Maryland HealthChoice Demonstration
Section §1115 Annual Report
Demonstration Year 25: 7/1/2021 - 6/30/2022
Quarter 1: 7/1/2021 - 9/30/2021

Introduction

Now in its twenty-fifth 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 serves behavioral health care to a limited number of HealthChoice beneficiaries in their primary care setting that began 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

Demonstration Populations	Participants as of June 30, 2021	Participants as of September 30, 2021
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	277,926	282,700
Affordable Care Act (ACA) Expansion Adults	395,822	410,114

Demonstration Populations	Participants as of June 30, 2021	Participants as of September 30, 2021
Medicaid Children	515,474	520,540
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	92,247	92,385
SSI/BD Children	24,518	24,881
Medically-Needy Adults	23,124	24,029
Medically-Needy Children	6,531	6,593
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	12,821	12,862
Maryland Children's Health Program (MCHP)	112,001	117,345
MCHP Premium	34,023	34,222
Presumptively Eligible Pregnant Women (PEPW)	-	-
Family Planning	13,348	13,379
Increased Community Services (ICS)	26	26
Women's Breast and Cervical Cancer Health Program (WBCCHP)	65	59

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 2021)	Current Quarter Month 1 (July 2021)	Current Quarter Month 2 (Aug. 2021)	Current Quarter Month 3 (Sept. 2021)	Total for Quarter Ending Sept. 2021
Parent/Caretaker Relatives <116% FPL and Former Foster Care	827,025	279,636	280,866	282,700	843,202
ACA Expansion Adults	1,172,348	400,869	405,907	410,114	1,216,890
Medicaid Children	1,541,957	516,977	518,868	520,540	1,556,385
SSI/BD Adults	276,789	92,314	92,314	92,385	277,013
SSI/BD Children	73,076	24,668	24,782	24,881	74,331

Eligibility Group	Total for Previous Quarter (ending June 2021)	Current Quarter Month 1 (July 2021)	Current Quarter Month 2 (Aug. 2021)	Current Quarter Month 3 (Sept. 2021)	Total for Quarter Ending Sept. 2021
Medically-Needy Adults	68,958	23,366	23,607	24,029	71,002
Medically-Needy Children	19,585	6,579	6,570	6,593	19,742
SOBRA Adults[1]	42,094	12,465	12,641	12,862	37,968
MCHP	330,866	113,683	115,517	117,345	346,545
MCHP Premium	102,385	34,064	34,136	34,222	102,422
PEPW	-	-	-	-	-
Family Planning	40,152	13,347	13,348	13,379	40,074
ICS	76	26	26	26	78
WBCCHP	195	59	59	59	177

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

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

[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.

Level of Service	No. of Participants	No. of Days
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 participants 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 provide a set of enhanced case management services, standardized social determinants of health screenings, and care coordination. Exact services and screenings were developed over the course of the MOM pre-implementation period (January 2020 - June 2021) and are being refined during the MOM transition period (July 2021 - June 2022), which is the first year of model services. During this quarter, the Department commenced participant enrollment, in addition to finalizing contracts between the MCOs and the St. Mary's County Health Department. Cooperative agreement funding from CMMI supports per member, per month payments to the MCOs to conduct the model intervention during SFY 2022. To continue the payments in SFY 2022 forward, the Department included the MOM model as a new addition to the HealthChoice demonstration in the waiver renewal application submitted in late June.

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. In the fourth quarter, 100 participants were served across the sites. In the first quarter, 115 participants were served across the sites.

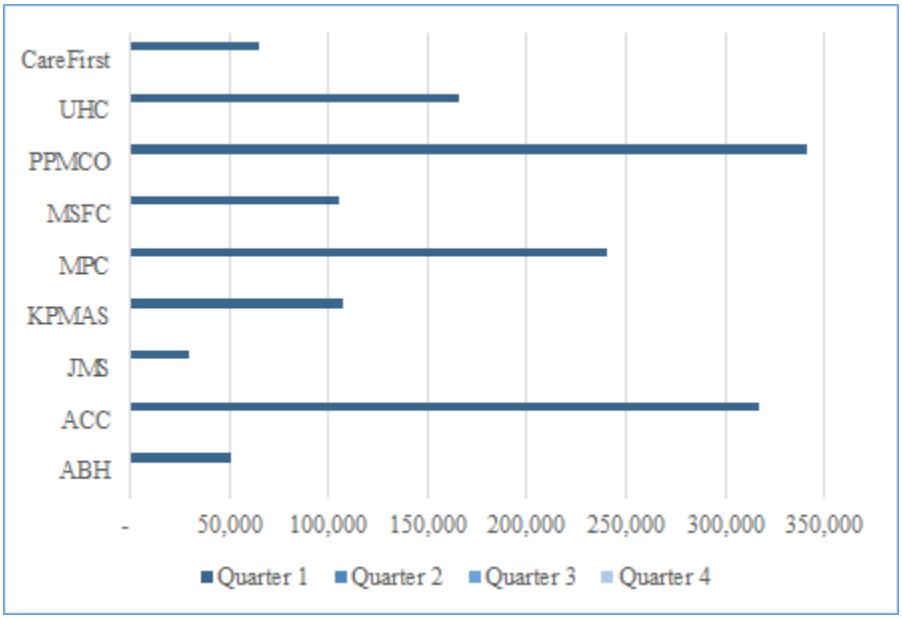
Operational/Policy Developments/Issues

Market Share

As of the end of the first quarter of FY 2022, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (3.6 percent), Amerigroup (22.3 percent); Jai Medical Systems (2.1 percent); Kaiser Permanente (7.5 percent); Maryland Physicians Care (16.9 percent); MedStar Family Choice (7.4 percent); Priority Partners (24.0 percent); CareFirst Community Health Plan of Maryland (4.5 percent); and United Healthcare (11.7 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 has been and continues to work 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 July and September of 2021; 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. Because the State's legislature was not in session, the MMAC was not briefed on any pertinent Medicaid bills.

During the July meeting, the MMAC was briefed by the Maryland Health Services Cost Review Commission (HSCRC) on the recent evaluation of the Total Cost of Care Model.

During the September meeting, the MMAC was updated on several initiatives, including provider enrollment extensions, interoperability, and COVID-19 vaccination and outreach. Additionally, the MMAC was briefed on eligibility and enrollment changes due to the maintenance of effort requirements due to COVID-19.

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 SPA to transition participants out of the §1115 was approved in June 2020.

Enrollment as of the end of the quarter was 13,379 participants, with an average monthly enrollment of 13,358, an increase of 1.6 percent over the previous quarter.

Table 4. Average Quarterly Family Planning Enrollment

Q1 Enrollment	Percent Change	Q2 Enrollment	Percent Change	Q3 Enrollment	Percent Change	Q4 Enrollment	Percent Change
13,358	1.6%						

Rare and Expensive Case Management (REM) Program

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

Table 5. Current REM Program Enrollment

FY 2022	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	206	189	50	99	4478
Quarter 2					
Quarter 3					
Quarter 4					

Table 6. REM Complaints

FY 22 Q1 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	1	0	1
Dental	0	0	0
DMS/DME	3	0	3
EPSDT	0	0	0
Clinical	2	0	2
Pharmacy	0	0	0
Case Mgt.	1	0	1
REM Intake	0	0	0
Access to MA Providers	0	0	0
Nursing	5	0	5
Other	2	0	2
Total	**14**	**0**	**14**

The table below 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 Incidents Reported by Case Managers

FY 22 Q1 Incidents	REM Enrollees Quarter 1	REM Enrollees Quarter 2	REM Enrollees Quarter 3	REM Enrollees Quarter 4
Abandonment	0			
Abuse	4			
Complaint	14			
Death	15			

FY 22 Q1 Incidents	REM Enrollees Quarter 1	REM Enrollees Quarter 2	REM Enrollees Quarter 3	REM Enrollees Quarter 4
Elopement	0			
ER	0			
Exploitation	0			
Failure to Follow Plan (Non-Compliance)	0			
Fall	1			
Hospitalization	2			
Medication Error	1			
Neglect	10			
Suicidal Ideation	2			
Theft	0			
Wound	0			
Other	22			
Total	**71**			

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, 2021, 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 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, 2021, the Premium program had 34,222 participants, with MCHP at 117,345 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. In this period, the Department received a new grant from CDC through NACDD to continue this infrastructure and capacity-building work with MCOs for the fourth year. Under this Coverage 2.0-Part 4 grant, work began to obtain a fully executed contract between NACDD and the Department, and prepare to issue grants to MCOs for the grant period of August 1, 2021 through July 31, 2022.

At the request of the Department, The Hilltop Institute (Hilltop) reports periodically on the number of HealthChoice members enrolled in the HealthChoice DPP. As of this reporting period (August 2021 report) Hilltop identified 301 encounters with DPP procedure codes and provided by licensed DPP providers to 50 unique participants between September 1, 2019 and July 31, 2021. Among the 50 unique Medicaid beneficiaries with a DPP encounter, most were women (78%), Black/African American (68%), and resided in Prince George's County (62%). Most (90%) beneficiaries were in the Families and Children Medicaid coverage group. Services were provided by four unique providers: Mid-Atlantic Permanente Medical Group, associated with the MCO Kaiser Permanente; the Continuum Wellness Center; Taylored 4 Life; and Welldoc, Inc. Number of encounters per participant ranged from one to 26. The majority of beneficiaries had four or fewer encounters.

The Department continued to 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, Amerigroup and Kaiser Permanente, have chosen to become CDC-recognized organizations themselves, and offer the program to their members in-house.

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-six DPP providers were fully-enrolled. MCOs continued efforts to contract with eligible DPP providers, expand their DPP provider network capacity, and prepare member and provider materials. During this reporting period, additional technical assistance and guidance was provided by the Department to Western Maryland CDC-recognized organizations around Medicaid enrollment.

Through an additional Part 3 funding stream received from CDC, the Department continued this quarter to work with the Chesapeake Regional Information System for our Patients (CRISP), the statewide health information exchange (HIE), to refine the prediabetes flag within CRISP that went live in June. After the initial 76,000 care alerts went out, a subsequent 14,000 were sent during this reporting period, indicating newly identified members eligible for the program. There continues to be further refinements around accurate BMI reporting. CRISP began to produce

monthly reports to MCOs containing the panels of their members who received the flag, so as to enable further follow-up and connection with an available in-network DPP provider. In addition, the Department worked with CRISP to onboard MCOs as intermediaries on the CRISP referral tool, and joined in an informational webinar to providers and MCOs to provide education on the tool.

The dedicated HealthChoice DPP web page, housed on the Maryland Department of Health website, was redesigned during this reporting period with the aim to make information more accessible to different audiences who may want to know more about HealthChoice DPP, including: individuals and families interested in enrolling; CDC-recognized organizations; Medicaid-enrolled DPP providers; public health professionals; healthcare providers and staff. Available on the website are new communications documents aimed at helping consumers understand the program and how to enroll: policy and program guidance documents, including the HealthChoice DPP Program Manual, and a Frequently-Asked Questions (FAQ) document. Also included on the website is a link to the Department's Public Health diabetes/prediabetes webpage, where a new campaign was launched called "Know Your Risk" wherein consumers can access the American Diabetes Association "Know Your Risk" prediabetes test.

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.

Community Health Pilots

As of September 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.

During Q1, the Department worked to secure FY2022 local match funding with each LE for the Community Health Pilots.

The HVS pilot LEs had a total family enrollment of 19 as of September 2021. LEs continue to provide doorstep drop offs to families to ensure needs are met in between home visits. HVS LEs have also begun their re-accreditation work for the next HFA accreditation cycle.

As of September 2021, approximately 401 participants are enrolled in the ACIS Pilot and receiving supportive housing services, representing 67 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).

The Lead Entities continue to work with their local housing authorities to locate housing placements for ACIS participants. Project staff participated in a Rapid Rehousing training series that focused on Rapid Re-Housing and Its Core Components; Sustaining Housing with Motivational Interviewing; and Tenancy and Housing Case Management.

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)

The HealthChoice MCOs provided their Preliminary Service Year 2020 HFMR reports (reported as of March 31, 2021) and the supporting Financial Templates in May 2021 of the prior quarter. During this quarter, Hilltop used the submitted information for trend analysis and validity testing purposes for developing rates for calendar year (CY) 2022. During this quarter, HealthChoice MCOs were also requested to prepare their CY 2021 and CY 2022 financial projections based on all known rate and State budget activities as of September 2021 and using provided financial templates. As of September 30, 2021, all MCO projections have been received by Hilltop. In September 2021, Hilltop provided the MCOs with updated HFMR templates and revised instructions in preparation of the MCO's November 2021 submissions.

During the upcoming quarter, the MCOs will restate their CY 2020 Date of Service experience as of September 30, 2021. An auditing firm will perform an independent review of each MCO's submission. The next MCO submissions will be due by November 23, 2021. Any additional modifications to the current reporting requirements, if requested by the Department, will likely be implemented during the month of December 2021.

MCO Rates

CY 2022 Rate Setting

During this reporting quarter of July to September 2021, Hilltop co-facilitated several HealthChoice MCO meetings on CY 2022 HealthChoice Rates with staff of the Maryland Department of Health (the Department). Hilltop, the actuary (Optumas), and the Health Services Cost Review Commission convened a meeting on July 7 to present preliminary estimates of PMPM trend ranges to the MCOs. A subsequent meeting was held with the MCOs on July 9 to discuss an ad hoc midyear adjustment to HealthChoice CY 2022 MCO rates, and the proposed

structure for the CY 2022 global risk corridor. Hilltop co-facilitated the sixth in the series of monthly rate setting meetings with the MCOs held on July 28. The following topics were addressed: review of CY 2022 Department and MCO issues, preliminary CY 2022 MCO risk scores for HIV/AIDS and geographic/demographic rates, final constant cohort analysis, and preliminary plan risk scores for Hepatitis C mix of HIV/AIDS recipients. Hilltop also co-facilitated the seventh and final CY 2022 HealthChoice MCO rate setting meeting held on August 31. Topics discussed included: CY 2022 rates, incentives, final trends, operating costs, the federally qualified health center (FQHC) ceiling on MCO per visit cost responsibility, noninvasive prenatal testing costs, and acuity adjustments. Hilltop staff also participated in preparatory sessions for these monthly meetings alongside staff of the Department and Optumas on July 26 and August 30 respectively. From September 13 to September 16, Hilltop staff participated in nine MCO "one-on-one" meetings with the Department to review MCO issues and financial projections for CY 2021 and CY 2022. Hilltop also prepared individual MCO profiles for the Department ahead of these meetings.

Hilltop assisted the Department with soliciting feedback from the HealthChoice MCOs on the proposed global risk corridor for CY 2022 in July 2021. Hilltop shared the survey responses from MCOs, and potential risk corridor methodologies with the Department in August. In conjunction with Optumas, Hilltop prepared responses to questions from the Maryland MCO Association (MMCOA) related to the CY 2022 global risk corridor and pharmacy trends. Also, in support of CY 2022 HealthChoice rates, Hilltop provided Optumas with the following data during the reporting quarter: final CY 2022 member month projections; evaluation & management (E&M) fee adjustments for CY 2021 midyear and CY 2022 rates; and FQHC base adjustments for CY 2022 HealthChoice rates. Hilltop also provided the Department with graduate medical education (GME) pool estimates through fiscal year (FY) 2023, and draft versions of January 2022 MCO rates.

In response to the Department's request for research on best practices regarding pharmacy management, Hilltop conducted an analysis in July 2021 on the cost and treatment uses of 21 existing and pipeline drugs that will be carved out of MCO payments for CY 2022. In support of the CY 2023 HealthChoice Rates, Hilltop prepared and provided new instructions and templates for HealthChoice MCOs to report on their final service year CY 2020 financial submissions.

Hilltop staff continued to hold weekly meetings with Optumas and biweekly meetings with Department staff to discuss rate-setting-related issues.

CY 2021 and Prior HealthChoice Rate Setting

Hilltop provided the Department with initial CY 2021 midyear payment adjustments for January 1, 2021 through September 30, 2021, and provided both the CMS and MCO versions of the CY 2021 Midyear HealthChoice certification letters. Hilltop prepared CY 2021 midyear rate tables effective October 1, 2021 for Department Operations which replaced incorrect rates provided for the month of September 2021.[3] Hilltop also supplied the MCOs with CY 2021 midyear rate sheets for the HealthChoice program.

[3] The aforementioned midyear payment included an estimated $554,248 for the month of September to account for an underpayment to the MCOs due to the error.

In July and September 2021, Hilltop provided quarterly updates to the Department on estimates of budgetary reconciliation for HealthChoice plans' expenditure on carved-in Hepatitis C therapies, based on surveys returned by MCOs for encounter experience from January 1 to June 30, 2021.

HealthChoice Capitation Rates

Hilltop provided the Department with trauma calculations for June 2021, July 2021, and August 2021. Hilltop prepared CY 2022 rates for the Program of All-Inclusive Care for the Elderly (PACE) and a methodology narrative for the Department. Finally, Hilltop provided the Department with preliminary results of analyses comparing CY 2019 to CY 2018 for utilization and expenditure of provider-sponsored MCOs (PSOs) to non-PSOs.

In September 2021, Hilltop worked with the Department to source accruals from the MCOs for CY 2020 global risk corridor recoupments. Hilltop developed a model to calculate the CY 2020 risk corridor accruals for each MCO to support the Department's withhold estimates. Hilltop analyzed the impact of value-based purchasing incentives and disincentives on each MCO's CY 2020 global risk corridor results.

During the reporting quarter, Hilltop also provided responses to MCO's inquiries related to reconciliation payments for carved-in Hepatitis C therapies, and member risk adjustment methodologies.

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 25,633 calls in the first quarter of FY 2022. 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) - FY 2022[4]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		CareFirst*		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Sub Totals	
1st Q FY22 vs. 4th Q FY21		1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4
Pharmacy	#	10	1	25	12	6	5	3	5	9	2	40	15	9	10	24	26	35	35	161	111
	%	6%	1%	16%	11%	4%	5%	2%	5%	6%	2%	25%	14%	6%	9%	15%	23%	22%	32%	23%	18%
Prenatal	#	1	7	14	8	6	4	2	1	10	10	6	7	7	5	6	6	15	9	67	57
	%	1%	12%	21%	14%	9%	7%	3%	2%	15%	18%	9%	12%	10%	9%	9%	11%	22%	16%	9%	9%
PCP	#	23	26	52	45	21	18	6	3	25	21	45	29	16	17	27	31	43	54	258	244
	%	9%	11%	20%	18%	8%	7%	2%	1%	10%	9%	17%	12%	6%	7%	10%	13%	17%	22%	36%	39%
Specialist	#	21	19	22	27	9	11	3	1	18	17	27	29	17	12	14	21	18	30	149	167
	%	14%	11%	15%	16%	6%	7%	2%	1%	12%	10%	18%	17%	11%	7%	9%	13%	12%	18%	21%	27%
Sub Totals	#	55	53	113	92	42	38	14	10	62	50	118	80	49	44	71	84	111	128	635	579
	%	9%	9%	18%	16%	7%	7%	2%	2%	10%	9%	19%	14%	8%	8%	11%	15%	17%	22%	90%	93%
All Complaint Totals	#	64	53	124	98	48	39	14	10	65	54	134	95	49	45	89	97	120	133	707	624
	%	9%	8%	18%	16%	7%	6%	2%	2%	9%	9%	19%	15%	7%	7%	13%	16%	17%	21%	100%	100%
Other Categories		9	0	11	6	6	1	0	0	3	4	16	15	0	1	18	13	9	5	72	45

There were 776 total MCO recipient complaints in the first quarter of fiscal year 2022 compared to 676 in the previous quarter (all ages). This quarter, the total MCO recipient complaints increased by thirteen percentage points. Ninety-one percent of the complaints (707) were related to access to care. The remaining nine percent (69) were billing complaints. The top three member complaint categories were accessing primary care providers (PCPs), specialists 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, and 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 was mainly attributed to difficulty accessing pharmacy services.

[4] Sourced from CRM.

The number of prenatal care complaints increased from 57 to 67. Prenatal complaints comprised 9 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, 47 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) - FY 2022[5]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		CareFirst*		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Sub Totals	
1st Q FY22 vs. 4th Q FY21		1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4
Pharmacy	#	1	0	6	6	1	1	1	1	0	0	8	2	1	6	5	1	5	6	28	23
	%	4%	0%	21%	26%	4%	4%	4%	4%	0%	0%	29%	9%	4%	26%	18%	4%	18%	26%	16%	14%
PCP	#	5	7	19	16	9	3	2	1	8	7	13	7	2	4	8	12	9	20	75	77
	%	7%	9%	25%	21%	12%	4%	3%	1%	11%	9%	17%	9%	3%	5%	11%	16%	12%	26%	44%	48%
Specialist	#	7	2	5	7	0	3	0	1	10	11	5	5	3	2	6	8	9	7	45	46
	%	16%	4%	11%	15%	0%	7%	0%	2%	22%	24%	11%	11%	7%	4%	13%	17%	20%	15%	26%	29%
Prenatal	#	0	1	2	2	0	1	0	0	1	1	1	0	3	0	2	2	1	1	10	8
	%	0%	13%	0%	25%	0%	13%	0%	0%	0%	13%	0%	0%	0%	0%	0%	25%	0%	13%	6%	5%
Sub Totals	#	13	10	32	31	10	8	3	3	19	19	27	14	9	12	21	23	24	34	158	154
	%	8%	6%	20%	20%	6%	5%	2%	2%	12%	12%	17%	9%	6%	8%	13%	15%	15%	22%	92%	97%
All EPSDT Complaint Totals	#	14	10	33	31	10	9	3	3	21	21	28	14	9	13	28	24	25	34	171	159
	%	8%	6%	19%	19%	6%	6%	2%	2%	12%	13%	16%	9%	5%	8%	16%	15%	15%	21%	100%	100%
Other Categories		0	0	1	0	0	1	0	0	2	2	1	0	0	1	7	1	1	0	13	5

There were 171 member complaints (non-billing) for recipients under age 21, or 22 percent of the total complaints (171 of 776) in the first quarter of FY22. The top complaint category was access to primary care providers (PCPs). Amerigroup 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 pharmacy services 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 - FY 2022[6]

[5] Source from CRM.
[6] Source: CRM.

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		CareFirst*		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Sub Totals	
1st Q FY22 vs. 4th Q FY21		1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4
Emergeny	#	1	1	5	2	0	0	1	0	4	1	5	0	3	2	4	2	0	1	23	9
	%	4%	11%	0%	22%	0%	0%	0%	0%	0%	11%	0%	0%	0%	22%	0%	22%	0%	11%	33%	17%
PCP	#	0	3	3	4	0	1	0	0	1	4	3	3	2	2	2	0	0	0	11	17
		0%	18%	27%	24%	0%	6%	0%	0%	9%	24%	27%	18%	18%	12%	18%	0%	0%	0%	16%	33%
Laboratory/ Test	#	0	0	5	3	1	0	0	0	1	1	7	5	0	0	1	3	4	1	19	13
	%	0%	0%	26%	23%	5%	0%	0%	0%	5%	8%	37%	38%	0%	0%	5%	23%	21%	8%	28%	25%
Specialist	#	0	0	1	2	1	0	0	0	0	0	1	1	0	1	0	1	1	0	4	5
	%	0%	0%	25%	40%	25%	0%	0%	0%	0%	0%	25%	20%	0%	20%	0%	20%	25%	0%	6%	10%
Sub Totals	#	1	4	14	11	2	1	1	0	6	6	16	9	5	5	7	6	5	2	57	44
	%	2%	9%	25%	25%	4%	2%	2%	0%	11%	14%	28%	20%	9%	11%	12%	14%	9%	5%	83%	85%
All Billing Complaint Totals	#	1	5	15	11	4	2	1	0	6	7	17	10	6	6	13	6	6	5	69	52
	%	1%	10%	22%	21%	6%	4%	1%	0%	9%	13%	25%	19%	9%	12%	19%	12%	9%	10%	100%	100%
Other Categories		0	1	1	0	2	1	0	0	0	1	1	1	1	1	6	0	1	3	12	8

Enrollee billing complaints comprised nine percent of total MCO complaints in the first quarter of FY22. Overall, the top bill type was Emergency, which comprised 33 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 ACCUs at the local health departments for follow-up to ensure the complaint has been resolved. When trends are identified, the HealthChoice Medical Advisor makes an inquiry to the MCO. If potential policy issues, systems issues, or barriers are identified, the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly convened its 2021 session on January 13, 2021 and it adjourned on April 12, 2021. The 2022 session will convene on January 12, 2022.

Quality Assurance/Monitoring Activity

The Medical Benefits Management Administration (MBMA) is responsible for contracting and oversight of the HealthChoice program within the Maryland Department of Health. 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	Complete	In September 2021, Qlarant finalized the CY 2020 Executive Summary Report. In July, the Department approved the Draft CY 2021 Standards and Guidelines for dissemination to the MCOs to begin the 45-day comment period. MCOs submitted their comments for the Draft CY 2021 Standards and Guidelines in August 2021. The Department and Qlarant reviewed MCO feedback and Qlarant provided responses to MCOs in September 2021. Qlarant finalized the CY 2021 Standards and Guidelines and the CY 2021 MCO Orientation Manual for the next comprehensive review, and disseminated to the MCOs with the Department's approval in September 2021.in September 2021, Qlarant held an SPR orientation for the MCOs and provided technical assistance as needed in preparation for the review.
EPSDT Medical Record Review	Qlarant	In Progress	Qlarant concluded the medical record review, which began on 7/1/2021 and ended 09/30/2021, and started compiling the results for analysis. Qlarant submitted individual MCO draft CY 2020 reporting templates and obtained the Department's approval in September 2021.
Consumer Report Card (CRC)	Qlarant	In Progress	Qlarant received the Department's approval to post the final draft version of the CY 2022 IRS and Methodology in September 2021. The final CY 2022 IRS and Methodology is due to be finalized in November 2021.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	In July 2021, Qlarant provided the MCOs with quarterly feedback for lead PIP submissions. Qlarant submitted the draft CY 2021 annual PIP reporting template for the Department's review and received approval in September 2021. MCO annual reporting submissions for both AMR and Lead PIPs were submitted to Qlarant in September 2021 and report validations were started. The Department began its review of the annual PIP submissions in September 2021.
Encounter Data Validation (EDV)	Qlarant	In Progress	Qlarant submitted the draft provider medical request letters for review in July 2021 and received the Department's approval in July 2021 Qlarant disseminated the ISCA Tool to the MCOs in August 2021 and provided feedback to the MCOs in September 2021.Qlarant requested medical records from provider offices via fax and MCOs (where appropriate) in August 2021 and began receiving records.Qlarant requested and received the Department's claims process standards and data dictionary to complete Activity 1 in September 2021.Hilltop has started its process in conducting Activity 3.

Activity	Vendor	Status	Comments
Network Adequacy Validation (NAV)	Qlarant	In Progress	Qlarant submitted the CY 2021 draft report template to the Department for review and received approval in July 2021. Qlarant concluded the activity in July 2021 and began collecting and analyzing results in August 2021. Qlarant began drafting the CY 2021 Draft NAV report in September 2021.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	In Progress	Qlarant finalized the Quarter 2 reporting for GAD. Highlights are listed below. The next quarterly report, Quarter 3, will be due in October 2021 for review by Qlarant. Qlarant submitted the Draft 2021 Annual GAD report to the Department for review in September 2021.
HEDIS Audits and Reporting (HEDIS)	MetaStar	Complete	MetaStar provided Final Audit Reports to HealthChoice organizations and the Department in July. HEDIS MY 2021 trending determinations for measures were released by NCQA. Final reports provided by MetaStar including the Statewide Analysis Report, the Executive Summary Report and the Consolidated Final Audit Report were reviewed, edited and approved by the Department in September. The Department provided the finalized HEDIS MY 2021 Measures List, along with official announcement letters, to MetaStar and all HealthChoice organizations in early September. MetaStar presented at the September QALC meeting reporting on HEDIS MY 2021 measure updates, including retired measures and changes to existing measures, the Department required measure set, highlights from the HEDIS MY 2021 Statewide Analysis Report, and a HEDIS MY 2022 preview.
Value Based Purchasing Initiative (VBP)	Qlarant	In Progress	Qlarant completed the validation of the final Lead Screening and Ambulatory rates for CY 2020 in July 2021. Qlarant submitted the CY 2020 draft annual report template to the Department for review and received approval in August 2021. Qlarant began developing the annual CY 2020 VBP report in August 2021.

Activity	Vendor	Status	Comments
CAHPS Survey Administration (CAHPS)	CSS	In Progress	The Center for the Study of Services (CSS) provided eReports for each HealthChoice MCO in July 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. The Department reviewed, edited, and approved reports including Adult and Child Aggregate CAHPS reports, and the Individual HealthChoice organizations Adult and Child CAHPS reports in August and September. CSS presented at the September QALC Meeting highlighting the results of the 2021CAHPS Adult and Child surveys. NCQA published HEDIS MY 2021, Volume 3: Specifications for Survey Measures on September 15, 2021.
PCP Satisfaction Survey Administration	CSS	In Progress	Highlight reports were available in July showing preliminary key survey results and a respondent profile. The Department reviewed, edited, and approved reports including the Primary Care Provider Aggregate and the Individual HealthChoice organizations reports in August and September. CSS presented at the September QALC Meeting highlighting the results of the 2021 Primary Care Provider survey.
Annual Technical Report (ATR)	Qlarant	In Progress	In July 2021, the Department and Qlarant collectively compiled an additional response as requested, to the CMS based on follow-up items from previous ATR submissions. Qlarant continues to develop the draft template for the Annual Technical Report for the upcoming measurement year.

Completed Activity Highlights:

- **Systems Performance Review (SPR)**
    - There are eleven standards in the Systems Performance Review. For the interim review in CY 2020, Qlarant reviewed standards requiring a corrective action plan (CAP) or scored as baseline in the CY 2019 review. There were eight CAPs required by five MCOs (ABH, ACC, CFCHP, KPMAS, and PPMCO) under this activity (see chart below for CAP breakdown per MCO).

CAPs Required	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
	2	1	2	0	2	0	0	1	0

- **Focused Reviews of Grievances, Appeals, and Denials (GAD)**
    - The second quarter of GAD was completed in August 2021.
        - Grievances Highlights
            - KPMAS and JMS had the highest grievance rate per 1,000 members (4.13/ 3.45).
            - All but two MCOs met the turnaround time (TAT) requirements for member grievances (ABH at 0% and PPMCO at 50%, each representing one grievance out of compliance).
            - TAT compliance for provider grievances was met by all seven of the applicable MCOs (KPMAS continues to report no provider grievances, MSFC had no provider grievances for this quarter).
        - Appeals Highlights
            - CFCHP and PPMCO had the highest appeal rate per 1,000 members (1.44/1.3).
            - CFCHP and MSFC had the highest appeal overturn rates (88%/ 74%).
            - The following MCOs scored below the 100 percent threshold for compliance with appeal timeframes in at least one category: ABH (87%), ACC (82%/ 99%), MPC (99%) and UHC (94%t). ABH and ACC have remained non-compliant in at least one category for the last four quarters. The Department continues to monitor the listed MCOs' performance in this area.
        - Denial Highlights
            - MPC and UHC have the highest denial rates per 1,000 members (31.6/ 31.2).
            - CFCHP (71%) did not meet the standard medical determination TAT.
            - JMS did not meet the relaxed TAT compliance threshold for notification of standard medical adverse determinations (88%).
            - KPMAS had the highest percentage of requests submitted with complete information (95%) and the highest approval rate (93%).
- **HEDIS Audits and Reporting**
    - Maryland MCOs have historically had high performance in their HEDIS rates. For MY 2020, COVID-19 caused performance to decrease across multiple measure domains, primarily for access to care, prevention and screening measures. In addition, it should be noted that due to COVID-19, NCQA allowed MCOs to rotate hybrid

measure rates using HEDIS MY 2018 audited results for reporting in MY 2019. Therefore, some HEDIS MY 2020 hybrid rate changes appear to be even more significant than what they may have been if hybrid rotation had not been allowed for HEDIS MY 2019.

- Telehealth was added to some measure specifications which may have helped to bump up measure rates so performance would not be quite so low, for example, for Statin Therapy for Patients with Diabetes (SPD), Antidepressant Medication Management (AMM), and Follow-Up Care for Children Prescribed ADHD Medication (ADD) to name a few. Telehealth was also added to the new Child and Adolescent Well-Care Visits (WCV) and Well-Child Visits in the First 30 Months of Life (W30) measures. This change no doubt helped to boost rates where they may have substantially lower. In addition, although telehealth was added to the Ambulatory Care (AMB) outpatient indicator, utilization rates for all MCOs were down sharply.
- There were several measures where eight of nine MCO rates were above/better than the National HEDIS Mean (NHM); Weight Assessment and Counseling for Physical Activity for Children/Adolescents (WCC-PA), Lead Screening in Children (LSC), Asthma Medication Ratio (AMR), Chlamydia Screening in Women (CHL) – Total, Prenatal and Postpartum Care (PPC)-Post, and Use of Opioids (UOP) – Multiple pharmacies.
- All MCOs scored above the NHM for Lower Back Pain (LBP).
- ADD acute phase– despite COVID, with the addition of telehealth visits to the specifications, each MCO that had a denominator of 30 or greater had a higher rate than the previous year.
- The Maryland Average Reportable Rate (MARR) increased for several medication–related measures/indicators, such as AMR, SPD 80% compliance and Statin Therapy for Patients with Cardiovascular Disease (SPC) 80% compliance.

Demonstration Evaluation

During the quarter, the Department collaborated with its independent evaluator, the Hilltop Institute, to complete work on the CY 2021 evaluation, which covers from CY 2015 through CY 2019 (see Appendix B). During the quarter, an initial meeting was held to kick off the CY 2022 evaluation planning process.

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 submitted its revised SUD monitoring protocol on June 7, 2021 and is awaiting approval.

Enclosures/Attachments

- Appendix A: Maryland Budget Neutrality Report as of September 30, 2021

State Contact(s)

Ms. Tricia Roddy,
Deputy Medicaid Director
Office of Health Care Financing
Maryland Department of Health
201 W. Preston Street, Rm. 224
Baltimore, Maryland 21201
(410) 767-5809

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