Maryland HealthChoice Demonstration
Section §1115 Annual Report
Demonstration Year 22
7/1/2018 - 6/30/2019

Introduction

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

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

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

Subsequent to the initial approval, Maryland requested and received several program extensions and changes. The most recent amendment approved in 2019 made the following changes to the demonstration:

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

Enrollment Information

Tables 1 and 2 below provides a comparison of enrollment counts between the previous and current years. These counts represent individuals enrolled at a point in time, as opposed to total member months.

Table 1. Enrollment Counts and Annual Growth

Demonstration Populations	Enrollees as of June 30, 2018	Enrollees as of June 30, 2019	Year 22 Change	Year 22 Percent Change
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	207,538	217,196	3,920	1.8%
Affordable Care Act (ACA) Expansion Adults	310,968	310,031	4,600	1.5%
Medicaid Children	456,508	453,455	-3,959	-0.9%
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	90,051	89,898	1,580	1.8%
SSI/BD Children	22,792	23,248	633	2.8%
Medically-Needy Adults	21,547	22,724	66	0.3%
Medically-Needy Children	5,899	6,153	245	4.1%
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	13,393	13,219	4,412	50.1%
Maryland Children's Health Program (MCHP)	118,708	116,006	1,139	1.0%
MCHP Premium	36,327	35,497	4,615	14.9%
Presumptively Eligible Pregnant Women (PEPW)	0	0	N/A	N/A
Family Planning	10,484	11,032	1,415	14.7%
ICS	33	30	N/A	N/A
Women's Breast and Cervical Cancer Health Program (WBCCHP)	99	94	N/A	N/A

Table 2. Enrollment as a Proportion of Total

Demonstration Populations	Total Enrollment % - June 2018	Total Enrollment % - June 2019	Share Change
Parents/Caretaker Relatives <116% FPL and Former Foster Care	16.7%	16.7%	-0.1%
ACA Expansion Adults	23.9%	23.9%	0.0%
Medicaid Children	35.7%	34.9%	0.8%
SSI/BD Adults	6.9%	6.9%	0.0%
SSI/BD Children	1.8%	1.8%	0.0%
Medically-Needy Adults	1.8%	1.7%	0.0%
Medically-Needy Children	0.5%	0.5%	0.0%
SOBRA Adults	0.7%	1.0%	-0.3%

Demonstration Populations	Total Enrollment % - June 2018	Total Enrollment % - June 2019	Share Change
MCHP	9.0%	8.9%	0.0%
MCHP Premium	2.4%	2.7%	-0.3%
PEPW*	0.0%	0.0%	0.0%
Family Planning	0.8%	0.8%	-0.1%
ICS*	N/A	N/A	N/A
WBCCTP*	N/A	N/A	N/A

**Percent is less than 0.0*

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

Table 3. Member Months

Eligibility Group	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Parent/Caretaker Relatives <116% FPL and Former Foster Care	615,023	211,180	214,530	217,196	642,906
ACA Expansion Adults	930,848	309,842	310,073	310,031	929,946
Medicaid Children	1,368,128	455,332	454,889	453,455	1,363,676
SSI/BD Adults	269,866	90,366	89,935	89,898	270,199
SSI/BD Children	68,030	23,085	23,098	23,248	69,431
Medically-Needy Adults	64,943	21,907	22,335	22,724	66,966
Medically-Needy Children	17,817	5,897	6,043	6,153	18,093
SOBRA Adults	35,476	13,399	13,333	13,219	39,951
MCHP	357,778	118,187	117,414	116,006	351,607
MCHP Premium	109,818	36,027	35,847	35,497	107,371
PEPW	0	0	0	0	0
Family Planning	30,608	10,709	10,838	11,032	32,579
WBCCTP	303	98	94	94	286
ICS	102	30	30	30	90

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 (licensed at 3.7D in Maryland), 3.7, 3.5, and 3.3. The Department also phased in coverage of ASAM level 3.1 as of January 1, 2019.

Table 4. Substance Use Disorder Residential Treatment Utilization Limited to Medicaid Funding, FY 2019[1]

Level of Service	No. of Participants	No. of Days
Level 3.7-WM	4,660	27,859
Level 3.7	5,679	87,783
Level 3.5	2,362	43,105
Level 3.3	1,131	23,911
Level 3.1	340	8,835
Total	**8,696**	**178,875**

Beginning in July 2019, the Residential Treatment for Individuals with SUD will extend coverage of ASAM level 4.0 services for up to 15 days in a month for individuals 21 through 64 in IMD who have a primary SUD diagnosis and a secondary mental health diagnosis. Preliminary results will be available in ensuing reports.

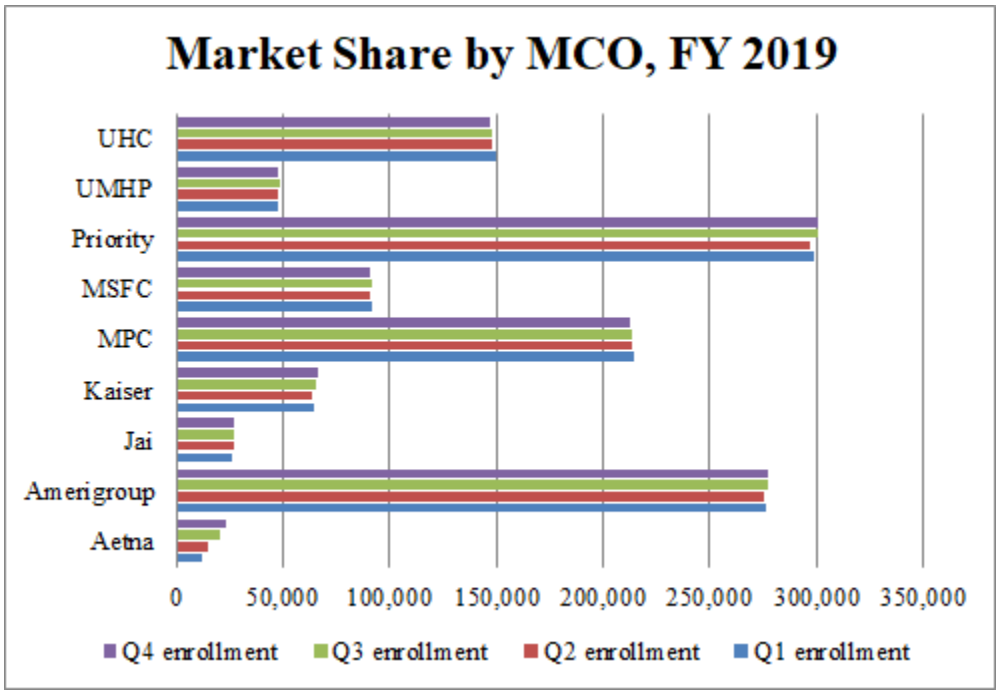
Operational/Policy Developments/Issues

Market Share

As of the culmination of FY 2019, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (2.0 percent), Amerigroup (23.2 percent); Jai Medical Systems (2.3 percent); Kaiser Permanente (5.6 percent); Maryland Physicians Care (17.8 percent); MedStar Family Choice (7.6 percent); Priority Partners (25.2 percent); University of Maryland Health Partners (4.0 percent); and United Healthcare (12.3 percent).

[1] Based On Claims Paid Through June 30, 2019

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in April, May, and June during the past quarter. These meetings covered a wide variety of topics, including general department updates, behavioral health specific updates, and waiver, state plan, and regulations changes.

During the April meeting, the MMAC was briefed on the recent MMIS summit. The Department announced that it was putting $30 million towards expanding Hepatitis C coverage and treatment, with certain coverage expansions (*i.e.*, to a Metavir score of 1) taking effect July 1, 2019. The Department provided the MMAC an update about the new adult dental pilot program, the final legislative overview of which bills had been signed, recent provider transmittals, and the newly formed Provider Services Administration. One of the MMAC members gave an update on two specific pieces of recently passed legislation, House Bill 814/ Senate Bill 802 and House Bill 768 (see Legislative section below for more information).

During the May MMAC meeting, the Department continued its update on the MMIS summit. Additionally, the MMAC was briefed on Maryland's Opioid response. The Department began its presentation on the 2019 HealthChoice Evaluation, which continued into the June meeting.

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 11,032 women, with an average monthly enrollment of 10,860, an increase of 6.4 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.

The Department is in the process of expanding eligibility under its Family Planning Program to lift the age limit, open coverage to include men, and cover services for individuals, effective July 1, 2018. Services were previously limited to women up to the age of 51 at or below 200 percent of FPL. CMS approved the Department's §1115 amendment to transition authority for the program to a State Plan Amendment (SPA) in March 2019, in conjunction with accepting the matching SPA with an effective date of July 1, 2018.

The Department will need to continue to operate a small portion of its Family Planning Program under its §1115 waiver until the Family Planning Program can be integrated into the Maryland Health Connection (MHC). Specifically, the §1115 waiver would continue to cover post-partum individuals. Pregnant women continue to be eligible for full Medicaid benefits for two months postpartum. Those who no longer qualify for benefits after the end of the postpartum period because their income is over scale are automatically enrolled in the Family Planning Program for one year (12 months). After 12 months, these women must re-apply for benefits to continue their enrollment in the Family Planning Program. Once the Family Planning Program is integrated into MHC, the Department will transition all participants to be covered under the SPA.

Table 5. Average Quarterly Family Planning Enrollment

Q1 Enrollment	Percent Change	Q2 Enrollment	Percent Change	Q3 Enrollment	Percent Change	Q4 Enrollment	Percent Change
9,601	(0.2)	9,851	2.6	10,203	3.6	10,860	6.4

Table 6. Family Planning and Related Statistics, July 2017 – June 2018[2]

No. of Individuals Enrolled in the Demonstration (Total with Any Period of Eligibility)	Total No. of Participants[3]	No. of Actual Births to Family Planning Demonstration Participants After Enrollment	Average Total Medicaid Expenditures for a Medicaid-funded Birth[4]
13,066	2,097	185	$27,967

[2] The HealthChoice program utilizes a look-back period to the previous fiscal year to allow for run-out.
[3] Includes all individuals who obtain one or more covered family planning services through the demonstration.
[4] Includes all individuals who obtain one or more covered family planning services through the demonstration.

Rare and Expensive Case Management (REM) Program

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

Table 7. Current REM Program Enrollment

FY 2019	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	160	103	69	121	4,284
Quarter 2	212	142	71	109	4,267
Quarter 3	221	145	100	94	4,270
Quarter 4	283	206	132	97	4,286

Table 8. REM Complaints

FY 2019 Q4	Transportation	Dental	DMS/ DME	EPSDT	Clinical	Pharmacy	Case Mgt.	REM Intake	Other
REM Case Management Agencies	0	0	0	0	0	0	7	0	0
REM Hotline	0	0	0	0	0	0	1	0	0
Total	0	0	0	0	0	0	8	0	0

Table 9 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 2019 Q4	DMS/ DME	Legal	Media	Other	Protective Services	Appeals	Services	Total
REM Enrollees	2	6	1	49	16	1	7	82

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, 2019, there were 30 individuals enrolled in the ICS Program. The ICS Program does not currently have a registry. All new applicants begin receiving services upon approval of their application.

Maryland Children's Health Program (MCHP) and MCHP Premium Status/Update/Projections

Maryland moved its separate CHIP program, MCHP, and MCHP Premium, into the Medicaid expansion CHIP waiver in 2008, so that Maryland's entire CHIP program is operated as a Medicaid expansion. As of June 30, 2019, the Premium program had 35,497 participants, with MCHP at 116,006 participants.

Medicaid and National Diabetes Prevention Program (DPP) Demonstration

The Medicaid and National DPP Demonstration concluded January 31, 2019. In November, Maryland received the first draft of the external evaluation, which was shared with the Department leadership and the Department of Budget and Management. The final CDC-cleared Executive Summary was published and presented at the January 2019 Capstone meeting.

Although new enrollment in the demonstration ended January 31, 2018, Medicaid participants were able to continue the yearlong program through January 31, 2019. Throughout this reporting period, the Department continued to focus on preparing for sustainability efforts following the demonstration's conclusion through a new grant known as Coverage 2.0: Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program (Coverage 2.0). The purpose of the funding is to continue sustainability work begun in the Medicaid and National Diabetes Prevention (National DPP) demonstration, which involved four of the nine MCOs.

Through Coverage 2.0, the Department and MCOs are working to incorporate lessons learned from the demonstration in the areas of operational and financial management systems building, quality improvement processes, and the identification, strengthening, and coordination of stakeholders' roles into the development of sustainable coverage models for the National DPP Lifestyle Change Program in Medicaid.

The Department held a kick-off meeting to initiate the start of Coverage 2.0 grant activities in December 2018. Six MCOs are participating in Coverage 2.0: the original four from the demonstration—Amerigroup, Jai Medical Systems, MedStar Family Choice and Priority Partners—and two additional MCOs—Aetna Better Health and United HealthCare.

The March 2019, CMS §1115 waiver amendment approval authorized the HealthChoice Diabetes Prevention Program. The program's effective date is September 1, 2019. The HealthChoice DPP will be implemented statewide, and will be available to eligible HealthChoice beneficiaries. Delivery modes will include both in-person and virtual CDC-recognized organizations.

The new Maryland Medicaid provider type "Diabetes Prevention Provider" went live on May 10, 2019 allowing CDC-recognized organizations to begin enrollment with Maryland Medicaid.

HealthChoice DPP program information was developed and disseminated through a policy transmittal, program manual and website (attached). This information was shared with MCOs,

CDC-Recognized Organizations, and stakeholders on June 10, 2019.

The Department submitted amendments to the following COMAR regulations to include the National DPP:

(1) Regulation .01 under COMAR 10.09.62 Maryland Medicaid Managed Care Program: Definitions; and
(2) Regulation .24 under COMAR 10.09.67 Maryland Medicaid Managed Care Program: Benefits.

The amendments are expected to be finalized and go into effect on August 26, 2019.

In preparation for the September 1, 2019 effective date, all nine HealthChoice MCOs are in process of contracting with CDC-recognized organizations and making the necessary internal systems changes to implement HealthChoice DPP.

Community Health Pilots

As of June 2019, six local government entities were participating in the Community Health Pilots approved as part of the 2016 HealthChoice waiver renewal: four in the Assistance in Community Integration Services (ACIS) Pilot and two in the Evidence-Based Home Visiting Services (HVS) Pilot. The pilots are effective through December 31, 2021 and are scheduled to be funded for the duration of the five-year waiver.

The two HVS Pilots had enrolled 43 families through June 2019.

Participant enrollment is still underway in three of the four counties participating in the ACIS Pilot Program and continues steadily increase. Approximately 195 individuals are enrolled and receiving supportive housing services as of June 2019, achieving 65 percent of the pilot's initial statewide enrollment cap of 300 spaces. Lead Entities continue to improve processes related to pilot enrollment, Medicaid eligibility verification and best practices for working with ACIS enrolled individuals.

In February 2019, the Department initiated an ACIS Learning Collaborative series. These collaboratives provide an opportunity for Lead Entities to meet, discuss best practices, and hold targeted discussions on relevant ACIS topics. The third ACIS Learning Collaborative will be held in October 2019. It will focus on legal barriers for individuals experiencing homelessness.

The Department's July 2018 waiver amendment application included a request to expand ACIS to serve 300 additional individuals, which was approved in March 2019 and brought the statewide cap to 600 spaces. A competitive third round for the ACIS Pilot will be conducted in July 2019. The statewide competition for the additional 300 spaces will be open to all qualified applicant organizations, as well as to those qualified organizations participating in the first or second rounds of the ACIS Pilot initiative that seek to further expand their delivery of ACIS.

Expenditure Containment Initiatives

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

HealthChoice Financial Monitoring Report (HFMR)

During this quarter, the Department's contracted auditors finalized all MCO financial reviews for 2017, and the MCOs' reported IBNR was independently evaluated. Consolidated reports were also prepared. Instructions and templates for 2018 data were provided to the MCOs in March. These reports reflect Service Year 2018 MCO experience as of March 31, 2019 and were due on May 14, 2019.

MCOs provided Service Year 2018 HFMR reports (including Financial Templates) as of March 31, 2019 during May 2019. This data was used by Hilltop and the Department's contracted actuarial firm to assist in the HealthChoice trend analysis, regional analysis and for the validation process of CY 2020 HealthChoice rates. Unadjusted consolidated 2018 HFMRs by region were provided to all MCOs on June 17, 2019. MCOs will have an opportunity to update their Service Year 2018 experience in November. The 2018 submission in November will most likely be the base period for the 2021 HealthChoice rate-setting period. Updated instructions will likely be provided in September of 2019.

MCO Rates

CY 2020 Rate-Setting

The rate-setting team participated in a number of meetings to support the CY 2020 rate-setting process. They participated in the Department workgroup and provided analytic support regarding the utilization and value of independent pharmacies in the HealthChoice program.

They also co-facilitated three 2020 HealthChoice MCO rate-setting meetings, where they discussed mid-year adjustments of HIV and geographic/demographic rates, constant cohort analysis for CY 2017 and CY 2018, presentation of final Departmental and MCO issues, presentation of the impact of FFS claims on MCO case-mix, review of Adult hearing experience, discussion regarding high cost drug mitigation strategies, regional presentation, base presentation, MCO outlier adjustment, non-state plan service adjustments, constant cohort analysis, discussion regarding the HealthChoice DPP and high-cost drug mitigation strategy, preliminary 2019 geographic/demographic adjustments, final 2018 Hepatitis C therapy analysis, FFS HIV drug statistics, and the actuarial firm's trend presentation. The rate-setting team also held conference calls with the MCOs and the Department.

The rate-setting team also provided information to different stakeholders. They provided the Department's contracted accounting firm comments and revisions regarding nine 2017 MCO financial review as well as proposed comments and revisions regarding nine 2017 IBNR reviews,

as well as various data sets. The team also provided the Maryland Insurance Administration Chief Actuary with several years of HealthChoice rate setting information for review.

CY 2019 Rate-Setting

The rate-setting team provided the Maryland Health Services Cost Review Commission (HSCRC) with restated monthly MCO membership in support of HSCRC trend analysis. They also provided the actuarial firm with restated physician evaluation and management (E&M) adjustment reflecting new E&M fees effective July 1, 2019, and mid-year adjustment regarding the implementation of the HealthChoice DPP. The rate-setting team provided the Department with first semi-annual rural access incentive calculation for 2019.

CY 2018 Rate-Setting

For CY 2018 the rate-setting team provided the Department with MCO settlement calculations for adult hearing services for the second half of CY 2018.

Additional Activities

The rate-setting team provided the Department the monthly trauma calculations. Additionally, the team provided the Department with FY 2018 FFS hospital statistics as requested by the accounting firm. The team also completed a review of nursing home wage surveys for 2018. They attended three nursing home liaison meetings held during the quarter. The rate-setting team also provided the accounting firm with a status and availability of potential MMIS pharmacy encounter fields to be used in the development of an MCO data request as part of their analysis regarding MCO and pharmacy benefit manager (PBM) payment transactions.

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 Department’s mandated central complaint program. Call volume decreased from 211,022 calls in FY 2018 to 196,296 calls during this demonstration year. This may be due to decreases in the overall number of prenatal calls. 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, for example, behavioral health services, covered by Medicaid on a FFS basis.

When a consumer experiences a medically-related issue, such as difficulty getting appointments with a specialist, getting a prescription filled, or getting a service preauthorized, the call is classified as a complaint. Complaints are referred to the State's Complaint Resolution Unit

(CRU), which is staffed with registered nurses. If necessary, the CRU engages a local Ombudsman, who is stationed at the county-level local health departments and has the ability to meet with the member face-to-face. If the MCO has issued a denial letter to a member and the member wishes to appeal the decision through the MCO, or if a member disagrees with the MCO's appeal decision and wishes to request a State Fair Hearing, the CRU will assist the member with these processes.

Table 10. Total Recipient Complaints by MCO and Fiscal Year (not including billing)[5]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
Fiscal Year		2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
Specialist	#	15	106	79	77	10	17	39	54	66	139	60	45	45	58	50	109	21	49	385	654
	%	4%	16%	21%	12%	3%	3%	10%	8%	17%	21%	16%	7%	12%	9%	13%	17%	5%	7%	13%	25%
Prenatal	#	18	53	146	98	12	8	92	79	91	75	86	59	150	134	133	99	27	21	755	626
	%	2%	8%	19%	16%	2%	1%	12%	13%	12%	12%	11%	9%	20%	21%	18%	16%	4%	3%	26%	24%
Pharmacy	#	11	9	251	95	17	9	61	26	189	137	65	35	222	141	200	127	36	40	1,052	619
	%	1%	1%	24%	15%	2%	1%	6%	4%	18%	22%	6%	6%	21%	23%	19%	21%	3%	6%	36%	24%
PCP	#	12	77	80	58	16	16	28	30	54	53	47	41	54	70	50	55	14	23	355	423
	%	3%	18%	23%	14%	5%	4%	8%	7%	15%	13%	13%	10%	15%	17%	14%	13%	4%	5%	12%	16%
Sub Totals	#	56	245	556	328	55	50	220	189	400	404	258	180	471	403	433	390	98	133	2,547	2,322
	%	2%	11%	22%	14%	2%	2%	9%	8%	16%	17%	10%	8%	18%	17%	17%	17%	4%	6%	87%	89%
All Complaint Totals	#	63	260	651	400	61	53	245	201	484	496	288	189	551	441	482	423	109	141	2,934	2,604
	%	2%	10%	22%	15%	2%	2%	8%	8%	16%	19%	10%	7%	19%	17%	16%	16%	4%	5%		
Other Categories		7	15	95	72	6	3	25	12	84	92	30	9	80	38	49	33	11	8	387	282

There were 3,826 total MCO recipient complaints in FY 2019 compared to 4,225 in FY 2018 (all ages). This fiscal year, the total MCO recipient complaints decreased by nine percentage points. Sixty-eight percent of the complaints (2,604) were related to access to care. The remaining 32 percent (1,222) were billing complaints. The top three member complaint categories were access to specialists, prenatal care, and pharmacy. The categories not specified ("Other Categories") for the non-billing complaints includes appeal and grievance, access to therapies (occupational therapy, physical therapy and speech), adult dental and vision services, and obtaining Durable Medical Equipment (DME) and Durable Medical Supplies (DMS). Overall, Maryland Physicians Care and Priority Partners had a high percentage of complaints (19 percent and 17 percent of all care-related complaints respectively), which were mainly attributed to difficulty accessing specialists, prenatal services, and pharmacy.

[5] Source from CRM

The number of prenatal care complaints decreased from 755 to 626. Prenatal complaints comprised 24 percent of total complaints, compared to 26 percent in the previous fiscal year. All pregnant women were connected with an MCO network prenatal care provider and referred to Administrative Care Coordinators at the local health departments for follow-up and education. In addition, 1,522 pregnant women called the Help Line for general information. These women were also referred for follow-up and education.

Table 11. Recipient Complaints under Age 21 by MCO and Fiscal Year (not including billing)[6]

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)		Sub Totals	
Fiscal Year		2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
PCP	#	4	28	34	32	3	7	14	13	22	22	17	17	29	27	14	24	8	10	145	180
	%	3%	16%	23%	18%	2%	4%	10%	7%	15%	12%	12%	9%	20%	15%	10%	13%	6%	6%	28%	32%
Specialist	#	3	30	15	16	1	1	9	11	14	27	7	9	16	14	14	30	4	11	83	149
	%	4%	20%	18%	11%	1%	1%	11%	7%	17%	18%	8%	6%	19%	9%	17%	20%	5%	7%	16%	26%
Pharmacy	#	1	1	67	23	0	2	6	5	27	23	12	5	44	24	28	18	4	4	189	105
	%	1%	1%	35%	22%	0%	2%	3%	5%	14%	22%	6%	5%	23%	23%	15%	17%	2%	4%	36%	18%
Prenatal	#	0	6	9	13	1	1	4	2	8	6	2	7	8	19	10	14	0	2	42	70
	%	0%	9%	21%	19%	2%	1%	10%	3%	19%	9%	5%	10%	19%	27%	24%	20%	0%	3%	8%	12%
Sub Totals	#	8	65	125	84	5	11	33	31	71	78	38	38	97	84	66	86	16	27	459	504
	%	2%	13%	27%	17%	1%	2%	7%	6%	15%	15%	8%	8%	21%	17%	14%	17%	3%	5%		
All EPSDT Complaint Totals	#	11	67	143	98	7	11	35	36	82	97	42	41	111	93	73	96	16	29	520	568
	%	2%	12%	28%	17%	1%	2%	7%	6%	16%	17%	8%	7%	21%	16%	14%	17%	3%	5%		
Other Categories		3	2	18	14	2	0	2	5	11	19	4	3	14	9	7	10	0	2	61	64

There were 568 member complaints in FY 2019 for recipients under age 21, or 22 percent of the total non-billing complaints, compared to 16 percent in FY 2018. The top three complaint categories were access to primary care providers (PCPs), access to specialists, and pharmacy. Complaints related to access to a specialist increased by 10 percentage points while the complaints related to pharmacy services authorization decreased by 18 percentage points. Amerigroup, Maryland Physicians Care, and United Healthcare were major contributors to the complaint for recipients under age 21.

The analysis of complaints by adults vs. children (under 21) revealed that access to care was the main issue for both categories. Adults most often seek assistance accessing specialists, while children (under 21) most often report difficulty accessing a PCP.

[6] Source from CRM

Table 12. Total Recipient Billing Complaints by MCO and Fiscal Year [7]

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		2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
PCP	#	2	7	108	132	8	3	38	22	63	76	58	46	53	70	51	28	14	11	395	395
	%	1%	2%	27%	33%	2%	1%	10%	6%	16%	19%	15%	12%	13%	18%	13%	7%	4%	3%	31%	32%
Emergency	#	1	10	82	120	4	5	37	35	64	77	43	38	79	59	31	30	10	11	351	385
	%	0%	3%	0%	31%	0%	1%	0%	9%	0%	20%	0%	10%	0%	15%	0%	8%	0%	3%	27%	32%
Laboratory /Test	#	3	10	59	36	0	2	5	11	46	25	27	17	43	33	22	28	14	8	219	170
	%	1%	6%	27%	21%	0%	1%	2%	6%	21%	15%	12%	10%	20%	19%	10%	16%	6%	5%	17%	14%
Specialist	#	0	3	33	15	1	1	12	5	29	21	19	12	20	7	10	7	1	1	125	72
	%	0%	4%	26%	21%	1%	1%	10%	7%	23%	29%	15%	17%	16%	10%	8%	10%	1%	1%	10%	6%
Sub Totals	#	6	30	282	303	13	11	92	73	202	199	147	113	195	169	114	93	39	31	1,090	1,022
	%	1%	3%	26%	30%	1%	1%	8%	7%	19%	19%	13%	11%	18%	17%	10%	9%	4%	3%	84%	84%
All Billing Complaint Totals	#	8	35	338	354	13	12	113	98	237	238	170	138	227	197	137	113	48	37	1,291	1,222
	%	1%	3%	26%	29%	1%	1%	9%	8%	18%	19%	13%	11%	18%	16%	11%	9%	4%	3%		
Other Categories		2	5	56	51	0	1	21	25	35	39	23	25	32	28	23	20	9	6	201	200

Enrollee billing complaints comprised 32 percent of total MCO complaints in FY 2019. Overall, 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, there was no significant change in participant PCP billing complaints. Billing complaints for emergency services increased by five percentage points, while the billing complaints for laboratory/test decreased by three percentage points. Other categories are the billing complaints related to the inpatient services, urgent care center, DME/DMS, therapies, pharmacy, and optional services such as adult dental and vision. Amerigroup continues to have the highest rate of billing complaint cases.

MCOs are required to respond to all recipient grievances and complaints. The CRU works with MCOs on behalf of the consumer to resolve the complaint. Once a plan is in place, the CRU refers the case to the Administrative Care Coordination Unit (ACCU) at the local health departments for follow-up to ensure the complaint has been resolved. When trends are identified, the HealthChoice Medical Advisor makes an inquiry to the MCO. If potential policy issues, systems issues, or barriers are identified, the MCO may be directed to take corrective action.

Legislative Update

[7] Source from CRM

The Maryland General Assembly's 2019 session began on January 9 and adjourned on April 8. Medicaid-related legislation that the General Assembly passed during this year's session included the following:

- **HB 1407** (Budget Reconciliation and Financing Act of 2019) increases the amount of deficit assessment by $15 million in FY 2020; uses $10 million from the Maryland Health Insurance Program fund balance for Medicaid provider reimbursements.
- **SB 239/HB 258** (Individual Market Stabilization - Provider Fee) imposes a one-percent health insurance provider assessment for CY 2020 - CY 2023 (MCOs to pay on a quarterly basis).
- **SB 802/HB 814** (Maryland Health Insurance Option) establishes the Maryland Health Insurance Option to develop and implement systems, policies and practices that encourage, facilitate and streamline determinations of eligibility for insurance affordability programs (including Medicaid and MCHP) and enrollment in minimum essential coverage. MHBE or the Department shall determine eligibility for insurance affordability programs as soon as possible after an uninsured individual files a tax return indicating interest in obtaining minimum essential coverage.
- **HB 589** (Medical Assistance Program and MCOs that Use PBMs - Audit and Professional Dispensing Fees) requires the Department to contract with an independent auditor to conduct an audit of Pharmacy Benefit Managers (PBMs) that contract with MCOs to determine the amount of Medicaid funds used to reimburse MCOs, PBMs and pharmacies (results of audit to be provided by December 1, 2019). By January 1, 2020, the Department and the Maryland Insurance Administration (MIA) must develop recommendations for a process for appealing decisions made between a PBM and an MCO.
- **HB 798** (Prescription Drug Affordability Board) establishes a board to protect State residents, State and local governments, commercial health plans, providers, pharmacies and other stakeholders from the high cost of prescription drugs; a stakeholder council is also established to provide input to the board in making decisions
- **SB 699/HB 832** (Home and Community-Based Waiver Services - Prohibition on Denial) prohibits the Department from denying access to a HCBS waiver due to a lack of funding if an individual is living at home or in the community at the time of application for waiver services, they received home- and community-based services through Community First Choice for at least 30 consecutive days, they will be or have been terminated from participation on becoming entitled to or enrolled in Medicare Part A or Part B, they meet the eligibility criteria for participation in the waiver within six months after completion of the application, and the home- and community-based services provided would qualify for federal matching funds.
- **HB 166/SB 280** (Payment of Wages - Minimum Wage) requires phased-in increase in minimum wage to $15 per hour by CY 2025, and includes rate increases for behavioral health providers and providers of long-term care services.
- **HB 1421** (MHBE - Functions and Outreach) authorizes MHBE to perform certain administrative, technological, operational and reporting functions for Medicaid, as requested by the Department, to the extent that it will aid in efficient operation of MHBE and Medicaid.

- **SB 524/HB 605** (Medicaid Program - Telemedicine - Psychiatric Nurse Practitioners) adds psychiatric nurse practitioners who provide assertive community treatment or mobile treatment services to the list of providers eligible for reimbursement for delivery of services through telemedicine; report on expenditures due September 30, 2021.
- **SB 598/HB 962** (Medicaid Program - Coverage of Hepatitis C Drugs) requires Medicaid coverage of any medically-appropriate drug approved by the FDA for treatment of Hepatitis C.

Quality Assurance/Monitoring Activities

Overview

The Department's HealthChoice and Acute Care Administration (HACA) is responsible for coordination and oversight of the HealthChoice program. HACA ensures compliance with the initiatives established in 42 CFR 438, Subpart D, and that all MCOs that participate in the HealthChoice program apply these principles universally and appropriately. The functions and infrastructure of HACA support efforts to identify and address quality issues efficiently and effectively. Quality monitoring, evaluation, and education through participant 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 in accordance with COMAR 10.09.65 for the HealthChoice program.

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

Systems Performance Review (SPR)

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

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. HACA leadership and the DHQA approved the MCO performance standards used in the CY 2016 review before application.

In 2015, the SPR was changed from an annual to a triennial review. During interim years, baseline standards and corrective action plans (CAPs) are reviewed for compliance. The final CY 2017 Statewide Executive Summary was shared with the MCOs.

The CY 2018 SPR was the first full review since switching to a triennial review process. The Orientation Manual was provided to the MCOs in fall 2018. The CY 2018 SPR Standards and Guidelines were updated to incorporate process and policy changes resulting from the Medicaid and CHIP Managed Care Final Rule. HACA and the EQRO also provided technical assistance to the MCOs regarding CY 2018 standards.

The EQRO conducted on-site reviews for the CY 2018 SPR for each MCO in January through March 2019. The EQRO also issued exit letters and provided technical assistance.

CAPs related to the SPR can be directly linked to specific components or standards. The SPR for CY 2019 will determine whether the CAPs from the CY 2018 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.

Table 13: CY 2018 SPR Scores by MCO

Standard	MD MCO Compliance Score	ABH+	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Systematic Process of Quality Assessment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Accountability to Governing Body	93%	93%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
Oversight of Delegated Entities	88%	**50%***	**58%***	100	**63%***	100%	100%	100%	100%	100%
Credentialing and Recredentialing	99%	99%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
Enrollee Rights	91%	94%	**91%***	100%	**69%***	**89%***	**97%***	**88%***	100%	**88%***
Availability and Accessibility	86%	95%	**85%***	100%	**85%***	**80%***	**90%***	**85%***	100%	**55%***
Utilization Review	93%	93%	**90%***	100%	**83%***	**95%***	100%	**88%***	**95%***	**91%***
Continuity of Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Health Education	100%	100%	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
Outreach	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Fraud, Waste, and Abuse	94%	90%	**90%***	100%	**79%***	**96%***	100%	100%	100%	**88%*♦**
Composite Score	**97%**	**95%**	**95%**	**100%**	**90%**	**96%**	**99%**	**96%**	**99%**	**94%**

+ABH's minimum compliance threshold was set at 80%, as this was the MCO's first scored SPR.
Underlined/Bolded/Asterisk denotes that the minimum compliance score of 100% was unmet (or 80% for ABH).
♦Quarterly updates required on CAP per the Department Performance Monitoring Policy.

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

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

EPSDT review indicators are based on current pediatric preventive care guidelines and Department-identified priority areas. The guidelines and criteria are divided into five component areas. Each MCO was required to meet a minimum compliance score of 80 percent for each of the five components. If an MCO did not achieve the minimum compliance score, the MCO was required to submit a CAP. The final CY 2017 EPSDT results were reported to the MCOs. All MCOs met or exceeded the minimum compliance score for all component areas.

Table 14: CY 2017 MCO EPSDT Results

Component	CY 2017 MCO Results								Aggregate Results
	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP	CY 2017
Health and Developmental History	94%	99%	98%	91%	93%	94%	92%	92%	92%
Comprehensive Physical Examination	96%	99%	97%	93%	96%	96%	92%	93%	96%
Laboratory Tests/At Risk Screenings	81%	99%	92%	82%	82%	81%	80%	81%	82%
Immunizations	89%	95%	96%	86%	93%	89%	87%	87%	90%
Health Education/ Anticipatory Guidance	93%	99%	97%	91%	93%	94%	90%	92%	94%
Total Score	**91%**	**98%**	**96%**	**88%**	**92%**	**92%**	**88%**	**89%**	**92%**

Consumer Report Card

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

The Consumer Report Card is meant to help Medicaid participants select a HealthChoice MCO. Information in the Report Card includes data from Healthcare Effectiveness Data and Information Set (HEDIS®) measures, encounter data measures calculated by the Department and validated by the EQRO, and selected results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Consumer Report Card results are displayed below.

Table 15: CY 2019 Consumer Report Card Results

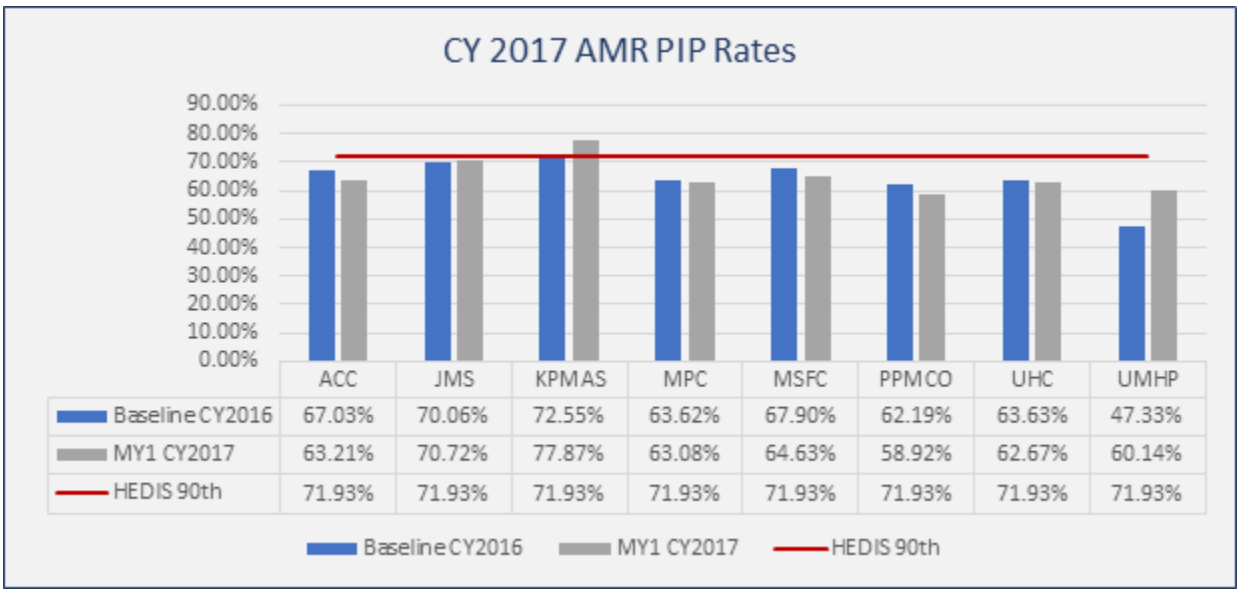
HealthChoice MCOs	Performance Area					
	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Care for Adults with Chronic Illness
ABH	N/A	N/A	N/A	N/A	N/A	N/A
ACC	★★	★★	★★★	★	★★	★★
JMS	★★★	★★	★★★	★★	★★★	★★★
KPMAS	★	★★	★★	★★	★★★	★★★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

★ 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)

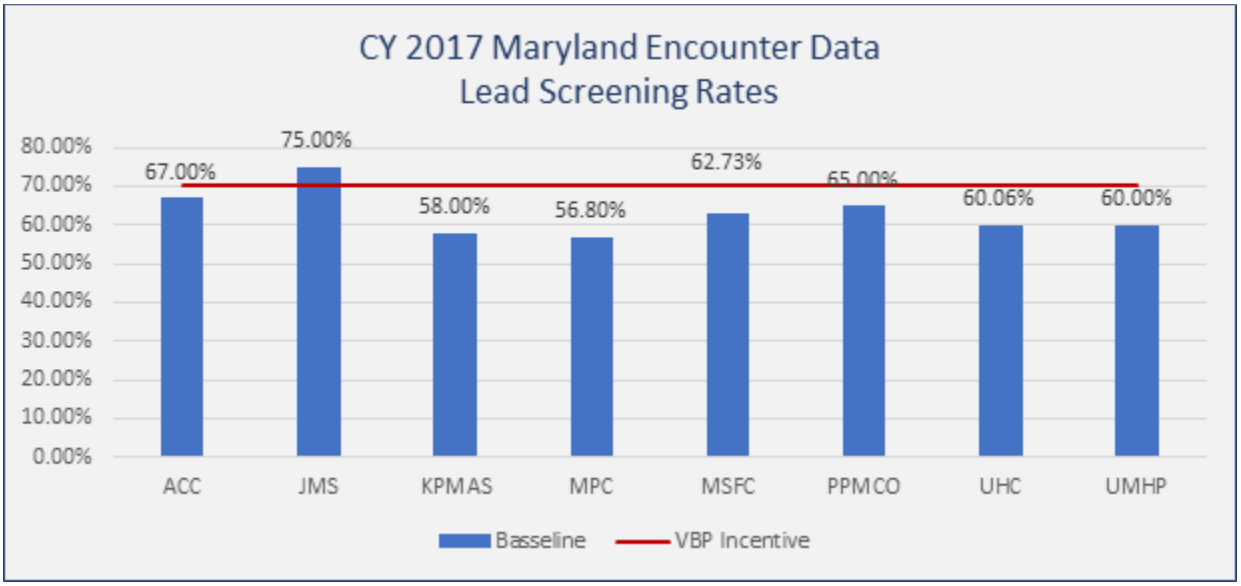
Each MCO is required to conduct PIPs designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care, or non-clinical care areas that were expected to have a favorable effect on health outcomes. HealthChoice MCOs conduct two PIPs annually. The two PIPs selected are Asthma Medication Ratio and Lead Screening for Children. The Asthma Medication Ratio PIP measurements are based on the corresponding HEDIS® measure. The Lead Screening for Children PIP is based on the HEDIS® measure and the encounter data measure. The EQRO is responsible for evaluating the PIPs submitted by the MCOs according to CMS' External Quality Review Protocol 3: Validating Performance Improvement Projects.

Results for each of the PIPs are below:



	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
Baseline CY2016	67.03%	70.06%	72.55%	63.62%	67.90%	62.19%	63.63%	47.33%
MY1 CY2017	63.21%	70.72%	77.87%	63.08%	64.63%	58.92%	62.67%	60.14%
HEDIS 90th	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%	71.93%

There is wide variation among the MCOs in their performance relative to the 2018 HEDIS® Medicaid 90th Percentile benchmark. Kaiser Permanante is performing above the 90th percentile. Jai Medical System is performing slightly below the 90th percentile. Amerigroup, Maryland Physicians Care, MedStar Family Choice and United Healthcare are performing slightly above the 50th percentile. Priority Partners and University of Maryland Health Partners are performing below the 50th percentile.



Jai Medical System is the only MCO with Maryland encounter data rates for lead screening that are in the incentive benchmark range of greater than or equal to 70 percent for Maryland's Value-Based Purchasing (VBP) program. Two MCOs (Amerigroup and Priority Partners) have rates within the VBP neutral benchmarks (64 percent to 69 percent). The remaining five have rates within the VBP disincentive benchmark (less than or equal to 63 percent).

Encounter Data Validation (EDV) Review

The purpose of EDV is to assess the completeness and accuracy of encounter data submitted by MCOs to the Department. Encounter data are the electronic records of services provided to MCO participants 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.

During this quarter, the EQRO determined the HealthChoice MCOs were found to have information systems in place that produce accurate and complete encounter data. This information was populated in the report. Because the Hilltop Institute at UMBC (Hilltop) serves as the Department's data warehouse for Medicaid encounter data, Hilltop conducted the analysis of the electronic encounter data submitted during CY 2017 during this quarter. The EQRO also conducted its medical record review activity as part of the encounter data validation. Hilltop and the EQRO collaborated to combine their findings for each activity.

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 encounter data submitted by the HealthChoice MCOs for CY 2017 can be considered reliable for reporting purposes, as the EDV overall match rate was 94.8 percent. This rate exceeded the recommended match rate standard of 90 percent for EDV set by the EQRO. The CY 2017 overall match rate was a 0.7 percentage point decrease from the CY 2016 rate of 95.5%, and one percentage point below the CY 2015 rate of 96 percent. While the inpatient and office visit match rates increased in CY 2017, these were offset by the 5.4 percentage point decrease in the outpatient rate. HealthChoice MCOs inpatient, outpatient, and office visit rates demonstrated little variation from CY 2015 to CY 2017, with no MCOs requiring CAPs.

Network Adequacy Validation

Beginning in 2017, the EQRO has administered a survey to test the accuracy of HealthChoice MCO provider directories. The EQRO conducted calls to a statistically-significant sample of PCPs within each MCO to validate the information reported in each MCO's online provider directory and to assess compliance with State access and availability requirements.

Significant improvements were made to the CY 2018 survey process that enhanced the data sample submission and collection process, including the survey tool itself. These changes improved the network adequacy validation by allowing MCOs to verify PCP data and reducing the burden on the providers.

Despite the improvements in the process, the overall response rate for the CY 2018 surveys was 46 percent, a decrease of 20 percentage points compared to the CY 2017 response rate of 66 percent. Even though the sample data was provided directly from the MCOs, a trend of inaccurate information continues. In CY 2017, 59 percent of the PCP addresses and phone numbers were accurate, and in CY 2018, the accuracy of PCP information fell 16 percentage points to 43 percent. This decrease is due to improvements made in the survey tool used to collect the data.

The majority of PCPs surveyed in 2018 (98 percent) for open access demonstrated that they accepted the MCO, a four percentage-point increase from the CY 2017 results (94 percent). Additionally, the majority of PCPs stated in CY 2018 (85 percent) that they accepted new patients, a decrease of two percentage points from the CY 2017 survey results (87 percent).

Overall, rates increased for both routine and urgent care appointment compliance. An increase of two percentage points was reflected in routine care appointment compliance from 89 percent in CY 2017 to 91 percent in CY 2018. However, a statistically-significant increase of 23 percentage points was seen in urgent care appointment compliance rates from 67 percent in CY 2017 to 90 percent in CY 2018. This was likely due to the change in the survey methodology that allowed practices to schedule an appointment with another provider in the same practice location as an alternative when the surveyed PCP was unable to see a patient within the required urgent care time frame.

Several barriers to network adequacy have been identified through conducting the surveys. Primarily, the inaccuracy of PCP contact information does not allow for members to easily access PCPs. Once a PCP is identified, it is difficult for members to obtain PCP appointments. Considering the Department relies on accurate data from the MCOs to ensure appropriate PCP coverage statewide, these barriers warrant further investigation to determine if they impact network adequacy determinations. Such barriers may cause members who are unable to contact their PCP to seek care from urgent care facilities or emergency services. Furthermore, members may delay annual preventative care visits for themselves or their children if they are unable to contact a PCP and/or obtain an appointment.

The Department set a minimum compliance score of 80 percent for the Network Adequacy Assessment. Based on the CY 2018 results, all nine MCOs are required to submit CAPs to the EQRO to correct PCP details noted in the online provider directory. Additionally, Kaiser Permanente is required to complete a CAP to improve compliance with urgent care appointment time frames.

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

The Department reviewed the MCOs' appeals, grievances and pre-service denials, and the EQRO finalized the second annual report and distributed it to the MCOs and the Department. Assessment of MCO compliance was completed by applying the systems performance review standards and regulatory standards defined for CY 2018. The EQRO reviewed records as well as self-reported data from each MCO. If an area of non-compliance was discovered, an additional 20 records were reviewed for the non-compliant component.

The review included studies of MCO grievance, appeal, and denial quarterly reports from the third quarter of 2017 through the second quarter of 2018. Additionally, a sample of grievance, appeal, and denial records were reviewed for CY 2017. Based upon the outcomes of these studies, supplemented by the annual record reviews, most MCOs demonstrated strong and consistent results in meeting the majority of grievance, appeal, and denial requirements. This level of compliance helps to ensure the delivery of quality care and services to HealthChoice participants is timely and accessible. Below are strengths identified in specific review components where all, or a majority, of the MCOs were in compliance:

- Appropriately classified and resolved grievances
- Fully documented grievance issues
- Processed appeals based upon level of urgency
- Documented appeal decisions well and resolved appeals timely
- Made appeal decisions by health care professional with appropriate expertise
- Made appeal decisions available to the participant in easy to understand language
- Appropriately provided adverse determinations

Major opportunities for improvement where five or more of the MCOs did not meet requirements on a consistent basis are identified in the following areas:

- Member grievance resolution time frames
- Grievance resolution letters
- Pre-service determination time frames
- Adverse determination notification time frames
- Required components in adverse determination letters

The validity of the data submitted by the MCOs continues to be a challenge after two years, despite detailed instructions and ongoing technical assistance. Consequently, assessment results documented in this report need to be considered with some caution. Subsequent reporting will yield a greater level of confidence in the review outcomes for annual reporting.

Healthcare Effectiveness Data and Information Set (HEDIS®)

For HEDIS 2018 (which measured calendar year 2017 data), the HealthChoice Program had the following highlights:

- The Maryland Average Reportable Rate (MARR) for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) increased by 6.9 percent from the prior year due to improved performance amongst all MCOs. Six out of eight MCOs experienced

significant improvement of greater than five percentage points compared to the prior year.

- All MCOs, with the exception of MedStar Family Choice and Kaiser Permanente, experienced a decline in the reported rate for Childhood Immunization Status-Combination 3 (CIS). The most significant declines were seen by United Healthcare, who had a 7.1 percent decline in the rate from the prior year, and Maryland Physicians Care, whose performance declined 14 percent from the prior year.
- Immunizations for Adolescents-Combination 2 (IMA) saw improvement amongst all MCOs in 2017. There was a significant change made to the measure specification numerator criteria in 2017 that likely attributed to the improvement in performance. The updated specifications allow for two HPV vaccines, where prior specifications required three doses of the HPV vaccine.
- For Persistence of Beta-Blocker Treatment after a Heart Attack (PBH), all MCOs except MedStar Family Choice saw a decline in performance from the prior year. This decline in reported rates from the majority of MCOs caused the MARR to drop 3.3 percentage points for the 2017 measurement year to 74.8 percent. It should be noted that while the eligible population for each MCO exceeded the minimum number of members to report the measure (30 members), the eligible populations were still relatively small for each MCO, which can result in volatility of the reported rate year-to-year.

Overall, utilization slightly increased for Inpatient and Outpatient settings, while Emergency Department utilization experienced a significant decline.

- Inpatient Utilization – General Hospital/Acute Care (IPU) – Total Discharges Per 1,000 Member Months was stable in 2017 for seven of the eight MCOs, which experienced only minor changes in reported rates from the prior year. UnitedHealthcare experienced a significant change in the utilization rate, increasing by approximately 10 percent from the prior year.
- Ambulatory Care (AMB) experienced a decrease in Emergency Department Visits for all MCOs except Kaiser Permanente. Jai Medical Systems and University of Maryland Health Partners experienced the most significant declines, each experiencing a greater than 10% change in the reported rate from the prior year. The decline in Emergency Department utilization amongst the MCOs resulted in an approximately 11 percent decrease to the MARR for this measure.
- Ambulatory Care (AMB) Outpatient Visits declined amongst all MCOs except University of Maryland Health Partners, who experienced a 34 percent increase in the number of outpatient visits per 1,000 member months.

Value Based Purchasing (VBP)

The goal of Maryland's VBP initiative is to achieve better participant 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.

Table 16: CY 2017 results for VBP

Performance Measure	CY 2017 Target	ACC	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	UMHP
		Incentive (I); Neutral (N); Disincentive (D)							
Adolescent Well Care	Incentive: ≥ 76% Neutral: 72%–75% Disincentive: ≤ 71%	73% (N)	81% (I)	59% (D)	55% (D)	60% (D)	66% (D)	64% (D)	57% (D)
Adult BMI Assessment	Incentive: ≥ 91% Neutral: 88%–90% Disincentive: ≤ 87%	92% (I)	99% (I)	98% (I)	88% (N)	96% (I)	91% (I)	94% (I)	93% (I)
Ambulatory Care Services for SSI Adults	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	83% (D)	90% (I)	65% (D)	84% (N)	82% (D)	86% (N)	80% (D)	85% (N)
Ambulatory Care Services for SSI Children	Incentive: ≥ 86% Neutral: 83%–85% Disincentive: ≤ 82%	84% (N)	91% (I)	70% (D)	82% (D)	78% (D)	86% (I)	78% (D)	86% (I)
Asthma Medication Ratio	Incentive: ≥ 71% Neutral: 66%–70% Disincentive: ≤ 65%	63% (D)	71% (I)	78% (I)	63% (D)	65% (D)	59% (D)	63% (D)	60% (D)
Breast Cancer Screening	Incentive: ≥ 75% Neutral: 71%–74% Disincentive: ≤ 70%	69% (D)	78% (I)	82% (I)	59% (D)	67% (D)	69% (D)	60% (D)	75% (I)
Childhood Immunization Status (Combo 3)	Incentive: ≥ 87% Neutral: 84%–86% Disincentive: ≤ 83%	83% (D)	84% (N)	70% (D)	65% (D)	83% (D)	78% (D)	71% (D)	75% (D)
Comprehensive Diabetes Care – HbA1c Testing	Incentive: ≥ 91% Neutral: 88%–90% Disincentive: ≤ 87%	91% (I)	95% (I)	92% (I)	81% (D)	90% (N)	88% (N)	86% (D)	82% (D)
Controlling High Blood Pressure	Incentive: ≥ 68% Neutral: 62%–67% Disincentive: ≤ 61%	62% (N)	75% (I)	85% (I)	46% (D)	73% (I)	53% (D)	65% (N)	52% (D)
Immunizations for Adolescents (Combo 1)	Incentive: ≥ 90% Neutral: 87%–89% Disincentive: ≤ 86%	89% (N)	90% (I)	84% (D)	85% (D)	89% (N)	87% (N)	87% (N)	88% (N)
Lead Screenings for Children Ages 12–23 Months	Incentive: ≥ 70% Neutral: 64%–69% Disincentive: ≤ 63%	67% (N)	75% (I)	58% (D)	57% (D)	63% (D)	65% (N)	61% (D)	60% (D)
Postpartum Care	Incentive: ≥ 78% Neutral: 74%–77% Disincentive: ≤ 73%	72% (D)	84% (I)	85% (I)	69% (D)	74% (N)	69% (D)	66% (D)	74% (N)
Well Child Visits for Children Ages 3–6	Incentive: ≥ 89% Neutral: 86%–88% Disincentive: ≤ 85%	89% (I)	91% (I)	78% (D)	77% (D)	77% (D)	86% (N)	82% (D)	70% (D)

HealthChoice Enrollee Satisfaction Survey

Annually, the Department uses its NCQA-certified survey vendor to conduct participant 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.

In Reporting Year (RY) 2018 the Department's contracted NCQA-certified survey vendor mailed the CAHPS® 5.0H Medicaid Adult and Child Member Satisfaction Surveys to participants to assess their Calendar Year (CY) 2017 experience. The final aggregated survey sample for the HealthChoice organizations included 10,800 adult members and 26,871 child members. 2,308 adult members completed the survey, resulting in a response rate of 22 percent, and 3,461 surveys were completed for child members, resulting in a response rate of 27 percent.

HealthChoice adults gave the highest satisfaction ratings to their Specialist and Personal Doctor and slightly lower positive satisfaction ratings to their Health Care and Health Plan. For the child population, HealthChoice MCOs received the highest satisfaction ratings from parents/guardians from the general and CCC populations regarding their child's Personal Doctor and Health Care, while receiving slightly lower positive satisfaction ratings for Health Plan and Specialist. Both HealthChoice adults and children were most pleased with how well doctors communicate, while being the least pleased with shared decision-making.

For RY 2019 (CY 2018 data), the survey administration began the week of February 18, 2019. The satisfaction survey vendor Center for the Study of Services (CSS) is conducting this year's survey administration. The mail and telephone follow-up phase has been completed. The vendor shared its response rate tracking with the Department via its secure portal beginning in March. Interim progress reports were provided in April. Data collection closed on May 13, 2019, and data submission to NCQA occurred during May. The vendor is currently processing and conducting final analysis of the survey data. The Department anticipates receiving the final data reports regarding the HealthChoice participant satisfaction ratings in October 2019.

Primary Care Provider (PCP) Satisfaction Survey

The Department's satisfaction survey vendor also administered the PCP Satisfaction Survey for RY 2018 (CY 2017 data) to PCPs from each of the eight[8] HealthChoice MCOs that participate in Maryland's HealthChoice program. The PCPs were asked to rate the HealthChoice MCO listed on the survey, as well as all other MCOs in which they participate. The survey questionnaire included questions on finance issues, utilization management, customer service and provider relations.

The survey vendor administered the 2018 PCP survey on behalf of the Department between March and June 2018. The final survey sample included 6,516 physicians from eight MCOs in the HealthChoice program. 1,136 physicians completed the survey, resulting in an adjusted response rate of 18 percent. From the RY 2018 data survey results, slightly over 75 percent of the PCPs surveyed in 2018 reported being very satisfied or somewhat satisfied with their specified HealthChoice MCO. 87 percent of PCPs would recommend their specified MCO to patients and 84 percent of PCPs would recommend their specified MCO to other physicians.

Interim progress reports were provided to the Department in May. Data collection for the survey closed in June 2019. Distribution of the final data reports to the Department and MCOs is anticipated in October.

[8] In CY 2017, there were only eight MCOs. Currently, there are nine MCOs; Aetna became an MCO on January 1, 2018.

Annual Technical Report (ATR)

The Annual Technical Report was completed and submitted to CMS.

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, quality of care, medical homes, preventive health and programs created using managed care efficiencies. New measures are envisioned to be gradually incorporated into the annual evaluation over the course of the waiver period. The 2019 HealthChoice Evaluation, which will covers performance from CY 2013 – CY 2017, can be found in Attachment B. The Department presented highlights from the 2019 evaluation during the May and June MMAC meetings.

The 2019 Post-Award Forum was held on May 23, 2019, after the MMAC. The Department presented on a number of initiatives, including the community health pilots, the HealthChoice DPP, dental benefits for former foster youth and the adult dental pilot program, and the Family Planning program. (See Appendix C for the 2019 Post-Award Forum public notice documentation and Appendix D for the 2019 Post-Award Forum presentation.) Additionally, the Department held its first public forum for its 2019 §1115 waiver amendment, which would allow the Department to pilot collaborative care in up to three sites.

Enclosures/Attachments
Appendix A: Maryland Budget Neutrality Report as of June 30, 2019
Appendix B: 2019 HealthChoice Evaluation (CY 2013 - CY 2017)
Appendix C: Maryland HealthChoice Post-Award Forum Public Notice
Appendix D: Maryland HealthChoice Post-Award Forum Presentation

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