

VI. HOLD MCOs ACCOUNTABLE

One of the guiding principles of HealthChoice is to hold MCOs accountable for performance and high quality care. This chapter discusses the systems in place to assure MCO accountability for both quality of care and administrative issues. The following analytic questions are addressed

- *What are the on-going quality of care review activities?* This section discusses the State's annual quality review audit, its process, results and the actions that follow.
- *What oversight is done of MCOs administrative activities?* This section will present two analyses. The first addresses MCO submission of encounter data. The second examines MCO performance with regard to prompt payment of provider claims.
- *How does the State assure that MCOs follow correct grievance and appeal procedures?* This section will review the procedures for complaints and grievances and denials of care and the State efforts to enforce those standards.
- *How does the State solicit input from stakeholders and interested parties?* This section will review and summarize the various committees and workgroups that provide ongoing oversight and guidance for the HealthChoice program.

ANNUAL QUALITY OF CARE AUDIT – FOCUSED MEDICAL RECORD REVIEWS

Overview

Federal and state regulations require that DHMH perform an annual audit of the health care delivered by each HealthChoice MCO. The Quality of Care audit must be performed by a federally qualified external quality review organization (EQRO). The audit has been conducted each year since the HealthChoice program began in July 1997. The most recent audit covered the period from January 2000 through December 2000.

The audit process can be broken into two distinct parts; first, an evaluation of each MCO's systems and operations (systems performance review); and, second, clinical care review that involves the review of medical records. The HealthChoice regulations require each MCO to meet specific performance targets of 100 for each of the 16 systems' performance standards as well as performance thresholds of 80 percent for the clinically focused studies for CY 2000.

The Quality of Care audit process currently in place for the HealthChoice program was also used for the pre-HealthChoice voluntary HMO program (25 percent of enrollees pre-HealthChoice). The biggest difference is that no EQRO type process was in place for enrollees who received care through the fee-for-service MAC program. Consequently, the audit findings cannot be used to assess how HealthChoice compares to the prior fee-for-service program.

The annual Quality of Care audit is a key management tool that the Department uses for ongoing oversight of MCO performance. As a direct result of the Quality of Care audit results for CY 1998, CY 1999, and CY 2000, the Department imposed financial penalties on MCOs related to the clinical care portion of the audit. The penalties were in the form of withholds from MCO capitation payments, so that MCOs had the opportunity to recover the money if they improved. The CY 1998 audit led the Department to impose withholds totaling more than \$640,000 on five of the eight participating MCOs. As a result of the CY 1999 audit, the Department imposed withholds totaling more than \$230,000 on four of the eight participating MCOs. The CY 2000 audit resulted in withholds of more than \$272,000 against five of eight MCOs.

Findings

Systems Performance Review. As was noted earlier, the Quality of Care audit has two distinct elements. The systems performance review is, as the name implies, a review of the MCOs internal systems for assuring quality of care. MCO performance is evaluated against 18 different standards ranging from credentialing procedures, composition of the quality assurance committee, health education, and outreach programs.

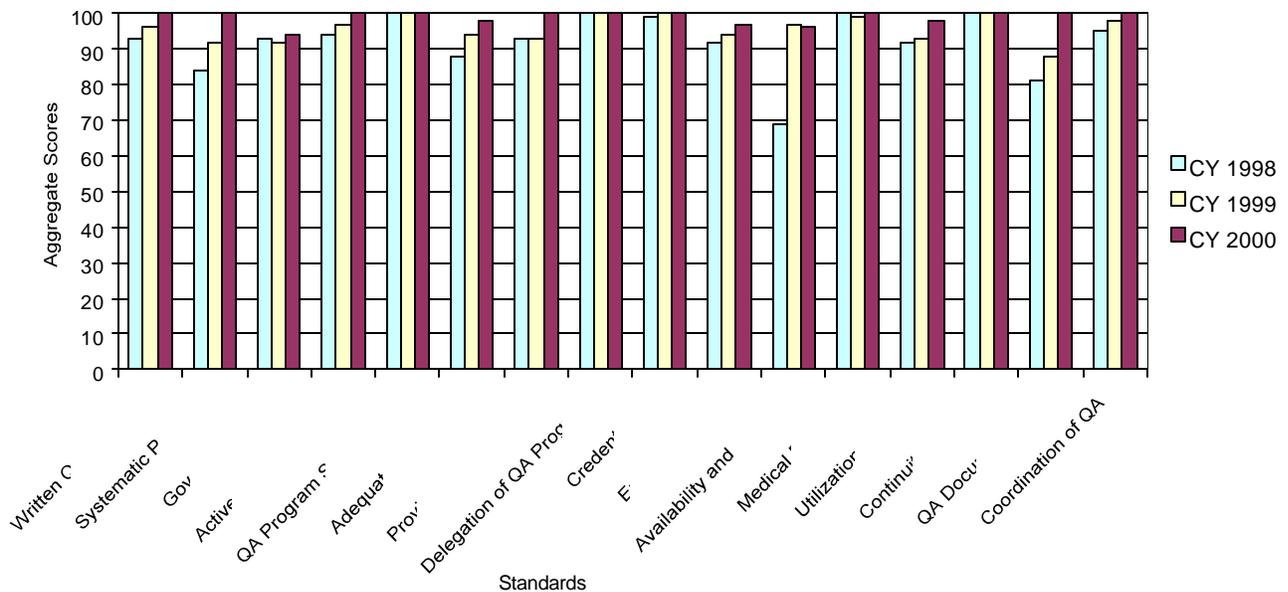
The most recent review showed that, overall, there was significant improvement in the

MCO systems performance compliance ratings. This is a continuation of the improvements in the previous two years' system performance review scores, and highlights the general improvement in review results over the past three years.

For CY 2000, the MCOs improved in 15 of the 16 standards over last year but failed to meet the minimum required score audit in five areas. In 1999, over half of the standards were lower than this year's standards. For the CY 2000 audit, all 16 of these standards require a 100 percent compliance rating in order to meet the performance threshold. Only 7 standards required 100 percent compliance rating for the CY1999 audit.

For CY 2000, the MCO aggregate availability and accessibility score decreased slightly from the previous year, to a score of 96 percent. The availability and accessibility standard assesses the policies and procedures that the MCOs have in place to insure that services are accessible and available (not the actual accessibility and availability of services). This is the only standard for which the aggregate score decreased from last year.

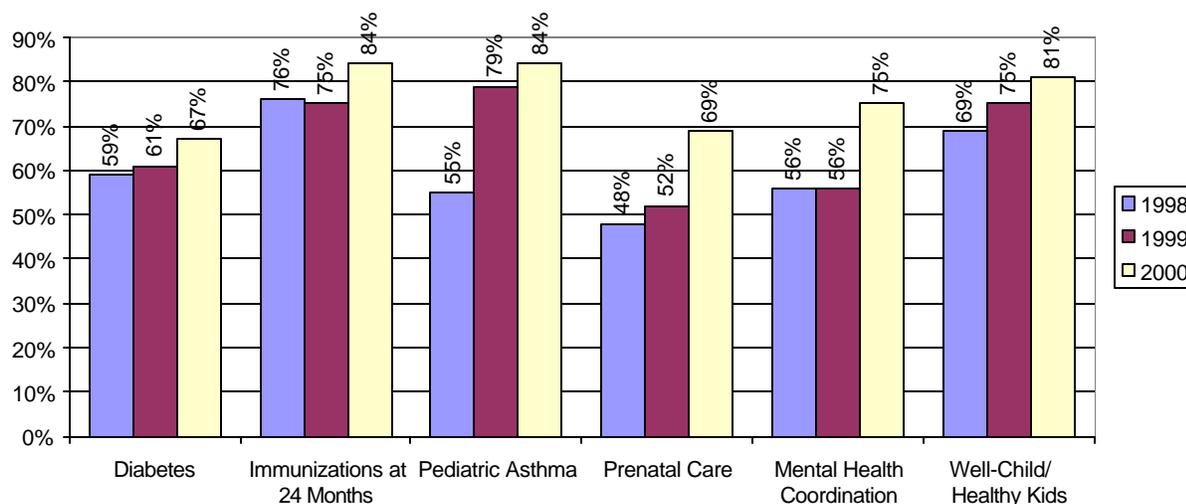
Figure VI-1: Aggregate Systems Performance Scores 1998-2000



Clinically Focused Review. The second part of the annual Quality of Care audit is clinically focused reviews. For this part of the audit, the review team pulls charts and analyzes them for compliance with specific clinical expectations.

In the most recent audit, there was a significant improvement in each of the clinically focused review areas. Figure VI-2 shows the general improvement in each of the 6 clinical areas over the past three years. The minimum score in each clinical care area for CY 2000 was 80 percent, which increased from 75 percent in CY 1999 and 70 percent in CY 1998.

Figure VI-2: Improvement Trends in Clinically Focused Reviews



The audit showed improvement in MCO performance in a number of areas. For example:

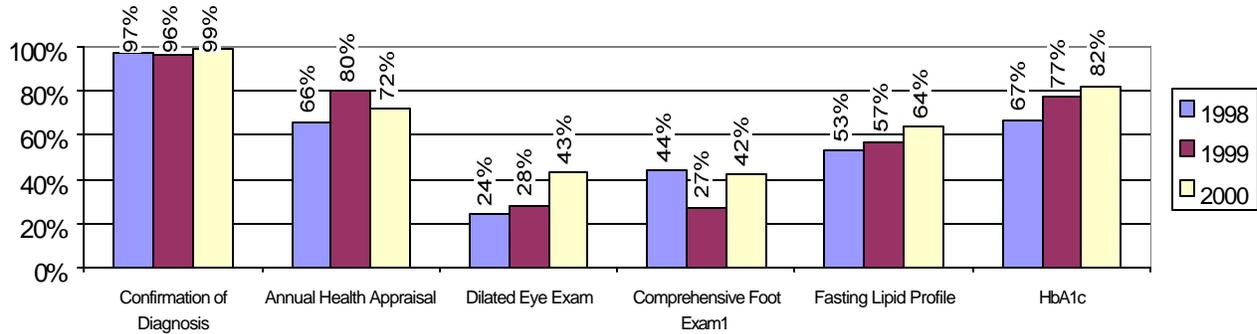
- Immunizations. Seven MCOs met or exceeded the performance standards for immunizations.
- Pediatric asthma. Six MCOs met or exceeded the performance standards.
- Prenatal care. Eight MCOs improved their scores in all prenatal care indicators.
- Somatic and mental health coordination. All eight MCOs made significant improvement across all five indicators for coordination of mental health care with primary care. Three MCOs - JAI Medical Systems, Freestate, and Maryland Physicians Care - met or exceeded the minimum standard.
- Healthy Kids – All eight MCOs met or exceeded the minimum compliance rate for comprehensive physical exams for the third year.

While the audit showed progress and improvement in a number of areas, it also highlighted areas of clinical performance where MCOs need to make additional improvements to meet the State's expectations. For example:

- Diabetes Care. Figure VI-3 shows the six indicators used to assess the quality of diabetic care. General diabetic care and focused physician encounters improved overall, however, there was a slight decline in comprehensive annual health appraisals. Both dilated eye and comprehensive foot exams improved from CY 1999 but the scores remain relatively low. When compared to the latest national HEDIS rates for diabetic eye exams, however, the HealthChoice rate is consistent with the national rate of 41 percent. One MCO exceeded the minimum standard (80

percent) for the CY2000 audit for diabetes care.

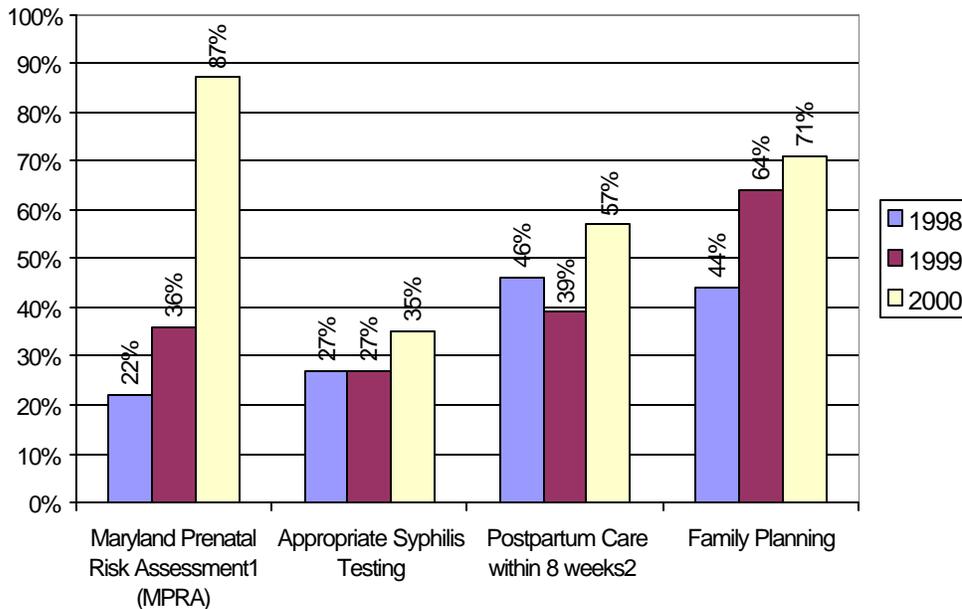
Figure VI-3: Trends in Diabetes Indicators



NOTE: CY1998 audit assessed whether a foot exam was performed; the CY 1999 and CY 2000 audits looked for five specific sub-components of diabetes care.

- Prenatal care. Figure VI-4 shows the individual indicators used to assess the quality of prenatal care. No MCO met the overall minimum compliance rate of 80 percent in this area. Two plans had minimum compliance rates that met or exceeded 75 percent, the minimum compliance score for this measure last year. While improvement occurred in the areas of risk assessment, syphilis testing, postpartum care, and family planning, the results indicate that these areas need continued attention.

Figure VI-4: Trends in Prenatal Indicators



NOTE: CY 1998/99 reflect MPRA only. CY 2000 reflects MPRA, ACOG, or ACOG-like risk assessment tools documentation in the medical records.

NOTE: CY 1998 reflects postpartum care scheduled within 4-6 weeks; CY 1999/2000

reflect actual visits.

Discussion

While a review of the audit findings does not yield any pre and post HealthChoice insights it does allow for an assessment of program progress. Although there have been some changes to the EQRO audit over the past three years, the measures and standards are generally consistent. The audit, therefore, serves as an important tool for assessing the clinical progress that has been made since the start of the program. The Department's use of financial penalties in the form of withholds demonstrates its commitment to the annual Quality of Care audit as part of its quality improvement strategy. The significant and measurable progress documented by the EQRO audit process demonstrates that in areas where the Department has focused real progress has been made.

Finally, it is important to highlight the important step forward the Quality of Care audit represents over Maryland's pre-HealthChoice approach to quality. The EQRO audit is a comprehensive, program-wide assessment of the delivery of health care. It is designed to hold MCOs accountable for their overall clinical performance, and to penalize MCOs that do not perform up to high standards. As such, it is a significant step forward in Maryland's approach to quality care.

MCO ENCOUNTER DATA

Overview

Encounter data is central to the Department's goal of operating the HealthChoice Program in a data driven manner. Toward this end, the Department and the MCO have been engaged in an intense collaborative effort to improve all aspects of the collection and submission of encounter data. Since March 1999, when the Encounter Data Workgroup was formed, the Department has worked extensively with the MCOs to improve the submission of encounter data. This collaborative effort has taken a number of forms including:

Group meetings with the MCOs. The Department has, since March 1999, regularly convened meetings of all HealthChoice MCOs (the 'Encounter Data Workgroup') to discuss and review progress on encounter data collection. Each of these meetings has included a formal presentation that reviewed the status of encounter data and presented summary findings.

Individual MCO Site Visits. The more than 40 individual MCO site visits conducted have been an invaluable complement to the full meetings of the MCO encounter data workgroup. Early in the process the Department realized that many, if not most, encounter data submission issues are unique to specific MCOs. Individual MCO issues range widely and include; internal MCO systems, network arrangements, payment practices and other more esoteric problems.

Aggressive Monitoring and Improved Feedback Mechanisms. Building on the insights gained through the group and face-to-face meetings, the Department has developed a series of tools that provide MCOs with useful feedback. Specifically these feedback tools have include:

- Date of service graphs. These graphs track (according to the encounter data received by the Department) the number of users over time an MCO has. The date of service graphs have proved to be a very useful feedback tool, as they allow the Department and the MCO to quickly identify 'gaps' in service delivery volume that can indicate missing or lost data. The dates of service graphs also provide a means to roughly compare performance across MCOs.
- Data submission targets. In the process of increasing the amount of encounter data accepted by the MMIS2 system, it was found useful to set targets for the MCOs to meet or surpass. Projection tables were developed for CY 1999 and CY 2000 for both HCFA-1500 and UB-92 record formats. These tables were based on a calculated ratio of encounters by date of service to enrollees for each month, and updated on a monthly basis.

There have been great strides made in both the quantity and the quality of encounter data

over the past few years. In the early stages of HealthChoice, the submission process was difficult and the MCOs were unprepared. From CY 1999 forward, the submission of acceptable encounter records reached a level to allow its use for rate setting, although it still required the use of a ‘completion factor’.

Encounter data is imperative in rate setting and in evaluation of the program. The improvement in data submissions can be accorded to the collaboration and cooperation of the MCOs and the Department.

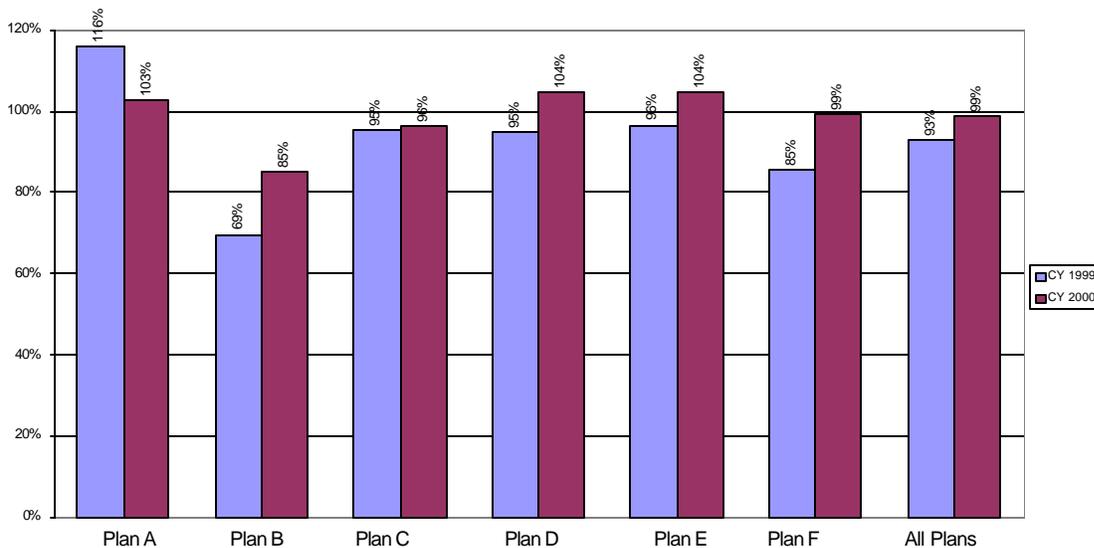
Findings

HCFA-1500. Early in the rate setting process it was determined that HCFA-1500 records were the largest factor in the assessing each enrollee’s health status and, therefore, the rate cell. Given the importance of HCFA-1500s for rate setting, initial studies on volume began with HCFA encounters.

HCFA-1500 submission targets were met or surpassed by most MCOs. In calendar year 1999, five of the six MCOs were 80 percent of the target or better. In calendar 2000, all MCOs hit at least an 80 percent rate. The overall percentage for all MCOs was approximately 85 percent in CY 1999 compared to 95 percent in CY 2000. Only one MCO performed at a lower level in 2000 as compared to 1999, but this MCO also well exceeded its initial projections.

In the future, these targets will be recalculated on more current data, and the ratios and corresponding targets will increase. In addition, further studies on specific service areas of possible missing data will be undertaken.

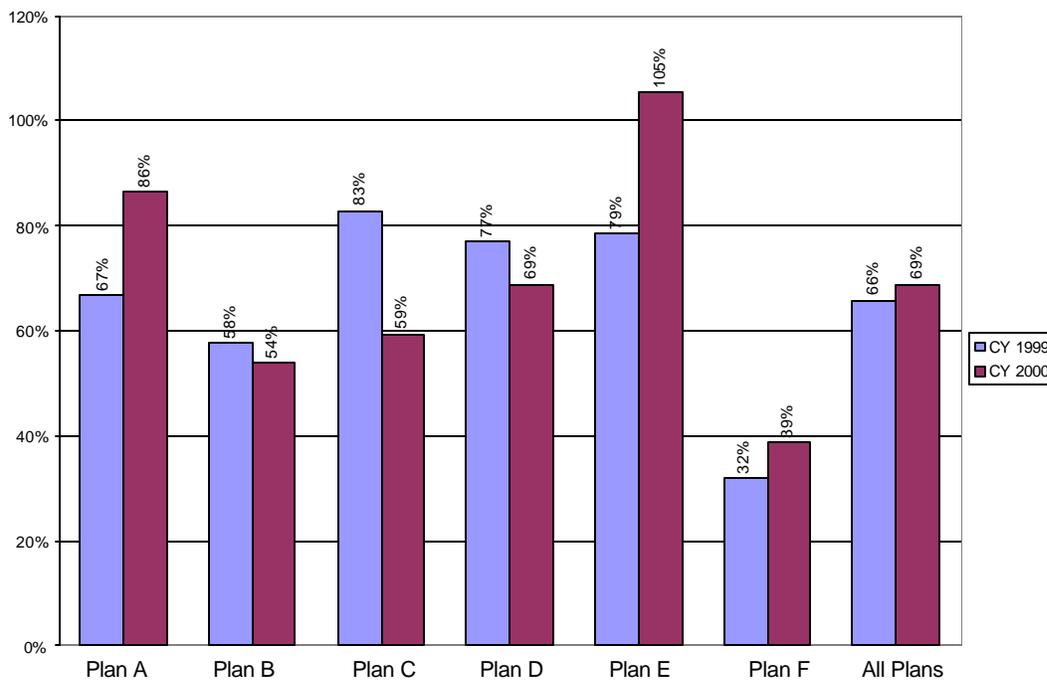
Figure VI-5: HCFA-1500 Submissions As Percent of Target CY 1999 and CY 2000



UB-92 Inpatient. The targets set for UB-92 Inpatient submissions were based on a combination of the average number of encounters per month (by month of service) and the highest average number of encounters by a single MCO. In addition, studies were undertaken that compared the maternity payments to each MCO in comparison to the hospital rate for deliveries.

Comparison of the MCO specific targets with actual MCO submissions demonstrates that there are impediments to the submissions of inpatient data. Only one MCO was able to meet and exceed the target projections for CY 2000. In contrast, one MCO was unable to meet even 50 percent rate for either CY 1999 or CY 2000. The overall average of the six MCOs was just over 60 percent for both years. Clearly, there are problems that need to be identified and solved in order to increase the level of inpatient submissions. The inpatient hospital encounters are not as important to the rate setting process as the HCFA 1500 data, as inpatient encounters are unlikely to pick up new diagnoses that have not previously been identified using HCFA 1500 data. The inpatient data is, however, important to quality oversight and monitoring of plans' performance.

Figure VI-6: UB-92 Submissions As Percent of Target CY 1999 and CY 2000



Conclusion

The improvement of encounter data submissions is an ongoing process. Both the MCOs and the Department understand the importance of this endeavor and will continue to look for ways to increase both the volume and the validity of the data.

As such, the Department must continue to improve the feedback mechanisms to the MCOs. Open communication is imperative. The Department has a fulltime specialist available to work with the MCOs to identify problems. Regular internal workgroup meetings provide an open forum for discussion of problems, identification of solutions, and development of new methods to validate data.

The MCOs need to work with their providers and outside vendors to receive as complete encounter data. The decrease in capitated contracts is causing a marked increase in the volume of data. Each MCO must provide easy methods for data to be accepted into their system and process this data within a shorter timeframe.

PROMPT PAY

Overview

One of the first concerns raised by providers in the HealthChoice program related to the lag in payment they experienced when submitting claims to MCOs. In order to respond to the providers' complaints, in 1998, the Department started to collect information from MCOs about the timeliness of claims processing activities. At that time, the Department established a standard of paying all claims within 30 days. The Department also began working with MCOs on corrective action plans to meet the new standard. Starting in the 2nd quarter of CY 2000, sanctions were imposed on MCOs that did not meet the standard of paying 80 percent of claims within 30 days in addition to the fact that interest is being paid by MCOs in accordance with State law. MCOs are able to recover these sanctions if they can demonstrate improvement over two consecutive quarters. Initially, the state required MCOs to report on all claims (paid, denied, and pending). One difficulty in addressing the issue of prompt claims payment is that providers and MCOs have not always agreed on the definition of a clean claim. In 2001, new regulations prepared by the Maryland Insurance Administration were adopted to standardize the definition statewide. In the future, MCOs will be required use this definition when reporting claims.

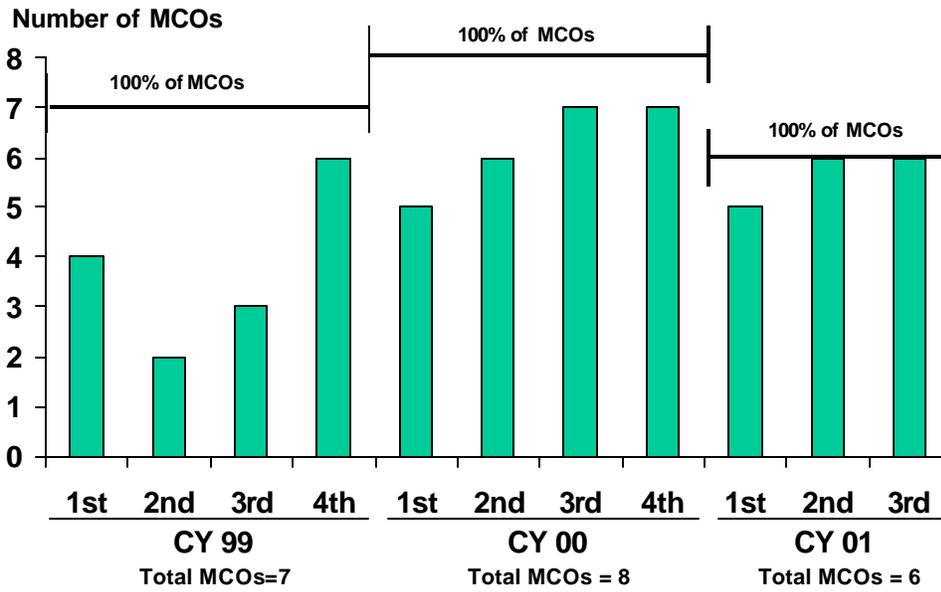
Findings

The implementation of a 30 day standard, increased monitoring by the Department, and the threat of sanctions appear to have improved claims processing times. Chart 88 shows the steady progress that MCOs have made towards meeting the 80 percent timeliness standard. Although the data used to monitor progress on this initiative is self-reported by the MCOs, the Department believes the data to be representative because some MCOs reported that they were below the 80 percent standard and, as a result, incurred sanctions.

In CY 2000, \$16,645 in sanctions were withheld from MCOs, however, withholds were refunded if the MCOs achieved a passing score for two consecutive quarters. This did occur in CY 2000. There were no withholds for the 4th quarter of CY 2000 or the 1st quarter of CY 2001 due to a management decision to give MCOs an opportunity to adjust to the membership/provider changes that occurred due to the FreeState and PrimeHealth exits.

The timeliness of payment of professional claims has improved more rapidly than payment to institutional providers. In addition, some MCOs have been better than others at paying providers in a timely manner. In the 3rd quarter of CY 2001, the latest quarter for which data were available, all of the MCOs exceeded the 80 percent standard and some had paid close to 100 percent of their claims within 30 days.

Figure VI-7: Compliance with Prompt Pay, By Quarter



COMPLAINT AND GRIEVANCE PROCESS

Overview

HealthChoice enrollees have numerous opportunities to complain about or appeal an MCO decision to deny, reduce or terminate benefits. Many enrollees, however, may not fully understand how to use the MCO's internal appeal and grievance process or be aware that they do not need to exhaust the MCO appeal process before seeking help from the Department's HealthChoice Enrollee Action Line.

Enrollees currently receive information about the MCO's internal complaint and grievance process, as well as the Department's HealthChoice Enrollee Action Line, at the time of enrollment. Information about the Department's line is in a pamphlet that is widely distributed through various means including DSS, LHDs, the Enrollment Broker, and advocacy groups. The HealthChoice Enrollee Action Line's toll-free number is also on all MCO identification cards. The MCOs are required to outline their internal complaint and grievance process in their MCO Member Handbook that is sent to everyone upon entry into HealthChoice and the provider manuals that the MCOs issue. Despite these efforts to educate enrollees, the Department continues to hear that HealthChoice enrollees do not know how to appeal when services have been denied, reduced, or terminated.

In April 2000, the HealthChoice internal appeal processes were significantly revised to assure that consumers were given complete and timely information regarding their appeal rights. When an enrollee makes a complaint to the Department and the problem is not resolved within ten days, he/she is informed of his/her right to appeal to the Office of Administrative Hearings. This change resulted in a slight increase in appeals and the need to hire additional staff within the Department to handle such appeals in a timely manner.

The MCOs are required to inform consumers in writing when a service is reduced, denied, or terminated. The Department has received requests to standardize and strengthen the adverse action notices distributed by MCOs and to place a greater emphasis on monitoring whether MCOs are sending such notices to affected enrollees.

Discussion

Monitoring the MCOs' processes for informing consumers of service reduction, denial or termination has been problematic. The Department's effort to monitor this process began in the fall of 1999 when it worked with the MCOs to develop eleven specific elements that an MCO denial letter must contain. Beginning in June 2000, the Department required the MCOs to send to the Department a copy of every denial letter issued. Over the last year, the Department received 1,672 MCO denial letters.

It has become clear that some of the MCO denial letters do not consistently contain all the required elements or have other deficiencies. The Department sought to improve the denial letters by instituting letter-review as part of the EQRO process. That review, however, has not been completed. The Department recognizes that it needs to more effectively monitor the denial process at the MCO level.

WORKGROUPS AND COMMITTEES

Overview

There are several standing HealthChoice Committees that advise the Department of Health and Mental Hygiene on the effectiveness of their assigned program components and make recommendations to improve program quality and efficiency.

Medicaid Advisory Committee. The Medical Care Advisory Committee, implemented under Section 1902 (a) (22) of the Social Security Act was reconstituted as the Maryland Medicaid Advisory Committee under section 15-103 (a) (27) (1) of the Annotated Code of Maryland in 1997 (SB 750). The Maryland Medicaid Advisory Committee improves and maintains the quality of the HealthChoice Program by assisting the Department of Health and Mental Hygiene with the implementation, operation and evaluation of the Program. The Maryland Medicaid Advisory Committee meets on a monthly basis and selected members participate on other standing HealthChoice committees/workgroups developed to focus on specific elements of the HealthChoice Program.

Medical Review Panel for the Rare and Expensive Case Management. The Medical Review Panel for the Rare and Expensive Case Management Program (REM) was developed in January 1998. The mission of the Panel is to review and recommend changes to the conditions appropriate for determining eligibility into the REM Program. The work of the Panel includes examining the REM diagnoses eligibility list and developing a service complexity tool. The Medical Review Panel meets on a monthly basis and will begin meeting quarterly beginning in 2002

Special Needs Children Advisory Council. The Department established the Special Needs Children Advisory Council (SNCAC) in April 1997. The mission of this Advisory Council is to provide information, consult with, and to advise the Deputy Secretary for Health Care Financing at the Department of Health and Mental Hygiene on the administration and delivery of care for special needs children through the HealthChoice program. The Advisory Council reviews available data related to special needs children to identify problems, suggest improvements, and make recommendations as appropriate. The SNCAC meets on a bi-monthly basis.

Oral Health Advisory Committee. The Oral Health Advisory Committee is a task force formed by the Health Secretary to examine the provision of dental services for Medicaid-eligible individuals. The Committee, which started in May 1998, is comprised of representatives from dental professional organizations, Medicaid, academia, public health agencies, consumer groups, and managed care organizations. The main purpose of the Committee is to increase access to dental services for Medicaid-eligible patients in accordance with the utilization targets established in statute by the 1998 Maryland General Assembly (SB 590). The OHAC meets on a monthly basis.

Medicaid Drug Treatment Workgroup. The Medicaid Drug Treatment Workgroup was

formed to examine access and coordination of substance abuse treatment services for Medicaid enrollees. Some of the goals of the workgroup include: providing accessible substance abuse treatment services through a self-referral process; expanding the network of substance abuse providers; and assuring treatment providers are paid in a timely manner.

Other *ad Hoc* Workgroups. In addition to the committees and workgroups mentioned above, there are other *ad hoc* groups that meet regularly on specific HealthChoice related issues. For example, there is a HealthChoice enrollment steering committee, encounter data workgroup, focusing on improving the submission of encounter data, and a newborn care coordination taskforce, which is dedicated to addressing all issues related to newborn enrollment and access to care.

Findings

The work of these committees is very important to the continued improvements in the HealthChoice program. For example, a number of recommendations have been developed through the work of these committees, which have resulted in significant improvements to the HealthChoice Program. However, there have been concerns expressed through various forums about the continuous changes to the Program and the impact some of the changes have had on enrollees, providers, and MCOs. Also, the lack of communication and education of enrollees and providers regarding the new policies is a concern. The lack of time given to implement the changes, as well as the continuous policy changes made to the Program were identified as a burden on the plans, as well as their provider networks. In addition, both advocates and providers have expressed concern about the lack of focus and resolution of some issues.