Maryland HealthChoice Demonstration
Section 1115 Annual Report
Demonstration Year 20
July 1, 2016 – June 30, 2017

Introduction

The HealthChoice section 1115 demonstration is designed to use a managed care delivery system to create efficiencies in the Maryland Medicaid program and enable the extension of coverage and targeted benefits to certain individuals who would otherwise be without health insurance or without access to benefits tailored to their specific medical needs. Now in its twentieth waiver year, Maryland implemented the HealthChoice program and moved its fee-for-service enrollees into a managed care payment system following approval of the waiver by what is now the Centers for Medicare and Medicaid Services (CMS) in 1996. Under the statewide health care reform program, the state enrolls individuals affected by or eligible through the demonstration into a managed care organization (MCO) for comprehensive primary and acute care, or into one of the demonstration's authorized health care programs.

The state'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 Maryland population;
- Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies;
- Providing patient-focused, comprehensive, and coordinated care designed to meet health care 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
- Using demonstration authority to test emerging practices through innovation and pilot programs.

Subsequent to the initial grant, the Maryland Department of Health (the Department) requested and received several program extensions, in 2002, 2005, 2008, 2011 2013, and 2017. The 2017 extension made the following changes to the demonstration:

- Created the Residential Treatment for Individuals with Substance Use Disorder Program as part of a comprehensive substance use disorder (SUD) strategy;
- Created two community health pilot programs:
    - Evidence-Based Home Visiting Services (HVS) Pilot for high-risk pregnant women and children up to two years of age; and
    - Assistance in Community Integration Services (ACIS) Pilot;
- Raised the enrollment cap for the Increased Community Services Program from 30 to 100; and
- Expanded dental benefits for former foster youth.

Enrollment Information

Table 1 below provides a comparison of enrollment counts between the previous and current years. These counts represent individuals, as opposed to member months.

Table 1. Enrollment Counts and Annual Growth

Demonstration Populations	Previous Year (as of June 2016)	Current enrollees (as of June 2017)	Year 20 Change	Year 20 Percent Change
Parents/Caretaker Relatives <116% FPL and Former Foster Care	202,369	213,276	10,907	5.4%
ACA Expansion Adults	264,580	305,431	40,851	15.4%
Medicaid Children	435,627	457,627	21,787	5.0%
SSI/BD Adults	87,587	88,318	731	0.8%
SSI/BD Children	23,826	22,615	-1,211	-5.1%
Medically-Needy Adults	20,612	22,658	2,046	9.9%
Medically-Needy Children	7,296	5,908	-1,388	-19.0%
SOBRA Adults	9,578	8,807	-771	-8.0%
MCHP	109,788	114,867	5,079	4.6%
MCHP Premium	30,542	30,882	340	1.1%
Family Planning	10,232	9,617	-615	-6.0%
ICS	23	28	5	21.7%
WBCCTP	177	138	-39	-22.0%
PEPW	1	5	4	N/A

Table 2. Enrollment as a Proportion of Total

Demonstration Populations	Total Enrollment % - June 2016	Total Enrollment % - June 2017	Share Change
Parents/Caretaker Relatives <116% FPL and Former Foster Care	17.2%	17.0%	0.2%
ACA Expansion Adults	22.5%	24.3%	-1.8%
Medicaid Children	37.0%	36.4%	0.6%
SSI/BD Adults	7.4%	7.0%	0.4%
SSI/BD Children	2.0%	1.8%	0.2%
Medically-Needy Adults	1.7%	1.8%	-0.1%
Medically-Needy Children	0.6%	0.5%	0.1%
SOBRA Adults	0.8%	0.7%	0.1%

Demonstration Populations	Total Enrollment % - June 2016	Total Enrollment % - June 2017	Share Change
MCHP	9.3%	9.1%	0.2%
MCHP Premium	2.6%	2.5%	0.1%
Family Planning	0.9%	0.8%	0.1%
ICS	N/A	N/A	N/A
WBCCTP	N/A	N/A	N/A
PEPW	N/A	N/A	N/A

Outreach/Innovative Activities

Medicaid and National Diabetes Prevention Program Demonstration

During this initial demonstration year, the four participating MCOs—Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners—made significant progress in building a Diabetes Prevention Program (DPP) delivery strategy including: 1) contracting with virtual and community-based DPP suppliers; 2) implementing billing and coding nomenclature aligned with Current Procedural Terminology (CPT) and International Classification of Disease (ICD)-10 guidelines and process for DPP suppliers to submit claims; 3) outreach and engagement with members to participate and stay with the program; 4) provider education; and 5) facilitating the independent evaluator's administration of the demonstration evaluation. As of June 2017, the Demonstration had enrolled 225 participants, with an additional 180 Medicaid MCO members scheduled to start their first class.

In addition to the achievements noted above, in January 2017, the Department and participating MCOs held a successful state visit with funder National Association of Chronic Disease Directors (NACDD), the Centers for Disease Control and Prevention (CDC), and Leavitt Partners. In June, the Department and participating MCOs presented at the Medicaid and National DPP Annual Meeting, which was sponsored by the demonstration's funders. The Department and the MCOs met routinely throughout the year to discuss program techniques, share lessons learned, and monitor progress on the Medicare DPP rule under development. Planning for the next program year also began during FY 2017, focusing on strengthening participant enrollment and retention, and sustainability strategies.

Community Health Pilots

As of June 2017, the Department and CMS had finalized the post-approval protocols for the two community health pilots included in the §1115 HealthChoice Waiver Renewal application: Evidence-based Home Visiting Services for High Risk Pregnant Women and Children Up to Age 2 (HVS); and Assistance in Community Integrated Services (ACIS) for high-risk, high-utilizing Medicaid enrollees who are either transitioning to the community from an institution or at high risk of institutional placement.

The pilots will be operated by local Maryland government entities, which need to supply local funding to generate a federal match under the waiver. Up to $2.7 million in federal matching funds are available for HVS; when combined with the local non-federal share, HVS expenditures may total up to $5.4 million annually. For the ACIS pilots, there is $1.2 million federal match available each year; when

combined with the local non-federal share, ACIS pilot expenditures may total up to $2.4 million annually. By the end of June 2017, stakeholders were made aware of the competitive funding opportunity, timeline, and eligibility for application through stakeholder communications and the Department's Community Health Pilots website.[1]

Funding for the pilots is available for four-and-a-half years of the current five-year waiver, from July 1, 2017 through December 31, 2021. The Department anticipates that initial awards will be made for both pilots by October 2017.

Operational/Policy Developments/Issues

Market Share

As of June 2017, there were eight MCOs participating in the HealthChoice program; their respective market shares were as follows: Amerigroup (24.2 percent); Jai Medical Systems (2.2 percent); Kaiser Permanente (5.1 percent); Maryland Physicians Care (18.7 percent); MedStar Family Choice (7.4 percent); Priority Partners (25.1 percent); University of Maryland Health Partners (3.5 percent); and United Healthcare (13.7 percent).

Maryland Medicaid Advisory Committee

The Maryland Medicaid Advisory Committee met monthly over the past year. These meetings covered a wide variety of topics, including:

- Behavioral health system reports;
- Waiver, state plan, and regulation changes;
- Departmental reports;
- HealthChoice evaluation updates;
- Budget updates;
- Legislative updates;
- Overviews of the various Joint Chairmen's Reports (JCRs) such as the telehealth JCR and the oral health JCR; and
- Eligibility and enrollment updates.

There were also several presentations related to the opioid abuse in Maryland, including a Naloxone training session for all MMAC committee members. In addition, there was also a focus on the 1115 waiver renewal, which was approved for January 1, 2017.

HealthChoice Post-Award Forum

The Maryland Medicaid program hosted its first HealthChoice Post-Award Forum, per Section 32 of the demonstration's Standard Terms and Conditions (STCs), on June 22, 2017. The forum consisted of overviews of the overall HealthChoice program and the demonstration's major components, including Residential Treatment for Individuals with Substance Use Disorders, the HVS and ACIS community health pilots and dental services for former foster youth. No comments were received from the audience. The Department compiled with all public notice and timeline requirements pursuant to STC 32; please see the appendices for additional information.

[1] Available: https://mmcp.health.maryland.gov/Pages/HealthChoice-Community-Health-Pilots.aspx

Maryland's legislative session began on January 11, 2017 and adjourned on April 10, 2017. For more information on legislative activity, please see the Legislative Update section.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women—currently, those women at less than 200 percent of the Federal Poverty Level (FPL). 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. Enrollment as of the end of the demonstration year was 9,617 women, an increase of 0.3 percent over the third quarter but a decrease of 6.7 percent over the previous demonstration year. Women who receive pregnancy coverage will continue to be automatically enrolled, if eligible, following the end of their pregnancy-related eligibility.

Table 3. Average Quarterly Family Planning Enrollment

Q1 Enrollment	% Change	Q2 Enrollment	% Change	Q3 Enrollment	% Change	Q4 Enrollment	% Change
10,097	-4.0%	9,777	-3.2%	9,521	-2.6%	9,550	0.3%

Table 4. Family Planning and Related Statistics, July 2015 – June 2016*

No. of Individuals Enrolled in the Demonstration (Total with Any Period of Eligibility)	Total No. of Participants[2]	No. of Actual Births to Family Planning Demonstration Participants After Enrollment	Average Total Medicaid Expenditures for a Medicaid-funded Birth[3]
17,666	3,771	469	$26,247

*The HealthChoice program utilizes a look-back period to the previous fiscal year to allow for run-out.

REM Program

The table below shows the current status of REM program enrollment.

Table 5. Current REM Program Enrollment

FY 2017	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	223	177	104	105	4,314
Quarter 2	212	159	85	104	4,344
Quarter 3	189	149	62	98	4,365
Quarter 4	185	135	65	99	4,365

[2] Includes all individuals who obtain one or more covered family planning services through the demonstration.
[3] Includes prenatal services, delivery- and pregnancy-related services, and services to infants from birth up to age 1.

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 the MCO.

Table 6. REM Complaints

FY 2017	Transportation	Dental	DMS/DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	30	0	7
REM Hotline	0	0	0	1	0	0	0	0	1
Total	0	0	0	1	0	0	30	0	8

The following table 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 2017	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services
REM Enrollees	13	38	1	195	66	22	33

ICS Program

The ICS Program does not currently have a registry. All new applicants begin receiving services upon approval of their application.

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 waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of the end of this state fiscal year, there were 28 individuals enrolled in the ICS Program.

MCHP and MCHP Premium Status/Update/Projections

Effective June 1, 2008, Maryland moved its separate CHIP program, Maryland Children's Health Program (MCHP) Premium, into the Medicaid expansion Children's Health Insurance Program (CHIP) waiver. Maryland's entire CHIP program is operated as a Medicaid expansion. As of June 30, 2017, the Premium program had 30,882 enrollees, with MCHP at 114,867 enrollees—these figures constitute an increase of 1.1 percent and 4.6 percent, respectively.

Expenditure Containment Initiatives

The Department, in collaboration with the Hilltop Institute at the University of Maryland, Baltimore County, has worked on several different fronts to contain expenditures, detailed below.

HealthChoice Financial Monitoring Report (HFMR)
During the final quarter of the demonstration year, auditors finalized all MCO financial reviews for 2015, and the MCOs reported incurred but not reported (IBNR) was independently evaluated. Consolidated reports were also prepared. Instructions and templates for 2016 data were provided to the MCOs in March. These reports reflect Service Year 2016 MCO experience as of March 31, 2017 and were due on May 15, 2017.

MCOs provided Service Year 2016 HFMR reports (including financial templates) as of March 31, 2017 during May of 2017. These data were used to assist in the HealthChoice trend analysis, regional analysis and for the validation process of calendar year (CY) 2018 HealthChoice rates. Unadjusted consolidated 2016 HFMRs by region were provided to all MCOs on June 22, 2017. MCOs will have an opportunity to update their Service Year 2016 experience in November. The 2016 submission in November will most likely be the base period for the 2019 HealthChoice rate-setting period. Updated instructions will likely be provided in September of 2017.

MCO Rates
The rate setting team performed the following activities in support of the CY 2018 HealthChoice rates:

- Co-facilitated third 2018 HealthChoice MCO rate-setting meeting on April 28, 2017. Topics discussed included: mid-year adjustments of HIV and geographic and demographic rates; constant cohort analysis for CY 2015 and CY 2016 (as of March 31, 2017); presentation of the final Department and MCO issues; base adjustments for Dyslipidemia lab test; and re-visiting of costs associated with extending long-term care (LTC) stay from 30 to 90 days.
- Provided auditors with proposed comments and revisions regarding eight 2015 MCO financial reviews.
- Provided auditors with proposed comments and revisions regarding eight 2015 Miller & Newberg IBNR reviews.
- Provided the actuarial firm with MCO encounter reports (including lag reports) by category of service for January 1, 2015 through March 31, 2017.
- Provided the actuarial firm with encounter data report to be used to analyze durational trends.
- Participated with auditors and the Department on eight MCO exit conference calls during the month of April.
- Provided the actuarial firm with updated Health Services Cost Review Commission (HSCRC) inpatient and outpatient trend data for January 1, 2015 through December 31, 2016.
- Co-facilitated fourth 2018 HealthChoice MCO rate-setting meeting held on May 31, 2017. Topics discussed included: regional presentation; base presentation; MCO outlier adjustment; non-state plan service adjustments; impact of transitioning from ICD-9 to ICD-10; impact of limiting observational stays; HealthChoice HIV drug statistics; and payment for multiple very low birth weight babies.
- Provided the actuarial firm with final audited 2015 financial base model.
- Provided the actuarial firm with 2015 re-insurance administrative cost adjustment.
- Provided the actuarial firm with 2015 efficiency adjustment based on methodology that was implemented ten years ago.

- Provided the actuarial firm with 2015 adult dental administrative cost adjustment.
- Provided the actuarial firm with prescription adult co-pay adjustment to the 2015 HealthChoice base.
- Provided the actuarial firm with base adjustments regarding non-state plan services to the 2015 HealthChoice base.
- Provided the actuarial firm 2015 adjustment to increase dyslipidemia utilization to 34 percent for 9-to-11 and 18-to-21 year olds for the 2018 rates.
- Provided the actuarial firm with prescription adjustment reflecting the increase in the dispensing period of contraceptives from 30 days to 6 months January 1, 2018.
- Hosted meeting with one MCO to review rate setting methodology with new actuary.
- Participated in meeting at the Department with new MCO and its executive team to review rate setting process.
- Provided the actuarial firm with CY 2014 versus CY 2016 risk-adjusted capital (RAC) cohorts to assist in evaluating ICD-10 impact.
- Co-facilitated fifth 2018 HealthChoice MCO rate-setting meeting held on June 23, 2017. Topics discussed included: preliminary 2018 geographic and demographic adjustments; CY 2015 and CY 2016 constant cohort analysis; final 2016 Hepatitis C therapy analysis; and the actuarial firm trend presentation.
- Provided the actuarial firm with preliminary detailed CY 2018 HealthChoice membership forecast.
- Provided MCOs with consolidated preliminary CY 2016 financials.
- Provided the actuarial firm with evaluation and management (E&M) fee adjustments for 2018 HealthChoice rates.
- Provided the actuarial firm with Hepatitis C therapy medical expenses for 2016 (final), 2017 (restated), and draft 2018 HealthChoice rates.
- Provided the actuarial firm with federally-qualified health center (FQHC) market rate base adjustment for 2018 HealthChoice rates.
- Provided the actuarial firm with restated consolidated 2015 financials due to specific MCO revisions.
- Provided the Department with feedback on outstanding policy issues influencing the 2018 Hepatitis C rates.

The rate setting team performed the following activities in support of the CY 2017 HealthChoice Rates:

- Provided the actuarial firm with CY 2016 and CY 2017 calculation of the change in the Graduate Medical Education (GME) discount.
- Provided the HSCRC with restated monthly MCO membership in support of HSCRC trend analysis.
- Provided the actuarial firm with revised 2017 mid-year and 2018 calculations of extending LTC stays from 30 to 90 days.
- Provided the Department with first semi-annual rural access incentive calculation for 2017.
- Participated in conference call with the HSCRC, the Department, and the actuarial firm regarding HSCRC trends and projections.

- Provided the actuarial firm with analysis of restated 2017 HC enrollment to determine whether a specific mid-year adjustment was warranted.

The rate setting team performed the following activities in support of the CY 2016 HealthChoice Rates:

- Provided the Department with 2016 Patient Protection and Affordable Care Act (ACA) Health Insurer Fee (HIF) settlement calculations by MCO.

The rate setting team also performed the following activities this quarter in addition to activities associated with HealthChoice capitation rates:

- Provided the Department with trauma calculations for March 2017.
- Provided the Department with the latest Medicaid HIV population statistics by county and program.
- Completed review of nursing home submission of wage surveys for 2017.
- Provided the Department with trauma calculations for April 2017.
- Provided the Department with 2015 Code of Maryland Regulations (COMAR) medical loss ratio (MLR) position for HealthChoice with traditional and current calculations based on where in the range the rates were paid.
- Provided the Department with trauma calculations for May 2017.

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.

Table 8 displays the total annual expenditures for the demonstration population, with administrative costs shown separately. Due to data run-out issues, these figures should be considered preliminary and are subject to change.

Table 8. Total Annual Expenditures

Demonstration Population	Annual Expenditures
Parent/Caretaker Relatives <116% FPL and Former Foster Care	$1,353,919,188
ACA Expansion Adults	$2,637,823,442
Medicaid Children	$1,448,108,400
SSI/BD Adults	$1,188,278,967
SSI/BD Children	$400,815,602
Medically-Needy Adults	$18,222,234
Medically-Needy Children	$3,331,840
SOBRA Adults	$164,649,413
MCHP	N/A

Demonstration Population	Annual Expenditures
MCHP Premium	N/A
Family Planning	($2,098,278)
WBCCTP	$1,167,935
PEPW	$28,443
Administrative Costs	$3,736,378

Member Month Reporting

Tables 9 and 10 display the number of member months for the current quarter by eligibility group. The corresponding figure from the last month of the previous quarter is provided for comparison.

Table 9. Member Month Reporting

Eligibility Group	Total for Previous Quarter (ending March 2017)	Current Quarter Month 1 (April 2017)	Current Quarter Month 2 (May 2017)	Current Quarter Month 3 (June 2017)	Total for Quarter Ending June 30, 2017
Parent/Caretaker Relatives <116% FPL and Former Foster Care	636,323	213,372	214,386	213,276	641,034
ACA Expansion Adults	897,625	302,777	305,354	305,431	913,562
Medicaid Children	1,364,776	458,471	459,686	457,414	1,375,571
SSI/BD Adults	266,438	88,490	88,355	88,318	265,163
SSI/BD Children	66,358	22,355	22,442	22,615	67,412
Medically-Needy Adults	66,861	22,275	22,688	30,882	67,621
Medically-Needy Children	16,537	5,663	5,794	5,908	17,365
SOBRA Adults	28,172	8,998	8,937	8,807	26,741
MCHP	341,944	114,100	114,681	114,867	343,648
MCHP Premium	91,367	30,745	30,865	30,882	92,492
Family Planning	28,563	9,438	9,596	9,617	28,651
WBCCTP	445	144	140	138	422
PEPW	19	5	3	5	13

Table 10. Member Month Reporting for New Programs (For Informational Purposes Only)

Demonstration Group	Total for Previous Quarter (ending December 2016)	Current Quarter Month 1 (January 2017)	Current Quarter Month 2 (February 2017)	Current Quarter Month 3 (March 2017)	Total for Quarter Ending March 31, 2017
ICS	78	26	28	28	82
Home Visiting Pilot*	N/A	N/A	N/A	N/A	N/A
ACIS Pilot*	N/A	N/A	N/A	N/A	N/A

** The Home-Visiting and ACIS Pilots were still in the preparatory phase as of the end of the quarter.*

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. 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—services not covered by the MCO but covered by Medicaid. When a consumer is experiencing medically-related issues such as difficulty getting an appointment 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 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 State's Fair Hearing process, the CRU will assist the member with that process.

The HealthChoice Help Line received 215,883 calls during this demonstration year, compared with 140,592 in fiscal year 2016 — an increase of 75,291 calls. The increase in call volume can be attributed to the increase in MCO enrollment; an increase in eligibility and enrollment questions encountered by consumers who now must apply for Medicaid through the Maryland Health Connection; and an internal change in work flow to streamline call center operations to improve customer service.

Table 11. Total Recipient Complaints (not including billing)

MCO	Amerigroup (ACC)		Jai Medical Systems (JMS)		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	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Pharmacy	242	311	30	22	62	75	223	229	64	98	186	251	206	201	35	41	**1,048**	**1,228**
	23%	25%	3%	2%	6%	6%	21%	19%	6%	8%	18%	20%	20%	16%	3%	3%	**26%**	**27%**
PCP	129	117	54	32	91	82	103	85	70	68	105	74	139	101	36	29	**727**	**588**
	18%	20%	7%	5%	13%	14%	14%	14%	10%	12%	14%	13%	19%	17%	5%	5%	**18%**	**13%**

MCO	Amerigroup (ACC)		Jai Medical Systems (JMS)		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	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Specialist	166	106	28	20	66	61	135	106	83	73	94	76	223	122	55	41	**850**	**605**
	20%	18%	3%	3%	8%	10%	16%	18%	10%	12%	11%	13%	26%	20%	6%	7%	**21%**	**13%**
Prenatal	58	65	6	8	45	55	45	49	50	47	53	56	61	56	12	23	**330**	**359**
	18%	18%	2%	2%	14%	15%	14%	14%	15%	13%	16%	16%	18%	16%	4%	6%	**8%**	**8%**
Pharmacy/ CMC	N/A	14	N/A	5	N/A	1	N/A	12	N/A	3	N/A	19	N/A	30	N/A	4	**NA**	**88**
	N/A	16%	N/A	6%	N/A	1%	N/A	14%	N/A	3%	N/A	22%	N/A	34%	N/A	5%	**2%**	**2%**
DMS/DME	35	32	1	2	4	6	14	27	8	7	15	10	18	11	3	4	**98**	**99**
	36%	32%	1%	2%	4%	6%	14%	27%	8%	7%	15%	10%	18%	11%	3%	4%	**2%**	**2%**
Laboratory /Tests	16	24	0	0	5	2	13	11	4	3	9	1	5	13	2	2	**54**	**56**
	30%	43%	0%	0%	9%	4%	24%	20%	7%	5%	17%	2%	9%	23%	4%	4%	**1%**	**1%**
Pain Management	20	22	1	1	2	1	3	6	4	18	8	4	10	7	1	3	**49**	**62**
	41%	35%	2%	2%	4%	2%	6%	10%	8%	29%	16%	6%	20%	11%	2%	5%	**1%**	**1%**

**Other categories-427/428*

Not including billing complaints, there were 3,513 recipient complaints in FY 2017, compared to 3,583 in FY 2016 (all ages). The top three member complaint categories were pharmacy (27 percent), access to specialists (13 percent), and access to primary care providers (PCPs) (13 percent). These accounted for 53 percent of all member complaints, compared to 65 percent in the previous fiscal year. There was no significant change in recipient complaints by MCO.

Amerigroup continues to have the highest percent of complaints related to pharmacy, PCP, prenatal, and durable medical supplies and equipment (DMS/DME).

Including billing complaints, there were l4,550 MCO recipient complaints, of which 455 were from pregnant women. In addition, any woman who self-identifies to the Help Line as pregnant is referred to the Medicaid-funded administrative care coordinator (ACC) in her county of residence. Another 781 women enrolled in MCOs also called the Help Line for general information and were subsequently referred to the ACC. Rates in FY 2017 were consistent with the previous fiscal year.

Table 12. Recipient Complaints under age 21 (not including billing)

MCO	ACC		JMS		KP		MPC		MSFC		PP		UHC		UMHP		Sub Totals	
Fiscal Year	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Pharmacy	66	94	2	2	7	9	29	37	7	18	33	44	32	23	5	4	**181**	**231**
	36%	41%	1%	1%	4%	4%	16%	16%	4%	8%	18%	19%	18%	10%	3%	2%	**32%**	**40%**
PCP	37	45	9	8	34	28	16	22	18	26	28	23	31	27	11	7	**184**	**186**
	20%	24%	5%	4%	18%	15%	9%	12%	10%	14%	15%	12%	17%	15%	6%	4%	**33%**	**33%**
Specialist	29	17	0	3	12	13	21	21	15	7	19	10	59	28	3	9	**158**	**108**
	18%	16%	0%	3%	8%	12%	13%	19%	9%	6%	12%	9%	37%	26%	2%	8%	**28%**	**19%**
DMS/ DME	9	8	0	0	0	0	2	5	2	1	1	2	5	3	1	0	**20**	**19**
	45%	42%	0%	0%	0%	0%	10%	26%	10%	5%	5%	11%	25%	16%	5%	0%	**4%**	**3%**
Pharmacy/ CMC	N/A	2	N/A	1	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0	**N/A**	**3**
	N/A	67%	N/A	33%	N/A	0%	N/A	0%	N/A	0%	N/A	0%	N/A	0%	N/A	0%	**N/A**	**1%**
Laboratory /Tests	1	6	0	0	1	0	4	1	1	1	5	1	0	0	0	1	**20**	**10**
	8%	60%	0%	0%	8%	0%	33%	10%	8%	10%	42%	10%	0%	0%	0%	10%	**2%**	**2%**
Vision	0	3	0	1	0	0	1	2	1	3	2	1	1	5	1	0	**6**	**15**
	0%	20%	0%	7%	0%	0%	17%	13%	17%	20%	33%	7%	17%	33%	17%	0%	**1%**	**3%**

Of the 3,583 complaints, 572 recipients were under age 21 in FY 2017, compared to 561 in FY 2016. This accounts for 16 percent in both FY 2016 and FY 2017. In the under 21 population, pharmacy complaints increased by eight percent. Two MCOs (Amerigroup and Priority Partners) contributed to the increase related to pharmacy services authorization.

The top three complaint categories for the under 21 population were the same as for adults: pharmacy (40 percent), access to PCPs (33 percent), and access to specialists (19 percent).

Table 13. Total Recipient Billing Complaints

MCO	ACC		JMS		KP		MPC		MSFC		PP		UHC		UMHP		Sub Totals	
Fiscal Year	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Specialist	6	72	0	3	5	26	4	68	4	30	21	75	6	51	0	12	**46**	**337**
	13%	21%	0%	1%	11%	8%	9%	20%	9%	9%	46%	22%	13%	15%	0%	4%	**23%**	**41%**
Emergency	11	58	0	1	3	25	6	53	2	16	37	76	2	20	2	5	**63**	**254**
	17%	23%	0%	0%	5%	10%	10%	21%	3%	6%	59%	30%	3%	8%	3%	2%	**31%**	**31%**
PCP	10	35	0	1	3	15	7	12	6	13	26	35	2	23	0	3	**54**	**137**
	19%	26%	0%	1%	6%	11%	13%	9%	11%	9%	48%	26%	4%	17%	0%	2%	**27%**	**16%**

MCO	ACC		JMS		KP		MPC		MSFC		PP		UHC		UMHP		Sub Totals	
Fiscal Year	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Laboratory/ Test	7	10	0	0	3	5	3	21	1	9	19	29	5	19	0	7	**38**	**100**
	18%	10%	0%	0%	8%	5%	8%	21%	3%	9%	20%	29%	13%	19%	0%	7%	**19%**	**12%**
Pharmacy	0	1	0	0	0	2	0	0	0	0	0	0	0	0	0	0	**0**	**3**
	0%	33%	0%	0%	0%	67%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	**0%**	**0%**

The State also investigates recipient billing complaints. There was a significant increase in these complaints during the reporting period. There were 1,037 complaints in 2017 (23 percent) in FY 2017, compared to 373 (nine percent) in the previous fiscal year.

The top three bill types were specialists, emergency department (ED), and PCP - the same as in 2016. During fiscal year 2017, specialists accounted for 41 percent of billing complaints, emergency services for 31 percent, and PCPs for 16 percent. Compared to the previous fiscal year, PCP billing complaints decreased by 11 percent, while billing issues for specialists increased by 18 percent. ED remained the same (31 percent).

Priority Partners had the highest percentage of billing complaints in both FY 2017 and FY 2016.

MCOs are required to respond to all recipient 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 ACC for follow-up to ensure the complaint has been resolved.

When trends are identified, an inquiry is made to the MCO by the HealthChoice Medical Advisor. If potential policy or systems issues or barriers are identified the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly's 2017 session adjourned on Monday, April 10. The major bills that were enacted and would affect the State's Medicaid program are as follows:

- **House Bill (HB) 152** (Budget Reconciliation & Financing Act of 2017) - Makes changes to the State's budgeted Medicaid deficit assessment and places restrictions on making changes to the program's eligibility and benefits rules.
- **HB 658/Senate Bill (SB) 570** (Maryland Medical Assistance Program - Telehealth - Requirements) - Requires coverage for, and reimbursement of, health care services delivered through telehealth, including services delivered through 'store and forward' technology or remote patient monitoring; the State may not limit eligibility for reimbursement of services provided through telehealth based on the type of setting in which the services are provided to Medicaid enrollees; these bills did not pass, but the bill's sponsors requested that the Department report on the planned expansion of its telehealth program.
- **HB 1083/SB 1081** (Health - Family Planning Services - Continuity of Care) - Establishes Family Planning Program to ensure continuity of family planning services (funding for

services shall be in addition to any funding applied by the Department before December 31, 2016 to the maintenance-of-effort requirement for federal funding under Title X); the Medical Assistance program must ensure access and continuity of services provided by family planning providers that received funding under Title X as of December 31, 2016 by reimbursing for services provided and establishing program requirements for family planning providers that are the same as for other providers of the same services.

- **SB 169** (Health - Cost of Emergency Room Visits to Treat Dental Conditions & Coverage of Dental Services Under Medicaid - Study) - Authorizes the Maryland Dental Action Coalition to conduct a study to determine the annual cost of emergency room visits to treat dental conditions of adult Medicaid enrollees, adults with private insurance and uninsured adults, and whether it is 'advisable' to include dental services for Medicaid enrollees who are adults with incomes below 133 percent of poverty; Medicaid is authorized to provide coverage of dental services for adults below 133 percent of poverty if the report finds that it is advisable.
- **SB 363/HB 613** (Pharmacists - Contraceptives - Prescribing & Dispensing) - Requires Medicaid and MCHP to provide coverage for services rendered by a licensed pharmacist to the same extent as services provided by any other licensed practitioner for screening and prescribing contraceptives for enrollees.
- **SB415/HB631** (Public Health - Essential Off-Patent or Generic Drugs - Price Gouging - Prohibition) - Seeks to prohibit price gouging by manufacturers and distributors of 'essential' off-patent or generic drugs by authorizing Medicaid to notify the Attorney General of any increase in the drug's price.
- **SB 571** - (Maryland Health Insurance Coverage Protection Act) - Establishes a commission to monitor potential and actual federal changes to, and assess the impact on, the ACA, Medicaid, MCHP, Medicare and the Maryland All-Payer Model, and provide recommendations for State and local action to protect access to affordable health coverage. A report from this commission is due annually on December 31, 2017-2019.
- **SB 967/HB 1329** (Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017) - Requires the Governor's budget for FY 2019 and FY 2020 to include 3.5-percent rate increase for community behavioral health providers. Medicaid the Behavioral Health Administration (BHA) are required to conduct a 'cost-driven' rate-setting study by September 30, 2019 to set community provider rates, and develop and implement a system that incorporates the study's findings (if BHA does not implement the system, the Governor's budget must include a three-percent rate increase in FY 2021). If services are provided by MCOs, they must pay rates in effect during prior fiscal year for the first year they provide services, and adjust the rate each succeeding fiscal year by at least the same amount. A report is due December 1, 2019 and annually thereafter on the impact of the rate adjustments and the payment system on community providers.

Quality Assurance/Monitoring Activity

Quality Assurance Monitoring

The Division of HealthChoice Quality Assurance (DHQA) monitors HealthChoice MCOs quality assurance activities in accordance with the Code of Maryland Regulations (COMAR) 10.09.65.

Systems Performance Review (SPR)
As required by Federal regulations, the State contracts with an External Quality Review Organization (EQRO), which conducts an annual assessment of the structure, process, and outcome of each MCO's internal quality assurance (QA) programs. Through the systems review, the team is able to identify, validate, quantify, and monitors problem areas, as well as identify and promote best practices.

The CY 2015 SPR was the last comprehensive on-site review conducted on an annual basis. Going forward, the Department will require the EQRO to conduct comprehensive on-site SPRs every three years, with exemption reviews in the interim years. Corrective Action Plans (CAPs) will continue to be reviewed on an annual basis.

The HealthChoice MCOs' annual SPR consists of 11 standards. For CY 2015, the Department established all MCOs' compliance threshold for all standards to 100 percent, with the exception of Kaiser Permanente, for which the compliance threshold is set at 90 percent (for its second SPR).

All eight HealthChoice MCOs were evaluated during the CY 2015 SPR. The EQRO's evaluation of Kaiser for calendar year (CY) 2015 included all EQRO activities, with the exception of Performance Improvement Projects and the Consumer Report Card, as the MCO did not have sufficient data. Kaiser Permanente's full participation in all EQRO activities will begin in CY 2017.

In areas where deficiencies were noted, the EQRO provided recommendations to the MCOs that, if implemented, should improve their performance for future reviews. CAPs were required from MCOs with scores below the minimum threshold. The following lists MCOs required to and not required to submit CAPs for CY 2015:

- CAPs required: Amerigroup, Kaiser Permanente, Priority Partners, University of Maryland Health Partners, and United HealthCare;
- No CAPs required: Jai Medical Systems, Maryland Physicians Care, and MedStar Family Choice—all three received perfect scores in all 11 standards.

Table 14. CY 2015 Compliance Score

Standard		Elements Reviewed	MD MCO Compliance Score	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC
1	Systematic Process	36	100%	100%	100%	100%	100%	100%	100%	100%	100%
2	Governing Body	12	99%	100%	100%	100%	100%	100%	100%	96%*	100%
3	Oversight of Delegated Entities	7	93%	100%	100%	100%	100%	100%	90%*	60%*	100%
4	Credentialing	42	99%	99%*	100%	100%	100%	100%	100%	96%*	99%*
5	Enrollee Rights	25	99%	100%	100%	94%	100%	100%	98%*	100%	100%
6	Availability and Access	10	98%	100%	100%	80%	100%	100%	100%	100%	100%
7	Utilization Review	24	94%	84%*	100%	98%	100%	100%	89%	91%	93%

Standard		Elements Reviewed	MD MCO Compliance Score	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC
8	Continuity of Care	6	100%	100%	100%	100%	100%	100%	100%	100%	100%
9	Health Education Plan	12	95%*	100%	100%	100%	100%	100%	92%*	92%*	79%*
10	Outreach Plan	14	96%*	100%	100%	71%*	100%	100%	100%	100%	100%
11	Fraud and Abuse	19	98%*	100%	100%	94%	100%	100%	100%	89%*	100%
Composite Score			**98%↑**	**98%↑**	**100%**	**95%↑**	**100%**	**100%**	**98%↑**	**95%↓**	**98%↑**

Maryland has set high standards for MCO quality assurance systems. In general, HealthChoice MCOs continue to make improvements in their quality assurance monitoring policies, procedures, and processes while working to provide the appropriate levels and types of health care services to managed care enrollees. This is evident in the comparison of annual SPR results demonstrated throughout the history of HealthChoice. For example, Jai Medical Systems, Maryland Physicians Care, and Medstar Family Choice received scores of 100 percent on the annual SPR in CY 2013, CY 2014, and CY 2015.

All MCOs have demonstrated the ability to design and implement effective quality assurance systems. The CY 2015 review provided evidence of the continuing progression of the HealthChoice MCOs to ensure the delivery of quality health care for their enrollees. The Two newest MCOs (University of Maryland Health Partners and Kaiser Permanente) have already demonstrated a commitment to quality with SPR scores at 88 percent and 91 percent, respectively, in their first year reviews. A collaborative quality improvement relationship between the MCOs, the Department, and the EQRO increased the scores of University of Maryland Health Partners during their second year's review to 97 percent and Kaiser Permanente to 95 percent on the second review.

The EQRO will conduct its next comprehensive on-site SPR in CY 2019. To promote continuous quality improvement, the Department and the EQRO will identify areas annually for focused review.

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

The EQRO annually completes an EPSDT medical record review. The medical records review findings assist the Department in evaluating the degree to which HealthChoice children and adolescents 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 the priority areas identified by the Department. 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 this threshold is not achieved, the MCO is required to submit a CAP. Two of the eight MCOs met the minimum compliance score of 80 percent in each of the five component areas for the CY 2015 review. CAPs for the Laboratory Tests and At Risk Screenings component were required from six MCOs: Amerigroup, Kaiser Permanente,

Maryland Physicians Care, Priority Partners, University of Maryland Health Partners, and United Healthcare.

Table 15. CY 2015 EPSDT Medical Record Review Results

Components	CY 2015 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC	CY 2013	CY 2014	CY 2015
Health & Developmental History	88%	99%	95%	89%	93%	91%	90%	88%	89%	88%	92%
Comprehensive Physical Examination	91%	97%	99%	91%	94%	92%	93%	91%	91%	93%	93%
Laboratory Tests/At Risk Screenings	79%	98%	62%	77%	81%	79%	74%	73%	77%	76%	78%
Immunizations	85%	88%	80%	84%	82%	87%	83%	83%	84%	83%	84%
Health Education/ Anticipatory Guidance	89%	98%	99%	90%	93%	93%	92%	88 %	89%	91%	92%

Underlined scores denote that the minimum compliance score of 75 percent was unmet for CY 2013 and CY 2014, and the 80 percent minimum compliance score was unmet for CY 2015.

Value Based Purchasing (VBP)

The goal of Maryland's value-based purchasing strategy 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 CY 2015 performance results were validated by the EQRO and the Department's contracted HEDIS® Compliance Audit firm. The contractors determined the validity and the accuracy of the performance measure results. All measures were calculated in a manner that did not introduce bias, allowing the results to be used for public reporting and qualifying all eight MCOs to participate in the VBP program.

Table 16. CY 2015 Value-Based Purchasing Performance Results*

Performance Measure	CY 2015 Target	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC
		Incentive (I); Neutral (N); Disincentive (D)							
Adolescent Well Care	Incentive: ≥ 73% Neutral: 68%–72% Disincentive: ≤ 67%	68% (N)	83% (I)	57% (D)	73% (I)	64% (D)	73% (I)	43% (D)	65% (D)
Adult BMI Assessment	Incentive: ≥ 81% Neutral: 77%–80% Disincentive: ≤ 76%	85% (I)	97% (I)	100% (I)	82% (I)	90% (I)	86% (I)	85% (I)	93% (I)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	83% (D)	89% (I)	60% (D)	84% (N)	82% (D)	85% (N)	74% (D)	81% (D)

Performance Measure	CY 2015 Target	ACC	JMS	KP	MPC	MSFC	PP	UMHP	UHC
		Incentive (I); Neutral (N); Disincentive (D)							
Ambulatory Care Services for SSI Children	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%	83% (N)	88% (I)	53% (D)	83% (N)	81% (D)	85% (N)	59% (D)	80% (D)
Breast Cancer Screening	Incentive: ≥ 66% Neutral: 59%–65% Disincentive: ≤ 58%	66% (I)	73% (I)	89% (I)	72% (I)	66% (I)	68% (I)	64% (N)	62% (N)
Childhood Immunization Status (Combo 3)	Incentive: ≥ 82% Neutral: 79%–81% Disincentive: ≤ 78%	82% (I)	87% (I)	78% (D)	82% (I)	83% (I)	83% (I)	80% (N)	81% (N)
Comprehensive Diabetes Care – HbA1c Testing	Incentive: ≥ 85% Neutral: 82%–84% Disincentive: ≤ 81%	87% (I)	94% (I)	95% (I)	86% (I)	88% (I)	89% (I)	88% (I)	83% (N)
Controlling High Blood Pressure	Incentive: ≥ 62% Neutral: 54%–61% Disincentive: ≤ 53%	54% (N)	76% (I)	86% (I)	56% (N)	71% (I)	60% (N)	48% (D)	57% (N)
Immunizations for Adolescents (Combo 1)	Incentive: ≥ 76% Neutral: 71%–75% Disincentive: ≤ 70%	87% (I)	82% (I)	83% (I)	85% (I)	80% (I)	89% (I)	83% (I)	85% (I)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 68% Neutral: 62%–67% Disincentive: ≤ 61%	64% (N)	74% (I)	51% (D)	57% (D)	60% (D)	64% (N)	44% (D)	57% (D)
Medication Management for People with Asthma – Medication Compliance 75%	Incentive: ≥ 43% Neutral: 31%–42% Disincentive: ≤ 30%	25% (D)	51% (I)	N/A**	36% (N)	26% (D)	24% (D)	48% (I)	29% (D)
Postpartum Care	Incentive: ≥ 78% Neutral: 74%–77% Disincentive: ≤ 73%	74% (N)	88% (I)	84% (I)	69% (D)	69% (D)	74% (N)	62% (D)	66% (D)
Well Child Visits for Children Ages 3–6	Incentive: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%	86% (N)	91% (I)	83% (D)	89% (I)	86% (N)	85% (N)	62% (D)	81% (D)

*****Most recent VBP results available as of the time of reporting.
**This measure is not applicable due to insufficient eligible population (e.g. <30 members).

Consumer Report Card

The EQRO, in conjunction with the National Committee for Quality Assurance (NCQA), produces a consumer report card that compares MCOs. The consumer report card provides Medicaid recipients with the information necessary to make informed choices regarding MCO selection. An updated consumer report card is produced each year in December, which are included in enrollment packets throughout the following calendar year and posted on the HealthChoice website in both English and Spanish.

Performance Improvement Projects (PIP)
Each MCO is required to conduct Performance Improvement Projects designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care, or in non-clinical areas expected to have a favorable effect on health outcomes.

As designated by the Department, the MCOs continued the Adolescent Well Care PIPs and the Controlling High Blood Pressure PIPs. Seven MCOs conducted PIPs in CY 2015. Kaiser Permanente did not have sufficient data to participate.

Table 17. CY2015 Adolescent Well Care PIP Indicator Rates

Measurement Year	Adolescent Well Care					
	ACC	JMS	MPC	MSFC	PP	UHC
Baseline Year 1/1/12–12/31/12	68.06%	76.85%	60.20%	69.40%	67.59%	59.71%
Measurement Year 1 1/1/13–12/31/13	67.93%	76.72%	68.75%	67.80%	61.57%	60.80%
Remeasurement Year 2 1/1/14–12/31/14	64.68%	80.27%	68.29%	61.20%	68.75%	58.48%
Remeasurement Year 3 1/1/15–12/31/15	67.92%	82.59%	73.15%	64.03%	72.79%	64.80%

Table 18. CY2015 Controlling High Blood Pressure PIP Indicator Rates

Measurement Year	Controlling High Blood Pressure						
	ACC	JMS	MPC	MSFC	PP	UMHP	UHC
Baseline Year 1/1/13 – 12/31/13	49.00%	56.20%	46.78%	65.52%	56.97%	N/A	42.34%
Measurement Year 1 1/1/14 – 12/31/14	63.87%	69.34%	61.38%	69.15%	59.52%	32.13%	50.85%
Remeasurement Year 2 1/1/15 – 12/31/15	54.10%	76.40%	55.85%	71.19%	60.18%	48.18%	56.93%
Remeasurement Year 3 1/1/16 – 12/31/16	N/A	N/A	N/A	N/A	N/A	N/A	N/A

HEDIS Performance Review
For reporting year 2016, which measured CY 2015 HEDIS data, the following observations were noted:

- Measures with the greatest percentage improvement all belonged to the Effectiveness of Care (EOC) domain, with notable gains in the Prevention and Screening and Respiratory Conditions categories. Measures with the greatest degree of improvement include:

    - Immunizations for both Adolescents and Children (with increases of 8.9 percent and 12.3 percent, respectively);
    - Appropriate Testing for Children with Pharyngitis (increase of 5.6 percent);
    - Medication Management for People with Asthma, both Total 50 Percent of Treatment Period and Total 75 Percent of Treatment Period (increases of 5.4 percent and 7.1 percent, respectively); and
    - Comprehensive Diabetes Care- Medical Attention for Nephropathy (increase of 8.2 percent).
- Measures with the greatest decline were primarily Effectiveness of Care measures, and included one Access/Availability of Care measure. Measures with the greatest rate decreases follow in declining order of degree:
    - Persistence of Beta-Blocker Treatment after a Heart Attack (with a decrease of 8.4 percent);
    - Chlamydia Screening in Women- Age 16-20 Years (decrease of 3.9 percent);
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents- Body Mass Index (BMI) Percentile Total Rate, Counseling for Nutrition Total Rate, and Counseling for Physical Activity Total Rate (decreases of 2.7 percent, 2.0 percent and 2.0 percent, respectively); and
    - Children and Adolescents Access to Primary Care Practitioners- Age 12–24 months and Age 7-11 years (both decreasing by 1.7 percent).
- The seven plans that reported in each of the last three years had an average improvement rate of nearly 61 percent, meaning that, on average, each plan improved on 35 of 57 measures from 2014 to 2016.

<u>HEDIS Year 2016 Highlights</u>

- The Maryland Average Reported Rate (MARR) for Childhood Immunization Status Combinations 2, 3, 4, 5 and 7 all increased by greater than five percentage points, while Immunizations for Adolescents Combination One increased by 12.3 points from HEDIS 2015 to 2016.
- All MCOs improved their Appropriate Testing for Children with Pharyngitis score, resulting in an increase of over five percentage points to the MARR.
- The MARR improved by more than five percentage points for the Human Papillomavirus Vaccine for Female Adolescents measure.
- The MARR improved by greater than five percentage points for both indicators (50 Percent Total and 75 Percent Total) of the Medication Management for People with Asthma measure from 2015 to 2016.
- There was a significant increase (nearly eight percent) to Comprehensive Diabetes Care – Medical Attention for Nephropathy rate, which may be partially attributable to a specification change allowing positive or negative results as long as a qualifying test was performed.
- The MARR experienced a significant decrease to the rate for Persistence of Beta-Blocker Treatment after a Heart Attack from 2015 to 2016, despite no changes to the specifications.

The Department continues to require each MCO to undergo a complete HEDIS compliance audit. The Department also requires HealthChoice organizations to report all measures applicable

to Medicaid, except where the measures are identified as Medicaid Carve-Out or exempted from reporting by the Department at the present time.

HealthChoice Enrollee Satisfaction Survey
Annually, the Department uses its NCQA-certified survey vendor to conduct enrollee surveys to assess satisfaction with the HealthChoice program. Separate surveys are conducted for adults and children. The child survey includes a measurement set to assess the experience of care for special needs children with chronic conditions (CCC). The Department continues to include a Spanish option to the survey methodology each year. Survey data results include Kaiser Permanente, the newest HealthChoice MCO, for the first time in this report.

In reporting year 2016, the Department's survey vendor mailed the CAHPS® 5.0H Medicaid Adult and Child Member Satisfaction Surveys to enrollees for CY 2015 data. A total of 13,971 Adult Member Satisfaction Surveys were mailed to enrollees, and 4,552 valid surveys were completed, yielding a response rate of 34 percent—up one percent when compared to the previous year's response rate. A total of 16,120 Child Member Satisfaction Surveys were mailed to enrollees among the general population, with 4,966 valid surveys completed and yielding a response rate of 31 percent. This reflects no change in the response rate when compared with the CY 2014 results.

Table 19. Overall Satisfaction Ratings – CY 2015

CAHPS Population	Personal Doctor	Specialist Seen Most Often	Health Care	Health Plan
Adult	79%	79%	75%	74%
Child (General)	90%	82%	88%	85%
CCC	88%	84%	86%	82%

With regard to the adult population, HealthChoice members give their highest satisfaction ratings to their Specialist and their Personal Doctor. Somewhat fewer HealthChoice members give positive satisfaction ratings to their Health Care and Health Plan; however, both of these measures performed statistically better than in the previous year. MCOs continue to receive high satisfaction ratings from parents and guardians from the general and CCC populations regarding their child's Personal Doctor, Health Care, Health Plan, and Specialist.

Survey administration began for reporting year 2017 (CY 2016 data) began on February 13, 2017. The mail and telephone follow-up phase has been completed, and the vendor is now processing and conducting final analysis of the survey data. The Department anticipates receiving the final data reports regarding the HealthChoice enrollee satisfaction ratings in October 2017, which will be included in next year's Annual Report.

Provider Satisfaction Survey
The Department's vendor also administered the Provider Satisfaction Survey for FY 2016 (CY 2015 data) to a random sample of Primary Care Providers (PCPs) from each of the eight MCOs.

The PCPs were asked to rate both the MCO listed on the survey, as well as all other MCOs in which they participate.

A total of 5,859 surveys were mailed to PCPs, with a total of 1,234 valid surveys being returned, yielding a response rate of 22 percent. This was consistent with the response rate from 2015.

Table 20. Provider Satisfaction Survey Results

PCPs	Overall Satisfaction	Would Recommend to Patients	Would recommend to Other Physicians
Specified HealthChoice MCO	77.6%	86.0%	84.1%
All Other HealthChoice MCOs	73.9%	N/A	N/A

From the CY 2015 data survey results overall, more than three-fourths of the PCPs surveyed in 2016 are satisfied with their specified HealthChoice MCO (77.6 percent). A slightly smaller proportion of PCPs surveyed (73.9 percent) reported being satisfied with all other MCOs with which they participate. The research also shows that more than eight in ten PCPs would recommend their specified MCO to their patients (86.0 percent) or to other physicians (84.1 percent).

The 2017 Provider Satisfaction Survey was mailed to PCPs for CY 2016 data in late March. Kaiser Permanente, the newest MCO, was included survey for the first time in 2017. Distribution of the final data reports to the Department and MCOs is anticipated in October; results will be included in next year's Annual Report.

Annual Technical Report (ATR)

The Department is required to submit an Annual Technical Report to CMS. The ATR describes the external quality review activities conducted by the EQRO, the methods used to aggregate and analyze information from the review activities, and draws conclusions as to the quality, timeliness, and access to healthcare services furnished by HealthChoice Program. The ATR for CY 2016 was submitted in April 2017.

Demonstration Evaluation

The Department submitted the draft Summative Evaluation on its due date of April 21, 2017. As of the end of the fiscal year, the Department had not received any comments nor made any additional changes.

The Department, in conjunction with the Hilltop Institute, which provides technical support and program assistance to the Department, are in the process of finalizing the annual evaluation of the HealthChoice program that covers CY 2011 through CY 2015. This rapid-cycle assessment provides program updates and reviews the areas of coverage and access, medical homes, quality of care, special topics, and the ACA expansion.

The Department also held a Post-Award Forum on June 22, 2017, as mentioned previously. Topics included an overview of the HealthChoice demonstration focusing on new programs implemented since the previous waiver, updates on CMS HealthChoice reporting, and a

stakeholder discussion. Maryland's public notice documents and a copy of the slides used in the forum are attached to this report (Appendices B and C, respectively).

Enclosures/Attachments

Appendix A: Maryland Budget Neutrality Report as of June 30, 2017
Appendix B: Maryland HealthChoice Post-Award Forum Public Notice
Appendix C: Maryland HealthChoice Post-Award Forum Presentation

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