Qlarant

Medicaid Managed Care Organization

Interim Systems Performance Review

Statewide Executive Summary Report

Calendar Year 2020

Maryland
DEPARTMENT OF HEALTH

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Maryland HealthChoice Program

CY 2020 Interim Systems Performance Review

Executive Summary

Overview and Introduction

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

HealthChoice's philosophy is to provide quality health care that is patient-focused, prevention-oriented, coordinated, accessible, and cost-effective. The foundation of the program hinges on providing a "medical home" for each enrollee. This is accomplished by connecting each enrollee with a primary care provider (PCP) responsible for providing preventive and primary care services, managing referrals, and coordinating all necessary care for the enrollee. HealthChoice emphasizes health promotion and disease prevention, and requires enrollees 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[1], 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 calendar year (CY) 2020's systems performance review (SPR). HealthChoice served over 1,337,165[2] enrollees during its 22nd 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 2020 were:

- Aetna Better Health of Maryland (ABH)
- AMERIGROUP Community Care (ACC)
- CareFirst Community Health Plan (CFCHP)[3]
- 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)

[1] Federal law - Section 1932(c)(2)(A)(i) of the Social Security Act

[2] Source: https://md-medicaid.org/mco/mco-enrollment_action.cfm

[3] Formerly University of Maryland Health Partners

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 2020's assessment as an interim desktop review in response to MDH's decision to move to comprehensive triennial, rather than annual, onsite reviews. 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). Standards scored as baseline or met with opportunities, or requiring a corrective action plan (CAP) in the CY 2019 review, were the focus of CY 2020's SPR. 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

For CY 2020, COMAR 10.67.04.03 required all HealthChoice MCOs to comply with SPR standards established by MDH and all applicable federal and state laws and regulations.

In September 2020, Qlarant provided the MCOs with an SPR orientation manual, "Medicaid Managed Care Organization Systems Performance Review Orientation Manual," for CY 2020 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 2020 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 2020 revisions

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 desktop reviews conducted in January and February of 2021, the team reviewed all relevant documentation needed to assess the standards. If an MCO chose to have standards in their policies and

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

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 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).

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. Five MCOs (ABH, ACC, CFCHP, KPMAS, and PPMCO) were required to submit CAPs for the CY 2020 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

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

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific elements, components, or standards. The interim SPR for CY 2020 determined whether the CAPs from the CY 2019 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 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 2019 SPR, five MCOs (ABH, CFCHP, KPMAS, MPC, and PPMCO) were required to submit quarterly updates of their CAPs to Qlarant.

Progress was reported quarterly to MDH and after the CY 2020 SPR was conducted, Qlarant recommended the following quarterly CAP closures as represented in Table 1.

Table 1. Quarterly CAP Closures

MCO	Standards
ABH	3.3c and 3.3e
CFCHP	6.3c and 11.4c
KPMAS	5.1g, 5.1h, and 7.9c
MPC	6.1b
PPMCO	5.1g and 5.6a

As a result of the CY 2020 SPR, four MCOs have new quarterly CAP monitoring as represented in Table 2 (ABH, ACC, CFCHP, and KPMAS).

Table 2. New Quarterly CAP Monitoring

MCO	Standards
ABH	6.2a, 7.5b, 7.7c, 7.7e, and 7.8c
ACC	7.4c, 7.7a, 7.7c, and 7.8c
CFCHP	5.8e and 7.8c
KPMAS	7.7c and 7.8c

As a result of the CY 2020 SPR, two MCOs have continued quarterly CAP monitoring as represented in Table 3 (KPMAS and PPMCO). The consecutive years in which the MCO has had the continued CAP is displayed below.

Table 3. Continued Quarterly CAP Monitoring

MCO	Standards	Consecutive Years
KPMAS	11.4c	3
	11.4d	3
PPMCO	7.4c	2
	7.7c.	2

Findings

If the MCOs did not receive a finding of Met or Met with Opportunity, for each standard, a CAP was required. Four MCOs (JMS, MPC, MSFC, and UHC) received findings of Met or Met with Opportunity in all standards reviewed. Five MCOs (ABH, ACC, CFCHP, KPMAS, and PPMCO) were required to submit CAPs for CY 2020. 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 4. Elements/Components Requiring CAPs and Met with Opportunities

Standard	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
5 Enrollee Rights	-	-	5.8e	-	-	-	-	-	-
6 Availability and Access	6.2a	-	-	-	-	-	-	-	
7 Utilization Review	7.5b 7.7c 7.7e 7.8c	7.4c 7.5b 7.6a 7.7a 7.7c 7.8c	7.5b 7.7a 7.8c	-	7.5b 7.7c 7.8c	7.7c	-	7.3c 7.4c 7.7c	-
11 Fraud, Waste, and Abuse	-	-	-	-	11.4c 11.4d	-	-	-	-
CAPs Required	**2**	**1**	**2**	**0**	**2**	**0**	**0**	**1**	**0**
MWOs	**0**	**1**	**1**	**0**	**1**	**1**	**0**	**0**	**0**

Red represents quarterly updates that are required on the CAP per MDH Performance Monitoring Policy
Green represents Met with Opportunity (MwO)
Black represents CAP without quarterly monitoring

For each standard assessed for CY 2020, the following section describes:

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

Standard 5: Enrollee Rights

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

The MCO must:

- Act to ensure the confidentiality of specified patient information and records are protected.
- Enact written policies regarding the appropriate treatment of minors.
- Identify and investigate sources of enrollee dissatisfaction, implement steps to follow up on the findings, inform practitioners and providers of assessment results, and reevaluate the

effectiveness of the implementation steps at least quarterly based on the results of the enrollee satisfaction surveys.

- Ensure there are systems in place to ensure new enrollees receive required information within established timeframes.
- Ensure that the MCO has an active Consumer Advisory Board (CAB).
- Notify enrollees and prospective enrollees about their nondiscrimination rights as well as maintaining written policies and procedure for advance directives.
- Ensure the MCO's marketing materials comply with regulatory requirements.
- Implement policies and procedures to ensure 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.

Results and Findings: One MCO (CFCHP) has a continued improvement opportunity from the CY 2019 SPR and is required to submit quarterly updates on their CAP.

Table 5. Standard 5 Interim Desktop Review Results for CY 2020

Element/ Component Reviewed	Element/Component Description	CFCHP
5.8e	MCO's electronic information provided to members must meet requirements set forth in COMAR.	**UM**

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

Follow up:

- Qlarant reviewed and approved the CAP submission.
- The approved CAP will be reviewed in CY 2021 SPR.

In accordance with MDH's Performance Monitoring Policy, CFCHP will provide quarterly updates on the CAP in CY 2021 for 5.8e.

Standard 6: Availability and Accessibility

Requirements: The MCO must have established measurable standards for access and availability.

The MCO must:

- Ensure there is a process in place to ensure MCO service, referrals to other health service providers, and accessibility and availability of health care services.
- Maintain a list of providers that are currently accepting new enrollees.
- Implement policies and procedures to ensure there is a system in place for notifying enrollees of due dates for wellness services.
- Implement policies and procedures to ensure coverage and payment of emergency services and post stabilization care services for enrollees.

Results and Findings: One MCO (ABH) has a continued improvement opportunity from the CY 2019 SPR and is required to submit quarterly updates on their CAP.

Table 6. Standard 6 Interim Desktop Review Results for CY 2020

Element/ Component Reviewed	Element/ Component Description	ABH
6.2a	The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population as specified in COMAR.	**PM**

PM=Partially Met
Red represents quarterly updates that are required on the CAP per MDH Performance Monitoring Policy

Follow up:

- Qlarant reviewed and approved the CAP submission.
- The approved CAP will be reviewed in CY 2021 SPR.

In accordance with MDH's Performance Monitoring Policy, ABH will provide a quarterly update on the CAP in CY 2020 for 6.2a.

Standard 7: Utilization Review

Requirements: The MCO must have a comprehensive Utilization Management Program monitored by the governing body and designed to evaluate systematically the use of services through the collection and analysis of data in order to achieve overall improvement. The MCO has a comprehensive Utilization Review (UR) Plan that specifies criteria for UR/UM decisions.

The MCO must:

- Implement mechanisms in place to detect overutilization and underutilization of services.
- Enact policies and procedures pertaining to preauthorization (PA) decisions and demonstrate implementation.
- Ensure adverse determination letters include a description of how to file an appeal.
- Demonstrate compliance with the requirements outlined in COMAR 10.67.09.04 pursuant to the notification requirement for preauthorization denials.
- Maintain written policies and procedures:
    - Pertaining to enrollee appeals and provider appeals;
    - Establishing mechanisms which evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures;
    - Outlining the complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO including the process for explaining how providers receiving an adverse medical necessity decision on claims for reimbursement may submit the adverse decision for review by an Independent Review Organization designated by MDH;
    - Establishing a corrective managed care program for enrollee abuse of medical assistance pharmacy benefits consistent with MDH's corrective managed care plan.

Results and Findings: Six MCOs (ABH, ACC, CFCHP, KPMAS, MPC, and PPMCO) have improvement opportunities in the area of Utilization Review and five MCOs require CAPs to become compliant for the CY 2020 SPR. These five MCOs who require CAPs also require quarterly updates on their CAPs as continued opportunities from the CY 2019 SPR. Four MCOs (ACC, CFCHP, KPMAS, AND MPC) received a finding of met with opportunities for improvement in the following elements/components to address for the CY 2020 SPR.

Table 7. Standard 7 Interim Desktop Review Results for CY 2020

Element/ Component Reviewed	Element/Component Description	ABH	ACC	CFCHP	KPMAS	MPC	PPMCO
7.3c	Corrective measures implemented must be monitored.	-	-	-	-	-	**PM**
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.	-	**PM**	-	-	-	**UM**
7.5b	Adverse determination letters include all required components.	**PM**	**MwO**	**MwO**	**MwO**	-	-
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.	-	**PM**	-	-	-	-
7.7a	The MCO's appeals policies and procedures must be compliant with the requirements of COMAR 10.67.09.02 and 10.67.09.05.	-	**UM**	**MwO**	-	-	-
7.7c	The MCO must adhere to appeal timeframes.	**UM**	**UM**	-	**PM**	**MwO**	**UM**
7.7e	Reasonable efforts are made to give the member prompt verbal notice of denial of expedited resolution and a written notice within 2 calendar days of the denial of the request.	**UM**	-	-	-	-	-
7.8c	The MCO must adhere to regulatory timeframes for providing written acknowledgment of the appeal and written resolution.	**UM**	**PM**	**PM**	**PM**	-	-

MwO=Met with Opportunity, **PM**=Partially Met, **UM**=Unmet
Red represents quarterly updates that are required on the CAP per MDH Performance Monitoring Policy
Black represents quarterly updates on the CAP that are not required.

Follow up:

- Qlarant reviewed and approved the CAP submissions.
- Approved CAPs will be reviewed in CY 2020 SPR.

In accordance with MDH's Performance Monitoring Policy:

- ABH will provide a quarterly update on the CAP in CY 2020 for 7.5b, 7.7c, 7.7e, and 7.8c;
- ACC will provide a quarterly update on the CAP in CY 2020 for 7.4c, 7.7a, 7.7c, and 7.8c;
- CFCHP will provide a quarterly update on the CAP in CY 2020 for 7.8c;
- KPMAS will provide a quarterly update on the CAP in CY 2020 for 7.7c and 7.8c; and
- PPMCO will provide a quarterly update on the CAP in CY 2020 for 7.4c and 7.7c.

Standard 11: Fraud and Abuse

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

The MCO must:

- Maintain 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.
- Implement administrative and management procedures that train employees to detect fraud and abuse and communicate to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns.
- Maintain 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.
- Utilize various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan.
- Explicitly refrain from knowingly having a relationship with individuals or entities debarred by federal agencies.

Results and Findings. One MCO (KPMAS) has a continued improvement opportunity from the CY 2019 SPR and is required to submit quarterly updates on their CAP.

Table 8. Standard 11 Interim Desktop Review Results for CY 2020

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

Element/ Component Reviewed	Element/ Component Description	KPMAS
11.4d	Evidence of review and approval of continuous and ongoing delegate reports regarding the monitoring of fraud and abuse activities, as specified in 11.1d.	**UM**

UM=Unmet
Red represents quarterly updates that are required on CAP per MDH's Performance Monitoring Policy

Follow-up:

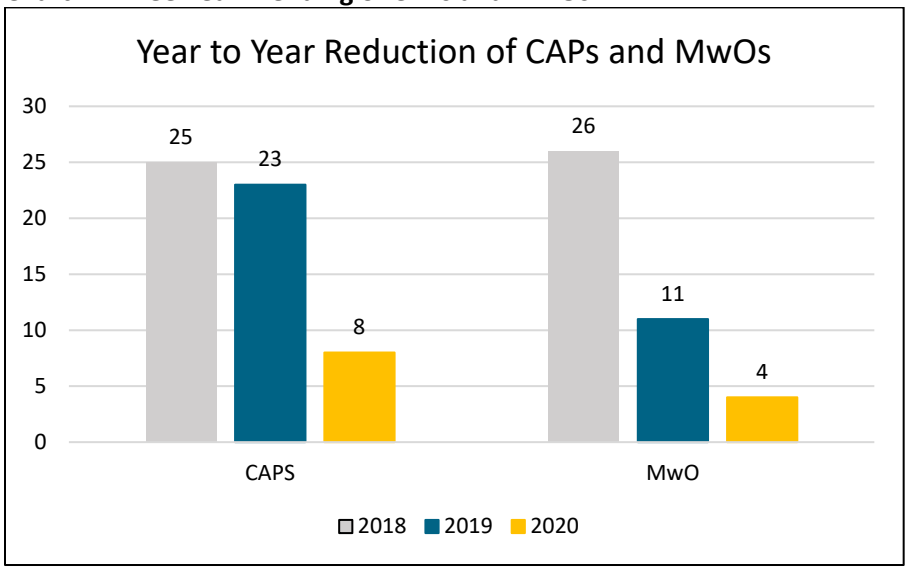
- Qlarant reviewed and approved the CAP submission.
- The approved CAP will be reviewed in CY 2021 SPR.

In accordance with MDH's Performance Monitoring Policy, KPMAS will provide quarterly updates on the CAPs in CY 2020 for 11.4c and 11.4d.

Conclusion

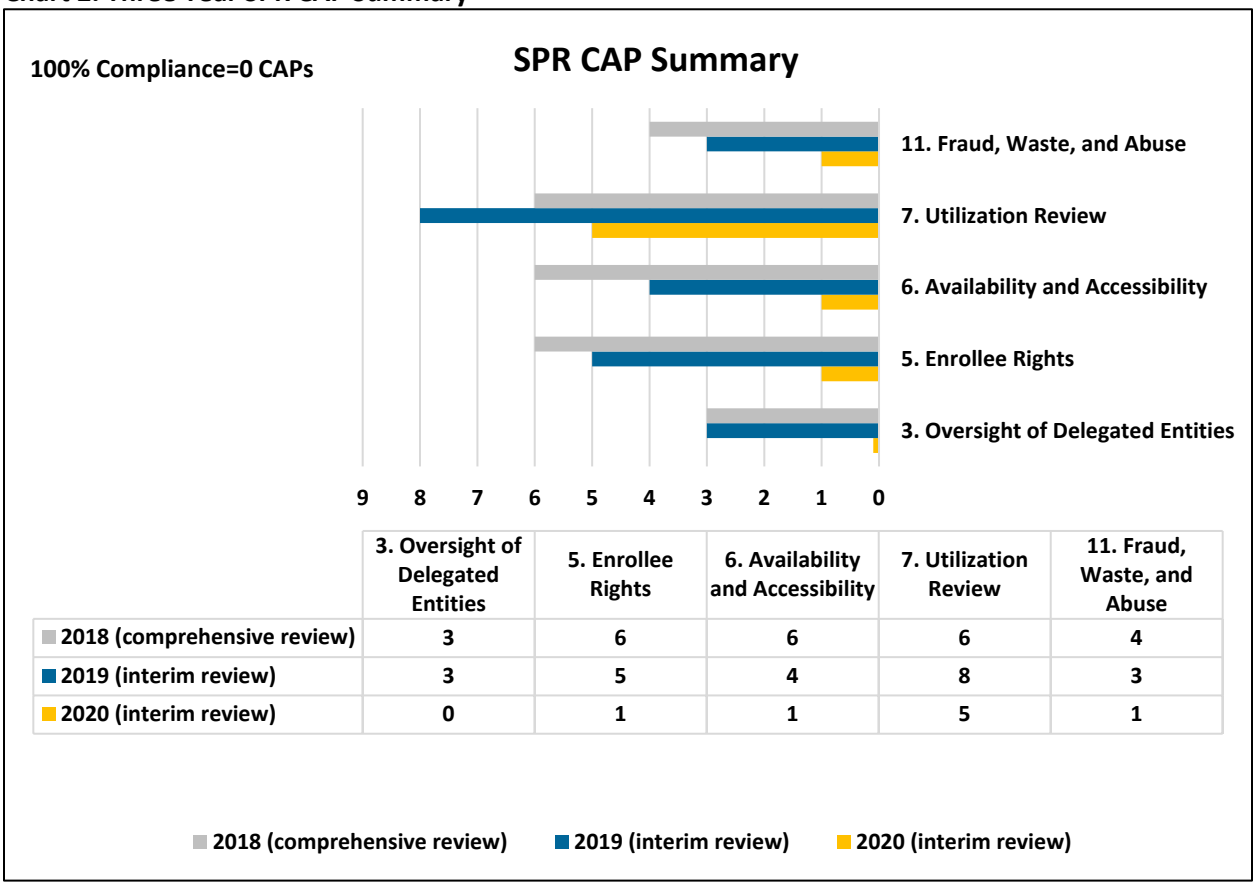
All MCOs have demonstrated the ability to design and implement effective quality assurance systems. Although numerical scores were not provided in CY 2020 SPR, improvement was seen across all MCOs. Chart 1 demonstrates a three year SPR CAP trend. The number of overall CAPs reduced from 25 in CY 2018 to 8 in CY 2020. The number of Met with Opportunity scores reduced from 26 in CY 2018 to 4 in CY 2020. Four MCOs (JMS, MPC, MSFC, and UHC) received a perfect score in the CY 2020 SPR.

Chart 1. Three Year Trending of CAPs and MwOs



Any standard that scored less than 100% in the 2018 SPR required a CAP. These standards required review in the subsequent interim SPRs. Chart 2 demonstrates SPR CAPs per standard during each review period. Utilization Review (Standard 7) continues to reveal opportunities for MCOs improvement while Oversight of Delegated Entities (Standard 3) is now 100% compliant. There were no CAPs in Standards 1, 2, 4, 8, 9, and 10, and the remaining standards (Standard 5, 6, and 11) are trending toward 100% compliance.

Chart 2. Three Year SPR CAP Summary



	3. Oversight of Delegated Entities	5. Enrollee Rights	6. Availability and Accessibility	7. Utilization Review	11. Fraud, Waste, and Abuse
2018 (comprehensive review)	3	6	6	6	4
2019 (interim review)	3	5	4	8	3
2020 (interim review)	0	1	1	5	1

In CY 2016, MDH revised its SPR Performance Monitoring Policy whereby any MCO that has had a CAP for two or more consecutive years in the same element/component is required to provide quarterly updates to Qlarant. In accordance with this policy, five MCOs are required to submit quarterly updates of their CAPs to Qlarant. Additionally, all CAPs based on the CY 2020 SPR will be reviewed during the CY 2021 SPR.

Maryland has set high standards for MCO quality assurance systems. HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. Qlarant will conduct a comprehensive onsite SPR for CY 2021 in January and February 2022.

Appendix A

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

Standard 5: Enrollee Rights

Findings

CareFirst Community Health Plan (CFCHP)

Component 5.8e (UM): In response to the CY 2019 review, CFCHP was required to update all applicable policies to include the requirement that all electronic information provided to enrollees will be 508 compliant. As indicated below, continued opportunities for improvement exist.

The Languages Services Policy addresses compliance with Americans with Disabilities Act of 1990 (ADA) requirements for language interpretation and translation of written materials into prevalent languages. The policy specifies the need for telecommunication relay language services, the readability of written materials, in-person translation services, and culturally appropriate communication. The policy now includes the requirement that all electronic information provided to enrollees be 508 compliant.

CFCHP provided evidence of four different months of email correspondence between the MCO and its certified 508 compliance vendor to demonstrate that electronic information on the CFCHP website is 508 compliant. Examples include 508 compliance with the CFCHP formulary and the provider newsletter.

While there is evidence of implementation of 508 compliance, the Language Services Policy still does not include COMAR regulations put forth in 10.67.05.01.

In order to receive a finding of met in the CY 2021 review, CFCHP must update relevant policies, such as the Language Services Policy, to include the requirement that all electronic information provided to enrollees be 508 compliant in conformance with COMAR 10.67.05.01 as follows:

- An MCO may provide enrollee information electronically so long as all of the following requirements are met:
    - The format is readily accessible;
    - The information is placed in a location on the MCO's website that is prominent and readily accessible;
    - The information is provided in an electronic form which can be electronically retained and printed;
    - The information is consistent with the content and language requirements of this Section;
    - The enrollee is informed that the information is available in paper form without charge upon request; and
    - Should the enrollee request it, the MCO provides the information in paper form within five business days

Standard 6: Availability and Accessibility

Findings

Aetna Better Health of Maryland (ABH)

Component 6.2a (PM): In response to the CY 2019 review, ABH was required to ensure online provider directories specify whether the office practice has ADA accommodations including specifics regarding offices, exam room(s), and equipment accessibility for patients with disabilities. As indicated below, continued opportunities exist.

The Practitioner Directory Updates Policy requires ABH to maintain a complete and up-to-date paper, electronic, and provider search feature directory that is organized geographically and evaluated regularly. ABH updates its paper Provider Directory at least monthly after provider information is received; the electronic paper directory is updated no later than 30 calendar days after provider information is received, and the online provider directory search feature is updated nightly. The policy fails to mention search function updates for handicap accessibility and accommodations, although it identifies other areas as required by regulation.

ABH demonstrated monthly monitoring of online directory updates for ADA-specific information for its newly contracted providers. An information request letter is sent to providers requesting ADA accommodations data when this information is incomplete or missing. Online provider directory screenshots were provided to identify providers with handicap accessibility and the availability of specific accommodations.

ABH's online provider directory is easy to review and includes designated placeholders for each component required by regulation; however, during the validation process, Qlarant reviewers discovered an inconsistency between ABH screenshots and its online directory, which still does not reflect required changes to add ADA accommodation specifics.

In order to receive a finding of met in the CY 2021 SPR, ABH must revise its policy to ensure all required regulatory elements for the online provider directory are updated regularly for new and existing providers and ensure online provider directories include specifics regarding ADA accommodations for patients with disabilities including offices, exam room(s), and equipment.

Standard 7: Utilization Review

Findings

Aetna Better Health of Maryland (ABH)

Component 7.5b (PM): In response to the CY 2019 review, ABH was required to include all 16 components in adverse determination letters and in the Prior Authorization Policy. As indicated below, continued opportunities for improvement exist.

The Prior Authorization Policy lists all required contents of the adverse determination letter. The list also includes an explanation that it is assumed the enrollee receives the letter five days after it is dated,

unless he/she shows evidence otherwise. This component has been removed from the list of requirements.

A sample review of 10 adverse determination letters confirmed inclusion of all required components. Errors were found in the appeal filing deadline in all MedSolutions letters. Additionally, many letters included an incorrect timeframe for requesting continuation of benefits.

In order to receive a finding of met in the CY 2021 review, ABH must ensure correct appeal filing and continuation of benefits timeframes in all adverse determination letters. Additionally, any explanation of assuming the enrollee receives the letter five days after it is dated, unless he/she shows evidence otherwise, must be removed from the list of adverse determination letter components in the Prior Authorization Policy.

Component 7.7c (UM): In response to the CY 2019 review, ABH was required to demonstrate consistent compliance with appeal resolution/notification timeframes. As indicated below, a continued opportunity for improvement exists.

The 2020 Monthly Member Appeals TAT report identifies compliance with resolution/notification timeframes for both expedited and standard appeals by month and for the year. Compliance results are as follows:

- Expedited appeals: Overall annual compliance of 60% (Outlier months ranged from 0% in August to 50% in November.)
- Standard appeals: Overall annual compliance of 80% (Outlier months ranged from 50% in December to 91% in February.)

A sample review of 19 available enrollee appeal records revealed the following:

- 0% (0/1) compliance with expedited resolution/notification timeframe.
- 0% (0/1) compliance with documentation of reasonable attempt to provide oral notification of expedited resolution to the enrollee.
- 83% (15/18) compliance with standard resolution/notification timeframe.
- There was no evidence of a resolution letter for one appeal, although case notes identify the date of written notification.
- One resolution letter was sent out 11 days after the appeal was resolved.

In order to receive a finding of met in the CY 2021 review, ABH must demonstrate compliance with appeal timeframes throughout the CY at the 100% compliance threshold. Additionally, there must be documentation of a reasonable attempt to provide the enrollee with an oral resolution of an expedited request.

Component 7.7e (UM): In response to the CY 2019 review, ABH was required to provide evidence of a reasonable attempt to give the enrollee prompt verbal notice of denial of expedited resolution. As indicated below, a continued opportunity for improvement exists.

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

Two denials of an expedited request were found in the sample of enrollee appeal records reviewed. In both cases, there was no documentation in the case record of a reasonable attempt to give the enrollee prompt verbal notice of the denial of an expedited resolution. Written notice was provided for one denial and met the timeframe requirement.

In order to receive a finding of met in the CY 2021 review, ABH must provide evidence of a reasonable attempt to give the enrollee prompt verbal notice of denial of expedited resolution and written notice within the required timeframe.

Component 7.8c (UM): In response to the CY 2019 review, ABH was required to demonstrate compliance with timeframe requirements for providing both a written acknowledgment and written resolution for all provider appeals. As indicated below, continued opportunities for improvement exist.

The Provider Appeals Policy requires written acknowledgment of provider appeals within 5 business days of receipt and resolution within 30 business days of receipt of each level. Written notice of appeal resolution is to be sent within 10 calendar days from the date of the decision for each level of appeal.

The 2020 Monthly Provider Appeals TAT report documents compliance with the percentage of appeals closed within 30 business days, which does not appear to address the MCO's turnaround time (TAT) for providing written resolution of the appeal. Additionally, the sample weekly reports listing individual provider appeals noting the date the acknowledgment letter was sent, and if it was sent within five business days, is insufficient in demonstrating compliance.

In order to receive a finding of met in the CY 2021 SPR, ABH must demonstrate compliance with timeframe requirements at MDH's established threshold for written acknowledgment and written resolution of provider appeals on at least a quarterly basis.

AMERIGROUP Community Care (ACC)

Component 7.4c (PM): In response to the CY 2019 review, ACC was required to provide evidence of compliance with PA determination timeframes for at least each quarter of the CY under review for both medical and outpatient pharmacy requests. As indicated below, continued opportunities for improvement exist.

As evidence of compliance, ACC submitted a slide presentation entitled "HCM Utilization Management 2020 Q3 Operational Metrics," which was presented at the Health Care Management Services Committee meeting of November 18, 2020. Compliance with determination timeframes was reported for the first three quarters of 2020 for both standard and expedited PA requests as follows:

- Q1 2020- standard 87%; expedited 95%
- Q2 2020- standard 96%; expedited 95%
- Q3 2020- standard 95%; expedited 95%

Pharmacy Department Reports for the first three quarters of 2020 demonstrated compliance with determination timeframes as follows:

- Q1 2020- pharmacy benefit 100%; medical injectables 90%
- Q2 2020- pharmacy benefit 100%; medical injectables 99%
- Q3 2020- pharmacy benefit 100%; medical injectables 99%

No reports were submitted for the fourth quarter of 2020.

A sample review of 10 enrollee adverse determination records, four pharmacy, and six medical, confirmed compliance with PA determination timeframes.

Subsequent to the initial review, ACC submitted additional documentation to support compliance. It submitted three documents, two detailed listings of adverse determinations from the fourth quarter, and the Q4 2020 MCO Quarterly Pre-Service Denial Report Analysis. These documents are insufficient in demonstrating compliance as this component addresses compliance with determination timeframes for all pre-service requests, both approvals and denials.

In order to receive a finding of met in the CY 2021 review, ACC must provide evidence of compliance with all PA determination timeframes for at least each quarter of the CY under review for both medical and outpatient pharmacy requests.

Component 7.5b (MwO): In response to the CY 2019 review, ACC was required to revise the Healthcare Management Denial – Core Process Policy to include all current adverse determination letter components. As indicated below, continued opportunities for improvement exist.

The Healthcare Management Denial – Core Process Policy lists the 17 components to be included in the adverse determination letter, which were required in the CY 2019 review. Since then, MDH has eliminated the requirement for a statement explaining that it is assumed that the enrollee receives the letter five calendar days after it is dated unless evidence shows otherwise. Additionally, the appeal filing timeframe has been changed from 60 calendar days from the date of receipt of the adverse determination letter (which was incorrectly stated in the Review Guidelines) to 60 days from the date on the notice of an adverse determination, to be consistent with federal regulations.

A sample review of 10 adverse determination letters confirmed the inclusion of the 16 required letter components; however, most letters included an additional five days in the embedded deadline dates for filing an appeal and requesting continuation of benefits.

In order to receive a finding of met in the CY 2021 review, ACC must revise the adverse determination letter components in all applicable policies to be consistent with current requirements. Additionally, calculation of the embedded deadline dates for filing an appeal and requesting continuation of benefits must be revised to eliminate the additional five days for mailing.

Component 7.6a (PM): In response to the CY 2019 review, ACC was required to revise the Pharmacy Prior Authorization Policy to eliminate reference to expedited authorization requests, which are not applicable to outpatient drug PA requests. As indicated below, a continued opportunity for improvement exists.

The Pharmacy Prior Authorization Policy requires the MCO to provide notice by telephone or other telecommunication devices within 24 hours of a PA request for a covered outpatient drug. The policy further requires denial letters to be sent to enrollees and providers within 24 hours from the case being closed. This language is insufficient in demonstrating compliance with the COMAR requirement for sending enrollees and the requesting provider notice of an adverse determination within 72 hours from the date of the determination.

Subsequent to the initial review, ACC submitted additional documentation to support compliance. ACC's 10 Day Exit Letter Response indicated that the Pharmacy Prior Authorization Policy submitted required the enrollee to be notified within 24 hours for both expedited and standard adverse determinations. It explained that its internal process was more restrictive than the 72-hour regulatory requirement; however, it reported it revised its policy to reflect the 72-hour standard. Based upon Qlarant's initial review, the issue with the policy related to language requiring denial letters be sent to enrollees and providers within 24 hours from the case being closed, rather than from the date of the determination. If ACC chooses to have a more stringent requirement of 24 hours from the date of the determination, compliance will be measured based upon this standard. Additionally, there is only one category for outpatient pharmacy PA requests. There is no differentiation between standard and expedited requests. The Pharmacy Prior Authorization Policy submitted with a revised date of February 1, 2021, referenced in ACC's response, is outside of the review period. The initial finding, therefore, remains unchanged.

In order to receive a finding of met in the CY 2021 review, ACC must revise the Pharmacy Prior Authorization Policy to be compliant with the COMAR requirement for sending enrollees and the requesting provider notice of an adverse determination within 72 hours from the date of the determination. ACC may choose to have a more stringent requirement, but the timeframe must be measured from the date of determination rather than from the date of case closure.

Component 7.7a (UM): In response to the CY 2019 review, ACC was required to revise the Member Appeals - Maryland Policy to reflect the regulatory timeframe for appeal filing, which is 60 calendar days from the date on the MCO's notice of an adverse determination. As indicated below, a continued opportunity for improvement exists.

The Member Appeals - Maryland Policy allows the enrollee, or their authorized representative, to file an appeal within 60 calendar days from the date of receipt of the notice of an adverse benefit determination. This is inconsistent with the COMAR appeal filing timeframe of 60 calendar days from the date on the MCO's notice of an adverse determination.

Subsequent to the initial review, ACC submitted the Member Appeals-MD Policy with a revised date of February 4, 2021. This is outside of the CY 2020 review period. The initial review decision, therefore, remains unchanged.

In order to receive a finding of met in the CY 2021 review, ACC must revise the Member Appeals - Maryland Policy to reflect the regulatory timeframe for appeal filing, which is 60 calendar days from the date on the MCO's notice of an adverse determination.

Component 7.7c (UM): In response to the CY 2019 review, ACC was required to demonstrate consistent compliance with appeal resolution/notification timeframes at the 100% threshold for all 12 months of the year under review. As indicated below, a continued opportunity for improvement exists.

MCO Appeal Quarterly Reports for each quarter of 2020 identified compliance with appeal resolution/notification timeframes as follows:

- Q1 2020- Expedited 88%; Standard 96%
- Q2 2020- Expedited 78%; Standard 88%
- Q3 2020- Expedited 83%; Standard 100%
- Q4 2020- Expedited 100%; Standard 99%

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

In order to receive a finding of met in the CY 2021 review, ACC must demonstrate consistent compliance with appeal resolution/notification timeframes at the 100% threshold for all 12 months of the year under review.

Component 7.8c (PM): In response to the CY 2019 review, ACC was required to provide evidence of compliance with timeframes for acknowledgment and resolution of provider administrative appeals. As indicated below, continued opportunities for improvement exist.

ACC provided evidence of compliance with timeframes for sending written acknowledgment in response to a provider administrative (claims) appeal for only the last six months of 2020. ACC results ranged from 96% to 100% during this timeframe, well exceeding the compliance threshold.

No results were provided to demonstrate compliance with the appeal resolution timeframe.

Subsequent to the initial review, ACC submitted additional documentation to support compliance, as presented below. Compliance was determined based upon the review of the MCO's Provider Claims Payment Dispute Process Policy.

The Provider Claims Payment Dispute Process Policy requires ACC to resolve all disputes, regardless of the number of dispute levels allowed by the MCO, within 90 business days of receipt of the initial dispute. Furthermore, if the decision is to uphold a previous decision at either level, the provider must receive written communication of the decision within 30 calendar days of the decision. If the decision is to overturn a previous decision at either level, the claim must be paid within 30 calendar days of the decision.

The MD Metrics spreadsheet provided TAT results for both provider appeal acknowledgment and appeal decisions by month throughout 2020. Compliance with appeal acknowledgment letters all exceeded the relaxed 90% threshold due to the COVID-19 state of emergency. Results ranged from 91% in March to 100% in October.

Appeal decisions were reported in two separate categories. The percentage of overturned decisions within 30 business days (42 calendar days) exceeded 90% in 8 of the 12 months. Results for months falling below ranged from 86% to 89%. Reported compliance with the 90 business day timeframe for overturned and upheld decisions exceeded the threshold in all months. This component, however, addresses compliance with the written resolution of provider appeals, not compliance with the decision timeframe.

In order to receive a finding of met in the CY 2021 review, ACC must provide evidence of compliance with timeframes for written resolution of all, upheld and overturned, provider administrative appeals, consistent with the MCO's policies for the entire CY under review.

CareFirst Community Health Plan (CFCHP)

Component 7.5b (MwO): In response to the CY 2019 review, CFCHP was required to revise all applicable policies that list the required adverse determination letter components and ensure the adverse determination letter template is updated accordingly. As indicated below, this opportunity for improvement was successfully addressed.

The UM Approval/Denial Process Policy lists the 16 components to be included in the adverse determination letter. However, the appeal filing timeframe specified in the policy as 60 calendar days from the date of receipt of the adverse determination letter (which was incorrectly stated in the Review Guidelines) needs to be revised to 60 days from the date on the notice of an adverse determination, to be consistent with regulatory requirements.

A sample review of 10 enrollee adverse determination letters confirmed compliance with all 16 required components.

In order to receive a finding of met in the CY 2021 review, CFCHP must revise the appeal filing timeframe in the list of adverse determination letter components included in the UM Approval/Denial Process Policy to 60 calendar days from the date on the notice of adverse determination.

Component 7.7a (MwO): In response to the CY 2019 review, CFCHP was required to revise its Members Appeals Policy to include missing elements and the correct expedited appeal resolution/notification timeframe. As indicated below, these opportunities for improvement were successfully addressed.

The Members Appeals Policy was revised to include the following missing elements:

- Oral requests for an appeal are considered the initiation of the appeal to establish the earliest possible filing date.
- CFCHP 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.
- Parties to the appeal include the enrollee, the enrollee's representative, or the estate representative of a deceased enrollee.

Additionally, the expedited appeal timeframe for resolution/notification has been revised to be consistent with regulatory requirements.

In order to receive a finding of met in the CY 2021 review, CFCHP must revise the appeal filing timeframe in the Members Appeals Policy to within 60 days from the date on the notice of adverse determination.

Component 7.8c (PM): In response to the CY 2019 review, CFCHP was required to demonstrate compliance with acknowledgment and resolution timeframes for provider appeals, on at least a quarterly basis. As indicated below, continued opportunities for improvement exist.

As evidence of compliance, CFCHP submitted PowerPoint presentations from three Quality Improvement Committee meetings in 2020 which included the following TAT compliance results for provider appeal acknowledgment and resolution letters:

- Q1 2020 - acknowledgment letter 0%; resolution letter 100%
- Q2 2020 - acknowledgment letter 0%; resolution letter 100%
- Q3 2020 - acknowledgment letter 0%; resolution letter 100%

According to the Q3 2020 presentation, CFCHP reported that it would be implementing a solution to auto-generate provider appeal acknowledgment letters in the fourth quarter of 2020.

No compliance results were presented for acknowledgment and resolution letters for the fourth quarter of 2020.

In order to receive a finding of met in the CY 2021 review, CFCHP must demonstrate compliance with TATs for sending providers a written appeal acknowledgment and written resolution within required timeframes at MDH's established threshold. Reports of compliance must be no less than quarterly.

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

Component 7.5b (MwO): In response to the CY 2019 review, KPMAS was required to add a partially missing adverse determination letter component to the Assessing Compliance MD HealthChoice Determination and Notifications Policy. As indicated below, this opportunity for improvement was successfully addressed.

The Assessing Compliance MD HealthChoice Determination and Notifications Policy lists all 16 required adverse determination letter components, including the previously missing requirement that the enrollee is provided a copy of their medical record upon request, free of charge. However, the appeal filing timeframe was incorrectly stated as 60 days from the date of receipt (which also was incorrectly stated in the Review Guidelines) rather than 60 days from the date on the MCO's notice of an adverse determination.

A sample review of 10 adverse determination letters included all 16 required components.

In order to receive a finding of met in the CY 2021 review, KPMAS must revise the appeal filing timeframe in the adverse determination letter components listed in the Assessing Compliance MD HealthChoice Determination and Notifications Policy to within 60 days from the date on the MCO's notice of an adverse determination to be consistent with federal regulations.

Component 7.7c (PM): In response to the CY 2019 review, KPMAS was required to revise the Maryland HealthChoice Grievance and Appeal System Policy to reflect the resolution/notification timeframes for standard and expedited appeals. Additionally, the Maryland Medicaid Appeals and Grievances Dashboard Report was required to specify that compliance with the timeframe for expedited appeals includes resolution/notification. There should also be evidence in enrollee case notes of a reasonable attempt to provide the enrollee with oral notification of the resolution of an expedited appeal. As indicated below, continued opportunities for improvement exist.

The Maryland HealthChoice Grievance and Appeal System Policy requires written notice of resolution of a standard appeal within 30 calendar days of receipt. For expedited appeals, the policy requires verbal and written notification within 72 hours based on the date and time of health plan receipt.

As evidence of compliance with timeframe requirements, KPMAS submitted the Maryland Medicaid Member Grievances spreadsheet, which was limited to grievances.

A sample review of appeal records was limited to five appeals, all standard. Overall compliance with the timeframe for written notification of resolution was 60% (3/5). Two resolution notification letters were sent to the enrollee over two months after appeal receipt. Additionally, only 40% of the resolution letters utilized MDH-approved templates.

Subsequent to the initial review, KPMAS submitted additional documentation to support compliance. The MD Medicaid Member Appeals Q1 - Q4 2020 TAT spreadsheet provided TAT compliance results by month for both expedited and standard appeals. Results are as follows:

- Expedited appeals (18) - 100% compliance for 5/9 months. Outlier months ranged from 0% in November to 67% in September.
- Standard (18) - 100% compliance in 4/6 months. September compliance was reported as 60% and October as 67%.

In order to receive a finding of met in the CY 2021 review, KPMAS must demonstrate compliance with written notification timeframes for standard and expedited appeal resolutions throughout the CY under review. All enrollee letters must utilize MDH-approved templates.

Component 7.8c (PM): In response to the CY 2019 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. As indicated below, continued opportunities for improvement exist.

The Maryland HealthChoice Provider Appeals Policy requires KPMAS to send an appeal acknowledgment letter to the provider within five business days of receipt. Additionally, written notice of appeal resolution is to be provided within five business days after the decision has been made but no later than 30 calendar days after receipt of the appeal.

The Maryland Medicaid Provider Appeals Dashboard Report provides monthly and quarterly TAT compliance results for written acknowledgment of a provider appeal and written resolution.

Reported compliance with the appeal acknowledgment letter timeframe was met in two of the four quarters:

- Q1 2020 - 8%
- Q2 2020 - 91% (MDH relaxed the threshold from 95% to 90% during the declared state of emergency due to COVID-19.)
- Q3 2020 - 82%
- Q4 2020 - 95%

Reported compliance with the appeal resolution letter timeframe was met in three of the four quarters:

- Q1 2020 - 65%
- Q2 2020 - 100%
- Q3 2020 - 99%
- Q4 2020 - 100%

In order to receive a finding of met in the CY 2021 review, KPMAS must provide evidence of compliance with timeframes for written acknowledgment of receipt of a provider appeal and written resolution by each level of appeal, on at least a quarterly basis at the MDH-established threshold.

Maryland Physicians Care (MPC)

Component 7.7c (MwO): In response to the CY 2019 review, MPC was required to resolve the inconsistency in the resolution/notification timeframe for expedited appeals in the Member Appeal Policy. As indicated below, this opportunity for improvement was successfully addressed.
MPC has resolved the inconsistency in the resolution/notification timeframe for an expedited enrollee appeal in its Member Appeal Policy. The policy now consistently requires resolution/notification of an expedited appeal within 72 hours of receipt of the initial request.

MPC's corrected Key Indicator Report (KIR) identifies 100% compliance for resolution of expedited appeals within 3 days and 100% for resolution of all other appeals within 30 days.

A sample review of 10 enrollee appeal records, all standard, confirmed compliance with the timeframe for enrollee written notice of resolution.

In order to receive a finding of met in the CY 2021 review, MPC must revise the KIR to indicate appeal timeframes include both resolution and written notification. Additionally, the timeframe for resolution/notification of an expedited appeal must be revised from 3 days to 72 hours to be consistent with MPC's policy and regulatory requirements.

Priority Partners (PPMCO)

Component 7.3c (PM): In response to the CY 2019 review, PPMCO was required to demonstrate that the Utilization Management/Care Management (UM/CM) Work Group is monitoring interventions and evaluating success of the eMocha pilot and any other initiatives relating to the asthma readmission over/under utilization project. As indicated below, a continued opportunity for improvement exists.

The Over and Under Utilization Policy assigns responsibility for development and implementation of over and underutilization CAPs to the Health Services Cost of Care meeting. The Quality Assurance and Performance Improvement Committee provides guidance and approval of these CAPs and documents all associated activities, including follow up in its meeting minutes.

In the CY 2019 review, PPMCO reported plans to implement a three-month pilot with eMocha to improve medication adherence for enrollees with an asthma diagnosis on controller medications. Since the pilot was planned to last three months, results would not be available until early 2020. Based upon a review of meeting minutes from the Johns Hopkins Healthcare Accreditation and Regulatory Workgroup, the UM/CM Workgroup, and the Quality Assurance and Performance Improvement Committee, the pilot did not begin until May 2020. It was expected to run through August with a goal of 50 participants. As of August, only 12 to 15 enrollees were participating, which increased to 47 as of October 20, 2020. A PowerPoint presentation entitled "eMocha Asthma Descriptive Analysis of Initial Enrollment" presented

descriptive data on 15 of the enrolled participants. No analysis of the effectiveness of the pilot was provided.

It does not appear that any other corrective measures were implemented or monitored to address identified over and underutilization issues based upon meeting minutes reviewed. Delayed implementation of the eMocha pilot, which was planned during the summer of 2019, and limited participants, are insufficient in demonstrating PPMCO's commitment to effectively addressing over and underutilization issues.

In order to receive a finding of met in the CY 2021 review, PPMCO must demonstrate effective monitoring of planned interventions to ensure timely and successful implementation of utilization-related corrective measures.

Component 7.4c (UM): In response to the CY 2019 review, PPMCO was required to demonstrate consistent compliance with regulatory timeframes for PA determinations at MDH's established threshold. The compliance threshold of 95% was relaxed to 90% in March 2020 as a result of the public health emergency declared in response to COVID-19. As indicated below, a continued opportunity for improvement exists.

As evidence of compliance, PPMCO submitted the UM Turnaround Time for Pre-certification for Utilization Management report, which provides compliance results by month from January through December 2020. Compliance with determination timeframes by individual reporting categories are as follows:

- Total approved - Determinations exceeded the compliance threshold for six consecutive months (January through June). Compliance results for the remaining six months ranged from 43.81% in November to 72.27% in July.
- Total denied - Eight of the 12 reported months exceeded the applicable compliance threshold. Outlier months ranged from 85.1% in September to 94.81% in February.

Results for the first six months must be reviewed with caution. According to the UM/CM Workgroup meeting minutes from November 12, 2020, the significant drop in third quarter TAT rates was due to the misinterpretation of NCQA and Qlarant TATs reported in the first two quarters. As a result, the reported TAT compliance for the first two quarters was overstated.

A sample review of 10 enrollee adverse determination records demonstrated 80% overall compliance with PA determination timeframes. Six pharmacy requests demonstrated 100% compliance, while four medical requests demonstrated only 50% compliance. The six medical PA records in the remaining sample demonstrated 0% compliance with determination timeframes, resulting in 50% overall compliance. For the 8/10 medical PA requests not meeting the determination timeframe, requests for medical director review occurred between 13 and 15 days following receipt of the request. In five of these cases, the date of the request for additional clinical information was the same date as the denial (one was four minutes later), or the denial was the following day for one request. No additional clinical was requested for three, which were not sent to the medical director for review until 13 or 14 days following receipt of the PA request. All requests for additional clinical information must be submitted within two business days of receipt of the PA request.

In order to receive a finding of met in the CY 2021 SPR, PPMCO must demonstrate consistent compliance with regulatory timeframes for determinations at MDH's approved threshold, on at least a

quarterly basis, throughout the entire calendar year. This includes requesting additional clinical information, if needed, within 2 business days of receipt of the PA request.

Component 7.7c (UM): In response to the CY 2019 review, PPMCO was required to demonstrate consistent compliance with appeal timeframes. As indicated below, a continued opportunity for improvement exists.

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

As evidence of compliance, PPMCO submitted the Appeals TAT Report. This report identifies compliance with both expedited and non-urgent resolution/notification timeframes by month throughout 2020. PPMCO met the 100% compliance threshold for expedited appeals in 2 of the 12 months (July and September). Compliance results for the remaining 10 months ranged from 67% in April to 96% in January. TAT compliance for non-urgent appeals was reported at 100% for 8 of the 12 months. Compliance results for the remaining 4 months ranged from 93% in February to 98% in September.

A sample review of 10 enrollee appeal records submitted by PPMCO found all resolutions/notifications were completed within regulatory timeframes.

In order to receive a finding of met in the CY 2021 review, PPMCO must demonstrate 100% compliance with timeframes for written resolution of standard and expedited appeals throughout 2021.

Standard 11: Fraud, Waste, and Abuse

Findings

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

Component 11.4c (UM): In response to the CY 2019 review, KPMAS was required to provide evidence that it conducts an annual review of its own Compliance Program Plan and of its delegates. As indicated below, the CAP was not fully implemented, and continued opportunities for improvement exist.

KPMAS developed the Compliance Leadership Committee Oversight of Delegate Fraud Waste and Abuse Plans Policy (in draft), which describes several levels of review of delegated entity FWA plans. According to the draft policy, the review process starts at the Health Plan National FWA department, whose responsibility is to assess the delegates' FWA plans for compliance with statutory and regulatory requirements. Identified deficiencies are communicated to the local Medicaid Operations department. The KPMAS Medicaid Operations manager documents any of the delegate's compliance/FWA plan deficiencies, proposed CAPs, and the status of any CAP activity and submits these findings at the first quarter MOR Board meeting for review and discussion. This serves as the second tier of review.

Recommendations from the MOR and all accompanying delegate compliance plans, administrative and management reports, and policies and procedures are submitted to the Compliance Leadership Committee (CLC) for the final review, input, and approval prior to the first quarter meeting of the year.

Based upon a review of the CLC meeting minutes for March, June, September, and December 2020, it is not clear that the CLC reviewed the KPMAS Compliance Program Description or the Compliance/FWA Plans for MedImpact and Relations Insurance of Florida (formerly EMI). At each CLC meeting, there is a discussion of the need to develop a process for addressing this necessary oversight.

December 10, 2020, CLC meeting minutes indicate that work continues to refine oversight of subcontractors to ensure they are compliant in managing fraud, waste, and abuse (FWA) for KPMAS Medicaid plans. KPMAS submitted a slide deck from this CLC meeting which outlines the plan for coming into compliance with 11.4c in CY 2021.

In order to receive a finding of met in the CY 2021 review, KPMAS must provide evidence that it conducts an annual review of its own Fraud and Abuse Compliance Program Plan and of its delegates.

Component 11.4d (UM): In response to the CY 2019 review, KPMAS was required to provide evidence of the Compliance Committee's review and approval of continuous and ongoing delegate reports regarding the monitoring of FWA. As indicated below, the CAP was not fully implemented, and continued opportunities for improvement exist.

Based upon the review of the CLC meeting minutes for March, June, September, and December 2020, it is not clear that the CLC reviewed and approved quarterly delegate reports on FWA for MedImpact and Relations Insurance of Florida (formerly EMI). At each CLC meeting, there is a discussion of the need to develop a process for addressing this necessary oversight.

December 10, 2020, CLC meeting minutes indicate that work continues to refine oversight of subcontractors to ensure their compliance in managing FWA for KPMAS Medicaid plans.

KPMAS submitted a list of FWA reports reviewed for MedImpact and Relations Insurance Florida as follows:

MedImpact

- MedImpact Quarterly Fraud, Waste, and Abuse Update: January – March 2020
- MedImpact Quarterly Fraud, Waste, and Abuse Update: April – June 2020
- MedImpact Quarterly Fraud, Waste, and Abuse Update: July – September 2020
- MedImpact FWA Policies, Procedures, and Compliance Plans

Relations of Florida/EMI

- Relations of Florida FWA Cost Avoidance Report
- Relations of Florida SOC 1 Report for Claims Processing Services – December 1, 2019 – November 30, 2020
- EMI MAS Monthly Claims Report – April 2020
- EMI MAS Monthly Claims Report - May 2020
- EMI MAS Monthly Claims Report – June 2020
- EMI MAS Monthly Claims Report – July 2020
- Relations of Florida FWA Policies, Procedures, and Compliance Plans

It is not clear from the review of CLC meeting minutes that these reports were reviewed and approved by the CLC.

As with the finding for 11.c, KPMAS indicated it was developing procedures for ongoing review and approval of delegate FWA activities and submitted a document that outlines the plan for coming into compliance in CY 2021.

In order to receive a finding of met in the CY 2021 review, KPMAS must show ongoing efforts to review and monitor FWA activities of its delegated entities. This monitoring must include an annual review of each delegate's Compliance Plan and a quarterly review of the delegate's FWA activities. Monitoring and oversight must address elements specified in Element 11.1d of this standard, such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, and marketing.