

Medicaid Managed Care Organization



External Quality Review Organization Report

Executive Summary



Final Report

Calendar Year 2004



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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 2004

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, Part 434.53, 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 for Medical Care, Inc. (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) 2004, which is HealthChoice’s seventh year of operation. The HealthChoice program served approximately 479,000 enrollees during this period. A description of the corrective action process is included.

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 before the beginning of the audit process. The seven MCOs evaluated for CY 2004 are:

- AMERIGROUP Maryland, Inc. (AGM)
- Diamond Plan (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 outreach plan (OP) as required in COMAR 10.09.65.25, and an evaluation of each MCO’s claims reimbursement system. 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 2,708 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 19 standards. Sixteen standards are found in table 1 and the remaining three standards in tables 3, 4, and 5. For the CY 2004 review, eight of 19 standards were exempted for all the MCOs. In CY 2004, Delmarva and DHMH made minor modifications to the standards based upon discussion with staff and feedback received from the MCOs following the CY 2003 review.

The standards exempted from review during CY 2004 included those areas where the MCOs had previously met the required minimum compliance rates. The standards exempted include requirements associated with a written QA plan, an active QA committee, QA program supervision, adequate MCO staff resources, provider participation in the QA program, QA documentation, QA coordination with other management activity, and medical record standards.

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 five (CY 2002), six (CY 2003), and seven (CY 2004).

Table 1. Performance Standards Compliance Rates

Performance Standard	Standard Description	COMAR Requirement Year Five (CY 02)	COMAR Requirement Year Six (CY 03)	COMAR Requirement Year Seven (CY 04)
1	Written Quality Plan	Exempt	Exempt	Exempt
2	Systematic Process	100%	100%	100%
3	Governing Body	100%	100%	100%
4	Active QA Committee	Exempt	Exempt	Exempt
5	QA Plan Supervision	Exempt	Exempt	Exempt
6	Adequate Resources	Exempt	Exempt	Exempt
7	Provider Participation	Exempt	Exempt	Exempt
8	Delegation of QA Plan	Exempt	Baseline	70%
9	Credentialing	100%	100%	100%
10	Enrollee Rights	100%	100%	100%
11	Availability and Access	100%	100%	100%
12	Medical Records	Exempt	Exempt	Exempt
13	Utilization Review	100%	100%	100%
14	Continuity of Care	100%	100%	100%
15	QA Documentation	100%	Exempt	Exempt
16	Coordination of QA	100%	Exempt	Exempt

Table 2 provides for a comparison of SPR results across MCOs and the MCO aggregate for the CY 2004 review. The CY 2003 aggregate scores are included for comparative purposes. As stated in Table 1, CY 2004 minimum compliance is 100% for seven of the reviewed standards and 70% for one standard.

Table 2. CY 2004 MCO Compliance Rates

Performance Standard	Description	MCO Aggregate CY 2003	MCO Aggregate CY 2004	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
1	Written Quality Plan	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
2	Systematic Process	100%	99%*	100%	100%	100%	100%	99%*	97%*	100%
3	Governing Body	98%*	100%	100%	100%	100%	100%	100%	100%	100%
4	Active QA Committee	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
5	QA Plan Supervision	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
6	Adequate Resources	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
7	Provider Participation	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
8	Delegation of QAP Activities	55%	68%*	81%	88%	88%	100%	13%*	44%*	60%*
9	Credentialing	97%*	100%	100%	100%	100%	100%	100%	97%*	100%
10	Enrollee Rights	100%	100%	100%	100%	100%	100%	100%	100%	100%
11	Availability and Access	100%	100%	100%	100%	100%	100%	100%	100%	100%
12	Medical Records	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
13	Utilization Review	98%*	95%*	97%*	100%	100%	94%*	84%*	95%*	87%*
14	Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%
15	QA Documentation	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
16	Coordination of QA	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt

*Denotes that the minimum compliance rate was unmet

Each standard that was reviewed as part of the CY 2004 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. 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 decreased from 100% in CY 2003 to 99% for CY 2004.

One MCO demonstrated an opportunity for improvement in documenting their procedure and mechanism for tracking and monitoring CAPs within the organization. One MCO did not provide evidence of review and approval of clinical practice guidelines (CPGs) listed in their Provider Manual or evidence that CPGs were systematically disseminated to providers.

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 increased from 98% in CY 2003 to 100% in CY 2004.

Delegation of Activities

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 55% for CY 2003 to 68% in CY 2004.

Two MCOs demonstrated an opportunity for improvement in their written delegation agreements, including the written description of delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO. Two MCOs demonstrated an opportunity for improvement in their written procedures for monitoring and evaluating the implementation of delegated functions and verifying the QOC being provided. Six MCOs did not provide evidence of review and approval of delegate quality improvement (QI) plans, five MCOs did not provide evidence of review and approval of delegate QA and QI reports, two MCOs did not provide evidence of review and approval of quarterly delegate complaint, grievance and appeal reports, four MCOs did not provide evidence of review and approval of delegate claims payment activities, two MCOs did not provide evidence of review and approval of delegate UM plans, and two MCO did not provide evidence of review and approval of delegate over and under utilization reports.

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 increased from 97% in CY 2003 to 100% in CY 2004.

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 remained at 100% from CY 2003 to CY 2004.

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 2003 to CY 2004.

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. 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 decreased from 98% in CY 2003 to 95% in CY 2004.

Two MCOs demonstrated an opportunity for improvement with the review and approval of all UM criteria, both internally and externally developed. Two MCOs did not provide evidence of staff training on the interpretation and application of UM criteria and standards, and one MCO did not provide evidence that it evaluated the consistency of staff in applying UM criteria. One MCO demonstrated an opportunity for improvement in the review of services for over and under utilization. Three MCOs did not maintain policies and procedures that met State-required time limits for pre-authorization and concurrent review decisions or maintain a mechanism to track their compliance with State-required time limits. One MCO did not

consistently document the reasons for pre-authorization and concurrent review decisions, and two MCOs did not consistently meet the State-required resolution periods for appeals. One MCO did not provide documentation ensuring that utilization determinations made by an individual or entity is not directly influenced by financial incentive or compensation.

Continuity of Care

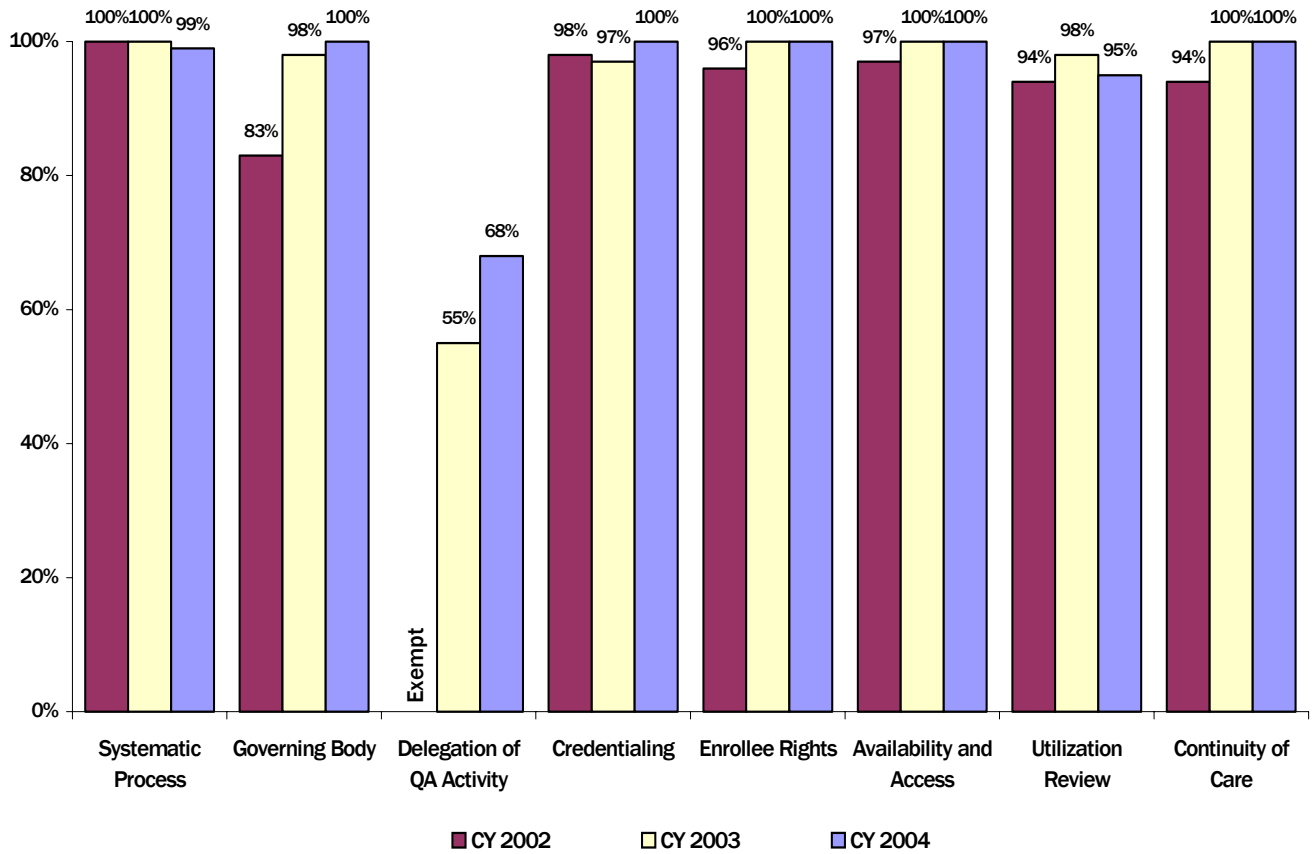
The findings, conclusions, actions taken, and results of actions taken as a result of the MCO's QA activity are documented and reported to appropriate individuals within the MCO's structure and through the established QA channels. All MCOs have allocated resources, such as automated tracking methodologies,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

- The MCO aggregate compliance rate remained at 100% from CY 2003 to CY 2004.

For CY 2004, the MCOs met the minimum compliance rate of 100% for five of the eight SPR standards. Three standards increased from CY 2003; accountability to the governing body increased from 98% in CY 2003 to 100% in CY 2004; delegation of activities increased from 55% in 2003 to 68% in 2004, and credentialing and recredentialing increased to 100% in CY 2004 from 97% in CY 2003. Enrollee rights, availability and accessibility, and continuity of care standards remained the same at 100% from CY 2003 to CY 2004. Two standards decreased from CY 2003 to CY 2004. They are systematic process of quality assessment and improvement from 100% to 99% and utilization review from 98% to 95%.

Figure 1 is a comparison of the HealthChoice systems performance compliance rates for standards evaluated in the CY 2002 through CY 2004 reviews. Between CY 2003 and CY 2004, the aggregate compliance rate remained unchanged at 100% for three standards; increased for three standards; and decreased for two standards.

Figure 1. HealthChoice Aggregate Systems Performance Compliance Rates for CY 2002 through CY 2004



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 2004 aggregate rate for the HEPs is 99%. This rate met the minimum compliance rate of 90%, and remained the same as CY 2003.

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 2004	90%	99%	96%	100%	100%	100%	100%	100%	100%
	CY 2003	70%	99%	100%	33%	100%	100%	100%	100%	92%
	CY 2002	70%	95%	100%	N/A	100%	100%	100%	93%	79%

As Table 3 indicates, all MCOs exceeded the minimum compliance rate of 90%. Six MCOs achieved a compliance rate of 100% for CY 2004. Two MCOs exhibited an increase from the CY 2003 rate and one MCO observed a decrease in rate.

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 is 90% for the CY 2004 OP development and implementation. The CY 2004 aggregate rate for all OPs is 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.

Table 4. Outreach Plan Compliance Rates

Description	Minimum Compliance Rate	MCO Aggregate Rate	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
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%
CY 2002 Outreach Plan (Implementation Only)	70%	100%	100%	N/A	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. The minimum acceptable compliance rate is 90% for the Claims Payment Review for CY 2004. The aggregate MCO compliance rate for this standard was 100%, an increase from the CY 2003 rate of 96%.

Table 5. Claims Payment Compliance Rates

Description	Review Year	Minimum Compliance Rate	MCO Aggregate Rate	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
Claims Payment	CY 2004	90%	100%	100%	100%	100%	100%	100%	100%	100%
	CY 2003	70%	96%	100%	100%	100%	100%	100%	83%	92%
	CY 2002	Baseline	76%	100%	N/A	80%	75%	75%	70%	55%

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 areas. These 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 80%. Findings related to key indicators for the Healthy Kids/EPSDT review for CY 2004 are described below in Table 6.

Table 6. Healthy Kids/EPSTDT Indicator Results by MCO

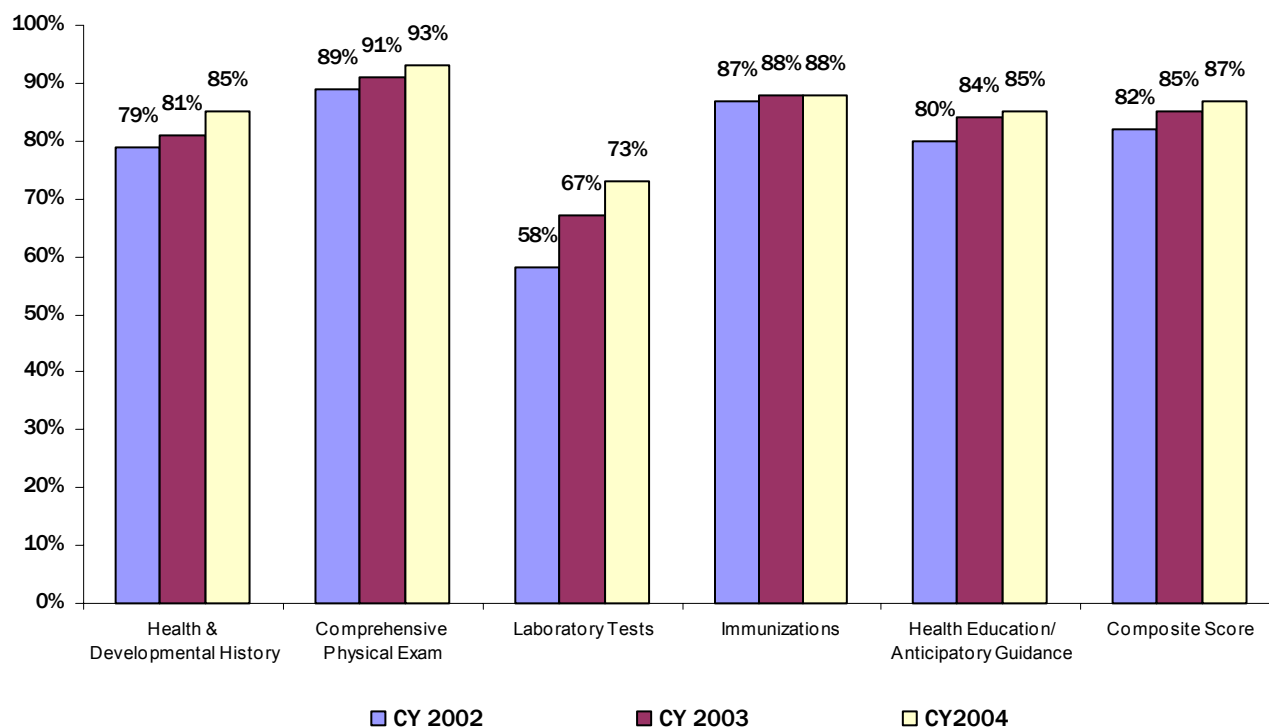
MCO	Health & Developmental History	Comprehensive Physical Examination	Laboratory Tests	Immunizations	Health Education/Anticipatory Guidance	Composite Score
AGM	81%	92%	69%	86%	82%	85%
DIA	81%	92%	76%	81%	86%	85%
HFC	84%	89%	78%	87%	85%	86%
JMS	98%	99%	96%	96%	99%	98%
MPC	88%	93%	75%	89%	87%	88%
PP	88%	92%	70%	89%	85%	87%
UHC	84%	93%	69%	89%	83%	86%
Aggregate Score	85%	93%	73%	88%	85%	87%

Analyses of the review components in the Healthy Kids/EPSTDT focused medical record review show that:

- All MCOs exceeded the 80% composite compliance rate.
- All MCOs met or exceeded the 80% compliance rate for health and developmental history, comprehensive physical examinations, immunizations, and health education.

Figure 2 compares the review results by MCO for CY 2002 through CY 2004. HealthChoice MCOs have demonstrated improvement over the 2002 composite rates for the Healthy Kids/EPSTDT review.

Figure 2. HealthChoice Aggregate Rates for Healthy Kids/EPSTD Program Review Indicators for CY 2002 through CY 2004



- Improvement was noted for all indicators between CY 2002 and CY 2004.
- All five indicators improved or remained the same between CY 2003 and CY 2004.
- Health Education/Anticipatory Guidance improved 5% between CY 2002 and CY 2004.
- Health and Developmental History improved 6% between CY 2002 and CY 2004.
- Laboratory Tests improved 6% in CY 2004 from CY 2003 and 15% from CY 2002.

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 2004.

Systems Performance Review CAPs

A review of all required systems performance standards, health education, OPs, and claims payment policies and procedures 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 2005 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.

Conclusion

All MCOs have demonstrated the ability to design and implement effective QA systems, HEPs, and outreach services. The CY 2004 review provided evidence of the continuing growth of the HealthChoice MCOs. 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 80% requirement. Continued collaboration between the Healthy Kids Program Nurse Consultant team and the HealthChoice MCOs contributed to improvements in four indicator scores in CY 2004.

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.