Maryland HealthChoice Demonstration
Section §1115 Quarterly Report
Demonstration Year 26: 7/1/2022 - 6/30/2023
Quarter 1: July - September 2022

Introduction

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

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

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

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

- Authorized the Maternal Opioid Misuse (MOM) initiative to reduce the burden of neonatal abstinence syndrome (NAS) and its associated costs, and improve maternal health outcomes, by providing enhanced case management services to pregnant people diagnosed with an opioid use disorder (OUD);
- Created a voluntary, five-year payment model in Annapolis, Baltimore City, and Montgomery counties, that provides greater flexibility to ambulance care teams to address emergency health care needs following a 911 call by allowing for payment for ground transports to alternative destinations such as urgent care providers in addition to the emergency department (ED);[1]

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

- Created an expenditure authority to cover Medicaid adults aged 21 to 64 that have an serios 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.

Adult Dental and Alternative Destination Sunsetting

During the Summer of 2022, the Department began the process of sunsetting both the Adult Dental Pilot Program and the Alternative Destination Pilot Program from the 1115 wavier. Both initiatives are in the process of being expanded statewide beginning January 1, 2023.

For both programs, state plan amendments were submitted during the quarter to CMS.

Enrollment Information

Table 1 below provides a comparison of enrollment counts between the previous and current years. These counts represent individuals enrolled at a point in time, as opposed to total member months.

Table 1. Enrollment Counts[2]

Demonstration Populations	Participants as of June 30, 2022	Participants as of September 30, 2022
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	296,114	300,996
Affordable Care Act (ACA) Expansion Adults	443,008	451,214
Medicaid Children	537,057	546,094
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	93,534	92,367
SSI/BD Children	24,085	24,248
Medically-Needy Adults	26,360	26,730
Medically-Needy Children	6,550	6,625
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	15,841	17,701
Maryland Children's Health Program (MCHP)	127,440	129,362

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

Demonstration Populations	Participants as of June 30, 2022	Participants as of September 30, 2022
MCHP Premium	33,515	33,424
Presumptively Eligible Pregnant Women (PEPW)	0	0
Increased Community Services (ICS)	21	21
Women's Breast and Cervical Cancer Health Program (WBCCHP)	56	53

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[3]

Eligibility Group	Total for Quarter Ending June 2022	Current Quarter Month 1 (July 2022)	Current Quarter Month 2 (Aug. 2022)	Current Quarter Month 3 (Sept. 2022)	Total for Quarter Ending Sept. 2022
Parent/Caretaker Relatives <116% FPL and Former Foster Care	884,293	297,538	299,528	300,996	898,062
ACA Expansion Adults	1,321,594	446,105	449,359	451,214	1,346,678
Medicaid Children	1,605,803	539,639	543,249	546,094	1,628,982
SSI/BD Adults	281,272	93,204	92,795	92,367	278,366
SSI/BD Children	71,841	24,149	24,226	24,248	72,623
Medically-Needy Adults	78,785	26,546	26,831	26,730	80,107
Medically-Needy Children	19,462	6,567	6,581	6,625	19,773
SOBRA Adults[4]	45,776	16,387	17,111	17,701	51,199
MCHP	381,215	127,876	128,637	129,362	385,875
MCHP Premium	100,859	33,452	33,513	33,424	100,389
PEPW	0	0	0	0	0
ICS	64	21	21	21	63
WBCCHP	168	56	54	53	163

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

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

Outreach/Innovative Activities

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

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

For more information, please refer to the SUD Monitoring Report. The Department has received CMS feedback on the initial SMI Monitoring Protocol submission.

Maternal Opioid Misuse (MOM) Model

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

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

Collaborative Care Model (CoCM) Pilot Program

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

Table 3. CoCM Member Months by Pilot Site

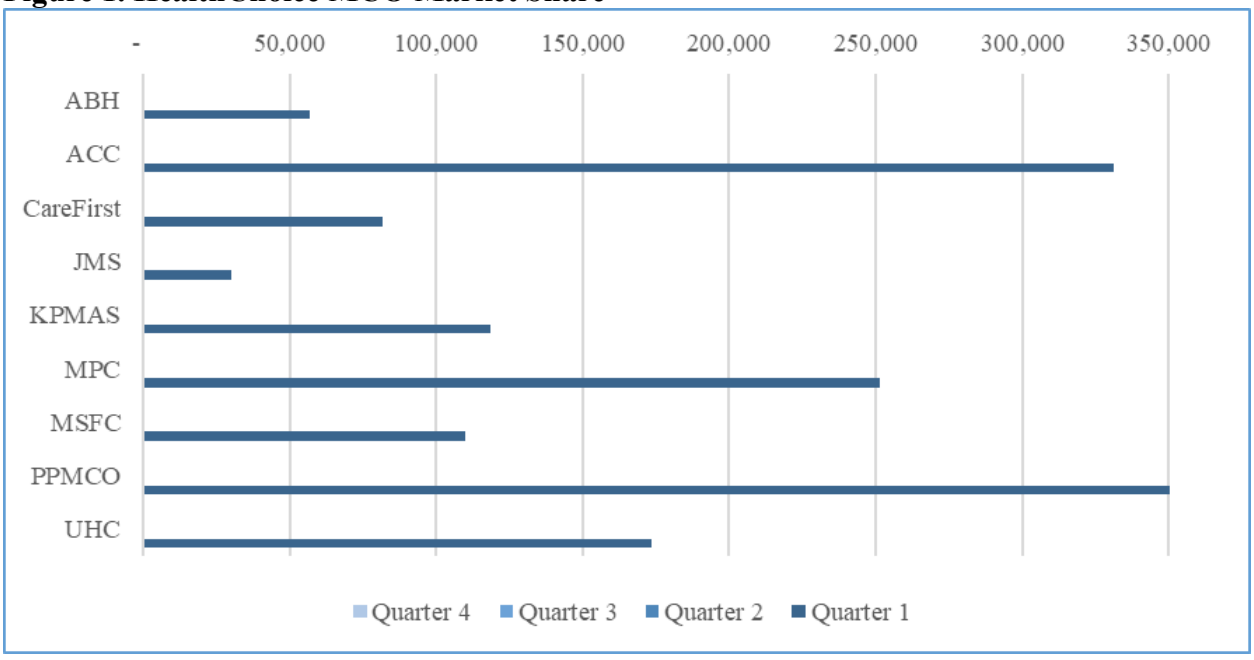
	July 2022	August 2022	September 2022	TOTAL
Urban	94	85	72	251
Rural	19	24	23	66
Ob/Gyn	20	21	16	59
TOTAL	**133**	**130**	**111**	**376**

Operational/Policy Developments/Issues

Market Share

As of the end of the last quarter of FY 2022, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (3.8 percent), Amerigroup (21.9 percent); CareFirst Community Health Plan of Maryland (5.4 percent); Jai Medical Systems (2.0 percent); Kaiser Permanente (7.8 percent); Maryland Physicians Care (16.7 percent); MedStar Family Choice (7.3 percent); Priority Partners (23.6 percent); and United Healthcare (11.5 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in July and September of 2022. All MMAC meetings were held via teleconference. These meetings covered a wide variety of topics, including general department updates, and waiver, state plan, and regulations changes.

During the July meeting, the MMAC was briefed on the Public Health Emergency (PHE) extension, telehealth, and the Program of All- Inclusive Care for the Elderly (PACE) expansion.

During the September meeting, the MMAC was briefed on EMS initiatives and Certified Peer Recovery Support (CPRS) for Substance Use Disorders Planned Coverage.

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 2023	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	236	191	47	93	4,579
Quarter 2					
Quarter 3					
Quarter 4					

Table 5. REM Complaints

FY 23 Q1 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	0	0	0
Dental	0	0	0
DMS/DME	3	0	3
EPSDT	0	0	0
Clinical	2	0	2
Pharmacy	1	0	1
Case Mgt.	5	0	5
REM Intake	0	0	0
Access to MA Providers	2	0	2
Nursing	1	0	1
Other	4	0	4
Total	18	0	18

Table 6 displays the types and total of significant events reported by the case management agencies during this quarter. Agencies report this information on a monthly basis.

Table 6. REM Incidents Reported by Case Managers

FY 23 Incidents	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Abandonment	0			
Abuse	2			
Complaint	18			
Death	20			
Elopement	3			
ER	2			
Exploitation	0			
Failure to Follow Plan (Non-Compliance)	0			
Fall	1			
Hospitalization	8			
Medication Error	2			
Neglect	9			
Suicidal Ideation	1			
Theft	1			
Wound	0			
Other	10			
Total	**77**			

Increased Community Services (ICS) Program

Through the ICS Program, Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the 2016 waiver renewal, Maryland raised the cap to a maximum of 100 participants. As of September 2022, 21 individuals enrolled in the ICS Program. The ICS Program does not currently have a registry. All new applicants begin receiving services upon approval of their application.

Maryland Children's Health Program (MCHP) and MCHP Premium Status/Update/Projections

Maryland moved its separate CHIP program, MCHP, and MCHP Premium, into the Medicaid expansion CHIP waiver in 2008, so that Maryland's entire CHIP program is operated as a Medicaid expansion. As of September 30, 2022, the Premium program had 33,424 participants, with MCHP at 129,362 participants.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

As per the most recent report (August 11, 2022), there were 783 encounters with DPP procedure codes and provided by Medicaid-enrolled DPP providers to 160 unique participants between September 1, 2019 and July 31, 2022. Among the 160 unique Medicaid beneficiaries with a DPP encounter, most were women (83 percent), Black/African American (63 percent), and resided in Prince George's County (38 percent). Most (93 percent) beneficiaries were in the Families and Children Medicaid coverage group. Services were provided by eight unique DPP providers: Amani Nicol Wellness, St Agnes Healthcare, Garrett Regional Medical Center, Mid-Atlantic Permanente Medical Group, associated with the MCO Kaiser Permanente; the Continuum Wellness Center; Omada Health, Taylored 4 Life; and Welldoc, Inc.. The number of encounters per participant ranged from one to 26. The majority of beneficiaries had four or fewer encounters.

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 July 2022, 35 unique DPP providers were fully enrolled and 16 of these are contracted with MCOs. MCOs continued efforts to contract with eligible DPP providers, expand their DPP provider network capacity, and prepare member and provider materials.

The Department finalized work during this quarter with CRISP to refine the prediabetes flag within CRISP, and CRISP continues to produce monthly reports to MCOs containing the panels of their members who received the flag, enabling further follow-up with members. In addition, the Department worked with CRISP and MCOs on the CRISP eReferral tool, and refined referral processes.

Community Health Pilots

Four local government entities participate in the Community Health Pilots (CHP), each as a Lead Entity (LEs) participating in the Assistance in Community Integration Services (ACIS) Pilot. During this reporting period, CHP LEs continued a hybrid of in-person and telephonic service delivery to remain agile throughout the ongoing COVID-19 Public Health Emergency.

Due to a delay in quarterly activity reporting with our partners, the quantity of member months for Quarter 1 is unknown at this time and will be added to next quarter's report. LEs continue to improve processes related to pilot enrollment, such as using the Medicaid Eligibility Verification

System, partnering with local community organizations, and implementing best practices for working with ACIS-enrolled participants.

For FY 2023, two LEs applied and were approved by the Department for additional ACIS participants. The scaling of these new allotments began during this quarter at both sites. ACIS LEs have expressed concern at increasing rental prices and continue searching for more local housing partners to meet their participants' needs. This concern has remained problematic for several quarters.

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

Expenditure Containment Initiatives

The Department, in collaboration with Hilltop, has worked on several different fronts to contain expenditures. The culmination of the Department and Hilltop's efforts are 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 2022 Hilltop participated in one-on-one meetings with each MCO along with the Department to discuss the 2023 rates. The MCOs projected 2023 gain/loss results in high-level HFMR rate cell categories. Overall, they projected a 2023 gain of 1.6 percent of revenue.

Hilltop calculated the impact on 2023 rates of programmatic changes, both legislative and non-legislative. Included were benefit enhancements for doulas, home visiting services, and other maternal and child health initiatives. The contracts with the MCOs specified penalties for different thresholds of rejected encounters as well as an updated risk corridor for the State's HealthChoice DPP.

The 2020 risk corridor resulted in $106 million being returned to the State by the MCOs. The federal match portion due back to the federal government was determined to be $71 million or 67 percent.

Hilltop allocated $38 million of funding for the "Maryland Quality Innovation Program" (MQIP) to rate cells for 2023.

Hilltop met with the Department and Myers and Stauffer to prepare for CMS' new "medical loss ratio" (MLR) template requirements.

MCO Rates

CY 2023 Rate Setting

The Department and Hilltop held four meetings with the MCOs; one in July, two in August, and one in September 2022. Topics covered included 1) the high-cost, low utilization drugs list; 2) final claims trend assumptions; 3) redeterminations; 4) rejected encounters; 5) the HSCRC maternal and child health program's risk corridor; and 6) the postpartum benefit enhancement from two months to 12.

The year-over-year (YoY) rate increase from 2022 (midyear rates) to 2023 was +1.1 percent. Hilltop provided several breakdowns of this increase by MCO, region, and category of aid. For context, financial results for YTD 2022 were gathered by Hilltop from quarterly financial statements and shared with the Department and MCOs. The YTD gain/loss, excluding Kaiser, was +4.3 percent.

Hilltop analyzed data related to third party liability (TPL) recoveries in support of the Department's safety net billing initiative. Hilltop convened with MCOs, the Department, and Optumas to secure funding to engage a communications vendor to alert members to all of their options when the PHE ends, and eligibility is redetermined.

CY 2022 HealthChoice Rates (and Prior)

Hilltop supported the calculation of midyear adjustments to rates resulting in a negative $19.5 million change to capitations. Quarterly rates were re-derived and provided to the MCOs. Supplemental payments from the MCOs to the State trued up the rates retrospectively until the updated rates were loaded for billing.

The first installment of rural access incentives totaling $4 million were allocated to certain MCOs. The second installment of $4 million will be done in December.

Other Rate Setting Team Activities

Hilltop assisted in responding to requests from the "Maryland Managed Care Organization Association" (MMCOA) including a review of the methodology used for risk scores prepared for geographic/demographic rate cells. Hilltop provided the Department with quarterly trauma payments for 2022 for each MCO, analyzed denied hospital claims reports by MCO from the Health Services Cost Review Commission (HSCRC), and fielded individual MCO inquiries most often related to risk corridors, redeterminations, and specialty drugs.

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 32,649 calls in Q1 of FY 23. The Help Line assists waiver-eligible consumers with eligibility and enrollment questions and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs, how to access carved-out services, or services covered by Medicaid on a FFS basis.

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

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

Table 7. Total Recipient Complaints[5] - Q1 FY 2023

CMS Quarterly Report
Total Recipient Complaints - excluding Billing
1st Quarter, FY 2023

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Sub Totals	
4th Q FY 22 vs. 1st Q FY 23		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Pharmacy	#	11	26	26	53	16	24	3	6	4	16	32	74	12	22	31	69	51	98	186	388
	%	6%	7%	14%	14%	9%	6%	2%	2%	2%	4%	17%	19%	6%	6%	17%	18%	27%	25%	29%	39%
Prenatal	#	4	7	24	37	8	15	1	2	17	25	13	13	4	9	15	32	16	13	102	153
	%	4%	5%	24%	24%	8%	10%	1%	1%	17%	16%	13%	8%	4%	6%	15%	21%	16%	8%	16%	15%
PCP	#	6	13	16	23	13	27	1	4	10	11	19	19	8	12	25	18	20	30	118	157
	%	5%	8%	14%	15%	11%	17%	1%	3%	8%	7%	16%	12%	7%	8%	21%	11%	17%	19%	18%	16%
Specialist	#	6	9	5	15	14	24	4	2	13	15	12	26	7	5	13	15	12	14	86	125
	%	7%	7%	6%	12%	16%	19%	5%	2%	15%	12%	14%	21%	8%	4%	15%	12%	14%	11%	13%	13%
Sub Totals	#	27	55	71	128	51	90	9	14	44	67	76	132	31	48	84	134	99	155	492	823
	%	5%	7%	14%	16%	10%	11%	2%	2%	9%	8%	15%	16%	6%	6%	17%	16%	20%	19%	77%	83%
All Complaint Totals	#	36	68	95	162	55	97	10	14	50	71	134	188	36	54	108	171	119	169	643	994
	%	6%	7%	15%	16%	9%	10%	2%	1%	8%	7%	21%	19%	6%	5%	17%	17%	19%	17%	100%	100%
Other Categories		9	13	24	34	4	7	1	0	6	4	58	56	5	6	24	37	20	14	151	171

*Name Change as of 2/1/2021: UMHP into CareFirst BlueCross BlueShield Community Health Plan of MD (CareFirst CHPMD)
Source: CRM

There were 1,222 total MCO recipient complaints in Quarter 1 of FY 2023 (all ages). Eighty-one percent of the complaints (994) were related to access to care. The remaining 19 percent (228) were billing complaints. The top three member complaint categories were accessing pharmacy, primary care providers (PCPs), and prenatal respectively. The categories not specified (Other Categories) for the non-billing complaints include appeals and grievances, access to therapies (occupational therapy-OT, physical therapy-PT, and speech therapy-ST), adult dental and vision services, and obtaining DME/DMS (Durable Medical Equipment/Durable Medical Supplies). Overall, Maryland Physicians Care, Priority Partners, and UnitedHealthcare had the highest percentage of complaints in this fiscal year.

Prenatal complaints comprised 13 percent of total complaints during the first quarter. All pregnant women were connected with an MCO network prenatal care provider and referred to Administrative Care Coordination Units (ACCUs) at the local health department for follow-up and education. In addition, pregnant women called the Help Line for general information. These women were also referred for follow-up and education.

[5] Billing not included.

Table 8. Recipient Complaints Under Age 21[6] - Q1 FY 2023

CMS Quarterly Report
Total Recipient Complaints - excluding Billing: Under age 21 only
1st Quarter, FY 2023

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Sub Totals	
4th Q FY 22 vs. 1st Q FY 23		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Pharmacy	#	1	3	5	19	2	2	0	0	0	3	3	11	0	2	5	16	9	17	25	73
	%	4%	4%	20%	26%	8%	3%	0%	0%	0%	4%	12%	15%	0%	3%	20%	22%	36%	23%	24%	37%
PCP	#	1	3	3	10	3	10	0	2	3	3	4	4	1	2	5	3	4	14	24	51
	%	4%	6%	13%	20%	13%	20%	0%	4%	13%	6%	17%	8%	4%	4%	21%	6%	17%	27%	23%	26%
Specialist	#	2	5	3	4	3	6	1	1	5	6	1	2	1	0	1	3	4	5	21	32
	%	10%	16%	14%	13%	14%	19%	5%	3%	24%	19%	5%	6%	5%	0%	5%	9%	19%	16%	20%	16%
Prenatal	#	0	0	4	6	0	0	0	0	1	2	1	1	0	2	1	3	1	1	8	15
	%	0%	0%	0%	40%	0%	0%	0%	0%	0%	13%	0%	7%	0%	13%	0%	20%	0%	7%	8%	8%
Sub Totals	#	4	11	15	39	8	18	1	3	9	14	9	18	2	6	12	25	18	37	78	171
	%	5%	6%	19%	23%	10%	11%	1%	2%	12%	8%	12%	11%	3%	4%	15%	15%	23%	22%	76%	86%
All EPSDT Complaint Totals	#	5	11	19	47	8	18	1	3	11	15	19	24	4	7	17	34	19	39	103	198
	%	5%	6%	18%	24%	8%	9%	1%	2%	11%	8%	18%	12%	4%	4%	17%	17%	18%	20%	100%	100%
Other Categories		1	0	4	8	0	0	0	0	2	1	10	6	2	1	5	9	1	2	25	27

*Name Change as of 2/1/2021: UMHP into CareFirst BlueCross BlueShield Community Health Plan of MD (CareFirst CHPMD)
Source:CRM

There were 198 member complaints (non-billing) for recipients under age 21 in Q1 of FY 2023, or twenty percent of the total complaints. The top complaint category was access to pharmacy services. Amerigroup, UnitedHealthcare, and Priority Partners were major contributors to the complaints for recipients under age 21.

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

[6] Billing not included.

Table 9. Total Recipient Billing Complaints - Q1 FY 2023

CMS Quarterly Report
Total Recipient Complaints - Billing only
1st Quarter, FY 2023

MCO / Type of Service		Aetna Better Health (ABH)		Ameri-group (ACC)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Sub Totals	
4th Q FY 22 vs. 1st Q FY 23		4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1	4	1
Emergency	#	1	4	5	8	1	3	0	2	6	13	5	10	0	7	7	16	2	6	27	69
	%	4%	6%	0%	12%	0%	4%	0%	3%	0%	19%	0%	14%	0%	10%	0%	23%	0%	9%	33%	30%
PCP	#	1	3	4	6	3	2	0	0	3	10	6	10	0	7	3	8	4	7	24	53
	%	4%	6%	17%	11%	13%	4%	0%	0%	13%	19%	25%	19%	0%	13%	13%	15%	17%	13%	29%	23%
Laboratory/ Test	#	0	1	2	6	2	0	0	0	0	1	0	6	3	2	1	4	2	3	10	23
	%	0%	4%	20%	26%	20%	0%	0%	0%	0%	4%	0%	26%	30%	9%	10%	17%	20%	13%	12%	10%
Specialist	#	0	1	2	6	0	3	0	0	4	6	1	6	0	1	3	3	1	3	11	29
	%	0%	3%	18%	21%	0%	10%	0%	0%	36%	21%	9%	21%	0%	3%	27%	10%	9%	10%	13%	13%
Sub Totals	#	2	9	13	26	6	8	0	2	13	30	12	32	3	17	14	31	9	19	72	174
	%	3%	5%	18%	15%	8%	5%	0%	1%	18%	17%	17%	18%	4%	10%	19%	18%	13%	11%	87%	76%
All Billing Complaint Totals	#	2	9	16	34	6	15	0	2	14	42	12	36	3	25	19	38	11	27	83	228
	%	2%	4%	19%	15%	7%	7%	0%	1%	17%	18%	14%	16%	4%	11%	23%	17%	13%	12%	100%	100%
Other Categories		0	0	3	8	0	7	0	0	1	12	0	4	0	8	5	7	2	8	0	54

*Name Change as of 2/1/2021: UMHP into CareFirst BlueCross BlueShield Community Health Plan of MD (CareFirst CHPMD)
Source: CRM

Enrollee billing complaints comprised nineteen percent of total MCO complaints in Q1 of FY 2023. Overall, the top bill type was emergency related billing issues followed by primary care providers, which comprised 30 percent and 23 percent, respectively, of all MCO billing complaints. Other categories are the billing complaints related to inpatient services, urgent care centers, DME/DMS, therapies, pharmacy, and optional services such as adult dental and vision. Kaiser Permanente had the highest percentage of billing complaints followed closely by Priority Partners.

MCOs are required to respond to all recipient grievances and complaints. The CRU works with MCOs on behalf of the consumer to resolve the complaint. Once a plan is in place, the CRU refers the case to the ACCUs at the local health departments for follow-up to ensure the complaint has been resolved. When trends are identified, the HealthChoice Medical Advisor makes an inquiry to the MCO. If potential policy issues, systems issues, or barriers are identified, the MCO may be directed to take corrective action.

Legislative Update

The 2022 legislative session ended on April 11, 2022. The 2023 session will begin January 11, 2023.

Quality Assurance/Monitoring Activity

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

The Department contracts with three vendors for its quality assurance activities:

- Qlarant Quality Solutions, Inc. (Qlarant) is the external quality review organization (EQRO) for the Department. Qlarant is responsible for performance improvement project validation; performance measure validation for the Value-Based Purchasing Initiative; compliance reviews to ensure MCOs comply with 42 CFR 438, Subpart D and 42 CFR 438.330; MCO network adequacy validation; encounter data validation; clinical quality studies focused on MCO appeals, grievances, and pre-service denials; and development of an annual consumer report card to assist HealthChoice enrollees with MCO selection.
- MetaStar, Inc. (MetaStar) is the HEDIS Compliance Auditor for the Department. MetaStar is responsible for ensuring compliance with the National Committee for Quality Assurance (NCQA) guidelines for reporting Healthcare Effectiveness Data and Information Set (HEDIS) measures, including onsite audits of MCO systems and processes to report data. MetaStar also reviews and approves the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey sample frame. At the end of the audit cycle, MetaStar compiles a comprehensive report with trending MCO performance on the HEDIS measures.
- Center for the Study of Services, Inc. (CSS) is the survey administration vendor for the Department. CSS administers the CAHPS surveys for adults and children, as well as the Primary Care Provider (PCP) Satisfaction Survey. CSS monitors compliance with survey protocols and compiles reporting on the results of both survey efforts.

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

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

Activity	Vendor	Status	Comments
Systems Performance Review (SPR)	Qlarant	Complete	Qlarant submitted the CY 2021 SPR Executive Summary for the Department's review and approval in August 2022. The draft CY 2022 Standards and Guidelines and the draft CY 2022 Orientation Manual for the next comprehensive review were disseminated for MCO comment in July 2022 and finalized in September 2022. The CY 2022 SPR MCO Orientation was held in September 2022 to launch the next round of SPR activities.
EPSDT Medical Record Review	Qlarant	In progress	The CY 2021 EPSDT medical record review activity began in July 2022 to conclude in October 2022. Qlarant revised the CY 2020 EPSDT Aggregate report, several individual MCO reports (Aetna, Amerigroup, and Jai), and the 2020-2021Annual Technical Report (ATR) based on a needed recalculation of the Anemia Screening results and received the Department's approval in September 2022. Results were disseminated to the MCOs in September 2022.
Consumer Report Card (CRC)	Qlarant	Complete	Qlarant submitted the 2023 draft Information Reporting Strategy (IRS) and Methodology for the Department's review in July 2022 and was approved in August 2022. MCOs were notified in August 2022. Qlarant submitted confidence internal data for the CY 2022 CRC to MCOs upon request in September 2022.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	Qlarant reviewed quarterly Lead PIP submissions from the MCOs and those were submitted to the Department for review and approval in July 2022. Quarterly PIP reporting templates were revised and disseminated to the MCOs in July 2022. Qlarant revised the annual reporting templates and PIP validation/scoring tools in July 2022 and received the Department's approval in August 2022. In September 2022, Qlarant began preparing PIP educational materials for an upcoming MCO training on developing SMART objectives for the Department's new rapid cycle PIP topics. Qlarant began receiving annual Lead PIP submissions and annual AMR PIP submissions from the MCOs in September and started the PIP validation process. The Department began the Annual Intervention Evaluation in September 2022.
Encounter Data Validation (EDV)	Qlarant	In Progress	MDH approved the sample data request and Qlarant submitted their request to Hilltop in July 2022. Hilltop returned the EDV data sample in August 2022. Qlarant mailed the Department-approved provider medical request letters in August 2022. Qlarant requested Information Systems Capabilities Assessments (ISCAs) from the MCOs in August 2022 and began review of submissions.
Network Adequacy Validation (NAV)	Qlarant	In Progress	Qlarant concluded the NAV survey calls and online directory validations and began drafting the CY 2022 NAV report in August 2022.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	In Progress	Qlarant finalized the Quarter 2 reporting for GAD in August 2022. Highlights are listed below.

Activity	Vendor	Status	Comments
HEDIS Audits and Reporting (HEDIS)	MetaStar	Complete	MetaStar provided Final Audit Reports to HealthChoice organizations and the Department in July. Final reports provided by MetaStar, including the Statewide Analysis Report and the Consolidated Final Audit Report were reviewed, edited, and approved by the Department in September. The Executive Summary Report was pending final edits and review at the end of September. The Department provided the finalized HEDIS MY 2022 Measures List, along with official announcement letters, to MetaStar and all HealthChoice organizations in early September. The Department approved a request from the vendor to change lead auditor assignments for 6 of the 9 HealthChoice MCOs for the MY 2022 audit season. MetaStar presented at the September QALC meeting reporting on highlights from the MY 2021 Statewide Analysis Report on HealthChoice MCO performance, MCO Performance Monitoring updates regarding important changes with some of the HEDIS reporting measures, a discussion of new, revised, and retired measures for the upcoming MY 2022 audit season, and finally, a HEDIS MY 2023 preview.
Value Based Purchasing Initiative (VBP)	Qlarant	In progress	Qlarant received final validation results from Hilltop for both Ambulatory and Lead measures in August 2022 and began drafting the CY 2022 VBP reporting template. The CY 2022 VBP reporting template was reviewed and approved by the Department in September 2022. Draft VBP results will be sent to Qlarant for draft report development in the next quarter.
CAHPS Survey Administration (CAHPS)	CSS	Complete	The Department reviewed, edited, and approved reports including Adult and Child Aggregate CAHPS reports, and the Individual HealthChoice organizations Adult and Child CAHPS reports from late July through September. The CAHPS Executive Summary Report was pending final edits and review at the end of September. CSS presented at the September QALC Meeting highlighting the results of the 2022 CAHPS Adult and Child surveys. NCQA published HEDIS MY 2022, Volume 3: Specifications for Survey Measures on September 15, 2022.
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 HealthChoice organizations reports in August and September. The PCP Executive Summary Report was pending final edits and review at the end of September. CSS presented at the September QALC Meeting highlighting the results of the 2022 Primary Care Provider survey.
Annual Technical Report (ATR)	Qlarant	In progress	Qlarant is currently developing the draft template for the Annual Technical Report for the upcoming measurement year. Qlarant revised the 2020-2021 ATR based on a needed recalculation of the EPSDT Anemia Screening results and received the Department's approval in September 2022.

Completed Activity Highlights:

Focused Reviews of Grievances, Appeals, and Denials (GAD) Quarter 2 Review

- The second quarter of GAD reporting was completed in August 2022.
    - Grievances Highlights
        - Kaiser had the highest grievance rate per 1,000 members (4.9). JMS follows with the second highest rate (2.31).
        - CareFirst and Amerigroup had the highest grievance rate per 1,000 providers (3.58 and 1.19, respectively).
        - Member and provider grievance turnaround times (TATs) remained strong with all but Kaiser and Priority Partners meeting or exceeding the lowered threshold of 95 percent.
    - Appeals Highlights
        - Priority Partners and Maryland Physicians Care had the highest appeal rate per 1,000 members (2.64 and 1.74, respectively).
        - Jai had the highest appeal overturn rate at 100 percent, although this represents only two appeals. Kaiser had the next highest overturn rate (90 percent).
        - All MCOs with the exception of Amerigroup met or exceeded the TAT compliance threshold in all applicable categories. Amerigroup fell slightly below the compliance threshold for expedited appeals at 93 percent.
    - Denial Highlights
        - Aetna and Maryland Physicians Care have the highest denial rates per 1,000 members (31.5 and 31.3, respectively).
        - Kaiser and MedStar continue to have the highest approval rates (92 percent and 89 percent, respectively).
        - TAT was met in all categories for determinations and notifications by seven MCOs. Aetna and Amerigroup did not meet one of the determination timeframes at 92 percent and 94 percent respectively.

HEDIS Audits and Reporting

Maryland MCOs had high overall performance in their HEDIS rates prior to the COVID-19 pandemic. COVID is likely to have a continuing impact on healthcare delivery and measure performance for the foreseeable future.

- The NCQA benchmarks and HEDIS means used to gauge performance for MY 2021 were derived from reported rates during the first year of the COVID pandemic. With a few exceptions, the National HEDIS Mean (NHM) decreased for most measures. Also, since the pandemic has persisted, it is likely that benchmark data will be impacted for at least another year.
- Eligible populations for Appropriate Testing for Pharyngitis (CWP), Appropriate Treatment for Upper Respiratory Infection (URI), and Adults with Acute Bronchitis/Bronchiolitis (AAB) were noted to have decreased significantly for many health plans across the nation. NCQA evaluated this with the Licensed Organizations conducting HEDIS audits, and it is suspected that this shift may have been due to several factors, including provider billing

procedures and diagnosis code assignments in the context of COVID. The Maryland Average Reportable Rate (MARR) for CWP decreased from 80.7 percent to 67.5 percent, potentially as a result of the shifts observed in the eligible populations.

- The MARR increased for many measures compared to prior year performance (year one of COVID).
- Utilization measure rates rebounded somewhat, but still remained low. For example, Ambulatory Care: Total (AMBA) outpatient and emergency department visits per 1000 Member Months (MM) rates were higher than last year for all MCOs, but most were still lower than pre-pandemic rates.
- There were several measures/indicators where eight of nine MCO rates were above/better than the NHM: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Physical Activity, WCC – Nutrition, Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator, Comprehensive Diabetes Control (CDC) – HbA1c testing, Use of Imaging Studies for Low Back Pain (LBP), Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS), Prenatal and Postpartum Care (PPC) – Prenatal, and Child and Adolescent Well-Care Visits (WCV) – total rate.
- All nine MCOs scored above/better than the NHM for Chlamydia Screening in Women (CHL), CDC – HbA1c Poor Control, CDC – HbA1c control <8, Kidney Health Evaluation for Patients with Diabetes (KED), and PPC – Postpartum.

CAHPS Survey Administration

Adult Survey

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

Child Survey

- Overall, the HealthChoice Aggregate performed poorly, scoring in the bottom third of the 2021 NCQA Quality Compass Child Medicaid National distribution on most survey measures. The only exception in the non-CCC measures was Rating of Personal Doctor and Rating of All Healthcare. Rating of All Healthcare has trended upward over the past two years. However, the HealthChoice Aggregate still only placed in the middle third of the distribution on Rating of All Healthcare. The HealthChoice Aggregate scored poorly on

Getting Needed Care, Getting Care Quickly and How Well Doctors Communicate, with all three measures experiencing statistically significant declines from the prior year.
- Among the CCC measures set, HealthChoice performed especially poorly on Getting Needed Information and Coordination of Care for Children with Chronic Conditions, with the former experiencing a statistically significant decline compared to the prior two years, and the latter experiencing a consistent negative two-year trend. While HealthChoice also earned relatively low overall scores on Personal Doctor Who Knows Child, Access to Prescription Medicines and Access to Specialized Services had variable performance from plan to plan.

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

Demonstration Evaluation

During the quarter, the Department collaborated with its independent evaluator, the Hilltop Institute, to start work on the CY 2023 Summative Evaluation, which covers from CY 2017 through CY 2021. The Department has been in ongoing conversations with CMS about the 2017-2021 §1115 summative evaluation. The Department and CMS have collaborated on updating the materials, as well as discussed the evaluation design for the 2022-2026 waiver period.

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

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