



Medicaid Quality Strategy

HealthChoice Program: 2012 - 2016

Department of Health and Mental Hygiene
June 1, 2015 - DRAFT

Per 42 C.F.R. § 438.202(a), each state contracting with a Managed Care Organization must have a written strategy for assessing and improving the quality of managed care services. The following document was developed by Maryland to outline the quality strategy of the Maryland HealthChoice Program.

Table of Contents

SECTION I: INTRODUCTION	1
Managed Care Goals, Objectives, and Overview	1
History of Maryland’s Medicaid and CHIP Managed Care Programs	1
Maryland Quality Management Structure Overview	3
Maryland’s Decision to Contract with Managed Care Organizations	5
Goals and Objectives of the Maryland HealthChoice Program	6
Development & Review of Quality Strategy	9
Development of Quality Strategy – 42 CFR §438.202(b)	9
Public Comment Process – 42 CFR §438.202(b)	9
Timeline for Assessing the Effectiveness of the Quality Strategy – 42 CFR §438.202(d).....	9
Updating and Modifying the Quality Strategy – 42 CFR §438.202(d).....	9
SECTION II: ASSESSMENT	11
Quality and Appropriateness of Care.....	11
Assessment of Quality and Appropriateness of Care for Medicaid Program – 42 CFR §	
438.204(b)(1)	11
Identification of Race, Ethnicity, and Primary Language of Medicaid Participants – 42 CFR §	
438.204(b)(2)	12
Efforts and Initiatives to Reduce Disparities in Health Care	13
National Performance Measures	13
Required National Performance Measures Identified – 42 CFR 438.204(c)	13
CMS Core Performance Measures for Children and Adults in Medicaid/CHIP	14
Monitoring and Compliance	15
Monitoring and Evaluation of HealthChoice MCO Compliance – 42 CFR §438.204(b)(3).....	15
External Quality Review.....	15
Overview of the Maryland HealthChoice External Quality Review (EQR) Process – 42 CFR	
§438.204(d).....	16
Optional Services Performed by EQRO	16
EQR Standards Using Medicare or Private Accreditation Reviews – 42 CFR §438.360(b)(4)	16
Non-Duplication of Activities for MCOs Serving Dual Eligibles – 42 CFR §438.360(c)(4).....	17
SECTION III: STATE STANDARDS	18
Access Standards	18
Availability of Services – 42 CFR §438.206	18

Assurances of Adequate Capacity and Services – 42 CFR §438.207	21
Coordination and Continuity of Care – 42 CFR §438.208	22
Coverage and Authorization of Services – 42 CFR §438.210	24
Structure and Operations Standards	27
Provider Selection – 42 CFR §438.214	27
Participant Information – 42 CFR §438.218.....	28
Confidentiality – 42 CFR §438.224.....	29
Enrollment and Disenrollment – 42 CFR §438.266.....	29
Grievance Systems – 42 CFR §438.228	30
Subcontractual Relationships and Delegation – 42 CFR §438.230	31
Measurement and Improvement Standards.....	32
Practice Guidelines - 42 CFR §438.236.....	32
Quality Assessment and Performance Improvement Program – 42 CFR §438.240.....	33
Health Information Systems – 42 CFR §438.242	34
SECTION IV: IMPROVEMENT AND INTERVENTIONS.....	35
Improving Quality of Care through Interventions	35
1115 Waiver.....	35
Chronic Health Homes.....	36
Million Hearts	36
State Innovation Models Grant	37
Maryland Quitline.....	38
CHIPRA Bonus Payments	38
Intermediate Sanctions – 42 CFR 438.204(e).....	39
HealthChoice Program and Intermediate Sanctions – 42 CFR §438.204(e).....	39
Methodology for Using Intermediate Sanctions	39
Health Information Technology.....	39
Maryland’s Information Systems and the Quality Strategy – 42 CFR §438.204(f).....	39
Health Information Technology Initiatives Supporting the Quality Strategy	40
SECTION V: DELIVERY SYSTEM REFORMS	44
Mental Health/Substance Use Disorder Carve-Out	44
Carve-Out Rationale	44
Performance Measures and Rationale.....	45
Related Performance Improvement Projects.....	46

Dental Program Carve-Out – Maryland Healthy Smiles Program.....	46
Carve-Out Rationale	46
Performance Measures and Rationale.....	47
Related Performance Improvement Projects.....	47
Medicaid Expansion under the ACA	47
Carve-In Rationale	48
Performance Measures and Rationale.....	48
Related Performance Improvement Projects.....	48
SECTION VI: CONCLUSION.....	49
EQR Quality Improvement Highlights	49
Department Quality Improvement Highlights	50
APPENDICES	51
APPENDIX A - Public Comment Process	52
APPENDIX B – MCO Required Reports to the Department	53
APPENDIX C – Maryland Business Associate Agreement	57
APPENDIX D – Report Links	64
APPENDIX E – Acronym List	65
APPENDIX F – 2014 Maryland Systems Performance Review Standards and Guidelines.....	67

SECTION I: INTRODUCTION

Managed Care Goals, Objectives, and Overview

History of Maryland's Medicaid and CHIP Managed Care Programs

The Maryland Medicaid Managed Care Program, better known as the Maryland HealthChoice Program, has been operational since June 1997. The management provisions and requirements for the Maryland HealthChoice Program (HealthChoice) appear in the Code of Maryland Regulations (COMAR) in chapters 10.09.62 – 10.09.75, and 10.09.86. HealthChoice is based upon a comprehensive system of continuous quality improvement that includes problem identification, analysis, corrective action, and reevaluation. The objective is to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding the care received by HealthChoice participants.

HealthChoice's philosophy is to provide quality health care that is patient focused, prevention oriented, coordinated, accessible, and cost effective. It currently enrolls more than 80% of the state's Medicaid population. The program also includes children in the Maryland Children's Health Program (MCHP), Maryland's implementation of the federal Children's Health Insurance Program (CHIP). The foundation of the plan hinges on providing a "medical home" for each participant, by connecting each participant with a primary care provider (PCP). HealthChoice participants choose a managed care organization (MCO) and a PCP from their MCO's network to oversee their medical care. The PCP is responsible for providing preventive and primary care services, managing referrals, and coordinating necessary care for the participant. HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid participants through the fee-for-service (FFS) system. The Program emphasizes health promotion and disease prevention, and requires that participants be provided health education and outreach services.

The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include:

- Families with low income that have children
- Families that receive Temporary Assistance for Needy Families (TANF)
- Children younger than 19 years who are eligible for MCHP
- Children in foster care, and those who age out of foster care on their 18th birthday, up to age 26
- Women with low income who are pregnant or less than 60 days postpartum
- Individuals receiving SSI who are younger than 65 years and not eligible for Medicare

Additional populations covered under the HealthChoice waiver include individuals in the Family Planning program, Rare and Expensive Case Management Program (REM), and Primary Adult Care (PAC) program.¹ HealthChoice-eligible individuals with certain diagnoses may choose to

¹ The PAC program provided limited benefits to low-income adults, and ended effective January 1, 2014. Its population now receives full benefits through the Medicaid expansion.

receive care on a fee-for-service (FFS) basis through the REM program. Family Planning and PAC are both limited benefit packages under the waiver.

Not all Maryland Medicaid beneficiaries are enrolled in HealthChoice MCOs. Groups that are not eligible for MCO enrollment include:

- Medicare beneficiaries
- Individuals aged 65 years and older
- Individuals in a “spend-down” eligibility group who are only eligible for Medicaid for a limited period of time
- Individuals who are continuously enrolled in a long-term care facility or an institution for mental illness or substance use disorder for more than 30 days
- Individuals who reside in an intermediate care facility for mental illness
- Individuals enrolled in the Employed Individuals with Disabilities program
- Refugees and certain categories of undocumented immigrants

HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid participants through the FFS system. Services in the MCO benefit package include, but are not limited to:

- Inpatient and outpatient hospital care
- Physician care
- Clinic services
- Laboratory and x-ray services
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children
- Prescription drugs, with the exception of behavioral health and HIV/AIDS drugs, which are provided under the FFS system²
- Substance use disorder treatment services (until December 31, 2014)³
- Durable medical equipment and disposable medical supplies
- Home health care
- Vision services
- Dialysis
- Skilled nursing facility or rehabilitation center care (up to 30 days)

² Substance use disorder prescription drugs will be carved out of the HealthChoice program, effective January 1, 2015.

³ Substance use disorder services will be carved out of the HealthChoice program, effective January 1, 2015.

Some services are carved out of the MCO benefit package and instead are covered by the Medicaid FFS system. These include:

- Specialty behavioral health care
- Substance use disorder treatment services (as of January 1, 2015)
- Dental care for children, pregnant women, and adults in the REM program
- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Education Plan or Individualized Family Service Plan
- Therapy services (occupational, physical, speech, and audiology) for children
- Personal care services
- Long-term care services after the first 30 days of care⁴
- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS
- HIV/AIDS drugs, specialty behavioral health drugs, and substance use disorder drugs⁵
- Services covered under 1915(c) home and community-based services waivers

Maryland Quality Management Structure Overview

The Department's Office of Health Services is responsible for coordination and oversight of the HealthChoice program. Within the Office of Health Services, the Managed Care Administration ensures that the initiatives established in 42 CFR 438, subpart D are adhered to and that all MCOs that participate in the HealthChoice program apply these principles universally and appropriately. Quality monitoring, evaluation, and education through participant and provider feedback are integral parts of the managed care process and help to ensure that health care is not compromised. The functions and infrastructure of the administration support efforts to identify and address quality issues efficiently and effectively. The administration is responsible for a systematic process where it identifies both positive and negative trends in service delivery and outcomes.

There are four divisions under the Managed Care Administration: HealthChoice Quality Assurance, HealthChoice Provider Network Management, Community Liaison and Care Coordination, and HealthChoice Complaint Resolution, as illustrated in the following chart.

⁴ Individuals in long-term care facilities for more than 30 days are disenrolled from HealthChoice.

⁵ Substance use disorder prescription drugs will be carved out of the HealthChoice program, effective January 1, 2015.

Maryland Medicaid Quality Strategy

Page 4 of 122

Unit	Responsibilities
Office of Health Services	Develops and reviews policies and regulations that establish eligibility criteria, define services, detail coverage, specify limitations, and determine reimbursement rates for Medicaid. Updates the State Plan, and secures federal approval for program changes to assure the continued availability of federal matching funds.
Managed Care Administration	Directs the four divisions responsible for oversight of the HealthChoice Program.
HealthChoice Quality Assurance	Manages external quality review, HEDIS [®] and CAHPS [®] vendors, Consumer Report Card process, Medicaid Quality Strategy, and quality improvement reporting.
HealthChoice Provider Network Management	Manages MCO network adequacy issues, provider contracting, MCO materials, new MCO applications, and provider complaints.
Community Liaison and Care Coordination	Manages the Helpline Call Center, the local health department administrative care coordination units and ombudsman grants, OB/GYN and family planning policy, and public health initiatives.
HealthChoice Complaint Resolution	Manages recipient complaint resolution and medical reviews, member complaint process and reports, and the independent review organization process.

Four additional offices work in collaboration with the Office of Health Services in managing the HealthChoice program, as illustrated in the following chart.

Unit	Responsibilities
Office of Planning	Monitors and analyzes the impact of State and Federal legislative activities on Maryland Medicaid. Plans new programs and evaluates existing programs within Maryland Medicaid. Coordinates health care reform initiatives across state agencies to maximize Medicaid coverage and ensure continuity of care. Acts as lead for Medicaid in comprehensive payment and delivery reforms.
Office of Finance	Charged with oversight responsibility with regard to the establishment and maintenance of management systems, logistical support systems, and financial operations for the Maryland Medicaid Program. Conducts financial analysis; prepares and monitors the budget, year-end closeout, and MCO rate setting; and handles management and procurement functions for the Office of Health Care Financing. Includes the Legal Services unit, which provides legal representation in the courts and before administrative adjudicative bodies for the Deputy Secretary for Health Care Financing.
Office of Eligibility Services	Ensures through statewide outreach efforts that eligible Marylanders receive the Medical Assistance benefits for which they are eligible. Provides benefit information, enrollment assistance, and problem resolution. Develops and implements eligibility policy, and provides training to staff in local health departments.
Office of Systems, Operations, and Pharmacy	Develops and maintains systems for prompt and accurate payment to providers of health care services. Maintains files of approved providers of services and of Maryland residents certified as eligible to receive services through Medicaid.

The Division of HealthChoice Quality Assurance (DHQA) bears primary responsibility for coordinating the quality activities involving external quality review and fulfilling CMS quality improvement requirements for the program. DHQA manages the contract with Delmarva Foundation for Medical Care, Inc. (Delmarva Foundation), HealthChoice's external quality review organization (EQRO).

Nine MCOs have served the HealthChoice population during the time period of this quality strategy submission.

- AMERIGROUP Maryland, Inc.
- Coventry Health Care of Delaware, Inc. (exited in October 2013)
- Jai Medical Systems Managed Care Organization, Inc.
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (joined in June 2014)
- Maryland Physicians Care Managed Care Organization, Inc.
- MedStar Family Choice, Inc.
- Priority Partners Managed Care Organization, Inc.
- Riverside Health of Maryland, Inc. (joined in February 2013)
- United Healthcare of the Mid-Atlantic, Inc.

Maryland's Decision to Contract with Managed Care Organizations

The Maryland General Assembly passed Senate Bill 750 on April 8, 1996, which authorized the Department to require Medicaid participants to enroll in MCOs. To implement SB 750, Maryland prepared an application for waiver of certain Medicaid requirements, under Section 1115(a) of the Social Security Act (1115 Waiver). The 1115 Waiver proposed the development and implementation of a Medicaid Managed Care Program. The application was submitted to the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), on May 3, 1996 and was approved by HCFA on October 30, 1996.

HealthChoice enables the extension of coverage and/or targeted benefits to certain individuals who would otherwise be without health insurance or access to benefits tailored to the participant's specific medical needs. Maryland's goal in implementing and continuing the demonstration is to improve the status of low-income Marylanders by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider (PCP); and
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care.

Goals and Objectives of the Maryland HealthChoice Program

The mission of the Department is to continue to improve both the clinical and administrative aspects of the HealthChoice program. The overall goals of the Department's Quality Strategy are to:

- Ensure compliance with changes in Federal/State laws and regulations affecting the Medicaid program;
- Improve quality and health care performance continually using evidence-based methodologies for evaluation;
- Compare Maryland results to national and state performance benchmarks to identify areas of success and improvement;
- Reduce administrative burden on MCOs and the program overall; and,
- Assist the Department with setting priorities and responding to identified areas of concern within the HealthChoice participant population.

The Department works collaboratively with MCOs and stakeholders to identify opportunities for improvement and to initiate quality improvement activities that will impact the quality of health care services for HealthChoice participants. The following activities have been implemented by the DHQA and have identified multiple opportunities for quality improvement.

HEDIS[®] and CAHPS[®] Collection

The Department requires MCOs to collect and report Healthcare Effectiveness and Data Information Set (HEDIS[®]) measures each year to assist in measuring clinical quality performance and participant satisfaction. Developed by the National Committee for Quality Assurance (NCQA), HEDIS[®] is a widely used tool that measures performance on dimensions of care and service. DHQA currently contracts with certified auditor HealthcareData Company, Inc. to validate the information submitted by MCOs for scoring. The Department expects all MCOs to meet or exceed the national average for all applicable HEDIS[®] measures.

The Department also requires in COMAR 10.09.65.03C(4), administration of the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) survey for Medicaid plans. CAHPS[®] is a survey designed to capture accurate and reliable information from participants about their experiences with HealthChoice. WBA Research currently serves as DHQA's CAHPS[®] survey vendor. The Department expects each MCO to maintain a high level of satisfaction by meeting or exceeding the NCQA Quality Compass[®] benchmarks.

Performance Improvement Projects

COMAR 10.09.65.03 requires that all HealthChoice MCOs conduct performance improvement projects (PIPs) that focus on clinical and nonclinical areas. Through MCO and stakeholder input, the Department selects projects that would have significant impact on the quality, access, or timeliness of service delivery. The PIPs include measurements of performance using objective quality indicators, the implementation of system interventions to achieve improvement in quality, evaluation of the effectiveness of the interventions, and planning and initiation of the

activities for increasing or sustaining improvement. Using HEDIS[®] measures, the Department establishes a baseline year measurement for the project, and each MCO sets a quantifiable goal for sustained improvement throughout the project period.

EPSDT/Healthy Kids Medical Record Reviews

The Department also conducts an EPSDT/Healthy Kids Program which requires all PCPs providing services under Medicaid to children and adolescents through 20 years of age with timely and screening and preventive care. Each year, the EQRO annually completes an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical record review. The Department established a minimum compliance rate of 75% for all components of the review. The components are:

- Health & Developmental History;
- Comprehensive Physical Examination;
- Laboratory Tests/At-Risk Screenings;
- Immunizations; and,
- Health Education/Anticipatory Guidance.

Systems Performance Review

The Department conducts a systems performance review (SPR) annually to provide an assessment of the structure, process, and outcome of each MCO's internal quality assurance programs. COMAR 10.09.65.03 requires that all HealthChoice MCOs comply with the SPR standards established by the Department and all applicable federal and state laws and regulations. The performance standards used to assess the MCO's operational systems were developed from applicable Maryland Health-General Statutes and COMAR, the CMS document "A Health Care Quality Improvement System for Medicaid Managed Care,"⁶ Public Health Code of Federal Regulations, and Departmental requirements.

The EQRO, in conjunction with the DHQA, creates and revises the standards used to assess each MCO annually. The SPRs are conducted at the MCO's corporate offices and performed by a review team consisting of health professionals, a nurse practitioner and two masters prepared reviewers. The minimum compliance rate for an established MCO is 100%. For new MCOs, the minimum compliance rate starts at 80% and increases incrementally on an annual basis. The Department's goal is for all MCOs to meet the minimum compliance rate for the eleven performance standards:

- Systematic Process of Quality Assessment;
- Accountability to the Governing Body;
- Oversight of Delegated Entities;
- Credentialing and Recredentialing;
- Participant Rights;
- Availability and Accessibility;

⁶ This document can be found here: https://archive.org/details/healthcarequalit00unit_0

- Utilization Review;
- Continuity of Care;
- Health Education;
- Outreach; and,
- Fraud and Abuse.

For any standard, or components of a standard, that did not meet the minimum compliance rate, the MCO is required to develop and implement an approved Corrective Action Plan (CAP).

Value Based Purchasing Initiative

The HealthChoice Value Based Purchasing Initiative improves quality by awarding financial incentives to MCOs based on their performance. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice. The Department solicits input from stakeholders, including MCOs and the Maryland Medicaid Advisory Committee (MMAC). The MMAC improves and maintains the quality of the HealthChoice Program by assisting the Department of Health and Mental Hygiene with the implementation, operation, and evaluation of the Program. Together, the Department and its stakeholders identify legislative priorities in selecting the performance measures. The performance measures are from the HEDIS[®] measures and encounter data. Measures may be added or removed, based upon evolving priorities and participant health care needs. The Department uses a standard methodology to calculate the incentive, neutral, and disincentive ranges, based on previous MCO performance in HEDIS[®] and encounter data measures.

Consumer Report Card

The Department contracts with an EQRO to develop a Medicaid Consumer Report Card. The current EQRO, Delmarva Foundation, collaborates with NCQA to assist in its development and production. The Consumer Report Card assists Medicaid participants in selecting one of the participating HealthChoice MCOs. Information in the Report Card includes performance measures from HEDIS[®], the CAHPS[®] survey, and the Value Based Purchasing Initiative. There are six reporting categories, with one level of summary scores for each reporting category:

- Access to Care
- Doctor Communication and Service
- Keeping Kids Healthy
- Care for Kids with Chronic Illness
- Taking Care of Women
- Diabetes Care

After the ACA-related Medicaid Expansion in 2014, the Department incorporated additional measures that impact Medicaid-eligible adults and changed the Diabetes Care category to Care for Adults with Chronic Illnesses, effective in 2015. Stars represent performance that is above the Maryland HealthChoice average (three stars), the same as the Maryland HealthChoice average (two stars) or below the Maryland HealthChoice average (one star).

NCQA Accreditation

Many of the NCQA Medicaid accreditation standards align with the priorities of the Department in administering quality health care to its participants. Beginning in calendar year 2013, the Department added a requirement to COMAR that all MCOs participating in the HealthChoice program as of January 1, 2013 have NCQA accreditation by January 1, 2015. New plans joining the HealthChoice program must have NCQA accreditation within two years of the date they begin providing HealthChoice services.

Development & Review of Quality Strategy

Development of Quality Strategy – 42 CFR §438.202(b)

The State of Maryland, specifically the Office of Health Services Managed Care Administration of the Department, developed the Quality Strategy through a multi-faceted approach. Members of the Managed Care Administration researched approaches to drafting the strategy, including using the CMS Quality Strategy Toolkit for States as a roadmap. The Managed Care Administration collaborated with other divisions and administrations within the Office of Health Services for technical assistance for subject matters specific to their areas, such as health information technology, current grants, and information on waivers. From there, the Quality Strategy was drafted and circulated amongst the Office of Health Services for comments and revisions. The draft was then finalized for stakeholder and CMS input. The final version of the Maryland Medicaid Quality Strategy will be shared publicly after resolution of all comments received from stakeholders, along with CMS final review and approval.

Public Comment Process – 42 CFR §438.202(b)

The Department posted notice for public comments on the Maryland Medicaid website, located at <http://dhmh.maryland.gov>, to solicit feedback on its strategy from June 1, 2015 to June 30, 2015. A screenshot of the notice announcement, along with the comments and feedback received, is included as Appendix A.

Timeline for Assessing the Effectiveness of the Quality Strategy – 42 CFR §438.202(d)

Maryland will assess the effectiveness of the Quality Strategy on an annual basis. The assessment will be performed by the EQRO and reported in an Annual Technical Report on the quality of the HealthChoice program. The Annual Technical Report is required under Section 1932(c)(2)(A)(i) of the Social Security Act.

Updating and Modifying the Quality Strategy – 42 CFR §438.202(d)

The Department will publish an updated Quality Strategy every five years. The next version of the Quality Strategy will be published in 2020, unless significant changes warrant an update to the Quality Strategy.

Maryland defines significant changes as changes that are likely to affect the delivery or measurement of the quality of health care services delivered through the HealthChoice program.

Additionally, changes to NCQA standards, which are published annually, could also be considered significant if they impact the measurement of the quality of health care services. Significant changes do not include formatting, dates, or any change that does not impact the intent or content of the Quality Strategy. All significant changes will be subject to a public comment period, CMS review and approval, and a reissuance of the Quality Strategy.

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SECTION II: ASSESSMENT

Quality and Appropriateness of Care

This section describes quality assessment and appropriateness of care for HealthChoice, including defining special needs populations and linkages to care. This section will also explain the identification process of race, ethnicity, and primary language of HealthChoice participants; along with efforts and initiatives to reduce disparities in health care.

Assessment of Quality and Appropriateness of Care for Medicaid Program – 42 CFR § 438.204(b)(1)

All Participants

The Department assesses the quality and appropriateness of care for all participants in the HealthChoice program through the following activities:

- **State-mandated reporting required under regulations and contractual provisions.** The Department mandates in COMAR 10.09.65.15 that MCOs submit reports at various frequencies throughout the calendar year.
- **Annual quality improvement activities conducted and/or validated by EQRO (Delmarva Foundation).** A brief summary of the activities conducted and/or validated by the Delmarva Foundation, the Department's current EQRO, appears in this report.
- **State-developed quality measurements.** In addition to using HEDIS[®] measures to assess quality of care, the Department also performs its own assessments with measures using MCO encounter data. An example is the Lead Screenings for Children Ages 12–23 Months measure, which tracks the percentage of children ages 12–23 months (enrolled 90 or more days) who received a lead test during the current or prior calendar year. Maryland requires all children to receive two lead screenings. The Hilltop Institute extracts data from the Maryland Lead Registry housed by the Maryland Department of the Environment, and maps the participant information to the HealthChoice MCOs. The EQRO validates this measure.
- **Annual State-developed program evaluation.** The Department contracts with The Hilltop Institute to assist in performing an annual evaluation of the HealthChoice program. The evaluation includes a general overview of the program, recent program changes, coverage and access, medical home, quality of care, and other special topics (e.g., dental care, behavioral health care, substance use disorder services).

Special Health Care Needs Populations

HealthChoice defines seven non-mutually exclusive populations as having special health care needs:

- Children with special health care needs
- Individuals with a physical disability
- Individuals with a developmental disability

- Pregnant and postpartum women
- Homeless individuals
- Individuals with HIV/AIDS
- Children in State-supervised care

In order for MCOs to properly serve special health care needs populations, the Department requires them to have the following mechanisms in place:

- A demonstration that its pediatric and adult primary care providers and specialists are clinically qualified to provide or arrange for the provision of appropriate health care services
- Ensure providers have experience treating individuals in special needs populations
- Demonstrate the use of a primary care system of care delivery, which includes a comprehensive plan of care for participants and uses a coordinated and continuous case management approach that involves the participant (and, as appropriate, the participant's family, guardian, or caregiver) in all aspects of care
- Include in its outreach plan ways to contact and educate participants in special needs populations who fail to appear for appointments or who have been noncompliant with a regimen of care
- Identification of a special needs coordinator to serve as a point of contact for health care services information and referral, and to participate on the MCO's consumer advisory board

Identification of Race, Ethnicity, and Primary Language of Medicaid Participants – 42 CFR § 438.204(b)(2)

Maryland provides applications via Maryland Health Connection in English and in Spanish. Spanish has been identified as the second most prevalent language following English among the HealthChoice population. The application also provides a call-in assistance number⁷ for individuals whose primary language is not English or Spanish.

Questions 16 and 17 of the application ask potential participants to provide their race and ethnicity. The following chart lists the race and ethnicity options available on the Maryland Health Connection application.

⁷ The call-in number for customer assistance is 1-855-642-8572.

<p>Race (Question 17)</p>	<p>White Black or African-American American Indian or Alaska Native Asian Indian Chinese Filipino Japanese Korean</p>	<p>Vietnamese Other Asian Native Hawaiian Guamanian or Chamorro Samoan Other Pacific Islander Other</p>
<p>Ethnicity (Question 16)</p>	<p>Mexican Mexican-American Chicano/Chicana Puerto Rican Cuban Other</p>	

If the race, ethnicity, and primary language information is missing, the HealthChoice program’s enrollment broker contacts the participant and gathers the information for transmission to the MCO. The enrollment broker also has HealthChoice materials for Spanish-speaking participants.

Efforts and Initiatives to Reduce Disparities in Health Care

Maryland's Office of Minority Health and Health Disparities works to promote health equity among African Americans, Asian Americans, Hispanic/Latino Americans, and Native Americans toward improving the health of all Marylanders.

MHHD, Maryland Community Health Resources Commission (MCHRC) and the Department are working to implement the Maryland Health Improvement and Disparities Reduction Act of 2012 to reduce health disparities in the state; improve health outcomes such as infant mortality, obesity and cancer; and lower health cost and hospital readmissions.

National Performance Measures

Maryland primarily collects national performance measures created by NCQA, a private, 501(c)(3) not-for-profit organization.

Required National Performance Measures Identified – 42 CFR 438.204(c)

Prior to requiring all HealthChoice MCOs to receive NCQA accreditation and report all measures, the Department collected 32 HEDIS® measures for children and adults.

NCQA Domain	Measures
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<p>Effectiveness of Care</p>	<p>Childhood Immunization Status (CIS) Immunizations for Adolescents (IMA) Breast Cancer Screening (BCS) Cervical Cancer Screening (CCS) Comprehensive Diabetes Care (CDC), all indicators except HbA1c good control (<7.0%) Use of Appropriate Medications for People with Asthma (ASM) Appropriate Treatment for Children with Upper Respiratory Infection (URI) Appropriate Testing for Children with Pharyngitis (CWP) Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) Chlamydia Screening in Women (CHL) Use of Imaging Studies for Low Back Pain (LBP) Annual Monitoring for Patients on Persistent Medications (MPM) Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) Medication Management for People with Asthma (MMA) Controlling High Blood Pressure (CBP) Adult BMI Assessment (ABA) Asthma Medication Ratio (AMR) Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) Pharmacotherapy Management of COPD Exacerbation (PCE) Persistence of Beta Blocker Treatment After a Heart Attack (PBH) Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)</p>
<p>Access/Availability of Care</p>	<p>Adults' Access to Preventive/Ambulatory Health Services (AAP) Children and Adolescents' Access to Primary Care Practitioners (CAP) Prenatal and Postpartum Care (PPC) Call Answer Timeliness (CAT) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)</p>
<p>Utilization and Relative Resource Use</p>	<p>Frequency of Ongoing Prenatal Care (FPC) Well-Child Visits in the First 15 Months of Life (W15) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) Adolescent Well-Care Visits (AWC) Ambulatory Care (AMB) Identification of Alcohol and Other Drug Services (IAD)</p>

The Department also evaluated HealthChoice participant experiences of each participating MCO and the Maryland HealthChoice Program using the NCQA CAHPS[®] 2013 5.0 H Child⁸ and Adult Medicaid Survey tools.

CMS Core Performance Measures for Children and Adults in Medicaid/CHIP

During measurement years 2011 – 2013 (HEDIS[®] reporting years 2012 – 2014), Maryland voluntarily collected 13 of the 23 CMS core performance measures for adults. Of these 13, 3 are part of the HealthChoice Value Based Purchasing Incentive for HEDIS[®] reporting year 2015 (measurement year 2014). These measures are indicated by an asterisk.

- Flu Vaccinations for Adults Ages 18 to 64
- Adult Body Mass Index Assessment
- Breast Cancer Screening*

⁸ The CAHPS[®] 2013 5.0H Child Medicaid Survey also includes questions specifically for Children with Chronic Conditions (CCC).

- Cervical Cancer Screening
- Medical Assistance with Smoking and Tobacco Use Cessation
- Chlamydia Screening in Women Ages 21 to 24
- Controlling High Blood Pressure*
- Comprehensive Diabetes Care: LDL-C Screening
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Annual Monitoring for Patients on Persistent Medications
- CAHPS Health Plan Survey 5.0H – Adult Questionnaire
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Postpartum Care Rate*

During measurement years 2011 – 2013 (HEDIS[®] reporting years 2012 – 2014), Maryland voluntarily collected 13 of the 26 CMS core performance measures for children. Of these 13, 4 are part of the HealthChoice Value Based Purchasing Incentive for HEDIS[®] reporting year 2015 (measurement year 2014). These measures are indicated by an asterisk.

- Adolescent Well-Care Visits*
- Child and Adolescents' Access to Primary Care Practitioners
- Chlamydia Screening in Women*
- Childhood Immunization Status*
- Consumer Assessment of Healthcare Providers and Systems[®] CAHPS 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)
- Developmental Screening in the First Three Years of Life
- Frequency of Ongoing Prenatal Care
- Immunization Status for Adolescents
- Medication Management for People with Asthma*
- Timeliness of Prenatal Care
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

Because all Maryland MCOs are required to have or obtain NCQA accreditation as a condition of participating in HealthChoice, MCOs will be expected to collect and report the full roster of HEDIS[®] measures to the Department. The Department assesses and monitors MCO performance against national HEDIS[®] means and percentiles and against Maryland averages.

Monitoring and Compliance

Monitoring and Evaluation of HealthChoice MCO Compliance – 42 CFR §438.204(b)(3)

The Department requires MCOs to submit multiple reports to monitor HealthChoice program activities. Please see Appendix B for a listing of required reports and submission frequency.

External Quality Review

Overview of the Maryland HealthChoice External Quality Review (EQR) Process – 42 CFR §438.204(d)

For the purpose of external quality review of the HealthChoice program, the Department contracts with the Delmarva Foundation. Delmarva Foundation is a non-profit organization established in 1973 as a Professional Standards Review Organization. Over the years, the company has grown in size and mission. Delmarva Foundation is designated by the Centers for Medicare and Medicaid Services (CMS) as a Quality Improvement Organization for the State of Maryland⁹ and performs EQRs and other services to Medicaid agencies in many jurisdictions across the United States. The Department's contract with the Delmarva Foundation expires August 31, 2016.

In accordance with Federal regulations, the Delmarva Foundation conducts the following required activities to assess managed care performance in Maryland:

1. Conduct a review of MCOs' operations to assess compliance with State and Federal standards for quality program operations;
2. Validate State required performance measures; and
3. Validate State required Performance Improvement Projects (PIPs) that were underway during the prior 12 months.

Optional Services Performed by EQRO

Maryland contracts with the Delmarva Foundation to conduct the following optional activities on behalf of the HealthChoice program:

- Validates MCO-reported encounter data annually;
- Calculates performance measures in addition to those reported by MCOs and validated by EQRO, by creating the Maryland HealthChoice Consumer Report Card; and
- Conducts an annual EPSDT Medical Record Review of all MCOs to determine if they are compliant with the Maryland Healthy Kids Program.

EQR Standards Using Medicare or Private Accreditation Reviews – 42 CFR §438.360(b)(4)

Since requiring all HealthChoice MCOs to obtain NCQA accreditation, the Department is working in conjunction with its EQRO to determine which, if any, of its regulatory standards will be deemed during annual systems performance reviews.

⁹ In summer 2014, Delmarva Foundation designation has changed to being a QIO-like entity by CMS, as a result of changes to the national QIO structure.

Non-Duplication of Activities for MCOs Serving Dual Eligibles – 42 CFR §438.360(c)(4)

As the HealthChoice program does not enroll the dual eligible population in MCOs, this section is not applicable.

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SECTION III: STATE STANDARDS

Access Standards

This section discusses the standards Maryland has established in MCO contracts and state regulations for access to care, as required by 42 CFR Part 438, subpart D. These standards are related to the overall goals and objectives listed for the Maryland HealthChoice Program.

Availability of Services – 42 CFR §438.206

The following tables map HealthChoice requirements for MCOs to satisfy service availability requirements.

<p>Maintain and Monitor a Network of Appropriate Providers [42 CFR §438.206(b)(1)]</p>
<p>The Department requires MCOs to develop and maintain a complete network of adult and pediatric services, including primary care, specialty care, ancillary services, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of required Maryland Medicaid benefits. The Department also requires MCOs to clearly define and specify referral requirements to specialty and other providers.</p> <p><i>Source: COMAR 10.09.66.05, SPR Standard 6.2</i></p>
<p>Female Participants Have Direct Access to a Women’s Health Specialist [42 CFR §438.206(b)(2)]</p>
<p>The Department requires MCOs to provide direct access, without the need for a referral, to a women’s health specialist within the MCO’s network for covered services necessary to provide routine and preventive health services. This provision applies if the participant’s PCP is not a women’s health specialist. The Department also allows the MCO to include OB/GYN practitioners and certified nurse midwives as primary care providers for female participants.</p> <p><i>Source: COMAR 10.09.66.05</i></p>
<p>Provide for a Second Opinion from a Qualified Health Professional [42 CFR §438.206(b)(3)]</p>
<p>The Department requires MCOs to provide for a second opinion from a qualified health professional within the network, or, if necessary, arrange for the participant to obtain one outside of the MCO network.</p> <p><i>Source: COMAR 10.09.67.01</i></p>

Adequate and Timely Coverage of Services Not Available in Network
[42 CFR §438.206(b)(4)]

For all participants, the Department requires MCOs to be financially responsible for medically necessary emergency services delivered outside of the MCO's service area. MCOs may require authorization for services outside of its service area that are not emergencies.

For children with special health care needs, the Department requires the following process:

- The parent or guardian of a child may request approval from an MCO for a specific out-of-network specialty provider when the MCO does not have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same service and modality.
- If denied, the parent or guardian has the right to appeal to the Department, in accordance with the provisions of COMAR 10.09.72.*
- If out-of-network services are terminated or reduced, and the parent or guardian exercises the right to appeal to the Department, MCOs must continue to cover the services during the appeal until the Office of Administrative Hearings issues its decision.

*The appeals process for parents and caregivers of children with special health care needs is outlined in COMAR 10.09.72.05C(2) – (3). For medically necessary services being denied, reduced, or terminated, the Office of Administrative Hearings must make a decision within 3 days of the hearing. For services not involving medical necessity determinations, the Office of Administrative Hearings must schedule a hearing within 30 days' notice from the Department and make a decision within 30 days of the hearing.

Sources: COMAR 10.09.66.07, COMAR 10.09.65.05

Out-of-Network Providers Coordinate with MCO with Respect to Payment
[42 CFR §438.206(b)(5)]

The Department details MCO payment procedures for multiple self-referred, emergency, and out-of-network provider services, including, but not limited to:

- Self-referred services, which include undisputed self-referred services
- School-based health clinic services
- Family planning services
- Initial medical examinations for children in State-supervised care
- Annual diagnostic and evaluation service visits for participants diagnosed with HIV/AIDS
- OB/GYN care for pregnant women, under certain conditions
- Renal dialysis services in a Medicare-certified facility
- Substance use disorder services (until 2015 carve-out)
- Free-standing birth center services
- Initial medical examinations for newborns, when performed in a hospital by an on-call physician, and the MCO failed to provide for the service before the newborn was discharged from the hospital
- Emergency services provided at a hospital
- Out-of-network federally qualified health center (FQHC) services

Source: COMAR 10.09.65.20

Credential All Providers As Required by §438.214
[42 CFR §438.206(b)(6)]

The Department requires all MCOs to comply with Maryland Insurance Article §15-112 when credentialing its providers (the same standard applied to all Maryland carriers); ensure they do not discriminate against providers that serve high-risk populations or require costly treatment; ensure that they do not employ or contract providers excluded from participating in Federal health care programs; and send written notice for declining to include providers in its network.

Source: COMAR 10.09.65.02, SPR Standard 4.0

<p>Meet State Standards for Timely Access to Care and Services [42 CFR §438.206(c)(1)(i)]</p>
<p>The Department requires all MCOs to:</p> <ul style="list-style-type: none"> • Follow prescribed preauthorization turnaround guidelines, notice guidelines, and the definition of what constitutes an adverse action. • Adhere to timeliness standards for actions and decisions for emergency and non-emergency medically related requests. • Establish mechanisms to ensure that its provider network complies with access requirements, has adequate capacity, and provides all covered services. • Set baselines for its provider network in terms of appointment turnaround times, office hours, and provider availability. • Monitor its provider networks regularly to determine compliance and take corrective action if there is a failure to comply. <p>Sources: <i>COMAR 10.09.71.04, COMAR 10.09.66.05, COMAR 10.09.66.07, SPR Standard 6.2</i></p>
<p>Network Providers Offer Hours of Operation That Are No Less Than the Hours of Operations Offered to Commercial Participants or Comparable to Medicaid Fee-For-Service [42 CFR §438.206(c)(1)(ii)]</p>
<p>The Department requires all MCOs to establish, or require its subcontractors to establish, a comparable and reasonable schedule of operating hours for clinics and pharmacies during which its service delivery sites are open to participants, with very limited circumstances for exceptions. The Department also requires MCOs to inform primary and specialty care providers of their responsibility to provide or arrange for medically necessary accessible health care services that are continuous, comprehensive, and coordinated for each participant.</p> <p>Source: <i>COMAR 10.09.66.04, COMAR 10.09.66.07</i></p>
<p>Services Available 24 Hours a Day, 7 Days a Week [42 CFR §438.206(c)(1)(iii)]</p>
<p>The Department requires MCOs to:</p> <ul style="list-style-type: none"> • Submit written protocols detailing how they will provide 24-hour per day, 7-day per week coverage for emergency medical situations, including compliance with Maryland Institute for Emergency Medical Services Systems (MIEMSS) protocols and the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). • Inform primary and specialty care providers of their responsibility to provide or arrange for medically necessary accessible health care services that are continuous, comprehensive, and coordinated for each participant. • Inform primary and specialty care providers of their responsibility to provide 24-hour per day, 7-day per week coverage. • Pay undisputed claims of hospital emergency facilities and providers for MCO participants. <p>Source: <i>COMAR 10.09.64.05, COMAR 10.09.66.04, COMAR 10.09.66.08</i></p>
<p>Mechanisms/Monitoring to Ensure Provider Compliance [42 CFR §438.206(c)(1)]</p>
<p>The Department requires its MCOs to establish mechanisms to ensure that its provider network complies with access requirements, adequate capacity, and services. MCOs must also monitor provider networks regularly to determine compliance and take corrective action if there is a failure to comply.</p> <p>Source: <i>COMAR 10.09.66.05, SPR Standard 6.2</i></p>

<p>Culturally Competent Services to All Participants [42 CFR §438.206(c)(2)]</p>
<p>The Department requires MCOs to provide access to health care services and information in a manner that addresses individualized needs of participants. The services and information must be provided in a culturally sensitive manner; at an appropriate reading comprehension level; in the prevalent non-English languages identified by the Department; and in a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 and all applicable regulations. MCOs must also make interpretation services available free of charge to each participant and potential participant who does not speak English or is hearing impaired.</p> <p><i>Source: COMAR 10.09.66.01</i></p>

Assurances of Adequate Capacity and Services – 42 CFR §438.207

<p>Provide Assurances and Documentation of Capacity to Serve Expected Enrollment [42 CFR §438.207(a)]</p>
<p>The Department requires MCOs to present the following information to participate in the HealthChoice program:</p> <ul style="list-style-type: none"> • The county or counties in which the MCO proposes to provide health care services; • Information grouped by medical specialty and county for each individual practitioner, including primary care providers and specialists, that includes: <ul style="list-style-type: none"> ○ Name, address, and practice locations; ○ State licensure number; ○ Specialty, if applicable, indicating the type of services to be provided; ○ Whether the provider is a PCP; ○ A description of the practitioner’s employment relationship to the MCO; and ○ Any restrictions as to the age of patients or numbers of participants the provider will serve; and • Provider-to-participant ratios in the county or counties in which the MCO proposes to provide health care services. <p>MCOs must submit documentation that participants will have access to primary care services, including obstetrics/gynecology and diagnostic laboratory services, within a reasonable distance of their places of residence.¹⁰ MCOs also must provide written evidence of their preparedness to provide the mandated level of benefits for the Maryland Medical Assistance Program and describe any additional benefits it will offer, along with sharing the provider networks and limitations corresponding with the additional benefits.</p> <p><i>Source: COMAR 10.09.64.05, COMAR 10.09.64.06</i></p>
<p>Offer an Appropriate Range of Preventive, Primary Care, and Specialty Services [42 CFR §438.207(b)(1)]</p>
<p>The Department requires MCOs to develop and maintain a complete network of adult and pediatric primary care, specialty care, ancillary service, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of benefits as required. MCOs must also maintain a list of its proposed and existing subcontracts with health care providers who are necessary to fulfill the MCO’s delivery obligations and provide it to the Department.</p> <p><i>Source: COMAR 10.09.66.05, SPR Standard 6.2</i></p>

¹⁰ Urban areas: within a 10-mile radius; suburban areas: within a 20-mile radius; rural areas: within a 30-mile radius.

**Maintain Network Sufficient in Number, Mix, and Geographic Distribution
[42 CFR §438.207(b)(2)]**

The Department requires its MCOs to establish mechanisms to ensure that its provider network complies with access requirements, adequate capacity, and services. MCOs must monitor provider networks regularly to determine compliance and take corrective action if there is a failure to comply.

MCOs must comply with specific participant-to-provider ratios for primary care within local access areas or counties, unless the MCO can establish to the Department’s satisfaction that a higher ratio is adequate. MCOs are also required to contract with eight core specialties in regulation-defined specialty care regions: cardiology, otolaryngology, gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology. MCOs must also contract with at least one provider in six additional specialties: allergy, dermatology, endocrinology, infectious disease, nephrology, and pulmonology. Failure to meet the specialty network requirements may result in suspension in automatic assignment of participants to the MCO within the affected specialty care region.

Source: COMAR 10.09.66.05, COMAR 10.09.66.05-1, SPR Standard 6.2

Coordination and Continuity of Care – 42 CFR §438.208

**Ensure Each Participant Has an Ongoing Source of Primary Care Appropriate to His or Her Needs
[42 CFR §438.208(b)(1)]**

The Department requires MCOs to provide access to health care services and information in a manner that addresses individualized needs of participants. The services and information must be provided in a culturally sensitive manner; at an appropriate reading comprehension level; in the prevalent non-English languages identified by the Department; and in a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990 and all applicable regulations. MCOs must make interpretation services available free of charge to each participant and potential participant who does not speak English or is hearing impaired.

MCOs must assign each participant to the PCP the participant chooses from their panels or at the MCOs’ selection if the participant fails to choose. The MCO must assign participants younger than 21 years of age to Maryland EPSDT-certified PCPs, unless the parent, guardian, or caretaker specifically requests a PCP who is not certified. If a specific request for a non-certified PCP is made, the MCO must send a notice to the parent, guardian, or caretaker that the option to choose an EPSDT-certified PCP is available.

Source: COMAR 10.09.66.01, COMAR 10.09.66.05

**Ensure All Services the Participant Receives Are Coordinated with the Services the Participant Receive from Any Other MCO; Share with Other MCOs Serving the Participant with Special Health Care Needs the Results of Its Identification and Assessment to Prevent Duplication of Services
[42 CFR §438.208(b)(2); 42 CFR §438.208(b)(3)]**

The Department requires that if for any reason a participant disenrolls from one MCO and joins another, upon request from the Department, the MCO must transmit, with any request for participant disenrollment, the MCO’s medical and utilization history for the participant.

Source: COMAR 10.09.63.06

Protect Participant Privacy When Coordinating Care
[42 CFR §438.208(b)(4)]

Upon joining the Maryland HealthChoice Program, every MCO is responsible for signing a standard Department-issued Business Associate Agreement. The Business Associate Agreement requires MCOs to comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Maryland Confidentiality of Medical Records Act (MCMRA). A copy of the Business Associate Agreement is included as Appendix C.

To protect the privacy of HealthChoice participants, the MCO must:

- Have established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data.
- Ensure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.
- Hold confidential all information obtained by its personnel about participants related to their care and not divulge it without the participant's authorization unless: (1) required by law, (2) necessary to coordinate the patient's care, or (3) necessary in compelling circumstances to protect the health or safety of an individual.
- Ensure that the release of any information in response to a court order is reported to the patient in a timely manner.
- Have policies concerning the disclosure of participant records, with or without the participant's authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual participant in any report of research or otherwise disclose participant identity in any manner.

Source: COMAR 10.09.65.02, State of Maryland Business Associate Agreement, SPR Standard 5.3

Comply with State Mechanisms to Identify Persons with Special Health Care Needs
[42 CFR §438.208(c)(1)]

At the time of MCO enrollment, the enrollment broker and/or the Department attempts to collect a Health Service Needs Assessment to determine if new participants fall into one of seven non-mutually exclusive special needs populations.¹¹ The enrollment broker and/or Department attempts to collect this information within five days of enrollment, unless the participant cannot be reached or is uncooperative.

This information is transferred to the MCO within five business days. Upon receipt of the health service needs information, the MCO is responsible for ensuring the new participant receives necessary services in a timely manner.

Source: COMAR 10.09.63.03

Maintain Mechanisms to Assess Participants with Special Health Care Needs by Appropriate Health Care Professionals
[42 CFR §438.208(c)(2)]

The Department requires MCOs to demonstrate that its pediatric and adult PCPs and specialists are clinically qualified, based upon generally accepted community standards, to provide or arrange for the provision of appropriate health care services to individuals who are members of a special needs population. MCOs are required to determine the providers' clinical qualifications through the MCO's credentialing and recredentialing processes, including a review of the provider's medical education, special training, and work history and experience. The specialty and subspecialty providers shall (a) have experience in treating individuals within a special needs population; (b) have experience in interdisciplinary medical management; and (c) understand the relationship between somatic and behavioral health care issues and interventions.

Source: COMAR 10.09.65.04

¹¹ The seven non-mutually exclusive special health care needs populations are located in COMAR 10.09.65.04.

Develop PCP Treatment Plans with Participant Participation, and in Consultation with Specialists; Approve Plans in a Timely Manner and in Accordance with Applicable Maryland Standards
[42 CFR §438.208(c)(3)]

The Department requires MCOs to demonstrate the use of a primary care system of care delivery which includes a comprehensive plan of care for a participant who is a member of a special needs population and which uses a coordinated and continuous case management approach, involving the participant and, as appropriate, the participant's family, guardian, or caregiver, in all aspects of care, including primary, acute, tertiary, and home care.

The Department also requires that MCOs document the plan of care and treatment modalities provided to participants in special populations, assuring that the plan of care is updated annually; involves the participant and, as appropriate, the participant's family, guardian, and caregiver in care decisions; and be familiar with community-based resources available for the special populations.

Source: COMAR 10.09.65.04

Provide Direct Access to Specialists for Participants with Special Health Care Needs
[42 CFR §438.208(c)(4)]

The Department requires MCOs to demonstrate that its pediatric and adult PCPs and specialists are clinically qualified based upon generally accepted community standards to provide or arrange for the provision of appropriate health care services to individuals who are members of a special needs population. MCOs are required to determine the providers' clinical qualifications through the MCO's credentialing and recredentialing processes, including a review of the provider's medical education, special training, and work history and experience. The specialty and subspecialty providers shall (a) have experience in treating individuals within a special needs population; (b) have experience in interdisciplinary medical management; and (c) understand the relationship between somatic and behavioral health care issues and interventions.

For children with special health care needs, the Department requires the following process:

- The parent or guardian of a child may request approval from an MCO for a specific out-of-network specialty provider when the MCO does not have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same service and modality.
- If denied, the parent or guardian has the right to appeal to the Department, in accordance with the provisions of COMAR 10.09.72.
- If out-of-network services are terminated or reduced, and the parent or guardian exercises the right to appeal to the Department, MCOs must continue to cover the services during the appeal until the Office of Administrative Hearings issues its decision.

Source: COMAR 10.09.65.04, COMAR 10.09.65.05, SPR Standard 4.0

Coverage and Authorization of Services – 42 CFR §438.210

Identify, Define, and Specify the Amount, Duration, and Scope of Each Service
[42 CFR §438.210(a)(1)]

The Department requires MCOs to deliver all services described in the required benefits package in COMAR 10.09.67. Prior to joining the HealthChoice program, a MCO must include in its application written evidence of its preparedness to provide benefits equivalent to the benefit level mandated by Maryland.

Source: COMAR 10.09.64.06, COMAR 10.09.67, SPR Standard 7.0

<p style="text-align: center;">Ensure Services Are Furnished in an Amount, Duration, and Scope That Is No Less Than Those Furnished to Beneficiaries under Fee-For-Service Medicaid [42 CFR §438.210(a)(2)]</p>
<p>The Department requires MCOs to deliver all services described in the required benefits package in COMAR 10.09.67. Prior to joining the HealthChoice program, a MCO must include in its application written evidence of its preparedness to provide benefits equivalent to the benefit level mandated by the Department for the Medicaid program.</p> <p><i>Source: COMAR 10.09.64.06, COMAR 10.09.67, SPR Standard 7.0</i></p>
<p style="text-align: center;">Ensure Services Are Sufficient in Amount, Duration, and Scope to Reasonably Be Expected to Achieve the Purpose for Which the Services Are Furnished [42 CFR §438.210(a)(3)(i)]</p>
<p>The Department requires MCOs to submit and update a comprehensive utilization management program designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement. The plan must include, at a minimum, policies and procedures for referral processes, services requiring preauthorization, criteria for determining medical necessity, provider responsibilities for utilization management activities, case management processes; utilization tracking mechanisms, integration of activities with quality improvement for provider profiling, and appeals and grievance processes.</p> <p><i>Source: COMAR 10.09.64.06, SPR Standard 7.0</i></p>
<p style="text-align: center;">Ensure There Is No Arbitrary Denial or Reduction in Service Solely Because of Diagnosis, Type of Illness, or Condition [42 CFR §438.210(a)(3)(ii)]</p>
<p>The Department requires MCOs to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the participant’s condition or disease, and may not be arbitrarily based on diagnosis, type of illness, or condition.</p> <p><i>Source: COMAR 10.09.71.04</i></p>
<p style="text-align: center;">Place Appropriate Limits on a Service, Such as Medical Necessity [42 CFR §438.210(a)(3)(iii)]</p>
<p>The Department requires MCOs to specify criteria for utilization review decisions that are based on acceptable medical practice. MCOs must use appropriate mechanisms to assess the consistency with which physician and non-physician reviewers apply medical necessity criteria. MCOs must describe the mechanism or process for the periodic updating of the criteria and include participating provider involvement. The MCO must demonstrate its staff receives annual training on the interpretation and application of standards, and that it evaluates the consistency with which all staff involved applies utilization review criteria on an annual basis.</p> <p><i>Source: COMAR 10.09.62.01, COMAR 10.09.64.06, SPR Standard 7.2</i></p>
<p style="text-align: center;">Specify What Constitutes “Medically Necessary Services” [42 CFR §438.210(a)(4)]</p>
<p>In Maryland, “medically necessary” means that the service or benefit is directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition; consistent with current accepted standards of good medical practice; the most cost efficient service that can be provided without sacrificing effectiveness or access to care; and not primarily for the convenience of the participant, the participant’s family, or the provider.</p> <p><i>Source: COMAR 10.09.62.01</i></p>

<p>Ensure MCOs and Subcontractors Have Written Policies and Procedures for Authorization of Services [42 CFR §438.210(b)(1)]</p>
<p>The Department requires MCOs to have a comprehensive written utilization management program that specifies, at a minimum, policies and procedures for referral processes; services requiring preauthorization, including mechanisms for ensuring consistent application and requesting provider consultation when appropriate; criteria for determining medical necessity; provider responsibilities for utilization management activities; case management processes; utilization tracking mechanisms and the determination of over-utilization and under-utilization of health care services; integration of activities with quality improvement for provider profiling; and appeals and grievance processes.</p> <p><i>Source: COMAR 10.09.64.06, COMAR 10.09.71.04, SPR Standard 7.1, SPR Standard 7.4</i></p>
<p>Have Mechanisms to Ensure Consistent Application of Review Criteria for Authorization Decisions [42 CFR §438.210(b)(2)]</p>
<p>The Department requires MCOs to specify criteria for utilization review decisions that are based on acceptable medical practice. MCOs must use appropriate mechanisms to assess the consistency with which physician and non-physician reviewers apply medical necessity criteria.</p> <p><i>Source: COMAR 10.09.62.01, SPR Standard 7.2</i></p>
<p>Have Any Decision to Deny or Reduce Services Made by an Appropriate Health Care Professional [42 CFR §438.210(b)(3)]</p>
<p>The Department requires MCOs to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the participant’s condition or disease, and may not be arbitrarily based on diagnosis, type of illness, or condition.</p> <p><i>Source: COMAR 10.09.71.04</i></p>
<p>Notify Requesting Provider and Give Participant Written Notice of Any Decision to Deny or Reduce a Service Authorization Request, or to Authorize a Service in an Amount, Duration, or Scope That Is Less Than Requested [42 CFR §438.210(c)]</p>
<p>The Department requires MCOs to include 13 components in its letters for denial, reduction, or termination of care and/or services. The required adverse determination letter components include:</p> <ol style="list-style-type: none"> 1. Explanation of the requested care, treatment, or service. 2. Clear, full, and complete factual explanation of the reasons for the denial, reduction, or termination in understandable language. 3. Clear explanation of the criteria, standards, and interpretive guidelines the MCO used to make the decision. Use of the phrase “nationally recognized medical standards” is acceptable. 4. Description of any additional information the MCO needs for reconsideration. 5. Statement that the participant has access to his/her medical records. 6. Direction to the participant to call the Enrollee Help Line (EHL) to discuss the participant’s right to appeal if he/she disagrees with the MCO’s decision. This direction should appear prior to any direction to call the MCO. 7. Explanation to the participant that if he/she calls the EHL or the MCO within 10 days of receiving the adverse action letter, he/she may continue to receive the ongoing services that he/she is currently receiving and may have to pay. 8. Statement that the participant may represent self or use legal counsel, a relative, a friend, or other spokesperson. 9. Explanation that it is assumed a participant receives the letter five days after it is dated unless he/she shows evidence otherwise. 10. Explanation that the EHL staff will investigate the MCO decision, resolve within 10 days, or provide information about how to request a Fair Hearing. 11. Evidence that the letter is copied to the PCP. 12. Statement explaining the availability of the expedited review process. 13. Statement of availability of the letter in other languages and alternate formats.

<p><i>Source: COMAR 10.09.71.04, SPR Standard 7.5</i></p>
<p>Provide for Authorization Decisions and Notices [42 CFR §438.210(d)]</p>
<p>The Department requires that notice of decision to deny initial services must be provided to the participant within 24 hours for emergency, medically related requests, and not more than 72 hours for non-emergency, medically related requests. For any previously authorized service, written notice to the participant must be provided at least 10 days prior to reducing, suspending, or terminating a covered service.</p>
<p><i>Source: COMAR 10.09.71.04, SPR Standard 7.4</i></p>
<p>Ensure Compensation to Individuals or Entities That Conduct Utilization Management Activities Does Not Provide Incentives to Deny, Limit, or Discontinue Medically Necessary Services [42 CFR §438.210(e)]</p>
<p>The Department requires MCOs to present documentation that compensation is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any participant.</p>
<p><i>Source: SPR Standard 7.1</i></p>

Structure and Operations Standards

Provider Selection – 42 CFR §438.214

<p>Written Policies and Procedures for Selection and Retention of Providers [42 CFR §438.214(a)]</p>
<p>The Department requires MCOs to have written policies and procedures for selection, recruitment, and retention of providers in the HealthChoice Program. Policies and procedures should be directed at ensuring that recipient choice is enhanced by providers participating in multiple MCOs. Also, MCOs should work to ensure that its providers are retained within the Medicaid network.</p>
<p><i>Source: COMAR 10.09.65.02, SPR Standard 4.10</i></p>
<p>Uniform Credentialing and Recredentialing Policy That Each MCO Must Follow [42 CFR §438.214(b)(1)]</p>
<p>The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process. The Credentialing Plan designates a Credentialing Committee or other peer review body that makes recommendations regarding credentialing decisions. The Credentialing Plan must identify the practitioners who fall under its scope of authority and action. The Credentialing Plan must include policies and procedures for communication with providers regarding provider applications within the time frames specified by Maryland Insurance law. The type of credentialing application must be the Maryland Uniform Credentialing Application or its equivalent, be reviewed, and be in compliance with Maryland Insurance Administration regulations.</p>
<p><i>Source: COMAR 10.09.65.02, COMAR 31.10.26.03, Md. Code Ann. Ins. Law §15-112, SPR Standard 4.0</i></p>
<p>Documented Process for Credentialing and Recredentialing That Each MCO Must Follow [42 CFR §438.214(b)(2)]</p>
<p>The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process, identifies the practitioners who fall under its scope of authority and action, and includes communication with providers regarding provider applications within the time frames specified by Maryland Insurance law. The type of credentialing application must be the Maryland Uniform Credentialing Application or its equivalent and be in compliance with Maryland Insurance Administration regulations.</p>
<p><i>Source: COMAR 10.09.65.02, COMAR 31.10.26.03, Md. Code Ann. Ins. Law §15-112, SPR Standard 4.0</i></p>

Provider Selection Policies and Procedures Do Not Discriminate Against Providers Serving High-Risk Populations or Specialize in Conditions That Require Costly Treatment

[42 CFR §438.214(c)]

MCOs shall establish a mechanism, subject to Department approval, which provides for an equitable distribution of participants and which ensures a provider shall not receive a disproportionate number of participants.

Source: Md. Code Ann. Health-Gen. Law §15-102.5, COMAR 10.09.65.02

MCOs May Not Employ or Contract with Providers Excluded from Federal Health Care Programs

[42CFR §438.214(d)]

MCOs must have policies and procedures in place for the suspension, reduction, or termination of practitioner privileges. There must be a documented process for and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner.

MCOs must request from recognized monitoring organizations information about the practitioner. They must check for any revocation of suspension of a State license or a Drug Enforcement Agency/Bureau of Narcotics and Dangerous Drugs number, any curtailment or suspension of medical staff privileges (other than for incomplete medical records), any sanctions imposed by Medicare and/or Medicaid, and information about the practitioner from the National Practitioner Database and the appropriate Maryland board.

Source: COMAR 10.09.36.03, HCQIS IX E.8-12, SPR Standard 4.2, SPR Standard 4.5

Participant Information – 42 CFR §438.218

Participant Information Must Incorporate the Requirements of 42 CFR § 438.10

[42 CFR §438.218]

Maryland requires MCOs to write participant information that is readable and easily understood. This information must be available in the prevalent non-English languages identified by the Department. Currently, Maryland has determined that Spanish is the prevalent language in which the MCOs must make vital materials available to participants. These types of information include but are not limited to the participant handbook, newsletters, and health education materials. All materials must be written at the appropriate reading comprehension level for the Medicaid population. The SMOG readability formula or the Flesch-Kincaid Grade Level Index will be applied to determine readability.

Source: COMAR 10.09.65.02, COMAR 10.09.66.01, SPR Standard 5.2

Confidentiality – 42 CFR §438.224

Confidentiality [42 CFR § 438.224]
<p>Upon joining the Maryland HealthChoice Program, every MCO is responsible for signing a standard Department-issued Business Associate Agreement. The Business Associate Agreement requires MCOs to comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Maryland Confidentiality of Medical Records Act (MCMRA). A copy of the Business Associate Agreement is included as Appendix C.</p> <p>To protect the privacy of HealthChoice participants, the MCO must:</p> <ul style="list-style-type: none">• Have established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data.• Ensure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO.• Hold confidential all information obtained by its personnel about participants related to their care and not divulge it without the participant’s authorization unless: (1) required by law, (2) necessary to coordinate the patient’s care, or (3) necessary in compelling circumstances to protect the health or safety of an individual.• Ensure that the release of any information in response to a court order is reported to the patient in a timely manner.• Have policies concerning the disclosure of participant records, with or without the participant’s authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual participant in any report of research or otherwise disclose participant identity in any manner. <p><i>Source: COMAR 10.09.65.02, State of Maryland Business Associate Agreement, SPR Standard 5.3</i></p>

Enrollment and Disenrollment – 42 CFR §438.226

The Department Complies with the Enrollment and Disenrollment Requirements and Limitations in 42 CFR §438.56 [42 CFR §438.226]
<p>Upon determination of Medicaid eligibility, the Department shall enroll eligible individuals into an MCO by:</p> <ul style="list-style-type: none">• Mail;• Telephone;• Face-to-face meeting, if requested; or• Face-to-face meeting in the recipient's home, if medically necessary. <p>Regarding the enrollment of children:</p> <ul style="list-style-type: none">• A newborn shall be automatically enrolled from birth in its biological mother's MCO. The MCO is responsible for the newborn's health care from birth until the newborn enrolls into another MCO, except if the newborn is hospitalized at the time of enrollment into the new MCO, in which case the original MCO is responsible for the hospitalization.• The following children shall be automatically enrolled in the MCO of the adoptive parent unless the parent notifies the Department otherwise:<ul style="list-style-type: none">○ A child who has been legally adopted;○ A child who is the subject of a petition for adoption who has been placed in the participant's home with the expectation that the placement will be permanent, and for whom a temporary custody order has been issued by a court of competent jurisdiction pending finalization of the child's adoption by the participant; or○ A child who is the subject of a petition by a licensed adoption agency for the termination of parental rights, and who has been placed in the participant's home by the licensed adoption agency with the expectation that the placement will be permanent and that the child will be legally adopted by the participant.

A participant may disenroll from an MCO and enroll into another MCO if:

- The participant moves to a county that is not served by the participant's present MCO;
- The family members are enrolled in different MCOs and the adult participant requests that other family members be enrolled in one of the MCOs in which another family member is currently enrolled;
- The participant requests enrollment into the MCO that contracts with the PCP of any other family member who is not a HealthChoice participant;
- The participant moves or becomes homeless, creating a transportation hardship that may be resolved by enrollment into another MCO serving the participant's new local access areas;
- The participant requests a change of MCO within 90 days after the termination of the participant's PCP's contract if the PCP's contract with the participant's MCO, MCO's medical management group, or its subcontractors is terminating for the following reasons:
 - By the MCO for reasons other than the quality of care or the PCP's failure to comply with contractual requirements related to quality assurance activities; or
 - The MCO's reduction of PCP's reimbursement to the extent that the reduction in rate is greater than the actual change in capitation paid to the MCO by the Department, and the MCO and PCP's inability to negotiate a mutually acceptable rate.

Source: COMAR 10.09.63.02, COMAR 10.09.63.06

Grievance Systems – 42 CFR §438.228

Grievance System Meets the Requirements of 42 CFR Part 438, Subpart F

[42 CFR §438.228(a)]

Maryland requires MCOs to have written procedures in place for registering and responding to grievances. The grievance system requires documentation of the substance of the grievances and steps taken. The system must ensure that the resolution of a grievance is documented according to policy and procedure. The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for quality improvement. MCOs must provide documented evidence that this process is in place and is functioning.

The MCO must also have a documented appeals process. The participant must be able to present his/her case to the MCO's CEO or his/her designee as the final level of grievance process. The policies and procedures must describe what types of information will be collected when grievances are recorded and processed. The MCO must have a grievance form. The policies and procedures must include the process stating how the form is used and how a participant can get assistance from the MCO in completing the form.

Timeframes for resolving grievances in the policy and procedure must be in accordance with the following:

- Emergency medically related grievances not > 24 hours.
- Non-emergency medically related grievances not > 5 days.
- Administrative grievances not > 30 days.

Source: COMAR 10.09.71.02, COMAR 10.09.71.04, SPR Standard 5.1

Random State Reviews of Notice of Action Delegation to Ensure Notification of Participants in a Timely Manner

[42 CFR §438.228(b)]

The Department requires its EQRO to review a sample of selected grievances during the SPR to ensure that the process is complete and is being followed for compliance with the required time frames. The Department also requires MCOs to submit quarterly and annual appeals and grievance reports for departmental review.

Source: COMAR 10.09.65.15, SPR Standard 5.1

Subcontractual Relationships and Delegation – 42 CFR §438.230

<p>Each MCO Must Oversee and Be Accountable for Any Delegated Functions and Responsibilities [42 CFR §438.230(a)]</p>
<p>When delegating or subcontracting functions, services, or responsibilities, the MCO retains a primary duty to the HealthChoice program and to its participants to ensure that its subcontractor delivers the required services in a manner that is consistent with HealthChoice requirements. The MCO remains accountable for all functions, even if certain functions are delegated to other entities.</p> <p><i>Source: COMAR 10.09.65.17, SPR Standard 3</i></p>
<p>Before Delegation, MCO Must Evaluate Prospective Subcontractor’s Ability to Perform [42 CFR §438.230(b)(1)]</p>
<p>The Department requires MCOs to submit its subcontracting policies for review prior to joining the HealthChoice program. Its written procedures for delegation are also reviewed during the annual SPR, to ensure the MCO is monitoring and evaluating the implementation of the delegated functions and verifying the quality of care being provided.</p> <p><i>Source: COMAR 10.09.64.07, COMAR 10.09.65.17, SPR Standard 3.2</i></p>
<p>Written Agreement That Specifies the Activities and Report Responsibilities Delegated to the Subcontractor; Provides for Revoking Delegation or Imposing Other Sanctions if Subcontractor Performance Is Inadequate [42 CFR §438.230(b)(2)]</p>
<p>The Department requires MCOs to include a minimum of the following 11 contractual provisions with its subcontractors:</p> <ol style="list-style-type: none"> 1. The subcontractor is subject to all of the requirements that the MCO is subject to under its contract with the Department and pursuant to the Department's regulations; 2. A clear description of the services to be performed under the subcontract; 3. The subcontractor must release to the MCO and to the Department, upon request, any information necessary for the MCO to perform any of its contractual and regulatory obligations under its contract with the Department, including, but not limited to, its records, reporting, and quality assurance duties; 4. The subcontractor's facilities and records must be open to inspection by the MCO, the Department, and other government agencies, and the subcontractor is subject to all audits and inspections to the same extent that audits and inspections may be required of the MCO under law or under its contract with the Department; 5. Copies of the subcontractor's medical records pertaining to the MCO's participants shall be furnished to the MCO upon request for transfer to a subsequent provider in the event of a termination of the subcontract; 6. No termination of the subcontract shall be effective without prior written notice to the Department; 7. The subcontractor will look solely to the MCO for compensation for covered services provided to the MCO's participants under the subcontract; 8. Evidence of the subcontractor's professional liability coverage must be submitted annually to the MCO; 9. No assignment of the subcontract by the subcontractor is effective without prior written notice to the Department; 10. If authorized by the MCO to make referrals, the subcontractor is required to use the uniform consultation referral form adopted by the Maryland Insurance Administration; and 11. Each provision of the subcontract that is required under this section supersedes and controls over any conflicting terms that appear in the subcontract. <p>Delegated agreements are reviewed during the annual SPR to ensure the minimum terms are present.</p> <p><i>Source: COMAR 10.09.65.17, SPR Standard 3.3</i></p>

<p>Monitoring of Subcontractor Performance on an Ongoing Basis [42 CFR §438.230(b)(3)]</p>
<p>The Department requires the MCOs to engage in continuous and ongoing evaluation of its delegated activities. In the annual SPR, MCOs must present evidence that an appropriate committee or body within the organization makes process improvement decisions and acts upon the conclusions drawn from delegated entity monitoring, according to the MCO’s internal policies and procedures and/or the terms set forth in the delegate’s contract. There must be review and approval of reports submitted, oversight of the delegated entity’s performance, and review and approval of function-specific plans and procedures.</p> <p><i>Source: Md. Code Ann. Ins. Law §15-1004, Md. Code Ann. Ins. Law §15-1005, COMAR 10.09.65.17, COMAR 31.10.11, COMAR 31.10.23.01, SPR Standard 3.3</i></p>
<p>Corrective Action for Identified Deficiencies or Areas of Improvement [42 CFR §438.230(b)(4)]</p>
<p>The Department requires MCOs to have policies and procedures in place to monitor and evaluate the implementation of the delegated functions and verify the quality of care being provided. Performance monitoring areas include, but are not limited to, participant and provider complaints, access issues, quality assurance activities, record keeping, and reporting requirements. In the annual SPR, MCOs must present evidence that an appropriate committee or body within the organization makes process improvement decisions and acts upon the conclusions drawn from delegated entity monitoring, according to the MCO’s internal policies and procedures and/or the terms set forth in the delegate’s contract.</p> <p><i>Source: COMAR 10.09.65.17, SPR Standard 3.2, SPR Standard 3.3</i></p>

Measurement and Improvement Standards

This section discusses the standards Maryland has established for MCOs through contract provisions and State regulations for measurement and improvement, as required by 42 CFR Part 438, subpart D. These standards relate to the overall objectives for the Maryland HealthChoice Program.

Practice Guidelines - 42 CFR §438.236

<p>Ensure Practice Guidelines Are Based on Valid and Reliable Clinical Evidence or a Consensus of Health Care Professionals in the Particular Field; Consider the Needs of Participants; Are Adopted in Consultation with Contracting Health Professionals; and Are Reviewed and Updated Periodically, As Appropriate [42 CFR §438.236(b)]</p>
<p>The Department requires MCOs to specify criteria in its utilization review plan for its decisions. The criteria must be based on acceptable medical practice, describe the mechanism or process for periodic updating of criteria, and describe the involvement of participating providers in review and updating criteria.</p> <p><i>Source: COMAR 10.09.64.06, SPR Standard 7.2</i></p>
<p>Disseminate Practice Guidelines to All Providers, and Upon Request, to Participants [42 CFR §438.236(c)]</p>
<p>The Department requires MCOs to submit its plan for distributing practice guidelines to providers. During the annual SPR, MCOs must provide evidence that guidelines are included in provider manuals or disseminated to the providers as they are adopted.</p> <p><i>Source: COMAR 10.09.64.09, SPR Standard 1.3</i></p>

Quality Assessment and Performance Improvement Program – 42 CFR §438.240

<p>Have an Ongoing Quality Assessment and Performance Improvement Program [42 CFR §438.240(a)] §438.240</p>
<p>The Department requires MCOs to have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services delivered to enrollees including individuals with special health care needs. This program must comply with all federal and state laws and regulations, comply with all access and quality standards and levels of performance established for the HealthChoice program, be able to provide the Department with accurate information, and identify and manage individuals with special health care needs. The MCO’s quality assurance plan must objectively and systematically monitor and evaluate the quality of care and services to participants, through quality of care studies and related activities. It also must pursue opportunities for improvement on an ongoing basis.</p> <p><i>Source: COMAR 10.09.65.03, SPR Standard 1.0</i></p>
<p>Conduct PIPs and Measure and Report Its Performance to Maryland [42 CFR §438.240(b)(1); 42 CFR §438.240(d)]</p>
<p>The Department requires MCOs to conduct performance improvement projects that focus on clinical or nonclinical areas and include measurement of performance using quality objective indicators, implementation of system interventions to achieve improvement in quality, evaluation of effectiveness of interventions, planning and initiation of activities to sustain improvement, and reporting of results to the Department.</p> <p><i>Source: COMAR 10.09.65.03, SPR Standard 1.0</i></p>
<p>Measure and Report Performance Measurement Data As Specified by Maryland [42 CFR 438.240(b)(2)]</p>
<p>The Department requires MCOs to participate in all quality assessment activities required by the Department in order to determine if the MCO is providing medically necessary participant health care. These activities include, but are not limited to, the annual SPR, HEDIS[®] and CAHPS[®] participation, the Value Based Purchasing Initiative, and PIPs. This information must be reported to the Department.</p> <p><i>Source: COMAR 10.09.65.03</i></p>
<p>Have Mechanisms to Detect Both Underutilization and Overutilization of Services [42 CFR 438.240(b)(3)]</p>
<p>The Department requires MCOs to have the ability at a minimum to provide accurate information about utilization of services. Upon joining the HealthChoice program, the MCO must provide its proposed utilization management program, which includes policies and procedures for utilization tracking mechanisms and the determination of over-utilization and under-utilization of health care services. In the annual SPR, these policies and procedures must result in reports and data analysis that provide the ability to identify problems and take appropriate corrective action. If corrective measures are needed, the MCOs must demonstrate the ability to develop, implement, and follow up on corrective actions for identified issues. The MCOs must also maintain a comprehensive fraud and abuse monitoring program.</p> <p><i>Source: COMAR 10.09.64.06, COMAR 10.09.65.03, SPR Standard 7.3, SPR Standard 11.0</i></p>
<p>Have Mechanisms to Assess the Quality and Appropriateness of Care Furnished to Participants with Special Health Care Needs [42 CFR 438.240(b)(4)]</p>
<p>Through their required quality assessment and outreach plans, MCOs must provide the Department with their approaches to identifying and managing patients with special health care needs, which include but are not limited to participants with HIV, pregnant women, participants with disabilities, adult participants with diabetes, pediatric participants with asthma, and/or children with special health care needs.</p> <p><i>Source: COMAR 10.09.65.03, SPR Standard 10.0</i></p>

Comply with Maryland’s Annual Review of Each Quality Assessment and Performance Improvement Program

[42 CFR 438.240(e)]

The Department requires MCOs to participate in all quality assessment activities required by the Department in order to determine if they are providing medically necessary participant health care. These activities include but are not limited to an SPR performed by the EQRO hired by the department to assess and MCO’s structure and operations in order to provide health care to its participants.

Source: COMAR 10.09.65.03, SPR Standard 1.0

Health Information Systems – 42 CFR §438.242

Maintain a Health Information System That Can Collect, Analyze, Integrate, and Report Data and Provide Information on Areas Including, But Not Limited to, Utilization, Grievances and Appeals, and Disenrollments for Causes Other Than Loss of Medicaid Eligibility

[42 CFR §438.242(a)]

The Department assesses the viability of the MCO’s Health Information System when the MCO submits its initial application. The MCO must provide a description of its management information system, including but not limited to capacities, software, characteristics, and the ability to interface with other systems. The information system must also ensure inclusion in the medical record of reports of health care services or diagnostic testing performed in a referral setting. In addition, the MCO must describe whether manual or automated processes will be used to track participants' complaints, determine any patterns of complaints, and report findings to the proposed MCO's quality assurance or quality improvement system.

Source: COMAR 10.09.64.09, COMAR 10.09.64.11

Collect Data on Participant and Provider Characteristics and on Services Furnished to Participants

[42 CFR §438.242(b)(1)]

During the initial application process and review of the MCOs health information system, the MCO must show evidence of its ability to collect and report all data necessary to derive indicators for HEDIS report cards. Also, the Department requires the MCOs to generate and submit the following information:

- Encounter data monthly, reflecting 100% of provider-participant encounters, in CMS1500 and UB04 format or an alternative format previously approved by the Department
- Open PCP panel reports monthly
- Updated list of the PCP's assigned participants must be sent to each PCP at least monthly
- Quarterly pre-service denials or reduction of services or benefits issued by the MCO or MCO subcontractors during the preceding quarter

Source: COMAR 10.09.64.11, COMAR 10.09.65.15

Ensure Data Received Is Accurate and Complete

[42 CFR §438.242(b)(2)]

The Department requires MCOs to identify to the Department any inaccuracies it or its subcontractor reported in encounter data within 30 days of discovery. MCOs also must participate in the electronic enrollment reconciliation process to identify discrepancies in enrollment data between the Department and the MCO. MCOs are also required to participate in the annual encounter data validation review conducted by the EQRO.

Source: COMAR 10.09.65.02, COMAR 10.09.65.15

SECTION IV: IMPROVEMENT AND INTERVENTIONS

Improving Quality of Care through Interventions

The following section describes, based on the results of assessment activities, how Maryland will attempt to improve the quality of care delivered by MCOs through interventions.

1115 Waiver

As described earlier in the strategy, HealthChoice is Maryland's statewide mandatory Medicaid managed care program. The program was implemented in 1997 under authority of a waiver through Section 1115 of the Social Security Act. This initial waiver was approved for five years. In January 2002, the Department completed a comprehensive evaluation of HealthChoice as part of the first 1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during the final year without managed care (fiscal year 1997). CMS approved the most recent waiver renewal in 2013. Maryland has taken the following actions under Section 1115 waiver authority:

- Maryland implemented the Primary Adult Care (PAC) program. PAC offered limited benefits to childless adults aged 19 years and older who were not eligible for Medicare or Medicaid and whose incomes were at or below 116% of the FPL. The Department began using HEDIS[®] measures to evaluate health outcomes in the PAC program in CY 2008. As a result of the Medicaid expansion option in the ACA, the PAC program transitioned into a categorically-eligible Medicaid population on January 1, 2014. Childless adults under the age of 65 years and with incomes up to 138% of the FPL now receive full Medicaid benefits, and services are provided through HealthChoice MCOs.
- Maryland extended full Medicaid eligibility to parents and caretaker relatives of children enrolled in Medicaid or MCHP with household incomes below 116% of the federal poverty level (FPL) in July 2008. Enrollment in this expansion program increased from 7,832 enrollees in July 2008 to 100,963 enrollees in December 2012.
- In 2011, Maryland began a three-year pilot program to test the use of a patient-centered medical home (PCMH), called the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP). The MMPP provides Maryland patients with many services, such as integrated care plans, chronic disease management, medication reconciliation at every visit, and same-day appointments for urgent matters. Across Maryland, 52 primary practices, multispecialty practices, and federally qualified health centers participate in MMPP. These practices are paid through HealthChoice MCOs and private insurance carriers, depending on their patient population. The Maryland Health Care Commission completed the evaluation of the pilot in October 2014.¹²
- Maryland continues to cover pregnant women with income up to 250% of the FPL. Women with incomes between 138% and 250% of the FPL are eligible for health care coverage through qualified health plans. Once pregnant, women within these income groups can choose to receive their services through their qualified health plan or

¹² To read the MMPP evaluation, please visit the following link:
http://mhcc.maryland.gov/mhcc/pages/plr/plr_pcmh/documents/PCMH_Practice_Evaluation.pdf

Medicaid. Their Medicaid eligibility continues through 60 days of postpartum care and includes full Medicaid benefits. Pregnant women also receive dental services through Medicaid.

Chronic Health Homes

In the FY 2013 budget, the Maryland General Assembly set aside funds for the development of a chronic health home demonstration to take advantage of the opportunity in Section 2703 of the ACA. Section 2703 allows states to amend their Medicaid State Plans to offer health homes that provide comprehensive systems of care coordination for participants with two or more defined chronic conditions. The Department received approval for its Chronic Health Homes program from CMS on September 27, 2013. Eligibility for Maryland's chronic health home services will extend to individuals diagnosed with a serious and persistent mental illness, children diagnosed with a serious emotional disturbance, or individuals diagnosed with an opioid substance use disorder (SUD) along with being at-risk for another chronic condition based on tobacco, alcohol, or other non-opioid substance use.

Chronic health homes include psychiatric rehabilitation programs (PRPs), mobile treatment services, and opioid maintenance therapy programs. Maryland requires interested sites to enroll as Medicaid providers, receive health home accreditation, and demonstrate capabilities to comply with data collection, reporting, and other technological activities. Providers receive payments per member per month for performing care management activities related to preventive care and health promotion, coordination of care, disease self-management, discharge planning, and patient monitoring, among other activities. Maryland will evaluate providers based on a combination of monitoring hospital and emergency department (ED) admissions, cost savings, HEDIS[®] measures, and other State-developed measures. The Health Homes went into effect on October 1, 2013.

Million Hearts

The Department is partnering with the Center for Chronic Disease Prevention and Control (CCDPC) in their Million Hearts effort. Million Hearts in Maryland set out to improve clinical and community linkages through the use of community health workers and community referrals. By June 30, 2014, its goal was to decrease ED visits for high blood pressure by 5% and to improve blood pressure control by 5% among residents in Baltimore City, Cecil, St. Mary's and Washington Counties, especially among low-income and/or uninsured individuals.

Community health workers identified hypertensive patients in one FQHC from each jurisdiction, and they worked with that site to decrease the ED visits within that population.

The Department already collects a number of measures pertaining to the Million Hearts efforts around hypertension, asthma, diabetes, and smoking cessation through its quality improvement activities. Maryland shares this data with CCDPC.

HealthChoice's role in the Million Hearts Initiative is to:

- Identify hypertensive patients and establish a baseline for medication adherence among this population.
- Connect with Rare and Expensive Case Management (REM) caseworkers to initiate conversations with participants about smoking cessation and hypertension.
- Link with MCOs to inform them of the Million Hearts Initiative and encourage them to promote the use of case managers more frequently for hypertensive patients.

CCDPC received additional funding to continue its Million Hearts Initiative efforts in Maryland until June 2015. This funding will be provided to MCOs for improving outreach or developing special projects around hypertension awareness and control. The Department and CCDPC will also reach out to local health departments to see how many offices have the resources (interest, staffing, time, etc) to target Medicaid FFS recipients for outreach and possible care coordination assistance.

State Innovation Models Grant

The State Innovation Models (SIM) Initiative provides support to states for the development and testing of models to transform payment and healthcare delivery systems. Its aim is to improve healthcare system performance for residents of the participating states.

Maryland was awarded up to \$2.3 million in the first round of the model design program of the SIM Initiative. The Department sought to expand Maryland's community integrated medical homes (CIMH) model by partnering with healthcare providers and community health organizations. The CIMH model focuses on preventative health care and management rather than urgent intervention of serious medical issues. The CIMH model would improve quality of care by reducing the severity of illnesses at the time of treatment, working with patients to avoid preventable illnesses, and detecting other illnesses in early stages. This payment model aligns hospital incentives with community and primary care efforts to improve health by rewarding hospitals when they prevent avoidable admissions. By 2017, the All-Payer Hospital System Modernization will require the Department to submit to CMS a plan to move away from hospital-focused success tests to a total cost of care success test.

With the help of the SIM planning grant, Maryland developed the capacity to use its data resources for community health assessment and planning. Maryland's health information exchange (HIE), known as the Chesapeake Regional Information System for our Patients (CRISP), accesses data in real time from all of Maryland's acute care hospitals and emergency departments. It provides real-time admission data to primary care clinicians thousands of times a day via secure email, in order to improve communication between hospitals and PCPs.

CRISP can also access and report claims data through the all-payer claims database (APCD), which contains health services, prescription drug, and eligibility data from Medicare and all private health insurance carriers in the state. Maryland is working towards integrating the HIE with MMIS claims data and electronic Clinical Quality Measures (eCQMs) from providers who participate in quality-reporting initiatives, potentially including those described in the SIM grant.

Another initiative started with the SIM grant is the State Health Improvement Program (SHIP). SHIP is designed to leverage data from health reporting systems, including Medicaid claims, Maryland Behavioral Risk Factors Surveillance System Survey data, Youth Tobacco and Risk Behavior Survey data, and the Pregnancy Risk Assessment Monitoring System data. These health reporting systems create and track a number of new health measures with targets based on national benchmarks. These measures are included in Appendix D.

With the successes attained via the first SIM grant, Maryland submitted a proposal for Round 2 of the SIM model design grant. While Maryland's SIM proposal was ultimately not funded at the level anticipated, Maryland plans to leverage the investments made during the design phase to support the hospital waiver, increase patient satisfaction and the quality of care, and decrease unnecessary health care costs.

Maryland Quitline

The Maryland Quitline (1-800-QUIT-NOW) started in June 2006 and is a free and confidential call-in service provided to Maryland residents to aid in tobacco cessation. The Quitline is voluntary and provides coaching services as well as nicotine replacement therapy to registered callers. The Quitline receives an average of 23,000 inbound calls per year. It improves Medicaid quality of care by mitigating the risks associated with tobacco use.

In December 2012, the Department made improvements to the Maryland Quitline, which includes Web Coach, an online service made available to participants. With Web Coach, a participant gets a personalized smoking cessation program tailored to their needs. Additionally, a participant can order a free 4-week course of nicotine replacement therapy. Each participant has unlimited access to information about the risks of smoking; the benefits of smoking cessation; and the motivation, feedback, and consultation from their Quit Coach.

Another improvement to the Maryland Quitline is Text2Quit, an outreach program designed to use text messaging to send participants tips, encouragement, and information that would be useful to smoking cessation. The concept behind this innovative program is to ensure participants remain motivated throughout the smoking cessation process. Additionally, the Quitline has developed targeted counseling services for teens ages 13-17 and an intensive support program for pregnant women.

Since the program's inception, the Maryland Quitline has also increased its call-in service availability. The call-in portion of the program is now outfitted to be a 24/7 hotline. Callers can reach a live Quit Coach at any time of any day.

CHIPRA Bonus Payments

Maryland received three performance bonus payments from CMS, authorized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Bonus payments are granted to states that implemented at least five CMS-identified initiatives known to promote enrollment and retention in coverage for children and have demonstrated a significant increase in Medicaid enrollment among children. Maryland's first bonus payment was \$10.5 million for

federal fiscal year (FFY) 2010, and the bonus payment was \$28.0 million for FFY 2011. Maryland received \$36.5 million for FFY 2012.

Intermediate Sanctions – 42 CFR 438.204(e)

HealthChoice Program and Intermediate Sanctions – 42 CFR §438.204(e)

The Department's sanction authority is described in COMAR 10.09.73. The Department has the discretion to impose sanctions if the MCO fails to comply with any law, regulation, or contract term. The Department may also sanction a MCO if it has other good cause reasons to do so. Examples of sanctions include fines, suspension of further enrollment, withholding all or part of the capitation payment, termination of the provider agreement, and/or disqualification from participating in the HealthChoice program. The Department can also require an MCO to submit and complete a corrective action plan if it violates HealthChoice provisions. The MCO has the right to appeal any sanctions imposed by the Department. The Department also complies with all notification requirements to CMS after making sanction determinations.

Methodology for Using Intermediate Sanctions

The HealthChoice program has developed a performance monitoring policy. Beginning in calendar year 2013, the Department notified MCOs that it may impose enforcement options on MCOs that demonstrate consistent issues. The Department monitors network adequacy, HEDIS[®] performance, report submission compliance, and the systems performance review results. There are three levels of issues on which the Department may take action: minor, moderate, and major. Minor issues may take place within the span of a calendar year. Moderate issues are problems tracked for consecutive calendar years. Major issues are persistent, or when a MCO has not demonstrated improvement over multiple years. An example of a major issue is when an MCO fails to implement a CAP recommended by the Department fully. The Department considers the severity of the problem when deciding to sanction an MCO.

For minor issues, the Department may require the MCO to submit and complete a CAP or to pay a small fine. Moderate issues may result in submitting a CAP and freezing auto-assignment of participants to the MCO. Major issues may result in permitting participants to switch voluntarily to another MCO, freezing voluntary and auto-assigned enrollment in geographic areas, reducing capitation payments, or contract termination. The MCO is notified in writing of all actions taken by the Department. COMAR 10.09.73 also outlines the MCO's rights to appeal sanctions issued by the Department.

Health Information Technology

Maryland's Information Systems and the Quality Strategy – 42 CFR §438.204(f)

To support initial and ongoing operation and review of the State's quality strategy, Maryland is in the process of updating its antiquated Medicaid Management Information System (MMIS) with a modern, web-based system with decision support and Surveillance and Utilization Review Services (SURS) capabilities, public health repositories, and Health Information Exchange. When completed, this system will allow for closer monitoring of recipient services and quality

outcomes, using built-in and add-on decision support and SURS systems. The State plans to incorporate a data warehouse that integrates MMIS claims data with quality reporting from the Health Information Exchange (HIE) and electronic Clinical Quality Measures (eCQMs) from providers participating in the Electronic Health Record (EHR) Incentive Program, the State's Patient Centered Medical Home (PCMH), and other quality-reporting initiatives, such as those described in the section on the State Innovations Model (SIM).

To monitor diseases and track vaccine reporting, Maryland collects provider data from the National Electronic Disease Surveillance System (NEDSS), the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE), and ImmuneNet. Maryland is in the process of connecting all these systems to the HIE. Once Maryland implements its updated MMIS, HealthChoice and the fee-for-service programs will be able to collect and report on this information as it applies to its providers.

Maryland continues to make progress towards a fully self-sustaining HIE. Since 2009, the Chesapeake Regional Information System for Our Patients (CRISP), a not-for-profit membership corporation, has been the state-designated HIE. Information available through CRISP includes lab results, radiology reports, discharge summaries, consultation notes, history and physical notes, operative notes, and secure clinical messaging and referrals, among other things. CRISP also serves as a conduit and provider access point for Maryland's Prescription Drug Monitoring Program (PDMP). Additionally, the HIE receives information about ER visits and inpatient admissions in real time from all Maryland hospitals through the Encounter Notification Service (ENS). These systems help providers avoid unnecessary procedures, medical mistakes, and costly medical bills. As the user base grows, the HIE will begin accepting eCQMs, which will be the cornerstone for quality-based differential payments within the Maryland Medicaid program.

Health Information Technology Initiatives Supporting the Quality Strategy

Statewide Health Information Exchange (HIE)

Maryland uses master patient and provider indices that link all patient and provider information to unique identifiers that span the entire HIE. The master patient index (MPI) houses roughly 4 million unique identities.

The HIE allows for analytical reporting, "hot-spotting" of overuse or misuse of medical services, and use of data for public health and biosurveillance. Maintaining databases of anonymized health information provides opportunity for State-directed quality improvement initiatives aimed at identifying best practices, defining evidence-based practices, and developing care management plans.

Connecting public programs to the HIE is integral to improving health care quality, safety, and efficiency. Exchanging electronic patient information through the HIE will help improve delivery and coordination of care for all Medicaid recipients.

Clinical Quality Reporting

Maryland is implementing a streamlined clinical quality reporting strategy, which includes provider and EHR vendor use of the open-source software, popHealth. popHealth can integrate with a provider’s EHR to report clinical quality measures to the HIE. The software allows for individual and state-level data dashboards on quality and empowers providers to understand and analyze their patient population’s health, as well as meet meaningful use reporting objectives.

As part of this strategy, Maryland developed a core set of quality metrics, which will allow for enhanced quality monitoring and improvement at the practice level. Initially, reporting requirements will only include claims-based measures. Requiring claims-based reporting will allow input from all practices without adding administrative burden. In the future, reporting requirements will expand to include clinically-enriched measures and clinical measures once CRISP is able to report them. Clinically-enriched measures differ from claims-based measures, as they incorporate lab values. Clinical measures are typically found in medical records rather than in claims. As of now, CRISP lacks functionality to report these types of metrics, but will be able to do so in the future.

Currently, CRISP can access and report claims-based data through the all-payer claims database (APCD) or hospital utilization data.

Minimum Core Metric Set

ADULTS	
MEASURE DESCRIPTION	METRIC TYPE
Use of Imaging for Low Back Pain	Claims-based
Preventable Hospitalizations – AHRQ PQI	CRISP-generated
Body Mass Index (BMI) Screening and Follow-Up	Clinical
Influenza Immunization	Claims-based
Pneumococcal Vaccination for Patients 65 Years and Older	Claims-based
Breast Cancer Screening	Claims-based
Colorectal Cancer Screening	Claims-based
Tobacco Use Assessment & Tobacco Cessation Intervention	Clinical
Coronary Artery Disease Composite: ACE Inhibitor or ARB Therapy - Diabetes or LVSD	Claims-based
Coronary Artery Disease: Oral Antiplatelet Therapy Prescribed for Patients with CAD	Claims-based
Coronary Artery Disease Composite: Lipid Control	Clinically-enriched
Coronary Artery Disease : Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction	Claims-based
Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction	Claims-based
Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic	Clinically-enriched
Diabetes: Eye Exam	Claims-based
Diabetes: Foot Exam	Claims-based
Diabetes: Blood Pressure Management	Clinical
Diabetes: LDL Management	Clinically-enriched

Diabetes: HbA1c Control	Clinically-enriched
Hypertension: Controlling High Blood Pressure	Clinical
Use of Appropriate Medications for People with Asthma	Claims-based
Antidepressant Medication Management	Claims-based
Screening for Clinical Depression and Follow-Up Plan	Claims-based
Initiation and engagement of alcohol and other drug dependence treatment	Claims-based
CHILDREN	
Appropriate Treatment of Children with Upper Respiratory Infection	Claims-based
Preventable Hospitalizations: AHRQ PDI	CRISP-generated
Appropriate Testing for Children with Pharyngitis	Claims-based
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Clinical
Childhood Immunization Status	Claims-based
6+ Well Child Visits, 0-15 months	Claims-based
Preventive Care & Screening: Tobacco Use Assessment & Cessation Intervention	Clinical
Asthma Assessment	Claims-based
Use of Appropriate Medications for People with Asthma	Claims-based
ADHD: Follow-up Care for Children Prescribed ADHD Medication	Claims-based

All-Payer Claims Database (APCD)

Maryland Health Care Commission (MHCC) developed Maryland’s all-payer claims database to support analysis of health care spending and service utilization. Maryland is using a unique patient identifier in its APCD to identify patients consistently across all submitters and to allow for inclusion of Medicaid claims data. The APCD is able to generate quality and cost reports, and it contains health services, prescription drug, and eligibility data from all private health insurance carriers in the state, including Medicare eligibility and services data. Pharmacy benefit management data will also be added to enable reporting on prescription claims-based measures.

Medicaid EHR Incentive Program

Providers who benefit from the EHR Incentive Program must demonstrate they meet meaningful use objectives to receive program payments for their second year of participation and onward. Meaningful Use is defined in federal regulations as the minimum functionality necessary to optimize an EHR. Meaningful Use occurs in stages and is comprised of a series of “core” and “menu” objectives. Examples include e-prescribing, computerized provider order entry, and demographics recording, to receive incentive payments. Providers also report clinical quality measures (CQMs) such as blood pressure measurement, tobacco use assessment, and weight screening to receive payments. Meeting these objectives will help providers improve clinical outcomes, increase care transparency and efficiency, and empower patients. Complying with meaningful use requirements and CQM reporting could also yield improved population health and more robust health data.

Regional Extension Center

CRISP is Maryland's regional extension center (REC), a support center for all EHR and health IT assistance. State-designated management services organizations (MSOs) enable the REC to help providers adopt EHR, connect to the HIE, achieve meaningful use and optimize health IT (HIT) to improve outcomes. The MHCC provides state designation to MSOs that are nationally accredited and meet stringent privacy and security criteria. In order to meet these criteria, an MSO must demonstrate and document:

- a meaningful use assessment strategy;
- transformation procedures to help providers participating in innovative care delivery models maximize use of HIT;
- procedures to assist practices with extraction of reportable data;
- a strategic communication plan to expand HIT to providers in the MSO service area;
- procedures to assist providers expand patient engagement with HIT and awareness of its benefits;
- a HIT gap assessment to help providers identify workflow and care delivery deficiencies that HIT can mitigate; and
- a service agreement with EHR vendor to offer a hosted or web-based EHR solution with current meaningful use certification.

So far, the REC has partnered with 15 MSOs that are candidates for state designation. Medicaid is committed to growing the REC into a single point of contact for meaningful use support and optimization of HIT.

SECTION V: DELIVERY SYSTEM REFORMS

Mental Health/Substance Use Disorder Carve-Out

Carve-Out Rationale

Due to the correlation between mental health and SUDs, the Department began a Behavioral Health Integration stakeholder process in CY 2011. As part of the fiscal year (FY) 2012 budget, the Maryland General Assembly asked the Department to convene a workgroup and provide recommendations “to develop a system of integrated care for individuals with co-occurring serious mental illness and substance use disorder issues.” In making this request, the Maryland General Assembly recognized the current need for improved coordination in Maryland’s approach to individuals with behavioral health conditions.

Phase 1 of the process involved collaborative work between the Department, a consultant, and stakeholders in order to assess the strengths and weaknesses in Maryland’s current system. While noting the strengths in the current system, including generally good access in each service domain (behavioral health, substance use treatment, and somatic care), the resulting report reached five conclusions:

- benefit design and management across the domains are poorly aligned;
- purchasing and financing are fragmented;
- care management is not coordinated;
- performance and risk are lacking; and
- care integration needs improvement.

Phase 2 of the process began in early 2012 as the Department and stakeholders set out to develop a broad financing model to better integrate care across the service domains. Between March and September 2012, the Department held a series of public stakeholder meetings to inform the selection of a financing model. The Department accepted comments in writing and verbally within 24 public meetings. After review of the various options, a cross-disciplinary leadership steering committee within the Department offered its recommendation that Maryland pursue a transformative behavioral health carve-out that combines treatment for specialty mental illness and SUDs under the management of a single administrative service organization (ASO). On April 12, 2013, the Secretary announced the decision to move forward with establishing a performance-based carve-out for substance use disorder and behavioral health services.

The new behavioral health model carves substance use services out of the package of services currently administered by the HealthChoice MCOs and merges these services with the current specialty mental health carve-out. In spring 2014, the Department released a Request for Proposals for the competitive selection of the ASO that will implement the integrated behavioral health carve-out. The selected ASO, Value Options, will be expected to participate in risk-based performance measure schemes and in data-sharing and care coordination with the MCOs that will continue to provide somatic care. The ASO will also work collaboratively with local addictions authorities, core service agencies, and other safety net providers.

By improving the quality of care and realigning financial incentives through risk-based performance, Maryland's integrated behavioral health model is anticipated to save the Department \$1.62 million annually. The Department will implement the new system in January 2015. For more information on behavioral health integration, please see the link in Appendix E.

Performance Measures and Rationale

Data reporting under the new model is expected to be more robust and integrated, allowing the Department to measure additional outcomes. The Department's goals for the new integrated model are:

- **Reducing the total cost of care from behavioral health and addictions services, and also from somatic services, per member per month.** In an integrated system, there will be greater capacity to calculate the total cost of care and evaluate trends and costs over time.
- **Reducing the number of preventable inpatient hospital days through intensive case management for individuals requiring high level, intensive services.** Intensive case management of High Inpatient Utilization (HIU) cases intends to reduce the number of inpatient days required, thereby reducing cost, improving value, and providing treatment in the least restrictive environment possible.
- **Increasing the number of providers in the Public Behavioral Health System (PBHS) cross-trained in both behavioral health and SUD treatment.** Enhancing the number of dually-trained providers will increase the capacity of the PBHS to provide integrated care.
- **Expanding the Physician Pharmacy Alert System, with special attention to physician alerts for non-adherence to medication.** Preliminary reports to the MHA suggest that providing physicians with alerts about non-adherence to medication is correlated with a reduction in the number of hospital days.
- **Increasing the volume of individuals receiving treatment for a first episode of psychosis in the Early Intervention Program First Episode Clinics.** Early identification and treatment of psychotic disorders can alter the course of illness, reduce disability, and maximize the likelihood of recovery. The new behavioral health system will provide increased resources to support first episode programs.
- **Increasing the length of stay across different American Society of Addiction Medicine levels of care.** A greater length of time spent in treatment programs often leads to improved outcomes for individuals.
- **Reducing overdose deaths in Maryland.** Deaths due to unintentional drug overdose are likely preventable through education, outreach, and surveillance. The Governor has set a strategic policy goal to reduce overdose deaths by 20% by the end of 2015.
- **Reducing substance use by Maryland youth aged 12 to 17 through substance use prevention.**
- **Increasing the number of individuals trained in suicide awareness and prevention.** The Department will also support suicide prevention outreach services provided by the Suicide Prevention Hotline.

Moreover, the Department is in the process of developing additional behavioral health outcome measures in the areas of residential treatment centers and transition-age youth. The new system should continuously review new and useful behavioral health outcome measures and seek to apply these as appropriate.

Additional information on outcome-level performance measures related to behavioral health and substance use services can be found in Appendix E.

Related Performance Improvement Projects

Financial incentives and penalties for performance will be built into the new ASO contract for the performance-based behavioral health carve-out. The risk-based performance measures will be allocated across nationally-recognized outcome measures (e.g., HEDIS[®]), state-specific outcome measures, customer service metrics, and provider service measures.

The development of a competent provider network will be necessary to facilitate the achievement of performance-based targets. Providers will be trained by the BHA to develop and enhance provider competency in the areas of behavioral health treatment. The rollout of the new ASO will include provider education on how to seek authorization and payment. Drawing upon evidence-based research, the Behavioral Health Administration (BHA) will develop and implement trainings on co-occurring disorders. These training opportunities will increase network adequacy in the field and enhance freedom of choice for participants to find providers that meet their needs. In addition, the State is moving forward with an initiative to require providers to be either independently licensed to provide care or part of a program that is accredited by a national accreditation body.

Dental Program Carve-Out – Maryland Healthy Smiles Program

In June 2007, the Secretary of the Department convened the Dental Action Committee (DAC), a broad-based group of stakeholders, in an effort to increase children's access to oral health services. The DAC reviewed dental reports and data to develop a comprehensive series of recommendations, building on past dental initiatives, lessons learned, and best practices from other states, culminating in a comprehensive report to the Secretary on September 11, 2007. The DAC's report called for establishing a dental home for all Medicaid-covered children. To accomplish this goal, the DAC recommended several changes to the Medicaid program for connecting eligible children with a dentist to receive comprehensive dental services on a regular basis. The DAC also included suggestions to enhance education, outreach, dental public health infrastructure, provider participation, and provider scope of practice.

Carve-Out Rationale

Prior to the implementation of the Maryland Healthy Smiles dental ASO on July 1, 2009, dental care was a covered benefit provided by HealthChoice MCOs. HealthChoice MCOs were required to offer comprehensive oral health services including preventive care to children through 20 years of age, participants in the REM program, and pregnant women. HealthChoice MCOs were also required to develop and maintain an adequate network of dentists who could

deliver the full scope of oral health services for children and pregnant women. HealthChoice regulations specified the capacity and geographic standards for dental networks. They required that the dentist-to-enrollee ratio be no higher than 1:2,000 for each MCO. In addition, each MCO ensured that enrollees had access to a dentist within a 30-minute or 10-mile radius for urban areas, and a 30-minute or 30-mile radius for rural areas. Through the toll-free HealthChoice Enrollee Action Line, the Department monitored access issues via enrollee complaints.

During this period, the dental network was not very strong. Approximately 743 dentists enrolled as providers in the HealthChoice program as of July 2008. As part of the DAC's investigation, dentists were questioned about joining the Medicaid network. Many disliked having to contract with multiple MCOs and the multiple points of contact for credentialing, billing, and dental provider issues. By switching to the ASO model in July 2009 with DentaQuest, dental providers now interact with a single point of contact for all administrative issues, which promotes better network growth for all Medicaid participants receiving dental benefits. As a result, the dental provider network increased to over 1,200 providers in August 2012.

Performance Measures and Rationale

Prior to the inception of the HealthChoice program in 1997, the percentage of children receiving dental services was 19.9%. In 1999, HealthChoice utilization increased dramatically to 25.9%. After the DAC made its 2007 recommendations, access to care for children enrolled in HealthChoice increased from 54.6% (CY 2008) to 60.9% (CY 2009). The 2009 dental utilization rate is over 13 percentage points above the 2010 HEDIS[®] (CY 2009) national Medicaid average of 47.8%. As of CY 2012, the percentage of children in Maryland Medicaid receiving a dental service was 67.8%.¹³ As a comparison, the HEDIS[®] 2013 (CY 2012) national average for Medicaid was 47.1%.

The Department uses the HEDIS[®] national Medicaid average, as well as comparison to performance in previous years, to set its priorities for increasing access to dental care for Medicaid participants. The Department also assesses the program annually by measuring access to care by type of service, rates of access to restorative dental care, rates of emergency room visits by Medicaid children with dental diagnoses, and dental utilization rates for pregnant women enrolled in Medicaid.

Related Performance Improvement Projects

The Department is using the dental utilization rate and dental provider network information collected to establish incentives and benchmarks for future dental ASO efforts. These goals include increasing participation of general dentists and dental specialists in each county, and improving dental utilization rates by at least one percentage point each year of the contract.

Medicaid Expansion under the ACA

¹³ Rate based on children ages 4-20 enrolled in the Medicaid program for at least 320 days. The Annual Dental Visit measure for HEDIS[®] tracks children ages 2-21.

Effective January 1, 2014, Maryland received CMS approval for its Alternative Benefit Plan (ABP) for individuals aged 19 to 64 years who are eligible for Medicaid as a part of implementing the Affordable Care Act (ACA).

The ABP provides the same benefits available to other Medicaid participants in amount, scope, and duration, with the exception of the addition of habilitative services, to comply with the ACA's minimum essential coverage standards. Habilitative services available to the ABP population include physical, occupational, and speech therapies. All of these services will be delivered by HealthChoice MCOs.

Carve-In Rationale

The Medicaid expansion under the ACA extends full Medicaid benefits to childless adults and parents or other caretakers up to 138% of the Federal Poverty Level (FPL), which includes participants in the former Primary Adult Care (PAC) program. By aligning the benefit package for this population with its current State Plan (with the exception of adding habilitative services), Maryland is working to mitigate churn between this population and groups previously eligible for Medicaid.

Performance Measures and Rationale

The Department will incorporate this population into the quality improvement activities conducted to assess, monitor, and evaluate the HealthChoice program. Additionally, since the inception of the HealthChoice program in 1997, the Department has conducted five comprehensive evaluations of the program as part of renewing its 1115 Waiver. Between waiver renewals, the Department continually monitors HealthChoice performance on a variety of measures and completes an annual evaluation, which is reported to Department staff and stakeholders. The Medicaid expansion population will be included in future HealthChoice evaluations.

Related Performance Improvement Projects

This population's quality of care will be assessed using the quality improvement activities conducted for the HealthChoice program. The Department, in collaboration with stakeholders, has promoted four HEDIS[®] measures from the CMS Adult CORE Set into its Value Based Purchasing Initiative – Adult BMI Assessment, Breast Cancer Screening, HbA1c Testing for Comprehensive Diabetes Care, and Controlling High Blood Pressure. The Department also initiated a PIP for Controlling High Blood Pressure in 2013 to promote Maryland's goals for reducing hypertension in its population. Maryland will pursue additional opportunities to improve the health of HealthChoice participants.

SECTION VI: CONCLUSION

The Department has identified highlights in HealthChoice quality improvement, through EQR activities and departmental initiatives. The Department remains committed to providing quality health care to Marylanders through HealthChoice.

EQR Quality Improvement Highlights

MCO Consumer Report Card performance has shown consistent ratings for MCOs performing above the HealthChoice average for multiple performance areas, represented by a three-star rating. For example, three MCOs received above average (three-star) ratings for Access to Care in the 2014 Consumer Report Card, compared to one MCO receiving that rating in 2012.

In EPSDT/Healthy Kids medical record reviews, the HealthChoice aggregate scores showed improvement for each of the components. For example, Health and Developmental History increased from 86% in 2009 to 89% in 2012, and Health Education and Anticipatory Guidance increased from 88% in 2009 to 92% in 2012. The Department has required only two current MCOs to submit corrective action plans for a component within the past three reported years.

Annual SPRs have shown that the MCOs remain committed to complying with Federal and Maryland HealthChoice requirements. Three of seven MCOs performed at 100% compliance for all SPR standards in 2012, and four of seven MCOs performed at 100% compliance in 2013. Although MCOs occasionally did not meet the minimum compliance score of 100%, the HealthChoice aggregate score for each standard has not fallen below 89% over the past three years. The Department consistently reviews all new Federal and State laws and regulations. Any new laws and regulations are immediately put into the standards and guidelines for review and communicated to the MCOs. For example, in the 2016 SPR, the Department will include a standard requiring all MCOs to provide a notice to participants about continuity of care between MCOs and commercial insurance providers. The MCOs have implemented many programs and activities that are considered best and promising practices for providing care to participants. Please see the 2013 Annual Technical Report for examples of MCO efforts to improve quality.

The Department continues to seek opportunities to improve quality, access, and timeliness of care through its selection and monitoring of PIPs. The current PIPs for the HealthChoice program are Adolescent Well-Care and Controlling High Blood Pressure. The Adolescent Well-Care PIP started in 2012, and the Controlling High Blood Pressure PIP started in 2013. The Controlling High Blood Pressure PIP was selected in conjunction with the Value Based Purchasing Initiative and to coincide with the Department's commitment to the federal Million Hearts Initiative. PIPs typically operate on a three-year reporting cycle, and the Department has the discretion to extend projects.

Department Quality Improvement Highlights

Starting on October 1, 2014, the Department implemented Hospital Presumptive Eligibility (HPE), a program designed to increase access to care and health insurance under the provisions of the ACA. HPE allows hospitals to collect data from a patient at intake for applying to Medicaid. During the HPE period, the patient will receive temporary medical assistance through the FFS program until the Department makes a Medicaid eligibility determination. The presumptive eligibility period will not exceed 60 days.

To serve the incoming adult population entering Medicaid as a result of health care reform, the Department added new HEDIS[®] measures that impact adults to its Value Based Purchasing Initiative – Adult BMI Assessment, Breast Cancer Screening, HbA1c Testing for Comprehensive Diabetes Care, and Controlling High Blood Pressure. MCOs will have the opportunity to collect incentives for 13 measures, an increase from 10 measures in previous years. The Department prioritized HEDIS[®] measures identified by CMS as a core performance measure for adults.

In an effort to bolster its quality improvement activities, the Department changed its regulations to require all MCOs to have NCQA accreditation, to report the full panel of HEDIS[®] measures, and to maintain accreditation for as long as the MCO serves the HealthChoice population. MCOs participating in the HealthChoice program prior to January 1, 2013 were required to achieve NCQA accreditation by January 1, 2015. MCOs joining the HealthChoice program after 2013 have two years from its program start date to achieve NCQA accreditation.

The Department volunteered to collect many of the Medicaid Adult and Child CORE Measures, as defined but not required by CMS. The collection of these additional measures will assist CMS and Maryland to assess the quality of health care that Medicaid participants receive.

The Department regularly hosts MMAC meetings. Committee members represent the provider, MCO, and participant communities. Each meeting is public, and committee members are encouraged to propose changes and recommendations to improve the HealthChoice program.

The Department holds monthly MCO Liaison Meetings to keep MCOs informed of program changes, quality efforts, and ways to improve care for HealthChoice participants. MCOs share feedback and questions related to the HealthChoice program. Through these meetings, the Department has reduced unnecessary administrative burden to MCO operations, and also solicits feedback from the MCOs on an ad hoc basis.

The Department conducts quarterly Quality Assurance Liaison Committee meetings with quality improvement staff from each MCO to discuss any changes or questions concerning external quality review, HEDIS[®] validation, and CAHPS[®] survey administration.

The Department is committed to continuing its efforts to improve the health of Marylanders through HealthChoice.

APPENDICES

Appendix A. Public Comment Process

Appendix B. MCO Required Reports to the Department

Appendix C. Maryland Business Associate Agreement

Appendix D. Report Links

Appendix E. Acronym List

Appendix F. 2014 Maryland Systems Performance Review Standards and Guidelines

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APPENDIX A - Public Comment Process

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APPENDIX B – MCO Required Reports to the Department

Report Name	Reporting Requirement	Reference	Frequency/Mode
Death of an Enrollee	An MCO shall notify the Department immediately when it has a knowledge of an enrollee's death	10.09.65 15 A	Daily/Fax
Formulary Updates	Submit electronic formulary updates (for next month) to DHMH on a monthly basis.	10.09.67.04D(5)	Monthly/Electronic
Pre-Service Denial or Reduction of Service Report	MCO must submit a list of all pre-service denials or reduction of services or benefits issued by the MCO or MCO subcontractors during the preceding month, which shall include for each recipient: (a) Name; (b) Medical assistance number; (c) Date of denial or reduction of services; (d) Service or benefit denied or reduced; (e) Reason for denial or reduction of services; (f) Date of denial or reduction of services letter; and (g) An indication of review by the MCO Medical Director	COMAR 10.09.65.15C(3)	Monthly/Electronic
Compliance Activity Report	Report template includes the following fields: Number of complaints alleging possible fraud, beginning balance, # of new cases opened, # of cases closed, ending balance, # of providers termed for suspected fraud, # of providers not re-credentialed, enrolled, or have limits applied due to fraud, # of providers who received notification of exclusion	Instruction from Department (OIG)	Monthly/Electronic
Third Party Liability	Submit to the Department, on a monthly basis, a report detailing third party collections and activities during the month, including but not limited to amounts the MCO has cost avoided and recovered and current amounts receivable for all third party liability cases. Reports include-- *TPL Tort *Data Exchange (OHI) *COB *Casualty Report	COMAR 10.09.65.18 (F)(1)	Monthly/Electronic
Pharmacy Lock-in Participants	The MCO must submit monthly a list of the enrollees who have been enrolled in the MCO's corrective managed care program ("pharmacy lock-in" participants)	COMAR 10.09.75.04(B)(2)	Monthly/Electronic
Claims Monitoring Report	The MCO must submit the CMR (for the previous month's data) to DHMH 30 calendar days after the last day of the month. (E.g., report due August 30th will reflect July data.)	Instruction from Department	Monthly/Electronic

Maryland Medicaid Quality Strategy

Report Name	Reporting Requirement	Reference	Frequency/Mode
Provider Terminations	The MCO is to notify DHMH as it becomes aware of provider terminations that fall under the continuity of care requirements that would allow a recipient to disenroll from the MCO to follow their PCP to another MCO at least 30 days before the termination. No termination or assignment of a subcontract (health care provider) shall be effective without prior written notice to the Department. The MCO is required to notify DHMH of all provider terminations prior to the effective date of termination.	COMAR 10.09.65.17(A)(5)(f) COMAR 10.09.65.17(A)(5)(i), COMAR 10.09.63 06 A(1)(e) DHMH Transmittal No.22	Monthly/Electronic
Marketing/Outreach, and COV Calendars	The MCO must submit updated Marketing/Health Promotion Events & COV Calendar (for upcoming month) to DHMH on a monthly basis.	Department Instruction Marketing/Outreach Calendar: COMAR	Monthly/Electronic
Third Party Liability Summary	Submit to the Department, on a quarterly basis and in a format specified by the Department, amounts the MCO has cost -avoided and recovered and the number of cases the MCO has handled in each case area during the quarter.	COMAR 10.09.65.18 (F)(1) Template provided in COB Training Guide (Monitoring & Sanctions)	Quarterly/Electronic
Quality Assurance Reports	Submit to the Department quarterly - within 30 calendar days, of the close of each calendar quarter - Quality Assurance reports including, but not limited to: (a) quality assurance committee minutes reflecting major quality assurance corrective action plans, initiatives and activities; (b) complaint and grievances logs, including emergency room based complaints and grievances; (c) resolutions of all complaints and grievances. (items (b) and (c) should be reported up through the QAC and reflected in the minutes)	COMAR 10.09.65.15(D)(1)(a)	Quarterly/Electronic
Quality Assurance Reports - Complaint & Grievance Logs	Submit to the Department quarterly - Quality Assurance reports including, but not limited to: (a) QAC minutes; (b) an analysis of recipient complaint logs including significant trends or anomalies, what caused the trend or anomaly, and any actions taken to address the trend or anomaly.	COMAR 10.09.65.15(D)(1)	Quarterly/Electronic
HealthChoice Financial Monitoring Reports	Designed as a supplemental schedule to the quarterly and annual filings to the MIA. The report includes 3 sections: Section I: Background (quarterly submission); Section II: Expense and Utilization Structure (Incurred Basis) (quarterly submission); Section III: Major Subcapitated Provider Schedule (annual submission)	UMBC Letter of June 30, 1999 COMAR 10.09.65.15.E(5) E-mail from Audrey Parham-Stewart on 2/11/09 Reporting Instructions for HFMR	Bi-Annually/Mail and electronic

Maryland Medicaid Quality Strategy

Report Name	Reporting Requirement	Reference	Frequency/Mode
Physician Incentive Plan	An MCO shall disclose to the Department and, on request, to the U.S. Department of Health and Human Services, the information on its provider incentive plans listed in 42 CFR §417.479(h)(1), at the times indicated in 42 CFR §434.70(a)(3), in order to determine whether the incentive plans meet the requirements of 42 CFR §417.479(d)-(g) and, as applicable (i), when there exist compensation arrangements under which payment for designated health services furnished to an individual on the basis of a physician referral would otherwise be denied under §1903(s) of the Social Security Act.	COMAR 10.09.65.02(V)	Annual/Electronic
Third Party Liability - Annual Summary	Submit to the Department, on an annual basis and in a format specified by the Department, amounts the MCO has cost -avoided and recovered and the number of cases the MCO has handled in each case area during the previous year.	Instruction from Department Template provided in COB Training Guide (Monitoring & Sanctions)	Annual/Electronic
Case Management Plans	The MCO must submit to the Department annually (within 90 days after the end of the calendar year) any revisions to the case management plans.	COMAR 10.09.65.15(E)(4)	Annual/Electronic
Quality Assurance Plan	The MCO must submit to the Department annually (within 90 days after the end of the calendar year) any revisions to the MCO's quality assurance plan.	COMAR 10.09.65.15(E)(4)	Annual/Electronic
Utilization Management Plan	Submit to the Department annually - within 90 days after the end of the calendar year - any revisions to the utilization management plan.	COMAR 10.09.65.15(E)(4)	Annual/Electronic
Consumer Advisory Board	The MCO must submit to the Department annually (within 90 days after the end of the calendar year) a report of the MCOs consumer advisory board outlining the board's activities and recommendations, including minutes of the meetings.	COMAR 10.09.65.12(D) COMAR 10.09.65.15(E)(2)	Annual/Electronic
Complaint/Grievance Summary	The MCO must submit to the Department annually (within 90 days after the end of the calendar year) a summary of the information contained in §D(1)(b) of this regulation.	COMAR 10.09.65.15(E)(1) COMAR 10.09.65.15(D)(1)(b)	Annual/Electronic
Drug Formulary	The MCO must submit to the Department annually (within 90 days after the end of the calendar year) a copy of the MCOs drug formulary.	COMAR 10.09.65.15(E)(3)	Annual/Mail and electronic
MCO Drug Use Mgmt. Program Annual Assessment	An MCO must Establish and maintain a drug use management program and Adhere to the minimum performance standards established by the Department for these programs, whenever used, including but not limited to standards for the following drug use mgmt components: (a) Formulary Management, (b) Generic Substitution, (c) Therapeutic, Substitution, (d) Prior Authorization, (e) Drug Use Evaluation, (f) Disease Management, and (g) Pharmacy and Therapeutic Committee	COMAR 10.09.67.04 F & G	Annual/Electronic

Maryland Medicaid Quality Strategy

Report Name	Reporting Requirement	Reference	Frequency/Mode
HEDIS Reporting	By July 1 of each year, an MCO shall submit to the Department a record of its health care delivery and organizational performance during the preceding year measured utilizing the most recent version of the Health Plan Employer Data Information Set (HEDIS) applicable to the reporting period.	COMAR 10.09.65.15(F) COMAR 10.09.65.03.B(2)	Annual/Electronic
Notice of Intent to Participate	The MCO shall provide written notification to the Department of the MCO's intent to participate and accept new enrollees in each of the local access areas by September 14 for the next calendar year.	COMAR 10.09.65.02(K)(1)	Annual/ Mail and electronic
Enrollee Outreach Plan	An MCO shall submit a written Enrollee Outreach plan that: (1) describes how the MCO intends to comply, with the outreach requirements of Health-General Article 15-103(b)(9), Annotated Code of Maryland; to be reviewed as part of the annual audit performed by an external quality review organization (EQRO); (2) provides evidence of compliance during previous year.	COMAR 10.09.65.25(A)	Annual/Electronic

APPENDIX C – Maryland Business Associate Agreement

This Business Associate Agreement (the “Agreement”) is made by and between the _____ The Maryland Department of Health and Mental Hygiene (herein referred to as “Covered Entity”) and _____ (Insert Name of Contractor) (hereinafter known as “Business Associate”). Covered Entity and Business Associate shall collectively be known herein as the “Parties.”

WHEREAS, Covered Entity has a business relationship with Business Associate that is memorialized in a separate agreement (the “Underlying Agreement”) pursuant to which Business Associate may be considered a “business associate” of Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 including all pertinent privacy regulations (45 C.F.R. Parts 160 and 164) and security regulations (45 C.F.R. Parts 160, 162, and 164), as amended from time to time, issued by the U.S. Department of Health and Human Services as either have been amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), as Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (collectively, “HIPAA”); and

WHEREAS, the nature of the contractual relationship between Covered Entity and Business Associate may involve the exchange of Protected Health Information (“PHI”) as that term is defined under HIPAA; and

WHEREAS, for good and lawful consideration as set forth in the Underlying Agreement, Covered Entity and Business Associate enter into this Agreement for the purpose of ensuring compliance with the requirements of HIPAA and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§ 4-301 et seq.) (“MCMRA”); and

WHEREAS, this Agreement supersedes and replaces any and all Business Associate Agreements the Covered Entity and Business Associate may have entered into prior to the date hereof;

NOW THEREFORE, the premises having been considered and with acknowledgment of the mutual promises and of other good and valuable consideration herein contained, the Parties, intending to be legally bound, hereby agree as follows:

Definitions.

- A. Catch-all definition. The following terms used in this Agreement, whether capitalized or not, shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.
- B. Specific definitions:

1. Business Associate. “Business Associate” shall generally have the same meaning as the term “business associate” at 45 C.F.R. 160.103, and in reference to the party to this agreement, shall mean (**Insert Name of MCO**).
2. Covered Entity. “Covered Entity” shall generally have the same meaning as the term “covered entity” at 45 C.F.R. § 160.103, and in reference to the party to this agreement, shall mean (**DHMH**).
3. HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.
4. Protected Health Information (“PHI”). Protected Health Information or “PHI” shall generally have the same meaning as the term “protected health information” at 45 C.F.R. § 160.103.

Permitted Uses AND Disclosures of PHI by Business Associate.

- A. Business Associate may only use or disclose PHI as necessary to perform the services set forth in the Underlying Agreement or as required by law.
 - B. Business Associate agrees to make uses and disclosures and requests for PHI consistent with Covered Entity’s policies and procedures regarding minimum necessary use of PHI.
 - C. Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Covered Entity.
- I. Business Associate may, if directed to do so in writing by Covered Entity, create a limited data set, as defined at 45 CFR 164.514(e)(2) , for use in public health, research, or health care operations. Any such limited data sets shall omit any of the identifying information listed in 45 CFR § 164.514(e)(2). Business Associate will enter into a valid, HIPAA-compliant Data Use Agreement, as described in 45 CFR § 164.514(e)(4), with the limited data set recipient. Business Associate will report any material breach or violation of the data use agreement to Covered Entity immediately after it becomes aware of any such material breach or violation.
 - II. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration, or legal responsibilities of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
 - III. The Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual pursuant to §§13405(d)(1) and (2) of the HITECH Act. This prohibition does not apply to the State’s payment of Business Associate for its performance pursuant to the Underlying Agreement.
 - IV. The Business Associate shall comply with the limitations on marketing and fundraising communications provided in §13406 of the HITECH Act in connection with any PHI of Individuals.

Duties of Business Associate Relative to PHI.

- A. Business Associate agrees that it will not use or disclose PHI other than as permitted or required by the Agreement or as Required by Law;
- B. Business Associate agrees to use appropriate administrative, technical and physical safeguards to protect the privacy of PHI.
- C. Business Associate agrees to use appropriate safeguards, and comply with Subpart C of 45 C.F.R. Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the Agreement;
- D.
 - 1. Business Associate agrees to Report to Covered Entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware without reasonable delay, and in no case later than fifteen calendar days after the use or disclosure;
 - 2. If the use or disclosure amounts to a breach of unsecured PHI, the Business Associate shall ensure its report:
 - A. Is made to Covered Entity without unreasonable delay and in no case later than fifteen (15) calendar days after the incident constituting the Breach is first known, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this Section III.D.1, Business Associate must notify Covered Entity of an incident involving the acquisition, access, use or disclosure of PHI in a manner not permitted under 45 C.F.R. Part E within fifteen (15) calendar days after an incident even if Business Associate has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA;
 - B. Includes the names of the Individuals whose Unsecured PHI has been, or is reasonably believed to have been, the subject of a Breach;
 - C. Is in substantially the same form as APPENDIX A-1 attached hereto; and
 - D. Includes a draft letter for the Covered Entity to utilize to notify the affected Individuals that their Unsecured PHI has been, or is reasonably believed to have been, the subject of a Breach that includes, to the extent possible:
 - i) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
 - ii) A description of the types of Unsecured PHI that were involved in the Breach (such as full name, Social Security number, date of birth, home address, account number, disability code, or other types of information that were involved);

- iii) Any steps the affected Individuals should take to protect themselves from potential harm resulting from the Breach;
 - iv) A brief description of what the Covered Entity and the Business Associate are doing to investigate the Breach, to mitigate losses, and to protect against any further Breaches; and
 - v) Contact procedures for the affected Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, website, or postal address.
- E. To the extent permitted by the Underlying Agreement, Business Associate may use agents and subcontractors. In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2) shall ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information, Business Associate must enter into Business Associate Agreements with subcontractors as required by HIPAA;
- F. Business Associate agrees it will make available PHI in a designated record set to the Covered Entity, or, as directed by the Covered Entity, to an individual, as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.524, including, if requested, a copy in electronic format;
- G. Business Associate agrees it will make any amendment(s) to PHI in a designated record set as directed or agreed to by the Covered Entity pursuant to 45 C.F.R. § 164.526, or take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.526;
- H. Business Associate agrees to maintain and make available the information required to provide an accounting of disclosures to the Covered Entity or, as directed by the Covered Entity, to an individual, as necessary to satisfy Covered Entity's obligations under 45 C.F.R. § 164.528;
- I. To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 C.F.R. Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s);
- J. Business Associate agrees to make its internal practices, books, and records, including PHI, available to the Covered Entity and/or the Secretary for purposes of determining compliance with the HIPAA Rules.
- K. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

IV. TERM AND TERMINATION

- A. Term. The Term of this Agreement shall be effective as of the effective date of the Contract entered into and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or the PHI created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, in accordance with the termination provisions in this Section IV, or on the date the Covered Entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner. If it is impossible to return or destroy all of the PHI provided by Covered Entity to Business Associate, or the PHI created or received by Business Associate on behalf of Covered Entity, Business Associate's obligations under this contract shall be ongoing with respect to that information, unless and until a separate written agreement regarding that information is entered into with Covered Entity.
- B. Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Agreement by Business Associate, Covered Entity shall:
1. Provide an opportunity for Business Associate to cure the breach or end the violation and, if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, terminate this Agreement; or
 2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and Covered entity determines or reasonably believes that cure is not possible.
- C. Effect of Termination.
1. Upon termination of this Agreement, for any reason, Business Associate shall return or, if agreed to by Covered Entity, destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that the Business Associate still maintains in any form. Business Associate shall retain no copies of the PHI. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.
 2. Should Business Associate make an intentional or grossly negligent Breach of PHI in violation of this Agreement or HIPAA or an intentional or grossly negligent disclosure of information protected by the MCMRA, Covered Entity shall have the right to immediately terminate any contract, other than this Agreement, then in force between the Parties, including the Underlying Agreement.
- D. Survival. The obligations of Business Associate under this Section shall survive the termination of this agreement.

V. **CONSIDERATION**

Business Associate recognizes that the promises it has made in this Agreement shall, henceforth, be detrimentally relied upon by Covered Entity in choosing to continue or commence a business relationship with Business Associate.

VI. **REMEDIES IN EVENT OF BREACH**

Business Associate hereby recognizes that irreparable harm will result to Covered Entity, and to the business of Covered Entity, in the event of breach by Business Associate of any of the covenants and assurances contained in this Agreement. As such, in the event of breach of any of the covenants and assurances contained in Sections II or III above, Covered Entity shall be entitled to enjoin and restrain Business Associate from any continued violation of Sections II or III. Furthermore, in the event of breach of Sections II or III by Business Associate, Covered Entity is entitled to reimbursement and indemnification from Business Associate for Covered Entity's reasonable attorneys' fees and expenses and costs that were reasonably incurred as a proximate result of Business Associate's breach. The remedies contained in this Section VI shall be in addition to, not in lieu of, any action for damages and/or any other remedy Covered Entity may have for breach of any part of this Agreement or the Underlying Agreement or which may be available to Covered Entity at law or in equity.

VII. MODIFICATION; AMENDMENT

This Agreement may only be modified or amended through a writing signed by the Parties and, thus, no oral modification or amendment hereof shall be permitted. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA rules and any other applicable law.

VIII. INTERPRETATION OF THIS AGREEMENT IN RELATION TO OTHER AGREEMENTS BETWEEN THE PARTIES

Should there be any conflict between the language of this Agreement and any other contract entered into between the Parties (either previous or subsequent to the date of this Agreement), the language and provisions of this Agreement shall control and prevail unless the parties specifically refer in a subsequent written agreement to this Agreement by its title and date and specifically state that the provisions of the later written agreement shall control over this Agreement.

IX. COMPLIANCE WITH STATE LAW

The Business Associate acknowledges that by accepting the PHI from Covered Entity, it becomes a holder of medical information under the MCMRA and is subject to the provisions of that law. If the HIPAA Privacy or Security Rules and the MCMRA conflict regarding the degree of protection provided for PHI, Business Associate shall comply with the more restrictive protection requirement.

X. MISCELLANEOUS

- A. Ambiguity. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy and Security Rules.
- B. Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.
- C. Notice to Covered Entity. Any notice required under this Agreement to be given Covered Entity shall be made in writing to:

Ramiek James, Esq.
Privacy Officer and Compliance Analyst
Department of Health & Mental Hygiene

Office of the Inspector General
201 W. Preston Street, Floor 5
Baltimore, MD 21201-2301
Phone: (410) 767-5411

- D. Notice to Business Associate. Any notice required under this Agreement to be given Business Associate shall be made in writing to:

Address: _____

Attention: _____

Phone: _____

- E. Survival. Any provision of this Agreement which contemplates performance or observance subsequent to any termination or expiration of this contract shall survive termination or expiration of this Agreement and continue in full force and effect.
- F. Severability. If any term contained in this Agreement is held or finally determined to be invalid, illegal, or unenforceable in any respect, in whole or in part, such term shall be severed from this Agreement, and the remaining terms contained herein shall continue in full force and effect, and shall in no way be affected, prejudiced, or disturbed thereby.
- G. Terms. All of the terms of this Agreement are contractual and not merely recitals and none may be amended or modified except by a writing executed by all parties hereto.
- H. Priority. This Agreement supersedes and renders null and void any and all prior written or oral undertakings or agreements between the parties regarding the subject matter hereof.

IN WITNESS WHEREOF and acknowledging acceptance and agreement of the foregoing, the Parties affix their signatures hereto.

COVERED ENTITY:

BUSINESS ASSOCIATE:

By: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

APPENDIX D – Report Links

For more information on behavioral health integration:

<http://dhmh.maryland.gov/bhd/SitePages/integrationefforts.aspx>

Additional information on outcome-level performance measures related to mental health and substance use services:

<http://dhmh.maryland.gov/bhd/SitePages/integrationefforts.aspx>

2013 Annual Oral Health Legislative Report:

<https://mmcp.dhmh.maryland.gov/Documents/dentalJCRfinal9-13.pdf>

2013 Annual Technical Report:

<https://mmcp.dhmh.maryland.gov/healthchoice/Documents/2013%20Maryland%20Annual%20Technical%20Report.pdf>

2013 Systems Performance Review – Statewide Executive Summary:

https://mmcp.dhmh.maryland.gov/healthchoice/Documents/CY%202012_MCO%20SPR-Statewide%20Executive%20Summary_FINAL.pdf

2013 HEDIS[®] Executive Summary:

<https://mmcp.dhmh.maryland.gov/healthchoice/SiteAssets/SitePages/CY%202012/2013%20HEDIS%20Executive%20Summary%20HealthChoice%20and%20Primary%20Adult%20Care.pdf>

2013 CAHPS[®] Executive Summary:

<https://mmcp.dhmh.maryland.gov/healthchoice/Documents/Executive%20Summary%20-%20Adult%20and%20Child%20CAHPS%20-%20Final.pdf>

APPENDIX E – Acronym List

ABP	Alternative Benefit Plan
ACA	Affordable Care Act
ADA	American Dental Association
APCD	All Payer Claims Database
ASO	Administrative Service Organization
BHA	Behavioral Health Administration
BMI	Body Mass Index
CAHPS [®]	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCC	Child with Chronic Conditions
CCDPC	Center for Chronic Disease Prevention and Control
CHIP	Children’s Health Insurance Program
CHIPRA	Children’s Health Insurance Program Reauthorization Act
CIHM	Community Integrated Medical Home
CMS	Centers for Medicare and Medicaid Services
COMAR	Code of Maryland Regulations
CQM	Clinical Quality Measure
CRISP	Chesapeake Regional Information System for our Patients
CY	Calendar Year
DAC	Dental Action Committee
DES	Diagnostic and Evaluation Service
DHMH	Maryland Department of Mental Health and Hygiene
eQMs	Electronic Clinical Quality Measures
ED	Emergency Department
EHL	Enrollee (Participant) Help Line
EMTALA	Emergency Medical Treatment and Active Labor Act
ENS	Encounter Notification Service
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ESSENCE	Electronic Surveillance System for the Early Notification of Community-Based Epidemics
FFS	Fee For Service
FFY	Federal Fiscal Year
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HCFA	Health Care Financing Administration
HEDIS [®]	Healthcare Effectiveness and Data Information Set
EHR	Electronic Health Records
HIE	Health Information Exchange

Maryland Medicaid Quality Strategy

Page 66 of 122

HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HIU	High Inpatient Utilization
HPE	Hospital Presumptive Eligibility
MCHP	Maryland Children's Health Program
MCHRC	Maryland Community Health Resources Commission
MCMRA	Maryland Confidentiality of Medical Records Act
MHA	Mental Hygiene Administration
MHCC	Maryland Health Care Commission
MIEMSS	Maryland Institute for Emergency Medical Services Systems
MMAC	Maryland Medicaid Advisory Committee
MMIS	Medicaid Management Information System
MMPP	Maryland Multi-Payer Patient-Centered Medical Home Program
MPI	Master Patient Index
MSO	Management Services Organization
NCQA	National Committee for Quality Assurance
NEDSS	National Electronic Disease Surveillance System
PAC	Primary Adult Care
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PDMP	Prescription Drug Monitoring Program
PRP	Psychiatric Rehabilitation Programs
REC	Regional Extension Center
REM	Rare and Expensive Case Management
RFP	Request For Proposal
SHIP	State Health Improvement Program
SIM	State Innovation Models
SUD	Substance Use Disorder
SURS	Surveillance and Utilization Review Services
TANF	Temporary Assistance for Needy Families
VBP	Value Based Purchasing

APPENDIX F – 2014 Maryland Systems Performance Review Standards and Guidelines

Standard	Description	Review Guidelines	Documents to be Reviewed
1.0	Systematic Process of Quality Assessment and Improvement – The QAP objectively and systematically monitors and evaluates the QOC and services to enrollees, through QOC studies and related activities, and pursues opportunities for improvement on an ongoing basis.		
1.1	<p>The QAP has written guidelines for QOC studies and related activities that include the specification of clinical or health services to be monitored.</p> <p>a. The monitoring and evaluation of care reflects the population served by the MCO in terms of age, disease categories, and special risk status.</p> <p>b. The QAP monitors and evaluates priority areas of concern selected by the State and any additional areas of concern identified by the MCO.</p>	<p>The MCO demonstrates the ability to capture and analyze data that describe the demographic, health status, and utilization patterns of the enrolled population.</p> <p>The MCO documents processes used to prioritize problems and develop a time frame for QAP studies and projects.</p>	<ul style="list-style-type: none"> • QA Plan • Policies & Procedures • Data Analysis • Enrollee Profiles (demographic data; medical and pharmacy utilization data) • QAC Meeting Minutes • QA Timeline/Work Plan
1.2	<p>The QAP’s written guidelines for the MCO’s QOC studies and related activities require the use of quality indicators.</p> <p>a. The organization identifies and uses quality indicators that are objective, measurable, and based on current knowledge and clinical experience.</p> <p>b. Methods and frequency of data collection are appropriate and sufficient to detect the need for program change.</p>	<p>QOC study designs or project plan contain indicators based on sound clinical evidence or guidelines. The methodology and frequency of data collection will be evaluated to determine if they are sufficient to detect change.</p>	<ul style="list-style-type: none"> • QA Plan • Policies & Procedures • QOC Study Designs • QOC Project Plans • Quality Indicators • Data Analysis

Standard	Description	Review Guidelines	Documents to be Reviewed
1.3	<p>The QAP has written guidelines for its QOC studies and related activities and must include the use of clinical practice guidelines.</p> <ol style="list-style-type: none"> The QAP studies and other activities monitor QOC against clinical practice guidelines. The guidelines are based on reasonable evidence based practices and are developed or reviewed by MCO providers. The guidelines focus on the process and outcomes of health care delivery and access to care. A mechanism is in place for continuously updating the guidelines as appropriate. There is evidence that this occurs. The guidelines are included in the provider manuals or disseminated to the providers as they are adopted. There are guidelines to address preventive health services. The guidelines are developed for the full range of populations enrolled in the MCO. The QAP has written guidelines to evaluate the QOC provided by the MCO’s providers. 	<p>There must be a comprehensive set of guidelines that address preventive care and the range of the populations enrolled in the MCO. Clinical practice guidelines provide the basis for QOC studies and related QA activities.</p> <p>There is evidence that these guidelines are based on reasonable evidence based practice and have been developed or reviewed by plan providers. The guidelines in use allow for the assessment of the process and outcomes of care. The MCO must have a mechanism in place for reviewing the guidelines at least every two years and updating them as appropriate. There must be evidence that the providers receive the guidelines. The QAP has written guidelines to evaluate the QOC provided.</p>	<ul style="list-style-type: none"> • QA Plan • Policies & Procedures • Practice Guidelines • Clinical Care Standards • QOC Study Designs • QOC Study Tools • QOC Project Plans • Quality Indicators • Data Analysis
1.4	<p>The QAP has written guidelines for its QOC studies and related activities that require the analysis of clinical and related services.</p> <ol style="list-style-type: none"> Appropriate clinicians monitor and evaluate quality through review of individual cases and through studies analyzing patterns of clinical care. Multidisciplinary teams are used to analyze, identify, and address systems issues. Clinical and related service areas requiring improvements are identified through activities described in a. and b. above. 	<p>The QA Plan and/or related documents describe the methodology for monitoring clinical and related services through individual case review and pattern analysis.</p> <p>The composition of the team is described in the QA Plan and/or related documents. There is evidence that through these activities those areas requiring improvement are identified and acted upon.</p>	<ul style="list-style-type: none"> • QA Plan • Data Analysis • Policies & Procedures • QA/QIC Meeting Minutes • QA/QIC Membership • QA/QIC Attendance Records

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Standard	Description	Review Guidelines	Documents to be Reviewed
1.5	<p>The QAP includes written procedures for taking appropriate remedial action whenever inappropriate or substandard services are furnished or services that should have been furnished were not. The remedial/corrective action procedures specifically include:</p> <ol style="list-style-type: none"> a. The types of problems requiring remedial/corrective action. b. The person(s) or body responsible for making the final determinations regarding quality problems. c. The specific actions to be taken. d. The provision of feedback to the appropriate health professionals, providers, and staff. e. The schedule and accountability for implementing corrective actions. f. The approach to modifying the corrective action if improvements do not occur. g. The procedures for terminating health professionals, providers, or staff. 	<p>The QA Plan specifies the process for identifying problems and taking appropriate corrective actions. Documentation must be provided to ensure that policies and procedures are in place that support the process and address all components of this element. This would include the identification, development, implementation and monitoring of CAPs.</p>	<ul style="list-style-type: none"> • QA Plan • Policies & Procedures • Data Analysis • Provider Feedback • CAPs
1.6	<p>The QAP has written guidelines for the assessment of the effectiveness of CAPs.</p> <ol style="list-style-type: none"> a. The implementation of CAPs is monitored to assure that appropriate changes have been made. Changes in practice patterns are tracked. b. The MCO must ensure that actions for improvement have been effective. 	<p>The QA Plan and/or related policies and procedures must describe the CAP monitoring process. This plan must address the tracking of changes in practice patterns as well as follow-up by the MCO.</p>	<ul style="list-style-type: none"> • QA Plan • Policies & Procedures • Data Analysis • Provider Feedback • CAPs • CAP Monitoring Documents

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
1.7	<p>The QA Plan incorporates written guidelines for evaluation of the continuity and effectiveness of the QAP.</p> <ol style="list-style-type: none"> a. The MCO conducts regular and periodic examination of the scope and content of the QAP to ensure that it covers services in all settings. b. There is evidence that QA activities have contributed to improvements in the care and services delivered to enrollees. 	<p>The QA Plan describes the method to be used to assure that the QAP is routinely reviewed to assess its scope and content.</p> <p>Documentation must be provided to substantiate that QA activities have resulted in improvements to care. QOC study data, analysis, reports and findings may support these improvements.</p>	<ul style="list-style-type: none"> • QA Plan • QAC Meeting Minutes • QOC Studies • QAP Annual Report
1.8	<p>A comprehensive annual written report on the QAP is completed, reviewed, and approved by the MCO’s governing body. The annual report on the QAP must include:</p> <ol style="list-style-type: none"> a. QA studies and other activities completed. b. Trending of clinical and service indicators and other performance data, including HEDIS® CAHPS® results. c. Demonstrated improvements in quality. d. Areas of deficiency. e. Recommendations for CAPs. f. An evaluation of the overall effectiveness of the QAP. 	<p>The annual report on the QAP must include all required components.</p> <p>Note: Element 2.1 requires this report to be reviewed and approved by the governing body to assess the QAP’s continuity, effectiveness, and current acceptability.</p>	<ul style="list-style-type: none"> • Annual QAP Evaluation Report • QAC Meeting Minutes
1.9	<p>The QA Plan must contain an organizational chart that includes all positions required to facilitate the QAP.</p>	<p>The organizational chart must be comprehensive, indicating all appropriate positions and their relationships to one another.</p>	<ul style="list-style-type: none"> • QAP Organizational Chart

Standard	Description	Review Guidelines	Documents to be Reviewed
2.0	<p>Accountability to the Governing Body – The governing body of the MCO is the BOD or, where the Board’s participation with the QI issues is not direct; a committee of the MCO’s senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care.</p>		
2.1	<p>There is documentation that the governing body has oversight of the QAP. The governing body must approve the overall QAP and an annual QA Plan.</p>	<p>The governing body is the BOD or the designated entity of senior management that has accountability and oversight of the operations of the MCO, including but not limited to the QAP.</p> <p>The QA Plan must specify that the governing body has oversight of the QAP. The governing body meeting minutes must reflect the review and approval of the overall QAP and the annual QA Plan.</p>	<ul style="list-style-type: none"> • QA Plan • MCO Organizational Chart • QA Organizational Chart • Governing Body Meeting Minutes
2.2	<p>The governing body formally designates an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide oversight as a committee.</p>	<p>Documentation must be provided to indicate what committee or body the governing body has designated as the entity accountable for oversight of QA activities.</p> <p>Note: When the BOD or the designated entity of senior management does not choose to provide direct oversight of the day-to-day operations of the QAP, it must formally designate in writing a committee or other entity to provide such oversight. For example, this may be the MCO’s Quality Committee. However, the governing body must continue to perform all of the responsibilities noted in Standard 1.0.</p>	<ul style="list-style-type: none"> • Governing Body Meeting Minutes • QA Plan • QAC Meeting Minutes • QA Organizational Chart

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
2.3	The governing body routinely receives written reports on the QAP that describe actions taken, progress in meeting QA objectives, and improvements made.	There must be evidence that the governing body receives written reports from the QAC that include all required components. Reporting to the governing body should occur according to the time frames documented in the QA Plan (e.g., monthly, quarterly, etc.).	<ul style="list-style-type: none"> • Governing Body Meeting Minutes • QA Plan
2.4	<p>The governing body formally reviews, at least annually, the written report on the QAP.</p> <p>a. The written report on the QAP must include studies undertaken, results, and subsequent actions.</p> <p>b. The written report on the QAP must include an analysis of aggregate data on utilization and quality of services rendered.</p>	<p>An annual report on the QAP must be completed that contains all of the components addressed in this element.</p> <p>There must be evidence in the governing body meeting minutes that this document was reviewed and approved by the governing body.</p>	<ul style="list-style-type: none"> • QAP Annual Evaluation Report • Governing Body Meeting Minutes
2.5	The governing body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review of findings and issues of concern within the MCO.	The governing body receives regular written reports from the QAP delineating actions taken and improvements made (Element 2.3). As a result, the governing body takes action and provides follow-up when appropriate. These activities are documented in the minutes of the meetings in sufficient detail to demonstrate that it has directed and followed up on necessary actions pertaining to the QAP.	<ul style="list-style-type: none"> • QA Plan • Governing Body Meeting Minutes • QAC Meeting Minutes

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
2.6	<p>The governing body is active in credentialing and recredentialing functions. The following activities related to credentialing and recredentialing must be evident:</p> <ol style="list-style-type: none"> a. The governing body or delegate approves the credentialing and recredentialing plan and reviews credentialing and recredentialing committee minutes/reports. b. If credentialing or recredentialing is delegated, evidence of governing body oversight of the delegated entity is present in the governing body’s meeting minutes. 	<p>There must be evidence that the credentialing plan and recredentialing committee minutes/reports have been reviewed and approved by the appropriate body, group or individual.</p> <p>There is evidence that the MCO is monitoring the delegate’s activities.</p> <p>There is evidence that the MCO monitors the effectiveness of the delegate’s activities.</p>	<ul style="list-style-type: none"> • Governing Body Meeting Minutes
2.7	<p>The governing body is active in UR activities. The governing body meeting minutes reflect ongoing reporting of:</p> <ol style="list-style-type: none"> a. UR activities, b. UR findings, and c. Evaluation of UR progress. 	<p>The UR Plan provides a clear definition of the overall authority and responsibility of the governing body.</p>	<ul style="list-style-type: none"> • Governing Body Meeting Minutes • UR Plan
2.8	<p>An MCO may not knowingly have a relationship with individuals debarred by Federal Agencies.</p> <ol style="list-style-type: none"> a. An MCO must have written policies and procedures ensuring that its directors, officers, and/or partners do not knowingly have any relationship with or an affiliation with individuals debarred by Federal Agencies. b. An MCO must have written policies and procedures ensuring that it does not have an individual debarred by Federal Agencies with beneficial ownership of five percent or more of the MCO’s equity. c. An MCO must have written policies and procedures ensuring that it does not have an individual debarred by Federal Agencies with an employment, consulting or other arrangement with the MCO. 	<p>An MCO may not have a relationship with an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.</p> <p>An MCO may not have an affiliation with an individual who has been debarred by Federal Agencies, as defined in the Federal Acquisition Regulation.</p>	<ul style="list-style-type: none"> • Governance Policies and Procedures • Subcontracting and Employment Policies and Procedures

Standard	Description	Review Guidelines	Documents to be Reviewed
3.0	Oversight of Delegated Entities – The MCO remains accountable for all functions, even if certain functions are delegated to other entities.		
3.1	There is a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO.	The contract for delegated activities contains the components listed in this element.	<ul style="list-style-type: none"> • Delegation Contract • Delegation Policies & Procedures
3.2	The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the QOC being provided.	The MCO has policies and procedures in place to monitor and evaluate the delegated functions and for verifying the care provided.	<ul style="list-style-type: none"> • Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities
3.3	<p>There is evidence of continuous and ongoing evaluation of delegated activities, including:</p> <ol style="list-style-type: none"> a. Oversight of delegated entities' performance to ensure the quality of the care and/or service provided, through the review of regular reports, annual reviews, site visits, etc. b. Quarterly review and approval of reports from the delegates that are produced at least quarterly regarding complaints, grievances, and appeals, where applicable. c. Review and approval of claims payment activities, where applicable. d. Review and approval of the delegated entities' UM plan, which must include evidence of review and approval of UM criteria by the delegated entity, where applicable. e. Review and approval of over and under utilization reports, where applicable. 	<p>There is evidence that an appropriate committee or body within the MCO makes process improvement decisions and acts upon the conclusions drawn from delegated entity monitoring according to the MCO's internal policies and procedures and/or the terms set forth in the delegate's contract.</p> <p>The MCO must provide evidence of items a. through e.</p>	<ul style="list-style-type: none"> • Delegation Contract • Delegation Policies & Procedures • Documentation of Monitoring Activities • Delegation Committee Meeting Minutes • Delegated Entities' Complaints, Grievances, and Appeals Reports, where applicable • Delegated Entities' Claims Payment Monitoring Reports, where applicable • Delegated Entities' Utilization Activity Reports, where applicable

Standard	Description	Review Guidelines	Documents to be Reviewed
<p>4.0</p>	<p>Credentialing and Recredentialing – The QAP contains all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services.</p>		
<p>4.1</p>	<p>The MCO has written policies and procedures for the credentialing process that govern the organization’s credentialing and recredentialing.</p> <ol style="list-style-type: none"> a. The MCO must have a written Credentialing Plan that contains the policies and procedures describing the initial credentialing and subsequent recredentialing process. b. The Credentialing Plan designates a CC or other peer review body that makes recommendations regarding credentialing decisions. c. The Credentialing Plan must identify the practitioners who fall under its scope of authority and action. d. The Credentialing Plan must include policies and procedures for communication with providers regarding provider applications within the time frames specified in Insurance Article Section 15-112(d). 	<p>The MCO must have a comprehensive written Credentialing Plan and/or policies and procedures outlined in the QA Plan that describe the process for credentialing and recredentialing.</p> <p>The Credentialing Plan must designate the peer review body that has the authority to make recommendations regarding credentialing decisions and must identify the practitioners who fall under its authority.</p> <p>Within 30 days of receipt of a completed application, the MCO shall send to the provider at the address listed in the application written notice of:</p> <ol style="list-style-type: none"> 1. The MCO’s intent to continue to process the provider’s application to obtain necessary credentialing information. 2. The MCO’s rejection of the provider for participation in the MCO’s provider panel. <p>If the MCO provides notice to the provider of its intent to continue to process the providers application, the MCO, within 120 days after the date the notice is provided, shall:</p> <ol style="list-style-type: none"> 1. Accept or reject the provider for 	<ul style="list-style-type: none"> • Credentialing Plan • Credentialing Process in QA Plan • Governing Body Meeting Minutes • Delegation Committee/Oversight Committee Meeting Minutes • Credentialing Policies & Procedures

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>participation on the MCO’s provider panel.</p> <p>2. Send written notice of the acceptance or rejection to the provider at the address on the application.</p> <p>After the MCO receives the completed application, the MCO is subject to the aforementioned time frames for completed application processing.</p> <p>When an “online credentialing system” is utilized by the MCO the following applies:</p> <ul style="list-style-type: none"> • The MCO is required to track the date of the application i.e. query the online credentialing system so that dates of credentialing can be calculated. • The “10 Day Letter” is not applicable since the entire application must be completed prior to exiting the application. • The “30 Day Letter” still applies with the above mentioned timeframes. • If an MCO does not accept applications through an “online credentialing system”, notice shall be given to the provider at the address listed in the application within 10 days after the date the application is received that the application is complete. 	

Standard	Description	Review Guidelines	Documents to be Reviewed
4.2	<p>There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. Documentation includes:</p> <ul style="list-style-type: none"> a. Written policies and procedures for the suspension, reduction, or termination of practitioner privileges. b. A documented process for, and evidence of implementation of, reporting to the appropriate authorities, any serious quality deficiencies resulting in suspension or termination of a practitioner. c. A documented process for provider appeals in the event of the MCO’s suspension, termination, or reduction of a practitioner’s privileges with the organization. 	<p>There are policies and procedures in place for the suspension, reduction, or termination of practitioner privileges. There is evidence that these policies and procedures have been implemented.</p> <p>The policies and procedures must identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.</p>	<ul style="list-style-type: none"> • Credentialing Plan • Recredentialing Plan • Credentialing Policies & Procedures • Provider Appeal Policy & Procedure • Provider Appeals Files • Facility Site Reviews (completed forms/files)
4.3	<p>If the MCO delegates credentialing/recredentialing activities, the following must be present:</p> <ul style="list-style-type: none"> a. A written description of the delegated activities. b. A description of the delegate’s accountability for designated activities. c. Evidence that the delegate accomplished the credentialing activities. 	<p>The contract for delegated services includes a description of the delegated activities and the delegate’s accountability for designated activities.</p> <p>The delegate provides reports to the MCO according to the contract requirements.</p>	<ul style="list-style-type: none"> • Delegation Contract • Delegate Progress Reports to the MCO • MCO Monitoring Documents

Standard	Description	Review Guidelines	Documents to be Reviewed
4.4	<p>The credentialing process must be ongoing and current. At a minimum, the credentialing process must include:</p> <ul style="list-style-type: none"> a. A review of a current valid license to practice. b. A review of a valid DEA or CDS certificate, if applicable. c. A review of graduation from medical school and completed residency or post-graduate training, as applicable. d. A review of work history. e. A review of a professional and liability claims history. f. A review of current adequate malpractice insurance according to the MCO's policy. g. A review of good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility. h. A review of EPSDT certification. i. Adherence to the time frames set forth in the MCO's policies regarding credentialing date requirements. j. Adherence to the time frames set forth in the MCO's policies for communication with providers regarding provider applications within the time frames specified in Insurance Article Section 15-112(d). 	<p>The credentialing plan and policies and procedures require, at a minimum, that the MCO obtain the information required in components a-h for the credentialing process.</p> <p>Note: (h) is applicable to those PCPs who deliver preventive health care services to enrollees less than 21 years of age. The reviewer will assess the MCO's methodology for verifying whether PCPs in the MCO's network that see patients under age 21 are EPSDT certified.</p> <p>As a result of House Bill 444, changes were made to Maryland Insurance Article Section 15-112 in CY 2011. Updates must be made to credentialing policies and procedures to reflect the following: If the MCO does not accept applications through an online credentialing system, the MCO must provide notice to the provider that the application is complete at the address listed in the application within 10 days after the date the application is received.</p>	<ul style="list-style-type: none"> • Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Written correspondence to providers.
4.5	<p>There should be evidence that the MCO requests from recognized monitoring organizations information about the practitioner. The evidence must include:</p> <ul style="list-style-type: none"> a. Any revocation or suspension of a State license or a DEA/BNDD number. b. Any curtailment or suspension of medical staff privileges (other than for incomplete medical records). 	<p>The credentialing plan and policies and procedures require that the MCO request information required in components a-d from recognized monitoring organizations.</p>	<ul style="list-style-type: none"> • Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Credentialing Committee Meeting Minutes

Standard	Description	Review Guidelines	Documents to be Reviewed
	<p>c. Any sanctions imposed by Medicare and/or Medicaid.</p> <p>d. Information about the practitioner from the NPDB and the MBP.</p>		
4.6	<p>The credentialing application includes the following:</p> <p>a. The use of illegal drugs.</p> <p>b. Any history of loss of license.</p> <p>c. Any history of loss or limitation of privileges or disciplinary activity.</p> <p>d. Attestation to the correctness and completeness of the application.</p>	<p>The credentialing plan and policies and procedures describe the application process. This process includes the requirement that the applicant must provide a statement that includes components a-d.</p> <p>There must be evidence in the credentialing files that this statement is completed. Type of credentialing application must be reviewed and in compliance with MIA regulatory requirements noted.</p>	<ul style="list-style-type: none"> • Credentialing Plan • Credentialing Policies & Procedures • Sample Credentialing Records • Completed Application • Completed Uniform Credentialing Form
4.7	<p>There is evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the ADA and the MCO's standards.</p>	<p>The credentialing plan and policies and procedures must require an initial visit to each potential primary care practitioner's office. There must be documentation that a review of the site includes both an evaluation of ADA compliance and medical record keeping, and that these practices are in conformance with the MCO's standards. Such standards should consider:</p> <ul style="list-style-type: none"> • Handicapped designated parking clearly marked and close to the entrance. • Ramps for wheelchair access. • Door openings to the practice and restroom and hallways should facilitate access for disabled individuals. 	<ul style="list-style-type: none"> • Credentialing Plan • Credentialing Policies & Procedures • Site Visit Tool • Sample Completed Site Visit Tools • Sample Credentialing Records • Applicable Reports of On-site Visits • Credentialing Committee Meeting Minutes

Standard	Description	Review Guidelines	Documents to be Reviewed
		<ul style="list-style-type: none"> Elevator availability for practices above ground level. 	

Standard	Description	Review Guidelines	Documents to be Reviewed
4.8	<p>There is evidence that recredentialing is performed at least every three years and:</p> <ol style="list-style-type: none"> Includes a review of information from the NPDB. Includes a review of available performance data. Includes all items contained in element 4.4 a–h. Includes all items contained in 4.6 a–d. Meets the time frames set forth in the MCO’s policies regarding recredentialing decision date requirements. 	<p>The credentialing plan and policies and procedures indicate that recredentialing is performed at least every three years.</p> <p>The recredentialing process requires a review of components contained in a-d. There is evidence in individual provider credentialing files that this has occurred. This information is used to decide whether or not to renew the participating physician agreement.</p>	<ul style="list-style-type: none"> Credentialing Plan Recredentialing Policies & Procedures Sample Credentialing Records Credentialing Committee Meeting Minutes
4.9	<p>There is evidence that the recredentialing process includes a review of the following:</p> <ol style="list-style-type: none"> Enrollee complaints. Results of quality reviews. Hospital privileges and current licensure. Office site compliance with ADA standards, if applicable. 	<p>The credentialing process described in the credentialing plan and policies and procedures requires review of components a–d. There is evidence in provider recredentialing files that this has occurred.</p> <p>There is a process in place to reassess provider site ADA compliance when:</p> <ol style="list-style-type: none"> the provider has relocated to a site that has not previously been evaluated and approved as being ADA compliant, or there is evidence of ADA non-compliance issues with a particular site of care delivery. 	<ul style="list-style-type: none"> Credentialing Plan Recredentialing Policies & Procedures Sample Recredentialing Records
4.10	<p>The MCO must have policies and procedures regarding the selection and retention of Providers.</p> <ol style="list-style-type: none"> The MCO must have written policies and procedures for selection and recruitment of 	<p>Policies and procedures should be directed at ensuring that recipient choice is enhanced by providers participating in multiple MCOs. Also, ensuring that providers are retained</p>	<ul style="list-style-type: none"> Credentialing Plan Credentialing Policies and Procedures

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
	providers in the HealthChoice Program. b. The MCO must have written policies and procedures for the retention of providers in the HealthChoice Program.	within the Medicaid network.	

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Standard	Description	Review Guidelines	Documents to be Reviewed
4.11	<p>The MCO must ensure that enrollees' parents/guardians are notified if they have chosen for their child to be treated by a non-EPSDT certified PCP.</p> <p>a. The MCO must have a written policy and procedure regarding notifying parents/guardians within 30 days of enrollment that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.</p> <p>b. The MCO must provide evidence of notification to parents/guardians that the PCP they chose to treat their child is a non-EPSDT certified physician and they have the option to switch to a certified EPSDT PCP if desired.</p>	<p>The MCO must include in the notification, with a copy to the Department, an explanation of the:</p> <ul style="list-style-type: none"> • EPSDT preventive screening services to which an enrollee is entitled according to the EPSDT periodicity schedule; • Importance of accessing the EPSDT preventive screening services; and • Process for requesting a change to an EPSDT-certified PCP to obtain preventive screening services. 	<ul style="list-style-type: none"> • Policies and Procedures • Letters to Parents/Guardians

Standard	Description	Review Guidelines	Documents to be Reviewed
5.0	Enrollee Rights – The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities.		
5.1	<p>The MCO has a system linked to the QAP for resolving enrollees’ grievances. This system meets all requirements in COMAR 10.09.71.02 and 10.09.71.04.</p> <ol style="list-style-type: none"> a. There are written procedures in place for registering and responding to grievances in accordance with COMAR 10.09.71. b. The system requires documentation of the substance of the grievances and steps taken. c. The system ensures that the resolution of a grievance is documented according to policy and procedure. d. The policy and procedure describes the process for aggregation and analysis of grievance data and the use of the data for QI. There is documented evidence that this process is in place and is functioning. e. The MCO has a documented appeal process. This process must provide for the enrollee to present his/her case to the MCO’s CEO or his/her designee as the final level of grievance process. 	<p>Time frames for resolving grievances in the policy and procedure must be in accordance with the following:</p> <ul style="list-style-type: none"> • Emergency medically related grievances not > 24 hours. • Non-emergency medically related grievances not > 5 days. • Administrative grievances not > 30 days. <p>The policy and procedures must describe what types of information will be collected when grievances are recorded and processed. The MCO must have a grievance form. The policies and procedures must include the process stating how the form is used and how an enrollee can get assistance from the MCO in completing the form.</p>	<ul style="list-style-type: none"> • Grievance Policies & Procedures • Grievance Form • Grievance Logs • Grievance Reports • Grievances Files • QAC/QIC Meeting Minutes • CAB Meeting Minutes • Quarterly Complaint/Grievance/ Appeal Reports Sent to DHMH

Standard	Description	Review Guidelines	Documents to be Reviewed
	<p>f. There is complete documentation of the substance of the grievances and steps taken.</p> <p>g. The MCO adheres to the time frames set forth in its policies and procedures for resolving grievances.</p>	<p>The policies and procedures must describe the complete process from the registration through resolution of grievances. The policies and procedures must allow participation by the provider or an ombudsman, if appropriate, and must ensure the participation of individuals within the MCO who have authority to require corrective action.</p> <p>A sample of selected grievances is reviewed to assure that the process is complete and is being followed.</p> <p>The policies and procedures describe the process to be used for data collection and analysis. This must include time frames for collection and reporting. (e.g., collected and analyzed quarterly, reported to the QAC quarterly).</p> <p>The policies and procedures must include the notification of results to the provider and the QACs as required by COMAR.</p> <p>If problems are identified, the reviewer will track the progress of problem resolution. The appeal process must include a final level of appeal to the MCO’s CEO or his/her designee.</p>	

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
5.2	Enrollee information is written to be readable and easily understood. This information is available in the prevalent non-English languages identified by the Department.	Enrollee information including, but not limited to, enrollee handbook, newsletters, and health education materials are written at the appropriate reading comprehension level for the Medicaid population. The SMOG formula or the Flesch-Kincaid Grade Level Index will be applied to determine readability. Currently, the State has determined that Spanish is the prevalent language in which the MCOs must make vital materials available to enrollees.	<ul style="list-style-type: none"><li data-bbox="1535 237 1856 293">• Enrollee Informational Materials

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Standard	Description	Review Guidelines	Documents to be Reviewed
5.3	<p>The organization acts to ensure that the confidentiality of specified patient information and records is protected. The MCO:</p> <ul style="list-style-type: none"> a. Has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records and electronic data. b. Ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the MCO. c. Must hold confidential all information obtained by its personnel about enrollees related to their care and shall not divulge it without the enrollee’s authorization unless: (1) it is required by law, (2) it is necessary to coordinate the patient’s care, or (3) it is necessary in compelling circumstances to protect the health or safety of an individual. d. Must ensure that the release of any information in response to a court order is reported to the patient in a timely manner. e. May disclose enrollee records, with or without the enrollee’s authorization, to qualified personnel for the purpose of conducting scientific research, but such personnel may not identify any individual enrollee in any report of research or otherwise disclose participant identity in any manner. 	<p>The policies and procedures address all required components described in a-e. The MCO must provide evidence that these policies and procedures have been implemented.</p> <p>The MCO must provide documentation to demonstrate that it ensures patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information.</p>	<ul style="list-style-type: none"> • Medical Records Policies & Procedures • Confidentiality Policies & Procedures • Sample Provider Contracts • Sample Provider Site Visit Evaluation Tool • Credentialing Policies & Procedures • Tools Related to Assessing Confidentiality of Patient Medical Records • Sample of MCO Employee Confidentiality Statement • Signed MCO Employee Confidentiality Statements • Sample Vendor Contracts
5.4	<p>The MCO has written policies regarding the appropriate treatment of minors.</p>	<p>The MCO has a written policy addressing the appropriate treatment of minors. This policy must address the minor’s right to receive treatment without parental consent in cases of sexual abuse, rape, family planning, and</p>	<ul style="list-style-type: none"> • Treatment of Minors Policy

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
		sexually transmitted diseases.	

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Standard	Description	Review Guidelines	Documents to be Reviewed
5.5	<p>As a result of the enrollee satisfaction surveys, the MCO:</p> <ul style="list-style-type: none"> a. Identifies and investigates sources of dissatisfaction. b. Implements steps to follow up on the findings. c. Informs practitioners and providers of assessment results. d. Reevaluates the effects of b. above at least quarterly. 	<p>There is a process in place for identifying sources of dissatisfaction. The MCO must have mechanisms in place to identify problems, develop plans to address problems, and provide follow-up. There must be documentation (e.g. meeting minutes, CAPs) to demonstrate that policies and procedures are in place and are being followed.</p> <p>There is a mechanism in place to provide survey information to providers as a group, and to an individual provider(s) if warranted.</p>	<ul style="list-style-type: none"> • Patient Satisfaction Evaluation Policies and Procedures • Patient Satisfaction Evaluation Tool • Patient Satisfaction Survey Data Analysis • Corrective Action Plans • Appropriate Committee Meeting Minutes

Standard	Description	Review Guidelines	Documents to be Reviewed
5.6	<p>The MCO has systems in place to assure that new enrollees receive required information within established time frames.</p> <p>a. Policies and procedures are in place that address the content of new enrollee packets of information and specify the time frames for sending such information to the enrollee.</p> <p>b. Policies and procedures are in place for newborn enrollments, including issuance of the MCO’s ID card.</p> <p>c. The MCO has a documented tracking process for timeliness of newborn enrollment that has the ability to identify issues for resolution.</p>	<p>Policies and procedures address the content of new enrollee information packets and time frames for receipt of the packets. At a minimum, new enrollee information packets contain:</p> <ul style="list-style-type: none"> • Enrollee ID card • Enrollee handbook • Provider Directory <p>New enrollee information packets are provided to new enrollees within 10 calendar days of DHMH’s notification to the MCO of enrollment.</p> <p>The MCO has a written procedure that tracks and monitors timeliness of receipt of ID cards (including newborns). Such monitoring is analyzed and if timelines are not met, there is evidence of corrective action and evaluation of progress. Performance is reported through committee or the MCO’s administrative structure.</p> <p>There is a documented process for newborn enrollment that includes time frames. The MCO has a documented internal mechanism for processing and follow-up on the Daily MCO Newborn Enrollment Report from the Department.</p>	<ul style="list-style-type: none"> • Sample New Enrollee Information Packet • New Enrollee Policies & Procedures • Committee Meeting Minutes • ID Card Fulfillment Reports • ID Card Fulfillment Tracking and Trending Analysis
5.7	<p>The MCO must have an active Consumer Advisory Board (CAB).</p> <p>a. The MCO’s CAB membership must reflect the special needs population requirements.</p> <p>b. The CAB must meet at least six times a year.</p> <p>c. The MCO must have a mechanism for tracking enrollee feedback from the</p>	<p>An MCO shall establish a CAB to facilitate the receipt of input from enrollees. The CAB membership shall consist of enrollees and enrollees’ family members, guardians, or caregivers. It is to be comprised of no less than 1/3 representation from the MCO’s special needs populations, or their representatives. Pursuant to regulation, the CAB shall annually report its activities and recommendations to the Secretary.</p>	<ul style="list-style-type: none"> • Policies and Procedures • Committee Charter • CAB Meeting Minutes • CAB Annual Summary

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
	meetings.		

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Standard	Description	Review Guidelines	Documents to be Reviewed
6.0	Availability and Accessibility – The MCO has established measurable standards for access and availability.		
6.1	<p>The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services.</p> <ol style="list-style-type: none"> a. The MCO has developed and disseminated written access and availability standards. b. The MCO has processes in place to monitor performance against these standards. c. The MCO has established policies and procedures for the operations of its customer/enrollee services and has developed standards/indicators to monitor, measure, and report on its performance. d. The MCO has documented review of the Enrollee Services Call Center performance. 	<p>The MCO has established access and availability standards that comply with HCQIS and COMAR requirements and demonstrates that these standards have been disseminated to providers. These standards must include:</p> <ul style="list-style-type: none"> • routine appointments • urgent appointments • emergency care/services • telephone appointments • advice • enrollee service lines • outreach • clinical and pharmacy access <p>The MCO has also established policies and procedures for the operations of its internal customer/enrollee services. Performance standards have been developed, such as telephone answering time, wait time, abandon call rates, and time frames for response to enrollees’ inquiries. Such standards are measured for performance and identification of issues that affect enrollee services and are reported through established channels, such as committees.</p>	<ul style="list-style-type: none"> • Access and Availability Standards • Access and Availability Policies & Procedures • Provider Manual • Newsletters • Monitoring and Evaluation Processes • Committee Meeting Minutes • Monitoring Reports • Performance Trends

Standard	Description	Review Guidelines	Documents to be Reviewed
6.2	<p>The MCO has a list of providers that are currently accepting new enrollees.</p> <p>a. The MCO must verify that its providers are listed geographically and are adequate to meet the needs of the population as specified in COMAR.</p> <p>b. At the time of enrollment, enrollees are provided with information about the MCO’s providers that includes requirements set forth in COMAR 10.09.66.</p> <p>c. The MCO has a methodology in place to assess and monitor the network needs of its population, including individuals with disabilities.</p>	<p>The MCO must comply with the network capacity and geographic access requirements required in COMAR 10.09.66.05.B and COMAR 10.09.66.06.B-D. Some of these are listed below:</p> <ul style="list-style-type: none"> • Enrollee to physician ratio for local access area = 200:1 • Enrollee to advance practice nursing specialties = 100:1. • Travel time (urban) - 10 mile radius • Travel time (suburban) – within 20 mile radius • Travel time (rural) - within 30 mile radius. <p>Refer to COMAR for more specific requirements.</p> <p>The listing of individual practitioners who are the MCO’s primary and specialty care providers are grouped by county and by medical specialty and include the following information:</p> <ul style="list-style-type: none"> • Name • Address • Practice location(s) • An indication of whether or not the provider is accepting new Medicaid patients • An indication of whether or not access to the provider is otherwise limited (e.g. by age of patient or number of enrollees the provider will serve.) <p>The directory must also include:</p>	<ul style="list-style-type: none"> • Provider Directory • Provider Manual • New Enrollee Packet • New Enrollee Orientation Materials • Availability & Access Standards • Access and Availability Policies & Procedures • Monitoring Methodology • Monitoring Reports • Committee Meeting Minutes • Top Ten Diagnoses for all Care Settings • Enrollee Complaint Reports • Documentation of any CAPs

Standard	Description	Review Guidelines	Documents to be Reviewed
		<ul style="list-style-type: none"> • A listing of the MCO’s hospital providers, of both inpatient and outpatient services, in the enrollee’s county and their addresses and services provided. The MCO has a methodology in place to assess and monitor the network needs of its Medicaid population. The methodology substantiates how the MCO determines that it has sufficient numbers and the types of specialists, as well as PCPs, within its network to meet the care and service needs of its population in all care settings. The methodology includes a process of monitoring that has the ability to identify problem areas that are reported through the MCO’s established structure. Follow-up activities and progress towards resolution are evident. • Direct access to specialists. Each MCO must have a mechanism in place to allow enrollees with special health care needs who have been determined to need a course of treatment or regular care monitoring to directly access a specialist as appropriate for the enrollee’s condition and identified needs. This is determined through an assessment by appropriate health care professionals and can be provided for example, through a standing referral or an approved number of visits. <p>“An MCO shall provide access to health care services and information in a manner that</p>	

Standard	Description	Review Guidelines	Documents to be Reviewed
		addresses the individualized needs of its enrollees, including, but not limited to, the delivery of services and information to enrollees: In a manner that accommodates individuals with disabilities consistent with the requirements of the Americans with Disabilities Act of 1990, P.L. 101-330, 42 U.S.C. §12101 et seq., and regulations promulgated under it.”	
6.3	<p>The MCO has implemented policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services.</p> <p>a. The MCO must have policies and procedures in place for notifying enrollees of due dates for wellness services, IHAs, and preventive services.</p> <p>b. The policies and procedures include the procedures for notification and outreach for noncompliant enrollees.</p> <p>c. Trending and analysis of data are included in the QAP and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.</p>	<p>Policies and procedures must be in place and address all components a-c.</p> <p>MCO must provide evidence that these policies and procedures have been implemented and are functioning appropriately.</p> <p>Documentation must be provided to substantiate that time frames are adhered to and that tracking procedures are in place.</p> <p>The MCO has a written procedure/methodology that tracks and monitors timeliness of IHAs. Such monitoring is analyzed and if un-timeliness is identified, there is evidence of corrective action and evaluation of progress. Performance is reported through committee or the MCO’s administrative structure.</p>	<ul style="list-style-type: none"> • New Enrollee Policies & Procedures • New Enrollee Packet • New Enrollee Orientation Materials • Scheduling of IHA Policies & Procedures • IHA completion analysis • Outreach Policies & Procedures • Policies & Procedures for Tracking Non-Compliant Enrollees • Sample Letters to Enrollees • Sample Letters to Physicians • Sample Notices • QA Plan

Standard	Description	Review Guidelines	Documents to be Reviewed
7.0	Utilization Review – The MCO has a comprehensive UM program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement.		
7.1	<p>There is a comprehensive written UR Plan.</p> <p>a. This plan includes procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.</p> <p>b. The scope of the UR Plan includes a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services.</p> <p>c. There is documentation that ensures that utilization determinations made by an individual or entity are not directly influenced by financial incentive or compensation.</p>	<p>The UR Plan is comprehensive and addresses components a-c.</p> <p>Component 7.1(c) requires that the MCO documentation reflect that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.</p>	<ul style="list-style-type: none"> • UR Plan • UR Meeting Minutes • Governing Body Meeting Minutes
7.2	<p>The UR Plan specifies criteria for UR/UM decisions.</p> <p>a. The criteria used to make UR/UM decisions must be based on acceptable medical practice.</p> <p>b. The UR Plan must describe the mechanism or process for the periodic updating of the criteria.</p> <p>c. The UR Plan must describe the involvement of participating providers in the review and updating of criteria.</p> <p>d. There must be evidence that the criteria are reviewed and updated according to MCO policies and procedures.</p> <p>e. There is evidence that UR/UM staff receive annual training on the interpretation and application of UR/UM standards.</p> <p>f. There is evidence that the MCO evaluates the consistency with which all staff involved applies</p>	<p>There is evidence that UR criteria are based on acceptable medical practice. The UR Plan must describe the process for reviewing and updating the criteria and for involving providers. There must be evidence that criteria are reviewed and updated per the policies and procedures. The MCO must use an appropriate mechanism to assess the consistency with which physician and non-physician reviewers apply medical necessity criteria.</p>	<ul style="list-style-type: none"> • UR Plan • UR Criteria Reflecting Review/Revision Dates • Policies & Procedures for Criteria Review/Revision • UR Committee Meeting Minutes • Documentation of UR/UM Criteria Application Consistency

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
	UR/UM criteria on at least an annual basis.		

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Standard	Description	Review Guidelines	Documents to be Reviewed
7.3	<p>The written UR Plan has mechanisms in place to detect over utilization and under utilization of services.</p> <p>a. Services provided must be reviewed for over and under utilization.</p> <p>b. UR reports must provide the ability to identify problems and take the appropriate corrective action.</p> <p>c. Corrective measures implemented must be monitored.</p>	<p>The UR Plan describes the process to be used for detecting over and under utilization of services.</p> <p>UR reports and data analysis must be available and should demonstrate the ability to identify problems.</p> <p>There must be documentation to support that the MCO has developed, implemented, and provided follow-up of corrective actions for the identified issues.</p>	<ul style="list-style-type: none"> • UR Plan • UR Policies & Procedures • Data Reports and Analysis • CAPs • UR Committee Meeting Minutes • Provider Profiles
7.4	<p>For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that:</p> <p>a. Preauthorization, concurrent review, and appeal decisions are made and supervised by appropriate qualified medical professionals.</p> <p>b. Efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate.</p> <p>c. The reasons for decisions are clearly documented and available to the enrollee.</p> <p>d. There are well publicized and readily available appeal mechanisms for both providers and enrollees.</p> <p>e. Preauthorization and concurrent review decisions are made in a timely manner as specified by the State.</p> <p>f. Appeal decisions are made in a timely manner as required by the exigencies of the situation.</p> <p>g. The MCO maintains policies and procedures pertaining to provider appeals as outlined in COMAR 10.09.71.03.</p>	<p>The MCO must demonstrate that appropriate medical staff supervises the review decisions. The method to collect information for review decisions is documented.</p> <p>For services to enrollees that require preauthorization by the MCO, the MCO shall provide the preauthorization in a timely manner so as not to adversely affect the health of the enrollee and within 2 business days of receipt of necessary clinical information but not later than 7 calendar days from the date of the initial request. The MCOs shall notify the enrollee and the provider in writing whenever the provider's request for preauthorization for a service is denied.</p> <p>The state specified threshold for all preauthorization review decisions has been lowered to 95%. A sample of preauthorization reviews must be reviewed for compliance with state specified</p>	<ul style="list-style-type: none"> • UR Plan • UR Policies & Procedures • UR Organizational Charts • UM Position Descriptions • UM Staffing Plan • UR Committee Meeting Minutes • Enrollee Appeals Policies & Procedures • Selected UR Cases • Sample UM Delegation Contract • Delegate Reports to MCO • MCO Monitoring of Delegate Reports • Appeals Policies & Procedures • Appeals Forms & Logs • Appeals Reports • Appeal Records

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>timeliness by the MCO according to their policies (i.e., weekly, monthly, or quarterly). This review is required to be completed using a statistically valid sample size with a confidence level of 95% and a sampling error of 5%.</p> <p>Notice of decision to deny initial services must be provided to the enrollee within: 24 hours for Emergency, medically related requests, not more than 72 hours for non-emergency, medically related requests. For any previously authorized service written notice to the enrollee must be provided at least 10 days prior to reducing, suspending, or terminating a covered service.</p> <p>There is evidence that review decisions are documented and available to enrollees.</p> <p>There is evidence that initial review decisions and appeal determinations are made within the time frames established by the State.</p> <p>Time frames for resolving appeal in the policy and procedure must be in accordance with the following:</p> <ul style="list-style-type: none"> • Expedited Appeals within 3 business days. • Non-emergency Appeals within 30 days, unless extended pursuant to 438.408 b and c. <p>The MCO must ensure that decision makers</p>	

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>on appeal were not involved in previous levels of review or decision making and are health care professionals with clinical expertise in treating the enrollee's condition.</p> <p>A selected sample of enrollee appeals, or provider appeals submitted on behalf of the enrollee, will be reviewed to assure that the policies and procedures are being followed.</p> <p>The MCO must include in its provider complaint process at least the following elements:</p> <p>An appeal process which:</p> <ul style="list-style-type: none"> (a) Is available when the provider's appeal or grievance is not resolved to the provider's satisfaction; (b) Acknowledges receipt of provider appeals within 5 business days of receipt by the MCO; (c) Allows providers 90 business days from the date of a denial to file an initial appeal; (d) Allows providers at least 15 business days from the date of denial to file each subsequent level of appeal; (e) Resolves appeals, regardless of the number of appeal levels allowed by the MCO, within 90 business days of receipt of the initial appeal by the MCO; (f) Pays claim within 30 days of the appeal decision when a claim denial is overturned; (g) Provides at its final level an opportunity 	

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>for the provider to be heard by the MCO’s chief executive officer, or the chief executive officer’s designee;</p> <p>(h) Provides timely written notice to the provider of the results of the internal appeal.</p>	
7.5	<p>Adverse determination letters include a description of how to file an appeal and all other required components.</p>	<p>There must be documented policies and procedures for appeals. Such policies and procedures must address all 13 required letter components for denial of care and/or services. The required adverse determination letter components include:</p> <ol style="list-style-type: none"> 14. Explanation of the requested care, treatment, or service. 15. Clear, full and complete factual explanation of the reasons for the denial, reduction or termination in understandable language. <ul style="list-style-type: none"> • Conclusive statements such as “services included under another procedure” and “not medically necessary” are not legally sufficient. 16. Clear explanation of the criteria, standards and interpretive guidelines MCO used to make the decision. Use of the phrase “nationally recognized medical standards” is acceptable. 17. Description of any additional information MCO needs for reconsideration. 18. Statement that the enrollee has access to his/her medical records. 19. Direction to the enrollee to call the Enrollee Help Line (EHL) to discuss the enrollee’s right to appeal if he/she disagrees with the MCO decision. This direction should appear prior to any 	<ul style="list-style-type: none"> • Enrollee Adverse Determination Letter Policies and Procedure • Sample Enrollee Adverse Determination Letters • Selected UR Cases

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>direction to call the MCO.</p> <p>20. Explanation to the enrollee that if he/she calls the EHL or the MCO within 10 days of receiving the adverse action letter, he/she may continue to receive the ongoing services that he/she is currently receiving and may have to pay.</p> <p>21. Statement that the enrollee may represent self or use legal counsel, a relative, a friend, or other spokesperson.</p> <p>22. An explanation that it is assumed an enrollee receives the letter 5 days after it is dated unless he/she shows evidence otherwise.</p> <p>23. An explanation that the EHL staff will investigate the MCO decision, resolve within 10 days, or provide information about how to request a Fair Hearing.</p> <p>24. There is evidence that the letter is copied to the PCP.</p> <p>25. A statement explaining the availability of the expedited review process.</p> <p>26. A statement of availability of the letter in other languages and alternate formats.</p>	
7.6	<p>There are policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.</p> <p>a. The MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.</p> <p>b. The MCO demonstrates review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the</p>	<p>The intent of this element is to provide a mechanism for enrollees and providers to offer opinions on the UR process in place at the MCO and assure that the MCO is reviewing and acting upon identified issues.</p> <p>There must be evidence these processes are in place and functioning.</p> <p>There must be evidence that these policies and procedures have been followed. The policies and procedures must describe the</p>	

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
	appropriate oversight committee. c. The MCO acts upon identified issues as a result of the review of the data.	process to evaluate the effects of the program using data on provider satisfaction and/or other appropriate measures.	

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Standard	Description	Review Guidelines	Documents to be Reviewed
8.0	Continuity of Care – The MCO has put a basic system in place that promotes continuity of care and CM.		
8.1	<p>Enrollees with special needs and/or those with complex health care needs must have access to CM according to established criteria and must receive the appropriate services.</p>	<p>The MCO must have policies and procedures in place to identify enrollees with special needs and/or complex health care needs, such as uncontrolled diabetes, severe asthma and high-risk pregnancy, and to enroll them into CM according to the MCOs established criteria. This system must allow for the enrollee to access the appropriate services provided by the MCO.</p> <p>Per COMAR 10.09.65.04B, special needs populations are identified as:</p> <ol style="list-style-type: none"> 1. Children with special health care needs. 2. Individuals with a physical disability. 3. Individuals with a developmental disability. 4. Pregnant and postpartum women. 5. Individuals who are homeless. 6. Individuals with HIV/AIDS. 7. Individuals with a need for substance abuse treatment. 8. Children in State supervised care. <p>Specifically, the MCO has documented evidence of the following:</p> <ul style="list-style-type: none"> • CM Plan that describes the MCO’s CM program and/or CM policies and procedures. • Mechanisms for coordination of care/ services with the PCP. • CM criteria and/or standards for the following: <ul style="list-style-type: none"> ◊ Identification of children and adult enrollees with special needs ◊ Assessment of enrollees with special 	<ul style="list-style-type: none"> • CM Plan • CM Criteria/Standards • CM Policies & Procedures • CM Cases • Committee Meeting Minutes (e.g., QA/UR) • Job Descriptions • Reports and Analysis • Orientation/Training Materials

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>needs</p> <ul style="list-style-type: none"> ◇ Plans of care ◇ Caseload <ul style="list-style-type: none"> • Methodology for monitoring the plans of care. • Methodology for evaluating plans of care. • Data collection methodology. • Methodology to evaluate the effectiveness of the CM program. • Collaboration with other department activities such as quality and outreach. • Committee reporting structure. • Minimum qualifications for case managers and case manager supervisors. • Orientation/Training for case managers. • Number of FTEs allocated for CM. 	
8.2	The MCO must have policies and procedures in place to coordinate care with other appropriate agencies or institutions (e.g., school health programs).	The MCO must have policies and procedures in place to assure the coordination of services for its enrollees, including coordination of care/services with the enrollee’s PCP.	<ul style="list-style-type: none"> • Continuity of Care Policies & Procedures
8.3	The MCO must monitor continuity of care across all services and treatment modalities. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).	There is documented evidence of monitoring activities. This includes the collection and analysis of data.	<ul style="list-style-type: none"> • Continuity of Care Policies & Procedures (e.g. hospitalizations, prenatal care) • Data Analysis • QA & UR Committee Meeting Minutes
8.4	The MCO must ensure appropriate initiation of care based on the results of HRA data supplied to the MCO. This must include a process for gathering HRA data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.	There is documented evidence of HRA: <ul style="list-style-type: none"> • data collection methodology • data analysis activities, and • evidence that follow-up based on the results of the analysis is occurring in a timely manner. 	<ul style="list-style-type: none"> • HRA Policies and Procedures • Reports and Analysis

Standard	Description	Review Guidelines	Documents to be Reviewed
9.0	<p>Health Education Plan – The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the enrollee population.</p>		
9.1	<p>The MCO has a comprehensive written HEP, which must include:</p> <ol style="list-style-type: none"> The education plan’s purpose and objectives. Outlines of the educational activities such as seminars and distribution of brochures and calendars of events. A methodology for notifying enrollees and providers of available educational activities. A description of group and individual educational activities targeted at both providers and enrollees. 	<p>The MCO’s HEP must contain all of the components listed in a-d.</p> <p>There must be an indication of how the objectives were established.</p>	<ul style="list-style-type: none"> • HEP & Work Plan • Health Education Schedule of Events • Health Education Materials • Enrollee/Provider Notification Methodology
9.2	<p>The HEP incorporates activities that address needs identified through the analysis of enrollee data.</p>	<p>The MCO must provide evidence that enrollee data were analyzed to determine the need for certain health education programs.</p>	<ul style="list-style-type: none"> • HEP • Enrollee Data Analysis • Health Education Calendar of Events

Standard	Description	Review Guidelines	Documents to be Reviewed
9.3	<p>The MCO’s HEP must:</p> <ul style="list-style-type: none"> 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. b. Provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the members. 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 member referrals. 	<p>The HEP must describe the qualifications of the staff that will conduct the educational sessions (e.g., certified diabetes instructor, registered dietician, or certified mental health provider).</p> <p>The education plan must describe how a provider can access a health educator/ educational program through the MCO (e.g., the MCO may designate a contact person to assist the provider in connecting the enrollee to a health educator or program).</p>	<ul style="list-style-type: none"> • Data Analysis and Studies • HEP and Work Plan • Provider Manual • Impact Evaluation Methodology
9.4	<p>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.</p>	<p>Mechanisms to identify enrollees in special need of educational efforts may include CM, outreach, or PCP referral for one-on-one education of the enrollee with complex medical needs, the home bound enrollee, the noncompliant enrollee with health issues.</p>	<ul style="list-style-type: none"> • Special Educational Need Identification Mechanisms
9.5	<p>The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended. The MCO must provide:</p> <ul style="list-style-type: none"> a. Samples of notifications, brochures, and mailings. b. Attendance records and session evaluations completed by enrollees. c. Provider evaluations of health education programs. 	<p>The MCO must demonstrate that enrollees are notified of educational programs and that they have been afforded the opportunity to evaluate these programs. The MCO must provide documentation in the form of notifications, attendance records and session evaluations. There must be evidence that providers are given the opportunity to evaluate enrollee educational sessions and the overall health education program.</p>	<ul style="list-style-type: none"> • Enrollee Mailings • Attendance Records • Completed Session Evaluations • Program Evaluations • Completed Provider Evaluations

Standard	Description	Review Guidelines	Documents to be Reviewed
<p>10.0</p>	<p>Outreach Plan – The MCO has developed a comprehensive written outreach services plan to assist enrollees in overcoming barriers in accessing health care services. The OP adequately describes the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.</p>	<p>The content of the OP, applicable policies and procedures, applicable flow charts and organizational charts will be reviewed to assess whether the MCO has a comprehensive plan in place for the provision of outreach services. Outreach logs, CM logs, data reports, enrollee and provider mailings and educational materials will be reviewed to determine if the MCO has implemented the OP.</p>	<ul style="list-style-type: none"> • OP and Work Plan • Outreach Policies & Procedures to include Special Needs Population, Response Times, Referral Processes, etc. • Organizational Charts • Job Descriptions and Qualifications • Delegation Agreements • MOUs • Data Reports • Subcontractor Monitoring Reports • Committee Meeting Minutes for Outreach, QA, LHD, etc.

Standard	Description	Review Guidelines	Documents to be Reviewed
10.1	<p>The MCO has developed a written OP that describes the following:</p> <ul style="list-style-type: none"> a. Populations to be served through the outreach activities and an assessment of common health problems within the MCO’s membership. b. MCO’s organizational capacity to provide both broad-based and enrollee-specific outreach. c. Unique features of the MCO’s enrollee outreach initiatives. d. Community partnerships. e. Role of the MCO’s provider network in performing outreach. f. MCO’s relationship with each of the LHDs and ACCUs. 	<p>Each of the MCOs participating in HealthChoice is unique in the manner in which it facilitates the outreach requirements. The OP must describe the individual MCO’s approach to providing outreach. This written plan must provide an overview of outreach activities that includes components 10.1a through 10.1f. Supporting policies and procedures must be in place to provide details regarding how these activities are carried out.</p> <p>The OP must include an overview of the populations to be served. At a minimum the populations must include:</p> <ul style="list-style-type: none"> • Those in need of wellness/ preventive services. • Those children eligible for EPSDT services. • Those enrollees (both adults and children) who are difficult to reach or miss appointments. • Those enrollees comprising the following special populations defined in COMAR 10.09.65.04 B: <ul style="list-style-type: none"> 1) Children with special health care needs. 2) Individuals with a physical disability. 3) Individuals with a developmental disability. 4) Pregnant and postpartum women. 5) Individuals who are homeless. 6) Individuals with HIV/AIDS. 7) Individuals in need of substance abuse treatment. 8) Children in State supervised care. 	<ul style="list-style-type: none"> • Educational Materials • DM and CM Program Descriptions • MOUs • Community Event Calendars or Education Program Schedules • Provider Manual • Provider Contracts • MOUs

Standard	Description	Review Guidelines	Documents to be Reviewed
		<ul style="list-style-type: none"> <li data-bbox="961 238 1516 537">• The OP must briefly describe common health problems within the MCO’s membership (i.e., diabetes, HIV/AIDS, pediatric asthma) and any identified barriers or specific areas where outreach has been or is anticipated to be particularly challenging (i.e., rural population, non-English speaking populations). <p data-bbox="961 570 1516 868">The OP must provide an overview of how the MCO’s internal and external resources are organized to provide an effective outreach program. For example, the OP briefly describes the roles of various departments such as provider relations, enrollee services, CM, DM, health education and delegated entities in the performance of outreach activities.</p> <p data-bbox="961 901 1516 1058">The OP must briefly describe data management systems to be utilized in performing outreach activities. This may include data systems or software used to identify, track, and report outreach activities.</p>	

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>The OP briefly describes any unique educational activities related to the populations served, such as:</p> <ul style="list-style-type: none"> • Languages in which materials are printed and availability of interpreter services. • TTD/TTY services for those who are hearing impaired. • Any unique educational activities such as, CM or DM programs related to special populations (i.e., mother/baby programs, substance abuse programs for pregnant women, asthma management programs, etc.). • Any other unique services related to education. <p>The OP briefly describes any community partners and their role in providing outreach activities to assist the MCO in bringing enrollees into care (i.e., church groups, YMCA, homeless shelters, community based school programs, parks and recreation programs, medical societies and/or associations such as the American Diabetes Assoc., etc.). The community partner may provide educational health fairs or screenings, educational materials, speakers, personnel who assist the enrollee in completing necessary medical paperwork or who assist the enrollee in locating special services to facilitate bringing the enrollee in to care, etc.</p> <p>(Do not include the role of the local health departments, since they are addressed in 10.1f)</p> <p>The OP must include a brief description of the role and responsibilities of providers for participating in outreach activities.</p>	

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>The OP must demonstrate the MCO’s relationship with the LHD/ACCU regarding collaborative efforts being undertaken (i.e. methods of referral). The description must include:</p> <ul style="list-style-type: none"> • The LHD’s responsibilities in outreach. • How results of the LHD’s efforts are conveyed to the MCO. 	
10.2	<p>The MCO has implemented policies and procedures for:</p> <ol style="list-style-type: none"> a. The provision of outreach services for new enrollees as well as those enrolled over time. b. Responding to a request for outreach from a provider, enrollee, or other source. c. The provision of outreach via telephone, written materials, and face-to-face contact. d. Monitoring of all outreach activities, including those delegated or subcontracted to other entities. 	<p>There must be evidence that the MCO has policies and procedures in place and implemented for each of the activities in 10.2 a-d.</p> <p>The MCO has methods/activities in place to identify enrollees in need of outreach for both new enrollees and those enrolled over time (i.e., review of HRAs and data reports). There must be evidence that these activities are occurring.</p> <p>The MCO must have policies and procedures in place to guide outreach staff in the outreach process. This guidance may be in the form of policies and procedures or process flow charts. There must be evidence that these processes are being followed.</p>	<ul style="list-style-type: none"> • Data Reports • Outreach Logs • Enrollee Mailings • Educational Materials • LHD Reports

Standard	Description	Review Guidelines	Documents to be Reviewed
		<p>There must be evidence that the MCO utilizes a systematic process to provide outreach services that employs:</p> <ul style="list-style-type: none"> • Telephone contact. • Written materials. • Face-to-face contact. <p>There must be evidence that outreach activities are monitored. There must be evidence that the MCO monitors any delegated activities to assure that contracted or delegated activities are carried out. For example, if the MCO has an agreement with the LHD to perform specific outreach activities such as face-to-face contact with enrollees, the MCO must have a mechanism for monitoring outcomes of these activities (i.e., number of enrollees referred for LHD outreach and number successfully reached).</p>	
10.3	<p>The MCO has implemented strategies:</p> <ol style="list-style-type: none"> a. To encourage utilization of wellness/ preventive health services through education and notification to enrollees of due dates for wellness services. b. To assist the special needs populations described in COMAR with scheduling and coordination of services. c. To promote the provision of EPSDT services and respond to no shows and non-compliant behavior related to children in need of EPSDT services. d. To bring enrollees into care who are difficult to reach or who miss appointments. 	<p>There must be evidence that the MCO has implemented strategies to provide outreach to the populations in 10.3 a-d.</p> <p>The MCO has identified those enrollees in need of wellness/ preventive services and has initiated activities to encourage utilization of these services. There is evidence that the MCO has implemented a system to track and monitor access to these services. For example, the MCO identifies and notifies enrollees of due dates for preventive services such as mammograms and cervical cancer screenings through reminder notices such as letters or postcards.</p>	<ul style="list-style-type: none"> • Outreach Work Plan • Data Reports • Tracking/Referral logs • Enrollee Mailings • Provider Mailings

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		<p>The MCO has identified those enrollees in each of the special needs populations described in COMAR and has initiated strategies to track these enrollees and link them to necessary services. For example, the MCO identifies pregnant women with substance abuse and assists in coordinating counseling and/or treatment services.</p> <p>The MCO identifies and tracks children (up to 21 years of age) who are eligible for EPSDT services or treatment. The MCO identifies those enrollees due for services, enrollees who miss appointments, and non-compliant enrollees. There is evidence that the MCO provides outreach to schedule those children in need of EPSDT services and/or to bring those children who miss appointments into care.</p> <p>The MCO identifies enrollees and provides outreach to those who are difficult to reach or who miss appointments.</p>	

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11.0	<p>Fraud and Abuse - The MCO maintains a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program also includes guidelines for defining failure to comply with these standards.</p>		
11.1	<p>The MCO maintains administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The mandatory compliance plan must be written and include:</p> <ol style="list-style-type: none"> a. Documentation that articulates the organization’s commitment to comply with all applicable Federal and State laws, regulations, and standards. b. Designation of a Compliance Officer and a Compliance Committee that is accountable to senior management and is responsible for ongoing monitoring of the MCO’s mandatory compliance plan. c. Designation of a Compliance Officer to serve as the liaison between the MCO and the Department. d. A documented process for internal monitoring and auditing, both routine and random, for potential fraud and abuse in areas such as encounter data, claims submission, claims processing, billing procedures, utilization, customer service, enrollment and disenrollment, marketing, as well as 	<p>The MCO demonstrates the ability to detect and identify inappropriate and unlawful conduct, fraudulent activities, and abusive patterns through detailed policies, procedures, education and training.</p> <p>The MCO demonstrates the ability to internally monitor and audit for potential fraud and abuse in such areas as encounter data, claims submission, claims processing, billing procedures, underutilization, customer service, enrollment and disenrollment, marketing, and provider/enrollee education materials.</p> <p>The MCO documents its processes used to detect and identify incidences of fraud and abuse.</p>	<ul style="list-style-type: none"> • Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Compliance Officer Job Description and Qualifications • Compliance Committee Membership • Compliance Committee Meeting Minutes • Communication Between Compliance Officer & Compliance Committee • Routine and Random Audit Reports for Fraud and Abuse • Reports tracking the receipt and dispensation of all incidences of reported suspected fraud and abuse

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
	<p>mechanisms responsible for the appropriate fraud and abuse education of MCO staff, enrollees, and providers.</p> <p>e. A documented process for timely investigation of all reports of suspected fraud as well as prompt response to detected offenses of fraud and abuse through the development of CAPs to rectify a deficiency or non-compliance situation.</p>		
11.2	<p>The MCO maintains administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization’s standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. They must include:</p> <p>a. Education and training for the Compliance Officer and the MCO’s employees on detection of fraud and abuse.</p> <p>b. A documented process for distributing and communicating all new regulations, regulatory changes, and modifications within the organization between the Compliance Officer and the MCO’s employees.</p> <p>c. A documented process for enforcing standards by means of clear communication to employees, in well publicized guidelines, to sanction incidents of fraud and abuse.</p> <p>d. A documented process for enforcement of standards through clear communication of well publicized guidelines to subcontractors of the MCO regarding sanctioning incidents of fraud and abuse.</p> <p>e. A documented process for enforcement of</p>	<p>The MCO demonstrates clear and well-publicized communication of disciplinary guidelines to employees, subcontractors of the MCO, and enrollees to sanction fraud and abuse offenses.</p> <p>The MCO demonstrates its process exists, e.g. a hotline, which allows employees, subcontractors of the MCO, and enrollees to report suspected fraud and abuse without fear of reprisal. The MCO will also demonstrate its procedures for timely investigation, dispensation, and tracking of reported suspected incidences of fraud and abuse.</p>	<ul style="list-style-type: none"> • Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Staff orientation, education, and training protocols pertaining to fraud and abuse • Sign-in rosters for employee training sessions regarding fraud and abuse

Maryland Medicaid Quality Strategy

Standard	Description	Review Guidelines	Documents to be Reviewed
	<p>standards through clear communication of well publicized guidelines to enrollees regarding sanctioning incidents of fraud and abuse.</p> <p>f. A documented process for the reporting by employees of suspected fraud and abuse within the organization, without fear of reprisal.</p> <p>g. A documented process for reporting by subcontractors of the MCO suspected fraud and abuse within the organization, without fear of reprisal.</p> <p>h. A documented process for reporting by enrollees of the MCO suspected fraud and abuse within the organization without fear of reprisal.</p>		
11.3	<p>The MCO maintains administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. It must include:</p> <p>a. A documented process for reporting all suspected cases of provider fraud and abuse to the DHMH Office of the Inspector General and the Medicaid Fraud Control Unit within 30 calendar days of the initial report.</p> <p>b. A documented process for cooperating with the DHMH Office of the Inspector General and the State Medicaid Fraud Control Unit when suspected fraud and abuse is investigated.</p>	<p>The MCO documents its processes for reporting and tracking suspected incidences of fraud and abuse to the appropriate State and Federal agencies within the appropriate time frames and its cooperation with those agencies investigating those alleged incidences.</p>	<ul style="list-style-type: none"> • Compliance Plan • Fraud Manual • Fraud and Abuse Policies & Procedures • Documentation of reported incidences of fraud and abuse to State Medicaid Agency • Documentation of collaboration and cooperation with State Medicaid Fraud Control Unit
11.4	<p>The MCO utilizes various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan. The mechanisms must address:</p>	<p>The MCO documents the mechanisms which evaluate the effectiveness of its fraud and abuse compliance plan through routine and</p>	<ul style="list-style-type: none"> • Compliance Committee Minutes • Routine and Random Fraud

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	<p>a. Evidence of review of routine and random reports by the Compliance Officer and Compliance Committee.</p> <p>b. Evidence that any CAP is reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAP.</p> <p>c. Evidence of the Compliance Committee’s review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse for each delegate that the MCO contracts with.</p> <p>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.</p>	<p>random reports, CAPs and their implementation, administrative and management procedures.</p> <p>The MCO documents oversight of fraud and abuse activities for each delegate, including delegate compliance plans and fraud and abuse activity reports.</p>	<p>and Abuse Reports</p> <ul style="list-style-type: none"> • CAPs • CAP Implementation Reports • Delegate Fraud and Abuse Reports