**Maryland HealthChoice Demonstration**
**Section §1115 Quarterly Report**
**Demonstration Year 22**
**7/1/2018 - 6/30/2019**
**Quarter 1**
**7/1/2018 - 9/30/2018**

## Introduction

Now in its twenty-second year, Maryland implemented the HealthChoice program and moved its fee-for-service 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;
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies;
- 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); and
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care.

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 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 Assisted Community Integration Services 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 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 June 30, 2018 | Participants as of September 30, 2018 |
|---|---|---|
| Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care | 213,276 | 207,105 |
| Affordable Care Act (ACA) Expansion Adults | 305,431 | 307,932 |
| Medicaid Children | 457,414 | 457,979 |
| Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults | 88,318 | 88,765 |
| SSI/BD Children | 22,615 | 23,392 |
| Medically-Needy Adults | 22,658 | 22,620 |
| Medically-Needy Children | 5,908 | 6,467 |
| Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults | 8,807 | 7,796 |
| Maryland Children's Health Program (MCHP) | 114,867 | 117,864 |
| MCHP Premium | 30,882 | 36,026 |
| Presumptively Eligible Pregnant Women (PEPW) | 5 | 0 |
| Family Planning | 9,617 | 9,616 |
| ICS | 28 | 36 |
| Women's Breast and Cervical Cancer Health Program (WBCCHP) | 138 | 109 |

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 June 30, 2018) | Current Quarter Month 1 (July 2018) | Current Quarter Month 2 (August 2018) | Current Quarter Month 3 (September 2018) | Total for Quarter Ending September 30, 2018 |
|---|---|---|---|---|---|
| Parent/Caretaker Relatives <116% FPL and Former Foster Care | 638,152 | 208,237 | 208,892 | 207,105 | 624,234 |
| ACA Expansion Adults | 931,594 | 306,497 | 308,613 | 307,932 | 923,042 |
| Medicaid Children | 1,387,990 | 457,276 | 459,137 | 457,979 | 1,374,392 |
| SSI/BD Adults | 270,333 | 89,588 | 88,905 | 88,765 | 267,258 |
| SSI/BD Children | 70,904 | 23,553 | 23,346 | 23,392 | 70,291 |
| Medically-Needy Adults | 64,300 | 21,836 | 22,385 | 22,620 | 66,841 |
| Medically-Needy Children | 17,561 | 6,238 | 6,413 | 6,467 | 19,118 |
| SOBRA Adults | 25,832 | 8,151 | 8,064 | 7,796 | 24,011 |
| MCHP | 344,892 | 116,035 | 117,405 | 117,864 | 351,304 |
| MCHP Premium | 104,838 | 35,421 | 35,953 | 36,026 | 107,400 |
| PEPW | 7 | 2 | 0 | 0 | 2 |
| Family Planning | 28,396 | 9,783 | 9,405 | 9,616 | 28,804 |
| WBCCTP | 339 | 110 | 109 | 109 | 328 |
| ICS | 108 | 36 | 36 | 36 | 108 |

## 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.

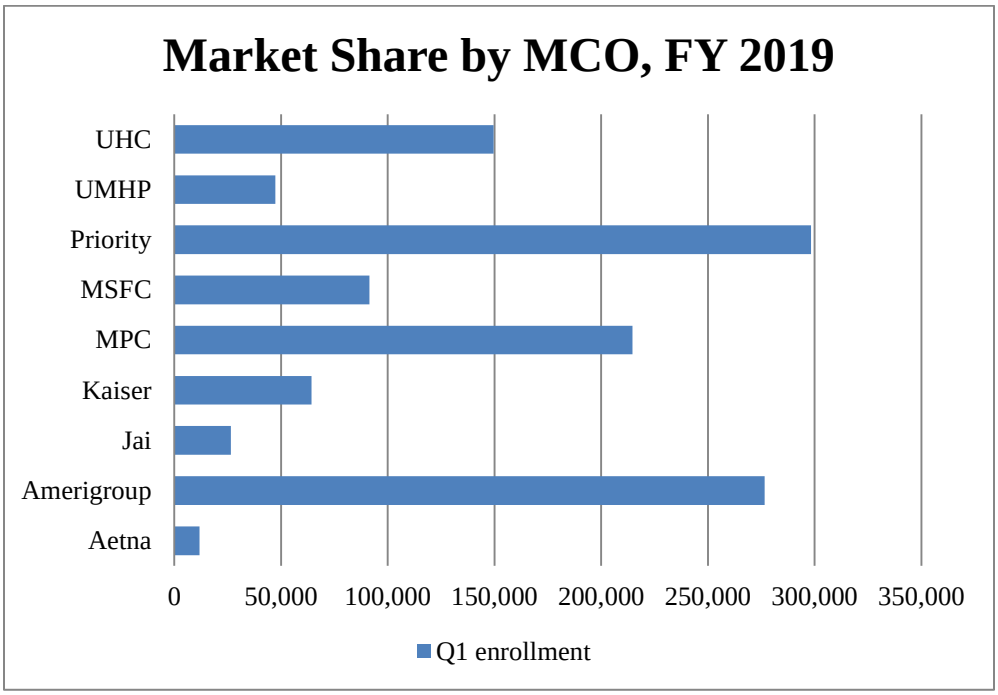
## Operational/Policy Developments/Issues

## Market Share

As of the culmination of FY 2019, Quarter 1, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (1.0 percent),

Amerigroup (23.4 percent); Jai Medical Systems (2.2 percent); Kaiser Permanente (5.4 percent); Maryland Physicians Care (18.2 percent); MedStar Family Choice (7.7 percent); Priority Partners (25.3 percent); University of Maryland Health Partners (4.0 percent); and United Healthcare (12.7 percent).

**Figure 1. HealthChoice MCO Market Share**




## Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in July and September during the past quarter. These meetings covered a wide variety of topics. In July, the MMAC discussed the proposed 1332 waiver for a reinsurance program and received overviews of Maryland's Crisis Service System and the MCO auto-assignment process. In September, the MMAC discussed the new State Opioid Response grant and the Maryland Primary Care Program. At both meetings, the MMAC received general updates on the Department as well as behavioral health reports.

## Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women—currently, those women at less than 200 percent of the FPL. 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 9,601, a decrease of 0.2 percent over the previous quarter. Women who receive pregnancy coverage will continue to be automatically enrolled, if eligible, following the end of their pregnancy-related eligibility.

The Department is in the process of expanding eligibility under its Family Planning (FP) 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% FPL. The Department submitted a § 1115 amendment to transition authority for the program to a SPA on July 2, 2018, and submitted a matching SPA with an effective date of July 1, 2018 to the Centers for Medicare and Medicaid Services (CMS). Based on preliminary negotiations with CMS, the Department will need to continue to operate a small portion of its FP Program under its §1115 waiver until the FP Program can be integrated into the Maryland Health Connection (MHC). Specifically, the §1115 waiver would continue to cover postpartum pregnant women. Pregnant women continue to be eligible for full Medicaid benefits for two months postpartum. Those who no longer qualify for benefits after the end of the postpartum period because their income is over scale are automatically enrolled in the FP Program for one year (12 months). After 12 months, these women must re-apply for benefits to continue their enrollment in the FP Program. Once the FP Program is integrated into MHC, the Department will transition all participants to be covered under the SPA.

**Table 3. 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) | | | | | | |

**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 4. 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*** | | | | | |
| ***Quarter 3*** | | | | | |
| ***Quarter 4*** | | | | | |

**Table 5. REM Complaints**

| FY 2019 Q1 | Transportation | Dental | DMS/ DME | EPSDT | Clinical | Pharmacy | Case Mgt. | REM Intake | Other |
|---|---|---|---|---|---|---|---|---|---|
| REM Case Management Agencies | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 0 | 0 |
| REM Hotline | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Total | 0 | 0 | 0 | 0 | 0 | 0 | 12 | 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 6. REM Significant Events Reported by Case Managers**

| FY 2019 Q1 | DMS/ DME | Legal | Media | Other | Protective Services | Appeals | Services | Total |
|---|---|---|---|---|---|---|---|---|
| REM Enrollees | 4 | 11 | 0 | 52 | 20 | 7 | 11 | 105 |

## 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 September 30, 2018, there were 36 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 September 30, 2018, the Premium program had 36,026 enrollees, with MCHP at 117,864 enrollees.

## Medicaid and National Diabetes Prevention Program (DPP) Demonstration

As of June 2018, the Medicaid and National DPP demonstration had completed its second and final program year; however, the demonstration was granted a no-cost extension to continue through January 31, 2019 with the four original participating MCOs: Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners. Continuous engagement and retention through September 2018 is reflected in Table 7.

**Table 7: Continuous Engagement and Retention through September 2018**

| Enrolled (attended at least one class) | Retained Months 1-6 (attended at least 4 classes) | Retained Months 7-12 (attended at least 4 classes months 1-6 and at least 3 classes months 7-12) |
|---|---|---|
| 637 | 269 | 143 |

Throughout this period, the Department has 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 collection and reporting system; capturing best practices for recruitment and retention; sharing a provider credentialing summary, systems change document, and Maryland's draft handbook with Michigan and Oregon; presenting on the demonstration at the Michigan Diabetes Prevention Network Meeting; refining and finalizing materials for the handbook; finalizing the 'suite of diseases' for the secondary outcomes study; providing training to DPP suppliers; and meeting for sustainability.

As noted above, the Department included a request to implement a limited National DPP Pilot program at the conclusion of this demonstration in its July 2018 waiver amendment application. The Department responded to all questions received from CMS related to the proposed National DPP Pilot. CMS approval was pending as of the end of the quarter.

**Community Health Pilots**

As of September 2018, there were six local government entities 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 20 families through September 2018, achieving 47 percent of the pilot's target goal. During this period, the Department presented a workshop session at the Maryland Maternal, Infant and Early Childhood Home Visiting Program Annual Conference on Medicaid and Home Visiting Programs.

Participant enrollment is underway in three of the four counties awarded ACIS pilot funding with 120 individuals receiving supportive housing services as of September 2018. The fourth county is in the process of finalizing agreements and operationalizing services. The pilots are effective through December 31, 2021 and are scheduled to be funded for the duration of the five-year waiver.

The Department's July 2018 waiver amendment application included a request to implement an ACIS expansion 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)

Preliminary Service Year 2017 HealthChoice Financial Monitoring Reports (HFMRs) (reported as of March 31, 2018) and the supporting financial templates were provided by the MCOs in May of the prior quarter. This information was used this quarter for trend analysis and validity testing purposes during the 2019 rate-setting development.

During this quarter, MCOs were requested to prepare 2018 and 2019 financial projections based on all known rate and State budget activities as of September 2018 using provided financial templates. As of September 30, 2018, all MCO projections were received. In September, MCOs were provided with updated HFMR templates and revised instructions in preparation of the MCO's November submissions.

During the next quarter, MCOs will restate their 2017 Date of Service experience as of September 30, 2018. The final 2017 submissions will most likely be the base period for the 2020 HealthChoice rate-setting period. An independent auditing firm will perform an independent review of each MCO's submission. The next MCO submissions will be due by November 19, 2018. Any additional modifications to the current reporting requirements if requested by the Department will likely be implemented during the month of October.

## MCO Rates

### CY 2020 Rate-Setting

In support of the CY 2020 HealthChoice Rates, the rate setting team prepared and provided new instructions as well as templates for the final service year 2017 HealthChoice MCO financial submissions.

### CY 2019 Rate-Setting

The rate-setting team participated in several meetings—both internal and external, including with the MCOs—in support of the CY 2019 HealthChoice rates. Topics covered during rate-setting meetings included: review of 2019 issues, preliminary 2019 MCO risk scores for HIV/AIDS and geographic and demographic rates, final constant cohort analysis, 2016 Hepatitis C and HIV/AIDS relative rates, review of 2019 rate impact and assumptions used, 2019 FQHC market rate, modifications to the 2019 MCO rates, and 2019 incentives. The rate-setting team also participated in one-on-one meetings with the Department and each of the MCOs to review MCO issues and financial projections for CYs 2018 and 2019.

The rate-setting team provided the actuarial firm with the final and revised CY 2019 member month projections. The rate-setting team also prepared and provided MCOs with the new rates. The final plan risk scores for 2019 rates will be prepared no later than October 12, 2018.

**CY 2018 Rate-Setting**

The rate-setting team participated on a conference call held July 18, 2018 with MCOs, the Department, and the actuarial firm regarding financial impact of mid-year 2018 HealthChoice rates. The rate-setting team provided the MCOs and the Department with multiple data, document, and rate requests, including:

- The 2018 mid-year rate sheets for HealthChoice;
- The mid-year rate tables to be implemented effective September 1, 2018;
- Initial 2018 mid-year payment adjustments for January 1. 2018 through August 31, 2018;
- New minimum loss ration (MLR) template to be submitted to CMS for CY 2017 to be completed by September 15, 2018; and
- CMS and MCO versions of the 2018 Mid-Year HealthChoice certification letters.

**Additional Activities**

The rate-setting team provided the Department with trauma calculations for June and July 2018. The team also participated in several nursing home liaison meetings held in July, August, and September 2018. The rate-setting team also prepared a nursing home wage survey for the Department to be implemented in December 2018. The team also provided the Department with:

- Graduate Medical Education (GME) pool estimates through fiscal year 2020;
- Cost projections for Employed Individuals with Disabilities (EID) Program through fiscal year 2021; and
- CY 2019 Program for All-Inclusive Care of the Elderly (PACE) rates, including a methodology narrative.

**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. 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 preauthorized, 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 member face-to-face. If the MCO has issued a denial letter to a member, and the member wishes to appeal the decision through the State's Fair Hearing process, the CRU will assist the member with that process.

The HealthChoice Help Line received in excess of 44,137 calls during the quarter. Note: While the Help Line was fully operational for the entire quarter, call volume is missing for nine days in August when the system that logs the total number of calls received was not operational.

**Table 8. Total Recipient Complaints (not including billing) - Quarter 1- FY 2019[1]**

| 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 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4th Q of FY 18 & 1st Q of FY 19 | | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 |
| Pharmacy | # | 6 | 7 | 36 | 22 | 5 | 2 | 10 | 11 | 29 | 37 | 4 | 5 | 50 | 39 | 21 | 30 | 10 | 8 | 171 | 161 |
| | % | 4% | 4% | 21% | 14% | 3% | 1% | 6% | 7% | 17% | 23% | 2% | 3% | 29% | 24% | 12% | 19% | 6% | 5% | 27% | 26% |
| Prenatal | # | 9 | 10 | 23 | 35 | 2 | 2 | 21 | 11 | 21 | 20 | 16 | 15 | 42 | 36 | 35 | 30 | 2 | 3 | 171 | 162 |
| | % | 5% | 6% | 13% | 22% | 1% | 1% | 12% | 7% | 12% | 12% | 9% | 9% | 25% | 22% | 20% | 19% | 1% | 2% | 27% | 26% |
| Specialist | # | 7 | 11 | 25 | 16 | 2 | 2 | 12 | 10 | 31 | 29 | 30 | 15 | 12 | 11 | 16 | 34 | 9 | 6 | 144 | 134 |
| | % | 5% | 8% | 17% | 12% | 1% | 1% | 8% | 7% | 22% | 22% | 21% | 11% | 8% | 8% | 11% | 25% | 6% | 4% | 23% | 21% |
| PCP | # | 10 | 13 | 20 | 11 | 4 | 3 | 4 | 6 | 11 | 13 | 15 | 8 | 11 | 19 | 11 | 9 | 1 | 4 | 87 | 86 |
| | % | 11% | 15% | 23% | 13% | 5% | 3% | 5% | 7% | 13% | 15% | 17% | 9% | 13% | 22% | 13% | 10% | 1% | 5% | 14% | 14% |

There were 991 MCO total recipient complaints in the quarter, compared to 1,009 in the previous quarter. Sixty-three percent of the complaints (627) were related to access to care. The remaining 37 percent (364) were billing complaints. The top three member complaint categories were pharmacy, access to prenatal care and access to specialists. Overall, United Healthcare had the highest percent of complaints, which were mainly-attributed to difficulty accessing specialists.

Complaints related to access to prenatal care remained level comprising 26 percent (162) of total complaints vs. 27 percent (171) 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. An additional 340 pregnant women called the Help Line for general information. These women were also referred for follow-up and education.

[1] Source from CRM

**Table 9. Recipient Complaints under age 21 (not including billing) - Quarter 1- 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 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4th Q of FY 18 & 1st Q of FY 19 | | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 |
| Specialist | # | 1 | 3 | 7 | 7 | 0 | 0 | 3 | 0 | 6 | 7 | 3 | 2 | 5 | 3 | 3 | 12 | 2 | 2 | 30 | 36 |
| | % | 3% | 8% | 23% | 19% | 0% | 0% | 10% | 0% | 20% | 19% | 10% | 6% | 17% | 8% | 10% | 33% | 7% | 6% | 27% | 31% |
| PCP | # | 3 | 4 | 6 | 8 | 0 | 1 | 1 | 3 | 3 | 5 | 6 | 1 | 5 | 2 | 4 | 4 | 0 | 2 | 28 | 30 |
| | % | 11% | 13% | 21% | 27% | 0% | 3% | 4% | 10% | 11% | 17% | 21% | 3% | 18% | 7% | 14% | 13% | 0% | 7% | 25% | 26% |
| Pharmacy | # | 0 | 1 | 6 | 7 | 0 | 0 | 1 | 1 | 3 | 5 | 2 | 0 | 9 | 6 | 4 | 2 | 1 | 0 | 26 | 22 |
| | % | 0% | 5% | 23% | 32% | 0% | 0% | 4% | 5% | 12% | 23% | 8% | 0% | 35% | 27% | 15% | 9% | 4% | 0% | 23% | 19% |

Non-billing member complaints for recipients under age 21 remained at 12 percent (117) with the top three complaint categories being access to specialists, access to primary care providers (PCPs), and pharmacy. While all other access complaints either remained the same or decreased, access to specialists increased by four percent; this was largely driven by complaints from United Healthcare members. The CRU engaged United Healthcare and assisted all members in accessing care.

**Table 10. Total Recipient Billing Complaints - Quarter 1- 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 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4th Q of FY 18 & 1st Q of FY 19 | | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 | 4 | 1 |
| PCP | # | 2 | 2 | 50 | 68 | 2 | 1 | 15 | 7 | 28 | 29 | 27 | 21 | 13 | 30 | 20 | 16 | 4 | 5 | 161 | 179 |
| | % | 1% | 1% | 31% | 38% | 1% | 1% | 9% | 4% | 17% | 16% | 17% | 12% | 8% | 17% | 12% | 9% | 2% | 3% | 42% | 49% |
| Emergency | # | 1 | 1 | 30 | 31 | 2 | 1 | 4 | 8 | 18 | 18 | 11 | 10 | 24 | 10 | 8 | 7 | 3 | 3 | 101 | 89 |
| | % | 1% | 1% | 30% | 35% | 2% | 1% | 4% | 9% | 18% | 20% | 11% | 11% | 24% | 11% | 8% | 8% | 3% | 3% | 27% | 24% |
| Laboratory /Test | # | 2 | 1 | 13 | 14 | 0 | 0 | 2 | 1 | 11 | 6 | 8 | 3 | 11 | 8 | 8 | 6 | 5 | 2 | 60 | 41 |
| | % | 3% | 2% | 22% | 34% | 0% | 0% | 3% | 2% | 18% | 15% | 13% | 7% | 18% | 20% | 13% | 15% | 8% | 5% | 16% | 11% |
| Specialist | # | 0 | 0 | 2 | 6 | 0 | 0 | 1 | 0 | 3 | 4 | 1 | 3 | 1 | 1 | 0 | 0 | 1 | 0 | 9 | 14 |
| | % | 0% | 0% | 22% | 43% | 0% | 0% | 11% | 0% | 33% | 29% | 11% | 21% | 11% | 7% | 0% | 0% | 11% | 0% | 2% | 4% |

[2] Source from CRM
[3] Source from CRM

Member billing complaints comprised 37 percent of total complaints in the first quarter of FY 2019. Many of the complaints are FFS-related, meaning the service was received prior to enrollment in the MCO. The top three bill types this quarter were PCP, emergency services, and laboratory and tests. Compared to the previous quarter, primary care provider (PCP)-related complaints increased by percentage points, and specialist billing complaints increased two percentage points. Billing complaints for emergency services and laboratory/tests decreased by three percentage points and five percentage points, respectively. Amerigroup had the highest percentage of billing complaints, with a seven-percentage point increase compared to the previous quarter.

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 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**

**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. The HealthChoice and Acute Care Administration 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, CY 2017 MCO CAPs were reviewed by the EQRO. CAPs related to the SPR can be directly linked to specific components or standards. The comprehensive SPR for CY 2018 will determine whether the CAPs from the CY 2017 review were implemented and effective. In order to make this determination, the EQRO will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO did not implement or follow through with the tasks identified in the CAP, the Department is notified for further action and potential intermediate sanctions.

## 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. MDH reviewed and approved the MCO components and elements scored. The final CY 2017 EPSDT results will be reported next quarter.

## Consumer Report Card

As part of its External Quality Review contract with Department, the EQRO is 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 CY 2019 Information Reporting Strategy (IRS) and Analytic methodology was approved by the Department and shared with the MCOs.

## 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 MCOs submitted their annual PIP validation reports and they were reviewed for compliance and scored by the EQRO.

## Encounter Data Validation (EDV) Review

The purpose of EDV is to assess the completeness and accuracy of encounter data submitted by MCOs to the State. 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 received the EDV sample from the Hilltop Institute with MCO encounter data. The EQRO validated the sample for completeness.

The HealthChoice MCOs were found to have information systems in place that produce accurate and complete encounter data. The MCOs use standard forms and coding schemes that allow for capturing appropriate data elements for claims processing. The Department has a comprehensive 837 process, which instructs the MCOs on the collection and submission of encounter data. The EQRO has recommended that these guidelines be enhanced with formal data dictionaries and

standards for encounter data completeness. The 2017 encounter data results will be available 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 State access and availability requirements. MCO-specific results and recommendations 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 completed the second annual report to the Department for review and approval. 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**

During the quarter, the HEDIS vendor provided Final HEDIS Audit Reports, including the HEDIS Statewide Analysis Report and the Executive Summary Report. The HEDIS Statewide Analysis Report includes the National HEDIS Mean (NHM), the HEDIS percentile benchmarks, and the Maryland Average Reportable Rate (MARR). The MARR is an unweighted average of all MCO HEDIS scores for each performance measure. The Executive Summary Report omits the NHM and the HEDIS percentile benchmarks for public reporting. Both reports show MCO performance scores on HEDIS measures above and below the NHM and MARR. The HEDIS vendor also sent the HealthChoice Means report, which contains raw data of HEDIS scores for use with specific projects, and the consolidated files to assist with setting targets for the HEDIS measures used in the 2019 Value-Based Purchasing program.

The Department continues to require each HealthChoice plan to undergo a full HEDIS compliance audit that includes all measures applicable to Medicaid, except where the Department identifies measures as part of the Medicaid Carve-Out or exempts measures from reporting. At the September Quality Assurance Liaison Committee (QALC) meeting with DHQA, the MCOs, and the three quality assurance vendors, MCOs were provided copies of the Statewide Analysis Report. The vendor reported on specification and guideline changes for the

upcoming 2019 HEDIS audit, the 2019 Audit Timeline, and reviewed the MDH required measure set for 2019.

**HEDIS Performance Highlights**

For HEDIS 2017:

- The MARR for Adult BMI Assessment (ABA) increased by greater than two percentage points, while Immunizations for Adolescents (IMA) increased by 1.6 points from HEDIS 2016 to 2017;
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) showed an increase of 5.7 percentage points, which was the second biggest performance increase in the MARR for 2017;
- The MARR improved by more than eight percentage points for the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure. That marked the biggest performance increase of all the measures. WCC Counseling for Nutrition and Counseling for Physical Activity showed MARR increases of 4.8 and 5.4 percentage points, respectively;
- The MARR improved by 1.6 percentage points for Asthma Medication Ratio (AMR) and 2.7 percentage points for Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR);
- Children and Adolescents' Access to Primary Care Practitioners (CAP) showed modest improvements in the MARR in the 12-24 months and 12-19 years age ranges of 0.5 and 1.0 percentage points;
- The MARR showed increases for all Chlamydia Screening in Women (CHL) measures, with the 16-20 year age group showing improvement by every HealthChoice MCO;
- Likewise, the both Prenatal and Postpartum Care (PPC) measures showed increases in the MARR for .6 percentage points up to 3.2 percentage points, while Frequency of Ongoing Prenatal Care (FPC) measures showed a 3.1 percentage increase in the MARR when compared to the previous year;
- Controlling High Blood Pressure (CBP) showed a strong increase in the MARR of over 4.5 percentage points;
- The MARR for Comprehensive Diabetes Care (CDC) increased for the Testing, Control, and Blood Pressure Control indicators modestly; and
- Finally, there was solid performance increases in the MARR for Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD), Statin Therapy for Patients with Diabetes (SPD), and Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART) of 3.0, 1.8, and 2.1 percentage point increases, respectively.

**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 CY 2017 VBP performance results will be reported next quarter. During this quarter, the EQRO validated the

final codes and results for the ambulatory supplemental security income (SSI) adult and child measures and lead encounter data measures developed by the Department and calculated by the Hilltop Institute. The remaining 10 VBP measures are HEDIS measures and were validated through the HEDIS Compliance Audit.

**HealthChoice Enrollee Satisfaction Survey**

The Department uses a NCQA-certified survey vendor to conduct an annual HealthChoice enrollee survey to assess satisfaction with the HealthChoice program. Separate surveys are conducted for adults and children. The child survey includes a measurement set to assess the experience of care for special needs children with chronic conditions (CCC). The Department includes a Spanish translation of the survey tool each year to reach more enrollees. During this quarter, the Department approved the 2018 CAHPS, PCP Satisfaction Survey and REM reports.

The CAHPS vendor presented the highlights of each report at the September QALC Meeting. The final aggregated Adult CAHPS survey sample included 10,800 adult members. 2,308 members completed the survey, resulting in the NCQA response rate of 21.7 percent. The final aggregated Child - Children with Chronic Conditions CAHPS survey sample included 12,986 child members and 3,461 members completed the survey, resulting in the survey response rate of 26.7 percent. Survey respondents gave their highest ratings for the Adult survey to their Specialist and Personal Doctor ahead of Health Plan and Health Care. With regard to the Child survey, survey respondents gave their highest ratings to Personal Doctor and Health Care ahead of Health Plan and Specialist. Survey respondents for both the Adult and Child survey were pleased with how well doctors communicate.

**Provider Satisfaction Survey**

The Department's satisfaction survey vendor also administered the 2018 PCP Satisfaction Survey to a random sample of PCPs from each of the MCOs. 6,515 provider surveys were mailed. A mixed methodology was used, including telephone follow-up and the option of a web survey. A total of 1,136 completed surveys were collected. The PCPs were asked to rate the MCO listed on the survey, as well as all other MCOs in which they participate.

The final results for the 2018 Provider Survey were presented at the September QALC meeting. When compared to the prior year results, there were no significant differences noted for the overall satisfaction and finance issues composites The utilization management and customer service/provider relations composites continue to show sustained improved with regard to provider satisfaction. There was no significant difference in loyalty scores from the 2018 survey when compared to the prior two years. Results of the pharmacy questions included on the 2018 Provider Satisfaction survey were shared with the Maryland Medicaid Pharmacy Program in September. This information aids the Pharmacy Program in completing HealthChoice MCO Annual Assessment reports.

**REM Satisfaction Survey**

A REM Satisfaction Survey was administered by the satisfaction survey vendor for the first time in 2018. The survey instrument was developed to measure the experience of REM members getting care and services through the REM program. Adult and Child surveys—with the option to complete the survey in Spanish—were distributed to 1,474 Adults and 2,628 Children. 621 Adult and 969 Child surveys were received, with a response rate of 42 percent and a 37 percent response rate respectively. The Adult survey showed that respondents were most satisfied with their REM Case Manager, followed by the REM Program and the health care that they received. For the Child survey, results showed that respondents were most satisfied with the REM Program, followed by the health care they received and their REM Case Manager.

**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.

**Enclosures/Attachments**

Appendix A: Maryland Budget Neutrality Report as of September 30, 2018

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