Maryland HealthChoice Demonstration
Section §1115 Annual Report
Demonstration Year 25: 7/1/2021 - 6/30/2022

Introduction

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

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

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

Effective January 1, 2022, the Centers for Medicare & Medicaid Services (CMS) approved and renewed Maryland's §1115 demonstration waiver, known as HealthChoice, for a period of five years. The 2021 renewal made the following changes to the demonstration:

- Authorized the Maternal Opioid Misuse (MOM) initiative to reduce the burden of neonatal abstinence syndrome (NAS) and its associated costs, and improve maternal health outcomes, by providing enhanced case management services to pregnant people diagnosed with an opioid use disorder (OUD);
- Created a voluntary, five-year payment model in Annapolis, Baltimore City, and Montgomery counties, that provides greater flexibility to ambulance care teams to address emergency health care needs following a 911 call by allowing for payment for ground transports to alternative destinations such as urgent care providers in addition to the ED;[1]
- Created an expenditure authority to cover Medicaid adults aged 21 to 64 that have an SMI diagnosis who are residing in a private IMD;
- Modified Maryland's coverage of ASAM Level 4.0 to include not only providers located in Maryland, but also those based in contiguous states;

[1]Due to legislation introduced in Maryland's 2022 Legislative Session and signed into law, both the Alternative Destination Pilot and the Adult Dental Pilot programs will be sunset as these programs transition from the § 1115 Waiver to the Maryland State Plan. New coverage in both programs, as indicated in HB6/SB150 Maryland Medical Assistance Program – Dental Coverage for Adults and SB295 Maryland Medical Assistance Program - Emergency Service Transporters – Reimbursement, will become effective January 1, 2023.

- Raised the participant spaces for the Assistance in Community Integration Services (ACIS) Pilot from 600 to 900; and
- Expanded the allowable timeframe of eligibility in the Healthy Families America (HFA) evidence-based Home Visiting Services (HVS) Pilot from age two to age three.

Enrollment Information

Table 1 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[2]

Demonstration Populations	Participants as of June 30, 2021	Participants as of June 30, 2022	DY 25 Change (#)	D 25 Change (%)
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	277,926	296,114	18,188	6.5%
Affordable Care Act (ACA) Expansion Adults	395,822	443,008	47,186	11.9%
Medicaid Children	515,474	537,057	21,583	4.2%
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	92,247	93,534	1,287	1.4%
SSI/BD Children	24,518	24,085	-433	-1.8%
Medically-Needy Adults	23,124	26,360	3,236	14.0%
Medically-Needy Children	6,531	6,550	19	0.3%
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	12,821	15,841	3,020	23.6%
Maryland Children's Health Program (MCHP)	112,001	127,440	15,439	13.8%
MCHP Premium	34,023	33,515	-508	-1.5%
Presumptively Eligible Pregnant Women (PEPW)	0	0	0	0.0%
Increased Community Services (ICS)	26	21	-5	-19.2%
Women's Breast and Cervical Cancer Health Program (WBCCHP)	65	56	-9	-13.8%

[2] As of January 1, 2022, the Family Planning program is no longer in the §1115 Waiver. As such, it has been removed from this report.

Table 2. Enrollment as a Proportion of Total

Demonstration Populations	Share of Participants as of June 30, 2021	Share of Participants as of June 30, 2022	Share Change
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	18.4%	18.5%	0.0%
Affordable Care Act (ACA) Expansion Adults	26.2%	27.6%	1.4%
Medicaid Children	34.2%	33.5%	-0.7%
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	6.1%	5.8%	-0.3%
SSI/BD Children	1.6%	1.5%	-0.1%
Medically-Needy Adults	1.5%	1.6%	0.1%
Medically-Needy Children	0.4%	0.4%	0.0%
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	0.9%	1.0%	0.1%
Maryland Children's Health Program (MCHP)	7.4%	7.9%	0.5%
MCHP Premium	2.3%	2.1%	-0.2%
Presumptively Eligible Pregnant Women (PEPW)	0.0%	0.0%	0.0%
Increased Community Services (ICS)	0.0%	0.0%	0.0%
Women's Breast and Cervical Cancer Health Program (WBCCHP)	0.0%	0.0%	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[3]

Eligibility Group	Total for Quarter Ending March 2022	Current Quarter Month 1 (April 2022)	Current Quarter Month 2 (May 2022)	Current Quarter Month 3 (June 2022)	Total for Quarter Ending June 2022
Parent/Caretaker Relatives <116% FPL and Former Foster Care	868,831	293,446	294,733	296,114	884,293
ACA Expansion Adults	1,294,358	438,074	440,512	443,008	1,321,594
Medicaid Children	1,586,068	533,569	535,177	537,057	1,605,803

[3] As of January 1, 2022, the Family Planning program is no longer in the §1115 Waiver. As such, it has been removed from this report.

Eligibility Group	Total for Quarter Ending March 2022	Current Quarter Month 1 (April 2022)	Current Quarter Month 2 (May 2022)	Current Quarter Month 3 (June 2022)	Total for Quarter Ending June 2022
SSI/BD Adults	283,006	93,956	93,782	93,534	281,272
SSI/BD Children	70,858	23,834	23,922	24,085	71,841
Medically-Needy Adults	77,057	26,243	26,182	26,360	78,785
Medically-Needy Children	19,211	6,429	6,483	6,550	19,462
SOBRA Adults[4]	42,442	14,694	15,241	15,841	45,776
MCHP	376,590	126,731	127,044	127,440	381,215
MCHP Premium	101,934	33,740	33,604	33,515	100,859
PEPW	0	0	0	0	0
ICS	74	22	21	21	64
WBCCHP	166	56	56	56	168

Outreach/Innovative Activities

Residential Treatment for Individuals with Substance Use Disorders (SUD) and SMI

Effective July 1, 2017, the Department began providing reimbursement for up to two nonconsecutive 30-day stays annually for American Society of Addiction Medicine (ASAM) levels 3.7D, 3.7, 3.5 and 3.3. Effective January 1, 2019, the Department extended coverage for up to two nonconsecutive 30-day stays annually for ASAM 3.1 and for up to 15 days per month for ASAM 4.0. Effective January 1, 2020, the Department extended coverage for dual eligibles.

The Department received approval of its SUD monitoring protocol during the previous quarter. For more information, please refer to the SUD Monitoring Report.

Maternal Opioid Misuse (MOM) Model

The Department launched its MOM model in January 2020, with funding from the Center for Medicare and Medicaid Innovation (CMMI) and in collaboration with the Centers for Medicare and Medicaid Services (CMS). The MOM model focuses on improving care for pregnant and postpartum Medicaid participants diagnosed with opioid use disorder (OUD). With over 21,000 individuals of childbearing age diagnosed with an OUD in Maryland, substance use is a leading cause of maternal death and has a significant impact on the approximately 1,500 infants born to Medicaid beneficiaries with OUD in Maryland per year. Utilizing HealthChoice managed care organizations (MCOs) as care delivery partners, the MOM model focuses on improving clinical

[4] Substantive increases are observed over several MAGI demonstration populations, due to maintenance of effort requirements under the 2020 COVID-19 Public Health Emergency (PHE).

resources and enhancing care coordination to Medicaid beneficiaries with OUD during and after their pregnancies.

Under the Maryland MOM model, HealthChoice MCOs provide a set of enhanced case management services, standardized social determinants of health screenings and care coordination. Exact services and screenings were developed over the course of the MOM pre-implementation period (January 2020 - June 2021) and were refined during the MOM transition period (July 2021 - June 2022), which was the first year of model services. During this quarter, the Department continued participant enrollment, in addition to finalizing contracts between the MCOs and the St. Mary's County Health Department. Cooperative agreement funding from CMMI supported per member, per month payments to the MCOs to conduct the model intervention during Fiscal Year (FY) 2022. To continue the payments in FY 2022 forward, the Department included the MOM model as a new addition to the HealthChoice demonstration in the waiver renewal application submitted in late June.

Collaborative Care Model (CoCM) Pilot Program

The Department's CoCM Pilot Program began enrolling participants on July 1, 2020. The table below provides the member months enrollment for the previous quarter.

Table 3. CoCM Member Months by Pilot Site

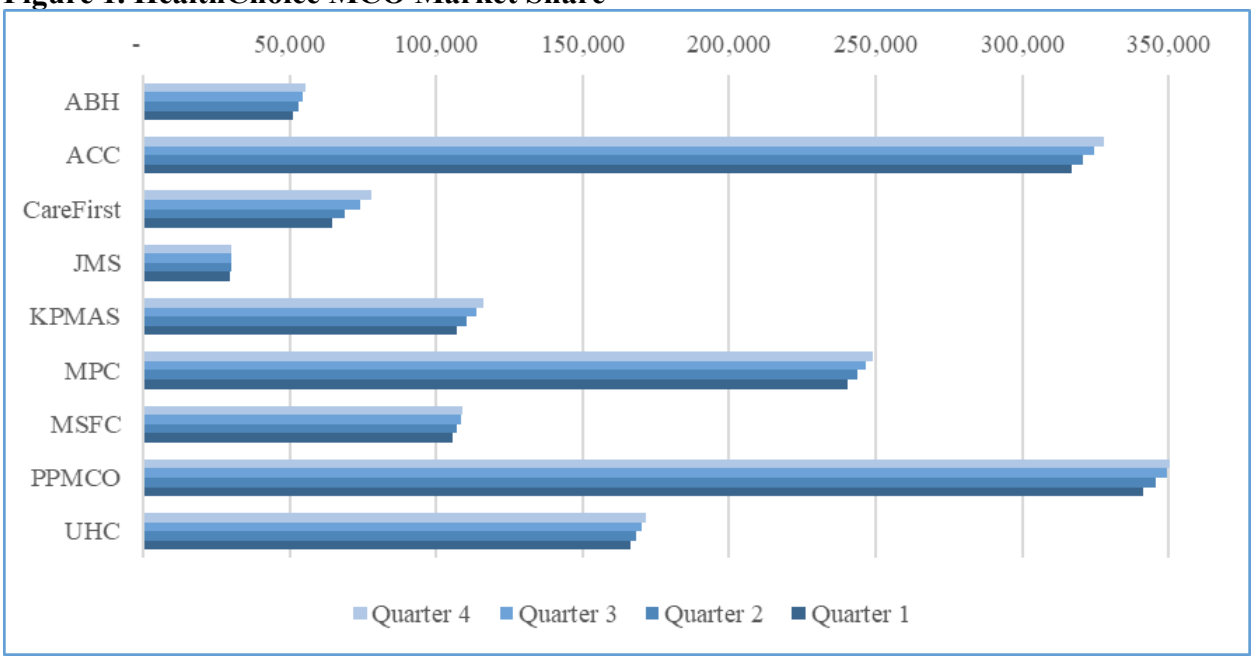
	April 2022	May 2022	June 2022	TOTAL
Urban	74	79	84	237
Rural	18	22	18	58
Ob/Gyn	12	12	11	35
TOTAL	**104**	**113**	**113**	**330**

Operational/Policy Developments/Issues

Market Share

As of the end of the last quarter of FY 2022, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (3.7 percent), Amerigroup (22.0 percent); CareFirst Community Health Plan of Maryland (5.2 percent); Jai Medical Systems (2.0 percent); Kaiser Permanente (7.8 percent); Maryland Physicians Care (16.7 percent); MedStar Family Choice (7.3 percent); Priority Partners (23.7 percent); and United Healthcare (11.5 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in April, May, and June of 2022. Due to COVID-19, all MMAC meetings were held via teleconference. These meetings covered a wide variety of topics, including general department updates, and waiver, state plan, and regulations changes.

During the April meeting, the MMAC was briefed on the events of the 2022 Maryland Legislative Session and bills relevant to Medicaid, an American Rescue Plan Act spending update, and the annual update on dental services.

During the May meeting, the MMAC was briefed on the §1115 Post-Award Forum and HealthChoice Evaluation.

During the June meeting, the MMAC was briefed on the PHE Unwinding, health data utility, and the Maryland Primary Care Program.

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 4. Current REM Program Enrollment

FY 2022	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	206	189	50	99	4,478
Quarter 2	206	136	35	69	4,496
Quarter 3	239	217	48	102	4,511
Quarter 4	218	163	47	73	4,560

Table 5. REM Complaints

FY 22 Q4 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	2	0	2
Dental	0	0	0
DMS/DME	0	0	0
EPSDT	0	0	0
Clinical	0	0	0
Pharmacy	1	0	1
Case Mgt.	0	1	1
REM Intake	0	0	0
Access to MA Providers	2	0	2
Nursing	5	0	5
Other	1	0	1
Total	11	1	12

Table 6 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 6. REM Incidents Reported by Case Managers

FY 22 Incidents	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Abandonment	0	0	0	**0**
Abuse	4	4	4	6
Complaint	14	19	19	12
Death	15	16	26	21

FY 22 Incidents	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Elopement	0	0	0	2
ER	0	0	1	0
Exploitation	0	0	0	0
Failure to Follow Plan (Non-Compliance)	0	1	1	0
Fall	1	1	0	0
Hospitalization	2	4	16	2
Medication Error	1	2	1	0
Neglect	10	8	12	5
Suicidal Ideation	2	2	0	0
Theft	0	0	0	0
Wound	0	0	0	1
Other	22	17	17	13
Total	**71**	**74**	**97**	**62**

Increased Community Services (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 2022, 21 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, 2022, the Premium program had 33,515 participants, with MCHP at 127,440 participants.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Throughout FY 2022, the Department continued to focus on implementing the HealthChoice DPP, and continued to convene MCOs through implementing the Coverage 2.0-Part 4: Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle Change Program (Coverage 2.0-Part 4) grant. The purpose of this grant, funded by the Centers for Disease Control

and Prevention (CDC) through the National Association of Chronic Disease Directors (NACDD), has been to continue sustainability work begun in the Medicaid and National DPP demonstration, which involved four of Maryland's nine MCOs, and which subsequently expanded to include all nine MCOs as the Department implemented the HealthChoice DPP benefit statewide. During the Coverage 2.0-Part 4 grant period, all participating nine MCOs continued to show efforts in supporting HealthChoice DPP benefit implementation, system operationalization and refinement, as well as enrollment. The Department also continued to focus on supporting use of the Chesapeake Regional Information System for our Patients (CRISP)—Maryland's Health Information Exchange (HIE)—referral tools to increase identification and referral of potentially eligible members to MCOs, for connecting to in-network DPP providers.

At the request of the Department, The Hilltop Institute (Hilltop) periodically reported on the number of HealthChoice members enrolled in the HealthChoice DPP. As per the most recent report (May 4, 2022), Hilltop identified 568 encounters with DPP procedure codes and provided by Medicaid-enrolled DPP providers to 104 unique participants between September 1, 2019 and April 30, 2022. Among the 104 unique Medicaid beneficiaries with a DPP encounter, most were women (80%), Black/African American (63%), and resided in Prince George's County (46%). Most (93%) beneficiaries were in the Families and Children Medicaid coverage group. Services were provided by six unique DPP providers: Mid-Atlantic Permanente Medical Group, associated with the MCO Kaiser Permanente; the Continuum Wellness Center; Garrett Regional Medical Center; Omada Health; Taylored 4 Life; and Welldoc, Inc. The number of encounters per participant ranged from one to 26. The majority of beneficiaries had four or fewer encounters.

Throughout the year, the Department participated at various forums, learning collaborative sessions, webinars and conferences and discussed the work related to the Medicaid Demonstration Project, its benefits and challenges as well as information and lessons learned on MCO engagement and partnerships with Public Health. Most recently, the Department participated at NACDD's General Member Webinar titled *Making an Impact on Population Health: Utilizing a State-wide Health Information Exchange to Promote the National Diabetes Prevention Program* on June 9, 2022. The Department presented at the webinar along with CRISP and provided an overview of the work as well as discussed Maryland's population health focus on improving Body Mass Index (BMI) with the goal of decreasing diabetes. Additionally, the Department hosted monthly HealthChoice DPP Coverage 2.0 meetings with the MCOs throughout the year which provided an opportunity for information sharing and progress of the HealthChoice DPP benefit between the Department and the nine MCOs.

CDC-recognized lifestyle change programs with pending, preliminary or full recognition status continued to apply to become Maryland Medicaid DPP providers through the online provider portal known as ePREP. As of the end of the year, 36 unique DPP providers were fully enrolled and 16 of these are contracted with MCOs. MCOs continued efforts to contract with eligible DPP providers, expand their DPP provider network capacity, and prepare member and provider materials.

The Department continued this year to work with CRISP to refine the prediabetes flag within CRISP, and CRISP continues to produce monthly reports to MCOs containing the panels of their

members who received the flag, enabling further follow-up with members. In addition, the Department worked with CRISP and MCOs on the CRISP eReferral tool, and refined referral processes.

The Department has made the decision to not apply to continue to administer the HealthChoice Coverage 2.0-Part 5 grant due to capacity limitations. Internal discussions are underway to determine the way forward for this grant opportunity to continue to support the work on HealthChoice DPP benefit.

Community Health Pilots

Six local government entities participate in the Community Health Pilots (CHP). Four Lead Entities (LEs) participate in the Assistance in Community Integration Services (ACIS) Pilot and two LEs in the Home Visiting Services (HVS) Pilot. During this reporting period, CHP LEs continued a hybrid of in-person and telephonic service delivery to remain agile throughout the ongoing COVID-19 crisis. For ACIS Pilots, this included continuation of service provision via telecommunications methods when necessary. For HVS Pilots, LEs follow the Healthy Families America model guidance, which allows service provision via telecommunication methods. LEs continued to deal with complications due to the ongoing PHE.

HVS LEs had a combined family enrollment of approximately 146 member months during Q4. They continue to pursue strategies to meet the needs of families in between home visits. HVS LEs have also begun their re-accreditation work for the next HFA accreditation cycle. Staff at LE sites have been completing courses aimed to improve cultural competence and sensitivity training.

FY 2022 Q4 was the last active quarter for the HVS Pilot. HVS is now a covered Medicaid benefit in Maryland. HVS LEs and the Department have completed the programmatic transition in order to continue to deliver services in this new authority.

As of June 2022, a total of 756 member months were completed throughout the quarter for the ACIS Pilot. LEs continue to improve processes related to pilot enrollment, such as using the Medicaid Eligibility Verification System, partnering with local community organizations, and implementing best practices for working with ACIS-enrolled participants.

As required by the terms of the Pilot, the Department and ACIS LEs (alongside their partners) underwent contract negotiations for establishing the unit rate for services for FY 2023. Each of the ACIS LEs budgets were submitted and approved. Additionally, two LEs applied and were approved by the Department for additional ACIS participants to begin in FY 2023 Q1. The increase in allotment of ACIS participants was accompanied with additional vouchers from their local housing authorities to locate housing placements for ACIS participants. In the prior quarter, ACIS LEs have expressed concern at increasing rental prices and continue searching for more local housing partners to meet their participants' needs. This concern has remained problematic.

The Department continues to accept any new ACIS pilot applications or expansions from current ACIS sites on a rolling basis. Lead local government entities are encouraged to apply for the remaining statewide ACIS beneficiary spaces.

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. The Hilltop Institute works with the Department's contracted actuarial firm, Optumas, and the Department's contracted accounting firm, Myers & Stauffer (M&S).

HealthChoice Financial Monitoring Report (HFMR)

During January 2022, Hilltop participated in entrance meetings with each MCO along with M&S to discuss the 2020 HFMR and 2020 MLR audits. Hilltop requested corrections to the HealthChoice Financial Monitoring Reports (HFMRs) to the MCOs and fielded questions regarding the 2020 risk corridor from M&S. Hilltop convened a meeting with HSCRC and Optumas staff to plan for trend analyses. Annual financial statement reports for 2021 were requested of the Maryland Insurance Administration (MIA) under the public information act. A monthly data template was constructed and shared with the Department and Optum, the Department's behavioral health administrative services organization (ASO), to monitor behavioral health data for use in assigning risk adjustment categories (RACs) at the member level. Also, claim rejection codes were analyzed at the MCO- and year- level to aid in clarifying data elements needed from MCOs for claims to be processed.

During April 2022, Hilltop participated in exit meetings with each MCO along with M&S to discuss the 2020 HFMR and 2020 MLR audits. The audit reports for the 2020 HFMRs came in on April 29, 2022 and were analyzed, aggregated, and shared with the MCOs by Hilltop. The result of the audit was a reduction in claims of $58M and an increase in revenue of $17M. The initial 2021 HFMRs were reported by the MCOs on May 17, 2022, and were analyzed, aggregated, and shared with the MCOs by Hilltop. Some of the analyses included gain/loss detail by MCO, region, and rate cell.

The 2020 risk corridor calculations were finalized by Hilltop and reviewed by Optumas. The audit by M&S had a significant impact in bringing the amount paid back to the State from $97 million to $106 million. To check the assignment of members to RACs, 100 members were randomly chosen to trace their ACG-based mapping to a rate cell.

MCO Rates

CY 2023 Rate Setting

The Department and Hilltop held three monthly meetings with the MCOs on April 27, May 25, and June 29, 2022. Topics covered included relevant bills under consideration during the legislative session, regional profitability differences, and HIV and AIDS drug cost tracking. Several meetings with the Department, Optumas, and the MCOs were held regarding Hepatitis C leading to a change in methodology for 2023. The final payback from MCOs to the State for

2021 was $59 million. For context, financial results for 1Q22 were gathered by Hilltop from quarterly financial statements and shared with the Department and MCOs. The YTD gain/loss, excluding Kaiser, was 3.9 percent.

Hilltop gathered data related to third party liability (TPL) recoveries in support of the Department's safety net billing initiative. One MCO postulated that acuity will be higher in 2023 because the pandemic kept members away from their doctors and from preventive care and early detection. Hilltop tested this theory with available data and shared it with the MCOs.

Hilltop convened the HSCRC, Department, Optumas, and the MCOs in May and June to discuss trends, hospital cost trends in particular.

CY 2022 HealthChoice Rates (and Prior)

Hilltop quantified the impact of Medicare's (MC) changes to their CY 2022 "evaluation and management" (E&M) fees. Medicaid (MA) moved its reimbursement from approximately 93 percent of MC to 100 percent effective on July 1, 2022, contributing to midyear rate adjustment.

Other Rate Setting Team Activities

Hilltop provided the Department with quarterly trauma payments for 2022 for each MCO, analyzed denied claims reports by MCO from the HSCRC, updated the "graduate medical education" (GME) discount for teaching hospitals, and updated its list of "high cost, low utilization" drugs with an annual cost exceeding $400,000.

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).

The Department is currently updating internal reports in order to be able to update its budget neutrality reports. Per an email sent to CMS on February 28, 2022, the Department would like to continue its extension request for budget neutrality reports.

Consumer Issues[5]

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. The Help Line received 118,551 calls and emails in FY 2022. 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, how to access carved-out services, or services covered by Medicaid on a FFS basis.

[5] This report presents data for FY 2022 excluding October through December 2021. This data is unavailable due to a security incident in December 2021. Help Line data indicates cases for each month of FY2022.

When a consumer experiences a medically-related issue, such as difficulty getting appointments with a specialist, getting a prescription filled, or getting a service pre-authorized, the call is classified as a complaint. Complaints are referred to the State's Complaint Resolution Unit (CRU), which is staffed with registered nurses. If necessary, the CRU engages a local Ombudsman, who is stationed at the county-level health departments and has the ability to meet with the member face-to-face. If the MCO has issued a denial letter to a member and the member wishes to appeal the decision through the MCO, or if a member disagrees with the MCO's appeal decision and wishes to request a State Fair Hearing, the CRU will assist the member with these processes.

MCOs receive a complaint report each quarter so that they can monitor their performance in terms of the member complaint case handled by the HealthChoice Help Line. This report breaks down the complaints by type and by region. When needed, the Department meets with an MCO to discuss the report findings.

Table 7. Total Recipient Complaints[6] - FY 2022

CMS Quarterly Report
Total Recipient Complaints - excluding Billing
FY 22 vs FY 21

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		2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
Specialist	#	51	150	62	171	9	17	56	91	79	160	38	87	39	136	50	178	42	73	426	1063
	%	12%	14%	15%	16%	2%	2%	13%	9%	19%	15%	9%	8%	9%	13%	12%	17%	10%	7%	17%	28%
Prenatal	#	17	52	85	76	4	7	67	74	42	55	29	45	52	86	54	70	27	23	377	488
	%	5%	11%	23%	16%	1%	1%	18%	15%	11%	11%	8%	9%	14%	18%	14%	14%	7%	5%	15%	13%
Pharmacy	#	24	12	18	49	4	5	10	19	39	126	12	40	36	93	100	132	20	19	263	495
	%	9%	2%	7%	10%	2%	1%	4%	4%	15%	25%	5%	8%	14%	19%	38%	27%	8%	4%	10%	13%
PCP	#	50	176	108	229	11	19	73	100	119	169	41	81	93	147	102	210	67	69	664	1200
	%	8%	15%	16%	19%	2%	2%	11%	8%	18%	14%	6%	7%	14%	12%	15%	18%	10%	6%	26%	31%
Sub Totals	#	142	390	273	525	28	48	206	284	279	510	120	253	220	462	306	590	156	184	1,730	3,246
	%	8%	12%	16%	16%	2%	1%	12%	9%	16%	16%	7%	8%	13%	14%	18%	18%	9%	6%	68%	84%
All Complaint Totals	#	194	395	420	603	37	62	241	318	458	665	161	310	403	594	427	694	196	210	2,537	3,851
	%	8%	10%	17%	16%	1%	2%	9%	8%	18%	17%	6%	8%	16%	15%	17%	18%	8%	5%	100%	100%
Other Categories		52	5	147	78	9	14	35	34	179	155	41	57	183	132	121	104	40	26	807	605

*Name Change as of 2/1/2021: UMHP into CareFirst BlueCross BlueShield Community Health Plan of MD (CareFirst CHPMD)
10/10/2017: the New CRM was launched
10/23/2017: Aetna Better Health was launched
Source: CRM

[6] Billing not included.

There were 2,537 total MCO recipient complaints in the fiscal year 2022 (all ages). Sixty-eight percent of the complaints (1,730) were related to access to care. The remaining 32 percent (807) were billing complaints. The top three member complaint categories were accessing primary care providers (PCPs), specialist, and prenatal. The categories not specified (Other Categories) for the non-billing complaints include appeals and grievances, access to therapies (occupational therapy-OT, physical therapy-PT, and speech therapy-ST), adult dental and vision services, and obtaining DME/DMS (Durable Medical Equipment/Durable Medical Supplies). Overall, Amerigroup, Maryland Physicians Care, and United Healthcare had the highest percentage of complaints in this fiscal year, which was mainly attributed to difficulty accessing PCPs.

Prenatal complaints comprised fifteen percent of total complaints during the fiscal year. All pregnant women were connected with an MCO network prenatal care provider and referred to Administrative Care Coordination Units (ACCUs) at the local health department for follow-up and education. In addition, pregnant women called the Help Line for general information. However, due to phone line issues there was no way to calculate the number of calls from pregnant women from September 2021 to June 2022. These women were also referred for follow-up and education.

Table 8. Recipient Complaints Under Age 21[7] - FY 2022

CMS Quarterly Report
Total Recipient Complaints - excluding Billing: Under age 21 only
FY 22 vs FY 21

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		2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
PCP	#	15	36	37	52	5	5	37	29	26	40	8	15	23	41	22	42	25	16	198	276
	%	8%	13%	19%	19%	3%	2%	19%	11%	13%	14%	4%	5%	12%	15%	11%	15%	13%	6%	39%	51%
Specialist	#	14	9	19	26	1	2	27	28	13	23	9	9	8	15	18	30	5	9	114	151
	%	12%	6%	17%	17%	1%	1%	24%	19%	11%	15%	8%	6%	7%	10%	16%	20%	4%	6%	23%	28%
Pharmacy	#	1	1	1	7	1	0	1	1	4	12	1	4	8	7	15	9	2	0	34	41
	%	3%	2%	3%	17%	3%	0%	3%	2%	12%	29%	3%	10%	24%	17%	44%	22%	6%	0%	7%	8%
Prenatal	#	1	1	8	3	0	0	2	2	1	0	3	1	6	2	3	1		1	24	11
	%	4%	9%	33%	27%	0%	0%	8%	18%	4%	0%	13%	9%	25%	18%	13%	9%	0%	9%	5%	2%
Sub Totals	#	31	47	65	88	7	7	67	60	44	75	21	29	45	65	58	82	32	26	370	479
	%	8%	10%	18%	18%	2%	1%	18%	13%	12%	16%	6%	6%	12%	14%	16%	17%	9%	5%	100%	100%
All EPSDT Complaint Totals	#	37	47	99	94	8	8	73	65	75	86	28	41	78	77	70	90	36	29	504	537
	%	7%	9%	20%	18%	2%	1%	14%	12%	15%	16%	6%	8%	15%	14%	14%	17%	7%	5%	100%	100%
Other Categories		6	0	34	6	1	1	6	5	31	11	7	12	33	12	12	8	4	3	134	58

*Name Change as of 2/1/2021: UMHP into CareFirst BlueCross BlueShield Community Health Plan of MD (CareFirst CHPMD)
10/10/2017: the New CRM was launched
10/23/2017: Aetna Better Health was launched
Source:CRM

There were 504 member complaints (non-billing) for recipients under age 21 in FY 2022, or

[7] Billing not included.

twenty percent of the total complaints. The top complaint category was access to primary care providers (PCPs). Amerigroup, Maryland Physicians Care, and Priority Partners were major contributors to the complaints for recipients under age 21.

The analysis of complaints by adults versus children (under 21) revealed that access to care is the main issue for both adults and children. Adults and children (under 21) most often report difficulty accessing a primary care provider followed by difficulty accessing a specialist.

Table 9. Total Recipient Billing Complaints - FY 2022

CMS Quarterly Report
Total Recipient Complaints - Billing only
FY 22 vs FY 21

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		2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
PCP	#	8	9	20	15	0	1	8	9	19	19	4	4	14	6	11	4	7	1	91	68
	%	9%	13%	22%	22%	0%	1%	9%	13%	21%	28%	4%	6%	15%	9%	12%	6%	8%	1%	28%	29%
Emergency	#	5	6	16	11	2	0	16	11	19	6	5	4	20	10	7	5	4	3	94	56
	%	5%	11%	0%	20%	0%	0%	0%	20%	0%	11%	0%	7%	0%	18%	0%	9%	0%	5%	29%	24%
Laboratory /Test	#	1	2	13	4	0	0	2	2	14	13	8	1	3	8	8	5	3	1	52	36
	%	2%	6%	25%	11%	0%	0%	4%	6%	27%	36%	15%	3%	6%	22%	15%	14%	6%	3%	16%	16%
Specialist	#	1	4	8	4	0	1	5	3	4	6	3	4	5	8	8	5	2	1	36	36
	%	3%	11%	22%	11%	0%	3%	14%	8%	11%	17%	8%	11%	14%	22%	22%	14%	6%	3%	11%	16%
Sub Totals	#	15	21	57	34	2	2	31	25	56	44	20	13	42	32	34	19	16	6	273	196
	%	5%	11%	21%	17%	1%	1%	11%	13%	21%	22%	7%	7%	15%	16%	12%	10%	6%	3%	83%	85%
All Billing Complaint Totals	#	15	24	66	36	2	2	37	27	60	55	22	14	61	39	45	27	19	7	327	231
	%	5%	10%	20%	16%	1%	1%	11%	12%	18%	24%	7%	6%	19%	17%	14%	12%	6%	3%	100%	100%
Other Categories		0	3	9	2	0	0	6	2	4	11	2	1	19	7	11	8	3	1	54	35

*Name Change as of 2/1/2021: UMHP into CareFirst BlueCross BlueShield Community Health Plan of MD (CareFirst CHPMD)
10/10/2017: the New CRM was launched
10/23/2017: Aetna Better Health was launched
Source: CRM

Enrollee billing complaints comprised thirteen percent of total MCO complaints in FY 2022. Overall, the top bill type was emergency related billing issues followed closely by primary care providers, which comprised 29 percent and 28 percent, respectively, of all MCO billing complaints. Other categories are the billing complaints related to inpatient services, urgent care centers, DME/DMS, therapies, pharmacy, and optional services such as adult dental and vision. Amerigroup had the highest percentage of billing complaints.

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 ACCUs 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

The Maryland General Assembly convened its 2022 session on January 12, 2022 and it adjourned on April 11, 2022. The following bills that affect Maryland's Medicaid program were enacted during this year's session:

- **HB 6/SB 150** (Md. Medical Assistance Program – Dental Coverage for Adults) requires Medicaid coverage of dental services (including diagnostic, preventive, restorative and periodontal services) for adults below 133 percent of poverty, beginning Jan. 1, 2023.
- **HB 413** (Health Insurance – Individual Market Stabilization – Extension of Provider Fee) continues stabilization of individual market by extending to CY 2028 the assessment of a health insurance provider fee (including MCOs).
- **HB 544/SB 600** (Health Facilities – Residential Service Agencies (RSAs) – Reporting Requirement) requires RSAs that receive Medicaid reimbursement for home care provided by personal care aides to report annually by Oct. 1 on the number of personal care aides classified by the RSA as employees and independent contractors; by July each year, the Department must create a report concerning Medicaid reimbursement rates, the cost of delivering services and aggregated employment classifications of individuals who provide personal care.
- **SB 19/HB 229** (Pharmacists – Administration of Injectable Medications for Treatment of STIs) requires that the Maryland Medicaid program and the Maryland Children's Health Program cover injectable medications for the treatment of STIs.
- **HB 684** (Md. Medical Assistance Program – Psychiatric Inpatient Care – Admissions Restrictions (Psychiatric Hospital Admissions Equity Act)) prohibits the Department from limiting or restricting admission of a Medicaid enrollee for inpatient care at a specialty psychiatric hospital or an acute general care hospital that has separately identified inpatient psychiatric service unless it is based on medical necessity or it is established in regulation; report of average length-of-stay due each year beginning July 1, 2024.
- **HB 970** (MCOs & Health Insurance Carriers – Prior Authorization for HIV Post-Exposure Prophylaxis – Prohibition) prohibits MCOs and commercial insurers from applying a prior authorization requirement for prescription drugs used as post-exposure prophylaxis for the prevention of HIV.
- **HB 1080** (Md. Medical Assistance Program - Children & Pregnant Women (Healthy Babies Equity Act)) requires Medicaid coverage for comprehensive medical care and other health care services to non-citizen pregnant women who would qualify for the program but for their immigration status and their children up to one year of age.
- **SB 28** (Home- & Community-Based Services Waiver – Participation & Applications) requires HCBS Options waiver to include at least 7,500 participants; the Department must send waiver applications to all individuals on the waiting list if there are fewer than 600 on the list, and to at least 600 individuals if there are more than 600 on the list. The Department must apply for 1915(c) waiver by Oct. 31, 2022 to increase waiver cap size to be consistent with the bill.

- **SB 166/HB 669** (Md. Medical Assistance Program – Doula Services – Coverage) requires doulas providing services under Medicaid to meet certification requirements and are authorized by the Department to provide services to Medicaid enrollees; the Department must review the participation of doulas in the Medicaid program and evaluate the effectiveness of doula services covered by the program; services are to be reimbursed at a rate equal to the lesser of the customary charge the provider charges to the general public (unless the services are free to individuals not eligible for the program), or the program's fee schedule.
- **SB 207** (Insurance Carriers & MCOs – Cybersecurity Standards) requires insurers (including MCOs) to develop, implement, and maintain a comprehensive written information security program based on their risk assessment program.
- **SB 244/HB 534** (Md. Medical Assistance Program – Self-Measured Blood Pressure Monitoring) requires Medicaid coverage for self-measured blood pressure monitoring for all enrollees diagnosed with uncontrolled high blood pressure, including the provision of validated home blood pressure monitors and reimbursement of providers and other staff time for patient training, transmission of blood pressure data, interpretation of readings and reporting and the delivery of co-interventions (i.e., educational materials or classes, behavioral change management and medication management), effective Jan. 1, 2023.
- **SB 295** (Md. Medical Assistance Program – Emergency Service Transporters – Reimbursement) requires reimbursement for EMS transporters for the cost of transportation and medical services to increase by $50 in FY 2023 and remain at that level for each subsequent fiscal year; also requires reimbursement for mobile integrated health services at a rate of at least $100 (to increase by $50 in FY 2023 and remain at that level for each subsequent year); the Department will report by Nov. 1, 2024 on adequacy of the rate of reimbursement.
- **SB 323/HB 578** (Public Health –Medications to Treat an Opioid Use Disorder – Preferred & Non-Preferred Medications) requires the Department to adopt a reporting system to monitor the prescribing of medications to treat opioid use disorders; the Department must also analyze patterns of prescribing medications, conduct outreach and identify barriers related to prescribing medications to treat OUD and report annually by Oct. 1 on findings.
- **SB 350/HB 1005 (**Md. Medical Assistance Program – Community Violence Prevention Services) requires Medicaid program to provide community violence prevention services beginning July 1, 2023 to enrollees who have been exposed to community violence or have a personal history of injury sustained as a result of community violence and have been referred by a health care or social services provider to a certified violence prevention professional to receive community violence prevention services.
- **SB 527** (Elderly Individuals – Howard County & Montgomery County Adult Day Health Care Services Pilot Program & Task Force) establishes a pilot program to integrate the provision of medical adult day care services, health care services and medical services provided under Medicaid and authorizes counties to jointly authorize the operation of one or more integrator entities to coordinate the services provided under the pilot program.
- **SB 531/HB 636** (Md. Health Care Commission – Assisted Living Programs – Study) requires the Health Care Commission, in consultation with Medicaid, OHCQ, the Md. Long-Term Care Ombudsman, the Governor's Workforce Development Board and interested stakeholders to study the quality of care in assisted living programs with nine or fewer beds.

- **SB 636** (Md. Dept. of Health – Waiver Programs – Wait-List Reduction (End the Wait Act)) requires the Department to develop a plan to reduce the waitlist for its waiver programs by 50 percent beginning in FY 2024 (plans to be submitted to General Assembly by Jan. 1, 2023); beginning with FY 2024. the Governor must include sufficient funds in the annual budget submission to carry out this requirement.
- **SB 868/HB 1020** (DDA – Self-Directed Services (Self-Direction of Services Act of 2022)) requires DDA (in consultation with stakeholders) to establish and provide training materials to coordinators of community services on self-directed services, including training materials on self-directed services policies and resources; DDA must provide any support broker services, and may not establish a limit on the dollar amount of individual-directed family goods and services provided to an enrollee or the number of hours of overnight supports provided to an enrollee who receives self-directed services; the State may not require an enrollee to demonstrate competency before DDA authorizes them to receive self-directed services; DDA must provide 40 hours of support broker services each month that are authorized under guidance issues by CMS under §1915(c); DDA must submit an amendment to CMS on the Community Pathways Waiver that includes overnight supports requirements by Jan. 1, 2023.

Quality Assurance/Monitoring Activity

The Medical Benefits Management Administration (MBMA) is responsible for contracting and oversight of the HealthChoice program within the Department MBMA ensures compliance with the initiatives established in 42 CFR 438, Subpart D, and that all MCOs that participate in the HealthChoice program apply these principles universally and appropriately. The functions and infrastructure of MBMA support efforts to identify and address quality issues efficiently and effectively. Quality monitoring, evaluation, and education through enrollee and provider feedback are integral parts of the managed care process and help to ensure that health care is not compromised. The Division of HealthChoice Quality Assurance (DHQA) within MBMA is primarily responsible for coordinating quality activities and monitoring CMS quality improvement requirements for the HealthChoice program.

The Department contracts with three vendors for its quality assurance activities:
- Qlarant Quality Solutions, Inc. (Qlarant) is the external quality review organization (EQRO) for the Department. Qlarant is responsible for performance improvement project validation; performance measure validation for the Value-Based Purchasing Initiative; compliance reviews to ensure MCOs comply with 42 CFR 438, Subpart D and 42 CFR 438.330; MCO network adequacy validation; encounter data validation; clinical quality studies focused on MCO appeals, grievances, and pre-service denials; and development of an annual consumer report card to assist HealthChoice enrollees with MCO selection.
- MetaStar, Inc. (MetaStar) is the HEDIS Compliance Auditor for the Department. MetaStar is responsible for ensuring compliance with the National Committee for Quality Assurance (NCQA) guidelines for reporting Healthcare Effectiveness Data and Information Set (HEDIS) measures, including onsite audits of MCO systems and processes to report data. MetaStar also reviews and approves the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey sample frame. At the end of the audit cycle, MetaStar compiles a comprehensive report with trending MCO performance on the HEDIS measures.

- Center for the Study of Services, Inc. (CSS) is the survey administration vendor for the Department. CSS administers the CAHPS surveys for adults and children, as well as the Primary Care Provider (PCP) Satisfaction Survey. CSS monitors compliance with survey protocols and compiles reporting on the results of both survey efforts.

Consistent with updates in earlier reports, the Department is actively adjusting reporting and record collecting due to COVID-19.

An update on quality assurance activity progress appears in the next chart.

Activity	Vendor	Status	Comments
Systems Performance Review (SPR)	Qlarant	In Progress	Qlarant finalized individual comprehensive calendar year (CY) 2021 MCO reports for the Department's review and approval in May 2022. The CY 2021 SPR Executive Summary is currently being drafted for the Department's review and approval. The draft CY 2022 Standards and Guidelines and the draft CY 2022 Orientation Manual are in development for the next comprehensive review.
EPSDT Medical Record Review	Qlarant	Complete	Qlarant finalized the CY 2020 EPSDT Aggregate report and received the Department's approval in March 2022. Results were disseminated to the MCOs in March 2022. Highlights are listed below. The Department approved the CY 2021 methodology as well as the CY 2021 EPSDT orientation manual in March 2022. The CY2021 EPSDT orientation manual was disseminated to the MCOs in March 2022. Qlarant conducted their nurse reviewer training, received the requested data sample frame from Hilltop, and requested medical records from provider offices via fax and MCOs (where appropriate).
Consumer Report Card (CRC)	Qlarant	Complete	Qlarant submitted blinded results for MCOs review and finalization in March 2022. Qlarant finalized the CY 2022 CRC in April 2022 (please see hyperlink to the document below).
Performance Improvement Projects (PIPs)	Qlarant	Complete	Qlarant reviewed March, June and December quarterly Lead PIP submissions from the MCOs and those were submitted to the Department for review and approval. Annual MCO reporting submissions for the Asthma Medication Ratio and the Lead PIPs were reviewed by Qlarant for development of the annual report in September 2021. The 2021 Annual PIP report was reviewed and approved by the Department in January 2022 and disseminated to the MCOs.
Encounter Data Validation (EDV)	Qlarant	In Progress	Qlarant submitted the draft CY 2021 orientation manual, the sample data request, and the provider medical request letters for the CY2021 reviews for Department review and approval in June 2022. The Department approved the CY 2021 orientation manual and Qlarant disseminated it to the MCOs in June 2022.
Network Adequacy Validation (NAV)	Qlarant	In Progress	The final CY 2021 NAV report was reviewed and approved in November 2021 and disseminated to the MCOs. For the CY 2022 activity, Qlarant conducted their surveyor and validator training in May 2022 and started conducting the activity on June 1, 2022.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	Complete	Qlarant finalized the Quarter 1 reporting for GAD in May 2022. Highlights are listed below. The next quarterly report, Quarter 2, will be due in August 2022 for review by Qlarant.

Activity	Vendor	Status	Comments
HEDIS Audits and Reporting (HEDIS)	MetaStar	In Progress	Maryland MCOs have historically had high performance in their HEDIS rates. For HEDIS measurement year (MY) 2020, COVID-19 caused performance to decrease across multiple measure domains, primarily for access to care, prevention, and screening measures. In addition, it should be noted that due to COVID-19, NCQA allowed MCOs to rotate hybrid measure rates using HEDIS 2019 audited results for reporting in HEDIS MY 2020. Therefore, some HEDIS MY 2020 hybrid rate changes appear to be even more significant than what they may have been if hybrid rotation had not been allowed for HEDIS MY 2020.
Value Based Purchasing Initiative (VBP)	Qlarant	Complete	Qlarant finalized the annual CY 2020 VBP report in February 2022 and received the Department's approval in March 2022. Highlights of this activity include: The impact of the COVID-19 public health emergency during CY 2020 significantly impacted VBP rates for most MCOs. Two MCOs (JMS and KPMAS) achieved the incentive range for CY 2020 performance measure reporting (7/9 and 3/9, respectively). The remaining MCOs scored in the neutral range or disincentive range for the CY 2020 performance measure reporting.
CAHPS Survey Administration (CAHPS)	CSS	Complete	In CY2021, the CAHPS® 5.1H Medicaid Adult and Child Member Satisfaction Surveys were mailed to enrollees to collect MY 2020 data. The final aggregated survey sample for the HealthChoice organizations included 12,150 adult members. During the survey fielding period, 1,928 sample members completed the survey, resulting in a response rate of 16 percent. For child members, the final overall survey sample for the HealthChoice MCOs included 30,352 members (14,850 from the general population and 15,502 from the CCC population). During the survey fielding period, 3,822 general population sample members completed the survey, resulting in a response rate of 26 percent.
PCP Satisfaction Survey Administration	CSS	Complete	The PCP Satisfaction Survey for CY 2021 (i.e., MY 2020) included PCPs from each of the nine HealthChoice MCOs that participate in Maryland's HealthChoice program. The PCPs were asked to rate their satisfaction with a specified MCO that they participate with through questions from a variety of composite categories. The final survey sample included 7,597 physicians enrolled in the HealthChoice program. 1,049 physicians completed the survey, resulting in the adjusted response rate of 15 percent.
Annual Technical Report (ATR)	Qlarant	Complete	The Annual Technical Report was submitted to CMS by the deadline of April 30, 2021. CMS provided recommendations to meet compliance and the Department addressed those concerns in June 2022. Qlarant is currently developing the draft template for the Annual Technical Report for the upcoming measurement year.

Completed Activity Highlights:

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

- The activity consisted of the assessment of over 2,667 medical records with a minimum compliance threshold for each of the five indicators set at 80 percent.
- All MCOs met or exceeded the 80 percent minimum compliance threshold set by the Department for three of the five components. Additionally, all five component scores increased when comparing the CY 2020 scores to the CY 2019 scores. Health and Development History increased and Comprehensive Physical Exam increased by six and three percentage points, respectively. Laboratory Test/At-Risk Screenings and Immunizations increased 11 and 15 percentage points, respectively. Health Education/Anticipatory Guidance remained more consistent, having only increased by two percentage points.
- For CY 2020, the medical record review process was continued as a full desktop review due to the COVID-19 PHE which impacted all scoring areas, particularly Laboratory Test/At-Risk Screenings and Immunizations.

Consumer Report Card (CRC)

- The 2021 Consumer Report Card can be found by utilizing the following link: https://health.maryland.gov/mmcp/healthchoice/Documents/2021%20HealthChoice%20Consumer%20MCO%20Report%20Card%20%28English%29.pdf

Focused Reviews of Grievances, Appeals, and Denials (GAD) Annual Review

- The activity reviewed grievances, appeals, and denials from the final two quarters of calendar year 2020 and the first two quarters of CY 2021. The enrollee grievance assessment found that six MCOs (Amerigroup, CareFirst, Jai Medical Systems, Kaiser, Maryland Physicians Care, and MedStar Family Choice) met resolution timeframe requirements in all four quarters. Three MCOs (Aetna Better Health, Priority Partners, and United Healthcare) received one or more partially met findings. Analysis of the appeals for MCOs revealed that three MCOs (CareFirst, Jai, and Medstar) met appeal resolution timeframes for all four quarters. Two MCOs (Kaiser and Maryland Physicians Care) demonstrated compliance with appeal resolution timeframes for three quarters and two MCOs (Priority Partners and United Healthcare) demonstrated compliance for two quarters. Two MCOs (Aetna and Amerigroup) received a Partially Met for three quarters and an Unmet for one quarter with appeal resolution timeframes. Overall, assessment of the MCO denials continued to demonstrate relatively strong and consistent results.
- **The first quarter of GAD reporting was completed in May 2022.**
    - Grievances Highlights
        - Kaiser had the highest grievance rate per 1,000 members (4).
        - CareFirst and Amerigroup had the highest grievance rate per 1,000 providers (2.58 and 1.73, respectively).
        - All MCOs except Priority Partners met the 95 percent threshold for turnaround time (TAT) requirements for member and provider grievances.
    - Appeals Highlights
        - Priority Partners and Maryland Physicians Care had the highest appeal rate per 1,000 members (2.76 and 1.60, respectively).

        - Jai had the highest appeal overturn rate at 100 percent, although this represents only two appeals. MedStar had the next highest overturn rate (79 percent).
        - Aetna, CareFirst, Jai, and Priority Partners met or exceeded the TAT compliance threshold in all applicable categories.
    - Denial Highlights
        - Aetna and Maryland Physicians Care have the highest denial rates per 1,000 members (27 and 32, respectively).
        - Kaiser and MedStar continue to have the highest approval rates (93 percent and 91 percent, respectively).
        - TAT was met in all categories for determinations and notifications by all except Kaiser and MedStar (91 percent).

The Annual Technical Report (ATR)

- The ATR is a compilation of quality assurance activity reports for services and activities rendered during measurement years 2020 and 2021. The Department has listed highlights for each activity below. The full ATR can be found at: https://health.maryland.gov/mmcp/healthchoice/Documents/FINAL%20MD%202021%20ATR%20Report.pdf

HEDIS Audits and Reporting

- The full reporting and analysis can be found at: https://health.maryland.gov/mmcp/healthchoice/Documents/Statewide%20Analysis%20Report%20HealthChoice%20Participating%20Organizations%20HEDIS%c2%ae%20Measurement%20Year%20%28MY%29%202020.pdf

For HEDIS Measure Year (MY) 2020, Telehealth was added to some measure specifications, which may have helped to bump up measure rates so performance would not be quite so low. For example, telehealth was added to Statin Therapy for Patients with Diabetes (SPD), Antidepressant Medication Management (AMM), and Follow-up Care for Children Prescribed ADHD Medication (ADD). Telehealth was also added to the new Children and Adolescent Well-Care Visits (WCV) and Well-Child Visits in the First 30 Months of Life (W30) measures. Though no direct comparison can be made to the previous Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34), and Adolescent Well-Care Visits (AWC) measures, this change no doubt helped to boost rates where they may have substantially lower. In addition, although telehealth was added to the Ambulatory Care (AMB) outpatient indicator, utilization rates for all MCOs were down sharply.

There were several measures where eight of nine MCO rates were better than the National HEDIS Mean (NHM): Weight Assessment and Counseling for Physical Activity for Children (WCC-PA), Lead Screening in Children (LSC), Asthma Medication Ratio (AMR), Chlamydia Screening in Women (CHL) – Total, Prenatal and Postpartum Care (PPC)-Postpartum Care, and Use of Opioids From Multiple Providers (UOP) – Multiple pharmacies.

All MCOs scored above the NHM for Use of Imaging Studies for Low Back Pain (LBP).
The MCOs that were able to report ADD acute phase had a higher rate than the previous year with the addition of telehealth visits to the specifications and despite the impact of COVID. The

Maryland Average Reportable Rate (MARR) increased for several medication–related measures/indicators, such as AMR, SPD-80% Compliance, and Statin Therapy for Patients with Cardiovascular Disease (SPC)-80% Compliance. For AMR, the MARR increased from 65.1 percent to 68.6 percent. Two MCOs (Jai and Kaiser) scored above the NCQA 90th percentile benchmark.

For Breast Cancer Screening (BCS), the MARR decreased from 70.6 percent to 65.2 percent. However, three MCOs (Jai, Kaiser, and MedStar) scored above the 2020 NCQA 90th percentile benchmark. For Comprehensive Diabetes Care (CDC) HbA1c Control (<8%), the MARR decreased from 55.6 percent to 51.0 percent. However, two MCOs (Jai and Kaiser) scored above the 2020 NCQA 75th percentile.

CAHPS Survey Administration

Adult Survey

- Overall, the HealthChoice Aggregate performed on par with the 2020 levels across the measure spectrum, with no statistically significant improvements or declines in scores.
- At the plan level, there were relatively few statistically significant performance gains compared to the prior year across the measure spectrum. Similarly, almost none of the observed declines in performance reached statistical significance.
- HealthChoice exhibited a consistent positive directional trend on Getting Needed Care, Rating of Doctor, and Rating of All Health Care, and a consistent negative directional trend on Coordination of Care. Neither was statistically significant.
- On five measures, Rating of All Health Care, Rating of Health Plan, Rating of Specialist Seen Most Often, Rating of Personal Doctor, and Coordination of Care, HealthChoice scored in the bottom third of the 2021 NCQA Quality Compass Adult Medicaid percentile distribution. HealthChoice scored in the middle third on Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service.

Child Survey

- Overall, the HealthChoice Aggregate performed poorly, scoring in the bottom third of the 2021 NCQA Quality Compass Child Medicaid National distribution on most survey measures. The only exception in the non-CCC measures was Rating of Personal Doctor and Rating of All Healthcare. Rating of All Healthcare has trended upward over the past two years. However, the HealthChoice Aggregate still only placed in the middle third of the distribution on Rating of All Healthcare. The HealthChoice Aggregate scored poorly on Getting Needed Care, Getting Care Quickly and How Well Doctors Communicate, with all three measures experiencing statistically significant declines from the prior year.
- Among the CCC measures set, HealthChoice performed especially poorly on Getting Needed Information and Coordination of Care for Children with Chronic Conditions, with the former experiencing a statistically significant decline compared to the prior two years, and the latter experiencing a consistent negative two-year trend. While HealthChoice also earned relatively low overall scores on Personal Doctor Who Knows Child, Access to Prescription Medicines and Access to Specialized Services had variable performance from plan to plan.

Primary Care Provider Survey Administration

- Results from the PCP survey showed that overall satisfaction among PCPs with their MCO improved slightly for 2021 when compared to the 2020 results, but still down 2 percent from 2019 results. No significant statistical differences were observed when reviewing the results of the claims composite. Satisfaction with the Claims, Preauthorization, and Customer Service/Provider Relations composites was down just slightly, but not significantly among PCPs during the survey period. The overall experience for PCPs in obtaining prior authorization of outpatient and inpatient services and the number and quality of specialists in network continued to show significantly higher rates when compared to rates from 2019. The loyalty analysis of the survey showed that loyalty to their MCO among PCPs was about 40 percent, which is not a significant difference when compared to prior years. The number of PCPs indicating indifference or not loyal continues to reflect the majority.

Demonstration Evaluation

During the quarter, the Department collaborated with its independent evaluator, the Hilltop Institute, to complete work on the CY 2022 evaluation, which covers from CY 2016 through CY 2020. Additionally, the Department held is Annual Post-Award Forum. The Department used the May MMAC meeting as the Forum, in accordance with previous CMS guidance. At that meeting, the Department presented the draft HealthChoice evaluation as well as other waiver updates. For further details, please see the attached slide deck, meeting agenda, and minutes from the May MMAC meeting.

The Department has been in ongoing conversations with CMS about the 2017-2021 §1115 summative evaluation. The Department and CMS have collaborated on updating the materials, as well as discussed the evaluation design for the 2022-2026 waiver period. During the quarter, the Department submitted the evaluation design for the current waiver period.

The Department submitted the SMI Monitoring Protocol during the quarter and received approval for the SUD Monitoring Report in April 2022. The Department continues to collaborate with CMS and the Hilltop Institute regarding Monitoring Report implementation and technical specifications.

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Attachments:

Appendix A: 2022 Post-Award Forum Slides
Appendix B: May 2022 Maryland Medicaid Advisory Committee Meeting Agenda and Minutes