Maryland HealthChoice Demonstration
Section §1115 Quarterly Report
Demonstration Year 23
7/1/2019 - 6/30/2020
Quarter 1
7/1/2019 - 9/30/2019

Introduction

Now in its twenty-third 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 healthcare 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 has requested and received several program extensions and amendments. The most recent amendment, approved in March 2019, authorizes the Department to:

- Pay for certain inpatient treatments for participants with a primary substance use disorder (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 (ACIS) Community Health Pilot;
- Cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age;
- Cover the National Diabetes Prevention Program (National DPP) lifestyle change program services for eligible HealthChoice enrollees; and
- Transition the Family Planning program from the waiver into a State Plan Amendment (SPA) with expanded services and eligibility criteria.

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, 2019	Participants as of September 30, 2019
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	217,196	225,642
Affordable Care Act (ACA) Expansion Adults	310,031	312,137
Medicaid Children	453,455	451,038
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	89,898	89,675
SSI/BD Children	23,248	23,551
Medically-Needy Adults	22,724	23,287
Medically-Needy Children	6,153	6,140
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults[1]	13,219	13,455
Maryland Children's Health Program (MCHP)	116,006	111,094
MCHP Premium	35,497	35,844
Presumptively Eligible Pregnant Women (PEPW)	0	0
Family Planning	11,032	11,322
ICS	30	28
Women's Breast and Cervical Cancer Health Program (WBCCHP)	94	85

[1] The increase in the SOBRA category can be attributed to changes in the eligibility determination process that re-categorizes individuals reporting pregnancies to one of the pregnancy eligibility groups, rather than retaining their historic eligibility group.

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 2019)	Current Quarter Month 1 (July 2019)	Current Quarter Month 2 (August 2019)	Current Quarter Month 3 (Sept. 2019)	Total for Quarter Ending Sept. 2019
Parent/Caretaker Relatives <116% FPL and Former Foster Care	642,906	219,902	223,516	225,642	669,060
ACA Expansion Adults	929,946	311,534	312,759	312,137	936,430
Medicaid Children	1,363,676	452,726	452,898	451,038	1,356,662
SSI/BD Adults	270,199	89,855	88,963	89,675	268,493
SSI/BD Children	69,431	23,481	23,561	23,551	70,593
Medically-Needy Adults	66,966	22,955	23,049	23,287	69,291
Medically-Needy Children	18,093	6,224	6,187	6,140	18,551
SOBRA Adults[2]	39,951	218,772	222,403	224,571	665,746
MCHP	351,607	114,468	112,926	111,094	338,488
MCHP Premium	107,371	35,288	35,296	35,844	106,428
PEPW	-	-	-	-	-
Family Planning	32,579	11,097	11,193	11,322	33,612
ICS	90	30	30	25	88
WBCCHP	286	92	87	85	264

Outreach/Innovative Activities

Residential Treatment for Individuals with Substance Use Disorders

As of January 1, 2019, 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 (licensed at 3.7D in Maryland), 3.7, 3.5, 3.3, and 3.1.

[2] The increase in the SOBRA category can be attributed to changes in the eligibility determination process that re-categorizes individuals reporting pregnancies to one of the pregnancy eligibility groups, rather than retaining their historic eligibility group.

Table 3. Substance Use Disorder Residential Treatment Utilization (Medicaid-funded only, paid through September 30, 2019), FY 2019[3]

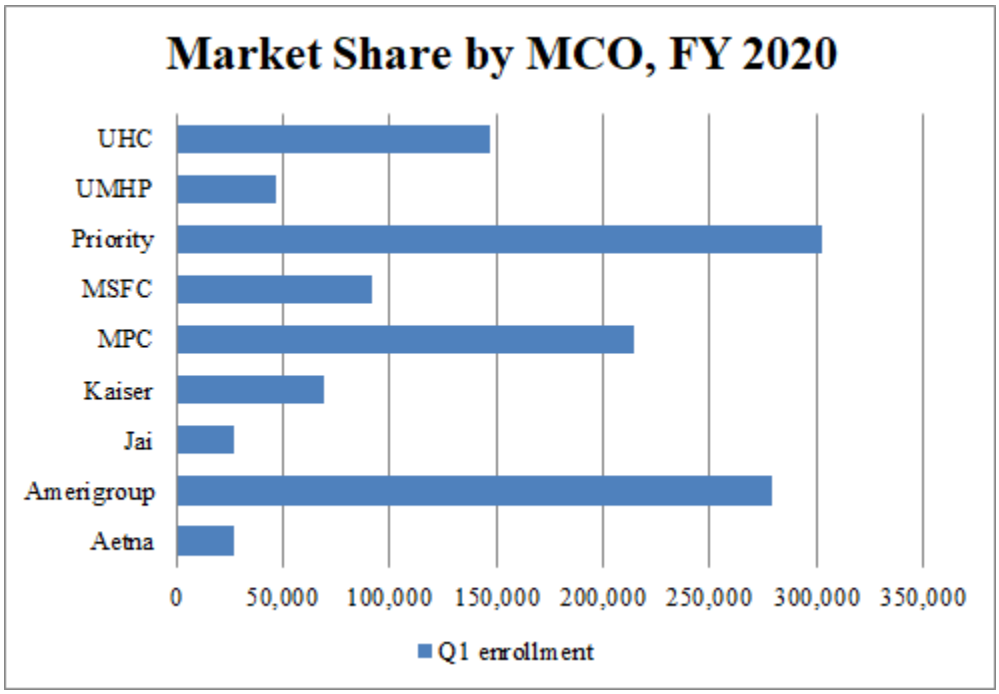
Level of Service	No. of Participants	No. of Days
Level 3.7-WM	4,626	28,969
Level 3.7	5,665	86,139
Level 3.5	1,833	34,772
Level 3.3	1,197	29,269
Total	8,703	179,149

Operational/Policy Developments/Issues

Market Share

As of the culmination of FY 2020, Quarter 1, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (2.2 percent), Amerigroup (23.2 percent); Jai Medical Systems (2.3 percent); Kaiser Permanente (5.7 percent); Maryland Physicians Care (17.8 percent); MedStar Family Choice (7.6 percent); Priority Partners (25.1 percent); University of Maryland Health Partners (3.9 percent); and United Healthcare (12.2 percent).

Figure 1. HealthChoice MCO Market Share



[3] Based on claims paid through September 30, 2019; data should be considered preliminary due to run out.

Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in July and September during the past quarter; the committee does not meet in August. These meetings covered a wide variety of topics, including general department updates, and waiver, state plan, and regulations changes.

In July, the MMAC received a presentation on the home- and community-based waiver registry and the changes to prioritize participants with the highest and most urgent need for care. The MMAC also learned about the different ways participants can access services through the Maryland Department of Aging. The Behavioral Health Administration (BHA) also announced that, beginning January 1, 2020, the Department would begin providing behavioral health services through a new administrative service organization (ASO) called Optum Behavioral Health.

During the September meeting, four of the nine MCOs presented to the MMAC on their care model and how they serve Medicaid participants. The MMAC also received an update on the Department's provider enrollment system, ePrep.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible individuals. 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. The Department has expanded eligibility under its Family Planning Program to lift the age limit, and open coverage to include men, effective July 1, 2018.

In conjunction with the most recent §1115 waiver amendment, the Department submitted a matching SPA with an effective date of July 1, 2018 to CMS. Based on conversations with CMS, the Department will continue to operate a small portion of the Family Planning program under the waiver, specifically, postpartum pregnant women who do not qualify for full Medicaid, until the Family Planning program can be integrated into the Maryland Health Connection (MHC). The Department anticipates integration to be completed in January 2020. Women who receive pregnancy coverage will continue to be automatically-enrolled, if eligible, following the end of their pregnancy-related eligibility. Once the Family Planning program is integrated into MHC, the Department will transition all participants to be covered under the SPA.

Enrollment as of the end of the quarter was 11,322 participants, with an average monthly enrollment of 11,204, an increase of 1.6 percent over the previous quarter.

Table 4. Average Quarterly Family Planning Enrollment

Q1 Enrollment	Percent Change	*Q2 Enrollment*	*Percent Change*	*Q3 Enrollment*	*Percent Change*	*Q4 Enrollment*	*Percent Change*
11,204	1.6						

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 2020	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	256	189	114	114	4293
Quarter 2					
Quarter 3					
Quarter 4					

Table 6. REM Complaints

FY 2020 Q1	Transportation	Dental	DMS/ DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	5	0	0
REM Hotline	0	0	1	0	0	0	1	0	1
Total	0	0	1	0	0	0	6	0	1

Table 7 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 2020 Q1	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	4	1	0	56	20	3	2	86

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, 2019, there were 28 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 Update

Maryland moved its separate CHIP programs, 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, 2019, the Premium program had 35,844 participants, with MCHP at 111,094 participants.

Medicaid and National Diabetes Prevention Program (DPP) Demonstration

Throughout this reporting period, the Department continued to focus on implementing HealthChoice DPP, and continued to convene MCOs through the Coverage 2.0: Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program (Coverage 2.0) grant. As mentioned in previous reports, the purpose of this funding from the Centers for Disease Control and Prevention (CDC) is to continue sustainability work begun in the Medicaid and National DPP demonstration, which involved four of Maryland's nine MCOs.

The Department continues to work with all nine MCOs 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 Lifestyle Change Program in Medicaid.

During this quarter, regulations including the new diabetes prevention services were finalized and published, making the HealthChoice Diabetes Prevention Program (HealthChoice DPP) effective as of September 1, 2019. The Department issued a policy transmittal to MCOs and CDC-recognized lifestyle change organizations that defined key program parameters in the areas of access, billing/reimbursement and conditions of participation by DPP providers. The Department continues to address program implementation questions through a Frequently Asked Questions (FAQ) document, which is posted on the Department's website, as well as respond to questions received through our dedicated HealthChoice DPP mailbox and direct emails from MCOs and DPP providers. The Department continues to hold technical assistance calls with MCOs and DPP providers. In an effort to facilitate the DPP provider enrollment and MCO contracting processes, the Department convened DPP provider information sessions for MCOs so they could learn more about the in-person and virtual DPP programs available from interested CDC-recognized lifestyle change programs. CDC-recognized lifestyle change programs with pending, preliminary or full recognition status began to apply to be Maryland Medicaid DPP providers through the online provider portal known as ePrep. MCOs continued their efforts to contract with eligible DPP providers and prepared member and provider materials during the quarter.

Community Health Pilots

As of September 2019, there were six local government entities approved for 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 pilots are effective through December 31, 2021 and are scheduled to be funded for the duration of the five-year waiver period.

The two HVS Pilots had enrolled 45 families through September 2019. Participant enrollment is still underway in each of the counties awarded HVS pilot funding and continues to pick up steadily.

After the most-recent amendment approval in April 2019, in July 2019, Round Three awards were granted to one existing Lead Entity, Baltimore City Mayor's Office of Homeless Services, to serve an additional 100 individuals annually. As of August 9, 2019, the Department began accepting ACIS Pilot Applications on a rolling basis for the remaining 200 statewide ACIS beneficiary spaces.

Approximately 203 individuals are enrolled and receiving supportive housing services as of September 2019, achieving 34 percent of the pilot's new statewide enrollment cap. Counties continue to improve processes related to pilot enrollment, such as Medicaid eligibility verification and best practices for working with ACIS enrolled individuals.

During the reporting period, the Department held the third ACIS Learning Collaborative meeting. This collaborative focused on best practices for transitions off Medicaid, strategies for increasing enrollment, and the Coordinated Entry System. The collaborative also included a presentation by the Homeless Persons Representation Project, Inc, a legal services and advocacy organization, which is located in Baltimore City and Montgomery County; all participating Lead Entities were in attendance. The fourth ACIS Learning Collaborative meeting will be held in the next quarter.

In July 2019, a group representing the majority of Baltimore City's hospitals provided $2 million in funding to serve as the local match for continued ACIS activities in Baltimore City. This first-of-its-kind investment demonstrates a recognition from the hospital industry of the importance of housing-related supports in decreasing potentially-avoidable health care utilization

In September 2019, the Department began its site visit process with ACIS Lead Entities. This is an important aspect of program oversight and monitoring. Site visits will continue through the next 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 2018 HFMR reports (reported as of March 31, 2019) 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 2020 rate setting development.

During this quarter, MCOs were requested to prepare 2019 and 2020 financial projections based on all known rate and State budget activities as of September 2019 using provided financial templates. As of September 30, 2019, all MCO projections had been received. In September, MCOs were provided with updated HFMR templates and revised instructions in preparation of the MCOs' November submissions.

During the next quarter, MCOs will restate their 2018 Date of Service experience as of September 30, 2019. The final 2018 submissions will most likely be the base period for the 2021 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, 2019. 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 2021 Rate-Setting

The rate-setting team participated in a July 2019 conference call with the Department's contracted actuarial firm to review adjusted clinical grouper (ACG) to risk-adjusted capital (RAC) analysis for CY 2021 HealthChoice rate setting. They also prepared and provided new instructions and templates for the final service year 2018 HealthChoice MCO financial submissions (including new RAC definitions for 2021 implementation).

CY 2020 Rate-Setting

The rate-setting team, in conjunction with the actuarial firm, provided draft responses to the Department to questions raised regarding the trend presentation from the June rate-setting meeting. They also participated in several rate setting preparatory meetings with the Department prior to official meeting. The rate-setting team co-facilitated two 2020 HealthChoice MCO rate-setting meetings (one of which was the final); topics discussed included:

- Review of 2020 issues,
- Preliminary 2020 MCO risk scores for HIV/AIDS and geographic and demographic rates,
- Final constant cohort analysis, and 2017 Hepatitis C, HIV/AIDS relative weights.
- Review of 2020 rate impact and assumptions used,
- 2020 federally-qualified health center (FQHC) market rate,
- 2020 incentives, and
- A presentation on new RAC definitions for calendar year 2021 MCO rates.

MCO packets including individual rate impact analysis were distributed following the final meeting.

The rate-setting team provided the actuarial firm with the final CY 2020 member month projections. They also provided the Department with graduate medical education (GME) pool estimates through fiscal year 2021. The rate-setting provided profiles for the Department's and

MCOs' one on one meetings, participated in preparatory meetings with the Department, and attended nine MCO one on one meetings at the Department to review MCO issues and financial projections for CY's 2019 and 2020. The rate-setting team also assisted the Department in developing their 2020 rate presentation to the Secretaries of both the Department, as well as the Maryland Department of Budget and Management.

The team provided MCOs' 2018 annual RAC assignments and modified one MCO's CY 2020 stop-loss rate to account for benefit changes. The rate-setting team calculated the aggregate HealthChoice ACA health insurer fee for CY 2020 and provided the Department with budget impact. In addition, the rate-setting team participated in a conference call with the Department, the Health Services Cost Review Commission (HSCRC), and the actuarial firm to discuss refinements to the HSCRC methodology for determining MCO hospital unit cost and impact on 2020 mid-year rates.

The rate-setting team also attended and participated in a meeting at the Department with Sellers Dorsey and University of Maryland Faculty Physicians regarding new supplemental payments for CY 2020.

CY 2019 Rate-Setting

For the 2019 rate-setting process, the team participated in a conference call with MCOs, the Department, and the actuarial firm regarding financial impact of mid-year 2019 HealthChoice rates. The rate-setting team provided MCOs with 2019 mid-year rate sheets for HealthChoice. The also provided the Department initial 2019 Mid-Year payment adjustments for January 1, 2019 through August 31, 2019, mid-year rate tables effective September 1, 2019, and modified minimum loss ratio (MLR) template to be submitted to CMS for CY 2018. On behalf of the rate-setting team, the actuarial firm provided the Department with both the CMS and MCO versions of the 2019 mid-year HealthChoice certification letters.

Additional Activities

The rate-setting team provided the Department with trauma calculations for June, July, and August 2019. They also attended multiple nursing home liaison meetings to provide consultation on the rate-setting process. The rate-setting team provided Department with draft responses to questions regarding the impact of the Department's provider enrollment software platform on HealthChoice risk adjustment. The rate-setting team provided the Department with cost projections for Employed Individuals with Disabilities Program through fiscal year 2022 and prepared for the Department CY 2020 PACE rates including 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. Call volume decreased from 49,361 calls in the fourth quarter of FY 2019 to 48,967 calls during this quarter. 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 covered by Medicaid on a FFS basis.

When a consumer experiences a medically-related issue, 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 is stationed at the county-level local health departments and 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 MCO, or if a member disagrees with the MCO's appeal decision and wishes to request a State Fair Hearing, the CRU will assist the member with these processes.

Table 8. Total Recipient Complaints (not including billing) - Quarter 1 - FY 2020

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 19 & 1st Q of FY 20		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Pharmacy	#	0	1	28	25	6	5	5	9	38	37	10	21	44	41	35	46	14	11	180	196
	%	0%	1%	16%	13%	3%	3%	3%	5%	21%	19%	6%	11%	24%	21%	19%	23%	8%	6%	23%	22%
Prenatal	#	19	22	22	39	6	2	23	27	28	22	16	17	41	37	30	33	7	10	192	209
	%	10%	11%	11%	19%	3%	1%	12%	13%	15%	11%	8%	8%	21%	18%	16%	16%	4%	5%	24%	23%
Specialist	#	33	35	26	31	8	9	21	9	44	43	10	16	14	20	18	31	18	13	192	207
	%	17%	17%	14%	15%	4%	4%	11%	4%	23%	21%	5%	8%	7%	10%	9%	15%	9%	6%	24%	23%
PCP	#	43	31	27	36	5	8	9	16	18	33	11	16	16	28	23	30	8	9	160	207
	%	27%	15%	17%	17%	3%	4%	6%	8%	11%	16%	7%	8%	10%	14%	14%	14%	5%	4%	20%	23%
Sub Totals	#	95	89	103	131	25	24	58	61	128	135	47	70	115	126	106	140	47	43	724	819
	%	13%	11%	14%	16%	3%	3%	8%	7%	18%	16%	6%	9%	16%	15%	15%	17%	6%	5%	91%	91%
All Complaint Totals	#	100	96	127	145	25	25	58	67	153	156	49	71	125	142	113	149	48	45	798	896
	%	13%	11%	16%	16%	3%	3%	7%	7%	19%	17%	6%	8%	16%	16%	14%	17%	6%	5%	100%	100%
Other Categories		5	7	24	14	0	1	0	6	25	21	2	1	10	16	7	9	1	2	74	77

There were 1,138 total MCO recipient complaints in the quarter, compared to 1,048 in the previous quarter. Seventy-nine percent of the complaints (896) were related to access to care. The remaining 21 percent (242) were billing complaints. The top three member complaint

categories were accessing primary care providers (PCPs), prenatal care, and specialists. The categories not specified ("Other Categories") for the non-billing complaints includes appeals & grievances, access to therapies (occupational, physical and speech), adult dental and vision services, and obtaining DME (Durable Medical Equipment)/DMS(Durable Medical Supplies). Overall, Maryland Physicians Care and United Healthcare had a high percentage of complaints (both 17 percent of all care-related complaints), which were mainly attributed to difficulty accessing pharmacy services and specialists.

The number of prenatal care complaints increased from 192 to 209. Prenatal complaints comprised 23 percent of total complaints, compared to 24 percent in the previous quarter. All pregnant women were connected with an MCO network prenatal care provider and referred to Administrative Care Coordination Units (ACCUs) at the local health departments for follow-up and education. In addition, 376 pregnant women called the Help Line for general information. These women were also referred for follow-up and education.

Table 9. Recipient Complaints under age 21 (not including billing) - Quarter 1 - FY 2020

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 19 & 1st Q of FY 20		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Specialist	#	10	5	5	8	0	3	4	3	11	8	1	2	3	3	2	9	4	1	40	42
	%	25%	12%	13%	19%	0%	7%	10%	7%	28%	19%	3%	5%	8%	7%	5%	21%	10%	2%	22%	19%
PCP	#	17	13	12	20	1	2	5	5	7	12	6	7	11	11	8	17	3	3	70	90
	%	24%	14%	17%	22%	1%	2%	7%	6%	10%	13%	9%	8%	16%	12%	11%	19%	4%	3%	38%	42%
Pharmacy	#	0	1	4	7	1	0	1	1	6	6	4	3	10	12	6	7	2	3	34	40
	%	0%	3%	12%	18%	3%	0%	3%	3%	18%	15%	12%	8%	29%	30%	18%	18%	6%	8%	18%	19%
Prenatal	#	2	4	3	4	1	0	0	2	4	2	1	3	5	3	3	4	0	2	19	24
	%	11%	17%	0%	17%	0%	0%	0%	8%	0%	8%	0%	13%	0%	13%	0%	17%	0%	8%	10%	11%
Sub Totals	#	29	23	24	39	3	5	10	11	28	28	12	15	29	29	19	37	9	9	163	196
	%	18%	12%	15%	20%	2%	3%	6%	6%	17%	14%	7%	8%	18%	15%	12%	19%	6%	5%	89%	91%
All EPSDT Complaint Totals	#	30	24	30	44	3	5	10	14	34	29	12	16	34	35	21	39	10	10	184	216
	%	16%	11%	16%	20%	2%	2%	5%	6%	18%	13%	7%	7%	18%	16%	11%	18%	5%	5%	100%	100%
Other Categories		1	1	6	5	0	0	0	3	6	1	0	1	5	6	2	2	1	1	21	20

There were 216 member complaints (non-billing) for recipients under age 21, or 24 percent of the total complaints (216 of 896). The top complaint category was access to PCPs, which increased by four percentage points. Amerigroup was a major contributor to the complaints for recipients under age 21.

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

Table 10. Total Recipient Billing Complaints - Quarter 1 - FY 2020

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 19 & 1st Q of FY 20		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
PCP	#	4	4	19	18	0	1	8	1	17	13	6	5	10	14	6	5	1	5	71	66
	%	6%	6%	27%	27%	0%	2%	11%	2%	24%	20%	8%	8%	14%	21%	8%	8%	1%	8%	23%	22%
Emergency	#	3	6	29	21	1	0	9	7	29	24	9	11	19	22	7	13	1	1	107	105
	%	3%	6%	27%	20%	1%	0%	8%	7%	27%	23%	8%	10%	18%	21%	7%	12%	1%	1%	34%	35%
Laboratory /Test	#	6	2	4	7	0	0	5	0	4	11	5	4	5	8	11	7	2	2	42	41
	%	14%	5%	10%	17%	0%	0%	12%	0%	10%	27%	12%	10%	12%	20%	26%	17%	5%	5%	13%	14%
Specialist	#	2	2	9	5	0	0	1	3	7	3	4	5	3	6	4	4	0	2	30	30
	%	7%	7%	30%	17%	0%	0%	3%	10%	23%	10%	13%	17%	10%	20%	13%	13%	0%	7%	10%	10%
Sub Totals	#	15	14	61	51	1	1	23	11	57	51	24	25	37	50	28	29	4	10	250	242
	%	6%	6%	24%	21%	0%	0%	9%	5%	23%	21%	10%	10%	15%	21%	11%	12%	2%	4%	80%	81%
All Billing Complaint Totals	#	17	16	78	61	1	3	31	17	69	64	28	31	49	60	33	35	8	11	314	298
	%	N/A	5%	25%	20%	0%	1%	10%	6%	22%	21%	9%	10%	16%	20%	11%	12%	3%	4%	100%	100%
Other Categories		N/A	2	17	10	0	2	8	6	12	13	4	6	12	10	5	6	4	1	64	56

Enrollee billing complaints comprised 21 percent of total MCO complaints this quarter, which decreased by three percentage points compared to the previous quarter. Maryland Physicians Care has the highest percentage of billing complaints. Overall, the top bill type this quarter was Emergency (ED), which comprised 35 percent of all MCO billing complaints. Other categories are the billing complaints related to inpatient services, urgent care centers, DME/DMS, therapies, pharmacy, and optional services such as adult dental and vision.

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 ACCUs at the local health departments 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 issues, systems issues, or barriers are identified, the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly's 2019 adjourned on April 8, 2019. The next legislative session begins on January 8, 2020.

Quality Assurance/Monitoring Activity

Overview

The Department's Medical Benefits Management Administration (MBMA) is responsible for coordination and oversight of the HealthChoice program. MBMA 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 MBMA 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 MBMA 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 evaluate the quality of care provided to HealthChoice participants by contracting MCOs annually. In adherence to federal law [Section 1932(c) (2) (A) (i) of the Social Security Act], the Department contracts 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 program. Through the review, MBMA is able to identify, validate, quantify, and monitor problem areas, as well as identify and promote best practices.

In 2015, the SPR was changed from an annual to a triennial 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. DHQA and the EQRO also provided technical assistance to the MCOs regarding CY 2018 standards.

During the quarter, the EQRO provided technical assistance to the MCOs regarding SPR CAPs. CAP submissions were reviewed and approved. The Statewide Executive Summary Report of SPR findings was drafted, reviewed, and finalized. DHQA and the EQRO also revised and completed updates of the CY 2019 SPR standards and CY 2019 SPR Orientation Manual.

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. In July and August, the EQRO collected provider medical records from the sample selected for the CY 2018 review. The EQRO also performed onsite EPSDT reviews. The review activities concluded in September, and report templates and scoring were approved by the Department. Reports of MCO results will be finalized and available next quarter.

Consumer Report Card

As part of its 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 EQRO submitted and received approval for the draft CY 2020 Consumer Report Card Information Reporting Strategy (IRS) and Methodology.

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. This quarter, the MCOs submitted their project updates for review to the EQRO in September. Validation results will be available next quarter.

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. 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 State's data warehouse for Medicaid encounter data, Hilltop conducted the analysis of the electronic encounter data submitted during CY 2018 during this quarter. The EQRO also conducted its medical record review activity as part of EDV. Hilltop and the EQRO will collaborate to combine their findings for each activity next quarter for the report.

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 directory and to assess compliance with State access and availability requirements. The EQRO's subcontractor conducted its secret shopper activities in July and August. In September, the EQRO completed validation of the data results and began data analysis and reporting. The report will be finalized next quarter.

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

The Department and the EQRO updated the Grievance and Appeal Template and Instructions, based on feedback from the MCOs and observations during reporting. The updated reporting template was shared with the MCOs along with instructions for reporting in the next quarter. The EQRO also completed review of MCO submitted reports for the second quarter of CY 2019.

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

The HEDIS vendor provided Final Audit Reports to MCOs, the National Committee for Quality Assurance (NCQA), and the Department in mid-July. The HEDIS vendor also provided the National HEDIS Mean (NHM) and Maryland Average Reportable Rate (MARR) report to the Department in late July. This report shows MCO performance scores on HEDIS measures above and below the NHM and MARR and is used by the Department to aid in the enforcement of the Department's MCO Performance Monitoring Policy.

The HEDIS vendor also provided the consolidated files with Value-Based Purchasing measures highlighted, showing all denominators and numerators, to the Department at the end of July. These files aid the Department in setting targets for its Value-Based Purchasing program. The HealthChoice Means Report was also provided to the Department by the HEDIS vendor in July. This report contains raw data of HEDIS scores for use with specific projects within the Department.

In July, NCQA released HEDIS 2019 specifications. These specifications alert the Department to any changes in the HEDIS measures that the HealthChoice organizations are required to report under the HealthChoice program.

During the quarter, the HEDIS vendor provided draft reports of the Statewide Analysis Report, the Executive Summary Report, and the Consolidated Final Audit Report in August for review and approval by the Department. After review and editing, the Department notified the HEDIS vendor of final approval of all reports in early September.

The Department provided the finalized HEDIS 2020 Measures List, along with official announcement letters, to the HEDIS vendor and all HealthChoice organizations in early September. The Department will continue to require each HealthChoice plan to undergo a full

HEDIS compliance audit that includes all measures applicable to Medicaid, except where the measures are identified as exempted from reporting by the Department.

The HEDIS vendor presented at the September Quality Assurance Liaison Committee (QALC) meeting reporting on HEDIS 2020 specifications and general guidelines, audit timeline, the Department's required measure set, and highlights from the HEDIS 2019 Statewide Analysis Report.

The HEDIS vendor provided other final reports to the Department that included the Statewide Executive Summary Report and the Consolidated Final Audit Report prior to the end of September.

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. In August, Hilltop submitted measure results for the three encounter-based measures to the EQRO for validation. The EQRO completed validation of all three measures in September with no comments or concerns.

HealthChoice Enrollee Satisfaction Survey

The satisfaction survey vendor provided electronic reports for each HealthChoice MCO on its secure client portal. The electronic reports provide highlighted results that include statistically-significant differences on reportable measures, when compared to the prior year results and when compared to national benchmarks. A summary of results on key measures was also included. Cross-tabulation data for all survey questions for each HealthChoice MCO was also provided.

The satisfaction survey vendor began providing individual MCO and aggregate draft reports for review and editing by the Department in July. The Department continued review and editing of all reports including Adult and Child Aggregate Consumer Assessment of Health Providers and Systems (CAHPS) reports, individual HealthChoice organizations Adult and Child CAHPS reports, and the Adult and Child CAHPS Executive Summary report throughout August and September. After the satisfaction survey vendor completed all requested edits, the Department granted final approval of all reports by the end of September.

The satisfaction survey vendor presented at the September QALC Meeting highlighting the results of the 2019 CAHPS survey. Highlights of the CAHPS survey included a 20.6 percent and 25.4 percent response rate for the Adult and Child surveys, respectively.

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 continue to be most pleased with how well doctors communicate based on survey results.

The Department anticipates all final survey reports, which will include Quality Compass data, to be printed and distributed to all HealthChoice organizations and the Department by the satisfaction survey vendor next quarter.

Primary Care Provider (PCP) Satisfaction Survey

The Department began reviewing and editing draft reports of the PCP Satisfaction Survey provided by the vendor in late July through the month of August. Once the satisfaction survey vendor had completed all requested edits, the Department gave final approval of the aggregate, individual MCO, and executive reports to the satisfaction survey vendor in September.

The satisfaction survey vendor highlighted the final results for the 2019 PCP Satisfaction Survey at the September QALC meeting. A total of 1,266 completed surveys were collected from an overall sample size of 7,044. The response rate was 19 percent, which reflected a one-percent increase when compared to last year's response rate, for this survey administration.

The satisfaction survey vendor continued to administer overall a mixed methodology, which involved a mailed survey with telephone follow-up and the web survey option.

Key findings from the 2019 survey show that of the 1,266 completed survey that were received, 607 were from mail, 464 from phone, and 195 from web. For the 2019 survey, all composite areas, including overall satisfaction, finance issues, utilization management, and customer service/provider relations, showed continued improvement when compared to the 2018 results. Physician loyalty showed an increase when compared to the prior year results. Also, the 2019 survey results reflected a decrease in the number of indifferent and not loyal providers.

The Department provided the Maryland Medicaid Pharmacy Program with the results of the pharmacy questions included on the 2019 PCP Satisfaction Survey in September. This information aids the Pharmacy Program in completing the HealthChoice MCO Annual Assessment reports.

Final reports of the survey are expected to be distributed to all HealthChoice organizations and the Department by the satisfaction survey vendor 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, 2020. The Department and the EQRO will begin compiling and editing the report for submission towards the end of next quarter.

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. The Department, in collaboration with its independent evaluator, the Hilltop Institute, began planning the evaluation to be released in CY 2020, which will cover CY 2014 through CY 2018.

The Department also received feedback on its draft summative evaluation design and its SUD monitoring protocol during the quarter and is in the process of updating the both the evaluation design and the protocol in accordance with CMS's comments.

Enclosures/Attachments
Appendix A: Maryland Budget Neutrality Report as of September 30, 2019

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Date Submitted to CMS: 11/27/2019