Maryland HealthChoice Demonstration
Section §1115 Annual Report
Demonstration Year 26: 7/1/2022 - 6/30/2023

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 (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 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 (WD);[1]
- 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);

[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.

- 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, MDH began the process of sunsetting both the Adult Dental Pilot Program and the Alternative Destination Pilot Program from the 1115 wavier. Both initiatives have been expanded statewide, as of 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

Demonstration Populations	Participants as of June 30, 2022	Participants as of June 30, 2023	DY 26 Change (#)	D 26 Change (%)
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	93,534	87,138	-6,396	-6.8%
SSI/BD Children	24,085	22,326	-1,759	-7.3%
Medically-Needy Adults	26,360	29,163	2,803	10.6%
Medically-Needy Children	6,550	6,743	193	2.9%
Medicaid Children	537,057	564,447	27,390	5.1%
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	296,114	308,660	12,546	4.2%
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	15,841	21,593	5,752	36.3%
Affordable Care Act (ACA) Expansion Adults	443,008	466,465	23,457	5.3%
Maryland Children's Health Program (MCHP)	127,440	132,029	4,589	3.6%
MCHP Premium	33,515	33,146	-369	-1.1%

Demonstration Populations	Participants as of June 30, 2022	Participants as of June 30, 2023	DY 26 Change (#)	D 26 Change (%)
Presumptively Eligible Pregnant Women (PEPW)	-	-	-	0.0%
Increased Community Services (ICS)	21	18	-3	-14.3%
Women's Breast and Cervical Cancer Health Program (WBCCHP)	56	42	-14	-25.0%

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 March 2023	Current Quarter Month 1 (April 2023)	Current Quarter Month 2 (May 2023)	Current Quarter Month 3 (June 2023)	Total for Quarter Ending June 2023
SSI/BD Adults	275,867	89,859	88,618	87,138	265,615
SSI/BD Children	68,575	22,693	22,519	22,326	67,538
Medically-Needy Adults	84,531	29,083	29,235	29,163	87,481
Medically-Needy Children	19,458	6,819	6,771	6,743	20,333
Children	1,677,313	564,696	567,600	564,447	1,696,743
Parents/caretakers and former foster care	924,832	310,152	311,207	308,660	930,019
SOBRA	61,337	21,326	21,687	21,593	64,606
ACA expansion	1,388,747	466,489	468,979	466,465	1,401,933
MCHP	398,544	133,674	133,698	132,029	399,401
MCHP Premium	99,129	32,811	32,925	33,146	98,882
PEPW	23	*	-	-	*
ICS	71	18	19	18	55
WBCCHP	115	41	41	42	124

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

Table 3. Enrollment as a Proportion of Total

Demonstration Populations	Share of Participants as of June 30, 2022	Share of Participants as of June 30, 2023	Share Change
SSI/BD Adults	5.8%	5.2%	-0.6%
SSI/BD Children	1.5%	1.3%	-0.2%
Medically-Needy Adults	1.6%	1.7%	0.1%
Medically-Needy Children	0.4%	0.4%	0.0%
Children	33.5%	33.8%	0.3%

Demonstration Populations	Share of Participants as of June 30, 2022	Share of Participants as of June 30, 2023	Share Change
Parents/caretakers and former foster care	18.5%	18.5%	0.0%
SOBRA	1.0%	1.3%	0.3%
ACA expansion	27.6%	27.9%	0.3%
MCHP	7.9%	7.9%	0.0%
MCHP Premium	2.1%	2.0%	-0.1%
PEPW	0.0%	0.0%	0.0%
ICS	0.0%	0.0%	0.0%
WBCCHP	0.0%	0.0%	0.0%

Outreach/Innovative Activities

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

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.

For more information, please refer to the SUD Monitoring Report. MDH submitted the SMI monitoring protocol last quarter and is awaiting CMS approval.

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.

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. Beginning October 1, 2023, the CoCM Pilot Program will be sunset into a statewide expansion.

Table 3. CoCM Member Months by Pilot Site

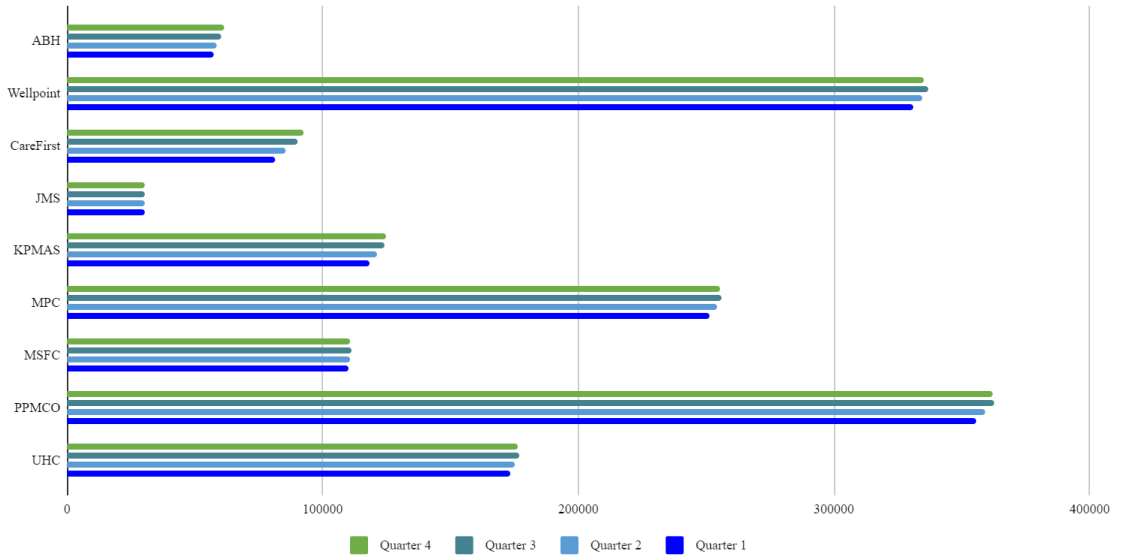
	January 2023	Feb. 2023	March 2023	TOTAL
Urban	69	67	75	211
Rural	13	11	11	35
Ob/Gyn	15	14	13	42
TOTAL	**97**	**92**	**99**	**288**

Operational/Policy Developments/Issues

Market Share

As of the end of the last quarter of FY 2023, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (4.0 percent), Wellpoint (formerly known as Amerigroup; 21.6 percent); CareFirst Community Health Plan of Maryland (6.0 percent); Jai Medical Systems (2.0 percent); Kaiser Permanente (8.0 percent); Maryland Physicians Care (16.5 percent); MedStar Family Choice (7.1 percent); Priority Partners (23.4 percent); and United Healthcare (11.4 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in April, May, and June of 2023. Due to COVID-19, all MMAC meetings were held via teleconference. These meetings covered a wide variety of topics, including general department updates, public health emergency unwinding, and enrollment, waiver, state plan, and regulations changes.

During the April meeting, the MMAC was briefed on the Public Health Emergency (PHE) unwinding, electronic advance directives, enrollment and MCO marketing activities regarding enrollment, and the legislative update.

During the May meeting, the MMAC was briefed on the Healthy Babies Equity Act, Total Cost of Care Progression: Payer Alignment Workgroup, and Health Choice Evaluation in addition to enrollment updates.

During the June meeting, the MMAC was briefed on enrollment figures after the first month of redetermination, and the new Community Violence Prevention benefit, in addition to PHE unwinding, PHE communications outreach efforts.

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	214	175	39	70	4,591
Quarter 3	242	196	44	102	4,677
Quarter 4	281	195	71	86	4461

Table 5. REM Complaints

FY 23 Q4 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	2	0	1
Dental	0	0	2
DMS/DME	6	0	5
EPSDT	0	0	0
Clinical	2	0	2
Pharmacy	1	0	0
Case Mgt.	4	1	4
REM Intake	0	0	0
Access to MA Providers	9	0	2
Nursing	9	1	7
Other	27	0	8
Total	60	2	31

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	0	1	0
Abuse	2	3	2	3
Complaint	18	8	62	31
Death	20	25	19	14

FY 23 Incidents	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Elopement	3	0	0	0
ER	2	1	0	0
Exploitation	0	0	0	0
Failure to Follow Plan (Non-Compliance)	0	0	0	0
Fall	1	2	3	2
Hospitalization	8	16	16	10
Medication Error	2	0	2	0
Neglect	9	10	11	10
Suicidal Ideation	1	1	0	1
Theft	1	1	0	1
Wound	0	0	2	0
Other	10	18	15	18
Total	**77**	**85**	**133**	**90**

Increased Community Services (ICS) Program

Through the ICS Program, Maryland continued providing Medicaid State Plan benefits and home- and community-based services to residents aged 18 and over, enabling qualifying individuals to live at home with appropriate supports, as opposed to residing in a nursing facility. Under the terms of the 2016 waiver renewal, Maryland raised the cap to a maximum of 100 participants. 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 June 30, 2023, the Premium program had 33,146 participants with MCHP at 132,029 participants.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Per the most recent report (June 12, 2023), there were 1,565 encounters with DPP procedure codes provided by licensed Medicaid-enrolled DPP providers to 252 unique participants between September 1, 2019 and May 31, 2023. Among the 252 unique Medicaid beneficiaries with a DPP encounter, most were women (83 percent), Black/African American (71 percent), and resided in

Prince George's County (35.3 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 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 June 2023, 42 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.

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.

During FY Q3, the ACIS pilot had 486 enrollees while by the end of FY 23 Q4 the ACIS pilot had 517 enrollees. Programmatically, LEs continue to improve processes related to pilot enrollment, partnering with local community partners, landlords, management companies, and continue to implement best practices for working with ACIS-enrolled participants. ACIS LEs are also working towards improving data quality and reporting by implementing improved training and communication processes.

ACIS LEs maintain their concern at increasing rental prices and landlord's noncompliance with the state laws. This results in continued search for more local housing partners to meet their participants' needs as well as insufficient supply of affordable local housing. They have also indicated absence of required eligibility determination documentation for enrollment in benefits, inconsistent access to a working telephone as well as consumer's behavioral health concerns and refusal to accept offered services as some of the concerns that have decreased efficiencies by program staff to house ACIS participants.

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 280 statewide ACIS beneficiary spaces.

Expenditure Containment Initiatives

MDH, in collaboration with Hilltop, has worked on several different fronts to contain expenditures. The culmination of MDH and Hilltop's efforts are 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)

Hilltop performed its annual "MCO Outlier" analysis from 2021 HFMR data. One MCO fell outside the boundary of efficient delivery of care and consequently, $11.5 million of cost was removed from the base year for pricing purposes.

The second of two meetings was held with the Health Services Cost Review Commission (HSCRC) to plan for CY 2024 rate adjustments. The 2024 hospital revenue growth "update" factor for "global budget revenue" (GBR) was relayed at 4.32 percent and incorporated into rate setting.

Instructions for the MCOs for the initial 2022 HFMR submission included an updated definition of "primary care." In support of the Maryland Primary Care Program (MDPCP), Hilltop consulted with the Maryland Health Care Commission (MHCC) to accurately and uniformly measure PCP utilization across payers toward improving outcomes and constraining cost growth. The instructions were also amplified to prevent perennial audit findings toward more accurate initial submissions.

The audit of the 2021 HFMR by Myers & Stauffer, LLC was reviewed, edited, and incorporated into 2024 rate setting as the base year. Claims were reduced by approximately $93 million and pandemic-related adjustments were identified to make the year usable for projecting costs.

MCO Rates

Activities in Support of the CY 2024 HealthChoice Rates

Three monthly meetings with the MCOs covered topics such as rejected encounters and associated penalties, maternal and child health improvement initiatives, DPP, regional analyses including reasons and possible solutions for disparate financial results, redetermination of eligibility and its implication on cost acuity with the ending of the Families First Coronavirus Response Act continuous enrollment, and claims trend analyses.

A three-phased, graded approach for incorporating health equity and social health determinants into rate setting was formulated. Phase 1 was aimed for implementation in 2024. It defined domains (e.g., food insecurity, community safety, housing instability) and measurements toward identifying needy counties and providing an incentive payment to those MCOs serving those counties). In addition, race, ethnicity, and claims-based homelessness data were gathered for potential future use.

For adjusting the 2021 base year for COVID, data were sought for cost-impacting ramifications such as post-pandemic flu/influenza cost resurgence and abatement of coordination of benefits (COB) payments. At the request of CMS, a prescribed risk corridor data template for 2020 and 2021 was completed and submitted for national aggregation, evaluation, and reporting.

Per Maryland **HB 413 / SB 395**, "Health Insurance – Individual Market Stabilization," and in concert with the Maryland Insurance Administration and the Maryland Health Benefits Exchange, Hilltop began modeling various scenarios of expanding Medicaid coverage to undocumented Marylanders including gauging eligible members, cost, uncompensated care impacts, and funding options. Per recent guidance from CMS, "in lieu of services" (ILOS) were gathered by MCO to ensure consistency.

Activities in Support of the CY 2022 HealthChoice Rates

The transitional +/- 2 percent risk corridor for Hepatitis C was estimated to result in the MCOs owing approximately $6 million for all of 2022.

Other Rate Setting Activities

Hilltop analyzed denied hospital claims reports by MCO from the HSCRC, began to analyze legislation to expand coverage to undocumented Marylanders, and fielded individual MCO inquiries most often related to risk corridors, eligibility redeterminations, and specialty drugs.

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 34,996 calls in Q4 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, MDH meets with an MCO to discuss the report findings.

Table 7. Total Recipient Complaints[2] - Q4 FY 2023

CMS Quarterly Report
Total Recipient Complaints - excluding Billing
4th Quarter, FY 2023

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	
Q3 FY 23 vs. Q4 FY 23		3	4	3	4	3	4	3	4	3	4	3		3	4	3	4	3	4	3	4
Pharmacy	#	22	20	66	53	4	7	33	21	78	60	55	44	87	81	148	113	67	64	560	463
	%	4%	4%	12%	11%	1%	2%	6%	5%	14%	13%	10%	10%	16%	17%	26%	24%	12%	14%	56%	42%
Prenatal	#	4	11	11	7	0	1	29	29	22	18	16	6	29	35	29	12	26	22	166	141
	%	2%	8%	7%	5%	0%	1%	17%	21%	13%	13%	10%	4%	17%	25%	17%	9%	16%	16%	17%	13%
PCP	#	8	18	28	16	7	7	15	10	34	21	15	5	14	27	21	20	19	16	161	140
	%	5%	13%	17%	11%	4%	5%	9%	7%	21%	15%	9%	4%	9%	19%	13%	14%	12%	11%	16%	13%
Specialist	#	14	13	23	15	1	2	11	13	20	13	4	5	17	11	29	12	9	12	128	96
	%	11%	14%	18%	16%	1%	2%	9%	14%	16%	14%	3%	5%	13%	11%	23%	13%	7%	13%	13%	9%
Sub Totals	#	48	62	128	91	12	17	88	73	154	112	90	60	147	154	227	157	121	114	1015	840
	%	5%	7%	13%	11%	1%	2%	9%	9%	15%	13%	9%	7%	14%	18%	22%	19%	12%	14%	102%	77%
All Complaint Totals	#	57	66	142	104	13	17	93	78	254	216	108	74	217	217	247	178	143	142	994	1092
	%	6%	6%	14%	10%	1%	2%	9%	7%	26%	20%	11%	7%	22%	20%	25%	16%	14%	13%	128%	100%
Other Categories		9	4	14	13	1	0	5	5	100	104	18	14	70	63	20	21	22	28	171	252

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

There were 1,370 total MCO recipient complaints in Quarter 4 of FY 2023 (all ages). Eighty percent of the complaints (1,092) were related to access to care. The remaining twenty percent (278) were billing complaints. The top three member complaint categories were accessing pharmacy, prenatal, and primary care providers (PCPs) respectively. Pharmacy complaints made up the majority of complaints. The categories not specified (Other Categories) for the non-billing complaints include appeals and grievances, access to therapies (occupational therapy-OT, physical therapy-PT, and speech therapy-ST), adult dental and vision services, and obtaining Durable Medical Equipment/Durable Medical Supplies (DME/DMS). Overall Maryland

[2] Billing not included.

Physicians Care, Priority Partners, and UnitedHealthcare had the highest percentage of complaints in this quarter.

Prenatal complaints comprised 13 percent of total complaints during the fourth 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.

Table 8. Recipient Complaints Under Age 21[3] - Q4 FY 2023

CMS Quarterly Report
Total Recipient Complaints - excluding Billing: Under age 21 only
4th Quarter, FY 2023

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	
Q3 FY 23 vs. Q4FY 23		3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4
Pharmacy	#	5	4	4	5	1	1	6	4	14	8	5	10	24	24	22	20	20	19	101	95
	%	5%	4%	4%	5%	1%	1%	6%	4%	14%	8%	5%	11%	24%	25%	22%	21%	20%	20%	41%	41%
PCP	#	4	3	7	5	4	2	5	5	11	9	3	1	4	11	8	10	11	4	57	50
	%	7%	6%	12%	10%	7%	4%	9%	10%	19%	18%	5%	2%	7%	22%	14%	20%	19%	8%	23%	22%
Specialist	#	5	6	3	2	0	0	4	3	2	1	0	2	6	4	3	4	3	2	26	24
	%	19%	25%	12%	8%	0%	0%	15%	13%	8%	4%	0%	8%	23%	17%	12%	17%	12%	8%	11%	10%
Prenatal	#	0	0	3	0	0	0	3	4	1	4	1	0	6	6	5	1	3	5	22	20
	%	0%	0%	0%	0%	0%	0%	14%	20%	5%	20%	9%	0%	27%	30%	23%	5%	14%	25%	9%	9%
Sub Totals	#	14	13	17	12	5	3	18	16	28	22	9	13	40	45	38	35	37	30	206	189
	%	7%	7%	8%	6%	2%	2%	9%	8%	14%	12%	4%	7%	19%	24%	18%	19%	18%	16%	84%	82%
All EPSDT Complaint Totals	#	16	13	20	13	5	3	19	19	38	38	12	16	54	58	41	37	40	34	245	231
	%	7%	6%	8%	6%	2%	1%	8%	8%	16%	16%	5%	7%	22%	25%	17%	16%	16%	15%	100%	100%
Other Categories		2	0	3	1	0	0	1	3	10	16	3	3	14	13	3	2	3	4	39	42

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

There were 231 member complaints (non-billing) for recipients under age 21 in Q4 of FY 2023, or fifteen percent of the total complaints. The top complaint category was access to pharmacy services. Priority Partners, UnitedHealthcare, and Maryland Physicians Care 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 pharmacy services followed by difficulty accessing a primary care provider.

[3] Billing not included.

Table 9. Total Recipient Billing Complaints - Q4 FY 2023

CMS Quarterly Report
Total Recipient Complaints - Billing only
4th Quarter, FY 2023

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	
Q3 FY 23 vs. Q4 FY 23		3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4
Emergency	#	9	2	5	5	0	0	14	5	11	6	5	7	15	12	5	7	15	6	79	50
	%	11%	4%	6%	10%	0%	0%	18%	10%	14%	12%	6%	14%	19%	24%	6%	14%	19%	12%	25%	18%
PCP	#	5	7	5	11	1	1	9	7	12	19	4	12	9	20	14	5	12	14	71	96
	%	7%	5%	7%	11%	1%	1%	13%	7%	17%	20%	6%	13%	13%	21%	20%	5%	17%	15%	23%	35%
Laboratory/ Test	#	5	2	8	2	1	0	4	3	12	10	1	3	6	6	7	6	3	9	47	41
	%	11%	9%	17%	5%	2%	0%	9%	7%	26%	24%	2%	7%	13%	15%	15%	15%	6%	22%	15%	15%
Specialist	#	1	3	2	1	0	1	2	6	9	5	5	7	4	5	3	4	6	2	32	34
	%	3%	4%	6%	3%	0%	3%	6%	18%	28%	15%	16%	21%	13%	15%	9%	12%	19%	6%	10%	12%
Sub Totals	#	20	14	20	19	2	2	29	21	44	40	15	29	34	43	29	22	36	31	229	221
	%	9%	14%	9%	9%	1%	1%	13%	10%	19%	18%	7%	13%	15%	19%	13%	10%	16%	14%	73%	79%
All Billing Complaint Totals	#	25	16	30	21	2	4	40	32	57	47	19	33	52	61	43	27	46	37	314	278
	%	9%	6%	10%	8%	1%	1%	13%	12%	18%	17%	6%	12%	17%	22%	14%	10%	15%	13%	100%	100%
Other Categories		5	2	10	2	0	2	11	11	13	7	4	4	18	18	14	5	10	6	85	57

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

Enrollee billing complaints comprised seventeen percent of total MCO complaints in Q4 of FY 2023. Overall, the top bill type was primary care providers followed by emergency related billing issues, which comprised thirty-five percent and eighteen 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 vision. Priority Partners had the highest percentage of billing complaints followed by Maryland Physicians Care and Wellpoint Maryland.

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 2023 legislative session began on January 11, 2023 and ended on April 10, 2023. The General Assembly passed and the Governor signed into law the following bills that affect Maryland's Medicaid program:

- **HB 202** (Budget Reconciliation & Financing Act) - A bill to reduce the amount of the Medicaid deficit assessment by $50 million in FY24.
- **HB 716/SB 474** (MCOs - Retroactive Denial of Reimbursement - Information in Written Statement) - A bill that provides that if a retroactive denial of reimbursement is the result of coordination of benefits, a written statement by an MCO to a provider shall include the name & address of the entity identified by the MCO as responsible for payment.
- **HB 279/SB 202** (Prescription Drug Affordability Board - Upper Payment Limits) - A bill that authorizes the Board to set upper payment limits for drugs purchased by the Medicaid program.
- **HB 374** (Health Insurance - Audits of Pharmacies & Pharmacists) - A bill that requires MDH to adopt regs for PBMs that contract with MCOs that establish requirements for conducting audits of pharmacies or pharmacists that are substantively similar to the audit provisions of Insurance Article §15-1629 and consistent with federal law.
- **HB 382** (MDH & Prescription Drug Affordability Board - MCOs & Prescription Drug Claims - Study) - A bill that requires MDH & the Prescription Drug Affordability Board jointly to study the total amount that MCO paid pharmacies for prescription drug claims in 2021-22 and what the total amount would have been if they had been reimbursed at FFS rates, and how best to address the inconsistency in the amounts paid.
- **SB 678/HB 1151** (Health Insurance - Reimbursement for Services Rendered by a Pharmacist) - A bill that requires Medicaid, MCHP & commercial insurers to provide coverage for all services rendered to an enrollee by a licensed pharmacist within their lawful scope of practice, to the same extent as services rendered by any other health care practitioner.
- **SB 255/HB 322** (Public Health - Home- & Community-Based Services for Children & Youth) - A bill that requires MDH to expand access to and provide reimbursement for wrap-around services delivered under a high-fidelity wrap-around model under the 1915(i) model or a mental health case management program, as well as intensive in-home services delivered by providers using family-centered treatment, functional family therapy and other evidence-based practices under the 1915(i) model, and at least one pilot program using value-based purchasing for case management services.
- **SB 622/HB 1149** (Medicaid Waiver Programs - Wait-List & Registry Reduction) - A bill that requires Medicaid funds to be used to provide community services to individuals waiting for services through waiver programs; a portion of the funds may be used for expanding provider capacity, incl. for hiring & retaining staff & providers, increasing rates & addressing other issues that limit provider capacity.
- **HB 48/HB 101** (Md. Medical Assistance Program - Collaborative Care Model Services - Implementation & Reimbursement Expansion) - A bill that repeals the Collaborative Care Pilot Program and requires MDH to implement and provide reimbursement for services provided in accordance with the Collaborative Care Model under the Medicaid program.
- **HB 283/SB 460** (Md. Medical Assistance Program - Gender-Affirming Treatment) - A bill that requires Medicaid coverage for gender-affirming treatment by Jan. 1, 2024.
- **HB 1146** (MDH & Md. Health Care Commission - Dental Services Survey & Regional Needs Assessment) - A bill that requires MDH, in consultation with the Md. Hospital Association, to conduct a survey of hospitals to identify the availability of hospital

operating room resources for dentist use; requires MDH & the Health Care Commission, in consultation with MHA & the Md. Ambulatory Surgery Association, to conduct a regional needs assessment for dental procedures requiring anesthesia or moderate sedation; requires MDH & the Health Care Commission, in consultation with MHA, to develop regional plans to ensure the availability of appropriate operating room space for dental procedures for Medicaid enrollees.

- **SB 26/HB 111** (Md. Medical Assistance Program, MCHP & Workgroup on Low-Income Utility Assistance) - A bill that requires MDH to adopt express lane eligibility program for enrollment of individuals in Medicaid & MCHP based on eligibility findings for SNAP, and MDH may not consider any other income or eligibility requirements.
- **SB 231/HB 726** (Md. Medical Assistance Program - Autism Waiver - Military Families) - A bill that requires that a child on the Autism Waiver registry remain on the registry if their family relocates out of the state for military service.
- **HB 290** (Public Health - Dental Services - Access) - A bill that requires MDH to annually evaluate reimbursement rates for dental services.
- **SB 362** (Certified Behavioral Health Clinics - Planning Grant Funds & Demonstration Application) - A bill that requires MDH to apply to the federal Substance Abuse & Mental Health Services Administration for federal planning, development & implementation grant funds related to CCBHCs for FY25, and for inclusion in the State CCHBC demonstration program for FY26.
- **SB 534** (Preserve Telehealth Access Act of 2023) - A bill that extends the inclusion of audio-only phone conversations under definition of "telehealth" until June 30, 2025.
- **SB 581** (Behavioral Health Care Coordination Value-Based Purchasing Pilot Program) - A bill that establishes a pilot program in MDH to establish & implement an intensive care coordination model using VBP in the specialty behavioral health system.
- **SB 582/HB 1148** (Behavioral Health Care - Treatment & Access) - A bill that establishes Commission on Behavioral Health Care Treatment & Access to make recommendations to provide appropriate, accessible & comprehensive behavioral health services; establishes Behavioral Health Care Coordination Value-Based Purchasing Pilot Program in MDH.
- **SB 805/HB 1217** (Md. Medical Assistance Program & Health Insurance - Required Coverage for Biomaker Testing) - A bill that requires Medicaid (incl. MCOs) and commercial insurers to provide coverage for biomarker testing that is supported by medical & scientific evidence by July 1, 2025.

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.

Consistent with updates in earlier reports, MDH is actively adjusting reporting and record collecting due to COVID-19. An update on quality assurance activity progress appears in the chart below.

Activity	Vendor	Status	Comments
Systems Performance Review (SPR)	Qlarant	In progress	The Measurement Year (MY) 2023 Interim SPR Orientation Manual and MY 2023 Interim SPR Standards and Guidelines were submitted to MDH for review and approval in June 2023 and will be disseminated in the next quarter. The Statewide Executive Summary was submitted to MDH for review for next quarter's approval. Five MCO Corrective Action Plans were reviewed and approved by MDH. The remainder will be submitted and reviewed.
EPSDT Medical Record Review	Qlarant	In progress	MCOs submitted the MY 2021 Reconciliation Project records, and review has commenced. MY 2022 EPSDT Training materials were finalized in May 2023. MCO Patient Listings were finalized and onsite reviews have been scheduled as of early June 2023. PSN recruitment and training occurred mid-June 2023.
Consumer Report Card (CRC)	Qlarant	In progress	The 2024 CRC IRS and Methodology Draft was submitted for MDH review and approval in June 2023.
Performance Improvement Projects (PIPs)	Qlarant	In progress	MDH conducted a PIP Sustainability Survey in June 2023 for MY 2022 Lead and AMR PIPs to outline active, omitted, and best practice PIPs performed by MCOs. MCO TA Trainings were held in June 2023 to streamline and clarify MDH expectations for newly introduced Prenatal and Postpartum PIP Topics. The PIP Scoring Tool and Evaluation Template for MY 2023 PIPs were approved by MDH as of June 2023.
Encounter Data Validation (EDV)	Qlarant	In progress	The MY 2022 EDV Orientation Manual and Provider Request Letter were approved by MDH June 2023.
Network Adequacy Validation (NAV)	Qlarant	In progress	The NAV Survey and telephonic surveying occurred in late May 2023. The MY 2023 NAV Report Template has been submitted for review and approval for next quarter.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	In progress	The Q1 GAD Analysis and narrative summary was submitted to MDH and MCOs in June 2023. Q2 submissions are due next quarter. The summary of the quarterly findings are listed below under Completed Activity Highlights.

Activity	Vendor	Status	Comments
HEDIS Audits and Reporting (HEDIS)	MetaStar	In progress	In April, MDH confirmed with MetaStar that data would be available for two new Child Measures that were added to the core sets for reporting to CMS. HEDIS Vendor completed preliminary rate review of data provided by the HealthChoice MCOs. Medical Record Review Validation was completed in May with all HealthChoice MCOs successfully passing all requirements. All HEDIS data for MY 2022 was provided to NCQA by all HealthChoice MCOs by the deadline in June with no issues. The HEDIS vendor provided key HEDIS measures and Value Based Purchasing deliverable data to MDH by the end of June for data review, analysis, and reporting.
Population Health Incentive Program (PHIP)	Qlarant	In progress	Value Based Purchasing (VBP) was sunsetted after MY 2021 reporting, and the Population Health Incentive Program (PHIP) launched for MY 2022. Preliminary encounter-based performance measures for Lead and Ambulatory were validated by the EQRO for MY 2022.
CAHPS Survey Administration (CAHPS)	CSS	In progress	In April, the Satisfaction Survey fielding phase was on-going. The Vendor continued to receive returned mail surveys and continued to make telephone attempts to non-responding sample members. The Vendor provided Interim Reports to MDH that reflected a status update with preliminary survey results.In May, the Satisfaction Survey fielding phase closed, and the Vendor processed member-level data files and submitted them to NCQA and NCBD. In June, MDH received Highlight Reports from the Vendor that reflected HealthChoice MCO performance for key areas of the survey results. MDH and the Vendor submitted HealthChoice MCO data, survey questionnaires, and the survey data file to the CAHPS Database Online Submission System.
Primary Care Provider (PCP) Satisfaction Survey Administration	CSS	In progress	In April, the Primary Care Provider (PCP) Survey fielding phase continued with the mailing of second survey questionnaires and reminder postcards to PCPs. In May, the survey fielding phase wrapped up and the telephone follow-up calls were conducted. The Vendor provided an Interim Report to MDH at the end of May that included a status update and preliminary survey results. In June, the survey administration of the PCP survey concluded and MDH was provided with a final survey response rate from the Vendor.
Annual Technical Report (ATR)	Qlarant	Complete	The MY 2022 ATR Report was finalized and submitted to MDH in April 2023 and to the MCOs in May 2023. A revised MY 2022 ATR Report will be submitted and uploaded to the MDH HealthChoice Quality Assurance Annual Reports Page.

Completed Activity Highlights:

Annual Technical Report: The MY 2022 ATR Report was submitted to CMS in April 2023; for more information please find it as Attachment 1 to this report.

Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD): Below is a summary of the Quarter 1 (Q1) 2023 findings from the GAD activity:

Member Grievances: CFCHP's range of grievances totaled at the low end at 0.22/1000 members; whereas Kaiser's range of grievances totaled at 4.76/1000 members. The most prevalent category outlined was Administrative. All but two MCOs met grievance turnaround time (TAT) requirements. Kaiser did not meet the TAT for Category 1: "Emergency medically related member grievances" with a rate of 80 percent against the performance threshold of 95 percent. UHC did not meet TAT for Category 2: "Non-emergency medically related grievances," with a rate of 75 percent where performance has typically been 100 percent.

Provider Grievances: Maryland Physicians Care (MPC)'s range of grievances totaled at the low end at 0.07/1000 members; whereas Wellpoint's range of grievances totaled 1.19/1000 members. All provider grievances fell into Category 3: "Administrative," with the top two reason codes of Billing/Financial and Access. Jai and Kaiser had no provider grievances during this quarter.

Appeals: Kaiser and Priority cited a higher rate of member appeals versus provider appeals. Eight MCOs indicated 100 percent of appeals come from denials. Kaiser and MedStar received the lowest number of appeals/1000 members, with rates of 0.12 and 0.39. The MCOs with the highest appeals/1000 members were Priority (3.49) and MPC (2.09). Eight of nine MCOs met standard (non-emergency) appeals resolution TAT requirements with one MCO (MedStar's) at 50 percent. Six of eight MCOs met the expedited appeals resolution TAT. Outliers here included Wellpoint (89 percent) and MedStar (50 percent). Kaiser had no expedited appeals this quarter.

Denials: Pre-service denials varied across MCOs with MPC rating the highest at 33.50/1000 denials and Kaiser the lowest at 1.87/1000 denials. Wellpoint maintained the highest number of prior authorization (PA) requests submitted with complete information at 97 percent, and Priority had the lowest at 72 percent. The MCOs with the highest percentage of PA requests approved were Kaiser (93 percent) followed by MedStar (87 percent). Priority had the lowest PA request approvals (46 percent) followed by Aetna (68 percent). The MCOs with the highest and lowest percentage of Standard Pre-Service Medical denials were Kaiser and Jai. The MCOs with the highest and lowest Pre-Service Outpatient Pharmacy denials were Jai and MPC (second lowest). Kaiser had no outpatient pharmacy denials. All MCOs met or exceeded the pre-service denial determination TAT performance threshold of 95 percent for standard, expedited, and pre-service outpatient pharmacy. Jai reported having no expedited pre-service medical denials. All MCOs met or exceeded the Pre-Service Denial Notification TAT for standard, expedited, and pre-service outpatient pharmacy, with one exception. Wellpoint did not meet compliance threshold of 95 percent for the expedited pre-service medical denials, with a TAT of 93 percent.

PIP: To further support the latest PIP topics, the June 2023 Quality Assurance Liaison Committee (QALC) Meeting highlighted Health Equity in the 2023 PIP Process for CY 2023 - CY 2026. The MDH Annual 2022 Report Analysis can be found as Attachment 2 to this report.

Value Based Purchasing Initiative (VBP): Beginning with MY 2022, MDH is transitioning from VBP to an incentive-only structure known as the Population Health Incentive Program (PHIP). Updates on PHIP will be available in the next quarterly report. The CY 2021 Final VBP Report was resubmitted in April 2023 to include updated language in the Financial Incentive/Disincentive Methodology section (Page 5), and can be found as Attachment 3 to this report.

HEDIS Audits and Reporting: The full reporting and analysis can be found as Attachment 4 to this report.

Maryland MCOs had high overall performance in their HEDIS rates prior to the COVID19 pandemic. COVID is likely to have continuing impact to 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 through MY 2023, it is likely that benchmark data will be impacted for at least another year.

The Maryland Average Reportable Rate (MARR) for Appropriate Testing for Pharyngitis (CWP) decreased from 80.7 percent to 67.5 percent, potentially as a result of the shifts observed in the eligible populations for this measure in Maryland and across the nation. NCQA performed an evaluation, and it is suspected the shifts in this measure and others may have been due to several factors, including provider billing procedures and diagnosis code assignments in the context of COVID.

The MARR increased for many measures in MY 2021 compared to prior year performance (year one of COVID). Utilization measure rates rebounded somewhat but remained low. For example, Ambulatory Care (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 (WCC)-Physical Activity
- WCC – Nutrition
- Pharmacotherapy Management of COPD Exacerbation (PCE) – Bronchodilator
- Comprehensive Diabetes Care (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

- 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 2021 levels across the measure spectrum, with no statistically significant improvements or declines in scores. Rating of Health Plan for Aetna Better Health of Maryland was the only measure that saw statistically significant performance gain among the participating plans compared to the prior year across the measure spectrum. None of the observed declines in performance reached statistical significance.

HealthChoice exhibited a consistent positive directional trend on Rating of All Health Care, and a consistent negative directional trend on Getting Care Quickly and Rating of Specialist Seen Most Often. Neither was statistically significant. For a majority of the measures, HealthChoice scored in the middle third of the 2021 NCQA Quality Compass Adult Medicaid percentile distribution. HealthChoice only scored in the bottom third on Rating of Personal Doctor, Rating of All Health Care and Rating of Health Plan and scored in the bottom decile for Rating of Specialist Seen Most Often.

Child Survey
While some plans performed better than others, the HealthChoice Aggregate performed poorly overall, 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 Customer Service, which still scored in the middle third of the Quality Compass distribution. The HealthChoice Aggregate scored particularly poorly on the Rating of Specialist Seen Most Often, scoring in the bottom decile of the Quality Compass distribution and showed a three-year decline. Rating of All Health Care experienced a statistically significant decline from the prior year.

For the CCC measures set, HealthChoice scored in the bottom third of the NCQA Quality Compass Child Medicaid National Distribution on all measures. In addition, the score for Access to Prescription Medicines and Access to Specialized Services showed a three-year decline, with the former being a statistically significant decrease from the previous years.

Primary Care Provider Survey Administration: Results from the PCP survey showed that overall satisfaction among PCPs with their MCO declined slightly for 2022 when compared to the 2021 results, but not a significant difference. Satisfaction with the Claims, Preauthorization, and Customer Service/Provider Relations composites showed a decrease when compared to the previous year, but no significant statistical differences were evident. The overall experience for PCPs in obtaining prior authorization of outpatient and inpatient services remained consistent, showing steady improvement over the previous year. The number and quality of specialists in the network showed a slight decrease for 2022, however the decrease did not meet the criteria of

being considered significant. The loyalty analysis of the survey showed that loyalty to their MCO among PCPs was about 43 percent, up from 40 percent in 2021, but not considered a significant difference. The number of PCPs indicating indifference or not loyal continues to reflect the majority, with more than 56 percent of PCPs expressing this feeling.

Demonstration Evaluation

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

Additionally, the 2023 Post-Award Forum was held on Thursday, May 25th, 2023, during the Maryland Medicaid Advisory Committee meeting via webinar. The Department used the May MMAC meeting as the Forum, in accordance with previous CMS guidance. At that meeting, the Department presented the draft HealthChoice evaluation as well as other waiver updates. For further details, please see the attached slide deck, meeting agenda, and minutes from the May MMAC meeting as Attachment 5, 6, and 7.

MDH received approval for the SUD Monitoring Report in April 2022. MDH continues to collaborate with CMS and the Hilltop Institute regarding 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.

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Attachments:

1. 2022 MD HeathChoice ATR Report
2. 2022 MDH PIP Evaluation Report
3. CY21 VBP Report
4. Statewide Executive Summary Report – HEDIS MY21
5. 2023 HealthChoice MMAC Presentation
6. MMAC May Agenda
7. MMAC May Minutes (June Agenda)