Maryland HealthChoice Demonstration
Section §1115 Annual Report
Demonstration Year 27: 7/1/2023 - 6/30/2024
Annual Report Period: July 1, 2023 - June 30, 2024

Introduction

Now in its twenty-seventh 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 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 and postpartum HealthChoice participants with an opioid use disorder (OUD);
- Created an expenditure authority to cover Medicaid adults aged 21 to 64 that have a Serious Mental Illness (SMI) diagnosis who are residing in a private Institute of Mental Disease (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;
- 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.

During the quarter, the Department submitted a Waiver Amendment request on March 6, 2024. The Department is seeking federal approval to offer a set of targeted Medicaid services to certain incarcerated populations who are soon to be released from a state-managed jail or prison. Eligible people experiencing incarceration will receive services up to 90 days prior to release that consist of case management, medication-assisted treatment (MAT), and a 30-day supply of

prescribed medications upon release. The State received comments during the 30-day public comment period between January 12, 2024 and February 12, 2024. The Waiver Amendment request, submitted on March 6 2024, is pending CMS approval.

The amendment seeks federal approval to update existing payment methodologies and request additional participant spaces for the Assistance in Community Integration Services (ACIS) pilot to support statewide expansion. Additionally, the Department seeks approval to cover fertility preservation procedures for individuals with iatrogenic infertility, including those receiving gender-affirming services.

Submitted as a Waiver Amendment request in 2023, the Department is seeking authority to include the non-Modified Adjusted Gross Income (non-MAGI) adult population in the previously submitted amendment requesting authority for an Express Lane Eligibility (ELE) program, enabling Maryland to renew Medicaid coverage for certain adults based on Supplemental Nutrition Assistance Program (SNAP) data. Additionally, MDH is requesting 1115 waiver authority to adopt on a permanent basis the temporary 1135 waiver granted during the national public health emergency, regarding the Four Walls Requirement for clinics authorized under C.F.R. § 440.90. The Waiver Amendment request, submitted on October 25, 2023, is pending CMS approval.

The current §1115 waiver period was approved on December 10, 2021 for a period of January 1, 2022 through December 31, 2026. As such, the Department has begun preparations for the upcoming waiver renewal which would encompass a period of January 1, 2027 through December 31, 2031. The Department will continue to work with CMS to update the §1115 waiver to better serve the Maryland Medicaid population and achieve approval for the next five-year waiver period, beginning in CY 2025.

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. Between calendar year (CY) 2020 and April 2023, Maryland Medicaid was not disenrolling participants who would otherwise have lost eligibility due to the continuous eligibility requirements mandated by the COVID-19 public health emergency (PHE). The unwinding of the PHE beginning in April of 2023 has therefore resulted in lower enrollment counts in the months following the unwinding period, as ineligible participants are no longer required to remain enrolled.

Table 1. Enrollment Counts[1]

Demonstration Populations	Participants as of June 30, 2023	Participants as of June 30, 2024	DY 27 Change (#)	DY 27 Change (%)
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	87,138	78,775	-8,363	-9.6%
SSI/BD Children	22,326	19,615	-2,711	-12.1%
Medically-Needy Adults	29,163	25,729	-3,434	-11.8%
Medically-Needy Children	6,743	5,256	-1,487	-22.1%
Medicaid Children	564,447	528,555	-35,892	-6.4%
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	308,660	267,954	-40,706	-13.2%
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	21,593	21,059	-534	-2.5%
Affordable Care Act (ACA) Expansion Adults	466,465	422,600	-43,865	-9.4%
Maryland Children's Health Program (MCHP)	132,029	139,135	7,106	5.4%
MCHP Premium	33,146	36,661	3,515	10.6%
Presumptively Eligible Pregnant Women (PEPW)	*	*	*	0.0%
Increased Community Services (ICS)	18	14	-4	-22.2%
Women's Breast and Cervical Cancer Health Program (WBCCHP)	42	17	-25	-59.5%

Table 2 provides member month counts for each month of the quarter and compares this quarter's totals against the previous quarter.

[1] Small cell sizes (populations smaller than 11) are suppressed due to privacy reasons and are marked with an asterisk.

Table 2. Member Months

Eligibility Group	Total for Quarter Ending March 2024	Current Quarter Month 1	Current Quarter Month 2	Current Quarter Month 3	Total for Quarter Ending June 2024
SSI/BD Adults	243,606	80,050	79,639	78,775	238,464
SSI/BD Children	59,263	19,661	19,614	19,615	58,890
Medically-Needy Adults	85,320	29,291	28,162	25,729	83,182
Medically-Needy Children	16,987	5,774	5,664	5,256	16,694
Children	1,652,795	538,227	534,528	528,555	1,601,310
Parents/caretakers and former foster care	821,556	273,922	272,806	267,954	814,682
SOBRA	60,720	20,623	20,908	21,059	62,590
ACA expansion	1,301,299	429,808	427,678	422,600	1,280,086
MCHP	377,492	131,843	135,744	139,135	406,722
MCHP Premium	105,833	36,131	36,614	36,661	109,406
PEPW	28	*	*	*	19
ICS	45	14	14	14	42
WBCCHP	61	27	27	17	71

Table 3 compares the proportions of total enrollment year over year.

Table 3. Enrollment as a Proportion of Total

Demonstration Populations	Share of Participants as of June 30, 2023	Share of Participants as of June 30, 2024	Share Change
SSI/BD Adults	5.2%	5.1%	-0.1%
SSI/BD Children	1.3%	1.3%	-0.1%
Medically-Needy Adults	1.7%	1.7%	-0.1%
Medically-Needy Children	0.4%	0.3%	-0.1%
Children	33.8%	34.2%	0.4%
Parents/caretakers and former foster	18.5%	17.3%	-1.1%
SOBRA	1.3%	1.4%	0.1%
ACA expansion	27.9%	27.3%	-0.6%
MCHP	7.9%	9.0%	1.1%
MCHP Premium	2.0%	2.4%	0.4%
PEPW	0.0%	0.0%	0.0%
ICS	0.0%	0.0%	0.0%
WBCCHP	0.0%	0.0%	0.0%

Outreach/Innovative Activities

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

In 2016, the Centers for Medicare and Medicaid Services (CMS) approved Maryland Medicaid to expand specialty SUD and mental health coverage to include SUD treatment in IMDs. Effective July 1, 2017, the approval permitted otherwise-covered services to be provided to all

full-benefit Medicaid-eligible individuals aged 21 to 64 who reside in a non-public IMD for American Society of Addiction Medicine (ASAM) residential levels 3.3, 3.5, 3.7, and 3.7-WM (licensed as 3.7D in Maryland) for up to two non-consecutive 30-day stays annually.
On January 1, 2019, the Department phased in coverage of ASAM level 3.1. The Department extended coverage to individuals dually eligible for Medicare and Medicaid as of January 1, 2020.

In March 2019, the Department received approval for a waiver amendment to allow coverage for ASAM level 4.0 for beneficiaries with a primary SUD and a secondary mental health disease (MHD) in inpatient hospital settings only for up to 15 days per month. The Department implemented coverage effective July 1, 2019.

Residential Treatment was again expanded in the current 2022 to 2026 waiver renewal, which (1) removed any caps on length of stays for SUD treatment and (2) included coverage for IMD services for individuals with SMI and serious emotional disturbance (SED). The current §1115 waiver special terms and conditions (STCs) require the State to aim for a statewide average length of stay (ALOS) of 30 days or less in residential and inpatient treatment settings, to be monitored pursuant to the SUD and SMI/SED Monitoring Protocols as to ensure short-term residential stays.

For more information, please refer to the SUD Monitoring Report. The SMI Monitoring Protocol is pending CMS approval; results from Part B of the SMI Monitoring Report will be included with the FY 2025 report.

MOM Case Management Services

As part of a suite of innovative maternal and child health services, the MOM program 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 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. Originally part of a federal demonstration led by the Center for Medicare and Medicaid Innovation, the MOM program addresses fragmentation in care through the provision of enhanced case management services, led by Medicaid's nine MCOs.

Under the Maryland MOM program, HealthChoice MCOs provide a set of enhanced case management services, standardized social determinants of health screenings, and care coordination. During this quarter, the Department continued participant enrollment statewide. A total of 90 participants have been enrolled in the program as of June 30, 2024. Since becoming enrolled in the MOM program, participants in the program have achieved successes such as acquiring a car seat for their child, applying for cash assistance, finding employment, securing housing, and achieving sobriety.

Collaborative Care Model (CoCM) Pilot Program

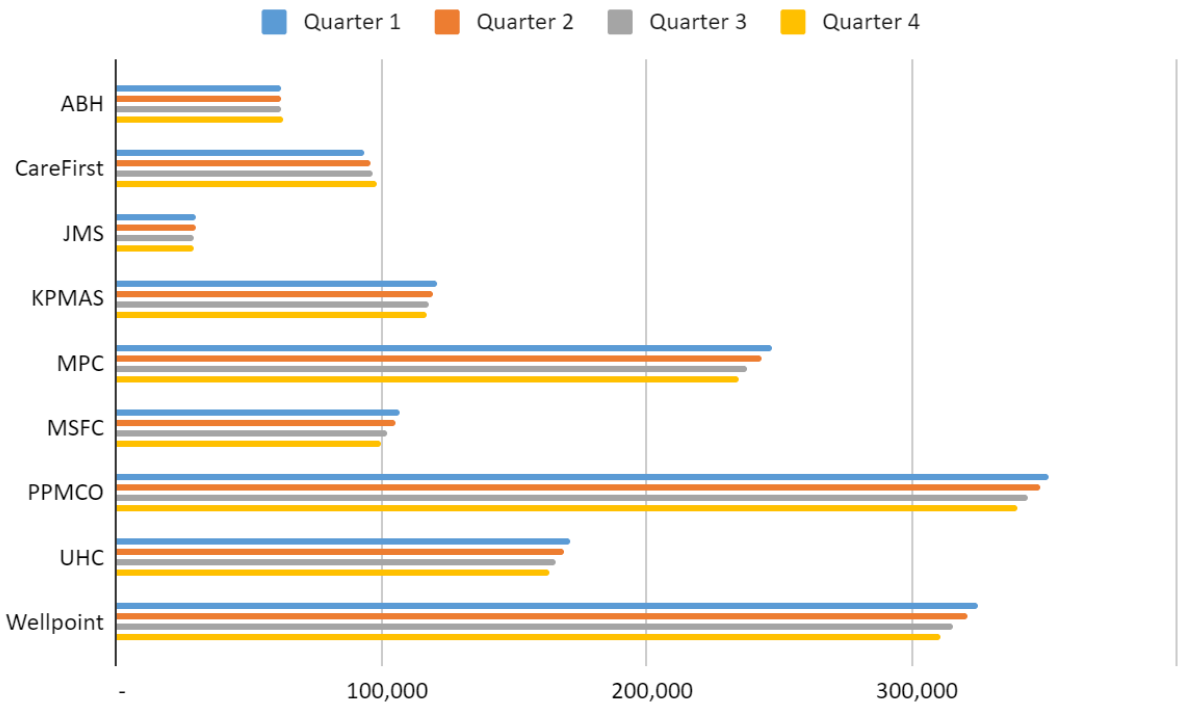
Maryland's CoCM Pilot Program began enrolling participants on July 1, 2020. On October 1, 2023, the Department expanded the pilot program statewide. The Department submitted a State Plan Amendment (SPA) in December 2023 (MD 23-0021) and requested the CoCM Pilot Program to be sunset.

Operational/Policy Developments/Issues

Market Share

As of the end of the first quarter of FY 2024, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (4.3 percent); CareFirst Community Health Plan of Maryland (6.7 percent); Jai Medical Systems (2.0 percent); Kaiser Permanente (8.1 percent); Maryland Physicians Care (16.1 percent); MedStar Family Choice (6.9 percent); Priority Partners (23.3 percent); United Healthcare (11.2 percent); and Wellpoint Maryland (21.4 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in April and May. All MMAC meetings were held via teleconference. These meetings covered a wide variety of topics, including general department updates, enrollment data, and waiver, state plan, and regulations changes.

During the April meeting, the MMAC was briefed on the Public Health Emergency (PHE) unwinding and the new Managed Care Access Rule and the Home and Community-based Services Long Term Services and Supports (HCBS) Access Rule. The MMAC was also provided a summary of the legislative session and key bills that were passed.

During the May meeting, the MMAC was provided with an update on the PHE unwinding and an overview of the HealthChoice Evaluation. The new Behavioral Health Administrative Services Organization, Carelon, presented on their organization and the activities that they are undertaking to prepare for a January 1, 2025 implementation date.

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 2024	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	236	191	47	93	4,579
Quarter 2	244	218	42	110	4,733
Quarter 3	209	181	40	129	4,746
Quarter 4	235	163	49	103	4,504

Table 5. REM Complaints

FY 24 Q4 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	3	0	3
Dental	0	0	0
DMS/DME	2	0	2
EPSDT	0	0	0
Clinical	0	0	0
Pharmacy	2	0	2
Case Mgt.	3	2	5
REM Intake	0	0	0
Access to MA Providers	0	0	0
Nursing	15	0	15

FY 24 Q4 Complaints	REM Case Management Agencies	REM Hotline	Total
Other	6	0	6
Total	31	0	33

Table 5 displays the types and total of significant events reported by the case management agencies during this quarter. Agencies report this information monthly.

Table 6. REM Incidents Reported by Case Managers

FY 24 Incidents	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Abandonment	0	0	0	0
Abuse	5	5	3	3
Complaint	17	11	21	33
Death	24	25	28	13
Elopement	0	0	0	0
ER	0	0	1	3
Exploitation	0	0	2	0
Failure to Follow Plan (Non-Compliance)	0	0	0	1
Fall	0	0	0	3
Hospitalization	9	6	10	8
Medication Error	0	0	1	3
Neglect	7	6	9	7
Suicidal Ideation	0	0	0	1
Theft	0	0	0	0
Wound	0	0	0	1
Other	20	15	23	14
Total	**83**	**68**	**98**	**90**

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 raised the cap to a maximum of 100

participants. As demonstrated in Table 2, ICS enrollment as of the end of FY 2024 was 14. 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, therefore Maryland's entire CHIP program is operated as a Medicaid expansion. As of June 30, 2024, the Premium program had 36,077 participants with MCHP at 139,135 participants.

The Department received legislative approval to remove premiums for the MCHP Premium coverage groups effective May 1, 2024. Uninsured children under age 19 qualify for MCHP Premium if their household income is above the MCHP income guidelines but is at or below 322 percent FPL for their family size. Prior to this change, MCHP Premium required a small monthly premium per family. This change also removes the 90-day lockout rule for premium nonpayment as this rule is no longer applicable.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Per the most recent report published on May 16, 2024, there were 2,282 encounters with DPP procedure codes provided by licensed Medicaid-enrolled DPP providers to 556 unique participants between September 1, 2019, and April 30, 2024. Among the 556 unique Medicaid beneficiaries with a DPP encounter, most were women (86 percent), Black/African American (63 percent), and resided in Prince George's County (28 percent). Most beneficiaries (92 percent) were in the Families and Children Medicaid coverage category. Services were provided by 12 unique DPP providers while the number of encounters per participant ranged from one to 30. The majority of beneficiaries had four or fewer encounters.

Centers for Disease Control (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 May 14, 2024, 37 unique DPP providers were fully enrolled. MCOs continued efforts to contract with eligible DPP providers, expand their DPP provider network capacity, and prepare member and provider materials.

The Chesapeake Regional Information System for our Patients (CRISP), Maryland's state Health Information Exchange, continues to produce monthly reports to MCOs containing the panels of their members who received a prediabetes flag, enabling further follow-up with members. In addition, the MCOs continue to utilize the CRISP eReferral tool, to streamline the referral process for DPP members.

Community Health Pilots

Four local government entities participate as Lead Entities (LEs) in the Assistance in Community Integration Services (ACIS) Pilot program.

As of FY 2024 Quarter 4, the ACIS pilot had 541 enrollees. LEs continue to work towards improving data quality and reporting by implementing improved training and communication processes. LEs engage with the Participating Entities (PEs) regularly to discuss updates on caseloads and data accuracy. One of the LEs started a rate study with an external partner to assist the LE with reviewing ACIS rates, its impact on the ACIS providers and sustainability with the upcoming statewide expansion. Another LE continues to receive referrals through the UniteUs platform from a local hospital resulting in an increase in ACIS enrollment. LEs are also being referred to the Maryland Medicaid MOM Program as an additional resource to the ACIS Pilot resulting in an increase in referrals. Overall, ACIS LEs continue to work closely with providers and get their feedback. LEs are committed to improving processes to increase intake and referrals for pilot enrollment; collaborating with local community partners, landlords, and management companies to assist ACIS enrollees; as well as implementing best practices to work with ACIS-enrolled participants.

ACIS LE's have indicated that ACIS enrollees with SUD are experiencing issues balancing housing and long-term treatment. ACIS enrollees continue to have delays with the local housing authority on voucher briefing appointments as well as appointments with local affordable housing developers Many ACIS enrollees with extensive criminal background and health issues are ineligible for Section 8 vouchers leading to difficulty in getting participants housed. Re-enrollment into the ACIS program remains a concern due to ongoing appropriate housing stock issues, especially with accessible units for those with impairments.

Governor Moore's appropriated budget for FY 2025 includes $5.4 million in State General Funds for ACIS expansion. Work is underway to expand the ACIS pilot statewide and create a claims reimbursement pathway. This change would require increasing the number of authorized slots available for the ACIS program in FY 2025 to serve more Medicaid beneficiaries experiencing or at risk of homelessness in more jurisdictions. In order to increase the number of slots, the Department is planning on submitting an §1115 waiver amendment during fall 2024.

Expenditure Containment Initiatives

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

Throughout the fiscal year, Hilltop met many times with the Department, Optumas, M&S, and one MCO about the MCO's financial reporting and fee schedule concerns, as well as sanctions toward enabling the MCO's inclusion in the 2023 base experience for the 2026 rates. Hilltop performed its annual "MCO Outlier" analysis from the 2022 HFMR data. Of the nine MCOs,

one MCO fell outside the boundary of efficient delivery of care. Consequently, $17.8 million of cost was removed from the base year for pricing purposes.

The second of two meetings was held with the Health Services Cost Review Commission (HSCRC) to plan for CY 2024 rate adjustments. The 2024 hospital revenue growth update factor for the global budget revenue (GBR) was relayed at 5.11 percent and incorporated into rate setting. Instructions for the MCOs for the final 2023 HFMR submission included a new financial summary section showing gain/loss and net income.

The audit of the 2022 HFMR by M&S was reviewed, edited, and incorporated into 2025 rate setting as the base year. Claims were reduced by approximately $87 million and underwriting gain/loss was increased by $152 million.

MCO Rates

Activities in Support of the CY 2025 HealthChoice Rates

During the last quarter of the fiscal year, Hilltop participated in three monthly meetings with the MCOs which covered the following topics: top issues from the Department and the Maryland Managed Care Organization Association (MMCOA), impacts from the 2024 legislative session, a Hepatitis C risk corridor expansion, the maternal and child health risk corridor payments for 2023, the DPP risk corridor payments for 2023, quarterly financial results including surplus, regional analyses, the risk adjusting of Recovery Audit Contractors (RACs), HIV and AIDS prescription costs by rate cell, the redetermination of eligibility membership tracking and its implication on cost acuity, calculating the final 2022 aggregate risk corridor, and claims trend analyses including specialty drugs.

Additionally, data points regarding health equity and social determinants of health were incorporated into the HealthChoice program, outside of rates, in 2024. Source data was updated to define the most underserved six Maryland counties based on the four domains of community safety, food insecurity, housing security, and transportation access.

Activities in Support of the CY 2024 HealthChoice Rates

The transitional +/- 2 percent risk corridor for Hepatitis C was estimated to result in the MCOs owing approximately $3 million for the first quarter of CY24. Hilltop also modeled expanding the Hepatitis C risk corridor from +/-2 percent to +/- 4 percent and assisted in finalizing the high-cost, low volume (HCLV) 2024 list, adding 6 pipeline drugs.

Activities in Support of the CY 2023 HealthChoice Rates (and Prior)

The transitional +/- 2 percent risk corridor for Hepatitis C was estimated to result in the MCOs owing approximately $9 million for all of 2023.

Other Rate Setting Activities

Hilltop continued tracking 2024 monthly reimbursements to trauma providers, highlighting denied hospital claims reports by MCO from the HSCRC, and modeling potential legislative

changes that would expand coverage for biomarkers for eight conditions.

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.

Consumer Issues

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. The Help Line received 47,789 calls in Quarter 4 of FY 2024. The Help Line assists waiver-eligible consumers with eligibility and enrollment questions and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs, and how to access carved-out services or services covered by Medicaid on an FFS basis.

When a consumer experiences a medically related issue—such as difficulty getting appointments with a specialist, getting a prescription filled, or getting a service 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 can 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 findings.

Table 7. Total Recipient Complaints – Quarter 4 FY 2024

CMS Quarterly Report Total Recipient Complaints - excluding Billing 4th Quarter, FY 2024																					
MCO / Type of Service		Aetna Better Health (ABH)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Wellpoint Maryland (WPMD)*		Sub Totals	
3rd Q FY 24 vs. 4th Q FY 24		3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4
Pharmacy	#	30	17	34	29	7	10	15	20	55	50	33	45	55	65	79	106	44	42	352	384
	%	9%	4%	10%	8%	2%	3%	4%	5%	16%	13%	9%	12%	16%	17%	22%	28%	13%	11%	38%	36%
Prenatal	#	9	14	14	24	0	1	14	17	22	19	19	8	37	35	32	24	14	15	161	157
	%	6%	9%	9%	15%	0%	1%	9%	11%	14%	12%	12%	5%	23%	22%	20%	15%	9%	10%	17%	15%
PCP	#	13	9	9	13	6	0	4	4	17	7	7	6	6	22	20	11	12	21	94	93
	%	14%	10%	10%	14%	6%	0%	4%	4%	18%	8%	7%	6%	6%	24%	21%	12%	13%	23%	10%	9%
Specialist	#	8	10	12	15	4	3	8	10	10	26	9	2	13	11	11	17	11	14	86	108
	%	9%	9%	14%	14%	5%	3%	7%	9%	12%	24%	10%	2%	15%	10%	13%	16%	13%	13%	9%	10%
Sub Totals	#	60	50	69	81	17	14	41	51	104	102	68	61	111	133	142	158	81	92	693	742
	%	9%	7%	10%	11%	2%	2%	6%	7%	15%	14%	10%	8%	16%	18%	20%	21%	12%	12%	74%	69%
All Complaint Totals	#	68	66	82	100	17	16	55	66	196	208	75	79	156	192	166	209	116	134	931	1,070
	%	7%	6%	9%	9%	2%	1%	6%	6%	21%	19%	8%	7%	17%	18%	18%	20%	12%	13%	100%	100%
Other Categories		8	16	13	19	0	2	14	14	92	106	7	18	45	59	24	51	35	42	238	328
Source: CRM																					

There were 1,623 total MCO recipient complaints in Quarter 4 of FY 2024 (all ages). Eighty percent of the complaints (1,300) were related to access to care. The remaining twenty percent (230) were billing complaints.

The top three member complaint categories were accessing pharmacy, prenatal services, and specialist services, respectively. Pharmacy complaints made up the majority of complaints (384). Specialist services complaints comprised ten percent of total complaints during the fourth quarter. 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 Durable Medical Equipment/Durable Medical Supplies (DME/DMS). Overall, UnitedHealthcare, Maryland Physicians Care (MPC), and Priority Partners had the highest percentage of complaints in this quarter.

Table 8. Recipient Complaints Under Age 21 – Quarter 4 FY 2024

CMS Quarterly Report
Total Recipient Complaints - excluding Billing: Under age 21 only
4th Quarter, FY 2024

MCO / Type of Service		Aetna Better Health (ABH)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Wellpoint Maryland (WPMD)		Sub Totals	
3rd Q FY 24 vs. 4th Q FY 24		3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4
Pharmacy	#	5	2	2	4	0	0	5	2	17	5	6	9	12	14	20	16	8	14	75	66
	%	7%	3%	3%	6%	0%	0%	7%	3%	4%	8%	8%	14%	16%	21%	27%	24%	3%	21%	37%	29%
PCP	#	4	3	1	5	2	0	3	2	4	0	4	2	4	17	8	4	3	8	33	41
	%	12%	7%	3%	12%	6%	0%	9%	5%	1%	0%	12%	5%	12%	41%	24%	10%	1%	20%	16%	18%
Specialist	#	2	3	2	3	1	0	3	4	1	6	4	0	2	5	5	8	1	4	21	33
	%	10%	9%	10%	9%	0%	0%	14%	12%	5%	18%	19%	0%	10%	15%	24%	24%	5%	12%	10%	14%
Prenatal	#	1	1	3	7	0	0	1	0	5	6	3	0	9	5	9	2	1	3	32	24
	%	3%	4%	9%	29%	0%	0%	3%	0%	16%	25%	9%	0%	28%	21%	28%	8%	3%	13%	16%	10%
Sub Totals	#	12	9	8	19	3	0	12	4	27	17	17	11	27	41	42	11	13	9	161	164
	%	7%	5%	5%	12%	2%	0%	7%	2%	17%	10%	11%	7%	17%	25%	26%	7%	8%	5%	79%	71%
All EPSDT Complaint Totals	#	14	11	10	21	3	1	17	13	43	37	17	15	34	50	46	41	19	41	203	230
	%	7%	5%	5%	9%	1%	0%	8%	6%	21%	16%	8%	7%	17%	22%	23%	18%	9%	18%	100%	100%
Other Categories		2	2	2	2	0	1	5	9	16	20	0	4	7	9	4	30	6	32	42	66

Source:CRM

There were 230 member complaints (non-billing) for recipients under age 21 in Quarter 4 of FY 2024, or 14 percent of the total complaints. The top complaint category was access to pharmacy services. Priority Partners, UnitedHealthcare, and Wellpoint Maryland 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 most often report difficulty accessing pharmacy services followed by difficulty accessing prenatal care services. Children under 21 most often report difficulty accessing pharmacy services followed by primary care services.

Table 9. Total Recipient Billing Complaints – Quarter 4 FY 2024

CMS Quarterly Report
Total Recipient Complaints - Billing only
4TH Quarter, FY 2024

MCO / Type of Service		Aetna Better Health (ABH)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Wellpoint Maryland (WPMD)		Sub Totals	
3rd Q FY 24 vs. 4th Q FY 24		3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4
Emergency	#	1	1	8	9	3	1	4	6	8	10	3	5	10	14	2	8	10	5	49	59
	%	2%	2%	16%	15%	6%	2%	8%	10%	16%	17%	6%	8%	20%	24%	4%	14%	20%	8%	16%	18%
PCP	#	0	6	8	5	1	2	9	9	10	17	14	6	18	28	21	15	16	17	97	105
	%	0%	6%	8%	5%	1%	2%	9%	9%	10%	16%	14%	6%	19%	27%	22%	14%	16%	16%	32%	33%
Laboratory/ Test	#	4	3	2	5	1	2	1	1	9	13	5	4	3	10	4	4	7	1	36	43
	%	11%	7%	6%	12%	3%	5%	3%	2%	25%	30%	14%	9%	8%	23%	11%	9%	19%	2%	12%	13%
Specialist	#	1	0	4	0	1	1	4	3	6	4	4	9	4	4	6	11	6	6	36	38
	%	3%	0%	11%	0%	3%	3%	11%	8%	17%	11%	11%	24%	11%	11%	17%	29%	17%	16%	12%	12%
Sub Totals	#	6	10	22	19	6	6	18	19	33	44	26	24	35	56	33	38	39	29	218	245
	%	3%	4%	10%	8%	3%	2%	8%	8%	15%	18%	12%	10%	16%	23%	15%	16%	18%	12%	73%	76%
All Billing Complaint Totals	#	7	16	31	30	6	7	26	31	42	55	35	31	51	69	46	47	56	37	300	323
	%	2%	5%	10%	9%	2%	2%	9%	10%	14%	17%	12%	10%	17%	21%	15%	15%	19%	11%	100%	100%
Other Categories		1	6	9	11	0	1	8	12	9	11	9	7	16	13	13	9	17	8	82	78

Source: CRM

Enrollee billing complaints comprised 19 percent of total MCO complaints in Quarter 4 of FY 2024. Overall, the top bill type was primary care providers followed by emergency-related billing issues, which comprised thirty-three percent and eighteen percent, respectively, followed by Laboratory/Test and specialist 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 vision. Priority Partners had the highest percentage of billing complaints followed by Maryland Physicians Care.

MCOs are required to respond to all recipient grievances and complaints. The CRU works with MCOs on behalf of the consumer to resolve the complaint. Once a plan is in place, the CRU refers the case to the Administrative Care Coordination Units (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

Maryland's 2024 legislative session began on January 10, 2024, and ended on April 9, 2024. The General Assembly passed the following bills that would impact the Maryland Medical Assistance program:

- **SB362** (Budget Reconciliation & Financing Act) – A bill that authorizes use of excess Senior Prescription Drug Assistance Program funds to subsidize the Kidney Disease Program and mental health services for the uninsured, authorizes use of Coordinated Community Supports Partnership Fund in FY25 to reimburse Medicaid for school-based behavioral health services provided through fee-for-service; and authorizes transfer of $216,845 from Health Information Exchange to Medicaid to support IT activities.
- **SB18/HB76** (Health Occupations - Pharmacists - Administration of Vaccines) – A bill that authorizes a pharmacist to order and administer certain vaccines to individuals who are at least three years old if the pharmacist has met certain conditions.
- **SB219** (Senior Prescription Drug Assistance Program - Sunset Extension) – A bill that extends sunset of SPDAP by six years to Dec. 31, 2030.
- **HB39/SB197** (Residential Service Agencies - Reimbursement - Personal Assistance Services (Homecare Worker Rights Act of 2024) - A bill that authorizes MDH to reimburse an RSA for personal assistance services only if they are provided by someone if they are classified as an employee (takes effect Jan. 1, 2026).
- **HB189/SB371** (Md. Medical Assistance Program - Personal Care Aides - Wage Reports) - A bill that requires RSAs to report to Maryland Dept. of Labor annually by Sept. 1 on average wage rates and highest and lowest wage rates for personal care aides; six months after the release of the final federal Ensuring Access to Medicaid Services rule, MDH must report on an overview of the final rule and plans or steps that MDH will take to operationalize it.
- **HB96/SB117** (Health – Newborn Screening Program – Implementation of Testing) A bill that requires the Department to implement testing for a core condition within 1 year & 6 months after it is added to the Recommended Uniform Screening Panel (RUSP); requires MDH to implement testing for infantile Krabbe disease within one year after HHS issues a final recommendation to add screening of the condition to RUSP.
- **HB103/SB600** (Md. Medical Assistance Program – Dental Services – Coverage & Rate Study) – A bill that requires the Department to study the feasibility of including removable full and partial dentures and reimbursement for providers on a per-patient basis for house-calls & extended care facility calls, and setting reimbursement rates for these services at a level that ensures all dental providers are adequately reimbursed and not less than 60% of the average commercial rate or the benchmark charge for the ADA's CDT code for those services.
- **HB119/SB211** (Public Health – Giving Infants a Future without Transmission (GIFT) Act) – A bill that requires universal syphilis and HIV screening for all pregnant women at the time of delivery.
- **HB822/SB790** (Md. Medical Assistance Program - Employed Individuals w/ Disabilities) - A bill that requires MDH to provide Medicaid services to individuals enrolled in EID who are at least 16 years-old and for existing enrollees in the EID program; eligibility may not be limited based on enrollee's earned or unearned income, or any assets or resources; MDH must meet w/ State-based coalition of disability advocates to receive feedback, and apply to CMS for any SPAs or waivers necessary for implementation; MDH to report by Dec. 1, 2024 on implementation of an EID program for those age 65 and older, and on establishing a premium contribution based on earned & unearned income.

- **HB1051/SB1059** (Maternal Health – Assessments, Referrals & Reporting) – A bill that establishes requirements on local health depts. and health care providers and facilities for maternal health, incl. requirements for prenatal risk assessment forms & post-partum infant and maternal referral forms.
- **HB1078** (Md. Medical Assistance Program – Remote Ultrasound Procedures & Remote Fetal Non-Stress Tests) – A bill that requires Medical Assistance program to cover remote ultrasound procedures and remoted fetal non-stress tests if the patient is in a residence or in a location other than the office of their provider and the provider follows the same standard of care they would follow when providing the services on-site.
- **HB1521** (Maryland Children's Health Program - Eligibility & Administration) – A bill that eliminates the premium requirement for children enrolled in MCHP premium program and repeals the requirement that the program be administered through the Medical Assistance program & MCOs or the MCHP premium plan.
- **SB212/HB1048** (Behavioral Health Advisory Council & Commission on Behavioral Health Care Treatment & Access – Alterations) – A bill that requires the Behavioral Health Advisory Council and the Commission on Behavioral Health Care Treatment and Access to work in conjunction with one another; alters the membership and terms of the council; and requires the commission to make specified recommendations regarding continuation of the behavioral health carve-out and the integration of somatic and behavioral health services in Medicaid.
- **SB594/HB986** (Md. Medical Assistance Program – Coverage for the Treatment of Obesity – Required Study) – A bill that requires the Department (in consultation with relevant stakeholders) to study the impact of requiring Medicaid coverage for treatment of obesity; report is due December 31, 2024.
- **SB614/HB865** (Md. Medical Assistance Program & Health Insurance – Coverage for Prostheses) – A bill that requires Medicaid and commercial insurers to cover prostheses by Jan. 1, 2025, and requires insurers and MCOs to report on compliance to MIA & the Department; requires the Department & Health Care Commission to report on cost impact of requiring coverage for orthoses by Medicaid & commercial insurers.

Quality Assurance/Monitoring Activity

The Office of Medical Benefits Management (OMBM) 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. 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 Department contracts with three vendors to support its quality assurance activities:
- Qlarant Quality Solutions, Inc. (Qlarant), the external quality review organization (EQRO);
- MetaStar, Inc. (MetaStar), HEDIS Compliance Auditor; and
- Center for the Study of Services, Inc. (CSS), the survey administration vendor.

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

Activity	Vendor	Status	Comments (April - June 2024)
Systems Performance Review (SPR)	Qlarant	Complete	Measurement Year (MY) 2023 SPR Quarterly Corrective Action Plan (CAP) closures were completed for Carefirst, Kaiser, MPC, Priority Partners, UHC, and Wellpoint in April 2024. SPR CAPs for Carefirst, Kaiser, MPC, and Wellpoint were reviewed and approved in May 2024. The MY 2023 Statewide Executive Summary was approved and disseminated to MCOs in June 2024. The MY 2024 Standards and Guidelines will be reviewed throughout the quarter and will be approved to adhere to all CMS protocols.
EPSDT Medical Record Review	Qlarant	Complete	The MY 2022 Priority Partners CAP submission was reviewed and approved after Technical Assistance with MDH and Qlarant in April 2024. The MY 2022 Statewide Executive Summary was reviewed and approved by MDH in April 2024. MY 2023 EPSDT Onsite Medical Record Review Training will also begin at the close of Q4.
Consumer Report Card (CRC)	Qlarant	In Progress	MDH has requested revisions to the Consumer Report Card Template and reporting measures. Qlarant will review all associated recommendations during its development of the IRS & Methodology next quarter.
Performance Improvement Projects (PIPs)	Qlarant	Complete	The MY 2024 PIP Orientation Manual and Postpartum Annual PIP Template were approved in April 2024. The HealthChoice Performance Improvement Project (PIP) Interventions Annual 2023 Report Analysis was disseminated to all MCOs and posted to the HealthChoice MDH Quality Assurance Annual Reports website. MY 2024 Quarter 1 (Q1) MCO PIP Submissions were reviewed and distributed to all MCOs in May 2024. MY 2024 PIP Quarterly Templates were edited, and an example report for completion guidance was made available as a reference guide on the MCO Resource Site. The 2024 MCO PIP Sustainability Survey for MY 2023 was distributed to all MCOs and responses reviewed in June 2024. MDH presented the 2023 (MY 2022) PIP Intervention Evaluation Results Summary to all MCOs during the June 2024 QALC Meeting.
Encounter Data Validation (EDV)	Qlarant	Complete	The EDV Data Memo request was submitted by Qlarant in May 2024. The MY 2023 EDV Orientation Manual and MY 2023 EDV Provider Request Letter were reviewed and approved in June 2024.
Network Adequacy Validation (NAV)	Qlarant	In Progress	The new NAV protocol methodology for validation is currently under review this quarter. MY 2024 NAV Validation activities began in May 2024, as well as a newly updated timeline for EQRO NAV activities. NAV Protocol Orientation Manual and MCO Training Slides were reviewed and approved and training provided to MCOs in June 2024. MY 2023 Q2 NAV CAPs were reviewed and approved for Jai, Kaiser, and UHC. The MY 2023 Priority Partners NAV CAP was returned to the MCO for further revision.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	In Progress	MDH is in the process of updating the language for all MCO Model Notices for Grievances, Appeals, and Denials. All edits will be finalized by Q1 2025. The MY 2023 GAD Report was reviewed and approved in May 2024.

Activity	Vendor	Status	Comments (April - June 2024)
			The Q1 MY 2024 MCO GAD Analysis and Narrative Summary was submitted to MDH and MCOs in June 2024. Q2 submissions are due next quarter. A summary of the Q1 MY 2024 findings is listed below under Activity Highlights.
HEDIS Audits and Reporting (HEDIS)	MetaStar	In Progress	In April, National Committee for Quality Assurance (NCQA) announced a two-week extension for the HEDIS MY 2023 data submission, from June 14 to June 28, 2024. The reason for the extension was due to the Change Healthcare cyberattack that caused a disruption on quality reporting efforts for some health plans. The HEDIS vendor completed the preliminary rate review of data provided by the MCOs. The HEDIS MY 2024 Technical Update was released by NCQA in April, with no impact on the current HEDIS measures that are required to be reported by MCOs. Medical Record Review Validation was completed in May with all MCOs successfully passing all requirements. As a result of the collaborative efforts between MDH, the HEDIS vendor, and the MCOs, all HEDIS data for MY 2023 was provided to NCQA by the original deadline in June with no issues. Updates for the HEDIS MY 2024 Performance Monitoring Measures were communicated to the MCOs in June. Updates and changes for the HEDIS MY 2024 accreditation measures were reviewed at the quarterly meeting in June. The HEDIS vendor provided key MY 2023 HEDIS deliverable data to MDH by the end of June for review, analysis, and reporting.
Population Health Incentive Program (PHIP)	Qlarant	Complete	MY 2023 PHIP Preliminary Data Validation was completed for both Ambulatory and Lead, and the final CY 2023 Ambulatory Care and Lead PHIP Results will be provided to all MCOs next quarter.
CAHPS Survey Administration (CAHPS)	CSS	In Progress	In April, the Satisfaction Survey fielding phase was on-going. The vendor continued to receive returned mail surveys and continued to make telephone attempts to non-responding sample members. The vendor provided Interim Reports to MDH that reflected a status update with preliminary survey results. In May, the Satisfaction Survey fielding phase closed, and the vendor processed member-level data files and submitted them to NCQA and National CAHPS Benchmarking Database (NCBD). In June, MDH received Highlight Reports from the vendor that reflected MCO performance for key areas of the survey results. MDH and the vendor submitted MCO data, survey questionnaires, and the survey data file to the CAHPS Database Online Submission System. The database submission was subsequently reviewed and approved with no issues. MY 2023 report finalization to begin next quarter.

Activity	Vendor	Status	Comments (April - June 2024)
Primary Care Provider (PCP) Satisfaction Survey Administration	CSS	In Progress	In April, the Primary Care Provider (PCP) Survey fielding phase continued with the mailing of second survey questionnaires and reminder postcards to PCPs. In May, the survey fielding phase wrapped up and the telephone follow-up calls were conducted. The vendor provided an Interim Report to MDH at the end of May that included a status update and preliminary survey results. In June, the survey administration of the PCP survey concluded and MDH was provided with a final survey response rate from the vendor. MY 2023 report finalization to begin next quarter.
Annual Technical Report (ATR)	Qlarant	Complete	The MY 2023 Annual Technical Report was completed, approved, and made available on the MDH HealthChoice website in April 2024. The report was disseminated to all MCOs in May 2024. A new link was curated on the MDH HealthChoice website to chronologize all ATR reports dated 2013-2023 according to CMS ATR Feedback.

Activity Highlights

Annual Technical Report

The MY 2023 ATR Report was submitted to CMS in May 2024.

Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)

Below is a summary of the Quarter 1 (Q1) 2024 findings from the GAD activity:

Member Grievances: Carefirst's range of grievances was the lowest at 0.18 per thousand members; whereas MedStar's range of grievances was the highest at 5.98 per thousand members. Medstar's high member grievances in Q1 were due to miscategorization of grievances as inquiries and member misplacement of identification cards.

The most prevalent reason code category outlined was Access. The most prevalent service code category outlined was Medical Surgical. Eight out of the nine MCOs met member grievance turnaround time (TAT) requirements. Jai did not meet the TAT for Category 2: Non-emergency Medically Related member grievances, with a rate of 83 percent against their previous performance threshold of 100 percent.

Provider Grievances: Maryland Physicians Care (MPC)'s range of grievances was the lowest at 0.04 per thousand members, whereas Wellpoint's range of grievances was the highest, totaling 2.26 per thousand members. The overall median for provider grievances per thousand members was 0.36. Jai, Kaiser, and Medstar reported no provider grievances for this quarter. The most prevalent reason code category outlined was Finance/Billing. Eight out nine MCOs met provider grievance TAT requirements; Wellpoint was the exception at 30 percent, largely due to staffing reductions in Q4 2023.

Appeals: Priority cited the highest rate of member appeals at 3.24 per thousand members, followed by MPC at 2.66 per thousand members, a slight increase in comparison to Q3 2023. Kaiser cited the lowest rate of member appeals at 0.18 per thousand members. The overall median rate of member appeals across all MCOs was 0.72 per thousand members. Eight MCOs indicated 100 percent of appeals come from denials. Carefirst, Jai, Kaiser, and Medstar's overturned appeal rates were greater than 51 percent, a rate considered as a best outcome for enrollees. Jai was highlighted with the highest appeal overturn rate, while Aetna was indicated as the lowest appeal overturn rate. The top appeal service code reported was Medical Surgical. All nine MCOs met standard (non-emergency) appeals resolution TAT requirements. Seven of the nine MCOs met the expedited appeals resolution TAT. Outliers here included Jai with no expedited appeals this quarter, and Wellpoint at 83 percent.

Denials: Pre-service denials varied across MCOs with MCO outliers Aetna, Carefirst, and UHC rates above 30 percent. MPC maintained the highest pre-service denial rate at 39.12 percent, and Kaiser had the lowest at 1.81 per thousand members. Currently, Carefirst falls within the median. The top pre-service denial service category is Medical/Surgical, and the top pre-service denial reason was NMN-1 Not Medically Necessary/Full Denial. In regard to outpatient pharmacy denials, Jai maintains the highest denial rate at 92 percent, followed by Carefirst at 82 percent,

Medstar at 72 percents, and Aetna at 57 percent. Kaiser cited no pharmacy denials. Wellpoint reported a pharmacy denial rate of 39 percent; the lowest pharmacy denial rate was reported by MPC at 37 percent. Eight out of nine MCOs met or exceeded the 95 percent denial resolution and timeliness notification requirements. Priority is the one outlier; Priority met all compliance metrics outside of timeliness notification for Standard Pre-service medical denials, at 91 percent.

Performance Improvement Projects (PIPs)

The June 2024 QALC Meeting highlighted key components of the 2023 MCO PIP Intervention Evaluation Results Summary in which the Sustainability Review Process, HEDIS Measure AMR and Lead Screening score comparisons, and Activities for Improvement topics were discussed. The MDH Annual 2023 Report Analysis was provided to all MCOs in April 2024, and can be found on the HealthChoice Quality Assurance Annual Reports website and as Attachment 4 to this report.

HEDIS Audits and Reporting

Final MY 2022 results were provided in the previous quarterly report to CMS.

CAHPS Survey Administration

Final MY 2023 results were provided in the previous quarterly report to CMS.

Primary Care Provider (PCP) Survey Administration

Final MY 2023 results were provided in the previous quarterly report to CMS.

Demonstration Evaluation

The Department continues to collaborate with CMS and the Hilltop Institute regarding SUD Monitoring Report implementation and technical specifications. The Department and CMS continue to collaborate on the SMI Monitoring Protocol and the §1115 Summative Evaluation Design. The §1115 Post-Award Forum was held on May 23, 2024 during the monthly MMAC meeting. For further details, please see the attached slide deck, meeting agenda, and minutes from the May MMAC meeting as Attachment 1, 2, and 3.

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Attachments:

1. 2024 HealthChoice MMAC Presentation
2. MMAC May Agenda
3. MMAC May Minutes (June Agenda)
4. MDH PIP Evaluation Cumulative Annual 2023 Report