteria for UR/UM decisions.

**This element is Met.**

**7.2 e.** There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM criteria/guidelines.

**This component is Met with Opportunity.**

As evidence of annual staff training on MCG criteria, a document was submitted entitled "MCG Training 2021." The training encompassed a review of six test cases from the 25th edition of Milliman Care Guidelines (MCG), which was conducted by the MCG trainer in the UM team meeting held on August 10, 2021. Case studies reviewed were provided, and names of medical directors and UM nurses participating in the training and the subsequent inter-rater reliability assessment were listed.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate the requirement for annual training of UM staff on the interpretation and application of UM criteria is included in either the Utilization Management Program Description or a UM policy.

**7.3** - The written UR Plan has mechanisms in place to detect overutilization and underutilization of services.

**This element is Partially Met.**

**7.3 a.** Services provided must be reviewed for over and underutilization.

**This component is Partially Met.**

The Health Services (HS) Program Description includes as two of its measurable goals:

- Reduction in the 30-day readmission rate after hospital stays of three days or more by two percentage points compared to 2020.
- Reduction in emergency department (ED) visits in target populations by two percentage points in 12 months.

Assessing performance data and reports on care, reviewing data, and responding to utilization issues are among the responsibilities assigned to the QIC. UM leadership is responsible for monitoring the following measures to identify potential areas of overutilization/underutilization of medical services:

- Admissions per 1000 enrollees
- Bed days per 1000 enrollees
- LOS



- Readmissions
- Quality, utilization, risk management indicators

The HS Program Description does not address the role of the Medical Management Review Committee (MMRC) in reviewing UM data to assess potential overutilization/underutilization. However, in the 2021 QIPD, the MMRC is identified as responsible for reviewing UM data to identify trends and variations and recommending modifications to the program as needed. As evidence of a review of utilization data, a PowerPoint presentation entitled "MMRC 2nd Quarter 2021 Update to the QIC" was presented at the MMRC meeting on October 18, 2021. This presentation included overall IP and ED trends, as displayed in a line graph and a table identifying the top five facilities and their admits and days per 1000, and the average LOS. There also was a brief analysis of the data noting that the increase in IP measures during the second quarter compared to the same quarter of 2020 was challenging due to the impact of COVID on IP trends. Minutes from three QIC meetings also were reviewed. In the March 31, 2021 meeting, a report from MMRC appeared to include a PowerPoint presentation that was not submitted for review. In the June 9, 2021 meeting, it was reported that the MMRC did not meet in the first quarter, so first and second quarter data would be reviewed at the next QIC. In the draft minutes of September 8, 2021, there was no documentation of a review of utilization data. The MMRC report to the QIC addressed the increasing volume of PA requests and TAT metrics.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate that it is reviewing, at least quarterly, utilization data to assess areas of overutilization/underutilization. The role of the MMRC in reviewing UM data to identify any areas of overutilization/underutilization should be included in the HS Program Description, and the frequency of review specified for both the MMRC and QIC.

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

**This component is Unmet.**

As noted in component 7.3a, the HS Program Description includes two of its measurable goals as a reduction in the 30-day readmission rate and a reduction in ED visits. There was no evidence of any corrective action that was taken to address either of these goals. Rather, contributing factors to IP admissions, LOS, and readmissions were identified as delayed care due to COVID and new, sicker enrollees in the plan in the third quarter MMRC minutes.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate that it is taking corrective action to address identified areas of overutilization/underutilization.

**7.3 c.** Corrective measures implemented must be monitored.

**This component is Unmet.**

As noted in component 7.3b, there was no evidence of any corrective action taken to address identified areas of overutilization, identified as readmissions and ED visits, in minutes from MMRC and QIC meetings held in 2021.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate that it routinely monitors corrective action taken to address identified areas of overutilization/underutilization.

**7.6** - The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials.

**This element is Partially Met.**

**7.6 a.** The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.

**This component is Partially Met.**

According to the Timeliness of Utilization Management Decisions Standard Operating Procedure, the adverse determination notification timeframe for standard PA requests is within 72 hours of the date of the determination, which is consistent with regulatory requirements. For expedited PA requests, the MCO is required to make a determination and provide notice no later than 72 hours of receipt of the request. This is consistent with regulatory requirements; however, the statement that follows requiring notice of a denial decision for an expedited PA request to be provided to the enrollee within 72 hours of the determination is not. Additionally, there was no evidence of the requirement for providing written notice to an enrollee at least 10 days prior to reducing, suspending, or terminating a covered service.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must revise the Timeliness of Utilization Management Decisions Standard Operating Procedure to eliminate the inconsistency in the timeframe for sending enrollees an adverse determination letter for an expedited PA request. Additionally, the requirement for providing written notice to an enrollee at least 10 days prior to reducing, suspending, or terminating a covered service must be documented in a UM policy.

**7.7** - The MCO must have written policies and procedures pertaining to enrollee appeals.

**This element is Partially Met.**

**7.7 a.** The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05.

**This component is Partially Met.**

The Member Appeals Policy allows an enrollee, or their authorized representative with written consent, to file an appeal within 60 days of the adverse determination notice. This timeframe description does not specifically indicate the date of the adverse determination notice beginning the 60 day timeframe. Appeals are accepted orally or in writing. Timeframes specified for written acknowledgment and written resolution of standard and expedited appeals are consistent with regulatory requirements.

The Appeals and Grievances Desktop Procedures provide additional detail relating to the processing of appeals and enrollee rights. Responsibilities of the A&G coordinators include logging the appeal into the A&G database while A&G investigators document the substance of the appeal, including the reason for the appeal and any aspects of clinical care involved, and any actions taken. The A&G investigator takes into account information provided by the enrollee or their authorized representative without regard to whether such information was submitted or considered in the initial action. The enrollee, or their authorized representative, is provided the opportunity to examine the enrollee's case file, including medical records and any other documents and records before and during the appeal process, free of charge. Review procedures are documented for both clinical and administrative appeals. Additionally, the contents of the notice of resolution are listed. Parties to the appeal also are identified. Although not documented in either the Member Appeals Policy or the desktop procedure, the Provider Appeals Policy asserts that CFCHP will not take any punitive action against a provider for supporting an enrollee's

appeal or for requesting expedited resolution for an enrollee's appeal. This information would be more appropriately included in the Member Appeals Policy.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must revise the Member Appeals Policy to clarify the appeal filing timeframe is 60 calendar days from the date on the notice of adverse benefit determination. This also should be clarified in the desktop procedure.

**RECOMMENDATION:** Qlarant recommends that CFCHP consider including, in the Member Appeals Policy, that no punitive action will be taken against a provider for supporting an enrollee's appeal or for requesting expedited resolution for an enrollee's appeal.

**7.7 e.** Reasonable efforts are made to give the enrollee prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.

**This component is Partially Met.**

The Member Appeals Policy requires the MCO to make a reasonable effort to give the enrollee and treating provider prompt verbal notice and written notice within two calendar days of a denial of a request for an expedited appeal resolution.

A review of an initial sample of 10 enrollee appeal records found two denials of an expedited resolution. Written notice of the denial was provided within the required timeframe; however, there was no evidence that a reasonable attempt had been made to provide the enrollee with oral notice. Three denied requests were found in the additional 20 records reviewed, with all three demonstrating compliance with the written notification and none with an oral notification.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate a reasonable attempt to provide the enrollee with oral notification of the denial of a request for an expedited appeal resolution.

**7.8 -** The MCO must have written policies and procedures pertaining to provider appeals.

**This element is Partially Met.**

**7.8 c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.

**This component is Unmet.**

In response to the CY 2021 review, CFCHP was required to demonstrate compliance with TATs for sending providers a written appeal acknowledgment and written resolution within the required timeframes at the MDH-established thresholds. As indicated below, continued opportunities for improvement exist.

As evidence of compliance, CFCHP submitted the quarterly MDH Appeal Reports for enrollee appeals rather than provider appeals. Following a request for additional documentation, CFCHP submitted an updated CAP that identified TAT compliance with written provider appeal acknowledgment for the last three quarters of 2021. Results met the threshold for the second quarter but fell below for the remaining two quarters at 80% and 83%. No results were provided for written appeal acknowledgment for the first quarter, and no TAT compliance reports were submitted for written resolution for 2021.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate TAT compliance for written acknowledgment and written resolution of provider appeals at or above the MDH-established threshold.

**7.9** - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

**This element is Partially Met.**

**7.9 b.** The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.

**This component is Partially Met.**

Review of Member Experience Committee (MEC) minutes from meetings held in March, May, and August found no evidence of review of results from the 2020 CAHPS and Provider Satisfaction Surveys. In the August meeting, it was noted the CAHPS survey response rates for 2021 were lower than in previous years.

The March 31, 2021, QIC meeting reported that the 2020 CAHPS survey results were reviewed, and a plan for improvement is in development. In the draft, QIC minutes of December 8, 2021, results from the 2021 CAHPS survey were reported, including areas of strengths and opportunities. Based upon the results of the child survey, Getting Needed Care and Getting Care Quickly were identified as opportunities. It was noted the MEC would be working on developing ideas and strategies to improve response rate and scores. There was no mention of either the 2020 or 2021 Provider Satisfaction Survey results in minutes from the March, June, September, and two December QIC meetings.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate a review of UM-related results from the CAHPS and Provider Satisfaction Surveys by the committee(s), consistent with its policies.

**7.9 c.** The MCO acts upon identified issues as a result of the review of the data.

**This component is Unmet.**

A review of several minutes from 2021 MEC and QIC meetings found no evidence of development and implementation of any action plans to address UM opportunities based on the results from either the 2020 or 2021 CAHPS and Provider Satisfaction Surveys.

As evidence of the implementation of action plans, CFCHP submitted the 2021 Member Experience Quality Improvement Analysis. This analysis included data from grievances, appeals, the CAHPS survey, and the MCO's internal Experience of Care & Health Outcomes Survey. This analysis, which was apparently completed in the first quarter of 2022, is outside of the review period. It was considered; however, it offered no action plans to address UM-related opportunities from the CAHPS and Provider Satisfaction Surveys.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must demonstrate that it develops and implements action plans to address UM-related opportunities based upon the results of the annual CAHPS and Provider Satisfaction Surveys.

**7.10** - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the

MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.

**This element is Partially Met.**

The Provider Appeals – IRO Request Policy includes the requirement for the establishment of an online account with the independent review organization (IRO) for providing all required information, the timeframe for reimbursing the provider in the event of an overturn by the IRO, and payment of the fixed case fee within 60 calendar days, should the IRO rule against the MCO. The policy does not include the timeframes for uploading the complete case record within five business days of receipt of the request and any additional case-related documentation requested by the IRO within two business days of receipt of the notification. The policy also does not include the process for ensuring all IRO invoices are paid within 60 days. A review of the Provider Appeals - IRO Request Desktop Procedure did not find either of these missing requirements.

As evidence of the implementation of this policy, CFCHP provided a screenshot from the Maximus Dashboard. This dashboard provided a case history for requests submitted in 2019 and 2020. A spreadsheet entitled “Advanced Medical Reviews Payment History 2021” demonstrated the timely payment of IRO invoices submitted from January through September 2021.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must revise the Provider Appeals – IRO Request Policy to include the timeframes for uploading the complete case record and any additional case-related documentation requested by the IRO and a process for ensuring that all IRO invoices are paid within the required 60-day timeframe.

### Jai Medical Systems, Inc. (JMS)

**7.10** - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.

**This element is Met with Opportunity.**

The Claims Payment Appeals Process Policy describes the Independent Review Organization (IRO) process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO, which is consistent with regulatory requirements. The policy requires the MCO to create an online account with the IRO and upload the complete case record for each medical case review request within five business days of receipt of the request from the IRO. Any additional case-related documentation requested by the IRO must be uploaded within two business days of receipt of the request. If the MCO receives an adverse decision by the IRO, it must fully reimburse the provider for the claim that was deemed to be medically necessary by the IRO within 60 calendar days of the adverse determination, including any interest owed. The MCO also must pay the IRO the fixed case fee within 60 days of receiving the invoice. In the event the MCO does not pay the IRO within 60 calendar days of the release of the invoice, the MCO is subject to payment of liquidated damages. The policy is silent on the process that JMS has in place to ensure all IRO invoices are paid within 60 days.

As evidence of compliance, JMS submitted a copy of the Medical Necessity Case Review Agreement between Maximus and JMS, which was signed by the MCO's CEO. Additionally, the MCO submitted a

screenshot from the IRO portal documenting JMS' upload of a case record on August 11, 2021, and an email from Maximus confirming the successful upload of a case record, dated November 10, 2021. JMS also submitted a number of screenshots from the IRO portal documenting the timely payment of several IRO invoices throughout 2021.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, JMS must provide documentation of a process to ensure that all IRO invoices are paid within 60 days.

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

**7.3** - The written UR Plan has mechanisms in place to detect overutilization and underutilization of services.

**This element is Partially Met.**

**7.3 a.** Services provided must be reviewed for over and underutilization.

**This component is Partially Met.**

The UMP Description includes, within its scope, the development of indicators and thresholds for monitoring and evaluating overutilization, underutilization, and misutilization. One of the identified responsibilities of the Regional Utilization Management Committee (RUMC) is to monitor utilization targets for IP and ambulatory care. According to the UMP Description, aggregate ad hoc UM reports are generated to identify and analyze trends, as determined by the specific need or purpose. Review findings are compiled into reports for the purpose of analyzing root causes of trended outcomes and formulating recommendations.

The Utilization Management Work Plan Goals document for MD HealthChoice includes the following:

- Achieve hospital patient day rate targets
- Reduce extended length of stay
- Reduce skilled nursing patient day rate

The UM Work Plan documents performance against set goals and allows tracking for key UM measures, on a quarterly basis. Barriers and major interventions to achieve stated goals are identified, and general comments are included, to address ongoing activities. Performance against established UM goals for the HealthChoice membership is reported and discussed by the RUMC on a quarterly basis. For example, in the RUMC meeting of May 26, 2021, review of performance against UM work plan goals was documented for hospital utilization, readmissions, extended length of stay, and SNF patient day rates. Minutes did not always identify results specific to Maryland HealthChoice. For example, the Medicaid readmission rate was reported to include Maryland HealthChoice and Virginia Medicaid.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must report utilization rates specific to the Maryland HealthChoice population.

**7.3 c.** Corrective measures implemented must be monitored.

**This component is Partially Met.**

RUMC minutes demonstrated ongoing monitoring of interventions. For example, the August 25, 2021 meeting minutes reported that Maryland HealthChoice (DC Metropolitan area) demonstrated favorable improvement to variance from the first quarter. The Baltimore area of HealthChoice fell below the



target, as compared to having met it in the first quarter. Overall barriers and interventions to decrease hospital utilization were identified for the region and included Commercial/Exchanges, Medicare Advantage, and VA Medicaid, in addition to the Maryland HealthChoice population.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must report barriers and interventions relating to identified overutilization and underutilization of services specific to the Maryland HealthChoice population.

**7.6** - The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials.

**This element is Partially Met.**

**7.6 a.** The MCO maintains policies and procedures pertaining to timeliness of adverse determination notifications in response to preauthorization requests as specified by the State.

**This component is Partially Met.**

The Assessing Compliance MD HealthChoice Determination and Notifications Policy includes a table listing enrollee 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. There is an additional requirement that the written notification must be provided within 24 hours of the determination (within the 72-hour timeframe), which is not included. 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 enrollee 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.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must revise the Assessing Compliance MD HealthChoice Determination and Notifications Policy to specify that an adverse determination notice, in response to an expedited PA request, must be provided to the enrollee within 24 hours of the determination and within the 72-hour timeframe from receipt of the request.

**7.7** - The MCO must have written policies and procedures pertaining to enrollee appeals.

**This element is Partially Met.**

**7.7 a.** The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05.

**This component is Partially Met.**

The Mid-Atlantic States Non-Medicare Grievance and Appeals Policy addresses regulatory requirements for operationalizing an appeal system. Major components include:

- Timeframes for filing appeal acknowledgment, and written, appeal resolution, consistent with regulatory requirements.
- Documentation of the appeal, and any action taken related to a case in the Member Experience Tracking and Reporting System.
- Appeal extension requirements.
- Appeals may be filed verbally, in person, or in writing.

- Enrollees, their authorized representatives, or their providers acting on the enrollee's behalf, may appeal an adverse action.
- Enrollee right to request any new or additional evidence considered, relied upon, or generated in connection with the appeal.
- Assertions that KPMAS will not take punitive action against a provider who requests an expedited resolution or who supports an enrollee's appeal.

Missing in the policy is identification of parties to the appeal, to include the enrollee, the enrollee's representative, or the estate representative of a deceased enrollee. These parties are specified under the "State Fair Hearing Process" section, but are not included under the MCO's appeal procedures.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must identify the parties to the MCO's appeal process in the Mid-Atlantic States Non-Medicare Grievance and Appeals Policy.

**7.8** - The MCO must have written policies and procedures pertaining to provider appeals.  
**This element is Partially Met.**

**7.8 c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.  
**This component is Unmet.**

In response to the CY 2020 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, on at least a quarterly basis at MDH's established threshold. As indicated below, continued opportunities for improvement exist.

The Maryland Medicaid Provider Appeals Dashboard Report identified monthly compliance with required provider appeal timeframes, by month and quarter, throughout 2021. Written acknowledgment of provider appeals met or exceeded the compliance threshold in three of the four quarters. The percentage of compliance was 53% for the fourth quarter. The MCO reported 100% compliance with written notice of appeal resolution in 30 days for the first three quarters. It fell below the 95% threshold in the fourth quarter, with a compliance rate of 90%.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must demonstrate TAT compliance with MDH's threshold for written appeal acknowledgment and written resolution for all four quarters.

**7.9** - There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.  
**This element is Partially Met.**

**7.9 c.** The MCO acts upon identified issues as a result of the review of the data.  
**This component is Unmet.**

As evidence of compliance with this requirement, KPMAS submitted a document entitled "Actions\_ Access to Care\_Care Coordination\_2021," which is a comprehensive report of actions and interventions to address opportunities related to Access to Care and Care Coordination. It does not appear that these



opportunities are specifically related to the Maryland HealthChoice population and UM-related results from the CAHPS and Provider Satisfaction Surveys.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must demonstrate that it acts upon identified issues as a result of the review of UM satisfaction data specific to the HealthChoice population and the providers within the HealthChoice service area.

### Maryland Physicians Care (MPC)

**7.7** - The MCO must have written policies and procedures pertaining to enrollee appeals.  
**This element is Partially Met.**

**7.7 e.** Reasonable efforts are made to give the enrollee prompt verbal notice of denial of expedited resolution and a written notice within two calendar days of the denial of the request.  
**This component is Partially Met.**

The Enrollee Appeal Policy requires the MCO to make reasonable efforts to give an enrollee, or their representative, prompt verbal notice of the denial of a request for an expedited resolution and written notice of the denial no later than 72 hours of the initial appeal request. This timeframe is inconsistent with regulatory requirements that specify written notice is to be provided within two calendar days of the decision to deny.

A sample of 10 appeal records was reviewed for compliance. There was one denied request for an expedited appeal. Written notice was provided within the required timeframe; however, there was no evidence of a reasonable attempt to provide the enrollee with oral notice of the denial. There were no further denied requests for an expedited appeal in the additional 20 records reviewed.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MPC must revise the Enrollee Appeal Policy to reflect the 2 calendar day regulatory timeframe for providing the enrollee with written notice of the denial of an expedited appeal request. Additionally, case records must demonstrate a reasonable attempt to provide the enrollee with oral notice of the denial of an expedited request.

**7.8** - The MCO must have written policies and procedures pertaining to provider appeals.  
**This element is Partially Met.**

**7.8 b.** The MCO's provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely.  
**This component is Met with Opportunity.**

The Provider Appeal Policy requires the MCO to provide timely written notice to the provider of the results of the internal appeal but does not identify a specific timeframe for written notification of resolution for each of the two appeal levels.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MPC must document in the Provider Appeal Policy, the timeframe for providing written resolution of the appeal at each level.

**7.8 c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.

**This component is Partially Met.**

The Key Indicator Report (KIR) tracks compliance with timeframes for written appeal acknowledgment to the provider and overall resolution, which includes written notification. Results were provided for each of the four quarters of 2021.

Compliance with the five-business day timeframe for written acknowledgment of an appeal fell below the relaxed 90% threshold in place for the first quarter, with a rate of 88%. Compliance with the 90-business-day standard for appeal resolution, with written notification, exceeded the compliance threshold in place for all four quarters. It does not appear that MPC tracks compliance with an MCO-established timeframe for providing a written resolution of the appeal at each appeal level.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MPC must demonstrate compliance with the established threshold for providing written acknowledgment of provider appeals, on at least a quarterly basis, for the CY under review. Additionally, compliance with the MCO-established timeframe for written notice of the resolution, at each appeal level, must be tracked and reported on at least a quarterly basis.

### MedStar Family Care (MSFC)

**7.10** - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.

**This element is Met with Opportunity.**

The External Appeals and IRO Process Policy provides a comprehensive outline of the complaint resolution process for disputes between the MCO and providers regarding adverse determinations made by the MCO. Specifically, the policy includes requirements for the establishment of an online account with the independent review organization (IRO) and timeframes for responding to initial and subsequent requests for case records. Should the IRO rule against the MCO, the policy also details timeframes for payment of the IRO fixed-case rate and timeframes for payment of the provider. Finally, the policy details penalties, including liquidated damages, in the event the IRO is not paid within the required timeframe. The Manager of Appeals/Grievances/ER Reviews, or designee, is responsible for forwarding the IRO invoice to the Finance Department to remit payment within the allotted timeframe. The policy does not address how the timeliness of payment is monitored.

As evidence of compliance with the IRO complaint resolution process, MSFC submitted an executed agreement with Maximus, the IRO, and a screenshot of IRO notification of a successful case file documentation upload. A screenshot from the Maximus database was submitted to demonstrate invoices are paid in 60 days; however, compliance could not be determined as each listed invoice listed a paid amount and date, but the date of the invoice was not recorded.

MSFC subsequently provided an explanation of how it monitors the timely payment of IRO invoices within 60 days. According to MSFC, prior to August 2021, it needed to manually interact with the Accounts Payable Department of MSH to get an exception to MedStar's rule of checks being sent at day

60. To meet the 60-day payment deadline for the MDH, this manual email process was required for each Maximus IRO invoice to have a check go out by day 30 in order to meet the deadline. Beginning in August 2021, MSFC established a new process involving the submission of tickets through a tracker system for payment. Prior authorization is in place and checks are cut within 30 days of submission. MSFC's Executive Assistant and Manager of Appeals monitors the actual check mail date in the ticketing/tracking system. This system replaces the previous process whereby email confirmation of payment was forwarded to the Manager of Appeals and AVP Clinical Operations.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MSFC must document the process for ensuring timely payment of IRO invoices in the External Appeals and IRO Process Policy or in a desktop procedure.

### Priority Partners (PPMCO)

**7.3** - The written UR Plan has mechanisms in place to detect overutilization and underutilization of services.

**This element is Partially Met.**

**7.3 a.** Services provided must be reviewed for over and underutilization.

**This component is Partially Met.**

The Over- and Under- Utilization Policy outlines procedures for data analysis, trending, reporting, action plans, and follow-up on identified issues related to overutilization/ underutilization of medical services and devices provided to enrollees. Potential trends, interventions, and opportunities for improvement are reviewed and assessed during the PPMCO Health Services (HS) and Provider Network Management (HSNM) Committee monthly meetings and reported to the QAPI governing board, at least quarterly. Associated activities related to the analysis of overutilization/underutilization, reporting, CAP(s), and follow-up are documented in the QAPI governing body minutes. The following data is monitored in order to detect potential overutilization/underutilization:

- IP acute care utilization trends by hospital and diagnosis
- ED visits
- Pre-service authorizations
- Denial rates

PPMCO provided examples of multiple dashboards, which visually displayed IP metrics such as admits and days per 1000, length of stay, and 30-day readmission rates for 2019 through 2021. Minutes from multiple committees were submitted; however, there was no evidence that a review of any utilization data occurred to determine potential areas of overutilization/underutilization. Specifically, minutes from monthly QAPI meetings from January through June were focused on determining an appropriate forum for discussion of overutilization/underutilization to meet the 7.3 element/components of the SPR.

In the June 3, 2021 meeting, it was reported that the Over- and Under- Utilization Policy was updated and assigned responsibility to the PPMCO HSNM Committee, as noted above, for review of utilization data and development of interventions, as indicated, with quarterly reporting to QAPI. A review of HSNM Committee minutes from the June 14, July 8, and August 5, 2021 meetings did not evidence any review of utilization data to assess for potential overutilization and underutilization of services. Additionally, minutes from the August 5, 2021 QAPI meeting did not demonstrate a review of utilization data. According to a document submitted by PPMCO, overutilization and underutilization of services

have been tracked in collaboration between the UM Department, HS, and Finance. Although it was discussed in strategy sessions, it was not presented in the QI structure.

In response to the CY 2021 exit letter, PPMCO indicated agreement with these findings and shared its plan for improvement, which will need to be included in the CAP submission.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, PPMCO must demonstrate a routine review of utilization data to assess potential overutilization and underutilization of services consistent with its Over- and Under- Utilization Policy.

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

**This component is Met with Opportunity.**

In the minutes of the April 1, 2021 HS Committee of the Board of Directors, it was reported that asthma was the focus of underutilization for CY 2020; however, the plan is looking to move to other opportunities for broader overutilization/underutilization. In the HSNM Committee meeting held on July 8, 2021, a discussion focused on interventions to address the asthma medication ratio. Among the planned interventions identified were outreach calls by Pharmacy to noncompliant and barely compliant enrollees offering refill reminders and refill support. Provider outreach was also identified as necessary to address barriers.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, there must be documentation to support the selection of any identified areas(s) of overutilization/underutilization and corrective action by the appropriate committees consistent with its Over- and Under- Utilization Policy.

**7.7** - The MCO must have written policies and procedures pertaining to enrollee appeals.

**This element is Partially Met.**

**7.7 e.** Reasonable efforts are made to give the enrollee prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.

**This component is Partially Met.**

The Priority Partners Enrollee Appeals Policy asserts that if the MCO denies a request for an expedited appeal resolution, reasonable efforts must be made to provide the enrollee with oral notice of denial and a written notice within two calendar days of the denial.

A sample of 10 enrollee records was reviewed for compliance. There were no denials of an expedited request in the 30 records reviewed; however, one expedited request was processed as standard, although there was no evidence that a request for an expedited resolution was denied.

In response to the CY 2021 SPR exit letter, PPMCO agreed with these findings and shared a plan for improvement, which needs to be included in the CAP submission.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, PPMCO must demonstrate that if it denies a request for an expedited appeal resolution, reasonable efforts are made to provide the enrollee with oral notice of the denial and a written notice within two calendar days of the denial.

**7.8** - The MCO must have written policies and procedures pertaining to provider appeals.

**This element is Met.**

**7.8 c.** The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.

**This component is Met with Opportunity.**

The PPMCO Provider Appeals TAT Report identified TAT compliance with provider acknowledgment and notification of appeal resolution by quarter throughout 2021. Written acknowledgment and resolution letters met the TAT compliance threshold in all four quarters based upon a corrected report provided in response to the exit letter. Additionally, it was noted that PPMCO continues to report compliance for expedited provider appeals. All provider administrative appeals are to be classified as non-emergency, as previously advised.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of met in the CY 2022 review, all provider administrative (claims) appeals must be classified as non-emergency.

**7.10** - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.

**This element is Met with Opportunity.**

The Provider Adverse Medical Necessity Dispute Policy outlines the specific responsibilities of PPMCO to provide a complaint-resolution process for disputes between the MCO and providers regarding adverse medical necessity determinations made by the MCO. These include the establishment of an online account with the Independent Review Organization (IRO) for uploading complete case records and any additional information, upon request, within required timeframes. In the event the IRO rules against PPMCO, the MCO is required to fully reimburse the provider within 60 calendar days of the date of an adverse decision, including any interest owed. Additionally, the MCO must pay the case review charge within 60 calendar days of the date of the IRO invoice. The policy further asserts that financial penalties will be imposed by the MDH in response to any payment delinquencies of the IRO invoice. The policy does not include a process to ensure IRO invoices are paid within 60 days.

Screenshots were provided affirming Maximus's review of cases submitted by PPMCO providers, including a screenshot entitled "View Invoices/Statements," which displayed an invoice dated July 3, 2021, as past due.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, PPMCO must either revise the Provider Adverse Medical Necessity Dispute Policy or develop a desktop that documents the process for assuring that IRO invoices are paid within 60 days.

## UnitedHealthcare (UHC)

**7.3** - The written UR Plan has mechanisms in place to detect overutilization and underutilization of services.

**This element is Met.**

**7.3 c.** Corrective measures implemented must be monitored.

**This component is Met with Opportunity.**

Updated UM work plans and meeting minutes of the Health Care Quality and Utilization Management Committee (HQUMC) and QMC support ongoing monitoring of current performance against established 2021 goals for identified areas of overutilization and underutilization. For example, in the September 9, 2021, HQUMC meeting, it was reported that all categories of preterm births increased from 2020 to 2021, driving the average length of stay. Additionally, it was noted that for June 2021, the highest length of stay cases were micro-preemies with 153- and 126-day stays.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, UHC must demonstrate that it not only reviews current utilization against established goals but also the effectiveness of interventions that have been developed to address identified areas of overutilization and underutilization. Use of the Plan, Do, Study, Act approach may facilitate needed revisions to existing interventions or replacement, as indicated.

**7.8 -** The MCO must have written policies and procedures pertaining to provider appeals.

**This element is Met.**

**7.8 a.** The MCO's provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.

**This component is Met with Opportunity.**

The Provider Grievance and Appeal Policy outlines the procedures and timeframes for resolving provider appeals related to payment disputes. The policy allows the provider 90 business days from the date on the reconsideration notice to file an initial appeal. A written acknowledgment of appeal receipt is required within five business days of receipt by the MCO. A final, second level appeal includes the MCO's Chief Executive Officer (CEO) or designee and must be received by the MCO within 15 business days of the first level appeal resolution notice. Resolution of the first level appeal determination is required within 40 calendar days of receipt of the appeal, and the final level of determination within 35 days of receipt of the request for reconsideration of the appeal. Resolution of both levels is to be completed within 90 business days of receipt of the initial appeal. The policy requires a written resolution of the appeal outcome but does not include a timeframe for sending this notice from the date of determination. If a denial is overturned, the disputed claim is required to be paid within 30 days of the appeal decision.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, UHC must revise the Provider Grievance and Appeal Policy to specify the timeframe it has established for providing written notice of appeal resolution for both first and second levels.

**7.9 -** There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

**This element is Partially Met.**

**7.9 c.** The MCO acts upon identified issues as a result of the review of the data.

**This component is Partially Met.**



UHC developed limited project plans to address identified opportunities for improvement related to the 2020 CAHPS and Provider Satisfaction surveys. For example, the 2021 CAHPS work plan listed the following interventions related to Getting Needed Care:

- Review the Outreach Productivity Report for the prior quarter to determine the number of enrollees reached, the number of appointments made by the Outreach agent, and the number of appointments scheduled rate.
- Review Member Outreach - Missed Appointments.
- Review provider access-related concerns from enrollee verbatims.

No goals were identified for any of the above interventions or follow-up activities if goals were not met.

The Provider Satisfaction Survey Work Plan listed one intervention to monitor PA TATs for medical and pharmacy requests to ensure compliance thresholds are met. As noted in a prior compliance review, this UM-related action plan is limited and does not address the provider's overall experience in obtaining authorizations, which was also identified as an opportunity.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, UHC must demonstrate that it conducts a root cause analysis of UM-related opportunities to ensure that its interventions will be effective in increasing rates for targeted measures from both the CAHPS and Provider Satisfaction Surveys. For example, improving the timeliness of PA determinations may have no impact on providers' overall experience in obtaining authorizations. The use of feedback from the CAB and the PAC also may be helpful in informing interventions.

**7.10** - The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.

**This element is Partially Met.**

The Provider Grievance and Appeal Policy includes a section, "Independent Review Process," that documents the MCO's responsibilities for supporting the independent review process, which is available to providers for resolving disputes with the MCO regarding medical necessity claim denials. The policy does not include the requirement that the MCO must establish an online account with the IRO and provide all required documentation through this account. The policy requires the MCO to submit the case record within five calendar days of receipt of the IRO's request, which is more stringent than the MDH's requirement of five business days of receipt. The policy does not address the requirement for uploading any additional, case-related documentation requested by the IRO within two business days of receipt of the IRO's request. If the IRO rules against UHC, the MCO is required to fully reimburse the provider within 60 calendar days of the adverse determination and pay the fixed case fee to the IRO within 60 calendar days of the invoice. The policy does not include a documented process to ensure that IRO invoices are paid timely.

As evidence of implementation, UHC provided a signed agreement with the IRO, Maximus, dated July 23, 2021. Additionally, it submitted an invoice tracking log, which included the IRO invoice date, date received, check date, and check amount for five invoices received from January to July 2021. One invoice dated February 28, 2021, was not reported as received until July 15, 2021.

As part of the exit letter response, UHC provided additional policies and procedures to support compliance with IRO process requirements. These newly submitted policies contain some of the required elements but not all. In other words, there is not one policy and procedure that captures all of the IRO process requirements. For example, the MD External Review SOP outlines the steps for implementing the IRO process. This procedure includes requirements for the MCO to submit the case record within five business days of receipt of the IRO's request and for uploading any additional, case-related documentation requested by the IRO within two business days of receipt of the IRO's request. It does not include the requirement that the MCO is to fully reimburse the provider within 60 calendar days of the adverse determination and pay the fixed case fee to the IRO within 60 calendar days of the invoice.

On April 21, 2022, UHC submitted a revised Provider Grievance and Appeal Policy to support compliance. This revised policy is outside of the CY 2021 review timeframe. It may be resubmitted for review as part of the corrective action process.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, UHC must revise the Provider Grievance and Appeal Policy and the MD External Review SOP to include all required components. The MCO's specific responsibilities under the MD Medicaid Managed Care Independent Review Services process are as follows and should be included in the policy and procedure:

- Establish an online account with the IRO and provide all required information through this account.
- Upload the complete case record for each medical case review request within five business days of receipt of the request from the IRO.
- Upload any additional, case-related documentation requested by the IRO within two business days of receipt of notification of a request for additional information from the IRO.
- Agree to pay the fixed case fee should the IRO rule against the MCO and has a documented process to assure IRO invoices are paid within 60 days per COMAR 10.67.13.07C(2).

**RECOMMENDATION:** Qlarant recommends that UHC establish one IRO policy and procedure that addresses all aspects of the IRO process. This may eliminate the inconsistencies with having more than one policy and procedure.

## 8.0 - Continuity of Care

### Findings

#### Amerigroup (ACC)

**8.6** - The MCO has processes in place for coordinating care with the State's behavioral health and substance use vendors and demonstrates implementation of these procedures.

**This element is Met with Opportunity.**

ACC submitted numerous documents to demonstrate compliance with this element.

According to the document entitled, "Continuity and Coordination Between Medical Care and Behavioral Healthcare," ACC has processes in place for coordinating care with MDH's behavioral health (BH) and substance use disorder (SUD) vendor, Optum. These processes ensure that enrollees with co-



occurring BH and physical health conditions are identified and interventions delivered appropriately. The 2021 Emergency Room Frequent Flyer Report offers a sample of ways to identify enrollees with co-occurring conditions.

The Coordination of Care Between Behavioral Health and Medical Management Policy outlines roles for coordination and communication between the UM case managers and ACC's BH case managers, Population Health care managers, and physical health case managers.

To ensure coordination of care occurs with BH and physical health providers, ACC has a Coordination of Care Between Physical and Behavioral Health Care Providers Policy. According to this policy, the "Provider Line" is used when either a PCP or BH specialist recognizes a co-occurring BH or physical health need requiring assessment and/or treatment.

ACC uses the provider manual and provider newsletter to educate providers on how to access BH services and provides telephone numbers for Optum. ACC did not provide evidence to show provider education and promotion for the Screening, Brief Intervention, and Referral to Treatment process; provider education about the substance use release of information process under 42 CFR, Part 2; and more detailed provider education for enrollee identification and referrals to the administrative services organization or core service agencies for BH services.

The Access to Behavioral Health Care Policy documents requirements for an enrollee's timely access to BH services.

Interviews with CM staff indicate ACC staff have monthly clinical rounds with Optum to discuss enrollees with co-occurring disorders, identify options for the appropriate level of care placements, and address challenging cases. Participants in these rounds may include ACC BH and Optum BH medical directors, BH case managers from both organizations (registered nurses and social workers), the Optum MCO liaison to the health plans, and the peer recovery specialist as the advocate for the enrollee.

Numerous examples were submitted to support the implementation of BH rounds. As an example, in October 2021, there was correspondence between Optum and ACC's CM team pertaining to a minor with injuries from an attempted suicide. Options for placement at a facility that could address the youth's physical rehabilitation needs, as well as BH treatment, were discussed. In another example, email correspondence showed the ACC case manager working with Optum and the BH Administration's Adolescent and Youth Service Division to facilitate the placement of an enrollee in a transitional program for at-risk youth.

In the April 7, 2021 QMC meeting, the 2021 Continuity & Coordination Between Medical and Behavioral Healthcare Report was given. There was a lengthy discussion on methods for improving provider understanding of BH issues and showing what is working well with the Optum and ACC collaboration. The greatest challenge remains to obtain Optum data on enrollee utilization. Without an enrollee's release of information, the MCO cannot learn about enrollees with SUD and BH issues.

Other evidence submitted to support compliance includes:

- Behavioral Health Telephonic Intake Protocol for Members Policy
- Corrective Managed Care Prescriber Program - MD Policy
- Screenshots of Documentation in CareCompass on ACC Rounds with Optum
- Claims file from 2021 of enrollees on BH medications

- 2021 QMC meeting minutes

In response to the CY 2021 SPR exit letter, ACC submitted additional documentation to show evidence of communication with providers on the BH/SUD system. This additional evidence includes CY2021 Quick Reference Guides and Specialty Reference Guides with information on how to access BH/SUD services for each of its county service areas in the state. The provider newsletter from February 2021 also was submitted. These documents provide greater detail on access and treatment resources for BH/SUD available to providers.

There remains an opportunity to conduct provider education and promotion for the Screening, Brief Intervention, Referral to Treatment process, and education about the substance use release of information process under 42 CFR, Part 2, per CY 2021 SPR Standards and Guidelines.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ACC must show documentation in policy, proof of implementation of provider education on, and promotion of the Screening, Brief Intervention, and Referral to Treatment process. ACC must also show documentation in policy and in proof of implementation of provider education about the substance use release of information process under 42 CFR, Part 2.

### CareFirst Community Health Plan (CFCHP)

**8.2** - The MCO must ensure appropriate initiation of care based on the results of HSNI data supplied to the MCO. This must include a process for gathering HSNI data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.

**This element is Met with Opportunity.**

According to the Case Management Process for Reviewing the HSNI Data document, when HSNI enrollment data from the MDH is sent to CFCHP, it is captured in a report in the MCO's electronic data warehouse and is shared with the CM team. Members are prioritized for CM by the following identified areas:

- Pregnancy
- Asthma
- Homelessness
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- BH/SUDs

CFCHP staff contact the enrollee and open a case. For enrollees indicating they need assistance with scheduling an appointment or transportation to an appointment, text messages are sent requesting contact with the correct department for assistance.

The Health Risk Assessment Desktop Procedure outlines the process for assessing and stratifying enrollees based on the health risk assessment (HRA). CFCHP uses an electronic program to auto-triage electronic HRA data received from the State upon enrollment. This program assigns cases with positive risks to the appropriate HS staff to further evaluate the enrollee's needs by completing a comprehensive HRA and wellness screening and initiating appropriate action plans based on that assessment and the resources available.

It is unclear how CFCHP is tracking the 10- and 90-day timeframes for contacting the enrollee if an HSNI is not received from the State.

HRA reporting is done through the PAC and the QIC, as evidenced in meeting minutes.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must ensure that policies for HSNI and HRA are clear on the distinctions between the HSNI data received from the State versus an HRA performed by CM when a member is enrolled in CM. As it is now, the two policies confuse the processes.

## 10.0 - Outreach Plan

### Findings

#### Aetna Better Health (ABH)

**10.1** - The MCO has developed a written Outreach Plan that describes the following:  
**This element is Met.**

**10.1 f.** MCO's relationship with each of the LHDs and ACCUs.  
**This component is Met with Opportunity.**

ABH has memorandums of understanding (MOUs) with all LHDs across the state. The MOUs outline the responsibilities of ABH and the LHDs regarding enrollee outreach and states that the MCO, providers, and LHDs will work collaboratively to bring enrollees into care. Specifically, the LHDs will:

- Designate a staff member to serve as a contact person for ABH and providers.
- Maintain a single point of entry for referrals from the MCO and its providers for outreach to noncompliant enrollees.
- Ensure that LHD staff are knowledgeable about Medicaid services covered by the MCO and the right of enrollees to self-refer to out-of-plan providers for certain services.
- Within 10 business days of its receipt of a written referral from the MCO or its provider, make a determination, consistent with applicable COMAR regulations and with the MOU between MDH and the LHD, as to what action, if any, will be taken on the case by the LHD and inform the MCO of its determination to accept or refuse the referral.
- Within 15 business days of its receipt of a referral that is accepted by the LHD, attempt to contact the referred enrollee directly by telephone; if telephone contact is unsuccessful, attempt face-to-face contact at the enrollee's home or in another community setting, as appropriate.
- Within 30 calendar days of its receipt of a referral that the LHD accepts, provide the MCO up-to-date information, in writing, regarding the LHD's successful and or unsuccessful attempts to contact the enrollee.
- Maintain the confidentiality of client records and eligibility information in accordance with all federal, state, and local laws and regulations, and use this information only in assisting the enrollee to receive needed health care services.

Outreach and CM staff provided additional information regarding referrals made to the LHD. Referrals are tracked and monitored through an internal data system, Dynamo. With a referral, an event is

created in the system, and the open and closed referrals can be tracked and monitored. Upon receiving updated information from the LHD, the updated information is entered into the system. Staff have 30 days to update information or close the event. Staff are reminded to follow up on the referral event through set tasks, which are explained in the Community Resource Referral Event Job Aid. If the LHD is unable to reach the enrollee after 30 days, the event is closed. ABH then utilizes a vendor, Best Foot Forward, to continue outreach attempts. Referral numbers are reported through the CM Department.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must provide detail in the Outreach Plan regarding how the MCO tracks and monitors referrals to, and responses from, the LHD.

## CareFirst Community Health Plan (CFCHP)

**10.1** - The MCO has developed a written OP that describes the following:  
**This element is Met.**

**10.1 d.** Community partnerships.  
**This component is Met with Opportunity.**

CFCHP has developed and maintained various partnerships within the community it serves. These relationships have been developed with the intent to outreach to current and potential enrollees with the goal of responding to individual and community concerns. CFCHP partners assist in providing outreach services to enrollees, often through direct face-to-face contact. This includes providing health education and other wellness services. CFCHP continues to build relationships in the community to increase the resources available to its membership. CFCHP outreach staff regularly travel to community partners and provider offices to conduct face-to-face outreach. CFCHP participates in a multitude of community health events.

CFCHP works with its provider and community partners to participate in community health events. It maintains a calendar of health events, which is posted on its website, and certain events are included in enrollee newsletters. CFCHP also conducts phone/text/mailing outreach campaigns to inform enrollees about health events in their area. Its representatives offer face-to-face outreach at selected health events. CFCHP also contracts with clinical providers to attend health events and administer certain health care services.

CFCHP sponsors a CAB forum that is held six times a year. The CAB's purpose is to provide a format for communication between enrollees and CFCHP staff. Objectives include reviewing enrollee concerns, providing health education, offering community resources, and developing initiatives to increase value-added services. The board reviews enrollee educational materials, marketing information, newsletters, and other relevant communication to provide valuable input for process improvements. Beginning March 2020, due to the COVID-19 public health emergency, meetings have been conducted virtually via Zoom.

In addition to vendors, which assist in community outreach, internal CFCHP community health workers are planted within select communities to work with enrollees and connect them to local and neighborhood resources. These workers outreach to enrollees at their homes and have a detailed knowledge of local health care stakeholders.

During the virtual onsite review, CFCHP provided information regarding their community partners. CFCHP collaborates with Maryland food banks, food pantries, and churches. It arranges and conducts community events in these venues to support the OP by distributing various enrollee materials. Evidence of enrollee material was provided for events that occurred in 2021; these include Healthy House 101, Green & Healthy Homes Initiative, Credit Report Review Checklist, and Consumer Financial Protection Bureau.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must provide examples in the Outreach Plan of their community partners and their role in providing outreach activities to assist in bringing enrollees into care.

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

**This component is Met with Opportunity.**

CFCHP maintains collaborative relationships with the LHDs through a memorandum of understanding with 21 county health departments. CFCHP staff collaborate with the LHD/Administrative Care Coordination Unit (ACCU) to fulfill outreach and transportation needs. The LHD's ACCU assists CFCHP in locating enrollees and encouraging them to get preventive or chronic health services.

When enrollees miss three consecutive follow-up appointments, CFCHP will, within 10 business days, make or ensure the enrollee's provider submits a written referral via the referral form to the LHD requesting outreach assistance to bring the enrollee into care. The Desktop Procedure explaining the process for completing a LHD referral was provided for review. After a referral has been generated to the LHD, CFCHP will continue to work collaboratively with the LHD to bring the enrollee into care until the enrollee comes back into compliance. If CFCHP has not heard anything about the enrollee from the ACCU within two weeks, the ACCU will be asked for further information. The Desktop Procedure for Outreach and Tasking for LHD referrals was provided for review. The procedure explains how tasks are set in a case for tracking and monitoring.

If the LHD is successful in finding the enrollee, the outreach designee updates the new demographic information in CFCHP's claims/CM platform system's Health Rules and Click4Care and proceeds with efforts to get the enrollee into care. If the LHD is not successful in finding the enrollee, the LHD communicates, in writing and by phone, their efforts and the status of the outreach.

CFCHP works with the LHD to improve services to enrollees. It attends meetings held by the LHDs and works collaboratively with the LHD and other attendees to address enrollee- and provider-related topics. Additionally, CFCHP works with the LHD to find solutions to problems, determine better methods of access and care coordination, and identify opportunities for case management services.

CFCHP continues working with all LHDs on outreach efforts, local events, and other activities in order to better serve its enrollees.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022, CFCHP must provide information regarding how LHD referrals are tracked and monitored.

### **Jai Medical Systems, Inc. (JMS)**

**10.1** - The MCO has developed a written OP that describes the following:

**This element is Met.**

**10.1 a.** Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership.

**This component is Met with Opportunity.**

JMS' OP describes a total membership of 29,286 as of April 19, 2021, with the largest percentage of enrollees residing in Baltimore City (65%). Twenty-five percent live in Baltimore County, five percent live in Anne Arundel County, and one percent live outside of the MCO's current contracted area. Thirty-two percent of JMS enrollees are under 21 years of age.

Below is the approximate number of JMS' enrollees in each of the Special Populations groups as defined by the enrollees' HSNI:

- Children in State-supervised care (165)
- Children with special health care needs (272)
- Individuals with physical disabilities (518)
- Individuals with HIV/AIDS (305)
- Individuals who are homeless (114)
- Pregnant enrollees (128)

Common health problems among the JMS population include:

- Hypertension
- Diabetes
- Asthma
- Substance use
- Obesity
- Hepatitis C
- HIV/AIDS

JMS has reduced barriers that impede access to health care:

- Inconvenient service hours
- Lack of transportation

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, JMS must provide the total number of enrollees comprising the special needs population categories as defined in COMAR 10.67.04.04B. Individuals with developmental disabilities and postpartum women should be included.

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

**This component is Met with Opportunity.**

After JMS exhausts its efforts to contact and bring the enrollee into care, they will refer the enrollee to the LHD Administrative Case Coordination Unit for assistance. To refer an enrollee to the LHD for outreach, JMS completes a Local Health Services Request form. After ensuring all applicable areas of the request form are completed, the request is forwarded to the appropriate LHD in the city/county where the enrollee resides. A copy of this form is retained and tracked by the JMS staff member making the request. The staff member monitors whether the enrollee is located and whether they enter into care. A

claims analysis is completed for enrollees who are referred to the LHD to determine the effectiveness of the LHD in helping the enrollee to access health care services. The LHD will attempt to contact the enrollee by telephone, mail, and face-to-face. Once an enrollee has been contacted, the LHD will work collaboratively with JMS to link the enrollee with an appointment and transportation.

The LHD will contact the enrollee and provide written feedback to JMS as soon as possible. The LHD will connect the MCO with the enrollees they locate. The process is frequently facilitated while the LHD outreach worker is in the enrollee's home. This includes the social worker calling a special number at JMS to coordinate immediate care when the enrollee is located. When an enrollee does not respond or is not located by the LHD, the LHD will close the referral, and the MCO will initiate the outreach process from the beginning.

An attachment within JMS' OP provides detailed information regarding returned referrals from the LHDs. The number of referrals was included along with the overall response rate.

***OPPORTUNITY FOR IMPROVEMENT:*** In order to receive a finding of Met in the CY 2022 review, JMS must provide further detail in the outreach plan regarding how the MCO tracks and monitors referrals to the LHD.

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

**10.1** - The MCO has developed a written OP that describes the following:

**This element is Partially Met.**

**10.1 d.** Community partnerships.

**This component is Partially Met.**

KPMAS' Community Health team invests in programs and initiatives focused on advancing total health by partnering with local governments, school districts, and businesses. KPMAS provided company and agency logos of community partners; however, a description of their role in supporting outreach activities is not included in the OP.

KPMAS submitted an updated 2022 Outreach Plan with descriptions of community partnerships and their role in supporting outreach activities. However, the 2021 finding will remain Partially Met since the 2021 Outreach Plan did not meet requirements.

***OPPORTUNITY FOR IMPROVEMENT:*** In order to receive a finding of Met in the CY 2022 review, KPMAS must provide a description of the community partnerships, and their role, in supporting outreach activities to bring enrollees into care.

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

**This component is Met with Opportunity.**

KPMAS has established Memoranda of Understanding (MOU) with nine participating LHDs. Coordination with LHDs occurs for high-risk obstetric enrollees and enrollees who have missed a specific number of appointments with failed outreach. According to the Local Health Department Referral Process Policy, data is utilized from the Failure To Keep Appointment report, which identifies enrollees with consecutive missed appointments for further follow up and outreach.



In the event that an enrollee requires a referral to their LHD based on the above criteria, the Clinical Call Center staff forwards the enrollee with consecutive missed appointments to CM via HealthConnect® for completion of the Local Health Services Request Form. CM faxes the Local Health Services Request Form to the respective LHD within 10 business days and collects fax receipt confirmation. After successful correspondence with the LHD, CM sends the completed form to the Medicaid Office for monitoring and tracking in the database.

KPMAS provided additional information during the virtual onsite review regarding referral tracking and monitoring. Referral requests received from the LHD requesting CM support are entered into EPIC, (screenshot provided), via the order entry function. KPMAS clinical screeners review all referrals and assign cases, as appropriate. Clinical screeners keep track of all referrals received, the assigned case manager, and the line of business associated with the referral. Therefore, KPMAS is able to track referrals sent to CM.

The MOU provided for review outlines the responsibilities of KPMAS and the LHDs regarding enrollee outreach; and states that the MCO, providers, and LHDs will work collaboratively to bring enrollees into care. Specifically, the LHDs will:

- Designate a staff member to serve as the contact person for KPMAS and its providers.
- Maintain a single point of entry for referrals from the MCO and its providers for outreach to hard-to-reach and noncompliant enrollees.
- Ensure LHD staff are knowledgeable about Medicaid services covered by the MCO and enrollees' right to self-refer to out-of-plan providers for certain services.
- Within 10 business days of its receipt of a written referral from the MCO or its provider, make a determination, consistent with applicable COMAR and with the MOU between the MDH and the LHD, as to what action, if any, will be taken on the case by the LHD, and inform the MCO of its determination to accept or refuse the referral.
- Within 15 business days of its receipt of a referral that is accepted by the LHD, attempt to contact the referred enrollee directly by telephone; if telephone contact is unsuccessful, attempt face-to-face contact at the enrollee's home or in another community setting, as appropriate.
- Within 30 calendar days of its receipt of a referral that the LHD accepts, provide the MCO up-to-date information, in writing, regarding the LHD's successful and unsuccessful attempts to contact the enrollee.
- Maintain the confidentiality of client records and eligibility information, in accordance with all federal, state, and local laws and regulations; and use this information only in assisting the enrollee to receive needed health care services.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must provide further detail in the Outreach Plan regarding how the referrals are tracked and monitored.

### Maryland Physicians Care (MPC)

**10.1** - The MCO has developed a written OP that describes the following:  
**This element is Met.**

**10.1 f.** MCO's relationship with each of the LHDs and ACCUs.  
**This component is Met with Opportunity.**



MPC CM works closely with the LHDs/ACCUs to refer enrollees for both outreach and transportation services, as outlined in the current HealthChoice regulations. MPC's Case Managers educate enrollees on the criteria for transportation through the LHD. Case Managers and ACCU communicate with PCPs to assist with the completion of applications for transportation assistance through the LHD.

MPC currently has signed Memoranda of Understanding with LHDs in each of the counties in Maryland and Baltimore City. The MOUs outline responsibilities of the MPC and the LHDs regarding enrollee outreach. Specifically, the LHDs will:

- Designate a staff to serve as the contact person for the MPC and providers.
- Maintain a single point of entry for referrals from the MCO, and its providers, for outreach to hard-to-reach noncompliant enrollees.
- Ensure LHD staff are knowledgeable about Medicaid services covered by the MCO and the right of enrollees to self-refer to out-of-plan providers for certain services.
- Within 10 business days of its receipt of a written referral from the MCO or its provider, make a determination, consistent with applicable COMAR regulations and with the MOU between the MDH and the LHD, as to what action, if any, will be taken on the case by the LHD, and inform the MCO of its determination to accept or refuse the referral.
- Within 15 business days of its receipt of a referral that is accepted by the LHD, attempt to contact the referred enrollee directly by telephone; if telephone contact is unsuccessful, attempt face-to-face contact at the enrollee's home or in another community setting, as appropriate.
- Within 30 calendar days of its receipt of a referral, the LHD accepts and provides the MCO with up-to-date information, in writing regarding the LHD's successful and unsuccessful attempts to contact the enrollee.
- Maintain the confidentiality of client records and eligibility information, in accordance with all federal, state, and local laws and regulations, and use this information only in assisting the enrollee to receive needed health care services.

MPC CM staff provided information regarding the LHD referral process for assistance in outreach. In order to complete the referral to the LHD, the Case Manager completes the electronic Health Service Request form and submits it to the enrollee's LHD. After submitting the referral, the case manager sets a reminder in the internal data system to ensure they follow up with the LHD if a response is not provided. Responses from the LHD are delivered through a special needs mailbox. The referral and the response are documented in the data management system so they can be tracked and monitored.

As of September 2021, there were 509 enrollees who were unresponsive to three or more outreach attempts by MPC's Case Managers. These enrollees were referred to the LHDs for assistance in locating during the months of January through September. The LHD provided 190 responses to MPC.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MPC must be more specific regarding their relationships with the LHD/ACCUs by providing further detail in the OP regarding the responsibilities of the LHD that are included in the MOU and how referrals to the LHD are tracked and monitored.

## MedStar Family Care (MSFC)

**10.1** - The MCO has developed a written OP that describes the following:  
**This element is Met.**

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

**This component is Met with Opportunity.**

The CM and Outreach departments maintain a close working relationship with the LHD in the city/counties where MSFC enrollees are located. Referrals to the LHD are generated according to the LHD criteria and/or the Case Management/Outreach – Coordination of Care Policy. The policy explains when an outreach coordinator or case manager cannot locate an enrollee with special needs, despite multiple outreach attempts by phone, text, and letter, a representative will refer the enrollee to the LHD. A LHD referral form is completed and submitted, and the information is documented in the clinical software system. After completing the referral, the Outreach coordinator also sets a forward reminder in the system to track and monitor the referral. The Outreach Dashboard reflects the number of referrals to the LHD by month, whether they were successful or unsuccessful, and the response numbers within 30 days. The CM and Outreach departments meet with the LHD when necessary, to improve communication and coordination of care. The MSFC Outreach Department utilizes the LHD for transportation and face-to-face contacts when appropriate.

MSFC has a joint Memorandum of Understanding (MOU) with the LHDs in the counties that MSFC services. The MOUs outline the responsibilities of MSFC and the LHDs regarding enrollee outreach and asserts that the MCO, providers, and LHDs will work collaboratively to bring enrollees into care. Specifically, the LHDs will:

- Designate a staff member to serve as a contact person for MSFC and providers.
- Maintain a single point of entry for referrals from the MCO and its providers for outreach to noncompliant enrollees.
- Ensure LHD staff are knowledgeable about Medicaid services covered by the MCO and the right of enrollees to self-refer to out-of-plan providers for certain services.
- Within 10 business days of its receipt of a written referral from the MCO or its provider, make a determination, consistent with applicable COMAR, and with the MOU between the MDH and the LHD, as to what action, if any, will be taken on the case by the LHD, and inform the MCO of its determination to accept or refuse the referral.
- Within 15 business days of its receipt of a referral that is accepted by the LHD, attempt to contact the referred enrollee directly by telephone; if telephone contact is unsuccessful, attempt face-to-face contact at the enrollee's home or in another community setting, as appropriate.
- Within 30 calendar days of its receipt of a referral, the LHD accepts and provides the MCO up-to-date information, in writing, regarding the LHD's successful and or unsuccessful attempts to contact the enrollee.
- Maintain the confidentiality of client records and eligibility information in accordance with all federal, state, and local laws and regulations, and use this information only in assisting the enrollee to receive needed health care services.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, MSFC must be more specific regarding their relationships with the LHD/Administrative-Care Coordination

Units by providing further detail in the OP regarding the responsibilities of the LHD that are included in the MOU, and how referrals to the LHD are tracked and monitored.

### Priority Partners (PPMCO)

**10.1** - The MCO has developed a written OP that describes the following:

**This element is Met.**

**10.1 a.** Populations to be served through the outreach activities and an assessment of common health problems within the MCO's membership.

**This component is Met with Opportunity.**

PPMCO's Outreach Plan (OP) reported the total population in 2020 as approximately 325,361 enrollees. Currently, 56% of the enrollees are children under the age of 21. A detailed breakdown of enrollees by county was provided and showed that the largest portions of PPMCO enrollees reside in Baltimore City (16.90%), Baltimore County (12.64%), Anne Arundel County (9.72%), Prince George's County (9.36%), and Montgomery County (8.34%).

PPMCO provided the following breakdown of the identified SNPs:

- Children with special health care needs (16,849)
- Disabled Individuals (20,327)
- Pregnant and postpartum women (3,154)
- Individuals who are homeless (none reported)
- Individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (1,605)
- Children in State-supervised care (4,680)

PPMCO identifies the top five diagnoses through analysis of claims and enrollment data:

- Routine child exam without abnormal findings
- Single live infant delivery; Cesarean
- Single live infant delivery; Vaginally
- Sepsis unspecified organism
- COVID-19

The following barriers to health care have been identified:

- Language Barriers - While only 0.6% of enrollees identify their race as Hispanic, PPMCO receives a much higher rate of requests for Spanish interpreter services. PPMCO preemptively provides material in both Spanish and English. In addition, PPMCO offers interpreter services over the phone for most languages.
- Geographic/Transportation Barriers - Transportation is often a barrier for enrollees that reside in rural counties, which is about 40% of PPMCO's population. To combat this barrier, PPMCO has partnered with various transportation companies to ensure access is available. PPMCO continues to expand its telehealth options to help overcome the transportation barrier.

- Socioeconomic Barriers - PPMCO offers outreach, health education, and financial incentives to enrollees to help overcome socioeconomic barriers.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, PPMCO must provide the total number of enrollees comprising the SNPs categories as defined in COMAR 10.67.04.04 B. Individuals with a physical disability should be differentiated from individuals with a developmental disability.

**RECOMMENDATION:** Qlarant recommends that PPMCO review the method used for reporting on homeless individuals to ensure accuracy.

## UnitedHealthcare (UHC)

**10.1** - The MCO has developed a written OP that describes the following:  
**This element is Met.**

**10.1 f.** MCO's relationship with each of the LHDs and ACCUs.  
**This component is Met with Opportunity.**

UHC has a Memorandum of Understanding with each LHD and collaborates with them in various ways. UHC attends LHD monthly meetings where concerns, barriers, and potential interventions are discussed. UHC also works with the LHDs to find solutions to problems, determine better methods of access and care coordination, and identify opportunities for greater provider involvement. Evidence of this partnership is in the coordination of efforts to address specific health disparities based on geographic location and level of disparity amongst races.

The LHD also assists in locating and/or contacting UHC enrollees and encouraging them to get preventive or chronic care health services. When the local outreach agent is unable to reach or locate the enrollee after three attempts, the Local Health Services Request Form is generated and sent to the respective LHD for assistance in outreaching or locating the enrollee. If the LHD is successful in finding the enrollee, the Outreach Team updates the demographic information and proceeds with efforts to assist the enrollee with obtaining an appointment. If the LHD is not successful in finding the enrollee, the health plan will use other modalities in an attempt to locate the enrollee. The SOP Telephonic Outreach Process explains the LHD's referral process, which includes monitoring whether a response is received from the LHD. During the virtual onsite, UHC staff provided additional detail regarding how the referral is tracked and monitored. There is a tracking mechanism within the system that notifies UHC when a response has not been provided by the LHD within 30 days. At that time, a call will be placed to the respective LHD to determine the status. UHC will continue working in partnership with all LHDs on outreach efforts, local events, and other activities to better serve enrollees in the calendar year 2022.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, UHC must provide further detail in the Outreach Plan regarding how LHD referrals are tracked and monitored.

## 11.0 - Fraud and Abuse

### Findings

#### Aetna Better Health (ABH)

**11.1** - The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include:

**This element is Partially Met.**

**11.1 f.** A documented process to ensure that services billed to the MCO were actually received by the enrollee.

**This component is Unmet.**

According to ABH leadership, a staffing vacancy for the ABH SIU investigator position led to a gap in conducting the surveys usually performed to assess whether the services billed to the health plan were actually received by the enrollee. To ensure that this activity occurs in 2022 and subsequent years, ABH is in the process of contracting with an external vendor to perform this activity.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must update its existing policies or create a new policy to document how the MCO intends to verify that services billed by the MCO were actually received by its enrollees. The policy should reflect who is conducting this assessment and the methods used to make the determination, and at what intervals (monthly or quarterly) that enrollee verification of services should occur. The interval must be completed no less frequently than quarterly. Additionally, the process must include the quality committee that is responsible for reviewing the data and ensuring the process is completed as required.

**11.4** - The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address:

**This element is Partially Met.**

**11.4 a.** Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee.

**This component is Partially Met.**

Compliance Committee meeting minutes for 2021 were provided for review. The minutes demonstrate that the committee reviews the SIU report that summarizes case investigation activities, delegates FWA activities, and performs other routine and random FWA reporting. The minutes further include a section placeholder for FWA; however, there is little documentation on what FWA activities have been initiated and addressed.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must document details of its FWA activities in the Compliance Committee meeting minutes. At a minimum, this reporting should occur on a quarterly basis.

**11.4 d.** Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.

**This component is Partially Met.**

ABH provided the CY 2021 Compliance Committee meeting minutes for review. Although 10 meetings were held in 2021, minutes did not consistently demonstrate a review of quarterly FWA activity reports for each delegate. For example, Superior Vision's FWA activities were reported and reviewed by the Compliance Committee quarterly in March, June, September, and December 2021. However, no FWA reports were documented for CVS Pharmacy and eviCore in any of the Compliance Committee meeting minutes.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must document the findings from the review of each delegate's FWA activities in the Compliance Committee meeting minutes, at least quarterly.

**11.5** - An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies.

**This element is Met.**

**11.5 b.** An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO's equity.

**This component is Met with Opportunity.**

The Compliance Plan clearly specifies that ABH prohibits affiliations with individuals, owners, and managing employees debarred by any federal agency.

According to the Excluded Individuals Policy, it is the objective of ABH that 100% of ABH personnel and contracted providers are screened against the OIG or other related exclusion databases prior to hiring or contracting. This policy indicates that ABH will not employ or contract with any individual that has been excluded from participation in state or federally funded health care programs (e.g., Medicare or Medicaid). ABH will terminate employment and contracting activities for anyone identified on an exclusion database. At the time of the CY 2018 review, the policy also specified that:

"Should ABH determine and verify that a candidate, provider, or contractor is listed on the OIG or other related exclusion databases, ABH will cease employment and contracting activities if the identified individual has beneficial ownership of 5% or more in any excluded entity."

This language is not included in the 2021 policy.

According to the Reporting Sanctions: NPDB and State Licensing Authorities Practitioner Application Policy, it is the policy of ABH that the health plan does not employ or contract with any individual that has been excluded from participation in state or federally funded health care programs (e.g., Medicare or Medicaid). There are no exceptions to this policy.

Provider Agreements include language that ABH searches the Department of Health and Human Services' OIG's LEIE, the General Services Administration Excluded Parties List System, the Social Security Administration Death Master File, and the National Plan & Provider Enumeration System for individuals excluded from the Medicaid Program. Searches are performed at the time of contracting, and at least

monthly thereafter, using the names of all contracted individuals and entities, those with an ownership or control interest, and their agents and managing employees, in accordance with 42 CFR 455.436.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ABH must update the Excluded Individuals Policy to include the language that "ABH does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO's equity." This language was in the policy at the time of the CY 2018 review. While it appears that ABH will terminate any party debarred by federal agencies regardless of ownership status, including this language will be more in concert with the federal requirement.

### AMERIGROUP Community Care (ACC)

**11.1 f.** A documented process to ensure that services billed to the MCO were actually received by the enrollee.

**This component is Met with Opportunity.**

The Member Verification of Service Policy describes the process for periodically verifying with enrollees that services billed by providers were received. On a monthly basis, Beneficiary Explanation of Medicaid Benefits letters are mailed to enrollees identified from a random sample of claims submitted during the previous month. The letters contain information on services billed by providers and direct enrollees to call the National Call Center, or use the self-addressed stamped envelope, to respond if the enrollee does not think the service information provided is accurate.

ACC provided evidence in the Compliance Committee meeting minutes that this process is occurring. In discussion with compliance staff, very few, if any, enrollees call to report that a service billed wasn't rendered. This practice places the responsibility on the enrollee and is not an active method for determining fraudulent activity.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, ACC must re-evaluate its procedures for verifying if services billed to enrollees were, in fact, rendered. While the process of mailing surveys to a random number of enrollees reaches a large population, it places the onus on the enrollee to contact the plan. Conversations with SIU, the Compliance Committee, and QM and CM staff may identify a way to integrate outreach efforts under the guise of satisfaction checks. It might be feasible, for example, to add questions to the CAHPS® survey or work with ACC's complex CM vendor for transitional care coordination to reach more vulnerable enrollees who would be more apt to have an IP or ER visit if a service was not delivered. This is especially true for enrollees with specific durable medical equipment requirements and enrollees having medically fragile, technology-dependent needs.

### CareFirst Community Health Plan (CFCHP)

**11.4** - The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address:

**This element is Partially Met.**

**11.4 c.** Evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with.

**This component is Unmet.**



CFCHP did not submit evidence of review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse, from each delegated entity.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must ensure delegated entities' compliance committees annually review and approve each delegate's Compliance Plans and administrative procedures, such as policies and procedures for the services delegated (claims, UM, call center, and more).

**11.4 d.** Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.

**This component is Partially Met.**

There is evidence of oversight of delegate FWA in different formats and in different committees. Some delegate reports on FWA are submitted to the Compliance Committee by the SIU, some are submitted to the DOC in the form of dashboards (Versant Health), while CVS/Caremark submits oversight tracking spreadsheets. It is unclear in which committee the consistent oversight of delegate FWA reports occurs.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, CFCHP must determine which committee should review and approve quarterly FWA delegate reports.

**RECOMMENDATION:** Qlarant recommends that CFCHP consider using a consistent format for reporting delegate FWA activities. This may alleviate confusion and prevent under-reporting.

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

**11.1** - The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include:

**This element is Partially Met.**

**11.1 f.** A documented process to ensure that services billed to the MCO were actually received by the enrollee.

**This component is Partially Met.**

KPMAS informs enrollees of the reporting process for fraud and abuse through the enrollee handbook. An Explanation of Benefits (EOB) is provided to enrollees monthly and includes the following, "Please review all services listed on the EOB. If you did not receive one or more of the services listed, please contact Member Services."

According to KPMAS staff, this EOB notification to the enrollee procedure is acceptable in other markets for identifying if services billed were rendered. In Maryland, this process places the burden on the enrollee to reach out to the MCO and the intent of the standard is that this be more of an active process for identifying potentially fraudulent activity.

**RECOMMENDATION:** KPMAS might consider other methods for assessing if services billed were received. KPMAS might consider working with its CAB to investigate other options for verifying if services billed were actually received.



**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the CY 2022 review, KPMAS must develop a process for verifying that services billed to enrollees were actually received. This process could be implemented through random surveys of enrollees by Member Services or CM queries of enrollees who receive DME or other therapies (PT, OT, speech language therapy). Many MCOs are surveying at least 25 enrollees per quarter for this purpose and reporting findings to the Compliance Committee.

## Appendix B: Compliance Score Requirements and Standard Descriptions

Appendix B displays each of the SPR standards and the minimum compliance requirement for the CY 2021 review.

**Table 13. SPR Compliance Score Requirements and Standard Descriptions**

Compliance Requirement	Element/Component Reviewed	Standard Description
100%	<b>1.0: Systematic Process of Quality Assessment and Improvement</b>	
	<b>1.1</b>	<b>The QAP ensures monitoring and evaluation of the enrolled population and areas of concern for the enrolled population.</b>
	1.1a	The monitoring and evaluation of care reflects the population served by the MCO in terms of age, disease categories, and special risk status.
	1.1b	The QAP monitors and evaluates priority areas of concern selected by the State and any additional areas of concern identified by the MCO.
	<b>1.2</b>	<b>The QAP’s written guidelines for the MCO’s Quality of Care studies and related activities require the use of quality indicators.</b>
	1.2a	The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.
	1.2b	Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.
	<b>1.3</b>	<b>The QAP has written guidelines for its Quality of Care studies and related activities must include the use of clinical practice guidelines.</b>
	1.3a	<i>Deleted in CY 2018.</i>
	1.3b	Clinical practice guidelines are based on evidence-based practices or professional standards of practice and are developed or reviewed by MCO providers.
	1.3c	The guidelines focus on the process and outcomes of health care delivery and access to care.
	1.3d	A mechanism is in place for continuously updating the guidelines as appropriate. There is evidence that this occurs
	1.3e	The guidelines are included in the provider manuals or disseminated to the providers (electronically or faxed) as they are adopted.
	1.3f	There are guidelines to address preventive health services for children and adults.
	1.3g	The guidelines are developed for the relevant populations enrolled in the MCO as noted in Standard 1.1a.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	1.3h	The MCO’s clinical guidelines policies and procedures must reflect how the guidelines are used for UM decisions, enrollee education, and coverage of services.
	<b>1.4</b>	<b>The QAP has written guidelines for its Quality of Care studies and related activities that require the analysis of clinical and related services.</b>
	1.4a	The QAP has written guidelines to evaluate the quality of care provided by the MCO’s providers.
	1.4b	Appropriate clinicians monitor and evaluate quality through review of individual cases and through studies analyzing patterns of clinical care.
	1.4c	Multidisciplinary teams are used to analyze, identify, and address systems issues.
	1.4d	Clinical and related service areas requiring improvements are identified through activities described in a. and b. above.
	1.4e	Mechanisms to detect both over and underutilization of services.
	1.4f	Mechanisms to assess the quality and appropriateness of the care provided to enrollees with special health care needs.
	<b>1.5</b>	<b>The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The remedial/corrective action procedures specifically include:</b>
	1.5a	Performance thresholds to identify when actual or potential problems may exist that require remedial/corrective action.
	1.5b	The individual(s) or department(s) responsible for making the final determinations regarding quality problems.
	1.5c	The specific actions to be taken.
	1.5d	The provision of feedback to the appropriate health professionals, providers, and staff (as appropriate).
	1.5e	The schedule and accountability for implementing corrective actions.
	1.5f	The approach to modifying the corrective action if improvements do not occur.
	1.5g	The procedures for terminating health professionals, providers, or staff (as appropriate).
	<b>1.6</b>	<b><i>Deleted in CY 2017.</i></b>
	<b>1.7</b>	<b>The QA Plan incorporates written guidelines for evaluation of the status of QAP activities and the continuity and effectiveness of the QAP.</b>
	1.7a	The MCO reviews the status of QAP activities against the QA Work Plan on a quarterly basis.

Compliance Requirement	Element/Component Reviewed	Standard Description
	1.7b	There is evidence that QA activities are assessed to determine if they have contributed to improvements in the care and services delivered to enrollees.
	<b>1.8</b>	<b>A comprehensive annual written report on the QAP is completed. The annual report on the QAP must include:</b>
	1.8a	QA studies and other activities undertaken, results, and subsequent actions.
	1.8b	Trending of clinical and service indicators and other performance data, including HEDIS and CAHPS results.
	1.8c	Analysis of aggregate data on utilization and quality of services rendered.
	1.8d	Demonstrated improvements in quality.
	1.8e	Areas of deficiency.
	1.8f	Recommendations for improvement to be included in the subsequent year’s QA Work Plan.
	1.8g	An evaluation of the overall effectiveness of the QAP.
	<b>1.9</b>	<b>The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.</b>
	<b>1.10</b>	<b>The MCO must have a Disaster Recovery Plan that is updated on an annual basis.</b>
<b>N/A</b>	<b>2.0: Accountability to the Governing Body</b>	
	<i>Standard 2 was exempt from the CY 2021 SPR as the MCO attained 100% compliance in previous SPRs.</i>	
<b>100%</b>	<b>3.0: Oversight of Delegated Entities</b>	
	<b>3.1</b>	<b>The MCO must ensure that delegates have detailed agreements and are notified of the grievance and appeal system.</b>
	3.1a	The MCO must ensure that there is a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO.
	3.1b	The MCO must provide evidence of informing delegates and subcontractors of the grievance and appeal system.
	<b>3.2</b>	<b>The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided.</b>
	<b>3.3</b>	<b>There is evidence of continuous and ongoing evaluation of delegated activities, including:</b>
	3.3a	Oversight of delegated entities’ performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc.
	3.3b	Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable.
	3.3c	Review and approval of claims payment activities at least semi-annual, where applicable.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	3.3d	Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable.
	3.3e	Review and approval of over and underutilization reports, at least semi-annually, where applicable.
	<b>3.4</b>	<b>The MCO has written policies and procedures for subcontractor termination that impacts the MCO's operations, services, or enrollees.</b>
<b>100%</b>	<b>4.0: Credentialing and Recredentialing</b>	
	<b>4.1</b>	<b>The MCO has written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing.</b>
	4.1a	The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process.
	4.1b	The Credentialing Plan designates a CC or other peer review body that makes recommendations regarding credentialing decisions.
	4.1c	The Credentialing Plan must identify the practitioners who fall under its scope of authority and action.
	4.1d	The Credentialing Plan must include policies and procedures for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d)
	<b>4.2</b>	<b>There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. Documentation includes:</b>
	4.2a	Written policies and procedures for the suspension, reduction, or termination of practitioner privileges.
	4.2b	A documented process for and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner.
	4.2c	<i>Deleted in CY 2019.</i>
	<b>4.3</b>	<b>If the MCO delegates credentialing/ recredentialing activities, the following must be present:</b>
	4.3a	A written description of the delegated activities.
	4.3b	A description of the delegate's accountability for designated activities.
	4.3c	Evidence that the delegate accomplished the credentialing activities.
	<b>4.4</b>	<b>The credentialing process must be ongoing and current. At a minimum, the credentialing process must include:</b>
	4.4a	A review of a current valid license to practice.
	4.4b	A review of a valid DEA or CDS certificate, if applicable.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	4.4c	A review of graduation from medical/ancillary (NP, PT, OT, SLP, etc.) school and completed residency or post-graduate training, as applicable.
	4.4d	A review of work history.
	4.4e	A review of a professional and liability claims history.
	4.4f	A review of current adequate malpractice insurance according to the MCO's policy.
	4.4g	<i>Deleted in CY 2017.</i>
	4.4h	A review of EPSDT certification.
	4.4i	Adherence to the timeframes set forth in the MCO's policies regarding credentialing date requirements.
	4.4j	Adherence to the timeframes set forth in the MCO's policies for communication with providers regarding provider applications within the timeframes specified in Insurance Article Section 15-112(d).
	4.4k	Verification that the provider is actively enrolled in Medicaid at the time of credentialing.
	<b>4.5</b>	<b>The MCO should request and review information from recognized monitoring organizations regarding practitioners. The evidence must include:</b>
	4.5a	Any revocation or suspension of a State license or a DEA/BNDD number
	4.5b	Any curtailment or suspension of medical staff privileges (other than for incomplete medical records).
	4.5c	Any sanctions imposed by Medicare and/or Medicaid.
	4.5d	Information about the practitioner from the NPDB and the MBP.
	<b>4.6</b>	<b>The credentialing application includes the following:</b>
	4.6a	The use of illegal drugs
	4.6b	Any history of loss of license.
	4.6c	Any history of loss or limitation of privileges or disciplinary activity.
	4.6d	Attestation to the correctness and completeness of the application.
	<b>4.7</b>	<b>There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the ADA and the MCO's standards.</b>
	<b>4.8</b>	<b>There is evidence that recredentialing is performed at least every three years and:</b>
	4.8a	Includes a review of information from the NPDB.
	4.8b	<i>Deleted in CY 2019.</i>
	4.8c	Includes all items contained in element 4.4 a–h, except 4.4 d (work history).
	4.8d	Includes all items contained in 4.6 a–d.
	4.8e	Meets the timeframes set forth in the MCO's policies regarding recredentialing decision date requirements.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	4.8f	Ensures the MCO is verifying that the provider is actively enrolled in Medicaid at the time of recredentialing.
	<b>4.9</b>	<b>There is evidence that the recredentialing process includes a review of the following:</b>
	4.9a	Enrollee complaints/grievances
	4.9b	Results of quality reviews.
	4.9c	<i>Deleted in CY 2018.</i>
	4.9d	Office site compliance with ADA standards, if applicable
	<b>4.10</b>	<b>The MCO must have policies and procedures regarding the selection and retention of providers.</b>
	4.10a	The MCO must have written policies and procedures for selection and recruitment of providers in the HealthChoice Program.
	4.10b	The MCO must have written policies and procedures for the retention of providers in the HealthChoice Program.
	<b>4.11</b>	<b>The MCO must ensure that enrollees' parents/guardians are notified if they have chosen for their child to be treated by a non-EPSDT certified PCP.</b>
	4.11a	The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.
	4.11b	The MCO must have written policies and procedures for notifying the Department of provider terminations.
	<b>4.12</b>	<b>The MCO must have written policies and procedures for notifying the Department of provider terminations.</b>
<b>100%</b>	<b>5.0: Enrollee Rights</b>	
	<b>5.1</b>	<b>The MCO has a system linked to the QAP for resolving enrollees' grievances. This system meets all requirements in COMAR 10.67.09.02 and 10.67.09.04.</b>
	5.1a	There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.67.09.
	5.1b	The system requires documentation of the substance of the grievances and steps taken.
	5.1c	The system ensures that the resolution of a grievance is documented according to policy and procedure.
	5.1d	The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning.
	5.1e	<i>Deleted in CY 2018.</i>
	5.1f	There is complete documentation of the substance of the grievance, steps taken to resolve, and the resolution in the case record.



Compliance Requirement	Element/ Component Reviewed	Standard Description
	5.1g	The MCO adheres to the MDH timeframe for written acknowledgment of a grievance and the regulatory timeframe for resolution of all grievances.
	5.1h	The MCO ensures enrollees receive written notification of the resolution of all grievances, even if the resolution was provided verbally, within the timeframe documented in the MCO's policy.
	5.1i	Written resolution letters describe the grievance and the resolution in easy to understand language.
	<b>5.2</b>	<b>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.</b>
	<b>5.3</b>	<b>The organization acts to ensure that the confidentiality of specified patient information and records is protected.</b> <b>The MCO:</b>
	5.3a	Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data.
	5.3b	Ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.
	5.3c	Must hold confidential all information obtained by its personnel about enrollees related to their care and shall not divulge it without the enrollee's authorization unless: (1) it is required by law, (2) it is necessary to coordinate the patient's care, or (3) it is necessary in compelling circumstances to protect the health or safety of an individual.
	5.3d	Must ensure that the release of any information in response to a court order is reported to the patient in a timely manner.
	5.3e	May disclose enrollee records, with or without the enrollee's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner.
	<b>5.4</b>	<b>The MCO has written policies regarding the appropriate treatment of minors.</b>
	<b>5.5</b>	<b>As a result of the enrollee satisfaction surveys, the MCO:</b>
	5.5a	Identifies and investigates sources of dissatisfaction.
	5.5b	Implements steps to follow up on the findings
	5.5c	Informs practitioners and providers of assessment results.
	5.5d	Reevaluates the effects of b. above at least quarterly.
	<b>5.6</b>	<b>The MCO has systems in place to assure that new enrollees receive required information within established timeframes.</b>
	5.6a	Policies and procedures are in place that address the content of new enrollee packets of information and specify the time timeframes for sending such information to the enrollee.

Compliance Requirement	Element/Component Reviewed	Standard Description
	5.6b	Policies and procedures are in place for newborn enrollments, including issuance of the MCO's ID card.
	5.6c	The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution.
	5.6d	The MCO includes the Continuity of Health Care Notice in the new enrollee packet.
	5.6e	The MCO must have all Enrollee Handbook templates approved by MDH and use all enrollee notice templates provided by MDH.
	<b>5.7</b>	<b>The MCO must have an active Consumer Advisory Board (CAB).</b>
	5.7a	The MCO's CAB membership must reflect the special needs population requirements.
	5.7b	The CAB must meet at least six times a year.
	5.7c	The MCO must have a mechanism for tracking enrollee feedback from the meetings.
	<b>5.8</b>	<b>The MCO must notify enrollees and prospective enrollees about their nondiscrimination rights.</b>
	5.8a	Materials distributed by the MCO to the enrollee will include a nondiscrimination notice and a language accessibility statement in English and at least the top 15 non-English languages spoken by the individuals with limited English proficiency in Maryland.
	5.8b	Notices and Taglines must be posted in a conspicuously visible location on websites accessible from the home page.
	5.8c	Notices and Taglines must be posted in significant communications and publications.
	5.8d	Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.
	5.8e	MCO's electronic information provided to enrollees must meet requirements set forth in COMAR.
	<b>5.9</b>	<b>The MCO must maintain written policies and procedures for advance directives.</b>
	5.9a	The MCO must educate staff regarding advance directives policies and procedures.
	5.9b	The MCO must provide adult enrollees with written information on advance directives policies, including a description of the most recent Maryland Health Care Decisions Act (Md. Code Health-General §§5-601 through 5-618).
	5.9c	The MCO must amend advance directive information to reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.
	<b>5.10</b>	<b>MCO must comply with the marketing requirements of COMAR 10.67.04.23.</b>
	5.10a	An MCO may not have face-to-face contact with a recipient who is not an enrollee of the MCO unless contact is authorized by the Department or contact is initiated by the recipient.
	5.10b	An MCO cannot engage in marketing activities without prior approval of the Department.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	5.10c	<i>Deleted in CY 2018.</i>
	5.11	<b>The MCO has implemented policies and procedures to ensure that the MCO does not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient.</b>
<b>100%</b>	<b>6.0: Availability and Accessibility</b>	
	<b>6.1</b>	<b>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.</b>
	6.1a	The MCO has developed and disseminated written access and availability standards.
	6.1b	The MCO has processes in place to monitor performance against its access and availability standards at least quarterly.
	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.
	6.1d	The MCO has documented a review of the Enrollee Services Call Center performance.
	<b>6.2</b>	<b>The MCO has a list of providers that are currently accepting new enrollees.</b>
	6.2a	The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population.
	6.2b	At the time of enrollment, enrollees are provided with information about the MCO’s providers.
	6.2c	The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities.
	6.2d	The MCO has evidence of monitoring performance against its network capacity and geographic access requirements at least annually by conducting geo mapping.
	<b>6.3</b>	<b>The MCO has implemented policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services.</b>
	6.3a	<i>Deleted in CY 2019.</i>
	6.3b	<i>Deleted in CY 2019.</i>
	6.3c	Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.
	<b>6.4</b>	<b>The MCO has implemented policies and procedures to ensure coverage and payment of emergency services and post-stabilization care services for enrollees.</b>

Compliance Requirement	Element/Component Reviewed	Standard Description
100%	<b>7.0: Utilization Review</b>	
	<b>7.1</b>	<b>There is a comprehensive written UR Plan.</b>
	7.1a	This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.
	7.1b	The scope of the UR Plan includes a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services.
	7.1c	There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.
	<b>7.2</b>	<b>The UR Plan specifies criteria for UR/UM decisions.</b>
	7.2a	The criteria used to make UR/UM decisions must be based on acceptable medical practice.
	7.2b	The UR Plan must describe the mechanism or process for the periodic updating of the criteria.
	7.2c	The UR Plan must describe the involvement of participating providers in the review and updating of criteria.
	7.2d	There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures.
	7.2e	There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM criteria/guidelines.
	7.2f	There is evidence that the MCO evaluates the consistency with which all staff involved apply UR/UM criteria on at least an annual basis.
	<b>7.3</b>	<b>The written UR Plan has mechanisms in place to detect overutilization and underutilization of services.</b>
	7.3a	Services provided must be reviewed for overutilization and underutilization.
	7.3b	UR reports must provide the ability to identify problems and take the appropriate corrective action.
	7.3c	Corrective measures implemented must be monitored.
	<b>7.4</b>	<b>The MCO maintains policies and procedures pertaining to preauthorization decisions and demonstrates implementation.</b>
	7.4a	Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
	7.4b	Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate.
	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.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	<b>7.5</b>	<b>Adverse determination letters include a description of how to file an appeal.</b>
	7.5a	All adverse determination letters are written in easy to understand language.
	7.5b	Adverse determination letters include all required components.
	<b>7.6</b>	<b>The MCO must be compliant with the requirements of COMAR 10.67.09.04 pursuant to notification requirements for preauthorization denials.</b>
	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.
	7.6b	The MCO demonstrates compliance with adverse determination notification timeframes in response to preauthorization requests as specified by the State.
	<b>7.7</b>	<b>The MCO must have written policies and procedures pertaining to enrollee appeals.</b>
	7.7a	The MCO’s appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and COMAR 10.67.09.05.
	7.7b	The MCO’s appeals policies and procedures must include staffing safeguards to avoid conflicts of interest when reviewing appeals.
	7.7c	The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes.
	7.7d	The MCO’s appeal policies must include procedures for how the MCO will assist enrollees with the appeal process.
	7.7e	Reasonable efforts are made to give the enrollee prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.
	7.7f	Written notifications to enrollees include appeal decisions that are documented in easy to understand language.
	7.7g	The MCO’s appeal policies and procedures must include oral inquiries seeking to appeal are treated as appeals.
	<b>7.8</b>	<b>The MCO must have written policies and procedures pertaining to provider appeals.</b>
	7.8a	The MCO’s provider appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.03.
	7.8b	The MCO’s provider appeals policies and procedures must include a provider complaint and appeal process for resolving provider appeals timely.
	7.8c	The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.
	<b>7.9</b>	<b>There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.</b>
	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.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	7.9b	The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee.
	7.9c	The MCO acts upon identified issues as a result of the review of the data.
	7.10	<b>The MCO must have a written policy and procedure outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. The policy and procedure must include the process for explaining how providers that receive an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization (IRO) designated by the Department.</b>
	7.11	<b>The MCO must have written policies and procedures for establishing a corrective managed care plan for enrollee abuse of medical assistance pharmacy benefits consistent with the Department’s corrective managed care plan.</b>
	7.11a	The MCOs policies and procedures regarding corrective managed care plans must include all steps outlined in the regulation.
	7.11b	The MCOs must provide evidence of implementation of the corrective managed care plan.
	7.12	<i>Deleted in CY 2019.</i>
<b>100%</b>	<b>8.0: Continuity of Care</b>	
	8.1	Enrollees with special needs and/or those with complex health care needs must have access to CM according to established criteria and must receive the appropriate services.
	8.2	The MCO must ensure appropriate initiation of care based on the results of HSNI data supplied to the MCO. This must include a process for gathering HSNI data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.
	8.3	The MCO must have policies and procedures in place to coordinate care with primary care, Local Health Departments (LHDs), school health programs, and other frequently involved community based organizations (CBOs).
	8.4	The MCO must monitor continuity of care across all services and treatment modalities including discharges or admissions to inpatient setting to home. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).
	8.5	The MCO must monitor the effectiveness of the CM Program.
	8.6	The MCO has processes in place for coordinating care with the State’s behavioral health and substance use vendors and demonstrates implementation of these procedures.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	8.7	The MCO must comply with providing the Continuity of Health Care Notice to enrollees and have policies and procedures in place to provide services in accordance with the MIA requirements when requested by enrollees.
N/A	9.0: Health Education Plan	
	<i>Standard 9 was exempt from the CY 2021 SPR as the MCO attained 100% compliance in previous SPRs.</i>	
100%	10.0: Outreach Plan	
	10.1	<b>The MCO has developed a written OP that describes the following:</b>
	10.1a	Populations to be served through the outreach activities and an assessment of common health problems within the MCO’s membership
	10.1b	MCO’s organizational capacity to provide both broad-based and enrollee-specific outreach.
	10.1c	Unique features of the MCO’s enrollee outreach initiatives.
	10.1d	Community partnerships.
	10.1e	Role of the MCO’s provider network in performing outreach.
	10.1f	MCO’s relationship with each of the LHDs and ACCUs.
	10.2	<b>The MCO has implemented policies and procedures for:</b>
	10.2a	The provision of outreach services for new and existing enrollees for wellness/preventive health services.
	10.2b	<i>Deleted in CY 2019.</i>
	10.2c	The provision of outreach via telephone, written materials, and face-to-face contact.
	10.2d	Monitoring of all outreach activities, including those delegated or subcontracted to other entities.
	10.3	<b>The MCO has implemented strategies:</b>
	10.3a	<i>Deleted in CY 2019.</i>
	10.3b	<i>Deleted in CY 2019.</i>
	10.3c	To promote the provision of EPSDT services and respond to no-shows and non-compliant behavior related to children in need of EPSDT services.
	10.3d	To bring enrollees into care who are difficult to reach or who miss appointments.
100%	11.0: Fraud and Abuse	
	11.1	The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include:



Compliance Requirement	Element/ Component Reviewed	Standard Description
	11.1a	Documentation that articulates the organization’s commitment to comply with all applicable Federal and State laws, regulations, and standards.
	11.1b	Designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and is responsible for ongoing monitoring of the MCO’s mandatory compliance plan.
	11.1c	Designation of a Compliance Officer to serve as the liaison between the MCO and the Department.
	11.1d	A documented process for internal monitoring and auditing, both routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as mechanisms responsible for the appropriate fraud and abuse education of MCO staff, enrollees, and providers.
	11.1e	A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation.
	11.1f	A documented process to ensure that services billed to the MCO were actually received by the enrollee.
	<b>11.2</b>	<b>The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization’s standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include:</b>
	11.2a	Education and training for the Compliance Officer and the MCO’s employees on detection of fraud and abuse.
	11.2b	A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO’s employees.
	11.2c	A documented process for enforcing standards by means of clear communication to employees, in well-publicized guidelines, to sanction incidents of fraud and abuse.
	11.2d	A documented process for enforcement of standards through clear communication of well-publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse.
	11.2e	A documented process for enforcement of standards through clear communication of well-publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse.
	11.2f	A documented process for the reporting by employees of suspected fraud and abuse within the organization, without fear of reprisal.
	11.2g	A documented process for reporting by subcontractors of the MCO suspected fraud and abuse within the organization, without fear of reprisal.

Compliance Requirement	Element/ Component Reviewed	Standard Description
	11.2h	A documented process for reporting by enrollees of the MCO suspected fraud and abuse within the organization without fear of reprisal.
	<b>11.3</b>	<b>The MCO maintains administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. It must include:</b>
	11.3a	A documented process for reporting all suspected cases of provider fraud and abuse to the MDH Office of the Inspector General and the Medicaid Fraud Control Unit within 30 calendar days of the initial report.
	11.3b	A documented process for cooperating with the MDH Office of the Inspector General and the State Medicaid Fraud Control Unit when suspected fraud and abuse is investigated.
	<b>11.4</b>	<b>The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address:</b>
	11.4a	Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee.
	11.4b	Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP.
	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 that the MCO contracts with.
	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.
	<b>11.5</b>	<b>An MCO may not knowingly have a relationship with individuals or entities debarred by Federal Agencies.</b>
	11.5a	An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals or entities debarred by Federal Agencies.
	11.5b	An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO's equity.
	11.5c	An MCO must have written policies and procedures ensuring that it does not have an individual or entities debarred by Federal Agencies with an employment, consulting, or other arrangement with the MCO
	11.5d	An MCO must provide evidence of initial and monthly checks of the following databases as applicable: Social Security Death Master File; National Plan and Provider Enumeration System; List of Excluded Individuals/Entities; Excluded Parties List Systems/SAM.
	11.5e	An MCO must have written policies and procedures for providing written disclosure of any prohibited affiliation and/or termination to MDH.