Medicaid Managed Care Organization

Systems Performance Review

Statewide Executive Summary

Final Report for CY 2011

Submitted by:
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HealthChoice and Acute Care Administration
Division of HealthChoice Management
and Quality Assurance

CY 2011 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 to serve as the EQRO. This executive summary describes the findings from the systems performance review (SPR) for calendar year (CY) 2011, which is HealthChoice's fourteenth year of operation. The HealthChoice program served over 754,000 enrollees during this period.

COMAR 10.09.65 requires that all HealthChoice MCOs comply with the SPR standards and all applicable federal and state laws and regulations. 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 2011 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 Foundation 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. The compliance threshold established by DHMH for all standards for CY 2011is 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 the100% threshold, 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 MD MCO Compliance for the CY 2011 review. The CY 2010 MD MCO Compliance Rates are included for comparative purposes.

Table 1. CY 2011 MCO Compliance Rates

Performance Standard	Description	MD MCO Compliance Rate CY 2010	MD MCO Compliance Rate CY 2011	ACC CY 2011	DIA CY 2011	JMS CY 2011	MPC CY 2011	MSFC CY 2011	PPMCO CY 2011	UHC CY 2011
1	Systematic Process	Exempt	100%	100%	100%	100%	100%	100%	100%	100%
2	Governing Body	Exempt	100%	100%	100%	100%	100%	100%	100%	100%
3	Oversight of Delegated Entities	**89%***	**92%***	**75%***	**93%***	100%	100%	100%	100%	**79%***
4	Credentialing	**99%***	100%	100%	100%	100%	100%	100%	**99%***	100%
5	Enrollee Rights	100%	100%	100%	100%	100%	100%	100%	100%	**98%***
6	Availability and Access	100%	100%	100%	100%	100%	100%	100%	100%	100%
7	Utilization Review	**94%***	**98%***	**98%***	**98%***	100%	100%	100%	**93%***	**98%***
8	Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%
9	Health Education Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%
10	Outreach Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%
11	Fraud and Abuse	**99%***	100%	100%	100%	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 2010 to CY 2011 score along with MCO opportunities for improvement, if applicable.

Systematic Process of Quality Assessment/Improvement

All MCOs continue to have processes in place to monitor and evaluate the QOC 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.

- This area of review was exempt from the CY 2010 SPR; however, in CY 2011 the MD MCO Compliance Rate was 100%.

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 designating 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.

- This area of review was exempt from the CY 2010 SPR; however, in CY 2011 the MD MCO Compliance Rate was 100%.

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 MD MCO Compliance Rate increased from 89% in CY 2010 to 92% in CY 2011.

Two MCOs demonstrated two opportunities for improvement and one MCO demonstrated one opportunity for improvement in the Oversight of Delegated Entities standard. Opportunities identified were in regards to providing evidence of the MCO's quality committee's review and approval of all delegated entity's quarterly complaint, grievance, and appeal reports; providing evidence of the MCO's quality committee's review and approval of all delegated entity's claims payment activities; and providing evidence of the MCO's quality committee's review and approval of over and under utilization reports submitted from each entity to whom UM activities have been delegated.

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 MD MCO Compliance Rate increased from 99% in CY 2010 to 100% in CY 2011.

One MCO demonstrated an opportunity for improvement in the Credentialing and Recredentialing standard. The opportunity identified for improvement was regarding the adherence to time frames set forth in the MCO's policies for recredentialing decision date requirements.

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 MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2010 to CY 2011.

Although the MD MCO Compliance rate remained at 100% there was an opportunity for improvement identified with one of the MCOs. The opportunity for improvement that was identified was regarding adherence to the time frames set forth in the MCO's policies and procedures for resolving grievances.

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 MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2010 to CY 2011.

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 MD MCO Compliance Rate increased from 94% in CY 2010 to 98% in CY 2011.

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

- One MCO had an opportunity for improvement regarding services provided must be reviewed for over and under utilization.
- Three MCOs had opportunities for improvement identified regarding appeal decision being made in a timely manner as required by the exigencies of the situation.
- One MCO had an opportunity for improvement regarding the MCO acting upon identified issues as a result of the review of the 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 MD MCO Compliance Rate remained at a consistent rate of 100% from CY 2010 to CY 2011.

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 MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2010 to CY 2011.

Outreach Plan Review

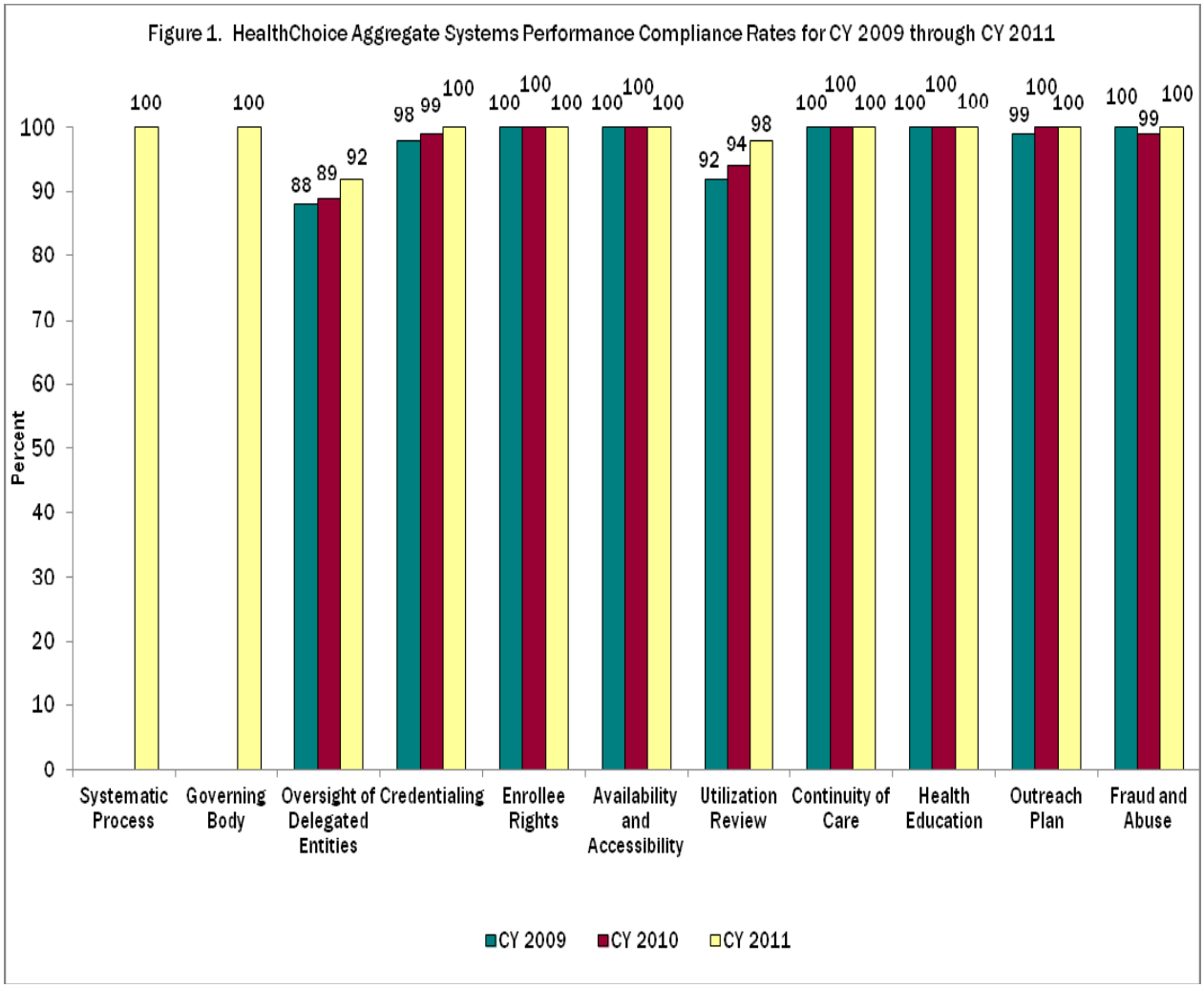
COMAR 10.09.65.25 requires each MCO to develop an annual written outreach plan (OP) to address outreach services to HealthChoice enrollees. MCO's OPs describe their populations served through the outreach activities along with an assessment of common health problems within the MCO's membership. In addition, 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 MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2010 to CY 2011.

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 MD MCO Compliance Rate increased from 99% in CY 2010 to 100% in CY 2011.



Between CY 2010 and CY 2011, the MD MCO Compliance rate remained unchanged in five standards and increased in four standards. These changes were similar to changes seen from CY 2009 to CY 2010 where the MD MCO Compliance rate remained unchanged for four standards, increased for four standards and decreased for one standard. The overall MD MCO Compliance Composite Score increased from CY 2010 to CY 2011 to a rate of 99%.

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 Foundation to determine whether the plans are acceptable. In the event that a CAP is deemed unacceptable, Delmarva Foundation 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 2011.

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 2012 will determine whether the CAPs were implemented and effective. In order to make this determination, Delmarva Foundation 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 2011 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.