Medicaid Managed Care Organization

External Quality Review Organization Report

Executive Summary

Final Report

Calendar Year 2006

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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 2006

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) 2006, which is HealthChoice's ninth year of operation. The HealthChoice program served approximately 481,000 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 2006 were:

- 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 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 2,543 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 11 standards. Eight standards are found in table 1 and the remaining three standards in tables 3, 4, and 5. In CY 2006, Delmarva and DHMH made minor modifications to the standards based upon discussion with staff and feedback received from the MCOs following the CY 2005 review. For the CY 2006 review, two standards were exempted and one standard was deleted from the review.

The first standard exempted from review during CY 2006 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. The second standard exempted from review during CY 2006 was the evaluation of the MCO's Health Education Plan (HEP). This standard will also be reviewed on a rotating basis every three years. The next review of this standard will be in 2009 as part of the CY 2008 SPR. The Claims Payment Standard was deleted from the SPR in August 2006 due to the fact that for the past two years, each MCO received a compliance rating of 100%. In addition, 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.

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 displays each of the systems performance standards with the minimum compliance ratings as defined in COMAR 10.09.65 for the reviews during years seven (CY 2004), eight (CY 2005), and nine (CY 2006).

Table 1. Performance Standards Compliance Rates

Performance Standard	Standard Description	COMAR Requirement Year Seven CY 2004	COMAR Requirement Year Eight CY 2005	COMAR Requirement Year Nine CY 2006
1	Systematic Process	100%	100%	100%
2	Governing Body	100%	100%	100%
3	Oversight of Delegated Entities	70%	80%	90%

Performance Standard	Standard Description	COMAR Requirement Year Seven CY 2004	COMAR Requirement Year Eight CY 2005	COMAR Requirement Year Nine CY 2006
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 2006 review. The CY 2005 aggregate scores are included for comparative purposes. As stated in Table 1, CY 2006 minimum compliance is 100% for seven of the reviewed standards and 90% for one standard.

Table 2. CY 2006 MCO Compliance Rates

Performance Standard	Description	MCO Aggregate CY 2005	MCO Aggregate CY 2006	AGM	DIA	HFC	JMS	MPC	PPMCO	UHC
1	Systematic Process	100%	100%	100%	100%	100%	100%	100%	100%	100%
2	Governing Body	**96%***	100%	100%	100%	100%	100%	100%	100%	100%
3	Oversight of Delegated Entities	84%	**82%***	**79%***	**79%***	93%	100%	**71%***	**79%***	**75%***
4	Credentialing	**99%***	**97%***	**96%***	**97%***	100%	**90%***	**99%***	**99%***	**99%***
5	Enrollee Rights	**99%***	**98%***	100%	**93%***	100%	100%	**98%***	**95%***	**97%***
6	Availability and Access	100%	100%	100%	100%	100%	100%	100%	100%	100%
7	Utilization Review	**96%***	**95%***	100%	**88%***	100%	100%	**92%***	**95%***	**92%***
8	Continuity of Care	**98%***	**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 2006 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 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 remained consistent at a rate of 100% from CY 2005 to CY 2006.

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.

- The MCO aggregate compliance rate increased from 96% in CY 2005 to 100% in CY 2006.

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 84% for CY 2005 to 82% in CY 2006.

Six MCOs demonstrated opportunities for improvement in the Oversight of Delegated Entities standard. One MCO had an opportunity identified regarding written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care being provided. One MCO did not provide evidence of oversight of delegated entities performance to ensure the quality of care and/or service provided through the review of regular reports, annual reviews, site visits, etc. Two MCOs had issues regarding reviewing and approving delegate's reports which are produced at least quarterly regarding complaints, grievances, and appeals. Six MCOs had issues regarding reviewing and approving delegate's claims payment activities. Two MCOs had opportunities identified regarding review and approval of delegate's utilization management plan, including review and approval of utilization management criteria by delegated entity. And, four MCOs had opportunities identified regarding the review and approval of delegate's 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 decreased from 99% in CY 2005 to 97% in CY 2006.

Six MCOs demonstrated opportunities for improvement in the Credentialing and Recredentialing standard. The opportunities for all six plans were to consistently adhere to the written policies, procedures, and timelines for initial credentialing and recredentialing. One MCO had additional opportunities regarding assuring that credentialing records included evidence of review of work history and good standing of clinical privileges and signed and dated attestations in both credentialing and recredentialing records. Another MCO had opportunities regarding providing evidence in all PCP and/or OB records of review of the site and medical record keeping practices to ensure compliance with the Americans with Disabilities Act of 1990 and the MCO's standards. One MCO had additional opportunities regarding certification by the Maryland Healthy Kids Program.

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 99% in CY 2005 to 98% in CY 2006.

Four MCOs demonstrated opportunities for improvement in the Enrollee Rights standard. The first MCO did not completely document the substance of complaints or grievances and the actions taken. In addition, the MCO did not inform providers of the member's satisfaction survey results. The second MCO was required to revise its policies and procedures to reflect the definition of a major population group as being at least 5% of the MCO's membership. The third MCO also had to revise its policies and procedures for major population group definition and provide evidence of assessment of the member population for race/ethnicity. In addition, this MCO had opportunities in the areas of identifying and investigating sources of member dissatisfaction, outlining action steps to follow up on the findings and continually re-evaluating the effects of these actions. The fourth MCO did not investigate or follow up on member dissatisfaction issues.

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 2005 to CY 2006.

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 decreased from 96% in CY 2005 to 95% in CY 2006.

Four MCOs demonstrated opportunities for improvement in the Utilization Review standard. Three MCOs did not provide evidence of review and approval of all medical necessity criteria. One MCO did not provide evidence of a process for monitoring and reporting compliance with appeal processing timeframes. Two MCOs had issues regarding inter-rater reliability assessments for the consistent application of utilization criteria. One MCO did not provide evidence of a systematic process for routinely reviewing for over and under utilization and did not provide evidence of regularly monitoring all action plans developed to address identified areas of over and under utilization. This MCO is also required to correctly communicate the definition of an appeal and timeframes for resolution to members and providers.

Continuity of Care

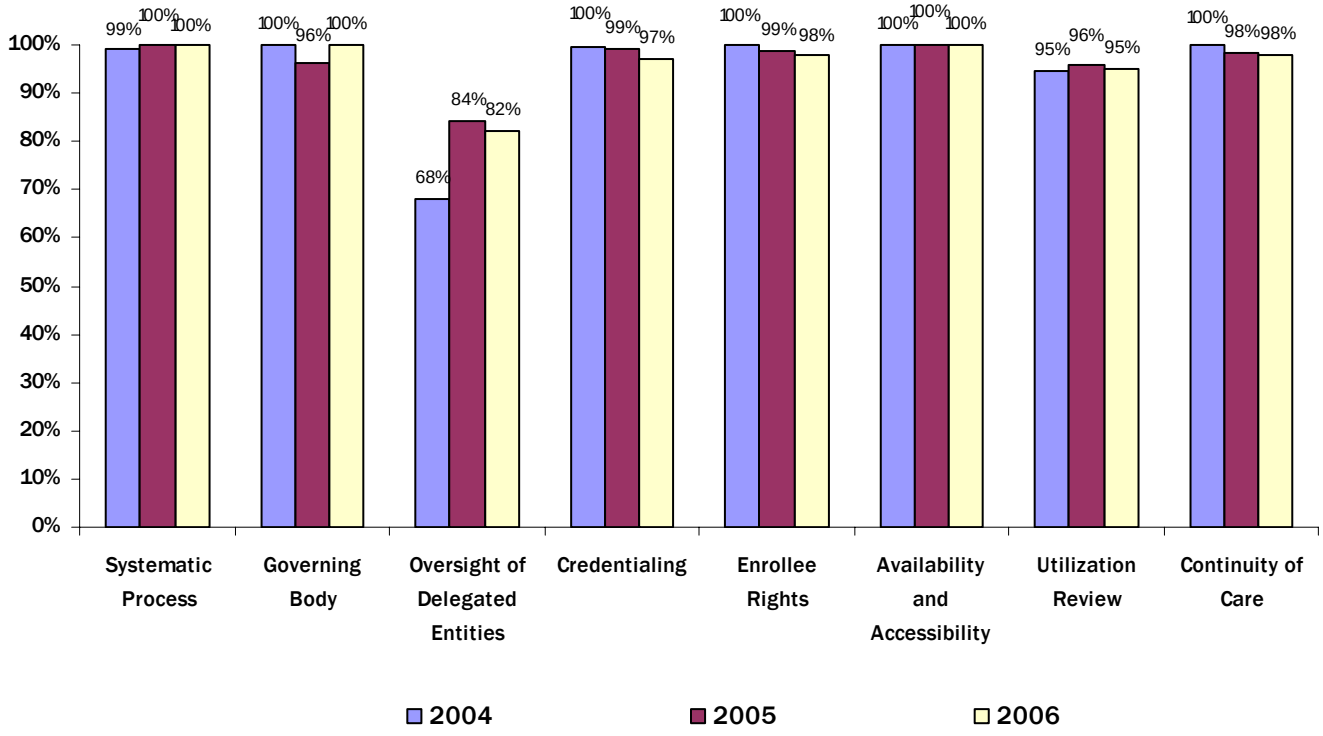
The findings, conclusions, actions taken, and results of actions taken as a result of the MCO's QA activities are documented and reported to appropriate individuals within the MCO's structure and through the established QA channels. All MCOs have allocated resources, such as automated tracking methodologies,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

- The MCO aggregate compliance rate remained at 98% from CY 2005 to CY 2006.

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 2004 through CY 2006 reviews.

Figure 1. Health Choice Aggregate Systems Performance Compliance Rates for CY2004 through CY 2006



Between CY 2005 and CY 2006, the aggregate compliance rate remained unchanged for three standards; increased for one standard; and decreased for four standards.

Health Education Plan Review

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

As noted in Table 3, all MCOs met the minimum compliance rate of 100% during the CY 2005 SPR.

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 2006	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
	CY 2005	100%	100%	100%	100%	100%	100%	100%	100%	100%
	CY 2004	90%	99%	96%	100%	100%	100%	100%	100%	100%

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 90% for CY 2004 for the OP development and implementation. This standard was not reviewed as part of the CY 2005 or CY 2006 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 achieved 100% compliance and 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 2006 Outreach Plan (Development & Implementation)	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
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%

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 5, the minimum compliance rate for Fraud and Abuse is 70% for CY 2006 as CY 2005 was scored as a baseline. Table 5 includes the MCO aggregate rate which is 94% for the fraud and abuse review for CY 2006.

Table 5. 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 2006	70%	94%	100%	95%	100%	100%	100%	89%	71%
	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% and a minimum compliance rate of 70% for each of the five components. Findings related to key components for the Healthy Kids/EPSDT review for CY 2006 are described below in Table 6.

Table 6. Healthy Kids/EPSDT Component Results by MCO

MCO	Health & Developmental History	Comprehensive Physical Examination	Laboratory Tests	Immunizations	Health Education/ Anticipatory Guidance	Composite Score
AGM	90%	94%	77%	95%	87%	91%
DIA	87%	95%	77%	87%	88%	89%
HFC	88%	96%	75%	94%	91%	91%
JMS	94%	98%	94%	94%	96%	96%
MPC	88%	97%	83%	94%	90%	92%
PPMCO	89%	96%	75%	95%	91%	91%
UHC	86%	93%	72%	93%	86%	88%
Aggregate Score	89%	95%	79%	94%	90%	91%

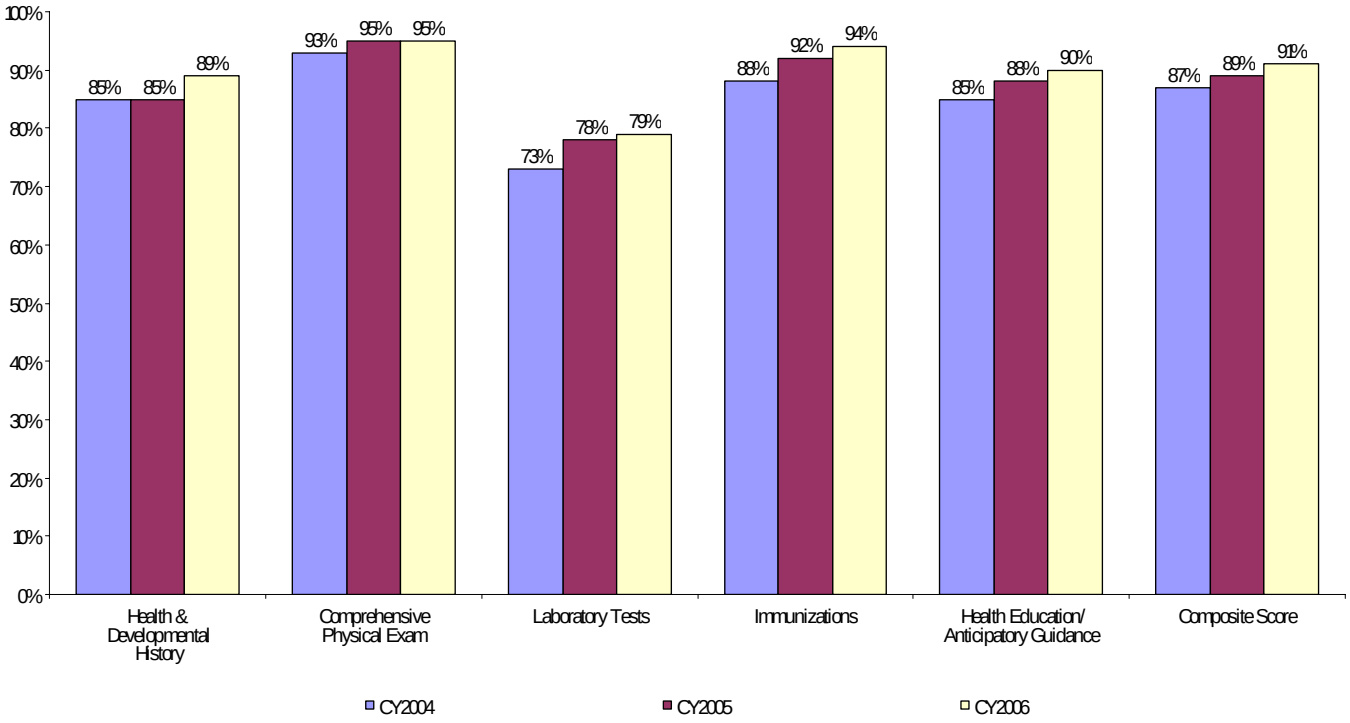
Analyses of the review components in the Healthy Kids/EPSDT focused medical record review indicate that:

- All MCOs exceeded the required 85% composite compliance rate.
- All MCOs exceeded the minimum 70% compliance rate for each of the five components.
- All MCOs exceeded 85% compliance for health and developmental history, comprehensive physical examinations, immunizations, and health education.
- Five of seven MCOs need to develop targeted interventions to improve the laboratory tests component.

Figure 2 compares the review results by MCO for CY 2004 through CY 2006. HealthChoice MCOs have demonstrated improvement over the 2004 composite rates for the Healthy Kids/EPSDT review.

An analysis of the review results by MCO indicates that there was improvement in all components between CY 2004 and CY 2006. All five components improved or remained the same between CY 2005 and CY 2006. Laboratory Tests and Immunizations each improved by 6%, Health Education improved by 5%, Health & Developmental History improved by 4%, and Comprehensive Physical Exam improved by 2% between CY 2004 and CY 2006.

Figure 2. HealthChoice Aggregate Rates for Healthy Kids/EPSDT Program Review Components for CY 2004 through CY 2006



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 2006.

Systems Performance Review CAPs

A review of all required systems performance standards and fraud and abuse programs are completed annually for each MCO. HEPs and OPs are reviewed every three years. Since CAPs related to the SPR can be directly linked to specific components or standards, the annual SPR for CY 2007 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 and fraud and abuse programs. The CY 2006 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.

The Healthy Kids Program results exhibit MCO compliance with EPSDT screening requirements. Each MCO achieved a composite score above the 85% requirement and above the minimum 70% compliance rate for each of the five components. Continued collaboration between the Healthy Kids Program Nurse Consultant team and the HealthChoice MCOs contributed to improvements in four component scores in CY 2006.

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.