Continuity of Care Report

Maryland Health Benefit Exchange
October 31, 2018

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I. Introduction

In the fall of 2012, the Maryland Health Benefit Exchange (MHBE) convened a stakeholder advisory committee to develop recommendations to promote continuity of care for individuals transitioning between health plans.[1] In response to these recommendations, the Maryland Health Progress Act of 2013[2] established new statutory continuity of care requirements to advance Maryland's progress in protecting residents from harmful disruptions in health care services and to promote the reasonable continuity of health care for all individuals who may be transitioning between plans.[3] This law also requires the Maryland Health Benefit Exchange (MHBE), the Maryland Department of Health (MDH), the Maryland Insurance Administration (MIA), and the Maryland Health Care Commission (MHCC) to conduct a study on the implementation and efficacy of the continuity of care requirements. To the extent feasible, the study should examine the extent to which the continuity of care requirements have been effective in promoting continuity of care for Marylanders, affected newly eligible populations and trends in health disparities, had a disparate impact on specific populations, including individuals suffering from mental health and substance use disorders, and had a discriminatory impact based on gender identity or sexual orientation. The study should also include recommendations, as to additional legislation (if any) that should be considered that would increase the effectiveness of Maryland's efforts to promote continuity of care. The study was originally due to the Maryland General Assembly by December 1, 2017, but was delayed. In accordance with this requirement, the MHBE submits this report to the Governor and the Maryland General Assembly.

II. Background

Maryland Requirements

The Maryland Health Progress Act of 2013 established new statutory continuity of care requirements to minimize interruptions in resident's health care services and promote continuity of healthcare for individuals changing health insurance plans. Specifically, the Act created two new consumer protections regarding access to services requiring prior authorizations and access to out-of-network providers. This Act was passed prior to the federal regulations discussed in the next section of this report that provide additional consumer protections. The Maryland continuity of care requirements apply to Medicaid managed care organizations (MCOs); individual, small employer, and large employer health benefit plans; and dental plans issued on or after January 1, 2015. The requirements do not apply to transitions from a commercial carrier to the Medicaid fee-for-service (FFS) program, but they do apply to transitions from Medicaid FFS to commercial coverage.[4] The statute also grants the MIA, the MHBE, and MDH the authority to collect data from the health plans to assess the implementation and efficacy of these continuity of care requirements.[5]

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[1] For more information, see https://www.marylandhbe.com/wp-content/uploads/2016/02/MHBE-CoC-Recommendations-01.04.2013.pdf
[2] 2013 Md. Laws ch. 159, Sec. 5.
[3] Ins. Art. § 15-140(b), Ann. Code of MD.
[4] Ins. Art. § 15-140(b)(2), Ann. Code of MD.
[5] Ins. Art. § 15-140(h), Ann. Code of MD.

Prior Authorizations

The first requirement offers consumer protections related to prior authorizations. Upon request, a receiving carrier or MCO must accept a preauthorization from the previous carrier or MCO for covered procedures, treatments, and medications for the lesser of the duration of the course of treatment or 90 days, or the duration of a pregnancy through the first postpartum visit.[6] A receiving carrier or MCO is defined as the carrier that receives an enrollee transitioning from another carrier or MCO.[7] The previous carrier or MCO must provide a copy of the preauthorization to the receiving carrier within 10 days of receipt of the request.[8] After the treatment, 90-day period, or pregnancy has ended, the receiving carrier may choose to perform its own utilization review to determine whether continued treatment is medically necessary.[9] This only applies to benefits that are covered by the receiving carrier or MCO.

Non-Participating Providers

The second requirement offers consumer protections related to non-participating providers. A receiving carrier must allow a new enrollee who is receiving treatment from a non-participating provider at the time of transition to continue treatment with that provider if the treatment is for an acute condition, a serious chronic condition, pregnancy, a mental health condition, a substance use disorder, or any other condition upon which the receiving carrier and out-of-network provider agree.[10] Examples of acute and serious chronic conditions include: bone fractures, joint replacements, heart attacks, cancer, HIV/AIDS, and organ transplants.[11] An enrollee is allowed to continue to receive services for these conditions for the lesser of the duration of the course of treatment or 90 days, or the duration of a pregnancy through the first postpartum visit.[12]

The receiving carrier or MCO must pay the non-participating provider the same rate it would normally pay participating providers who offer similar services within the same geographic area.[13] Enrollees may not be subject to balance billing for these services, and enrollee cost sharing must remain the same as it would be from a participating provider. The non-participating provider, however, may decline to accept this payment rate by providing both the enrollee and the carrier 10 days' prior notice. If agreement on the payment rate is not reached, the non-participating provider is not required to continue to provide the service.

[6] Ins. Art. § 15-140(c)(2), Ann. Code of MD.
[7] Ins. Art. § 15-140(a)(13), Ann. Code of MD.
[8] Ins. Art. § 15-140(c)(3), Ann. Code of MD.
[9] Ins. Art. § 15-140(c)(4), Ann. Code of MD.
[10] Ins. Art. § 15-140(d), Ann. Code of MD.
[11] Ins. Art. § 15-140(d)(2)(ii), Ann. Code of MD.
[12] Ins. Art. § 15-140(d)(2)(iii), Ann. Code of MD.
[13] Ins. Art. § 15-140(d)(3)(ii), Ann. Code of MD.

Notices

The MIA issued a bulletin and promulgated regulations to provide guidance on the required continuity of health care notices to inform new enrollees about their rights and responsibilities.[14] For the purpose of the notices, a carrier is considered a receiving carrier/MCO if the enrollee's new coverage states within one month of the termination date of the prior coverage. There are two different notices; one is for MCOs and the other is for all other carriers. Except for retroactive enrollments, the receiving carrier must provide the notice within 30 days of the effective date of coverage. If coverage for an enrollee is retroactive, then notice must be given within 30 days of the date the receiving carrier is notified of the enrollment. The notice includes information about how enrollees can request these services and how to appeal denials of these services. The carrier notice template may be found here, and the MCO notice template may be found here.

Federal Continuity of Care Requirements

The Centers for Medicare & Medicaid Services (CMS) has also implemented continuity of care requirements for qualified health plans (QHPs)[15] and Medicaid MCOs.[16] The QHP continuity of care requirements apply when a QHP terminates a provider's contract. The QHP must make a good faith effort to provide written notice to enrollees who are regular patients of a provider 30 days before provider's contract ends.[17] In cases where a provider is terminated without cause, the QHP must allow an enrollee in an active course of treatment to continue that treatment until it is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.[18] This requirement applies to treatment for a life-threatening condition, a serious acute condition, the second or third trimester of a pregnancy, or a health condition for which discontinuing the treatment would worsen the condition.[19]

Continuity of care requirements for MCOs apply when an individual is dis-enrolled from an MCO or transitions to a new MCO. States are required to arrange for Medicaid services to be provided without delay to any enrollees of an MCO that is terminated by the state or any enrollees who are disenrolled from a MCO for any reason other than Medicaid ineligibility.[20] States must also have a transition of care policy to ensure a Medicaid enrollee's continued access to care when transitioning from FFS to an MCO or between MCOs when the interruption of continued treatment could cause a serious deterioration of the enrollee's health.[21] The policy must allow the enrollee to continue treatment with the current provider for a limited period time

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[14] COMAR 31.10.42 and Maryland Insurance Administration. *Bulletin 14-22 Amended* (November 20, 2014). Available at http://insurance.maryland.gov/Insurer/Documents/bulletins/14-22-continuity-of-care-notice-amended.pdf.

[15] HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,203 (March 8, 2016) (to be codified at 45 CFR Parts. 144, 147, 153, 154, 155, 156, and 158).

16 [16] Medicaid and Children's Health Insurance Program Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27,498 (May 6, 2016)(to be codified at 42 CFR Parts 431, 433, 438, 440, 457 and 495.

[17] 45 CFR § 156.230(d)(1).

[18] 45 CFR § 156.230(d)(2).

[19] 45 CFR § 156.230(d)(2)(i).

[20] 42 CFR § 438.62(a).

[21] 42 CFR § 438.62(b).

if that provider is not in the network of the enrollee's new MCO's.[22] The transition of care policy must be made publically available and included in materials provided to Medicaid enrollees.[23] States are also required to ensure through their contracts that the MCOs implement procedures to coordinate care for all enrollees between settings of care, other MCOs, Medicaid FFS, and community and social support providers.[24]

III. Evaluation

To evaluate the implementation of Maryland's continuity of care requirements, the MHBE collected/reviewed the following data, with analyses conducted by The Hilltop Institute at the University of Maryland, Baltimore County:

- Medicaid and QHP enrollment data to evaluate continuous enrollment and churn between these programs
- Consumer complaints data reported to the MIA
- Data and policies collected from the MCOs and QHPs

Enrollment Data

Because Maryland's continuity of care protections were developed out of concern about individuals churning between health plans, Hilltop analyzed both Medicaid and QHP enrollment data to evaluate continuous enrollment and the level of churn between programs. Person-level, identifiable, data for non-QHP commercial health care plans were not available for this study. Data sources for these analyses include:

- The Medicaid Management Information System (MMIS2) eligibility files spanning calendar years (CYs) 2015 through 2017
- QHP effectuated enrollment files for CYs 2015 through 2017

Continuous Medicaid Enrollment

Table 1 presents the number and percentage of Medicaid participants aged one year[25] and older who remained continuously enrolled in Medicaid for the entire year for CYs 2015 through 2017. While QHP enrollment is restricted to the annual open enrollment period (with some exceptions for special enrollments), individuals can enroll in Medicaid throughout the year. Continuous enrollment increased each year over the measurement period to just below 80 percent in CY 2017. Please note that the state implemented a new Medicaid eligibility auto-renewal process in

[22] 42 CFR § 438.62(b)(1).
[23] 42 CFR § 438.62(b)(3).
[24] 42 CFR § 438.208(b).
[25] Age is calculated as of December 31 of the measurement year. Infants were excluded because they could only have one year of enrollment if they were born on January 1.

the Maryland Health Connection system the fall of 2015, which uses administrative data to automatically renew Medicaid coverage for individuals who remain eligible.[26]

Table 1. Number and Percentage of Medicaid Participants (Aged 1 Year or Older) Continuously Enrolled in Medicaid during the Year, CY 2015-2017

Enrollment Length	CY 2015		CY 2016		CY 2017	
	#	%	#	%	#	%
12 Months	809,050	63.8%	935,074	74.9%	1,023,372	77.7%
< 12 Months	458,972	36.2%	313,976	25.1%	293,949	22.3%
Total	**1,268,022**	**100%**	**1,249,050**	**100%**	**1,317,321**	**100%**

Table 2 displays the demographic characteristics of these participants. Among racial and ethnic groups, the Hispanic population was the most likely to maintain 12 months of continuous coverage in each year of the study period. Children, participants with disabilities, and women (in 2015 and 2017) were also more likely to maintain continuous coverage.

Table 2. Demographics of Medicaid Participants (Aged 1 Year or Older) Continuously Enrolled in Medicaid during the Year, CY 2015-2017

Demographics	CY 2015				CY 2016				CY 2017			
	< 12 Months		12 Months		< 12 Months		12 Months		< 12 Months		12 Months	
	#	%	#	%	#	%	#	%	#	%	#	%
Race/Ethnicity												
Asian	21,010	37.3%	35,285	62.7%	14,046	25.6%	40,806	74.4%	14,971	25.3%	44,170	74.7%
Black	211,655	36.9%	361,450	63.1%	138,927	25.1%	413,706	74.9%	117,281	20.7%	450,245	79.3%
White	130,824	35.0%	243,397	65.0%	88,906	24.4%	274,949	75.6%	82,012	22.0%	291,254	78.0%
Hispanic	33,626	27.2%	89,777	72.8%	21,938	19.1%	93,219	80.9%	20,663	18.3%	92,086	81.7%
Other	61,857	43.9%	79,141	56.1%	50,159	30.9%	112,394	69.1%	59,022	28.8%	145,617	71.2%
Sex												
Female	241,759	34.9%	450,652	65.1%	168,566	24.8%	512,446	75.2%	156,556	21.9%	556,954	78.1%
Male	217,213	37.7%	358,398	62.3%	145,410	25.6%	422,628	74.4%	137,393	22.8%	466,418	77.2%
Age Group (Years)												
1-18	177,399	29.3%	428,872	70.7%	124,108	20.7%	475,432	79.3%	116,326	18.7%	504,732	81.3%
19-39	177,986	45.4%	213,988	54.6%	120,999	31.2%	266,648	68.8%	114,580	27.3%	305,543	72.7%
40+	103,587	38.4%	166,190	61.6%	68,869	26.3%	192994	73.7%	63,043	22.8%	213,097	77.2%
Eligibility Category												
ACA Expansion	151,722	50.6%	147,845	49.4%	105,650	33.8%	207,188	66.2%	102,230	29.3%	246,413	70.7%
Disabled	9,079	10.3%	79,275	89.7%	6,144	7.1%	80,165	92.9%	7,335	8.5%	79,043	91.5%
Families & Children	249,161	34.6%	471,673	65.4%	165,130	23.8%	527,344	76.2%	142,994	19.9%	574,858	80.1%
Maryland Children's Health Program (MCHP)	49,010	30.8%	110,257	69.2%	37,052	23.5%	120,377	76.5%	41,390	25.2%	123,058	74.8%
Total	**458,972**		**809,050**		**313,976**		**935,074**		**293,949**		**1,023,372**	

[26] Maryland Department of Health. (2016). *Maryland Medicaid and You: Measuring Medicaid Impact*. Retrieved from https://mmcp.health.maryland.gov/docs/Medicaid_and_You_2016_e.pdf.

Table 3 presents the number and percentage of Medicaid participants aged 3 years and older who remained continuously enrolled in Medicaid across all three years of the measurement period. Overall, 37.8 percent were enrolled across all three years.

Table 3. Number and Percentage of Medicaid Participants (Aged 3 Years and Older) Continuously Enrolled for 3 Years, CY 2015-2017

Enrollment Length	CY 2015 to CY 2017	
	#	%
36 Months of Enrollment	580,873	37.8%
< 36 Months of Enrollment	957,382	62.2%
Total	**1,538,255**	**100%**

Table 4 presents the demographic characteristics of those enrolled for all three years. The findings were similar to those with one year of continuous coverage, with Hispanics, women, children, and participants with disabilities being the most likely to maintain three years of continuous coverage.

Table 4. Demographics of Medicaid Participants (Aged 3 Years or Older) Continuously Enrolled for 3 Years, CY 2015-2017

Demographics	CY 2015-CY2017			
	< 36 Months		36 Months	
	#	%	#	%
Race/Ethnicity				
Asian	46,908	65.3%	24,925	34.7%
Black	415,879	61.8%	257,556	38.2%
White	281,103	61.5%	175,732	38.5%
Hispanic	63,448	48.3%	67,797	51.7%
Other	150,044	73.2%	54,863	26.8%
Sex				
Female	507,616	61.0%	324,116	39.0%
Male	449,766	63.7%	256,757	36.3%
Age Group (Years)				
3-18	322,054	51.3%	305,607	48.7%
19-39	389,469	71.9%	152,566	28.1%
40-64	245,859	66.7%	122,700	33.3%
Coverage Category				
ACA Expansion	356,500	77.7%	102,132	22.3%
Disabled	35,921	34.6%	67,850	65.4%
Families and Children	459,928	58.1%	331,570	41.9%
MCHP	105,033	57.0%	79,321	43.0%
Total	**957,382**		**580,873**	

Medicaid-QHP Churn

Because eligibility for Medicaid and QHP subsidies is based household income and size, individuals may transition between eligibility for the two programs as their income and household composition changes. To evaluate this transitioning—or churning—between programs, Hilltop linked QHP and Medicaid enrollment files for CYs 2015 through 2017.[27] The second column in Table 5 below presents the number of participants enrolled in QHPs in each year. Of those QHP participants, the third and fourth columns present the number and percentage who were enrolled in Medicaid in the prior year. The fifth and sixth columns show the number and percentage who were enrolled in Medicaid the year after their QHP enrollment. Among participants enrolled in QHPs in 2015, 13.3 percent were enrolled in Medicaid in 2014, and 12.1 percent were enrolled in Medicaid in 2016. There was in increase in the level of churn from Medicaid to QHPs from 2015 to 2016, which appears to have leveled back down in 2017.

Table 5. Medicaid Enrollment Prior to and After QHP Enrollment, CY 2015-2017

CY	QHP Enrollment Total	# Enrolled in Medicaid in Prior Year	% Enrolled in Medicaid in Prior Year	# Enrolled in Medicaid in Next Year	% Enrolled in Medicaid in Next Year
2015	149,388	19,845	13.3%	18,116	12.1%
2016	179,119	37,262	20.8%	24,788	13.8%
2017	178,762	24,282	13.6%	N/A	N/A

Complaints Data

Maryland's Appeals and Grievances law allows consumers to challenge carrier decisions that result in total or partial denial of a covered health care service.[28] As described above, the required continuity of care notices provide consumers with information about how to appeal denials of continuity of care requests. The MIA collects and tracks complaints file by consumers regarding adverse carrier decisions, and has specific codes to track complaints related to continuity of care. The MIA reviewed their complaints data for this report and found that no complaints have been filed related to continuity of care to date.

MCO and Carrier Data

Finally, the MHBE and MDH requested the carriers and MCOs to provide information about the continuity of care notices sent to new enrollees, as well as the number of requests for, denials of, and complaints about continuity of care benefits. See Appendix A for details of the request.

[27] Participants enrolled in partial benefit Medicaid Assistance programs, such as individuals in the Family Planning Program and undocumented immigrants who are only eligible for emergency services were excluded from the analysis because these programs are not considered minimum essential coverage.
[28] Md. Code Ann., Insurance §15-10A

All carriers and MCOs provided their continuity of care notices, and all notices contained information about how to request and appeal continuity of care decisions. Table 6 below presents the number of continuity of care requests related to prior authorization by year. Due to small cell sizes, responses were combined. Overall, only a small percentage of requests were denied, and few complaints were submitted. The request also asked the MCOs and carriers to report the diagnoses associated with these requests and the reasons for denial if available.

Table 6. MCO and Carrier Self-Reported Prior Authorization Continuity of Care Requests

CY	# of Requests[29]	# Denied	% Denied	# of Complaints[30]
2015	5,553	456	8.2%	38
2016	4,374	329	7.5%	30
2017	3,710	236	6.4%	*

*Cells too small to report

Table 7 below presents the number of continuity of care requests related to out-of-network provider requests by year. Due to small cell sizes, responses were combined. A slightly larger percentage of these requests were denied, but few complaints were submitted.

Table 7. MCO and Carrier Self-Reported Out-of-Network Provider Continuity of Care Requests

CY	# of Requests	# Denied	% Denied	# of Complaints
2015	11,216	1,988	17.7%	13
2016	9,362	1,478	15.8%	*
2017	6,364	1,174	18.4%	*

*Cells too small to report

The data request also asked the MCOs and carriers to report the diagnoses associated with these requests and the reasons for denial to the extent available. Due to small cell sizes across the various diagnosis codes and reasons, the full list of responses cannot be reported in order to protect participant privacy. The more common reasons for denial included: medical necessity review and that the service was not a covered benefit. The more common conditions included pregnancy/delivery-related and radiology.

IV. Conclusions

In summary, Maryland enacted legislation in 2013 to provide additional continuity of care protections for consumers who may transition between health plans. Since that time, the federal government has enacted additional legislation to provide further protections. Medicaid and QHP enrollment data show that there has been a level of churn between the programs in recent years. However, upgrades to the Maryland Health Connection system, such as the implementation of

[29] Four of the Medicaid MCOs were unable to identify the number of requests, approvals, or denials within their current data systems.
[30] Three of the Medicaid MCOS were unable to identify the number of complaints within their current data systems.

Medicaid automatic renewals for those who are eligible, have improved the rate of continuous enrollment within Medicaid. In reviewing data submitted by the MIA, the Medicaid MCOs, and the commercial insurance carriers, it appears that denials of continuity of care requests are relatively low, and there have been little to no consumer complaints. The MCOs and carriers also report compliance with the current member notification requirements. Therefore, the MHBE does not recommend additional legislation at this time. The MHBE recommends that the state agencies continue to monitor eligibility churning and compliance with the existing continuity of care requirements.

Appendix A. Continuity of Care Data Request

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

July 17, 2018

Dear MCO Directors:

The Maryland Health Progress Act of 2013 directs the Maryland Health Benefit Exchange, the Maryland Department of Health, the Maryland Insurance Administration, and the Maryland Health Care Commission to report to the Maryland General Assembly by October 2018 on the implementation and efficacy of the continuity of care requirements enumerated in § 15–140 of the Insurance Article, as enacted by Section 3 of the Act. Specifically, these requirements offer some consumer protections regarding prior authorizations and access to out-of-network providers when participants transition between health plans and/or managed care organizations (MCOs) while undergoing a course of treatment. The Act also authorizes these state agencies to collect data from the MCOs and carriers in order to carry out the study and requires the MCOs and carriers to submit these data upon request.

In order to meet this statutory requirement, the Department respectfully requests the MCOs to submit the following information by August 3, 2018. You may use the accompanying Excel template for questions 2 and 3. Please email your responses to Laura Spicer at The Hilltop Institute at lspicer@hilltop.umbc.edu.

1. Please provide a copy of the notice provided to new enrollees that describe their continuity of care options and responsibilities as required under § 15-140(f)(1) of the Insurance Article.
2. Regarding the prior authorization continuity of care protections, please provide:
    a. The number of enrollee requests for this benefit, by year, for calendar years (CYs) 2015 through 2017.
        i. If available, please provide the diagnosis or health conditions tied to these requests.
    b. The number of prior authorization continuity of care requests that were approved and the number that were denied.
        i. If available, please provide a summary of the reasons for denials.
    c. If available, please provider the number of complaints filed by enrollees related to this benefit.
3. Regarding the out-of-network provider protections, please provide:
    a. The number of enrollee requests for this benefit, by year, for CYs 2015 through 2017.

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i. If available, please provide the diagnosis or health conditions tied to these requests.

b. The number of out-of-network provider requests that were approved, the number that were denied, and the number in which the MCO and the out-of-network provider could not come to agreement upon the payment rate.

i. If available, please provide a summary of the reasons for denials.

c. If available, the number of complaints filed by enrollees related to this benefit.

d. If available, please provide the number of complaints filed by providers related to this benefit.

Thank you for your attention to this matter.

Sincerely,

Alyssa L. Brown
Deputy Director
Planning Administration

750 EAST PRATT STREET, 6TH FLOOR
BALTIMORE, MD 21202
marylandhbe.com

MARYLAND HEALTHBENEFIT EXCHANGE

July 24, 2018

Dear Carriers:

The Maryland Health Progress Act of 2013 directs the Maryland Health Benefit Exchange, the Maryland Department of Health, the Maryland Insurance Administration, and the Maryland Health Care Commission to report to the Maryland General Assembly by October 2018 on the implementation and efficacy of the continuity of care requirements enumerated in § 15–140 of the Insurance Article, as enacted by Section 3 of the Act. Specifically, these requirements offer some consumer protections regarding prior authorizations and access to out-of-network providers when participants transition between health plans and/or managed care organizations (MCOs) while undergoing a course of treatment. The Act also authorizes these state agencies to collect data from the MCOs and carriers in order to carry out the study and requires the MCOs and carriers to submit these data upon request.

In order to meet this statutory requirement, the Maryland Health Benefit Exchange respectfully requests carriers to submit the following information by August 15, 2018. You may use the accompanying Excel template for questions 2 and 3. Please email your responses to Laura Spicer at The Hilltop Institute at lspicer@hilltop.umbc.edu.

1. Please provide a copy of the notice provided to new enrollees that describe their continuity of care options and responsibilities as required under § 15-140(f)(1) of the Insurance Article.
2. Regarding the prior authorization continuity of care protections, please provide:
    a. The number of enrollee requests for this benefit, by year, for calendar years (CYs) 2015 through 2017.
        i. If available, please provide the diagnosis or health conditions tied to these requests.
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        i. If available, please provide a summary of the reasons for denials.
    c. If available, please provider the number of complaints filed by enrollees related to this benefit.
3. Regarding the out-of-network provider protections, please provide:
    a. The number of enrollee requests for this benefit, by year, for CYs 2015 through 2017.
        i. If available, please provide the diagnosis or health conditions tied to these requests.

b. The number of out-of-network provider requests that were approved, the number that were denied, and the number in which the MCO and the out-of-network provider could not come to agreement upon the payment rate.
    i. If available, please provide a summary of the reasons for denials.
c. If available, the number of complaints filed by enrollees related to this benefit.
d. If available, please provide the number of complaints filed by providers related to this benefit.

Thank you for your attention to this matter.

Sincerely,

Michele Eberle

Michele Eberle
Executive Director