Maryland HealthChoice Demonstration
Section §1115 Quarterly Report
Demonstration Year 24
7/1/2020 - 6/30/2021
Quarter 3 Report
1/1/2021 - 3/31/2021

Introduction

Now in its twenty-fourth 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 waiver amendment approved in April 2020 allowed the Department to establish a limited Collaborative Care Model (CoCM) Pilot Program that will serve a limited number of HealthChoice beneficiaries behavioral health care in their primary care setting beginning in July 2020.

Enrollment Information

Tables 1 and 2 below provide a comparison of enrollment counts between the previous and current years. These counts represent individuals enrolled at a point in time, as opposed to total member months.

Table 1. Enrollment Counts[1]

Demonstration Populations	Participants as of December 21, 2020	Participants as of March 31, 2021
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	263,202	271,442
Affordable Care Act (ACA) Expansion Adults	366,815	380,891
Medicaid Children	498,183	510,385
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	91,989	92,299
SSI/BD Children	23,828	24,046
Medically-Needy Adults	22,858	22,720
Medically-Needy Children	6,443	6,545
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	14,086	14,532
Maryland Children's Health Program (MCHP)	108,603	108,438
MCHP Premium	35,119	34,313
Presumptively Eligible Pregnant Women (PEPW)	0	0
Family Planning	13,341	13,262
Increased Community Services (ICS)	26	27
Women's Breast and Cervical Cancer Health Program (WBCCHP)	64	65

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 Dec. 2020)	Current Quarter Month 1 (Jan. 2021)	Current Quarter Month 2 (Feb. 2021)	Current Quarter Month 3 (Mar. 2021)	Total for Quarter Ending Mar. 2021
Parent/Caretaker Relatives <116% FPL and Former Foster Care	779,302	266,966	269,357	271,442	807,765
ACA Expansion Adults	1,077,111	372,144	376,041	380,891	1,129,076
Medicaid Children	1,479,694	502,529	506,211	510,385	1,519,125
SSI/BD Adults	275,627	92,172	92,162	92,299	276,633
SSI/BD Children	71,343	23,895	24,001	24,046	71,942
Medically-Needy Adults	69,223	22,610	22,494	22,720	67,824
Medically-Needy Children	19,337	6,472	6,500	6,545	19,517
SOBRA Adults[1]	41,171	14,083	14,383	14,532	42,998
MCHP	325,020	108,252	108,209	108,438	324,899
MCHP Premium	105,699	34,646	34,400	34,313	103,359
PEPW	1	0	0	0	0
Family Planning	39,514	13,280	13,212	13,262	39,754
WBCCHP	194	65	65	65	195
ICS	78	27	27	27	81

[1] Substantive increases are observed over several MAGI demonstration populations, due to maintenance of effort requirements under the 2020 COVID-19 Public Health Emergency.

Outreach/Innovative Activities

Residential Treatment for Individuals with Substance Use Disorders

Effective July 1, 2017, the Department began providing reimbursement for up to two nonconsecutive 30-day stays annually for American Society of Addiction Medicine (ASAM) levels 3.7D, 3.7, 3.5 and 3.3. Effective January 1, 2019, the Department extended coverage for up to two nonconsecutive 30-day stays annually for ASAM 3.1 and for up to 15 days per month for ASAM 4.0. Effective January 1, 2020, the Department extended coverage for dual eligibles.

Table 3. Substance Use Disorder Residential Treatment Utilization Limited to Medicaid Funding, FY 2020[2]

Level of Service	No. of Participants	No. of Days
Level 3.7-WM	2,556	14,455
Level 3.7	2,822	41,540
Level 3.5	1,821	34,459
Level 3.3	658	12,693
Level 3.1	649	15,561
Total	**5,939**	**118,708**

Maternal Opioid Misuse (MOM) Model

The Department launched its Maternal Opioid Misuse (MOM) model in January 2020, with funding from the Center for Medicare and Medicaid Innovation (CMMI) and in collaboration with the Centers for Medicare and Medicaid Services (CMCS). The MOM model focuses on improving care for pregnant and postpartum Medicaid beneficiaries diagnosed with opioid use disorder (OUD). With over 21,000 individuals of childbearing age diagnosed with an OUD in Maryland, substance use is a leading cause of maternal death and has a significant impact on the approximately 1,500 infants born to Medicaid beneficiaries with OUD in Maryland per year. Utilizing HealthChoice managed care organizations (MCOs) as care delivery partners, the MOM model focuses on improving clinical resources and enhancing care coordination to Medicaid beneficiaries with OUD during and after their pregnancies.

Under the Maryland MOM model, HealthChoice MCOs will provide a set of enhanced case management services, standardized social determinants of health screenings and care coordination. Exact services and screenings will be developed over the course of the MOM pre-implementation period (January 2020 - June 2021) and refined during the MOM transition period

[2] Based On Claims Paid Through January 2, 2020. Data should be considered preliminary due to the Administrative Services Organization transition launch in January 2020 and the delay in data availability. The Department expects to report on residential SUD data next quarter when improvements have been made in the accuracy of Medicaid claims.

(July 2021 - June 2022), which is the first year of model services. During this quarter, the Department finalized the selection of St. Mary's County as its pilot site. The pilot approach will facilitate the reporting of broad monitoring data requirements. The Department conducted additional design activities with the MCOs and the St. Mary's County Health Department. Additionally, as part of the model's capacity-building activities, the Department finalized its MOM sub-award with the Maryland Addiction Consultation Service and launched an incentive program to encourage primary care providers to seek DATA 2000 waivers.

Collaborative Care Model (CoCM) Pilot Program

The Department's CoCM Pilot Program began enrolling participants on July 1, 2020. During the second quarter, 95 participants were served across all of the sites. In the third quarter, 107 participants were served across the sites.

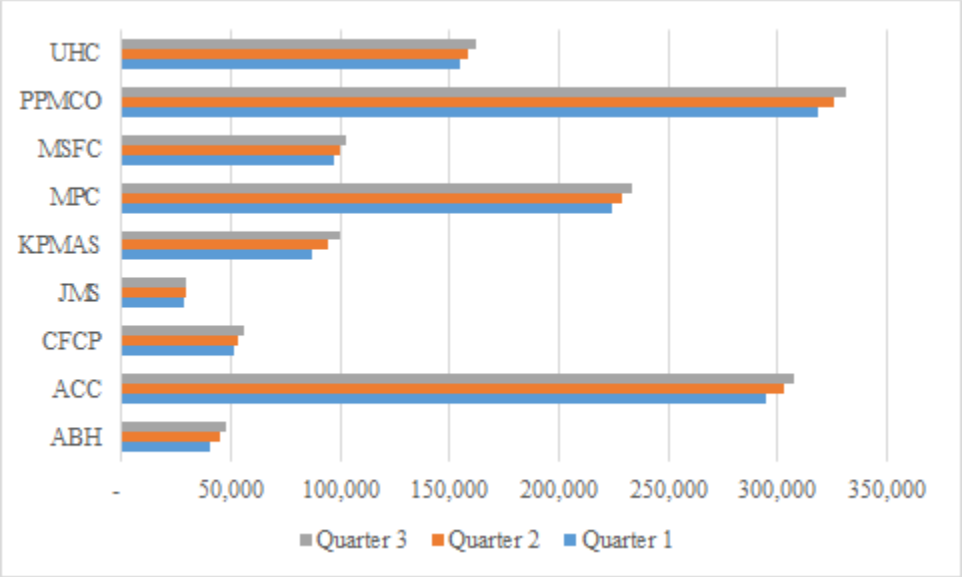
Operational/Policy Developments/Issues

Market Share

As of the culmination of FY 2020, Quarter 4, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (3.4 percent), Amerigroup (22.5 percent); Jai Medical Systems (2.1 percent); Kaiser Permanente (7.3 percent); Maryland Physicians Care (17.0 percent); MedStar Family Choice (7.5 percent); Priority Partners (24.2 percent); University of Maryland Health Partners (4.1 percent); and United Healthcare (11.8 percent).

In October 2020, CareFirst BlueCross Blue Shield acquired University of Maryland Health Partners. Effective February 1, 2021, University of Maryland Health Partners was renamed CareFirst BlueCross BlueShield Community Health Plan of Maryland. The Department is working with CareFirst staff to ensure the transition is smooth for members and providers.

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in January, February, and March of 2021. Due to COVID-19, all of the MMAC meetings were held via teleconference. These meetings covered a wide variety of topics, including general department updates, and waiver, state plan, and regulations changes. Because the State's legislature was in session, the MMAC was also briefed on pertinent Medicaid bills.

During the January meeting, the MMAC was given a presentation by the Acting Deputy Secretary of Public Health on COVID-19 vaccine distribution in the State. The MMAC also learned about the special enrollment period (SEP) due to COVID-19 from the Maryland Health Benefit Exchange (MHBE), the State's health insurance exchange. The MMAC received an overview of the new eligibility and enrollment system, MDTHINK.

During the February meeting, the MMAC received an update on ongoing health information exchange (HIE) efforts to aid the COVID-19 response; this included a presentation from the Chesapeake Regional Information System for our Patients (CRISP), the regional HIE for the State. The MMAC was also given an update about the annual oral health report.

During the March meeting, the MMAC received an extensive presentation from multiple stakeholders on the Statewide Integration Health Improvement Strategy (SIHIS), which includes different state-wide initiatives in priority areas including diabetes, opioid use disorder, maternal health, and pediatric asthma.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women. The program covers medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments for sexually-transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education and referrals. 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 continues to operate a small portion, specifically postpartum pregnant women who do not qualify for full Medicaid, of its Family Planning Program under its §1115 waiver until the Family Planning Program can be integrated into the Maryland Health Connection (MHC). Women who receive pregnancy coverage will continue to be automatically-enrolled, if eligible, following the end of their pregnancy-related eligibility.

The Family Planning Program was integrated into MHC on February 1, 2020. Participants can now apply and renew their Family Planning coverage online. The Department has submitted a SPA to transition all participants to be covered under the SPA rather than the §1115 waiver.

Enrollment as of the end of the quarter was 13,262 participants, with an average monthly enrollment of 13,251, an increase of 1.0 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*
12,683	1.6%	13,171	1.0%	13,251	1.0%		

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 2021	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	179	149	34	97	4,334
Quarter 2	221	161	49	80	4,359
Quarter 3	263	217	53	81	4,378
Quarter 4					

Table 6. REM Complaints

FY 2021 Q 3	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	1	0	0	0	0	0	0	0
Total	**0**	**1**	**0**	**0**	**0**	**0**	**5**	**0**	**0**

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 2021 Q 3	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	2	5	0	42	13	0	19	**81**

Increased Community Services (ICS) Program

Through the ICS Program, Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the 2016 waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of March 31, 2021, there were 27 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 March 31, 2021, the Premium program had 34,313 participants, with MCHP at 108,438 participants.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Throughout this reporting period, the Department continued to focus on implementing the HealthChoice DPP, and continued to convene MCOs through implementing the Coverage 2.0-Part 3: Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program (Coverage 2.0-Part 3) grant. As mentioned in previous reports, the purpose of this grant—funded by 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, and subsequently through the three years of the Coverage 2.0 capacity-building grant.

As part of its Coverage 2.0-Part 3 work plan, Medicaid engaged a vendor to produce two testimonial videos outlining the experiences of Medicaid and National DPP demonstration participants, as well as capturing perspectives of lifestyle coaches and a physician provider. The two videos with social clips and associated print ads were completed and are slated to go live on The Department's website and social media in June 2021. The Department is working with their internal communication's team to develop a marketing guide and plan to be rolled out concurrently with the social media campaign. Through an additional Part 3 funding stream received from CDC, the Department continued work with CRISP, the statewide HIE, to develop a prediabetes flag within CRISP that will enable providers to be notified of potentially eligible patients at the point of care, and will allow CRISP to generate reports to MCOs of panels of their members who received the flag, so to enable further follow-up and connection with an available in-network DPP provider. The prediabetes flag and corresponding CareAlerts for providers at the point of care are expected to go live in spring 2021.

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.

In this reporting period, the Department continued to address program implementation questions through an updated Frequently-Asked Questions (FAQ) document posted online, respond to questions received through a dedicated HealthChoice DPP mailbox and direct emails from MCOs and DPP providers, and hold technical assistance calls with MCOs and DPP providers. Nearly all MCOs have now contracted with at least one DPP Provider, and most have now contracted with at least one virtual and one in-person DPP provider. Two MCOs have chosen to become CDC-recognized organizations themselves, and offer the program to their members in-house. The Department continued working with MCOs to refine the eligibility determination algorithm provided in the previous quarter. The algorithm was developed to support MCOs in directly identifying members through data analysis using claims and encounters, lab and or EMR/EHR data and enabling outreach to these members.

CDC-recognized lifestyle change programs with pending, preliminary or full recognition status continued to apply to become Maryland Medicaid DPP providers through the online provider portal known as ePREP. As of the end of the quarter, twenty DPP providers were fully-enrolled. MCOs continued efforts to contract with eligible DPP providers and prepare member and provider materials. The 8th Diabetes Prevention Program Provider Information Session for Managed Care Organizations (MCOs) was held in March 2021, with three newly enrolled DPP providers attending: Garrett Regional Medical Center, Prince George's County Health Department, and Heritage Care, Inc. The purpose of the information session was to enable new DPP providers to share their programs with the MCOs, to allow for more efficient MCO contracting, and to connect with new providers.

Community Health Pilots

As of March 2021, six local government entities participate in the Community Health Pilots (CHP). Four Lead Entities (LEs) participate in the Assistance in Community Integration Services (ACIS) pilot and two LEs in the 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.

During this reporting period, CHP LEs continued telephonic service delivery due to COVID-19. For ACIS Pilots, this included allowing service provision via telecommunications methods. For HVS Pilots, LEs follow the Healthy Families America model guidance, which allows service provision via telecommunication methods.

The Department released its annual budget planning guidance in March of 2021. This guidance started the FY22 budget negotiation process. As of the end of Q3, one ACIS LE had submitted their draft budget package, according to a prearranged schedule. During Q4 CHP LEs will continue to submit budget packages for the Department to review and approve.

The HVS Pilot LEs have enrolled a total of 47 families through March 2021. Both LEs reached and maintained their projected enrollment during this quarter.

HVS LEs are partnering with local community based organizations to provide educational and support groups for participating families. LEs continue devising strategies to improve family engagement and virtual home visiting experience by testing a hybrid model of virtual and in-person home-visits. LEs continue to provide virtual networking opportunities for families and support staff with skills development to improve health outcomes for at-risk expectant families and their young children

As of March 2021, approximately 364 participants are enrolled in the ACIS Pilot and receiving supportive housing services, representing 61 percent of the pilot's statewide total enrollment cap.

LEs continue to improve processes related to pilot enrollment, such as using the Medicaid Eligibility Verification System, partnering with local community organizations, and improving best practices for working with ACIS-enrolled participants. LEs continue to deal with complications due to the ongoing Public Health Emergency (PHE).

In March of 2021, the Department coordinated with Hilltop to host a data training session for ACIS LEs and their Participating Entities. The data training focused on improving the overall quality of data collection, processing, and accuracy of data submitted to Hilltop.

The Department continues to provide technical assistance and guidance to ACIS LEs as they deliver services under the national PHE.

The ACIS Pilot continues to accept applications on a rolling basis. Lead local government entities are encouraged to apply for the remaining 180 statewide ACIS beneficiary spaces.

Expenditure Containment Initiatives

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

HealthChoice Financial Monitoring Report (HFMR)

Final 2019 HFMR MCO submissions were updated and reviewed. Unadjusted consolidated 2019 HFMRs by region were provided to all MCOs on March 17, 2021.

The final reviewed 2019 submissions will be the base period for the 2022 HealthChoice rate-setting period. The firm Myers & Stauffer, the Department's contracted accounting firm, is currently in the process of performing independent reviews of each MCO's submission which are due May 1, 2021. A separate actuarial firm is completing draft analyses of each MCOs incurred but not reported (IBNR) estimates.
During the next quarter, all MCOs will submit their first HFMR reports for 2020 (reported as of March 31, 2021). These reports are due to the Department by May 18, 2021. MCOs were provided on March 23, 2021 with updated financial templates and instructions for completing their May submissions.

MCO Rates

CY 2022 Rate-Setting

In support of the CY 2022 rates, the rate-setting team participated in a conference call with the Department and the accounting firm to provide working 2019 HealthChoice HFMRs and MCO financial reconciliation files for all nine MCOs. The team developed HealthChoice constant cohort analysis to evaluate changes in the MCO case mix using data available as of February 28, 2021. The team co-facilitated the first two 2021 HealthChoice MCO rate setting conference calls on February 26 and March 24, 2021; topics included the goals, organization, and methodology of the HealthChoice rate setting, the presentation of the Department's issues, status of the accounting firm's review, the American Rescue Plan Act of 2021, and the constant cohort analysis. On February 11, the team hosted a planning conference call with the Department, HSCRC, and Optumas (the Department's contracted actuarial firm) to discuss timelines for information needed from hospital regulators in the development of 2021 mid-year and 2022 HealthChoice rates. The team also incorporated multiple revised 2019 HFMR submissions provided by the MCOs and provided the MCOs with the current consolidated 2019 HealthChoice submission. Lastly, the team provided the MCOs with templates to use for the first CY 2020 financial submission for the HealthChoice program.

CY 2021 Rate-Setting

In support of the 2021 rates, the rate-setting team reviewed December 2020 prospective payments for January 2021 MCO services as reported on the MCO capitation file, where all rate cells appeared to have been implemented correctly. The team responded to questions sent to the Department from MCOs to confirm the accuracy of payments for their rate cells. In conjunction with Optumas, the team provided the Department with first round responses to CMS questions regarding the 2021 HealthChoice original certification. The team held a conference call on January 7 with CMS, the Department, and Optumas to discuss issues regarding the certification of CY 2021 Maryland Quality Innovation Program (M-QIP) payments.

The team also created, in conjunction with Optumas, two supporting exhibits in response to questions from CMS actuaries: a table illustrating how fiscal year rate factors from the HSCRC are combined into calendar year rates for MCO rate setting, and a table showing the distribution of M-QIP supplemental payments across all rate cells. On February 2, the team joined a conference call with the Department and CMS actuaries to discuss the exclusion of one MCO from the CY 2021 risk corridor. Lastly, the team met with Department staff on March 17 to discuss and answer questions on the High-Cost Low-Volume Drug Reporting Template that MCOs are required to submit quarterly.

CY 2020 and CY 2019 Rate-Setting

The rate-setting team calculated aggregate HealthChoice ACA health insurer fee settlements for CY 2020 and provided the Department with its budget impact. The team also determined the need for additional adjustments related to M-QIP, with the final settlements to be completed in April.

Additional Activities

The rate-setting team provided the Department with trauma calculations for December 2020, and January and February 2021. The team also coordinated bi-weekly meetings with the Department's Director and Deputy Director of Finance for Medicaid to provide updates on the status of rate setting activities and met weekly with Optumas staff to discuss the status of rate setting activities. On March 5 and 23 the team met with Department staff and Optumas to discuss results from an audit by the Office of Legislative Audits regarding MCO claims processing in 2018. On March 12, the team met with Department staff and members of the Maryland Insurance Administration (MIA) to discuss potential areas that MIA might support the Department in a consultative role for rate setting. The team also provided responses to questions sent by the MIA Chief Actuary following this discussion. On February 18, the team participated in a conference call held with the Department and representatives of the National PACE Association regarding PACE expansion. Lastly, the team provided the Department with additional recommendations to improve classifying PACE rates on the HMOCAP file in preparation for potential PACE expansion.

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).

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. The Help Line received 24,243 calls during the 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, or 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 pre-authorized, the call is classified as a complaint. Complaints are referred to the State's Complaint Resolution Unit (CRU), which is staffed with registered nurses. If necessary, the CRU engages a local Ombudsman, who is stationed at the county-level 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.

MCOs receive a complaint report each quarter so that they can monitor their performance in terms of the member complaint case handled by the HealthChoice Help Line. This report breaks down the complaints by type and by region. When needed, the Department meets with an MCO to discuss the report findings.

Table 8. Total Recipient Complaints (not including billing) - Quarter 3 FY 2021[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	
2nd Q of FY 21 & 3rd Q of FY 21		2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
Pharmacy	#	6	3	9	7	4	1	6	6	29	20	8	8	27	24	22	32	6	4	117	105
	%	5%	3%	8%	7%	3%	1%	5%	6%	25%	19%	7%	8%	23%	23%	19%	30%	5%	4%	19%	17%
Prenatal	#	13	2	14	9	0	1	11	9	13	5	4	8	13	15	8	10	1	5	77	64
	%	17%	3%	18%	14%	0%	2%	14%	14%	17%	8%	5%	13%	17%	23%	10%	16%	1%	8%	13%	10%
Specialist	#	19	26	21	29	2	3	13	15	21	29	21	17	18	22	25	26	13	10	153	177
	%	12%	15%	14%	16%	1%	2%	8%	8%	14%	16%	14%	10%	12%	12%	16%	15%	8%	6%	25%	28%
PCP	#	28	28	40	39	4	4	18	28	37	41	20	12	26	32	41	36	10	14	224	234
	%	13%	12%	18%	17%	2%	2%	8%	12%	17%	18%	9%	5%	12%	14%	18%	15%	4%	6%	37%	37%
Sub Totals	#	66	59	84	84	10	9	48	58	100	95	53	45	84	93	96	104	30	33	571	580
	%	12%	10%	15%	14%	2%	2%	8%	10%	18%	16%	9%	8%	15%	16%	17%	18%	5%	6%	94%	93%
All Complaint Totals	#	68	59	90	91	10	9	50	62	114	110	57	50	86	102	102	110	32	34	609	627
	%	11%	9%	15%	15%	2%	1%	8%	10%	19%	18%	9%	8%	14%	16%	17%	18%	5%	5%	100%	100%
Other Categories		2	0	6	7	0	0	2	4	14	15	4	5	2	9	6	6	2	1	38	47

University of Maryland Health Partners (UMHP) transitioned to CareFirst BlueCross BlueShield Community Health Plan of Maryland (CareFirst CHPMD) as of 2/1/2021

There were 685 total MCO recipient complaints in the quarter compared to 657 in the previous quarter (all ages). Ninety-two percent of the complaints (627) were related to access to care. The remaining 8 percent (58) were billing complaints. The top three member complaint categories were accessing specialists, primary care providers (PCPs) and pharmacy services. The categories not specified (Other Categories) for the non-billing complaints include appeals and grievances, access to therapies (occupational therapy-OT, physical therapy-PT, speech therapy-ST), adult dental and vision services, and obtaining DME/DMS (Durable Medical Equipment/Durable Medical Supplies). Overall, Maryland Physicians Care and UnitedHealthcare had the highest percentage of complaints (18 percent of all care-related complaints), which were mainly attributed to difficulty accessing pharmacy services.

[3] Sourced from CRM.

The number of prenatal care complaints slightly decreased from 77 to 64. Prenatal complaints comprised 10 percent of total complaints. All pregnant women were connected with an MCO network prenatal care provider and referred to Administrative Care Coordinators at the local health department for follow-up and education. In addition, 54 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 3 FY 2021[4]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)*		Sub Totals	
2nd Q of FY 21 & 3rd Q of FY 21		2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
Specialist	#	0	1	8	6	0	0	5	7	6	8	4	4	2	4	9	7	2	0	36	37
	%	0%	3%	22%	16%	0%	0%	14%	19%	17%	22%	11%	11%	6%	11%	25%	19%	6%	0%	27%	27%
PCP	#	9	6	12	11	1	1	8	9	11	12	7	2	6	14	9	7	5	3	68	65
	%	13%	9%	18%	17%	1%	2%	12%	14%	16%	18%	10%	3%	9%	22%	13%	11%	7%	5%	51%	47%
Pharmacy	#	0	1	0	2	0	0	1	0	5	2	1	2	4	5	4	5	0	1	15	18
	%	0%	6%	0%	11%	0%	0%	7%	0%	33%	11%	7%	11%	27%	28%	27%	28%	0%	6%	11%	13%
Prenatal	#	0	0	4	5	0	0	2	0	1	0	0	2	0	2	1	1	0	1	8	11
	%	0%	0%	0%	45%	0%	0%	0%	0%	0%	0%	0%	18%	0%	18%	0%	9%	0%	9%	6%	8%
Sub Totals	#	9	8	24	24	1	1	16	16	23	22	12	10	12	25	23	20	7	5	127	131
	%	7%	6%	19%	18%	1%	1%	13%	12%	18%	17%	9%	8%	9%	19%	18%	15%	6%	4%	95%	94%
All EPSDT Complaint Totals	#	9	8	24	25	1	1	17	18	26	23	13	11	12	27	23	21	8	5	133	139
	%	7%	6%	18%	18%	1%	1%	13%	13%	20%	17%	10%	8%	9%	19%	17%	15%	6%	4%	100%	100%
Other Categories		0	0	0	1	0	0	1	2	3	1	1	1	0	2	0	1	1	0	6	8

University of Maryland Health Partners (UMHP) transitioned to CareFirst BlueCross BlueShield Community Health Plan of Maryland (CareFirst CHPMD) as of 2/1/2021

There were 139 member complaints (non-billing) for recipients under age 21, or 20 percent of the total complaints (139 of 685). The top complaint category was access to primary care providers (PCPs). Priority Partners was a major contributor to the complaints for recipients under age 21.

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

[4] Source from CRM.

Table 10. Total Recipient Billing Complaints - Quarter 3 FY 2021[5]

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	
2nd Q of FY 21 & 3rd Q of FY 21		2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
PCP	#	1	2	2	2	0	1	4	1	3	11	0	2	1	2	1	1	0	0	12	22
	%	8%	9%	17%	9%	0%	5%	33%	5%	25%	50%	0%	9%	8%	9%	8%	5%	0%	0%	25%	38%
Emergency	#	3	0	2	5	0	0	3	2	4	1	1	0	2	1	0	1	2	1	17	11
	%	18%	0%	12%	45%	0%	0%	18%	18%	24%	9%	6%	0%	12%	9%	0%	9%	12%	9%	35%	19%
Laboratory /Test	#	0	1	0	0	0	0	0	1	3	4	1	0	1	0	1	1	0	0	6	7
	%	0%	14%	0%	0%	0%	0%	0%	14%	50%	57%	17%	0%	17%	0%	17%	14%	0%	0%	13%	12%
Specialist	#	0	0	0	0	0	0	0	3	1	2	1	2	3	0	2	1	0	1	7	9
	%	0%	0%	0%	0%	0%	0%	0%	33%	14%	22%	14%	22%	43%	0%	29%	11%	0%	11%	15%	16%
Sub Totals	#	4	3	4	7	0	1	7	7	11	18	3	4	7	3	4	4	2	2	42	49
	%	10%	6%	10%	14%	0%	2%	17%	14%	26%	37%	7%	8%	17%	6%	10%	8%	5%	4%	88%	84%
All Billing Complaint Totals	#	5	4	4	8	0	1	7	7	13	21	3	4	7	5	7	6	2	2	48	58
	%	10%	7%	8%	14%	0%	2%	15%	12%	27%	36%	6%	7%	15%	9%	15%	10%	4%	3%	100%	100%
Other Categories		1	1	0	1	0	0	0	0	2	3	0	0	0	2	3	2	0	0	6	9

University of Maryland Health Partners (UMHP) transitioned to CareFirst BlueCross BlueShield Community Health Plan of Maryland (CareFirst CHPMD) as of 2/1/2021

Enrollee billing complaints comprised 8 percent of total MCO complaints in the third quarter of FY 2021. Overall, the top bill type was Primary Care Providers (PCPs), which comprised 38 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. Maryland Physicians Care had the highest percentage of billing complaints.

MCOs are required to respond to all recipient grievances and complaints. The CRU works with MCOs on behalf of the consumer to resolve the complaint. Once a plan is in place, the CRU refers the case to the Administrative Care Coordination Unit (ACCU) 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.

[5] Source: CRM.

Legislative Update

The Maryland General Assembly convened its 2021 session on January 13, 2021. It is scheduled to adjourn on April 12, 2021. To date, the legislature has considered several bills that would affect Maryland's Medicaid program:

- **HB589** (Budget Reconciliation and Financing Act) transfers $100 million of premium tax liability assessment to Medicaid provider reimbursement.
- **HB34/SB278** (MSDE & MDH – School-Based Health Center Standards – Telehealth) requires MSDE & the Department to allow health care practitioners at school-based health centers to provide services through telehealth.
- **HB141/SB275** (MDH – Residential Service Agencies – Training Requirements) requires each RSA to ensure that direct care or supervisory staff are trained to provide the care required by clients, incl. 3 hours of on-line or in-person training regarding dementia.
- **HB318/SB441** (DDA – Self-Directed Services) requires Medicaid, in coordination with DDA & the State Advisory Council on Self–Directed Services to apply for a new 1915(c) HCBS waiver to cover delivery of self-directed services for both Medicaid and DDA enrollees.
- **HB434** (Public Health – Telehealth – Health Care Practitioners & the Md. Medical Assistance Program) requires Medicaid coverage for health care services appropriately delivered through telehealth, including services provided using an audio-only call; expands definition of 'telehealth' to include mental health & SUD services, and the use of audio-only calls.
- **HB513/SB695** (Md. Non-Emergency Medical Transportation Fund & Task Force to Study the Maryland Non-Emergency Medical Transportation Fund) establishes special, non-lapsing NEMT fund to offset the direct costs that qualified sub-recipients of grants incur to provide transportation for dialysis patients to and from treatment; requires kidney dialysis centers to pay the Department a $20 fee for each transport of a patient to a center for treatment.
- **HB534** (Public Health – Healthy Maryland Program – Establishment) establishes Healthy Maryland Program to provide comprehensive universal single-payer health care coverage for all State residents beginning Jan. 1, 2023; all Medicaid, MCHP, Medicare and ACA subsidy funds would be paid by the federal gov't into the Healthy Maryland Trust Fund to pay for coverage and eliminate cost-sharing, and all programs would be merged into Healthy Maryland.
- **HB547/SB485** (Md. Medical Assistance Program – Dental Prophylaxis Care & Oral Health Exams) effective Jan. 1, 2022, prohibits Medicaid from including a frequency limitation on dental prophylaxis care or oral health exams that requires them to be provided at an interval greater than 120 days within a plan year.
- **HB598/SB469** (Md. Medical Assistance Program – Applied Behavior Analysis Sciences – Reimbursement) prohibits Medicaid reimbursement of applied behavior analysis services provided to enrollees from requiring the presence or availability of the parent or caregiver of the enrollee in the setting where the services are provided.
- **HB602** (Md. Medical Assistance Program & MCOs that Use PBMs – Reimbursement Requirements) requires that Medicaid establish reimbursement levels, rather than maximum reimbursement levels, for drug products for which there is a generic equivalent; requires minimum reimbursement levels be at least equal to NADAC for

generic products, plus the FFS dispensing fee determined by the Department in accordance w/ most-recent in-State cost-of-dispensing survey.

- **HB786** (DHS, MDH & MSDE – Easing Access to Family Support Programs) requires DHS, the Department & MSDE to simplify the application process for family supports programs (incl. Medicaid & MCHP).
- **HB1107** (Md. Medical Assistance Program – Supplemental Rebate Program – Subscription Model for Hepatitis C Therapies) requires Dept. to apply to CMS by December 1, 2021 for a SPA that authorizes the State to enter into value-based arrangements w/ drug manufacturers through supplemental rebates and a subscription model for hepatitis C therapies regardless of disease severity or fibrosis level; to the extent practicable, the Department (in coordination w/ DPSCS & other relevant State agencies) shall develop a subscription model for hepatitis C therapies that covers all individuals served by a State program while preserving the ability to maximize the use of federal funds.
- **HB1233** (Correctional Services – Inmates – Intake & Release Requirements) requires Division of Correction, six months before the anticipated release of an inmate, to provide the appropriate forms to and work with an inmate to ensure Medical Assistance benefits.
- **SB3/HB123** (Preserve Telehealth Access Act of 2021) requires Medicaid to provide health care services delivered through telehealth regardless of the location of the enrollee at the time services are rendered, and to allow a distant-site provider to provide services to an enrollee from any location at which the services may be delivered through telehealth (the Department to obtain any federal authority necessary to implement these requirements).
- **SB14/HB742** (Compensation to Individual Erroneously Convicted, Sentenced & Confined (The Walter Lomax Act) authorizes ALJ to direct the appropriate State agency or service provider to provide the individual 'free of charge health care & dental care for at least five years after release from confinement.'
- **SB56/HB191** (Md. Medical Assistance Program – Psychiatrist & Psychiatric Nurse Practitioner Telemedicine Reimbursement – Sunset Termination) permanently authorizes reimbursement for psychiatrists & psychiatric nurse practitioners who provide assertive community treatment or mobile treatment services to enrollees in a home- or community-based setting through telemedicine.
- **SB163** (Md. Medical Assistance Program – Doula Pilot Program) establishes pilot program to provide doula services to enrollees in Baltimore City, Charles County & Prince George's County who are pregnant or postpartum from June 1, 2022 to May 31, 2025.
- **SB389/HB552** (Md. Medical Assistance Program – Emergency Service Transporters – Reimbursement) requires reimbursement for EMS transporters for the cost of transportation & medical services by $25 in each fiscal year (beginning in FY22) until reimbursement is at least $300.
- **SB393/HB551** (Md. Medical Assistance Program & Health Insurance – Coverage & Reimbursement of Telehealth Services) expands the definition of telehealth services to include audio-only conversations between a health care practitioner and patient, and remote patient monitoring; also requires store-and-forward communications to be treated as a telehealth encounter, and would require the Department to deliver services to Medicaid enrollees irrespective of their location.

- **SB465/HB710** (Md. Medical Assistance Program – Dental Providers & Dental Students – Reimbursement) requires Medicaid to reimburse a dental provider for services rendered by a student of dentistry who is in a program at a school of dentistry and is providing services under the supervision of a licensed dentist.
- **SB514/HB565** (Health Facilities – Hospitals – Medical Debt Protection) -requires hospitals to report to annually to HSCRC on the total # of patients who incur bad debt and the total dollar amount of costs of hospital services provided but not collected; a hospital's debt collection policy must provide a mechanism for a patient to modify the terms of their payment plan, and prohibit the hospital from collecting debt owed by a patient who is eligible for free or reduced-cost care and limits the amount of interest the hospital may charge on a bill; hospitals must offer an installment plan to patients who incur medical debt.
- **SB567/HB731** (Telehealth Services – Expansion) requires Medicaid coverage for telehealth services regardless of the patient's location and allow distant-site providers to provide services from any location (telehealth services to include audio-only conversations and remote patient monitoring); Dept. must apply to CMS for any waivers necessary to implement these requirements.
- **SB568/HB732** (Health Care Practitioners – Telehealth – Out-of-State Health Care Providers) authorizes an out-of-state health care practitioner to provide telehealth services to a patient located in the state.
- **SB614/HB709** (PBMs – Drug Reimbursement – Reporting Requirements) requires PBMs to file quarterly reports (beginning Jan. 1, 2022) w/ MIA on drugs appearing on the NADAC list that were reimbursed at an amount below the NADAC price plus the FFS dispensing fee.
- **SB615/HB819** (PBMs – Prohibited Actions) prohibits PBMs from engaging in any practice that bases reimbursement on patient outcomes, scores or metrics; prohibits engaging in spread-pricing; prohibits taking more than 30 days to review the application of a pharmacy or pharmacist to participate in a policy or contract.
- **SB865** (Md. Medical Assistance Program – Emergency Service Transporters – Reimbursement) requires reimbursement for EMS transporters for the cost of transportation & medical services regardless of whether the patient is taken to a facility.
- **SB923** (Md. Medical Assistance Program – Eligibility) requires Medicaid coverage of comprehensive medical & other health care services (incl. dental services) for pregnant enrollees for the duration of the pregnancy and for one year immediately following the end of the woman's pregnancy.
- **SB932** (Md. Medical Assistance Program – Coverage – Acupuncture Services) requires coverage for acupuncture services administered by licensed health care practitioners operating within their scope of practice.

Quality Assurance/Monitoring Activity

The Medical Benefits Management Administration (MBMA) is responsible for contracting and oversight of the HealthChoice program within the Department. 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 quality activities and monitoring CMS quality improvement requirements for the HealthChoice program.

The Department contracts with three vendors for its quality assurance activities:

- Qlarant Quality Solutions, Inc. (Qlarant) is the external quality review organization (EQRO) for the Department. Qlarant is responsible for performance improvement project validation; performance measure validation for the Value-Based Purchasing Initiative; compliance reviews to ensure MCOs comply with 42 CFR 438, Subpart D and 42 CFR 438.330; MCO network adequacy validation; encounter data validation; clinical quality studies focused on MCO appeals, grievances, and pre-service denials; and development of an annual consumer report card to assist HealthChoice enrollees with MCO selection.
- MetaStar, Inc. (MetaStar) is the HEDIS Compliance Auditor for the Department. MetaStar is responsible for ensuring compliance with the National Committee for Quality Assurance (NCQA) guidelines for reporting Healthcare Effectiveness Data and Information Set (HEDIS) measures, including onsite audits of MCO systems and processes to report data. MetaStar also reviews and approves the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey sample frame. At the end of the audit cycle, MetaStar compiles a comprehensive report with trending MCO performance on the HEDIS measures.
- Center for the Study of Services, Inc. (CSS) is the survey administration vendor for the Department. CSS administers the CAHPS surveys for adults and children, as well as the Primary Care Provider (PCP) Satisfaction Survey. CSS monitors compliance with survey protocols and compiles reporting on the results of both survey efforts.

Consistent with updates in earlier reports, the Department is actively making adjustments to reporting and record collecting due to COVID-19.

An update on quality assurance activity progress appears in the next chart.

Activity	Vendor	Status	Comments
Systems Performance Review (SPR)	Qlarant	In Progress	Qlarant submitted draft MCO Interim SPR reports to the Department for review and approval, along with CAP closure recommendations for ABH, CFCHP, KPMAS and PPMCO. Qlarant began drafting the CY 2020 Executive Summary Report and finalizing the individual MCO CY 2020 Interim SPR reports.
EPSDT Medical Record Review	Qlarant	In Progress	The Department gave approval for Qlarant to finalize the CY 2019 EPSDT Statewide Aggregate Report and it was posted to the MCO Resource portal. Qlarant, the Department, and Hilltop began and concluded discussions surrounding telehealth visits for the CY 2020 review period. The sample data request memo was approved by the Department for Qlarant to send to Hilltop. Medical record review request letters were also approved by the Department.
Consumer Report Card (CRC)	Qlarant	In Progress	Qlarant submitted the draft CY 2020 CRC analysis, along with the CY 2021 CRC proof, to the Department for review and approval. Qlarant posted the approved 2021 CRC to both the Department portal site and MCO Resource portal site, along with the blinded MCO CRC reports.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	The Department and Qlarant worked together to approve the quarterly LSC PIP reports in January 2021. In February 2021, the new template for both annual and quarterly reporting was approved for MCO use. Qlarant is currently developing a training session for the MCOs to help them utilize the new, approved templates slated for the end of April 2021.
Encounter Data Validation (EDV)	Qlarant	Complete	Qlarant finalized the CY 2019 EDV report and posted it to the MCO Resource portal in January 2021. Qlarant has now begun drafting the CY 2021 orientation manual, provider medical record request letter, and the sample data request for CY 2020 reviews. A summary of EDV results can be found below the chart.

Activity	Vendor	Status	Comments
Network Adequacy Validation (NAV)	Qlarant	Complete	Qlarant finalized the CY 2020 NAV report, with approval from the Department, to post on the MCO resource portal in January 2021. In March 2021, Qlarant requested provider data from MCOs, continued testing the survey tool, revised training materials for CY 2020 activities and received provider data and provider directory URLs from six MCOs (follow-up emails were sent to the three outstanding MCOs: ABH, ACC, and MSFC). A summary of NAV results can be found below the chart.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	Complete	Qlarant finalized the fourth quarter report for GAD. Highlights are listed below and the final report will be posted on the Department's website soon. The next quarterly reporting, Quarter 1, will be due on April 30, 2021 for review by Qlarant.
HEDIS Audits and Reporting (HEDIS)	MetaStar	In Progress	The HEDIS audit vendor provided verification to the Department that all of their auditors are currently certified with NCQA and all certification requirements are up to date. The HEDIS audit vendor also provided its NCQA Licensed Compliance Audit Organization seal for 2021. Hilltop (UMBC) provided the final CAHPS Sample frame, which was compiled by its NCQA-certified vendor, to the Department in January. The HEDIS audit vendor subsequently provided approval of the CAHPS Sample frame in late January. The HealthChoice MCO visits were completed by the HEDIS audit vendor virtually for HEDIS 2021 as of March 24. The HEDIS audit vendor presented at the March QALC meeting with a review of the audit and reporting timeline, discussion of the HEDIS Specification timeline changes instituted by NCQA, and a recap of the proposed changes for HEDIS measures effective beginning 2022.
Value Based Purchasing Initiative (VBP)	Qlarant	Complete	The Department reviewed and approved the CY 2019 VBP report in January 2021. Qlarant posted the final VBP report on the MCO Resource portal. A summary of VBP results can be found below the chart.

Activity	Vendor	Status	Comments
CAHPS Survey Administration (CAHPS)	CSS	In Progress	In January, approved sample frame files were uploaded to the vendor's secure file exchange portal for use with the 2021 survey administration. The Department reviewed and approved questionnaires and all collateral materials, which were subsequently submitted by the survey vendor to NCQA and approved by the end of January. The vendor completed survey administration activities throughout February that included checking the sample frame and pulling sample files, printing survey and collateral materials, outbound mail processing, and the mailing of the first survey questionnaires. In March, on-going processing of completed returned questionnaires continued, and second questionnaires and reminder postcards were mailed. The response rates for the survey are updated weekly.
PCP Satisfaction Survey Administration	CSS	In Progress	In January, the survey questionnaire was updated by the vendor to add questions related to telehealth as a result of the Covid-19 pandemic. The Department notified the survey vendor of the approval of the questionnaire and collateral materials for the 2021 Survey administration in late January. Two waves of fax outreach will replace the wave one survey mailing for 2021. The 2020 PCP Executive Summary Report was reviewed and approved by the Department in January and also posted on the Department website. The first survey questionnaires for the 2021 survey administration were mailed out in mid-February, and survey fielding continued through March.
Annual Technical Report (ATR)	Qlarant	In Progress	In March 2021, Qlarant submitted the draft CY 2020 ATR to the Department for review. Also in March, CMS sent over findings of previous ATR submissions. Both the Department and Qlarant are working with CMS to resolve those findings.

Completed Activity Highlights

- **Encounter Data Validation (EDV)**
    - Minimum compliance indicators for the Encounter Data Validation were set at 90 percent for the medical record review activity, with all nine MCOs achieving or exceeding this goal for CY 2019.
- **Network Adequacy Validation (NAV)**
    - The activity assessed quality, timeliness, and the accessibility of providers and provider directory compliance for calendar year 2020, with the compliance threshold set to 80 percent. Three MCOs (ABH, KPMAS and PPMCO) were required to submit a CAP to improve compliance with online provider directory accuracy and are required to submit those CAPs quarterly to Qlarant.
- **Value Based Purchasing (VBP)**
    - In CY 2019, there were nine measures that were evaluated among the nine MCOs. Three MCOs (JMS, KPMAS, and UMHP) earned net incentives while the remaining six (ABH, ACC, MPC, MSFC, PPMCO, and UHC) incurred net disincentives.
- **Focused Reviews of Grievances, Appeals, and Denials (GAD)**
    - The fourth quarter of GAD was completed in February 2021.
    - Grievances Highlights
        - All MCOs met the TAT for member grievances except ABH, who fell just shy at 78 percent.
        - TAT compliance for provider grievances were met by ACC, CFCHP, JMS, MSFC and PPMCO, while ABH and UHC were unmet (KPMAS and MPC were not applicable).
    - Appeals Highlights
        - The following MCOs scored below the 100 percent threshold for compliance with appeal timeframes in at least one category: ABH (50 percent/65 percent), ACC (99 percent), and PPMCO (88 percent). These are the same MCOs that were not compliant in the prior two quarters. The Department is continuing to monitor the listed MCOs above repeated performance scores.
    - Denial Highlights
        - ABH and PPMCO did not consistently meet the determination TAT, ABH (74 percent) and PPMCO (89 percent, 73 percent). PPMCO did not consistently meet the notification timeframe (85 percent/73 percent).
        - UHC continues to be the major outlier in the reported number of PA requests submitted with complete information, 73 percent, and has the lowest approval rate at 64 percent.
- **HEDIS Audits and Reporting**
    - Results from HEDIS Year 2020 show that Maryland HealthChoice MCOs are high performing across the majority of measures and within each measure domain. There were 27 measures/measure indicators where ACC, JMS, KPMAS, MSFC, MPC, PPMCO, UHC, and UMHP performed above the National HEDIS Mean. There were 27 measures/measure indicators where all of the MCOs, with the exception of ABH, performed above the National HEDIS mean. ACC, JMS,

KPMAS, and MSFC met and exceeded performance expectations under the MCO Performance Monitoring Policy, which require plans to perform at or above the national average for at least 70 percent of reportable performance measures. However, opportunities for improvement continue to exist for ABH, CFCHP, MPC, PPMCO and UHC to maintain or achieve scores above the National HEDIS Mean.

- **CAHPS Survey Administration**
    - Results from the CAHPS Adult survey showed overall the HealthChoice Aggregate performed on par with the 2019 levels across the measure spectrum, with no statistically significant improvements or declines in scores.
    - Individual Plan Performance gains largely outnumbered losses across the entire array of MCOs and measures. A few of the gains reached statistical significance, and a larger number of them have held steady over the past two years.
    - Results from the CAHPS Child survey showed overall that the HealthChoice Aggregate performed in the middle-to-top third of the 2019 NCQA Quality Compass Child Medicaid National distribution on most survey measures. A notable exception measure was the *Rating of Health Plan*, which has declined slightly over the past two years, placing the HealthChoice Aggregate in the bottom third of the distribution. Among the surveyed MCOs, none placed in the top third of the Quality Compass distribution on *Rating of Health Plan*, and none improved significantly compared the prior years.
- **Primary Care Provider Survey Administration**
    - Results from the Primary Care Provider survey showed that overall satisfaction among Providers with their MCO declined slightly for 2020 when compared to the 2019 results. Satisfaction with Claims and Customer Service/Provider Relations was up among Providers during the survey period. The loyalty analysis of the survey showed that loyalty to their MCO among Physicians increased, while the number of Physicians indicating indifference or not loyal reflected a decrease.

Demonstration Evaluation

During the quarter, the Department collaborated with its independent evaluator, the Hilltop Institute, to continue working on the CY 2021 evaluation, which will cover from CY 2015 through CY 2019. The Department expects to have a draft to review in May 2021. Highlights from the evaluation will be included in the 2021 HealthChoice Post-Award Forum, which is scheduled for May 28, 2021.

The Department has been in ongoing conversations with CMS about the 1115 evaluation design and the SUD monitoring protocol. The Department and CMS collaborated on updating the materials. The 1115 evaluation design has been accepted and the Department is working on implementing it. The Department is reviewing the latest changes to the SUD monitoring protocol.

The Department has begun writing the latest renewal package for the 1115 waiver. The Department plans to submit the renewal packet to CMS prior to July 1, 2021, which will include a pre-final draft of the 2021 HealthChoice Evaluation.

Enclosures/Attachments

- Appendix A: Maryland Budget Neutrality Report as of March 31, 2021

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