MARYLAND HEALTHCHOICE PROGRAM:

Options for Changing Its Purchasing Strategy for Managed Care Organizations

Provisions of the Affordable Care Act taking effect in the near future will place new demands on HealthChoice. Medicaid eligibility will expand to 133 percent of the federal poverty level (FPL), adding roughly 175,000 individuals to Maryland's Medicaid program. [1] Maryland's Health Benefit Exchange will launch in October 2013, which will place new burdens on HealthChoice to coordinate care and coverage between Medicaid enrollees and the Exchange population. The linkage between HealthChoice and the Exchange also will inform Maryland's decision whether to utilize the Basic Health Plan (**BHP**) option, and cover adults to 200 percent FPL in the BHP. While shouldering these new burdens, HealthChoice must continue to provide high-quality care.

These issues, in part, prompted the Department to seek input on this question: should Medicaid adopt a competitive purchasing (selective contracting) strategy as a way to improve the HealthChoice program. In July 2011, the Department published a policy paper titled, "*Maryland HealthChoice Program: Should Maryland Move To A Selective Contracting Strategy?*," which outlines the benefits and challenges of selective contracting. The policy paper draws on interviews with Medicaid programs in six states. The paper highlights a number of issues including implications for quality, coordination, and access, and it seeks to initiate public discussion around the benefits and challenges of adopting a selective contracting strategy. A full version of this paper may be found in **Appendix A**.

After releasing the paper, the Department actively solicited public comments on the proposals by holding Listening Sessions, posting material on our website, and accepting written comments.[2] Medicaid staff also delivered presentations to stakeholder groups, including the Medicaid Advisory Committee and the Managed Care Organization (**MCO**) Liaison Workgroup. The Department has received several comments from a range of stakeholders, including HealthChoice enrollees, MCO representatives, provider communities, local health departments, and advocates. A full listing of these comments may be found in **Appendix B**. Several comments echoed the benefits of selective contracting outlined in the paper, while others expressed serious concern over the impact selective contracting may have on enrollee choice, plan transition, and care continuity. One MCO's consumer advisory board submitted a petition of over 3,000 signatures, citing concern over plan transition issues and quality. Comments from HealthChoice enrollees shared first-hand perspectives of the risks to care continuity that arise from plan transition. Among the comments critical of selective contracting, many queried whether the Department had already developed a clear vision of what a selective contracting strategy would look like and expressed concern that such a strategy would contain strict requirements for MCO expansion and participation in the Exchange. To be clear: the Department has not defined a specific vision for a selective contracting strategy and this issue remains one under active consideration.

1 The Maryland Health Care Coordinating Council's interim report, July 26, 2010.

2 Three Listening Sessions were held across the state: Wye Mills, Frederick, and Baltimore City.

The Department is considering other alternatives as well, including a selective contracting strategy as well as other purchasing strategies. This paper presents these options, which include: (1) Continuing HealthChoice's existing purchasing strategy while refining certain regulations; (2) Adopting a selective contracting strategy that reflects public concerns and does not require statewide expansion; and, (3) Adopting a purchasing strategy that resembles a 'hybrid' of Options 1 and 2.

The Department intends to continue to openly seek and reflect upon stakeholder comments. No option will be adopted without the opportunity for substantial public input. The goal of the Department is to increase quality of care in Maryland, to hold the MCOs accountable for quality and access, and to ensure that enrollees' interests are pursued as Medicaid expands and the Exchange launches. We require stakeholder engagement to achieve our desired outcome. Thank you for the hard work you are devoting to this effort, and the Department looks forward to working with you in the time ahead.

OTHER ALTERNATIVES

Option #1 – Improving HealthChoice Utilizing the Current Regulatory Process

The first option is to continue HealthChoice's current purchasing strategy, which allows all qualified MCOs to participate (if they meet the Department's regulatory requirements), while making enhancements to the existing regulatory apparatus. Under this option the Department would make the following enhancements.

Incorporating More Incentives for Quality

The Department would review and modify the existing regulatory apparatus related to care quality in order to provide additional incentives to increase the quality of care, and to sanction MCOs that fail to deliver high-quality care. For example, the Department could increase the financial incentives and disincentives in the Value-Based Purchasing program.[3] Another tool would involve modifying the MCO auto-assignment algorithm to favor higher quality plans. Currently, when a person who is newly eligible for the HealthChoice program fails to choose an MCO within a specified time limit, this person is auto-assigned to an MCO operating in their region. The Department could modify the auto-assignment algorithm so that MCOs with higher quality scores are provided a greater weighting – meaning they are more likely to have the newly eligible persons assigned to their MCO. Of the six states interviewed, weighted auto-assignments are practiced in four of them. Weighted algorithms are fairly sophisticated but typically possess common features, including:

- Assigns a larger proportion of new beneficiaries who have not chosen an MCO to MCOs with a higher quality ranking.
- Considers MCO capacity.
- Maintains the family unit whenever possible.

[3]The Department is proposing regulation changes to increase the incentives/disincentives for Value-Based Purchasing from one half percent to one percent of capitation rates. If approved, the increase in financial incentives/disincentives will be effective for measurement year 2012.

Streamlining the Application Process

If HealthChoice continues to operate through the existing regulatory process where any qualified MCO is entitled to participate, the program could benefit from a more predictable MCO application process. One proposal is to establish an "open application window" during which an MCO could initiate the application process. An interested MCO would need to apply during this annual window, or wait until the next year. This suggestion would create a more organized process for reviewing and determining MCO participation. An application window could be aligned with other seasonal program efforts such as outreach for eligible but unenrolled children; budgeting; and rate-setting.

Adjusting Regional Participation Requirements

Currently, MCO service areas are defined by Local Access Areas (**LAAs**). There are 40 LAAs in Maryland. An MCO may elect to operate in as many or few of the LAAs as it chooses.[4] A statewide rural enrollment supplemental payment is offered if the MCO operates statewide – meaning in all 40 LAAs.[5]

Apart from the LAAs, current regulations also divide the state into ten specialty care regions and define a set of medical specialties for which the MCOs must provide coverage.[6] For each specialty care region in which the MCO operates, the MCO must contract with at least one provider in each of the identified specialty medical fields, such as Cardiology. For example, if an MCO operates in four counties, and three of those counties are located in one specialty care region, and the other county is located in another specialty care region, the MCO must contract with a specialty care provider – such as a cardiologist – in both specialty care regions. So an MCO operating in Allegany, Garrett, Washington, and Frederick counties would have to contract with specialty providers in specialty care region 1 (Allegany, Garrett, and Washington) as well as specialty care region 6 (Frederick and others).

Beyond that, the Department currently utilizes three regions in the state for rate-setting purposes; distinct rates are paid by rate-setting cohort in these three regions.[7]

Currently, MCOs in Maryland determine independently *each year* whether they are open or closed to new enrollees. The MCOs make these decisions based on the Department's proposed rates in the three regions; the MCOs' ability to build and maintain specialty provider networks; and other factors. This process creates an annual patchwork-quilt process for the Department to determine MCO participation, and to ensure that federal requirements are met regarding enrollee

4 As of June 2010, all new MCO applications must include two services defined in statute. These service areas include: (1) Allegany, Garrett, Washington; (2) Prince George's Northeast, Prince George's Northwest, Prince George's Southeast, Prince George's Southwest; (3) Calvert, Charles, St. Mary's; (4) Caroline, Kent, Queen Anne's, Talbot, Cecil; or (5) Dorchester, Somerset, Wicomico, Worcester.

5 COMAR 10.09.65.19-3.

6 COMAR 10.09.66.05-1.

7 COMAR 10.09.65.19 (1. Baltimore City; 2. Allegany, Frederick, Garrett, Montgomery, Prince George's and Washington Counties; 3. Rest of State).

choice. Because of the challenges in this approach, the Department could require MCOs to participate based on specialty care regions, or rate-setting regions, rather than LAAs.

Decisions for Serving New Enrollees

As mentioned above, MCOs in Maryland determine independently each year whether they are open or closed to new enrollees. This means that an MCO may elect to operate in an area yet indicate to the Department that it will not accept *new* enrollees in that area. Should all MCOs in a particular area elect not to accept new enrollees – meaning the MCOs advise that they will continue to serve existing enrollees but will be "closed" to new enrollees – the new enrollees would have no opportunity to join any MCO in that particular area. The Department would address this issue by removing the ability of MCOs to independently decide annually whether they are open or closed in a particular region. This means that the Department would require MCOs that elect to operate in a particular region to make a commitment to accept new enrollees from that region for a set period of time, *e.g*, four years.

Option #2 – Adopt a Selective Contracting Strategy

One alternative is to selectively contract with MCOs, which some states have been doing for years. *See* the policy paper attached at Appendix A. Summarized briefly, under this approach MCOs are selected in accordance with state procurement policies, such that the procurement process serves as a replacement to the Department's current application process. This approach allows states to select MCOs that demonstrate the capacity and commitment to meet and exceed program standards set forth in the request for proposals (**RFP**), in contrast to the current approach that defines minimum criteria and welcomes all MCOs meeting a defined, minimum threshold. The selective contracting approach would also permit Maryland the flexibility to favor those MCOs that exhibit higher quality standards, or report characteristics that the Department deems beneficial to low-income individuals. Additionally, the Department could provide incentives to encourage MCOs to coordinate care when enrollees transition to Exchange plans.

If the Department chooses this approach, it would develop the strategy based on principles established in the initial policy paper, including care quality, coordination, and geographic access. The Department would also consider public comments in its strategy development. Many comments expressed opposition to a selective contracting strategy that imposes strict requirements on statewide participation. In responding to these criticisms, the Department confirms that any selective contracting strategy would not require statewide expansion. Rather, it would define geographic regions and require offerors to submit a separate proposal for each region. Similar to the Option 1, the Department would require the MCOs to commit to operating and accepting new enrollees for the period of time established by the procurement and contract, *e.g*, four years. This would also minimize the administrative burden associated with the procurement process.

Option #3 – Adopting a "Hybrid" Strategy

Alternatively, the Department could consider implementing a hybrid strategy that combines elements from Option #1 and Option #2 as explained in the preceding sections. For instance, the

Department could utilize an approach that allows all interested MCOs to participate, but to offer the "open application" window every few years, rather than annually. Another example of the hybrid approach is to create a more extensive performance-based contract between the Department and the MCOs, in addition to the regulatory requirements, and to require that all interested MCOs agree to execute that contract. Another example of the hybrid approach is to utilize the "open" process in certain parts of the state, and to utilize selective contracting in other parts of the state where many, many MCOs want to operate (such as Baltimore City). Employing an approach that permits the best of both strategies might enable the Department to economically respond to issues that ultimately will improve quality of care.

NEXT STEPS

Ultimately the Department's goal is to increase quality of care to those enrolled under HealthChoice. The Department has outlined specific options for addressing these issues and welcomes any additional public input concerning these initiatives. Comments may be sent to Tricia Roddy at roddyt@dhmh.state.md.us but should be received no later than November 21, 2011, so that the Department may advise on next steps in this process by mid December 2011.

Appendix A – Policy Paper: *"Maryland HealthChoice Program: Should Maryland Move To A Selective Contracting Strategy?"*

MARYLAND HEALTHCHOICE PROGRAM:

SHOULD MARYLAND MOVE TO A SELECTIVE CONTRACTING STRATEGY?

INTRODUCTION

Maryland Medicaid and the Maryland Children's Health Program (**MCHP**) provide health care services to low-income individuals. Between them, the two programs cover over 950,000 individuals, approximately 80 percent of whom receive services through HealthChoice, a capitated managed care program. Beginning in January 2014, the Medicaid expansion that is included in the Affordable Care Act (**ACA**) is expected to add approximately 175,000 individuals to Medicaid, and these individuals will receive coverage from the Medicaid managed care organizations (**MCOs**).[1] The newly created Health Care Exchange will provide coverage for an estimated 187,000 more adults in the subsidized individual market between 133 and 400 percent of the federal poverty level (**FPL**).[2] Occasionally, certain parents will be covered in the Exchange at the same time their children will be insured by Medicaid or MCHP.

Individuals are expected to move between Medicaid and the Exchange as their households move above or below the line at 133 percent of the FPL that divides Medicaid and the Exchange.[3] These fluctuations could arise for a number of reasons: *e.g.*, small changes in income; additions or subtractions in the household size; and children aging out of Medicaid or MCHP into adulthood and the Exchange. These transitions between Medicaid and the Exchange, in part, prompted us to review our managed care contracting procedures and the experiences of other states in order to determine whether and to what extent Medicaid should align its purchasing strategy with the commercial products likely to be offered in the Exchange.[4]

Currently Maryland serves children with family incomes up to 300 percent of the FPL. This will not change. Under the ACA Medicaid expansion, Medicaid will cover parents and childless adults with incomes up to 133 percent of the FPL.[5] In Maryland, parents now are covered up to 116 percent of the FPL, and childless adults receive the limited benefit package available in the

1 The Maryland Health Care Coordinating Council's interim report, July 26, 2010.

2 *See id.*

3 It is estimated nationwide that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year, 50 percent, or 28 million, will. (" Issues in Health Reform: How Changes In Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Benjamin D. Sommers and Sara Rosenbaum, Health Affairs, February 2011.)

4 Related to this analysis is the availability of the Basic Health Plan (BHP) option, which is available to adults up to 200 percent of the FPL. The BHP option would not eliminate the transition issues, or family cohesion issues in the same insurance carrier, however, given the fact that adults would transition between a BHP and the Exchange at 200 percent of the FPL, and given the fact children still would remain in MCHP up to 300 percent of the FPL.

5 The ACA requires states to allow for a five percentage point income disregard, effectively increasing the 133 percent income threshold to 138 percent for parents and childless adults and the 300 percent income threshold to 305 percent for children.

Primary Adult Care (**PAC**) program up to 116 percent of the FPL.[6] Between 133 and 300 percent of the FPL, parents and their children will not be covered in the same program: parents will be in the Exchange, and children in Medicaid or MCHP. If the present market continues into 2014, this would virtually ensure that parents and their children not only would be insured through different programs, they would be insured by different insurance companies: only two of the seven Medicaid MCOs – United and Coventry – currently participate in Maryland's commercial market.

These issues, in part, prompted the Department to seek public input on whether Medicaid should adopt a competitive purchasing (or selective contracting) strategy, as one strategy to increase the likelihood of coordination between the Medicaid MCO market and the Exchange commercial market. One of our goals in the implementation of the ACA, and in this analysis, is to promote provider network continuity for individuals and families.

Specifically, we would like feedback on whether the Department should change how we contract with MCOs. Under current rules, any MCO that meets the Department's regulation standards is entitled to participate in the program.[7] One alternative is to selectively contract with MCOs, which some states have been doing for years. Under this approach, MCOs are selected in accordance with state procurement policies, such that the procurement process serves as a replacement to the Department's current application process. This approach allows states to select MCOs that demonstrate the capacity and commitment to meet and exceed program standards set forth in the request for proposals (**RFP**), in contrast to the current approach that defines minimum criteria and welcomes all MCOs meeting a defined, minimum threshold. The selective contracting approach also would permit Maryland the flexibility to favor those MCOs that offer products in the commercial market, exhibit higher quality standards or report characteristics that the Department deems beneficial to low-income individuals. In other words, it would provide a way for the Department to create incentives that encourage simultaneous participation in both the Medicaid and commercial markets.

While there could be an opportunity to utilize selective contracting to encourage price competition (within the actuarial rate range), cost containment is not prompting this initiative to explore selective contracting. Rather, our primary reason is and remains the same: improving quality of care. While the onset of the ACA presents interesting and novel continuity of care issues for Maryland, the potential solutions – such as selective contracting – have been employed by other states for years. We are cognizant of the lessons learned in the six states we interviewed, and the following sections address the benefits and challenges these states have faced with selective contracting.[8] (*See* Appendix 1.) The Department will discuss these benefits and challenges fully with key stakeholders when determining next steps with selective contracting, if any.

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6 Under today's eligibility rules, there are certain income disregards for parents. Therefore, for Maryland, the majority of the eligibility expansion under ACA will be from the childless adult population.

7 COMAR 10.09.64

8 Based on a 2009 National Association of Medicaid Directors survey, there are 16 states plus Puerto Rico that utilize selective contracting in their MCO contracting process. In total, 29 states and Puerto Rico responded to the survey. The six reviewed by Maryland represent an illustrative sampling of those states employing this technique.

DISCUSSION OF POSSIBLE BENEFITS AND CHALLENGES

Quality

- *Continuity of Care*

Quality care must be present in any program considered for Maryland enrollees, and a key goal of quality care in Maryland is ensuring provider network continuity for individuals and families. Selective contracting may be a tool for Maryland to increase network continuity for individuals and families. One example of continuity is parents receiving benefits through the same MCO as their children. Another example is those individuals and families whose incomes increase – so they are no longer eligible for Medicaid – purchasing insurance through the Exchange and maintaining their MCO and provider network.

According to Michigan officials, selective contracting provides significant benefits to the oversight and operation of managed care programs in that state – such officials told the Department that, "We are raising the bar all the time."[9] And most of the states interviewed note the fierce competition that is generated through selective contracting, which they credit with forcing MCOs to deliver quality of care and services beyond what was provided historically in those states.

Fierce competition among offerors suggests that incentives work in a selective contracting environment. Incentives may be provided via a point system that is evaluated during the procurement process – the higher the points, the more likely the MCO will be selected. In this example, selective contracting would allow Maryland to create incentives for MCOs to participate in both the Medicaid and commercial markets. Such incentives would provide flexibility to MCOs – they would not be required to operate in the Medicaid market as well as the commercial market, although the Medicaid MCOs would understand that higher points would be awarded to those that do. Similarly, such an approach would provide flexibility to Maryland, as well. For instance, MCOs may be required through the contract process to state how they would manage transitions across markets. Other possible innovative solutions include continuing to cover services for those undergoing existing treatment plans or encouraging Medicaid MCOs to work with new providers so that the new providers receive prior health records through the health information exchange with the consent of enrollees.[10]

There is a risk (or downside of selective contracting), however, if an MCO servicing Medicaid enrollees is not selected during the procurement process and those enrollees must transition to new MCOs (and potentially new providers). While none of the state officials interviewed identified significant transition issues through their own procurement processes, all cited this is a potential risk associated with a selective contracting process.[11]

9 Interview with Michigan Department of Community Health.

10 But such an approach is viable only if the MCO payment rates allow for additional services and do not result in overall financial losses.

11 For instance, although Tennessee decreased from 10 MCOs to 2 MCOs as a result of selective contracting, Tennessee officials reported that many of the MCOs did not experience any transition issues because most of the non-selected MCOs merged with those that were selected.

- *Quality Measures and Accreditation*

Selective contracting also could allow Maryland to award contracts to those MCOs that exceed other quality standards. Quality performance oversight in Maryland focuses generally on five main initiatives: (1) requiring MCOs to participate in reporting quality measures through HEDIS; (2) conducting enrollee and provider satisfaction surveys; (3) requiring an outside external quality review organization to conduct an annual review of MCOs' systems; (4) requiring MCOs to conduct performance improvement plans; and (5) providing financial incentives and penalties for certain key quality measures through a value-based purchasing system.

How states evaluate quality depends largely on procurement rules. Most states interviewed require offerors to provide past quality data during the procurement process. The rules in Pennsylvania, however, do not allow quality score comparisons among offerors so Pennsylvania must instead compare state scores to national scores. A number of the states compare individual offeror scores to the other offeror scores, permitting an apples-to-apples comparative analysis among the offerors. Most states – such as Pennsylvania – review an offeror's performance across multiple years. In many states, new MCOs to the market (who presumably have no historical performance data) are permitted to report quality scores from other markets. Conversely, Texas does not review any historical quality data, since it would preclude new startup MCOs from submitting offers.

Two of the states interviewed – Tennessee and Michigan – require offerors to be certified by the National Committee for Quality Assurance (**NCQA**) in addition to annual systems review by an external quality review organization.[12] NCQA is an independent, not-for-profit organization that assesses and reports the quality of health plans and a wide range of other health-related programs and organizations. Its mission is to improve the quality of health care, although it focuses primarily on commercial MCOs and health management organizations (HMOs) rather than those operating exclusively in Medicaid. NCQA Health Plan Accreditation begins with an off-site evaluation of performance standards. NCQA then sends a team of trained health care experts, including physicians, to conduct an on-site survey of the health plan. NCQA uses information from, among other things, health plan records, CAHPS consumer surveys, staff interviews, and the results of selected HEDIS measures to assign the health plan's accreditation level.

- *Sanction Authority*

A few of the states interviewed place more of the capitation payments at-risk for sanctions. For instance, Texas places five percent of the capitation payment for the MCO(s) at-risk for non-performance; the amount withheld is paid out to the higher performing MCOs who have met the minimal performance standards in the form of an incentive payment. Tennessee withholds a set amount each month from every MCO but returns such funds the next month provided an MCO meets specific, transparent performance requirements, such as timely submission of encounter

12 Tennessee also accepts either an NCQA or URAC accreditation.

data.[13] In contrast, the most financial risk MCOs in Maryland are subject to through the Value-Based Purchasing Initiative is a gain or loss of only one-half percent (0.5 percent) of their capitation payment.[14,15] But while these states have higher financial sanctioning authority, it is important to note that a move to selective contracting does not mandate increased sanctioning authority. Rather Maryland may promulgate new regulations to increase such sanctions today – the Department has the authority to do so based on authority delegated by existing state legislation.

Care Coordination

Coordination between MCOs and Administrative Service Organizations (**ASOs**) is one quality area the Department may want to target in a procurement process. Medicaid contracts with two ASOs to administer certain services outside of the MCOs' range of covered services, *i.e.*, dental and specialty mental health. Ensuring coordination of care between MCOs and ASOs is a priority for the Department. Moving to selective contracting may provide an opportunity to improve the coordination of care between MCOs and ASOs through the procurement process.

Another example of coordination could occur between the MCOs and the Exchange. For example, even if separate organizations serve the two different markets, with Medicaid MCOs serving Medicaid and MCHP, and unrelated insurance carriers serving the Exchange, the procurement could make coordination of care a condition of a competitively-awarded contract. For example, the RFP might require offerors to approve any previously-authorized services for up to 90 days when a person moves from the Exchange to Medicaid (to avoid disruption in medications, therapies, treatments, or inpatient stays).[16]

All states interviewed required offerors to include information in their proposals addressing how they will coordinate services across the MCO benefit and carved-out services. Both Michigan and Pennsylvania include specific coordination requirements in their RFP. Maryland could promulgate new regulations detailing such requirements. One benefit to selective contracting would be requiring offerors to provide specific details about how they plan to coordinate services. A written, detailed plan would provide a benchmark for the state to evaluate the success or failure of that offeror in the future and ultimately hold such offeror accountable.

13 The amount withheld decreases throughout the year, ranging from a 10 percent withholding to a 2.5 percent withholding at the end of the year, and these terms are stated in each MCO contract.

14 The Department is proposing regulation changes to increase the incentives/disincentives for Value-Based Purchasing from one half percent to one percent. If approved, the increase in financial incentives/disincentives will be effective for measurement year 2012.

15 The Department has broad sanctioning authority, although typically it acts on this authority only rarely. Value-Based Purchasing incentives (and disincentives) are specified in the regulations, although the Department welcomes comments on whether a more transparent explanation of existing or new, proposed measures should be articulated to maximize understanding of incentives and any desired deterrent effects.

16 Again, such an approach is viable only if the MCO payment rates allow for additional services and do not result in overall financial losses.

Underserved Areas of the State

In addition to creating incentives that both (1) encourage simultaneous participation in Medicaid and commercial markets and (2) improve quality of care, selective contracting also would permit Maryland to use its purchasing power to encourage MCOs to serve presently underserved areas of the State. For instance, the Department could award points in the procurement process to MCOs that operate statewide or in both urban and underserved areas, such as the Eastern Shore and Western Maryland. This practice could be utilized instead of the current effort of offering a financial bonus to those MCOs that operate statewide.

Such an approach might create more MCO options in underserved areas of the state. Currently HealthChoice has only two statewide MCOs – Priority and Maryland Physicians Care. By contrast, United operates statewide but is closed to new enrollees in three counties; Amerigroup operates in 22 counties but is closed to new enrollees in 11 counties; and the three remaining MCOs – Jai, Medstar, and Coventry – provide services in four or fewer counties. (*See* Appendices 2a, 2b, and 3.) Medicaid beneficiaries in several counties do not have many MCO options.

The states interviewed all promote larger regional service areas or statewide contracts through their RFP process. Most states have defined geographic regions (larger than counties), and offerors must submit a separate proposal for each region. The contracts are evaluated separately within each region. Michigan is one such state we interviewed. Although it allows offerors to define their own service region by county, Michigan awards additional evaluation points to offerors that service more than one county and, ultimately, it awards the most regionally-allocated points to those offerors that service all ten counties. In Maryland, one key difference between selective contracting and the current system is that, if awarded, an MCO must be open to new enrollees in all areas in which it received a contract. As mentioned above, currently MCOs in Maryland determine independently each year whether they are open or closed to new enrollees, so they might operate in areas of the MCO's selection, and yet indicate to the Department that they will not accept new enrollees in certain areas. This amounts to no additional options for new enrollees in those closed areas. Additionally, in certain counties, HealthChoice MCOs are not required to serve the entire area; Maryland defines its regions based on 40 different local access areas.

Likely the Department would be better positioned to provide increased quality of care options to enrollees with a contracting strategy that encourages both (a) expansions into underserved areas of the state and (b) commercial participation. The potential downside to a selective contracting approach with these goals is the effect on smaller, community-based MCOs that currently serve an important role. These organizations may not be structured in a way that allows for rapid growth, or they may not have an interest in greater expansion. The Department welcomes a discussion on alternative approaches, provided such alternative methods create additional quality of care choices for enrollees.

The Department does not intend, here, to overemphasize the desire for geographic coverage expansion or participation in the commercial market above core quality of care concerns. The larger national MCOs that appear better positioned to implement coverage statewide while also

operating commercial MCOs must also be evaluated based on their quality of care. (*See* Appendix 4.) The goal of increased geographic and market coverage should not be achieved at the expense of quality improvement and health outcomes.

Managed Care Payments

The Department's primary reason for exploring selective contracting is to improve provider network continuity and quality of care, not to save money on capitation rates. But capitation rates are and remain important. A difficulty associated with selective contracting is accepting payment rates that are either too high or too low.

Under the current process, the Department works with an outside, independent firm to develop rate ranges for the various HealthChoice enrollees, which in accordance with federal requirements is actuarially certified. This rate range identifies both the high- and low-end payment range. Under a selective contracting approach, Maryland would need to continue to comply with federal actuarial requirements – the issue, however, is whether the Department would permit negotiation within the rate range that is independently determined to be actuarially sound.

Two states interviewed – Arizona and Tennessee – both provide offerors with rate ranges and require them to bid a price within that rate. In Arizona, all respondents bid rates that were very close to the lower-end of the provided range, which suggests that the bid process provides an incentive to not bid at the higher-end of the range (which is good for states, as ultimately they pay lower rates). In Arizona, while offerors can negotiate rates within the range, it resets rates each year and compares the negotiated rates of offerors to the mid-point. But the system is not perfect, particularly if MCOs cannot afford to operate in the market. In Iowa, for instance, the budget shortfall resulted in the state deciding not to accept bids that fell above the actuarially sound mid-point range (meaning the state would have to pay higher rates). As a result, no contractors submitted proposals.[17] The other states interviewed did not evaluate rates in the proposal.

Selective contracting also may have some indirect impacts on payment rates. One issue for examination, for instance, is whether MCOs would have the same commitment to contain costs under a selective contracting process. All the states interviewed suggest just the opposite. Because the MCO's participation is not guaranteed and the MCO must compete during any follow-on procurement process, MCOs are encouraged to increase quality of care while also controlling costs.

Recently, as Maryland has grappled with balancing its budget, the Department reduced MCO rates during the year. The reduction was not tied to a service or provider rate cut. This type of rate cut would not be permitted in five of six states interviewed; all mid-year cuts must be tied to a provider or service reduction. By contrast, Michigan's contracts permit the state to make

17 Iowa discontinued its managed care program and, instead, began a primary care case management program (PCCM). Under a PCCM, typically providers bill the state directly under fee-for-service for those services provided. Primary care providers also receive a flat per member per month fee (or an increase in preventive service fees) to pay for case management services. (Interview with Iowa Medicaid).

reductions mid-year not directly tied to provider or service cuts, but MCOs are afforded six months to decide whether to exit the program.

Administrative Implications

Under selective contracting, Maryland should expect variations in administrative expenses. For instance, if Maryland were to reduce the number of managed care contracts in the near term, costs related to MCO monitoring and oversight should diminish. But additional administrative costs likely would be spent preparing requests for proposals, selecting MCOs, and transitioning patients from MCOs that were not selected.

A number of the states interviewed limit the offers or contracts selected. Federal rules require a choice of at least two MCOs, unless the region has been defined officially as a rural area. For example, Ohio hired Milliman to research the optimal number of lives per MCO. Based on this research, Ohio limits the number of MCOs to three per region. Pennsylvania accepts a maximum of five per region but allows flexibility to accept less. Tennessee only accepts two offers per each of its three regions. Tennessee notes that it was able to improve monitoring efforts once it limited MCOs. Tennessee officials also recognize that only accepting two MCOs is a bit risky if one of the two MCOs exits the program. Limiting the number of MCOs, however, may result in concentrated negotiating power on the part of MCOs, which could affect periodic rate modifications.[18]

The Department would need to assess what impact such an approach would have on overall expenses, if any.

Free Market Competition and Beneficiary Choice

Maryland's current contracting strategy allows for broad participation, in terms of the number and types of MCOs. This approach encourages MCOs to enter into new markets because they have a more secure expectation that they will be able to participate in the program for more than a single contract term, which is particularly important when states first start managed care programs.

Also, some would argue that since broad participation encourages all types of MCOs to enter markets, it promotes consumer choice. In Maryland, this is demonstrated in the Baltimore City region with all seven MCOs participating. Enrollees have a choice of large statewide MCOs and smaller community-based and staff model MCOs. This broad participation approach, however, has not generated the same participation levels in other regions of the state, such as Eastern and Western Maryland.

Procurement / Transition Process

Consistent across our interviews is the observation that the procurement process requires a great deal of state resources for a sustained period of time. For instance, Texas' procurement process

18 The Pacific Health Care Group, A Managed Care Study, Prepared for: The Florida House of Representatives, March 2010.

takes roughly 12 to 18 months (and is closer to 18 months if the MCO is new to the market). Maryland has never selectively contracted with MCOs, although there is some experience in procuring ASOs for two services provided outside the MCO benefit package, *i.e.*, dental and specialty mental health. The Department began writing the Dental ASO RFP in September 2007. The Department awarded the contract to DentaQuest in January 2009, and DentaQuest began operations on July 1, 2009. (Please note that this procurement was simpler since it related only to dental services and the State was selecting one statewide vendor.)

Because of this resource commitment, states are not re-procuring MCO contracts on an annual basis but instead are focusing on large contract periods. Tennessee contracts with MCOs for three years and allows for two, one-year extensions (resulting in a potential five year procurement period). Similarly, Pennsylvania switched from a three year procurement with a two year option to renew – a potential for five years – to a five year contract with an option to renew for three years (resulting in a potential eight year procurement period).

All states build time into the procurement timeline for appeals. And although none of them cited significant adverse implications to their programs as a result of appeals, Arizona hires The Pacific Health Group to ensure there is inter-rater comparability across the evaluation sections. This ensures its selection process is sound and, according to those interviewed, an independent assessment that all "i's have been dotted and t's have been crossed."[19] Arizona officials credit the ability to detail what is being done in a transparent manner as one advantage of selective contracting. But as MCOs are evaluated and details emerge in new programs, the chances for appeals and the concomitant delays and cost issues associated with them increase.

NEXT STEPS

The determination of whether to proceed with selective contracting requires a detailed, measured examination of the pros and cons offered by such an approach. The primary question is whether selective contracting would enable the State to expand coverage statewide and to underserved areas with the promise of better quality of care and oversight. The Department also would need to consider the effort and resources required to conduct the procurement, which impacts not only the State but the MCOs as well. The length of time between procurement periods could reach eight years or longer given the experience of other states. And the effort associated with each specific procurement period would require extensive attention to detail – the stakes are too high for both the State and offerors to not spend a significant amount on the process.

Selective contracting alone will not improve quality of care. The ability to sanction MCOs for poor or non-performance presents a strong, independent incentive to improve quality and reporting mechanism (and such authority would not be tied exclusively to a selective contracting model – Maryland can, and likely should, implement similar measures now, regardless of how it proceeds with selective contracting). So a more complex, nuanced review of the data suggests that MCOs participating in the contracting process maintain and exhibit high standards because the penalties associated with non-performance – losing the procurement – are so great. Whether

19 Interview with Arizona Health Care Cost Containment System.

selective contracting is the correct approach for Maryland, however, should be explored soberly and thoroughly with the assistance of all relevant stakeholders. Plus while the Department is seeking to maximize geographic coverage for Medicaid and to encourage the simultaneous participation in the Medicaid and commercial markets, any contracting approach must not disregard quality of care issues and must examine and consider the benefits provided by community-based MCOs. Ultimately, Maryland could proceed with a hybrid approach that combines the best elements of selective contracting and the existing system.

The Department is interested in gaining stakeholder feedback over the next six months. To provide feedback, please send comments to Tricia Roddy, Director of the Planning Administration, at roddyt@dhmh.state.md.us. If a decision is made to move forward, likely a RFP would be posted sometime in July 2012 (with an estimated start date for contracts to be in July 2013).

Appendix 1.

Summary of Selective Contracting Experiences by State

State*	Medicaid Population**	% Managed Care**	Bid Rates?	Quality Considered in Proposal Review?	Contract Term	Statewide Requirement?	Benefits of Selective Contracting	Challenges of Selective Contracting
Arizona	1,223,371	89.6%	Yes	Yes	Three years, with up to two one-year renewals (five year max.)	No – regional requirement	• Holds MCOs more accountable • Encourages competition • Encourages MCOs to go above and beyond requirements • Provides detail in a transparent process (the MCO lays out what it intends to do) • Drives down costs	• CMS' actuarial soundness requirement for managed care payments reduces the risk with selective contracting • Chances of appeals increase as more detail is added to the proposal and evaluation process
Michigan	1,629,959	88.8%	No	Yes (NCQA Accreditation Required as well)	Three years; with three, one-year renewals (six year max.)	No – define individual service areas by counties; more proposal points awarded for more counties	• Can limit number of MCOs serving a region • Dictate program needs and MCOs must demonstrate performance • Brings rigor to the oversight of the program • Allows state to raise the bar	• Procurement process is often arduous and political • Need to ensure all "i's" have been dotted and all "t's" have been crossed • Removed the price from the procurement process in 2000 (Risk of MCOs going bankrupt was too great)
Ohio	1,951,511	70.4%	No	Yes	One year; with unlimited one-year renewals State may re-procure at any time. Most recent was in 2005.	No – regional requirement	• More control over the number of MCOs, resulting in better oversight • Better possibility of long-term players • Develop knowledge of MCOs and track record through long-term investment • Guarantees a market share for MCOs in a region • Ability to make MCO changes if an MCO is under- or not performing	• Always a risk of MCOs dropping out, and possibly forcing enrollees into a fee-for-service program for a year (or until can re-procure) • Procurement process is a lot of work and tedious • Possible disruption in service for members • Meeting timelines can be challenging for a new MCO
Pennsylvania	1,920,134	82.1%	No	Yes	Five years; with one-time renewal of three years (eight year max.)	No – regional requirement	• RFP process encourages in-depth review of MCOs	• Rate bidding process is risky if MCOs underbid • Readiness reviews can take longer than six months; concern about whether new MCOs can meet readiness timeframes
Tennessee	1,230,750	100.0%	Yes	Yes (NCQA Accreditation Required as well)	Three years, with up to two, one-year renewals (five year max.)	No – regional requirement	• Ability to limit MCOs • Increases the oversight of MCO operations (know the day-to-day operations of the MCOs) • Encourages MCOs to perform better • Guarantees a market share for MCOs in a region	• Operates a backup administrative service organization, in the event an MCO exits the program • Contract term years must allow an MCO to settle into program
Texas	3,343,241	64.6%†	No	Limited (Does not want to preclude startup MCOs)	Four years, with one or more renewals not to exceed four additional years (eight year max.)	No – regional requirement	• Drives MCO performance through procurement • Dictate what you want to buy • Allows more detail (in contracts) than state plans or regulatory process • Ensures MCOs work with provider community	• Still need to be concerned about MCOs' profits and the need to closely monitor MCOs (requires robust financial and medical monitoring)

*States identified based on a 2009 National Association of Medicaid Directors survey. Seven states interviewed represent an illustrative sampling of those states employing selective contracting. Iowa is not displayed because state officials reported that its managed care program had been discontinued and replaced by a primary care case management program (PCCM).
**As of June 30, 2009. Source: Centers for Medicare and Medicaid Services.
†Texas is planning to expand its managed care program to rural areas (after expansion 80 percent of enrollees will receive services through a managed care plan).

Appendix 2A.

Table of Current HealthChoice MCOs; Size; and Geographic Service Area

MCO	Number of Enrollees (as of June 2011)	Percent of Enrollees	Service Areas
AmeriGroup*	201,693	27%	Anne Arundel, Baltimore City, Baltimore County, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, Somerset, St. Mary's, Talbot, Wicomico, Worcester
Priority Partners	200,393	27%	All Counties
Maryland Physicians Care	144,812	20%	All Counties
UnitedHealthcare*	132,519	18%	All Counties
MedStar Family Choice*	28,982	4%	Anne Arundel, Baltimore City, Baltimore County, Harford
Jai Medical Systems	13,617	2%	Baltimore City, Baltimore County
Coventry (Diamond Plan)*	13,335	2%	Baltimore City, Baltimore County, Cecil, Harford

*Enrollment frozen in some areas of Maryland. See Appendix 3.

Appendix 2B.

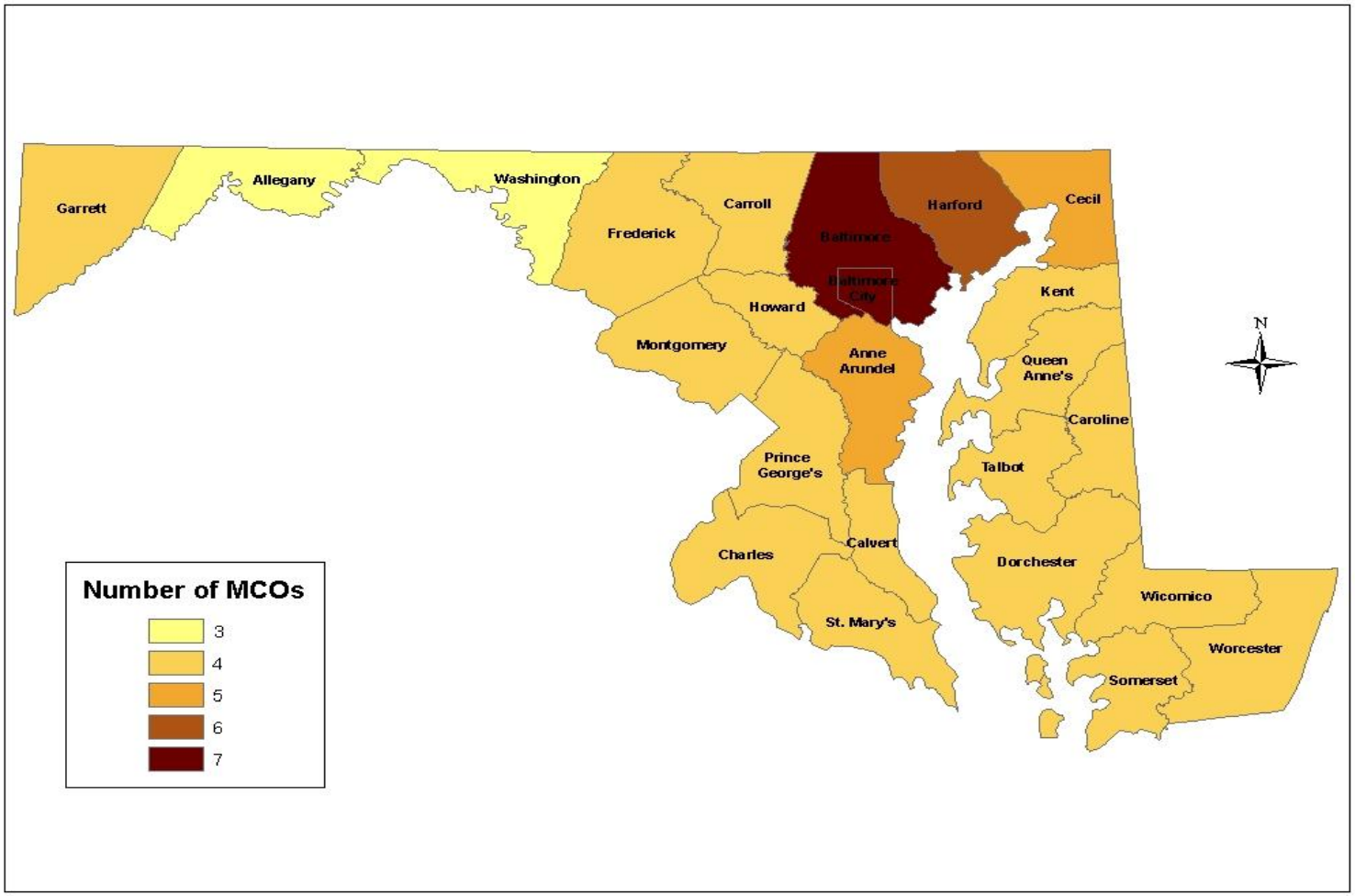
Table of Current Primary Adult Care (PAC) MCOs; Size; and Geographic Area

MCO	Number of Enrollees (as of June 2011)	Percent of Enrollees	Service Areas
AmeriGroup*	5,640	10.6%	Anne Arundel, Baltimore City, Baltimore County, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, Somerset, St. Mary's, Talbot, Wicomico, Worcester
Priority Partners	9,265	17.4%	All Counties
Maryland Physicians Care	16,125	30.3%	All Counties
UnitedHealthcare*	15,091	28.3%	All Counties
Jai Medical Systems	7,139	13.4%	Baltimore City, Baltimore County

*Enrollment frozen in some areas of Maryland. See Appendix 3.

Appendix 3.

Map of MCO Service Areas by County, as of June 2011



Note: The following MCOs have frozen enrollment in certain counties:

- **AmeriGroup**: Caroline, Cecil, Dorchester, Garrett, Kent, Queen Anne's, Somerset, St. Mary's, Talbot, Wicomico, and Worcester Counties.
- **Coventry (Diamond Plan)**: Cecil County.
- **MedStar**: Frozen for new enrollments in South Anne Arundel County and East Harford County.
- **UnitedHealthcare**: Frozen for new enrollments in Somerset, Wicomico, and Worcester Counties.

Appendix 4.

2011 HealthChoice Report Card*

All health plans in HealthChoice received high satisfaction ratings from the majority of their members.

This Report Card shows how the health plans in HealthChoice compare to each other in key areas. You should use this Report Card along with other items in the enrollment packet to help you choose a health plan.

To choose a health plan, call 1-800-977-7388. If you are hearing impaired, you can call the TDD line 1-800-977-7389.

Key
- ☆☆☆ Above HealthChoice Average
- ☆☆ HealthChoice Average
- ☆ Below HealthChoice Average

HealthChoice — Maryland's Medicaid Health Plan Program	Access to Care	Doctor Communication and Service	Keeping Kids Healthy	Care for Kids with Chronic Illness	Taking Care of Women	Diabetes Care
	Performance Areas					
Health Plans						
AMERIGROUP	☆☆	☆	☆	☆☆	☆☆	☆
DIAMOND PLAN	☆	☆	☆	Not Rated By Researchers	☆	☆
JAI MEDICAL SYSTEMS	☆☆	☆☆☆	☆☆☆	☆☆	☆☆☆	☆☆☆
MARYLAND PHYSICIANS CARE	☆☆☆	☆☆	☆☆☆	☆☆	☆☆	☆☆
MEDSTAR FAMILY CHOICE	☆☆	☆☆	☆☆☆	☆☆	☆☆☆	☆☆☆
PRIORITY PARTNERS	☆☆☆	☆☆☆	☆☆	☆☆	☆☆	☆☆
UNITED HEALTHCARE	☆☆	☆☆	☆☆	☆	☆	☆

This information was collected from health plans and their members and is the most current performance data available. The information reported was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member composition. "Not Rated by Researchers" does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan.

Performance Area Descriptions

Access to Care
- Appointments are scheduled without a long wait
- The health plan has good customer service
- Everyone sees a doctor at least once a year

Doctor Communication and Service
- Doctors explain things clearly and answer questions
- The doctor's office staff is helpful
- Doctors provide good care

Keeping Kids Healthy
- Kids get shots to protect them from serious illness
- Kids see a doctor and dentist regularly
- Kids get tested for lead

Care for Kids with Chronic Illness
- Doctors give personal attention
- Kids get the medicine they need
- A doctor or nurse knows the child's needs
- Doctors involve parents in decision making

Taking Care of Women
- Women are tested for breast cancer and cervical cancer
- Moms are taken care of when they are pregnant and after they have their baby

Diabetes Care
- Blood sugar levels are monitored and controlled
- Cholesterol levels are tested and controlled
- Eyes are examined for loss of vision
- Kidneys are healthy and working properly

*Note below ratings reads: "The information was collected from health plans and their members and is the most current performance data available. The information reported was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member competition. "Not Rated by Researchers" does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan."

Appendix B – Selective Contracting Public Comments

Selective Contracting - Public Comments

Topic	Comment	Commenter
Accountability/Oversight	As a part of a selective contracting model, require timely data sharing and public access to data.	Maryland Addictions Directors Council
Accountability/Oversight	Current Value Based Purchasing penalty is not large enough.	Cecil County Health Department
Accountability/Oversight	Selective contracting is not necessary to achieve more accountability.	Maryland Physicians Care
Accountability/Oversight	Whatever purchasing process is ultimately chosen, DHMH must increase oversight and accountability.	Cecil County Health Department
Administrative Impact	Administrative burden and cost can be reduced by establishing a single standard for documentation and requiring all MCOs to adhere to that standard.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Administrative Impact	Allowing state staff to focus on a fewer number of health plans, and using contractual performance measures as a guide lessens the burden on your staff and also provides important clarity to plans and other stakeholders on expectations and program goals.	United Healthcare
Administrative Impact	Create a data collection system that not only gathers and analyzes uniform data from MCOs, but also from community-based providers, hospital-based providers, and local health departments.	National Council on Alcoholism and Drug Dependence, Maryland Chapter
Administrative Impact	HealthChoice is stable. At a time when resources are limited, and an overwhelming number of initiatives must be completed in order to prepare for ACA, DHMH should not risk the disruption of the program by pursuing selective contracting. Program needs to be stable to support influx of new enrollees under ACA. DHMH should focus on Cost Containment, long term care reform, and upgrading eligibility systems.	MedStar Health
Administrative Impact	If the State chooses to look at ways to improve quality of care, one way to do so is to ease the administrative burden of providers by making uniform many of the procedural functions and paperwork across the MCOs. This will result in more resources spent on patient care and less on administration.	National Council on Alcoholism and Drug Dependence, Maryland Chapter
Administrative Impact	Selective contracting will increase administrative burden.	Consumer

Topic	Comment	Commenter
Administrative Impact	Jai does not have a fully electronic claims submission and billing system, which results in processing errors and adds significant delay to reimbursement. Electronic claims submission and payment should be a minimum requirement. All other disparate process should be identified and remedied to ease administrative burden.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Administrative Impact	Moving to selective contracting would consume several years of significant time and resources from all stakeholders. It is unlikely the Department is able to handle the work within existing limited resources.	MedStar Health
Administrative Impact	Post selective contracting, the Medicaid program may become more expensive given the additional bargaining power the selected plans will gain.	Jai Medical Systems
Administrative Impact	Selective contracting will cost the State more money and require additional resources without providing more care.	Jai Medical Systems Consumer Advisory Board (with petition of 3000+ signatures)
Administrative Impact	The Department should establish a periodic schedule for the acceptance of new MCO applications.	Jai Medical Systems
Administrative Impact	The Department should meet separately with individual MCOs on a one-on-one basis at least twice a year to discuss Accountability and Strategic Planning.	Jai Medical Systems
Administrative Impact	The development and implementation of the procurement process will be an expense that currently does not exist and will require budget development.	Jai Medical Systems
Administrative Impact	The use of standard forms and procedures with all MCOs will greatly reduce administrative burdens on providers.	Maryland Addictions Directors Council
Commercial Participation	Concerns about introducing an Exchange participation requirement. HealthChoice is stable, quality has been improving year over year. Four of the seven MCOs are Maryland provider locally-owned organizations with good networks; five of the seven are Medicaid-only health plans, with a focus on only the state program and the program's requirements, which are in many cases very different than commercial requirements. Many HealthChoice members are served under a Medicaid-only MCO model. MPC has no desire to become an insurance company; selective contracting would go against MPC's core mission.	Maryland Physicians Care
Commercial Participation	Selective contracting will reduce quality if it favors commercial plans with low quality and eliminates noncommercial high quality health plans.	Jai Medical Systems Consumer Advisory Board (with petition of 3000+ signatures)

Topic	Comment	Commenter
Commercial Participation	The State should not limit participation to plans that participate in commercial market because some of the plans that work best with providers are some of the plans that do not participate in the commercial market and there are opportunities to get around DHMH's concerns about coordination of care, through CRISP or other means of data sharing with plans that participate in the commercial market.	Frederick Memorial Hospital
Commercial Participation	Selective contracting could eliminate most, if not all, of the current provider sponsored organizations.	MedStar Health
Commercial Participation	Community-based plans may not have an interest in participating in the commercial market.	Consumer
Conflict of Interest Requirements	A key component of a successful selective contracting strategy is the application of rigorous conflict of interest requirements, particularly among provider-sponsored managed care organizations, to ensure appropriate alignment of quality and cost objectives of the Medicaid program.	United Healthcare
Consumer Choice	Selective contracting will reduce the choice for enrollees and for providers. Understanding the needs of the communities being served is an important function that the current MCOs provide, each in its own way. Providing care in a culturally sensitive manner is essential for program success.	Jai Medical Systems
Coordination of Care	A new Coordination of Benefits (COB) and Coordination of Care (COC) process should be developed. The process would involve the communication of enrollment transactions to carriers identifying enrollees that were transitioning from one market to the next in addition to prior carrier enrollment. These individuals would be afforded a different administrative benefit level by the new carrier that would forgo any outpatient authorization requirements, such as referrals for the first ninety days of enrollment. Inpatient admissions would remain subject to utilization review. Transition Care Coordinators would be established at each carrier as a designated point of contact to facilitate the sharing of diagnostic history and provider information between carriers.	Jai Medical Systems

Topic	Comment	Commenter
Coordination of Care	Allowing families to stay under a single plan umbrella with the ability to keep the same doctors as their eligibility changes greatly enhances continuity of care and care coordination, resulting in improved health outcomes.	United Healthcare
Coordination of Care	Encourage the State to consider eliminating carve-outs. Fully-integrated care through the support of electronic health records is best provided through a seamless and complete sharing of data. Providing all services to members through their plan allows for more timely data access and can improve the ability of all plans to provide integrated, quality care while decreasing administrative costs.	United Healthcare
Coordination of Care	MCOs must be able to demonstrate that the Plan promotes and provides incentives to providers for coordination of care services for specified health services, including substance use disorder treatment.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Coordination of Care	People may end up using the Emergency Room more often if they are confused about their provider and/or MCO.	Jai Medical Systems Consumer Advisory Board (with petition of 3000+ signatures)
Coordination of Care	People may end up using the Emergency Room more often if they are confused about their provider and/or MCO.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Coordination of Care	Specific conditions should be included in the selective contracting process to ensure that behavioral health and physical health are coordinated.	Maryland Addictions Directors Council
Coordination of Care	Require MCOs to have a uniform process for authorization of care, and reexamine the clinical value of and need for constant reauthorization.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Coordination of Care	MCOs need to use their information to inform providers in a timely manner that Medicaid will not reimburse for specific care.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Geographic Service Area	Expand geographic service through the existing regulatory process. Real constraint on this expansion is lack of provider participation.	MedStar Health
Geographic Service Area	None of the states surveyed in the paper required statewide participation.	Maryland Physicians Care

Topic	Comment	Commenter
Geographic Service Area	Require all MCOs in the RFP process to demonstrate a willingness to serve a statewide service area. Require Federally Qualified Health Centers to participate with all MCOs at reimbursement rates no less than their current Medicaid rates, particularly considering the level of federal funding deployed to support FQHCs. This is consistent with the mission of FQHCs and helps to ensure adequate access as well as choice among MCOs for Medicaid eligibles in underserved areas of the state.	United Healthcare
HealthChoice-Exchange Coordination	DHMH can ensure care coordination with Exchange through the regulatory process.	MedStar Health
HealthChoice-Exchange Coordination	MCOs must demonstrate either (i) that they offer comparable plans under Medicaid and in the Exchange or (ii) they have in place mechanisms to permit a smooth transition between Medicaid plans and Exchange plans, including mechanisms for transitioning patients without disruption of treatment or allowing non-network providers to continue a course of treatment.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
HealthChoice-Exchange Coordination	The creation of a Basic Health Program should be seriously considered.	MedStar Health
HealthChoice-Exchange Coordination	The selection of a limited number of qualified MCOs will allow for coordination between the Medicaid MCO market and the health care exchange commercial market.	Maryland Addictions Directors Council
Other	Allows ACCU staff to develop a more personal relationship with our representatives.	Cecil County Health Department
Other	Jai Medical Systems is the only minority business participating in the HealthChoice program at the MCO level. It is unclear if selective contracting will ensure the continued participation of at least one minority business.	Jai Medical Systems
Other	Selective Contracting will eliminate Maryland jobs.	Jai Medical Systems Consumer Advisory Board (with petition of 3000+ signatures)
Other	The Department should get legislative input before making a decision.	Jai Medical Systems Consumer Advisory Board (with petition of 3000+ signatures)
Other	Provider-sponsored MCOs were the ones that absorbed the largest segment of the recent Medicaid expansion populations. It would not be prudent to disrupt the HealthChoice program at a time when we're all preparing for the 2014 expansion.	MedStar Health

Topic	Comment	Commenter
Plan Choice	There are advantages to having only a few open MCOs in a county.	Cecil County Health Department
Plan Choice	If a virtual monopoly is a byproduct of the selective contracting process, significant antitrust legal issues may arise.	Jai Medical Systems
Plan Choice	Limiting plan choice is a double edged sword – it could be less confusing for members but also may limit consumer choice to bad plans.	Cecil County Health Department
Plan Choice	Providers need to be able to choose from a variety of plans in order to garner the best reimbursement for their services. A lack of MCO competition for provider services will result in a loss of provider leverage and ultimately result in downward pricing pressure on providers.	Jai Medical Systems
Plan Choice	Selective Contracting will reduce plan choice, which is contrary to Medicaid program goals.	Jai Medical Systems Consumer Advisory Board (with petition of 3000+ signatures)
Plan Choice	Limit the number of plans selected not only to ensure plan viability, but also to enhance your ability to oversee the operations and services of each MCO. We understand the concern about member transitions and service disruption that downsizing might bring about, but we can share our experiences in other states where we have gone through transitions with minimal impact on consumers and health care professionals. Consumer choice is important, but just as employers often limit plan options for their employees, there are ways to ensure choice while increasing the opportunity for the state to oversee the quality of each MCO.	United Healthcare
Provider Networks	If multi-state MCOs are selected, a significant amount of the administrative dollars previously spent in State by the Maryland-based companies would be shifted out of state. Further, safety net providers may not be able to afford to contract with the remaining MCOs due to rates offered, and may similarly go out of business.	Jai Medical Systems
Provider Networks	Selective contracting would result in strained provider networks and increased ER usage.	Consumer

Topic	Comment	Commenter
Quality of Care	A comparison of the average Medicaid Program results for the HEDIS measures within the Value Based Purchasing Initiative indicates that Maryland's current system is superior to [other states] in terms of driving quality improvement.	Jai Medical Systems
Quality of Care	Community-based MCOs offer quality care; selective contracting would threaten their participation in the program and create transitions issues for members of those plans.	Jai Medical Systems
Quality of Care	Community-based MCOs offer quality care; selective contracting would threaten their participation in the program and create transitions issues for members of those plans.	Consumer
Quality of Care	Community-based MCOs offer quality care; selective contracting would threaten their participation in the program and create transitions issues for members of those plans.	Consumer
Quality of Care	Community-based MCOs offer quality care; selective contracting would threaten their participation in the program and create transitions issues for members of those plans.	Consumer
Quality of Care	Encourage the Department to consider assessment and accreditation by an external organization such as the National Committee for Quality Assurance that applies consistent measures and requirements for health plan quality programs and outcomes.	United Healthcare
Quality of Care	Modify sanction authority to include a trial Nursing Facility diversion policy. Punish MCOs that are either failing to provide sufficient preventative primary care to prevent institutionalization, or punish MCOs who have the majority of the short-terms who go into Medical Assistance long term care.	Maryland Disability Law Center
Quality of Care	Require plans to operate a medical home model that addresses the needs of certain populations, including those with co-occurring mental illness and substance use disorders, or who are identified as high cost users, or those with chronic disease, including substance use disorders.	University of Maryland Francis King Carey School of Law Drug Policy Clinic

Topic	Comment	Commenter
Quality of Care	Require that providers should be located within specific reasonable distance parameters, have office and treatment hours that make the needed treatment easily accessible, have same day access to treatment for initial intake, ensure limited wait times for appointments, and ensure that at least some providers provide 24/7 coverage.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Quality of Care	Selective contracting may negatively impact care quality and coordination because of transition issues for members of plans that are not selected in the procurement.	Consumer
Quality of Care	Selective contracting supports the use of quality indicators and reporting, both for current plans and for new entrants who may submit bid proposals through the competitive process. We encourage the State of Maryland to consider indicators that provide a holistic and consistent assessment of plans that considers a plan's size, geographic footprint, and the varying risk levels of enrolled populations.	United Healthcare
Quality of Care	The Department could place plans on probation based on poor quality performance and employ progressive negative reinforcement for MCOs that did not improve. As an example, negative reinforcement could include suspension of auto-assignments.	Jai Medical Systems
Quality of Care	We can achieve quality through existing regulatory process, and have done so.	MedStar Health
Quality of Care	it would be helpful to have 'more teeth' from DHMH in terms of the ability to control the MCOs and their quality, network adequacy, and ability to enable providers to work with MCOs on claims payment and program administration.	Frederick Memorial Hospital
Quality of Care	Require MCOs to be at-risk for outcomes, which will incentivize MCOs to provide the full length of needed care to produce better outcomes.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Quality of Care	Require providers to screen for alcohol and drug problems.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Quality of Care	Investigate potential for MCOs to use provider contracts to manipulate service delivery, particularly for addiction services.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Quality of Care	Prohibition on billing two different services on the same day is a barrier to good care.	University of Maryland Francis King Carey School of Law Drug Policy Clinic

Topic	Comment	Commenter
Substance Abuse Reforms	A process must be developed to allow programs to be reimbursed for [buprenorphine] visits [at a treatment program] in order for a patient's medication monitoring to be coordinated with his or her counseling.	National Council on Alcoholism and Drug Dependence, Maryland Chapter
Substance Abuse Reforms	At a minimum, MCOs should provide the following data relating to addiction treatment services: (i) the total reimbursement for substance use disorder services by level of care and number of enrollees served in each level of care; (ii) the cost of other Medicaid services (including ER and in-patient hospital costs) and other medical services for enrollees with substance use disorders; (iii) the number and type of addiction treatment claims denied for each level of care; (iv) the average length of time between submission of claim and payment; (v) the dollar amount of each claim for each level of service; and (vi) the number of persons identified with co-occurring conditions or identified as high cost users and the level and cost of general medical and substance use disorder services provided to these individuals. Failure to submit data as required should result in immediate sanction and penalty, including withholding of payment from the Medicaid program.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Substance Abuse Reforms	Could the ASAM levels of care for substance use disorder be included in the contracting requirements for treating substance use disorders?	Maryland Addictions Directors Council
Substance Abuse Reforms	Include the following elements as part of the selective contracting process: • ASAM criteria are used in determining substance use disorder level of care coverage. • Criteria for approving care are objective and based on clinical evidence. • Procedures for approving and denying care are objective and transparent. • Practitioners are involved in procedures development. • Practitioners can obtain the criteria upon request. • The MCO evaluates the consistency with which the criteria is applied.	Maryland Addictions Directors Council

Topic	Comment	Commenter
Substance Abuse Reforms	Methadone patients who have Medicare as their primary coverage generally must bill Medicaid for that treatment because Medicare does not cover certain codes. Priority Partners has created a coordination of benefits (COB) code to seamlessly address this issue and process payments. Other MCOs have not done the same and, thus, reject claims and delay reimbursement unnecessarily. Uniform adoption of the COB code should be required.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Substance Abuse Reforms	Plans must offer a State-defined list of preventive services without cost sharing across all general care settings.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Substance Abuse Reforms	Require MCOs to identify the highest cost users of medical services and determine which of those individuals have substance use conditions so that all services can be coordinated.	University of Maryland Francis King Carey School of Law Drug Policy Clinic
Substance Abuse Reforms	Substance use disorder providers currently are challenged by the fact they do not have access to the criteria that MCOs use in determining approval for levels of care services. Could you include within the selective contracting contract a requirement that MCOs share their criteria?	Maryland Addictions Directors Council
Substance Abuse Reforms	The contracting process should require that MCOs cover the cost of linking their billing and data systems to the SMART system. SMART has a billing component that is not currently being utilized. The main obstacle is the cost of linking the SMART system with many different MCO systems. Requiring the MCOs to cover the cost of linkage as part of their contract would solve the problem.	Maryland Addictions Directors Council
Transition	Selective Contracting is intended to reduce the number of MCOs, which would break the presidential promise that people could keep their health plan.	Jai Medical Systems Consumer Advisory Board (with petition of 3000+ signatures)
Transition	Selective Contracting may cause enrollees to lose historic providers.	Jai Medical Systems Consumer Advisory Board (with petition of 3000+ signatures)
Transition	Transitioning patients from MCOs not selected would negatively impact care quality and coordination.	Consumer