



**Health Choice**



# Medicaid Managed Care Organization



# Systems Performance Review



# Statewide Executive Summary

Final Report for CY 2008

Submitted by:  
Delmarva Foundation  
August 2009

HealthChoice and Acute Care Administration  
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## Maryland Medical Assistance HealthChoice Program Evaluation of Participating Managed Care Organizations

# CY 2008 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) 2008, which is HealthChoice's eleventh year of operation. The HealthChoice program served approximately 551,873 enrollees during this period.

COMAR 10.09.65 requires that all HealthChoice MCOs comply with the systems performance review (SPR) standards defined in the Centers for Medicare & Medicaid Services (CMS) document "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care". In addition, each MCO is required to adhere to the 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 2008 were:

- AMERIGROUP Community Care (ACC)
- Diamond Plan from Coventry Health Care, Inc. (DIA)
- MedStar Family Choice, Inc. (MSFC)
- 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. 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. Table 1 includes each standard and its compliance rate for CY 2006, CY 2007, and CY 2008. In CY 2008, Delmarva and DHMH made minor modifications to the standards based upon discussion with staff and feedback received from the MCOs following the CY 2007 review.

The Claims Payment Standard was deleted from the SPR in August 2006 because each MCO received a compliance rating of 100% for the prior two review years. 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 nine (CY 2006), ten (CY 2007), and eleven (CY 2008).

**Table 1. Performance Standards Compliance Rates**

Performance Standard	Standard Description	COMAR Requirement Year Nine CY 2006	COMAR Requirement Year Ten CY 2007	COMAR Requirement Year Eleven CY 2008
1	Systematic Process	100%	100%	100%
2	Governing Body	100%	100%	100%
3	Oversight of Delegated Entities	90%	100%	100%
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%
9	Health Education Plan	Exempt	Exempt	100%
10	Outreach Plan	Exempt	100%	100%
11	Claims Payment	Deleted	Deleted	Deleted
12	Fraud and Abuse	70%	80%	90%

Table 2 provides for a comparison of SPR results across MCOs and the MCO aggregate for the CY 2008 review. The CY 2007 aggregate scores are included for comparative purposes. As stated in Table 1, CY 2008 minimum compliance is 100% for ten of the reviewed standards and 90% for one standard.

Table 2. CY 2008 MCO Compliance Rates

Performance Standard	Description	MCO Aggregate CY 2007	MCO Aggregate CY 2008	ACC	DIA	JMS	MPC	MSFC	PPMCO	UHC
1	Systematic Process	100%	100%	100%	100%	100%	100%	100%	100%	100%
2	Governing Body	100%	100%	100%	100%	100%	100%	100%	100%	100%
3	Oversight of Delegated Entities	98%*	90%*	86%*	64%*	100%	100%	100%	79%*	100%
4	Credentialing	96%*	92%*	97%*	80%*	87%*	87%*	100%	95%*	97%*
5	Enrollee Rights	99%*	99%*	100%	100%	100%	100%	100%	100%	96%*
6	Availability and Access	100%	99%*	100%	95%*	100%	100%	100%	100%	100%
7	Utilization Review	94%*	95%*	98%*	88%*	98%*	98%*	100%	90%*	95%*
8	Continuity of Care	100%	98%*	100%	88%*	100%	100%	100%	100%	100%
9	Health Education Plan	Exempt	99%*	100%	96%*	100%	100%	100%	100%	100%
10	Outreach Plan	95%*	99%*	100%	96%*	100%	96%*	100%	100%	100%*
11	Claims Payment	Deleted	Deleted	Deleted	Deleted	Deleted	Deleted	Deleted	Deleted	Deleted
12	Fraud and Abuse	96%	97%	100%	89%*	100%	97%	100%	95%	97%

\*Denotes that the minimum compliance rate was unmet.

Each standard that was reviewed as part of the CY 2008 SPR 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 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.

- The MCO aggregate compliance rate remained consistent at a rate of 100% from CY 2007 to CY 2008.

**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 remained consistent at a rate of 100% from CY 2007 to CY 2008.

**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 98% for CY 2007 to 90% in CY 2008.

One MCO demonstrated five opportunities for improvement and two MCOs demonstrated two opportunities for improvement in the Oversight of Delegated Entities standard. Opportunities identified were in regards to 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 decreased from 96% in CY 2007 to 92% in CY 2008.

Six MCOs demonstrated opportunities for improvement in the Credentialing and Recredentialing standard. Opportunities are outlined below:

- Five of the MCOs had opportunities 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).
- Three MCOs had opportunities surrounding the review of EPSDT certification during credentialing and recredentialing.
- One MCO had an opportunity regarding providing evidence of attestation to the correctness and completeness of a credentialing application.
- One MCO had an opportunity regarding providing evidence of an initial visit to each potential PCP's office with documentation of a review of the site and medical record keeping practices to ensure compliance with the ADA and the MCO's standards.
- Three MCO had opportunities for to consistently adhere to the written policies, procedures, and timelines for initial credentialing and recredentialing.
- Five MCOs continued to have difficulty 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.
- Three MCOs had opportunities regarding the inclusion of practitioner performance data, complaints, and the results of quality reviews during the recredentialing process.
- One MCO had an opportunity regarding providing evidence of office site compliance with ADA standards.

### **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 consistent at a rate of 99% from CY 2007 to CY 2008.

One MCO demonstrated opportunities for improvement in the Enrollee Rights standard. The opportunities for improvement were regarding completely documenting the substance of the grievances and the steps taken to resolve the grievance and adhering 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 MCO aggregate compliance rate decreased from 100% in CY 2007 to 99% in CY 2008.

One MCO demonstrated opportunities for improvement in the Availability and Accessibility standard. The opportunity for improvement was regarding providing evidence of the trending and analysis of data which are included in the QA program and incorporate mechanisms for review of policies and procedures, with CAPs developed as appropriate.

### **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 increased from 94% in CY 2007 to 95% in CY 2008.

Six MCOs demonstrated opportunities for improvement in the Utilization Review standard. All six MCOs had opportunities for improvement regarding providing evidence that preauthorization and concurrent review decisions are made in a timely manner as required by the State. One MCO had opportunities with providing evidence that UR criteria are reviewed and updated according to the MCO's policies and procedures; the written UR Plan has mechanisms in place to detect over utilization and under utilization of services and providing evidence of monitoring corrective measures; there are well publicized and readily available appeal mechanisms for both providers and enrollees; and the MCO has a process in place to evaluate the effects of the UR program by using enrollee satisfaction, provider satisfaction, and/or other appropriate measures.

### **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 2007 to 98% in CY 2008.

One MCO demonstrated an opportunity for improvement in the Continuity of Care standard. The opportunity for improvement identified was in regards to providing evidence of monitoring the continuity of

care across all services and treatment modalities. This must include an ongoing analysis of referral patterns and the demonstration of continuity of individual cases (timeliness and follow-up of referrals).

### **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 for CY 2008 is 99%.

One MCO demonstrated an opportunity for improvement in the Health Education Plan Standard. The opportunity for improvement was regarding the completion of attendance records and session evaluations by enrollees following health education activities.

### **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 increased from 95% in CY 2007 to 99% in CY 2008.

Two MCOs demonstrated opportunities for improvement in the Outreach Plan standard. One MCO had an opportunity for improvement identified regarding outlining the population served through outreach activities and/or an assessment of the common health problems within the MCO's membership and another MCO had an opportunity regarding the role of the MCO's provider network in performing outreach.

### **Fraud and Abuse**

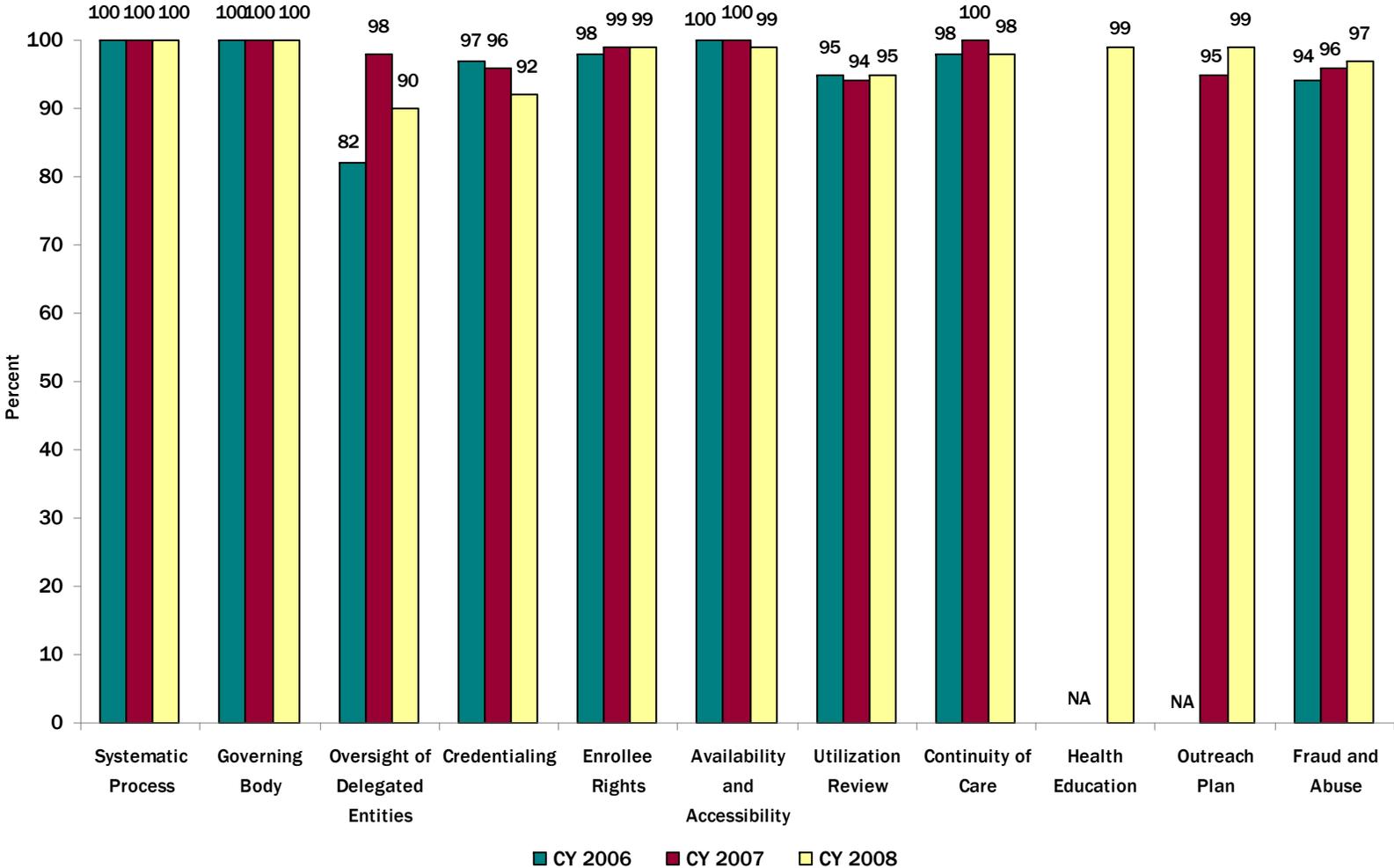
COMAR 10.09.65.02, COMAR 10.09.65.03, COMAR 31.04.15, and CMS 438.608 require that each MCO maintain a Medicaid Managed Care Compliance program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse.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

- The MCO aggregate compliance rate increased from 96% in CY 2007 to 97% in CY 2008.

One MCO demonstrated opportunities for improvement in the Fraud and Abuse standard regarding providing evidence of review of routine and random reports by the Compliance Officer and Compliance Committee, providing evidence that CAPs are reviewed and approved by the Compliance Committee and that the Compliance Committee receives information regarding the implementation of the approved CAPs, and providing evidence of the Compliance Committee's review and approval of delegated entities' administrative and management fraud and abuse procedures.

Figure 1 on the following page represents a comparison of the HealthChoice systems performance compliance rates for standards reviewed from CY 2006 through CY 2008.

Figure 1. HealthChoice Aggregate Systems Performance Compliance Rates for CY 2006 through CY 2008





Between CY 2007 and CY 2008, the aggregate compliance rate remained unchanged for three standards; increased for three standards; and decreased for four standards. These changes were very similar to the changes which occurred from CY 2006 to CY 2007 where the aggregate compliance rate remained unchanged for three standards, increased for four standards and decreased for two standards. However in comparing these two years, only nine areas of assessment could be compared as both Health Education and Outreach had been reviewed on a rotating basis and not reviewed until CY 2007 and CY 2008.

### **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 2008.

### **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 2009 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 2008 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.