Maryland HealthChoice Demonstration
Section §1115 Quarterly Report
Demonstration Year 23
7/1/2019 - 6/30/2020
Quarter 2
10/1/2019 - 12/31/2019

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 most recent amendment, approved in March 2019, authorizes the Department to:

- Pay for certain inpatient treatments for participants with a primary substance use disorder (SUD) diagnosis and secondary mental health diagnosis at Institutions for Mental Disease (IMDs)—an expansion of the demonstration's Residential Treatment Services for Individuals with SUD Program;
- Expand the annual cap of the Assisted Community Integration Services (ACIS) Community Health Pilot;
- Cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age;
- Cover National Diabetes Prevention Program (National DPP) lifestyle change program services for eligible HealthChoice enrollees; and
- Transition the Family Planning program from the waiver into a State Plan Amendment (SPA) with expanded services and eligibility criteria.

Enrollment Information

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

Table 1. Enrollment Counts

Demonstration Populations	Participants as of September 30, 2019	Participants as of December 31, 2019
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	225,642	234,324
Affordable Care Act (ACA) Expansion Adults	312,137	311,314
Medicaid Children	451,038	446,854
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	89,675	91,225
SSI/BD Children	23,551	23,219
Medically-Needy Adults	23,287	23,825
Medically-Needy Children	6,140	6,073
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults[1]	13,455	12,759
Maryland Children's Health Program (MCHP) [2]	111,094	105,599
MCHP Premium	35,844	34,174
Presumptively Eligible Pregnant Women (PEPW)	0	0
Family Planning	11,322	11,936
ICS	28	29
Women's Breast and Cervical Cancer Health Program (WBCCHP)	85	80

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

[1] Increases observed in the SOBRA category during the previous demonstration year can be attributed to changes in the eligibility determination process that re-categorizes individuals reporting pregnancies to one of the pregnancy eligibility groups, rather than retaining their historic eligibility group. The Department intends to revert to its previous eligibility process during the current demonstration year.

[2] 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. Member Months

Eligibility Group	Total for Previous Quarter (ending Sept. 2019)	Current Quarter Month 1 (October 2019)	Current Quarter Month 2 (November 2019)	Current Quarter Month 3 (December. 2019)	Total for Quarter Ending December 2019
Parent/Caretaker Relatives <116% FPL and Former Foster Care	642,906	219,902	223,516	225,642	669,060
ACA Expansion Adults	929,946	311,534	312,759	312,137	936,430
Medicaid Children	1,363,676	452,726	452,898	451,038	1,356,662
SSI/BD Adults	270,199	89,855	88,963	89,675	268,493
SSI/BD Children	69,431	23,481	23,561	23,551	70,593
Medically-Needy Adults	66,966	22,955	23,049	23,287	69,291
Medically-Needy Children	18,093	6,224	6,187	6,140	18,551
SOBRA Adults[1]	39,951	218,772	222,403	224,571	665,746
MCHP	351,607	114,468	112,926	111,094	338,488
MCHP Premium	107,371	35,288	35,296	35,844	106,428
PEPW	0	0	0	0	0
Family Planning	32,579	11,097	11,193	11,322	33,612
WBCCTP	90	30	30	28	88
ICS	286	92	87	85	264

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[3]

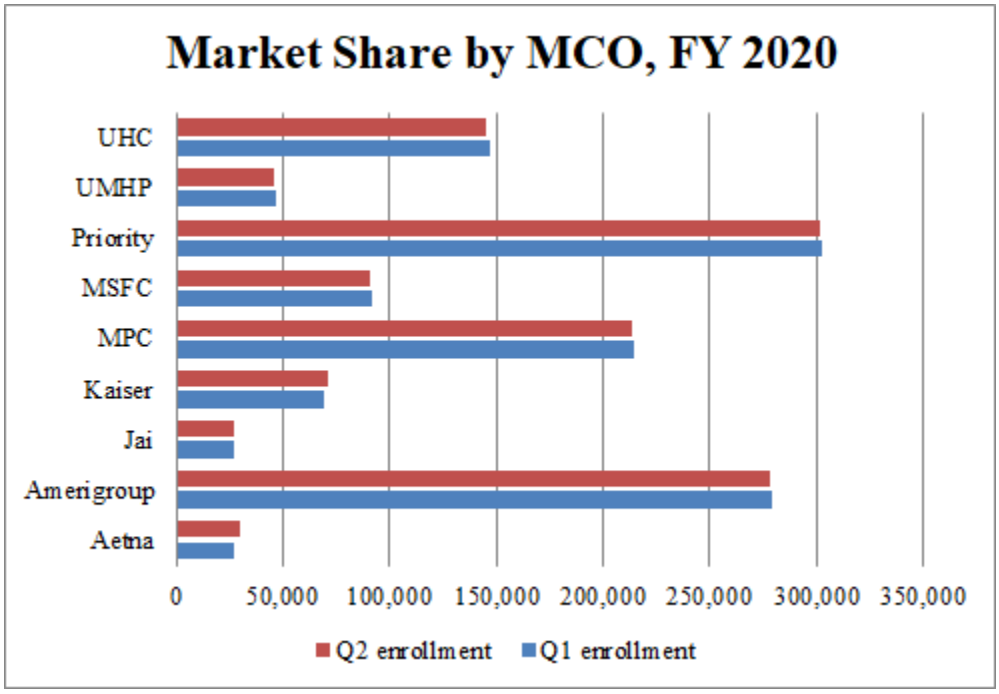
Level of Service	No. of Participants	No. of Days
Level 3.7-WM	2,556	14,455
Level 3.7	2,822	41,540
Level 3.5	1,821	34,459
Level 3.3	658	12,693
Level 3.1	649	15,561
Total	**5,939**	**118,708**

Operational/Policy Developments/Issues

Market Share

As of the culmination of FY 2020, Quarter 2, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (2.5 percent), Amerigroup (23.1 percent); Jai Medical Systems (2.3 percent); Kaiser Permanente (5.9 percent); Maryland Physicians Care (17.7 percent); MedStar Family Choice (7.6 percent); Priority Partners (25.0 percent); University of Maryland Health Partners (3.8 percent); and United Healthcare (12.1 percent).

Figure 1. HealthChoice MCO Market Share



[3] Based On Claims Paid Through January 2, 2020. Data should be considered preliminary due to run out.

Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in October and November during the past quarter; there was no meeting held in December. These meetings covered a wide variety of topics, including general department updates, and waiver, state plan, and regulations changes.

In October, the MMAC received updates on the transition to a new behavioral health administrative services organization (ASO). The Department recently decided to carve in HIV/AIDS medications to the MCO benefit package; the MMAC was given an overview of the change and the process of implementation. The MMAC also learned about several updates on the lead program and services provided through the Children's Health Insurance Program (CHIP) Health Services Initiative.

During the November meeting, the Behavioral Health Administration (BHA) briefed the MMAC on the Behavioral Health System of Care design and the accompanying workgroup meetings. The MMAC also received an overview of the Non-Emergency Medical Transportation (NEMT) program and the Departmental plans to move the program forward.

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 will continue 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. Once the Family Planning Program is integrated into MHC, the Department will transition all participants to be covered under the SPA.

Enrollment as of the end of the quarter was 11,936 women, with an average monthly enrollment of 11,693, an increase of 4.4 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*
11,204	1.6	11,693	4.4				

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 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					
Quarter 4					

Table 6. REM Complaints

FY 2020 Q 2	Transportation	Dental	DMS/ DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	4	0	0
REM Hotline	0	0	1	0	0	0	1	0	0
Total	**0**	**0**	**1**	**0**	**0**	**0**	**5**	**0**	**0**

Table 7 displays the types and total of significant events reported by the case management agencies during this quarter. Agencies report this information on a monthly basis.

Table 7. REM Significant Events Reported by Case Managers

FY 2020 Q 2	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	2	6	0	65	22	2	4	**101**

ICS Program

Through the ICS Program, Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying

individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the 2016 waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of December 31, 2019, 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 December 31, 2019, the Premium program had 34,174 participants, with MCHP at 105,599 participants.

Medicaid and National Diabetes Prevention Program (DPP) Demonstration and HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Throughout this reporting period, the Department continued to focus on implementing 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 videos will be available for use across the HealthChoice program in early 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 issued an updated policy transmittal to MCOs and CDC-recognized lifestyle change organizations that outlined an alternative milestone-based reimbursement model available for virtual DPP providers. 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. In an effort to facilitate the DPP provider enrollment and MCO contracting processes and align with other diabetes prevention initiatives in Maryland, the Department presented in-person at the Maryland Diabetes Prevention Network Meeting, via webinar on HealthChoice DPP provider information to Maryland-based CDC-recognized organizations and Minority Health and Technical Assistance (MOTA) grantees so they could learn more about the DPP provider enrollment process and potentially apply to become

Medicaid-enrolled providers if eligible.

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, five DPP providers were fully-enrolled, and eight more were in the review process. MCOs continued efforts to contract with eligible DPP providers and prepared member and provider materials.

Community Health Pilots

As of December 2019, 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 December 2019. The Department is pleased to report that with this development, both Lead Entities (LEs) have reached their projected enrollment for FY20.

HVS LEs continue to engage with local community based organizations MCOs to implement innovative supports for pilot participants. In Quarter 2, one entity worked in partnership to fund and install diaper-changing tables in the men's room of their facility. Another hosted a baby shower for participants with a Maryland MCO. In Quarter 2 members of the Medicaid Community Health Pilots team joined Maryland Maternal, Infant, and Early Childhood Home Visiting (MIECHV) colleagues at a Health Resources and Services Administration (HRSA) site visit where Medicaid staff highlighted collaborative work including the HVS Pilot and recently-awarded Maternal Opioid Misuse (MOM) Model grant

Approximately 242 individuals are enrolled in the Assistance in Community Integration Services (ACIS) Pilot and are receiving supportive housing services as of December 2019, achieving 40 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 2, the Department completed its first site visit process with ACIS LEs. Each visit was comprised of a half day convening of the Department's Community Health Pilot team, LE programmatic staff, Hilltop staff, and Participating Entities. During the visits, the Department conducted a preliminary discussion of the ACIS Pilot Annual Evaluation Results for CY 2018 and performed a random sample case note review. LEs presented on successful and challenging ACIS Pilot cases. These three activities generated thoughtful discussion regarding the past, present, and future of the pilot. Each LE will receive a site visit memo from the Department in

Quarter 3. These memos will summarize the visit and report best practices and recommendations to each of the entities.

The Department continues to host quarterly learning collaboratives to bring each of the ACIS LEs together to discuss relevant topics and best practices. The fourth ACIS Learning Collaborative meeting will be held in Quarter 3. It will focus on continuity of care for the dual Medicare-Medicaid eligible population and data quality standards.

Expenditure Containment Initiatives

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

HealthChoice Financial Monitoring Report (HFMR)

Final Service Year 2018 HFMR submissions (reported as of September 30, 2019) and the supporting financial templates were provided to the Department and Hilltop for review and for eventual distribution to MCOs on a consolidated basis. MCO submissions were due to the Department by November 19, 2019. The final 2018 submissions are expected to be the base period for the 2021 HealthChoice rate-setting period. The Department's contracted accounting firm is expected to perform an independent review of each MCO's submission including an income statement of each MCO's underwriting results. All initial submissions were received by December 9, 2019, with revised submissions expected from certain MCOs as of the end of the quarter.

During the next quarter, the accounting firm will review all MCOs submissions for 2018, and their reported incurred but not reported (IBNR) will be independently evaluated. The next MCO submissions will be due by May 18, 2020 and will reflect preliminary 2019 results.

MCO Rates

CY 2021 Rate-Setting

The rate-setting team participated in several meetings and calls with the Department, including a call with the accounting firm and a separate call with the Department's contracted actuarial firm regarding high costs drugs and the MCO program. The rate setting team provided the Department and the accounting firm with an analysis related to MCO profitability for pharmacy services and the 2018 HealthChoice MCO financial files for seven of the nine MCOs.

CY 2020 Rate-Setting

The rate-setting team provided individual HealthChoice rate schedules effective January 1, 2020 to all MCOs based on their final plan risk scores and ACA Health Insurer Fee. The rate-setting team also provided the Department with annual HFMR and HealthChoice rate tables effective

January 1, 2020. On behalf of the rate-setting team, the actuarial firm provided the Department with both the CMS and MCO versions of the 2020 HealthChoice certification letters.

The rate setting team provided the Department with annual tape of CY 2018 risk-adjusted capital (RAC) assignments for CY 2020 payments and prepared a formal memo to the Department which includes the adjusted clinical grouper (ACG) recipient distribution by the number of months enrolled in the calendar year, the current MCO of the recipient, and provided resolution of any duplicate records on the ACG tape.

CY 2019 Rate-Setting

For the 2019 rate-setting process, the team participated in a conference call with one of the MCOs to discuss HealthChoice rate impact due a July 1, 2019 change to the Medicaid hospital differential. The team provided the Department with rural access calculations for the second half of 2019 and prepared final 2019 Mid-Year MCO supplemental payments for service months January through August.

Additional Activities

The rate-setting team provided the Department with trauma calculations for September 2019, October 2019, and November 2019. They also provided the Department with the 2017 Provider Sponsored Organizations (PSO) analysis including observations and assisted the Department in the development of the "Trends in Managed Care" section of a Medicaid Cost-Savings report for the state legislature. The rate-setting team also participated in a nursing home liaison meeting in October 2019 and participated in a conference call with the actuarial firm and the Department to discuss potential MCO appeal of 2019 value-based purchasing (VBP) calculations.

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). A budget neutrality worksheet is attached to this report (see Appendix A).

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. Call volume decreased from 48,967 calls in the first quarter of FY 2020 to 46,343 calls during this quarter. The Help Line assists waiver-eligible consumers with eligibility and enrollment questions and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs and how to access carved-out services, or services covered by Medicaid on a FFS basis.

When a consumer experiences a medically-related issue, such as difficulty getting appointments with a specialist, getting a prescription filled, or getting a service preauthorized, 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 discuss the report findings.

Table 8. Total Recipient Complaints (not including billing) - Quarter 2- FY 2020[4]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
1st Q of FY 20 & 2nd Q of FY 20		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Pharmacy	#	1	4	25	34	5	5	9	9	37	35	21	6	41	27	46	25	11	9	196	154
	%	1%	3%	13%	22%	3%	3%	5%	6%	19%	23%	11%	4%	21%	18%	23%	16%	6%	6%	22%	22%
Prenatal	#	22	9	39	29	2	4	27	21	22	16	17	20	37	27	33	23	10	12	209	161
	%	11%	6%	19%	18%	1%	2%	13%	13%	11%	10%	8%	12%	18%	17%	16%	14%	5%	7%	23%	23%
Specialist	#	35	28	31	31	9	3	9	13	43	20	16	10	20	23	31	30	13	8	207	166
	%	17%	17%	15%	19%	4%	2%	4%	8%	21%	12%	8%	6%	10%	14%	15%	18%	6%	5%	23%	24%
PCP	#	31	25	36	23	8	2	16	11	33	23	16	9	28	25	30	27	9	14	207	159
	%	15%	16%	17%	14%	4%	1%	8%	7%	16%	14%	8%	6%	14%	16%	14%	17%	4%	9%	23%	23%
Sub Totals	#	89	66	131	117	24	14	61	54	135	94	70	45	126	102	140	105	43	43	819	640
	%	11%	10%	16%	18%	3%	2%	7%	8%	16%	15%	9%	7%	15%	16%	17%	16%	5%	7%	91%	91%
All Complaint Totals	#	96	66	145	133	25	15	67	56	156	117	71	48	142	115	149	111	45	45	896	706
	%	11%	9%	16%	19%	3%	2%	7%	8%	17%	17%	8%	7%	16%	16%	17%	16%	5%	6%	100%	100%
Other Categories		7	0	14	16	1	1	6	2	21	23	1	3	16	13	9	6	2	2	77	66

There were 905 total MCO recipient complaints in the quarter, compared to 1,194 in the previous quarter. Seventy-eight percent of the complaints (706) were related to access to care. The remaining 22 percent (199) were billing complaints. The top three member complaint categories were accessing primary care providers (PCPs), prenatal care, and specialists. 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 (Durable Medical Equipment)/ DMS(Durable Medical Supplies). Amerigroup had the highest percentage of complaints (19 percent of all care-

[4] Sourced from CRM.

related complaints), which were mainly attributed to difficulty accessing pharmacy services and specialists.

The number of prenatal care complaints decreased from 207 to 166. Prenatal complaints comprised 23 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, 291 pregnant women called the Help Line for general information. These women were also referred for follow-up and education.

Table 9. Recipient Complaints under age 21 (not including billing) - Quarter 2- FY 2020[5]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
1st Q of FY 20 & 2nd Q of FY 20		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Specialist	#	5	6	8	6	3	0	3	3	8	2	2	3	3	5	9	6	1	3	42	34
	%	12%	18%	19%	18%	7%	0%	7%	9%	19%	6%	5%	9%	7%	15%	21%	18%	2%	9%	19%	20%
PCP	#	13	4	20	13	2	1	5	5	12	8	7	1	11	12	17	7	3	3	90	54
	%	14%	7%	22%	24%	2%	2%	6%	9%	13%	15%	8%	2%	12%	22%	19%	13%	3%	6%	42%	33%
Pharmacy	#	1	2	7	10	0	0	1	3	6	4	3	2	12	11	7	6	3	2	40	40
	%	3%	5%	18%	25%	0%	0%	3%	8%	15%	10%	8%	5%	30%	28%	18%	15%	8%	5%	19%	24%
Prenatal	#	4	3	4	6	0	0	2	1	2	4	3	3	3	0	4	5	2	2	24	24
	%	17%	13%	0%	25%	0%	0%	0%	4%	0%	17%	0%	13%	0%	0%	0%	21%	0%	8%	11%	14%
Sub Totals	#	23	15	39	35	5	1	11	12	28	18	15	9	29	28	37	24	9	10	196	152
	%	12%	10%	20%	23%	3%	1%	6%	8%	14%	12%	8%	6%	15%	18%	19%	16%	5%	7%	91%	92%
All EPSDT Complaint Totals	#	24	15	44	40	5	1	14	12	29	20	16	10	35	33	39	25	10	10	216	166
	%	11%	9%	20%	24%	2%	1%	6%	7%	13%	12%	7%	6%	16%	20%	18%	15%	5%	6%	100%	100%
Other Categories		1	0	5	5	0	0	3	0	1	2	1	1	6	5	2	1	1	0	20	14

There were 166 member complaints (non-billing) for recipients under age 21, or 24 percent of the total complaints (166 of 706). The top complaint category was access to primary care providers (PCPs), which decreased by nine percentage points. Amerigroup was a major contributor to the complaints for recipients under age 21.

The analysis of complaints by adults vs. 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.

[5] Source from CRM.

Table 10. Total Recipient Billing Complaints - Quarter 2- FY 2020[6]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
1st Q of FY 20 & 2nd Q of FY 20		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
PCP	#	4	4	18	16	1	1	1	3	13	3	5	2	14	8	5	6	5	5	66	48
	%	6%	8%	27%	33%	2%	2%	2%	6%	20%	6%	8%	4%	21%	17%	8%	13%	8%	10%	22%	24%
Emergency	#	6	3	21	13	0	0	7	5	24	8	11	4	22	12	13	6	1	6	105	57
	%	6%	5%	20%	23%	0%	0%	7%	9%	23%	14%	10%	7%	21%	21%	12%	11%	1%	11%	35%	29%
Laboratory /Test	#	2	0	7	6	0	0	0	1	11	13	4	4	8	5	7	2	2	1	41	32
	%	5%	0%	17%	19%	0%	0%	0%	3%	27%	41%	10%	13%	20%	16%	17%	6%	5%	3%	14%	16%
Specialist	#	2	2	5	5	0	0	3	6	3	4	5	1	6	3	4	4	2	1	30	26
	%	7%	8%	17%	19%	0%	0%	10%	23%	10%	15%	17%	4%	20%	12%	13%	15%	7%	4%	10%	13%
Sub Totals	#	14	9	51	40	1	1	11	15	51	28	25	11	50	28	29	18	10	13	242	163
	%	6%	6%	21%	25%	0%	1%	5%	9%	21%	17%	10%	7%	21%	17%	12%	11%	4%	8%	81%	82%
All Billing Complaint Totals	#	16	12	61	47	3	3	17	17	64	35	31	14	60	36	35	21	11	14	298	199
	%	5%	6%	20%	24%	1%	2%	6%	9%	21%	18%	10%	7%	20%	18%	12%	11%	4%	7%	100%	100%
Other Categories		2	3	10	7	2	2	6	2	13	7	6	3	10	8	6	3	1	1	56	36

Enrollee billing complaints comprised 22 percent of total MCO complaints this quarter, which decreased by three percentage points compared to the previous quarter. Amerigroup has the highest percentage of billing complaints. Overall, the top bill type this quarter was Emergency Department, which comprised 29 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.

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

[6] Source: CRM.

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 2019 adjourned on April 8, 2019. The next legislative session begins on January 8, 2020. The Quarter 4 report will contain a summary of legislation affecting the HealthChoice demonstration.

Quality Assurance/Monitoring Activity

Overview

The Department's Medical Benefits Management Administration (MBMA) is responsible for coordination 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 the quality activities involving external quality review and monitoring CMS quality improvement requirements in accordance with COMAR 10.67.04 for the HealthChoice program.

The Department is required to annually evaluate the quality of care provided to HealthChoice participants by contracting MCOs. In adherence to federal law [Section 1932(c) (2) (A) (i) of the Social Security Act], the Department contracts with an External Quality Review Organization (EQRO) to perform an independent annual review of services provided by each contracted MCO to ensure that the services provided to the participants meet the standards set forth in the regulations governing the HealthChoice Program.

Systems Performance Review (SPR)

The purpose of the SPR is to provide an assessment of the structure, process, and outcome of each MCO's internal quality assurance program. Through the review, MBMA is able to identify, validate, quantify, and monitor problem areas, as well as identify and promote best practices.

In 2015, the SPR was changed from an annual to a triennial review. During interim years, baseline standards and corrective action plans (CAPs) are reviewed for compliance. The comprehensive CY 2018 SPR was completed during the last quarter. Jai Medical Systems received a perfect score for the ninth year of review. Aetna Better Health of Maryland, the newest MCO, performed 15 percentage points higher than the minimum compliance score for new plans (95 percent compared to 80 percent). UnitedHealthcare showed improvement in its composite score; however, Amerigroup Community Care, Kaiser Permanente, Maryland

Physicians Care, Priority Partners, and University of Maryland Health Partners had composite score decreases ranting from one to five percentage points and they were all below their minimum composite score. Eight MCOs were required to submit CAPs for the CY 2018 SPR. The results from the CY 2018 review will be available in the Annual Technical Report in April.

The CY 2019 SPR will be a desktop review of standards that were previously baseline; record reviews of grievances, appeals, and adverse benefit determinations; and any standard that required a corrective action plan (CAP) in the CY 2018 review. Last quarter, the CY 2019 Orientation Manual was provided to the MCOs. The CY 2019 SPR Standards and Guidelines incorporated process and policy changes resulting from the Medicaid and CHIP Managed Care Final Rule.

In October, the EQRO provided technical assistance to the MCOs regarding the CY 2019 SPR and uploading pre-site documents. The EQRO also prepared the review tool for the CY 2019 SPR. In November, the EQRO began performing record reviews for the grievance, appeal, and adverse determination components of the SPR. These reviews were completed in December 2019. MCOs also began uploading SPR documentation for review to the secure EQRO portal in December. This activity will be completed during the next quarter.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medical Record Review

The EQRO completes an EPSDT medical record review on an annual basis. The medical record review findings assist the Department in evaluating the degree to which HealthChoice children and adolescents from birth through 20 years of age receive timely screening and preventive care in accordance with the Maryland Preventive Health Schedule.

EPSDT review indicators are based on current pediatric preventive care guidelines and Department-identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance score of 80 percent for each of the five components. If an MCO did not achieve the minimum compliance score, the MCO was required to submit a CAP.

In October, the individual MCO reports for the EPSDT review were approved by DHQA, and the EQRO distributed them to the MCOs. Only one MCO (Amerigroup Community Care) performed below the minimum compliance score in the Laboratory Tests/At Risk Screenings component and was required to submit a CAP.

In November, the EQRO and DHQA finalized the executive summary of the results. For CY 2018, the HealthChoice aggregate scores for four of the five components increased compared to both CY 2016 and CY 2017, and the fifth component score remained consistent with CY 2017.

Table 11: HealthChoice Aggregate Results, CY 2016 through CY 2018

Component	HealthChoice Aggregate Results		
	CY 2016	CY 2017	CY 2018
Health and Developmental History	92%	92%	94%

Component	HealthChoice Aggregate Results		
	CY 2016	CY 2017	CY 2018
Comprehensive Physical Examination	96%	96%	97%
Laboratory Tests/At Risk Screenings	85%	82%	87%
Immunizations	83%	90%	93%
Health Education/Anticipatory Guidance	95%	94%	94%
Total Score	**90%**	**91%**	**94%**

In December, the EQRO approved the CAP from Amerigroup Community Care. The full results from the CY 2018 review will be available in the Annual Technical Report in April. The EQRO and DHQA also began preparation for the CY 2019 review.

Consumer Report Card

As part of its External Quality Review contract, the EQRO is responsible for developing a Medicaid Consumer Report Card. The Consumer Report Card is meant to help Medicaid participants select a HealthChoice MCO. Information in the Report Card includes data from Healthcare Effectiveness Data and Information Set (HEDIS®) measures, encounter data measures calculated by the Department and validated by the EQRO, and selected results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. During this quarter, the EQRO shared the final CY 2020 Consumer Report Card Information Reporting Strategy (IRS) and Methodology with the MCOs and began analysis of the report card measures. The final consumer report card will be available during the next quarter.

Performance Improvement Projects (PIPs)

Each MCO is required to conduct PIPs designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care, or non-clinical care areas that were expected to have a favorable effect on health outcomes. PIP measures are a part of VBP; performance in PIP does impact their performance in that initiative as well. HealthChoice MCOs conduct two PIPs annually. The two PIPs selected are Asthma Medication Ratio and Lead Screening for Children. Because Aetna Better Health of Maryland joined the program in CY 2017, it is not participating in the current PIP cycle.

In October and November, the EQRO developed the PIP annual report, and DHQA reviewed and approved the report. Amerigroup Community Care, Jai Medical Systems, and Priority Partners improved their performance in the Asthma Medication Ratio project compared to the first re-measurement year; the remaining five MCOs experienced a decline. For the Lead Screening for Children project, all MCOs improved their measurement scores compared to the HEDIS baseline rate. However, for the departmental encounter data measure, only Kaiser Permanente, Priority Partners, and University of Maryland Health Partners demonstrated improvement. Jai Medical

Systems maintained their performance, and the remaining four MCOs experienced a decline compared to the baseline rate.

In December, the EQRO reviewed and validated the quarterly MCO Lead submissions and provided feedback to the MCOs. The PIP validation results will be available in the Annual Technical Report in April.

Encounter Data Validation (EDV) Review

The purpose of EDV is to assess the completeness and accuracy of encounter data submitted by MCOs to the State. During this quarter, the EQRO determined the HealthChoice MCOs were found to have information systems in place that produce accurate and complete encounter data. This information was populated in the report. Because the Hilltop Institute (Hilltop) serves as the State's data warehouse for Medicaid encounter data, Hilltop conducted the analysis of the electronic encounter data submitted during CY 2018 during this quarter. The EQRO is continuing its medical record review activity as part of EDV. DHQA, Hilltop, and the EQRO will collaborate to combine their findings for the report. The report will be available next quarter, and its findings will be incorporated into the Annual Technical Report in April.

Provider Directory Validation

Beginning in 2017, the EQRO has administered a survey to test the accuracy of HealthChoice MCO provider directories. The EQRO conducted calls to a statistically-significant sample of PCPs within each MCO to validate the information reported in each MCO's online provider directory and to assess compliance with State access and availability requirements. The EQRO's subcontractor conducted its secret shopper activities in July and August. In September, the EQRO completed validation of the data results and began data analysis and reporting. In October, DHQA and the EQRO finalized the report for this activity, and the results will be incorporated into the Annual Technical Report in April.

Quarterly Review of Appeals/Grievances/Pre-Service Denial Activities

The Department and the EQRO updated the Grievance and Appeal Template and Instructions, based on feedback from the MCOs and observations during reporting. The updated reporting template was shared with the MCOs along with instructions for reporting. The EQRO and the Department also provided technical assistance to the MCOs about the reporting changes and revisited the updates. A new reporting template will be available next quarter, and MCOs will be required to submit information using the new template for the first quarter of 2020.

Healthcare Effectiveness Data and Information Set (HEDIS®) Performance Review

NCQA released the 2019 Volume 2: Technical Update on October 1, 2019 Changes and/or updates of interest include:

- HEDIS 2019 first-year measure, Risk of Continued Opioid Use, will be publicly-reported for HEDIS 2020.
- New measures for HEDIS 2020 include the following: Follow-Up After High-Intensity Care for Substance Use Disorder (FUI), Pharmacotherapy for Opioid Use Disorder

(POD), Prenatal Depression Screening and Follow-Up (PND), and Postpartum Depression Screening and Follow-Up (PDS).
- Retired measures for HEDIS 2020 are the following: Annual Monitoring for Patients on Persistent Medications (MPM), Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC), and Standardized Healthcare-Associated Infection Ratio (HAI).

The 2019 HEDIS Statewide Executive Summary Report was posted on the Department's website, along with an updated HealthChoice MCO accreditation document in early October. The HEDIS 2020 edition of Volume 3, which provides specifications for the CAHPS surveys and survey process, was used by the Department and the HEDIS vendor, to develop the annual CAHPS data file request, which was sent to the Hilltop Institute in late October.

The Department provided an updated HEDIS 2020 Measures List to all HealthChoice MCOs on November 1, 2019. The HEDIS vendor held its annual HEDIS Kickoff webinar on November 13, 2019, discussing the HEDIS 2020 Timeline, changes regarding the general guidelines, HEDIS measures, and the audit process, and questions regarding the digital measures and the electronic clinical data system (ECDS) developed by NCQA. The HEDIS vendor completed scheduling onsite visits for the 2020 audits and included this information in the updated audit timeline and key dates provided to the Department in November.

Per request from the Department, the HEDIS vendor provided its NCQA-Licensed Organization Certificate to the Department in November. The Department obtained current updated lists of NCQA-certified HEDIS compliance auditors and organizations licensed by NCQA to conduct HEDIS compliance audits for its records in December. The HEDIS vendor provided the Department with information regarding its audit team for 2020 in late December that included a list of auditors and audit seconds assigned for each HealthChoice MCO.

In December, the CAHPS Source Code and Sample Files were provided by the Hilltop Institute to the Department. The Department uploaded this data to a secure data exchange portal for review and approval by the HEDIS vendor. The HEDIS vendor presented at the December Quality Assurance Liaison Committee (QALC) meeting, discussing required reporting measures, audit timeline review, and audit reminders.

The HEDIS vendor approved the CAHPS source code submitted by the Hilltop Institute in mid-December and will review and approve the final CAHPS Sample Frame once the Department has received it from the Hilltop Institute and uploads it to the secure web portal.

Value-Based Purchasing (VBP) Program

The goal of Maryland's VBP initiative is to achieve better enrollee health through improved MCO performance. Appropriate service delivery is promoted by aligning MCO incentives with the provision of high-quality care, increased access, and administrative efficiency. Maryland's VBP strategy aims to better coordinate a variety of quality improvement efforts toward a shared set of priorities that focus on the core populations served by HealthChoice. The MCOs received their results for CY 2018 in early November, and the validation report was finalized in December. Three MCOs (Jai Medical Systems, Kaiser Permanente, and University of Maryland

Health Partners) earned incentives. The results will be incorporated in the Annual Technical Report.

HealthChoice Enrollee Satisfaction Survey

The Department provided updated official State of Maryland logo and letterhead materials to the satisfaction survey vendor, Center for the Study of Services, for use with the 2020 CAHPS survey administration in October.

The satisfaction survey vendor notified the Department at the end of October that the CAHPS survey instrument was revised resulting in several questions being removed from the survey. Any questions that were typically considered core questions were automatically approved as supplemental questions, however the maximum number of supplemental questions is still limited to 12. As a result, the Department had to review its current supplemental questions and decide whether to add or remove any of them, while not exceeding the maximum amount of 12 allowed by NCQA. The satisfaction survey vendor was able to successfully incorporate the Department's updates for the supplemental questions in both the Adult and Child survey tool, resulting in a total of 11 supplemental questions for the Adult survey and nine supplemental questions for the Child survey.

The Department completed review and editing of all CAHPS reports, including MCO, Aggregate, and Executive Summary reports in October and November, and granted final approval of all reports in early November to the satisfaction survey vendor. All final reports for 2019 were distributed electronically to the HealthChoice organizations and the Department in November. The results will be incorporated into the Annual Technical Report.

The satisfaction survey vendor reviewed the data file specifications for any necessary edits for the CAHPS 2020 survey administration per request by the Department. After feedback from the satisfaction survey vendor, the Department sent the CAHPS data file request memo to the Hilltop Institute in early November.

The satisfaction survey vendor provided a survey administration timeline for CAHPS 2020 to the Department in November, along with its updated, current HEDIS Survey Vendor Certificate from NCQA.

At the QALC meeting held in December, the satisfaction survey vendor provided a summary of CAHPS changes to the survey tool for 2020, discussed the use of larger carrier envelopes for the 2020 survey administration, and reviewed the required sample size for the surveys.

Pre-survey administration for CAHPS 2020 is underway. The Department provided updated MCO logos and a signature for cover letters to the satisfaction survey vendor in early December. Potential survey enhancements that were proposed by the satisfaction survey vendor and approved by the Department include sending out emails regarding the surveys prior to the first survey packages being mailed out approximately two weeks later and mailing the surveys in larger 6" x 9.5" carrier envelopes in an effort to increase the overall response rate.

Primary Care Provider (PCP) Satisfaction Survey

The Department completed review and editing of all provider satisfaction survey reports prior to granting final approval in October to the satisfaction survey vendor. All final reports for 2019 were distributed electronically to the HealthChoice MCOs and the Department in early November.

Based on recommendations from the satisfaction survey vendor for possibly improving the PCP Satisfaction Survey response rate, the Department approved a revised protocol schedule that involves sending out a round of emails about the survey prior to the survey questionnaires and reminder postcards being mailed out.

For 2020, at no additional cost, the survey vendor will also run a test for the survey fielding to determine the effect of fax outreach on the response rate compared to using the standard mailing outreach. Finally, the survey vendor will redesign the reminder postcard so that instructions on how to complete the survey are more prominently displayed.

The 2020 PCP Data File request memo was sent to all HealthChoice organizations by the Department in mid-November with instructions and requirements for providing the data file to the satisfaction survey vendor for use for the 2020 Survey Administration. The satisfaction survey vendor and the Department are currently working on minor changes to the survey questionnaire that were still pending at the end of December.

Pre-survey administration activities are underway for the 2020 Provider Survey. The final sample frame is due to the satisfaction survey vendor and the Department in late January. The Department requested that the MCOs provide a test sample frame of at least 25 PCPs to the satisfaction survey vendor for review no later than early December. The satisfaction survey vendor will again use National Provider Identifier (NPI) numbers to match providers across health plan data files. Providers will have the option to complete the survey online. Providers will see the option to complete the survey online on the cover letter, which will include a web address and unique login in code for completing the survey online.

At the QALC meeting held in December, the satisfaction survey vendor discussed the survey protocol and timeline for the upcoming 2020 survey administration. HealthChoice MCOs will be asked to include the provider fax number with the provider data file for the 2020 survey administration.

Annual Technical Report (ATR)

The next Annual Technical Report, which is a comprehensive report summarizing all quality activities performed by the quality assurance vendors and the results, is due to CMS on April 30, 2020. The Department and the EQRO are compiling and editing the report for submission by the end of next quarter.

Demonstration Evaluation

During the quarter, the Department, in collaboration with Hilltop (its independent evaluator) began planning the evaluation to be released in CY 2020, which will cover CY 2014 through CY 2018.

The Department is in the process of updating the evaluation design in accordance with CMS's comments after receiving CMS feedback during the previous quarter.

The 2020 HealthChoice Post-Award Forum has been scheduled for May 28, 2020.

Enclosures/Attachments
Appendix A: Maryland Budget Neutrality Report as of December 31, 2019

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