Maryland HealthChoice Demonstration
Section §1115 Quarterly Report
Demonstration Year 22
7/1/2018 - 6/30/2019
Quarter 2: 10/1/2018 - 12/31/2018

Introduction

Now in its twenty-second year, Maryland implemented the HealthChoice program and moved its fee-for-service (FFS) enrollees into a managed care payment system following federal approval in 1996. Under the statewide health care reform program, the State enrolls individuals eligible through the demonstration into a managed care organization (MCO) for comprehensive primary and acute care or one of the demonstration's authorized health care programs.

The Maryland Department of Health's (the Department's) goal in implementing and continuing the demonstration is to improve the health status of low-income Marylanders by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider (PCP);
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care; and
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies.

Subsequent to the initial approval, Maryland requested and received several program extensions. The most recent extension in 2016 made the following changes to the demonstration:

- Created a Residential Treatment for Individuals with Substance Use Disorders (SUD) Program as part of a comprehensive SUD strategy;
- Created Community Health Pilot Programs:
    - Evidence-Based Home Visiting Services (HVS) pilot program for high-risk pregnant women and children up to two years of age; and
    - Assistance in Community Integration Services (ACIS);
- Raised the enrollment cap for the Increased Community Services (ICS) Program from 30 to 100; and
- Expanded dental benefits for former foster youth.

On July 2, 2018, the Department submitted an amendment to the waiver. This amendment would authorize the Department to:

- Pay for certain medically managed intensive inpatient treatments for participants with a primary SUD diagnosis and secondary mental health diagnosis at Institutions for Mental Disease (IMDs)—an expansion of the demonstration's Residential Treatment Services for Individuals with SUD Program;
- Expand the annual cap of the ACIS Community Health Pilot;

- Cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age;
- Cover National Diabetes Prevention Program (DPP) services through a limited pilot program; and
- Transition certain eligibility groups for the Family Planning program from the waiver into a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services.

Enrollment Information

Table 1 below provides a comparison of enrollment counts between the previous and current quarters. These counts represent individuals enrolled at a point in time, as opposed to total member months.

Table 1. Enrollment Counts

Demonstration Populations	Participants as of September 30, 2018	Participants as of December 31, 2018
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	207,105	204,613
Affordable Care Act (ACA) Expansion Adults	307,932	309,758
Medicaid Children	457,979	455,108
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	88,765	89,588
SSI/BD Children	23,392	22,231
Medically-Needy Adults	22,620	22,725
Medically-Needy Children	6,467	6,124
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	7,796	8,247
Maryland Children's Health Program (MCHP)	117,864	119,480
MCHP Premium	36,026	37,236
Presumptively Eligible Pregnant Women (PEPW)	0	0
Family Planning	9,616	9,873
Increased Community Services (ICS)	36	34
Women's Breast and Cervical Cancer Health Program (WBCCHP)	109	105

Table 2 provides member month counts for each month of the quarter and compares this quarter's totals against the previous quarter.

Table 2. Member Months

Eligibility Group	Total for Previous Quarter (ending September 30, 2018)	Current Quarter Month 1 (October 2018)	Current Quarter Month 2 (November 2018)	Current Quarter Month 3 (December 2018)	Total for Quarter Ending December 31, 2018
Parent/Caretaker Relatives <116% FPL and Former Foster Care	624,234	205,629	205,626	204,613	615,868
ACA Expansion Adults	923,042	308,841	309,524	309,758	928,123
Medicaid Children	1,374,392	458,212	457,225	455,108	1,370,545
SSI/BD Adults	267,258	89,611	89,400	89,588	268,599
SSI/BD Children	70,291	22,107	21,973	22,231	66,311
Medically-Needy Adults	66,841	22673	22566	22725	67,964
Medically-Needy Children	19,118	6123	6186	6124	18,433
SOBRA Adults	24,011	7,831	8,048	8,247	24,126
MCHP	351,304	118,715	119,260	119,480	357,455
MCHP Premium	107,400	35,748	36,125	37,236	109,109
PEPW	2	0	0	0	0
Family Planning	28,804	9,817	9,864	9,873	29,554
WBCCHP	328	36	36	34	106
ICS	108	109	106	105	320

Outreach/Innovative Activities

Residential Treatment for Individuals with Substance Use Disorders

Effective July 1, 2017, the Department provides reimbursement for adults aged 21 through 64 for up to two non-consecutive 30-day stays annually in institutions for mental disease (IMDs) for American Society of Addiction Medicine (ASAM) levels 3.7-WM, 3.7, 3.5, and 3.3. The Department also plans to phase in coverage of ASAM level 3.1 by January 1, 2019.

Table 3. Substance Use Disorder Residential Treatment Utilization Covered Under §1115 Authority, FY 2019[1]

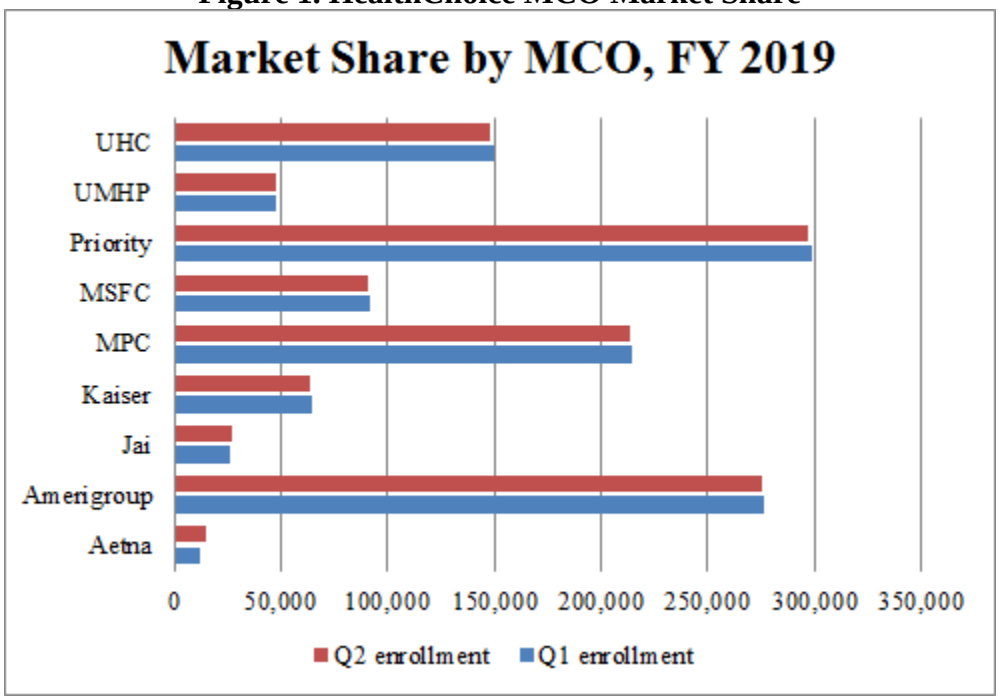
Level Of Care	Individuals	Days
Level 3.7 WM	2,329	12,866
Level 3.7	2,900	39,466
Level 3.5	958	15,940
Level 3.3	777	16,389
Total	**4,995**	**84,661**

Operational/Policy Developments/Issues

Market Share

As of the culmination of FY 2019, Quarter 2, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (1.3 percent), Amerigroup (23.4 percent); Jai Medical Systems (2.3 percent); Kaiser Permanente (5.4 percent); Maryland Physicians Care (18.1 percent); MedStar Family Choice (7.7 percent); Priority Partners (25.2 percent); University of Maryland Health Partners (4.1 percent); and United Healthcare (12.6 percent).

Figure 1. HealthChoice MCO Market Share



[1] Based On Claims Paid Through December 31, 2018

Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in October and November 2018 during the past quarter. These meetings covered a wide variety of topics, including general department updates, and waiver, state plan, and regulations changes.

In October, the Maryland Health Connection briefed the MMAC on the open enrollment period. Additionally, the MMAC discussed Maryland's opioid response protocol in cases where a provider is about to surrender or has surrendered their Controlled Dangerous Substance (CDS) license. The MMAC also listened to a presentation on initiatives in schools to improve oral health, as well as a presentation on lead poisoning prevention activities in honor of "Lead Poisoning Prevention Week."

During the November meeting, the MMAC discussed the LTSSMaryland (Long Term Services and Supports) system and the features being updated for future implementation. A representative from Maryland Citizens' Health Initiative briefed the MMAC on two legislative proposals being introduced during the upcoming 2019 Maryland General Assembly session—a Health Insurance Down Payment Plan and Prescription Drug Affordability Board. Following the opening of the legislative session in January, Medicaid agency staff will brief MMAC members on all legislation introduced that may impact the Program.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women. The program covers medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments for sexually-transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education and referrals. Enrollment as of the end of the quarter was 9,616 women, with an average monthly enrollment of 9,851, an increase of 2.6 percent over the previous quarter. Women who receive pregnancy coverage will continue to be automatically enrolled for a period of twelve months, if eligible, following the end of their pregnancy-related eligibility.

The Department is in the process of expanding eligibility under its Family Planning Program to lift the age limit, open coverage to include men, and cover services for individuals, effective July 1, 2018. Services were previously limited to women up to the age of 51 at or below 200 percent of the FPL. The Department submitted a §1115 amendment to transition authority for the program to a State Plan Amendment (SPA) on July 2, 2018, and submitted a matching SPA with an effective date of July 1, 2018 to CMS. Based on preliminary negotiations with CMS, the Department will need to continue to operate a small portion of its Family Planning Program under its §1115 waiver until the Family Planning Program can be integrated into the Maryland Health Connection (MHC). Specifically, the §1115 waiver would continue to cover post-partum women. Women eligible under a pregnancy track continue to be eligible for full Medicaid benefits for two months post-partum. Those who no longer qualify for Medicaid pregnancy benefits after the end of the post-partum period because their income is over scale are automatically enrolled in the Family Planning Program for one year (12 months). After 12

months, these women must re-apply for benefits to continue their enrollment in the Family Planning Program. Once the Family Planning Program is integrated into MHC, the Department will transition all participants to be covered under the SPA.

Table 4. Average Quarterly Family Planning Enrollment

Q1 Enrollment	Percent Change	Q2 Enrollment	Percent Change	*Q3 Enrollment*	*Percent Change*	*Q4 Enrollment*	*Percent Change*
9,601	(0.2)	9,851	2.6				

Rare and Expensive Case Management (REM) Program

The table below shows the status of REM program enrollment. Reasons for disenrollment or discharge from REM include aging out of the REM qualifying diagnosis, loss of HealthChoice eligibility, loss of Medicaid eligibility, death, or a request to return to managed care coverage.

Table 5. Current REM Program Enrollment

FY 2019	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	160	103	69	121	4,284
Quarter 2	212	142	71	109	4,267
Quarter 3					
Quarter 4					

Table 6. REM Complaints

FY 2019 Q2	Transportation	Dental	DMS/ DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	14	0	0
REM Hotline	0	0	0	0	0	0	1	0	1
Total	0	0	0	0	0	0	15	0	1

Table 6 displays the types and total of significant events reported by the case management agencies during this quarter. Agencies report this information on a monthly basis.

Table 7. REM Significant Events Reported by Case Managers

FY 2019 Q2	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	3	4	0	48	14	5	6	80

Increased Community Services (ICS) Program

Through the ICS Program, Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the 2016 waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of December 31, 2018, there were 34 individuals enrolled in the ICS Program. The ICS Program does not currently have a registry. All new applicants begin receiving services upon approval of their application.

Maryland Children's Health Program (MCHP) and MCHP Premium Status/Update/Projections

Maryland moved its separate CHIP program, MCHP, and MCHP Premium, into the Medicaid expansion CHIP waiver in 2008, so that Maryland's entire CHIP program is operated as a Medicaid expansion. As of December 31, 2018, the Premium program had 37,236 enrollees, with MCHP at 119,480 enrollees.

Medicaid and National Diabetes Prevention Program (DPP) Demonstration

The Medicaid and National DPP Demonstration will conclude on January 31, 2019. In November, Maryland received the first draft of the final report from RTI International, "Evaluation of the Medicaid Coverage for the National Diabetes Prevention Program Demonstration Project - Executive Summary." This report was shared with departmental leadership and with the Department of Budget and Management. The final CDC-cleared Executive Summary is scheduled to be published and presented at the January 2019 Capstone meeting.

Although new enrollment in the demonstration ended June 30, 2018, Medicaid beneficiaries are able to continue the program through January 31, 2019. Throughout this reporting period, the Department continued to focus on engagement, retention, sustainability, as well as quality improvement efforts around billing. This included making necessary system changes and continuing to test the Department and the Hilltop Institute's encounter data collection and reporting system; capturing best practices for recruitment and retention; preparing for CDC-recognized lifestyle change organization enrollment with Maryland Medicaid; ensuring that a new provider type was implemented; finalizing Maryland's handbook; and preparing for sustainability efforts following the demonstration's conclusion.

In anticipation of this, in October 2018, the National Association of Chronic Disease Directors issued a new funding opportunity of $250,000 to Maryland and Oregon, called Coverage 2.0: Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program (Coverage 2.0). The purpose of the funding was to continue sustainability work begun in the Medicaid and the National DPP demonstration, which involved four of the nine MCOs. The overall grant period for Coverage 2.0 is October 1, 2018 through July 31, 2019.

Through Coverage 2.0, the Department and MCOs will work to incorporate lessons learned from

the demonstration in the areas of operational and financial management systems building, quality improvement processes, and the identification, strengthening, and coordination of stakeholders' roles into the development of sustainable coverage models for the National DPP in Medicaid.

Participating MCOs are responsible for identifying and/or making the necessary systems changes to operationalize a delivery and reimbursement model for the National DPP Pilot to be implemented under the HealthChoice demonstration authority, as noted earlier.

As of December 2018, the Department ensured that the necessary processes and infrastructure were in place at the departmental and MCO levels to kick-off the Coverage 2.0 grant activities. Six MCOs are participating in Coverage 2.0, four from the demonstration (Amerigroup, Jai Medical Systems, MedStar Family Choice, Priority Partners), and two additional MCOs (Aetna Better Health, and United HealthCare).

Community Health Pilots

As of December 2018, six local government entities had been approved for federal matching funds in support of the Community Health Pilots that were included as part of the 2016 HealthChoice waiver renewal—four in the Assistance in Community Integration Services (ACIS) pilot and two in the Evidence-Based Home Visiting Services (HVS) pilot.

The two HVS Pilots had enrolled and provided home visiting services to 27 families through December 2018.

Participant enrollment is now underway in all four of the counties awarded ACIS pilot funding and continues to pick up steadily. Approximately 101 individuals are enrolled and receiving supportive housing services as of December 2018, achieving 34 percent of the pilot's statewide enrollment cap. Counties continue to improve processes related to pilot enrollment, Medicaid eligibility verification and best practices for working with ACIS-enrolled individuals. During the reporting period, the Department issued a survey to determine interest in an ACIS Learning Collaborative and is now planning for the first inaugural ACIS Learning Collaborative meeting.

The pilots are authorized through December 31, 2021.

The Department's July 2018 waiver amendment application included a request to expand the ACIS pilot to serve an additional 300 individuals. CMS approval was pending as of the end of the quarter.

Expenditure Containment Initiatives

The Department, in collaboration with the Hilltop Institute, has worked on several different fronts to contain expenditures. The culmination of the Department and the Hilltop Institute's efforts are detailed below.

HealthChoice Financial Monitoring Report (HFMR)

Final Service Year 2017 HFMR submissions (reported as of September 30, 2018) and the supporting Financial Templates were provided to the Department and Hilltop for review and for eventual distribution to MCOs on a consolidated basis. MCO submissions were due to the Department by November 19, 2018. The final 2017 submissions are expected to be the base period for the 2020 HealthChoice rate-setting period. The Department's contracted accounting firm is expected to perform an independent review of each MCO's submission including an income statement of each MCO's underwriting results. All initial submissions were received by November 28, 2018.

During the next quarter, the accounting firm will review all MCOs submissions for 2017, and their reported incurred but not reported (IBNR) will be independently evaluated. The next MCO submissions will likely be due by mid-May 2019 and will reflect preliminary 2018 results.

MCO Rates

CY 2020 Rate-Setting

In support of the CY 2020 HealthChoice rates, the rate-setting team provided the Department with financial scenarios regarding the impact on the 2020 base due to operating inefficiencies of one MCO. They also provided the accounting firm and the Department with working 2017 HealthChoice MCO financials files for eight of the nine MCOs. The rate-setting team also participated on December 20, 2018 conference call with the accounting firm and the Department to kick off 2017 annual MCO financial review for 2020 HealthChoice rate-setting. The rate-setting team is still in the process of reviewing final 2017 MCO financial submissions that will be the basis for the CY 2020 HealthChoice rates.

CY 2019 Rate-Setting

For the 2019 rates, the rate-setting team participated in several conference calls with the actuarial firm to discuss MCO data and its impact on rates. The rate-setting team also hosted a meeting with two MCOs to review their data submission and financial impact.

The actuarial firm, on behalf of the rate-setting team, obtained emerging 2018 financial data from all nine MCOs to analyze the impact on 2019 HealthChoice trends.

On October 26, 2018, the rate-setting team provided individual HealthChoice rate schedules effective January 1, 2019 to all MCOs based on their final plan risk scores. The rate setting team also provided the Department with HealthChoice rate tables effective January 1, 2019, as well as annual tape of CY 2017 risk-adjusted capital (RAC) assignments for CY 2019 payments. On behalf of the rate-setting team, the actuarial firm provided the Department with both the CMS and MCO versions of the 2019 HealthChoice certification letters.

CY 2018 Rate-Setting

For CY 2018, the-rate setting team Institute prepared final 2018 Mid-Year MCO supplemental payments for service months January through August and provided the Department with the HealthChoice rural access calculation for the second half of 2018.

Additional Activities

The rate-setting team provided the Department with trauma calculations for August, September, October, and November 2018, the annual HealthChoice Financial Reporting and Performance report, and the 2016 PSO analysis including observations. The rate-setting team also hosted a meeting with the Department and the Department of Legislative Services (DLS) auditors to review the HealthChoice rate-setting methodology and procedures. The rate-setting team also participated in two nursing home liaison meetings and sent new nursing home wage survey forms and instructions to providers.

Financial/Budget Neutrality Development/Issues

The Department is in compliance with all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements sections of the Special Terms and Conditions (STCs). A budget neutrality worksheet is attached to this report (see Appendix A).

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. Call volume increased from 44,137 calls in the first quarter of FY 2019 to 50,129 calls during this quarter. Calls are typically higher during the second quarter as it coincides with open enrollment for the Maryland Health Benefit Exchange. The Help Line assists waiver-eligible consumers with eligibility and enrollment questions and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs and how to access carved-out services—services not covered by MCOs but covered by Medicaid on a FFS basis. When a consumer is experiencing medically-related issues such as difficulty getting appointments with a specialist, getting a prescription filled or getting a service pre-authorized, the call is classified as a complaint.

Complaints are referred to the State's Complaint Resolution Unit (CRU), which is staffed with registered nurses. If necessary, the CRU engages a local Ombudsman, who has the ability to meet with the enrollee face-to-face. If the MCO has issued a denial letter to an enrollee, and the member wishes to appeal the decision through the State’s Fair Hearing process, the CRU will assist the member with that process.

Table 8. Total Recipient Complaints (not including billing) - Quarter 2- FY 2019[2]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
1st & 2nd Quarter in FY 2019		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Specialist	#	11	29	16	19	2	6	10	12	29	41	15	11	11	18	34	36	6	9	134	181
	%	8%	16%	12%	10%	1%	3%	7%	7%	22%	23%	11%	6%	8%	10%	25%	20%	4%	5%	21%	31%
Pharmacy	#	7	1	22	25	2	1	11	6	37	29	5	8	39	28	30	24	8	8	161	130
	%	4%	1%	14%	19%	1%	1%	7%	5%	23%	22%	3%	6%	24%	22%	19%	18%	5%	6%	26%	22%
Prenatal	#	10	5	35	22	2	0	11	21	20	13	15	12	36	23	30	21	3	4	162	121
	%	6%	4%	22%	18%	1%	0%	7%	17%	12%	11%	9%	10%	22%	19%	19%	17%	2%	3%	26%	21%
PCP	#	13	7	11	9	3	5	6	9	13	12	8	12	19	18	9	11	4	5	86	88
	%	15%	8%	13%	10%	3%	6%	7%	10%	15%	14%	9%	14%	22%	20%	10%	13%	5%	6%	14%	15%

There were 843 MCO total recipient complaints in the quarter, compared to 991 in the previous quarter. Sixty-nine percent of the complaints (583) were related to access to care. The remaining 31 percent (260) were billing complaints. The top three member complaint categories were access to specialists, pharmacy, and access to prenatal care. Overall, Maryland Physicians Care had the highest percent of complaints, which were mainly attributed to difficulty accessing specialists.

The number of prenatal complaints related to access to prenatal care decreased from 162 to 121. Prenatal complaints comprised 21 percent of total complaints compared to 26 percent in the previous quarter. All pregnant women were connected with an MCO network prenatal care provider and referred to Administrative Care Coordinators for follow-up and education. In addition 369 pregnant women called the Help Line for general information. These women were also referred for follow-up and education.

[2] Sourced from the Department's CRM system.

Table 9. Recipient Complaints under age 21 (not including billing) - Quarter 2- FY 2019[3]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
1st & 2nd Quarter in FY 2019		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
PCP	#	4	3	8	4	1	4	3	3	5	6	1	6	2	7	4	5	2	1	30	39
	%	13%	8%	27%	10%	3%	10%	10%	8%	17%	15%	3%	15%	7%	18%	13%	13%	7%	3%	26%	30%
Specialist	#	3	8	7	2	0	1	0	3	7	5	2	3	3	2	12	8	2	1	36	33
	%	8%	24%	19%	6%	0%	3%	0%	9%	19%	15%	6%	9%	8%	6%	33%	24%	6%	3%	31%	25%
Pharmacy	#	1	0	7	7	0	1	1	2	5	7	0	0	6	4	2	6	0	0	22	27
	%	5%	0%	32%	26%	0%	4%	5%	7%	23%	26%	0%	0%	27%	15%	9%	22%	0%	0%	19%	21%

Member complaints (non-billing) for recipients under age 21 increased to 22 percent (130 of 583) total complaints. The top three complaint categories were access to primary care providers (PCPs), access to specialists, and pharmacy. All other access complaints either remained the same or decreased. Complaints regarding access to a PCP increased by four percentage points; this was attributed to complaints from Priority Partners members whose PCPs are no longer in the Priority Partners network. The CRU engaged Priority Partners and assisted all members in accessing care.

The analysis of complaints by adults vs. children (under 21) revealed that access to care is the main issue for both of adults and children. Adults seek assistance in accessing specialists while children (under 21) had difficulty accessing a PCP.

[3] Sourced from the Department's CRM system.

Table 10. Total Recipient Billing Complaints - Quarter 2- FY 2019[4]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
1st & 2nd Quarter in FY 2018		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Emergency	#	1	3	31	24	1	2	8	8	18	15	10	6	10	12	7	5	3	1	89	76
	%	1%	4%	0%	32%	0%	3%	0%	11%	0%	20%	0%	8%	0%	16%	0%	7%	0%	1%	24%	29%
PCP	#	2	0	68	22	1	2	7	3	29	9	21	7	30	21	16	4	5	3	179	71
	%	1%	0%	38%	31%	1%	3%	4%	4%	16%	13%	12%	10%	17%	30%	9%	6%	3%	4%	49%	27%
Laboratory /Test	#	1	3	14	7	0	2	1	1	6	9	3	6	8	13	6	6	2	0	41	47
	%	2%	6%	34%	15%	0%	4%	2%	2%	15%	19%	7%	13%	20%	28%	15%	13%	5%	0%	11%	18%
Specialist	#	0	1	6	0	0	1	0	3	4	3	3	2	1	0	0	2	0	1	14	13
	%	0%	8%	43%	0%	0%	8%	0%	23%	29%	23%	21%	15%	7%	0%	0%	15%	0%	8%	4%	5%

Enrollee billing complaints comprised 31 percent of total MCO complaints this quarter. This is a decrease of six percent compared to the previous quarter. The top three bill types this quarter were emergency services, PCP, and laboratory and tests. Billing complaints for primary care services decreased by sixty percent (179 to 71). Emergency services billing complaints increased by five percentage points and laboratory/tests increased by seven percentage points. While Amerigroup complaints decreased by twelve percentage points compared to the previous quarter, they continue to have the highest percentage of billing complaints.

MCOs are required to respond to all recipient grievances and complaints. The CRU works with MCOs on behalf of the consumer to resolve the complaint. Once a plan is in place, the CRU refers the case to the Administrative Care Coordination Unit (ACCU) for follow-up to ensure the complaint has been resolved. When trends are identified, the HealthChoice Medical Advisor makes an inquiry to the MCO. If potential policy or systems issues or barriers are identified the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly's 2018 session began on January 10, 2018 and adjourned on April 9, 2018. The General Assembly will reconvene Wednesday, January 9, 2019.

Quality Assurance/Monitoring Activity

[4] Sourced from the Department's CRM system.

Overview

The Department's HealthChoice and Acute Care Administration (HACA) is responsible for coordination and oversight of the HealthChoice program. HACA ensures compliance with the initiatives established in 42 CFR 438, Subpart D, and that all MCOs that participate in the HealthChoice program apply these principles universally and appropriately. The functions and infrastructure of HACA support efforts to identify and address quality issues efficiently and effectively. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care process and help to ensure that health care is not compromised. The Division of HealthChoice Quality Assurance (DHQA) within HACA is primarily responsible for coordinating the quality activities involving external quality review and monitoring CMS quality improvement requirements in accordance with COMAR 10.09.65 for the HealthChoice program.

The Department is required to annually evaluate the quality of care provided to HealthChoice participants by contracting MCOs. In adherence to Federal law [Section 1932(c) (2) (A) (i) of the Social Security Act], the Department is required to contract with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided by each contracted MCO to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice Program.

Systems Performance Review (SPR)

The purpose of the SPR is to provide an assessment of the structure, process, and outcome of each MCO's internal quality assurance programs. Through the review, HACA is able to identify, validate, quantify, and monitor problem areas, as well as identify and promote best practices.

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; COMAR; the CMS document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care;" Public Health Code of Federal Regulations; and Department requirements. HACA leadership and the DHQA approved the MCO performance standards used in the CY 2016 review before application.

In 2015, the SPR was changed from an annual to a tri-annual review. During interim years, baseline standards and corrective action plans (CAPs) are reviewed for compliance. The final CY 2017 Statewide Executive Summary was shared with the MCOs. In preparation for the comprehensive CY 2018 SPR, the CY 2018 Orientation Manual was provided to the MCOs. The CY 2018 SPR Standards and Guidelines were updated to incorporate process and policy changes resulting from the Medicaid and CHIP Managed Care Final Rule. HACA and the EQRO also provided technical assistance to the MCOs regarding CY 2018 standards.

During the quarter, the EQRO began preparation for the CY 2018 SPR and scheduled the onsite reviews with each MCO. MCOs were responsible for uploading pre-site review documents, including sample records and sample listings. The EQRO also notified the MCOs to upload their

outreach plans for review. The EQRO began their pre-site review activities and provided technical assistance.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review

The EQRO completes an EPSDT medical record review on an annual basis. The medical record review findings assist the Department in evaluating the degree to which HealthChoice children and adolescents from birth through 20 years of age receive timely screening and preventive care in accordance with the Maryland Preventive Health Schedule.

EPSDT review indicators are based on current pediatric preventive care guidelines and Department-identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance score of 80 percent for each of the five components. If an MCO did not achieve the minimum compliance score, the MCO was required to submit a CAP. During the quarter, the EQRO completed and validated MCO EPSDT scores for 2017. The Department reviewed and approved the MCO components and elements scored. The final CY 2017 EPSDT results were reported to the MCOs. All MCOs met or exceeded the minimum compliance score for all component areas.

Consumer Report Card

The EQRO is also responsible for developing a Medicaid Consumer Report Card. The Consumer Report Card is meant to help Medicaid participants select a HealthChoice MCO. Information in the Report Card includes data from Healthcare Effectiveness Data and Information Set (HEDIS®) measures, encounter data measures calculated by the Department and validated by the EQRO, and selected results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. During this quarter, the Department and the EQRO discussed changes to the 2019 format and methodology and reviewed recommendations.

Performance Improvement Projects (PIPs)

Each MCO is required to conduct PIPs designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care, or non-clinical care areas that were expected to have a favorable effect on health outcomes. HealthChoice MCOs conduct two PIPs annually. The two PIPs selected are Asthma Medication Ratio and Lead Screening for Children. The Asthma Medication Ratio PIP measurements are based on the corresponding HEDIS® measure. The Lead Screening for Children PIP is based on the HEDIS® measure and the encounter data measure. The EQRO is responsible for evaluating the PIPs submitted by the MCOs according to CMS' External Quality Review Protocol 3: Validating Performance Improvement Projects. This quarter, the annual PIP report was finalized and posted to the MCO resource sites. Copies were distributed to the Department.

Encounter Data Validation (EDV) Review

The purpose of EDV is to assess the completeness and accuracy of encounter data submitted by MCOs to the Department. Encounter data are the electronic records of services provided to MCO

enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be a billable service under FFS reimbursement systems. Encounter data provide substantially the same type of information that is found on claim forms (e.g., UB-04 or CMS 1500), but not necessarily in the same format. States use encounter data to assess and improve quality, monitor program integrity, and determine capitation payment rates.

During this quarter, the EQRO determined the HealthChoice MCOs were found to have information systems in place that produce accurate and complete encounter data. This information was populated in the report. Because the Hilltop Institute serves as the Department's data warehouse for Medicaid encounter data, Hilltop conducted the analysis of the electronic encounter data submitted during CY 2017 during this quarter. The EQRO also conducted its medical record review activity as part of the encounter data validation. Hilltop and the EQRO collaborated to combine their findings for each activity. The report will be finalized next quarter.

Provider Directory Validation

Beginning in 2017, the EQRO has administered a survey to test the accuracy of HealthChoice MCO provider directories. The EQRO conducted calls to a statistically-significant sample of PCPs within each MCO to validate the information reported in each MCO's online provider directories and to assess compliance with Maryland Medicaid access and availability requirements. MCO-specific results and recommendations were reported to the Department for review and approval. The final report will be available next quarter.

Quarterly Review of Appeals/Grievances/Pre-Services Denial Activities

The Department reviewed the MCOs' Appeals, Grievances and Pre-Service Denial Activities, and the EQRO finalized the second annual report and distributed it to the MCOs and the Department. Assessment of MCO compliance was completed by applying the systems performance review standards and regulatory standards defined for CY 2017. The EQRO reviewed records as well as self-reported data from each MCO. If an area of non-compliance was discovered, an additional 20 records were reviewed for the non-compliant component.

MCOs demonstrated strong and consistent results in meeting regulatory requirements relating to grievances, appeals, and pre-service denials. This may be attributed to comprehensive MCO oversight by the Department and its effective use of the contracted EQRO. Compliance with regulatory timeframes appears to be the greatest challenge as evidenced by MCO results. SPR CAPs are in place to address MCOs that have had ongoing issues in demonstrating compliance, along with quarterly reviews to assess progress in CAP implementation.

Healthcare Effectiveness Data and Information Set (HEDIS®) Performance Review

NCQA released the 2018 Volume 2: Technical Update on October 1, 2018, which included several changes that the HealthChoice program will adopt. In support of the HEDIS® performance review, the Department obtained current updated lists of NCQA-Certified HEDIS® Compliance Auditors and Organizations licensed by NCQA for its records in October. The

Department provided the HEDIS® Compliance Auditor with the 2019 HEDIS® list of measures required for reporting by all HealthChoice MCOs.

The HEDIS® 2019 edition of Volume 3, which provides specifications for the CAHPS® surveys and survey process, was used by the Department and the HEDIS® Compliance Auditor to develop the annual CAHPS® data file request, which was sent to Hilltop in early November. The HEDIS® Compliance Auditor provided the Department with information regarding its audit team for 2019 in late November that included a list of auditors assigned for each HealthChoice MCO. Per request from the Department, the HEDIS® Compliance Auditor provided current Auditor Certifications and its NCQA- Licensed Organization Certificate to the Department in November.

In December, the CAHPS® Source Code and Sample Files were provided by Hilltop to the Department. The Department uploaded the data to the HEDIS® Compliance Auditor's portal. The HEDIS® Compliance Auditor approved the CAHPS® source code submitted by Hilltop in mid-December and will review and approve the final CAHPS® Sample Frame once received from the Department. The HEDIS® Compliance Auditor presented at the QALC meeting in December, discussing Department required reporting measures, audit timeline review, and audit reminders. The HEDIS® Compliance Auditor completed scheduling onsite visits for the 2019 audits and included this information in the updated audit timeline.

Aetna Better Health of Maryland (ABH), which began operating as the newest HealthChoice organization in October 2018, will participate in its inaugural HEDIS® compliance audit in HEDIS® 2019.

Value Based Purchasing (VBP)

The goal of Maryland's VBP initiative is to achieve better enrollee health through improved MCO performance. Appropriate service delivery is promoted by aligning MCO incentives with the provision of high-quality care, increased access, and administrative efficiency. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice. The Department provided the CY 2017 VBP performance results to the MCOs.

HealthChoice Enrollee Satisfaction Survey

The Department completed review and editing of all CAHPS® reports prior to granting final approval in November to the survey vendor. All final reports for 2018 were distributed electronically to the HealthChoice MCOs and the Department in November.

The survey vendor reviewed the data file specifications for CAHPS® 2019 per request by the Department. After receiving feedback, the Department sent the CAHPS® data file request memo to Hilltop in early November. The Department notified the survey vendor that there will be no changes to the supplemental questions used in the Adult and Child CAHPS® surveys for 2019. In addition, no design changes to the survey questionnaires and collateral materials were requested for the 2019 survey administration. One potential survey enhancement approved by the Department is an increased telephone outreach period during the survey fielding period.

The survey vendor provided an administration timeline for CAHPS® 2019 to the Department in November. The survey vendor reviewed this timeline with the HealthChoice organizations at the December Quality Assurance Liaison Committee (QALC) meeting. The survey vendor also discussed CAHPS® changes for 2019, proposed updates for Health Plan accreditation for 2020, and key survey protocol for the 2019 survey administration. The survey vendor provided its 2019 certificate from NCQA to the Department. Pre-survey administration for CAHPS® 2019 is underway.

Primary Care Provider Satisfaction Survey

The Department completed review and editing of all PCP Satisfaction Survey reports prior to granting final approval in November. All final reports for 2018 were distributed electronically to the HealthChoice organizations.

The 2019 PCP Data File request memo was sent to all HealthChoice MCOs in early November with instructions and requirements for providing the data file to the survey vendor for use for the 2019 survey administration. In December, the Department and the survey vendor worked on minor changes to the survey questionnaire, as a result of HealthChoice organization feedback. Also, the survey vendor proposed revising the survey instrument so that it better focuses on the PCP's relationship with a single primary MCO.

Pre-survey administration activities are underway for the 2019 Provider Survey. The Department requested that the MCOs provide a test sample frame of at least 25 PCPs for review no later than early December. The survey vendor will use National Provider Identifier (NPI) numbers to match providers across health plan data files. Providers will again have the option to complete the survey online. At the QALC meeting held in December, the survey vendor discussed the survey protocol and timeline for the upcoming 2019 survey administration. The final sample frame is due next quarter.

Rare and Expensive Case Management (REM) Satisfaction Survey

The 2018 REM Adult, Child, and Executive Summary reports were provided electronically in November to the Department. This survey is conducted to gain an understanding of REM program recipients' level of satisfaction with the care and services that they receive. The Department requested no changes to the survey questionnaire or collateral materials for the 2019 survey administration. Pre-survey fielding is underway. The survey vendor has requested to have the REM data file for the 2019 survey administration no later than early next quarter.

Annual Technical Report (ATR)

The next Annual Technical Report, which is a comprehensive report summarizing all quality activities performed by the quality assurance vendors and the results, is due to CMS on April 30, 2019.

Demonstration Evaluation

During the quarter, the Department continued work on implementing measures proposed in the draft summative evaluation into the annual HealthChoice report, which will serve as the rapid-cycle assessment to provide program updates and review the areas of coverage and access, quality of care, medical homes, preventive health and programs created using managed care efficiencies. New measures are envisioned to be gradually incorporated into the annual evaluation over the course of the waiver period. Maryland has received preliminary data from its independent evaluator, the Hilltop Institute, for the 2019 Annual HealthChoice Evaluation, which will cover performance from CY 2013 – CY 2017.

The 2019 Post-Award Forum has been scheduled for May 23, 2019, to immediately follow the May MMAC meeting.

Enclosures/Attachments
Appendix A: Maryland Budget Neutrality Report as of December 31, 2018

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Date Submitted to CMS: February 28, 2019