Maryland HealthChoice Demonstration
Section §1115 Quarter 2 Report
Demonstration Year 27: 7/1/2023 - 6/30/2024
Quarter 2: October - December 2023

Introduction

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

The Maryland Department of Health's (MDH'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 an expenditure authority to cover Medicaid adults aged 21 to 64 that have a Serious Mental Illness (SMI) diagnosis who are residing in a private Institute of Mental Disease (IMD);
- Modified Maryland's coverage of ASAM Level 4.0 to include not only providers located in Maryland, but also those based in contiguous states;
- Raised the participant spaces for the Assistance in Community Integration Services (ACIS) Pilot from 600 to 900; and
- Expanded the allowable timeframe of eligibility in the Healthy Families America (HFA) evidence-based Home Visiting Services (HVS) Pilot from age two to age three.

Enrollment Information

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

Table 1. Enrollment Counts[1]

Demonstration Populations	Participants as of Sept. 30, 2023	Participants as of Dec. 31, 2023
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	84,091	82,352
SSI/BD Children	21,798	20,429
Medically-Needy Adults	29,107	30,447
Medically-Needy Children	6,625	6,314
Medicaid Children	565,522	563,309
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	286,067	277,284
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	20,186	19,247
Affordable Care Act (ACA) Expansion Adults	455,948	447,167
Maryland Children's Health Program (MCHP)	121,296	122,788
MCHP Premium	35,045	33,837
Presumptively Eligible Pregnant Women (PEPW)	*	*
Increased Community Services (ICS)	17	15
Women's Breast and Cervical Cancer Health Program (WBCCHP)	35	21

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

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

Table 2. Member Months

Eligibility Group	Total for Quarter Ending Sept. 2023	Current Quarter Month 1	Current Quarter Month 2	Current Quarter Month 3	Total for Quarter Ending Dec. 2023
SSI/BD Adults	255,089	84,263	83,451	82,352	250,066
SSI/BD Children	65,837	20,836	20,715	20,429	61,980
Medically-Needy Adults	87,560	29,254	29,818	30,447	89,519
Medically-Needy Children	19,965	6,313	6,299	6,314	18,926
Children	1,692,201	569,241	569,140	563,309	1,701,690
Parents/caretakers and former foster care	879,691	283,066	282,499	277,284	842,849
SOBRA	61,639	19,887	19,602	19,247	58,736
ACA expansion	1,376,766	457,294	459,559	447,167	1,364,020
MCHP	368,490	122,558	124,794	122,788	370,140
MCHP Premium	102,887	35,288	34,704	33,837	103,829
PEPW	31	*	*	*	14
ICS	54	16	15	15	46
WBCCHP	108	36	35	21	92

Outreach/Innovative Activities

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

Effective July 1, 2017, MDH 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, MDH 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, MDH extended coverage for dual eligibles. Effective June 2023, MDH extended coverage to Certified Peer Recovery Specialists. Consistent with CMS guidance, coverage in the future waiver period will be available for up to two non-consecutive 30-day stays every 12 months.

For more information, please refer to the SUD Monitoring Report.

Maternal Opioid Misuse (MOM) Model

As part of a suite of innovative maternal and child health services, the MOM program focuses on improving care for pregnant and postpartum Medicaid participants diagnosed with opioid use disorder (OUD). With over 21,000 individuals of childbearing age diagnosed with OUD in Maryland, substance use is a leading cause of maternal death and has a significant impact on the approximately 1,500 infants born to Medicaid beneficiaries with OUD in Maryland per year. Originally part of a federal demonstration led by the Center for Medicare and Medicaid Innovation, the MOM program addresses fragmentation in care through the provision of enhanced case management services, led by Medicaid's nine managed care organizations.

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, MDH continued participant enrollment statewide. 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 2023 forward, MDH included the MOM model as a new addition to the HealthChoice demonstration in the waiver renewal application, accepted in late June. A total of 64 participants have been enrolled in the program as of December 31, 2023.

Collaborative Care Model (CoCM) Pilot Program

MDH's CoCM Pilot Program began enrolling participants on July 1, 2020. The table below provides the member months enrollment for the previous quarter. On October 1, 2023, MDH expanded the pilot program statewide. MDH submitted a State Plan Amendment (SPA) in December 2023 (MD 23-0021).

Table 3. CoCM Member Months by Pilot Site

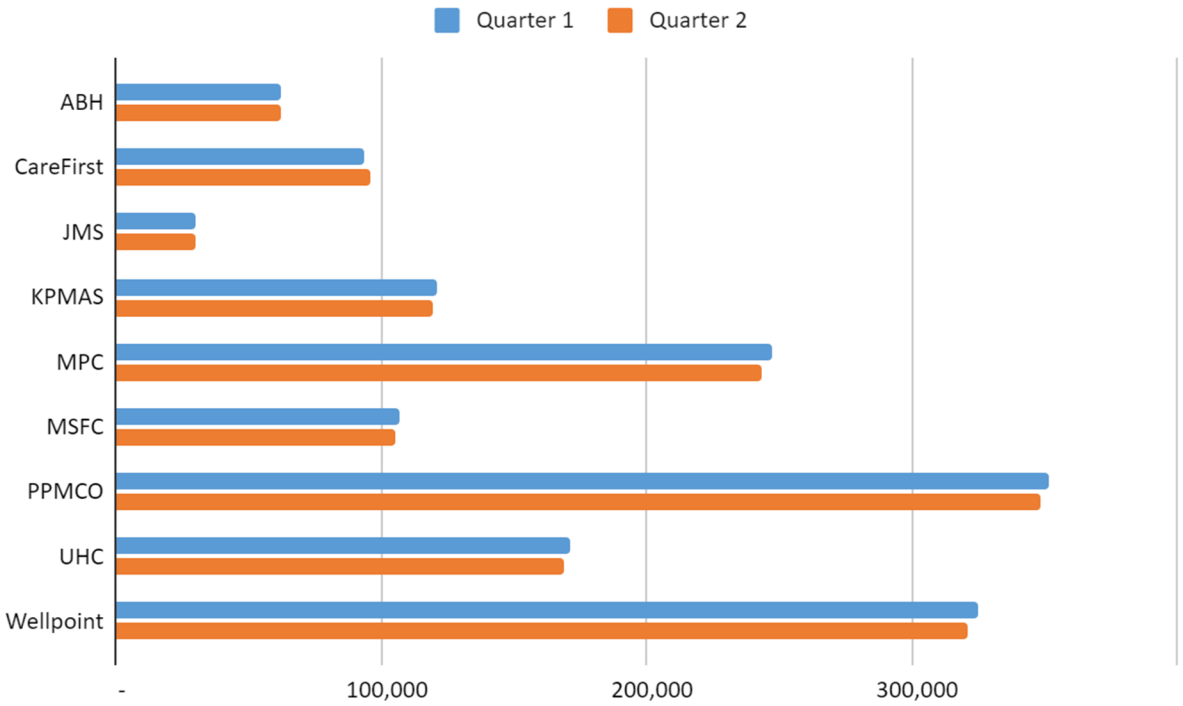
	July	August	September	TOTAL
Urban	86	86	84	256
Rural	11	*	*	27
Ob/Gyn	12	15	13	40
TOTAL	**109**	**109**	**105**	**323**

Operational/Policy Developments/Issues

Market Share

As of the end of the first quarter of FY 2024, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (4.2 percent); CareFirst Community Health Plan of Maryland (6.4 percent); Jai Medical Systems (2.0 percent); Kaiser Permanente (8.0 percent); Maryland Physicians Care (16.3 percent); MedStar Family Choice (7.0 percent); Priority Partners (23.3 percent); United Healthcare (11.3 percent); and Wellpoint Maryland (21.5 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in October and November. 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 October meeting, the MMAC was briefed on the Public Health Emergency (PHE) unwinding, statewide expansion of the Collaborative Care Model, and Order, Referring, Prescribing (ORP) provider enrollment policy that began implementation in November 2022.

During the November meeting, the MMAC was provided with updates to an overview of Senate Bill (SB) 678, and activities the Department has undertaken to implement the legislation. SB 678 requires Medicaid, the Maryland Children's Health program, and commercial insurance to cover services rendered by a licensed pharmacist within their lawful scope of practice. A representative from the Chesapeake Regional Information System for our Patients (CRISP) gave the Committee an overview of the Multi-Payer Reporting Suite which is rolling out. This was developed to align efforts between Maryland Medicaid and the State's Maryland Primary Care Program.

Rare and Expensive Case Management (REM) Program

The table below shows the status of REM program enrollment. Reasons for disenrollment or discharge from REM include aging out of the REM qualifying diagnosis, loss of HealthChoice eligibility, loss of Medicaid eligibility, death, or a request to return to managed care coverage.

Table 4. Current REM Program Enrollment

FY 2023	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	236	191	47	93	4,579
Quarter 2	244	218	42	110	4,733
Quarter 3	242	196	44	102	4,677
Quarter 4	224	163	53	113	4,712

Table 5. REM Complaints

FY 24 Q2 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	2	0	2
Dental	0	0	0
DMS/DME	1	0	1
EPSDT	0	0	0
Clinical	0	0	0
Pharmacy	0	0	0
Case Mgt.	2	0	2
REM Intake	0	0	0
Access to MA Providers	0	0	0
Nursing	3	0	3
Other	3	0	3
Total	11	0	11

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

Increased Community Services (ICS) Program

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

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

Maryland moved its separate CHIP program, MCHP, and MCHP Premium, into the Medicaid expansion CHIP waiver in 2008, so that Maryland's entire CHIP program is operated as a

Medicaid expansion. As of December 31, 2023, the Premium program had 33,837 participants with MCHP at 122,788 participants.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Per the most recent report published on November 8, 2023, there were 1,856 encounters with DPP procedure codes provided by licensed Medicaid-enrolled DPP providers to 285 unique participants between September 1, 2019 and October 31, 2023. Among the 285 unique Medicaid beneficiaries with a DPP encounter, most were women (85 percent), Black/African American (72 percent), and resided in Prince George's County (34.7 percent). Most beneficiaries (92 percent) were in the Families and Children Medicaid coverage group. Services were provided by 10 unique DPP providers while the number of encounters per participant ranged from one to 30. 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 December 2023, 39 unique DPP providers were fully enrolled. MCOs continued efforts to contract with eligible DPP providers, expand their DPP provider network capacity, and prepare member and provider materials.

CRISP 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 in the Community Health Pilots (CHP), each as Lead Entities (LEs) participating in the Assistance in Community Integration Services (ACIS) Pilot.

As of FY 2024 Quarter 2, the ACIS pilot had 556 enrollees. Programmatically, LEs are committed to working closely with providers and improving processes to increase intake and referrals for pilot enrollment, partnering with local community partners, landlords, and management companies to assist ACIS enrollees, as well as continuing to implement best practices for working with ACIS-enrolled participants. One of the LEs is receiving referrals through an online referral system managed by external partners resulting in an increased number of ACIS enrollees. Overall, ACIS LEs continue to work towards improving data quality and reporting by implementing improved training and communication processes.

ACIS LEs maintain their concern about lack of availability of affordable local housing as well as lack of timely response from landlords. They have also indicated inadequate availability of vouchers, lack of funding for security deposits and delays in getting clients scheduled for appointments with the housing authorities as some of the concerns that have decreased efficiencies by program staff to house ACIS participants.

Expenditure Containment Initiatives

MDH, in collaboration with the Hilltop Institute (Hilltop), have worked on several different fronts to contain expenditures. The culmination of MDH and Hilltop's efforts is detailed below. Hilltop works with MDH's contracted actuarial firm, Optumas, and MDH's contracted accounting firm, Myers & Stauffer (M&S).

HealthChoice Financial Monitoring Report (HFMR)

Throughout the quarter, Hilltop and MDH supported fee schedules, priced encounters, and crosswalks of HFMRs to Maryland Insurance Administration (MIA)-reported profit and loss (P&L) reports as requested. The result was a significant reduction in the variance, and an improvement in HFMR results.

MDH and Hilltop supported continuing improvement in encounter submissions by writing a memo defining rejected encounters and a deduplication process accompanied by a member-level file to each MCO for examination toward agreement. MDH and Hilltop also met with Kansas Medicaid officials to learn about their encounter process for possible "best practices" adoption.

Hilltop collaborated with MDH, the Maryland Health Care Commission, and the Health Services Cost Review Commission (HSCRC) to define primary care thoroughly, addressing grey areas such as hospitalists, urgent care, nurse practitioners, taxonomy codes, and place of service codes. Hilltop participated in the M&S 2023 HFMR kick-off meeting with the MCOs and began analyzing final 2022 HFMRs submitted by MCOs on November 15, 2023.

MCO Rates

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

Hilltop delivered provisional CY 2024 rates (PR24s) to MDH for testing and payment. Hilltop also reassigned members to "Risk-Adjusted Cells" (RACs) using CY 2022 data, updated "plan risk scores" (PRS) for Geographic/Demographic, HIV, and AIDS rate cells, and reviewed the rate filing of PR24s to CMS. Hilltop began analyzing the CY 2024 Medicare fee schedule released on November 15, 2023, with a focus on physician Evaluation and Management (E&M) codes.

<u>Activities in Support of the CY 2023 HealthChoice Rates (and Prior)</u>

Hilltop coordinated the calculation of midyear supplemental payments totaling approximately $9 million owed back to the state by the MCOs. Hilltop and Optumas continued monitoring the 12-month unwinding redetermination process that began in May 2023. The PHE adjustment to midyear 2023 rates was negative $31 million. Hilltop and Optumas calculated the reconciliation payments for Hepatitis C drugs as of year to date 2Q23 per the contractual +/- 2 percent risk corridor. Hilltop allocated $4 million for the second installment of the rural access incentive payment to MCOs for six eligible MCOs.

<u>Other Rate Setting Team Activities</u>

Hilltop provided MDH with monthly trauma payments for each MCO, analyzed denied hospital claims reports by MCO from the HSCRC, and fielded individual MCO inquiries most often related to risk corridors, redeterminations, and PCP care defining. Per MDH's request, Hilltop coordinated an analysis of regional financial differences with MDH, Optumas, and Johns Hopkins Bloomberg School of Public Health (Hopkins). Modeling of alternate geographic factors, PRS-adjusted RACs, and mix-adjusted geographic factors commenced toward vetting with Hopkins and the MCOs.

Hilltop's internal health equity workgroup continued meeting weekly, focusing on data analysis to support a potential "health equity measurement phase two," which could include an outcomes-based, gap-reduction dimension. Hilltop also examined "Z" social need codes from Hopkins' ACG system for possible usefulness for health equity.

Hilltop prepared the first report of the "Population Health Incentive Program" (PHIP) that began for CY 2022. Hilltop gathered final CY 2022 medical loss ratio (MLR) submissions from MCOs to check for compliance with the minimum of 85 percent. Per MDH's request, Hilltop calculated the actual FY 2024 spending for "health services initiatives" (HSI) to demonstrate compliance with the 10% limit. Per COMAR, Hilltop calculated the FY 2024 and FY 2025, hospital-specific, "graduate medical education" (GME) payments to teaching hospitals.

Financial/Budget Neutrality Development/Issues

MDH 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). MDH 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, MDH 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 15,978 calls in Quarter 2 of FY 2024. The Help Line assists waiver-eligible consumers with eligibility and enrollment questions and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs, and how to access carved-out services or services covered by Medicaid on an FFS basis.

When a consumer experiences a medically related issue, such as difficulty getting appointments with a specialist, getting a prescription filled, or getting a service pre-authorized, the call is classified as a complaint. Complaints are referred to the State's Complaint Resolution Unit (CRU), which is staffed with registered nurses. If necessary, the CRU engages a local Ombudsman, who is stationed at the county-level health departments and 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, MDH meets with an MCO to discuss the report findings.

Table 7. Total Recipient Complaints – Quarter 2 FY 2024

CMS Quarterly Report
Total Recipient Complaints - excluding Billing
2nd Quarter, FY 2024

MCO / Type of Service		Aetna Better Health (ABH)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Wellpoint Maryland (WPMD)*		Sub Totals	
1st Q FY 24 vs. 2nd Q FY 24		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Pharmacy	#	21	1	36	2	2	0	15	0	60	5	25	4	38	2	91	0	53	4	341	18
	%	6%	6%	11%	11%	1%	0%	4%	0%	18%	28%	7%	22%	11%	11%	27%	0%	16%	22%	38%	2%
Prenatal	#	5	11	8	15	4	4	15	14	12	11	21	19	12	34	24	12	32	22	133	142
	%	4%	8%	6%	11%	3%	3%	11%	10%	9%	8%	16%	13%	9%	24%	18%	8%	24%	15%	15%	17%
PCP	#	9	7	12	6	2	1	7	5	22	14	4	2	24	12	14	15	10	9	104	71
	%	9%	10%	12%	8%	2%	1%	7%	7%	21%	20%	4%	3%	23%	17%	13%	21%	10%	13%	12%	8%
Specialist	#	6	3	19	21	2	3	6	6	16	14	6	7	12	11	24	10	7	4	98	79
	%	6%	4%	19%	27%	2%	4%	6%	8%	16%	18%	6%	9%	12%	14%	24%	13%	7%	5%	11%	9%
Sub Totals	#	41	22	75	44	10	8	43	25	110	44	56	32	86	59	153	37	102	39	676	310
	%	6%	7%	11%	14%	1%	3%	6%	8%	16%	14%	8%	10%	13%	19%	23%	12%	15%	13%	76%	37%
All Complaint Totals	#	45	50	83	97	11	12	49	54	189	186	66	75	138	150	172	135	139	87	892	846
	%	5%	6%	9%	11%	1%	1%	5%	6%	21%	22%	7%	9%	15%	18%	19%	16%	16%	10%	100%	100%
Other Categories		4	28	8	53	1	4	6	29	79	142	10	43	52	91	19	98	37	48	216	536

*Name Change as of 1/1/2023: Amerigroup (ACC) into Wellpoint Maryland (WPMD)

Source: CRM

There were 1,065 total MCO recipient complaints in Quarter 2 of FY 2024 (all ages). Seventy-nine percent of the complaints (846) were related to access to care. The remaining twenty-one percent (219) were billing complaints.

The top three member complaint categories were accessing primary care providers (PCPs), specialists, and prenatal providers, respectively. Prenatal complaints made up the majority of complaints (142). 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, Priority Partners, UnitedHealthcare, and Maryland Physician Care (MPC) had the highest percentage of complaints in this quarter. Prenatal care complaints comprised thirty-eight percent of total complaints during the second quarter.

Table 8. Recipient Complaints Under Age 21 – Quarter 2 FY 2024

CMS Quarterly Report
Total Recipient Complaints - excluding Billing: Under age 21 only
2nd Quarter, FY 2024

MCO / Type of Service		Aetna Better Health (ABH)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Wellpoint Maryland (WPMD)		Sub Totals	
1st Q FY 24 vs. 2nd Q FY 24		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Pharmacy	#	4	1	4	1	0	0	0	0	11	1	1	1	13	1	24	0	14	1	71	6
	%	6%	17%	6%	17%	0%	0%	0%	0%	15%	17%	1%	17%	18%	17%	34%	0%	20%	17%	36%	3%
PCP	#	3	1	2	4	2	0	5	1	8	9	3	1	12	3	8	9	4	4	47	32
	%	6%	3%	4%	13%	4%	0%	11%	3%	17%	28%	6%	3%	26%	9%	17%	28%	9%	13%	24%	17%
Specialist	#	1	1	4	5	0	0	1	2	1	2	0	2	7	7	8	1	1	1	23	21
	%	4%	5%	17%	24%	0%	0%	4%	10%	4%	10%	0%	10%	30%	33%	35%	5%	4%	5%	12%	11%
Prenatal	#	0	1	0	4	0	1	1	1	3	2	6	4	4	7	3	1	8	3	25	24
	%	0%	4%	0%	17%	0%	4%	4%	4%	12%	8%	24%	17%	16%	29%	12%	4%	32%	13%	13%	13%
Sub Totals	#	8	4	10	14	2	1	7	4	23	14	10	8	36	18	43	11	27	9	166	83
	%	5%	5%	6%	17%	1%	1%	4%	5%	14%	17%	6%	10%	22%	22%	26%	13%	16%	11%	83%	44%
All EPSDT Complaint Totals	#	9	8	12	22	2	3	8	12	30	41	12	13	47	43	46	29	34	19	200	190
	%	5%	4%	6%	12%	1%	2%	4%	6%	15%	22%	6%	7%	24%	23%	23%	15%	17%	10%	100%	100%
Other Categories		1	4	2	8	0	2	1	8	7	27	2	5	11	25	3	18	7	10	34	107

*Name Change as of 1/1/2023: Amerigroup (ACC) into Wellpoint Maryland (WPMD)
Source:CRM

There were 190 member complaints (non-billing) for recipients under age 21 in Quarter 2 of FY 2024, or 22 percent of the total complaints. The top complaint category was access to primary care physician (PCP) services. UnitedHealthcare, Maryland Physicians Care, and Priority Partners were major contributors to the complaints for recipients under age 21.

The analysis of complaints by adults versus children (under 21) revealed that access to care is the main issue for both adults and children. Adults most often report difficulty accessing prenatal care services followed by difficulty accessing specialty services. Children (under 21) most often report difficulty accessing primary care services followed by prenatal care services; specialty services have been reported to be a close third access concern.

Table 9. Total Recipient Billing Complaints – Quarter 2 FY 2024

CMS Quarterly Report
Total Recipient Complaints - Billing only
2nd Quarter, FY 2024

MCO / Type of Service		Aetna Better Health (ABH)		CareFirst (CHPMD)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		Wellpoint Maryland (WPMD)		Sub Totals	
1st Q FY 24 vs. 2nd Q FY 24		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Emergency	#	3	2	3	4	1	1	4	3	7	6	4	4	10	8	5	4	5	5	42	37
	%	7%	5%	7%	11%	2%	3%	10%	8%	17%	16%	10%	11%	24%	22%	12%	11%	12%	14%	18%	17%
PCP	#	3	1	9	9	0	0	23	9	12	11	5	5	9	15	8	6	11	9	80	65
	%	4%	2%	11%	14%	0%	0%	29%	14%	15%	17%	6%	8%	11%	23%	10%	9%	14%	14%	34%	30%
Laboratory/ Test	#	1	1	3	1	0	0	3	3	6	7	2	1	8	7	7	4	9	7	39	31
	%	3%	3%	8%	3%	0%	0%	8%	10%	15%	23%	5%	3%	21%	23%	18%	13%	23%	23%	17%	14%
Specialist	#	1	2	2	5	0	0	6	4	11	3	4	2	5	10	3	3	0	2	32	31
	%	3%	6%	6%	16%	0%	0%	19%	13%	34%	10%	13%	6%	16%	32%	9%	10%	0%	6%	14%	14%
Sub Totals	#	8	6	17	19	1	1	36	19	36	27	15	12	32	40	23	17	25	23	193	164
	%	4%	4%	9%	12%	1%	1%	19%	12%	19%	16%	8%	7%	17%	24%	12%	10%	13%	14%	83%	75%
All Billing Complaint Totals	#	12	11	24	25	2	2	44	27	46	33	15	17	37	44	27	27	26	33	233	219
	%	5%	5%	10%	11%	1%	1%	19%	12%	20%	15%	6%	8%	16%	20%	12%	12%	11%	15%	100%	100%
Other Categories		4	5	7	6	1	1	8	8	10	6	0	5	5	4	4	10	1	10	40	55

*Name Change as of 1/1/2023: Amerigroup (ACC) into Wellpoint Maryland (WPMD)
Source: CRM

Enrollee billing complaints comprised 26 percent of total MCO complaints in Quarter 2 of FY 2024. Overall, the top bill type was primary care providers followed by emergency-related billing issues, which comprised thirty percent and seventeen percent, respectively, followed by Laboratory/Test service access 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 Physician Care (MPC) and Wellpoint.

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

Maryland's 2024 legislative session will begin on January 10, 2024, and end on April 9, 2024.

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.

MDH contracts with three vendors to support its quality assurance activities:

- Qlarant Quality Solutions, Inc. (Qlarant) is the external quality review organization (EQRO).
- MetaStar, Inc. (MetaStar) is the HEDIS Compliance Auditor.
- Center for the Study of Services, Inc. (CSS) is the survey administration vendor.

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

Activity	Vendor	Status	Comments (October - December 2023)
Systems Performance Review (SPR)	Qlarant	In Progress	MCOs provided Measurement Year (MY) 2023 GAD and Credentialing/Recredentialing universes for the upcoming SPR review. Quarterly Corrective Action Plan (CAP) reviews commenced in October 2023. MY 2022 MCO SPR Quarterly CAPs were reviewed, approved, and provided to MCOs in December 2023. MY 2023 SPR Reporting Templates are currently in review and will be approved in the next quarter.
EPSDT Medical Record Review	Qlarant	In Progress	MDH reviewed and approved the MY2021 EPSDT UHC CAP in October 2023. Qlarant performed a Singles Sample Outreach to all MCOs for record reviews in October 2023. Scheduling for onsite reviews and medical record reviews was completed in November 2023. MDH review of all draft MCO EPSDT Reports began in December 2023. The MY 2022 Statewide Executive Summary review will commence next quarter.
Consumer Report Card (CRC)	Qlarant	In Progress	The Final 2024 IRS and Methodology was made available on the MCO Resource Site in October 2023. The 2024 Consumer Report Card Template was reviewed in December 2023, with beginning discussions regarding layout and report card categories. The 2024 analyzed results will be provided to MCOs within the next quarter.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	Quarter 3 MCO PIP Reports were submitted in October 2023, and MDH began review in October - November 2023. An 'Outreach Defined and Use in MCO PIPs' Presentation was provided to all MCOs during the December 2023 QALC Meeting and was made available as referential documentation on the MCO Resource Site. MPC was invited to share their best PIP Reporting practices with the remaining eight MCOs during the QALC Meeting. MDH and Qlarant performed Technical Assistance Training in October 2023. The first draft of the PIP Orientation Manual was submitted in December 2023 and will be approved within the next quarter.
Encounter Data Validation (EDV)	Qlarant	In Progress	The MY 2022 MCO ISCA findings were reviewed for approval by MDH in October 2023. The MY 2022 EDV Report Template was reviewed in October 2023. The first and second draft review of Hilltop's EQR Encounter Data Validation Report for CY 2020 to CY 2022 was reviewed from November - December 2023.
Network Adequacy Validation (NAV)	Qlarant	Complete	MY 2022 NAV CAPs were reviewed, approved, and disseminated to MCOs in November 2023. MY 2023 NAV CAPs were provided to MDH for review in December 2023. NAV Protocol Methodology discussions also commenced in December 2023.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	In Progress	The MY 2022 GAD Report was disseminated to all MCOs in October 2023. MCOs provided quarterly GAD reports in October 2023 for review and analysis. GAD MCO Annual Record Reviews were completed in November 2023. The Q3 GAD Report Analysis took place in December 2023. Discussions within MDH are underway regarding quarterly GAD CAP or opportunities for Improvement (OFI) implementation.

Activity	Vendor	Status	Comments (October - December 2023)
HEDIS Audits and Reporting (HEDIS)	MetaStar	In Progress	The HEDIS® MY 2023 Public Reporting memo was released in October by NCQA outlining all measures, product lines, and indicators that have been approved for public reporting starting in MY 2023 and MY 2024, as well as all measures, stratifications, and product lines that will not be publicly reported for MY 2023. The Draft 2023 HEDIS Statewide Executive Summary Report was provided to MDH for review in late December. The 2023 HEDIS Statewide Analysis Report was provided by the HEDIS vendor to MDH and all HealthChoice MCOs at the end of December. The HEDIS vendor provided an updated audit timeline, along with key dates and scheduled onsite visits for the HealthChoice MCOs for the upcoming HEDIS 2024 audit season.
Population Health Incentive Program (PHIP)	Qlarant	In Progress	Draft report development is underway for MY 2022. MCOs received their PHIP performance letters and rate calculations in December 2023. The final report and results will be available in the next quarter.
CAHPS Survey Administration (CAHPS)	CSS	In Progress	MDH completed review and editing of all CAHPS reports, including MCO, Aggregate, and Executive Summary reports. The survey vendor disseminated all approved final reports for 2023 to the MCOs and to MDH in December. The Executive Summary report was posted on the MDH Website in December. The survey vendor provided a survey administration timeline for CAHPS 2024 to MDH in November 2023. Pre-survey fielding activities are underway, which include reviewing and updating the survey questionnaires and collateral materials, obtaining the survey recipient data file, and providing it to the survey vendor.
Primary Care Provider (PCP) Satisfaction Survey Administration	CSS	In Progress	All 2023 PCP HealthChoice MCO survey reports and the 2023 Aggregate survey report were finalized, approved, and provided to MDH and all MCOs by the survey vendor in October 2023. The 2023 PCP Executive Summary Report was posted on the MDH Website in November. The 2024 PCP Data File request memo was sent to all MCOs by MDH with instructions and requirements for providing the data file to the survey vendor for the 2024 Survey Administration. Pre-survey fielding activities are underway, including any updates to the survey questionnaire design and other survey collateral materials.
Annual Technical Report (ATR)	Qlarant	In Progress	Qlarant began drafting the MY2023 ATR Report in September 2023. After incorporating the latest GAD and NAV finalized reports, Qlarant submitted its edit recovery to MDH for review in December 2023.

Activity Highlights

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

Below is a summary of the Quarter 3 (Q3) 2023 findings from the GAD activity.

The lowest range of MCO grievances totaled at 0.27 per 1,000 members; whereas the highest range of grievances totaled at 5.19 per 1,000 members, a slight increase from the previous quarter. The most prevalent reason codes for member grievances across MCOs were "Billing and Financial," while "Unable to Schedule an Appointment" was a newly added reason code to the top 5 reason codes reported.

Eight of nine MCOs met the grievance turnaround time (TAT) requirements with the outlier MCO missing the 95 percent thresholds but maintaining rate well over 50 percent (67 percent for Category One and 75 for Category Two). The top provider grievance reason code was "Billing/Financial." All Provider Grievance timeliness metrics were met. Four MCOs cited a higher rate of member appeals than the prior quarter. The lowest number of appeals per 1,000 members totaled a rate of 0.12, while the highest number of appeals per 1,000 members was 3.24.

Similar to the previous quarter, seven of the nine MCOs reported that more providers submitted appeals than members; while the remaining two MCOs reported that greater than 90 percent of their appeals came from members. Eight MCOs met the non-emergency standard appeals TAT requirements. Eight MCOs met the expedited appeals resolution TAT requirements, with the under-threshold compliance rate at 94 percent; this MCO did improve its metric from the previous quarter.

Pre-service denials varied across MCOs, with the highest rankings 33.91 per 1,000 and 32.59 per 1,000 member denials. The lowest denial rates were reported at 2.08 and 6.80, with the lowest in member denials. The highest rate of pre-service outpatient pharmacy denials was reported at 94 percent, while the lowest was reported at 24 percent. One MCO reported no outpatient pharmacy denials.

Seven MCOs met or exceeded the standard pre-service denial determination TAT performance threshold of 95 percent; the remaining two MCOs ranked at 92 percent and 84 percent, respectively. All MCOs met or exceeded the pre-service denial notification TAT for standard, expedited, and pre-service outpatient pharmacy. All MCOs met or exceeded the prescriber notification of outcome within 24 hours TAT compliance requirement.

Network Adequacy Validation (NAV)

The MY 2023 NAV Report was approved in October 2023 and disseminated to MCOs in November 2023. The MY 2023 HealthChoice MCO Aggregate results for Validation of Online Provider Directories Compliance Category rates ranged from 78 percent to 97 percent amongst all MCOs, with an 80 percent minimum compliance score. CareFirst, Jai, Kaiser, Priority Partners, UHC, and Wellpoint were required to submit NAV CAPs. All NAV CAP reviews have begun, and results will be provided in the next quarter.

HEDIS Audits and Reporting

This quarter saw Maryland MCO 2022 HEDIS performance normalized to rates similar to those of years prior to the COVID-19 pandemic.

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

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

CAHPS Survey Administration

Adult Survey

The 2023 HealthChoice Aggregate performed on par with 2022 measures with one measure exception: *Getting Needed Care*. The percentage of recipients indicating "Usually" or "Always" getting needed care was 78.19 percent in 2023 compared to 82.78 percent in 2022 and 84.61 percent in 2021.

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

Child Survey

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

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

Primary Care Provider (PCP) Survey Administration

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

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

Demonstration Evaluation

During the quarter, MDH submitted an 1115 Waiver Amendment. The Waiver Amendment requested waiver authority to adopt the Four Walls Requirement temporary 1135 waiver authority on a permanent basis, as well as approval to implement Express Lane Eligibility for members of an eligible child's SNAP household up to age 65 if they are already enrolled in Medicaid and/or CHIP. MDH submitted the Amendment on October 25, 2023.

MDH also worked on a second Waiver Amendment. MDH intends to seek federal approval to offer a set of targeted Medicaid services to certain incarcerated populations who are soon to be released from state prison or jail. 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.

MDH continues to collaborate with CMS and the Hilltop Institute regarding SUD Monitoring Report implementation and technical specifications, as well as batch submission of historical reports. MDH and CMS continue to collaborate on the SMI Monitoring Protocol and the 1115 Summative Evaluation Design.

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Attachments: