Maryland HealthChoice Demonstration
Section §1115 Annual Report
Demonstration Year 25: 7/1/2021 - 6/30/2022
Quarter 2: 10/1/21 - 12/31/21

Introduction

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

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

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

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

- Created the MOM model program to improve maternal health outcomes and reduce the burden of neonatal abstinence syndrome (NAS) and its associated costs, by providing case management along with somatic and behavioral care to pregnant people diagnosed with an opioid use disorder (OUD);
- Created a voluntary, five-year payment model in Annapolis, Baltimore City, and Montgomery counties, that provides greater flexibility to ambulance care teams to address emergency health care needs following a 911 call by allowing for payment for ground transports to alternative destinations such as urgent care providers in addition to the emergency department (ED);
- Created an expenditure authority to cover Medicaid adults aged 21 to 64 that have an serious mental illness (SMI) diagnosis who are residing in a private Institute of Mental Disease (IMD);
- Modified Maryland's coverage of American Society of Addiction Medicine (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 time-frame of eligibility in the Healthy Families America (HFA) evidence-based Home Visiting Services (HVS) Pilot from age two to age three.

Enrollment Information

Tables 1 and 2 below provide 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 September 30, 2021	Participants as of December 31, 2021
Parents/Caretaker Relatives <116% Federal Poverty Level (FPL) and Former Foster Care	282,700	286,198
Affordable Care Act (ACA) Expansion Adults	410,114	422,497
Medicaid Children	520,540	524,391
Supplemental Security Income (SSI)/ Blind or Disabled (BD) Adults	92,385	93,228
SSI/BD Children	24,881	23,479
Medically-Needy Adults	24,029	24,777
Medically-Needy Children	6,593	6,379
Sixth Omnibus Budget Reconciliation Act (SOBRA) Adults	12,862	13,556
Maryland Children's Health Program (MCHP)	117,345	122,756
MCHP Premium	34,222	34,247
Presumptively Eligible Pregnant Women (PEPW)	-	-
Family Planning	13,379	13,588
Increased Community Services (ICS)	26	25
Women's Breast and Cervical Cancer Health Program (WBCCHP)	59	56

Table 3 provides member month counts for each month of the quarter and compares this quarter's totals against the previous quarter.

Table 3. Member Months

Eligibility Group	Total for Previous Quarter (ending September 2021)	Current Quarter Month 1 (October 2021)	Current Quarter Month 2 (November 2021)	Current Quarter Month 3 (December 2021)	Total for Quarter Ending December 2021
Parent/Caretaker Relatives <116% FPL and Former Foster Care	843,202	284,214	285,266	286,198	855,678
ACA Expansion Adults	1,216,890	414,095	417,786	422,497	1,254,378
Medicaid Children	1,556,385	522,089	523,457	524,391	1,569,937
SSI/BD Adults	277,013	93,247	93,260	93,228	279.735
SSI/BD Children	74,331	23,412	23,448	23,479	70,339
Medically-Needy Adults	71,002	24,183	24,501	24,777	73,461
Medically-Needy Children	19,742	6,315	6,355	6,379	19,049
SOBRA Adults[1]	37,968	12,934	13,230	13,556	39,720
MCHP	346,545	119,057	120,810	122,756	362,623
MCHP Premium	102,422	34,245	34,299	34,247	102,791
PEPW	-	-	-	-	-
Family Planning	40,074	13,450	13,503	13,588	40,541
ICS	78	25	25	25	75
WBCCHP	177	59	58	56	173

Outreach/Innovative Activities

Residential Treatment for Individuals with Substance Use Disorders

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

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

up to two nonconsecutive 30-day stays annually for ASAM 3.1 and for up to 15 days per month for ASAM 4.0. Effective January 1, 2020, the Department extended coverage for dual eligibles.

Maternal Opioid Misuse (MOM) Model

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

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

Collaborative Care Model (CoCM) Pilot Program

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

Table 4. CoCM Member Months by Pilot Site

	October 2021	November 2021	December 2021	TOTAL
Urban	65	75	63	203
Rural	*	*	*	18
Ob/Gyn	*	*	*	33
TOTAL	**79**	**93**	**82**	**254**

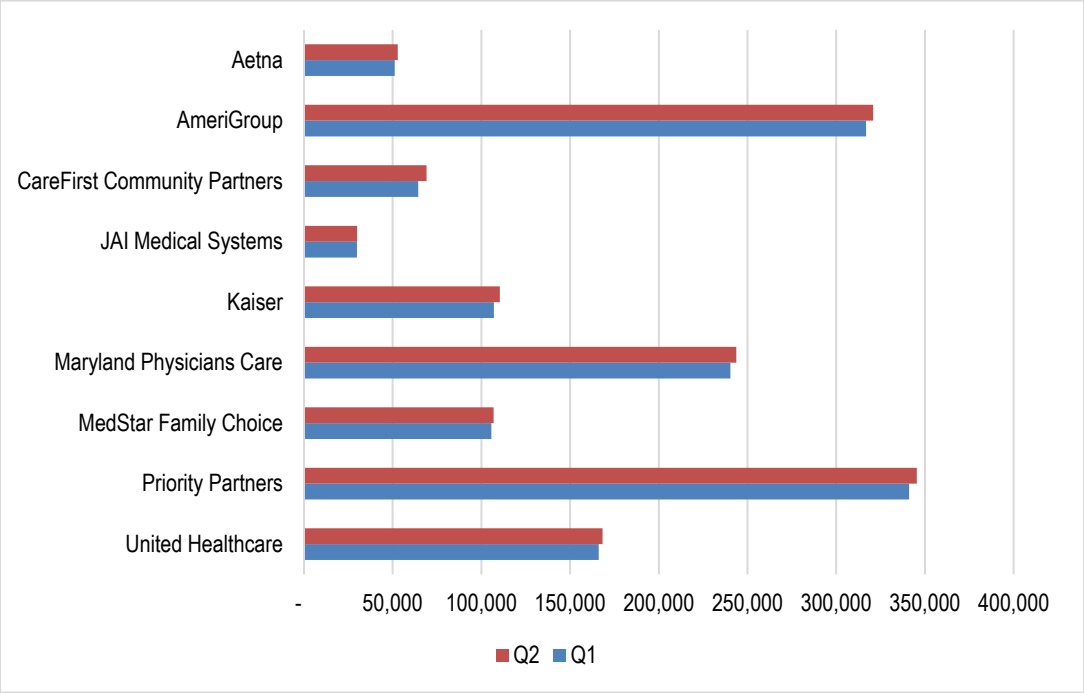
*Small cell sizes (10 participants or fewer) are suppressed for privacy

Operational/Policy Developments/Issues

Market Share

As of the end of the first quarter of FY 2022, there were nine MCOs participating in the HealthChoice program. The MCOs' respective market shares are as follows: Aetna (3.6 percent), Amerigroup (22.3 percent); Jai Medical Systems (2.1 percent); Kaiser Permanente (7.5 percent); Maryland Physicians Care (16.9 percent); MedStar Family Choice (7.4 percent); Priority Partners (24.0 percent); CareFirst Community Health Plan of Maryland (4.5 percent); and United Healthcare (11.7 percent).

Figure 1. HealthChoice MCO Market Share



Maryland Medicaid Advisory Committee (MMAC)

The MMAC met in October and November of 2021; there was no December meeting. Due to COVID-19, all of the MMAC meetings were held via teleconference. These meetings covered a wide variety of topics, including general department updates, and waiver, state plan, and regulations changes. Because the State's legislature was not in session, the MMAC was not briefed on any pertinent Medicaid bills.

During the October meeting, the MMAC was updated on 2022 open enrollment, given an overview on Respiratory Syncytial Virus (RSV), and received an update on pediatric COVID-19 vaccine efforts.

During the November meeting, the MMAC was briefed on ongoing COVID-19 vaccination and outreach, including a meeting that Department leadership had held with CMCS Deputy

Administrator Daniel Tsai. The MMAC also heard an update on lead testing efforts and waivers, regulations, and state plan amendment changes.

Family Planning Program

The HealthChoice waiver allows the Department to provide a limited benefit package of family planning services to eligible women. The program covers medical services related to family planning, including office and clinic visits, physical examinations, certain laboratory services, treatments for sexually-transmitted infections, family planning supplies, permanent sterilization and reproductive health counseling, education and referrals. The Department has expanded eligibility under its Family Planning Program to lift the age limit, and open coverage to include men, effective July 1, 2018.

In conjunction with the most recent §1115 waiver amendment, the Department submitted a matching SPA with an effective date of July 1, 2018 to CMS. Based on conversations with CMS, the Department continues to operate a small portion, specifically postpartum pregnant women who do not qualify for full Medicaid, of its Family Planning Program under its §1115 waiver until the Family Planning Program can be integrated into the Maryland Health Connection (MHC). Women who receive pregnancy coverage will continue to be automatically-enrolled, if eligible, following the end of their pregnancy-related eligibility.

The Family Planning Program was integrated into MHC on February 1, 2020. Participants can now apply and renew their Family Planning coverage online. The SPA to transition participants out of the §1115 was approved in June 2020.

Enrollment as of the end of the quarter was 13,588 participants, with an average monthly enrollment of 13,514, an increase of 1.2 percent over the previous quarter.

Table 5. Average Quarterly Family Planning Enrollment

Q1 Enrollment	Percent Change	Q2 Enrollment	Percent Change	Q3 Enrollment	Percent Change	Q4 Enrollment	Percent Change
13,358	1.6%	13,588	1.2%				

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 7. Current REM Program Enrollment

FY 2022	Referrals Received	Referrals Approved	Referrals Denied	REM Disenrollments	Currently Enrolled in REM
Quarter 1	206	189	50	99	4,478
Quarter 2	206	136	35	69	4,496
Quarter 3					
Quarter 4					

Table 8. REM Complaints

FY 22 Q2 Complaints	REM Case Management Agencies	REM Hotline	Total
Transportation	0	0	0
Dental	0	0	0
DMS/DME	1	0	1
EPSDT	0	0	0
Clinical	1	0	1
Pharmacy	0	0	0
Case Mgt.	4	0	4
REM Intake	0	0	0
Access to MA Providers	0	0	0
Nursing	13	0	13
Other	0	0	0
Total	19	0	19

Table 9 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 9. REM Incidents Reported by Case Managers

FY 22 Incidents	REM Enrollees Quarter 1	REM Enrollees Quarter 2	REM Enrollees Quarter 3	REM Enrollees Quarter 4
Abandonment	0	0		
Abuse	4	4		
Complaint	14	19		
Death	15	16		

FY 22 Incidents	REM Enrollees Quarter 1	REM Enrollees Quarter 2	REM Enrollees Quarter 3	REM Enrollees Quarter 4
Elopement	0	0		
ER	0	0		
Exploitation	0	0		
Failure to Follow Plan (Non-Compliance)	0	1		
Fall	1	1		
Hospitalization	2	4		
Medication Error	1	2		
Neglect	10	8		
Suicidal Ideation	2	2		
Theft	0	0		
Wound	0	0		
Other	22	17		
Total	71	74		

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 will increase enrollment incrementally over the course of the waiver to a maximum of 100 participants. As of December 31, 2021, there were 25 individuals enrolled in the ICS Program. The ICS Program does not currently have a registry. All new applicants begin receiving services upon approval of their application.

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

Maryland moved its separate CHIP program, MCHP, and MCHP Premium, into the Medicaid expansion CHIP waiver in 2008, so that Maryland's entire CHIP program is operated as a Medicaid expansion. As of December 31, 2021, the Premium program had 34,247 participants, with MCHP at 122,756 participants.

HealthChoice Diabetes Prevention Program (HealthChoice DPP)

Throughout this reporting period, the Department continued to focus on implementing the HealthChoice DPP, and continued to convene MCOs through implementing the Coverage 2.0-Part 4: Building Capacity for Public and Private Payer Coverage of the National DPP Lifestyle

Change Program (Coverage 2.0-Part 4) grant. As mentioned in previous reports, the purpose of this grant—funded by the Centers for Disease Control and Prevention (CDC)—is to continue sustainability work begun in the Medicaid and National DPP demonstration, which involved four of Maryland's nine MCOs, and which has now expanded to include all nine MCOs in this fourth year of the demonstration. During this period, the Department implemented the Part 4 grants with the nine MCOs, and reviewed and processed the first quarter of work plans and invoices from the MCOs.

At the request of the Department, The Hilltop Institute (Hilltop) reports periodically on the number of HealthChoice members enrolled in the HealthChoice DPP. As of this reporting period (October 2021 report) Hilltop identified 381 encounters with DPP procedure codes and provided by licensed DPP providers to 67 unique participants between September 1, 2019 and October 31, 2021. Among the 67 unique Medicaid beneficiaries with a DPP encounter, most were women (81 percent), Black/African American (66 percent), and resided in Prince George's County (48 percent). Most (91 percent) beneficiaries were in the Families and Children Medicaid coverage group. Services were provided by six unique providers: Mid-Atlantic Permanente Medical Group, associated with the MCO Kaiser Permanente; the Continuum Wellness Center; Garrett Regional Medical Center; Omada Health; Taylored 4 Life; and Welldoc, Inc. Number of encounters per participant ranged from one to 26. The majority of beneficiaries had four or fewer encounters.

During this quarter, the Department presented Maryland's HealthChoice DPP work at one national conference (MED Conference, 10/28/21) and a district meeting for Washington, DC (DC State Engagement Meeting, 10/20/21). For these meetings, the Department presented the history of implementation of HealthChoice DPP, as well as progress made in enrolling DPP providers, collaboration with internal and external partners, and our work with CRISP (the statewide HIE) on CareAlert/SmartAlerts, and with The Hilltop Institute on the eligibility algorithm.

The Department also hosted learning opportunities with our external partners for the MCOs during the scheduled monthly HealthChoice DPP Coverage 2.0 meetings. During November's meeting, a representative from CRISP provided a live demonstration of the eReferral tool for enrolling eligible members to DPP providers. The Department also hosted The Brancati Center from Johns Hopkins University to present *Distance Learning Engagement Strategies*, based on their successful work in this area.

Additionally, as part of the Department's continual efforts for cross functional collaboration with other states, the Department met with the state of Montana to learn about a marketing tool they worked to develop, and to discuss how the tool may be used for Maryland in the future.

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 the quarter, twenty-six 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. During this reporting period, additional technical assistance and guidance was provided by the Department to potential

DPP providers, including Western Maryland CDC-recognized organizations, Fruit Street and NOOM to assist with Medicaid enrollment.

Through additional funding from CDC, the Department continued this quarter to work with CRISP, the statewide HIE, to refine the prediabetes flag within CRISP that went live in June 2021. There continues to be further refinements around this Care Alert, including accurate BMI reporting. CRISP continues to produce monthly reports to MCOs containing the panels of their members who received the flag, so as to enable further follow-up and connection with an available in-network DPP provider. In addition, the Department worked with CRISP to onboard all remaining MCOs as intermediaries on the CRISP eReferral tool.

The Department continues to work with all nine MCOs to improve enrollment and retention in the National DPP.

Community Health Pilots

Six local government entities participate in the Community Health Pilots (CHP). Four Lead Entities (LEs) participate in the Assistance in Community Integration Services (ACIS) Pilot and two LEs in the Home Visiting Services (HVS) Pilot. As of December 2021, the Department was approved through its 1115 HealthChoice waiver renewal, for an additional 300 ACIS participant spaces. This will be effective on January 1, 2022 and will bring the total statewide ACIS participant spaces to 900.

During this reporting period, CHP LEs continued a hybrid of in-person and telephonic service delivery to remain agile throughout the ongoing COVID-19 crisis. For ACIS Pilots, this included allowing service provision via telecommunications methods. For HVS Pilots, LEs follow the Healthy Families America model guidance, which allows service provision via telecommunication methods.

During Q2, the Department worked to secure FY 2022 local match funding with each LE for the Community Health Pilots. LEs continued to deal with complications due to the ongoing Public Health Emergency (PHE). Multiple LEs reported high COVID-19 cases for staff and participants, resulting in general delays for service delivery or a lower quantity of services delivered. Staff resignation at the Participating Entity and LE level is also an area of concern.

ACIS LEs continue to work with their local housing authorities to locate housing placements for ACIS participants. ACIS LEs have expressed concern at increasing rent prices and continue searching for more local partners.

HVS LEs had a combined family enrollment of 15 as of December 2021, and continue to pursue strategies to meet the needs of families in between home visits, such as providing doorstep drop offs. HVS LEs have also begun their re-accreditation work for the next HFA accreditation cycle.

As of December 2021, approximately 402 participants are enrolled in the ACIS Pilot and receiving supportive housing services. This enrollment represents 67 percent of the pilot's current statewide total enrollment potential, 600. LEs continue to improve processes related to

pilot enrollment, such as using the Medicaid Eligibility Verification System, partnering with local community organizations, and improving best practices for working with ACIS-enrolled participants.

The Department continues to accept any new ACIS pilot applications on a rolling basis. Lead local government entities are encouraged to apply for the new, remaining 480 statewide ACIS beneficiary spaces.

Expenditure Containment Initiatives

The Department, in collaboration with the Hilltop Institute, has worked on several different fronts to contain expenditures. The culmination of the Department and the Hilltop Institute's efforts are detailed below.

HealthChoice Financial Monitoring Report (HFMR)

The HealthChoice managed care organizations (MCOs) provided their Final Service Year 2020 HFMR reports (reported as of September 30, 2021) by November 23, 2021, along with supporting Financial Templates. The closely-related 2020 "medical loss ratio" (MLR) reports were provided by November 15, 2021. During this quarter, Hilltop used the submitted information to estimate final "profit & loss" estimates in aggregate, by MCO, by rate cell, etc. and shared that with the Department.

During the upcoming quarter, the independent auditing firm, Myers & Stauffer (M&S), will review the 2020 HFMRs as well as data samples toward a final report due April 29, 2022. M&S and Hilltop will hold entrance meetings with each MCO in January 2022. Together with the 2020 HFMRs, M&S will be reviewing the MCOs' 2020 MLR reports. The 2021 HFMRs aren't due until May 17, 2022.

MCO Rates

CY 2023 Rate Setting

During this reporting quarter of October to December 2021, Hilltop set up the monthly meetings with the MCOs for the last Wednesday of each month starting on February 23, 2022, as well as the accompanying preparatory meetings within Hilltop and with Optumas. Toward preparing agendas, Hilltop began to draft preliminary top priorities and topics for 2023 to include the items below.

- Revisiting Kaiser Permanente's cost allocation approach per the Department;
- Measuring quality of care per the Department;
- Discerning if behavioral health data will be usable in any way to manage care;
- Improving our understanding of relational modeling adjustments as it relates to Geographic/Demographic and rate sloping (Included here is research on rating in other states.); and
- Deciding on whether 2019 should be used as the base year again or perhaps an adjusted 2020 or a hybrid.

CY 2022 and Prior HealthChoice Rate Setting

Hilltop provided the Department with final CY 2021 midyear payment adjustments for January 1, 2021, through September 30, 2021, with data as of October 31, 2021. Hilltop also supplied the MCOs with CY 2022 rate sheets for the HealthChoice program which were used by the Department to finalize MCO contracts. Hilltop supported a reload of January 2022 rates which were incorrectly loaded at the October 2021 level.

In December 2021, Hilltop began gathering quarterly estimates of budgetary reconciliation amounts for HealthChoice plans' expenditures on carved-in Hepatitis C therapies, based on surveys returned by MCOs for encounter experience from January 1 to September 30, 2021. Hilltop provided the Department with the Annual Report showing "profit and loss" (P&L) for years 2018 through 2020. Additional analyses were added to examine P&L results at the rate cell level and with roll-ups consistent with questions heard at the 1-on-1 meetings with MCOs in September 2021. Final rural access payments totaling $15M were allocated to the MCOs and provided to the Department.

Several ad hoc matters arose with which Hilltop assisted. First, an audit by Myers & Stauffer (M&S) of 2018 claims payments revealed that one MCO had misclassified the rate cells for $6.5M of claims. Per the Department's request, Hilltop estimated the impact on 2021 rates at $18.7M and partnered with Optumas to refine that estimate with their full pricing model to enable the Department to choose next steps. Second, the Department discovered an inconsistent handling of mental health claims in the emergency room amongst MCOs. They requested a multi-year data analysis to determine the size of the issue in terms of claims dollars for each MCO which Hilltop completed. Lastly, M&S found in their audit of 2019 claims that some MCOs were using the "claim date" and others were using the "admit date" to assign rate cell for hospital claims. Hilltop ran claims both ways at the Department's request and estimated the impact to support the Department's decision on how to direct the MCOs to use the same approach.

HealthChoice Capitation Rates

Hilltop provided the Department with trauma calculations for September 2021, October 2021, and November 2021. Hilltop prepared CY 2022 rates for the Program of All-Inclusive Care for the Elderly (PACE) and a methodology narrative for the Department in late November and early December. Finally, Hilltop provided the Department with updated P&L and other financial results for 2020 and YTD 3Q21 for the MCOs. Measures included surplus, risk-based capital (RBC), and loss ratios (both traditional loss ratios and summaries of the CMS loss ratios which are restricted to be >= 85 percent).

Financial/Budget Neutrality Development/Issues

The Department is in compliance with all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements sections of the Special Terms and Conditions (STCs).

Consumer Issues[2]

The HealthChoice Help Line serves as the front line of the State's mandated central complaint program. The Help Line received 9,607 in October 2021.[3] The Help Line assists waiver-eligible consumers with eligibility and enrollment questions and provides general education about managed care. Help Line staff explain to consumers how to work with their MCOs and how to access carved-out services, or services covered by Medicaid on a FFS basis.

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

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

[2] In this quarterly report, data for December 2021 is unavailable due to a security incident in December 2021, so data for October and November in 2021 are presented, respectively. Those numbers for December 2021 will be updated in a future report.

[3] Due to the security incident, only the number of calls in October 2021 received by Help Line is retrieved.

Table 10. Total Recipient Complaints (not including billing) - October & November 2021[4]

MCO / Type of Service		Aetna Better Health (ABH)		Amerigroup (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)*		Sub Totals	
OCT vs. NOV 2021		OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOC	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV
Pharmacy	#	9	4	15	14	2	1	6	6	12	3	7	6	20	12	24	21	2	7	97	74
	%	9%	5%	15%	19%	2%	1%	6%	8%	12%	4%	7%	8%	21%	16%	25%	28%	2%	9%	33%	28%
Prenatal	#	2	3	10	7	0	1	8	12	4	5	5	4	8	5	3	6	3	0	43	43
	%	5%	7%	23%	16%	0%	2%	19%	28%	9%	12%	12%	9%	19%	12%	7%	14%	7%	0%	15%	16%
PCP	#	4	4	8	9	1	1	7	10	17	12	3	9	8	8	10	10	12	8	70	71
	%	6%	6%	11%	13%	1%	1%	10%	14%	24%	17%	4%	13%	11%	11%	14%	14%	17%	11%	24%	26%
Specialist	#	8	6	5	10	1	1	5	9	11	7	3	3	4	3	6	4	6	6	49	49
	%	16%	12%	10%	20%	2%	2%	10%	18%	22%	14%	6%	6%	8%	6%	12%	8%	12%	12%	17%	18%
Sub Totals	#	23	17	38	40	4	4	26	37	44	27	18	22	40	28	43	41	23	21	259	237
	%	9%	7%	15%	17%	2%	2%	10%	16%	17%	11%	7%	9%	15%	12%	17%	17%	9%	9%	88%	88%
All Complaint Totals	#	24	20	46	44	4	4	28	39	53	30	19	22	51	43	46	45	24	21	295	268
	%	8%	7%	16%	16%	1%	1%	9%	15%	18%	11%	6%	8%	17%	16%	16%	17%	8%	8%	100%	100%
Other Categories		1	3	8	4	0	0	2	2	9	3	1	0	11	15	3	4	1	0	36	31

*University of Maryland Health Partners (UMHP) transitioned to CareFirst BlueCross BlueShield Community Health Plan of Maryland (CareFirst CHPMD) as of 2/1/2021

There were 650 total MCO recipient complaints in October (347) and November (303), 2021(all ages). Eighty-seven percent of the complaints (563) were related to access to care. The remaining thirteen percent (87) were billing complaints. The top three member complaint categories were accessing primary care providers (PCPs), specialists and pharmacy services. The categories not specified (Other Categories) for the non-billing complaints include appeals and grievances, access to therapies (occupational therapy-OT, physical therapy-PT, and speech therapy-ST), adult dental and vision services, and obtaining DME/DMS (Durable Medical Equipment/Durable Medical Supplies). Overall, Priority Partners and United Healthcare had the highest percentage of complaints in both months, which was mainly attributed to difficulty accessing pharmacy services.

Prenatal complaints comprised 15 percent in October and 16 percent in November of total complaints. 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, 36 pregnant women (21 in October and 15 in November) called the Help Line for general information. These women were also referred for follow-up and education.

[4] Sourced from CRM.

Table 11. Recipient Complaints under age 21 (not including billing) - October & November 2021[5]

MCO / Type of Service		Aetna Better Health (ABH)		Amerigroup (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)*		Sub Totals	
OCT vs. NOV 2021		OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV
Pharmacy	#	1	0	4	3	0	0	1	1	1	1	0	2	8	2	2	3	1	0	18	12
	%	6%	0%	22%	25%	0%	0%	6%	8%	6%	8%	0%	17%	44%	17%	11%	25%	6%	0%	25%	18%
PCP	#	2	2	4	7	1	1	4	7	2	2	2	3	4	2	3	3	6	2	28	29
	%	7%	7%	14%	24%	4%	3%	14%	24%	7%	7%	7%	10%	14%	7%	11%	10%	21%	7%	38%	43%
Specialist	#	3	1	2	4	0	0	1	4	0	1	2	2	0	2	4	1	0	0	12	15
	%	25%	7%	17%	27%	0%	0%	8%	27%	0%	7%	17%	13%	0%	13%	33%	7%	0%	0%	16%	22%
Prenatal	#	2	0	4	0	0	0	0	1	2	1	1	1	2	1	1	2	0	0	12	6
	%	17%	0%	0%	0%	0%	0%	0%	17%	0%	17%	0%	17%	0%	17%	0%	33%	0%	0%	16%	9%
Sub Totals	#	8	3	14	14	1	1	6	13	5	5	5	8	14	7	10	9	7	2	70	62
	%	11%	5%	20%	23%	1%	2%	9%	21%	7%	8%	7%	13%	20%	11%	14%	15%	10%	3%	96%	91%
All EPSDT Complaint Totals	#	8	3	15	15	1	1	6	13	7	5	5	8	14	12	10	9	7	2	73	68
	%	11%	4%	21%	22%	1%	1%	8%	19%	10%	7%	7%	12%	19%	18%	14%	13%	10%	3%	100%	100%
Other Categories		0	0	1	1	0	0	0	0	2	0	0	0	0	5	0	0	0	0	3	6

*University of Maryland Health Partners (UMHP) transitioned to CareFirst BlueCross BlueShield Community Health Plan of Maryland (CareFirst CHPMD) as of 2/1/2021

There were 141 member complaints (non-billing) for recipients under age 21 in October (73) and November (68), 2021, or 21 percent in October (73 of 347) and 22 percent in November (68 of 303) of the total complaints. The top complaint category was access to primary care providers (PCPs). Amerigroup was a major contributor 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 seek assistance accessing pharmacy services as well as primary care providers while children (under 21) most often report difficulty accessing a primary care provider.

[5] Source from CRM.

Table 12. Total Recipient Billing Complaints - October & November 2021[6]

MCO / Type of Service		Aetna Better Health (ABH)		Amerigroup (ACC)		JAI Medical Systems (JAI)		Kaiser Permanente (KP)		Maryland Physicians Care (MPC)		MedStar Family Choice (MSFC)		Priority Partners (PP)		United Healthcare (UHC)		University of Maryland Health Partners (UMHP)*		Sub Totals	
OCT vs. NOV 2021		OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV	OCT	NOV
Emergeny	#	2	0	2	1	0	0	3	1	3	2	1	0	2	2	3	0	0	2	16	8
	%	13%	0%	0%	13%	0%	0%	0%	13%	0%	25%	0%	0%	0%	25%	0%	0%	0%	25%	31%	23%
PCP	#	2	1	3	5	0	0	1	2	1	2	0	0	1	1	0	1	0	1	8	13
		25%	8%	38%	38%	0%	0%	13%	15%	13%	15%	0%	0%	13%	8%	0%	8%	0%	8%	15%	37%
Laboratory/ Test	#	0	1	2	2	0	0	0	0	2	2	2	1	1	0	2	0	0	0	9	6
	%	0%	17%	22%	33%	0%	0%	0%	0%	22%	33%	22%	17%	11%	0%	22%	0%	0%	0%	17%	17%
Specialist	#	1	0	2	0	0	0	0	0	0	0	0	0	1	0	2	0	0	0	6	0
	%	17%	0%	33%	0%	0%	0%	0%	0%	0%	0%	0%	0%	17%	0%	33%	0%	0%	0%	12%	0%
Sub Totals	#	5	2	9	8	0	0	4	3	6	6	3	1	5	3	7	1	0	3	39	27
	%	13%	7%	23%	30%	0%	0%	10%	11%	15%	22%	8%	4%	13%	11%	18%	4%	0%	11%	75%	77%
All Billing Complaint Totals	#	5	2	11	10	0	0	5	5	9	6	4	1	10	3	8	5	0	3	52	35
	%	10%	6%	21%	29%	0%	0%	10%	14%	17%	17%	8%	3%	19%	9%	15%	14%	0%	9%	100%	100%
Other Categories		0	0	2	2	0	0	1	2	3	0	1	0	5	0	1	4	0	0	13	8

*University of Maryland Health Partners (UMHP) transitioned to CareFirst BlueCross BlueShield Community Health Plan of Maryland (CareFirst CHPMD) as of 2/1/2021

Enrollee billing complaints comprised fifteen percent in October and twelve percent in November of total MCO complaints. Overall, the top bill type was Emergency, which comprised 31 percent in October, and it was primary care provider related billing issues, which comprised 37 percent in November of all MCO billing complaints. Other categories are the billing complaints related to inpatient services, urgent care centers, DME/DMS, therapies, pharmacy, and optional services such as adult dental and vision. Maryland Physicians Care had the highest percentage of billing complaints.

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.

[6] Source: CRM.

Legislative Update

The Maryland General Assembly convened its 2021 session on January 13, 2021 and it adjourned on April 12, 2021. The 2022 session will convene on January 12, 2022.

Quality Assurance/Monitoring Activity

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

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

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

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

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

Table 13. Quality Assurance Updates

Activity	Vendor	Status	Comments
Systems Performance Review (SPR)	Qlarant	In Progress	In October 2021, Qlarant began conducting a record review for the SPR grievance, appeals, and denials reporting. Qlarant provided an NCQA deeming crosswalk to the MCOs in December 2021 and provided technical assistance as needed. Qlarant also revised the CY 2021 SPR Orientation manual in December 2021 to address the complete review of Standard 4 as part of the CMS ATR feedback received. Comprehensive SPR schedules were confirmed for each MCO in December 2021 for the upcoming review.
EPSDT Medical Record Review	Qlarant	In Progress	Qlarant submitted individual MCO draft CY 2020 reporting in October 2021and obtained the Department's approval in December 2021. Qlarant submitted the CY 2020 Statewide Aggregate draft report for the Department's approval in December2021. Approval of the CY 2020 Statewide aggregate report is expected in January 2022 once MCO corrective action plans are reviewed and approved.
Consumer Report Card (CRC)	Qlarant	In Progress	Qlarant finalized the CY 2022 IRS and Methodology and obtained the Department's approval in November 2021. Qlarant submitted a new CRC template color scheme for the Department's review and approval in December 2021.
Performance Improvement Projects (PIPs)	Qlarant	In Progress	The Department completed its review of the annual PIP report validations in November 2021. Qlarant submitted the Annual 2021 PIP report to the Department for review and approval in December 2021. Qlarant also reviewed quarterly Lead PIP submissions from the MCOs and submitted to the Department for review and received approval in December 2021.
Encounter Data Validation (EDV)	Qlarant	In Progress	The Department received the Activity 3 reporting from Hilltop and sent the document to Qlarant in December 2021. Qlarant incorporated the Hilltop findings into the CY 2020 EDV report and submitted it to the Department for review and approval in December 2021. The Department submitted their edits to Qlarant and are awaiting the final EDV report.
Network Adequacy Validation (NAV)	Qlarant	Complete	Qlarant completed the CY 2021 NAV report in October 2021 and submitted it to the Department for review. The Department approved the CY 2021 NAV report in November 2021. The finalized report was posted to the MDH website and disseminated to the MCOs in November 2021.
Quarterly Review of Appeals, Grievances, and Pre-Service Denials (GAD)	Qlarant	In Progress	Qlarant finalized the Quarter 3 reporting for GAD in November 2021. Highlights are listed below. The next quarterly report, Quarter 4, will be due in January 2022 for review by Qlarant. The Department reviewed and approved Qlarant's 2021 Annual GAD reporting October 2021. The finalized report was posted to the MDH website and disseminated to the MCOs in October 2021. In October 2021, the Department and Qlarant collaborated on a new GAD reporting template to align with the CMS MCPAR report to be disseminated to the MCOs in 2022.
HEDIS Audits and Reporting (HEDIS)	MetaStar	Complete	NCQA released the HEDIS® Measurement year (MY) 2021 Public Reporting memo in October, which outlines all measures, product lines and indicators that have been approved for public reporting for MY 2021, MY 2022 and MY 2023, as well as all measures, product lines and indicators that will not be publicly reported for MY 2021.

Activity	Vendor	Status	Comments
			The 2021 HEDIS Statewide Executive Summary Report was posted on the Maryland Department of Health (MDH) Website. The HEDIS® vendor and MDH convened via Google Meet to discuss the importance of race/ethnicity information in enrollment files in order for HealthChoice MCOs to meet HEDIS® MY 2022 race/ethnicity stratification reporting requirements. The HEDIS vendor provided an audit timeline, along with key dates, for the upcoming HEDIS 2022 audit season. The scheduling of onsite visits for the HealthChoice MCOs for the 2022 has been finalized.
Value Based Purchasing Initiative (VBP)	Qlarant	In Progress	Qlarant validated the MDH developed VBP measures. The Department completed their analysis of the measure results and issued the first and second rounds of VBP letters to the MCOs in November 2021. Qlarant continued drafting the annual CY 2020 VBP report in December.
CAHPS Survey Administration (CAHPS)	CSS	Complete	The Department completed review and editing of all CAHPS reports, including MCO, Aggregate, and Executive Summary reports. All approved final reports for 2021 were distributed electronically to the HealthChoice organizations and the Department by the survey vendor. Executive Summary report was posted on the MDH Website. The survey vendor provided a survey administration timeline for CAHPS 2022 to the Department. Pre-Survey fielding activities underway, which included reviewing and updating the survey questionnaires and collateral materials and obtaining the survey recipient data file and providing it to the survey vendor.
PCP Satisfaction Survey Administration	CSS	Complete	All 2021 PCP survey reports were finalized, approved, and provided to the Department and all HealthChoice organizations by the survey vendor. The 2022 PCP Data File request memo was sent to all HealthChoice organizations by the Department with instructions and requirements for providing the data file to the survey vendor for use for the 2022 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	In December 2021, the Department began compiling additional information to respond to the CMS follow-up items from previous ATR submissions. Qlarant continues to develop the draft template for the Annual Technical Report for the upcoming measurement year.

Completed Activity Highlights:

- **Network Adequacy Validation (NAV)**
- For the CY 2021 NAV review, successful PCP contacts decreased by 1.8 percentage points (53.5 percent) below CY 2020 (55.4 percent and 2.3 percentage points below CY 2019 (55.9 percent)
- Almost all of the PCPs surveyed (94 percent) provided routine appointment availability, and of those, 99.6 percent were compliant with appointment timeframe requirements, comparable to CY 2020 results (100 percent).
- Urgent care appointment compliance decreased slightly by 1.3 percentage points (86.8 percent) compared to CY 2020 (88.1 percent).
- Aggregate scores sustained or improved in six out of the seven validation categories.
- Five MCOs[7] (JMS, KPMAS, MPC, MSFC, and PPMCO) are required to submit corrective action plans to improve compliance.
    - JMS, KPMAS, MPC, and PPMCO are required to submit CAPS to improve compliance with online provider directory accuracy of accepting new Medicaid patients for the listed MCO.
    - KPMAS and MSFC are required to submit CAPs to improve compliance with urgent care timeframes.

CAPs Required	ABH	ACC	CFCHP	JMS	KPMAS	MPC	MSFC	PPMCO	UHC
	0	0	0	1	2	1	1	1	0

- **Focused Reviews of Grievances, Appeals, and Denials (GAD)**
- The third quarter of GAD was completed in November 2021.
    - Grievances Highlights
        - KPMAS and JMS had the highest grievance rate per 1,000 members (4.34 and 2.38, respectively).
        - All but two MCOs met the turnaround time (TAT) requirements for member grievances (ABH at 74 percent and CFCHP at 0 percent)
        - TAT compliance for provider grievances was met by six of the applicable MCOs (KPMAS continues to report no provider grievances).
    - Appeals Highlights
        - MPC and PPMCO had the highest appeal rate per 1,000 members (1.39 and 2.67, respectively).
        - KPMAS and MSFC had the highest appeal overturn rates (85 percent and 82 percent, respectively).
        - The following MCOs scored below the 100 percent threshold for compliance with appeal timeframes in at least one category: ACC (Non-emergency = 99 percent), MPC (Expedited =80 percent and Non-emergency = 87 percent) and UHC (Expedited=95 percent and Non-emergency = 98 percent).
    - Denial Highlights
        - ABH and MPC have the highest denial rates per 1,000 members (28.9 and 31.2, respectively).

[7] ABH – Aetna Better Health; ACC – Amerigroup; CFCHP – Carefirst Community Health Plan; JMS – Jai Medical Systems; KPMAS – Kaiser Permanente; MPC – Maryland Physicians Care; MSFC – Medstar Family Choice; PPMCO – Priority Partners; UHC – United Healthcare

    - KPMAS and MSFC have the highest approval rates (93 percent and 90 percent, respectively).
    - CFCHP (29 percent continued to not meet the standard medical determination TAT.

- **HEDIS Audits and Reporting**
- Maryland MCOs have historically had high performance in their HEDIS rates. For MY 2020, COVID-19 caused performance to decrease across multiple measure domains, primarily for access to care, prevention and screening measures. In addition, it should be noted that due to COVID-19, NCQA allowed MCOs to rotate hybrid measure rates using HEDIS MY 2018 audited results for reporting in MY 2019. Therefore, some HEDIS MY 2020 hybrid rate changes appear to be even more significant than what they may have been if hybrid rotation had not been allowed for HEDIS MY 2019.
- The NHM used to gauge performance for MY 2020 was derived from a pre-COVID healthcare environment, so we suspect that the NCQA HEDIS means and percentiles for MY 2020 will change as a result of COVID-19's impact on healthcare.
- Telehealth was added to some measure specifications which may have helped to bump up measure rates so performance would not be quite so low, for example, for Statin Therapy for Patients with Diabetes (SPD), Antidepressant Medication Management (AMM), and Follow-Up Care for Children Prescribed ADHD Medication (ADD) to name a few. Telehealth was also added to the new Children and Adolescent Well-Care Visits (WCV) and Well-Child Visits in the First 30 Months of Life (W30) measures. Though no direct comparison can be made to the previous Well-Child Visits in the First 15 months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34), and Adolescent Well-Care Visits (AWC) measures, this change no doubt helped to boost rates where they may have substantially lower. In addition, although telehealth was added to the Ambulatory Care (AMB) outpatient indicator, utilization rates for all MCOs were down sharply.
- There were several measures where eight of nine MCO rates were above/better than the National HEDIS Mean (NHM); Weight Assessment and Counseling for Physical Activity for Children/Adolescents (WCC-PA), Lead Screening in Children (LSC), Asthma Medication Ratio (AMR), Chlamydia Screening in Women (CHL) – Total, Prenatal and Postpartum Care - Postpartum Care (PPC)-Post, and Use of Opioids (UOP) – Multiple pharmacies.
- All MCOs scored above the NHM for Use of Imaging Studies for Low Back Pain (LBP).
- ADD acute phase– despite COVID, with the addition of telehealth visits to the specifications, each MCO that had a denominator of 30 or greater had a higher rate than the previous year.
- The Maryland Average Reportable Rate (MARR) increased for several medication–related measures/indicators, such as AMR, SPD 80 percent compliance and Statin Therapy for Patients with Cardiovascular Disease (SPC) 80 percent compliance.

- **CAHPS Reporting**
- <u>Adult</u>
    - Overall, the HealthChoice Aggregate performed on par with the 2020 levels across the measure spectrum, with no statistically significant improvements or declines in scores.

- There were relatively few statistically significant performance gains among the participating plans compared to the prior year across the measure spectrum. Similarly, almost none of the observed declines in performance reached statistical significance.
- HealthChoice exhibited a consistent positive directional trend on Getting Needed Care, Rating of Doctor, and Rating of All Health Care, and a consistent negative directional trend on Coordination of Care. Neither was statistically significant.
- On five measures, HealthChoice scored in the bottom third of the 2021 NCQA Quality Compass Adult Medicaid percentile distribution. HealthChoice scored in the middle third on Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Customer Service.
- Adult Medicaid member ratings of the plan are strongly related to members' ability to get the care they need when they need it. Being able to obtain needed information from customer service and access to highly rated providers are all significant drivers of member experience. Survey results show that "Rating of Personal Doctor" shows room for most improvement and overall improvement opportunity for HealthChoice MCOs.

- <u>Child</u>
  - Overall, the HealthChoice Aggregate scored in the bottom third of the 2021 NCQA Quality Compass Child Medicaid National distribution on most survey measures. The only exception in the non-CCC measures was Rating of Personal Doctor and Rating of All Healthcare. Rating of All Healthcare has trended upward over the past two years. However, the HealthChoice Aggregate still only placed in the middle third of the distribution on Rating of All Healthcare. The HealthChoice Aggregate scored poorly on Getting Needed Care, Getting Care Quickly and How Well Doctors Communicate, with all three measures experiencing statistically significant declines from the prior year.
  - Among the Children with Chronic Conditions (CCC) measures set, HealthChoice performed especially poorly on Getting Needed Information and Coordination of Care for Children with Chronic Conditions, with the former experiencing a statistically significant decline compared to the prior two years, and the latter experiencing a consistent negative two-year trend. While HealthChoice also earned relatively low overall scores on Personal Doctor Who Knows Child, Access to Prescription Medicines and Access to Specialized Services had variable performance from plan to plan.
  - Child Medicaid member ratings of the plan are strongly related to members' ability to get the care they need when they need it. Being able to obtain needed information from customer service and access to highly rated providers are all significant drivers of member experience. Survey results show that "Rating of Personal Doctor" shows room for most improvement and overall improvement opportunity for HealthChoice MCOs.

- **Primary Care Provider Reporting**
- Over 78 percent of PCPs reported being *Very satisfied* or *Somewhat satisfied* with the specified MCO. This rate is not significantly different from the percentage of PCPs reporting being *Very satisfied* or *Somewhat satisfied* with the specified MCO in 2020. 87 percent of PCPs would recommend specified MCOs to patients and 86 percent of PCPs would

recommend specified MCOs to other physicians (answered *Definitely yes* or *Probably yes* to the recommendation questions). Both these rates are lower than 2020 rates, but not significantly different compared to 2020 rates.

- The loyalty analysis of the survey showed that loyalty to their MCO among Physicians decreased slightly, while the number of Physicians indicating indifference or not loyal reflected a slight increase when compared to the prior year results.

Demonstration Evaluation

During the quarter, the Department collaborated with its independent evaluator, the Hilltop Institute, to begin work on the CY 2022 evaluation, which covers from CY 2016 through CY 2020.

The Department has been in ongoing conversations with CMS about the §1115 evaluation design and the SUD monitoring protocol. The Department and CMS collaborated on updating the materials. The §1115 evaluation design has been accepted and the Department is working on implementing it.

In preparation of the waiver period beginning January 1, 2022, the Department submitted several drafts of the SMI Implementation Plan for CMS review.

Enclosures/Attachments

- Appendix A: Maryland Budget Neutrality Report as of December 31, 2021

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