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Maryland HealthChoice Demonstration
Section §1115 Annual Report
Demonstration Year 28: 7/1/2024 - 6/30/2025
Quarter 1: July 1, 2024 - September 30, 2024

Introduction

Now in its twenty-eighth 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—formerly the Maternal Opioid Misuse (MOM) Model--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.

Pending Amendments

Submitted as a Waiver Amendment request in 2023, the Department is seeking authority to include the Modified Adjusted Gross Income (MAGI) adult population in an Express Lane

Eligibility (ELE) program, enabling Maryland to renew Medicaid coverage for certain adults based on Supplemental Nutrition Assistance Program (SNAP) data. Additionally, the Department 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 under CMS review.

The Department is also 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 Waiver Amendment request, submitted on March 6, 2024, is under CMS review.

During the quarter, the Department gave public notice of its intent to sunset the Women's Breast and Cervical Cancer Program (WBCCHP) effective August 1, 2024. Following passage of the Affordable Care Act (ACA), in 2014, the Department expanded Medicaid to cover adults up to 138 percent of the federal poverty level (FPL) and the State launched the Maryland Health Connection to make qualified health plans available along with advanced premium tax credits and cost-sharing subsidies to higher income individuals. In response, the Department closed WBCCHP to new enrollees. The Department permitted existing enrollees between 138 percent and 250 percent FPL in active treatment for breast or cervical cancer as of December 31, 2013 to continue coverage. These WBCCHP enrollees qualify for comprehensive Medicaid coverage. As of April 2024, 27 individuals remained enrolled in the program.

Former WBCCHP enrollees have qualified for a sixty-day Special Enrollment Period (SEP) through Maryland Health Connection as a result of the loss of minimum essential coverage. Individuals over 65 also qualified for a six-month Medicare SEP to enroll in Medicare Part A and Part B. CMS approved the Department's plan to sunset the program effective August 1, 2024 in May 2024; the Department held a public comment period on this waiver program sunset from May 17, 2024 to June 16, 2024.

The Department has also submitted a Waiver Amendment request that 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, and an expansion of Express Lane Eligibility for non-MAGI income adults. The Waiver Amendment Request was submitted on November 14, 2024 to CMS.

The current §1115 waiver period was approved on December 10, 2021 for a period of January 1, 2022 through December 31, 2026. The Department has begun preparations for the upcoming waiver renewal 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 calendar year (CY) 2025.

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Enrollment Information

Table 1 below provides a comparison of enrollment counts between the previous and current years. The Department resumed normal operations after twelve months of unwinding in May 2024.

Table 1. Enrollment Counts[1]

Demonstration Populations	Participants as of June 30, 2024	Participants as of September 30, 2024
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	78,775	76,779
SSI/BD Children	19,615	19,722
Medically-Needy Adults	25,729	26,255
Medically-Needy Children	5,256	5,396
Medicaid Children	528,555	499,635
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	267,954	256,898
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	21,059	21,251
Affordable Care Act (ACA) Expansion Adults	422,600	401,890
Maryland Children's Health Program (MCHP)	139,135	144,332
MCHP Premium	36,661	41,379
Presumptively Eligible Pregnant Women (PEPW)	*	*
Increased Community Services (ICS)	14	12
Women's Breast and Cervical Cancer Health Program (WBCCHP)[2]	17	*

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

Table 2. Member Months

Eligibility Group	Total for Quarter Ending June 2024	Current Quarter Month 1	Current Quarter Month 2	Current Quarter Month 3	Total for Quarter Ending September 2024
SSI/BD Adults	238,464	78,171	77,479	76,779	232,429
SSI/BD Children	58,890	19,710	19,725	19,722	59,157
Medically-Needy Adults	83,182	25,784	25,890	26,255	77,929
Medically-Needy Children	16,694	5,322	5,343	5,396	16,061

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

[2] The WBCCHP Waiver Program has been sunset, effective August 1, 2024; CMS approved this sunset.

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Eligibility Group	Total for Quarter Ending June 2024	Current Quarter Month 1	Current Quarter Month 2	Current Quarter Month 3	Total for Quarter Ending September 2024
Children	1,601,310	509,433	502,292	499,635	1,511,360
Parents/caretakers and former foster care	814,682	265,241	261,540	256,898	783,679
SOBRA	62,590	21,541	21,395	21,251	64,187
ACA expansion	1,280,086	417,851	410,113	401,890	1,229,854
MCHP	406,722	141,018	142,743	144,332	428,093
MCHP Premium	109,406	38,593	39,486	41,379	119,458
PEPW	19	-	-	-	-
ICS	42	14	12	12	38
WBCCHP	71	15	*	*	19

Outreach/Innovative Activities

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

In 2016, 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 was approved by CMS on November 14, 2024; results from Part B of the SMI Monitoring Report will be included with the FY 2025 report.

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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 (CMMI), the MOM program addresses fragmentation in care through the provision of enhanced case management services, led by Medicaid's nine MCOs.

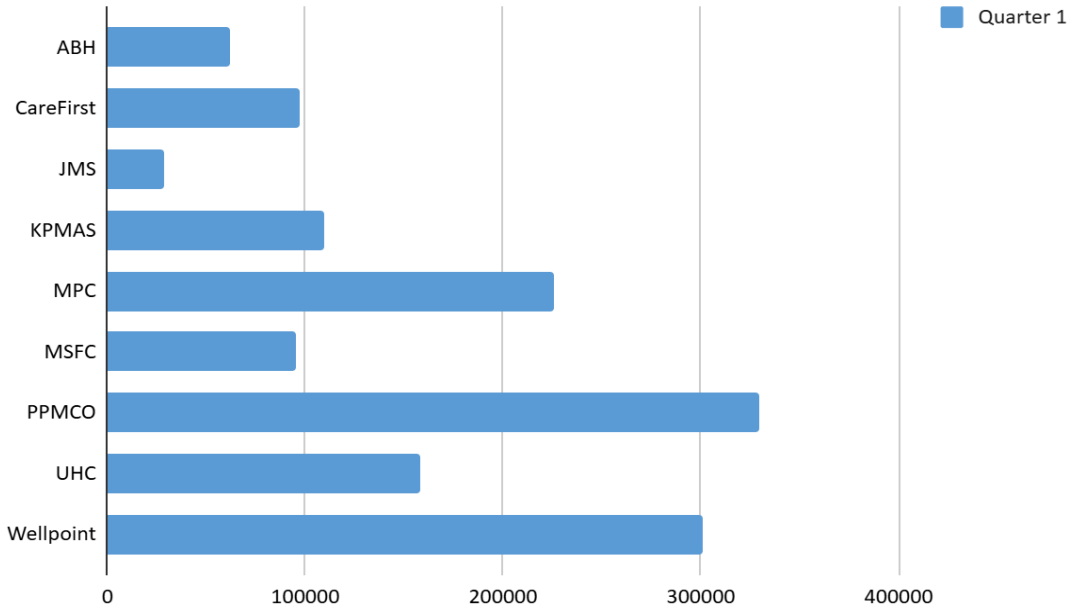
Under the Maryland MOM program, HealthChoice MCOs provide a set of enhanced case management services, standardized social determinants of health screenings, and care coordination. During this quarter, the Department continued participant enrollment statewide. A total of 108 participants have been enrolled in the program as of September 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.

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 (4.4 percent); CareFirst Community Health Plan of Maryland (6.9 percent); Jai Medical Systems (2.0 percent); Kaiser Permanente (7.8 percent); Maryland Physicians Care (16.0 percent); MedStar Family Choice (6.8 percent); Priority Partners (23.4 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 July and September. 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 July meeting, the MMAC was briefed on the results of the Medicaid redetermination process that took place over the last year. The MMAC was provided an overview and demonstration of the new Medicaid Provider Directory, and an overview of the Engaging Neighborhoods, Organizations, Unions, Governments, and Households (ENOUGH) initiative. The ENOUGH initiative is a first-of-its-kind, state-led, place-based investment strategy designed to create poverty-fighting opportunities driven by communities, data, and cross-sector partnerships, led by the Governor's Office. The MMAC was also given an update on the new upcoming request for applications for certification organizations for doulas. The MMAC did not meet in August 2024.

During the September meeting, the MMAC was provided with an update on contract renewals and negotiations between the Department and Kaiser Permanente that will enable the MCO to continue to participate as a HealthChoice managed care organization in 2025. The MMAC was also provided with updates to the §1115 Waiver Amendment submission, Maryland Health Benefits Exchange Open Enrollment, and the results of the 2023 Nursing Home Family Experience of Care Survey.

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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 2025	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	266	197	60	36	4,485
Quarter 2					
Quarter 3					
Quarter 4					

Table 5. REM Complaints

FY 25 Q1 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	0	0	0
Dental	3	0	3
DMS/DME	3	0	3
EPSDT	0	0	0
Clinical	2	0	2
Pharmacy	2	0	2
Case Mgt.	9	0	9
REM Intake	0	0	0
Access to MA Providers	5	0	5
Nursing	10	0	10
Other	0	0	0
Total	36	0	36

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

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FY 24 Incidents	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Abuse	1	0	0	0
Complaint	36	0	0	0
Death	18	0	0	0
Elopement	0	0	0	0
ER	1	0	0	0
Exploitation	0	0	0	0
Failure to Follow Plan (Non-Compliance)	1	0	0	0
Fall	0	0	0	0
Hospitalization	14	0	0	0
Medication Error	1	0		0
Neglect	10	0	0	0
Suicidal Ideation	3	0	0	0
Theft	0	0	0	0
Wound	0	0	0	0
Other	33	0	0	0
Total	**118**	**0**	**0**	**0**

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

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. Before 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.

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HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Since September 2019, the HealthChoice Diabetes Prevention Program (HealthChoice DPP) has enabled MCOs to provide the National Diabetes Prevention Program (National DPP) to eligible participants statewide. There were 2,330 encounters with DPP procedure codes provided by licensed Medicaid-enrolled DPP providers to 564 unique participants between September 1, 2019, and July 30, 2024. Among the 564 unique Medicaid beneficiaries with a DPP encounter, most were women (86 percent), Black/African American (63 percent), and resided in Prince George's County (27 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 July 30, 2024, 30 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 this quarter, the ACIS pilot had 533 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 concluded its rate study with external partners and presented it to the PEs. The study concluded that the ACIS rates have been competitive.

An LE reported that one of the ACIS participants was moved into a coalition housing while waiting for a Section 8 voucher to be approved providing the individual with housing security. 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.

One of the ACIS LEs has indicated that Section 8 vouchers are currently on a freeze leading to difficulty in getting participants housed. Eviction assistance also is seen to be scarce and funding sources for security deposits are also limited and low in number currently. Individuals slotted to get housed through the Continuum of Care (CoC) housing program are having difficulties due to funding issues as rents are increasing in certain areas.

Work is underway to expand the ACIS pilot statewide and LEs are expected to begin billing the Department beginning January 2025. The Department has submitted an §1115 waiver amendment in Quarter 2 of FY25 requesting CMS to increase the number of authorized participant spaces and update the payment methodology for ACIS allowing ACIS to serve more eligible Medicaid participants 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)

During September 2024, Hilltop participated in one-on-one meetings with each MCO along with the Department to discuss the CY 2025 rates. Key topics discussed included the emerging weight-loss drugs, PHE enrollment impacts, acuity measurement, and methods, plan risk score (PRS) methods for HIV, AIDS, and geographically/demographically rate populations. Hilltop calculated the impact of both legislative and non-legislative programmatic changes on CY 2025 rates. These changes included adjustments for vaccine fee schedule increases such as rotavirus and Hepatitis A, respiratory syncytial virus (RSV), fertility preservation services, the cessation of certain COVID cost reimbursements outside of rates, and PHE acuity changes per emerging data.

Hilltop allocated $36 million of funding for the Maryland Quality Innovation Program (MQIP) for CY 2025. Hilltop worked with the Department to reevaluate the list of carved out, high-cost, low-volume (HCLV) drugs, resulting in revisions to the final 2024 and initial 2025 lists. Hilltop delivered final CY 2023 HFMR instructions to the MCOs with an emphasis on consistently defining PCP care, clarifying that hospital inpatient claims should use date of service (DOS) rather than admit date, and exclusion of improper, zero-pay, and denied encounters.

Hilltop participated in numerous meetings with one MCO to establish a commitment to rework financial reporting and fee schedules to begin to include this MCO in the base experience for rate setting. Hilltop aggregated and analyzed the pre-audit 2023 HFMRs by region, MCO, and rate cell. Finally, new analyses were initiated related to specialty and J-code drugs.

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MCO Rates

Activities in Support of the CY 2025 HealthChoice Rates

The Department and Hilltop held three meetings with the MCOs on July 18, August 23, and August 27, 2024. Topics covered included PHE unwinding and acuity impacts, year-to-date (YTD) actual financial results including risk-based capital (RBC), final claims trend assumptions, PCP spend by MCOs versus targets from the All-Payer Health Equity Approaches and Development (AHEAD) model, rejected encounters, the health equity incentive, MCO-specific hospital claims denials, non-claims loading, and federally qualified health center (FQHC) adjustments to the market rate per visit.

The year-over-year (YoY) rate increase from measurement year 2024 rates to provisional 2025 rates (PR25) is +3.5 percent. Hilltop provided several breakdowns of this increase by MCO, region, and category of aid. Prior to finalization, the rates were presented to and discussed with the Secretary at the Department of Budget and Management (DBM). For context, financial results for YTD Quarter 2 of 2024 were gathered by Hilltop from quarterly financial statements and shared with the Department and MCOs. The YTD gain/loss—excluding one MCO—was +$96 million or +2.6 percent of revenue.

Work continued for Year 2 of the health equity incentive (HEI). The top six most disadvantaged counties were updated; $8 million was allocated to those MCOs serving those counties the most for CY 2025. Hilltop coordinated responses to issues raised by the Maryland Managed Care Organization Association (MMCOA) related to rate adjustments for the PHE acuity impacts, Health Services Cost Review Commission (HSCRC)-based measurement year 2024 impacts, and GLP-1 drugs.

Activities in Support of the CY 2024 HealthChoice Rates (and Prior)

Hilltop calculated that the initial measurement year 2024 supplemental adjustments from actual data through September 30, 2024. Hilltop collaborated with Optumas and the Department to finalize the CY 2024 list of high-cost, low-volume drugs.

Other Rate Setting Team Activities

Hilltop provided the Department with quarterly trauma payments for CY 2024 for each MCO and fielded individual MCO inquiries most often related to risk corridors, the PHE, the HSCRC, and the midyear calculations. Hilltop guided the modeling of the costs over the next five years for seven biomarkers plus expanded carrier testing (ECT) for a departmental report. Hilltop collaborated with the Department to reevaluate behavioral and mental health drugs for carving in or out of the MCO benefit package.

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

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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 51,106 calls in Quarter 1 of FY 2025. 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 a FFS basis.

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

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Table 7. Total Recipient Complaints – Quarter 1 FY 2025

CMS Quarterly Report
Total Recipient Complaints - excluding Billing
1st Quarter, FY 2025

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	
4th Q FY 24 vs. 1st Q FY 25		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Pharmacy	#	17	27	29	34	10	6	20	13	50	44	45	39	65	60	106	80	43	39	385	342
	%	4%	8%	8%	10%	3%	2%	6%	4%	13%	13%	12%	11%	17%	18%	28%	23%	11%	11%	36%	35%
Prenatal	#	14	10	24	13	1	0	17	10	19	13	8	17	35	25	24	29	15	27	157	144
	%	9%	7%	15%	9%	1%	0%	12%	7%	12%	9%	5%	12%	22%	17%	15%	20%	10%	19%	15%	15%
PCP	#	9	13	13	6	0	8	4	7	7	15	6	7	22	9	11	16	21	14	93	95
	%	10%	14%	14%	6%	0%	8%	4%	7%	8%	16%	6%	7%	24%	9%	12%	17%	23%	15%	9%	10%
Specialist	#	10	7	15	18	3	1	10	6	26	18	2	6	11	12	17	14	14	12	108	94
	%	9%	7%	14%	19%	3%	1%	11%	6%	24%	19%	2%	6%	10%	13%	16%	15%	13%	13%	10%	10%
Sub Totals	#	50	57	81	71	14	15	51	36	102	90	61	69	133	106	158	139	93	92	743	675
	%	7%	8%	11%	11%	2%	2%	7%	5%	14%	13%	8%	10%	18%	16%	21%	21%	13%	14%	69%	70%
All Complaint Totals	#	66	76	100	91	16	17	66	42	208	171	79	87	192	150	209	179	134	151	1070	964
	%	6%	8%	9%	9%	1%	2%	6%	4%	19%	18%	7%	9%	18%	16%	20%	19%	13%	16%	100%	100%
Other Categories		16	19	19	20	2	2	15	6	106	81	18	18	59	44	51	40	41	59	327	289

Source: CRM

There were 1,424 total MCO recipient complaints in Quarter 1 of FY 2025 (all ages). Eighty-two percent of the complaints (1,163) were related to access to care. The remaining eighteen percent (261) were billing complaints.

The top two member complaint categories were accessing pharmacy and prenatal services, respectively. Pharmacy complaints made up the majority of complaints (342). Specialist services complaints comprised ten percent of total complaints during the first 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.

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Table 8. Recipient Complaints Under Age 21 – Quarter 1 FY 2025

CMS Quarterly Report
Total Recipient Complaints - excluding Billing: Under age 21 only
1st Quarter, FY 2025

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	
4th Q FY 24 vs. 1st Q FY 25		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Pharmacy	#	2	3	4	4	0	0	2	4	5	5	9	6	14	10	16	12	14	6	66	50
	%	3%	6%	6%	8%	0%	0%	3%	8%	4%	10%	14%	12%	21%	20%	24%	24%	3%	12%	29%	25%
PCP	#	3	6	5	0	0	2	2	2	0	6	2	1	17	3	4	6	8	8	41	34
	%	7%	18%	12%	0%	0%	6%	5%	6%	1%	18%	5%	3%	41%	9%	10%	18%	1%	24%	18%	17%
Specialist	#	3	3	3	3	0	0	4	3	6	10	0	2	5	2	8	3	4	2	33	28
	%	9%	11%	9%	11%	0%	0%	12%	11%	5%	36%	0%	7%	15%	7%	24%	11%	12%	7%	14%	14%
Prenatal	#	1	1	7	3	0	0	0	1	6	3	0	3	5	3	2	7	3	3	24	24
	%	4%	4%	29%	13%	0%	0%	0%	4%	25%	13%	0%	13%	21%	13%	8%	29%	13%	13%	10%	12%
Sub Totals	#	9	13	19	10	0	2	8	10	17	24	11	9	41	18	30	28	9	19	144	136
	%	6%	10%	13%	7%	0%	1%	6%	7%	12%	18%	8%	7%	28%	13%	21%	21%	6%	14%	63%	68%
All EPSDT Complaint Totals	#	11	17	21	16	1	3	13	10	37	40	15	15	50	28	41	38	41	32	230	199
	%	5%	9%	9%	8%	0%	2%	6%	5%	16%	20%	7%	8%	22%	14%	18%	19%	18%	16%	100%	100%
Other Categories		2	4	2	6	1	1	5	0	20	16	4	6	9	10	11	10	32	13	86	63

Source:CRM

There were 199 member complaints (non-billing) for recipients under age 21 in Quarter 1 of FY 2025, or 14 percent of the total complaints. The top complaint category was access to pharmacy services. Maryland Physicians Care, 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.

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Table 9. Total Recipient Billing Complaints – Quarter 1 FY 2025

CMS Quarterly Report
Total Recipient Complaints - Billing only
1st Quarter, FY 2025

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	
4th Q FY 24 vs. 1st Q FY 25		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Emergency	#	1	3	9	8	1	2	6	5	10	6	5	6	14	18	8	4	5	6	59	58
	%	2%	5%	15%	14%	2%	3%	10%	9%	17%	10%	8%	10%	24%	31%	14%	7%	8%	10%	18%	22%
PCP	#	6	6	5	8	2	0	9	9	17	13	6	11	18	19	15	14	17	9	95	89
	%	6%	7%	5%	9%	2%	0%	9%	10%	18%	15%	6%	12%	19%	21%	16%	16%	18%	10%	29%	34%
Laboratory/ Test	#	3	1	5	2	2	0	1	4	13	4	4	2	10	7	4	4	1	6	43	30
	%	7%	3%	12%	7%	5%	0%	2%	13%	30%	13%	9%	7%	23%	23%	9%	13%	2%	20%	13%	11%
Specialist	#	0	4	0	0	1	1	3	5	4	7	9	5	4	3	11	4	6	3	38	32
	%	0%	13%	0%	0%	3%	3%	8%	16%	11%	22%	24%	16%	11%	9%	29%	13%	16%	9%	12%	12%
Sub Totals	#	10	14	19	18	6	3	19	23	44	30	24	24	46	47	38	26	29	24	235	209
	%	4%	7%	8%	9%	3%	1%	8%	11%	19%	14%	10%	11%	20%	22%	16%	12%	12%	11%	73%	80%
All Billing Complaint Totals	#	16	18	30	23	7	6	31	28	55	36	31	26	69	58	47	34	37	32	323	261
	%	5%	7%	9%	9%	2%	2%	10%	11%	17%	14%	10%	10%	21%	22%	15%	13%	11%	12%	100%	100%
Other Categories		6	4	11	5	1	3	12	5	11	6	7	2	23	11	9	8	8	8	88	52

Source: CRM

Enrollee billing complaints comprised 18 percent of total MCO complaints in Quarter 1 of FY 2025. Overall, the top bill type was primary care providers followed by emergency-related billing issues, which comprised thirty-four percent and twenty-two percent, respectively, followed by specialist and laboratory/test 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 2025 session will begin on January 8, 2025.

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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 (July - September 2024)
Systems Performance Review (SPR)	Qlarant	In Progress	The measurement year (MY) 2024 Orientation Manual and the SPR Standards and Guidelines with an additional Standard 12 newly developed to meet Disenrollment requirements were finalized and approved by the Department in September 2024. MY 2023 SPR Corrective Action Plans (CAPs) were reviewed and approved for Carefirst, Kaiser, and Wellpoint; SPR Quarterly CAPs are due next quarter in November 2024.
EPSDT Medical Record Review	Qlarant	In Progress	MY 2023 EPSDT Reporting templates were reviewed and approved by the Department in July 2024. Onsite medical record reviews began in July 2024 and continued throughout the quarter. All onsite medical record reviews will conclude at the start of the next quarter.
Consumer Report Card (CRC)	Qlarant	In Progress	The Department requested Qlarant revise the Consumer Report Card Template and reporting measures. The 2025 (MY 2023) draft Information Reporting Strategy& Methodology was reviewed and approved in September 2024. The finalized report will be reviewed next quarter.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	PIPs for Quarter 2 were submitted to the Department for review in July 2024. Qlarant held Technical Assistance sessions for MCOs throughout the submission month. Throughout the quarter, the Department issued a Global PIPs Recommendations Review document to ensure a focused quality assessment of Qlarant's feedback throughout the PIP cycle. The Annual PIP Sustainability Survey Summary results were presented during the September Quality Assurance Liaison (QALC) Meeting. This survey provided an opportunity for MCOs to describe the sustainable impact of their previously implemented PIP interventions in the selected topic areas of Lead Screening and the Asthma Medication Ratio. All MCO PIP reviews were completed in September 2024.
Encounter Data Validation (EDV)	Qlarant	In Progress	MY 2023 EDV Provider Request Letters were mailed to sampled providers to begin receiving requested medical records in July 2024. MCOISCAs were received in August. MY2023 EDV Activity 1 was reviewed and sent to Qlarant in September 2024. MY2023 EDV Activities 3 and 4 are underway and will be reviewed during the next quarter.
Network Adequacy Validation (NAV)	Qlarant	In Progress	MY 2024 secret shopper/telephonic surveys and provider directory validations were completed in July 2024. Validation activities concluded at the close of July 2024, and data analysis is currently in progress. The MY 2023 Priority Partners NAV CAP was approved in July 2024. Regarding Protocol 4, MCO ISCAs were received and virtual site interviews began in July 2024, and were completed in late August 2024. The NAV Draft Report and the Integrated Focused Study are in development.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	In Progress	The Department works to continue updating the language for all MCO Model Notices for Grievances, Appeals, and Denials. All edits will be finalized for MCO implementation on January 1, 2025. GAD findings for Quarter 2 were disseminated to MCOs in August 2024, and Activity highlights are listed below in detail.

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Activity	Vendor	Status	Comments (July - September 2024)
HEDIS Audits and Reporting (HEDIS)	MetaStar	In Progress	The HEDIS vendor provided Final Audit Reports to HealthChoice organizations and the Department in July. The Department provided an updated MY 2024 HEDIS Performance Measures List to the HEDIS vendor and all MCOs in mid-September. This list details changes in the reporting requirements regarding HEDIS measures for MY 2024. The HEDIS vendor presented at the September QALC meeting reporting on the timeline for MY 2023 report deliverables, discussed MY 2024 retired measures and changes to existing measures, reviewed the audit timeline for HEDIS MY 2024, and a brief preview of upcoming MY 2025 measures changes. The HEDIS vendor received the MY 2023 Medicaid Quality Compass (QC) data extract on 9/27/2024. This QC data will be included in the upcoming final MY 2023 HEDIS reports for the Department.
Population Health Incentive Program (PHIP)	Qlarant	In Progress	The MY 2023 PHIP Report Template was reviewed and approved in September 2024. The final encounter data validations for MY 2023 Ambulatory Care and Lead PHIP Results were completed and will be provided to all MCOs next quarter.
CAHPS Survey Administration (CAHPS)	CSS	In Progress	The CAHPS survey vendor presented at the September QALC Meeting highlighting key results from the MY 2024 CAHPS Adult and Child survey results. MY 2023 NCQA benchmarks were released in September and updated reports are underway. NCQA published HEDIS MY 2024, Volume 3: Specifications for Survey Measures on September 16, 2024. Activity highlights are listed below in detail and will be updated when NCQA benchmark comparisons are available.
Primary Care Provider (PCP) Satisfaction Survey Administration	CSS	Complete	Highlight reports were available in July showing preliminary key survey results and a respondent profile. The Department reviewed, edited, and approved reports including the Primary Care Provider Aggregate and the Individual MCO reports in August and September. The PCP Executive Summary Report was pending final edits and review at the end of September. The survey vendor presented at the September QALC Meeting discussing highlights of the survey results in the areas of Overall Satisfaction, Claims, Preauthorization, Customer Service/Customer Relations, and Loyalty Analysis. Activity highlights are listed below in detail.
Annual Technical Report (ATR)	Qlarant	In Progress	A new link was curated on the Department's HealthChoice website to chronologize all ATR reports dated 2013-2023 according to CMS ATR Feedback. The MY 2024 Annual Technical Report template was approved in August. The report will be updated as each EQRO task report is completed. Finalization is scheduled for April 2025.

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Activity Highlights:

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

Below is a summary of the Quarter 2 of 2024 findings from the GAD activity:

Member Grievances: Priority Partners' range of grievances was the lowest at 0.22 per thousand members; whereas MedStar's range of grievances remained high at 5.60 per thousand members, a decrease from the previous quarter. The most prevalent reason code category was Billing/Financial. The most prevalent service code category was Medical/Surgical. All MCOs met or exceeded member grievance resolution timelines.

Provider Grievances: Maryland Physicians Care (MPC)'s range of provider grievances was the lowest at 0.04 per thousand members, whereas MedStar's range was the highest, totaling 2.34 per thousand members. The overall median for provider grievances per thousand members was 0.18. CareFirst, Jai, and Kaiser reported no provider grievances for this quarter. The most prevalent reason code category was Finance/Billing. All MCOs with reported provider grievances met resolution timelines this quarter.

Appeals: Priority Partners continued to cite the highest rate of member appeals at 3.42 per thousand members, followed by MPC at 2.76 per thousand members. Both MCOs demonstrated a slight increase compared to the previous quarter. Kaiser continued to cite the lowest rate of member appeals at 0.18 per thousand members. The overall median rate of member appeals across all MCOs was 0.76 per thousand members. Eight MCOs indicated that 100 percent of appeals come from denials, while Kaiser reported 55 percent of its appeals come from denials. CareFirst, Jai, Kaiser, Medstar and Priority Partner's overturned appeal rates were greater than 50 percent, a rate considered the best outcome for enrollees. Jai was highlighted with the highest appeal overturn rate, while MPC was indicated with the lowest appeal overturn rate. The top appeal service code reported was Medical/Surgical. All nine MCOs met the standard (non-emergency) appeals resolution turnaround time (TAT) requirements for expedited and non-emergency appeals.

Denials: Across all MCOs, the range for prior authorization requests approved was 65 to 94 percent. For those denied, the MCO range was 27 percent. UHC was rated with the highest pre-service denial rate at 41.48 percent, a significant increase from the previous quarter; Kaiser maintained the lowest at 2.14 per thousand members, also an increase from the previous quarter. The top pre-service denial service category was Medical/Surgical, and the top pre-service denial reason was "NMN-1 Not Medically Necessary/Full Denial." Regarding outpatient pharmacy denials, Jai maintains the highest denial rate at 92 percent. Kaiser continued to cite no pharmacy denials.

Eight out of nine MCOs exceeded the 95 percent denial resolution and timeliness notification requirements. Priority Partners is the outlier; Priority Partners did not meet resolution for expedited per-service medical denials at a rate of 94 percent, timeliness of notification metrics for both standard pre-service medical denials at 90 percent, and expedited pre-service medical denials at 81 percent. Priority Partners cited expansive

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system implementation leading to a transient impact on cases, an issue which has since been rectified and improved the efficiency in processing times.

CAHPS Survey Administration

The 2024 CAHPS Adult Survey scores for *Getting Needed Care, Getting Care Quickly, Rating of Personal Doctor, Coordination of Care, Doctor Communication, Customer Service,* and *Rating of Specialist* saw increases compared to 2023 scores. The 2024 Adult Survey scores for *Rating of Health Plan* and *Rating of Healthcare* saw decreases compared to 2023 scores. Overall, the 2024 scores were not statistically different compared to 2023 scores.

The 2024 CAHPS Child Survey scores for *Rating of Health Plan* and *Customer Service* were significantly higher compared to 2023 scores. All other 2024 General Population measure scores also saw increases compared to 2023 scores, although the increases were not significantly different. There were no significant changes in the 2024 Children with Chronic Conditions measure scores compared to the 2023 scores.

Primary Care Provider (PCP) Survey Administration

In 2024, 76.4 percent of HealthChoice PCPs reported being "Very satisfied" or "Somewhat satisfied" with the specified MCO. This rate is not significantly different from the 2023 findings (77.6 percent). According to the results, 88.4 percent of PCPs would recommend the specified MCO to patients, and 89.0 percent of PCPs would recommend the specified MCO to other physicians. Both rates are higher than 2023 rates, but not significantly different compared to 2023 rates of 86.2 and 86.5 percent, respectively. The loyalty analysis indicated that of the PCPs surveyed for 2024, 37.0 percent of PCPs are considered loyal, 2.5 percent of PCPs are considered not loyal, and the remaining 60.5 percent of PCPs are indifferent. The findings showed no statistically significant differences in loyalty and indifference among providers when compared with the 2023 results.

Demonstration Evaluation

The Department continues to collaborate with CMS and the Hilltop Institute on SUD Monitoring Reports. CMS approved the SMI Monitoring Protocol and the §1115 Summative Evaluation Design in November 2024. The Department continues to collaborate with the Hilltop Institute on the Mid-Point Assessment for the SUD and SMI Demonstrations, due to CMS in February 2025.

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