Maryland HealthChoice Demonstration
Section §1115 Quarter 3 Report
Demonstration Year 27: 7/1/2023 - 6/30/2024
Quarter 3: January - March 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.

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[1]

Demonstration Populations	Participants as of Dec. 31, 2023	Participants as of March 31, 2024
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	82,352	80,538
SSI/BD Children	20,429	19,599
Medically-Needy Adults	30,447	29,905
Medically-Needy Children	6,314	5,865
Medicaid Children	563,309	541,611
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	277,284	274,211
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	19,247	20,501
Affordable Care Act (ACA) Expansion Adults	447,167	430,627
Maryland Children's Health Program (MCHP)	122,788	129,472
MCHP Premium	33,837	36,077
Presumptively Eligible Pregnant Women (PEPW)	*	*
Increased Community Services (ICS)	15	15
Women's Breast and Cervical Cancer Health Program (WBCCHP)	21	28

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 Dec. 2023	Current Quarter Month 1	Current Quarter Month 2	Current Quarter Month 3	Total for Quarter Ending March 2024
SSI/BD Adults	250,066	81,732	81,336	80,538	243,606
SSI/BD Children	61,980	19,936	19,728	19,599	59,263
Medically-Needy Adults	89,519	27,866	27,549	29,905	85,320
Medically-Needy Children	18,926	5,615	5,507	5,865	16,987
Children	1,701,690	563,003	548,181	541,611	1,652,795
Parents/caretakers and former foster care	842,849	272,062	275,283	274,211	821,556
SOBRA	58,736	19,924	20,295	20,501	60,720
ACA expansion	1,364,020	436,431	434,241	430,627	1,301,299
MCHP	370,140	121,446	126,574	129,472	377,492
MCHP Premium	103,829	33,562	36,194	36,077	105,833
PEPW	14	*	12	*	28
ICS	46	15	15	15	45
WBCCHP	92	17	16	28	61

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 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 75 participants have been enrolled in the program as of March 31, 2024.

Collaborative Care Model (CoCM) Pilot Program

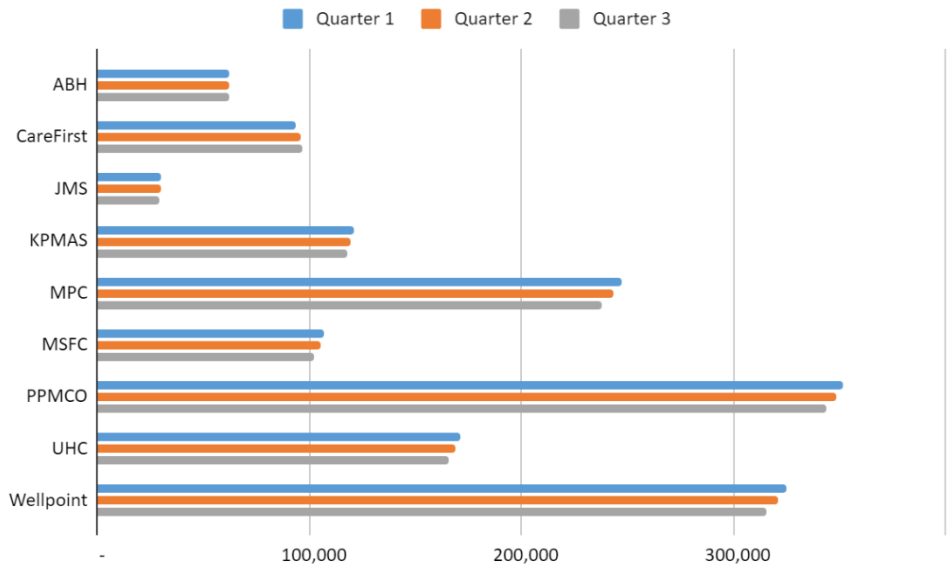
Maryland's CoCM Pilot Program began enrolling participants on July 1, 2020. On October 1, 2023, the Department expanded the pilot program statewide. The Department submitted a State Plan Amendment (SPA) in December 2023 (MD 23-0021), and requested the 1115 Waiver Amendment to be sunset.

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 (4.2 percent); CareFirst Community Health Plan of Maryland (6.6 percent); Jai Medical Systems (2.0 percent); Kaiser Permanente (8.0 percent); Maryland Physicians Care (16.2 percent); MedStar Family Choice (6.9 percent); Priority Partners (23.4 percent); United Healthcare (11.3 percent); and Wellpoint Maryland (21.4 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in January, February, and March. 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 January meeting, the MMAC was briefed on the Public Health Emergency (PHE) unwinding and the proposed §1115 Waiver Amendment Reentry Demonstration. The MMAC was also briefed on the upcoming legislative session.

During the February meeting, the MMAC was provided with a legislative update, detailing Medicaid bills of note, as well as an overview of the Medicaid budget and updates to state plan amendments and regulations.

During the March meeting, the MMAC was provided with a legislative update, detailing new Medicaid bills of note, as well as a brief update on prescriber enrollment and policy changes, and an update on Quality and the Population Health Improvement Programs.

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 3. 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					

Table 4. REM Complaints

FY 24 Q3 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	0	0	0
Dental	1	0	1
DMS/DME	0	0	0
EPSDT	0	0	0
Clinical	1	0	1
Pharmacy	0	0	0
Case Mgt.	5	0	5
REM Intake	0	0	0
Access to MA Providers	4	0	4
Nursing	8	0	6
Other	2	0	2
Total	21	0	21

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 5. REM Incidents Reported by Case Managers

FY 24 Incidents	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Abandonment	0	0	0	
Abuse	5	5	3	
Complaint	17	11	21	
Death	24	25	28	
Elopement	0	0	0	

FY 24 Incidents	Quarter 1	Quarter 2	Quarter 3	Quarter 4
ER	0	0	1	
Exploitation	0	0	2	
Failure to Follow Plan (Non-Compliance)	0	0	0	
Fall	0	0	0	
Hospitalization	9	6	10	
Medication Error	0	0	1	
Neglect	7	6	9	
Suicidal Ideation	0	0	0	
Theft	0	0	0	
Wound	0	0	0	
Other	20	15	23	
Total	**83**	**68**	**98**	

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. 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 March 31, 2024, the Premium program had 36,077 participants with MCHP at 129,472 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 of the federal poverty level 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 rules for premium nonpayment as this rule is no longer applicable.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Per the most recent report published on February 7, 2024, there were 2,263 encounters with DPP procedure codes provided by licensed Medicaid-enrolled DPP providers to 548 unique participants between September 1, 2019, and January 31, 2024. Among the 548 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 the end of January 31, 2024, 39 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.

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 3, the ACIS pilot had 545 enrollees. LEs continue to work towards improving data quality and reporting by implementing improved training and communication processes. LEs continue to engage with the Participating Entities (PEs) regularly to discuss updates on caseloads and data accuracy. One of the LEs recently held a Landlord Lunch and Learn providing landlords with program information, resources and funding sources. Another LE continues to receive referrals through an online referral system managed by external partners resulting in an increase in ACIS enrollment. 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 LEs maintain their concern about lack of availability of affordable local housing as well as lack of timely response from landlords. They have also indicated that 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.

Governor Moore's appropriated budget for FY25 includes $6.4M in State General Funds for ACIS expansion. Work is underway to make changes in the structure of the program and 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 FY25 to serve more Medicaid beneficiaries experiencing or at risk of homelessness in more jurisdictions.

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 quarter, Hilltop held their first of two meetings with the Health Services Cost Review Commission (HSCRC) to plan for midyear CY 2024 rate adjustments and to share expected hospital trends under the all-payer model. As part of these adjustments, Hilltop began analysis on the potential impact of adding one MCO that has been historically excluded to the 2022 base experience for 2025 pricing. Hilltop expects an impact of approximately -0.12 percent for claims PMPM, approximately -0.22 percent for administrative costs, and -0.30 percent for claims trend.

Hilltop drafted the 2023 HFMR instructions for MCOs to clarify reporting of Federally Qualified Health Center, high-cost/low-volume drugs, and PCP services. Hilltop also clarified restrictions on including denied encounters and updated measures of denied encounters for 2023 for each MCO as a tool to improve data quality and completeness.

Hilltop met with the MCOs and representatives from the Johns Hopkins Bloomberg School of Public Health to model adding ACG-based risk scores to "Risk Adjusted Cells" (RACs). Concurrently, Hilltop is conducting an analysis to refine geographic rates cells to account for MCO-specific enrollment mix.

MCO Rates

<u>Activities in Support of the CY 2024 HealthChoice Rates</u>

During this quarter, Hilltop assisted in replying to three rounds of questions from the Office of the Actuary of CMS related to CY 2024 provisional rates. Hilltop submitted a public information request (PIA) to the Maryland Insurance Administration (MIA) for 2023 MCO financial statements and shared underwriting gain/loss results with the Department and MCOs. The 2023 gain/loss was 4.5 percent or $260 million.

<u>Activities in Support of the CY 2025 HealthChoice Rates</u>

During this quarter, Hilltop participated in two monthly meetings with the MCOs which covered the following topics: top issues from the Maryland Department of Health, top issues from the

Maryland MCO Association, the annual legislative session, MCO financial results, PHE unwinding enrollment results, and risk corridors for DPP, maternal and child health programs, and collaborative care. Hilltop and the Department continued discussions and analyses on quantifying gaps in outcomes related to health equity and its associated incentives.

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

Hilltop processed midyear supplemental payments for 2023 rates for the MCOs and answered questions regarding the process. The MCOs owed $9 million in funds to the state. The transitional +/- 2 percent risk corridor for Hepatitis C was estimated to result in the MCOs owing approximately $8.5 million for 2023.

Other Rate Setting Activities

During this quarter, Hilltop conducted an actuarial request for proposals (RFP) and selected a vendor; the contract began in February 2024. Hilltop also finalized the annual report of 2023 reimbursements to trauma providers, highlighted denied hospital claims reports by MCO from the HSCRC with the MCOs, and began to analyze legislation to expand coverage for biomarkers for eight conditions. Hilltop calculated the Family Planning differential match rate for managed care claiming FFP by identifying the portion of Medicaid capitation rates attributable to family planning services.

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

The HealthChoice Help Line serves as the front line of the State’s mandated central complaint program. The Help Line received 56,379 calls in Quarter 3 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 6. Total Recipient Complaints – Quarter 3 FY 2024

CMS Quarterly Report
Total Recipient Complaints - excluding Billing
3rd 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	
2nd Q FY24 vs. 3rd Q FY24		2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
Pharmacy	#	20	30	51	34	4	7	23	15	52	55	32	33	51	55	82	79	32	44	347	352
	%	6%	9%	15%	10%	1%	2%	7%	4%	15%	16%	9%	9%	15%	16%	24%	22%	9%	13%	41%	38%
Prenatal	#	11	9	15	14	4	0	14	14	11	22	19	19	34	37	12	32	22	14	142	161
	%	8%	6%	11%	9%	3%	0%	10%	9%	8%	14%	13%	12%	24%	23%	8%	20%	15%	9%	17%	17%
PCP	#	8	13	6	9	1	6	5	4	14	17	2	7	13	6	15	20	10	12	74	94
	%	11%	14%	8%	10%	1%	6%	7%	4%	19%	18%	3%	7%	18%	6%	20%	21%	14%	13%	9%	10%
Specialist	#	3	8	21	12	3	4	6	8	14	10	7	9	11	13	10	11	5	11	80	86
	%	4%	9%	26%	14%	4%	5%	8%	9%	18%	12%	9%	10%	14%	15%	13%	13%	6%	13%	9%	9%
Sub Totals	#	42	60	93	69	12	17	48	41	91	104	60	68	109	111	119	142	69	81	643	693
	%	7%	9%	14%	10%	2%	2%	7%	6%	14%	15%	9%	10%	17%	16%	19%	20%	11%	12%	75%	74%
All Complaint Totals	#	51	68	98	82	12	17	54	55	187	196	75	75	151	156	135	166	89	116	852	931
	%	6%	7%	12%	9%	1%	2%	6%	6%	22%	21%	9%	8%	18%	17%	16%	18%	10%	12%	100%	100%
Other Categories		9	8	5	13	0	0	6	14	96	92	15	7	42	45	16	24	20	35	209	238

Source: CRM

There were 1,434 total MCO recipient complaints in Quarter 3 of FY 2024 (all ages). Seventy-nine percent of the complaints (1,134) were related to access to care. The remaining twenty-one percent (300) were billing complaints.

The top three member complaint categories were accessing pharmacy services, prenatal providers, PCPs, respectively. Pharmacy complaints made up the majority of complaints (352). Pharmacy complaints comprised thirty-eight percent of total complaints during the third 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, Maryland Physician Care (MPC), UnitedHealthcare, and Priority Partners had the highest percentage of complaints in this quarter.

Table 7. Recipient Complaints Under Age 21 – Quarter 3 FY 2024

CMS Quarterly Report
Total Recipient Complaints - excluding Billing: Under age 21 only
3rd 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	
2nd Q FY24 vs. 3rd Q FY24		2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
Pharmacy	#	3	5	8	2	2	0	5	5	11	17	5	6	18	12	16	20	7	8	75	75
	%	4%	7%	11%	3%	3%	0%	7%	7%	15%	23%	7%	8%	24%	16%	21%	27%	9%	11%	39%	37%
PCP	#	2	4	4	1	0	2	1	3	9	4	1	4	4	4	9	8	5	3	35	33
	%	6%	12%	11%	3%	0%	6%	3%	9%	26%	12%	3%	12%	11%	12%	26%	24%	14%	9%	18%	16%
Specialist	#	1	2	5	2	0	1	2	3	2	1	2	4	7	2	1	5	2	1	22	21
	%	5%	10%	23%	10%	0%	5%	9%	14%	9%	5%	9%	19%	32%	10%	5%	24%	9%	5%	11%	10%
Prenatal	#	1	1	4	3	1	0	1	1	2	5	4	3	7	9	1	9	3	1	24	32
	%	4%	3%	17%	9%	4%	0%	4%	3%	8%	16%	17%	9%	29%	28%	4%	28%	13%	3%	12%	16%
Sub Totals	#	7	12	21	8	3	1	9	4	24	14	12	17	36	27	27	42	17	13	156	138
	%	4%	9%	13%	6%	2%	1%	6%	3%	15%	10%	8%	12%	23%	20%	17%	30%	11%	9%	80%	68%
All EPSDT Complaint Totals	#	9	14	22	10	3	3	12	17	41	43	13	17	44	34	29	46	21	19	194	203
	%	5%	7%	11%	5%	2%	1%	6%	8%	21%	21%	7%	8%	23%	17%	15%	23%	11%	9%	100%	100%
Other Categories		2	2	1	2	0	2	3	13	17	29	1	0	8	7	2	4	4	6	38	65

Source:CRM

There were 203 member complaints (non-billing) for recipients under age 21 in Quarter 3 of FY 2024, or 14 percent of the total complaints. The top complaint category was access to pharmacy services. UnitedHealthcare, 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 most often report difficulty accessing prenatal care services followed by difficulty accessing specialty services. Children (under 21) most often report difficulty accessing pharmacy services followed by PCP services; prenatal services have been reported to be a close third access concern.

Table 8. Total Recipient Billing Complaints – Quarter 2 FY 2024

CMS Quarterly Report
Total Recipient Complaints - Billing only
3rd 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	
2nd Q FY24 vs. 3rd Q FY24		2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3	2	3
Emergency	#	2	1	4	8	1	3	3	4	6	8	4	3	8	10	4	2	5	10	37	49
	%	5%	2%	11%	16%	3%	6%	8%	8%	16%	16%	11%	6%	22%	20%	11%	4%	14%	20%	17%	16%
PCP	#	1	0	9	8	0	1	9	9	11	10	5	14	15	18	6	21	9	16	65	97
	%	2%	0%	14%	8%	0%	1%	14%	9%	17%	10%	8%	14%	23%	19%	9%	22%	14%	16%	30%	32%
Laboratory/ Test	#	1	4	1	2	0	1	3	1	7	9	1	5	7	3	4	4	7	7	31	36
	%	3%	11%	3%	6%	0%	3%	10%	3%	23%	25%	3%	14%	23%	8%	13%	11%	23%	19%	14%	12%
Specialist	#	2	1	5	4	0	1	4	4	3	6	2	4	10	4	3	6	2	6	31	36
	%	6%	3%	16%	11%	0%	3%	13%	11%	10%	17%	6%	11%	32%	11%	10%	17%	6%	17%	14%	12%
Sub Totals	#	6	6	19	22	1	6	19	18	27	33	12	26	40	35	17	33	23	39	164	218
	%	4%	3%	12%	10%	1%	3%	12%	8%	16%	15%	7%	12%	24%	16%	10%	15%	14%	18%	75%	73%
All Billing Complaint Totals	#	11	7	25	31	2	6	27	26	33	42	17	35	44	51	27	46	33	56	219	300
	%	5%	2%	11%	10%	1%	2%	12%	9%	15%	14%	8%	12%	20%	17%	12%	15%	15%	19%	100%	100%
Other Categories		5	1	6	9	1	0	8	8	6	9	5	9	4	16	10	13	10	17	55	82

Source: CRM

Enrollee billing complaints comprised 21 percent of total MCO complaints in Quarter 3 of FY 2024. Overall, the top bill type was primary care providers followed by emergency-related billing issues, which comprised thirty-two percent and sixteen 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. Wellpoint had the highest percentage of billing complaints followed by UnitedHealthcare and 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 will end on April 9, 2024. The General Assembly is considering 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, and authorizes transfer of $216,845 from Health Information Exchange to Medicaid to support IT activities.
- **HB184** (Public Health - Healthy Maryland Program - Establishment) – A bill that would establish single-payer health care program for all state residents beginning Jan. 1, 2026; all Medicaid, MCHP, Medicare & Affordable Care Act subsidy funds would be deposited into Healthy Maryland Trust Fund.
- **HB619** (Public Health - Commission on Universal Health Care) – A bill that establishes a commission to determine the feasibility of establishing a single-payer health care program.
- **HB340/SB388** (Prescription Drug Affordability Board - Authority for Upper Payment Limits & Funding) – A bill that requires the Board to establish a process for setting upper payment limits for all purchases and payor reimbursements of prescription drugs in the State that the Board determines have led or will lead to affordability challenges.
- **HB880/SB1021** (Pharmacy Benefits Administration - Md. Medical Assistance Program & Pharmacy Benefits Managers) – A bill that requires reimbursement levels for prescription drugs provided by the Medical Assistance program (incl. PBMs that contract w/ MCOs) to be at least equal to be at least equal to NADAC plus the FFS dispensing fee (does not apply to pharmacies owned by PBMs or mail-order pharmacies).
- **SB18/HB76** (Health Occupations - Pharmacists - Administration of Vaccines) – A bill that would authorize a pharmacist to order and administer certain vaccines to individuals who are at least three years old if the pharmacist has met certain conditions.
- **SB497/HB736** (Health Insurance & Md. Medical Assistance Program - Coverage - Opioid Reversal Drugs & Products) – A bill that requires Medicaid & commercial insurers to cover non-prescription naloxone hydrochloride and any other drug product approved by FDA for the complete or partial reversal of an opioid overdose without imposing a co-pay or co-insurance requirement that exceeds $10 per package.
- **SB990/HB1423** (Md. Medical Assistance Program & Health Insurance – Step Therapy, Fail-First Protocols & Prior Authorization – Prescription Drugs to Treat Serious Mental Illness) – A bill that prohibits Medical Assistance program & commercial insurers from applying a prior authorization requirement, step therapy protocol or fail-first protocol for drugs to treat serious mental illness or a medication-induced movement disorder associated w/ the treatment of mental illness.
- **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.
- **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.
- **HB167** (Public Schools – Student Health – Information on Accessible Dental Health) – A bill that requires the Maryland State Department of Education to support & facilitate each county board of education in publishing information on financially accessible dental health available in the county in student handbooks and on local school system websites.
- **HB509/SB599** (Developmental Disabilities – Community Providers – Federal Participation for Local Funds) – A bill that requires the Department to develop a process to receive FFP for the payment of county or municipal general funds appropriated to community providers that serve individuals w/ developmental disabilities, and requires the Department to allocate the FFP to the community providers to which the county or municipal general funds were appropriated.
- **HB767** (Md. Medical Assistance Program – Adult & Pediatric Dental Services – Reimbursement Rates) – A bill that requires the Department to conduct a study each year beginning Jan. 1, 2025 to conduct a review of billed charges & reimbursement rates for adult and pediatric dental services; requires the Department, based on data from the review, to revise the rates for adult & pediatric dental services provided under the Medical Assistance program to ensure sufficient access to care.
- **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.
- **HB1137** (Md. Medical Assistance Program & Health Insurance – Required Coverage for Calcium Score Testing) – A bill that requires Medicaid and commercial insurers to cover calcium score testing for individuals who have at least three of the following risk factors: diabetes, high blood pressure, high cholesterol or a family history or premature coronary artery disease.
- **HB1376** (Md. Medical Assistance Program, MCHP & Health Insurance – Special Pediatric Hospitals) – A bill that requires Medicaid and commercial insurers to provide coverage and reimbursement for a special administrative day at a special pediatric hospital, and prohibits them from requiring prior authorization for a transfer to a special pediatric hospital.
- **HB1521** (Maryland Children's Health Program - Eligibility & Administration) – A bill that eliminates the premium requirement for children enrolled in MCHP Premiums program and repeals the requirement that the program be administered through the Medical Assistance program & MCOs or the MCHP premium plan.
- **SB124/HB400** (Md. Medical Assistance Program & Health Insurance – Annual Behavioral Health Wellness Visits – Coverage & Reimbursement) – A bill that requires Medicaid coverage for annual behavioral health & wellness visits.

- **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 originally required Medicaid to provide comprehensive coverage for the treatment of obesity by July 1, 2025; Senate bill amended to require the Department (in consultation with relevant stakeholders) to study the impact of requiring Medicaid coverage for treatment of obesity; the report is due December 31, 2024.
- **SB614/HB865** (Md. Medical Assistance Program & Health Insurance – Coverage for Prostheses) – A bill that originally required Medicaid & commercial insurers to cover orthoses and prostheses by January 1, 2025; Senate bill amended to require 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.
- **SB716/HB1036** (Md. Medical Assistance Program – Maternal Fetal Medicine Services – Reimbursement) – A bill that requires Medical Assistance program to reimburse physicians billing for maternal fetal medicine services at the rate set under the federal Medicare fee schedule.
- **SB741/HB771** (Public Senior Higher Education Institutions – Pregnant & Parenting Students – Plan Requirements) – A bill that requires public senior higher education institutions to adopt a plan that informs pregnant & parenting students about the availability of government services, including Medicaid & MCHP.
- **SB876/HB1040** (Md. Medical Assistance Program – Limited Behavioral Health Services) – A bill that requires Medical Assistance program to provide limited behavioral health services to individuals under age 18 regardless of whether they have a behavioral health diagnosis, beginning Jan. 1, 2025; the Department must seek input from stakeholders in determining the services to be covered.
- **SB945/HB1043** (Md. Medical Assistance Program & Health Insurance – Individuals w/ Intellectual Disabilities – Study) – A bill that requires the Department & MIA to jointly conduct a study of the Medicaid program & commercial insurers to measure the number and percentage of individuals who have been denied coverage for treatment of an intellectual disability from July 1, 2022 to June 30, 2025; report due Dec. 1, 2025.
- **SB988** (Md. Medical Assistance Program – Self-Directed Mental Health Services – Pilot Program) – A bill that establishes Self-Directed Mental Health Services Pilot Program to facilitate access to clinically-appropriate, person-centered, culturally-responsive, and trauma-informed self-directed services in the most integrated setting appropriate; this bill requires the Governor to $1 million for program in the annual budget bill for FY26-28.

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 (January - March 2024)
Systems Performance Review (SPR)	Qlarant	In Progress	Measurement Year (MY) 2023 SPR Reporting Templates were reviewed and approved in January 2023. MY 2023 SPR Interim Review Exit Letters were approved by the Department and sent to MCOs in January 2023. The MY 2024 Draft Standards and Guidelines review began in February 2023. MY 2023 MCO SPR Final reports were reviewed and approved in March 2023. MCO Corrective Action Plans (CAP) responses are due next quarter.
EPSDT Medical Record Review	Qlarant	In Progress	MY 2022 EPSDT Singles Outreach to MCOs was performed in January 2024. The MY 2022 MCO EPSDT Reports and the MY 2023 EPSDT Performance Improvement Guide were reviewed and approved by the Department in February 2024. The MY 2022 Performance Monitoring Policy Notification for Priority Partners was issued in February 2024. The Priority Partners CAP submission is currently in review, and results will be provided next quarter. The MY 2024 EPSDT Orientation Manual was reviewed and approved by the Department at the close of March 2024. The MY 2022 Statewide Executive Summary review will be completed next quarter. MY 2023 EPSDT Onsite Review Training will also begin next quarter.
Consumer Report Card (CRC)	Qlarant	Complete	The 2024 CRC results summary was reviewed and approved by the Department in January 2024. CRC blinded results summaries for all MCOs were disseminated in February 2024, along with the MY 2024 CRC. The MY 2024 CRC has been published in English and Spanish on the Department HealthChoice Quality Assurance website.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	Qlarant performed technical assistance training in January 2024 for Jai before its MY 2023 Annual PIP submission. The MY 2022 Annual PIP Validation Report was reviewed, approved, and uploaded to the Department HCQA website in March 2024. The Department conducted the Annual PIP Validation Report review and concluded in March 2024. The MY 2024 PIP Orientation Manual and Postpartum Annual PIP Template are currently in review and will be approved by the Department next quarter. MY 2024 Q1 MCO PIP Submissions will be reviewed next quarter.
Encounter Data Validation (EDV)	Qlarant	Complete	The Hilltop Institute provided the Department and the EQRO with the finalized Encounter Data Validation report for calendar years (CYs) 2020-2022 for Activity 3, which was approved in February 2024. The EQRO MY 2022 EDV Report was also reviewed and approved at the close of February 2024. No MCOs received EDV CAPs for MY 2022.
Network Adequacy Validation (NAV)	Qlarant	Complete	MY 2023 NAV CAPs were reviewed and approved in January 2024, with the next round of NAV CAP updates submitted in March 2024 for Jai, Kaiser, Priority Partners, and UHC. UHC requested technical assistance with the Department to discuss its NAV CAP notification in February 2024 before its March 2024 NAV CAP submission. Qlarant submitted the MY 2024 NAV data request to MCOs in February 2024. MCO NAV CAPs were finalized, reviewed, and approved in March 2024. The next CAP submission is due next quarter.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	Complete	In January 2024, a revised MCO GAD reporting template was submitted to all MCOs to synonymously reflect CMS's updated MCPAR reporting template guidelines ahead of the month's Quarterly MCO GAD Submission. Discussions continued within the Department regarding opportunities for improvement (OFI) implementation through February 2024. Qlarant presented the MY 2023 MCO Annual GAD Review and narrative findings to the Department in March 2024. The MY 2022 GAD Report and the MY 2023 GAD Report template were reviewed and approved in March 2024.

Activity	Vendor	Status	Comments (January - March 2024)
HEDIS Audits and Reporting (HEDIS)	MetaStar	In Progress	In January, MetaStar completed sample frame validation and approved the CAHPS sample file that will be used with the 2024 CAHPS Survey Administration. Some final reports provided by the HEDIS vendor were updated and resubmitted due to some discrepancies with a portion of the data and the inadvertent omission of some data from the reports. As a result, the Department required a corrective action plan for the HEDIS vendor moving forward for future reporting. All HealthChoice MCOs submitted HEDIS Roadmaps for MY 2023 by the end of January, meeting the deadline required by NCQA. The HealthChoice MCO audit visits were completed by the HEDIS vendor, virtually, for HEDIS Measurement Year MY 2022 in February and March, with no significant issue identified. The HEDIS vendor reported at the quarterly meeting in March on the MY 2022 Statewide Analysis Report, the MY 2023 Performance Monitoring Measures that the HealthChoice MCOs will be required to report, and MY 2023 Audit reminders.
Population Health Incentive Program (PHIP)	Qlarant	Complete	MY 2022 MCO PHIP Benchmark percentiles were reported in January 2024. The MY 2022 PHIP report was reviewed, approved, and made available to all MCOs in March 2024.
CAHPS Survey Administration (CAHPS)	CSS	In Progress	In January, the Department uploaded approved sample frame files to CSS's secure file exchange portal for use with the 2024 survey administration. The Department reviewed and approved questionnaires and all collateral materials, which were subsequently submitted by CSS to NCQA and approved by the end of January. CSS provided sample frame demographics reports to the Department in late January with no issues identified. In February, CSS provided the Department with the survey sample size for each HealthChoice MCO. The survey fielding period began in February with CSS mailing the survey questionnaires to HealthChoice recipients. The CAHPS Response Rate Report showing early survey response rates for each MCO was made available in March to the Department and shared at the March QALC with the MCOs. Ongoing processing of surveys continued through March and will be followed by the telephone outreach phase of the survey.
Primary Care Provider (PCP) Satisfaction Survey Administration	CSS	In Progress	CSS received test data files from all HealthChoice MCOs to ensure that the layout of the files provided for the PCP survey administration was correct. All HealthChoice MCOs provided their individual PCP Data files to the survey vendor in January by the required due date with no issues. Survey mailings began in March with the fax and email phase of the survey, followed by the mailing phase and first reminder postcards. Ongoing processing and mailing of surveys continued throughout March.
Annual Technical Report (ATR)	Qlarant	In Progress	The subsequent MY 2023 ATR Draft, which included the latest GAD and NAV activity results, was reviewed and approved in January 2024. EPSDT and EDV Findings were reviewed and approved in March 2024. The next round of review will occur next quarter.

Activity Highlights

Consumer Report Card

The below chart provides results of the MY 2024 Consumer Report Card.

Performance Areas	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Access to Care	★	★★	★★★	★	★★★	★★	★★★	★★	★★
Doctor Communication and Service	★	★★	★★★	★	★★★	★	★★★	★★	★★
Keeping Kids Healthy	★	★	★★★	★★★	★	★	★★	★★	★★★
Care for Kids with Chronic Illness	N/A	★★	N/A	N/A	★★★	★★	★★	★	★★
Taking Care of Women	★	★★	★★★	★★★	★★	★★	★★	★	★★
Keeping Adults Healthy	★	★★	★★★	★★★	★★	★	★	★★	★

□□□= Above HealthChoice Average; □□ = HealthChoice Average; □ = Below HealthChoice Average; N/A = Not Applicable. N/A does not describe the performance or quality of care provided by the MCO.

- Jai, MPC, and Priority Partners were rated Above HealthChoice Average in the Access to Care and Doctor Communication and Service categories.
- Jai and Kaiser were rated Above HealthChoice Average in the Taking Care of Women and Keeping Adults Healthy categories.
- MPC was rated Above HealthChoice Average in Care for Kids with Chronic Illness, and four MCOs (CareFirst, MedStar, Priority Partners, and Wellpoint) rated at the HealthChoice Average in that category.
- There are opportunities for improvement in all performance areas for ABH, outside of Care for Kids with Chronic Illness.

Encounter Data Validation

The EQR Encounter Data Validation Report for MY 2022 resulted in no EDV CAPs required. MCOs achieved a match rate of 98 percent overall, meaning encounters submitted were largely supported by medical record documentation: 100 percent for inpatient, 99 percent for outpatient, and 96 percent for office visits.

All MCOs achieved match rates ranging from two to ten percentage points above the standard of compliance (90 percent), from MYs 2020 to 2022. Inpatient encounters overall ranged from 99 percent to 100 percent match rates for MY 2022. Outpatient encounters overall ranged from 97 percent to 100 percent for MY 2022. Office visit encounters overall ranged from 93 percent to 99 percent for match rates for MY 2022.

Network Adequacy Validation (NAV)

The MY 2023 HealthChoice MCO Aggregate results for Validation of Online Provider Directories ranged from 78 percent to 97 percent compliance across MCOs, compared to an 80 percent minimum compliance score. Discussions with Qlarant have commenced for a new NAV protocol methodology to comply with the updated protocol issued in February 2023. Kaiser was required to submit a NAV CAP for non-compliance with urgent care appointment timeframes, as well as non-compliance with routine care appointment timeframes. Jai, Priority Partners, UHC, and Wellpoint were required to submit NAV CAPs for online provider directory non-compliance. The next round of NAV CAPs will be reviewed next quarter.

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

Below is a summary of the annual 2023 findings from the GAD activity.

Member Grievances: The annual median for member grievances totaled 4.48 per 1,000 members across all MCOs. CareFirst, Priority Partners, UHC, and Wellpoint totaled below the median, while Jai, Kaiser, and MedStar totaled greater than the median for grievances. CareFirst had the lowest rate of member grievances at 1.08 and Kaiser had the highest rate at 20.50. The most prevalent reason codes for member grievances in order across MCOs were Attitude/Service and Attitude/Service-Administrative Staff, followed by Access and Access - Pharmacy/Prescription Issues. The lowest member grievance reason code was Billing and Financial.

Aetna, CareFirst, Jai, MPC, Medstar, Priority Partners, and Wellpoint met all performance requirements for member grievance resolution timeliness. Kaiser did not meet compliance turnaround time due to 12 emergency medically related grievances. For UHC, resolution turnaround time metrics were not met in the categories of Emergency Medically Related (80 percent) and Non-Emergency Medically Related member grievances (74 percent).

Provider Grievances: The annual median for provider grievances totaled 0.36 per 1,000 members across all MCOs. Kaiser continued to report no provider grievances throughout MY 2023. Wellpoint had the highest total of provider grievances at 6.85 per 1,000 members, while Jai had the lowest total at 0.08. The top three provider grievance categories reported throughout MY 2023 were Finance/Billing, Attitude and Service, Administrative Staff MCO Customer Service, and Other. Aetna, CareFirst, Kaiser, Jai, MPC, Medstar, and Priority Partners met resolution timeliness for provider grievances. UHC's provider grievance resolution timeliness turnaround time fell to 94 percent compliance, and Wellpoint fell to 92 percent compliance.

Appeals: The annual median for member appeals across all MCOs was 2.91 per 1000 members. Jai, Kaiser, Medstar, and Wellpoint totaled below the median, while CareFirst, MPC, Priority Partners, and UHC totaled above the median. Aetna totaled at the mid-range for member appeals. Out of all MCOs, Priority Partners had the highest total of member appeals at 13.27 per 1000 members, and Kaiser had the lowest at 0.47. In order of prevalence, the top five member appeal service codes were Medical Surgical, Pharmacy Services, DME/DMS, Medical Surgical: related to Therapies, and Diagnostic Lab: Radiology. Aetna, CareFirst, Jai, Kaiser, Medstar, Priority Partners, UHC, and Wellpoint met the required appeal resolution timeframe for both expedited and non-emergency appeals. MPC fell from 100 percent compliance in the first three quarters of 2023 to 92 percent in expedited appeals resolution timeframe compliance.

Denials: The annual median for pre-service denials across all MCOs was 84.64 per 1000 members. MPC had the highest denial rate at 153.77, followed by UHC, ABH, and Wellpoint. Kaiser had the lowest denial rate at 8.40, followed by Medstar, Jai, and Priority Partners. CareFirst totaled at the mid-range. In order of prevalence, the top five pre-service denial service codes were Medical/Surgical, Pharmacy Services, Diagnostic/Lab: Radiology, DME/DMS, and Medical/Surgical - related to Therapies (PT/OT/SLP) tied with Pharmacy Services - Chronic Pain Management. All nine MCOs met or exceeded the 95 percent compliance requirement for timeliness of a denial resolution, and notification requirements.

Population Health Incentive Program (PHIP)

PHIP is an incentive program designed to provide financial incentives to MCOs for meeting or exceeding defined benchmarks or demonstrating significant improvement in a subset of HEDIS measures and the Department-developed encounter measures.

Round 1 (Two Tiers)

Tier 1: Comparison of HEDIS performance measures to national benchmarks and non-HEDIS measures to HealthChoice benchmarks

Tier 2: Determine meaningful measure improvement compared to prior year performance.

Round 2

Rewards plans who earned more than 80% of Round 1 incentives and performed well on the HEDIS Performance Monitoring Policy requirements for the measurement year with an additional bonus payment.

In Round 1 - Tier 1, all nine MCOs received a financial reward for performance. Six of the nine MCOs (Aetna, CareFirst, MPC, MedStar, Priority Partners, and UHC) received an additional incentive for improvement in Round 1, Tier 2. No MCO received a Round 2 incentive for MY 2022.

Performance Incentives: MY 2022 PHIP Benchmark Percentiles for Round 1, Tier 1

Measure	ABH	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC	WPM
Ambulatory Care Visits for SSI Adults (MDH)	58.6%	72.6%	87.1%	70.9%	82.6%	79.6%	82.0%	76.2%	77.9%
Ambulatory Care Visits for SSI Children (MDH)	47.0%	70.5%	81.3%	71.0%	81.9%	75.3%	82.6%	75.2%	78.8%
Asthma Medication Ratio (AMR)	56.2%	75.8%	68.6%	98.1%	71.4%	65.4%	67.3%	56.8%	66.9%
Continued Opioid Use (COU): >=31 days covered^	3.5%	3.4%	3.9%	0.8%	3.8%	2.3%	3.9%	3.4%	2.4%
Hemoglobin A1c Control for Patients with Diabetes (HBD): Poor HbA1c Control (>9%)^	38.0%	38.0%	29.2%	30.7%	32.9%	30.7%	32.4%	36.3%	37.2%
Lead Screening in Children (LSC)*	66.2%	67.2%	82.2%	84.8%	65.0%	75.4%	72.0%	67.3%	74.0%
Lead Screenings for Children – Ages 12 to 23 Months* (MDH)	53.5%	58.0%	74.5%	69.6%	55.9%	61.0%	63.2%	56.0%	60.2%
Prenatal and Postpartum Care (PPC): Postpartum Care	78.6%	83.5%	85.3%	87.3%	83.5%	88.0%	82.0%	74.9%	80.4%
Prenatal and Postpartum Care (PPC): Timeliness of Prenatal Care	84.2%	88.9%	87.7%	88.6%	89.1%	83.2%	92.2%	87.4%	90.0%

Red = <50th percentile (no incentive); Yellow = 50-74th percentile (strong); Light green = 75-89th percentile (very strong); Dark green = 90th percentile (superlative)
*These measures are valued as a composite combining two submeasures, with each weighted at 50%: an MDH-homegrown measure for lead screenings in children, and a HEDIS measure for lead screening in children (LSC).
^A lower rate indicates a better performance.

HEDIS Audits and Reporting

The MY 2022 HEDIS Executive Summary was finalized. Maryland MCO MY 2022 HEDIS performance normalized to rates similar to those reported in the measurement years before the COVID-19 pandemic.

All nine MCOs scored at or above the Medicaid National HEDIS Mean (NHM) for the following measures: Chlamydia Screening in Women (CHL), Hemoglobin A1c Control for Patients With Diabetes (HBD): Hemoglobin A1c control <8, HBD Hemoglobin A1c poor control >9, CIS Combo 3, Risk of Continued Opioid Use (COU): 15 days, Kidney Health Evaluation for Patients With Diabetes (KED), Lead Screening in Children (LSC), and PPC -Timeliness of Prenatal Care.

Eight of nine MCO rates rated at or above the Medicaid NHM for the following measures: Breast Cancer Screening (BCS), Childhood Immunization Status (CIS) Combo 10, Appropriate Testing for Pharyngitis (CWP), Pharmacotherapy Management of COPD Exacerbation (PCE) Bronchodilator, Pharmacotherapy for Opioid Use Disorder (POD), Prenatal and Postpartum Care (PPC) -Postpartum Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) Nutrition Counseling, and WCC Physical Activity.

CAHPS Survey Administration

Adult Survey: The 2023 HealthChoice Aggregate performed on par with 2022 measures with one measure exception: *Getting Needed Care*. The percentage of recipients indicating "Usually"

or “Always” getting needed care was 78.19 percent in 2023, compared to 82.78 percent in 2022 and 84.61 percent in 2021.

HealthChoice exhibited a consistent negative directional trend on the *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Personal Doctor* measures. For the measures *Getting Care Quickly*, *Rating of All Health Care*, *Coordination of Care*, and *Customer Service*, HealthChoice scored in the middle third of the 2022 NCQA Quality Compass Adult Medicaid percentile distribution. HealthChoice scored in the bottom third on *Getting Needed Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, and *How Well Doctors Communicate* and scored in the bottom decile for *Rating of Specialist Seen Most Often*.

Child Survey: The 2023 HealthChoice Aggregate performed poorly overall, scoring in the bottom decile of the 2022 NCQA Quality Compass Child Medicaid National distribution on four of the nine non-Children with Chronic Conditions (CCC) measures (*Rating of Specialist Seen Most Often, Coordination of Care, How Well Doctors Communicate,* and *Customer Service*) and one CCC measure (*Coordination of Care for Children with Chronic Conditions*).

On all other measures, the 2023 HealthChoice Aggregate scored in the bottom third. Six non-CCC measures and one CCC measure have seen consistent three-year declines and two measures (*How Well Doctors Communicate* and *Customer Service*) have seen a statistically significant decline from 2022. One CCC measure (*Personal Doctor Who Knows Child*) has seen a consistent three-year gain.

Primary Care Provider (PCP) Survey Administration

In 2023, 58 percent of HealthChoice PCPs reported being “Very satisfied” or “Somewhat satisfied” with the specified MCO. Likewise, 86.20 percent of PCPs would recommend the specified MCO to patients, and 86.46 percent of PCPs would recommend the specified MCO to other physicians; however, both rates are lower than the 2022 rates of 88.56 and 88.35 percent, respectively.

The loyalty analysis indicated that of the PCPs surveyed for 2023, 36.09 percent of PCPs are considered loyal, 2.28 percent of PCPs are considered not loyal, and the remaining 61.63 percent of PCPs are indifferent. The percentage of loyal providers showed a statistically significant decrease compared to the percentage of loyal providers in 2022 (42.50 percent).

Demonstration Evaluation

During the quarter, the Department submitted a Waiver Amendment 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 is pending CMS approval. The Express Lane Eligibility Amendment is also pending CMS approval.

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 is scheduled for May 23, 2024 during the monthly MMAC meeting.

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