Maryland HealthChoice Demonstration
Section §1115 Quarterly Report
Demonstration Year 24
7/1/2020 - 6/30/2021
Quarter 1 Report
7/1/2020 - 9/30/2020

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 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. Since the declaration of the Public Health Emergency (PHE) and the introduction of Maintenance of Effort (MOE) Requirements, the Department has seen increased enrollment throughout its population.

Table 1. Enrollment Counts

Demonstration Populations	Participants as of June 30, 2020	Participants as of September 30, 2020
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	245,949	254,361
Affordable Care Act (ACA) Expansion Adults	334,226	347,788
Medicaid Children	468,135	484,982
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	90,783	90,726
SSI/BD Children	23,688	24,358
Medically-Needy Adults	23,479	22,998
Medically-Needy Children	6,557	6,599
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	12,142	13,076
Maryland Children's Health Program (MCHP) [1]	107,293	107,966
MCHP Premium	34,945	35,054
Presumptively Eligible Pregnant Women (PEPW)	0	0
Family Planning	12,207	13,012
Increased Community Services (ICS)	29	27
Women's Breast and Cervical Cancer Health Program (WBCCHP)	66	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 June 2020)	Current Quarter Month 1 (July 2020)	Current Quarter Month 2 (Aug. 2020)	Current Quarter Month 3 (Sept. 2020)	Total for Quarter Ending Sept. 2020
Parent/Caretaker Relatives <116% FPL and Former Foster Care	732,199	249,202	251,045	254,361	754,608

[1] A change was made to the Medicaid eligibility system in February 2019 to automatically grant Transitional Medicaid Assistance (TMA) coverage for certain low-income participants who lose eligibility for several reasons, such as an increase in earned income or hours of employment. Because of this, some children that were enrolled in CHIP are now enrolled under MAGI.

Eligibility Group	Total for Previous Quarter (ending June 2020)	Current Quarter Month 1 (July 2020)	Current Quarter Month 2 (Aug. 2020)	Current Quarter Month 3 (Sept. 2020)	Total for Quarter Ending Sept. 2020
ACA Expansion Adults	985,099	338,840	342,288	347,788	1,028,916
Medicaid Children	1,383,485	474,826	480,320	484,982	1,440,128
SSI/BD Adults	272,244	90,721	90,573	90,726	272,020
SSI/BD Children	70,216	23,937	24,123	24,358	72,418
Medically-Needy Adults	71,759	22,919	22,738	22,998	68,655
Medically-Needy Children	19,662	6,527	6,560	6,599	19,686
SOBRA Adults[1]	34,562	12,477	12,763	13,076	38,316
MCHP	319,531	107,708	107,965	107,966	323,639
MCHP Premium	105,182	35,014	34,704	35,054	104,772
PEPW	0	0	0	0	0
Family Planning	37,130	12,028	13,009	13,012	38,049
WBCCHP	89	27	27	27	81
ICS	200	65	65	65	195

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. Due to delays in the implementation of a new claims-submission system under the new behavioral health administrative services organization (BH ASO), the Department is unable to provide data for this quarter. The Department will submit updated quarterly data once it is available.

Maternal Opioid Misuse (MOM) Model

The Department launched its Maternal Opioid Misuse (MOM) model program 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 (July 2021 - June 2022), which is the first year of model services. During this quarter, the Maryland MOM team continued activities aimed at building the foundations for the pre-implementation year, including: 1) development of a coverage and payment strategy, including consultations with CMS; 2) briefing internal and external stakeholders on the model; and 3) leading the quarterly, webinar-based design collaboratives with Medicaid MCOs to design key areas of model implementation. The third design collaborative, held on September 14, 2020, focused on staffing models and case management requirements and was capped off by a panel representing MCOs and local health departments.

Collaborative Care Model (CoCM) Pilot Program

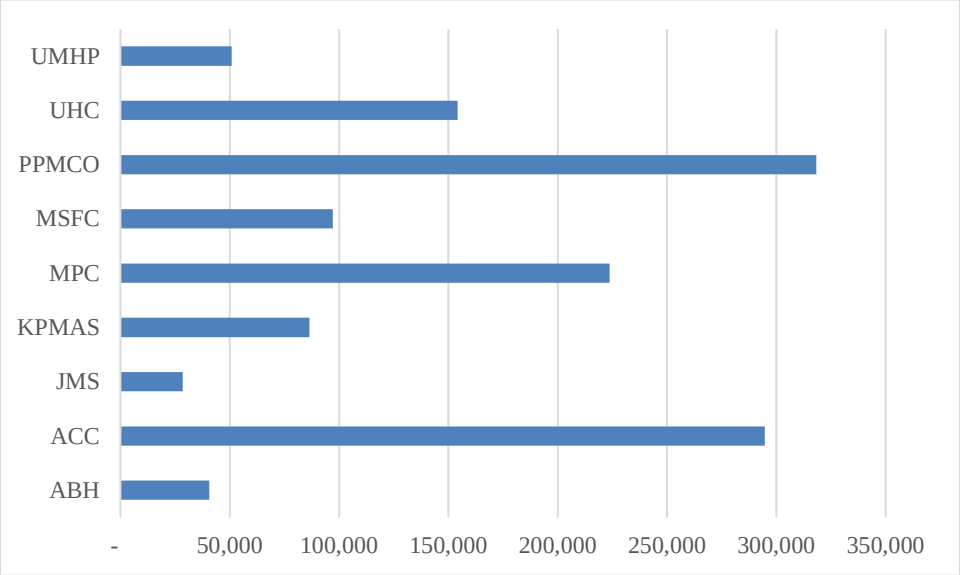
The Department began enrolling participants in its Collaborative Care Model (CoCM) Pilot Program on July 1, 2020 in collaboration with its selected vendor, who operates the pilot at three different sites. As of the end of September 2020, the CoCM Pilot Program was delivering services to 92 participants.

Operational/Policy Developments/Issues

Market Share

As of the end of the quarter, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (3.1 percent), Amerigroup (22.8 percent); Jai Medical Systems (2.2 percent); Kaiser Permanente (6.7 percent); Maryland Physicians Care (17.3 percent); MedStar Family Choice (7.5 percent); Priority Partners (24.6 percent); University of Maryland Health Partners (3.9 percent); and United Healthcare (11.9 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in July and September during the past quarter, there was no August meeting. 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.

During the July meeting, the MMAC received an update on the Maryland Health Benefit Exchange's (MHBE) two special enrollment periods, the COVID-19 special enrollment period and the Maryland Easy Enrollment Health Insurance Program, which utilizes tax return information to determine whether a person may or may not be eligible for coverage. The MMAC learned about a telehealth survey of behavioral health providers conducted by the Behavioral Health Administration (BHA). The Department also gave the MMAC an update on promoting COVID-19 testing among Medicaid participants.

During the September meeting, the MMAC learned about the new Family Planning Presumptive Eligibility (FPE) Program, which will give temporary short-term coverage of family planning services at participating clinics. The MMAC also received a public health update on flu vaccination.

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 fiscal year was 13,012 participants, with an average monthly enrollment of 12,683, an increase of 1.1 percent over the previous quarter.

Table 3. Average Quarterly Family Planning Enrollment

Q1 Enrollment	Percent Change	*Q2 Enrollment*	*Percent Change*	*Q3 Enrollment*	*Percent Change*	*Q4 Enrollment*	*Percent Change*
12,683	1.1%						

Rare and Expensive Case Management (REM) Program

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

Table 4. Current REM Program Enrollment

FY 2021	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	179	149	34	97	4,334
Quarter 2					
Quarter 3					
Quarter 4					

Table 5. REM Complaints

FY 2021 Q1	Transportation	Dental	DMS/ DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	1	0	0
REM Hotline	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	1	0	0

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

Table 6. REM Significant Events Reported by Case Managers

FY 2021 Q1	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	1	2	0	37	9	0	8	57

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 September 30, 2020, 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 September 30, 2020, the Premium program had 35,054 participants, with MCHP at 107,966 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 2: Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program (Coverage 2.0-Part 2) 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 initial year of Coverage 2.0 capacity-

building grant. As part of its Coverage 2.0-Part 2 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. The Department is working with their internal communication's team to develop a marketing guide and plan to be rolled out this fall.

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.

CDC-recognized lifestyle change programs with pending, preliminary or full recognition status continued to apply to be Maryland Medicaid DPP providers through the online provider portal known as ePREP. As of the end of the quarter, eighteen DPP providers were fully-enrolled, and several more were in the review process. MCOs continued efforts to contract with eligible DPP providers and prepare member and provider materials. The Department developed a supplemental guidance document that shares best practices and assists CDC-recognized lifestyle change programs with the DPP provider enrollment process. The Department held a webinar to review this guidance in April and provided HealthChoice DPP updates on the quarterly Maryland DPP network webinar.

Community Health Pilots

As of September 2020, six local government entities participate in the Community Health Pilots (CHP). Four Lead Entities (LE) 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.

In Quarter 1, CHP LEs continued telephonic service delivery due to COVID-19. For ACIS Pilots, this included allowing service provision via telecommunications methods. For HVS Pilots, the Department recommended LEs follow the Healthy Families America model guidance, which included allowing service provision via telecommunication methods.

The two HVS Pilot LEs have enrolled a total of 46 families through September 2020. Both Lead Entities (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. In the next quarter, LEs plan to provide virtual networking opportunities for families and continue supporting staff with skills to improve health outcomes for at-risk expectant families and their young children.

As of September 2020, approximately 302 participants are enrolled in the ACIS Pilot and receiving supportive housing services, representing 50 percent of the pilot's statewide total enrollment cap. LEs continue to improve processes related to pilot enrollment, such as Medicaid eligibility verification and best practices for working with ACIS-enrolled participants. In the next quarter, LEs plan to continue partnering with local organizations to assess the availability of housing placements for ACIS participants and reduce participant's barriers to housing placement.

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.

The Department continues to provide technical assistance and guidance to ACIS LEs as they deliver services under the national Public Health Emergency. A virtual Learning Collaborative will be held remotely during the next quarter. This meeting will focus on best practices employed by ACIS LEs for telephonic service delivery.

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 2019 HFMR reports (reported as of March 31, 2020) 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 2021 rate setting development.

During this quarter, MCOs were requested to prepare 2020 and 2021 financial projections based on all known rate and State budget activities as of September 2020 using provided financial templates. As of September 30, 2020, all MCO projections were received. In September, MCOs were provided with updated HFMR templates and revised instructions in preparation of the MCO's November submissions.

During the next quarter, MCOs will restate their 2019 Date of Service experience as of September 30, 2020. The final 2019 submissions will most likely be the base period for the 2022 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, 2020. 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 2022 Rate-Setting

For the CY 2022 rate-setting period, the team prepared and provided new instructions and templates for the final service year 2019 HealthChoice MCO financial submissions (base period for CY 2022).

CY 2021 Rate-Setting

The rate-setting team participated in multiple meetings, including a preparation meeting with the Department, conference calls with the MCOs, one on one calls with the Department and each MCO, and a call with the MCOs, the Department, and the Department's contracted actuarial firm regarding the analysis required to quantify PBM spread adjustment into rates. The rate setting team also co-facilitated two 2021 rate setting meetings. Topic included review of 2021 issues, preliminary 2021 MCO risk scores for HIV/AIDS and geographic/demographic rates, final constant cohort analysis, and 2018 Hepatitis C and HIV/AIDS relative weights, review of 2021 rate impact and assumptions used, 2021 FQHC market rate, 2021 incentives, and a presentation from the actuarial firm.

The rate-setting team prepared a number of analyses for stakeholders for CY 202 rate-setting. They provided the actuarial firm with final CY 2021 member month projections, E&M fee adjustments, and FQHC base adjustments. The rate setting team provided the MCOs with 2019 annual Risk Adjusted Capital (RAC) assignments for 2021 payments. The team also provided the Department with the Department with GME pool estimates through fiscal year 2022 as well as various rate and budget analyses in support of Department of Budget and Management (DBM) requests. The rate-setting team also provided draft 2021 rates to the Department.

In conjunction with the Department, the rate-setting team assisted in developing the 2021 rate presentation to the Maryland Budget Secretary. The rate setting team also worked with the actuarial firm to answer questions and provide 2021 MCO reporting template for determining Hepatitis C prescription settlement calculations.

CY 2020 and CY 2019 Rate-Setting

In support of the CY 2020 and prior rates, the rate-setting team participated in multiple conference calls with the MCOs, the Department, and the actuarial firm to discuss multiple topics, including a global risk corridor proposal, COVID-19 over and under charging, and financial impact of mid-year 2019 rates. The rate-setting team provided the Department with mid-year rate tables. In conjunction with the Department's legal team, the actuarial firm on behalf of the rate setting team co-wrote 2020 MCO contract language to incorporate an agreed to global risk corridor amendment. The actuarial firm also provided the Department with both the CMS and MCO versions of the 2020 Mid-Year HealthChoice certification letters on behalf of the rate-setting team. The rate-setting team provided the Department with initial 2020 mid-year payment adjustments for January 1, 2020 through September 30, 2020. They also provided the MCOs with 2020 mid-year rate sheets.

Additional Activities

The rate-setting team provided the Department with trauma calculations for June, July, and August 2020. The team also provided the Department with cost projections for Employed Individuals with Disabilities Program through fiscal year 2023 and 2018 Provider Sponsored Organization (PSO) analysis including observations. The rate setting team prepared for the Department CY 2021 PACE rates including the 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). The current budget neutrality report can be found in Appendix A.

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. The Help Line received 21,562 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 7. Total Recipient Complaints (not including billing) - Quarter 1 FY 2021[2]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
4th Q of FY 20 vs 1st Q of FY 21		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Pharmacy	#	0	0	28	15	6	4	5	9	38	39	10	14	44	28	35	37	14	6	180	152
	%	0%	0%	16%	10%	3%	3%	3%	6%	21%	26%	6%	9%	24%	18%	19%	24%	8%	4%	23%	19%
Prenatal	#	19	7	22	13	6	3	23	15	28	5	16	6	41	12	30	11	7	2	192	74
	%	10%	9%	11%	18%	3%	4%	12%	20%	15%	7%	8%	8%	21%	16%	16%	15%	4%	3%	24%	9%
Specialist	#	33	36	26	48	8	5	21	22	44	38	10	15	14	34	18	49	18	25	192	272
	%	17%	13%	14%	18%	4%	2%	11%	8%	23%	14%	5%	6%	7%	13%	9%	18%	9%	9%	24%	33%
PCP	#	43	32	27	51	5	3	9	14	18	37	11	22	16	29	23	38	8	11	160	237
	%	27%	14%	17%	22%	3%	1%	6%	6%	11%	16%	7%	9%	10%	12%	14%	16%	5%	5%	20%	29%
Sub Totals	#	95	75	103	127	25	15	58	60	128	119	47	57	115	103	106	135	47	44	724	735
	%	13%	10%	14%	17%	3%	2%	8%	8%	18%	16%	6%	8%	16%	14%	15%	18%	6%	6%	91%	90%
All Complaint Totals	#	100	75	127	135	25	15	58	63	153	153	49	68	125	112	113	145	48	47	798	813
	%	13%	9%	16%	17%	3%	2%	7%	8%	19%	19%	6%	8%	16%	14%	14%	18%	6%	6%	100%	100%
Other Categories		5	0	24	8	0	0	0	3	25	34	2	11	10	9	7	10	1	3	74	78

There were 886 total MCO recipient complaints in the quarter compared to 1,112 in the previous quarter (all ages). Ninety-two percent of the complaints (813) were related to access to care. The remaining 8 percent (73) 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 had the highest percentage of complaints (19 percent of all care-related complaints), which were mainly attributed to difficulty accessing pharmacy services, primary care providers, and specialists.

[2] Sourced from CRM.

The number of prenatal care complaints decreased from 192 to 74. Prenatal complaints comprised nine percent of total complaints. All pregnant women were connected with an MCO network prenatal care provider and referred to Administrative Care Coordination Units (ACCUs) at the local health department for follow-up and education. In addition, 92 pregnant women called the Help Line for general information. These women were also referred for follow-up and education.

Table 8. Recipient Complaints under age 21 (not including billing) - Quarter 1 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	
4th Q of FY 20 vs 1st Q of FY 21		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Specialist	#	10	7	5	7	0	2	4	7	11	7	1	0	3	4	2	9	4	5	40	48
	%	25%	15%	13%	15%	0%	4%	10%	15%	28%	15%	3%	0%	8%	8%	5%	19%	10%	10%	22%	28%
PCP	#	17	14	12	16	1	2	5	7	7	15	6	5	11	12	8	11	3	5	70	87
	%	24%	16%	17%	18%	1%	2%	7%	8%	10%	17%	9%	6%	16%	14%	11%	13%	4%	6%	38%	51%
Pharmacy	#	0	0	4	4	1	0	1	0	6	9	4	2	10	4	6	2	2	0	34	21
	%	0%	0%	12%	19%	3%	0%	3%	0%	18%	43%	12%	10%	29%	19%	18%	10%	6%	0%	18%	12%
Prenatal	#	2	1	3	0	1	0	0	0	4	0	1	1	5	1	3	2	0	0	19	5
	%	11%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	20%	0%	20%	0%	40%	0%	0%	10%	3%
Sub Totals	#	29	22	24	27	3	4	10	14	28	31	12	8	29	21	19	24	9	10	163	161
	%	18%	14%	15%	17%	2%	2%	6%	9%	17%	19%	7%	5%	18%	13%	12%	15%	6%	6%	89%	95%
All EPSDT Complaint Totals	#	30	22	30	28	3	4	10	14	34	33	12	9	34	23	21	26	10	11	184	170
	%	16%	13%	16%	16%	2%	2%	5%	8%	18%	19%	7%	5%	18%	14%	11%	15%	5%	6%	100%	100%
Other Categories		1	0	6	1	0	0	0	0	6	2	0	1	5	2	2	2	1	1	21	9

There were 170 member complaints (non-billing) for recipients under age 21, or 19 percent of the total complaints (170 of 886). The top complaint category was access to primary care providers (PCPs). Maryland Physicians Care 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 while children (under 21) most often report difficulty accessing a primary care provider.

[3] Source from CRM.

Table 9. Total Recipient Billing Complaints - Quarter 1 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	
4th Q of FY 20 vs 1st Q of FY 21		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
PCP	#	4	3	19	7	0	0	8	0	17	2	6	0	10	3	6	2	1	0	71	17
	%	6%	18%	27%	41%	0%	0%	11%	0%	24%	12%	8%	0%	14%	18%	8%	12%	1%	0%	23%	23%
Emergency	#	3	2	29	2	1	0	9	5	29	1	9	1	19	5	7	3	1	0	107	19
	%	3%	11%	27%	11%	1%	0%	8%	26%	27%	5%	8%	5%	18%	26%	7%	16%	1%	0%	34%	26%
Laboratory /Test	#	6	1	4	1	0	0	5	0	4	1	5	0	5	4	11	2	2	1	42	10
	%	14%	10%	10%	10%	0%	0%	12%	0%	10%	10%	12%	0%	12%	40%	26%	20%	5%	10%	13%	14%
Specialist	#	2	4	9	2	0	1	1	1	7	2	4	0	3	4	4	2	0	0	30	16
	%	7%	25%	30%	13%	0%	6%	3%	6%	23%	13%	13%	0%	10%	25%	13%	13%	0%	0%	10%	22%
Sub Totals	#	15	10	61	12	1	1	23	6	57	6	24	1	37	16	28	9	4	1	250	62
	%	6%	16%	24%	19%	0%	2%	9%	10%	23%	10%	10%	2%	15%	26%	11%	15%	2%	2%	80%	85%
All Billing Complaint Totals	#	17	10	78	13	1	1	31	6	69	11	28	1	49	21	33	9	8	1	314	73
	%	5%	14%	25%	18%	0%	1%	10%	8%	22%	15%	9%	1%	16%	29%	11%	12%	3%	1%	100%	100%
Other Categories		2	0	17	1	0	0	8	0	12	5	4	0	12	5	5	0	4	0	64	11

Enrollee billing complaints comprised eight percent of total MCO complaints in the first quarter of FY 2021. Overall, the top bill type was Emergency Department, which comprised 26 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. Priority Partners 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 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.

Legislative Update

Originally scheduled to adjourn on April 6, the legislative session adjourned sine die on March 18, 2020 due to the COVID-19 outbreak. The next legislative session is scheduled to begin on January 13, 2021.

[4] Source: CRM.

Quality Assurance/Monitoring Activity

The Department's Medical Benefits Management Administration (MBMA) is responsible for contracting 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 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 Department's external quality review organization (EQRO). 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 Department's HEDIS Compliance Auditor. 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 Department's survey administration vendor. 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 is in the validation phase of the SPR tool for CY 2020. Quarterly CAPS from CY 2019 are due for submission by the MCOs on October 28, 2020
EPSDT Medical Record Review	Qlarant	In Progress	Qlarant began reaching out to providers for the records back in May 2020 with a due date of August 1, 2020 for the providers. The minimum sample for records was achieved with the desktop medical review still underway. Qlarant will continue to evaluate the records from each of the MCOs and submit a preliminary findings report to the Department by November 13, 2020.
Consumer Report Card	Qlarant	In Progress	Qlarant is currently analyzing the HEDIS and CAHPS data that was received in September 2020. The IRS and Methodology will be finalized by Qlarant in early November 2020.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	The Department submitted feedback to Qlarant in October 2020 on the templates that will be utilized for the Annual PIP Validation Report. The AMR PIP will be due from the MCOs on October 23, 2020 and the Lead Screening PIP will be due on November 6, 2020.
Encounter Data Validation (EDV)	Qlarant	In Progress	The Department began discussion in October 2020 on upcoming EDV activities. Qlarant and Hilltop have both begun their respective processes on this particular activity.
Network Adequacy Validation (NAV)	Qlarant	In Progress	The Department and Qlarant worked collaboratively to make adjustments to the NAV Survey Tool in August 2020. Qlarant began the survey calls on September 1, 2020 and will end on October 30, 2020.

Activity	Vendor	Status	Comments
Quarterly Review of Appeals, Grievances, and Pre-Service Denials	Qlarant	Complete	Qlarant finalized the second 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 will be due on October 30, 2020 for review by Qlarant.
HEDIS Audits and Reporting (HEDIS)	MetaStar	Complete	MetaStar provided Final Audit Reports to HealthChoice organizations and the Department in mid-July. MetaStar also provided the National HEDIS Mean (NHM) and Maryland Average Reportable Rate (MARR) report and the consolidated csv files highlighting Value Based Purchasing measures to the Department in late July. Final reports provided by MetaStar including the Statewide Analysis Report, the Executive Summary Report and the Consolidated Final Audit Report were approved by the Department by early September. MetaStar presented at the September QALC meeting reporting on HEDIS 2021 specifications and general guidelines, audit timeline, the Department required measure set, and highlights from the HEDIS 2020 Statewide Analysis Report.
Value Based Purchasing Initiative (VBPI)	Qlarant	In Progress	The Department received HEDIS results in September 2020 and have completed analysis of the results. The Department is currently developing the VBP Letters to send to the MCOs. Qlarant is in the development phase of the CY 2019 report and will complete it once MCOs have been notified of their results in October 2020.
CAHPS Survey Administration (CAHPS)	CSS	In Progress	Center for the Study of Services (CSS) provided eReports for each HealthChoice MCO that included highlighted results of statistically significant differences on reportable measures from the surveys, when compared to the prior year results and when compared to national benchmarks.

Activity	Vendor	Status	Comments
			The Department reviewed, edited, and approved final reports including Adult and Child Aggregate CAHPS reports and Individual HealthChoice organizations Adult and Child CAHPS reports and by the end of September. The Adult and Child CAHPS Executive Summary was pending final review and editing at the close of September. CSS presented at the September QALC Meeting highlighting the results of the 2020 CAHPS survey.
PCP Satisfaction Survey Administration	CSS	In Progress	Fielding of the PCP satisfaction survey continued in July and August with the processing of incoming mail and fax surveys and a second wave of survey outreach, including mailed surveys and telephone interviews. Highlight reports were available in September reflecting preliminary key survey results with the final report available next quarter.
Annual Technical Report (ATR)	Qlarant	In Progress	Qlarant and the Department met in August 2020 to discuss updating the draft template for the ATR per the guidance issued from CMS. Qlarant is currently developing a template for the Annual Technical Report for the upcoming measurement year.

Completed Activity Highlights

- Focused Reviews of Grievances, Appeals, and Denials (GAD)
    - The second quarter of GAD was completed in August 2020.
    - Grievances Highlights
        - ABH, ACC, JAI, MSFC, MPC, UHC and UMHP all met the turnaround timeframe for member grievances. KPMAS did not meet the turnaround timeframe for non-emergent, medically related grievances and PPMCO did not meet timeframes in any category with results ranging from 45 percent to 52 percent.
    - Appeals Highlights
        - The following MCOs scored below the 100 percent threshold for compliance with appeal time frames in at least one category: ABH (77 percent), ACC (78/88 percent), and PPMCO (87/92 percent)
    - Denial Highlights
        - All nine MCOs met or exceeded the compliance threshold for prescriber notification within 24 hours of the request.
        - ABH, ACC, JAI, KPMAS, MPC, UHC, and UMPH all met the turnaround timeframe for all applicable notification categories, while MSFC (0 percent) and PPMCO (38 percent) scored below the 95 percent threshold for compliance.
    - Plans scoring below the minimum compliance score for these areas are subject to corrective action through the Systems Performance Review. If non-compliance continues for consecutive years, intermediate sanctions may apply under the Department's Performance Monitoring Policies.
- HEDIS
    - Results from HEDIS 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 at least eight out of the nine MCOs performed above the National HEDIS Mean.
    - According to the Department's HEDIS Performance Monitoring Policies, intermediate sanctions may be assessed if plans report 30 percent or more HEDIS elements with scores below the National Medicaid HEDIS Mean for multiple years within a five-year period. For HEDIS 2020, ABH, MPC, PPMCO, UHC, and UMHP fell into this category.
    - ACC, JMS, KPMAS, and MSFC all reported over 70% of their HEDIS scores above the National Medicaid HEDIS Mean.

Demonstration Evaluation

During the quarter, the Department collaborated with its independent evaluator, the Hilltop Institute, to begin planning for the CY 2021 evaluation, which will cover from CY 2015 through CY 2019.

Enclosures/Attachments

- Appendix A: Maryland Budget Neutrality Report as of September 30, 2020

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