Medicaid Managed Care Organization

Systems Performance Review

Statewide Executive Summary

Final Report for CY 2009

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

CY 2009 Statewide 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 systems performance review for calendar year (CY) 2009, which is HealthChoice's twelfth year of operation. The HealthChoice program served approximately 631,973 enrollees during this period.

COMAR 10.09.65 requires that all HealthChoice MCOs comply with the systems performance review (SPR) standards and all requirements of COMAR. 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 2009 were:

- AMERIGROUP Community Care (ACC)
- Diamond Plan from Coventry Health Care, Inc. (DIA)
- Jai Medical Systems, Inc. (JMS)
- Maryland Physicians Care (MPC)
- MedStar Family Choice, Inc. (MSFC)
- 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. A summary of the corrective action plan (CAP) process is also included in this report.

Systems Performance Review Results

The HealthChoice MCO annual SPR consists of 11 standards; however, for the CY 2009 review, Standards 1 and 2 were exempt from the review. These standards were exempt as each MCO has received compliance ratings of 100% for the past three consecutive years. In CY 2009, Delmarva and DHMH made minor modifications to the standards based upon discussion with staff and feedback received from the MCOs following the CY 2008 review. The compliance thresholds established by DHMH for all standards for CY 2009 were 100%.

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. If the MCO's score was below the COMAR requirement, a CAP was required. All required CAPs were submitted and deemed adequate.

Table 1 provides for a comparison of SPR results across MCOs and the MCO Aggregate for the CY 2009 review. The CY 2008 aggregate scores are included for comparative purposes.

Table 1. CY 2009 MCO Compliance Rates

Performance Standard	Description	MCO Aggregate CY 2008	MCO Aggregate CY 2009	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
1	Systematic Process	100%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
2	Governing Body	100%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
3	Oversight of Delegated Entities	90%*	88%*	83%*	57%*	100%	100%	100%	100%	75%*
4	Credentialing	92%*	98%*	97%*	100%	100%	97%*	99%*	96%*	97%*
5	Enrollee Rights	99%*	100%	100%	100%	100%	100%	100%	100%	97%*
6	Availability and Access	99%*	100%	100%	100%	100%	100%	100%	100%	100%
7	Utilization Review	95%*	92%*	85%*	91%*	98%*	95%*	100%	85%*	93%*
8	Continuity of Care	98%*	100%	100%	100%	100%	100%	100%	100%	100%
9	Health Education Plan	99%*	100%	100%	100%	100%	100%	100%	100%	100%
10	Outreach Plan	99%*	99%*	100%	93%*	100%	100%	100%	100%	100%
11	Claims Payment	Deleted	Deleted	Deleted	Deleted	Deleted	Deleted	Deleted	Deleted	Deleted
12	Fraud and Abuse	97%	100%	100%	97%*	100%	100%	100%	100%	100%

*Denotes that the minimum compliance rate of 100% was unmet.

Each standard reviewed is described in the following section and includes a comparison of the CY 2008 to CY 2009 score along with MCO opportunities for improvement, if applicable.

Systematic Process of Quality Assessment/Improvement

This area of review was exempt from the CY 2009 SPR.

Accountability to the Governing Body

This area of review was exempt from the CY 2009 SPR.

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 decreased from 90% in CY 2008 to 88% in CY 2009.

Two MCOs demonstrated two opportunities for improvement and one MCO demonstrated five opportunities for improvement in the Oversight of Delegated Entities standard. Opportunities identified were in regards to oversight of delegated entities' performance to ensure the QOC and/or service provided is consistent with the MCO's documented policies and procedure, through the review of regular reports, annual reviews, site visits, etc.; written procedures for monitoring and evaluating the implementation of the delegated functions including verifying the QOC being provided; reviewing and approving delegated complaints, grievances, and appeals reports; reviewing and approving delegated claims payment activities; reviewing and approving delegated entities' UM plans which include evidence of review and approval of UM criteria by the delegated entity, where applicable; and reviewing and approving delegated entities' 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 92% in CY 2008 to 98% in CY 2009.

Five MCOs demonstrated opportunities for improvement in the Credentialing and Recredentialing standard. Two of the MCOs had opportunities identified regarding the Credentialing Plans and/or policies and procedures stating appropriate timeframes for communication with providers regarding provider applications within the time frames specified in Insurance Article Section 15–112(d). Four MCOs had opportunities identified regarding consistently adhering to written policies, procedures, and timelines for recredentialing. Two MCOs had opportunities identified for implementing policies and procedures for communication after a provider application is received. These specified timeframes are set forth in Insurance Article Section 15-112(d). Most MCOs did have policies and procedures for communication. However, the MCOs lacked evidence of the communication or did not adhere to the timeframes set forth in the policies.

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 increased from 99% in CY 2008 to 100% in CY 2009.

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 increased from 99% in CY 2008 to 100% in CY 2009.

Utilization Review

The MCOs have written 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 decreased from 95% in CY 2008 to 92% in CY 2009.

Six MCOs demonstrated opportunities for improvement in the Utilization Review standard. The opportunities are outlined below:

- Six MCOs had opportunities identified regarding providing evidence that preauthorization and concurrent review decisions being made in a timely manner as required by the State.
- Three MCOs had opportunities identified in the area of UR/UM staff receiving training on the interpretation and application of UR/UM standards and in the area of notification letters of denial lacking one or more of the required components.
- Two MCOs had opportunities identified regarding appeal decisions being made in a timely manner as required by the exigencies of the situation.
- One MCO had an opportunity identified regarding the scope of the UR Plan including a review of all covered services in all settings, admissions in all settings, and collateral and ancillary services.
- One MCO had an opportunity identified regarding evidence that the MCO evaluates the consistency with which all staff involved apply UR/UM criteria.
- One MCO had an opportunity regarding preauthorization, concurrent review, and appeal decisions being made and supervised by appropriate qualified medical professionals.
- One MCO had an opportunity regarding the review of the data on enrollee satisfaction, provider satisfaction, and/or other appropriate data by the appropriate oversight committee and that the MCO acts upon the identified issues as a result of the review of this data.

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 increased from 98% in CY 2008 to 100% in CY 2009.

Health Education Plan Review

Each MCO is required to develop an annual health education plan (HEP) to address the educational programs to enrollees. Overall, the MCOs were found to have comprehensive HEPs which included policies and procedures for internal staff education, provider education and CEUs, and enrollee health education.

- The MCO aggregate compliance rate increased from 99% in CY 2008 to 100% in CY 2009.

Outreach Plan Review

COMAR 10.09.65.25 requires each MCO to develop an annual written outreach plan (OP) to address outreach services to HealthChoice enrollees. MCO's OPs describe their populations served through the outreach activities along with an assessment of common health problems within the MCO's membership. In addition, it describes the organizational capacity to provide both broad-based and enrollee specific outreach provided by the MCO. The unique features of the MCO's enrollee education initiatives, community partnerships, and the roles of the provider networks and local health departments are also included in the OP. The MCO is required to demonstrate its methodology and strategies for implementation of the OP.

- The MCO aggregate compliance rate remained consistent at a rate of 99% from CY 2008 to CY 2009.

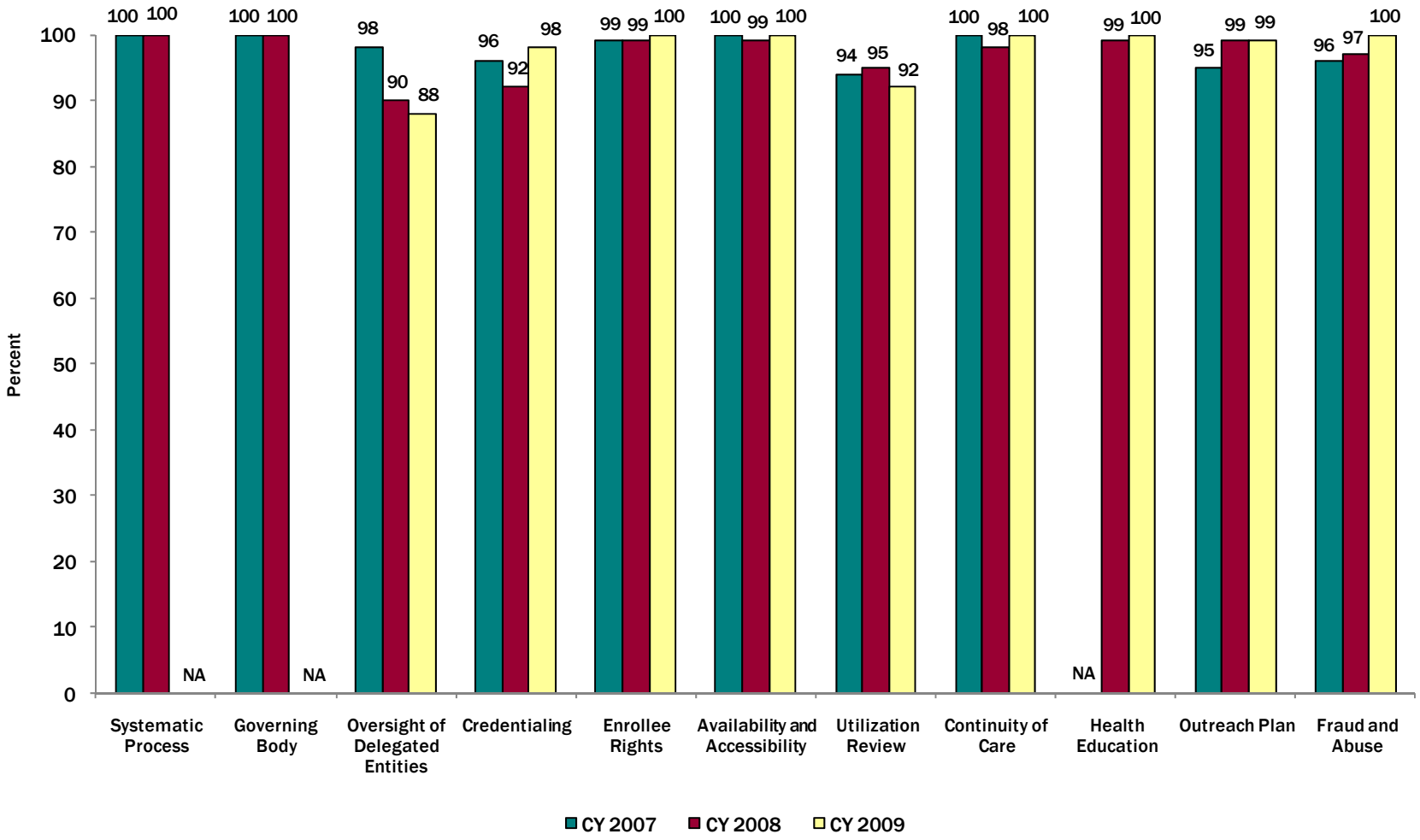
One MCO demonstrated an opportunity for improvement in the Outreach Plan standard regarding the role of the MCO's provider network in performing outreach.

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.

- The MCO aggregate compliance rate increased from 97% in CY 2008 to 100% in CY 2009.

Figure 1. HealthChoice Aggregate Systems Performance Compliance Rates for CY 2007 through CY 2009



Between CY 2008 and CY 2009, the aggregate compliance rate remained unchanged for one standard; increased for six standards; and decreased for two standards. These changes were an improvement over the previous comparison year from CY 2007 to CY 2008 where the aggregate compliance rate remained unchanged for three standards, increased for three standards and decreased for four standards. The overall MCO Aggregate Composite Score increased from 97% in CY 2008 to 98% in CY 2009.

Corrective Action Plan Process

Each year the CAP process is discussed during the annual review 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 2009.

Systems Performance Review CAPs

A review of all required systems performance standards are 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 2010 will determine whether the CAPs were implemented and 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. The CY 2009 review provided evidence of the continuing progression of the HealthChoice MCOs as each MCO demonstrated their ability to ensure the delivery of quality health care for their enrollees.

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 demonstrated throughout the history of the HealthChoice Program.