

External Quality Review of Centennial Care Program Compliance

Review Period: January 1 - December 31, 2016

Report: February 9, 2018

Summary Report



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1.0 Glossary

Item	Definition
ASPEN	Automated System Program and Eligibility Network: An integrated eligibility computer system used by the New Mexico Medicaid program.
BCBS	Blue Cross and Blue Shield of New Mexico: One of the four Medicaid managed care organizations in New Mexico. This organization was also contracted with the State under the Salud! program prior to the implementation of Centennial Care.
BH	Behavioral Health: The service by which behavioral healthcare services are provided and monitored by the State, EQR and the managed care organizations. While administered by the same Medicaid managed care organizations, behavioral health is considered distinct from physical health and long-term support services.
BHSD	Behavioral Health Services Division: The division within State government tasked with overseeing the provision of behavioral healthcare services for Medicaid members.
CAP	Corrective Action Plan: A plan that is implemented to correct serious issues that were identified either internally by the managed care organization or by an external review. A managed care organization can implement a corrective action plan internally or may be placed on one by the State if the managed care organization's EQR score falls below a predefined threshold.
CCP	Comprehensive Care Plans: Plans developed by the managed care organizations in collaboration with the member and the member's family to coordinate care for members who have complex medical cases or need additional help managing their healthcare.
Centennial Care	Centennial Care: The name given to the Medicaid managed care program administered by the State effective January 1, 2014. It replaced the previous Medicaid managed care system, which administered Salud!, State Coverage Insurance, coordination of long-term services and behavioral health as separate programs.
CFR	Code of Federal Regulations: The codification of the general and permanent rules published in the Federal Register by the departments and agencies of the federal government. It is divided into 50 titles. Title 42 deals with public health.
Citation of Authority	Citation of Authority: The official source from which the EQRO developed a question for the MCOs. The citation of authority is generally one of three things: 1) the contract between the MCOs and HSD; 2) the HSD Managed Care Policy Manual; or 3) the federal language found in the CFR.
CMS	Centers for Medicare & Medicaid Services: A department within the United States Department of Health and Human Services that oversees the implementation of the Medicare and Medicaid programs.

Item	Definition
CY	Calendar Year: A period of a year beginning with January 1 and ending with December 31. It is not to be confused with Fiscal Year or Measurement Year as defined elsewhere in this document.
EQR	External Quality Review: The analysis and evaluation by an External Quality Review Organization (EQRO) of information on quality, timeliness and access to the healthcare services that a MCO or its contractors furnish to Medicaid members.
EQRO	External Quality Review Organization: An organization contracted with the State to conduct reviews of the contracted Medicaid managed care organizations. The External Quality Review Organization also writes reports of findings and recommendations for improvement to the State. The contracted External Quality Review Organization that developed this report is HealthInsight New Mexico.
FH	Fair Hearing: The process by which the State hears an appeal by a member. Members submit appeals to the managed care organization.
FY	Fiscal Year: The year as defined for accounting purposes. It may or may not be concurrent with the calendar year. As of this writing, the State Fiscal Year is July 1 through June 30. This is not to be confused with Measurement Year or Contract Year, as defined elsewhere in this document.
FWA	Fraud, Waste and Abuse: The federal government monitors, investigates and prosecutes cases of fraud, waste, or abuse against the Medicaid program as a function of the Program Integrity program.
HSD	State of New Mexico Human Services Department, Medical Assistance Division: The agency of State government responsible for administering a portfolio of programs, including Medicaid.
IAP	Internal Action Plan: A mechanism utilized by HSD to address deficiencies identified with MCO contract implementation. It is similar to a Corrective Action Plan.
IRR	Inter-rater Reliability: A metric used to determine the extent to which two or more reviewers agree on a scored item. It is an indicator of the consistency of the implementation of a rating system. It is also an indicator of the accuracy and quality of a review or review process.
LEP	Limited English Proficiency: Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English. These individuals may be entitled language assistance with respect to a type or service, benefit, or encounter.
LTSS	Long-term Support Services: Services provided by the contracted managed care organizations for members who need long-term care. What care is needed is determined through a series of assessments. This care may be provided in a variety of settings.

Item	Definition
MCO	Managed Care Organization: An organization contracted with the State Human Services Department to provide Medicaid managed care services. As of this writing (2016) the four currently contracted Medicaid managed care organizations are Blue Cross and Blue Shield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Health Plan, Inc. and United Healthcare of New Mexico, Inc.
MHP	Molina Healthcare of New Mexico: One of the four Medicaid managed care organizations in New Mexico. This organization was also contracted with the State under the Salud! and State Coverage Insurance programs prior to the implementation of Centennial Care.
MY	Measurement Year: The year defined as criteria for measurement of a quality indicator or other metric. It may or may not be concurrent with the calendar year. It is not to be confused with Fiscal Year or Calendar Year as defined elsewhere in this document.
NCQA	National Committee for Quality Assurance: An independent nonprofit organization that works to improve healthcare quality through evidence-based standards, measures, programs and health plan accreditation.
NOD	Notice of Direction: Notices issued by the State to HealthInsight New Mexico, outlining the areas to be reviewed and deliverables to be completed as part of EQR audits and reviews. A separate Notice of Direction is issued for each review or review conducted.
NMAC	New Mexico Administrative Code: The official compilation of current rules filed by State agencies.
PDF	Portable Document Format File: PDF is a file format used to present and exchange documents reliably, independent of software, hardware, or operating system.
PCP	Primary Care Physician: A member's primary physician, who should serve as the member's primary point of contact with the healthcare system. Typically, a PCP is a general practice or family practice doctor or nurse practitioner.
PH	Physical Health: The process by which physical healthcare services are provided and monitored by the State, external quality review and the managed care organizations. While administered by the same Medicaid managed care organizations, physical health is considered distinct from behavioral health and long-term support services.
PHP	Presbyterian Health Plan, Inc.: One of the four Medicaid managed care organizations in New Mexico. This organization was also contracted with the State under the Salud! and State Coverage Insurance programs prior to the implementation of Centennial Care.
Review Subject / Review Area	Review Subject/Review Area: A review subject or review area is a particular area under review, such as program integrity or care coordination.

Item	Definition
Salud!	Salud! : A former Medicaid managed care program implemented by the State. The program ended and was replaced with Centennial Care, effective January 1, 2014.
SCI	State Coverage Insurance : is a former Medicaid managed care program implemented by the State. The program ended and was replaced with Centennial Care, effective January 1, 2014.
UHC	United Healthcare of New Mexico, Inc.: One of the four Medicaid managed care organizations in New Mexico. This organization was also contracted with the State under the Coordination of Long Term Services program prior to the implementation of Centennial Care.
UM	Utilization Management: UM is the evaluation of the medical necessity, appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the applicable health benefits plan, sometimes called utilization review.
Universe	A universe consists of all the records from a MCO that meet specified criteria. The universe is the dataset from which the analyst pulls the sample. The MCOs use the sample to pull the records for the file review.

2.0 How to Use This Report

This report contains details of the annual external quality review (EQR) of Centennial Care managed care organizations (MCOs) in New Mexico. The EQR is performed annually to assess each MCO's compliance with standards established by the State. The standards are drawn from the requirements set out in the Code of Federal Regulations (CFR) as well as applicable elements of each MCO's State contract. This report covers data gathered during calendar year 2016 (CY2016), the third year of the Centennial Care Medicaid managed care program.

The optimal way to read this report is in an electronic portable document format file (PDF) using the bookmarks to navigate between sections. The hyperlinks in the table of contents will also assist the reader to navigate the report.

To receive the most comprehensive understanding of this review, read the report in its entirety; however, the Executive Summary provides a synopsis of the entire audit.

The Summary Report presents an overview of scoring data and comparisons and provides year-to-year comparisons between MCOs.

As separate appendices to the Summary Report are MCO-specific sections, labeled: Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC. The four MCO-specific sections present detailed scoring, as well as findings and recommendations for each MCO where applicable. Findings are specific for areas that were found deficient. Where there are no deficiencies found, there are no findings noted. For example, records submitted for review are required to contain specific information, such as evidence that a service was provided, or that a process was completed within a specific timeframe. If that evidence is missing or incomplete in some way, that information becomes a finding. Recommendations offer suggestions on how to remedy the findings. The previous year's findings and recommendations are also revisited to assess any follow-up or improvements that may have occurred.

A Glossary is provided at the beginning of this report to aid in defining terms specific to the subject matter.

3.0 Executive Summary

As the EQRO, HealthInsight New Mexico is contracted by the State to report details of the annual external quality review (EQR) of New Mexico's Medicaid MCOs. The report includes an assessment of the MCOs for compliance with government regulations and covers data gathered during CY2016. This was the third year of implementation of New Mexico's redesigned Medicaid managed care program, Centennial Care. HSD contracted with four MCOs to provide and manage member services and each MCO has a section in this report where the EQRO provides additional details on findings and recommendations. The four MCOs and the respective sections are:

- Section A: BCBS
- Section B: MHP
- Section C: PHP
- Section D: UHC

The assessment was conducted according to EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, published by the Centers for Medicare & Medicaid Services (CMS) in September 2012 and included an evaluation of each MCO's policies, procedures and other documentation and an examination of case files. HSD determined the subjects for assessment and approved the assessment methodology.

Table 1 shows the overall results for each MCO included in this review. Detailed information about how each score was tabulated and recommendations about the results can be found in the Summary Report or in each MCO's respective section.

Table 1: Overall Compliance Scores by MCO			
MCO	Score		Compliance Level
BCBS	91.77%		Full
MHP	94.38%		Full
PHP	92.88%		Full
UHC	90.73%		Full
Full Compliance Score 90%-100%	Moderate Compliance Score 80%-89%	Minimal Compliance Score 50%-79%	Non-Compliance Score less than 49%

4.0 Background and Purpose

The federal Balanced Budget Act of 1997 requires each State's Medicaid agency to perform an EQR of all Medicaid MCOs to determine their compliance with government standards and applicable contractual requirements established by the State.

The State may use the output of EQRO reviews as indicators for its own internal assessment of the MCOs' comprehension of and adherence to the 1115 Demonstration Waiver. The 1115 Demonstration Waiver program in New Mexico is called Centennial Care. In addition, the State may use the content and findings of this external review as a resource to include in updates to CMS of the status of Centennial Care.

EQR Protocol 1 describes how to review documents, conduct interviews with MCO personnel, analyze the information obtained and make compliance determinations. HealthInsight New Mexico is the EQRO contracted by the State to review the MCOs for compliance with government quality standards for CY2016. HSD serves as the Medicaid agency for the State of New Mexico and, as such, determined the subjects for review and approved the assessment and methodology.

The primary activities conducted in this review were examination of documents and MCO staff interviews. A site visit provides an opportunity for reviewers to meet with MCO staff to discuss key components of the project. The site visit is a required element under Activity 3 in CMS EQR Protocol 1. In advance of the site visit, reviewers gathered and assessed information about each MCO and its practices. This preparation involved EQRO staff reviewing multiple documents including policies, procedures, reports, workflows and individual member case files. This extensive review is necessary to ensure a comprehensive EQR process and efficient and productive interactions with the MCO during the site visit. The EQRO asked clarifying questions as part of the examination of documents. In addition, all MCOs were given an opportunity to ask questions and to submit additional information prior to the site visit.

During each site visit, EQRO staff interviewed key MCO personnel, with a goal of assessing staff understanding of and adherence to MCO policies and procedures. These interviews provided an opportunity for the reviewers to gain a more thorough understanding of the approaches and processes used by the MCO to assess and improve quality of member care.

The purpose of these activities is to identify areas of each MCO's program where changes are needed to meet contractual and regulatory requirements. These requirements were established to help ensure that Medicaid members are provided access to quality healthcare in a timely manner.

5.0 Assessment Process

The compliance review process was designed to compare MCO policies, procedures, activities and outputs to the following:

- CMS EQR Protocols.
- Government Regulations and State Contractual Obligations.
- HSD Managed Care Policy Manual.
- Medicaid Managed Care Section of the Code of Federal Regulations.
- New Mexico Administrative Code.
- Specifications of the HSD Notice of Direction (NOD) issued to the EQRO.

The specific areas under review included the following:¹

- Enrollment/Disenrollment (MCO Contract Amendment 5, Section 4.2-4.3).
- Maintenance Medical Records (MCO Contract Amendment 5, Section 7.16.1).
- Member Materials (MCO Contract Amendment 5, Section 4.14).
 - This review included compliance with prior approval process, Member Handbook, member rights and responsibilities, Provider Directory, material distribution, member ID cards, member website and member health education plan.
- Member Services (MCO Contract Amendment 5, Section 4.15).
 - This review included call center, performance standards, interpreter/translator services and access to electronic versions of the member's personal health record.
- Program Integrity (MCO Contract Amendment 5, Section 4.17 Program Integrity; HSD Managed Care Policy Manual, Section 17 Managed Care Reporting; and 42 CFR 455.436 Federal Database Checks).
- Provider Network (MCO Contract Amendment 5, Section 4.8).
- Provider Services (MCO Contract Amendment 5, Section 4.11).
- Reporting Requirements (MCO Contract Amendment 5, Section 4.21).
- Self-Directed Community Benefit (MCO Contract Amendment 5, Section 4.6).
- Care Coordination (MCO Contract Amendment 5, Section 4.4).
 - This review included Health Risk Assessment (HRA) and Comprehensive Needs Assessments (CNA).
- Transitions of Care (MCO Contract Amendment 5, Section 4.4.16).
 - This review focused solely on transitions from a nursing facility to home or community-based services.
- Grievance and Appeal Systems (MCO Contract Amendment 5, Section 4.16).

¹ Parenthetical citations indicate the regulatory or contractual requirement from which the section derives.

- Primary Care Provider (PCP) and Pharmacy Lock-ins (MCO Contract Amendment 5, Section 4.22.2-3).
- UM: Adverse Benefit Determinations (MCO Contract Amendment 5, Section 4.12.10).

The EQRO developed tools for scoring, which were approved by HSD to score policy and procedure documents and member files. This review examined policies, procedures and other documentation and conducted reviews of MCO member files at each of the MCO's offices. Preliminary findings and scores were presented to each MCO at the close of each site visit. The finalized scores and findings were then reported to HSD.

The EQRO will make a recommendation in a report under the following circumstances:

- For any review subject that received less than full compliance (less than 90.00 percent).
- For any component of a review that received less than full compliance (less than 90.00 percent).
- Anytime the EQRO identified an obvious trend or pattern that indicated a systemic issue, regardless of the compliance level.
- If the composite score reflects full compliance and both component scores are fully compliant the EQRO may, at its discretion, make recommendations in specific situations when warranted.
- Other situations when warranted by the EQR findings or observations, whether or not the score in the current review was affected.

The data collection tools, reviewer instructions, review process and scoring methods were developed using the MCO Centennial Care Contract Amendments #5 and #6, the Managed Care Policy Manual, the applicable NMAC regulations, CMS EQR Protocol 1 and the CFR. The compliance assessment consisted of policy reviews, file reviews and interviews with MCO staff.

Table 2 provides the definitions and scoring ranges for each compliance level available.

Table 2: Compliance Level Definitions		
Full Compliance	90-100%	MCO met or exceeded the standard
Moderate Compliance	80-89%	MCO met most requirements of the standard but has deficiencies in certain areas
Minimal Compliance	50-79%	MCO met some of the requirements of the standard but has significant deficiencies requiring corrective action
Non-compliance	Less than 49%	MCO did not meet the standard and requires corrective action

6.0 Scoring Method

The scoring method is the numerical system used to determine the score for each subject and an overall score for compliance. A review subject or review area is a particular area under review, such as program integrity or care coordination.

7.0 Point Allocation

Each review subject was allocated a specific number of points, based on policy and file review questions. All of the point allocations were approved by HSD. These points were distributed within each review subject as illustrated below in Table 3. The maximum number of points a MCO could achieve is 95. The citations of authority listed below are from MCO Contract Amendments 5 and 6, unless otherwise noted.

In this audit, each review question was assigned one point and was scored zero, 0.5 or one. All review areas contribute equally to the overall score.

Table 3: Point Allocation			
Citation of Authority	Review Subject	Available Points	
Policy Review Only			
4.2-4.3 ²	Enrollment/Disenrollment	5	
7.16.1	Maintenance of Medical Records	See footnote ³	
4.14	Member Materials	5	
4.15	Member Services	5	
4.17, Section 17 and 42 CFR 455.436 ⁴	Program Integrity	5	
4.8	Provider Network	5	
4.11	Provider Services	5	
4.21	Reporting Requirements	5	
4.6	Self-Directed Community Benefit	5	
Policy and File Review		Policy Review Points	File Review Points
4.4	Care Coordination	5	6
4.4.16	Transitions of Care	5	6
4.16	Grievance and Appeal System	5	6
4.22.2-3	PCP and Pharmacy Lock-ins	5	6
4.12.10	UM: Adverse Benefit Determinations	5	6
Total		95	

² The citations of authority beginning with the number 4 reference the contract that exists between HSD and each MCO. The contracts are identical and thus the citation is applicable to all MCOs.

³ For CY2016, the review questions for this subject were redesigned; as a result, this review was not scored. The EQRO reviewed and assessed MCO policies and procedures; then, recommended strategies for improvement.

⁴ This citation of authority refers to three separate citations: the MCO contract Amendment 5, Section 4.17; the HSD Managed Care Policy Manual, Section 17 (revised March 1, 2017); and 42 CFR 455.436, Federal Database Checks.

8.0 Inter-rater Reliability

For the current review, EQRO staff conducted an inter-rater reliability (IRR) assessment before the file review. The inter-rater reliability process helps to ensure consistency in scoring between multiple reviewers. It allows the reviewers to develop a more robust understanding of the questions, the authority citation references and MCO document submission in advance of conducting the full review. Two reviewers were involved. Reviewer 1 assessed the first five records in each of their respective sections. After completion, those same five records were assessed by Reviewer 2. Then Reviewers 1 and 2 discussed any discrepancies and came to consensus. Revising the process is part of the EQRO's ongoing commitment to quality improvement.

9.0 Data Validation

During each site visit, electronic PDF records were used as source documentation for scoring. The EQRO provided each MCO a data report showing any file data elements that were either missing or requiring additional clarification. The intent was to give the MCOs additional concrete information to prepare for the site visit discussion. Any discrepancies, missing data elements, or unclear issues were discussed with EQR staff, including the EQRO medical director, as needed. After the discussion with MCO staff, each reviewer finalized the score in advance of reporting. The current year's review was the first where the EQRO completed the file reviews electronically at the EQRO offices rather than at the site visit.

10.0 Information Systems Capability Assessment

An Information Systems Capability Assessment (ISCA) was performed as part of the Encounter Data Validation (EDV) project. Federal protocols require a citation of this fact in all EQRO reports.

To determine if each MCO's information system and controls were capable of collecting and submitting complete and accurate encounter data, a survey was developed, documentation was requested from each MCO and site visit activities were performed. The survey consisted of two parts. The first part requested information about each MCO, the local plan environment and the ISCA. The second part asked questions about each MCO's claims, code sets, enrollment systems, data systems, controls and reporting mechanisms.

Documentation was requested in advance to gain an understanding of each MCO's processes and to facilitate site visit activities at each MCO's encounter data center. After this review was completed, a report was compiled with findings and recommendations and submitted to HSD. The EDV report is a public report and is available on the HSD website.

11.0 Potential Point Deductions from Overall Score

The scoring method included criteria to reduce the overall score of any MCO's program for late or inaccurate data submission. A late data submission refers to a submission after the deadline established by the HSD-approved work plan or by an extension request. An inaccurate data submission refers to a submission in which the MCO did not follow the instructions provided by the EQRO. One point may be deducted from the overall score for each identified violation.

As shown in Table 4, a MCO could be at risk for a deduction of up to seven points for late or inaccurate data submissions.

Identified Deficiency	Timeliness	Accuracy
Review Documents	-1	
Universe Submission	-1	-1
File Preparation	-1	-1
Clarification Documents	-1	
Closing – Deadline for Submission of Additional Documents	-1	

12.0 Calculation of Final Score

Final scores were calculated using the following method:

- The points earned within each subject area were divided by the points available to determine a percentage.
- Each subject was reported individually as a percentage with a corresponding compliance level.
- The total points earned for all subjects were divided by the total points available for all subjects to determine an overall percentage.
- The final overall score was reported as a percentage and it determined the overall compliance level.

13.0 Project Activities Prior to Each Site Visit

Site visits are an effective way to collect the information needed for quality oversight and compliance determination. The EQRO carefully planned each site visit to maximize the information obtained and to minimize the time required for collecting that information. Below is a detailed description of assessment activities that took place approximately six months prior to each site visit.

13.1 Project Overview Meeting

A meeting among EQR staff, MCO representatives and HSD staff was held on December 8, 2016. This Overview Meeting was organized and hosted by the EQRO. The meeting included a detailed overview of the subjects to be reviewed, documentation requirements, as well as a description of the process and the overall timeline of the review. The EQRO facilitated a discussion of criteria used to score the file review documents for three areas identified as problematic in the previous year's review. Additionally, the MCOs were encouraged to ask clarifying questions regarding requested documentation and review subjects during and after the meeting. The EQRO invited MCO staff to reach out with any additional questions they might have while preparing the requested documentation.

13.2 Policy Review

In preparation for the site visits, the EQRO reviewed all documentation submitted by the MCOs. This documentation consisted of the required policies and procedures, the member handbook, the provider handbook, provider directory, the quality management/quality improvement (QM/QI) plan, a report submission matrix and other documents as needed to demonstrate compliance with specific contractual or regulatory requirements.

13.3 File Sample Selection and File Review

Each MCO was required to submit a file universe in an electronic workbook. Prior to the site visits, a random selection of files from each MCO's universe submissions was sent to the MCO for compilation of PDF files, including oversample files.

The MCOs supplied completed files to the EQRO two weeks prior to the start of the site visits. The EQRO did a preliminary check of the files upon submission from the MCOs. The primary file review took place at the EQRO offices using PDF files submitted electronically. The EQRO followed up with the MCOs at site visits, held in June 2017. The site visits consisted of file reviews and interviews with key MCO staff.

A full sample contains 30 records. The MCOs were directed to submit 10 additional records as an oversample in the event a file was unable to be reviewed. In cases where the reviewed number of files is less than 30, this was because the MCO did not submit greater than 30 records in the universe. This does not represent an error on the part of the MCO as not all universes had 30 unduplicated records.

Member Expedited Appeal is a review section where this commonly occurs. If fewer than 30 of these appeals were received during the timeframe, it is reflected in the universe submission.

13.4 Site Visit Activities

The EQRO team conducted a two-day site visit at each MCO's physical location. The site visits consisted of file reviews and interviews with key MCO staff.

On the first day of each site visit, an opening session was held to discuss the site visit process. Once file reviews were complete, MCO staff had an opportunity to discuss deficiencies or provide clarification with the EQRO team.

For each file review subject, 40 randomly sampled records were requested from the MCO. Of these 40, 30 randomly sampled records were examined for compliance. The additional 10 records were oversamples available if a record was incorrectly included in the submission and that record could then be replaced with an appropriate record.

Once each file review subject was completed, the EQRO reviewer for that subject met with MCO staff to review individual deficiencies in the files. For each missing element, the MCO had the opportunity to either present additional data or offer additional insight for the reviewer to consider when finalizing the score.

After each site visit, EQRO staff conducted a closing conference attended by MCO staff and HSD staff. The project manager presented preliminary findings, provided feedback and addressed MCO staff questions. The EQRO's HSD contract manager also attended these sessions either in person or via telephone.

14.0 Findings for Individually Scored Subjects

Table 5 presents the CY2016 percentage scores for each subject evaluated for each MCO. Either the scores are for policy review only or the scores are composite scores, meaning that they include both policy and file review scores. The table shows the scores for the review subjects covered in this report. Cases where only policies are examined, are purely administrative, therefore, no member files are reviewed. When cases contain actual member files as well as policy, both are reviewed. This is done to see how the MCOs are applying their policies in caring for their members.

The reader should note that in most review areas, the MCOs are in full compliance with the contract requirements as previously shown in Table 1: Overall Compliance Scores by MCO. Each review subject is explored next in Section 15.0 Discussion of Review Subjects, which includes MCO scores, trends, findings and recommendations that stemmed from this review. Additional details can be found in the MCO's respective sections, Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Table 5: Individual Scored Subjects by MCO				
Review Subject	BCBS	MHP	PHP	UHC
Policy Review Only				
Enrollment/Disenrollment	100.00%	100.00%	100.00%	100.00%
Maintenance of Medical Records	See footnote ⁵			
Member Materials	95.00%	95.40%	91.00%	100.00%
Member Services	90.00%	90.00%	100.00%	90.00%
Program Integrity	81.00%	100.00%	100.00%	72.00%
Provider Network	100.00%	100.00%	100.00%	100.00%
Provider Services	100.00%	100.00%	100.00%	100.00%
Reporting Requirements	100.00%	100.00%	100.00%	100.00%
Self-Directed Community Benefit	100.00%	100.00%	100.00%	100.00%
File and Policy Review				
Care Coordination	90.73%	93.45%	83.45%	90.09%
Transitions of Care	72.18%	74.36%	69.45%	68.91%
Grievance and Appeal System	94.55%	99.45%	98.91%	95.64%
PCP and Pharmacy Lock-ins	100.00%	100.00%	100.00%	100.00%
UM: Adverse Benefit Determinations	95.09%	99.45%	99.45%	90.73%

In CY2014, the first year of Centennial Care's implementation, much of the review centered upon whether the MCOs had the policies and procedures they needed to care for members properly. In CY2015, the EQRO began to require more evidence that the MCO is compliant with their own policies and procedures. In CY2016, the year this report covers, the audit has required more detailed documentation from the MCOs.

⁵ For CY2016, the review questions for this subject were redesigned; as a result, this review subject was not scored. The EQRO reviewed and assessed MCO policies and procedures; then, recommended strategies for improvement. See section 15.2.

15.0 Discussion of Review Subjects

What follows is a description of each review subject, including the evidence examined and the findings. Also discussed are any follow-up actions on recommendations from the previous review and any year-to-year review comparisons. The scoring tables for each section below show composite scores, as previously explained in Table 5.

In years one and two of Centennial Care, the MCOs policies and procedures were reviewed for compliance with government regulations. In year three, the EQR required additional information, such as reports and screen prints to verify that the MCOs were following their policies and procedures.

15.1 Enrollment/Disenrollment

Rationale:

The MCO needs to track which current members are leaving and which new members are coming into its organization so that its staff can provide seamless communication with the member and can ensure continuous and effective access and delivery of services. It is the function of the EQR to verify that the MCO has policies and procedures in place to recognize and process enrollment and disenrollment of members per State standards.

Evidence Examined in the EQR:

- Policies and procedures for Enrollment/Disenrollment were reviewed for evidence that each MCO had reliable systems in place to provide continuous tracking of member enrollment status.
- A file review was not conducted for this review subject.

Summary of CY2016 Findings:

- BCBS achieved full compliance and no deficiencies were identified.
- MHP achieved full compliance and no deficiencies were identified.
- PHP achieved full compliance and no deficiencies were identified.
- UHC achieved full compliance and no deficiencies were identified.

Year-to-Year Score Comparison:

Table 6 shows the current three-year trend of composite scores for Enrollment/Disenrollment by MCO for the CY2014 through CY2016 reviews.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	100.00%	100.00%	100.00%
MHP	100.00%	100.00%	100.00%
PHP	100.00%	100.00%	100.00%
UHC	100.00%	80.00%	100.00%

Summary of CY2016 Recommendations:

- BCBS achieved full compliance and there are no recommendations.
- MHP achieved full compliance and there are no recommendations.
- PHP achieved full compliance and there are no recommendations.
- UHC achieved full compliance and there are no recommendations.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: In CY2015, one of UHC's policies was unclear and the MCO received a zero for the question associated with that policy. Since there were five questions, the missed question reduced the score by 20 percent of the review.
 - UHC Previous EQRO Recommendation Follow-Up: The deficient policy issue has since been addressed and it is now in full compliance.

15.2 Maintenance of Medical Records

Rationale:

Medical records provide physicians and the patient care team with vital information about their patients' needs and history. Without this historical record, the physician or other healthcare team members may miss critical information for diagnosis and treatment. It is necessary for a MCO to work with its providers to verify that the documented record is accurate, complete and understandable to others. It is a function of the EQR to assess whether or not the MCO has adequate policies and procedures in place to conduct effective oversight of its contracted medical providers for adherence to State standards.

Background:

During planning for compliance assessment of the MCO's CY2016 activities, the EQRO recommended that HSD consider changing the focus of the review from the provider's medical records to the MCO's oversight of its contracted medical providers, with a focus on maintenance of medical records. The shift in focus allowed the EQRO to report the level of compliance of the MCO to the State requirements and eliminated the need for direct review of the contracted providers' maintenance of medical records during CY2016. Since the focus shifted and the review questions were all redesigned, it was determined that the EQRO should review, assess and recommend strategies for improvement but this first review would not be scored. Scoring for this review subject will resume with the next EQR review.

Evidence Examined in the EQR:

- Policies governing medical record documentation requirements for medical and behavioral health contract providers.
- Tools used to abstract the information from the medical and the behavioral health records and the qualification and training provided to the medical record abstracters.
- Methodology employed to choose which providers were reviewed for compliance with these standards.
- Documentation that the MCO communicated the audit result back to the medical provider, with recommendations for performance improvement.
- Evidence of follow up by the MCO and corrective action when a provider's performance is below a certain threshold that is determined in advance by the MCO.

Summary of CY2016 Findings:

For CY2016, the review questions area were redesigned. As a result, this review was not scored, thus, there is no compliance level to report and the findings are listed below.

- BCBS provided sufficient evidence of the tools, processes and outcomes of provider oversight activities to demonstrate oversight of the providers' maintenance of medical records for CY2016.
- MHP provided sufficient evidence of the tools, processes and outcomes of provider oversight activities of the providers' maintenance of medical records during CY2016. Although not a scored item, the EQRO staff observed that the MCO's process for training medical record abstractors was not well defined.
- PHP provided sufficient evidence of the tools, processes and outcomes of provider oversight activities to demonstrate oversight of the providers' maintenance of medical records for CY2016.
- UHC provided sufficient evidence of the tools, processes and outcomes of provider oversight activities to demonstrate oversight of the providers' maintenance of medical records for CY2016.

Year-to-Year Score Comparison:

Table 7 shows composite scores for Maintenance of Medical Records for CY2014 and CY2015 only.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	96.78%	97.00%	At present, there are no new scores to report, because this subject area was restructured for the CY2016 review.
MHP	95.78%	96.56%	
PHP	96.22%	97.44%	
UHC	92.00%	96.89%	

Summary of CY2016 Recommendations:

- BCBS demonstrated sufficient oversight of the providers' maintenance of medical records for CY2016 and there are no recommendations.
- MHP will document a plan for training, support and IRR process for all staff performing medical record abstraction and will be prepared to provide a training plan for staff, along with evidence of implementing the plan, to the EQRO as follow up for this recommendation.
- PHP demonstrated sufficient oversight of the providers' maintenance of medical records for CY2016 and there are no recommendations.
- UHC demonstrated sufficient oversight of the providers' maintenance of medical records for CY2016 and there are no recommendations.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: BCBS should develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.
 - BCBS Previous EQRO Recommendation Follow-Up: The focus of this audit changed from review of the provider's medical records to review of the MCO's oversight activities of the provider's maintenance of medical records. The EQRO was therefore, unable to follow up on this CY2015 recommendation.
- MHP Previous EQRO Recommendation: MHP should develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.
 - MHP Previous EQRO Recommendation Follow-Up: The focus of this audit changed from review of the provider's medical records to review of the MCO's oversight activities of the provider's maintenance of medical records. The EQRO was therefore, unable to follow up on this CY2015 recommendation.
- PHP Previous EQRO Recommendation: PHP should develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.
 - PHP Previous EQRO Recommendation Follow-Up: The focus of this audit changed from review of the provider's medical records to review of the MCO's oversight activities of the provider's maintenance of medical records. The EQRO was therefore, unable to follow up on this CY2015 recommendation.
- UHC Previous EQRO Recommendation: UHC should develop and implement a way that providers can easily track that they have asked members about advance directives and then have an efficient way of providing that documentation for review purposes.
 - UHC Previous EQRO Recommendation Follow-Up: The focus of this audit changed from review of the provider's medical records to review of the MCO's oversight activities of the provider's maintenance of medical records. The EQRO was therefore, unable to follow up on this CY2015 recommendation.

15.3 Member Materials

Rationale:

For a member to access services, file a grievance, understand his/her rights and responsibilities, request a fair hearing, get proper authorizations, or use emergency services appropriately, the MCO must communicate information regarding services and processes to the member. The educational material needs to be in a format that is easily understood and that provides access to the full spectrum of services and benefits to which a member is entitled. It is a function of the EQR to verify that the member materials, including the member handbook, communicate all of the required information per State standards.

Evidence Examined in the EQR:

- Policies, procedures and other evidence was reviewed to determine if the MCO had the proper systems in place to generate and distribute materials that are designed in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees.
- A file review was not conducted for this subject area.

Summary of CY2016 Findings:

- BCBS achieved full compliance. The MCO provided appropriate policy and procedure documentation, but no evidence of having mailed a printed copy of the member handbook to each member within 30 days of enrollment.
- MHP achieved full compliance. The MCO provided appropriate policy and procedure documentation, but did not provide the screenshot that was requested as evidence that a member's preference for communication in an alternative format is documented in the MCO's internal system.
- PHP achieved full compliance. The MCO policies and procedures reflected a process by which a member's preference for communication in an alternative format is documented in the MCO's internal system but did not provide evidence of compliance. The MCO provided appropriate policy and procedure documentation, but no evidence of having mailed a printed copy of the member handbook to each member within 30 days of enrollment.
- UHC achieved full compliance and no deficiencies were identified.

Year-to-Year Score Comparison:

Table 8 shows the current three-year trend of composite scores for Member Materials by MCO for the CY2014 through CY2016 reviews.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	100.00%	100.00%	95.00%
MHP	100.00%	100.00%	95.40%
PHP	100.00%	100.00%	91.00%
UHC	100.00%	100.00%	100.00%

Summary of CY2016 Recommendations:

- BCBS will track the mailing dates of member handbooks to new members as evidence of compliance.
- MHP will adjust its policies and procedures to indicate how it will internally document a member's preference for communication in alternative formats and subsequently provide all member materials to the member in such format unless the member requests otherwise.
- PHP will adjust its policies and procedures to indicate how it will internally document a member's preference for communication in alternative formats and subsequently provide all member materials to the member in such format unless the member requests otherwise. The MCO will track the mailing dates of member handbooks to new members as evidence of compliance.
- UHC achieved full compliance and there are no recommendations.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.

15.4 Member Services

Rationale:

The member services department at each MCO is the primary point of contact for most members. It is responsible for the operation of the call center, which ensures a response to member needs. Members use the call center to gain information, clarify benefits and file a grievance or an appeal. The MCO is required to have policies and procedures in place to govern the call center and to report various metrics to HSD. It is a function of the EQR to verify that the MCO has the policies and procedures in place to serve their members per State standards.

Evidence Examined in the EQR:

- Policies and procedures were reviewed to determine if the MCO had the systems in place to properly manage a call center, provide vital services to members such as electronic access to their health records and report required metrics to HSD.
- A file review was not conducted for this subject area.

Summary of CY2016 Findings:

- BCBS achieved full compliance; however, the MCO did not provide evidence that it informed members that their personal health records are available electronically. The MCO did not provide evidence it informed members on how to access these records.
- MHP achieved full compliance; however, the MCO policy did not document that it does not require or suggest that members with limited English proficiency provide his/her own interpreters.
- PHP achieved full compliance and no deficiencies were identified.
- UHC achieved full compliance; however, the MCO policy did not document that it does not require or suggest that members with limited English proficiency provide his/her own interpreters.

Year-to-Year Score Comparison:

Table 9 shows the current three-year trend of composite scores for Member Services by MCO for the CY2014 through CY2016 reviews.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	100.00%	100.00%	90.00%
MHP	100.00%	100.00%	90.00%
PHP	100.00%	100.00%	100.00%
UHC	100.00%	100.00%	90.00%

Summary of CY2016 Recommendations:

- BCBS will clarify its policy to show how it shall provide members with access to electronic versions of their personal health records.
- MHP will clarify its policy to direct staff members that they are prohibited from requiring or suggesting that members with limited English proficiency (LEP) provide their own interpreters or utilize friends or family members. MHP will also direct its staff members that this requirement extends to members with LEP and is not limited to members who use sign language.
- PHP had no recommendations.
- UHC will clarify its policy to direct staff members that they are prohibited from requiring or suggesting that members with LEP provide their own interpreters or utilize friends or family members.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.

The reader should note that three of the MCO scores lowered due to an increased level of detailed scrutiny by the EQR reviewers for this section. PHP is the exception because PHP has achieved 100.00% for all three years of the review.

15.5 Program Integrity

Rationale:

Medical fraud, waste and abuse threaten the integrity of a Medicaid program. A Medicaid program that follows the standards set out for program integrity will be at less risk from these dangers and be better stewards of the government dollars being invested in its members. For these reasons, it is important that MCOs know how to identify and take appropriate action to address events of fraud, waste and abuse if they occur.

State Medicaid agencies are required by the CFR not to contract with health care providers who are under investigation or have been excluded from practice due to misconduct. The State delegates the requirement to the MCOs to check certain federal databases that contain the names of the excluded providers. These checks apply as well to any person with an ownership or controlling interest in the medical practice or who is an agent or managing employee of the provider. It is a function of the EQR to verify that the MCOs have the policies and procedures in place to perform these activities per State standards.

Evidence Examined in the EQR:

- Provider enrollment forms showing evidence that all the required databases had been checked by the MCO for excluded providers.
- Completed corrective action plans for providers.
- Work plans for announced and unannounced site visits to providers at higher risk for fraud and abuse.
- Reports from contracted providers and quarterly and annual reports that were sent to the State by the MCOs.
- A file review was not conducted for this subject area.

Summary of CY2016 Findings:

- BCBS achieved moderate compliance. The MCO's policies were inconsistent regarding which exclusion databases were checked. No one policy listed all of the databases they are required to check for contracted providers.
- MHP achieved full compliance and no deficiencies were identified.

- PHP achieved full compliance and no deficiencies were identified.
- UHC received minimal compliance. The MCO indicated that they are not contractually required to check the Social Security Administration's Death Master File for excluded providers; however, the MCO contract in Section 4.17.1.7.1 cites federal language that requires such a check.

Year-to-Year Score Comparison:

Table 10 shows the current three-year trend of composite scores for Program Integrity by MCO for the CY2014 through CY2016 reviews.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	95.80%	95.00%	81.00%
MHP	94.40%	98.30%	100.00%
PHP	100.00%	100.00%	100.00%
UHC	98.60%	95.00%	72.00% ⁶

Summary of CY2016 Recommendations:

- BCBS will consistently screen all contracted providers against the exclusion databases as required by the Centennial Care contract and federal regulations.
- MHP achieved full compliance and there are no recommendations.
- PHP achieved full compliance and there are no recommendations.
- UHC will consistently screen all contracted providers against the exclusion databases as required by the Centennial Care contract and federal regulations.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: Consistently screen all contracted providers against the exclusion databases as required by the Centennial Care contract and federal regulations.
 - BCBS Previous EQRO Recommendation Follow-Up: This MCO did not consistently screen all contracted providers against the exclusion databases as required by the Centennial Care contract and federal regulations during CY2016 as evidenced in the CY2016 score.
 - HSD will implement an internal action plan (IAP) to address the identified compliance deficiency.
- MHP Previous EQRO Recommendation: Add the requisite language to its policy regarding not infringing on the legal rights of persons involved and affording due process of law during an investigation.

⁶ In CY2016, an additional question was asked of all MCOs, for an example of corrective action plans for providers as the result of the MCO's internal monitoring and auditing program. UHC did not provide the additional required information. For additional detail regarding this score issues, see Section D: UHC.

- MHP Previous EQRO Recommendation Follow-Up: This MCO did revise its program integrity policy to include the requisite language during CY2016 as evidenced in the CY2016 score.
- PHP Previous EQRO Recommendation: MCO achieved full compliance and there were no recommendations.
- UHC Previous EQRO Recommendation: Update Program Integrity policies and procedures for identifying and investigating suspected fraud cases to state that the policy does not infringe on the legal rights of persons involved and affords due process of law.
 - UHC Previous EQRO Recommendation Follow-Up: Based on the documentation submitted for this review, this MCO has addressed this recommendation and resolved this issue.

15.6 Provider Network

Rationale:

In order to provide quality services in a timely manner, it is important that the MCO have a sufficient number of providers in general practice and in various specialties. An insufficient provider network can lead to service delays, poor quality of service and poor population health. It is a function of the EQR to verify that the MCO has the proper policies and procedures in place to develop and maintain a sufficient provider network per State standards.

Evidence Examined in the EQR:

- Policies and procedures governing the MCO's provider network were reviewed. The review included an evaluation of the provider manual, provider training programs, geographic access report, network update report and the provider satisfaction survey.
- A file review was not conducted for this subject area.

Summary of CY2016 Findings:

- BCBS achieved full compliance and no deficiencies were identified.
- MHP achieved full compliance and no deficiencies were identified.
- PHP achieved full compliance and no deficiencies were identified.
- UHC achieved full compliance and no deficiencies were identified.

Summary of CY2016 Recommendations

- BCBS achieved full compliance and there are no recommendations.
- MHP achieved full compliance and there are no recommendations.
- PHP achieved full compliance and there are no recommendations.
- UHC achieved full compliance and there are no recommendations.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Year-to-Year Score Comparison:

Table 11 shows the current three-year trend of scores for Provider Network by MCO for the CY2014 through CY2016 reviews.

Table 11: Provider Network Year-to-Year Score Comparison			
MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	100.00%	100.00%	100.00%
MHP	100.00%	100.00%	100.00%
PHP	100.00%	100.00%	100.00%
UHC	100.00%	100.00%	100.00%

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.

15.7 Provider Services**Rationale:**

A critical piece of a MCO managing a productive provider network is giving providers the tools and resources they need. This includes communicating with providers via a provider handbook, a provider services call center and ongoing training on a variety of subjects, per State standards.

Evidence Examined in the EQR:

- A review was conducted of the policies and procedures that govern the development and distribution of a provider handbook, the operation of a provider services call center and the development and implementation of provider training and outreach.
- A file review was not conducted for this subject area.

Summary of CY2016 Findings

- BCBS achieved full compliance and no deficiencies were identified.
- MHP achieved full compliance and no deficiencies were identified.
- PHP achieved full compliance and no deficiencies were identified.
- UHC achieved full compliance and no deficiencies were identified.

Year-to-Year Score Comparison:

Table 12 shows the current three-year trend of composite scores for Provider Services by MCO for the CY2014 through CY2016 reviews.

Table 12: Provider Services Year-to-Year Score Comparison			
MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	100.00%	100.00%	100.00%
MHP	100.00%	100.00%	100.00%
PHP	100.00%	100.00%	100.00%
UHC	100.00%	100.00%	100.00%

Summary of CY2016 Recommendations:

- BCBS achieved full compliance and there are no recommendations.
- MHP achieved full compliance and there are no recommendations.
- PHP achieved full compliance and there are no recommendations.
- UHC achieved full compliance and there are no recommendations.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.

15.8 Reporting Requirements**Rationale:**

The Balanced Budget Act of 1997 sets forth a requirement on the part of the states that they measure the quality of the care that they provide in their Medicaid programs. The MCOs are required to engage in quality measurement and improvement efforts as well. An integral part of a quality program is to demonstrate that quality indicators and other metrics are being measured and documented. Knowing the status of quality indicator values is one of the first steps to improvement. The MCOs are required to send reports to HSD regularly on a predefined timeline. It is a function of the EQR to verify that each MCO has the policies and procedures in place to accomplish this task per State standards.

Evidence Examined in the EQR:

- Policies and procedures were reviewed to determine that the MCO had the proper systems in place to generate, analyze and submit required reports to HSD.
- A file review was not conducted for this subject area.

Summary of CY2016 Findings:

- BCBS achieved full compliance and no deficiencies were identified.
- MHP achieved full compliance and no deficiencies were identified.
- PHP achieved full compliance and no deficiencies were identified.
- UHC achieved full compliance and no deficiencies were identified.

Year-to-Year Score Comparison:

Table 13 shows the current three-year trend of composite scores for Reporting Requirements by MCO for the CY2014 through CY2016 reviews.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	100.00%	100.00%	100.00%
MHP	100.00%	100.00%	100.00%
PHP	100.00%	100.00%	100.00%
UHC	100.00%	100.00%	100.00%

Summary of CY2016 Recommendations

- BCBS achieved full compliance and there are no recommendations.
- MHP achieved full compliance and there are no recommendations.
- PHP achieved full compliance and there are no recommendations.
- UHC achieved full compliance and there are no recommendations.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.

15.9 Self-Directed Community Benefit

Rationale:

Centennial Care provides a self-directed community benefit for members who are receiving long-term support and services in a home setting so that members may have greater freedom to take charge of their healthcare decisions. The Self-Directed Community Benefit program allows members to manage their own healthcare affairs to meet their needs in a community setting. It is a function of the EQR to verify that the MCOs are honoring this freedom but also providing the member a sufficient level of support and guidance to make the process successful per State standards.

Evidence Examined in the EQR:

- Policies and procedures were reviewed to determine that the MCO had the proper systems in place to monitor and guide member use of this benefit including budget management, critical incidence reporting, and fiscal management agency contracting.
- A file review was not conducted for this subject area.

Summary of CY2016 Findings:

- BCBS achieved full compliance and no deficiencies were identified.
- MHP achieved full compliance and no deficiencies were identified.
- PHP achieved full compliance and no deficiencies were identified.
- UHC achieved full compliance and no deficiencies were identified.

Year-to-Year Score Comparison:

Table 14 shows the current three-year trend of composite scores for the Self-Directed Community Benefit program by MCO for the CY2014 through CY2016 reviews.

Table 14: Self-Directed Community Benefit Year-to-Year Score Comparison			
MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	100.00%	100.00%	100.00%
MHP	100.00%	100.00%	100.00%
PHP	100.00%	100.00%	100.00%
UHC	100.00%	100.00%	100.00%

Summary of CY2016 Recommendations

- BCBS achieved full compliance and there are no recommendations.
- MHP achieved full compliance and there are no recommendations.
- PHP achieved full compliance and there are no recommendations.
- UHC achieved full compliance and there are no recommendations.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.

15.10 Care Coordination**Rationale:**

Coordinating the care of patients is one of the many important functions of managed care. The Health Risk Assessment (HRA) and the Comprehensive Needs Assessment (CNA) tools were implemented in Centennial Care to provide a consistent means of understanding a member's needs and how best to meet those needs. The Care Coordination review for CY2016 centered on the completion of HRAs, CNAs and Comprehensive Care Plans (CCPs). The HRA is completed for all newly enrolled members to assess the level of care coordination for which they qualify. Members who qualify for a higher level of care have a CNA completed, which is a more in-depth analysis of the member's situation. Finally, a CCP is developed for members who have had a CNA, so that the member's care needs are coordinated to ensure maximum effectiveness. It is a function of EQR to verify that each MCO has the policies and procedures in place to implement these tools in a timely and consistent manner per State standards.

Evidence Examined in the EQR:

- There was both a policy review and a file review for this area.
- Policies and procedures that govern the use of HRAs and CNAs and the development of the CCPs were reviewed.
- The file review portion included a random sample of care coordination files for members who qualify for a higher level of care with a focus on the timely completion of HRAs, CNAs and the development and authorization of the CCPs.

Summary of CY2016 Findings:

- BCBS achieved full compliance. BCBS was unable to consistently contact members who were new to care coordination in a timely manner to conduct a HRA and the initial comprehensive needs assessment. BCBS was unable to consistently complete the annual CNA and the CCP within one year from the previous assessment and CCP.
- MHP achieved full compliance. MHP was unable to consistently develop the CCP and authorize the services within one year from the previous CCP.
- PHP achieved moderate compliance. There was misalignment within the submitted policy regarding how the HRA is to be completed and the method to communicate to the member the timeframe in which to expect contact to schedule the CNA for those members who have a need for a higher level of care.
- UHC achieved full compliance. The submitted policy did not indicate how the MCO would communicate to the member the timeframe in which to expect the contact to schedule the CNA.

Year-to-Year Score Comparison:

Table 15 shows the current three-year trend of composite scores for Care Coordination by MCO for the CY2014 through CY2016 reviews.

Table 15: Care Coordination Year-to-Year Score Comparison			
MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	87.40%	73.10%	90.73%
MHP	96.70%	93.10%	93.45%
PHP	99.00%	80.76%	83.45%
UHC	96.00%	89.70%	90.09%

Summary of CY2016 Recommendations:

- BCBS will implement a process to improve the timeliness of completion of the HRA, CNA and will consistently develop the CCP and authorize the services within required timeframes.
- MHP will consistently conduct the CNA, develop the CCP and authorize the services within required timeframes.
- PHP will develop processes to provide information to the member during the health assessment for those members who complete an online or paper HRA and provide documentation of those processes for review.
- UHC will update the policy to state explicitly how it will communicate to the member the timeframe in which to expect contact regarding conducting a CNA for those member who complete an online or paper HRA and require a CNA. MCO will develop a consistent process to complete the CCPs within the required 14-business day timeframe.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: Complete all HRAs and CNAs within required timeframes and document their completion.
 - BCBS Previous EQRO Recommendation Follow-Up: Based on the documentation submitted for the CY2016 review, BCBS continues to have difficulty completing HRAs and CNAs in a timely manner.
 - HSD will be expanding an IAP to address the identified compliance issue.
- BCBS Previous EQRO Recommendation: Provide member notifications within required timeframes and document that activity.
 - BCBS Previous EQRO Recommendation Follow-Up: Based on the documentation submitted for the CY2016 review, BCBS has addressed timely member notification and documentation of the notification.
- BCBS Previous EQRO Recommendation: Conduct a root cause analysis to determine why such a high percentage (46.67 percent) of sampled members refused care coordination.
 - BCBS Previous EQRO Recommendation Follow-Up: Based on the documentation submitted for the CY2016 review, BCBS has addressed this recommendation.

- MHP Previous EQRO Recommendation: The EQRO recommended that the MCO document clearly and consistently the timing of the HRAs and CNAs and monitor them for completion.
 - MHP Previous EQRO Recommendation Follow-Up: Based on the documentation submitted for the CY2016 review, MHP has addressed these issues.
- MHP Previous EQRO Recommendation: Determine the best method for recording that the member and/or the member's representative participated in the care plan development.
 - MHP Previous EQRO Recommendation Follow-Up: The MCO continues to have difficulty obtaining the signature on the CCP.
 - HSD will be expanding an IAP to address the identified compliance issue.
- PHP Previous EQRO Recommendation: Add text to the phone script or other HRA-related member education material provided at the time of the HRA informing the member that she or he has the right to request a higher level of care coordination and appropriately document that this notification has occurred.
 - PHP Previous EQRO Recommendation Follow-Up: The contract no longer has this requirement because the standardized HRA contains this language.
- PHP Previous EQRO Recommendation: Update relevant policies and procedures to include a statement clearly defining how PHP will communicate the Care Coordination Unit contact information to the member and when to expect contact regarding having a CNA done.
 - PHP Previous EQRO Recommendation Follow-Up: The documentation submitted by the MCO does not address the communication of the Care Coordination Unit contact information on the timeframes around contact regarding CNA completion for members who complete the HRA other than telephonically.
 - HSD will be expanding an IAP to address the identified compliance issue.
- PHP Previous EQRO Recommendation: Document clearly and consistently the timing of the HRAs and CNAs and monitor them for completion.
 - PHP Previous EQRO Recommendation Follow-Up: Based on the documentation provided for the CY2016 review, PHP has addressed this issue.
- UHC Previous EQRO Recommendation: Update its policies and procedures for Care Coordination to reflect how the member will be informed of the timeframe expectations for the CNA.
 - UHC Previous EQRO Recommendation Follow-Up: Based on the documentation submitted for the CY2016 review, this issue has not been addressed. It was indicated to the EQRO on the last review that the policy would be updated. The policy submitted has not been updated.
 - HSD will be expanding an IAP to address the identified compliance issue.

15.11 Transitions of Care

Rationale:

Members may experience a care transition for a variety of reasons. In what can be a challenging time for a member, it is important that his/her needs are identified, assessed and addressed proactively by the MCO. This review was designed to focus on files of members who have transitioned from nursing facilities (NF) to home or community-based services.

A formal transition plan has been identified by HSD as a best practice for managing these member transitions. MCOs are required to have the proper policies and procedures in place to provide the member with a transition plan that facilitates a seamless transition process with no disruption in services. It is a function of the EQR to verify that these policies and procedures exist and are being followed per State standards as evidenced in the file review.

Evidence Examined in the EQR:

- There was both a policy review and a file review for this area.
- This area included a random sample file review of transitions of care (TOC) with particular focus on the development of a formal transition plan to help members successfully transition from a NF to a home or community-based setting.

Summary of CY2016 Findings:

- BCBS achieved minimal compliance. The MCO did not consistently provide sufficient evidence of a complete, discrete transition plan being created in advance of the member's discharge from a NF.
- MHP achieved minimal compliance. The MCO did not consistently provide sufficient evidence of a complete, discrete transition plan being created in advance of the member's discharge from a NF.
- PHP achieved minimal compliance. The MCO did not consistently provide sufficient evidence of a complete, discrete transition plan being created in advance of the member's discharge from a NF.
- UHC achieved minimal compliance. The MCO did not consistently provide sufficient evidence of a complete, discrete transition plan being created in advance of the member's discharge from a NF.

All MCOs are advised to follow the requirements for transition planning set out in the HSD Managed Care Policy Manual Section 5, which starts on page 46 of the version revised on March 1, 2017.

The compliance deficiencies surrounding MCO development and implementation of transition plans for members transitioning from a nursing facility to a home or community-based setting was initially identified in the CY2014 review. The MCOs were notified of the findings at the conclusion of the EQRO site visits in June 2014. The CY2015 and CY2016 EQRO reviews have confirmed that development and implementation of such plans is an ongoing issue. HSD and the EQRO have taken the following proactive steps to address the compliance deficiencies identified with transition of care:

- HSD updated the HSD Managed Care Policy Manual Section 5, effective March 1, 2017, to clarify the requirements
- HSD conducted an internal review of transition plans in September of CY2017 that confirmed the EQRO findings

- HSD instituted an IAP in October 2017 to address the continuing deficiencies
- HSD conducted educational outreach sessions in June and August of CY2017
- EQRO conducted “Listening Sessions” in May and September of CY2017. The sessions were designed to provide the MCOs with information on HSD requirements and provide a forum for MCO staff and EQRO staff to discuss concerns and ideas

HSD and the EQRO will continue monitoring and assessing MCO development and implementation of transition plans for members transitioning from a nursing facility to a home or community-based setting.

Year-to-Year Score Comparison:

Table 16 illustrates the scoring for the MCO policy, procedure and member file reviews for Transitions of Care for CY2015 and CY2016.

Table 16: Transitions of Care Year-to-Year Score Comparison		
MCO	CY2015 Score	CY2016 Score
BCBS	62.20%	72.18%
MHP	90.80%	74.36%
PHP	81.50%	69.45%
UHC	84.70%	68.91%

Summary of CY2016 Recommendations:

- BCBS will align its policy with its standard operating procedures (SOPs) documentation and job aid as supporting documentation for specifics related to TOC. BCBS will create, document and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from NF to community-based settings.
- MHP will create, document and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from NF to community-based settings.
- PHP will revise the PHP community transition plan document to have space specifically dedicated to each of the contractually required elements and document consistently both the need and the resulting intervention on the transition plan.
- UHC will train staff on the consistent use of a transition plan that identifies the member’s needs and consistent documentation of the interventions used to address the identified needs.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: The EQRO previously recommended that the MCO update its policies to reflect the need to develop and implement specific, individual transition plans.
 - BCBS Previous EQRO Recommendation Follow-Up: Based on the documentation submitted for the CY2016 review, BCBS has addressed this issue.
- BCBS Previous EQRO Recommendation: Create, document and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from a NF to community-based setting.
 - BCBS Previous EQRO Recommendation Follow-Up: BCBS has made strides toward improving documentation including soliciting and implementing EQRO input on the subject.
- MHP Previous EQRO Recommendation: Institute corrective action to create, document and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from a NF to a community-based setting.
 - MHP Previous EQRO Recommendation Follow-Up: MHP has made strides toward improving documentation based on this recommendation, including soliciting and implementing EQRO input on the subject.
- PHP Previous EQRO Recommendation: Create, document and implement specific, individual transition plans that are informed by assessments and other data gathering activities and interactions to facilitate smooth, successful member transitions from a NF to a community-based setting.
 - PHP Previous EQRO Recommendation Follow-Up: PHP has implemented a Community Transition Plan template but there are areas of transition planning that are not addressed on the template. In other cases, there was space on the template but it was either left blank or conflicted with needs identified in the assessments.
 - HSD will be expanding an IAP to address the identified compliance issue.
- UHC Previous EQRO Recommendation: Develop and implement a consistent way of documenting transition plans for members that puts the data in one place to facilitate care coordinator management of the transition process and follow-up.
 - UHC Previous EQRO Recommendation Follow-Up: Based on the documentation submitted for the CY2016 review, UHC implemented a new data system; however, the new system does not appear to have improved their TOC plan or assisted UHC staff in the capture of relevant member information in order to formulate a working TOC plan specific to a single TOC event.
 - HSD will be expanding an IAP to address the identified compliance issue.

15.12 Grievance and Appeal System

Rationale:

All MCOs are required to have policies and procedures in place so that members can take appropriate action when they feel the need to submit a grievance or appeal based on a decision the MCO has made on their behalf. It is a function of the EQR to verify that the policies and procedures exist, that they meet the contractual and regulatory requirements and that they are implemented properly per State standards. Further, the EQR ensures these processes are followed during the file review process.

Evidence Examined in the EQR:

- There was both a policy review and a file review for this area.
- Policies and procedures were reviewed for compliance with contractual and regulatory requirements. This included verifying that the MCOs followed the mandated timeframes, had the appropriate staff assigned to review the grievance or appeal and disseminated the required information to members and providers.
- The file review for this subject area included a random sample of grievances, appeals and expedited appeals, with particular focus on adherence to timeliness, policies and procedures.

Summary of CY2016 Findings:

- BCBS achieved full compliance. The MCO did not consistently provide written acknowledgement of receipt of the grievance or appeal and written resolution of the grievance or appeal to the member within the required timeframes.
- MHP achieved full compliance. The MCO did not consistently provide evidence that the MCO had advised the member of the right to file an appeal and the process for doing so.
- PHP achieved full compliance. The MCO did not consistently provide evidence that the MCO had advised the member of the right to file an appeal and the process for doing so.
- UHC achieved full compliance. The MCO did not consistently gather all necessary information from the member in one request.

Year-to-Year Score Comparison:

Table 17 shows the current three-year trend of composite scores for Grievance and Appeal System by MCO for the CY2014 through CY2016 reviews.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	99.30%	99.50%	94.55%
MHP	99.60%	99.60%	99.45%
PHP	99.30%	99.60%	98.91%
UHC	99.46%	97.60%	95.64%

Summary of CY2016 Recommendations:

- BCBS will consistently provide written acknowledgement of receipt of the grievance or appeal and written resolution of the grievance or appeal to the member within the required timeframes.
- MHP will consistently provide evidence for audit purposes that the MCO had advised the member of the right to file an appeal and the process for doing so upon request.
- PHP will consistently provide evidence for audit purposes that the MCO had advised the member of the right to file an appeal and the process for doing so upon request.
- UHC will consistently follow MCO procedures to support the identification of all necessary information from the member and to request all necessary information from the member at one time.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: Provide a process whereby members can present evidence in support of their appeals in person.
 - UHC Previous EQRO Recommendation Follow-Up: Based on the documentation provided for the CY2016 review, UHC has not addressed this recommendation.
 - HSD will implement an IAP to address the identified compliance deficiency.

15.13 Primary Care Physician and Pharmacy Lock-ins

Rationale:

Sometimes a member unnecessarily utilizes services and attention to patient safety mandates restricting access to those services. This restriction is referred to as a lock-in. When a member's access to a medication is locked-in to a specific physician or pharmacy, it is important that the MCO communicate with the member that a lock-in has been implemented, the reason for the lock-in action and the criteria for being released from the lock-in status. The MCO is also obligated to report these events to HSD regularly. It is a function of the EQR to verify that the MCO has the policies and procedures in place to accomplish these tasks per State standards.

Evidence Examined in the EQR:

- There was both a policy review and a file review for this area.
- Policies and procedures were reviewed to determine that the MCO had the proper systems in place to get members into and out of Primary Care Physician (PCP) or Pharmacy Lock-in situations when conditions warranted such an action.
- This area included a random sample file review of PCP and Pharmacy Lock-ins with particular focus on communication with the member.

Summary of CY2016 Findings:

- BCBS achieved full compliance and no deficiencies were identified.
- MHP achieved full compliance and no deficiencies were identified.
- PHP achieved full compliance and no deficiencies were identified.
- UHC achieved full compliance. While documentation supplied by the MCO was sufficient for positive scoring, the policy did not include criteria for identifying when a member could be released from a lock-in status.

Year-to-Year Score Comparison:

Table 18 shows the current three-year trend of composite scores for PCP and Pharmacy Lock-ins by MCO for the CY2014 through CY2016 reviews.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	100.00%	100.00%	100.00%
MHP	100.00%	100.00%	100.00%
PHP	78.75%	94.44%	100.00%
UHC	62.50%	100.00%	100.00%

Summary of CY2016 Recommendations

- BCBS achieved full compliance and there are no recommendations.
- MHP achieved full compliance and there are no recommendations.
- PHP achieved full compliance and there are no recommendations.
- UHC will update its policy to include what criteria will be used to determine when to implement and release a member from a PCP or pharmacy lock-in.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- MHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- PHP Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.
- UHC Previous EQRO Recommendation: There were no recommendations in the CY2015 EQR report.

15.14 UM: Adverse Benefit Determinations**Rationale:**

The MCOs must have written policies and procedures describing how members and contract providers access services including prior authorization and referral requirements for various types of medical and surgical treatments, emergency room services, behavioral health and long-term care services. Federal standards and the MCO's State contract prescribe consistent use of review criteria and qualified personnel to make benefit determinations. Additionally, there is specific information that must be communicated to the member with associated timeframes in which these notices must be completed. In cases where the request for service authorization is denied, the MCO is required to send written notice for the adverse benefit determination to the member in language that is easy for the member to understand. It is a function of the EQR to verify that these requirements are being met.

Evidence Examined in the EQR:

- There was both a policy review and a file review for this area.
- Policies and procedures that govern adverse benefit determinations were reviewed.
- Member files were also reviewed to ensure that policies and procedures were followed.

Summary of CY2016 Findings:

- BCBS achieved full compliance. The MCO did not consistently provide a written notification to members that the authorization for service request had been denied. In addition, the MCO did not consistently use a plain language explanation in the written notification to members that was clear and understandable to a layperson.
- MHP achieved full compliance. The MCO did not consistently document when it grants an extension of time to a facility in order to provide clinical documentation for an authorization.
- PHP achieved full compliance. The MCO did not consistently use a plain language explanation in the written notification to members that was clear and understandable to a layperson.

- UHC achieved full compliance. The member charts did not consistently contain the clinical information used to make the adverse benefit determination when dental services were requested. In addition, the MCO's dental vendor did not consistently use a plain language explanation in the written notification to members that was clear and understandable to a layperson.

Year-to-Year Score Comparison:

Table 19 shows the current three-year trend of composite scores for UM: Adverse Benefit Determinations by MCO for the CY2014 through CY2016 reviews.

MCO	CY2014 Score	CY2015 Score	CY2016 Score
BCBS	99.67%	91.00%	95.09%
MHP	97.67%	100.00%	99.45%
PHP	96.00%	100.00%	99.45%
UHC	100.00%	100.00%	90.73%

Summary of CY2016 Recommendations:

- BCBS will consistently provide a written denial of service benefit to members. In addition, the MCO will consistently use a plain language explanation that is clear and understandable to a layperson in the written notification.
- MHP will provide evidence that an extension of time was granted to a facility when the facility needed more time to provide documentation for consideration.
- PHP will consistently use a plain language explanation that is clear and understandable to a layperson in the written notification.
- UHC will work with its dental vendor to provide clinical information from each written notification for audit purposes as requested. In addition, the MCO will work with its dental vendor to consistently use a plain language explanation that is clear and understandable to a layperson in the written notification.

Details on MCO-specific audit recommendations can be found in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC.

Follow-up on Previous EQRO Recommendations to the MCOs:

- BCBS Previous EQRO Recommendation: Adopt the practice of having medical directors write a plain language summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.
 - BCBS Previous EQRO Recommendation Follow-Up: Based on the documentation supplied for the CY2016 review, this issue has not been resolved.
 - HSD will implement an IAP to address the identified compliance deficiency.

- MHP Previous EQRO Recommendation: Adopt the practice of having medical directors write a plain language summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.
 - MHP Previous EQRO Recommendation Follow-Up: Based on the documentation supplied for the CY2016 review, this issue has been resolved.
- PHP Previous EQRO Recommendation: Adopt the practice of having medical directors write a plain language summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.
 - PHP Previous EQRO Recommendation Follow-Up: Based on the documentation supplied for the CY2016 review, this issue has been resolved.
- PHP Previous EQRO Recommendation: Have medical directors review administrative denials as required by the contract. If this is being done already, discuss ways to provide documentation of this activity for review.
 - PHP Previous EQRO Recommendation Follow-Up: Based on the documentation supplied for the CY2016 review, this issue has been resolved.
- UHC Previous EQRO Recommendation: Work with its dental vendors to update the dental service written notification to match those issued by UHC.
 - UHC Previous EQRO Recommendation Follow-Up: Based on the documentation supplied for the CY2016 review, this issue has not been completely resolved. UHC did revise its internal letters to conform to the requirement that the letters be understandable to a layperson; however, the letters from dental providers remain deficient. Because additional improvement is needed, these recommendations stand for the CY2016 review.
 - HSD will implement an IAP to address the identified compliance deficiency.
- UHC Previous EQRO Recommendation: Adopt the practice of having medical directors write a plain language summary of the denial rationale for the member that is clear and understandable to a layperson. This documentation is to be included with the technical description that is required.
 - UHC Previous EQRO Recommendation Follow-Up: Based on the documentation supplied for the CY2016 review, this issue has not been completely resolved. UHC did revise its internal letters to conform to the requirement that the letters be understandable to a layperson; however, the letters from dental providers remain deficient. Because additional improvement is needed, these recommendations stand for the CY2016 review.
 - HSD will implement an IAP to address the identified compliance deficiency.

16.0 Rebuttal and Reconsideration

Each MCO will have the opportunity to offer rebuttals or requests for reconsideration of any findings or scores in this report. Any MCO rebuttal and/or request for reconsideration and the corresponding response from the EQRO will be outlined in the MCO-specific section. If the rebuttal or request for reconsideration results in a scoring change, only the revised score will be shown in the final report. HSD is notified of scoring changes and consulted as appropriate.

17.0 Conclusion

Based on the results of this audit, in CY2016 the MCOs met contractual requirements for the provision of Centennial Care Medicaid managed care benefits. With some exceptions, which are noted in Section A: BCBS, Section B: MHP, Section C: PHP and Section D: UHC, MCO policies and procedures are effective and are being followed at both the organizational and provider levels. Below is a brief discussion of two areas that are of notable concern to the Medicaid system.

Transitions of Care

The development and implementation of Transition Plans using the process required by the HSD Managed Care Policy Manual remains challenging for all four MCOs. Based on the documentation submitted for review, all MCOs have made improvements in their mechanisms for developing and documenting transition plans, especially noted in the file documentation for the last quarter of CY2016 but all four remain in Minimal Compliance for this review subject.

BCBS and MHP continue to implement policies to align with current HSD direction regarding best practices for TOC. PHP and UHC have made alterations in their systems and processes but those changes have yet to create a better score.

Care Coordination

Transitions of Care is a part of a MCO's overall Care Coordination program. Care Coordination is also an area that is included separately within the scope of the EQRO review. This is a notable improvement; thus, it being mentioned in the conclusion. There is more improvement to be made around Care Coordination but some improvement has already been documented.

HealthInsight New Mexico, as the EQRO for the State, will continue to work with HSD and the MCOs to improve timely access to quality care for all Medicaid beneficiaries.

18.0 MCO-Specific Sections List

Sections have a leading letter corresponding with each MCO or the information within the section.

- Section A: BCBS
- Section B: MHP
- Section C: PHP
- Section D: UHC

For additional information concerning this report, contact:



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