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

Introduction

Now in its twenty-third year, Maryland implemented the HealthChoice program and moved its fee-for-service (FFS) enrollees into a managed care payment system following federal approval in 1996. Under the statewide health care reform program, the State enrolls individuals eligible through the demonstration into a managed care organization (MCO) for comprehensive primary and acute care or one of the demonstration's authorized health care programs.

The Maryland Department of Health's (the Department's) goal in implementing and continuing the demonstration is to improve the health status of low-income Marylanders by:

- Improving access to health care for the Medicaid population;
- Improving the quality of health services delivered;
- Providing patient-focused, comprehensive, and coordinated care designed to meet healthcare needs by providing each member a single "medical home" through a primary care provider (PCP);
- Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services, such as regular prenatal care; and
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies.

Subsequent to the initial approval, Maryland has requested and received several program extensions and amendments. The waiver amendment approved in April 2020 allowed the Department to establish a limited Collaborative Care Model (CoCM) Pilot Program that will serve a limited number of HealthChoice participants to receive behavioral health care in their primary care setting beginning in July 2020.

Enrollment Information

Tables 1 and 2 below provides 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 June 30, 2019	Participants as of June 30, 2020	Year 23 Change	Year 23 Percent Change
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	217,196	245,949	28,753	13.0%
Affordable Care Act (ACA) Expansion Adults	310,031	334,226	24,195	7.8%
Medicaid Children	453,455	468,135	14,680	3.2%
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	89,898	90,783	885	1.0%
SSI/BD Children	23,248	23,688	440	1.9%
Medically-Needy Adults	22,724	23,479	755	3.3%
Medically-Needy Children	6,153	6,557	404	6.6%
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults[2]	13,219	12,142	-1,077	-8.1%
Maryland Children's Health Program (MCHP) [3]	116,006	107,293	-8,713	-7.5%
MCHP Premium	35,497	34,945	-552	-1.6%
Presumptively Eligible Pregnant Women (PEPW)	0	0	0	0.0%
Family Planning	11,032	12,207	1,175	10.7%
Increased Community Services (ICS)	30	29	N/A	N/A
Women's Breast and Cervical Cancer Health Program (WBCCHP)	94	66	N/A	N/A

[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] Decreases observed in the SOBRA category since the previous demonstration year can be attributed to changes in the eligibility determination process. In FY 2019, individuals reporting pregnancies had been re-categorized to one of the pregnancy eligibility groups, rather than retaining their historic eligibility group. The Department reverted to its previous eligibility process during the current demonstration year.

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

Table 2. Enrollment as a Proportion of Total

Demonstration Populations	Total Enrollment % - June 2019	Total Enrollment % - June 2020	Share Change
Parents/Caretaker Relatives <116% FPL and Former Foster Care	16.7%	18.1%	1.4%
ACA Expansion Adults	23.9%	24.6%	0.7%
Medicaid Children	34.9%	34.4%	-0.5%
SSI/BD Adults	6.9%	6.7%	-0.2%
SSI/BD Children	1.8%	1.7%	0.0%
Medically-Needy Adults	1.7%	1.7%	0.0%
Medically-Needy Children	0.5%	0.5%	0.0%
SOBRA Adults	1.0%	0.9%	-0.1%
MCHP	8.9%	7.9%	-1.0%
MCHP Premium	2.7%	2.6%	-0.2%
PEPW*	0.0%	0.0%	0.0%
Family Planning	0.8%	0.9%	0.0%
ICS*	N/A	N/A	N/A
WBCCTP*	N/A	N/A	N/A

**Percent is less than 0.0*

Table 3 provides member month counts for each month of the quarter and compares this quarter's totals against the previous quarter.

Table 3. Member Months

Eligibility Group	Total for Previous Quarter (ending March 2020)	Current Quarter Month 1 (April 2020)	Current Quarter Month 2 (May 2020)	Current Quarter Month 3 (June 2020)	Total for Quarter Ending June 2020
Parent/Caretaker Relatives <116% FPL and Former Foster Care	717,638	241,680	244,570	245,949	732,199
ACA Expansion Adults	938,031	321,879	328,994	334,226	985,099
Medicaid Children	1,344,013	453,665	461,685	468,135	1,383,485
SSI/BD Adults	272,761	90,642	90,819	90,783	272,244

Eligibility Group	Total for Previous Quarter (ending March 2020)	Current Quarter Month 1 (April 2020)	Current Quarter Month 2 (May 2020)	Current Quarter Month 3 (June 2020)	Total for Quarter Ending June 2020
SSI/BD Children	69,443	23,095	23,433	23,688	70,216
Medically-Needy Adults	70,593	24,154	24,126	23,479	71,759
Medically-Needy Children	18,772	6,555	6,550	6,557	19,662
SOBRA Adults[1]	37,891	10,821	11,599	12,142	34,562
MCHP	314,614	105,751	106,487	107,293	319,531
MCHP Premium	104,483	35,039	35,198	34,945	105,182
PEPW	0	0	0	0	0
Family Planning	37,108	12,562	12,361	12,207	37,130
WBCCHP	214	67	67	66	200
ICS	89	30	30	29	89

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 4. Substance Use Disorder Residential Treatment Utilization Limited to Medicaid Funding, FY 2020[4]

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

[4] 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.

Level of Service	No. of Participants	No. of Days
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 CMS. 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 participants 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.

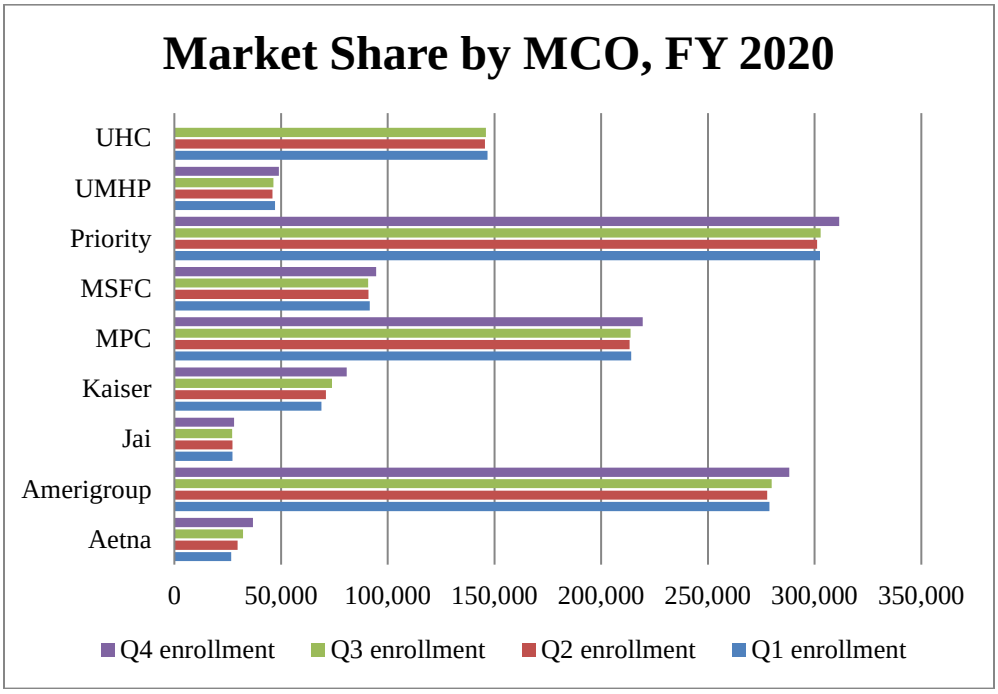
Under the Maryland MOM model, HealthChoice MCOs will provide a set of enhanced case management services, standardized social determinants of health screenings and care coordination. Exact services and screenings will be developed over the course of the MOM pre-implementation period (January 2020 - June 2021) and refined during the MOM transition period (July 2021 - June 2022), which is the first year of model services. During this quarter, the Maryland MOM team continued activities aimed at building the foundations for the pre-implementation year, including: 1) development of a coverage and payment strategy, including consultations with CMS; 2) briefing internal and external stakeholders on the model; and 3) leading the quarterly, webinar-based design collaboratives with Medicaid MCOs to design key areas of model implementation. The second design collaborative, held on May 12, 2020, focused on participant engagement strategies, informed consent and data-sharing.

Operational/Policy Developments/Issues

Market Share

As of the culmination of FY 2020, Quarter 4, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (2.i percent), Amerigroup (22.9 percent); Jai Medical Systems (2.2 percent); Kaiser Permanente (6.4 percent); Maryland Physicians Care (17.4 percent); MedStar Family Choice (7.5 percent); Priority Partners (24.7 percent); University of Maryland Health Partners (3.9 percent); and United Healthcare (12.0 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in April, May, and June during the past quarter. 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. While the annual legislative session adjourned early due to the pandemic in the previous quarter, the MMAC also received an update on passed legislation with potential impacts to Medicaid and the Department.

In April, the MMAC received an update on all of the waivers the Department applied for due to the state of emergency caused by the COVID-19 pandemic. They were also given a brief overview of the Department's annual quality assurance activities.

During the May meeting, the MMAC received several updates related to COVID-19 response, including health information exchange- (HIE-) related actions, the special enrollment period in the Maryland Health Benefit Exchange (MHBE), and changes in vaccination rates. The May MMAC meeting was followed by the HealthChoice Post Award Forum.

At the June meeting, the Department reviewed the latest HealthChoice evaluation (see the attached HealthChoice Evaluation) and gave COVID-19 updates.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women. The program covers medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments for sexually-transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education and referrals. The Department has expanded eligibility under its Family Planning Program to lift the age limit, and open coverage to include men, effective July 1, 2018.

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

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

Enrollment as of the end of the fiscal year was 12,588 participants, with an average monthly enrollment of 12,369, an increase of 5.8 percent over the previous quarter.

Table 5. Average Quarterly Family Planning Enrollment

Q1 Enrollment	Percent Change	Q2 Enrollment	Percent Change	Q3 Enrollment	Percent Change	Q4 Enrollment	Percent Change
11,204	1.6%	11,693	4.4%	12,369	5.8%	12,377	0.1%

Table 6. Family Planning and Related Statistics, July 2018 – June 2019

No. of Individuals Enrolled in the Demonstration (Total with Any Period of Eligibility)	Total No. of Participants	No. of Actual Births to Family Planning Demonstration Participants After Enrollment	Average Total Medicaid Expenditures for a Medicaid-funded Birth
15,064	1,905	200	$30,702

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 7. Current REM Program Enrollment

FY 2020	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	256	189	114	114	4,293
Quarter 2	227	174	100	88	4,295
Quarter 3	244	190	67	84	4,320
Quarter 4	185	181	91	96	4.366

Table 8. REM Complaints

FY 2020 Q4	Transportation	Dental	DMS/ DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	6	0	0
REM Hotline	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	6	0	0

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 9. REM Significant Events Reported by Case Managers

FY 2020 Q4	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	1	3	0	35	9	0	7	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 June 30, 2020, there were 29 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 June 30, 2020, the Premium program had 34,945 participants, with MCHP at 107,293 participants.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Throughout this reporting period, the Department continued to focus on implementing the HealthChoice DPP, and continued to convene MCOs through implementing the Coverage 2.0-Part 2: Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program (Coverage 2.0-Part 2) grant. As mentioned in previous reports, the purpose of this grant—funded by the Centers for Disease Control and Prevention (CDC)—is to continue sustainability work begun in the Medicaid and National DPP demonstration, which involved four of Maryland's nine MCOs, and subsequently through the initial year of Coverage 2.0 capacity-building grant. As part of its Coverage 2.0-Part 2 work plan, Medicaid engaged a vendor to produce two testimonial videos outlining the experiences of Medicaid and National DPP demonstration participants, as well as capturing perspectives of lifestyle coaches and a physician provider. The two videos with social clips and associated print ads were completed. The Department is working with their internal communication's team to develop a marketing guide and plan to be rolled out in fall 2020.

The Department continues to work with all nine MCOs to incorporate lessons learned from the demonstration in the areas of operational and financial management systems building, quality improvement processes, and the identification, strengthening, and coordination of stakeholders' roles into the development of sustainable coverage models for the National DPP Lifestyle Change Program in Medicaid.

In this reporting period, the Department continued to address program implementation questions through an updated Frequently-Asked Questions (FAQ) document posted online, respond to questions received through a dedicated HealthChoice DPP mailbox and direct emails from MCOs and DPP providers, and hold technical assistance calls with MCOs and DPP providers. As of the end of the quarter, nearly all MCOs had contracted with at least one DPP provider, and most have now contracted with at least one virtual and one in-person DPP provider.

CDC-recognized lifestyle change programs with pending, preliminary or full recognition status continued to apply to be Maryland Medicaid DPP providers through the online provider portal known as ePREP. As of the end of the quarter, 18 DPP providers were fully-enrolled, and several more were in the review process. MCOs continued efforts to contract with eligible DPP providers and prepare member and provider materials. The Department developed a supplemental guidance document that shares best practices and assists CDC-recognized lifestyle change programs with the DPP provider enrollment process. The Department held a webinar to review this guidance in April and provided HealthChoice DPP updates on the quarterly Maryland DPP network webinar.

Community Health Pilots

As of June 2020, there were six local government entities approved for the Community Health Pilots that were included as part of the 2016 HealthChoice waiver renewal, four in the Assistance

in Community Integration Services (ACIS) pilot and two in the Evidence-Based Home Visiting Services (HVS) pilot. The pilots are effective through December 31, 2021 and are scheduled to be funded for the duration of the five-year waiver period.

The two HVS Pilots had enrolled 46 families through June 2020. The Department is pleased to report that with this development, both Lead Entities (LEs) have reached their projected enrollment for FY 2020.

HVS LEs continue to engage with local community-based organizations and MCOs to implement innovative supports for pilot participants amid COVID-19. In Quarter 4, one entity worked in partnership to plan a virtual baby shower with meal delivery for participating families.

Approximately 278 individuals are enrolled in the ACIS Pilot and receiving supportive housing services as of June 2020, achieving 46 percent of the pilot's new statewide enrollment cap. Counties continue to improve processes related to pilot enrollment, such as Medicaid eligibility verification and best practices for working with ACIS-enrolled individuals.

The ACIS Pilot continues to accept applications on a rolling basis. Lead local government entities are encouraged to apply for the remaining 200 statewide ACIS beneficiary spaces.

In Quarter 4, ACIS LEs continued telephonic service delivery due to COVID-19. For ACIS Pilots, this included allowing service provision via telecommunications methods. For HVS Pilots, the Department recommended LEs follow the Healthy Families America model guidance, which included allowing service provision via telecommunication methods.

The Department continues to provide technical assistance and guidance to ACIS LEs as they deliver services under the national public health emergency. A virtual Learning Collaborative will be held remotely during the first quarter of FY 2021. Formal guidance regarding the Medicare-Medicaid eligible population is under review by the Department and will be shared during the upcoming quarter.

Expenditure Containment Initiatives

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

HealthChoice Financial Monitoring Report (HFMR)

During this quarter, the Department's contracted auditors finalized all MCO financial reviews for 2018, and the MCOs reported incurred but not reported (IBNR) was independently evaluated. Consolidated reports were also prepared. Instructions and templates for 2019 data were provided to the MCOs in March. These reports reflect Service Year 2019 MCO experience as of March 31, 2020 and were due on May 18, 2020.

MCOs provided Service Year 2019 HFMR reports (including Financial Templates) as of March 31, 2020 during May of 2020. This data is used by the Hilltop Institute and the Department's contracted actuary to assist in the HealthChoice trend analysis, regional analysis and for the validation process of CY 2021 HealthChoice rates. Unadjusted consolidated 2019 HFMRs by region were provided to all MCOs on June 12, 2020. MCOs will have an opportunity to update their Service Year 2019 experience in November. The 2019 submission in November will most likely be the base period for the 2022 HealthChoice rate-setting period. Updated instructions will likely be provided in September of 2020.

MCO Rates

CY 2021 Rate-Setting

The rate-setting team participated in several meetings this quarter. In April, they participated on nine MCO exit conference calls with the Department and the accounting firm. The rate-setting team also co-facilitated 2021 HealthChoice MCO rate-setting meetings that were held in April, May, and June 2020. Topics of discussion included:

- Mid-year adjustments of HIV;
- Geographic and demographic rates;
- Constant cohort analysis for CY 2018 and CY 2019;
- Presentation of final Departmental and MCO issues;
- Review of Adult hearing experience for CY 2019;
- High cost drug mitigation strategies;
- Regional presentation;
- MCO outlier adjustments;
- Non-state plan service adjustments;
- Global Risk Corridor Concept and proposed high-cost, low-volume drug list for 2021;
- Preliminary 2020 geographic and demographic adjustments;
- Final 2019 Hepatitis C therapy analysis;
- Impact of BH ASO claim processing on CY 2019 risk adjusted capital (RAC) assignments;
- Diabetes Prevention Program (Risk Corridor); and
- The actuarial firm's trend presentation.

The rate-setting team provided the accounting firm with proposed comments and revisions regarding nine 2018 MCO financial reviews as well as the proposed comments and revisions regarding nine CY 2018 incurred but not reported (IBNR) reviews.

The rate-setting team provided the actuarial firm with a number of different rates, adjustments, models and data. This included the final audited 2018 financial base model, the 2018 re-insurance administrative cost adjustment, the 2018 efficiency adjustment that incorporates the exclusion of Kaiser from the rate base, the 2018 adult dental administrative cost adjustment, the adult co-pay adjustment, the hearing benefit adjustment, the base adjustments regarding non-state plan services, the prescription adjustment reflecting the increase in the dispensing period of contraceptives from six months to 12 months, the cost shift adjustment of the pharmacy benefit manager (PBM) spread, the preliminary detailed CY 2021 HealthChoice membership forecast.

The preliminary 2019 financial base model, the budget adjustment for DPP, the CY 2019 and CY 2020 change in GMS discount calculation, and the CY 2018 and 2019 Health Services Cost Review Commission trend data.

The rate-setting team received preliminary MCO financials for 2019. The team is still finalizing two of the submissions. The rate-setting team also provided MCOs with consolidated preliminary CY 2019 financials.

CY 2020 and CY 2019 Rate-Setting

In support of the CY 2020 HealthChoice rates, the rate-setting team participated in a number of conference calls. They spoke with HSCRC and the actuarial firm regarding HSCRC trends and projections. The team participated on a call with the MCOs, the actuarial firm, and the Department to present findings regarding HIV prescription costs in CY 2020.

For the 2020 rates, the rate-setting team answered MCO questions regarding the HIV prescription carve-in and the global risk corridor in conjunction with the actuarial firm. They also provided HSCRC with restated monthly MCO membership in support of HSCRC trend analysis. In conjunction with the actuarial firm, the rate-setting team prepared a proposal to implement for global risk corridor to mitigate risk associated with COVID-19 beginning with calendar year 2020. The rate-setting team provided the Department with the first semi-annual rural access incentive calculation for 2020. On behalf of the rate-setting team, the actuarial firm provided a modified build-up of the HIV Rx component in the 2020 rates.

In support of the CY 2019 rates, the rate-setting team provided the Department with MCO settlement calculations for adult hearing services during the CY 2019 period. The also provided the Department with an estimate of the CY 2019 pharmacy revenue component of the HealthChoice rates. The team provided the actuarial firm with HealthChoice underwriting exhibit (Reported Basis) for CY 2019.

Additional Activities

The rate-setting team provided the Department with trauma calculations for March, April, and May 2020. They also participated in two nursing home liaison conferences calls, one held in April 2020 and the other held in May 2020.

The rate-setting team prepared illustrative CY 2020 regional rate ranges for the proposed PACE expansion program and also prepared a memo regarding the expansion.

Financial/Budget Neutrality Development/Issues

The Department is in compliance with all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements sections of the Special Terms and Conditions (STCs). The Department’s updated budget neutrality report can be found in Appendix A of this report.

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. The Help Line received 152,061 calls during this demonstration year.[5] 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 2020[6]

[5] Note: The Help Line was fully operational in the office until March 20, 2020 when the remote work process started due to the pandemic; the data for incoming call volume to the office are missing for eight days in March.
[6] Sourced from CRM.

CMS Quarterly Report
Total Recipient Complaints - excluding Billing
FY 19 vs FY 20

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	
Fiscal Year		2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
Specialist	#	106	112	77	106	17	18	54	46	139	109	45	48	58	84	109	107	49	35	654	665
	%	16%	17%	12%	16%	3%	3%	8%	7%	21%	16%	7%	7%	9%	13%	17%	16%	7%	5%	25%	24%
Pharmacy	#	9	8	95	98	9	15	26	35	137	132	35	53	141	122	127	146	40	32	619	641
	%	1%	1%	15%	15%	1%	2%	4%	5%	22%	21%	6%	8%	23%	19%	21%	23%	6%	5%	24%	23%
PCP	#	77	119	58	113	16	15	30	46	53	83	41	35	70	82	55	98	23	39	423	630
	%	18%	19%	14%	18%	4%	2%	7%	7%	13%	13%	10%	6%	17%	13%	13%	16%	5%	6%	16%	23%
Prenatal	#	53	54	98	99	8	8	79	75	75	63	59	59	134	104	99	89	21	33	626	584
	%	8%	9%	16%	17%	1%	1%	13%	13%	12%	11%	9%	10%	21%	18%	16%	15%	3%	6%	24%	21%
Sub Totals	#	245	293	328	416	50	56	189	202	404	387	180	195	403	392	390	440	133	139	2,322	2,520
	%	11%	12%	14%	17%	2%	2%	8%	8%	17%	15%	8%	8%	17%	16%	17%	17%	6%	6%	89%	90%
All Complaint Totals	#	260	303	400	467	53	58	201	211	496	466	189	206	441	454	423	466	141	154	2,604	2,785
	%	10%	11%	15%	17%	2%	2%	8%	8%	19%	17%	7%	7%	17%	16%	16%	17%	5%	6%		
Other Categories		15	10	72	51	3	2	12	9	92	79	9	11	38	62	33	26	8	15	282	265

There were 3,607 total MCO recipient complaints in FY 2020 compared to 3,826 in FY 2019 (all ages). Seventy-seven percent of the complaints (2,785) were related to access to care. The remaining 23 percent (822) were billing complaints. The top three member complaint categories were accessing specialists, pharmacy services, and primary care providers (PCPs). The categories not specified (Other Categories) for the non-billing complaints include appeals and grievances, access to therapies (occupational therapy-OT, physical therapy-PT, speech therapy-ST), adult dental and vision services, and obtaining DME/DMS (Durable Medical Equipment/Durable Medical Supplies). Overall, Amerigroup, Maryland Physicians Care, and United Healthcare had the high percentage of complaints (17 percent of all care-related complaints), which were mainly attributed to difficulty accessing pharmacy services, primary care providers, and specialists.

The number of prenatal care complaints decreased from 626 to 584. Prenatal complaints comprised 21 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, 996 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 2020[7]

CMS Quarterly Report
Total Recipient Complaints - excluding Billing: Under age 21 only
FY 19 vs FY 20

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	
Fiscal Year		2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
PCP	#	28	33	32	48	7	4	13	19	22	27	17	12	27	42	24	32	10	12	180	229
	%	16%	14%	18%	21%	4%	2%	7%	8%	12%	12%	9%	5%	15%	18%	13%	14%	6%	5%	32%	38%
Specialist	#	30	19	16	27	1	3	11	11	27	16	9	8	14	15	30	28	11	7	149	134
	%	20%	14%	11%	20%	1%	2%	7%	8%	18%	12%	6%	6%	9%	11%	20%	21%	7%	5%	26%	22%
Pharmacy	#	1	5	23	25	2	0	5	7	23	19	5	7	24	28	18	21	4	6	105	118
	%	1%	4%	22%	21%	2%	0%	5%	6%	22%	16%	5%	6%	23%	24%	17%	18%	4%	5%	18%	19%
Prenatal	#	6	9	13	15	1	0	2	3	6	8	7	10	19	7	14	12	2	4	70	68
	%	9%	13%	19%	22%	1%	0%	3%	4%	9%	12%	10%	15%	27%	10%	20%	18%	3%	6%	12%	11%
Sub Totals	#	65	66	84	115	11	7	31	40	78	70	38	37	84	92	86	93	27	29	504	549
	%	13%	12%	17%	21%	2%	1%	6%	7%	15%	13%	8%	7%	17%	17%	17%	17%	5%	5%		
All EPSDT Complaint Totals	#	67	67	98	129	11	7	36	44	97	78	41	40	93	114	96	99	29	31	568	609
	%	12%	11%	17%	21%	2%	1%	6%	7%	17%	13%	7%	7%	16%	19%	17%	16%	5%	5%		
Other Categories		2	1	14	14	0	0	5	4	19	8	3	3	9	22	10	6	2	2	64	60

There were 549 member complaints (non-billing) for recipients under age 21, or 15 percent of the total complaints (549 of 3,607). The top complaint category was access to primary care providers. 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 specialists while children (under 21) most often report difficulty accessing a primary care provider.

Table 10. Total Recipient Billing Complaints - FY 2020[8]

[7] Source from CRM.
[8] Source: CRM.

CMS Quarterly Report
Total Recipient Complaints - Billing only
FY 19 vs FY 20

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	
Fiscal Year		2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
Emergency	#	10	18	120	57	5	0	35	24	77	47	38	28	59	66	30	32	11	11	385	283
	%	3%	6%	0%	20%	0%	0%	0%	8%	0%	17%	0%	10%	0%	23%	0%	11%	0%	4%	32%	34%
PCP	#	7	16	132	54	3	3	22	12	76	27	46	16	70	41	28	16	11	14	395	199
	%	2%	8%	33%	27%	1%	2%	6%	6%	19%	14%	12%	8%	18%	21%	7%	8%	3%	7%	32%	24%
Laboratory /Test	#	10	8	36	26	2	1	11	3	25	30	17	10	33	18	28	13	8	4	170	113
	%	6%	7%	21%	23%	1%	1%	6%	3%	15%	27%	10%	9%	19%	16%	16%	12%	5%	4%	14%	14%
Specialist	#	3	4	15	13	1	1	5	11	21	9	12	9	7	12	7	13	1	3	72	75
	%	4%	5%	21%	17%	1%	1%	7%	15%	29%	12%	17%	12%	10%	16%	10%	17%	1%	4%	6%	9%
Sub Totals	#	30	46	303	150	11	5	73	50	199	113	113	63	169	137	93	74	31	32	1,022	670
	%	3%	7%	30%	22%	1%	1%	7%	7%	19%	17%	11%	9%	17%	20%	9%	11%	3%	5%	84%	82%
All Billing Complaint Totals	#	35	57	354	180	12	9	98	59	238	140	138	78	197	165	113	98	37	36	1,222	822
	%	3%	7%	29%	22%	1%	1%	8%	7%	19%	17%	11%	9%	16%	20%	9%	12%	3%	4%		
Other Categories		5	11	51	30	1	4	25	9	39	27	25	15	28	28	20	24	6	4	200	152

Enrollee billing complaints comprised 23 percent of total MCO complaints in FY 2020. Overall, the top bill type this fiscal year was Emergency Department, which comprised 34 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. Amerigroup continues to have 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 at the local health departments for follow-up to ensure the complaint has been resolved. When trends are identified, the HealthChoice Medical Advisor makes an inquiry to the MCO. If potential policy issues, systems issues, or barriers are identified, the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly's 2020 session began on January 8, 2020. Originally scheduled to adjourn on April 6, the legislative session adjourned sine die on March 18, 2020 due to the COVID-19 outbreak. The General Assembly approved the following bills during its 2020 session:

- **SB 192** (Budget Reconciliation & Financing Act) requires the Department to establish a Value-Based Purchasing Program that awards financial incentives to and assesses penalties on MCOs based on their performance on health measures established by the Department (not more than one percent of the amount of capitated payments received by an MCO each year shall be subject to the collection of penalties under the program, and any penalty or capitation adjustment imposed may not be implemented by withholding a capitation payment); also lowers amount of the Medicaid Deficit Assessment by $15 million, from $309.8 million to $294.8 million, for FY 2021 and each year thereafter; authorizes transfer of $750,000 from the State Board of Pharmacy Fund to the Medical Assistance Program in FY 2021 and FY 2022.
- **HB 409** (Maryland Medical Assistance Program – Participation of School-Based Health Centers – Regulations) requires the Department, by January 1, 2021 to revise its regulations regarding school-based health centers that may participate in Medicaid to include school-based health centers that have a written agreement with a sponsoring agency that meets the specified requirements identified by Maryland State Department of Education.
- **HB 601** (Health Insurance – Provider Panels – Providers of Community-Based Health Services) prohibits insurers from rejecting a provider who provides community-based health services for an accredited program for participation on their provider panel because the provider practices within the scope of the provider's license and holds a specified license or credential, including registered psychology associates.
- **HB 652/SB 931** (Maryland Medical Assistance Program & Health Insurance – Specialty Drugs – Definition) prohibits the Department from considering drugs prescribed to treat diabetes, HIV, or AIDS to be specialty drugs under Medicaid.
- **HB 1420** (Hospitals – Financial Assistance Policies & Bill Collection) alters the requirements of hospital financial assistance policies, including the thresholds for providing free and reduced-cost medically-necessary care; it also requires the HSCRC to evaluate the impact of specified additional changes to hospital financial assistance policies and report by January 1, 2021 on its findings and recommendations regarding any impact on (1) the amount of hospital uncompensated care included in hospital rates and (2) the total cost of care for Medicare, Medicaid, commercial insurers, and self-pay individuals.
- **SB 99** (Health Insurance Benefit Cards, Prescription Benefit Cards & Other Technology – Information of Regulatory Agency) requires commercial insurers and MCOs (and PBMs that contract with MCOs) to print on a health insurance benefit card or prescription benefit card the acronym used for the State agency that regulates the policy or contract (insurers, MCOs or PBMs are not precluded from including any other information on a card).
- **SB 402/HB 448** (Health Care Practitioners – Telehealth & Shortage) authorizes health care practitioners to establish a practitioner-patient relationship through either a 'synchronous' or 'asynchronous' telehealth interaction; health care practitioners may not prescribe a Schedule II opiate for treatment of pain through telehealth unless the individual receiving the prescription is in a healthcare facility or the Governor has declared a state of emergency due to a catastrophic health emergency. It is the intent of the General Assembly that the Governor must develop and implement a plan to facilitate the joining of the State with adjacent states and jurisdictions in interstate compacts regulating health care practitioners for the purpose of improving patient access to health care practitioners in State communities experiencing a health care practitioner shortage.

- **SB 475** (Health Insurance – Pediatric Autoimmune Disorders – Coverage) requires Medicaid (subject to the limitations of the State budget) and commercial insurers to provide coverage for medically-necessary diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute onset neuropsychiatric syndrome (PANS), including the use of intravenous immunoglobulin therapy (IVIG); Medicaid and commercial insurers are not required to cover rituximab unless the US Food and Drug Administration approves it for the treatment of PANDAS and PANS.
- **SB 502/HB 1208** (Telehealth – Mental Health & Chronic Condition Management Services – Coverage & Pilot Program) - requires Medicaid (subject to the limitations of the State budget) as well as commercial insurers to provide mental health services appropriately delivered through telehealth to a patient in the patient's home setting; by December 1, 2020 the Department must apply to CMS for a §1115 waiver to implement a telehealth pilot program (telehealth services under the pilot must be limited to chronic condition management services and include synchronous and asynchronous interactions, and the Department must collect outcomes data on recipients of telehealth services under the pilot program to evaluate the program's effectiveness). The Department must also report to the General Assembly by December 1, 2021 on whether substance use disorder services may be appropriately provided through telehealth to a patient in the patient's home setting; the pilot program and study provisions of the bill sunset on June 30, 2025.

Quality Assurance/Monitoring Activity

The Department's Medical Benefits Management Administration (MBMA) is responsible for contracting and oversight of the HealthChoice program. MBMA ensures compliance with the initiatives established in 42 CFR 438, Subpart D, and that all MCOs that participate in the HealthChoice program apply these principles universally and appropriately. The functions and infrastructure of MBMA support efforts to identify and address quality issues efficiently and effectively. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care process and help to ensure that health care is not compromised. The Division of HealthChoice Quality Assurance (DHQA) within MBMA is primarily responsible for coordinating quality activities and monitoring CMS quality improvement requirements for the HealthChoice program.

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

- Qlarant Quality Solutions, Inc. (Qlarant) is the Department's external quality review organization (EQRO). Qlarant is responsible for performance improvement project validation; performance measure validation for the Value-Based Purchasing program; compliance reviews to ensure MCOs comply with 42 CFR 438, Subpart D and 42 CFR 438.330; MCO network adequacy validation; encounter data validation; clinical quality studies focused on MCO appeals, grievances, and pre-service denials; and development of an annual consumer report card to assist HealthChoice enrollees with MCO selection.
- MetaStar, Inc. (MetaStar) is the Department's HEDIS Compliance Auditor. MetaStar is responsible for ensuring compliance with the National Committee for Quality Assurance (NCQA) guidelines for reporting Healthcare Effectiveness Data and Information Set (HEDIS) measures, including onsite audits of MCO systems and processes to report data.

MetaStar also reviews and approves the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey sample frame. At the end of the audit cycle, MetaStar compiles a comprehensive report with trending MCO performance on the HEDIS measures.

- Center for the Study of Services, Inc. (CSS) is the Department's survey administration vendor. CSS administers the CAHPS surveys for adults and children, as well as the Primary Care Provider (PCP) Satisfaction Survey. CSS monitors compliance with survey protocols and compiles reporting on the results of both survey efforts.

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

Activity	Vendor	Status	Comments
Systems Performance Review (SPR)	Qlarant	In Progress	Qlarant completed the preliminary review and shared those findings with the MCOs. The MCOs are in the process of submitting their corrective action plans (CAPs) to Qlarant for analysis.
EPSDT Medical Record Review	Qlarant	In Progress	This activity was placed on hold due to the COVID-19 state of emergency because the activity includes in-person medical record reviews. Qlarant and the Department worked collaboratively to execute a cloud-based secure exchange portal, Proofpoint (as well as secured fax) in order to resume the EPSDT review.
Consumer Report Card	Qlarant	Complete	The 2020 Consumer Report Card was finalized and released in early February. Results appear in the Annual Technical Report (ATR) that was submitted in April.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	The MCOs worked on quarterly submissions for the Lead Screening PIP, which is on a rapid-cycle project submission. Qlarant and the Department received, reviewed, and validated the submissions. Ongoing efforts are underway to provide feedback to MCOs on meaningful interventions.
Encounter Data Validation (EDV)	Qlarant	Complete	Qlarant and Hilltop worked together to finalize the CY 2018 report. Results appeared in the ATR, submitted in April. One MCO (UMHP) was required to submit a CAP.
Network Adequacy Validation (NAV)	Qlarant	In Progress	This activity was on hold due to the COVID-19 state of emergency. However, activities have resumed and currently awaiting provider listing submissions from the MCOs with a deadline of July 31, 2020.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials	Qlarant	In Progress	Qlarant and the Department reviewed the first quarter submissions that were submitted by the MCOs and provided feedback in regards to the formatting issues when submitting data. The next quarterly submissions are due July 31st.

Activity	Vendor	Status	Comments
HEDIS Audits and Reporting (HEDIS)	MetaStar	Complete	HEDIS 2019 was Aetna Better Health's (ABH) first year reporting Maryland Medicaid data as an MCO. Results show Maryland MCOs are high performing across the majority of measures and within each measure domain. There were 16 Effectiveness of Care measures where at least eight out of the nine MCOs performed above the National HEDIS Mean. This level of performance demonstrates that superior care is being delivered to HealthChoice participants.
Value Based Purchasing Initiative (VBP)	Qlarant	Complete	Qlarant finalized the CY 2018 VBP report in January and shared it with the Department and the MCOs. ABH did not participate in VBP because it joined the HealthChoice program in October 2017 and did not have sufficient data to report. Three MCOs (Jai, Kaiser, and UMHP) earned net incentives. Results appear in the ATR that was submitted in April.
CAHPS Survey Administration (CAHPS)	CSS	Complete	For Reporting Year (RY) 2019, ABH, the newest HealthChoice MCO, participated in the Enrollee Satisfaction survey for the first time. The survey was fielded between February and May 2019. The final aggregated survey sample for the HealthChoice organizations included 12,150 adult members. 2,443 adult members completed the survey, resulting in a response rate of 21%. The final aggregated survey sample for the HealthChoice organizations included 28,632 child members. 3,618 surveys were completed for child members, resulting in a response rate of 25%. Results appeared in the ATR that was submitted in April.
PCP Satisfaction Survey Administration	CSS	Complete	The PCP Satisfaction Survey for RY 2019 (CY 2018 data) was administered to primary care providers (PCPs) from each of the nine HealthChoice MCOs. ABH, the newest HealthChoice MCO, participated in the PCP survey for the first time in 2019. The PCP survey was fielded between March and June 2019. The final survey sample included 7,044 physicians. 1,266 physicians completed the survey, resulting in an adjusted response rate of 19%.
Annual Technical Report (ATR)	Qlarant	Complete	The ATR was submitted to CMS by the deadline of April 30, 2020.

The Annual Technical Report (ATR) is a compilation of quality assurance activity reports for services and activities rendered during measurement years 2018 and 2019 and is included in Appendix B. The Department has listed highlights for each activity below.

- Systems Performance Review
    - There are eleven standards in the Systems Performance Review. For calendar year 2018, all MCOs had a perfect score for three standards: Systematic Process of Quality Assessment, Continuity of Care, and Outreach. There were three other standards where eight of the MCOs (Amerigroup, Jai, Kaiser, MPC, MSFC, Priority Partners, UHC, and UMHP) were exempt, as they had a perfect score in past reviews: Accountability to Governing Body, Credentialing and Recredentialing, and Health Education. In total, there were twenty-five CAPs by all MCOs under this activity (see chart below for CAP breakdown per MCO).

CAPs Required	ABH	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
	1	5	0	5	4	2	3	1	4

- Value-Based Purchasing
    - In calendar year 2018, thirteen measures were evaluated among eight of the nine MCOs. ABH was exempt. Three MCOs (Jai, Kaiser, and UMHP) earned net incentives while the remaining five (Amerigroup, MPC, MSFC, Priority Partners, and UHC) incurred net disincentives.
- Performance Improvement Projects
    - Eight MCOs (excluding Aetna) conducted two performance improvement projects (PIPs) analyzed in calendar year 2019 against HEDIS measures and Maryland encounter data measures. For the Asthma Medication Ratio PIP, three MCOs (Amerigroup, Jai and Priority Partners) demonstrated improvement over one year. For the Lead Screening PIP, research showed that all eight MCOs improved performance over baseline rates for both the HEDIS measure and the Maryland encounter data measure.
- Encounter Data Validation
    - Minimum compliance indicators for the Encounter Data Validation were set at 90 percent for the medical record review activity, with only one MCO (UMHP) requiring a CAP.
- EPSDT Medical Record Review
    - The activity consisted of the assessment of over 2,400 medical records with a minimum compliance threshold for each of the five indicators set at 80 percent. One MCO (Amerigroup) required a CAP; however, the results showed that all MCO scores average at or above 90 percent, with the HealthChoice aggregate results demonstrating continuous improvement over the past three calendar years.
- Consumer Report Card
    - The 2019 Consumer Report Card appears below.

- Focused Reviews of Grievances, Appeals, and Denials
    - The activity reviewed grievances, appeals, and denials from the final two quarters of calendar year 2018 and the first two quarters of calendar year 2019. The grievance assessment found that five MCOs (ABH, Amerigroup, Jai, UHC, and UMHP) met all requirements with four MCOs (Kaiser, MPC, MSFC, and Priority Partners) receiving one or more partially met findings. Analysis of the appeals for MCOs revealed that three MCOs (Jai, MSFC, and UHC) met all applicable requirements with the remaining of six MCOs (ABH, Amerigroup, Kaiser, MPC, Priority Partners, and UMHP) had one or more areas of non-compliance. Assessment of the MCO denials demonstrated that overall relatively strong and consistent results.
- Network Adequacy Validation
    - The activity assessed quality, timeliness, and the accessibility of providers and provider directory compliance for calendar year 2019 in eight areas, with the compliance threshold set to 80 percent. Although performance in several areas increased overall, eight MCOs (ABH, Amerigroup, Jai, Kaiser, MPC, Priority Partners, UHC, and UMHP) required CAPs in one specific area: comparison telephone responses to online provider directories regarding PCP details. One MCO (UHC) was required to submit a CAP to improve compliance with routine care appointment time frames.
- HEDIS
    - Key highlights for HEDIS Year 2019 showed that the majority of HealthChoice MCOs performed above the National HEDIS Mean (NHM) for several measures

including Chlamydia Screening (CHL), Childhood Immunization Status (CIS) Combo 2 & 3, Appropriate Testing for Children with Pharyngitis (CWP), Lead Screening in Children (LSC), Timeliness of Prenatal Care (PPC), Asthma Medication Ratio (AMR), Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34), Adult BMI Assessment (ABA), Adolescent Well Care (AWC), and Immunizations for Adolescents (IMA).
    - The Controlling Blood Pressure (CBP) measure was significantly revised for HEDIS 2019. The changes to the measure specifications resulted in a trending break for HEDIS 2019. Six out of the eight MCOs (Amerigroup, Jai, Kaiser, MSFC, Priority Partners, and UHC) experienced a decline in the percentage of members that were identified as having adequate blood pressure control. As a result, the MCOs have an opportunity for improvement moving forward with this measure.
- CAHPS
    - Key findings from the survey in RY 2019 indicate both HealthChoice Adult and Child members give their highest satisfaction ratings to their Specialist and Personal Doctor, with Child members also highly satisfied with their health care. In addition, HealthChoice Adult and Child members continue to be most pleased with how well doctors communicate, while being the least pleased with shared decision making.
- PCP Satisfaction Survey
    - The survey results for RY 2019 showed that PCPs gave an 86 percent overall satisfaction rating to the specified MCO that they participate with. Eighty-nine percent of PCPs surveyed would recommend their specified MCO to patients, and 88 percent of PCPs would recommend their specified MCO to other physicians, up two and three percent, respectively, when compared to the 2018 results.

Demonstration Evaluation

During the quarter, the Department, in collaboration with Hilltop (its independent evaluator) released the CY 2020 HealthChoice Evaluation, which covers CY 2014 through CY 2018 (see Appendix C). The Department presented highlights from the 2020 evaluation during the June MMAC meeting.

The Department held its annual Post-Award Forum on May 28, 2020, after the MMAC. The Department presented on a number of initiatives, including the community health pilots, the HealthChoice DPP, dental benefits for former foster youth and the adult dental pilot program, and the Family Planning program. Due to COVID-19, the 2020 Post-Award Forum was conducted via webinar. (See Appendix C for the 2019 Post-Award Forum public notice documentation and Appendix D for the 2019 Post-Award Forum presentation.)

Enclosures/Attachments

- Appendix A: Maryland Budget Neutrality Report as of June 30, 2020
- Appendix B: CY 2019 Annual Technical Report
- Appendix C: 2020 HealthChoice Evaluation (CY 2014 - CY 2018)
- Appendix D: Maryland HealthChoice Post-Award Forum Public Notice

- Appendix E: Maryland HealthChoice Post-Award Forum Presentation

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