Medicaid Managed Care Organization

Systems Performance Review

Statewide Executive Summary

Final Report for CY 2012

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

CY 2012 Statewide Executive Summary

HealthChoice Program Overview

Maryland's HealthChoice Program is based upon a comprehensive system of continuous quality improvement that includes problem identification, analysis, corrective action, and reevaluation. The objective is to identify areas for improvement by developing processes and systems capable of profiling and tracking information regarding the care received by HealthChoice enrollees.

The Program's philosophy is to provide quality health care that is patient focused, prevention oriented, coordinated, accessible, and cost effective. The foundation of the plan hinges on providing a "medical home" for each enrollee. This is accomplished by connecting each enrollee with a primary care provider (PCP) who is responsible for providing preventive and primary care services, managing referrals, and coordinating all necessary care for the enrollee. The Program emphasizes health promotion and disease prevention, and requires that enrollee be provided health education and outreach services.

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 Annotated 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) 2012, which is HealthChoice's fifteenth year of operation. The HealthChoice program served over 790,600 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 2012 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)

Process

The purpose of the SPR is to provide an annual assessment of the structure, process, and outcome of each MCO's internal quality assurance (QA) programs. Through the systems review, the team is able to identify, validate, quantify, and monitor problem areas.

The SPRs were conducted at the MCO's corporate offices and performed by a team of health care professionals. Prior to the on-site reviews, MCOs were required to submit a pre-site survey form and supply documentation for various processes such as quality management, utilization management (UM), credentialing, enrollee rights, and fraud and abuse identification. Delmarva staff reviews these documents prior to the on-site visit.

The on-site component provides the MCOs with an opportunity to demonstrate the efficacy of their health care system. Policies, committee minutes, work plans, reports, and other written procedures were presented to the reviewers that demonstrate the continuous quality improvement efforts undertaken by the MCOs. Key staff interfaced with the team to further define their organization's operational protocols. In addition, the team evaluated the effectiveness of any Corrective Action Plans (CAPs) initiated as a result of the prior year's review.

The performance standards used to assess the MCO's operational systems were developed from applicable Health General Statutes and Code of Maryland Annotated Regulations (COMAR), the Centers for Medicare and Medicaid Services (CMS) document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care", Public Health Code of Federal Regulations, and Departmental requirements. The HealthChoice and Acute Care Administration leadership and the Division of Health Choice Management and Quality Assurance (DHMQA) approved the MCO performance standards used in the CY 2012 review before application.

The team that performed the annual SPRs consists of health professionals with experience in managed care and quality improvement (QI) systems. The team completed the reviews and provided feedback to the DHMQA and each MCO with the goal of improving the care provided to HealthChoice enrollees.

Methodology

For CY 2012, COMAR 10.09.65.03 required that all HealthChoice MCOs comply with the SPR standards established by the Department and all applicable federal and state laws and regulations.

The following eleven performance standards were included in the CY 2012 review cycle:

- Systematic Process of Quality Assessment
- Accountability to the Governing Body
- Oversight of Delegated Entities
- Credentialing and Recredentialing
- Enrollee Rights
- Availability and Accessibility
- Utilization Review (UR)
- Continuity of Care
- Health Education
- Outreach
- Fraud and Abuse

For CY 2012, the MCOs were expected to meet the compliance rate of 100% for all standards. The MCOs were required to submit a CAP for any standard that did not meet the minimum compliance rate.

In September 2012, Delmarva provided the MCOs with a "Medicaid Managed Care Organization Systems Performance Review Orientation Manual" for Calendar Year 2012 and invited the MCOs to direct any questions or issues requiring clarification to specific Delmarva and DHMQA staff. The manual included the following information:

- Overview of External Quality Review Activities
- CY 2012 Review Timeline
- External Quality Review Contact Persons
- Pre-site Visit Overview and Survey
- Pre-site SPR Document List
- Systems Performance Review Standards, including CY 2012 changes
- System Performance Standards and Guidelines

Prior to the on-site review, the MCOs were required to submit a completed pre-site survey form and provide documentation for various processes such as quality and UM, delegation, credentialing, enrollee rights, continuity of care, outreach, and fraud and abuse policies. The documents provided were reviewed by Delmarva staff prior to the on-site visit.

During the on-site review, the team conducted structured interviews with key MCO staff and reviewed all relevant documentation needed to assess the standards. At the conclusion, exit conferences were held with the MCOs. The purpose of the conferences was to provide the MCOs with preliminary findings, based on interviews and all documentation reviewed. Notification was also provided during the exit conferences that the MCOs would receive a follow-up letter describing potential issues that could be addressed by supplemental documents, if available. The MCOs were given 10 business days from receipt of the follow-up letter to submit any additional information to Delmarva; documents received were subsequently reviewed against the standard(s) to which they related.

After completing the on-site review, Delmarva documented its findings for each standard by element and component. The level of compliance for each element and component was rated with a review determination of met, partially met, or unmet, as follows:

Met	**100%**
Partially Met	**50%**
Unmet	**0%**

Each element or component of a standard was of equal weight. A CAP was required for each performance standard that did not meet the 100% minimum required compliance rate, as defined for the CY 2012 review.

If an MCO chooses to have standards in their policies and procedures that are higher than required by DHMH, the MCO will be held accountable to the standards which are outlined in their policies and procedures during the SPR.

The Department may change a reviewing finding to "Unmet" based on the fact that it has been found "Partially Met" for more than one consecutive year.

Preliminary results of the SPR were compiled and submitted to the DHMH for review. Upon the Department's approval, the MCOs received a report containing its individual review findings. After receiving the preliminary reports, the MCOs were given 45 calendar days to respond to Delmarva with required CAPs. The MCOs could have also responded to any other issues contained in the report at its discretion within this same time frame, and/or requested a consultation with DHMH and Delmarva to clarify issues or ask for assistance in preparing a CAP.

Corrective Action Plan Process

Each year the CAP process is discussed during the annual review 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. CAPs are reviewed by Delmarva and determined to be adequate only if they address the following required elements and components:

- Action item(s) to address each required element or component
- Methodology for evaluating the effectiveness of actions taken
- Time frame for each action item, including plans for evaluation
- Responsible party for each action item

In the event that a CAP is deemed unacceptable, Delmarva Foundation will provide technical assistance to the MCO until an acceptable CAP is submitted. Five MCOs were required to submit CAPs for the CY 2012 SPR. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred.

Delmarva reviewed any additional materials submitted by the MCO, made appropriate revisions to the MCO's final report, and submitted the report to the DHMH for review and approval. The Final MCO Annual System Performance Review Reports were mailed to the MCOs.

Corrective Action Plan Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2013 will determine whether the CAPs from the CY 2012 review 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.

System Performance Review Results

The HealthChoice MCO annual SPR consists of 11 standards. The compliance threshold established by DHMH for all standards for CY 2012 is 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 100% 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 2012 review. The CY 2011 MD MCO Compliance Rates are included for comparative purposes.

Table 1. CY 2012 MCO Compliance Rates

Performance Standard	Description	MD MCO Compliance Rate CY 2011	MD MCO Compliance Rate CY 2012	ACC CY 2012	DIA CY 2012	JMS CY 2012	MPC CY 2012	MSFC CY 2012	PPMCO CY 2012	UHC CY 2012
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	**92%***	**93%***	100%	100%	100%	100%	100%	**79%***	**79%***
4	Credentialing	100%	**99%***	100%	100%	**99%***	100%	100%	**97%***	100%
5	Enrollee Rights	100%	100%	100%	100%	100%	100%	100%	100%	100%
6	Availability and Access	100%	100%	100%	100%	100%	100%	100%	100%	100%
7	Utilization Review	**98%***	**96%***	**96%***	**98%***	100%	100%	100%	**89%***	**91%***
8	Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%
9	Health Education Plan	100%	**99%***	100%	**96%***	100%	100%	100%	100%	100%
10	Outreach Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%
11	Fraud and Abuse	100%	**99%***	100%	100%	100%	100%	100%	100%	**97%***

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

The following section describes for each standard: the requirements assessed for the standard; the CY 2012 results for the standard, a comparison of the MD MCO Compliance score from CY 2011 to CY 2012, and opportunities for improvement, if applicable.

Systematic Process of Quality Assessment/Improvement

Requirements: The Quality Assurance Plan (QAP) objectively and systematically monitors and evaluates the quality of care (QOC) and services to enrollees. Through QOC studies and related activities, the MCO pursues opportunities for improvement on an ongoing basis. The QAP studies monitor QOC against clinical practice guidelines which are based on reasonable evidence based practices. The QAP must have written guidelines for its QOC studies and related activities that require the analysis of clinical and related services. The QAP must include written procedures for taking appropriate corrective action whenever inappropriate or substandard services are furnished. The QAP must have written guidelines for the assessment of the corrective actions. The QAP incorporates written guidelines for evaluation of the continuity and effectiveness of the QAP. A comprehensive annual written report on the QAP must be completed, reviewed, and approved by the MCO governing body. The QAP must contain an organizational chart that includes all positions required to facilitate the QAP.

Results: Overall, MCOs continue to have comprehensive QAPs that appropriately monitor and evaluate the QOC and service to members using meaningful and relevant 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. Additionally, there is evidence of development, implementation, and monitoring of corrective actions.

- The MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2011 to CY 2012.

Accountability to the Governing Body

Requirements: The governing body of the MCO is the Board of Directors or, where the Board's participation with the QI issues is not direct; a committee of the MCO's senior management is designated. The governing body is responsible for monitoring, evaluating, and making improvements to care. There must be documentation that the governing body has oversight of the QAP. The governing body must approve the overall QAP and an annual QAP. The governing body formally designates an accountable entity or entities within the organization to provide oversight of QA, or has formally decided to provide oversight as a committee. The governing body must routinely receive written reports on the QAP that describe actions taken, progress in meeting quality objectives, and improvements made. The governing body takes action when appropriate and directs that the operational QAP be modified on an ongoing basis to accommodate review of findings and issues of concern within the MCO. The governing body is active in credentialing, recredentialing and UR activities.

Results: Overall, MCO's continue to have appropriate oversight by their governing boards. Evidence was provided of the oversight along with ongoing feedback and direction of QI activities and operational activities of the MCO.

- The MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2011 to CY 2012.

Oversight of Delegated Entities

Requirements: The MCO remains accountable for all functions, even if certain functions are delegated to other entities. There must be a written description of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to the MCO. The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the QOC being provided. The MCO must also provide evidence of continuous and ongoing evaluation of delegated activities.

Results: MCOs continue to demonstrate opportunities for improvement in this standard regarding delegation policies and procedures and in the monitoring and evaluation of delegated functions.

- The MD MCO Compliance Rate increased from 92% in CY 2011 to 93% in CY 2012.

Opportunities for Improvement: Two MCOs demonstrated two opportunities for improvement in the Oversight of Delegated Entities standard. Opportunities identified were in regards to having written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the quality of care (QOC) being provided; providing oversight of delegated entities' performance to ensure the QOC and/or service provided, through the review of regular reports, annual review, site visits, etc.; and providing evidence of the MCO's quality committee's quarterly review and approval of all delegated entity's quarterly complaint, grievance, and appeal reports.

Credentialing and Recredentialing

Requirements: The QAP must contain all required provisions to determine whether physicians and other health care professionals licensed by the State and under contract with the MCO are qualified to perform their services. The MCO must have written policies and procedures for the credentialing process that govern the organization's credentialing and recredentialing. There is documentation that the MCO has the right to approve new providers and sites and to terminate or suspend individual providers. The MCO may delegate credentialing/recredentialing activities with a written description of the delegated activities, a description of the delegate's accountability for designated activities, and evidence that the delegate accomplished the credentialing activities. The credentialing process must be ongoing and current. There must be evidence that the MCO requests from recognized monitoring organizations information about the practitioner. The credentialing application must include information regarding the use of illegal drugs, a history of loss of

license and loss or limitation of privileges or disciplinary activity, and an attestation to the correctness and completeness of the application. There must be 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 American's with Disabilities Act and the MCO's standards.

There must be evidence that recredentialing is performed at least every three years and includes a review of enrollee complaints, results of quality reviews, hospital privileges, current licensure, and office site compliance with ADA standards, if applicable.

Results: Overall, MCOs have appropriate policies and procedures in place 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. Evidence in credentialing and recredentialing records demonstrated that those policies and procedures are functioning effectively. There were issues identified with the recredentialing process over the past year which represented the slight decline in the overall MCO compliance rate.

- The MD MCO Compliance Rate decreased from 100% in CY 2011 to 99% in CY 2012.

Opportunities for Improvement: Two MCOs demonstrated opportunities for improvement in the Credentialing and Recredentialing standard. The opportunities identified for improvement were regarding the adherence to time frames set forth in the MCO's policies for recredentialing decision date requirements.

Enrollee Rights

Requirements: The organization demonstrates a commitment to treating enrollees in a manner that acknowledges their rights and responsibilities. The MCO must have a system linked to the QAP for resolving enrollees' grievances. This system must meet all requirements in COMAR 10.09.71.02 and 10.09.71.04. Enrollee information must be written to be readable and easily understood. This information must be available in the prevalent non-English languages identified by the Department. The MCO must act to ensure that the confidentiality of specified patient information and records are protected. The MCO must have written policies regarding the appropriate treatment of minors. The MCO must, as a result of the enrollee satisfaction surveys, identify and investigate sources of enrollee dissatisfaction, implement steps to follow-up on the findings, inform practitioners and providers of assessment results, and reevaluate the effectiveness of the implementation steps at least quarterly. The MCO must have systems in place to assure that new enrollees receive required information within established time frames.

Results: MCOs have policies and procedures in place that demonstrate their commitment to treating members in a manner that acknowledges their rights and responsibilities. Evidence of enrollee information was reviewed and found to be easily understood and written in Spanish as required by the Department.

Additionally, all MCOs provided evidence of their complaint, grievance, and appeals processes.

- The MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2011 to CY 2012.

Availability and Accessibility

Requirements: The MCO must have established measurable standards for access and availability. The MCO must have a process in place to assure MCO service, referrals to other health service providers, and accessibility and availability of health care services. The MCO must have a list of providers that are currently accepting new enrollees. The MCO must implement policies and procedures to assure that there is a system in place for notifying enrollees of due dates for wellness services.

Results: Overall, MCOs have established appropriate standards for ensuring access to care and have fully implemented a system to monitor performance against these standards. All MCOs have current provider directories that list providers that are currently accepting new enrollees along with websites and helplines that are easily accessible to members as well. Each MCO has an effective system in place for notifying members of wellness services.

- The MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2011 to CY 2012.

Utilization Review

Requirements: The MCO must have a comprehensive UM Program, monitored by the governing body, and designed to systematically evaluate the use of services through the collection and analysis of data in order to achieve overall improvement. The UR Plan must specify criteria for UR/UM decisions. The written UR Plan must have mechanisms in place to detect over utilization and under utilization of services. For MCOs with preauthorization or concurrent review programs, the MCO must substantiate that: preauthorization, concurrent review, and appeal decisions are made and supervised by appropriate qualified medical professionals; efforts are made to obtain all necessary information, including pertinent clinical information, and to consult with the treating physician as appropriate; the reasons for decisions are clearly documented and available to the enrollee; there are well publicized and readily available appeal mechanisms for both providers and enrollees; preauthorization and concurrent review decisions are made in a timely manner as specified by the State; appeal decisions are made in a timely manner as required by the exigencies of the situation; and the MCO maintains policies and procedures pertaining to provider appeals as outlined in COMAR 10.09.71.03. Adverse determination letters must include a description of how to file an appeal and all other required components. The MCO must also have policies, procedures, and reporting mechanisms in place to evaluate the effects of the UR Program by using data on enrollee satisfaction, provider satisfaction, or other appropriate measures.

Results: Overall, MCOs have strong 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 decreased from 98% in CY 2011 to 96% in CY 2012.

Opportunities for Improvement: Four MCOs demonstrated opportunities for improvement in the UR standard. The opportunities are outlined below:

- One MCO had an opportunity for improvement identified regarding resolving inconsistency between its UM Plan and other internal policies pertaining to the responsibility for the development of internal criteria.
- Two MCOs had opportunities for improvement identified regarding preauthorization and concurrent review decisions being made in a timely manner as specified by the State.
- Two 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 identified regarding consistently including all 13 required components in all adverse determination letters.

Continuity of Care

Requirements: The MCO must put a basic system in place that promotes continuity of care and case management. Enrollees with special needs and/or those with complex health care needs must have access to case management according to established criteria and must receive the appropriate services. The MCO must have policies and procedures in place to coordinate care with other appropriate agencies or institutions (e.g., school health programs). The MCO must monitor 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). The MCO must ensure appropriate initiation of care based on the results of the Health Risk Assessment (HRA) data supplied to the MCO. This must include a process for gathering HRA data, an ongoing analysis, and a process that calls for appropriate follow-up on results of the analysis.

Results: Overall, 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 2011 to CY 2012.

Health Education Plan Review

Requirements: The MCO must have a comprehensive educational plan and have mechanisms in place to oversee that appropriate health education activities are provided or are available at each provider site. The educational activities must include health education on subjects that affect the health status of the enrollee population. The Health Education Plan (HEP) must incorporate activities that address needs identified through the analysis of enrollee data and have a written methodology for an annual evaluation of the impact of the HEP on process and/or outcome measures, such as emergency room utilization, avoidable hospital admissions, utilization of preventive services, and clinical measures. The HEP must provide for qualified staff or contract with external organizations to develop and conduct educational sessions to support identified needs of the members. The HEP must contain a provision addressing how the MCO will notify providers of the availability and contact information for accessing a health educator/educational program for member referrals. The MCO must have mechanisms in place to identify enrollees in special need of educational efforts. Documentation must support that these mechanisms are in place and functioning. The MCO must make the education program available to the enrollee population and demonstrate that enrollees have attended.

Results: Overall, the MCOs were found to have comprehensive HEPs which included policies and procedures for internal staff education, provider education and continuing education units, and enrollee health education.

- The MD MCO Compliance Rate decreased from a rate of 100% in CY 2011 to 99% in CY 2012.

Opportunity for Improvement: One MCO demonstrated an opportunity for improvement in the HEP Review standard. The opportunity identified for improvement was regarding providing evidence of a written methodology for evaluating the impact of the HEP on process and/or outcomes measures.

Outreach Plan Review

Requirements: The MCO must have developed a comprehensive written outreach plan (OP) to assist enrollees in overcoming barriers in accessing health care services. The OP must adequately describe the populations to be served, activities to be conducted, and the monitoring of those activities. There must be evidence that the MCO has implemented the OP, appropriately identified the populations, monitored outreach activities, and made modifications as appropriate.

Results: Overall, MCO's were found to have adequately described their populations served, an assessment of common health problems, and barriers to outreach within the MCO's membership. MCOs described the organizational capacity to provide both broad-based and enrollee specific outreach in the plan. 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. Appropriate supporting evidence of the outreach activities was also provided.

- The MD MCO Compliance Rate remained consistent at a rate of 100% from CY 2011 to CY 2012.

Fraud and Abuse

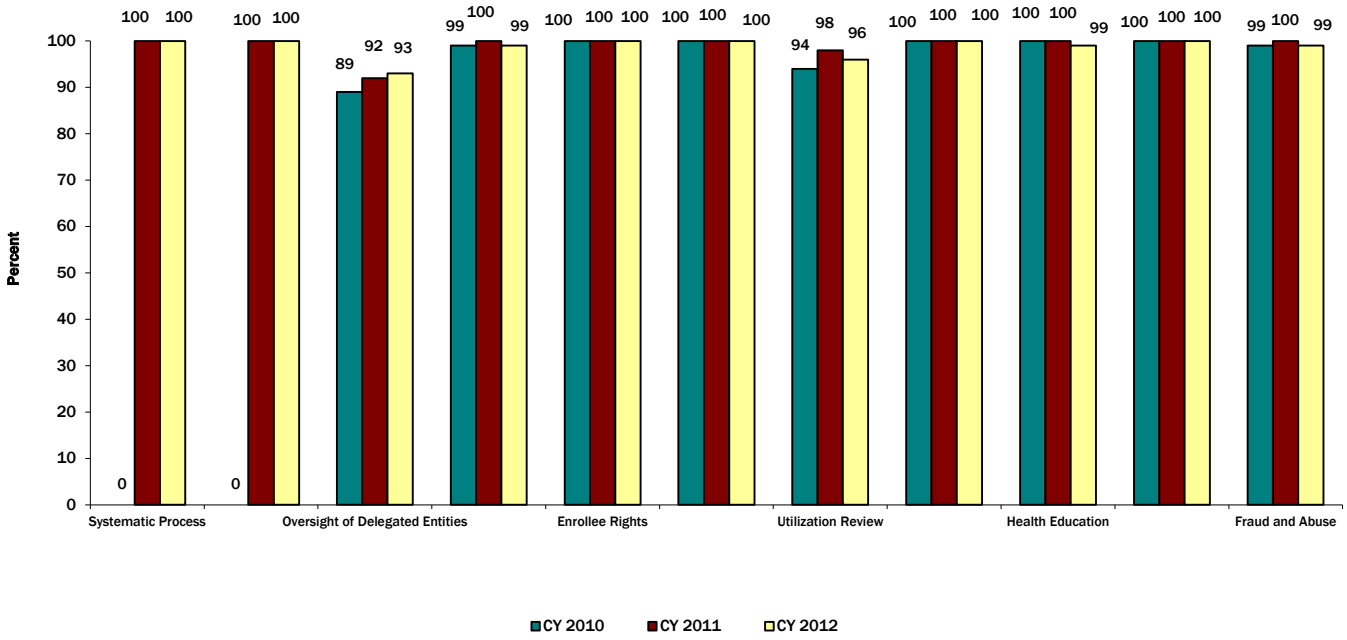
Requirements: The MCO must maintain a Medicaid Managed Care Compliance Program that outlines its internal processes for adherence to all applicable Federal and State laws and regulations, with an emphasis on preventing fraud and abuse. The program must include guidelines for defining failure to comply with these standards. The MCO must maintain administrative and management procedures, including a mandatory compliance plan, that are designed to support organizational standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The MCO must maintain administrative and management procedures that train employees to detect fraud and abuse and communicates to employees, subcontractors, and enrollees the organization's standards of integrity in identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The MCO must maintain administrative and management procedures by which personnel may report to and cooperate with the appropriate authorities regarding inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. The MCO must utilize various mechanisms to evaluate the effectiveness of its fraud and abuse compliance plan.

Results: Overall, the MCOs have strong compliance programs with internal policies and procedures that define failure to comply that are adherent to all Federal and State laws and regulations. The MCOs programs maintain administrative and management procedures for identifying and addressing inappropriate and unlawful conduct, fraudulent activities, and abusive patterns. MCOs also have programs and policies and procedures to train employees, subcontractors, and enrollees to detect and report fraud and abuse.

- The MD MCO Compliance Rate decreased from 100% in CY 2011 to 99% in CY 2012.

Opportunity for Improvement: One MCO demonstrated an opportunity for improvement in the Fraud and Abuse standard. The opportunity identified for improvement was regarding provide evidence of the Compliance Committee's review and approval of administrative and management procedures, including mandatory compliance plans to prevent fraud and abuse, for each delegate that the MCO contracts with.

Figure 1. HealthChoice Aggregate Systems Performance Compliance Rates for CY 2010 thru CY 2012



Between CY 2011 and CY 2012, the MD MCO Compliance rate remained unchanged for six standards, increased for one standard, and decreased for four standards. These changes were similar to changes seen from CY 2010 to CY 2011 where the MD MCO Compliance rate remained unchanged for five standards and increased for four standards. The overall MD MCO Compliance Composite Score remained unchanged from CY 2011 to CY 2012 at a rate of 99%.

Conclusions

All MCOs have demonstrated the ability to design and implement effective QA systems. The CY 2012 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.