



**Qlarant** 



**Maryland HealthChoice  
Program**



**Interim Systems Performance  
Review**

**Statewide Executive Summary  
Report**

**Measurement Year 2022**

Submitted July 2023



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# Maryland Department of Health Measurement Year 2022

## 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). In accordance with Title 42, Code of Federal Regulations (CFR), 438.204, MDH is responsible for monitoring the quality of care provided to MCO enrollees consistent with 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 HealthChoice Program regulations. MDH contracts with Qlarant to serve as the EQRO.

The executive summary report describes findings from the measurement year (MY) 2022's interim systems performance review (SPR). HealthChoice served over 1,528,338 enrollees during its 24<sup>th</sup> year of operation.

COMAR 10.67.04 requires all HealthChoice MCOs to comply with SPR standards and all applicable federal and state laws and regulations. MCOs were provided a 45-day comment period to review and comment on the SPR standards prior to the beginning of the audit process. The nine MCOs evaluated for MY 2022 were:

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

- Aetna Better Health of Maryland (ABH)
- CareFirst BlueCross BlueShield 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)
- Wellpoint Maryland (WPM)<sup>2</sup>

## Purpose and Process

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

Qlarant conducted MY 2022's assessment as an interim desktop review in response to MDH's decision to move to triennial, rather than annual onsite reviews. Reviewers completed this assessment by applying the systems performance standards defined for MY 2022 in COMAR 10.67.04.03B(1). Standards requiring a corrective action plan (CAP) or scored as a baseline in the MY 2021 review were the focus of MY 2022's SPR. Additionally, a sample review of appeal, grievance, and adverse determination records was conducted to assess compliance with applicable standards.

Performance standards used to assess the MCOs' operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; COMAR; the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care;" CFR; and Department requirements. The Office of Medical Benefits Management leadership and the Division of HealthChoice Quality Assurance (DHQA) approved the MCO performance standards before inclusion in the MY 2022 review.

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

## Methodology

### Review Activities

In October 2022, Qlarant provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for MY 2022 and invited the MCOs to direct any questions or issues requiring clarification to Qlarant and DHQA. The manual included the following information:

- Overview of HealthChoice program and Systems Performance Review
- MY 2022 Review Timeline
- External Quality Review Contacts
- Pre-onsite Visit Overview and Survey
- Pre-onsite SPR Document List

<sup>2</sup> Formerly Amerigroup Community Care

- MY 2022 Systems Performance Review Standards and Guidelines, including specific revisions
- Maryland Standards Eligible for Deeming

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

During the desktop reviews conducted in January and February of 2023, the team reviewed all relevant documentation needed to assess the standards. An exit letter was provided to each MCO detailing potential issues that could be addressed by supplemental documents, if available. The MCOs were given ten business days from receipt of the exit letter to submit any additional information to Qlarant; documents received were subsequently reviewed against the standard(s) to which they related.

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

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

MDH had the discretion to change a review finding to “Unmet” if the element or component was found “Partially Met” for more than one consecutive year.

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

## Non-duplication Deeming

CMS permits states the opportunity to use information from a private accreditation review, such as an 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 scores 100% on the applicable NCQA standards, there is an opportunity to “deem” or consider the MCO’s performance as meeting requirements. This process eliminates the need to review the deemed regulation as part of the SPR, thus reducing the administrative burden on the MCO.

MDH initiated this process for the MY 2021 comprehensive SPR. Standards and elements that were deemed in the MY 2021 comprehensive SPR review are not reviewed during interim review years. 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 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. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

For each standard assessed for MY 2022, the following section describes:

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

### Standard 4: Credentialing and Recredentialing

**Results and Findings:** Eight of the nine MCOs met the compliance threshold of 100% for Standard 4. One MCO (MPC) has opportunities for improvement in the area of Credentialing and Recredentialing and is required to submit a quarterly CAP.

**Table 2. Standard 4 Interim Review Results for MY 2022**

Element/Component Reviewed	MPC
4.4i	UM
4.4j	UM

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 MCO CAP submissions.
- The approved CAPs will be reviewed during the Interim MY 2023 SPR.

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

- MPC will provide a quarterly update on the CAP in MY 2022 for 4.4i and 4.4j.

### Standard 5: Enrollee Rights

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



**Table 3. Standard 5 Interim Review Results for MY 2022**

Element/ Component Reviewed	CFCHP	KPMAS	PPMCO	WPM
5.1a	UM	-	-	-
5.1d	-	UM	-	-
5.1g	UM	UM	-	-
5.1h	UM	UM	-	UM
5.5c	-	-	-	UM
5.8d	UM	-	-	UM
5.8e	-	-	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 MCO CAP submissions.
- The approved CAPs will be reviewed during the Interim MY 2023 SPR.

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

- CFCHP will provide a quarterly update on the CAP in MY 2022 for 5.1a and 5.1g.
- KPMAS will provide a quarterly update on the CAP in MY 2022 for 5.1d and 5.1g.
- WPM will provide a quarterly update on the CAP in MY 2022 for 5.5c.

## Standard 6: Availability and Accessibility

**Results and Findings:** All nine MCOs met the compliance threshold of 100% for Standard 6 therefore no MCOs are required to submit CAPs for MY 2022.

**Follow up:** There is no follow up required for Standard 6.

## Standard 7: Utilization Review

**Results and Findings:** Eight MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC, and WPM) have opportunities for improvement in the area of Utilization Review and are required to submit CAPs. Five MCOs (CFCHP, KPMAS, PPMCO, UHC, and WPM) are required to submit quarterly CAPs.

**Table 4. Standard 7 Comprehensive Review Results for MY 2022**

Element/ Component Reviewed	ABH	CFCHP	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
7.3c	-	-	-	-	-	-	PM	-
7.4c	-	UM	PM	PM	-	PM	-	PM
7.5a	PM	PM	-	-	-	-	-	-
7.5b	PM	-	-	-	-	PM	-	-
7.6a	-	UM	-	-	-	-	-	-
7.6b	-	-	-	-	-	-	-	UM
7.7c	-	PM	PM	PM	PM	PM	-	UM
7.7e	-	PM	-	-	-	UM	-	-
7.7f	-	-	-	-	-	-	-	-
7.7g	-	UM	-	-	-	UM	-	-
7.8c	-	UM	UM	-	-	-	-	-
7.9b	-	-	-	-	-	-	-	-
7.9c	-	UM	UM	-	-	-	-	-
7.10	-	UM	-	-	-	-	UM	UM

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 MCO CAP submissions.
- The approved CAPs will be reviewed during the Interim MY 2023 SPR.

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

- CFCHP will provide a quarterly update on the CAP in MY 2022 for 7.6a, 7.8c, 7.9c, and 7.10.
- KPMAS will provide a quarterly update on the CAP in MY 2022 for 7.8c and 7.9c.
- PPMCO will provide a quarterly update on the CAP in MY 2022 for 7.7e.
- UHC will provide a quarterly update on the CAP in MY 2022 for 7.10.
- WPM will provide a quarterly update on the CAP in MY 2022 for 7.6b and 7.10.

## Standard 9: Health Education Plan

**Results and Findings:** Three MCOs (CFCHP, PPMCO, and WPM) have opportunities for improvement in the area of Health Education Plan and are required to submit CAPs.

**Table 5. Standard 9 Comprehensive Review Results for MY 2022**

Element/Component Reviewed	CFCHP	PPMCO	WPM
9.2	-	-	PM
9.3a	-	PM	UM
9.3b	-	-	UM
9.3c	PM	PM	-
9.4	-	PM	-
9.5a	-	-	-
9.5b	PM	-	UM
9.5c	UM	-	UM

Yellow = PM, Red = UM

**Follow up:**

- Qlarant reviewed and approved the MCO CAP submissions.
- The approved CAPs will be reviewed during the Interim MY 2023 SPR.

## Standard 10: Outreach Plan

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

**Table 6. Standard 10 Comprehensive Review Results for MY 2022**

Element/Component Reviewed	PPMCO
10.1a	PM

Yellow = PM

**Follow up:**

- Qlarant reviewed and approved the MCO CAP submission.
- The approved CAP will be reviewed during the Interim MY 2023 SPR.

## Standard 11: Fraud and Abuse

**Results and Findings.** All nine MCOs met the compliance threshold of 100% for Standard 11 therefore no MCOs are required to submit CAPs for MY 2022.

**Follow-up:** There is no follow up required for Standard 11.

## 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 will provide technical assistance to the MCO until an acceptable CAP is submitted. Eight MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC, and WPM) were required to submit CAPs for the MY 2022 SPR.

### Corrective Action Plan Review

CAPs related to the SPR may be directly linked to specific elements, components, or standards. The interim SPR for MY 2022 determined whether the CAPs from the MY 2021 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 MY 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 MY 2022 SPR, six MCOs (CFCHP, KPMAS, MPC, PPMCO, UHC, and WPM) were required to submit quarterly updates of their CAPs to Qlarant.

After the MY 2022 SPR was conducted, Qlarant recommended the following quarterly CAP closures, as represented in Table 7.

**Table 7. SPR MY 2022 Quarterly CAP Closures**

MCO	Standards
ABH	7.8c
WPM	7.8c

### Met with Opportunity Review

Elements/components scored as Met with Opportunity (MwO) were found compliant with the requirement(s), along with an opportunity to improve. While MwO findings do not require a CAP, these improvements must be addressed in order to receive a Met finding in the next review period. This section identifies areas that were scored as MwO. Seven MCOs (ABH, CFCHP, JMS, MSFC, PPMCO, UHC, and WPM) received a finding of MwO in one or more standards, as represented in Table 8.

**Table 8. SPR MY 2022 Met with Opportunities**

MCO	Standards
ABH	7.8c, 11.4d
CFCHP	7.9b, 9.3a, 9.3b, 9.5a, 11.4d
JMS	5.1a
MSFC	9.5b
PPMCO	9.5b
UHC	9.3a, 9.4, 9.5c
WPM	6.2b, 9.1b

## Conclusion

The MY 2022 SPR was an interim desktop review. 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 a finding of Met and/or MWO for all standards reviewed. Eight MCOs (ABH, CFCHP, KPMAS, MPC, MSFC, PPMCO, UHC and WPM) were required to submit CAPs for MY 2022. As a result of the MY 2022 SPR, six MCOs (CFCHP, KPMAS, MPC, PPMCO, UHC, and WPM) have quarterly CAP monitoring. CFCHP and KPMAS have continued quarterly CAP monitoring for component 7.8c.

Maryland has set high standards for MCO quality assurance systems. In response, all MCOs have demonstrated the ability to design and implement effective 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 healthcare services to managed care enrollees.

## Appendix A

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

### 4.0 - Credentialing and Recredentialing

#### Findings

##### Maryland Physicians Care (MPC)

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

**This component is Unmet.**

In response to the MY 2021 review, MPC was required to demonstrate consistent compliance with the required turnaround time (TAT) for processing the credentialing application in less than or equal to 150 days from receipt of the application. As indicated below, continued opportunities for improvement exist.

MPC's management company is responsible for notifying the healthcare practitioner and the Provider Management Department of the final initial credentialing decision. The final initial decision must be within 120 days from the date of the letter of intent to continue the credentialing application process. This notification letter is sent to the practitioner within 30 days of receipt of the credentialing application. These procedures comply with the timeframes specified in Insurance Article Section 15-112(d).

In a sample review of ten initial credentialing records, credentialing TAT was not met in one record. For this record, the application date was December 13, 2021, the 30-day letter was sent to the provider on December 14, 2021, and the credentialing decision date was September 20, 2022; this is a processing time of 276 days from the date the application was received.

Upon review of an additional 20 records, three records were not processed within the required TAT of 150 days from receipt of the provider application. These three records were processed within 251, 166, and 269 days of receipt of application respectively. Overall compliance was 26/30 or 87%.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 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 Unmet.**

In response to the MY 2021 review, MPC was required to demonstrate consistent compliance with sending the practitioner the 30-day notice that informs the practitioner of the MCO's intent to move forward with the initial credentialing process. As indicated below, continued opportunities for improvement exist.

In a sample review of ten initial credentialing records, one record did not include the 30-day notice to inform the practitioner of the intent to move forward with the initial credentialing process. Upon review of an additional 20 records, a total of eight were out of compliance. Overall compliance was 21/30 or 70%.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, MPC must show evidence of sending the practitioner the 30-day notice that informs the practitioner of the MCO's intent to move forward with the initial credentialing process.

## 5.0 – Enrollee Rights

### Findings

#### CareFirst Community Health Plan (CFCHP)

**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 Unmet.**

In response to the MY 2021 review, CFCHP was required to revise the Member Grievances Policy and standard operating 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 medically related grievances that are not anticipated to be resolved within five calendar days or within the regulatory requirement, whichever is less. As indicated below, continued opportunities for improvement exist.

The Member Grievances Standard Operating Procedure has been revised to eliminate the timeframe requirement for filing a grievance; however, other provisions continue to be inconsistent with MDH requirements as described below.

The timeframe for sending a written acknowledgment of grievance receipt has not been revised and remains stated as "five business days" rather than "five calendar days from receipt of the grievance."

The desktop procedure continues to limit written grievance acknowledgments to administrative grievances. As stated in the MY 2021 review, grievance acknowledgment letters also must be sent for any medically related grievances that are not anticipated to be resolved within five calendar days or within the regulatory requirement, whichever is less.

The Member Grievances Policy was not submitted for review.

After the initial review, CFCHP submitted the Member Grievances Policy, which has been revised to eliminate the filing timeframe requirement and state the correct timeframe for sending an acknowledgment letter as within five calendar days of receipt of the grievance. Under the "Background/Business Rules" section the policy states "All grievances received by CareFirst CHPMD A&G Department will be: Acknowledged within five (5) calendar days of receipt". Further in this section, it indicates that acknowledgment letters will be sent if a non-emergency medically related grievance is not anticipated to be resolved within five calendar days.

CFCHP also submitted the Member Grievances Standard Operating Procedure that states November 1, 2022, as the review date which is the same date as the document initially reviewed; however, this version reflects the required changes as identified in the initial review. This subsequent version may be resubmitted in concert with CFCHP's corrective action plan.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must revise the Member Grievances Standard Operating Procedure to state the correct timeframe for sending a written acknowledgment of a grievance and require an acknowledgment letter be sent for medically related grievances that are not anticipated to be resolved within five calendar days or within the regulatory requirement, whichever is less.

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

**This component is Unmet.**

In response to the MY 2021 review, CFCHP was required to demonstrate compliance with timeframes for written grievance acknowledgment and resolution at the MDH-established threshold of 95%. As indicated below, continued opportunities for improvement exist.

A PowerPoint presentation was submitted which graphically displayed turnaround times by month from January through September 2022 for written grievance acknowledgments and grievance resolutions. Timeframe compliance with written grievance acknowledgment met the MDH threshold in one of the nine months reported. Outlier months ranged from 50% to 92% compliance. Similarly, compliance with the timeframe for grievance resolution was met in only one of the nine months. Although actual percentages of compliance were not included on the bar graph, outlier results appeared to range from approximately 30% to 60%.

An initial sample review of ten enrollee grievance records found that six records demonstrated compliance with the timeframe for written grievance acknowledgment and nine records with the resolution timeframes. A review of an additional 20 records found 13 records demonstrated compliance with the timeframe for written grievance acknowledgment and 14 records with the resolution timeframes. Overall compliance with timeframes for written grievance acknowledgment was 63% (19/30) and with resolution 77% (23/30).

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate compliance with timeframes for written grievance acknowledgment and grievance resolution at or above the MDH threshold of 95% on at least a quarterly basis for each of the four quarters of the review period.

**5.1 h.** 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.

**This component is Unmet**

In response to the MY 2021 review, CFCHP was required to revise all applicable member grievance policies/desktop procedures to specify a timeframe for providing the enrollee with a written grievance resolution following the resolution of the grievance. As indicated below, continued opportunities for improvement exist.



Review of the Member Grievances Standard Operating Procedure found no timeframe(s) for sending the enrollee written notice of grievance resolution. The Member Grievances Policy was not submitted for review.

A sample review of ten enrollee grievance records was unable to determine compliance with written resolution timeframe(s) in the absence of a policy or procedure stating the timeframe for written resolution.

After the initial review, CFCHP submitted the Member Grievances Policy, which outlines its Resolution Timeliness Standard as the following:

- Emergency Medically Related Grievances resolved in 24 hours;
- Non-Emergency Medically Related Grievances resolved in five calendar days; and
- Administrative Grievances acknowledged in five calendar days and resolved in 30 calendar days.

The policy also specifies that it requires the MCO to provide a written notice of resolution to the enrollee no more than 30 days from the date of receipt of grievance. This policy statement still does not include all grievances that potentially require written notification. Based on the written resolution timeframe documented within the policy, the initial sample review of ten enrollee grievance records found eight of the grievances received a written resolution within the required timeframe. A subsequent review of an additional 20 records found that 16 records met the required timeframe for written resolution. Overall compliance with written resolution timeliness was 80% (24/30).

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate compliance with its written grievance resolution timeframe at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period. In addition, CFCHP must revise its Member Grievance Policy to include written notification timeframes for all grievance types in accordance with the MDH MCO Model Notice guidance.

**5.8 d.** Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

**This component is Unmet.**

In response to the MY 2021 review, it was recommended that CFCHP consider placing taglines on the Nondiscrimination Notice displayed at events when it interacts with the public. As indicated below, continued opportunities for improvement exist.

CFCHP provided two photos of public event interactions, although the photos did not display evidence of nondiscrimination notice postings.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must provide evidence of notices and taglines being posted in conspicuous physical locations, where appropriate, when interacting with the public.

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

**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.**

In response to the MY 2021 review, JMS was required to 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 was required to revise the exception noted for sending a written grievance acknowledgment to be consistent with MDH requirements. As indicated below, continued opportunities for improvement exist.

The Enrollee Grievance and Appeal Policy has been revised to specify a five-calendar-day timeframe for sending the enrollee a written acknowledgment of the grievance receipt. This requirement is waived if JMS resolves the grievance within five calendar days. This is inconsistent with MDH requirements which allow for waiving acknowledgment letters if the MCO resolves the grievance within five calendar days or within the regulatory requirement, whichever is less. This additional language takes into consideration emergency medically related grievances.

After the initial review, JMS responded that it believes the language in its Enrollee Grievance and Appeal Policy, indicating written grievance acknowledgments may be waived if resolution occurs within five calendar days, meets requirements. It referenced a chart within the policy that explicitly outlines the required timeframes for an acknowledgment letter based on the grievance category. This chart identifies the acknowledgment letter timeframe for both emergency and non-emergency-related grievances as N/A with an asterisk that indicates if JMS resolves the grievance within five calendar days only a resolution notice will be sent to the enrollee. This does not address when the regulatory timeframe for an emergency medically related grievance may not be met. For this interim review the finding of "Partially Met" will be changed to "Met with Opportunity" with the additional policy language required to receive a finding of "Met" in the MY 2023 review.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of met in the MY 2023 review, JMS must revise the Enrollee Grievance and Appeal Policy to specify that enrollee written grievance acknowledgments may be waived if "the MCO resolves the grievance within five calendar days or within the regulatory requirement, whichever is less".

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

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

**This component is Unmet.**

In response to the MY 2021 review, KPMAS was required to 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 Grievance and Appeals Policy needed 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. As indicated below, continued opportunities for improvement exist.

The Mid-Atlantic States Non-Medicare Grievance and Appeals Policy indicates that grievance data will be routinely monitored and analyzed for trends as a component of the MCO's QI program. The policy has been revised to indicate Member Relations will report grievance data and any recommended action plans that will be implemented and monitored in response to opportunities for improvement to the Regional Quality Improvement Committee (RQIC) at least quarterly.

As evidence of compliance, KPMAS submitted the RQIC 2022 Mid-Year Assessment of the Member Experience in Kaiser Permanente (KP) report presented at the October RQIC meeting. This document demonstrated a comprehensive review of grievance trends for the Mid-Atlantic States region. No data was reported specifically for HealthChoice.

Minutes from the July and October 2022 RQIC meetings demonstrated a review of grievance data; however, it was limited to a report of compliance with grievance resolution timeframes. There was no discussion of trends or actions taken in response to identified opportunities for improvement.

***OPPORTUNITY FOR IMPROVEMENT:*** In order to receive a finding of Met in the MY 2023 review, KPMAS must demonstrate that it tracks and trends grievance data to identify opportunities for improvement and implements action plans, as indicated, specifically for MD HealthChoice.

**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 Unmet.**

In response to the MY 2021 review, KPMAS was required to demonstrate turnaround compliance with written acknowledgment and resolution of grievances at or above MDH's threshold of 95%. As indicated below, continued opportunities for improvement exist.

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 turnaround time reports indicating monthly compliance, by grievance category, for the first eight months of 2022. Compliance with acknowledgment letter timeliness was met in six of the eight months. Compliance with resolution timeframes was met in seven of the eight months.

A sample review of ten enrollee grievance records found 100% turnaround time compliance with written acknowledgment and resolution.

***OPPORTUNITY FOR IMPROVEMENT:*** In order to receive a finding of Met in the MY 2023 review, KPMAS must demonstrate compliance with timeframes for grievance acknowledgment and resolution at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.

**5.1 h.** 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.

**This component is Unmet.**

In response to the MY 2021 review, KPMAS was required to demonstrate compliance with written enrollee grievance resolutions within the timeframes specified in its policy. As indicated below, continued opportunities for improvement exist.

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

KPMAS submitted turnaround time reports indicating monthly compliance, by grievance category, for the first eight months of 2022. Compliance with written resolution timeframes was met in seven of the eight months.

A sample review of ten enrollee grievance records found 100% turnaround time compliance with written resolution.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, KPMAS must demonstrate compliance with written resolution timeframes at or above the MDH threshold on at least a quarterly basis for all four quarters of the review period.

### Priority Partners (PPMCO)

**5.8 e.** MCO's electronic information provided to members must meet requirements set forth in COMAR. **This component is Partially Met.**

In the MY 2021 baseline review, PPMCO provided reports as evidence that their electronic information provided to enrollees met requirements set forth in COMAR. While some samples were provided, this report was not provided for the MY 2022 review.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, PPMCO must provide a report that indicates their electronic information provided to enrollees meets requirements set forth in COMAR.

### Wellpoint Maryland (WPM)

**5.1 h.** 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.

**This component is Unmet.**

In response to the MY 2021 review, WPM was required to revise the Member Grievances - MD Policy to specify a timeframe for providing the enrollee written notice of grievance resolution following the resolution of the grievance. As indicated below, a continued opportunity for improvement exists.

The Member Grievances - MD Policy indicates that for administrative grievances WPM will provide a written resolution to the enrollee within three business days of the decision, not to exceed a total of 30 calendar days from the date the grievance was received. Immediately following this the policy identifies "response times" consistent with resolution requirements for emergency medically related grievances

and non-emergency related grievances. The policy does not include a timeframe for written resolution for either of these two categories.

No reports were provided demonstrating WPM's compliance with its timeframes for written grievance resolution.

Compliance could not be determined based on a sample review of ten grievances in the absence of specific timeframes for written grievance resolution.

After the initial review, WPM submitted two Excel spreadsheets. One sheet detailed each grievance received in 2022 which included the following fields: decision date, decision letter date, decision letter turnaround time, and grievance turnaround time. No overall compliance results on at least a quarterly basis were provided. The summary spreadsheet also did not include overall compliance results with WPM's written resolution timeframe. No additional documentation was provided.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must revise the Member Grievances - MD Policy to specify a timeframe for providing the enrollee written notice of grievance resolution for each grievance category. WPM also must demonstrate compliance with these timeframes at or above the MDH threshold on at least a quarterly basis for all four quarters of the review period.

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

**This component is Unmet.**

In response to the MY 2021 review, WPM was required to provide evidence that providers were notified of assessment results within the MY 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. As indicated below, continued opportunities for improvement exist.

In MY 2022, WPM demonstrated partial compliance by providing evidence of supplying its providers CAHPS® results via a newsletter in the provider update. No additional means were noted for informing providers of assessment results.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must provide evidence of any additional means by which providers were informed of assessment results, such as an online provider portal.

**5.8 d.** Notices and Taglines must be posted, where appropriate, in conspicuous physical locations where the MCO interacts with the public.

**This component is Unmet.**

In response to the MY 2021 review, it was recommended that WPM, upon interactions with the public, have notices and taglines posted where appropriate, in conspicuous physical locations to demonstrate compliance with this component. The MCO did not provide evidence of postings or interactions with the public in MY 2022.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must provide evidence of posted notices and taglines during public interactions, in conspicuous physical locations.

## 6.0 - Availability and Accessibility

### Findings

#### Wellpoint Maryland (WPM)

**6.2 b.** At the time of enrollment, enrollees are provided with information about the MCO's providers. **This component is Met with Opportunities.**

WPM did not provide clear evidence in the documentation presented for MY 2022 that enrollees are provided information about the MCO's providers at time of enrollment.

After the review, WPM provided the New Member Materials Policy. This policy outlines that new members are provided a New Member Welcome Kit, which includes guidance on how to access the provider directory, whether by mail or electronically; and that only enrollees with an "N" code receive this packet.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must provide a sample copy of the New Member Welcome Kit to ensure the MCOs provider information that is presented to enrollees at enrollment.

## 7.0 - Utilization Review

### Findings

#### Aetna Better Health (ABH)

**7.5 a.** All adverse determination letters are written in easy-to-understand language. **This component is Partially Met.**

The amendment to the Utilization Management Timeliness Standards and Decision Notification Policy requires notice of an adverse determination to the enrollee to be written at or below a fifth-grade reading level.

An initial sample review of ten adverse determination letters found nine written in easy-to-understand language. A review of an additional 20 records found that 18 records demonstrated compliance. Overall compliance was 90% (27/30). The three records that did not pass included language explaining the reasons for denial, reduction, or termination that were not easy-to-understand. For example, "Transforaminal epidural injections are considered medically necessary for the treatment of confirmed radiculopathy that causes functional limitations".

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, ABH must demonstrate adverse determination notices are written in easy-to-understand language.

**7.5 b.** Adverse determination letters include all required components.

**This component is Partially Met.**

In response to the MY 2021 review, ABH was required to revise the Prior Authorization Policy to further clarify the appeal filing timeframe as "within sixty days from the date of the adverse determination notice" in the list of contents for the adverse determination letter. As indicated below, this opportunity for improvement was successfully addressed.

The amendment to the Utilization Management Timeliness Standards and Decision Notification Policy lists the required components for adverse determination notices and reflects the required revision to the appeal filing timeframe. However, the list is incomplete and includes a component that has been removed from the required list. This component is "An explanation that it is assumed an enrollee receives the letter five (5) days after it is dated unless he/she shows evidence otherwise." Missing components are as follows:

- Clear, full, and complete factual explanation of the reasons for the denial, reduction, or termination in understandable language.
- Use of the phrase "nationally recognized medical standards" is acceptable; however, the exact clinical guideline reference must be included.
- Availability of a free copy of any guideline, code, or similar information MCO used to decide and the MCO contact number including TTY/TTD.
- Explanation to the enrollee that if he/she is currently receiving ongoing services that are being terminated or reduced, he/she may be able to continue receiving these services during the appeal process by calling the MCO or the HealthChoice Help Line within ten days from receipt of this letter or on or before the intended effective date of the MCO's proposed action. If the enrollee's appeal is denied, he/she may be required to pay the cost of the services received during the appeal process.
- Statement that the enrollee may represent self or use legal counsel, a relative, a friend, or other spokesperson.
- A statement containing the availability of the expedited review process, MCO phone number, and timeframe for making a determination.
- Appeals and Grievance Rights document.

An initial sample review of ten adverse determination letters found nine included all required components. Review of an additional 20 records found that 18 records demonstrated compliance. Overall compliance was 90% (27/30). Missing from three of the records was a clear, full, complete factual explanation of reasons for denial, reduction, or termination in understandable language. For example, one explanation required "one more pretreatment serum testosterone level from a different morning, one pretreatment free or bioavailable testosterone level that shows you have low testosterone" for authorization approval.

After the initial review, ABH resubmitted the Aetna Medicaid Administrators LLC Utilization Management Timeliness Standards and Decision Notification - Maryland which highlighted all required components of the adverse determination letter. However, as noted previously, the policy includes an additional component, "An explanation that it is assumed an enrollee receives the letter five (5) days after it is dated unless he/she shows evidence otherwise" which was removed as a requirement.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, ABH must:

- Remove the five–calendar-day mailing timeframe from the required adverse determination letter components.
- Demonstrate that explanations of the reasons for the adverse determination are in easy-to-understand language in adverse determination letters.

**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.**

In response to the MY 2021 review, ABH was required to demonstrate compliance with the timeframe for sending a written acknowledgment of receipt of a provider appeal and written resolution for all 12 months of the year under review. ABH also was required to resolve the inconsistency in the timeframe for providing written notice of appeal resolution, which is identified as ten calendar days from the decision in policy and three business days for compliance tracking. As indicated below, continued opportunities for improvement exist.

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 ten calendar days from the date of the decision, or as promptly as the enrollee’s health requires.

The 2022 Monthly Provider Appeals Turnaround Time report identifies the monthly percentage of compliance for written acknowledgment and resolution of provider appeals from January through December 2022. Compliance with a written acknowledgment of appeal receipt exceeded the threshold in all 12 months of 2022, as did resolution. The Turnaround Time report submitted did not identify compliance with written resolution; however, compliance with a three business day timeframe for written notice of the resolution was reported from January through November in the December 22, 2022, Appeal and Grievance Committee meeting.

After the initial review, ABH submitted the Monthly Provider Appeals Turnaround Time Report and provided compliance by quarter. It reported compliance with the three-business-day requirement for sending the provider written notice of appeal resolution as exceeding the 95% compliance threshold in all four quarters.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, ABH must revise the Provider Appeal Policy to reflect the three-business-day requirement for sending the provider written appeal resolution, which is the standard used by the MCO for compliance tracking.

### CareFirst Community Health Plan (CFCHP)

**7.4 c.** Timeframes for preauthorization decisions are specified in the MCO’s policies and decisions are made in a timely manner as specified by the State.

**This component is Unmet.**

In response to the MY 2021 review, CFCHP was required to revise the Timeliness of Utilization Management Decisions Policy to include the requirement that if additional clinical information is required, it must be requested within two business days of receipt of the request. Additionally, the Pharmacy Prior Authorization Policy must be revised to fully specify for outpatient drug preauthorization



(PA) decisions, the MCO shall approve, deny, or request additional information from the requesting provider within 24 hours of the request by telephone or other telecommunication device. This requirement also should be documented in the Pharmacy Prior Authorization Desktop Procedure. Additionally, CFCHP must demonstrate consistent turnaround time compliance at the established threshold for all PA determinations and prescriber notifications. As indicated below, continued opportunities for improvement exist.

According to the Timeliness of Utilization Management Decisions Policy, if there is insufficient clinical information submitted with the PA request the provider is contacted within two calendar days of receipt of the request. This is more stringent than the two business day requirement.

The Pharmacy Prior Authorization Policy requires responses to outpatient pharmacy PA requests must be made within 24 hours of the request. As noted in the MY 2021 review, this is insufficient in demonstrating compliance with the regulatory requirement, which specifies that for outpatient drug PA decisions, the MCO shall approve, deny, or request additional information by telephone or other telecommunication device from the requesting provider within 24 hours of the request.

The Pharmacy Prior Authorization Desktop Procedure specifies procedures for each of the three potential determinations, (approve, deny, or request additional information), for outpatient drug PA requests; however, the procedures are inconsistent with the regulatory requirement for prescriber notification. According to the Standard Operating Procedure, the requesting provider is notified of either an approval or denial through fax or mail within 24 hours of the PA request decision. If additional clinical information is needed, the PA representative will "inform or contact the prescriber or prescriber's representative that additional information is needed to process the PA." The policy further explains the next steps are determined based on receipt of additional clinical information within 24 hours from receipt of the PA request or lack of response to the request.

As evidence of compliance, CFCHP submitted the first three quarters of the Preservice Denial Reports required by MDH on a quarterly basis. These reports are insufficient in determining turnaround time compliance, as only determinations for adverse decisions are included in the report.

A sample review of ten adverse determination records found that CFCHP met the 95% compliance threshold for PA determination timeframes and prescriber notifications.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must:

- Revise both the Pharmacy Prior Authorization Policy and the Pharmacy Prior Authorization Desktop Procedure to specify the requirement to "approve, deny, or request additional information by telephone or other telecommunication device from the requesting provider within 24 hours of the PA request for all covered outpatient drugs."
- Demonstrate compliance with determination timeframes for all PA requests at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.
- Demonstrate compliance with notifying the prescriber of the determination of a covered outpatient PA request (approve, deny, request additional clinical) by telephone or other telecommunication device within 24 hours of the request at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.

**7.5 a.** All adverse determination letters are written in easy to understand language.

**This component is Partially Met.**

The Utilization Management Approval/Denial Process Standard Operating Procedure requires adverse determination notifications be produced in a manner, format, and language that may be easily understood.

An initial sample review of ten adverse determination records found that seven records were written in easy to understand language. Review of an additional 20 records found eight written in easy to understand language. Overall compliance was 50% (15/30).

Examples of language not easily understood include:

- "approved when being used for an FDA approved or compendia supported indication."
- "Your plan covers additional quantities of this drug when you meet one of these conditions: - You have hyperemesis gravidarum."
- "patient tried a topical calcineurin inhibitor on the skin in the past 180 days, and it a) did not control the atopic dermatitis well, or b) the use of topical calcineurin inhibitors on the skin is not appropriate for the patient."

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate all adverse determination letters are written in easy to understand language.

**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 Unmet.**

In response to the MY 2021 review, CFCHP was required to 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 ten days prior to reducing, suspending, or terminating a covered service must be documented in a utilization management policy. As indicated below, continued opportunities for improvement exist.

The Timeliness of Utilization Management Decisions Standard Operating Procedure was not submitted for review. According to the Timeliness of Utilization Management Decisions Policy, the MCO is required to "make a determination and provide notice within 24 hours of the decision" (identified as 72 hours from receipt of the request). Additionally, there is no evidence of the requirement for providing written notice to an enrollee at least ten days prior to reducing, suspending, or terminating a covered service.

After the initial review, CFCHP submitted the Timeliness of Utilization Management Decisions Standard Operating Procedure. The "Urgent Pre-Service" section of this standard operating procedure appears to require the MCO to make a determination "within seventy-two (72) hours of receipt of the request" which is followed by "the MCO shall make a determination and provide notice no later than 24 hours after receipt of the request for service. Notice of decision to deny shall be provided to the enrollee within 24 hours of the determination". This language is confusing and contradictory.

This standard operating procedure includes the requirement for providing written notice to the enrollee at least ten days prior to reducing, suspending, or terminating a covered service.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023, CFCHP must revise the Timeliness of Utilization Management Decisions Standard Operating Procedure and the Timeliness of Utilization Management Decisions Policy to eliminate the inconsistency in the timeframe for sending enrollees an adverse determination letter for an expedited PA request.

**7.7 c.** The MCO must adhere to appeal timeframes.

**This component is Partially Met.**

In response to the MY 2021 review, CFCHP was required to demonstrate compliance with the MDH threshold of 95% for enrollee written acknowledgment of appeal receipt. As indicated below, continued opportunities for improvement exist.

The Member Appeals Policy includes timeframes for written acknowledgment of an appeal and written resolution for standard and expedited appeals that are consistent with regulatory requirements.

Quality Improvement Committee (QIC) minutes from the April 28, 2022, meeting noted that compliance with appeal resolution notification timeframes was met for the first quarter. There was no report of compliance with written appeal acknowledgment. According to minutes from the QIC meetings of August 4 and October 27, 2022, compliance with timeframes for appeal acknowledgment and resolution notification were met in the second and third quarters, respectively. No compliance results were provided for fourth quarter.

An initial sample review of ten appeal records, all standard, found 100% compliance with the timeframe for enrollee written notification of appeal resolution. Written acknowledgment of an appeal was found in five of the ten cases. An additional 20 records were reviewed, with 18 demonstrating compliance with the timeframe for written appeal acknowledgment. Overall compliance for written acknowledgment of an appeal was 77% (23 out of 30 records).

After the initial review, CFCHP submitted a PowerPoint presentation from the January 2023 QIC meeting which displayed line graphs of compliance by month for appeal acknowledgment letters and resolution notifications. According to the line graph, acknowledgment letter timeframe compliance fell below the 95% threshold in seven of the 12 months with outlier months ranging from 72% to 94%. Compliance with appeal resolution notification was reported as falling below the compliance threshold in two of the 12 months at 87% and 93%.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate compliance with timeframes for written appeal acknowledgment and resolution/notification at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.

**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.**

In response to the MY 2021 review, CFCHP was required to demonstrate a reasonable attempt to provide the enrollee with oral notification of the denial of a request for an expedited appeal resolution. As indicated below, no determination could be made as to the compliance of this component.

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.

No denials of a request for an expedited appeal resolution were found in the sample review of ten appeal records. Additionally no denials were found within the additional 20 records reviewed. This component will be reviewed again in the next annual review since there were no cases found in this year's sample. This item will remain as Partially Met until a record review is completed that results in a met finding.

**7.7 g.** The MCO's appeal policies and procedures must include oral inquiries seeking to appeal are treated as appeals.

**This component is Unmet.**

In response to the MY 2021 review, CFCHP was required to revise the Member Appeals Policy to eliminate the requirement for written confirmation of oral requests for an appeal. As indicated below, continued opportunities for improvement exist.

The Member Appeals Policy in the "General Introduction" section states " Oral requests for appeal are considered the initiation of the appeal to establish the earliest possible filing date and are confirmed orally at the time of receipt, in writing, unless the enrollee, their representative, or the provider requests an expedited appeal."

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must remove all references to requiring written confirmation of an oral appeal in the Member Appeals Policy.

**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 MY 2021 review, CFCHP was required to demonstrate turnaround time compliance for written acknowledgment and written resolution of provider appeals at or above the MDH-established threshold of 95%. As indicated below, continued opportunities for improvement exist.

CFCHP submitted a PowerPoint deck, Grievance and Appeal Reporting, which displayed timeframe compliance for written acknowledgment of provider appeal receipt for the first nine months of 2022. Compliance results ranged from 7.7% in April to 96.5% in September. September was the only month that met the compliance threshold. No results were provided for the fourth quarter of 2022. No compliance results for written resolution of provider appeals were provided in either this deck or QIC minutes reviewed.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate turnaround time compliance for written acknowledgment and written resolution of provider appeals at or above the MDH-established threshold of 95% on at least a quarterly basis for all four quarters of the review period.

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

**This component is Met with Opportunity.**

In response to the MY 2021 review, CFCHP was required to demonstrate a review of utilization management-related results from the CAHPS® and Provider Satisfaction surveys by the committee(s), consistent with its policies.

The Member Experience Committee (MEC) Charter includes among the committee's primary responsibilities review of the CAHPS® survey results annually and Echo survey results quarterly.

Review of MEC minutes from the June 2022 meeting reflected discussion limited to the low response rates for both the CAHPS® and Provider Satisfaction surveys conducted in 2022. In the August meeting, a table was provided, which included CAHPS® specific results for 2019 through 2021. It was reported that satisfaction had declined in about every area of the adult survey which appeared to be related to COVID since all MCOs experienced a decline. For the child survey some improvements were identified; however, it was noted that CFCHP is still lagging behind other MCOs. Results for 2022 were anticipated to be available in October.

The Provider Advisory Committee (PAC) Charter includes among the committee's primary duties and responsibilities review of clinical and service indicator trends and other performance data, including HEDIS® and CAHPS®. It does not include an annual review of results from the State-administered Provider Satisfaction Survey.

Results from the 2021 Provider Satisfaction Survey were reviewed in the September 2022 PAC. It was reported there was a decline across the board in all survey questions, noting the root cause of declining scores was likely related to COVID; however, the MCO performed below the 2021 HealthChoice Aggregate in all but two measures: overall satisfaction and PA. Results from the 2022 Provider Satisfaction Survey were reviewed in the December PAC meeting, noting several opportunities for improvement in comparing 2022 results with 2021. In reviewing the table, improvement was observed in the composite score and sub-measures for PA.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate a more timely review of CAHPS® and Provider Satisfaction survey results to facilitate development and implementation of action plans in response to identified opportunities for improvement in utilization management related measures. Additionally, the PAC Charter must be revised to clearly state that the review of the annual Provider Satisfaction Survey results is one of the committee's responsibilities.

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

**This component is Unmet.**

In response to the MY 2021 review, CFCHP was required to demonstrate that it develops and implements action plans to address utilization management-related opportunities based on results of the annual CAHPS® and Provider Satisfaction surveys. As indicated below, continued opportunities for improvement exist.

The MEC Charter includes among the committee's primary responsibilities developing action plans and/or interventions related to opportunities for improvement and recommending QIC approval of action plans developed. Review of minutes from the June and August MEC meetings found no evidence

of development and implementation of any action plans to address utilization management opportunities based on the results from either the 2021 or 2022 CAHPS® survey.

The PAC Charter includes among the committee's primary duties and responsibilities clinical monitoring and evaluation activities and implementation/oversight of action plans to address issues and improve performance. The PAC reviews, develops/oversees improvement actions, and makes recommendations to the QIC.

The PAC minutes from the September meeting reported areas of focus for improvement efforts were “timeliness of obtaining authorization for meds” and “overall experience with obtaining authorization for meds or procedures.” In response, CFCHP was looking into updating auto adjudication and enhancements to the autopay list. Draft minutes from the December PAC included an interventions tracker table, which identified the date implemented, activity, barrier addressing, and business owner. Specific to utilization management related opportunities identified in the Provider Satisfaction Survey were planned improvements to the provider portal and provider pages on the CFCHP website. Barriers being addressed included overall experience with obtaining authorizations and accuracy and accessibility of drug formulary and formulary updates.

After the initial review, CFCHP submitted additional documents to demonstrate compliance. Minutes from the March 24, 2022, MEC meeting included confirmation that CAHPS® would be included in this meeting in response to a question from a committee member. It was noted that the 2021 CAHPS® survey results were presented in the last MEC meeting, and that Quality would be developing a CAHPS® tracking tool to review performance trends and capture interventions. No CAHPS® tracking tool was submitted. The additional documents submitted included a desktop procedure, Post Service Review Medicaid, which outlined the process for utilization management nurse review of a post-service request with a stated objective to decrease post-service enrollee and provider appeals. The Consultant Authorization Grid Update included an email trail describing the role of the consultant in recommending PA be added or removed to codes/categories with the goal of improving access and enrollee experience with benefits and utilization of benefits. The last document, ER Diagnoses Codes Updates, was an email that identified the purpose of these updates was to determine if ED denials could be decreased. None of these documents were clearly tied to any specific opportunities for improvement identified from review of the CAHPS® survey results.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate that it acts on identified opportunities for improvement related to utilization management measures as a result of CAHPS® survey results. These interventions need to be reported in the MEC meeting minutes and submitted to the QIC for approval consistent with its charter.

**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 Unmet.**

In response to the MY 2021 review, CFCHP was required to revise the Provider Appeals – Independent Review Organization 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. As indicated below, continued opportunities for improvement exist.

After the initial review, CFCHP submitted the Provider Appeals Desktop Procedure which indicates that all IRO invoices are forwarded to Accounts Payable and are paid within sixty calendar days. The remainder of the desktop includes procedures for reporting appeal data to key department stakeholders on a weekly basis and on a quarterly basis to the QIC through the MEC. There is no mention of how CFCHP tracks payment of IRO invoices to ensure compliance with the 60-day timeframe.

The Provider Appeals – Independent Review Organization Request Policy has been revised to 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 has not been updated, however, to include the process for ensuring all IRO invoices are paid within sixty days.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must revise the Provider Appeals – Independent Review Organization Request Policy or the desktop procedure to include a process for ensuring that all IRO invoices are paid within the required 60-day timeframe.

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

**7.4 c.** Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.

**This component is Partially Met.**

In response to the MY 2021 review, KPMAS was required to include in the Managing Referrals for Maryland HealthChoice Members Policy the requirement that if additional clinical information is required it must be requested within two business days of receipt of the request. As indicated below, this opportunity for improvement was successfully addressed.

The Managing Referrals for Maryland HealthChoice Members Policy includes a table listing determination timeframe requirements. For expedited PA requests, a determination and notification are to be made no later than 72 hours after receipt of the request. For standard authorization requests, a determination is required within two business days of receipt of clinical information, but no later than 14 calendar days from the date of the initial request. The policy further stipulates timeframes for standard and expedited authorization decisions may be extended up to 14 calendar days, if the enrollee, authorized representative, or the provider requests an extension. The policy has been revised and now includes the requirement that if additional clinical information is required, it must be requested within two business days of receipt of the request.

The MD HealthChoice Pharmacy Service Authorizations Policy specifies the timeframe for outpatient drug PA decisions (approve, deny, and request additional clinical information) is within 24 hours of the request. Additionally, it requires notice to the prescriber and enrollee within 24 hours of the PA request, by telephone or other telecommunication device.

The MD HealthChoice Utilization Management Internal Turnaround Time Report categorized compliance by approvals, denials, urgent, and routine for the first three quarters of 2022. Compliance with decision timeframes exceeded the threshold for the first and second quarters. Compliance for the third quarter fell below the 95% threshold at 90% for denials; however, it exceeded the threshold at 97% for approvals.

According to the Maryland HealthChoice Pharmacy Pre-Auth Decision Turnaround Time Report, KPMAS demonstrated 100% compliance with the timeframes for PA decisions of outpatient pharmacy PA requests and prescriber notification within 24 hours for the three reported quarters for 2022.

An initial sample review of ten adverse determination records, all standard requests, found eight records demonstrated compliance with PA determinations. Review of 20 additional records found all demonstrated compliance. Overall compliance was 93% (28/30).

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, KPMAS must demonstrate compliance with determination timeframes in response to preauthorization requests at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.

**7.7 c.** The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes. **This component is Partially Met.**

In response to the MY 2021 review, KPMAS was required to demonstrate turnaround time compliance within the MDH threshold of 95% for written acknowledgment and written appeal resolution. As indicated below, continued opportunities for improvement exist.

The Mid-Atlantic States Non-Medicare Grievance and Appeals Policy requires written acknowledgment of standard appeal receipt to the enrollee within five calendar days and verbal within 24 hours for expedited appeals. A written resolution must be provided within 30 calendar days of receipt of a standard appeal. For an expedited appeal, the policy requires verbal and written notification of resolution within 72 hours of MCO receipt.

The MD Medicaid Member Appeals document identifies compliance with written appeal acknowledgment and written resolution notification timeframes from January through August 2022. Compliance with the timeframe for written acknowledgment of appeal receipt was reported as 100% for seven of the eight months. Compliance was reported as 60% for the month of May.

Compliance with the resolution notification timeframe for expedited appeals was reported as 100% for two of the three applicable months. For the month of February, compliance was reported as 50%. Compliance with the resolution notification timeframe for standard appeals was reported as 100% for the seven applicable months.

A sample review of the seven enrollee appeal records submitted by KPMAS found that written acknowledgment of appeal receipt met the required timeframe. The timeframe for appeal resolution notification was met for the six standard appeals. The one expedited appeal did not meet the 72-hour written resolution timeframe or demonstrate a reasonable attempt to provide oral notification of the resolution. According to case notes, the enrollee requested an expedited appeal; however, it was processed as standard with no evidence in case notes indicating the expedited request had been denied. Additionally, there was no evidence of written notification to the enrollee of appeal resolution/notification.



**OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2023 review, KPMAS must:**

- Demonstrate compliance with written appeal acknowledgment and written appeal resolution notification timeframes at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.
- Demonstrate written notification within the required timeframe and oral notification of any denial of a request for an expedited appeal resolution.

**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 MY 2021 review, KPMAS was required to demonstrate turnaround time compliance with MDH's 95% threshold for written appeal acknowledgment and written resolution of provider appeals for all four quarters. As indicated below, continued opportunities for improvement exist.

As evidence of compliance, KPMAS submitted a sample Weekly Dashboard for Medicaid Disputes that appeared to address all of its Medicaid plans in the Mid-Atlantic region. The only measure of timeframe compliance was based on processing timeliness. There was no evidence of reporting timeframe compliance with written appeal acknowledgment and written resolution of provider appeals for Maryland.

After the initial review, KPMAS submitted the 2022 Maryland Medicaid Provider Appeals Dashboard Report, which identified timeframe compliance for written appeal acknowledgment and written resolution by month and by quarter for 2022. Compliance with the timeframe for written acknowledgment was met in the first two quarters and fell below the compliance threshold of 95% in the third and fourth quarters at 88% and 46% respectively. Compliance with the timeframe for providing written appeal resolution exceeded the compliance threshold in all four quarters.

**OPPORTUNITY FOR IMPROVEMENT: In order to receive a finding of Met in the MY 2023 review, KPMAS must demonstrate compliance with written acknowledgment of provider appeals at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period as required by Maryland Medicaid.**

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

**This component is Unmet.**

In response to the MY 2021 review, KPMAS was required to demonstrate that it acts upon identified issues as a result of the review of utilization management satisfaction data specific to the HealthChoice population and the providers within the HealthChoice service area. As indicated below, continued opportunities for improvement exist.

As evidence of compliance with this requirement, KPMAS submitted a document entitled "7.9c\_Acts\_Identified Issues" which provided a table that included 2021 identified issues/opportunities for improvement in 2022 as a result of a review of the data, actions taken in 2022 report of results, and 2022 identified issues/opportunities for improvement to act on in 2023 as a result of a review of the data. The 2021 utilization management-identified issues were reported as access to care and getting needed care. Key actions mirrored those identified in the Utilization Management Plan (UMP) work plan to address utilization issues. The action plans do not appear to directly address sub-measures under

getting needed care (i.e., ease of getting needed care, tests, or treatment) and getting care quickly (i.e., got an appointment for urgent care as soon as needed) as they address, for example, inpatient (IP) utilization and readmission rates. No evidence was provided of actions to address identified opportunities for improvement based upon results from the Provider Satisfaction Survey.

Additional documents submitted to demonstrate compliance also were reviewed. The December Regional Utilization Management Committee (RUMC) minutes identified opportunities for improvement from the Adult and Child CAHPS® surveys. There also was a comparison of the 2022 Provider Satisfaction Survey results with 2020, 2021, and the 2022 HealthChoice Aggregate. There was no evidence of reports on actions taken to address opportunities for improvement in response to either the 2021 or 2022 survey results.

The 2022 Medicaid CAHPS® Summary Internal Analysis included a table comparing HealthChoice Adult and Child results for composite measures from the 2022 CAHPS® surveys to 2019 and 2021. Among the identified opportunities for improvement was enrollee access to care (i.e., ease of getting needed care, tests, or treatment). There was no evidence of action plans to address the identified issues.

The 2022 State of Maryland PCP Satisfaction Results document provided a table comparing composite measure results from the Provider Satisfaction Survey from 2022 to 2020, 2021, and the 2022 Health Choice Aggregate. There was no evidence of action plans to address any identified issues.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, KPMAS must demonstrate that it acts upon identified issues from the CAHPS® and Provider Satisfaction surveys that specifically target identified opportunities for improvement in measurable results.

### Maryland Physicians Care (MPC)

**7.4 c.** Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.

**This component is Partially Met.**

In response to the MY 2021 review, MPC was required to demonstrate timeframe compliance with MDH's threshold in all areas, including prescriber notification of an outpatient pharmacy PA decision within 24 hours of receipt of the request. MPC also was required to revise the Prior Authorization Policy to include the availability of a 14 calendar day extension for standard PA requests. As indicated below, a continued opportunity for improvement exists.

The Prior Authorization Policy includes a table outlining the decision and notification timeframes for urgent and non-urgent pre-service authorization requests. Urgent pre-service decisions/notifications are required within 72 hours of receipt of the request. Non-urgent decisions are required within two business days of receipt of necessary clinical information, but no later than 14 calendar days from the date of the initial request. If additional clinical information is required for review, it must be requested within two business days of receipt of the request. The table also includes the availability of a 14-calendar-day extension for authorization decisions for both urgent and non-urgent requests.

The Pharmacy Prior Authorization (PA) Policy requires notice to the prescriber by telephone or other telecommunication device of all covered outpatient pharmacy decisions (approve, deny, or request additional clinical) within 24 hours of receipt of the request.

MPC exceeded the 95% compliance threshold for standard, expedited, and outpatient pharmacy PA determinations in the ten months (January through October 2022) reported based on the Key Indicator Report (KIR). Prescriber notification within 24 hours of receipt of an outpatient pharmacy PA request exceeded the compliance threshold in seven of the ten months reported. Reported compliance for outlier months ranged from 45% to 80%.

A sample review of an initial ten adverse determination records (eight standard and two outpatient pharmacy PA requests) found MPC met the required timeframes in nine of ten records. A review of an additional 20 records found all met the required timeframes. Overall compliance with determination timeframes was 97%. Compliance with the 24-hour prescriber notification of covered outpatient pharmacy decisions (approve, deny, or request additional clinical) was demonstrated in one of the two pharmacy records reviewed. Overall compliance for prescriber notification was 50%.

After the initial review, MPC submitted the Final MY 2022 KIR for review which reported determination timeframes for standard, expedited, and outpatient pharmacy requests exceeded the 95% compliance threshold in each of the four quarters of 2022. Compliance with 24-hour prescriber notification of the outcome of review of a PA request for a covered outpatient drug was reported as 75% for first quarter, 92% for second quarter, and 100% for the third and fourth quarters. MPC requested that the finding be changed to "Met" since compliance exceeded the 95% threshold for the last two quarters after it successfully implemented corrective action in response to preliminary results from the comprehensive SPR. It also noted that the volume of requests are very low for outpatient pharmacy denials; however, this component addresses all pharmacy requests, not just adverse determinations. MPC is to be commended for the success of its corrective action plan in achieving compliance with the 24-hour prescriber notification requirement; nevertheless, results for the entire MY must be considered in assessing compliance with this component.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, MPC must demonstrate compliance with the 24-hour timeframe for prescriber notification of covered outpatient pharmacy decisions within the MDH threshold of 95% for each quarter of the review period.

**RECOMMENDATION:** Qlarant recommends that MPC increase the frequency of monitoring compliance with the 24-hour timeframe for prescriber notification in order to address any non-compliance issues before it impacts overall compliance results for the quarter.

**7.7 c.** The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes. **This component is Partially Met.**

In response to the MY 2021 review, MPC was required to demonstrate timeframe compliance at the 95% threshold for sending the enrollee a written acknowledgment of appeal receipt and written notice of resolution. As indicated below, continued opportunities for improvement exist.

The Member Appeal Policy includes timeframes for notice of resolution for both standard and expedited appeals. The enrollee notice of standard appeal resolution is to be sent within 30 calendar days of appeal receipt. Written notice of an expedited appeal resolution is to be sent within 72 hours of receipt of the appeal.

The KIR identified compliance results for written acknowledgment of appeal receipt and written notice of resolution for the first ten months of 2022. Compliance with sending the enrollee a written acknowledgment of appeal receipt within the required timeframe exceeded the 95% threshold for all ten months reported. Compliance with written resolution of standard appeals exceeded the 95%

threshold for all ten months reported. Compliance with written resolution of expedited appeals exceeded the threshold in three of the five applicable months.

A sample review of ten appeal records, all standard, found 100% compliance with timeframes for written appeal acknowledgment and written appeal resolution.

After the initial review, MPC submitted the Final MY 2022 KIR which reported TAT compliance for written appeal acknowledgments and written standard appeal resolutions/notifications exceeded the 95% threshold for all four quarters of 2022. Compliance with the resolution/notification timeframe for expedited appeals was reported as 75% for the first quarter, 83% for the third quarter, and 100% for the fourth quarter. There were no expedited appeals for the second quarter. According to MPC, compliance results were negatively impacted by providers sending expedited appeals to the incorrect fax number which delayed processing. By way of further explanation, MPC reported that in 2022 it allowed providers to fax their administrative appeals to the MCO and despite education in various forms regarding this option in many cases, the appeal landed in the general provider appeal box that contained on average ~7,000 provider claims appeals per month. A root cause analysis was completed and MPC staff triaged the appeals coming in to catch the expedited appeals. It further noted that expedited appeals have an extremely low volume. In MY 2022, reporting shows that there were only 12 expedited appeals received with two out of TAT compliance.

**OPPORTUNITY FOR IMPROVEMENT:** In order to review a finding of Met in the MY 2023 review, MPC must demonstrate compliance with the timeframe for written expedited appeal resolutions within the MDH threshold of 95% for each quarter of the review period.

### MedStar Family Care (MSFC)

**7.7 c.** The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes. **This component is Partially Met.**

In response to the MY 2021 review, MSFC was required to demonstrate compliance with the MDH-established threshold of 95% for both written appeal acknowledgment and written resolution in all four quarters of the period under review. As indicated below, continued opportunities for improvement exist.

The Member Appeals Policy includes tables outlining timeframes for resolution notification for both standard and expedited appeals, which is consistent with regulatory requirements. The policy also specifies a timeframe of five business days for sending the enrollee acknowledgment of the appeal receipt.

The Appeals and Grievances (A&G) Dashboard reported compliance with appeal timeframes by month through October and by quarter for the first three quarters of 2022. Compliance with the timeframe for written appeal acknowledgement exceeded the MDH threshold for all ten months. Compliance with the resolution notification timeframe fell below the 95% threshold for the first quarter and exceeded it the following two quarters and in the month of October.

A sample review of ten enrollee appeal records found MSFC exceeded the established compliance threshold for both written appeal acknowledgment and written resolution. Additionally, for the one expedited appeal found within the sample, verbal notification of appeal resolution to the enrollee was documented in case notes.

After the initial review, MSFC submitted fourth quarter compliance results for appeal acknowledgment and resolution notification which exceeded the 95% threshold. This component remains Partially Met since MSFC did not meet the compliance threshold for resolution notification in the first quarter.

MSFC requested reconsideration of this finding since its annual result for appeals resolution timeliness exceeded the 95% threshold. It noted that neither the SPR standards nor COMAR specify quarterly versus annual results. Although COMAR does not specify the frequency of reporting results, it also does not include a provision for compliance of less than 100%. In response to requests from MCOs, MDH established a 95% threshold to assist MCOs in demonstrating compliance and required that results be reported on at least a quarterly basis.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, MSFC must demonstrate compliance with appeal resolution notification timeframes within MDH's 95% threshold on at least a quarterly basis for all four quarters of the review period.

### Priority Partners (PPMCO)

**7.4 c.** Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.

**This component is Partially Met.**

In response to the MY 2021 review, PPMCO was required to revise the UM Determination and Notification Timeframes Policy to include the requirement that if additional clinical information is required, it must be requested within two business days of receipt of the request. As indicated below, this opportunity for improvement was successfully addressed.

Appendix A within the UM Determination and Notification Timeframes Policy documents determination timeframes for standard and expedited PA requests that are consistent with regulatory requirements in the "Regulatory Requirements" section. It also specifies if additional clinical information is required, it must be requested within two business days of receipt of the request. Availability of an extension of the decision timeframe, under certain circumstances, is also noted.

The Prior Authorization, Quantity Limits, and Step Therapy Exceptions Policy requires Pharmacy staff to review and provide notice to the requesting provider by telephone or other telecommunication device within 24 hours of receipt of an outpatient pharmacy PA request, which is consistent with regulatory requirements.

As evidence of compliance with the timeframes for determinations, PPMCO submitted minutes from their utilization management/case management Workgroup meetings. Compliance with determination timeframes was reported for standard, expedited, and pharmacy PA requests for the first three quarters of 2022. The MDH threshold of 95% was exceeded for all three quarters; however, it is unclear if these results are related to the PPMCO lines of business (LOB). No results were provided for compliance with the 24-hour prescriber notification requirement.

A sample review of ten adverse determination records eight medical and two pharmacy, found compliance with the determination timeframe and the 24-hour prescriber notification.

After the initial review, PPMCO provided the MCO Preauthorization & Pre-Service Denials Quarterly and Annual Reports for the first three quarters of 2022, which confirmed compliance with the 24-hour timeframe for prescriber notification for all three quarters. The fourth quarter report was not

submitted. Additionally, compliance with determination timeframes for standard, expedited, and pharmacy were not submitted for the fourth quarter. According to PPMCO MY 2022 Q4 data will be presented to the utilization management/CM Workgroup in the first quarter of 2023. They will ensure that meeting minutes are submitted to Qlarant. This component, therefore, remains Partially Met.

***OPPORTUNITY FOR IMPROVEMENT:*** In order to receive a finding of Met in the MY 2023 review, PPMCO must provide determination timeframe and prescriber 24-hour notification compliance results on at least a quarterly basis for all four quarters of the review period, specifically for the Medicaid LOB.

**7.5 b.** Adverse determination letters include all required components.  
**This component is Partially Met.**

In response to the MY 2021 review, PPMCO was required to revise the list of adverse determination notice requirements listed in the Clinical and Administrative Denial Policy to reflect current requirements. As indicated below, a continued opportunity for improvement exists.

The Clinical and Administrative Denial Notification Policy lists specific components that must be included in all adverse determination letters. All required components are included; however, one continues to be stated incorrectly. The component addressing the timeframe for filing an appeal is stated as "within sixty days from the date of receipt" rather than "within sixty days from the date of the adverse determination notice".

A sample review of ten adverse determination letters demonstrated 100% compliance with required letter components.

After the initial review, PPMCO reported that it agreed with the findings and has updated the Clinical and Administrative Denial Notification Policy with the appropriate language. This policy revision will need to be detailed in the CAP submission.

***OPPORTUNITY FOR IMPROVEMENT:*** In order to receive a finding of Met in the MY 2023 review, PPMCO must revise the appeal filing timeframe to "within sixty calendar days from the date of the adverse determination notice" in the list of adverse determination letter components included in the Clinical and Administrative Denial Policy.

**7.7 c.** The MCO must adhere to written appeal acknowledgment and resolution/notification timeframes.  
**This component is Partially Met.**

In response to the MY 2021 review, PPMCO was required to demonstrate compliance with regulatory timeframes for written acknowledgment of an appeal and written resolution. Additionally, case notes were required to provide evidence that a reasonable attempt was made to provide the enrollee with oral notification of an expedited appeal resolution. As indicated below, continued opportunities for improvement exist.

The Monthly Member Appeals Turnaround Time Report identified compliance for written appeal acknowledgments and written resolution/notifications for the first nine months of 2022. PPMCO demonstrated compliance at or above the MDH threshold of 95% for both acknowledgment letters and appeal resolution/notifications during this timeframe.

An initial sample review of ten enrollee appeal records found that eight demonstrated turnaround time compliance with written appeal acknowledgment. Review of an additional 20 records found all 20

records demonstrated compliance. Overall compliance with the timeframe for written acknowledgments was 93% (28/30).

This same initial sample review of ten appeal records found six of seven standard appeals demonstrated compliance with the timeliness of written notice of resolution. An additional 20 records were reviewed and found to meet the timeliness requirement for all applicable standard appeals. Overall compliance for timeliness of resolution/notification for standard appeals was 96% (22/23). Review of all expedited appeal resolution/notifications within this sample found all exceeded the compliance threshold; however, there was no evidence in case notes that a reasonable attempt was made to provide oral notification of an expedited resolution.

After the initial review, PPMCO reported that Q3 2022 appeal resolution timeframe compliance was reported at the November QM/UM Committee meeting; however, there was no evidence found upon review. It did not submit any additional documentation to support compliance with written appeal acknowledgment and resolution/notification timeframes for the fourth quarter indicating that MY 2022 Q4 reports (which requires closing out MY 2022) will be reviewed by the QM/UM Committee during Q1 MY 2023. This component, therefore, remains Partially Met.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, PPMCO must demonstrate timeframe compliance at or above the MDH established threshold of 95% for written appeal acknowledgments and written resolution/notifications on at least a quarterly basis for all four quarters of the review period. Additionally, case notes must reflect that PPMCO made a reasonable attempt to provide the enrollee with oral notification of an expedited resolution.

**7.7 e.** 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.

**This component is Unmet.**

In response to the MY 2021 review, PPMCO was required to 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. As indicated below, continued opportunities for improvement exist.

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 review of 30 enrollee records found one denial of an expedited request. There was evidence that written notice of the denial of an expedited request was provided within the required two calendar days; however, there was no evidence in case notes that PPMCO made a reasonable attempt to provide the enrollee with oral notice of the denial of an expedited request.

After the initial review, PPMCO agreed with these findings and reported it has changed internal processes in MY 2022 based on the MY 2021 SPR results to capture oral notification in case notes. When collecting files for file review evidence, PPMCO did not include copies of these notes. PPMCO will ensure all relevant case information is included when collecting for file review. This process change will need to be detailed in the CAP submission.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 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.

**7.7 g.** The MCO's appeal policies and procedures must include oral inquiries seeking to appeal are treated as appeals.

**This component is Unmet.**

In response to the MY 2021 review, PPMCO was required to eliminate the requirement for written confirmation of an oral appeal in the Priority Partners Enrollee Appeals Policy. As indicated below, a continued opportunity for improvement exists.

The Priority Partners Enrollee Appeals Policy continues to indicate that oral requests for an appeal are considered the initiation of the appeal to establish the earliest possible filing date and are confirmed in writing unless the enrollee, their representative, or the provider requests an expedited resolution.

After the initial review, PPMCO agreed with these findings and reported it has updated the Enrollee Appeals Policy to remove the requirement for written confirmation of an oral appeal. This policy revision will need to be detailed in the CAP submission.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, PPMCO must eliminate the requirement for written confirmation of an oral appeal in the Priority Partners Enrollee Appeals Policy.

### UnitedHealthcare (UHC)

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

**This component is Partially Met.**

In response to the MY 2021 review, UHC was required to 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. As indicated below, continued opportunities for improvement exist.

According to UHC, updates to the utilization management workplan reflect the Plan, Do, Study, Act model. Results of interventions are compared to the goals to determine an intervention's effectiveness. Results are analyzed to identify barriers/challenges if the goal was not met. Adjustment to or replacement of the intervention are made accordingly.

A review of the Health Quality and Utilization Management (HQUM) workplan found several initiatives had been developed to address overutilization and underutilization in the areas of acute care, pharmacy, and post-acute care. The work plan included goals/objectives for each area of focus, measurable target/evidence goal was met, methodology/activity for reaching the target, expected start/end dates, results by quarter, and analysis of results and remediation plan, if applicable. For example, in addressing overutilization of acute care goals, were identified for decreasing admits per 1000, average length of stay (LOS), and readmissions. Initiatives to achieve each of the goals were identified, such as prior reviews for all targeted diagnoses. Additionally, updates to existing plans by quarter were provided, such as launching a *Ready for Discharge* initiative in the third quarter to further address readmissions.



Updated utilization management work plans and meeting minutes of the HQUMC support ongoing monitoring of current performance against established 2022 goals for initiatives addressing areas of overutilization and underutilization. For example, admissions per 1000, average LOS, and readmissions for the quarter were presented in comparison to 2022 targets as well as an updated HQUM workplan. Although it is evident that UHC monitors on a quarterly basis initiatives implemented to address identified areas of overutilization and underutilization, there was no discussion of these initiatives or the workplan documented in meeting minutes.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, there must be evidence in the HQUMC meeting minutes of discussion of current utilization management initiatives to address areas of overutilization and underutilization in addition to the presentation of the quarterly measure results and the HQUM workplan.

**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 IRO designated by the Department.

**This element is Unmet.**

In response to the MY 2021 review, UHC was required to revise the Provider Grievance and Appeal Policy and the MD External Review Standard Operating Procedure (SOP) to include all required components for a complaint resolution process for disputes between the MCO and providers regarding adverse medical necessity decisions made by the MCO. As indicated below, continuous opportunities for improvement exist.

The Independent Review Organization Policy includes a "Maryland Medicaid Contract Requirements" section which outlines specific provider and IRO responsibilities under COMAR 10.67.13. It does not include the specific responsibilities of the MCO.

The Provider Grievance and Appeal Policy includes a section, "UHCCP's Duties: Independent Review Process Requirements," that documents UHC'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 includes the requirement for submitting a request to the IRO for gaining access to their online portal for uploading case files upon request. The policy further requires the MCO to submit the case record within five calendar days of receipt of the IRO's request, which is more stringent than MDH's requirement of five business days of receipt of the request. It also requires UHC to upload 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 sixty calendar days of the adverse determination and pay the fixed case fee to the IRO within sixty 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, executed on July 23, 2014. It also submitted a sample case record relating to the denial of an IP admission which was submitted to the IRO upon request, a screenshot from the IRO noting the status of the review, and the IRO's Independent Review Determination Letter overturning UHC's denial. A Provider Remittance Advice demonstrated the provider was paid within the required timeframe.

After the initial review, UHC submitted an earlier version of the Provider Grievance and Appeal Policy (last revised 4/26/2022), which included the same content relating to the IRO process as the later version (last revised 7/1/2022) initially reviewed. UHC also submitted the UHC CAP Response dated August 18, 2022, which noted a completion date of April 26, 2022, for revision of the Provider Grievance and Appeal Policy. As noted above, the policy still does not include a documented process to assure IRO invoices are paid within sixty days per COMAR (please see the Reviewer Guidelines for this element).

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, UHC must provide a documented process that is designed to assure IRO invoices are paid within the 60-day timeframe required by COMAR. This could be added to either the Provider Grievance and Appeal Policy or a desktop procedure and include, for example, communication and follow-up on a routine basis with the Accounts Payable Department to assure all IRO invoices are paid within sixty days of receipt.

### Wellpoint Maryland (WPM)

**7.4 c.** Timeframes for preauthorization decisions are specified in the MCO's policies and decisions are made in a timely manner as specified by the State.

**This component is Partially Met.**

The UMP Description includes determination timeframes for both standard and expedited requests consistent with regulatory requirements. Additionally, if additional clinical information is required, it must be requested within two business days of receipt of the request. The UMP Description did not include the required 24-hour timeframe for prescriber notification of the outcome (approve, deny, request additional clinical information) of a preauthorization request for a covered outpatient drug; however, this requirement was included in the Maryland "Exceptions" section of the Pharmacy Prior Authorization Policy. Draft Maryland Health Care Management (HCM) Committee meeting minutes from May, August, and November 2022 included a report of compliance with determination timeframes; however, only adverse determinations were included. The Pharmacy Services Report for the third quarter of 2022 confirmed turnaround time compliance with the 24-hour prescriber notification exceeded the 95% threshold for the first three quarters of 2022.

An initial sample review of ten adverse determination records (seven standard records and three pharmacy records) found seven records demonstrated compliance with the determination timeframe. Review of an additional 20 records found that all records demonstrated compliance. Overall compliance with the determination timeframe was 90%. Compliance with 24-hour prescriber notification of the outcome of the review of a PA request for a covered outpatient drug was found in all three records representing 100% compliance.

After the initial review, WPM submitted the Pharmacy Services Program Description Medicaid 2022 which included the requirement for 24-hour prescriber notification of the outcome of review of a PA request for a covered outpatient drug; however, compliance results for the missing quarters for determinations and prescriber notifications identified above were not provided. The finding of "Partially Met" remains unchanged.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must:

- Demonstrate compliance with medical and pharmacy PA determination timeframes for all PA requests at or above the MDH threshold of 95% for all four quarters of the review period.

- Demonstrate compliance with 24-hour prescriber notification of the outcome of a PA request for a covered outpatient drug at or above the MDH threshold of 95% for all four quarters of the review period.

**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 Unmet.**

In response to the MY 2021 review, WPM was required to demonstrate compliance with adverse determination notification timeframes at or above the 95% threshold established by MDH for all four quarters. As indicated below, continued opportunities for improvement exist.

A review of draft HCM Committee minutes from the May, August, and November meetings confirmed compliance with notification timeframes for standard and expedited adverse determination for the first three quarters of 2022.

A sample review of ten adverse determination records (seven medical records and three pharmacy records) found 100% compliance with adverse determination notification timeframes.

After the initial review, WPM submitted minutes from the February 8, 2023, HCM Committee meeting that included compliance results for both standard and expedited adverse determination notifications for each of the four quarters of 2022. Adverse determination notification timeframe compliance for standard requests exceeded the 95% threshold for all four quarters. Timeframe compliance for expedited requests was met in only one of the four quarters. Results for non-compliant quarters ranged from 74% to 93%.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must demonstrate consistent compliance with adverse determination notification timeframes for expedited requests at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.

**7.7 c.** The MCO must adhere to appeal timeframes.

**This component is Unmet.**

In response to the MY 2021 review, WPM was required to demonstrate timeframe compliance at or above the MDH threshold of 95% for written acknowledgment of appeal receipt and written appeal resolution throughout the year under review. As indicated below, continued opportunities for improvement exist.

Quality Management Committee (QMC) presentations displaying enrollee appeal turnaround time compliance were provided for the first three quarters of 2022. Two measures were reported: written appeal acknowledgment and resolution/notification. Results reported are as follows:

- First quarter
  - Appeal acknowledgment - compliance was demonstrated in two of the three months
  - Appeal resolution/notification - compliance was demonstrated in two of the three months for expedited appeals and two of the reported months for standard appeals
- Second Quarter
  - Appeal acknowledgment - compliance demonstrated in none of the three months

- Appeal resolution/notification - compliance demonstrated in one of the three months for expedited appeals and all three months for standard appeals
- Third Quarter
  - Appeal acknowledgment - no results reported
  - Appeal resolution/notification - compliance demonstrated in none of the three months for expedited appeals and none of the three months for standard appeals

An initial sample review of ten enrollee appeal records found that nine records met the timeframe for written appeal acknowledgment. A review of an additional 20 records found that 19 records met the requirement. Overall compliance with written appeal acknowledgment was 93% (28/30). Full compliance with written resolution of standard and expedited appeals was found in the initial sample of ten appeal records. Within this same sample oral notice of an expedited resolution was found in one of the three expedited records. A review of an additional 20 records found an oral notice of an expedited resolution in four of the ten applicable records. Overall compliance with a reasonable attempt to provide oral notice of an expedited resolution was 38% (5/13).

After the initial review, WPM submitted a PowerPoint presentation entitled "Q3 and Q4 Appeals Report 2022" which documented compliance results for standard and expedited appeal resolution/notification and written appeal acknowledgment for the third and fourth quarters of 2022. Results are as follows:

- Third Quarter
  - Appeal acknowledgment - compliance demonstrated in two of the three months
  - Appeal resolution/notification - compliance demonstrated in one of the three months for expedited appeals and two of the three months for standard appeals
- Fourth Quarter
  - Appeal acknowledgment - compliance demonstrated in all three months
  - Appeal resolution/notification - compliance demonstrated in one of the three months for expedited appeals and one of the three months for standard appeals

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must:

- Demonstrate compliance with timeframes for written appeal acknowledgment and written resolution at or above the MDH threshold of 95% on at least a quarterly basis for all four quarters of the review period.
- Demonstrate compliance with a reasonable attempt to provide the enrollee with oral notice of an expedited appeal resolution.

**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 IRO designated by the Department.

**This element is Unmet.**

In response to the MY 2021 review, WPM was required to demonstrate that it has a documented policy and procedure for supporting the provider complaint resolution process through the IRO. As indicated below, continued opportunities for improvement exist.

The Provider Claim Payment Dispute Process Policy in the "Maryland" specific section of the policy outlines the responsibilities of the provider and the IRO for resolving disputes when a provider does not agree with the MCO's determination of the payment appeal. Aside from the payment of the IRO fixed case fee, the responsibilities of the MCO in supporting this process are not specified. Missing are the requirements to:

- Establish an online account with the IRO and provide all required information through this account.
- Upload the complete case record for each medical case review request within five business days of receipt of the request from the IRO.
- Upload any additional case-related documentation requested by the IRO within two business days of receipt of notification of a request for additional information from the IRO.
- Document the process for assuring IRO invoices are paid within sixty calendar days of receipt.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must include all MCO requirements for supporting the IRO dispute resolution process in its Provider Claim Payment Dispute Process Policy. This includes documenting a process for assuring IRO invoices are paid within sixty calendar days of receipt.

## 9.0 – Health Education

### CareFirst Community Health Plan (CFCHP)

**9.3 a.** Have a written methodology for an annual evaluation of the impact of the Health Education Plan (HEP) on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures.

**This component is Met with Opportunity**

The PHM Strategy document outlines goals and measures that will be utilized to evaluate the effectiveness of interventions for each segment of its population, i.e., Healthy, Emerging Risk, and Struggling. Measures include HEDIS®, CAHPS®, and utilization data.

According to CFCHP's Population Health Management (PHM) Evaluation for 2021, CFCHP utilized its HEDIS® performance to measure the success of its HEP. For example, it was reported that for measurement year (MY) 2021, 67% of CM Performance Monitoring measures achieved the 2021 National HEDIS® Mean. The Controlling Blood Pressure rate of 65.69% was a 15.81 percentage point improvement over the MY 2020 rate of 49.88%, which is a statistically significant improvement. The Postpartum Care rate of 81.66% demonstrated a 2.77 percentage point decline over the MY 2020 rate. Despite this decline, the Postpartum Care rate continued to achieve both MDH's goal of meeting the National HEDIS® Mean and the CareFirst Corporate goal of four-star performance.

Results also were provided for preventive health measures, quality measures such as specific screening rates, and pharmacy measures such as the asthma medication ratio and statins.

Although this is a very comprehensive evaluation, it reflects a multitude of interventions beyond health education and involves the entire applicable population within CFCHP, making it difficult to assess the effectiveness of health education interventions in isolation.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate that it specifically evaluates the effectiveness of various health education activities. This could be accomplished by comparing performance on selected process or outcome measures among program participants and non-participants. It also could be accomplished by comparing enrollee utilization on select measures of pre- and post-program participation.

**9.3 b.** Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the enrollees.

**This component is Met with Opportunity.**

According to the HEP, registered nurses and licensed practical nurses provide health education through Population Health Management (PHM) programs and other methods in conjunction with providers and community organizations who employ health educators, such as certified diabetes instructors or registered dietitians.

No evidence was provided to support the qualifications of staff or instructors from external organizations providing health education to CFCHP enrollees.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 year, CFCHP must provide a job description and qualifications of at least one licensed staff member who provides health education and a sample program brochure from an external organization identifying the qualifications of its health education instructors.

**9.3 c.** Contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for enrollee referrals.

**This component is Partially Met.**

According to the HEP, providers may refer enrollees to CFCHP for educational and PHM programs by contacting the QI or health services (HS) departments.

Review of the provider manual found contact information for referring an enrollee to either the CM or Disease Management program. There was no contact information evident for accessing a health educator/educational program for enrollee referrals.

After the initial review, CFCHP submitted several documents to support compliance. The New Provider Orientation document included contact information for Health Education Services for the MCO's Medicare Advantage line of business; however, this information was not included for its HealthChoice line of business. Several newsletters were submitted promoting the new CareFirst Engagement Center, which appears to include distribution to providers. These newsletters highlight a wide variety of health education activities scheduled throughout each month. The December 2022 edition of the provider newsletter informs providers about the MCO's Complex Case Management Program and how they can connect their patient to a care manager including contact information. While not specific to health education, the program clearly targets enrollees with a need for education based on new, worsening, or poorly controlled chronic conditions.

No provider referrals of enrollees in need of health education were submitted.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must provide evidence that notification to providers of the availability and contact information for

accessing a health educator/educational program for enrollee referrals is effective in the form of documented provider referrals of enrollees for health education.

**9.5 a.** Samples of notifications, brochures, and mailings.

**This component is Met with Opportunity.**

According to the HEP, CFCHP notifies its enrollees of health education opportunities as well as distributes educational materials through mailings, e.g., newsletters, notifications, health education materials, and preventive reminder letters/postcards.

CFCHP provided an extremely limited sample of enrollee mailings to demonstrate compliance with this component as identified below:

- *What You Need to Know: Diabetes*
- *We're Giving You Another Reason to Smile addressing the importance of good oral care*

Two other notifications/mailings did not address the health education needs of CFCHP enrollees as indicated below:

- *Don't Miss Your Shot at a \$100 Gift Card* (English and Spanish versions) advising enrollees of the incentive program for COVID vaccines
- *Medicaid Enrollment Is Always Open!* Which is a marketing piece directed at non-CFCHP Medicaid enrollees and potential enrollees

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must provide a more comprehensive sample of enrollee notifications, brochures, and mailings that are oriented toward providing health education.

**9.5 b.** Attendance records and session evaluations completed by enrollees.

**This component is Partially Met.**

CFCHP provided multiple examples of attendance records for various preventive screening and education events held in 2022; however, none of them identified the type of event. Three of the examples appeared to be for preventive screenings for lead and HbA1c results.

No completed evaluations of HEPs attended by enrollees were provided.

After the initial review, CFCHP submitted an enrollee sign-in sheet for the *Winter Wonderland Happy Holidays Event* held on December 22, 2022, which included 11 attendees. There was no evidence of submission of the Population Health Management (PHM) Baby Steps Program Evaluations that CFCHP referenced in its exit letter response.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of met in the MY 2023 review, CFCHP must provide a sample of completed evaluations of HEPs/events completed by enrollees.

**9.5 c.** Provider evaluations of health education programs.

**This component is Unmet.**

CFCHP reported that it submitted the Confidential Final Report v2.0 CF Provider Experience Survey to demonstrate compliance with this component; however, it was not found.

After the initial review, CFCHP submitted aggregate survey results for its new provider orientation courses, which do not address HEPs. According to the exit letter response submitted by CFCHP, an additional document, *CareFirst Center for Learning and Engagement Provider Education Evaluations of Health Education Programs*, was to be submitted to demonstrate compliance; however, it was not found. This component, therefore, remains "Unmet".

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate provider evaluations of its HEPs. This could be either through formal provider surveys or documented discussions of the HEP at a CFCHP committee attended by providers.

### MedStar Family Choice, Inc. (MSFC)

**9.5 b.** Attendance records and session evaluations completed by enrollees.

**This component is Met with Opportunity.**

MSFC provided examples of enrollee attendance at several educational programs, including the *Momma & Me* Program, the *Diabetes Boot Camp*, and workshops offered by the Good Health Center at MedStar Good Samaritan Hospital.

No evidence was provided of session evaluations completed by enrollees.

After the initial review, MSFC submitted additional documents to demonstrate compliance. The first document, an *emocha* MFC Member Exit Interview Script, included exit interview questions assessing the enrollee's satisfaction with various aspects of the *emocha* program. No examples were provided of enrollee responses. The second document, *emocha* Health Monthly Business Review, included quotes from an enrollee participating in the *emocha* program noting their first consecutive A1c reduction in almost three years and thanking the program for its help. The third document, an *emocha* Health presentation, included aggregate results of MSFC enrollee satisfaction with the *emocha* program and specific quotes from participants. No formal session evaluations of health education programs completed by individual enrollees were provided.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, MSFC must provide a sample of formal evaluations of health education programs completed by individual enrollees. Promotional quotes and aggregate results do not satisfy the requirements of this component.

### Priority Partners (PPMCO)

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

**This component is Partially Met.**

According to the HEP, the program's impact on enrollees' knowledge about important health topics and improvement in their confidence to make positive behavioral changes for a healthier lifestyle is measured by a survey tool that is administered at the conclusion of all health education programs. Additionally, other metrics used to evaluate the HEP include the number of classes offered, the number of enrollees registered, and the number attending each class. Lastly, the number of enrollees outreached through various methods, such as Facebook and email, also is considered in the evaluation.



The Annual Health Education Summary & Impact Evaluation for Priority Partners for MY 2021 states the following as its objectives:

- Describe enrollees' needs and how they are addressed by the HEP offerings
- Assess enrollee registration and participation in HEP
- Determine whether enrollee knowledge and confidence to make positive lifestyle/behavioral changes increased as a result of HEP participation
- Discuss enrollee outreach efforts and improvement plan

The following tables were subsequently provided to support the evaluation of the HEP:

- Program registration and attendance by topic and program name. As an example, the *Baby Basics* program addressing newborn care was attended by 68 enrollees out of 313 that registered.
- Effects of HEP on participant knowledge and behavior by topic and program name which displayed the percentage of positive responses of class participants to survey questions addressing increased knowledge and skills and improved confidence to change behavior. For example, *Matters of the Heart* had one participant who responded positively to both questions. It was noted that only 29.4% of class participants completed a post-class evaluation.
- Marketing outreach to Priority Partner members by methods such as newsletters, email, Facebook, and Instagram.

There was no evidence that PPMCO evaluated the impact of the HEP on process or outcome measures, such as changes in blood pressure pre- and post-participation of attendees in the *Blood, are you Pressuring Me!* class, or the number of emergency department (ED) visits and/or hospital admissions pre- and post-participation in the *Managing Diabetes* class.

After the initial review, PPMCO responded that it did not agree with the findings, citing the submission of the Annual Health Education Summary and Impact Evaluation for MY 2021. This document was previously reviewed and found, as noted above, to be missing an evaluation of the impact of PPMCO's health education programs on process and outcome measures, as required by this component. The finding for this component remains unchanged.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, PPMCO must include process and outcome measures in its evaluation of the impact of the HEP on PPMCO enrollees. For example, HEDIS® data could be used pre and post-program participation or ED visits, or hospital admissions pre and post for select diagnoses such as diabetes. PPMCO could also use the Healthy People 2030 recommendations to develop measurable goals for its HEP classes.

**9.3 c.** Contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for enrollee referrals.

**This component is Partially Met.**

According to the HEP, the JHHC website for providers and physicians advertises the HEP offerings, explains how enrollees can find and register for classes, and provides contact information for the HEP. A screenshot from this website included a section entitled "Health Education" with a toll-free number and email address for contacting PPMCO's health educators.

No evidence was submitted of provider referrals of PPMCO enrollees for health education supporting the effectiveness of provider notification of the HEP and contact information for referring PPMCO enrollees.

After the initial review, PPMCO responded that it did not agree with the findings since health education programs do not require a referral from a provider and are available to all PPMCO enrollees. It also noted that it encourages providers to refer enrollees to health education classes through direct outreach, emails, provider manual, etc. The purpose of requesting an example of a provider referral of a PPMCO enrollee for health education is to assess the effectiveness of outreach to providers encouraging referrals of PPMCO enrollees. If no referrals are being received, this would be an opportunity for PPMCO to review its communication strategy with providers. This component remains Partially Met.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, there must be evidence that providers are referring enrollees in need of health education to the program. For example, case notes demonstrating referrals or completed referral forms could be submitted as evidence.

**9.4 –** The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning.  
**This element is Partially Met.**

According to the HEP, enrollees with special/complex medical needs who are enrolled in CM are referred to appropriate health education classes by their care manager. Care managers also may refer an enrollee to receive direct outreach from a health educator, who will provide them with specialized health educational materials and resources. Providers may also encourage their patients who are enrollees to register for appropriate health education classes for disease prevention and management.

No evidence was provided to demonstrate that these mechanisms are in place and functioning effectively to identify enrollees in special need of educational efforts. Examples could include care manager case notes referring an enrollee to appropriate health education classes, or direct outreach from a health educator.

After the initial review, PPMCO disputed the findings based upon previous submission of the Special Needs Referral Policy and has included the job description for the position within the organization that focuses on ensuring enrollees with special healthcare needs are referred to appropriate programs. Neither of these demonstrates that mechanisms for identifying enrollees in special need of education are in place and functioning, such as sample case notes or reports. This component, therefore, remains Partially Met.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, PPMCO must demonstrate that these mechanisms are in place and functioning effectively to identify enrollees in special need of educational efforts.

**9.5 b.** Attendance records and session evaluations completed by enrollees.  
**This component is Met with Opportunity.**

PPMCO provided aggregate post-test results for four health education programs: *Blood, Are You Pressuring Me?*; *Eating the Healthy Way*; *Let's Get Physical*; and *Moving in the Right Direction*. Results were not exclusive to PPMCO enrollees. The post-test included a series of dichotomous questions requiring either a "yes" or "no" response, which was used to determine if enrollees believed the

program had increased their knowledge about the selected topic and if it had increased their level of confidence in making positive behavioral changes for a healthier lifestyle. With one exception, participants consistently responded positively to each question asked.

No attendance records or session evaluations completed by enrollees were submitted.

After the initial review, PPMCO submitted computer-generated redacted reports of PPMCO enrollees in attendance at various health education sessions throughout 2022. Samples include *Diabetes: A Healthier You*, held on April 6, 2022; *Pre-Diabetes and Me*, held on May 12, 2022; and *Baby Basics, Parts I and II*, held on April 27-28, 2022. No session evaluations completed by individual enrollees were submitted, only aggregate results, which does not meet the requirement of this component. This will need to be provided in the MY 2023 review to receive a finding of Met.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, PPMCO must submit session evaluations completed by individual enrollees for a sample of health education programs.

## UnitedHealthcare (UHC)

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

**This component is Met with Opportunity.**

According to the HEP, UHC measures program outcomes in four categories:

- Clinical
  - Adherence to disease-specific, evidence-based guidelines for all chronic conditions as well as preventive measures
  - Clinical markers and HEDIS® measures, such as lead, asthma, preventive health services, childhood immunizations, and well-child visits
- Financial
  - Improved access to care
  - Reduced ED visits
  - Improved use of formulary and generic drugs, including accessing the PreCheck My Script web-based application through a claims process
- Operational
  - Medical and pharmacy Turnaround Times
  - New Enrollee Welcome Calls
  - Delegated Entities (March Vision, Evicore)
  - Accessibility of Services (telephonic appointment scheduling audit)
- Performance
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Enrollee Engagement Survey: meet or exceed Quality Compass Percentile and year over-year trending
  - Provider Satisfaction Survey: meet or exceed HealthChoice Aggregate Rating and year over-year trending

The majority of program outcomes reported were activity-based such as the number of outreach calls, chronic condition health education pieces mailed, and preventive service letters sent. Only two programs included process measures:

- *The Baby Blocks Program:* Of the 6,393 pregnancies completed 43.9% completed prenatal visits and 28.7% completed postpartum visits
- *Closing Gaps in Care: Lead Screening:* Through outreach and home visiting: 792 gaps were closed yielding a 52.8% completion rate

UHC's ability to assess the effectiveness of its HEP is challenged based on the limited process and absence of outcome measures and lack of comparisons to prior measurements to determine the direction and extent of change.

After the initial review, UHC reported the annual impact analysis and evaluation methodology are documented as part of its PHM Annual Evaluation and the QI & PHM Annual Evaluation Report.

The PHM Annual Attachment under the section "Program Evaluation - Measuring Effectiveness of Programs," reported results for HEDIS® lead screening, asthma medication ratio, readmission rates for neonatal intensive care unit (NICU) babies, and IP admissions of enrollees with a chronic disease or condition referred into the *Intensive Opportunity Program*. For each of these measures, a goal or threshold was identified, and results were reported for each successive year from 2019 through 2021. A qualitative analysis was also provided for each of the outcomes. For example, the lead screening rate, although declining year over year, exceeded the 2020 National HEDIS® Mean. A contributing factor to this result was cited as the contracted vendor's and health coach's live outreach and educational efforts. As another example, the readmission rate for NICU babies was reported as meeting the goal and attributed to several interventions, including parental education ensuring parents understand how to care for their child once at home.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, UHC must demonstrate that it evaluates the effectiveness of its HEP through comparative statistics utilizing process and outcome measures based on specific educational interventions. For example, this could be accomplished by comparing process and/or outcome measures for participants versus non-participants in programs such as *Healthy First Steps*.

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

**This element is Met with Opportunity.**

The HEP includes among its health education activities identifying special needs in its population through analysis of the health risk assessment data, special needs referrals, and claims data. The HEP further indicates that identification of its special needs population occurs through referrals from local health departments (LHDs), internal HIV and Rare and Expensive CM diagnosis reports, foster care reports, NurseLine reports, State and HEDIS® missed opportunity reports, primary care providers, and self-referrals using the Customer Service or Care Management teams, Health Risk Assessments Survey (at the time of enrollment), IP CM, pharmacy data, and retrospective claims analyses.

As evidence of compliance, UHC presented the MD ID Strat Report which listed the source of the data for assigning individual enrollees to a risk level (low, high). It also provided minutes from the June 2022 HQUMC meeting, which included a report from CM on the number of enrollees identified for CM and the percentages outreached, reached, and enrolled.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, UHC must provide a specific example of an enrollee in need of special educational efforts through either a completed referral form or case notes.

**9.5 c. Provider evaluations of health education programs.****This component is Met with Opportunity.**

According to the HEP, providers are given the opportunity to evaluate HEPs during PAC meetings. During these meetings, providers are asked for comments, recommendations for improvement, and suggestions for new topics. In addition, new health education material produced by UHC is presented at the quarterly meetings. The Health Education Program Plan and a summary of yearly health education activities also are presented to the PAC membership, allowing the membership to evaluate and offer recommendations/improvements to the HEP.

As evidence of compliance, the MCO submitted PAC meeting minutes from June 16, 2022, which confirmed the presentation of the Q1 Health Education Update.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, UHC must document in PAC meeting minutes not just a presentation of health education updates, but also provider responses and discussions demonstrating evaluation of the HEP.

**Wellpoint Maryland (WPM)****9.1 b. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events.****This component is Met with Opportunity.**

WPM did not provide evidence to support this component such as a Health Promotion Program (HPP) work plan outlining activities and dates throughout 2022, or a calendar of health education activities for 2022.

After the initial review, WPM submitted its 2022 Enrollee Outreach Plan which included 2022 Outreach Plan Strategies under "Attachment A". Strategies/Key Activities were identified to support each objective and included timeframes, quantitative measures, and future initiatives. For example, under the Wellness/Preventive Health objectives activities included updating health education materials, sending adult annual preventive health reminders, and quarterly outbound call campaigns to enrollees overdue for wellness checkups.

According to the HPP Description, the Health Promotion (HP) Department develops a health education resource directory that lists local classes, events, and support groups for use by internal staff for enrollee referrals. The calendar is updated quarterly; however, it was not provided.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must submit the health education resource directory, which according to the HPP Description includes a calendar of local classes, events, and support groups.

**9.2 - The HEP incorporates activities that address needs identified through the analysis of enrollee data. This element is Partially Met.**

The HPP Description includes under one of its objectives the development of HPPs and initiatives specific to WPM's populations, including special needs, needed care based upon conditions or risk factors, or missed services.

WPM reports it utilizes the Member & Consumer Health Advisory Committee as an informal mechanism for identifying the health education needs of its enrollees; however, this is insufficient in meeting the requirements of this component. WPM must demonstrate analysis of data such as diagnoses, utilization, and health risk assessment (HRA) results to identify the health education needs of its enrollees and develop programs to address them.

After the initial review, WPM provided three documents, CPM Steering Committee PowerPoint, Maryland Whole Health Management PowerPoint, and a Maternal Child Health Update Slide. Each of these documents identified focus areas and related activities such as the barbershop initiative which addresses the importance of men's preventive health; however, no documentation was provided that demonstrated analysis of MCO data to support identified focus areas. This element, therefore, remains "Partially Met".

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must demonstrate analysis of data such as diagnoses, utilization, and HRA results to identify the health education needs of its enrollees. Programs must be based on identified needs.

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

**This component is Unmet.**

The HPP Description includes evaluating the effectiveness of HPPs/initiatives as one of its objectives. No written methodology for an annual evaluation of health education programs on process and/or outcome measures, such as ER utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures was provided. Additionally, no annual evaluation of the program's impact on process and/or outcome measures was submitted based on this written methodology.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must have a written methodology for evaluating the impact of the health education program on process and/or outcome measures and must submit an annual evaluation that is based upon this methodology.

**9.3 b.** Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the enrollees.

**This component is Unmet.**

No evidence was provided to support the development and delivery of educational sessions by qualified staff or external organizations such as job descriptions, specialized training, certifications, education, and experience.

After the initial review, WPM submitted position descriptions for Director, Quality Management (QM), Clinical Quality Program Manager, Clinical Quality Program Specialist, Clinical Quality Program Admin, and Care Consultant. None of the job descriptions reviewed included duties relating to the development and delivery of educational sessions to support identified needs of enrollees. If the MCO does not provide any health education sessions but rather refers enrollees to external programs, a description of the program and qualifications of the provider may be submitted to demonstrate compliance with this component.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must provide evidence of the qualifications of staff or external organizations that develop and conduct

educational sessions to support the needs of enrollees such as job descriptions, specialized training, certifications, education, and experience.

**9.5 b.** Attendance records and session evaluations completed by enrollees.

**This component is Unmet.**

As evidence of compliance with this component, WPM submitted minutes from six Member & Consumer Health Advisory Committee meetings held in 2022. A standard agenda was used for these meetings which focused on plan benefits, CM services, marketing issues such as renewing benefits and use of the WPM website, and enrollee incentives. There was no evidence that health education was provided on any specific topic during these meetings or evaluations of these educational presentations completed by the attendees.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must provide sample attendance records and completed evaluations of health education sessions completed by enrollees.

**9.5 c.** Provider evaluations of health education programs.

**This component is Unmet.**

No evidence was submitted of provider evaluations of health education programs.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, WPM must demonstrate that its health education programs are evaluated by providers. This could be accomplished by formal written provider surveys or presentation of the health education plan for review and discussion at any WPM committee meetings attended by providers.

## 10.0 - Outreach Plan

### Findings

#### Priority Partners (PPMCO)

**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 Partially Met.**

In response to the MY 2021 review, PPMCO was required to provide the total number of enrollees comprising the special needs population (SNP) categories as defined in COMAR 10.67.04.04 B. Additionally, individuals with a physical disability were required to be differentiated from individuals with a developmental disability. Qlarant also recommended that PPMCO review the method used for reporting on homeless individuals to ensure accuracy. As indicated below, continued opportunities for improvement exist.

PPMCO's Outreach Plan reported the total population in 2021 as approximately 340,836 enrollees. Currently, 191,712 of the enrollees are children under the age of 20. A detailed breakdown of enrollees by county was provided and showed that the largest portions of PPMCO enrollees reside in Baltimore City (16.71%), Baltimore County (12.82%), Anne Arundel County (9.73%), Prince George's County (9.25%), and Montgomery County (8.36%).

PPMCO provided the following breakdown of the identified SNPs:

- Special Needs Children – 398
- Development Delay – 191
- Homeless Flag – 355
- Physical Disability – 495
- HIV/AIDS – 99
- Pregnancy – 1248
- Mental Health – 1801
- Substance ETOH Abuse – 236
- State Supervised Foster Care – 5359

It is unclear whether PPMCO included postpartum women in the total amount of the Pregnancy category.

PPMCO Special Needs Coordinators (SNCs) identify homeless PPMCO enrollees by participating in Homeless Resource Days where the SNCs assist enrollees in completing a medical needs questionnaire and assist in getting the enrollees established with a PCP and transportation assistance. The SNCs attend a Homeless Resource Planning Committee, a Homeless Men's Sheltering Resource Committee, and a Coalition for Homeless Children and Families that each meet monthly to discuss available enrollee resources.

PPMCO identifies the following 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 healthcare 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. In response, 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.

After the initial review, PPMCO submitted a contestation stating its special needs population categories sufficiently comprise the number of enrollees for each category as required per COMAR 10.67.04.04 B. The finding remains Partially Met, as PPMCO's category for "Pregnancy" does not appear to include totals for its postpartum enrollees as per COMAR 10.67.04.04 B requirements. Additionally, PPMCO requested feedback on the method used for reporting on homeless individuals to ensure accuracy. PPMCO's outreach plan sufficiently included the total amount of homeless individuals, homeless



member outreach events, and plans to bring homeless members into care, which satisfies the recommendation outlined in the Exit letter.

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, PPMCO must provide the total number of enrollees comprising the SNP categories as defined in COMAR 10.67.04.04 B. Categories and totals must include PPMCO's postpartum population.

## 11.0 - Fraud and Abuse

### Findings

#### Aetna Better Health (ABH)

**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 Met with Opportunity.**

In response to the MY 2021 review, ABH was required to document in the Compliance Committee meeting minutes, at a minimum quarterly, the findings from a review of each delegate's fraud, waste, and abuse (FWA) activities. As indicated below, this opportunity for improvement was met.

ABH delegates services to five entities: Access2Care, Avesis, CVS Caremark, eviCore, and Superior Vision. All five delegates' FWA and Compliance Plans were reviewed and approved at the Compliance Committee meeting on October 27, 2022.

In addition to conducting an annual review of each delegate's FWA and Compliance Plans, the Delegation Oversight Committee (DOC) is accountable for reviewing delegates' FWA activities quarterly. The DOC subsequently reports these findings to the Compliance Committee. There is evidence in the 2022 Compliance Committee meeting minutes that the DOC gave a summary report of each delegate's FWA activities at the following Compliance Committee meetings:

- Q4 2021 FWA Report on June 23, 2022
- Q1 2022 FWA Report on September 22, 2022
- Q2 2022 FWA Report on October 27, 2022
- Q3 2022 FWA Report on December 14, 2022

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, ABH must ensure delegate FWA reports to the Compliance Committee are spread out over all four quarters of the year.

#### CareFirst Community Health Plan (CFCHP)

**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 Met with Opportunity.**

In response to the MY 2021 review, CFCHP was required to determine which committee is accountable for the quarterly review and approval of delegates' FWA reports.

The 2022 Compliance & Regulatory Committee (CRC) meeting minutes indicate quarterly FWA Reports were given on February 15, April 28, August 25, and November 2, 2022. Findings relative to the oversight of FWA for Super Vision (SV) and CVS are outlined below for each of the four CRC meetings.

**February 15, 2022**

A FWA Report was given indicating no issues of FWA from SV and CVS.

**April 28, 2022**

A 2021 Q4 FWA Total Case Report was given. There is no delegation oversight report on FWA documented for SV. It is unclear whether a FWA report for CVS was provided.

**August 25, 2022**

A 2022 Q2 FWA Report was given. The committee reviewed SV's Compliance and FWA Plans. There were no oversight reports of FWA for SV or CVS.

**November 2, 2022**

A FWA Report was given. The Committee reviewed the Q2 and Q3 FWA Reports from CVS. There is no delegation oversight report on FWA documented for SV or for CVS, though the minutes did indicate that CVS had no FWA cases in the first three quarters of 2022. This was not presented as such in the August 25, 2022, CRC meeting.

After the initial review, CFCHP submitted quarterly FWA reports for CVS and SV to support compliance with oversight. These documents and the PowerPoint presentation of CRC oversight provide greater clarity of FWA reporting as follows:

CRC meeting review of delegate FWA reports in 2022 are as follows:

- Q1 2022 – April 28, 2022
- Q2 2022 – August 25, 2022
- Q3 2022 – November 2, 2022
- Q4 2022 – scheduled for review at the February 15, 2023, meeting

**OPPORTUNITY FOR IMPROVEMENT:** In order to receive a finding of Met in the MY 2023 review, CFCHP must demonstrate the review and approval of four quarters of FWA reports by the CRC. It is acceptable to report on Q4 FWA findings in the first quarter of the next review year. As an example, for MY 2023, the CRC could review delegate reports at its meetings as follows:

- Q4 2022 FWA reports at the Q1 2023 CRC
- Q1 2023 FWA reports at the Q2 2023 CRC
- Q2 2023 FWA reports at the Q3 2023 CRC
- Q3 2023 FWA reports at the Q4 2023 CRC

**RECOMMENDATION:** Qlarant recommends the CFCHP Compliance Team consult with the plan's QI Department to use meeting minute formats similar to, for example, the QIC. FWA reports should be consistent in every meeting such as documenting the quarter under review and the names of the delegates so that it is easy to identify gaps in oversight. The format of the CRC meeting minutes reviewed changes from meeting to meeting making task accountability and consistency in reporting difficult to follow. In some meetings, the documents presented are embedded in the meeting minutes and the reviewer was not provided with the actual report.