Maryland HealthChoice Demonstration
Section §1115 Quarterly Report
Demonstration Year 24
7/1/2020 - 6/30/2021
Quarter 2 Report
10/1/2020 - 12/31/2020

Introduction

Now in its twenty-fourth year, Maryland's HealthChoice program moved Maryland Medicaid's 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. The CoCM Pilot Program will serve a limited number of HealthChoice beneficiaries with 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 September 30, 2020	Participants as of December 31, 2020
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	254,361	263,202
Affordable Care Act (ACA) Expansion Adults	347,788	366,815
Medicaid Children	484,982	498,183
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	90,726	91,989
SSI/BD Children	24,358	23,828
Medically-Needy Adults	22,998	22,858
Medically-Needy Children	6,599	6,443
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	13,076	14,086
Maryland Children's Health Program (MCHP)	107,966	108,603
MCHP Premium	35,054	35,119
Presumptively Eligible Pregnant Women (PEPW)	0	0
Family Planning	13,012	13,341
Increased Community Services (ICS)	27	26
Women's Breast and Cervical Cancer Health Program (WBCCHP)	66	64

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

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

Table 2. Member Months

Eligibility Group	Total for Previous Quarter (ending Sept. 2020)	Current Quarter Month 1 (Oct. 2020)	Current Quarter Month 2 (Nov. 2020)	Current Quarter Month 3 (Dec. 2020)	Total for Quarter Ending Dec. 2020
Parent/Caretaker Relatives <116% FPL and Former Foster Care	754,608	256,896	259,204	263,202	779,302
ACA Expansion Adults	1,028,916	352,398	357,898	366,815	1,077,111
Medicaid Children	1,440,128	489,371	492,140	498,183	1,479,694
SSI/BD Adults	272,020	91,754	91,884	91,989	275,627
SSI/BD Children	72,418	23,706	23,809	23,828	71,343
Medically-Needy Adults	68,655	23,387	22,978	22,858	69,223
Medically-Needy Children	19,686	6,424	6,470	6,443	19,337
SOBRA Adults[1]	38,316	13,459	13,626	14,086	41,171
MCHP	323,639	108,086	108,331	108,603	325,020
MCHP Premium	104,772	35,314	35,266	35,119	105,699
PEPW	0	0	1	0	1
Family Planning	38,049	13,023	13,150	13,341	39,514
WBCCHP	81	65	65	64	194
ICS	195	26	26	26	78

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 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 Department changed its model approach from statewide to a more-limited pilot, after encouragement from CMMI. The pilot approach will facilitate the reporting of broad monitoring data requirements. The Department held a ‘re-design’ collaborative on December, 9, 2020; the decision and announcement of the selected area was pending as of the end of the quarter.

[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.

Collaborative Care Model (CoCM) Pilot Program
The Department's CoCM Pilot Program began enrolling participants on July 1, 2020. In the first quarter of the pilot program, 91 participants were served across the sites. During the second quarter, 95 participants were served across all of the sites.

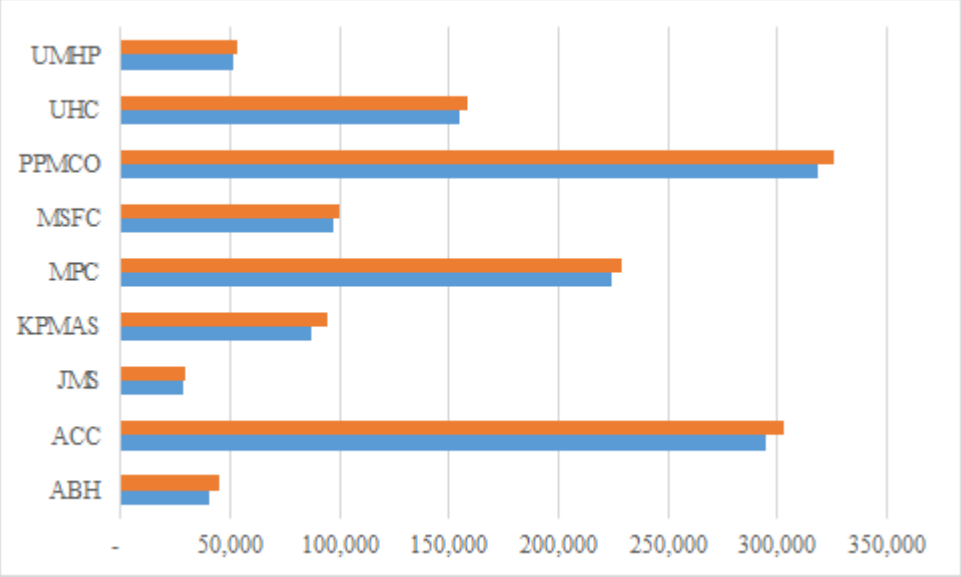
Operational/Policy Developments/Issues

Market Share

As of the culmination of FY 2021, Quarter 2, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (3.3 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 (4.0 percent); and United Healthcare (11.9 percent).

In October 2020, CareFirst BlueCross Blue Shield acquired University of Maryland Health Partners. Effective February 1, 2021, University of Maryland Health Partners will be renamed CareFirst BlueCross BlueShield Community Health Plan of Maryland. MDH 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 October and November during the past quarter; there was no December 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 October meeting, the MMAC received an update on Provider Enrollment and flexibilities in place due to COVID-19. The MMAC was informed that the Department recently received a grant from the Opioid Operational Command Center (OOCC) to improve outcomes among persons in crisis and reduce burdens on emergency departments (EDs), first responders, and law enforcement by increasing the capacity of outpatient mental health centers (OMHCs) to provide comprehensive crisis stabilization center services (CCSC). The Department also briefed the MMAC on a new proposal to increase provider rates for emergency transporters.

The MMAC discussed MCO quality of care with the Department at the November meeting. The MMAC received an update on the MOM Model in the State. The Department also gave the MMAC an update on long term services and supports (LTSS) deliverables currently being developed for CMMI.

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 state plan amendment (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 13,341 participants, with an average monthly enrollment of 13,171, 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%				

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					
Quarter 4					

Table 6. REM Complaints

FY 2021 Q2	Transportation	Dental	DMS/ DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	4	0	0
REM Hotline	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**4**	**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 2	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	0	0	0	19	25	0	11	**55**

Increased Community Services (ICS) Program

Through the ICS Program, Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the 2016 waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of December 31, 2020, there

were 26 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 Children's Health Insurance Program (CHIP) program, MCHP, and MCHP Premium, into the Medicaid expansion CHIP waiver in 2008, so that Maryland's entire CHIP program is operated as a Medicaid expansion. As of December 31, 2020, the Premium program had 35,119 participants, with MCHP at 108,603 participants.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Throughout this reporting period, the Department continued to focus on implementing the HealthChoice DPP, and continued to guide MCOs through the implementation of 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 to continue subsequently through the initial year of Coverage 2.0 capacity-building grant. As part of its Coverage 2.0-Part 2 work plan, the Department engaged a vendor to produce testimonial videos that outline the experiences of Medicaid and National DPP demonstration participants and capture perspectives of lifestyle coaches and a physician provider. Two videos with social clips and associated print ads were completed. The Department is working with their internal communications team to develop a marketing guide and plan to be rolled out in early 2021.

Through an additional Part 2 funding stream received from CDC, the Department continued work with CRISP, the statewide health information exchange (HIE), to develop a prediabetes flag within their system that will enable providers to be notified of potentially eligible patients at the point of care. This new flag will also allow CRISP to send reports to MCOs of panels of their members who received the flag, enabling further follow-up and connection with an available in-network DPP provider. In this reporting period, the Department was awarded additional funding by the CDC through new Coverage 2.0-Part 3 funding, which was then offered to all nine MCOs. Eight of nine MCOs applied and were selected to participate in this round of funding, which will enable further capacity-building around diabetes prevention efforts and the HealthChoice DPP program.

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 was notified that CDC had awarded the 2020 National Center for Chronic Disease Prevention and Health Promotion Health Equity Award to the National DPP Medicaid Demonstration Project. The Demonstration project was selected for the Health Equity Award in recognition of the impact Medicaid coverage

will have in reducing health-related disparities by expanding access to the evidence-based National DPP lifestyle change program to those populations at highest risk for type 2 diabetes.

In this reporting period, the Department continued to address program implementation questions through an updated Frequently-Asked Questions (FAQ) document posted online, responded to questions received through a dedicated HealthChoice DPP mailbox and direct emails from MCOs and DPP providers, and held 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 also finalized work on an eligibility algorithm that 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 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 2020 and provided HealthChoice DPP updates on the quarterly Maryland DPP network webinar.

Community Health Pilots

As of December 2020, 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, the Department recommended LEs follow the Healthy Families America model guidance, which allows service provision via telecommunication methods.

The two HVS Pilot LEs have enrolled a total of 65 families through November 2020. 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. LEs continue to provide virtual networking opportunities for families and support staff with skill development to improve health outcomes for at-risk expectant families and their young children

As of December 2020, approximately 343 participants are enrolled in the ACIS Pilot and receiving supportive housing services, representing 57 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). They have reported numerous challenges which include difficulties maintaining participant engagement and general concern regarding increased COVID-19 cases in the community and among staff. LEs continue to partner with local organizations to assess the availability of housing placements for ACIS participants and reduce participant's barriers to housing. In the next quarter, LEs plan to implement new training for Participating Entities (PEs) regarding data quality standards.

The Department continues to provide technical assistance and guidance to ACIS LEs as they deliver services under the national PHE. A virtual Learning Collaborative was held remotely during the past quarter. This meeting provided the platform for LEs to share their best practices and different experiences implementing telephonic service delivery. Based on comments from LEs during their monthly calls, the Department also invited a subject matter expert to discuss the importance of Trauma-Informed Care (TIC). The speaker provided training materials on TIC to LEs that could be customized to meet individual needs.

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 Medicaid expenditures. The culmination of the Department and the Hilltop Institute's efforts are detailed below.

HealthChoice Financial Monitoring Report (HFMR)

Final Service Year 2019 HFMR submissions (reported as of September 30, 2020) and the supporting Financial Templates were provided to the Department and Hilltop for review and for eventual distribution to the MCOs on a consolidated basis. MCO submissions were due to the Department by November 19, 2020. The final 2019 submissions are expected to be the base period for the 2022 HealthChoice rate-setting period. The Department's contracted accounting firm is expected to perform an independent review of each MCO's submission including an income statement of each MCO's underwriting results. All initial submissions were received by December 1, 2020. All working submissions were provided to the accounting firm as of December 10, 2020.

During the next quarter, the accounting firm will review all MCO submissions for 2019, and their reported incurred but not reported (IBNR) will be independently evaluated. The next MCO submissions will be due by May 18, 2021 and will reflect preliminary 2020 results.

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 review any changes for the upcoming review. The team developed initial CY 2019 base adjustment calculations related to MCO pharmacy services. They also provided the Department and the accounting firm with working 2019 HealthChoice MCO financials files for all nine MCOs.

CY 2021 Rate-Setting

In support of the 2021 rates, the rate-setting team provided the Department with multiple deliverables, including the annual HealthChoice Financial Reporting and Performance report, the HealthChoice rate tables effective January 1, 2021, proposed quarterly high-cost drug template for the MCOs to complete for reimbursement outside of capitation, and the annual tape of CY 2019 risk adjusted capital (RAC) assignments for CY 2021 payments. The rate-setting team provided individual HealthChoice rate schedules effective January 1, 2021 to all MCOs based on their final plan risk scores. The Department's contracted actuarial firm finalized both the CMS and MCO versions of the 2021 HealthChoice certification letters on the rate-setting team's behalf. The rate-setting team performed preliminary CY 2020 and CY 2021 graduate medical education trend calculations.

CY 2020 and CY 2019 Rate-Setting

The rate-setting team reviewed October 2020 prospective payments (the mid-year 2020 HealthChoice rates implemented) as reported on the MCO capitation file; all rate cells by MCO appear to have been implemented correctly. The team also provided the Department with the CY 2020 mid-year rate impact by category of aid and the HealthChoice rural access calculation for the second half of 2020. The team also prepared final 2020 Mid-Year MCO supplemental payments for service months January through September.

Additional Activities

The rate-setting team provided the Department with trauma calculations for September, October, and November 2020. They also provided the Department with draft statistics on Hepatitis C therapy supplemental payments and pharmacy costs.

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 21,019 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 2 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	
1st Q of FY 21 & 2nd Q of FY 21		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Pharmacy	#	0	6	15	9	4	4	9	6	39	29	14	8	28	27	37	22	6	6	152	117
	%	0%	5%	10%	8%	3%	3%	6%	5%	26%	25%	9%	7%	18%	23%	24%	19%	4%	5%	19%	19%
Prenatal	#	7	13	13	14	3	0	15	11	5	13	6	4	12	13	11	8	2	1	74	77
	%	9%	17%	18%	18%	4%	0%	20%	14%	7%	17%	8%	5%	16%	17%	15%	10%	3%	1%	9%	13%
Specialist	#	36	19	48	21	5	2	22	13	38	21	15	21	34	18	49	25	25	13	272	153
	%	13%	12%	18%	14%	2%	1%	8%	8%	14%	14%	6%	14%	13%	12%	18%	16%	9%	8%	33%	25%
PCP	#	32	28	51	40	3	4	14	18	37	37	22	20	29	26	38	41	11	10	237	224
	%	14%	13%	22%	18%	1%	2%	6%	8%	16%	17%	9%	9%	12%	12%	16%	18%	5%	4%	29%	37%
Sub Totals	#	75	66	127	84	15	10	60	48	119	100	57	53	103	84	135	96	44	30	735	571
	%	10%	12%	17%	15%	2%	2%	8%	8%	16%	18%	8%	9%	14%	15%	18%	17%	6%	5%	90%	94%
All Complaint Totals	#	75	68	135	90	15	10	63	50	153	114	68	57	112	86	145	102	47	32	813	609
	%	9%	11%	17%	15%	2%	2%	8%	8%	19%	19%	8%	9%	14%	14%	18%	17%	6%	5%	100%	100%
Other Categories		0	2	8	6	0	0	3	2	34	14	11	4	9	2	10	6	3	2	78	38

[3] Sourced from CRM.

There were 657 total MCO recipient complaints in the quarter compared to 886 in the previous quarter (all ages). Ninety-three percent of the complaints (609) were related to access to care. The remaining seven percent (48) 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 or OT, physical therapy or PT, and speech therapy or ST), adult dental and vision services, and obtaining Durable Medical Equipment/Durable Medical Supplies (DME/DMS). 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 prenatal cares.

The number of prenatal care complaints slightly increased from 74 to 77. Prenatal complaints comprised 13 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, 62 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 2 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	
1st Q of FY 21 & 2nd Q of FY 21		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Specialist	#	7	0	7	8	2	0	7	5	7	6	0	4	4	2	9	9	5	2	48	36
	%	15%	0%	15%	22%	4%	0%	15%	14%	15%	17%	0%	11%	8%	6%	19%	25%	10%	6%	28%	27%
PCP	#	14	9	16	12	2	1	7	8	15	11	5	7	12	6	11	9	5	5	87	68
	%	16%	13%	18%	18%	2%	1%	8%	12%	17%	16%	6%	10%	14%	9%	13%	13%	6%	7%	51%	51%
Pharmacy	#	0	0	4	0	0	0	0	1	9	5	2	1	4	4	2	4	0	0	21	15
	%	0%	0%	19%	0%	0%	0%	0%	7%	43%	33%	10%	7%	19%	27%	10%	27%	0%	0%	12%	11%
Prenatal	#	1	0	0	4	0	0	0	2	0	1	1	0	1	0	2	1	0	0	5	8
	%	20%	0%	0%	50%	0%	0%	0%	25%	0%	13%	0%	0%	0%	0%	0%	13%	0%	0%	3%	6%
Sub Totals	#	22	9	27	24	4	1	14	16	31	23	8	12	21	12	24	23	10	7	161	127
	%	14%	7%	17%	19%	2%	1%	9%	13%	19%	18%	5%	9%	13%	9%	15%	18%	6%	6%	95%	95%
All EPSDT Complaint Totals	#	22	9	28	24	4	1	14	17	33	26	9	13	23	12	26	23	11	8	170	133
	%	13%	7%	16%	18%	2%	1%	8%	13%	19%	20%	5%	10%	14%	9%	15%	17%	6%	6%	100%	100%
Other Categories		0	0	1	0	0	0	0	1	2	3	1	1	2	0	2	0	1	1	9	6

There were 133 member complaints (non-billing) for recipients under age 21, or 20 percent of the total complaints (133 of 657). The top complaint category was access to primary care

[4] Source from CRM.

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 as well as primary care providers while children (under 21) most often report difficulty accessing a primary care provider.

Table 10. Total Recipient Billing Complaints - Quarter 2 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	
1st Q of FY 21 & 2nd Q of FY 21		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
PCP	#	3	1	7	2	0	0	0	4	2	3	0	0	3	1	2	1	0	0	17	12
	%	18%	8%	41%	17%	0%	0%	0%	33%	12%	25%	0%	0%	18%	8%	12%	8%	0%	0%	23%	25%
Emergency	#	2	3	2	2	0	0	5	3	1	4	1	1	5	2	3	0	0	2	19	17
	%	11%	18%	11%	12%	0%	0%	26%	18%	5%	24%	5%	6%	26%	12%	16%	0%	0%	12%	26%	35%
Laboratory /Test	#	1	0	1	0	0	0	0	0	1	3	0	1	4	1	2	1	1	0	10	6
	%	10%	0%	10%	0%	0%	0%	0%	0%	10%	50%	0%	17%	40%	17%	20%	17%	10%	0%	14%	13%
Specialist	#	4	0	2	0	1	0	1	0	2	1	0	1	4	3	2	2	0	0	16	7
	%	25%	0%	13%	0%	6%	0%	6%	0%	13%	14%	0%	14%	25%	43%	13%	29%	0%	0%	22%	15%
Sub Totals	#	10	4	12	4	1	0	6	7	6	11	1	3	16	7	9	4	1	2	62	42
	%	16%	10%	19%	10%	2%	0%	10%	17%	10%	26%	2%	7%	26%	17%	15%	10%	2%	5%	85%	88%
All Billing Complaint Totals	#	10	5	13	4	1	0	6	7	11	13	1	3	21	7	9	7	1	2	73	48
	%	14%	10%	18%	8%	1%	0%	8%	15%	15%	27%	1%	6%	29%	15%	12%	15%	1%	4%	100%	100%
Other Categories		0	1	1	0	0	0	0	0	5	2	0	0	5	0	0	3	0	0	11	6

Enrollee billing complaints comprised seven percent of total MCO complaints in the second quarter of FY 2021. Overall, the top bill type was Emergency Department, which comprised 35 percent of all MCO billing complaints. Other categories are the billing complaints related to inpatient services, urgent care centers, DME/DMS, therapies, pharmacy, and optional services such as adult dental and vision. 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,

[5] Source: CRM.

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.

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), MetaStar, Inc. (MetaStar), and Center for the Study of Services, Inc. (CSS). 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 the development of an annual consumer report card to assist HealthChoice enrollees with MCO selection. MetaStar is the Department's Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Auditor. MetaStar is responsible for ensuring compliance with the National Committee for Quality Assurance (NCQA) guidelines for reporting 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. 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.

Table 11 provides an update on quality assurance activity progress.

Table 11. Quality Assurance Activity Status

Activity	Vendor	Status	Comments
Systems Performance Review (SPR)	Qlarant	In Progress	Qlarant has completed its review of the SPR Tool for CY 2020. Quarterly CAPs from CY 2019 have been reviewed and approved.
EPSDT Medical Record Review	Qlarant	In Progress	Qlarant completed their first year of 100% desktop medical record reviews for EPSDT due to COVID-19. The templates and drafts were approved by MDH for the CY 2019 EPSDT review. CAPs for the MCOs are due by the end of January 2021.
Consumer Report Card	Qlarant	In Progress	Qlarant completed the analysis of the HEDIS and CAHPS data received in September 2020. Qlarant produced the template and draft review that the Department approved in November 2020.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	The MCOs submitted their quarterly LSC PIP reports in December 2020. The Department is working with Qlarant on editing the quarterly reports along with the Annual PIP reports for both AMR and LSC.
Encounter Data Validation (EDV)	Qlarant	In Progress	Qlarant received Activity 3 from Hilltop in December and began drafting the EDV report for CY 2019. The Department submitted edits to Qlarant and is awaiting the final EDV report.
Network Adequacy Validation (NAV)	Qlarant	In Progress	Qlarant completed the survey calls on October 30, 2020 and created the draft of the NAV report. The Department returned the draft to Qlarant with its edits in December 2020.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials	Qlarant	Complete	Qlarant finalized the third quarter report for GAD. Highlights are listed below and the final report will be posted on the Department's website. The next quarterly reporting will be due on January 29, 2021 for review by Qlarant.
HEDIS Audits and Reporting (HEDIS)	MetaStar	Complete	NCQA released the 2020 Volume 2: Technical Update, reflecting any changes to the current HEDIS measures, on 10/1/2020. The 2020 HEDIS Statewide Executive Summary Report was posted on the Department's website. The HEDIS vendor provided an audit timeline, along with key dates, for the upcoming HEDIS 2021 audit season. The scheduling of onsite visits for the HealthChoice MCOS for the 2021 audits is pending and the timeline will be updated by the HEDIS vendor once finalized.
Value Based Purchasing Initiative (VBPI)	Qlarant	In Progress	The Department has completed its analysis of the HEDIS results and issued the first and second rounds of the VBP letters to the MCOs in November 2020. Qlarant has drafted the VBP report and edits are being performed by both MDH and Qlarant.

Activity	Vendor	Status	Comments
CAHPS Survey Administration (CAHPS)	CSS	Complete	The Department completed review and editing of all CAHPS reports, including MCO, Aggregate, and Executive Summary reports. All approved final reports for 2020 were distributed electronically to the HealthChoice organizations and the Department by the survey vendor. NCQA revised the CAHPS survey for 2021 to reflect the increase of Medicaid recipients using telehealth visits as a result of the coronavirus pandemic. NCQA also granted approval for the Department to add two supplemental questions related to telehealth to the survey questionnaire. The survey vendor provided a survey administration timeline for CAHPS 2021 to the Department.
PCP Satisfaction Survey Administration	CSS	Complete	All 2020 PCP survey reports were finalized, approved, and provided to the Department and all HealthChoice organizations by the survey vendor. The 2021 PCP Data File request memo was sent to all HealthChoice organizations by the Department with instructions and requirements for providing the data file to the survey vendor for use for the 2021 Survey Administration. Pre-survey fielding activities are underway including any updates to the survey questionnaire design and other survey collateral materials.
Annual Technical Report (ATR)	Qlarant	In Progress	Qlarant revealed the updated ATR template to MDH in November of 2020. The Department reviewed and sent back edits along with suggestions to update some of the format to better fit the Department's needs. Qlarant is currently working on its next iteration.

Completed Activity Highlights

Qlarant completed the third quarter of Focused Reviews of Grievances, Appeals, and Denials (GAD) in November 2020. All nine MCOs met the turnaround timeframe (TAT) for member grievances. The following MCOs scored below the 100% threshold for compliance with appeal time frames in at least one category: Aetna (0% which represents only 1 expedited), Amerigroup (83%), Kaiser Permanente (88%), and Priority Partners (88%). With the exception of Kaiser Permanente, these were the same MCOs that were not compliant in the prior quarter. The Department continues to monitor the listed MCOs' repeated performance scores.

All nine MCOs met or exceeded the compliance threshold for prescriber notification within 24 hours of the request. Aetna, Amerigroup, Jai, Kaiser Permanent, Maryland Physicians Care, Medstar, United Healthcare, and University of Maryland all met the TAT for all applicable determination and notification categories.

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 at least eight out of the nine MCOs performed above the National HEDIS Mean. Amerigroup, Jai Medical Systems, Kaiser Permanente, and MedStar Family Choice met and exceeded performance expectations under the Department's MCO Monitoring Policy, which require plans to perform at or above the national average for at least 70% of reportable performance measures. However, opportunities for improvement continue to exist for the remaining HealthChoice MCOs to maintain or achieve scores above the National HEDIS Mean.

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 was *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.

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 begin planning for the CY 2021 evaluation, which will cover from CY 2015 through CY 2019.

The Department has held several calls with CMS regarding the §1115 summative evaluation design and the SUD monitoring protocol. As of the end of the quarter, the Department was working with the Hilltop Institute to: 1) develop an outline for the qualitative section of the summative evaluation; and 2) update the SUD monitoring protocol, including a revised timeline for submission. The Department anticipates submitting updated materials to CMS in 2021.

Enclosures/Attachments

- Appendix A: Maryland Budget Neutrality Report as of December 31, 2020

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