Maryland HealthChoice Demonstration
Section §1115 Annual Report
Demonstration Year 21
7/1/2017 - 6/30/2018

Introduction

The HealthChoice section §1115(a) demonstration is designed to use a managed care delivery system to create efficiencies in the 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 the beneficiary's specific medical needs. Now in its twenty-first 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 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 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 innovative pilot programs.

Subsequent to the initial grant, Maryland requested and received several program extensions, in 2002, 2005, 2008, 2011, 2013, and 2016. The 2016 extension made the following changes to the demonstration:

- Created a Residential Treatment for Individuals with Substance Use Disorders (SUD) Program as part of a comprehensive SUD strategy;
- Created Community Health Pilot Programs:
    - Evidence-Based Home Visiting Services (HVS) pilot program for high-risk pregnant women and children up to two years of age; and
    - Assistance in Community Integration Services (ACIS);
- Raised the enrollment cap for the Increased Community Services (ICS) 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 quarters. These counts represent individuals enrolled at a point in time, as opposed to total member months.

Table 1. Enrollment Counts and Annual Growth

Demonstration Populations	Enrollees as of June 30, 2017	Enrollees as of June 30, 2018	Year 21 Change	Year 21 Percent Change
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	213,276	209,330	-3,946	-1.9%
Affordable Care Act (ACA) Expansion Adults	305,431	307,690	2,259	0.7%
Medicaid Children	457,414	459,218	1,804	0.4%
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	88,318	90,001	1,683	1.9%
SSI/BD Children	22,615	23,744	1,129	5.0%
Medically-Needy Adults	22,658	21,525	-1,133	-5.0%
Medically-Needy Children	5,908	5,928	20	0.3%
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	8,807	8,389	-418	-4.7%
Maryland Children's Health Program (MCHP)	114,867	114,949	82	0.1%
MCHP Premium	30,882	35,232	4,350	14.1%
Presumptively Eligible Pregnant Women (PEPW)	5	1	-4	-80.0%
Family Planning	9,617	9,543	-74	-0.8%
ICS	28	36	8	28.6%
Women's Breast and Cervical Cancer Health Program (WBCCHP)	138	111	-27	-19.6%

Table 2. Enrollment as a Proportion of Total

Demonstration Populations	Total Enrollment % - June 2017	Total Enrollment % - June 2018	Share Change
Parents/Caretaker Relatives <116% FPL and Former Foster Care	16.7%	16.3%	0.4%
ACA Expansion Adults	23.9%	23.9%	-0.1%
Medicaid Children	35.7%	35.7%	0.0%
SSI/BD Adults	6.9%	7.0%	-0.1%
SSI/BD Children	1.8%	1.8%	-0.1%

Demonstration Populations	Total Enrollment % - June 2017	Total Enrollment % - June 2018	Share Change
Medically-Needy Adults	1.8%	1.7%	0.1%
Medically-Needy Children	0.5%	0.5%	0.0%
SOBRA Adults	0.7%	0.7%	0.0%
MCHP	9.0%	8.9%	0.0%
MCHP Premium	2.4%	2.7%	-0.3%
PEPW*	N/A	N/A	N/A
Family Planning	0.8%	0.7%	0.0%
ICS*	N/A	N/A	N/A
WBCCTP*	N/A	N/A	N/A

**Percent is less than 0.0*

Table 3. Member Months

Demonstration Populations	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Parents/Caretaker Relatives <116% FPL and Former Foster Care	640,642	640,433	647,121	638,152	2,566,348
ACA Expansion Adults	917,937	926,839	937,672	931,594	3,714,042
Medicaid Children	1,370,411	1,371,570	1,393,224	1,387,990	5,523,195
SSI/BD Adults	265,736	268,985	269,032	270,333	1,074,086
SSI/BD Children	69,579	67,948	68,642	70,904	277,073
Medically-Needy Adults	67,530	67,552	65,590	64,300	264,972
Medically-Needy Children	17,767	17,554	17,611	17,561	70,493
SOBRA Adults	25,954	25,859	26,875	25,832	104,520
MCHP	341,897	340,979	343,778	344,892	1,371,546
MCHP Premium	94,039	99,169	104,456	104,838	402,502
PEPW	3	2	3	7	15
Family Planning	29,449	29,338	28,233	28,396	115,416
ICS	88	95	98	108	389
WBCCTP	403	378	353	339	1,473

Outreach/Innovative Activities

Residential Treatment for Individuals with Substance Use Disorders

Effective July 1, 2017, the Department provides reimbursement for adults aged 21 through 64 for up to two non-consecutive 30-day stays annually in Institutions for Mental Disease (IMDs) for American Society of Addiction Medicine (ASAM) levels 3.7-WM, 3.7, 3.5, and 3.3. The Department also plans to phase in coverage of ASAM level 3.1 by January 1, 2019.

Table 4 displays IMD utilization for individuals 21 and over under the HealthChoice demonstration from implementation in July 2017 through the end of June 2018. These results should be considered preliminary and subject to change to account for run-out.

Table 4. Utilization of Residential Treatment for Substance Use Disorders Services, FY 2018

Level of Service	Number of Participants	Number of Days
Level 3.7-WM	4,516	28,261
Level 3.7	5,594	84,758
Level 3.5	1,649	28,765
Level 3.3	965	22,753
Total	**8,236**	**164,537**

**Based on claims paid through August 31, 2018*

§1115 Waiver Amendment

The Department also recently submitted an §1115 waiver amendment, with the State's public comment period open from May 21, 2018 through June 19, 2018. The waiver amendment proposes:

1. Cover National Diabetes Prevention Program (DPP) services through a limited pilot program;
2. Pay for certain inpatient treatments for participants with a primary SUD diagnosis and secondary mental health diagnosis at IMDs;
3. Cover a limited adult dental benefit for dually-eligible participants who are 21 to 64 years of age;
4. Expand the annual cap of the Assisted Community Integration Services; and
5. Remove the Family Planning program from the waiver in anticipation of submitting a State Plan Amendment (SPA) for the same program with expanded eligibility requirements and services.

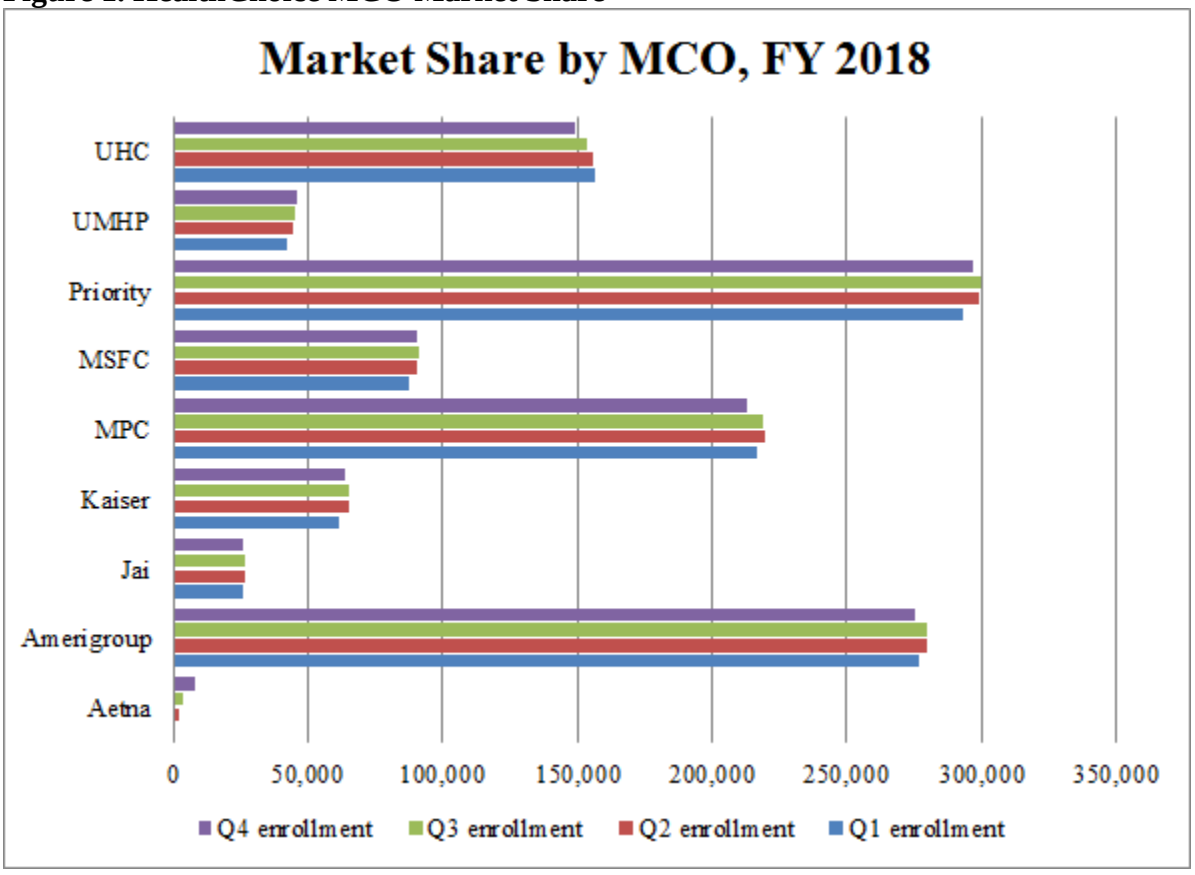
The Department provided public notice and solicited stakeholder participation for this §1115 waiver amendment application per the requirements in 42 C.F.R. §431.408. The Department also held two public hearings, the first on May 24, 2018 in conjunction with the annual Post-Award Forum in Baltimore, Maryland. The second was held on June 6, 2018 in Annapolis, Maryland. Please see Appendix E for the full amendment.

Operational/Policy Developments/Issues

Market Share

As of the culmination of FY 2018, there were nine MCOs participating in the HealthChoice program. Aetna Better Health joined the HealthChoice program and began accepting enrollments in October 2017. The MCOs' respective market shares are as follows: Aetna (0.7 percent), Amerigroup (23.5 percent); Jai Medical Systems (2.2 percent); Kaiser Permanente (5.5 percent); Maryland Physicians Care (18.3 percent); MedStar Family Choice (7.7 percent); Priority Partners (25.4 percent); University of Maryland Health Partners (3.9 percent); and United Healthcare (12.8 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC 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 managed care rate setting JCR and the oral health chart book; and
- Eligibility and enrollment updates.

In addition, there was also a presentation on the §1115 waiver amendment that was submitted to CMS on July 2, 2018. The MMAC also discussed the recently-released Medicaid and CHIP Scorecard. Additionally, the Department continued to keep the MMAC informed on its new provider enrollment system.

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 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 quarter was 9,543 women, with an average monthly enrollment of 9,465, an increase of 0.6 percent over the previous quarter. Women who receive pregnancy coverage will continue to be automatically enrolled, if eligible, following the end of their pregnancy-related eligibility.

On July 2, 2018, the Department submitted an §1115 waiver to CMS. Part of the waiver amendment included removing the Family Planning Program from the waiver in anticipation of submitting a SPA for the same program with expanded eligibility requirements and services, including lifting the age limit, opening coverage to include men, and covering services for individuals up to 250 percent of the FPL.

Table 5. Average Quarterly Family Planning Enrollment

Q1 Enrollment	% Change	Q2 Enrollment	% Change	Q3 Enrollment	% Change	Q4 Enrollment	% Change
9,816	2.1%	9,779	(0.4%)	9,411	(3.8%)	9,465	0.6%

Table 6. Family Planning and Related Statistics, July 2016 – June 2017*

No. of Individuals Enrolled in the Demonstration (Total with Any Period of Eligibility)	Total No. of Participants**	No. of Actual Births to Family Planning Demonstration Participants After Enrollment	Average Total Medicaid Expenditures for a Medicaid-funded Birth***
13,353	2,497	227	$27,457

**The HealthChoice program utilizes a look-back period to the previous fiscal year to allow for run-out.*
***Includes all individuals who obtain one or more covered family planning services through the demonstration.*
****Includes prenatal services, delivery- and pregnancy-related services and services to infants from birth to age one.*

Rare and Expensive Case Management (REM) Program

The table below shows the status of REM program enrollment.

Table 7. Current REM Program Enrollment

FY 2018	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	158	120	50	130	4,318
Quarter 2	167	126	78	125	4,306
Quarter 3	176	140	52	74	4,318
Quarter 4	205	155	94	105	4,329

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 8. REM Complaints

FY 2018	Transportation	Dental	DMS/ DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	22	0	7
REM Hotline	1	0	0	0	0	0	1	0	1
Total	1	0	0	0	0	0	23	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 9. REM Significant Events Reported by Case Managers

FY 2018 Q4	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	18	33	1	216	66	21	33	388

ICS Program

Through the ICS Program, Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the 2016 waiver renewal, Maryland will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of June 30, 2018, there were 36 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.

MCHP and MCHP Premium Status/Update/Projections

Effective June 1, 2008, Maryland moved its separate CHIP program, the Maryland Children's Health Program (MCHP), and MCHP Premium, into the Medicaid expansion CHIP waiver, so that Maryland's entire CHIP program is operated as a Medicaid expansion. As of June 30, 2018, the Premium program had 35,232 enrollees, with MCHP at 114,949 enrollees.

Medicaid and National Diabetes Prevention Program (DPP) Demonstration

During the demonstration's second year, the Department successfully met and surpassed the demonstration's enrollment target of 600 participants. As planned, enrollment in the demonstration ended January 31, 2018 with a total enrollment of 618.

As of June 2018, the Medicaid and National DPP demonstration completed its second and final program year; however, the demonstration was granted a no-cost extension to continue through January 31, 1019. The Department anticipates that the four original participating MCOs—Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners—will continue to be active partners in the demonstration extension. Major objectives for the no-cost continuation of the second program year are to improve retention, strengthen capacity, engage providers, and explore and recommend sustainability strategies beyond the grant funding period. The Department presented a demonstration update and a proposed sustainability plan to the Maryland Medicaid Advisory Committee (MMAC). The Department and MCOs also identified several program areas that require quality and process improvements particularly in the areas of clarity and standard terms used in reporting and payment. These matters will be addressed during the no-cost extension period.

Over eighty percent of enrollees in the demonstration participate in DPP services from virtual suppliers. The Department and MCOs achieved a critical milestone with the successful transmittal of DPP encounters from the MCO claims system to the Medicaid Management Information System (MMIS2). In addition, the Department consulted with the Medicaid operational area to ensure that the Medicare DPP Expanded Model Healthcare Common Procedure Coding System (HCPCS) codes were available through MMIS. This was done to ensure that any applicable cost sharing for dually-eligible Medicare-Medicaid beneficiaries could be reimbursed through the Medicare Diabetes Prevention Program (MDPP) Expanded model.

The Department continues to inform internal and external stakeholders on the value of DPP, at the local and national levels through in-person presentations, webinars, and articles. Presentations this program year were given to:

- The CMS Quality Conference;
- The Tennessee State Engagement Conference sponsored by the Centers for Disease Control and Prevention (CDC) and the National Association of Chronic Disease Directors (NACDD);
- AcademyHealth's Medicaid Medical Directors' Open Mic Call; and
- Other State Medicaid Agencies:
    - Oregon;
    - North Dakota;
    - New Jersey; and
    - Minnesota.

The Department, the participating MCOs, and participating National DPP suppliers continued to meet at least monthly to discuss program techniques, strategies for enrollment, recruitment and retention, credentialing and provider enrollment, program evaluation, sustainability, or other issues that arise, as well as monitor the requirements under and implementation progress of the Medicare DPP Expanded Model. The program evaluation is anticipated to be available by the end of CY 2018.

As noted above, the Department developed an §1115 waiver amendment to authorize continued provision of National DPP on a limited basis after the conclusion of the demonstration. The Department submitted the waiver amendment application on July 2, 2018. The decision to move forward with a continuation of a Medicaid DPP pilot is contingent on CMS approval of the waiver amendment, the Maryland Department of Budget and Management's acceptance of the plan, and the final demonstration evaluation conducted by the CDC contractor.

Community Health Pilots

As of June 2018, the Department awarded a second round of federal matching funds to three local government entities in support of the Community Health Pilots that were included as part of the 2016 HealthChoice waiver renewal. These awards are in addition to the three Community Health Pilots that were funded in FY 2017. One local health department was awarded Medicaid federal matching funds for the HVS Pilot, and two jurisdictions were approved for funding for the ACIS Pilot for high-risk, high-utilizing Medicaid enrollees who are either transitioning to the community from an institution or at high risk of institutional placement. Three counties approved in FY 2017 renewed their pilot agreements, including one of the counties awarded ACIS Pilot funding in Round 1, who also will receive Round 2 funds to expand its program. As of the end of FY 2018, there are a total of six Maryland jurisdictions implementing or approved for the Community Health Pilots. The four ACIS Pilots anticipate serving the §1115 waiver maximum of 300 individuals collectively, and the two HVS Pilots will serve up to 43 families annually.

The pilots are effective through December 31, 2021 and are scheduled to be funded for the duration of the five-year waiver.

Expenditure Containment Initiatives

The Department, in collaboration with the Hilltop Institute (based out of University of Maryland Baltimore County), has worked on several different fronts to contain expenditures. The culmination of the Department and the Hilltop Institute's efforts are detailed below.

HealthChoice Financial Monitoring Report (HFMR)

The Department's contracted accounting firm finalized all MCO financial reviews for 2016, and the MCOs' reported incurred but not reported (IBNR) submissions were independently evaluated. Consolidated reports were also prepared. Instructions and templates for 2017 data were provided to the MCOs in March. These reports reflect the Service Year 2017 MCO experience as of March 31, 2018 and were due on May 14, 2018.

In May, the MCOs provided Service Year 2017 HFMR reports (including Financial Templates) as of March 31, 2018. These data were used by the Hilltop Institute and the Department's contracted actuarial firm to assist in the HealthChoice trend analysis, regional analysis and for the validation process of calendar year (CY) 2019 HealthChoice rates. Unadjusted consolidated 2017 HFMRs by region were provided to all MCOs on June 21, 2018. MCOs will have an opportunity to update their Service Year 2017 experience in November. The 2017 submission in November will most likely be the base period for the 2020 HealthChoice rate-setting period.

MCO Rates

CY 2019 Rate-Setting

The rate-setting team participated in several meetings—both internal and external, including with the MCOs—in support of the CY 2019 HealthChoice rates. Topics covered during rate-setting meetings included: mid-year adjustments of HIV and geographic and demographic rates; constant cohort analyses; issues raised by the Department and the MCOs; costs associated with extending long-term care stays from 30 to 90 days; follow-up discussion regarding adult hearing risk arrangements; regional presentation; base presentation; MCO outlier adjustments; non-state plan service adjustments; impact of limiting observation stays; Hepatitis C therapy analysis; and presentation of actuarial trends. In addition, the rate-setting team presented to the MCOs the impact of additional cost of inpatient admissions offset by outpatient savings on the 2016 base, which determined the 2019 rates, as well as the consolidated preliminary CY 2017 financials and new actuarial firm durational template.

In collaboration with the accounting firm, the rate-setting team proposed comments and revisions regarding 2016 MCO financial reviews and IBNR reviews, as well as participating in eight MCO exit conference calls.

The rate-setting team also collaborated closely with the actuarial firm in support of the actuarial soundness of the CY 2019 rates, providing MCO encounter reports—including lag reports—by category of service from January 2016 through March 2018; updated hospital data; the CY 2017-CY 2018 calculations of the change in the graduate medical education (GME) discount; the 2016 base adjustment extending long-term care stays from 30 to 90 days; and the final audited 2016 financial base model. The actuarial firm also received 2016 adjustments for reinsurance administration costs, efficiency, adult dental administrative costs, adult prescription co-pays and non-state plan services, as well as Evaluation and Management (E&M) fee adjustments for the 2019 rates. In addition, the rate-setting team provided the actuarial firm with a preliminary detailed CY 2019 HealthChoice membership forecast and Hepatitis C therapy medical expenses for 2017 (final), 2018 (restated) and 2019 (draft HealthChoice rates).

CY 2018 Rate-Setting

The rate-setting team provided multiple organizations with data related to their analyses in support of the CY 2018 HealthChoice rates. They provided the actuarial firm with multiple data requests, including restated physician E&M adjustment reflecting new fees effective July 1, 2018, the 2016 base adjustment for MCO hearing benefit, and prescription adjustment reflecting the increase in dispensing period of contraceptive from 30 days to 12 months. Additionally, the

rate-setting team participated in a call with the actuarial firm, the Department, and the Health Services Cost Review Commission (HSCRC) regarding HSCRC trends and projections. HSCRC was also provided with restated monthly MCO membership in support of their trend analysis. The rate-setting team provided the actuarial firm with preliminary 2017 financial base model. They also assisted the newest MCO with improving its financial submissions.

Additional Activities

In addition to activities associated with HealthChoice capitation rates, the rate-setting team also performed provided the Department with other data requests, including trauma calculations for March, April, and May 2018, various Hepatitis C therapy statistics in support of an analysis regarding the expansion of Hepatitis C treatments, FY 2017 fee-for-service (FFS) hospital statistics requested by the accounting firm, 2014-2017 ACA expansion data to be used in support of a proposed new HSCRC payer differential, and 2016 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. The rate-setting team also attended two nursing home liaison meetings, one in April and the other in May 2018. They also completed review of nursing home submission of wage surveys for 2018, as well as technical evaluations (including finalist interviews) regarding the actuarial rate-setting request for proposals (RFP). Financial proposals and the final recommendation for award were expected to be completed the first week of May.

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. 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 MCOs but covered by Medicaid on a FFS basis. When a consumer is experiencing medically-related issues 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 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 211,022 calls during this demonstration year, compared with 215,883 in FY 2017, a decrease of 4,861 calls.

Table 10. Total Recipient Complaints (not including billing)

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
Fiscal Year		2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018
Pharmacy	#		11	325	251	27	17	76	61	241	189	101	65	270	222	231	200	45	36	1,316	1,052
	%		1%	25%	24%	2%	2%	6%	6%	18%	18%	8%	6%	21%	21%	18%	19%	3%	3%	37%	36%
Prenatal	#		18	65	146	8	12	55	92	49	91	47	86	56	150	56	133	23	27	359	755
	%		2%	18%	19%	2%	2%	15%	12%	14%	12%	13%	11%	16%	20%	16%	18%	6%	4%	10%	26%
Specialist	#		15	106	79	20	10	61	39	106	66	73	60	76	45	122	50	41	21	605	385
	%		4%	18%	21%	3%	3%	10%	10%	18%	17%	12%	16%	13%	12%	20%	13%	7%	5%	17%	13%
PCP	#		12	117	80	32	16	82	28	85	54	68	47	74	54	101	50	29	14	588	355
	%		3%	20%	23%	5%	5%	14%	8%	14%	15%	12%	13%	13%	15%	17%	14%	5%	4%	17%	12%

**Source from CRM: the New CRM (Customer Relationship Management) system was launched on October 10, 2017.*
**Aetna Better Health was launched on October 23, 2017.*

There were 4,222 MCO total recipient complaints in FY 2018 compared to 4,550 in FY 2017 (all ages). Seventy percent of the complaints (2,931) complaints were related to access to care. The remaining 30 percent (1,291) were billing complaints. The top three member complaint categories were pharmacy, access to prenatal care and access to specialists. Amerigroup had the highest percent of complaints in all three of these categories.

Access complaints regarding prenatal care increased this fiscal year from 10 percent to 26 percent (755 to 2,931) compared to the previous fiscal year. All pregnant women were connected with an MCO network prenatal care provider and referred to the Administrative Care Coordination Unit (ACCU) for follow-up and education. An additional 1,632 pregnant women called the Help Line for general information and were referred to the ACCU for follow-up and education.

Table 11. Recipient Complaints under age 21 (not including billing)

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
Fiscal Year		2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018
Pharmacy	#		1	96	67	3	0	9	6	37	27	18	12	44	44	23	28	4	4	234	189
	%		1%	41%	35%	1%	0%	4%	3%	16%	14%	8%	6%	19%	23%	10%	15%	2%	2%	41%	36%
PCP	#		4	45	34	8	3	28	14	22	22	26	17	23	29	27	14	7	8	186	145
	%		3%	24%	23%	4%	2%	15%	10%	12%	15%	14%	12%	12%	20%	15%	10%	4%	6%	33%	28%
Specialist	#		3	17	15	3	1	13	9	21	14	7	7	10	16	28	14	9	4	108	83
	%		4%	16%	18%	3%	1%	12%	11%	19%	17%	6%	8%	9%	19%	26%	17%	8%	5%	19%	16%

**Source from CRM: the New CRM (Customer Relationship Management) system was launched on October 10, 2017.*

**Aetna Better Health was launched on October 23, 2017.*

There were 520 member complaints for recipients under age 21 or 17 percent of the total non-billing complaints compared to 16 percent in 2017. The top three complaint categories for the under 21 population were pharmacy, access to primary care providers (PCPs), and access to specialists. Pharmacy complaints continue to be a major issue. Amerigroup and Priority Partners account for the majority of complaints related to pharmacy services authorization.

Table 12. Total Recipient Billing Complaints

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
Fiscal Year		2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018
PCP	#		2	35	108	1	8	15	38	12	63	13	58	35	53	23	51	3	14	137	395
	%		1%	26%	27%	1%	2%	11%	10%	9%	16%	9%	15%	26%	13%	17%	13%	2%	4%	13%	31%
Emergency	#		1	58	82	1	4	25	37	53	64	16	43	76	79	20	31	5	10	254	351
	%		0%	0%	23%	0%	1%	0%	11%	0%	18%	0%	12%	0%	23%	0%	9%	0%	3%	24%	27%
Laboratory /Test	#		3	10	59	0	0	5	5	21	46	9	27	29	43	19	22	7	14	100	219
	%		1%	10%	27%	0%	0%	5%	2%	21%	21%	9%	12%	29%	20%	19%	10%	7%	6%	10%	17%
Specialist	#		0	72	33	3	1	26	12	68	29	30	19	75	20	51	10	12	1	337	125
	%		0%	21%	26%	1%	1%	8%	10%	20%	23%	9%	15%	22%	16%	15%	8%	4%	1%	32%	10%

**Source from CRM: the New CRM (Customer Relationship Management) system was launched on October 10, 2017.*
**Aetna Better Health was launched on October 23, 2017.*

Billing complaints comprised 30 percent of total complaints in FY 2018, compared to 23 percent in FY 2017. Many of the complaints are FFS-related, meaning the service was received prior to enrollment in the MCO.

The top three bill types about which members had complaints this fiscal year were from PCPs, emergency services, and laboratory/tests. Compared to the previous year, PCP billing complaints increased by 18 percent, and billing issues for emergency services increased by three percent. In FY 2018, Amerigroup had the highest percentage of billing complaints, while the number of Priority Partners' billing complaints decreased by eight percent.

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 ACCU 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 or systems issues or barriers are identified the MCO may be directed to take corrective action.

Legislative Update

The Maryland General Assembly's 2018 session began on January 10, 2018 and adjourned on April 9, 2018. Below is a list of major Medicaid-related legislation that was enacted during the 2018 session:

Senate Bill (SB) 187: Budget Reconciliation & Financing Act - Increases amount of the Medicaid Deficit Assessment by $5 million in FY 2019, to $324.8 million; also requires the Department and HSCRC to develop five and 10-year Medicaid-specific cost-savings targets (including a reduction in total hospital costs, total cost of care, and quality measures).

House Bill (HB) 1310: Health Insurance - Providers Panels - Procedures & Credentialing Practices - Prevents insurers (including MCOs) from imposing a limit on the number of behavioral health providers at a health care facility that may be credentialed to participate on their provider panel.

HB 1696: Task Force to Study Access to Home Health Care for Children & Adults with Medical Disabilities and Report on Home- and Community-Based Services - Establishes a task force to determine the total number of home health care hours at the licensed practical nurse (LPN) level prescribed to children and adults with medical disabilities in Medicaid or managed Medicaid programs in 2017, and how many of those hours were not administered; determine how many children and adults have previously been authorized home health services at the LPN level and are currently authorized for certified nursing assistant care; and how many are on waiting lists or registries for home health care, whether the waiting lists have become longer or shorter and the extent of change in the length of any waiting lists; also requires the Department to compare REM reimbursement rates- for home and community-based care with the actual cost

to providers for providing care for direct-care services, coordinating care services and providing any other services; review specific services, licensure requirements, health occupations board requirements and any other State/local requirements; and determine the costs associated with providing service and care under other home- and community-based services programs.

HB 1782/SB 387: Health Insurance - Individual Market Stabilization (Maryland Health Care Access Act of 2018) - In CY 2019 only, commercial insurers, MCOs, dental plans, and fraternal health organizations are subject to an assessment of 2.75 percent on the amount used to calculate their premium tax or premium tax exemption for CY 2018, and funds are to be distributed to the Maryland Health Benefit Exchange (MHBE); also, requires the Health Insurance Coverage Protection Commission to study and make recommendations for individual and group insurance market stability, including whether to pursue a Basic Health Program and a Medicaid buy-in program (to be included in annual report submitted on December 31, 2019).

HB 1795/SB 1267: Maryland Health Benefit Exchange - Establishment of a Reinsurance Program - Requires MHBE to submit a State Innovation Waiver application by July 1, 2018 for a §1332 waiver to establish a program for reinsurance to mitigate the impact of high-risk individuals on rates in the individual insurance market inside and outside the health benefit exchange, and to seek federal pass-through funding.

SB 284: Maryland Medical Assistance Program - Dental Coverage for Adults - Pilot Program - Requires Maryland to apply for an §1115 waiver amendment to implement a pilot program to provide limited dental coverage for adult Medicaid enrollees; the pilot program may limit participation to dual-eligibles of a certain age and to certain geographic regions of the state.

SB 550/HB 782: Maryland Achieving a Better Life Experience (ABLE) Program - Modifications - Authorizes money and assets in an ABLE account to be transferred upon the death of a designate beneficiary to their estate or to an ABLE account for another eligible person; an 'agency or instrumentality of the State' may not seek payment from an ABLE account or its proceeds for any amount of Medical Assistance paid for the beneficiary; it would also allow funds from certain college savings plans to be transferred to an ABLE account.

SB 660/HB 1280: Maryland Department of Health - Enrollees in the Employed Individuals with Disabilities (EID) Program - Demonstration Program - Establishes a three-year demonstration program supported by State General Funds to cover health care services that are provided to individuals aged 21 to 64 who are enrolled in EID, have a qualifying condition and are not covered under Medicaid.

SB 682: Emergency Medical Services (EMS) Providers - Coverage and Reimbursement of Services - Reports and Plan - Requires the Maryland Health Care Commission and Maryland Institute for Emergency Medical Services Systems, in consultation with other stakeholders, to jointly develop a statewide plan for the reimbursement of services provided by EMS providers to Medicaid enrollees.

SB 704: Maryland Medical Assistance Program - Telemedicine - Assertive Community Treatment and Mobile Treatment Services - Requires the Medicaid program to reimburse

psychiatrists who are providing assertive community treatment or mobile treatment services through telemedicine to enrollees located in a home- or community-based setting.

SB 765/HB 772: Maryland Department of Health - Reimbursement for Services Provided by Certified Peer Recovery Specialists - Workgroup and Report - Requires the Department to convene a stakeholder workgroup to make findings and recommendations on issues related to the reimbursement of certified peer recovery specialists.

SB 774/HB 994: Maryland Medical Assistance Program - Family Planning Services - Requires Maryland to apply for a State Plan Amendment to provide family planning services for individuals below 250 percent of the federal poverty level, with no age restrictions; would require presumptive eligibility and exempts Family Planning program from federal coordination of benefits requirements; also would extend the length of time for which Medicaid and MCHP must provide coverage for a single dispensing of a supply of prescription contraceptives from six months to 12 months; also requires the Department to collaborate with stakeholders to establish a presumptive eligibility process and integrate that process into Maryland Health Connection, the State's insurance marketplace.

SB 835/HB 1682: Maryland Medical Assistance Program - Collaborative Care Pilot Program - Establishes a program to implement a Collaborative Care Model in primary care settings for HealthChoice enrollees; three sites with certain characteristics to be selected to participate.

SB 896: Maryland Health Care Commission - Health Record and Payment Program Advisory Committee - Requires the Maryland Health Care Commission to establish an advisory committee (including MCO representatives) to examine the feasibility of creating a health record and payment integration program, approaches for accelerating the adjudication of clean claims and other issues.

SB 1208/HB 1766 Sunset Extension and Repeal of Subsidy for Medicare Part D Coverage Gap - Extends funding to subsidize Senior Prescription Drug Assistance Program (SPDAP) through FY 2025 and extends SDPAP sunset through December 31, 2025.

Quality Assurance/Monitoring Activity

Quality Assurance Monitoring Overview

The Department's HealthChoice and Acute Care Administration (HACA) is responsible for coordination and oversight of the HealthChoice program. HACA ensures that the initiatives established in 42 CFR 438, Subpart D are adhered to and that all MCOs that participate in the HealthChoice program apply these principles universally and appropriately. The functions and infrastructure of HACA 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 HACA is primarily-responsible for coordinating the quality activities involving external quality review and

monitoring CMS quality improvement requirements and in accordance with COMAR 10.09.65 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 is required to contract 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 annual assessment of the structure, process, and outcome of each MCO's internal quality assurance programs. Through the systems review, the team is able to identify, validate, quantify, and monitor problem areas, as well as identify and promote best practices.

In view of the decision by the Department to move to triennial rather than annual onsite reviews, the assessment for CY 2017 was conducted as an Interim Desktop Review. This assessment was completed by applying the systems performance standards defined for CY 2016 in COMAR 10.09.65.03B (1). The focus of the review was primarily on three areas: standards that were not fully met in the CY 2016 review, standards that were scored as baseline in the CY 2016 review, and new standards introduced during CY 2016. Additionally, a review of a sample of credentialing and recredentialing records was conducted to assess compliance with applicable standards.

The performance standards used to assess the MCO's operational systems were developed from applicable Health-General Statutes from the Annotated Code of Maryland; COMAR; the CMS document, "A Health Care Quality Improvement System (HCQIS) for Medicaid Managed Care;" Public Health Code of Federal Regulations; and Department requirements. The HealthChoice and Acute Care Administration leadership and the DHQA approved the MCO performance standards used in the CY 2016 review before application.

Corrective Action Plan (CAP) Review

CAPs related to the SPR can be directly linked to specific components or standards. The annual SPR for CY 2017 will determine whether the CAPs from the CY 2016 review were implemented and effective. In order to make this determination, the EQRO will evaluate all data collected or trended by the MCO through the monitoring mechanism established in the CAP. In the event that an MCO has not implemented or followed through with the tasks identified in the CAP, the Department will be notified for further action.

Following the CY 2016 SPR, the Department implemented its quality monitoring policy, whereby an MCO that had a CAP for two or more consecutive years in the same element/ component would require quarterly monitoring by the EQRO. Under this policy, five MCOs have been required to submit quarterly updates of their CAPs to the EQRO.

The CY 2016 SPR Interim Desktop Review included all MCO CAPs from the CY 2015 SPR for any of the following areas:

- Systematic Process of Quality Assessment
- Utilization Review
- Accountability to the Governing Body
- Coordination of Care
- Oversight of Delegated Entities
- Health Education
- Credentialing and Recredentialing
- Outreach
- Enrollee Rights
- Fraud and Abuse
- Availability and Accessibility

Findings

A CAP is triggered if an MCO receives a finding other than "Met." Two MCOs received findings of "Met" in all standards reviewed. Six MCOs (Amerigroup, Kaiser Permanente, MedStar Family Choice, Priority Partners, United Healthcare, and University of Maryland Health Partners) were required to submit CAPs for CY 2016. All CAPs were submitted, reviewed, and found to adequately address the standard in which the deficiencies occurred. In areas where deficiencies were noted, the MCOs were provided recommendations that, if implemented, should improve their performance for future reviews.

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 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. Seven of the eight MCOs met the minimum compliance score of 80 percent in each of the five component areas for the CY 2016 review. A CAP for the Laboratory Tests/At Risk Screening component was required from one MCO. Findings for the CY 2016 EPSDT review by component area are described in Table 13.

Table 13. CY 2016 EPSDT Review by Component

Component	CY 2016 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2014	CY 2015	CY 2016
Health & Developmental History	90%	99%	99%	89%	91%	88%	90%	88%	88%	92%	92%
Comprehensive	95%	99%	99%	93%	97%	94%	94%	94%	93%	93%	96%

Component	CY 2016 MCO Results								HealthChoice Aggregate Results		
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2014	CY 2015	CY 2016
Physical Examination											
Laboratory Tests/At Risk Screenings	85%	99%	93%	82%	82%	82%	78%	82%	76%	78%	85%
Immunizations	85%	88%	85%	84%	86%	88%	82%	85%	83%	84%	85%
Health Education/ Anticipatory Guidance	94%	100%	100%	92%	94%	95%	92%	93%	91%	92%	95%

Underlined scores denote that the minimum compliance score of 75 percent was unmet for CY 2014, and the 80-percent minimum compliance score was unmet for CY 2015 and CY 2016.

Value Based Purchasing (VBP)

The goal of Maryland's 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 2016 performance results presented in Table 14 below were validated by the EQRO and the Department's contracted Healthcare Effectiveness Data and Information Set (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 the VBP program. In CY 2016, all eight HealthChoice MCOs qualified to participate.

Table 14. CY 2016 MCO-Specific VBP Results

Performance Measure	CY 2016 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Adolescent Well Care	Incentive: ≥ 73% Neutral: 68%–72% Disincentive: ≤ 67%	69% (N)	84% (I)	56% (D)	73% (I)	56% (D)	64% (D)	63% (D)	53% (D)
Adult BMI Assessment	Incentive: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%	91% (I)	98% (I)	98% (I)	89% (I)	91% (I)	90% (I)	90% (I)	89% (I)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	82% (D)	90% (I)	68% (D)	84% (N)	81% (D)	85% (N)	79% (D)	78% (D)
Ambulatory Care Services for SSI Children	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%	83% (N)	91% (I)	77% (D)	81% (D)	78% (D)	84% (N)	79% (D)	71% (D)
Breast Cancer Screening	Incentive: ≥ 71% Neutral: 66%–70% Disincentive: ≤ 65%	66% (N)	74% (I)	88% (I)	68% (N)	66% (N)	69% (N)	60% (D)	67% (N)
Childhood Immunization Status (Combo 3)	Incentive: ≥ 82% Neutral: 79%–81% Disincentive: ≤ 78%	83% (I)	88% (I)	70% (D)	79% (N)	82% (I)	83% (I)	78% (D)	79% (N)

Performance Measure	CY 2016 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Comprehensive Diabetes Care – HbA1c Testing	Incentive: ≥ 92% Neutral: 89%–91% Disincentive: ≤ 88%	85% (D)	95% (I)	93% (I)	89% (N)	92% (I)	89% (N)	86% (D)	83% (D)
Controlling High Blood Pressure	Incentive: ≥ 69% Neutral: 63%–68% Disincentive: ≤ 62%	63% (N)	72% (I)	84% (I)	69% (I)	73% (I)	51% (D)	65% (N)	BR (D)
Immunizations for Adolescents (Combo 1)	Incentive: ≥ 79% Neutral: 75%–78% Disincentive: ≤ 74%	88% (I)	89% (I)	81% (I)	88% (I)	84% (I)	89% (I)	87% (I)	81% (I)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 69% Neutral: 64%–68% Disincentive: ≤ 63%	64% (N)	78% (I)	48% (D)	59% (D)	58% (D)	63% (D)	58% (D)	51% (D)
Medication Management for People with Asthma – Medication Compliance 75%	Incentive: ≥ 42% Neutral: 31%–41% Disincentive: ≤ 30%	21% (D)	52% (I)	28% (D)	38% (N)	25% (D)	25% (D)	28% (D)	31% (N)
Postpartum Care	Incentive: ≥ 74% Neutral: 70%–73% Disincentive: ≤ 69%	74% (I)	81% (I)	84% (I)	67% (D)	71% (N)	71% (N)	71% (N)	71% (N)
Well Child Visits for Children Ages 3–6	Incentive: ≥ 88% Neutral: 85%–87% Disincentive: ≤ 84%	88% (I)	90% (I)	80% (D)	80% (D)	80% (D)	81% (D)	83% (D)	70% (D)

Biased Rate as reported by the HEDIS vendor (BR); Incentive (I); Neutral (N); Disincentive (D)

Consumer Report Card

As a part of its External Quality Review contract with Department, the EQRO is responsible for developing a Medicaid Consumer Report Card.

The Report Card is meant to help Medicaid participants select a HealthChoice MCO. Information in the Report Card includes performance measures from the HEDIS, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Table 15. CY 2017 Report Card Results

HealthChoice MCOs	Performance Area					
	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
ACC	««	«	««	««	««	«
JMS	«««	«««	«««	««	«««	«««
KPMAS	««	««	««	N/A	«««	«««
MPC	«««	««	««	««	«	«
MSFC	««	«««	««	««	«	««
PPMCO	««	««	«««	««	««	««
UMHP	«	««	«	««	«	«
UHC	««	««	««	««	«	«

« Below HealthChoice Average
«« HealthChoice Average

«« Above HealthChoice Average
Note: N/A means that ratings are not applicable and does not describe the performance or quality of care provided by the health plan.

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.

HealthChoice MCOs conduct two PIPs annually. As designated by the Department, the MCOs continued the Controlling High Blood Pressure PIP. The EQRO is responsible for evaluating the PIPs submitted by the MCOs according to CMS' External Quality Review Protocol 3: Validating Performance Improvement Projects.

Table 16. CY 2016 Adolescent Well Care PIP Indicator Rates

Measurement Year	Indicator 1: Adolescent Well Care					
	ACC	JMS	MPC	MSFC	PPMCO	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 17. CY 2016 Controlling High Blood Pressure PIP Indicator Rates

Measurement Year	Indicator 1: Controlling High Blood Pressure						
	ACC	JMS	MPC	MSFC	PPMCO	RHMD	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	63.00%	72.02%	68.65%	72.81%	51.05%	N/A	64.94%

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. Encounter data are the electronic records of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be a billable service under FFS reimbursement systems. Encounter data provide substantially the same type of information that is found on claim forms (e.g., UB-04 or CMS 1500), but not necessarily in the same format. States use encounter data to assess and improve quality, monitor program integrity, and determine capitation payment rates.

EDV Findings

The HealthChoice MCOs were found to have information systems in place that produce accurate and complete encounter data. The MCOs use standard forms and coding schemes that allow for capturing appropriate data elements for claims processing. The Department has a comprehensive 837 process, which instructs the MCOs on the collection and submission of encounter data. These guidelines could be enhanced with formal data dictionaries and standards for encounter data completeness.

The encounter data submitted by the HealthChoice MCOs for CY 2016 can be considered reliable for reporting purposes as the EDV overall match rate was 95.5 percent. This rate exceeded the recommended match rate standard of 90 percent, for EDV set by the EQRO. The CY 2016 overall match rate (95.5 percent) was a slight 0.5 percentage point decrease from the CY 2015 rate of 96 percent, but remains 2.7 percentage points higher than the CY 2014 match rate.

Although there were significant increases in the overall match rates in CY 2016 for both inpatient and outpatient encounter types, the office visit counter type decreased resulting in a 0.5 percentage point decline in the overall match rate.

In CY 2016, the lack of medical record documentation and incorrect diagnosis codes both contributed to the unmatched diagnosis codes for outpatient and office visit encounters. However, incorrect diagnosis codes alone contributed to the one unmatched diagnosis code for the inpatient encounters.

The majority of unmatched procedure code elements in inpatient, outpatient, and office visit encounters are contributed to incorrect procedure codes for CY 2016.

The majority of unmatched revenue code elements in inpatient encounter types resulted from a lack of medical record documentation in CY 2016. However, for outpatient encounter types, there were both issues with medical record documentation and revenue codes.

Annual Technical Report (ATR)

The EQRO completed the ATR and submitted to CMS.

Provider Directory Validation

Beginning in 2015, the Department collaborated with the Hilltop Institute to develop a validation method to test the accuracy of HealthChoice MCO provider directories. This was conducted in two phases. In Phase 1, the Hilltop Institute conducted a pilot survey from October to December of 2015. For Phase 2, the Department and the Hilltop Institute streamlined the survey tool and surveyed a statistically-significant sample of 361 primary care providers from the entire HealthChoice network by combining online provider directories from all MCOs. Surveys were conducted between January and February of 2017.

Phase 2 verified the accuracy of information in provider directories, such as name, address, phone number, whether the provider practices as a PCP, whether the provider was accepting new patients, and patient age range. Phase 2 results found that while most directory information was accurate, discrepancies exist in key areas such as contact information and PCP status. Nearly 19 percent of all providers surveyed reported a telephone number different from the one provided in the directory. The percentage of group practices listed with an incorrect telephone number was 23.9 percent. In addition, approximately 13 percent of providers listed as PCPs in directories indicated that they do not provide primary care services. Further, over 22 percent of providers surveyed indicated that they were not accepting new patients, which contradicted information in MCO provider directories.

The Department shared information regarding inaccurate directory entries with MCOs to ensure follow up with the surveyed providers in order to correct their directories. The Department also distributed this report to stakeholder groups, such as the MMAC.

In Phase 3, the Department transitioned the survey administration from the Hilltop Institute to the EQRO. Surveys were conducted in June and July of 2017 with the goal of validating the MCO's online provider directories and assessing compliance with State access and availability requirements. The EQRO adopted methodology similar to the Hilltop Institute's survey and conducted calls to a statistically-significant sample of PCPs within each MCO.

Surveys were conducted to 1,319 PCPs with successful contact made to 870 PCPs, yielding a response rate of 66 percent. This was an increase of 53 percent over Phase 2 response rate of 35 percent. In Phase 3, the EQRO surveyors verified:

- Accuracy of online provider directories, including telephone number and address;
- Whether the provider accepts the MCO listed in the provider directory;
- Whether the provider practices accepts new patients;
- What age range the provider serves;
- The first available routine appointment; and
- The first available urgent care appointment.

Results demonstrated the following:

- The correctness of the provider telephone number and address continued to be an area of weakness across the HealthChoice MCOs;
- The majority of PCPs surveyed (94 percent) stated that they accepted the MCO listed in the provider directory;
- The majority of PCPs surveyed (87 percent) stated that they accepted new patients, an increase from the Phase 2 results at 71.7 percent;
- Similar to Phase 2, 76 percent of PCPs surveyed accepted all ages versus specific ages;
- The majority of the PCPs surveyed (89 percent) were compliant with the first available routine appointment requirement; and
- An opportunity for improvement is noted regarding the compliance with the first-available urgent care appointment requirement in which results for PCPs surveyed were 67 percent.

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

Assessment of MCO compliance was completed by applying the systems performance standards defined for CY 2016 in COMAR 10.09.65. If an area of non-compliance was discovered, an additional 20 records were reviewed for the non-compliant component.

MCOs demonstrated strong and consistent results in meeting regulations relating to grievances, appeals, and preservice denials. This may be attributed to comprehensive MCO oversight by the Department and its effective use of the contracted EQRO. Compliance with regulatory timeframes appears to be the greatest challenge as evidenced by MCO results in the majority of categories. CAPs are in place to address MCOs that have had ongoing issues in demonstrating compliance. The Department has also instituted a quarterly review to assess progress in CAP implementation and related performance measures.

HEDIS Performance Highlights

For HEDIS 2016:

- The Maryland Average Reportable Rate (MARR) for Childhood Immunization Status (CIS) Combinations 2, 3, 4, 5, and 7 all increased by greater than five percentage points, while Immunizations for Adolescents (IMA) Combination 1 increased by 12.3 points from HEDIS 2015 to 2016;
- All HealthChoice MCOs improved their Appropriate Testing for Children with Pharyngitis (CWP) 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 (HPV) 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 (MMA) measure from 2015 to 2016;
- There was a substantial increase (greater than eight percent) to Comprehensive Diabetes Care (CDC) – 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; and
- The MARR experienced a significant decrease to the rate for Persistence of Beta-Blocker Treatment after a Heart Attack (PBH) from 2015 to 2016, without any changes to the specification.

For HEDIS 2017, the Department's HEDIS vendor completed the auditing process and completed the data submission tool validation for National Committee for Quality Assurance (NCQA) submission. The Department continues to require each HealthChoice plan to undergo a complete HEDIS compliance audit that includes reporting all measures applicable to Medicaid, except where the measures are identified as carved-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.

For Reporting Year 2017, the Department's contracted NCQA-certified survey vendor mailed the CAHPS® 5.0H Medicaid Adult and Child Member Satisfaction Surveys to enrollees for CY 2016 data. A total of 14,040 Adult Member Satisfaction Surveys were mailed to enrollees and 4,337 valid surveys were completed yielding a response rate of 32 percent, down two percent when compared to the previous year's response rate. A total of 17,160 Child Member Satisfaction Surveys were mailed to enrollees among the general population and 5,079 valid surveys were completed yielding a response rate of 30 percent. This reflects a one-percent decrease in the response rate when compared with the CY 2015 data results.

With regard to the adult population, HealthChoice members continue to give their highest satisfaction ratings in the areas of Specialist and Personal Doctor. HealthChoice members give slightly-lower positive satisfaction ratings in the areas of Health Care and Health Plan. When compared to the previous year, members' satisfaction with Specialist and Personal Doctor continues to show improvement; however, satisfaction with Health Plan and Health Care shows a slight decline among members. HealthChoice MCOs continue to receive high satisfaction ratings from parents and guardians from the general and CCC populations regarding Personal Doctor, Health Care, Health Plan, and Specialist.

For 2018 (CY 2017 data), the survey administration began the week of February 19, 2018. The mail and telephone follow-up phase has been completed. Response rate tracking was mail available by the vendor via its secure portal for the Department beginning the week of March 19, 2018. Interim progress reports were provided to the Department in mid-April. Data collection closed on May 14, 2018, and the vendor is currently processing and conducting final analysis of the survey data. Data submission to NCQA occurred during May. The Department anticipates receiving the final data reports regarding the HealthChoice enrollee satisfaction ratings in September 2018.

Provider Satisfaction Survey

The Department's enrollee satisfaction survey vendor also administered the Provider Satisfaction Survey for 2017 (CY 2016 data) to a random sample of PCPs from each of the eight HealthChoice MCOs. The PCPs were asked to rate the HealthChoice MCO listed on the survey, as well as all other MCOs in which they participate. A total of 6,235 surveys were mailed to PCPs with a total of 1,129 valid surveys returned, yielding a response rate of 19 percent, which was an overall decrease of three percent compared with the response rate from 2016.

From the CY 2016 data survey results overall, about three-fourths of the PCPs surveyed in 2017 are satisfied with their specified HealthChoice MCO (75.7 percent). A slightly smaller proportion of PCPS surveyed (71.0 percent) reported being satisfied with all other HealthChoice MCOs with which they participate. The research also shows that more than eight in ten PCPs

would recommend their specified HealthChoice MCO to their patients (84.9 percent) or to other physicians (84.6 percent).

Data collection for the 2018 Provider Satisfaction Survey began March 19, 2018, followed by telephone outreach on May 14, 2018. Interim progress reports were provided to the Department in mid-May. Data collection for the survey closed the week of June 5, 2018. Distribution of the final data reports to the Department and MCOs is anticipated for September 2018.

REM Satisfaction Survey

A REM Satisfaction Survey is being administered for the first time in 2018. The survey instrument was developed to measure the experience of REM members getting care and services through the REM program. Adult and Child surveys—with the option to complete the survey in Spanish—were distributed to REM members. The REM member data file was provided by the Hilltop Institute. Data collection began on February 28, 2018, followed by telephone outreach on April 27, 2018. Data collection closed for this survey administration the week of May 24, 2018. Interim progress reports were provided to the Department at the end of April. Distribution of final data reports to the Department and MCOs is expected in September 2018.

Demonstration Evaluation

During the quarter, the Department continued work on implementing measures proposed in the draft summative evaluation into the annual HealthChoice report, which will serve as the rapid-cycle assessment to provide program updates and review the areas of coverage and access, medical homes, quality of care, special topics and the ACA expansion. New measures are envisioned to be gradually incorporated into the annual evaluation over the course of the waiver period. The most-recent annual HealthChoice evaluation (see Appendix B) covers the period from CY 2012 through CY 2016.

The Department held its annual Post-Award Forum on May 24, 2018 to review the status of the waiver with interested stakeholders. The Department presented on the status of the waiver and the evaluation, with particular focus on the community health pilots, residential treatment for individuals with substance use disorders, and dental services for former foster youth. (See Appendix C for the 2018 Post-Award Forum public notice documentation and Appendix D for the 2018 Post-Award Forum presentation.)

Enclosures/Attachments - Nancy Brown
Appendix A: Maryland Budget Neutrality Report as of March 31, 2018
Appendix B: 2018 HealthChoice Evaluation (CY 2012 - CY 2016)
Appendix C: Maryland HealthChoice Post-Award Forum Public Notice
Appendix D: Maryland HealthChoice Post-Award Forum Presentation
Appendix E: §1115 Waiver Amendment

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