Medicaid Managed Care Organization

External Quality Review Organization Report

Executive Summary

Final Report

Calendar Year 2005

Submitted by:
Delmarva Foundation
July 2006

HealthChoice and Acute Care Administration
Division of HealthChoice Management and Quality Assurance

Maryland Medical Assistance HealthChoice Program
Evaluation of Participating Managed Care Organizations for Calendar Year 2005

Executive Summary

Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is required to annually evaluate the quality of care (QOC) provided to Maryland Medical Assistance enrollees in HealthChoice Managed Care Organizations (MCOs). DHMH, pursuant to Title 42, Code of Federal Regulations, 438.204, is responsible for monitoring the QOC provided to MCO enrollees when delivered pursuant to the Code of Maryland Regulations (COMAR) 10.09.65.

`

Under Federal law (Section 1932(c)(2)(A)(i) of the Social Security Act), DHMH is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided under each MCO contract. To ensure that the services provided to the enrollees meet the standards set forth in the regulations governing the HealthChoice Program, DHMH contracts with Delmarva Foundation (Delmarva) to serve as the EQRO. This executive summary describes the findings from the two areas reviewed—the systems performance and the Healthy Kids Quality Monitoring Program—for calendar year (CY) 2005, which is HealthChoice's eighth year of operation. The HealthChoice program served approximately 487,000 enrollees during this period.

COMAR 10.09.65 establishes compliance standards for the annual systems performance review (SPR). MCOs are given an opportunity to review and comment on the SPR standards 90 days prior to the beginning of the audit process. The seven MCOs evaluated for CY 2005 are:

- AMERIGROUP Maryland, Inc. (AGM)
- Diamond Plan from Coventry Health Care, Inc. (DIA)
- Helix Family Choice, Inc. (HFC)
- Jai Medical Systems, Inc. (JMS)
- Maryland Physicians Care (MPC)
- Priority Partners (PPMCO)
- UnitedHealthcare (UHC)

Delmarva visits each MCO annually to complete an objective assessment of the structure, process, and outcome of each MCO's internal quality assurance (QA) program. This on-site assessment involves the application of systems performance standards, as required by COMAR 10.09.65.03; an evaluation of each MCO's health education plan (HEP); an evaluation of each MCO's claims reimbursement system, and an evaluation of each MCO's fraud and abuse program. DHMH staff conducts the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) review as a component of the Maryland Healthy Kids Quality

Monitoring Program. The results of the EPSDT review of 2,349 medical records and a summary of the corrective action plan (CAP) process are included in this report.

Systems Performance Review Results

The HealthChoice MCO annual SPR consists of 12 standards. Eight standards are found in table 1 and the remaining four standards in tables 3, 4, 5 and 6. In CY 2005, Delmarva and DHMH made minor modifications to the standards based upon discussion with staff and feedback received from the MCOs following the CY 2004 review and added a new standard evaluating the MCO's fraud and abuse programs. For the CY 2005 review, one standard was exempted for all the MCOs and the new fraud and abuse standard was scored as baseline.

The standard exempted from review during CY 2005 was the evaluation of the MCO's Outreach Plans (OPs). This standard will be reviewed on a rotating basis every three years to augment the MCOs submission of annual OPs to DHMH. The next review of this standard will be in 2008 as part of the CY 2007 SPR.

All seven HealthChoice MCOs participated in the SPR. In areas where deficiencies were noted, the MCOs were provided recommendations that if implemented, should improve their performance for future reviews. All required CAPs were submitted and deemed adequate.

Table 1 displays each of the systems performance standards with the minimum compliance ratings as defined in COMAR 10.09.65 for the reviews during years six (CY 2003), seven (CY 2004), and eight (CY 2005).

Table 1. Performance Standards Compliance Rates

Performance Standard	Standard Description	COMAR Requirement Year Six (CY 03)	COMAR Requirement Year Seven (CY 04)	COMAR Requirement Year Eight (CY 05)
1	Systematic Process	100%	100%	100%
2	Governing Body	100%	100%	100%
3	Oversight of Delegated Entities	Baseline	70%	80%
4	Credentialing	100%	100%	100%
5	Enrollee Rights	100%	100%	100%
6	Availability and Access	100%	100%	100%
7	Utilization Review	100%	100%	100%
8	Continuity of Care	100%	100%	100%

Table 2 provides for a comparison of SPR results across MCOs and the MCO aggregate for the CY 2005 review. The CY 2004 aggregate scores are included for comparative purposes. As stated in Table 1, CY 2005 minimum compliance is 100% for seven of the reviewed standards and 80% for one standard.

Table 2. CY 2005 MCO Compliance Rates

Performance Standard	Description	MCO Aggregate CY 2004	MCO Aggregate CY 2005	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
1	Systematic Process	**99%***	100%	100%	100%	100%	100%	100%	100%	100%
2	Governing Body	100%	**96%***	100%	**80%***	100%	100%	**95%***	100%	100%
3	Oversight of Delegated Entities	**68%***	84%	100%	**64%***	100%	100%	**57%***	**86%***	**86%***
4	Credentialing	100%	**99%***	100%	**99%***	100%	**99%***	**99%***	**99%***	100%
5	Enrollee Rights	100%	**99%***	100%	100%	100%	100%	**96%***	**96%***	100%
6	Availability and Access	100%	100%	100%	100%	100%	100%	100%	100%	100%
7	Utilization Review	**95%***	**96%***	**97%***	**89%***	100%	**97%***	**87%***	100%	100%
8	Continuity of Care	100%	**98%***	100%	**88%***	100%	100%	100%	100%	100%

*Denotes that the minimum compliance rate was unmet.

Each standard that was reviewed as part of the CY 2005 audit is discussed in the following section.

Systematic Process of Quality Assessment/Improvement

All MCOs continue to have processes in place to monitor and evaluate the quality and appropriateness of care and service to members using performance measures. Clinical care standards and/or practice guidelines are in place, and clinicians monitor and evaluate quality through review of individual cases where there are questions about care. Overall, there is evidence of development, implementation, and monitoring of corrective actions.

- The MCO aggregate compliance rate increased from 99% in CY 2004 to 100% for CY 2005.

Accountability to the Governing Body

The governing body of the MCO must perform specific functions that include: oversight of the MCO, approval of the overall QA Program and annual QA Plan, formally designate an accountable entity or entities to provide oversight of the QA activities when not directly performed by the governing body, and receipt of routine reports related to the QA Program.

- The MCO aggregate compliance rate decreased from 100% in CY 2004 to 96% in CY 2005.

Two MCOs demonstrated opportunities for improvement. One MCO did not provide evidence of the reporting, reviewing, and approving of UR activities and findings to the appropriate governing body and one did not present evidence that the plan and policies for credentialing and recredentialing had been updated, submitted, and approved by the governing body.

Oversight of Delegated Entities

All MCOs remain accountable for all QA Program functions, even if certain functions are delegated to other entities. Delegate compliance monitoring includes a written description of the specific duties and reports of the delegate, policies and procedures for monitoring and evaluating the activities of all delegated entities, and the monitoring of compliance with those requirements.

- The MCO aggregate compliance rate increased from 68% for CY 2004 to 84% in CY 2005.

Four MCOs demonstrated opportunities for improvement in the Oversight of Delegated Entities standard. The first MCO did not provide evidence to support the review and approval of quarterly complaint, grievance, and appeal reports, claims payment activity reports, over and under utilization reports, and annual UM plans for all delegated entities that had been delegated those responsibilities. The second MCO did not provide evidence of consistent monitoring of delegated activities, explicit review and approval of quarterly complaint, grievance and appeal reports, claims activity reports, and over and under utilization reports. This MCO also did not provide evidence that their delegation policies accurately reflect the specific activities that the MCO delegates, and did not provide evidence of documented follow-up on CAPs for delegated entities. The third MCO did not provide evidence of review and approval of annual UM plans and over and under utilization reports from all delegated entities by the committees as specified in the delegation policy. The forth MCO did not provide evidence of appropriate committee review and approval of all claims activities reports submitted by delegated entities.

Credentialing and Recredentialing

All MCOs have provisions to determine whether physicians and other health care professionals, licensed by the State and under contract to the MCO, are qualified to perform their services. Such provisions include a plan that contains written policies and procedures for initial credentialing and recredentialing and evidence that these policies and procedures are functioning effectively.

- The MCO aggregate compliance rate decreased from 100% in CY 2004 to 99% in CY 2005.

Four MCOs demonstrated opportunities for improvement in the Credentialing and Recredentialing standard. The opportunities for all plans were to consistently adhere to the written policies, procedures, and timelines for initial credentialing and recredentialing.

Enrollee Rights

The MCOs have processes in place that demonstrate a commitment to treating members in a manner that acknowledges their rights and responsibilities. All MCOs have appropriate policies and procedures in place and educate enrollees on their complaint, grievance, and appeals processes.

- The MCO aggregate compliance rate decreased from 100% in CY 2004 to 99% in CY 2005.

Two MCOs demonstrated opportunities for improvement in the Enrollee Rights standard. Both MCOs did not provide evidence of the dissemination of member satisfaction survey results to providers and practitioners.

Availability and Accessibility

The MCOs have established standards for ensuring access to care and have fully implemented a system to monitor performance against these standards.

- The MCO aggregate compliance rate remained at 100% from CY 2004 to CY 2005.

Utilization Review

The MCOs have written utilization management (UM) plans that describe procedures to evaluate medical necessity criteria used, information sources, procedures for training and evaluating staff, monitoring of the timeliness and content of adverse determination notifications, and the processes used to review and approve the provision of medical services. The MCOs provided evidence that qualified medical personnel supervise pre-authorization and concurrent review decisions. The MCOs have implemented mechanisms to detect over and under utilization of services. Overall, policies and procedures are in place for providers and enrollees to appeal decisions.

- The MCO aggregate compliance rate increased from 95% in CY 2004 to 96% in CY 2005.

Four MCOs demonstrated opportunities for improvement in the Utilization Review standard. Two MCOs did not provide evidence that an inter-rater reliability assessment is conducted for all medical management staff for all applicable criterion sets. One MCO did not provide evidence of the review of over and under utilization reports at least quarterly or the review of corrective measures that have been implemented to address identified over and under utilization issues by the appropriate oversight committee. One MCO did not provide complete documentation of ongoing monitoring of corrective actions implemented to address

utilization issues, evidence of a formal tracking mechanism for monitoring compliance with appeal turnaround time frames, and evidence that all adverse determination letters were in compliance with state-required components.

Continuity of Care

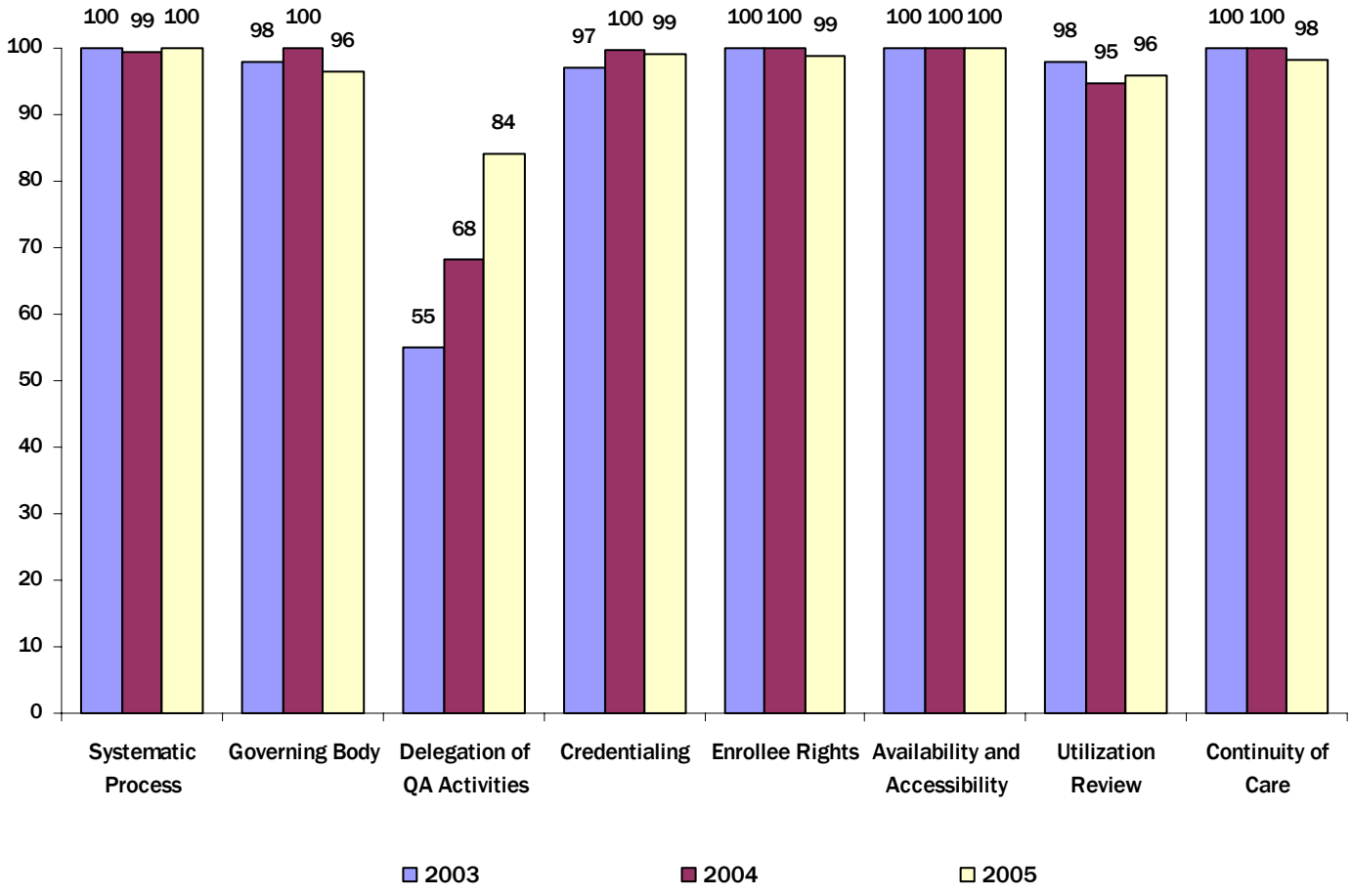
The findings, conclusions, actions taken, and results of actions taken as a result of the MCO's QA activities are documented and reported to appropriate individuals within the MCO's structure and through the established QA channels. All MCOs have allocated resources, such as automated tracking methodologies, that facilitate communication between members, primary care providers (PCPs), other health care professionals, and the MCO's care coordinators.

- The MCO aggregate compliance rate decreased from 100% in CY 2004 to 98% in CY 2005.

One MCO demonstrated an opportunity for improvement in the Continuity of Care standard. This MCO did not provide evidence of a policy and procedure which details the process for clinical care provided at school based health centers (SBHCs) to be relayed to PCPs in a timely manner including a method to ensure that members get urgent or emergency follow-up care based on the diagnosis and treatment provided by the SBHC.

Figure 1 is a comparison of the HealthChoice systems performance compliance rates for standards evaluated in the CY 2003 through CY 2005 reviews. Between CY 2003 and CY 2004, the aggregate compliance rate remained the same for three standards; increased for three standards; and decreased for two standards. Between CY 2004 and CY 2005, the aggregate compliance rate remained unchanged for one standard; increased for three standards; and decreased for four standards. Between CY 2003 and CY 2005, the aggregate compliance scores remained unchanged for two standards; increased for two standards; and decreased for four standards.

Figure 1. Health Choice Aggregate Systems Performance Compliance Rates for CY2003 through CY 2005



Health Education Plan Review

Each MCO is required to develop an annual HEP to address the educational programs and health care services to enrollees. Delmarva evaluated each MCO's HEP as part of the SPR. The CY 2005 aggregate rate for the HEPs is 100%. This rate met the minimum compliance rate of 100%, and improved from 99% in CY 2004 as well as 99% in CY 2003.

As noted in Table 3, all MCOs met the minimum compliance rate of 100%. Six MCOs achieved a compliance rate of 100% for CY 2004. One MCO exhibited an increase from the CY 2004 rate and six MCOs remained at 100%. This was an improvement over CY 2003 in which five MCOs met the 100% compliance rate.

Table 3. Health Education Plan Compliance Rates

Description	Review Year	Minimum Compliance Rate	MCO Aggregate Rate	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
Health Education Plan	CY 2005	100%	100%	100%	100%	100%	100%	100%	100%	100%
	CY 2004	90%	99%	96%	100%	100%	100%	100%	100%	100%
	CY 2003	70%	99%	100%	33%	100%	100%	100%	100%	92%

Outreach Plan Review

COMAR 10.09.65.25 requires each MCO to develop an annual written OP to address outreach services to HealthChoice enrollees. The minimum compliance rate was 70% for the CY 2003 for the OP development and implementation and 90% for CY 2004. This standard was not reviewed as part of the CY 2005 SPR. The next review of this standard will be in 2008 as part of the CY 2007 SPR and the minimum compliance rate will be 100%.

As noted in the Table 4, all MCOs exceeded the minimum compliance rate of 90% for the CY 2004 review of the development and implementation of the OP and were exempt from review in CY 2005.

Table 4. Outreach Plan Compliance Rates

Description	Minimum Compliance Rate	MCO Aggregate Rate	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
CY 2005 Outreach Plan (Development & Implementation)	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
CY 2004 Outreach Plan (Development & Implementation)	90%	100%	100%	100%	100%	100%	100%	100%	100%
CY 2003 Outreach Plan (Development & Implementation)	70%	100%	100%	79%	100%	100%	100%	100%	100%

Claims Payment Review

COMAR 31.10.11.08, 31.10.11.09, and Insurance Article §15-1005 of the Annotated Code of Maryland require that each MCO develop a process for the timely payment of claims and that each MCO pay interest on those claims paid beyond the time limit required by regulation. Additionally each MCO is required to report the acceptance and payment of all claims to the Maryland Insurance Administration on the Semi-Annual Claims Data Filing Form.

As noted in Table 5, the minimum compliance rate is 100% for the Claims Payment Review for CY 2005. The aggregate MCO compliance rate for this standard remained at 100% from the CY 2004 to CY 2005. This rate increased from 96% in CY 2003 to 100% in CY 2004 and CY 2005.

Table 5. Claims Payment Compliance Rates

Description	Review Year	Minimum Compliance Rate	MCO Aggregate Rate	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
Claims Payment	CY2005	100%	100%	100%	100%	100%	100%	100%	100%	100%
	CY 2004	90%	100%	100%	100%	100%	100%	100%	100%	100%
	CY 2003	70%	96%	100%	100%	100%	100%	100%	83%	92%

Fraud and Abuse

COMAR 10.09.65.02, COMAR 10.09.65.03, COMAR 31.04.15, and CMS 438.608 require that each MCO maintain a Medicaid Managed Care Compliance program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program is also required to include guidelines for failure to comply with these standards.

As noted in Table 6, this measure was scored as a baseline for the CY 2005 review. Table 6 represents the baseline scores for all MCOs and the MCO aggregate rate which is 74% for the fraud and abuse review for CY 2005.

Table 6. Fraud and Abuse Compliance Rates

Description	Review Year	Minimum Compliance Rate	MCO Aggregate Rate	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
Fraud and Abuse	CY 2005	Baseline	74%	75%	86%	100%	79%	54%	43%	85%

Healthy Kids Quality Monitoring Program Results

The overall compliance rates for the results of the Healthy Kids/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) focused medical record review are based on a review of five separate components.

These components are:

- Health and Developmental History
- Comprehensive Physical Examination
- Laboratory Tests
- Immunizations
- Health Education/Anticipatory Guidance

This Program requires each MCO to meet a minimum composite compliance rate of 85%. Findings related to key indicators for the Healthy Kids/EPSDT review for CY 2005 are described below in Table 7.

Table 7. Healthy Kids/EPSDT Indicator Results by MCO

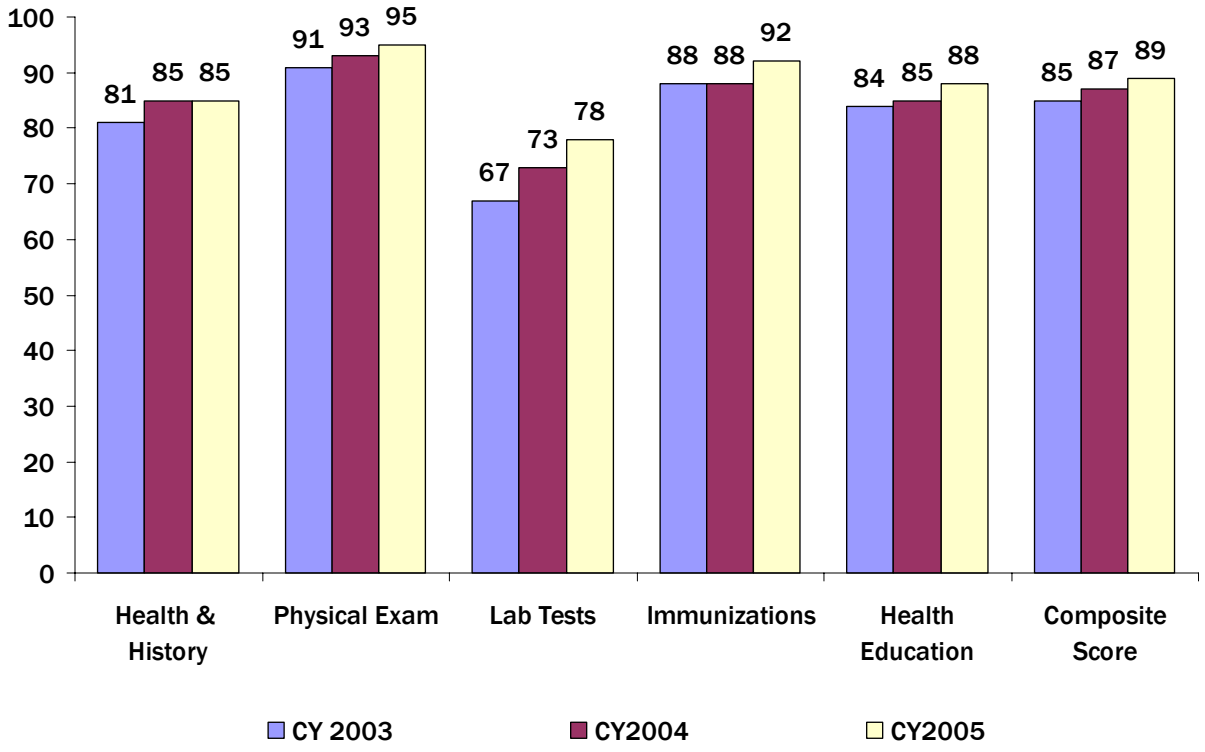
MCO	Health & Developmental History	Comprehensive Physical Examination	Laboratory Tests	Immunizations	Health Education/ Anticipatory Guidance	Composite Score
AGM	79%	93%	71%	91%	82%	86%
DIA	95%	95%	75%	92%	90%	93%
HFC	84%	96%	77%	91%	90%	89%
JMS	93%	99%	93%	94%	96%	96%
MPC	86%	96%	80%	92%	88%	90%
PPMCO	85%	94%	77%	92%	87%	89%
UHC	81%	92%	72%	92%	84%	87%
Aggregate Score	85%	95%	78%	92%	88%	89%

Analyses of the review components in the Healthy Kids/EPSDT focused medical record review indicate that:

- All MCOs composite compliance rates exceeded the required 85%.
- All MCOs met or exceeded the required 85% compliance rate for comprehensive physical examinations, immunizations, and health education.

Figure 2 compares the review results by MCO for CY 2003 through CY 2005. HealthChoice MCOs have demonstrated improvement over the 2003 composite rates for the Healthy Kids/EPSDT review.

Figure 2. HealthChoice Aggregate Rates for Healthy Kids/EPSDT Program Review Indicators for CY 2003 through CY 2005



An analysis of the review results by MCO indicates that there was improvement in all indicators between CY 2003 and CY 2005. All five indicators improved or remained the same between CY 2004 and CY 2005. Health & Developmental History, Physical Exams, Immunizations, and Health Education each improved 4% between CY 2003 and CY 2005. Laboratory Tests improved 11% between CY 2003 and CY 2005.

Corrective Action Plan Process

Each year the CAP process is discussed during the annual audit orientation meeting. This process requires that each MCO must submit a CAP which details the actions to be taken to correct any deficiencies identified during the SPR. CAPs must be submitted within 45 calendar days of receipt of the preliminary report. The CAPs are evaluated by Delmarva to determine whether the plans are acceptable. In the event that a CAP is deemed unacceptable, Delmarva will provide technical assistance to the MCO until an acceptable CAP is submitted. All MCOs have submitted adequate CAPs for the areas where deficiencies occurred for CY 2005.

Systems Performance Review CAPs

A review of all required systems performance standards, health education, OPs, claims payment policies and procedures, and fraud and abuse program is completed annually for each MCO. Since CAPs related to the SPR can be directly linked to specific components or standards, the annual SPR for CY 2006 will determine whether the CAPs have been implemented and are effective. In order to make this determination, Delmarva will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, DHMH will be notified for further action.

Conclusions

All MCOs have demonstrated the ability to design and implement effective QA systems, HEPs, and outreach services. The CY 2005 review provided evidence of the continuing growth of the HealthChoice MCOs as each MCO demonstrated their ability to ensure the delivery of quality health care for their enrollees.

The Healthy Kids Program results exhibit MCO compliance with EPSDT screening requirements. Each MCO achieved a composite score above the 85% requirement. Continued collaboration between the Healthy Kids Program Nurse Consultant team and the HealthChoice MCOs contributed to improvements in four indicator scores in CY 2005.

Maryland has set high standards for MCO QA systems. In general, HealthChoice MCOs continue to make improvements in their QA monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. This is evident in the comparison of annual SPR results and Healthy Kids Program results demonstrated throughout the history of the HealthChoice Program.