HealthChoice Evaluation

Final Report & Recommendations

January 15, 2002

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Acknowledgements

This report was completed with the guidance and support of the HealthChoice Evaluation Expert Panel and the HealthChoice stakeholder community. These two groups have assisted throughout the evaluation process and the Department sincerely appreciates their many valuable contributions.

The Expert Panel is composed of a group of health services researchers and Medicaid policy experts that we tremendously respect:

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These panel members generously volunteered their time to provide technical guidance throughout the evaluation process. Very early in the process the panel helped us by providing feedback on the pertinent evaluation questions to ask. The panel also played a very important role in reviewing and commenting on the analyses and the conclusions we drew. They served as our sounding board and they have been advisors throughout the evaluation process. We are extremely grateful for their generous contributions of time and expertise.

We would also like to recognize the HealthChoice stakeholder community for its ongoing cooperation and commitment. This community has offered a great deal of valuable feedback on the HealthChoice Program and it has contributed to developing recommendations for programmatic changes. HealthChoice stakeholders have been an integral part of the policy-making process and we greatly appreciate their collaboration and ongoing commitment to improving the HealthChoice Program.

The HealthChoice Evaluation, from initial design, through the extensive analysis and final production, was a collaborative effort of the Department of Health and Mental Hygiene and its partner, the Center for Health Program Development and Management at the University of Maryland, Baltimore County.

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EXECUTIVE SUMMARY

PURPOSE OF THE EVALUATION

In July 1997, the Maryland Department of Health and Mental Hygiene replaced a mixed model of fee-for-service and voluntary managed care enrollment for over 75 percent of Medicaid enrollees with a mandatory managed care system called HealthChoice. The goals of HealthChoice are to:

- Develop a patient focused system featuring a medical home;
- Create comprehensive, prevention-oriented systems of care;
- Build on the strengths of Maryland's existing health care delivery system;
- Hold managed care organizations accountable for delivering high-quality care; and
- Achieve better value and predictability for State dollars.

Over the last four years, the Maryland Department of Health and Mental Hygiene (the Department) has worked with the managed care organizations (MCOs) to improve the program by measuring and monitoring performance. The Department has always maintained a continuous improvement mindset regarding HealthChoice and has monitored and maintained quality of care through numerous activities and reports. This evaluation, however, is the first comprehensive evaluation of the program. In recent years, HealthChoice has been scrutinized by a variety of stakeholder groups due to the tension between the need to manage costs and the need to ensure the provision of access to high quality care. This tension is not unique to Maryland; both the commercial insurance market and the federal Medicare program face similar concerns in an era of rising health care costs.

In January 2001, the Department embarked on an extensive evaluation to assess the success of HealthChoice relative to the original program and to stakeholders' expectations. Extensive input from consumers, providers, MCOs, advocates, and the General Assembly was central to designing the evaluation. Using a mix of quantitative and qualitative data sources, as well as public input and expert consultation, the evaluation provides a comprehensive picture of the overall performance of the HealthChoice program over a period of time.

The Department is using the results of the evaluation to assess the overall performance of the program and to make recommendations about the program. The evaluation recommendations will provide the basis of the Department's multi-year work plan for improving the HealthChoice program and will constitute priority areas for focused attention. The Department's goal is to continue to provide access to high quality care to all enrollees.

MAIN FINDINGS

The comprehensive evaluation of the HealthChoice program demonstrates that the program made progress in meeting its originally stated goals. There is no compelling evidence to recommend a significant programmatic shift away from the HealthChoice model. However, areas of improvement were identified, and key changes need to be made to ensure that the program continues to improve access to high quality care for enrollees. Improvements under the HealthChoice program are largely due to the MCOs' establishment of a medical home for the enrollee and to the MCOs' care management systems. We have reached these conclusions based on the following key findings:

The Medicaid HealthChoice program serves a much larger and different population than before and was the platform for a major program expansion.

Since the inception of HealthChoice, over 100,000 individuals have been added to the Medicaid rolls. The decline in the number of adults and the rapid growth in the number of children in the program are due to changes in the welfare program and the implementation of the Maryland Children's Health Program in 1998.

Statewide, the percentage of all Maryland children enrolled in Medicaid has grown from 12.7 percent in 1990 to 22.2 percent in 2000. On the Eastern Shore, the percentage of all Maryland children served by Medicaid has more than doubled, from 12.4 percent in 1990 to 28.7 percent in 2000. One reason these significant program expansions were possible is that MCOs pay higher rates to physicians than the fee-for-service Medicaid program. Because of the low Medicaid physician fee schedule, it is questionable whether the previous fee-for-service system would have been able to support these major program expansions.

HealthChoice has helped more people, particularly children, access health care services overall. Although the number of services per person has decreased, the implications of this are unclear.

Access to care has increased compared to pre-HealthChoice, even with the significant increase in the number of people served in HealthChoice:

- Individuals who enroll in Medicaid stay in Medicaid longer than before. The number of enrollees who maintain a full year of eligibility within the year increased from 41.8 percent in FY 1997 to 48.5 percent in CY 2000.

- The percentage of children who received a well child visit increased from 36.0 percent in FY 1997 to 40.0 percent in CY 2000. The largest increase was for newborns, increasing from 54.5 percent in FY 1997 to 69.2 percent in CY 2000.

- The percentage of individuals who accessed any ambulatory service increased from 57.8 percent in FY 1997 to 60.3 percent CY 2000. The greatest increase was for newborns, increasing from 61.3 percent in FY 1997 to 75.1 percent in CY 2000.

- The number of well child services increased from 871 per thousand members in FY 1997 to 905 per thousand members in CY 2000. For newborns, the number of ambulatory services increased from 6,526 visits per thousand members in FY 1997 to 7,822 visits per thousand members in CY 2000.

- Overall emergency room use is down both in terms of the percentage of people who have an emergency room visit (15.2 percent in 1997 versus 14.4 percent in 2000) and in the number of visits per thousand members (345 in 1997 versus 301 in 2000).

- The volume of ambulatory services declined except for newborns and well child visits, as described above. Overall, the number of ambulatory services decreased from 4,301 visits per thousand members in FY 1997 to 3,667 visits per thousand members in CY 2000. The implications of this are unclear. This might indicate that people are not receiving needed medical services. However, the utilization decreases may be due to the healthier case mix of the new population, more appropriate management of care, or incomplete encounter data submitted by the MCOs.

- HealthChoice made significant progress in improving access to dental services, although access measures still fall short of the legislatively mandated targets. In CY 2000, for children between ages three and twenty enrolled in Medicaid for more than 90 days, 24 percent accessed dental services, up from 18 percent in FY 1997. The legislated targets start at 30 percent for CY 2000 and increase to 40 percent for CY 2001, 50 percent for CY 2001, 60 percent for CY 2002, and 70 percent by for CY 2004.

- Although overall access to care has improved for children with SSI eligibility, some populations of children with special needs may not be equally well served by HealthChoice:

    - The encounter data analysis shows that fewer children in foster care received outpatient services under HealthChoice and the number of services they received decreased. This analysis does not include important data on utilization of services before foster care children are enrolled in an MCO and therefore drawing conclusions is impossible. Service utilization by children in foster care is currently being studied further by the Department.

    - SSI-eligible children have experienced improved access to care, including preventive services. Overall, 65 percent of SSI children (including some children enrolled in the Rare and Expensive Case Management [REM]

program who receive services on a fee-for-service basis) received an ambulatory visit in CY/FY 2000, an increase from 58 percent in FY 1997. The level of services they received increased slightly: SSI/REM children received 3,740 visits per thousand members in CY/FY 2000 compared to 3,229 visits per thousand members in FY 1997.

Overall, HealthChoice saved money relative to what would have been spent on the fee-for-service delivery system, and has added value to the program for consumers and providers.

- HealthChoice has met the two federal cost-effectiveness requirements, the Federal Upper Payment Limit and the budget neutrality cap.

- The first four years of HealthChoice demonstrate that most MCOs were able to generate profits each year, suggesting that rates in the past have been adequate. This does not address losses that some downstream risk providers experienced.

- The higher administrative costs of HealthChoice are associated with the benefits of the MCOs' care management systems and establishment of medical homes for enrollees. New care management functions, such as outreach mandates, enrollee education responsibilities, and case management efforts, created new administrative burdens for MCOs and providers. Plans believe that increased administrative burdens hinder their ability to manage expenses adequately.

- Risk-adjusted rate setting methods contribute significantly to achieving purchaser value by more efficiently allocating funds among the MCOs according to the health status of their enrollees.

- MCOs have sufficient primary care providers (PCPs) to serve their enrolled population, including the 100,000 additional HealthChoice participants, at least in part due to the higher physician fees paid by the MCOs.

- The change in the number of MCOs participating in the HealthChoice program (initially eight, currently six) is similar to the magnitude of MCO withdrawals in other states.

Improvements in access may be threatened by diminishing number of physicians who are willing to participate in HealthChoice.

- Concern is greatest on the Eastern Shore and in Southern and Western Maryland due to the dramatic growth in the proportion of children served by Medicaid and the small number of physicians available to absorb program growth in those areas.

- Physicians have left HealthChoice or are threatening to leave because of inadequate reimbursement from MCOs, even though most MCOs' physician payments are greater than the Medicaid fee-for-service schedule.

The evaluation demonstrates that, to date, HealthChoice has made progress in advancing the goal of providing access to high quality care to all enrollees. However, progress has not been uniform across the range of populations served and health needs addressed by HealthChoice. Changes are needed in order to continue HealthChoice's progress and to promote the stability of the program. The evaluation findings can be used to address long-standing challenges that have the potential to significantly affect the program.

RECOMMENDATIONS

The evaluation findings point to a variety of program improvements. Each of the seven areas of improvement detailed below is followed by one or more recommendations that should serve as the Department's HealthChoice priorities.

Establish a long-term priority-setting process

The Department recommends an annual process to review and establish strategic priorities for the HealthChoice program. HealthChoice evaluation recommendations will be implemented as part of a multi-year process, beginning in CY 2002. To the extent possible, the Department would implement the subsequent changes one time a year in order to promote program stability and ease administrative burden.

Maintain the current MCO-based capitated program, but develop a back-up managed care system

The Department should develop a back-up care management program that includes linkage with a primary care provider; comprehensive care management and disease management programs; active quality assurance activities; and cost-containment efforts such as utilization control. However, given the significant administrative responsibilities for primary care physicians under a back-up managed care program, physician reimbursement rates must be increased in order to be able to recruit an adequate provider network.

Improve provider networks

- If physician fees are increased, the Department should monitor MCOs to ensure that the appropriate amount of the corresponding increase in capitation payments is passed on to physicians.

- The accuracy of provider data and the provider network directory (PND) should be improved by performing a manual clean-up of the PND file, developing a PND edit program to eliminate the overriding of data submitted by the MCOs, developing a

method to sanction MCOs for failure to submit accurate data, and eliminating duplicate listings of providers.

- The Department should fully implement its Network Adequacy Plan to monitor and enforce MCO network adequacy. This plan includes the development of specialty care standards and a method for implementing and enforcing these standards, the identification of geographic areas where there may be potential problems with access to care, and collaboration with MCOs to improve networks in problem areas.

- Administrative burdens for direct service providers should be streamlined.

  - The Department should utilize the payment performance information collected by the Maryland Insurance Administration (MIA) to ensure timely claims payment.

  - The new HIPAA-compliant eligibility verification system (EVS) should include the capability to automatically route a provider call to the MCO's eligibility phone line, resulting in the provider making only one call for both PCP and client eligibility information.

  - The Department recommends a variety of new and ongoing initiatives to ensure that mothers of newborns know where to take their newborn for care, and that appropriate newborn care is paid for by the MCO.

  - The Department should develop a quality assurance process more reliant on existing administrative data than on chart reviews. The exception to this should be chart reviews to monitor the provision of high quality well child care (since three quarters of the population served in HealthChoice are children) and focused reviews for certain special populations. In addition, administrative data collected by the Department will include audited chart reviews conducted by the MCOs and validated by the External Quality Review Organization to meet HEDIS requirements.

  - The Department should establish an MCO and provider workgroup to determine how to streamline and potentially standardize the MCO provider credentialing process.

- The Department should establish better mechanisms for communicating with HealthChoice providers. A new provider communication model would include a consolidated HealthChoice provider manual to be disseminated in hard copy and electronically, internet-based provider transmittals, and regional meetings convened by the Department and MCOs to relay updated program information to providers and their office managers and to receive providers' and office managers' input on issues.

Promote increased quality of care and improved program performance

The Department has been developing a Value Based Purchasing Initiative to encourage MCOs to improve performance. The Initiative is to be implemented beginning in CY 2002. As part of this strategy, the Department is collaborating with stakeholders to define the set of performance measures, develop targets for each measure, and create a system of financial incentives and disincentives.

Improve the program for consumers

- The Department recommends that any new enrollee who has been auto-assigned to an MCO be allowed to change MCOs once at any time during the first year (not just within 60 days of the auto-assignment) in addition to his or her annual right to change and the right-to-change for cause. The one exception should be enrollees in the middle of a hospital stay, who should wait until discharge to change MCOs.

- A case management workgroup composed primarily of LHD and MCO case management staff should be formed to make recommendations regarding: populations targeted for case management; scope of LHD and MCO case management services; MCO best practices for disease management; coordination of MCOs, LHDs, and other case management entities; and the feasibility of utilizing the local health department Administrative Care Coordinators/Ombudsman grants to provide intensive case management services to certain enrollees.

- An expert panel should be convened to develop a comprehensive list of system improvements to better serve the needs of foster care children. The panel should include representatives from the Department of Human Resources, Local Departments of Social Services, the Department of Health and Mental Hygiene, foster care parents, providers, and other key stakeholders. The expert panel should address expedited eligibility and training for DSS staff, foster care parents, and resource providers regarding accessing services. In addition, the Department should apply for a federal waiver to allow children enrolled in the State-only foster care eligibility coverage group to be enrolled in HealthChoice MCOs.

- The Department should increase efforts to educate and inform enrollees of the HealthChoice Enrollee Action Line and should ensure that consumer education materials outline consumers' rights. The Department should work in partnership with the Enrollment Broker, the Local Health Departments, community-based groups, providers, and the MCOs to accomplish this. The Department should also more closely monitor MCOs' adverse action notices and compliance with standard appeal and grievance processes.

- In order to meet consumers' desires for a more generous transportation benefit, the Department should retain a scheduled transportation system but modify it to support

enrollees' visits to scheduled appointments within or outside their jurisdiction. In addition, the Department should increase program oversight of grantees and collaborate with stakeholders to study whether provider network challenges in rural areas as well as other areas justify a reallocation of transportation funding. The Department will also continue to use complaint hotlines to monitor transportation services.

Improve the delivery of special services

Several areas have been recommended by some stakeholders for possible carve-out from the HealthChoice program. Carve-outs must be carefully considered because they are difficult to coordinate in a managed care system so that integrated care is still achieved, and their unintended consequences can be negative for HealthChoice enrollees.

- *Dental.* The Department should continue to increase funding for dental care in HealthChoice so that the utilization targets set by the legislature can be met; develop a system to monitor and enforce MCO dental network adequacy; develop a dental accountability plan to enforce the legislatively mandated utilization targets, including monitoring MCO dental fees and actual expenditures for dental services; study the utilization goals established in State law relative to other benchmarks for low-income populations; perform annual on-site visits with MCOs to review their strategies for meeting the utilization targets and to share successful strategies; and establish an MCO and provider workgroup to address streamlining, standardizing, and/or centralizing the MCO provider credentialing process. If dental utilization does not improve significantly based on the Department's new funding for CY 2001 and subsequent years, the Department should consider alternatives for the delivery of dental services.

- *Substance Abuse*. The Department formed the Medicaid Drug Treatment Workgroup to determine whether the MCOs are serving enrollees with substance abuse needs appropriately, if substance abuse should be carved out, and if so the model that should be used. The Workgroup has implemented a Substance Abuse Improvement Initiative for enrollees in HealthChoice. In addition, the Workgroup is designing a carve-out of substance abuse services from the HealthChoice program with the intention of implementing it if the new improvement initiative is not successful (to be determined in Spring 2002).

- *SOBRA Pregnant Women.* The Department does not recommend a carve-out of SOBRA pregnant women (women who gained Medicaid eligibility because they were pregnant) at this time. However, it should reconsider whether the 32-week gestation period is the appropriate cut-off period for enrollment into MCOs. The Department should conduct further study of general HealthChoice prenatal care delivery, including services for SOBRA pregnant women.

Establish strategies to stabilize the managed care system

- Given MCO projections of rapid increases in medical expenses and issues with the current baseline for setting capitation rates, the Department should establish a new method for establishing the baseline for the rate-setting process. This model will better reflect the MCOs' costs and market trends. Operational and financial audits should be used to confirm that MCO costs are accurate and reasonable.

- The annual rate-setting process eventually should be switched to a biennial schedule, with a trend factor applied for the second year based on a predetermined formula. This would allow the Department, MCOs, and other stakeholders to maximize resources and engage in longer term planning. Enrollee risk adjustments would take place annually, and interim adjustments would account for any benefit changes or fee-for-service rate changes as currently required by regulation.

- MCO exit notice requirements should be changed to require MCOs to provide at least 180 days (instead of 120 days) of advance notice to terminate their contracts between contract periods, or 90 days advance notice at the beginning of a rate year. This would guarantee longer periods of time to prepare for exits and transitions, and would enhance continuity of care. The Department should investigate and make recommendations regarding an equitable formula for sharing exit costs with the exiting MCO.

- Larger service areas should be established to discourage plans from freezing in or withdrawing from certain local access areas based on localized medical loss ratios. Local access areas would continue to exist for enrollee PCP and MCO assignment purposes.

- The Department should request an amendment to the federal waiver so that HealthChoice may continue to operate in areas where there is only one MCO as long as there is an adequate provider network. This will maintain choice of provider for enrollees.

- The Department, in collaboration with the MCOs, should identify initiatives that could reduce MCO costs and develop implementation plans that would begin in CY 2002. Potential opportunities include: maximizing third-party recoveries; reducing administrative requirements; coordinating and reducing overlaps of on-site audits; and reducing ancillary costs through collective purchasing in areas such as pharmacy, lab, and radiology, as well as surgery centers.

- The Department should streamline regulatory reporting by MCOs by coordinating the audit requirements and compliance standards of the Department, MIA, and the Health Services Cost Review Commission (HSCRC).

CONCLUSION

Managed care has been adopted in both the commercial insurance industry and in Medicaid programs nationwide as a means of controlling health care costs and improving quality of care through the promotion of appropriate utilization of health services. The comprehensive evaluation of Maryland's HealthChoice Medicaid managed care program has found that HealthChoice has been successful in meeting the dual goals of improving access to appropriate health care while controlling health care costs. As such, the HealthChoice program should continue as the health service delivery system for the majority of Maryland's Medicaid enrollees. Despite the successes of the program, the evaluation does identify areas for improvement within HealthChoice. Informed by the evaluation findings and input from stakeholders, the Department has outlined recommendations to improve HealthChoice. Legislation is not needed to implement any of the proposed changes. Collaboration among the Department, other state and local agencies, MCOs, providers, advocates, consumers, and other stakeholders has been and will continue to be central to the successful prioritization and implementation of the Department's recommendations.

I. INTRODUCTION AND PURPOSE OF THE EVALUATION

The implementation of the Maryland HealthChoice program began in July 1997; by January 1998 all eligible individuals were enrolled. HealthChoice represented a major change in Maryland's approach to service delivery for most Medicaid recipients. It replaced a mixed model delivery system--consisting of fee-for-service primary care case management and capitated Health Maintenance Organization (HMO) voluntary enrollment--with a mandatory system of enrollment in managed care organizations (MCOs). Under HealthChoice, all eligible families and individuals are required to enroll in a managed care organization (MCO) that has been approved by the Department of Health and Mental Hygiene (the Department). The MCOs are responsible for developing a network that can provide those services for its enrollees.

Over the last four years, the Department has worked with the MCOs to improve the program by measuring and monitoring performance. The Department has always maintained a continuous improvement mindset with HealthChoice, however, it has never performed a comprehensive evaluation of HealthChoice. In recent years, HealthChoice has received scrutiny from a variety of sources – providers, MCOs, advocates, legislators, and researchers.

Much of this scrutiny is a result of the tension between the need to control costs without compromising care during a period of general rising health care costs. This tension is not unique to Maryland as both the commercial insurance market and the federal Medicare program face similar concerns.

The HealthChoice program was in its fourth year when the Department embarked on an extensive evaluation that would assess the program's success relative to its original goals and stakeholders' expectations. To accomplish its goals, the evaluation uses a mix of quantitative data (such as encounter data and Health Services Cost Review Commission data) and qualitative data sources (such as community forums and focus groups). The evaluation presents the findings from these different data sources together in order to provide a broad and comprehensive picture of the overall performance of the HealthChoice program.

The evaluation is structured around HealthChoice's original program goals. These were to:

- Develop a patient focused system featuring a medical home;
- Create comprehensive, prevention-oriented systems of care;
- Build on the strengths of Maryland's existing health care delivery system;
- Hold managed care organizations accountable for delivering high-quality care; and
- Achieve better value and predictability for State dollars.

MEASURING PROGRAM PERFORMANCE

In conducting this evaluation, the Department was not only interested in learning how HealthChoice compares to its predecessor, the Maryland Access to Care (MAC) primary care case management program that the State operated on a non-risk, fee-for-service basis from 1991 to 1997, but also how HealthChoice has changed over the years.

Under the MAC program, each enrollee either chose or was assigned to a primary care provider (designated the enrollee's "primary medical provider" (PMP)), who would be responsible for coordinating that enrollee's care. The MAC program was limited, however, in its care management process (such as utilization review and disease management) because it lacked the necessary infrastructure to provide these services for high-risk MAC enrollees. In addition, PMPs were not required to assure access to appropriate specialty care. Unlike the PMPs on which the MAC program relied, HealthChoice MCOs receive a predetermined capitated payment each month in exchange for providing medically necessary covered services to each of their enrollees. This gives MCOs a financial incentive to implement and use care management processes to control costs and improve quality. There was no comparable incentive under the MAC program.

Many of the analyses presented in this evaluation compare FY 1997 fee-for-service claims for individuals (mostly MAC program participants) who would be HealthChoice-eligible under current program eligibility rules to CY 2000 MCO encounters by HealthChoice enrollees.

To the extent possible, the evaluation attempts to place the Maryland experience in context of other states' Medicaid managed care programs. It is difficult, however, to make meaningful comparisons between HealthChoice program data and Medicaid managed care program data collected by other states. This difficulty is primarily due to differences in program designs, populations covered, benefits provided, and means of collecting and analyzing data, along with the inability to adjust for these differences. Appendix 2 presents a discussion of these difficulties, and includes the results of reviews and analyses of other states' Medicaid managed care programs. These are compared, to the extent possible, to similar measures employed by the HealthChoice program.

PLANNING AND DESIGNING THE EVALUATION

The first step in designing the evaluation included identifying performance standards and outlining data sources. The Department used existing data sources whenever possible to avoid duplication of efforts and to minimize the cost of performing the evaluation. To complement and validate the evaluation's quantitative data, as well as to fill any gaps in data sources, the Department collected additional qualitative data through community forums, focus groups, and interviews.

Public Input

An outline of the evaluation, specifying topic areas, analytic questions, and data sources, was first shared with stakeholders in January 2001. Subsequently, the Department held a series of stakeholder meetings to review the outline and discuss its approach. In an effort to improve attendance, these stakeholder meetings (open to all interested persons) were held on the site of and immediately following the Medicaid Advisory Committee's standing meetings.

Expert Consultation

At several points during the evaluation process, the Department consulted with a group of independent experts familiar with Medicaid, managed care, and program evaluation. The experts reviewed the evaluation plan, and commented on the evaluation's methodology, analyses, and findings. Their background and knowledge helped the Department to ensure its analyses were comprehensive and provided the Department with valuable insights and context for the findings.

CHALLENGES TO EVALUATING THE HEALTHCHOICE PROGRAM

The Department faced several significant challenges in conducting its evaluation of the HealthChoice program. While the evaluation is an extensive analysis of quantitative and qualitative data sources, drawing conclusions about whether the program has been successful is difficult due to several limiting factors. The most significant factors limiting this evaluation can be categorized as follows:

- *Changes to the HealthChoice population.* As will be discussed in Chapter II, the HealthChoice population underwent two public policy changes that have led to dramatic changes in the HealthChoice population. The first of these changes, welfare reform, significantly reduced the number of adults eligible for the program. The second change, the establishment of the Maryland Children's Health Program (MCHP), dramatically expanded the number of children served, particularly between the ages of 6 and 18. These two changes resulted in a greater proportion of children enrolled in the HealthChoice program. The health needs of adults and children vary

considerably, causing them to access very different services. In addition, among the Medicaid-eligible population, children tend to be healthier than adults and, therefore, have a lower utilization rate of services. Together, these effects render comparisons of pre-and post HealthChoice performance problematic. The demographic changes are addressed in the analyses by presenting totals that are weighted by age to account for the changed population mix.

- *Pre-HealthChoice voluntary HMO program.* It is important to note that the population enrolled during FY 1997 in Maryland's voluntary Medicaid managed care program (roughly 100,000 individuals), representing a healthier population, is not included in the FY 1997 fee-for-service comparison group. The HMOs participating in this program during FY 1997 did not submit usable encounter data to the Department. As a result, the data required to include FY 1997 Medicaid HMO enrollees in the evaluation's comparison population are missing. Because the voluntarily enrolled individuals for whom utilization data are unavailable tended to be healthier than the MAC population, the FY 1997 comparison data reflect the higher utilization rates of a sicker population and therefore overstate the utilization of the 1997 comparison group. [1]

- *Lack of consistent comparison tools.* A number of tools to measure and monitor HealthChoice's performance were first implemented with HealthChoice in 1998, such as the external quality review organization (EQRO). Our ability to evaluate these measures with the 1997 fee-for-service comparison group, therefore, is limited. While these tools are discussed in this report and provide valuable insights into the progress of HealthChoice over time, they do not offer any opportunity to assess pre- and post HealthChoice performance.

- *Limited cross-state comparisons.* Generally a good way to measure the performance of any state program is to compare it to other states. Although Maryland examined the experiences of other states, comparative analysis is fraught with difficulty as Medicaid populations vary from state to state. States also use different types of data sources to measure performance. Actual encounter data provide the most valid source. Maryland's encounter data are considered among the best in the country and are used extensively in this report. States that have not been as successful in collecting encounter data rely on other sources (such as

[1] The Department, through its contractor, the UMBC Center for Health Program Development and Management, retained the actuarial firm of William H. Mercer, Inc. to provide assistance in setting HealthChoice capitation rates for CY 2001. In this capacity, Mercer conducted analyses to assess the relative services costs for individuals enrolled in the voluntary, capitated HMO program as compared to the fee-for-service "MAC" primary care case management program. Mercer's analysis indicated that individuals enrolled in the voluntary HMO program had a case mix that was 16 percent less costly than individuals enrolled in the MAC program.

telephone surveys) to evaluate their programs. The difficulties of making comparisons between disparate data sets is discussed in more detail in Appendix 2.

ORGANIZATION OF THE EVALUATION

The HealthChoice evaluation is organized in seven chapters:

Chapter I: Introduction

Chapter I discusses the evaluation's purpose and design, identifies challenges, and explains the organization of the document.

Chapter II: Background and Demographic Changes

Chapter II discusses the history of the HealthChoice program, including major legislative changes. It also reviews plan transitions and consolidations that have occurred in HealthChoice and place them in the context of large Medicaid and health care industry trends. Finally, Chapter II reviews changes in the HealthChoice-eligible population from 1997 to the present. A particular focus of the discussion is the increasing role of public-funded health insurance in providing health care access to children.

Chapter III: Medical Home and Comprehensive Care

Chapter III combines two of the original program goals, medical home and comprehensive care, into one discussion to allow for a more consistent presentation. The chapter presents extensive quantitative and qualitative analysis to assess the HealthChoice program's success in providing enrollees with a medical home and assuring comprehensive care. The chapter addresses a range of topics, including:

- *Changes in enrollee eligibility.* How do enrollee eligibility patterns compare before and after the implementation of HealthChoice?

- *Service utilization trends.* How has the utilization of specific services, such as ambulatory visits, well child visits and emergency room visits changed since the start of HealthChoice?

- *Service utilization for subpopulations*. What is the service utilization for sub-groups of HealthChoice, such as special needs children, individual with chronic conditions and different racial and ethnic groups?

- *Specific service analysis.* What has been the utilization experience for specific, important services, such as dental service, mammography, and substance abuse treatment?

- *Public perceptions.* Based on qualitative sources, how is the HealthChoice program viewed by those who it serves and those who provide services?

Chapter IV: Build on the Strengths of Maryland's Existing Healthcare System

Chapter IV will assess the degree to which the HealthChoice program has been able to perform its mission while complementing key and longstanding aspects of the health care delivery system. Specific analyses will look at provider networks and the stresses upon them; changes in hospital service patterns; and, the role of safety net provider such as federally qualified health centers (FQHCs) and local health departments.

Chapter V: Provide Value and Predictability

Chapter V examines and discusses the financing of the HealthChoice program. Topics addressed include the program's success in meeting federal requirements, the adequacy of program funding during the first four years, the effect of risk-adjustment on capitation rates and plan performance, and the administrative costs of operating HealthChoice.

Chapter VI: Hold Managed Care Organizations Accountable

This chapter reviews some of the key activities and systems that have been used to hold MCOs accountable for their performance. Specifically, the EQRO process, efforts to improve encounter data, and prompt pay requirement are reviewed.

Chapter VII: Summary and Recommendations

Based on the evaluation's findings, Chapter VII makes recommendations for the HealthChoice program moving forward.

II. HEALTHCHOICE BACKGROUND, PROGRAM DESCRIPTION, AND DEMOGRAPHIC CHANGES

BACKGROUND

Overview

Congress enacted legislation in 1965 creating the Medicaid program, designed as a partnership between federal and state governments to serve the mutual goal of providing needed health care services to low income Americans. Soon thereafter, Maryland implemented its State Medical Assistance Program. Initially, Maryland Medicaid delivered care entirely through traditional fee-for-service arrangements. In 1975, the State contracted with six State-certified health maintenance organizations (HMOs) to voluntarily enroll individuals in Medicaid. By the end of 1991, managed care assumed a greater role in the delivery of Medicaid services in Maryland with the advent of the Maryland Access to Care (MAC) primary care case management program. In 1997, prior to HealthChoice, about 20 percent of Maryland's Medicaid population was enrolled (on a voluntary basis) in HMOs, and about 50 percent were enrolled in the MAC program. The HealthChoice program's implementation completed the Maryland Medical Assistance program's evolution to mandatory enrollment in a comprehensive-risk managed care system. By CY 2001, three-fourths of Maryland's Medicaid enrollees were enrolled in an MCO.

Maryland Medical Assistance Programs Before HealthChoice

HMO-MA Program. Beginning in 1975, Medical Assistance instituted a program that allowed eligible individuals to voluntarily enroll in health maintenance organizations (HMOs) under contract to Medical Assistance (HMO-MA). An individual who opted not to enroll in an HMO would continue to receive services through the State's Medical Assistance fee-for-service program. The voluntary HMO-MA program was intended to promote preventive care and the efficient use of health resources. Under the voluntary program, there was no risk-adjustment to capitation rates. Just prior to HealthChoice implementation (June 30, 1997), around 100,000 individuals were enrolled in Medicaid HMOs.

MAC Program. Maryland implemented the Maryland Access to Care (MAC) program in 1991. Under the authority of a §1915(b) waiver, the MAC program offered primary care case management services to individuals who received cash assistance under either the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs, as well as children eligible under the Seventh Omnibus Budget Reconciliation Act (SOBRA). Children in foster care, dual (Medicare and Medicaid) eligibles, persons in

nursing homes, pregnant women in the Pregnant Women and Children (PWC) program, refugees, and those enrolled in an HMO or other special managed care program were not eligible to enroll in the MAC program.

The MAC program's emphasis was on enhancing recipients' access to primary care services; its aims were to promote quality care, continuous care, and to provide enrollees with a "medical home." The program linked each enrollee to a primary medical provider (PMP) whose responsibility was to ensure the enrollee's access to needed services while controlling unnecessary utilization. The PMP role could be filled by either a primary care physician, a hospital outpatient department, a clinic, a Maryland qualified health center (MQHC), or a federally qualified health center (FQHC). As of June 30, 1997, there were over 233,000 individuals enrolled in the MAC program.

HealthChoice Legislative History & Early Program Development

Mandatory Managed Care Study & Guiding Principles. In 1995, the Maryland General Assembly passed SB 694, requiring the Department of Health and Mental Hygiene to study the possibility of applying for a §1115 waiver to allow the State to deliver Medicaid services through a mandatory managed care framework. In the summer of 1995, the Department began an extensive, open, and inclusive process of public discussion and input. A key accomplishment resulting from this process was identifying (with the help of a 131-member advisory committee) five guiding principles that define the mission of the HealthChoice program. The principles are:

- To provide a patient-focused system with a medical home for all enrollees;
- To provide comprehensive, prevention-oriented systems of care;
- To build upon the strengths of the Maryland health care system;
- To achieve better value and predictability for State expenditures; and
- To hold MCOs accountable for high quality of care.

Enabling Legislation & Waiver Proposal

By enacting SB 750 in 1996, the General Assembly formally authorized the Maryland Medical Assistance program to seek federal approval of its plans to implement a statewide, comprehensive risk, mandatory enrollment Medicaid managed care program in Maryland. Federal approval for the program was received in late 1996, and the program was implemented effective July 1, 1997. Since then, the HealthChoice program has been a subject of ongoing legislative oversight. A number of legislative initiatives directly affecting the program have

been enacted, but none of these alters the core, essential elements of the program.[1] The program continues to operate with its key, fundamental design features still in place. These core program features include:

Inclusive Eligibility. HealthChoice eligibility rules are designed incorporate most Medicaid eligibility categories. The following groups of Medicaid-eligible individuals are eligible for HealthChoice enrollment:

- Low-income families with children;
- Supplemental Security Income (SSI) beneficiaries;
- Pregnant and post partum women and their children up to age five whose eligibility is based on the Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA), Title XXI of the Social Security Act, or federal waiver; and
- Children under age 19 eligible for the Maryland Children's Health Program (MCHP).

Statewide Mandatory Enrollment. Individuals who are eligible for HealthChoice enrollment must enroll in an MCO to access HealthChoice-covered Medicaid services.

Risk-based Purchasing. The HealthChoice program purchases health care services for enrollees on a capitated basis by contracting with MCOs for a comprehensive benefit package.[2]

Capitation rate-setting incorporating risk adjustment. Maryland's HealthChoice program is a leader in developing risk adjustment methods that result in a higher level of compensation to MCOs with a relatively sicker, more costly enrolled population.

Services Carve-outs. Several major categories of services have been carved out of the HealthChoice benefit package for which MCOs are responsible. Specialty mental health services and Rare and Expensive Case Management (REM) services have been carved out since the program's inception, as has the long-term nursing facility benefit, health-related special education services under an IEP or IFSP, and substance abuse treatment services in an Intermediate Care Facility –Addictions (ICF-A) for children younger than age 21. Occupational/physical therapy and speech therapy/audiology services for

[1] A discussion of significant legislative and regulatory initiatives (1998-2001) affecting the HealthChoice program is found in Appendix 1-A.

[2] The only exception is a relatively small number of Baltimore City enrollees currently being served through a third party administrator arrangement. This will be explained in detail below, in the "Plan Attrition" section of this chapter.

children were not carved out when the program began, the Department carved out these “therapy services” from the HealthChoice benefit package in 1999.[3]

[3]Services carve-outs are discussed in more detail in the “MCO Responsibilities and Reimbursement” section of this chapter, below.

PROGRAM DESCRIPTION

Enrollment Process

Enrollment Broker. During the program's first year of operation, the Department contracted with Foundation Health to serve as the program's enrollment broker and assist eligible individuals in choosing an MCO. The Department now contracts with Benova Inc. to perform this function. Eligible individuals receive materials regarding each MCO in their county of residence, including: the names and addresses of participating providers; a schedule of covered benefits, including any benefits offered beyond the required package; any forms necessary to select an MCO; a health risk assessment form; and the toll-free number of the enrollment unit. An enrollee may select an MCO and choose a PCP at the same time. These selections are passed from the Department's enrollment broker to the participating MCO. In most cases, the MCO is able to honor the enrollee's PCP preference. In some cases, however, the provider's panel may be full and the enrollee will need to choose another PCP.

Voluntary and Default MCO Assignment. An individual has 21 days to select an MCO, with the exception for children in foster care, who have 60 days. If an individual does not make a selection within the applicable time period, the enrollment broker selects an MCO for the individual pursuant to the program's autoassignment algorithm. In general, newly eligible enrollees receive a fee-for-service Medicaid card to use until the effective date of their MCO enrollment (the 10th calendar day after the date the Department links the enrollee to an MCO, except for newborns born to MCO-enrolled mothers' – each such newborn is assigned to the mother's MCO, effective on the date of birth.) The MCO must notify a new enrollee of the assignment within 10 days of the Department's notice to the MCO of the enrollment.

Health Risk Assessment. The Department (through its enrollment broker) administers a health risk assessment at the time of enrollment or within five days thereafter. The assessment tool includes only a few questions designed for the primary purpose of determining whether the enrollee has any special or immediate health care needs. The information collected is transmitted to the recipient's MCO within five business days. The Department monitors the risk assessment process to assure that MCOs have appropriate processes and procedures in place to respond to new enrollees' immediate health care needs, and that these needs are addressed in a timely manner.

Plan Participation

Any managed care entity that can adequately demonstrate its qualifications to participate in the program and agrees to accept the Department's capitation payments as the sole reimbursement for care delivered to its enrollees may participate.

MCO Qualifications

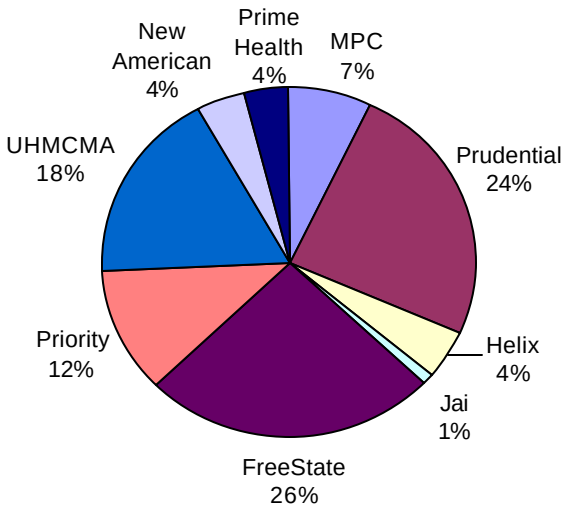
Before awarding a contract to participate in the HealthChoice program, the Department requires each MCO applicant to establish that it is qualified and capable of delivering the full HealthChoice MCO benefit package to its enrollees consistent with program standards. The Department verifies each successful applicant's qualifications through a rigorous review process and requires applicants to correct any identified deficiencies. An applicant must demonstrate the ability to meet program standards relating to corporate organization, organization, and financing, financial solvency, access to care, provider network capacity, services delivery, quality of care, quality assurance program, information systems, data submission, and special accommodations for enrollees who are members of special needs populations.

MCO Contracting

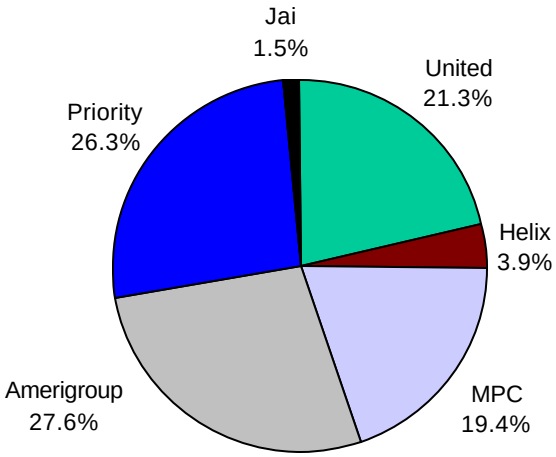
Consistent with its enabling statute and program regulations, the HealthChoice program contracts with "all willing and qualified" MCOs in a non-competitive selection process. An applicant still must demonstrate that it meets solvency, access, quality, and data requirements, and has sufficient provider capacity to meet the health care needs of its enrollees. To qualify as a HealthChoice MCO, an entity may be, but is not required to be, a State-certified HMO. Non-HMO MCOs may serve only Medicaid enrollees. At the program's inception, it was hoped that permitting both HMOs and non-HMO MCOs to participate in the program would preserve pre-existing patterns of care and encourage program participation by historic Medicaid providers. By early 1998, a total of 9 MCOs (including 4 HMOs) had successfully completed the qualifications review process and contracted with the program.

Currently six MCOs participate in the HealthChoice program. As of January 2002, three will be statewide – i.e., they will operate in every Maryland county. Five of the six currently participating MCOs – Americaid, Helix Family Choice, Jai Medical Systems, Maryland Physicians Care, and Priority Partners – serve Medicaid enrollees only. UnitedHealthCare serves both Medicaid enrollees and commercial members. All HealthChoice MCOs are for-profit organizations.

Figure II-1: Health Plan Changes, Enrollment by MCO



Total Enrollment: 312,009
July 30, 1998



Total Enrollment:421,266
October 5, 2001

MCO RESPONSIBILITIES & REIMBURSEMENT

MCO-Covered Benefits

HealthChoice Benefit Package. An MCO is responsible for providing the full range of health care services covered by the HealthChoice MCO benefit package as specified in program regulations. The HealthChoice MCO benefit package is equivalent to benefits covered by Medicaid fee-for-service program as of January 1, 1997, except for certain Medicaid-covered benefits that are "carved-out" and made available to enrollees outside the program's MCOs. Examples include: nursing home services after the first continuous 30 days, community-based long-term care services, health-related special education services, and specialty mental health services.

Self-referred Services. HealthChoice enrollees may access certain MCO-covered services without regard to the provider's network status. An MCO is required to reimburse out-of-network providers that provide specified "self-referred" services to the MCO's enrollees. Services that may be accessed by self-referral include:

- Specified acute and urgent health care services delivered by school-based health centers;
- Specified family-planning services;
- Pregnancy-related services for a pregnant enrollee whose initial enrollment occurs after she has received, from an out-of-plan provider, prenatal care during her current pregnancy that includes a full prenatal examination, a risk assessment, and appropriate laboratory services;
- Initial medical exam for children in State custody;
- One annual diagnostic and evaluation service (DES) visit for any enrollee diagnosed with HIV/AIDS;
- Renal dialysis;
- Under certain specified circumstances, initial medical examination of a newborn; and
- Most specified substance abuse treatment services effective January 2001.

Additional Services. "Additional services" are not part of the HealthChoice benefits package, and MCOs are not required to provide them. But all MCOs offer at least one additional service (adult dental) that is not a required benefit, and therefore is not included in the capitation rate.

Carve-Out Services

As mentioned above, some services traditionally covered under the Medical Assistance fee-for-service program are not included among the benefits for which MCOs are responsible. Payments for carved-out services are not included in

MCO capitation rates. The most significant Medicaid-covered services provided to HealthChoice enrollees as carve-outs are discussed below.

Specialty Mental Health Services (SMHS). The State provides and funds medically necessary and appropriate mental health services (other than "primary mental health services," which are an MCO responsibility) separately through the Public Mental Health System. (PMHS). PMHS is administered by the Mental Hygiene Administration (MHA) in conjunction with local Core Service Agencies and Maryland Health Partners. Maryland Health Partners enrolls patients, coordinates benefits, pre-authorizes services, and performs other administrative duties. This arrangement assures access to mental health services for low-income persons with serious mental illness. HealthChoice enrollees can be referred by their provider for entry into the PMHS, or they can self-refer. Public mental health clinics and other SMHS providers are paid on a fee-for-service basis.

Rare and Expensive Case Management (REM). The Department also administers a carve-out program that addresses the special requirements of HealthChoice-eligible individuals diagnosed with one or more of about 150 rare and expensive conditions. The Department identifies these qualifying conditions by diagnosis, based on criteria such as the condition's frequency of occurrence, the cost of treating the condition, and the degree to which an individual that has the condition would likely benefit from REM enrollment. They are eligible to receive all services covered by the Medical Assistance fee-for-service program's benefit package, as medically necessary and appropriate. REM enrollees additionally are eligible for expanded benefits that are specified in program regulations. REM enrollees are not enrolled in an MCO. The Medical Assistance program reimburses all services provided to REM enrollees on a fee-for-service basis.

Once determined eligible and enrolled, each new REM enrollee is assigned a case manager. The case manager assesses an enrollee's needs; links the enrollee to appropriate providers; participates in the multidisciplinary team; has primary responsibly for developing the enrollee's plan of care, and updating it to reflect changes in the enrollee's needs; facilitates the enrollee's access to clinical care services; assists in service coordination and family supports; and, when appropriate, recommends an enrollee's disenrollment from the REM program.

Other Carve-outs.

- *Long-term care - institutional services*. Nursing facility services are an MCO responsibility until an enrollee admitted to the facility has remained in care for 30 continuous days. At this point, the responsible MCO may seek the enrollee's disenrollment pursuant to procedures specified in the program's regulations. The Medical Assistance fee-for-service program

covers the individual's continuing nursing facility care following disenrollment.

- *Home and community-based services*. Long-term home and community-based services are not included in the HealthChoice benefit package. Medical Assistance operates waiver programs that provide cost-effective home and community-based services as an alternative to institutional care for individuals who:

  - Are certified to require the applicable level of institutional care;
  - Choose to enroll in the waiver program as an alternative to institutionalization; and
  - Are financially eligible.

  Children enrolled in the State's Home Care for Disabled Children under a Model Waiver program are not eligible for HealthChoice enrollment.

- *Health-related special education services.* Health-related special education services delivered through the schools or Children's Medical Services (CMS) community-based providers pursuant to a child's Individualized Family Services Plan (IFSP) or Individualized Education Plan (IEP) are not the responsibility of the child's MCO. Receipt of these services does not affect an enrollee's eligibility for HealthChoice. A HealthChoice-enrolled child receiving carved-out special education services continues to access other needed health care services through the MCO.

Therapies When the HealthChoice program was implemented, physical therapy, speech therapy, occupational therapy, or audiology services for enrollees less than 21 years old were an MCO responsibility (unless they were provided by schools as special education services) and MCOs could require enrollees to access them through in-plan providers. HealthChoice regulations regarding these services have subsequently been changed twice. First, in 1998 to allow special needs children the flexibility of being able to access "medical services such as physical therapy, occupational therapy, or speech therapy" by self-referral under certain circumstances. MCOs would then have to reimburse the self-referred providers of these services at applicable Medicaid fee-for-service rates. Effective November 1999, the regulations were changed a second time to create a carve-out for physical therapy, speech therapy, occupational therapy, and audiology services. Except when delivered as part of an inpatient hospital stay or as part of a home health service, medically necessary physical therapy, speech therapy, occupational therapy, and audiology services may be accessed by enrollees under 21 years old through any willing Medicaid provider, who is paid by the Department on a fee-for-service basis.

MCO Reimbursement

Capitation Rate-Setting. The State pays HealthChoice MCOs for enrollees' care at a fixed capitation rate, set by the State annually by enrollment, geodemographic, and diagnostic categories. The rate-setting process is comprehensive and complex, requiring the analysis of data from numerous State and national sources (e.g., Medicaid claims data, commercial health insurance cost and utilization data, Health Services Cost Review Commission (HSCRC) data) and trend projections from the major national sources.

As required by the federal government, rate setting for the HealthChoice program builds on historic Medicaid fee-for-service costs associated with providing HealthChoice MCO-covered benefits to those historic Medicaid-eligible individuals who would have been eligible for HealthChoice enrollment under present-day eligibility rules. These costs are trended forward to account for inflation, and discounted to reflect expected savings due to managed care. When the program began, the Department used a managed care discount rate of 10 percent. For the CY 2001 and 2002 capitation rates, the managed care discount used is about 2 percent.

Risk-Adjustment. MCOs are paid capitation rates on a monthly, prospective basis to provide all medically necessary and appropriate covered services to their enrollees in accordance with program standards. HealthChoice capitation rates are "risk adjusted," so that monthly payments to an MCO for providing all needed covered services to a particular enrollee are higher or lower based on the individual's documented health status. Specifically, the Department uses encounter data to assign each enrollee, if they have at least six months of continuous Medicaid enrollment in the base year, to an Adjusted Clinical Group (ACG). ACGs are a type of health status measurement based on diagnosis. The use of encounter data for risk adjustment creates strong financial incentives for MCOs to submit complete encounter data. (See chapter V of this evaluation for a review of the program's rate setting and risk adjustment processes.)

Access and Quality

MCOs are required to follow stringent access and quality standards to assure enrollees' adequate access to the full range of services for which an MCO is responsible. An MCO is required to demonstrate the adequacy of its Quality Improvement Program, and maintain a Quality Assurance Plan (QAP) that meets the requirements of "A Health Care Quality Improvement System: A Guide for the States" (HCQIS).

An MCO's QAP must include a substantial amount of material specified by the program, including referral protocols for special needs populations; provider credentialing and re-credentialing procedures, and a committee structure that allows for effective communication between staff and the governing body, as well

as timely and appropriate review and action as to quality-related reports, activities, and issues, including enrollee and provider complaints and grievances. The QAP must also provide for conducting annual patient and provider satisfaction surveys; annual medical record audits; focused studies of special populations; a consumer advisory board; and an internal dispute resolution process for addressing enrollees' complaints and grievances.

Administration

Since the program's initial implementation, the Department's administrative structures and functions have been modified significantly to accommodate a growing number of HealthChoice enrollees and to address the change from administering a predominantly fee-for-service program to overseeing a managed care program for the population covered under HealthChoice. The Department's current administrative structure has been in place since 1999. Over time, the Department has increased its emphasis on consolidating functions to meet the needs of families, MCOs, and providers. The Department also meets regularly with key stakeholders, including MCOs, providers, and health care advocates. These advisory meetings help the Department gather information to make improvements in the program's administration and delivery of services.

PLAN TRANSITIONS

Soon after HealthChoice's mid-1997 implementation, nine plans (including three commercial HMOs) were participating in the program. Since then, through a combination of mergers, purchases and plan departures the number of plans participating in the program has declined to six (including one commercial HMO). The specific circumstances leading to this erosion of participation are highly relevant to any evaluation of the program's overall vitality. By considering the exit decisions made by four HealthChoice plans between 1998 and 2001, it becomes apparent that the circumstances prompting them vary greatly.

Plan Transitions - Chronology

New American Health MCO. New American was a Medicaid-only MCO that served 12,300 enrollees in Baltimore City and 13 Maryland counties.

- *New American financial issues*. Although not a Maryland-certified HMO, New American had accepted substantial financial risk in the commercial market. New American's Medicaid operations were less financially significant than their commercial risk-based activities as a subcontractor for United Health Care and FreeState Health Plan. Losses on the commercial side of New American's business undermined the plan's financial viability. As a result, New American withdrew from the HealthChoice program effective October 31, 1998.

- *Transition of New American enrollees.* New American's 12,300 enrollees had the opportunity to choose to enroll in one of at least three MCOs still operating in New American's former service area. Enrollees who did not complete and return the enrollment materials distributed by the State (or contact the enrollment broker by another means) were randomly auto-assigned to another MCO serving their geographic area of residence, having the effect of potentially separating some enrollees from their former PCP. In the latter situation, enrollees were permitted to change their MCO 90 days following the date they were autoassigned.

Prudential Health Plan. Prudential Health Plan, a Maryland-certified HMO operating commercial and Medicare risk product lines as well as a Medicaid product, served approximately 80,000 Medicaid enrollees. Prudential was purchased by Aetna in 1999. Because Aetna did not want to participate in Maryland's Medicaid managed care market, it made a business decision to sell Prudential's Medicaid business.

- *Prudential sale.* The purchase of Prudential's Medicaid provider contracts allowed a new HealthChoice MCO operated by Amerigroup Corporation to expand its existing multi-state Medicaid managed care operations into Maryland. After successfully completing the State's MCO qualifications

review process, Amerigroup was awarded a HealthChoice MCO contract, and began operating Americaid Community Care MCO on June 1, 1999.

- *Prudential/Americaid transition.* The State notified Prudential enrollees of the need to change plans, and advised them how to do so. As stated in the notice, if they did not choose another MCO, they would be assigned to Americaid. Those in Prudential who enrolled in Americaid (either voluntarily or through auto-assignment) were able to continue, in most cases, with the same PCP they used while enrolled in Prudential.

FreeState Health Plan (HMO). FreeState, a Maryland-certified HMO, operated statewide to serve about 98,000 HealthChoice enrollees until it withdrew from the program in 2001. The reasons for this were financial and may also have been part of the FreeState strategy to prepare for movement from non-profit to for-profit status. It occurred shortly after they decided to leave the Medicare+Choice program. FreeState's exit occurred in two stages.

- *FreeState - stage one withdrawal.* First, FreeState pulled out of 22 counties of the State, although it continued to serve 38,000 enrollees through its subcontractor, CarePartners, in Baltimore City and County.

- *FreeState - stage one transition*. FreeState's aggregate Medicaid enrollment in the 22 counties was about 60,000. All of these enrollees were sent notices that they would have to change MCOs. The notice provided directions for selecting a new plan. FreeState enrollees who did not respond to the notice were randomly auto-assigned to HealthChoice plans operating in their area. Those who were auto-assigned were given the opportunity to choose a different MCO. FreeState's Medicaid pullout from the 22 counties became effective January 1, 2001. FreeState enrollees who were auto-assigned were given the opportunity to choose a different MCO.

- *FreeState - stage two withdrawal.* Following its withdrawal from the 22 counties, FreeState initially continued to serve enrollees in Baltimore City and Baltimore County through its subcontractor, CarePartners. The contractual arrangement between these parties shifted 100 percent of FreeState's HealthChoice-related financial risk to CarePartners. The subcontractor was responsible for the actual delivery of care to FreeState's approximately 38,000 remaining HealthChoice enrollees. After a relatively brief interval, however, CarePartners concluded that the arrangement was no longer financially viable, and notified FreeState of its decision to discontinue performance under the subcontract. FreeState notified the State of its intention to cease all Medicaid operations in Baltimore City and Baltimore County, completing its withdrawal from the program effective April 1, 2001.

- *FreeState - stage two transition to MPC.* None of the MCOs still operating in Baltimore City and Baltimore County were willing to accept the FreeState enrollees on a risk basis. Several MCOs indicated they would freeze their enrollment in these areas as a means of avoiding taking on enrollees previously assigned to FreeState. These factors seriously complicated the transition of FreeState's Baltimore City and Baltimore County enrollees into new plans. Therefore, the State contracted with Maryland Physicians Care MCO (MPC) to serve these enrollees on a substantially non-risk basis. Under this agreement, the State was at risk for services and certain other requirements at the current Medicaid fee-for-service fee schedule. All of FreeState's Baltimore City and Baltimore County enrollees were reassigned to MPC, where they would be treated the same as enrollees for which MPC was at risk. All enrollees were able to stay with their PCPs. Under the terms of the contract, MPC is reimbursed for the costs of services plus an administration and case management fee.

PrimeHealth HMO. PrimeHealth began operations as a Maryland-certified HMO in November 1996, then became a HealthChoice MCO in July 1997. As of 2000, the plan served about 17,000 HealthChoice enrollees.

- *PrimeHealth insolvency.* In March 1998, the Maryland Insurance Administration (MIA) determined that PrimeHealth was insolvent. MIA took over the plan's operation through a receiver in October 1998. Effective May 1, 2001, MIA selected Amerigroup Corporation to purchase PrimeHealth's Medicaid product.

- *PrimeHealth/Americaid transition*. PrimeHealth's 17,000 HealthChoice enrollees were transferred to Amerigroup unless they exercised the opportunity offered by the State to opt out in favor of another MCO. The agreement between Amerigroup and the State receiver included assignment of PrimeHealth's Maryland-based primary care physician and specialist contracts to Amerigroup and required Amerigroup to assign any enrollee it received from PrimeHealth back to his or her historic PCP.

Plan Attrition-Discussion

As detailed above, a number of changes in the plans participating in HealthChoice have occurred since the program's 1997 implementation. In general, these turnovers meant that a total of over 200,000 had to change plans. In this context, some degree of confusion and inconvenience was unavoidable. Nevertheless, the Department worked diligently, and with considerable success, to bring about enrollees' transitions with only a minimum of the disruption inherent in such transitions.

Preserving Provider Networks. The program's job was made easier because the enrollment of two of the MCOs was absorbed by other MCOs pursuant to sale transactions designed to keep provider networks intact. In addition, another MCO agreed to accept FreeState enrollees in Baltimore City and Baltimore County on a non-risk basis where the networks remained intact.

Successful Transitions and Adjustments. All in all, the enrollment transitions necessitated by plan turnover were administered efficiently. All enrollees maintained continuous enrollment in a HealthChoice MCO, and efforts were made to allow families to stay with the same PCP. Thousands of enrollees made the transition from their old MCO to a new one, under diverse circumstances. In each case, however, the affected enrollees:

- Received appropriate information about selecting a new MCO, including directions on how to enroll in a new MCO;
- Were afforded a meaningful opportunity to choose their new MCO and PCP; and
- When possible, were linked by their new MCO with the PCP to whom they were assigned while enrolled in their former MCO.

Transition Costs - Maryland. Until now, because its MCO contract does not address the financial responsibility for transition costs, the Department has borne all transition costs. For transitions where there are either less than 20,000 affected enrollees or a single MCO assuming another MCO's entire membership, costs have been minimal. Four of the five transitions have fit one of these scenarios. However, the fifth transition – FreeState Transition One – did not and the resulting costs to the Department were substantial.

Transition Costs – Other States. The Department has subsequently sought the experience of other states for assistance in this area. Department staff has identified only one comprehensive study on the principles governing the relationship between MCOs and states under Medicaid managed care. This publication is by the Center for Health Services Research and Policy at the George Washington University entitled: "Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts." Although this publication concludes that, like Maryland, 37 states have specified language

addressing an MCO's termination in either their Requests for Proposals (RFPs) or contracts, it does not mention whether such language specifically addresses costs associated with termination. In addition, through Internet searches and telephone surveys, staff was able to locate only one state – Arizona – that specifically addressed termination costs in its RFP. In this instance, however, the state only alludes to the fact that an MCO may be liable for such costs; offering the possibility that such liability may be waived if at least 180 days notice of termination is supplied.

HealthChoice Plan Attrition in Context

An analysis of the program's performance regarding plan retention must consider the overall managed care environment (both commercial and Medicaid-specific) in which the program has operated.

The Managed Care Market Environment. In the early 1990s, the high profitability of the American managed care industry fueled aggressive expansion and rapid growth. Maryland implemented its HealthChoice program about the same time this tide ebbed. The managed care market became more competitive. The early savings that resulted from the initial imposition of managed care business techniques were about gone. Smaller, weaker, and less efficient plans were finding it increasingly difficult to sustain profitability, so that closings, consolidations, and general retrenchment became more common. These trends could be observed in commercial and Medicaid markets and across regions.

- *Commercial HMOs.* The total number of HMOs operating in the United States dropped from 643 (January 1, 1999) to 540 (January 1, 2001),[4] representing a 16 percent decline in only two years. The independent insurance rating service, Weiss Ratings, reported in its September 2000 financial report that about half of all American HMOs lost money in 1999, noting a "disturbing disparity" between the profits of a few large HMOs and the financial struggles of the rest of the industry. This negative market trend is also apparent on the regional and State (Maryland) level.

- *Mid-Atlantic States*. Between 1997 and 1999, each of the Mid-Atlantic states had at least one year in which a substantial number of HMOs lost money. In the aggregate, 54 of the region's 93 plans (58 percent) were unprofitable for at least one of those years.

- *New England*. The managed care industry in New England dropped from 54 plans in 1998 to 48 at the end of 1999, a 12 percent decline in one year, the result of consolidations and plans pulling out of the region. In Vermont, for example, 90,000 consumers had to find a new HMO when

[4] *Source: InterStudy Publications 2001 HMO Directory*

Kaiser Permanente announced the termination of its unprofitable operations in the Northeast.

- *Maryland.* Maryland's experience is typical of the national and regional trends discussed above. In 1996, 23 State-certified HMOs were operating in Maryland. By the end of 2000, just 14 HMOs continued to operate in Maryland, and one of these served Medicaid enrollees as well as commercial members. [5]

Medicaid Managed Care Programs. CMS reports that between 1998 and 2000, the number of plans participating in Medicaid managed care programs nationwide dropped from 223 to 172, a 23 percent reduction in plans serving Medicaid enrollees. As discussed above, Maryland's experience (a net loss of 3 out of 9, or 33 percent of its plans), although higher, is actually lower than plan attrition in Maryland's commercial managed care market.

Figure II-2: MCOs Participating in States with Statewide, Full-Risk, Medicaid Managed Care Programs

State	1998	2000	98 vs 2000	98 vs 2000 % Change
AZ	17	17	0	0%
CO	8	6	-2	-25%
CT	7	4	-3	-43%
DE	3	2	-1	-33%
DC	8	7	-1	-13%
FL	16	14	-2	-13%
GA	2	0	-2	-100%
HI	6	6	0	0%
IN	3	2	-1	-33%
KS	3	1	-2	-67%
KY	3	3	0	0%
MA	11	4	-7	-64%
MD	9	8	-1	-11%
MN	8	9	1	13%
MO	11	9	-2	-18%
MT	3	2	-1	-33%
NE	2	2	0	0%
OH	13	10	-3	-23%
OK	4	3	-1	-25%
OR	17	15	-2	-12%
PA	10	7	-3	-30%
RI	4	3	-1	-25%
TN	11	8	-3	-27%
VT	2	0	-2	-100%
WA	14	10	-4	-29%
WI	28	20	-8	-29%
All	223	172	-51	-23%
Avg. loss for states that lost MCOs			-2	-37%
Avg. gain for states that gained MCOs			1	13%

[5] Source: Maryland Insurance Administration report, "Five Year Historical Data of Maryland Licensed HMOs MCOs Year Ending December 31, 2000" and unpublished historical data. Two Maryland-certified HMOs (Elder Health and Aetna US Healthcare-DE) were *not* counted because they had no Maryland income or enrollees in 2000. Two HMOs that *were* included are only marginally active. George Washington University Health Plan froze enrollment in August 2001, and is expected to discontinue operations in early 2002. PrimeHealth Corporation has been in rehabilitation for insolvency since 1999, and has lost its Medicaid enrollment.

Comparing Performance of Medicaid-only and Commercial MCOs in Maryland's HealthChoice Program. By the end of the HealthChoice program's first year, five out of the nine MCOs participating were Medicaid-only MCOs. Of these five Medicaid-only MCOs, at least four were hospital-led provider sponsored plans. Four Medicaid-only MCOs (including three that are provider-sponsored) participate today. In contrast, of the four State-certified HMOs originally participating as HealthChoice MCOs, only one remains in the program. Although the reasons are unclear, the foregoing demonstrates that Medicaid-only MCOs increasingly dominate Maryland's Medicaid managed care market.

Conclusion

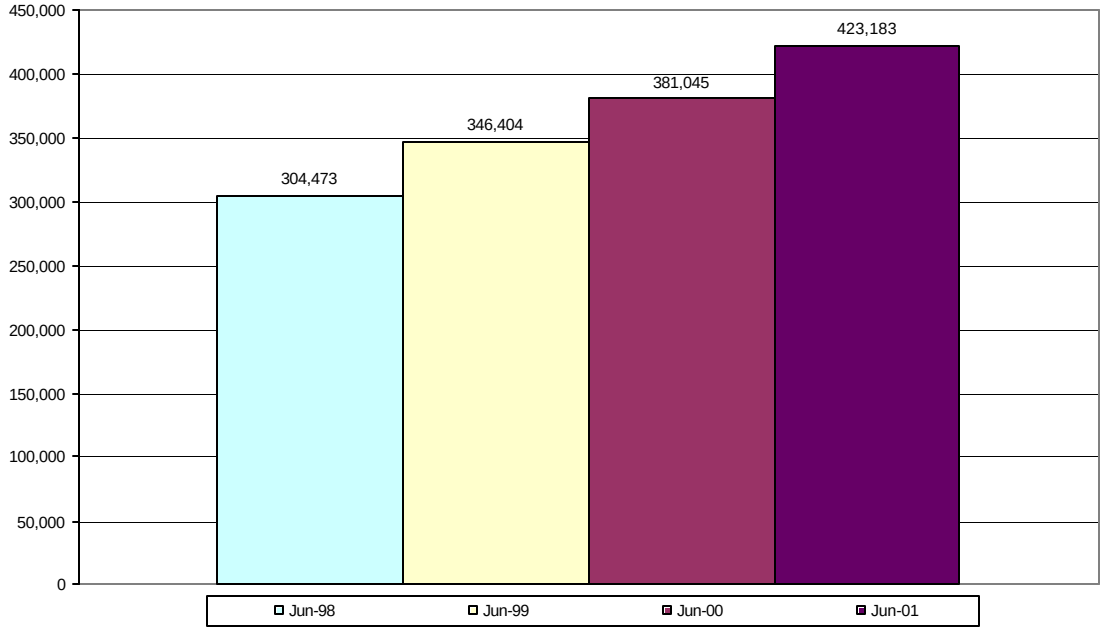
It has always been expected that, consistent with other states' experiences, some HealthChoice MCOs would be more successful than others over time, and that these would be the plans that would continue to participate. In fact, compared to the experience of Medicaid managed care programs in other states, the HealthChoice program has been relatively successful in maintaining a stable number of participating MCOs. As discussed above, many states have seen sharp contractions in the number of plans participating in their Medicaid managed care programs as their programs mature. The loss of plans experienced by the HealthChoice program is consistent with national trends for both Medicaid and commercial markets, as well as with the performance of commercial HMOs operating in Maryland during the same period.

Even so, the large-scale movement of enrollees from plan to plan that is always occasioned by plan turnover creates significant difficulties for the program's enrollees and providers. In one instance, a plan's withdrawal from the program forced the State to negotiate an administrative service organization arrangement with another MCO. In doing so, however, the State was able to avoid having to shift a sizeable number of HealthChoice enrollees into the fee-for-service program.

DEMOGRAPHIC CHANGES

Between June 1998 and June 2001, the number of individuals enrolled in the HealthChoice program increased by roughly 100,000. In addition to this substantial growth, the program has also experienced significant changes in the composition of the covered population. New enrollees coming into the program as a result of eligibility expansions were primarily ages 6-18. There were smaller increases in the number of enrollees ages 1-2 and 3-5, and the number of adults enrolled in the program has decreased. These changes can be attributed to changes in Medicaid eligibility criteria that have altered the composition of the Medicaid population.

Figure II-3: HealthChoice Population Growth[6]



Eligibility Changes

Maryland Children's Health Program (MCHP)**.** Much of the HealthChoice program's growth has occurred in the adolescent age groups. The increase in the size of the HealthChoice population, and the concentration of the increase in adolescent age groups, is attributable to the implementation of MCHP in July of 1998. At that time, children age 18 and under living in families with income up to 200 percent of the Federal Poverty Line became eligible to enroll in HealthChoice. Prior to that time, the income eligibility criteria for children varied

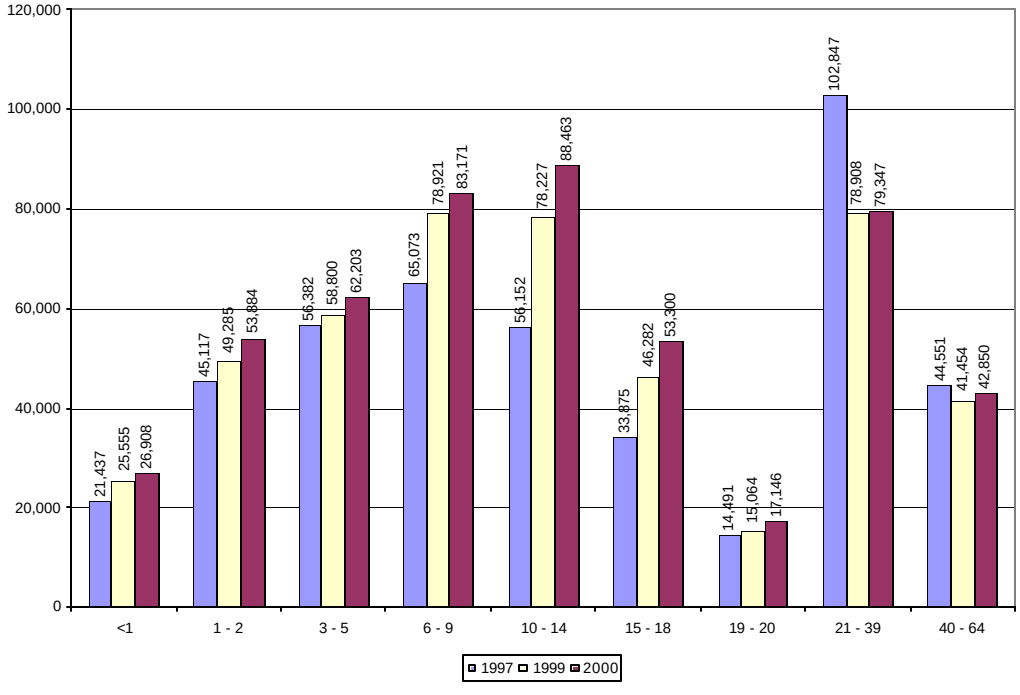
[6] Population totals in Figure II-3 are based on point-in-time enrollment. Population totals in Figure II-4 and II-5 are based on individuals with eligibility during the year. The totals in these charts, therefore, will not balance.

by age, ranging from 40-185 percent of the Federal Poverty Line. (A subsequent expansion of MCHP took effect July 1, 2001, but enrollment data after the expansion is not included in this analysis.) By June 2001, 87,332 individuals were enrolled in HealthChoice in the MCHP eligibility category, constituting roughly 20 percent of total program enrollment.

HealthChoice enrollees in the MCHP eligibility category have certain characteristics that are different from the rest of the HealthChoice population. As noted above, by definition, MCHP enrollees live in families with higher incomes than other program participants. Enrollees ages 6-18 constituted 35 percent of the total program population in 1997 (calculated using the total population in 1997, including voluntary HMO enrollees). In 2000, enrollees in this age range were 44 percent of the total enrolled population. As age and income are correlated with health status and service utilization patterns, these factors must be considered when trying to determine the impact of the implementation of HealthChoice. The population in HealthChoice in 2000 is healthier, so its service utilization would be expected to be less than that of the pre-HealthChoice population.

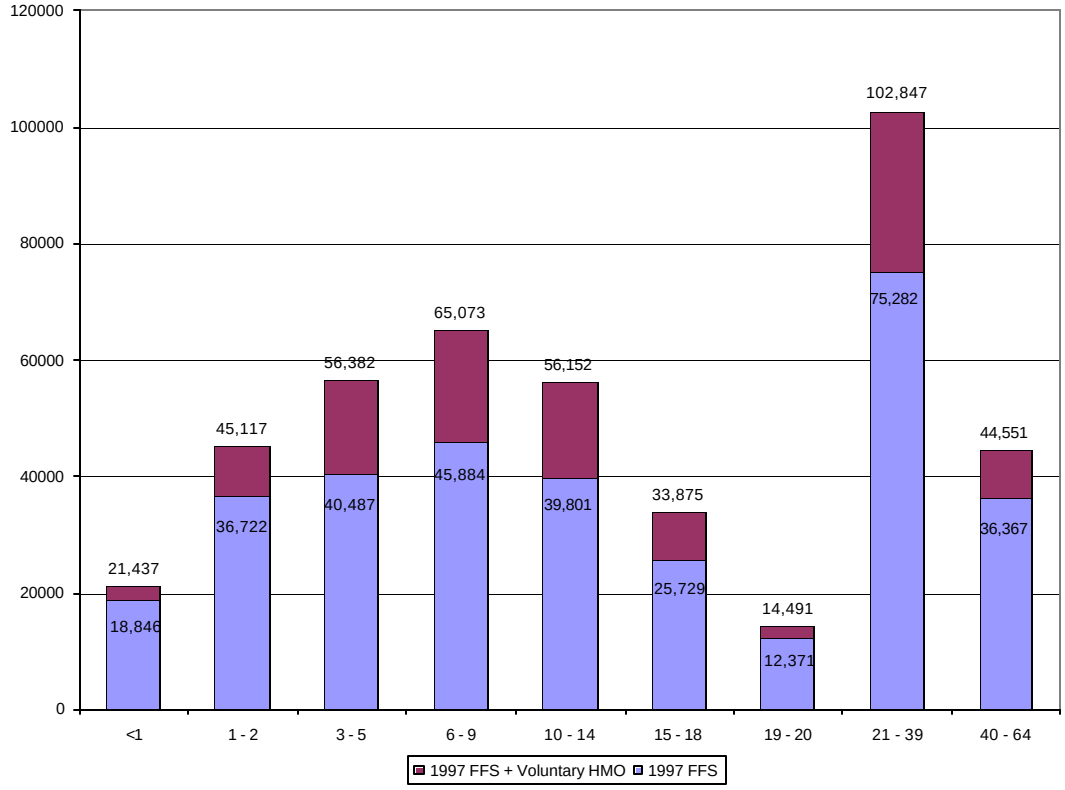
Welfare Reform. The implementation of welfare reform may explain another shift in the composition of the HealthChoice population. Between 1997 and 2000, the total number of enrollees ages 21-39 decreased by 23 percent, or 23,500 individuals. This is the only age group in which a significant decrease in the number of enrollees occurred. This is important to consider when examining the data for this population under HealthChoice.

Figure II-4: Maryland HealthChoice Enrollment By Age



Voluntary HMO Data. Further compounding attempts to compare service utilization before and after HealthChoice implementation is the lack of pre-HealthChoice data for a significant number of enrollees. In June1997, immediately prior to the implementation of HealthChoice, there were roughly 100,000 individuals voluntarily enrolled in Medicaid HMOs in Maryland. Utilization data is not available for these enrollees because the HMOs were not required to submit administrative data to the Department. Consequently, the pre-HealthChoice data available for comparison to HealthChoice does not reflect the service utilization of nearly 30 percent of the HealthChoice-eligible population. The voluntarily enrolled population was healthier; therefore pre-HealthChoice data reflect the service utilization of a sicker population.

Figure II-5: 1997 Medicaid Population By Enrollment - Voluntary HMO vs. HealthChoice Eligible Fee-For-Service

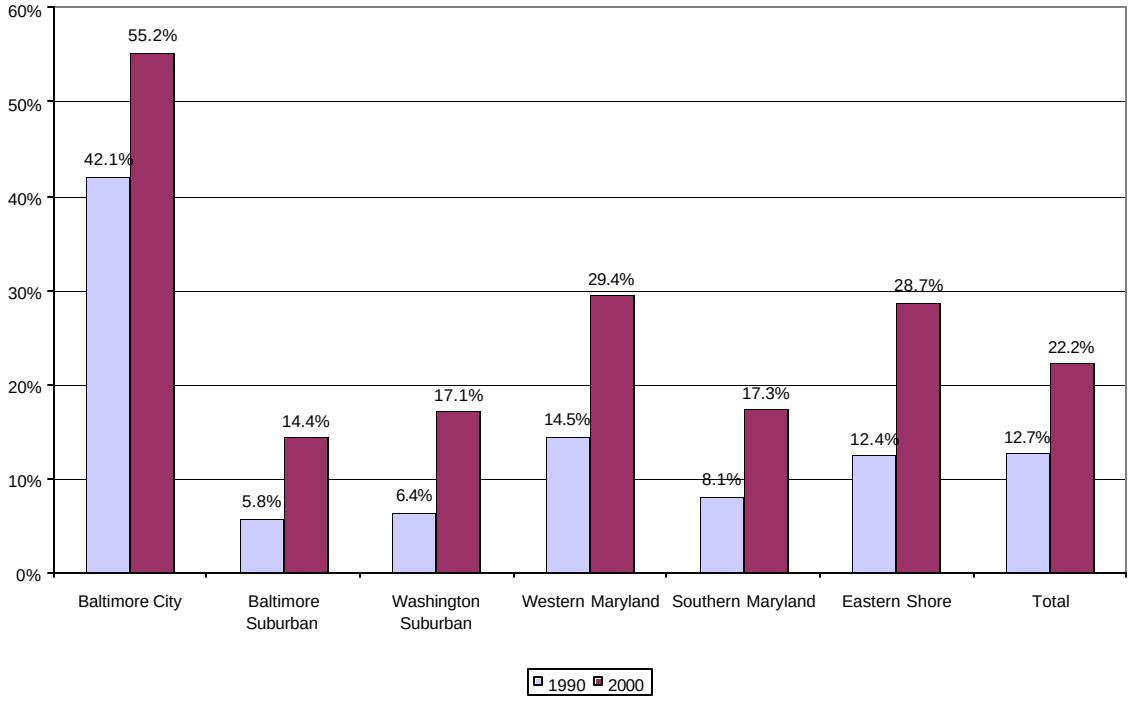


Proportion of Participating State Population Age 20 and Under

A comparison of census data for Maryland from 1990 and 2000 indicates only very small variations in the composition of the population of the State by age, race, and region. The proportion of the total population enrolled in Maryland's Medicaid program, however, changed significantly during this time period. Overall, 9.9 percent of the State's population was enrolled in 2000, compared to 6.5 percent in 1990.

Most notably, the proportion of the State's total population age 20 and under eligible for Medicaid/HealthChoice enrollment (including MCHP enrollees in HealthChoice in 2000) has increased dramatically. In 1990, 12.7 percent of Marylanders age 20 and under were Medicaid recipients. By 2000, this number had increased to 22.2 percent. Some regions of the State experienced an even greater increase. In both the Western Maryland and Eastern Shore regions, the proportion of enrollees age 20 and under more than doubled to nearly 30 percent enrolled in Medicaid/HealthChoice. This dramatic increase in the proportion of Maryland residents with Medicaid coverage means that Medicaid-financed coverage plays a much greater role in the economic life of Maryland providers. This is particularly true for physicians who serve children, such as pediatricians and family practitioners.

Figure II-6: Proportion of the Total State Population Age 20 and Under Enrolled in Medicaid



III. MEDICAL HOME / PREVENTION-ORIENTED CARE

A primary goal of the HealthChoice program is to establish, for each enrollee, a medical home to facilitate the delivery of comprehensive, prevention-oriented care. Since a medical home and prevention-oriented care are multi-faceted concepts, this chapter of the evaluation presents and discusses a wide-ranging set of analyses. Central to these analyses are extensive comparisons of HealthChoice encounter data for CY 2000 with fee for service data from the MAC Program for FY 1997. This chapter also reviews and summarizes the insights gained from the extensive efforts that were made over the summer of 2001 to gather input from consumers, providers and other interested parties about the HealthChoice program.

Since the analyses in this Chapter are wide-ranging, it is useful to gather them around a set of discrete analytical questions. Specifically:

- *Have patterns of enrollee eligibility changed since HealthChoice began?* One aspect of continuity is coverage continuity. This section examines whether enrollee coverage experience has changed.

- *How has access and service utilization changed?* Changes in specific services such as ambulatory visits, well child visits and emergency room visits since the start of HealthChoice are examined.

- *How has service utilization for subpopulations within HealthChoice changed?* The service utilization patterns for vulnerable subsets of the HealthChoice population may differ from the population-wide patterns. These analyses examine the experience of specific subgroups of HealthChoice such as special needs children, individuals with chronic conditions, and different racial and ethnic groups.

- *What has been the utilization experience for specific services?* Specific important services, such as dental services, mammography, and well child services are important components of the HealthChoice program.

- *What are the perceptions of those who are involved in the program?* Based on qualitative data (particularly information gathered during the consumer and provider forums conducted during the summer of 2001), the analysis assesses the perceptions of the program that are held by those it serves and by those who provide services to them.

LENGTH OF ELIGIBILITY AND ENROLLMENT

Overview

A fundamental element of any individual's ability to secure regular and continuous health care services is acquiring and maintaining health insurance coverage. At the program's outset, the Governor, the legislature, and the Department recognized how important enrollees' maintenance of continuous coverage is to ensure that other program goals are met. Consequently, the program's eligibility provisions guarantee a minimum six months of eligibility for enrollees in all eligibility categories other than eligibility based on pregnancy. The tables below demonstrate the progress made under the HealthChoice program towards ensuring that eligible individuals can maintain public health insurance coverage, thereby allowing them to obtain needed health care services.

Figure III-1: Percentage of HealthChoice Individuals With Twelve Months of Enrollment in a Specified Year

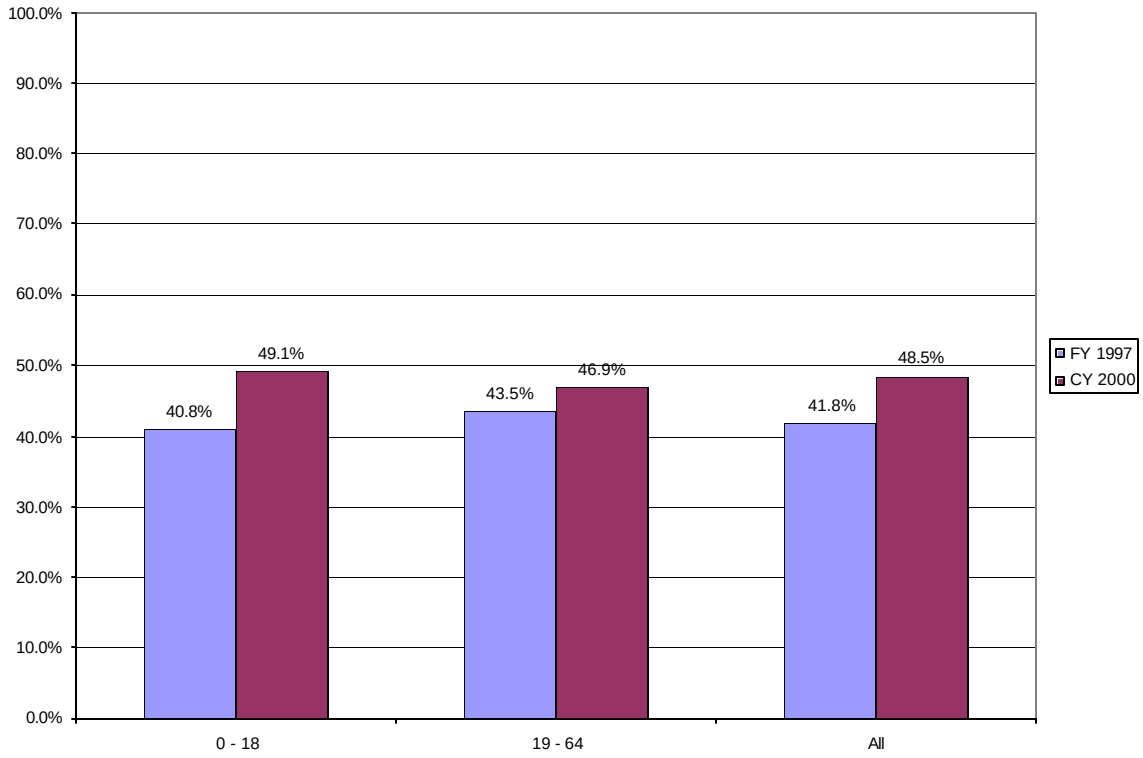
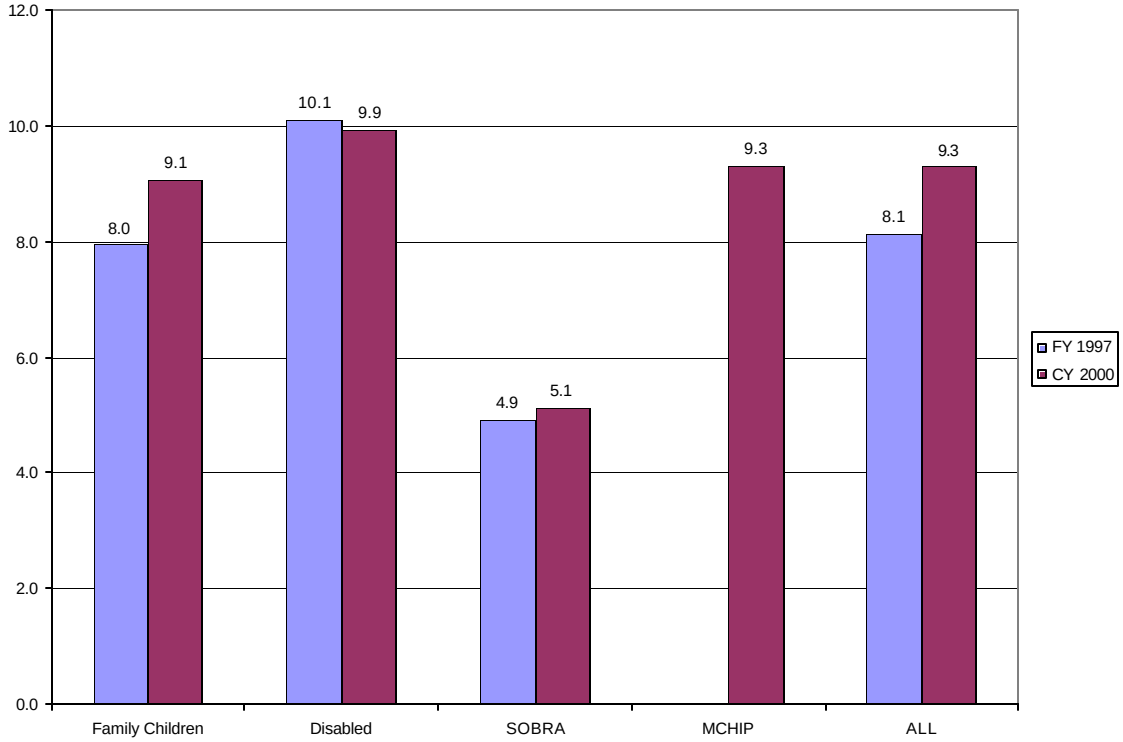


Figure III-2: Average Length of Enrollment in a Specified Year



Findings

The comparisons of the length of time individuals remain eligible are limited solely to the years being studied (FY 1997 and CY 2000). It is important to note that this section does not address the entirety of an enrollee's time in the program. It is focused strictly on the time spent during the specified twelve-month period. As such, an enrollee that entered the program in July 1999 and exited in June 2000 would register only six months of eligibility for CY 2000, reflecting only the months (i.e., January through June) of enrollment that occurred within CY 2000. When interpreting the findings presented in this section, it is important to remember that the percentages reflect the percentage of enrollees eligible for the entire year.

In FY 1997, 41.8 percent of all individuals enrolled at any time during the year were in the program for the entire year. In CY 2000, the proportion of all enrollees who were in the program for the duration of the year increased to 48.5 percent, a 16 percent increase. The increased duration of eligibility has been a trend since the beginning of HealthChoice, showing particularly marked improvement from 1999 to 2000.

The average length of enrollment during CY 2000 was just over 9 months, as compared to slightly over 8 months during FY 1997. For children under age two, the trend is even more positive, as their average length of enrollment for CY

2000 was nearly 1.5 months higher than for FY 1997. As expected, there are variations across coverage categories. During FY 1997, the average length of eligibility for the Family & Children population was 8 months. This increased to slightly more than 9 months during CY 2000. There was slightly less impact on the SOBRA and Disabled coverage groups with length of eligibility changing only marginally. There is no historical point for comparison of the MCHP population, which averaged just over 9 months of eligibility during CY 2000.

Discussion

In this section, duration of eligibility refers only to the average length of enrollment for the study population during the study years. Although these measures do not seek to determine the totality of a given enrollees length of time in the program, they do serve as proxy measures by which to assess whether HealthChoice has afforded longer periods of enrollment to enrollees. The increased average duration of eligibility under HealthChoice is an encouraging finding, as it indicates that the program has been successful at increasing children's access to services. Several factors may account for the increasing period of eligibility, for example:

- *Guaranteed six-month eligibility.* As noted above, a key design feature of the HealthChoice program is the initial six-month guarantee of continuous eligibility.

- *MCO financial incentives.* Managed care organizations may have provided outreach to enrollees close to their redetermination date, encouraging them to submit all required information and evidence of eligibility in a timely manner.

SERVICE UTILIZATION - GENERAL

Service Utilization Analysis

This section and the ones following explore a number of service use comparisons between the HealthChoice program and the pre-HealthChoice fee-for-service program. These include comparisons of pre-HealthChoice and HealthChoice standard measures from various perspectives, as well as analyses of service-specific utilization. Before presenting these results, it is important to review the general approaches that will be used, as well as the challenges inherent in comparing pre-HealthChoice claims data with HealthChoice encounter data.

Challenges in comparing pre-HealthChoice Medicaid data with HealthChoice program data. Comparing the experience of the relevant population before and after HealthChoice implementation is complicated by a number of factors:

- *Demographic changes in the eligible population*. A central issue is how to conduct reasonable comparisons of two populations that are fundamentally different. As discussed earlier, the HealthChoice population has undergone dramatic changes since 1997. The most significant of these is the substantial increase in the adolescent population resulting from MCHP expansion and the concurrent decline in the adult population due to welfare reform. The analyses address the demographic changes by presenting totals that are weighted by age to account for the changed age mix.

- *HMO-MA enrollment*. The pre-HealthChoice voluntary HMO-MA program introduces a further complication. As was noted earlier, before implementation of HealthChoice, Maryland operated a voluntary Medicaid managed care program that served roughly 100,000 enrollees. Enrollment in these Medical Assistance HMOs was disproportionately higher in the Baltimore City and Washington Suburban regions. Enrollment in Medicaid HMOs was also significantly higher among recipients in "Families and Children" eligibility categories rather than those in a "Disabled" category. Consistent with the other states that operated voluntary HMO programs, Maryland collected no usable utilization data (encounters or claims) for individuals enrolled in HMOs. Therefore, no utilization experience for this population is available for analysis. The lack of these data is problematic since analyses have shown that the individuals enrolled in the voluntary HMO program were healthier than the Medicaid population generally.[1] Thus, the pre-HealthChoice comparison population (drawn primarily from the MAC Program) would be expected to have higher utilization of

[1] Analysis by the actuarial firm of Mercer in 2000 found that individuals enrolled in voluntary HMOs had better health status than the population in general.

services because, overall, it was less healthy than the population currently enrolled in HealthChoice.

- *Claims data versus encounter data.* It should also be noted that the comparisons are based on two different types of data, claims data and encounter data. The HealthChoice program's introduction of risk-based managed care eliminated the traditional source of Medicaid health care utilization data, i.e., fee-for-service claims. In order to continue to receive information about the services provided to HealthChoice enrollees, the program requires MCOs to submit encounter data. Encounter data seek to capture every service provided to a HealthChoice enrollee by the enrollee's MCO, or by non-participating providers paid by the MCO, including information on diagnosis and the provider of the service.

- *Encounter data collection.* Encounter data include much of the same information as claims data: both identify the type of service provided and its associated diagnosis. Unlike claims data, however, encounter data are not associated with payments to providers. Consequently, encounter data tend to be less complete than claims data. The Department and the HealthChoice MCOs have made enormous strides in the collection of encounter data (particularly encounter data relating to physician services). In fact, Maryland is viewed as a national leader in this area.[2] This progress would not have occurred without the sustained effort expended by the MCOs and the Department. The data have improved significantly over time, such that the professional claims encounter data for CY 2000 are estimated to be between 90 and 95 percent complete. (Encounter data for earlier years of the program are less complete.) Inpatient data remain a significant problem, and therefore are not used in any of this report's analyses. For the purposes of presenting analyses, this report will make comparisons only between FY 1997 fee-for-service data and CY 2000 encounter data. In addition, the data are presented "as is." No adjustment is made to utilization measures to adjust for suspected under-reporting of encounter data. Therefore, the post-HealthChoice should be slightly higher.

Populations Studied. The population studied for CY 2000 consisted of all HealthChoice enrollees with any period of enrollment during the year[3]. The FY 1997 population was comprised of all Medicaid enrollees that would have been HealthChoice-eligible had the program existed at that time.[4] Data analyses included in the evaluation were based on the experience of the entire population studied – no population sampling was used. Because the data on which the findings are based include the experience of total populations rather than just samples, there can be no issue as to their statistical significance or levels of confidence in their accuracy. Except as expressly noted, the data presented in

[2] Maryland is the lead State for CMS's risk adjustment forums

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this evaluation represents the actual, documented experience of the entire HealthChoice-eligible populations of CY 2000 and FY 1997.

This does not negate the fact that the professional claims encounter data for CY 2000 are estimated to be between 90 and 95 percent complete, nor does it alleviate the potential for data volatility among studies of relatively small sub-populations where the experience of a small handful of outliers could dramatically impact overall utilization rates.

Standard Utilization Measures. Although the challenges just discussed are significant, comparing pre-HealthChoice and HealthChoice data can be useful, valid, and revealing. To make these comparisons, three standard measures have been developed for use in the majority of the comparative studies included in this report. These measures are:

- *Ambulatory visits.* The definition used for an ambulatory visit is the most inclusive "visit" definition used in the evaluation. An ambulatory visit is defined as any time an enrollee had a contact with a doctor (or a nurse practitioner) in an ambulatory setting. To address multiple services occurring during a single visit, ambulatory visits are reported as an unduplicated count that may not exceed one per day.

- *Well child visits*. A consideration of well child visits is important because there are many children enrolled in HealthChoice. Well child visits are defined by one comprehensive measure, inclusive of well child visits, EPSDT, and preventive services. This measure includes what the State uses to report EPSDT services for federal reports, and includes clinic services in an OPD that are accompanied by an appropriate diagnosis code. Well child visits are a subset of all ambulatory visits.

- *Emergency room visits.* Emergency room visits that do not result in a hospital admission are counted as ambulatory visits because they are likely to represent inappropriate ER utilization triggered by inadequate access to community-based primary care services.

Measurement Approaches. The standard measures identified above are examined in two ways, each of which yields different insights and conclusions:

- *Percentage of eligible population receiving service.* This measurement looks at the percentage of the population that had contact with a health care provider. As such, it serves as a measure of overall access to care. This measure reveals the relative success HealthChoice has had in bringing people into care.

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[3] Some studies included the FY 2000 population.

[4] The FY 1997 population does not include individuals enrolled in the voluntary HMO program.

- *Visits per thousand member months (annualized).* This is a standard method for presenting units of service (e.g., physician visits). This measure supports an assessment of the level of service provided, as opposed to simply the access provided.

Presenting the Data. To clarify comparisons of data representing services provided before and after the implementation of HealthChoice, most of the data are considered from several standard perspectives, primarily:

- *By age.* Looking at measures by age helps to control for the large demographic shifts that have occurred in the HealthChoice population since 1997. Some age groups, such as under age 5 and over age 40, have remained relatively stable in size, while others changed significantly, either by expanding (ages 6-20 years) or contracting (ages 21-39 years). Presenting the data by age allows better consideration of the changes.

- *By region.* The health care delivery system in Maryland (as in other states) is not uniform. Significant regional variations exist in access and local systems. Similarly, the substantial growth of the HealthChoice population since FY 1997 did not occur in a uniform manner throughout the State. Regional breakdowns allow closer examination of these effects. For presentation purposes, six regions are used:

  - Baltimore City;
  - Baltimore Suburban;
  - Washington Suburban;
  - Western Maryland;
  - Eastern Shore; and
  - Southern Maryland.[5]

  Although the regional breakouts reflect important variations across the State, this approach can lead to some analyses of very small populations. Particularly in rural areas of the State (Western Maryland, Eastern Shore, and Southern Maryland) the resulting comparison may be based on relatively small numbers, and should be interpreted more cautiously.

[5] These six designated regions include the following constituent jurisdictions:
- The "Baltimore City" region includes a single jurisdiction - Baltimore City;
- The "Baltimore Suburban" region includes Anne Arundel, Carroll, Harford, Howard, and Baltimore Counties;
- The "Washington Suburban" region includes Prince Georges, Montgomery, and Frederick Counties;
- The "Western Maryland" region includes Allegany, Garrett, and Washington Counties;
- The "Eastern Shore" region includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.
- The "Southern Maryland" region includes Calvert, Charles, and St. Mary's Counties.

- *By eligibility category.* The Maryland Children's Health Program is a completely new eligibility category that did not exist before HealthChoice. The MCHP population has a distinctly different makeup than the overall HealthChoice population. Compared to Medicaid-eligibles enrolled in HealthChoice, individuals whose HealthChoice eligibility is based on MCHP have more income and include proportionally more adolescents. In addition, a section of the analysis is devoted to the differences between eligibility groups such as Families & Children and Disabled. Presenting data by eligibility category allows differences between groups to be observed more closely.

Accounting for Demographic Changes. There are inherent problems with the comparison of the FY 1997 and CY 2000 data. The primary problem results from significant changes that have occurred in age distribution in the program's population. Even if the members of each age group were to receive the same number of visits in CY 2000 as they did in FY 1997, the total number of visits provided in CY 2000 would appear lower. This is because older children now account for a larger proportion of the population and older children receive fewer visits than do younger children.

Clearly, this can lead to potentially confusing and misleading interpretations as to the impact of the HealthChoice program on service utilization. In fact, it would be possible for every age group to receive more visits in CY 2000 than in FY 1997 and still have total utilization for CY 2000 appear lower than for FY 1997. In order to address this problem, the "All" categories reflect an adjustment to the age distribution of the populations in CY 2000 and FY 1997 so that they are more comparable. No changes are made to the utilization rates of the individual age, region or coverage groups. All that is changed is the proportion of the total population comprised of each age group. This is done in an effort to foster more meaningful comparisons between the study years.

Ambulatory and Well Child Visits

Ambulatory Visits. Ambulatory visits are the most inclusive measure used in this evaluation. Examining whether HealthChoice enrollees received an ambulatory visit and how many visits the typical enrollee received can provide important insights into utilization patterns in the HealthChoice program.

➢ *Ambulatory visits - findings.*

- *Ambulatory visits - percentage of eligible people receiving services.* The overall percentage of individuals receiving an ambulatory visit has increased from 57.8 percent to 60.3 percent. The increase was greatest for children aged 0-14. Among individuals aged 19-39 a smaller percentage received an ambulatory visit. Most encouraging is the finding that the percentage receiving an ambulatory service has increased in every region of the State with the greatest improvements in the typically underserved rural areas of Southern Maryland and the Eastern Shore.

Figure III-3: Percentage of the Population Receiving Ambulatory Care Service by Age

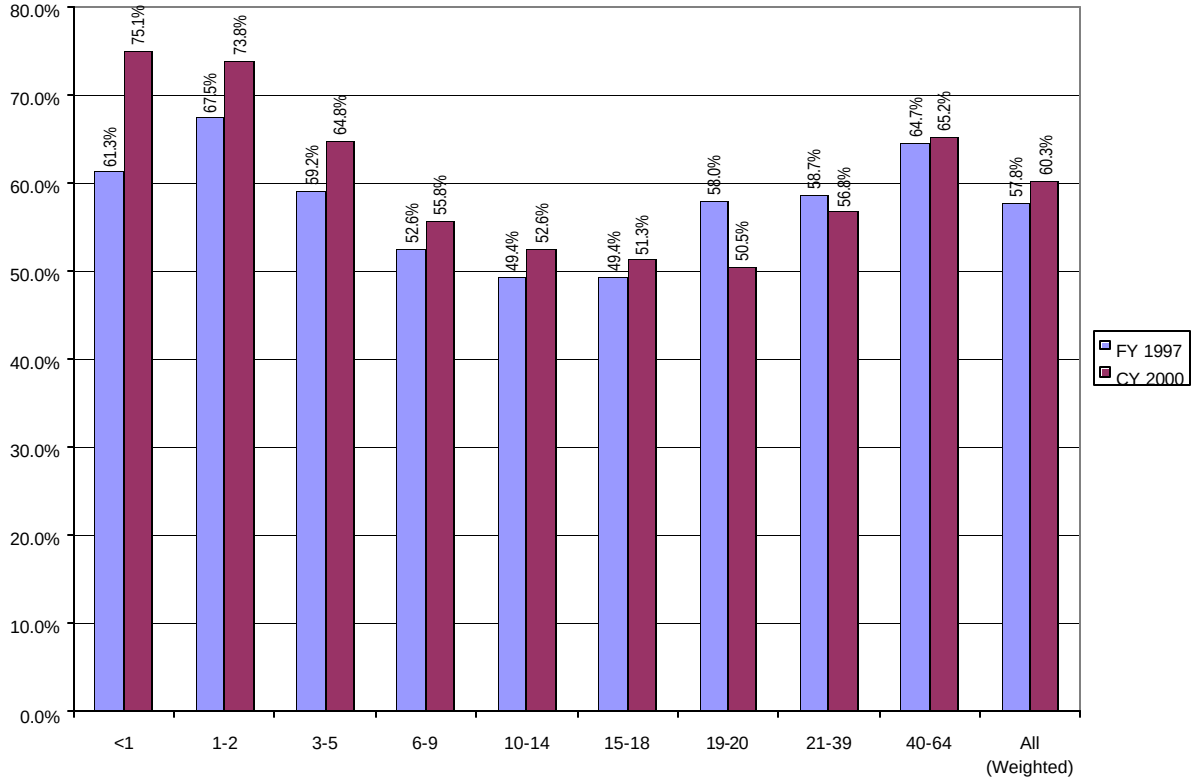
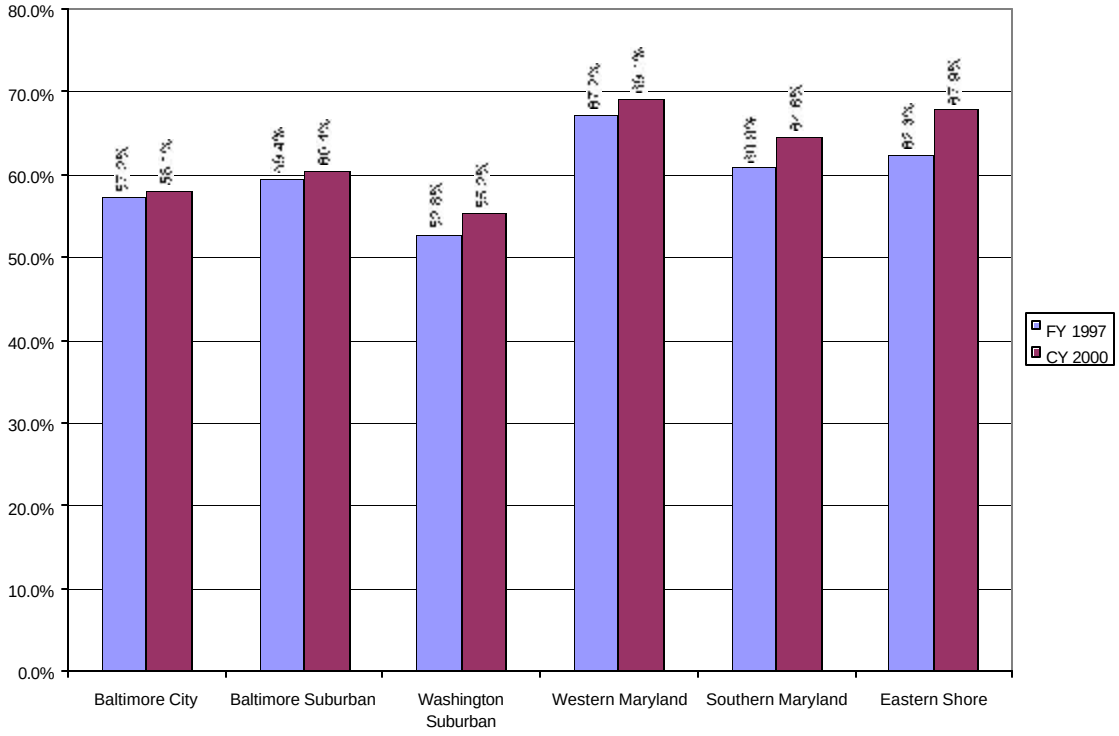


Figure III-4: Percentage of the Population Receiving Ambulatory Care Service by Region



- *Ambulatory visits – number per thousand annualized.* Overall there were fewer visits per thousand in CY 2000 (3,667) than there were in FY 1997 (4,301). The greatest difference in the number of visits per thousand during the two years under consideration was for individuals aged 15-39. In addition, the differences were greater in urban and suburban regions, with only modest differences in the rural areas of the state. Individuals in Baltimore City were more likely to be enrolled in voluntary HMOs in FY 1997 and not included in the FY 1997 comparison data. Because no data reflecting utilization by the relatively healthy Medicaid HMO-enrolled population in FY 1997, it could not be included in FY 1997 comparison data. Consequently, the FY 1997 utilization may be exaggerated, and the decline in visits less pronounced than available data indicate.

  In contrast to the overall decline in ambulatory visits was the experience of children under age one. This age group received considerably more services than their pre-HealthChoice counterparts. This is particularly interesting as the under one population has changed little in size or eligibility standards since 1997 and there have been strong anecdotal criticisms that access to care for newborns has declined. This finding suggests that

linking newborns to their mothers' MCOs may have had a positive outcome by bringing more infants into care more quickly.

Figure III-5: Ambulatory Care Visits per Thousand Annualized by Age

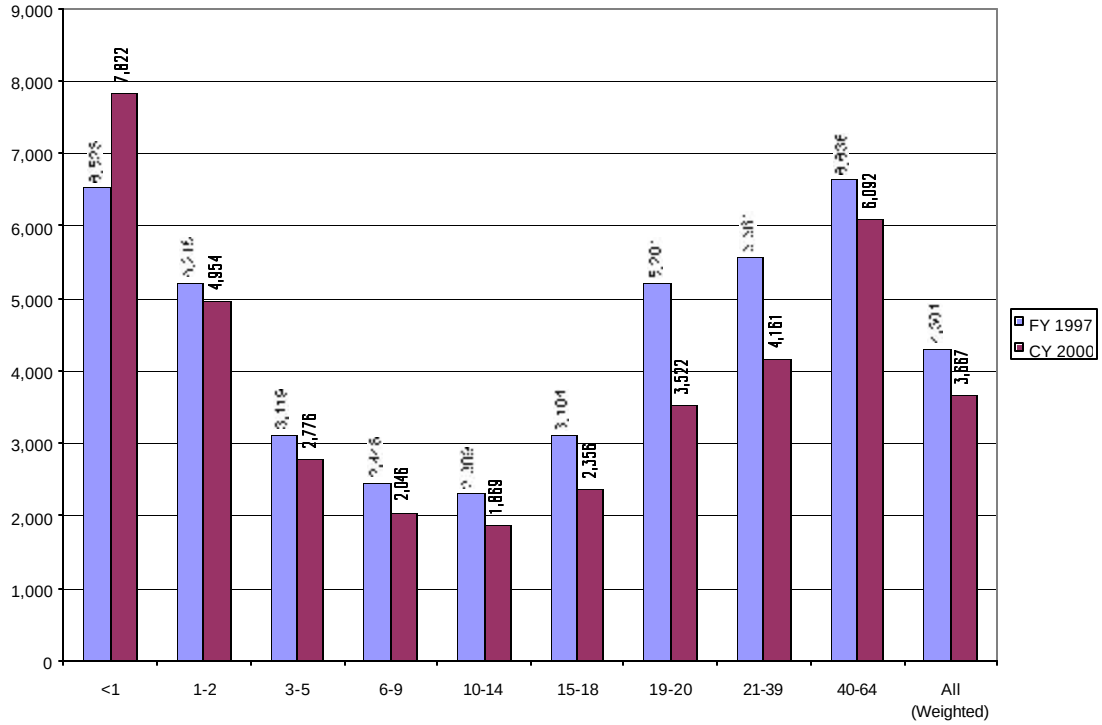
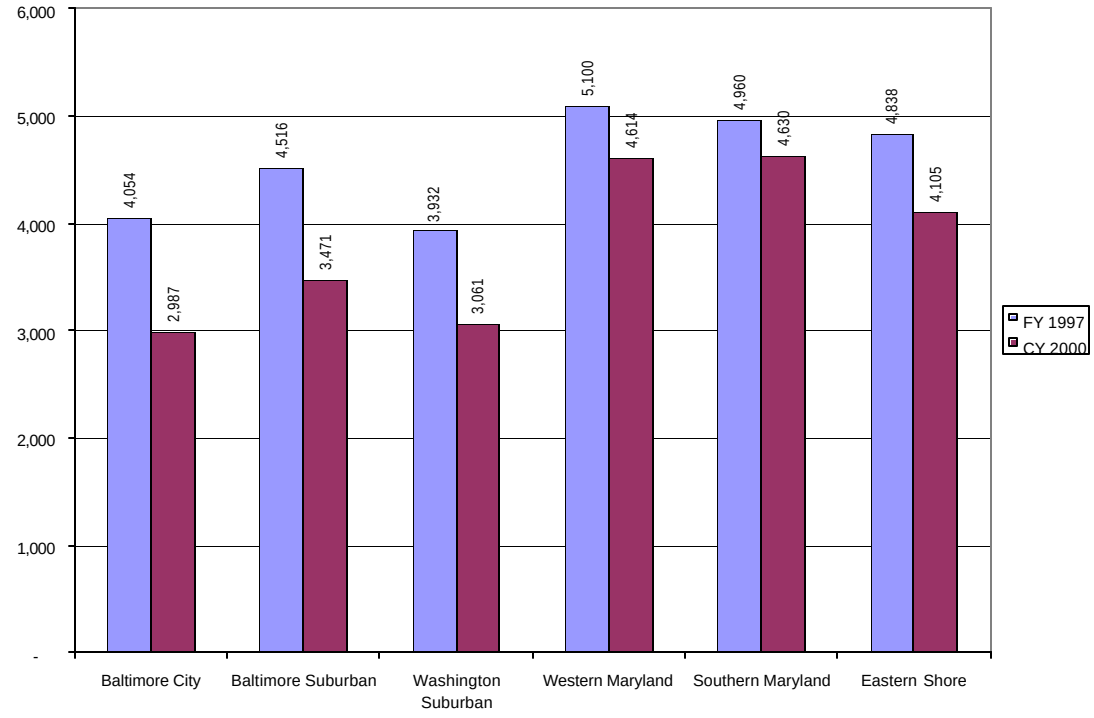


Figure III-6: Ambulatory Care Visits per Thousand Annualized by Region



➢ *Ambulatory visits – discussion.* The HealthChoice program has been successful in improving access to ambulatory care for children under age 18. At the same time, individuals 19 to 39 have experienced slight declines in access. The number of visits per thousand reveals a more complex picture. Especially encouraging is the increase in services to children under one. This dramatic increase may be related to the HealthChoice program's success in increasing the average length of eligibility for children under one (since infants are seen very frequently, an increase in the duration of their eligibility is likely to result in a higher number of visits per thousand).

The fact that, on average, the overall HealthChoice population receives fewer ambulatory visits than the pre-HealthChoice population is difficult to categorize as either positive or negative. The MCHP expansion introduced a new population to the Medicaid program. A common assumption is that higher income individuals have better health status and, therefore, will use fewer services[6]. This assumption is borne out by the data presented here. The argument that the HealthChoice population has better health status is further strengthened by the results of the risk adjustment methodology used in the rate setting process. That process showed that overall the family and children category (including MCHP) has a lower risk score in 2000 than they did in 1997. (See Chapter IV for further discussion). The sharp differences observed in services received by adolescents seem to also be indicative of a different population mix in 2000 than compared to 1997.

Well child Visits. Looking at well child visits addresses some of the problems of comparability that complicate the examination of all ambulatory visits. In theory, well child visits should be indifferent to health status. Well child service should be provided according to the periodicity schedule and not affected by the child's health status. In this way looking at well child visits presents a 'cleaner' comparison.

➢ *Well child visits - findings.*

- *Well child – percentage receiving service.* The percentage of the population receiving a well child services has shown an increase overall and across all ages. The increase was from 36 percent in 1997 to 40 percent in 2000. The progress was seen across the State, with only Western Maryland showing a small decline and Baltimore suburban showing no change.

[6] National Center for Health Statistics. *Health, United States, 2000: Adolescent Health Chartbook*. Hyattsville, Maryland: 2000.

Figure III-7: Percentage of Children Receiving a Well Child Service by Age

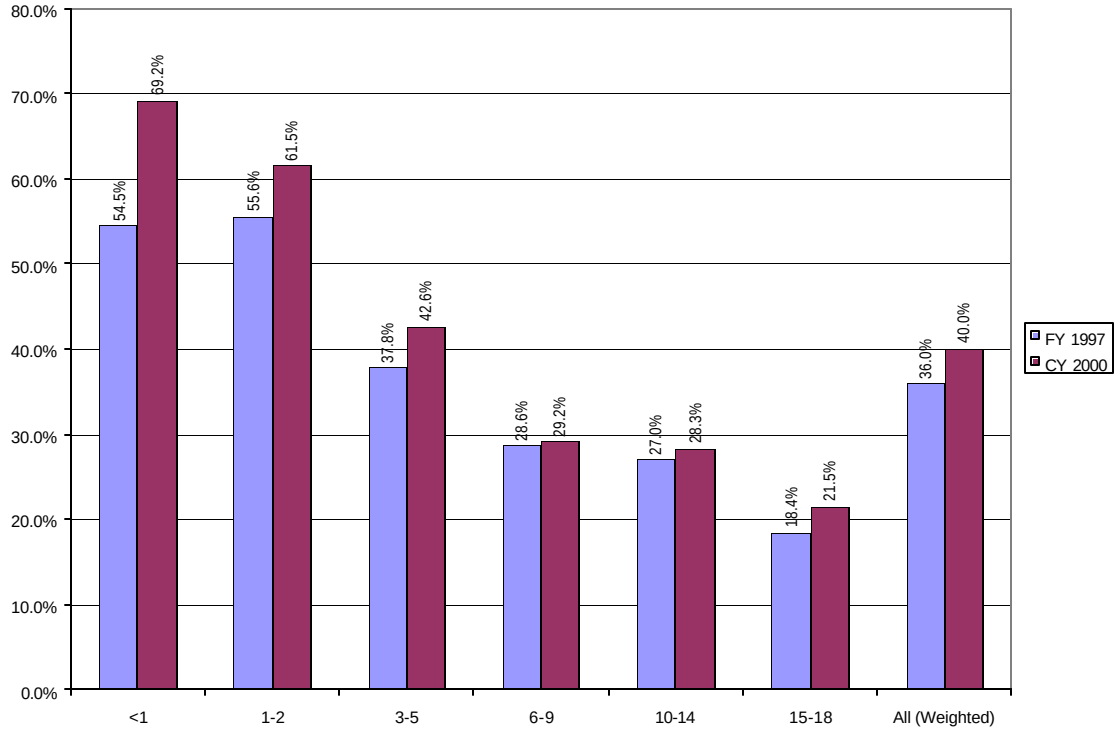
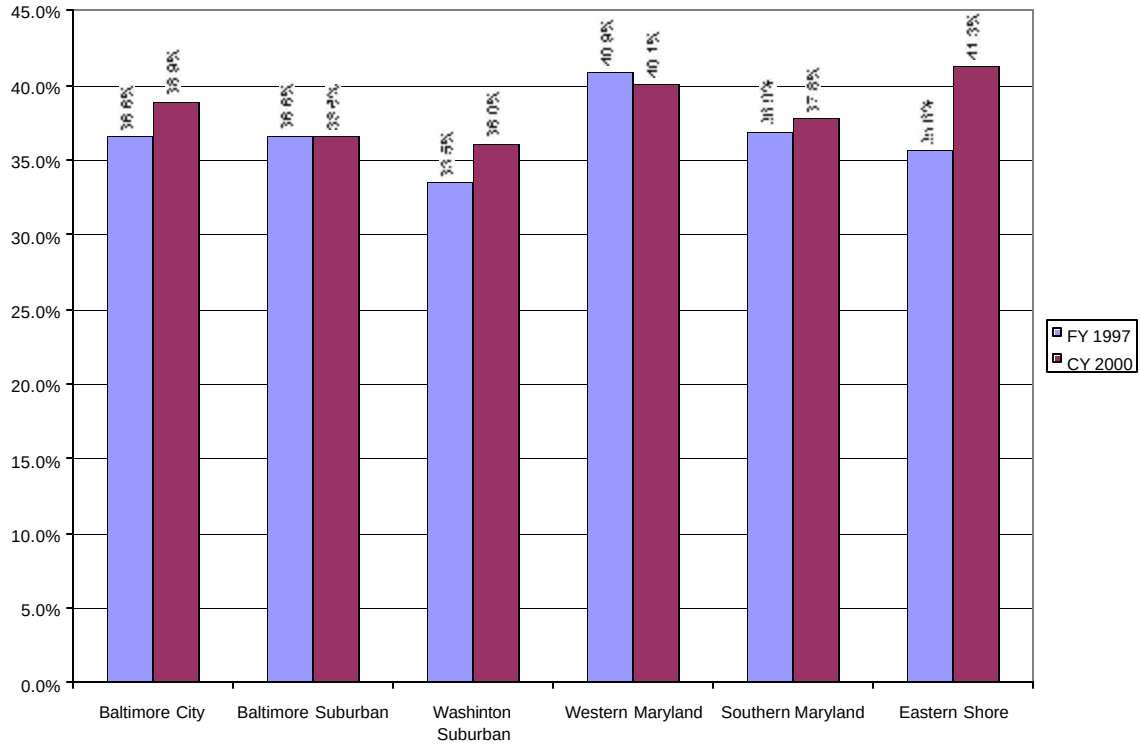
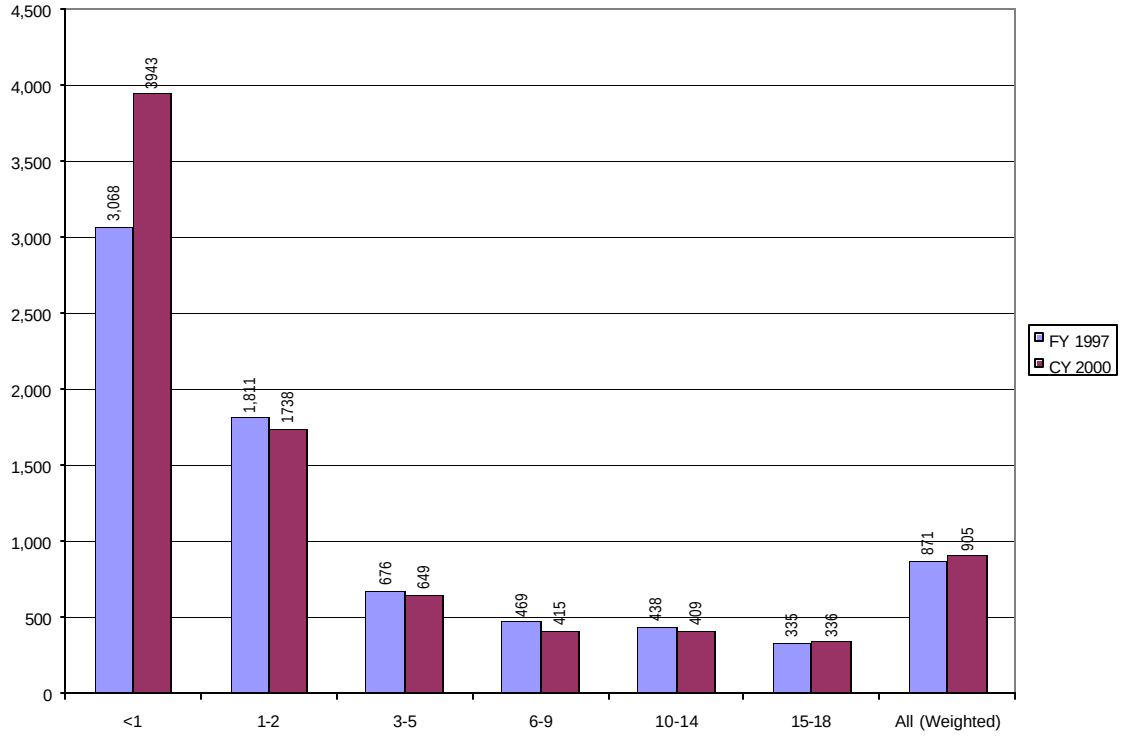


Figure III-8: Percentage of Children Receiving a Well Child Service by Region



- *Well child – visits per thousand annualized.* The number of well child visits per thousand, showed similar increases. When weighted to reflect the population distribution, the number of well child visits per thousand increased slightly from 871 to 905. The increase in well child visits in children under 2 offsets the modest declines in the number of well child visits for children 3 to 14.

Figure III-9: Well Child Visits per Thousand Annualized by Age



➢ *Well child visits - discussion.* The findings regarding well child services are among the most positive findings of the HealthChoice program review, especially when considering that children make up approximately 75 percent of all enrollees. Most encouraging was the growth in the percentage of children receiving Well Child Visits. This percentage increased significantly for children under age 5, and held steady for other age groups (less than a one percent decline). The provision of well child services is essential to the provision of comprehensive prevention oriented care. HealthChoice has been successful in significantly increasing the number of children who receive a well child visit. Possible reasons for the increase include:

- *Longer eligibility encourages primary and preventive care.* By allowing children to maintain eligibility for longer periods greater opportunity is available for them to seek out and receive preventive care.

- *Outreach efforts by participating MCOs.* Community forums and other meetings with consumers demonstrated that enrollees had received prevention-oriented outreach materials from their MCO. The results indicate a level of success for MCO outreach efforts.

EMERGENCY ROOM UTILIZATION

Overview

There is a general consensus that, unlike ambulatory care and well child visits, emergency room use (both the percentage of individuals who use ER services and the overall level of use) should decrease under managed care. This consensus is based on assumptions that emergency room services are expensive, and inappropriate except for 'true' emergencies, and that effective controls capable of restricting emergency room use to appropriate circumstances are implicit in a managed care system of care.

Our analysis of emergency room use under the HealthChoice program examined emergency room visits that did not lead to hospitalization, as these visits were the most likely to be sensitive to managed care controls. Furthermore, only paid claims submitted as encounters are included in the analysis. This analysis, however, cannot assess whether the implementation of HealthChoice has increased the number of denied claims or direct billing of patients, two scenarios that were cited during discussions with providers and consumers, which would mean that the delivery of such services was still occurring. Under federal law, MCOs are required to pay for screening services in an emergency room.

Findings

The patterns of emergency room use under HealthChoice are interesting and somewhat conflicting. Overall emergency room use is down, both in terms of the percentage of people who have an emergency room visit (15.2 percent in 1997 versus 14.4 percent in 2000) and in the number of visits per thousand (345 in 1997 versus 301 in 2000). By age, the analysis shows that emergency room use is down across all ages except individuals aged 40 to 64. Again, these declines are for both percent of eligibles receiving services and the number of services per thousand. This finding would indicate some success by MCOs in reducing inappropriate emergency room use.

The declines in emergency room use are regionally concentrated. Significant declines are observed in the urban and suburban regions of the State. In contrast, the highest areas of emergency room utilization and the smallest declines relative to pre-HealthChoice are in the more rural parts of the State (Western Maryland, Southern Maryland and the Eastern Shore), a pattern that also existed in Maryland's Medical Assistance fee-for-service system prior to the implementation of HealthChoice.

Figure III-10: Percentage of Population Receiving an Emergency Room Service by Age

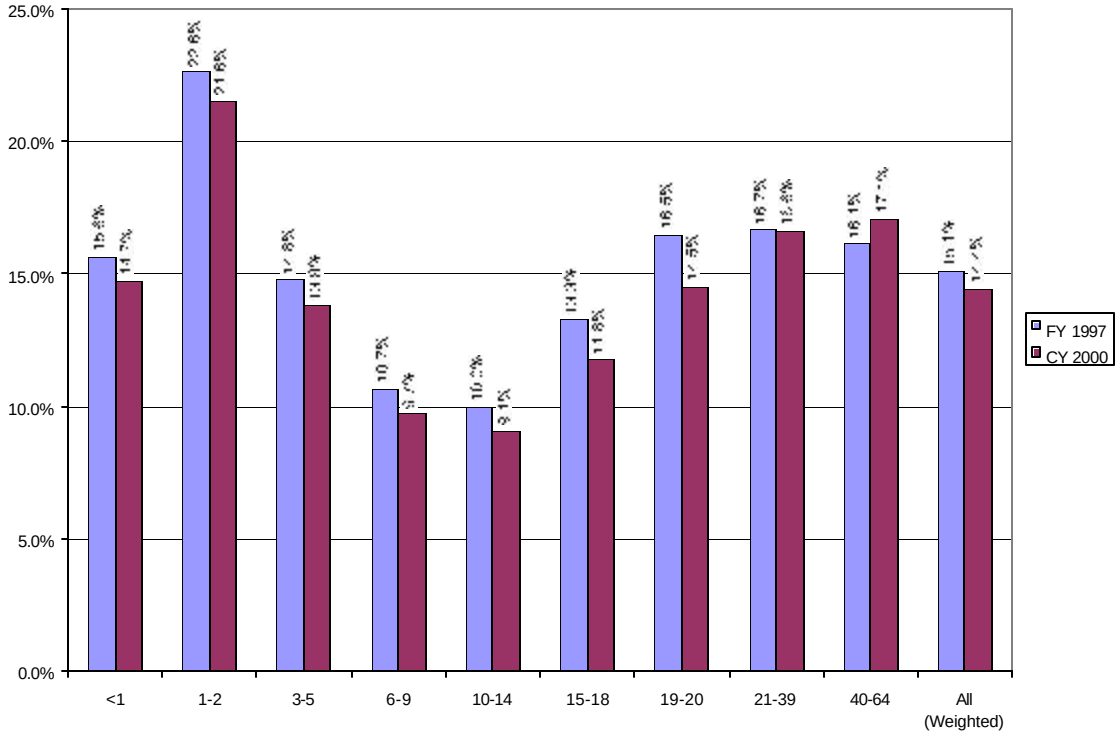


Figure III-11: Percentage of Population Receiving an Emergency Room Service by Region

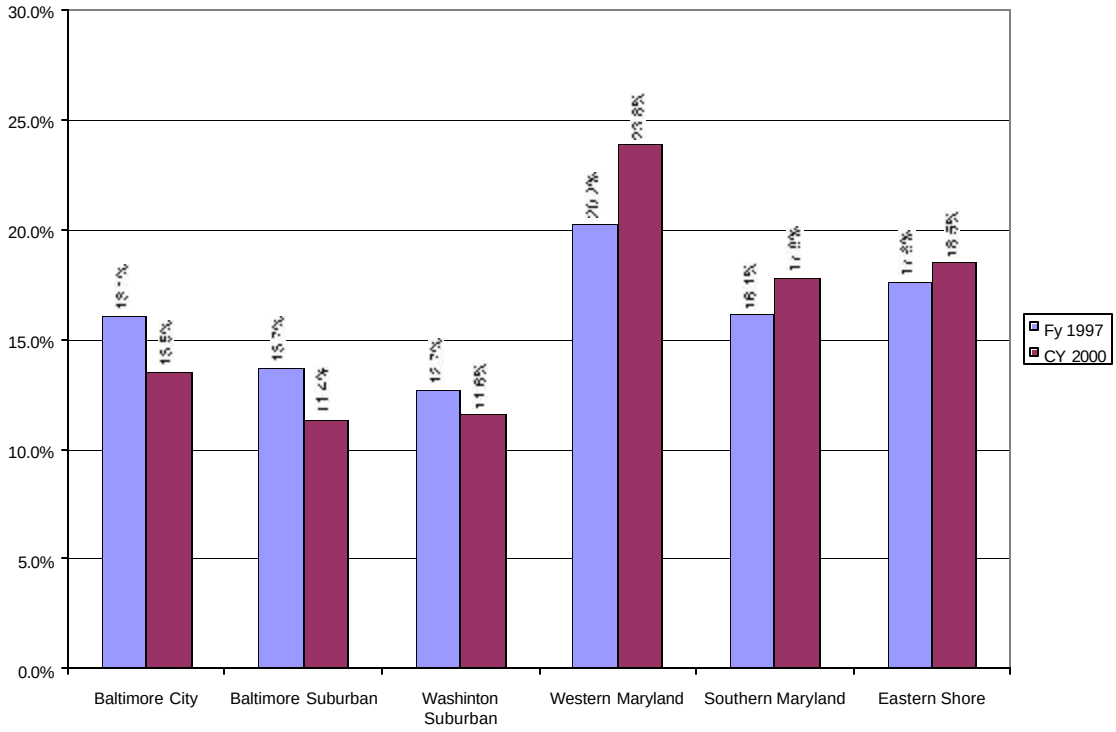


Figure III-12: Emergency Room Visits per Thousand Annualized by Age

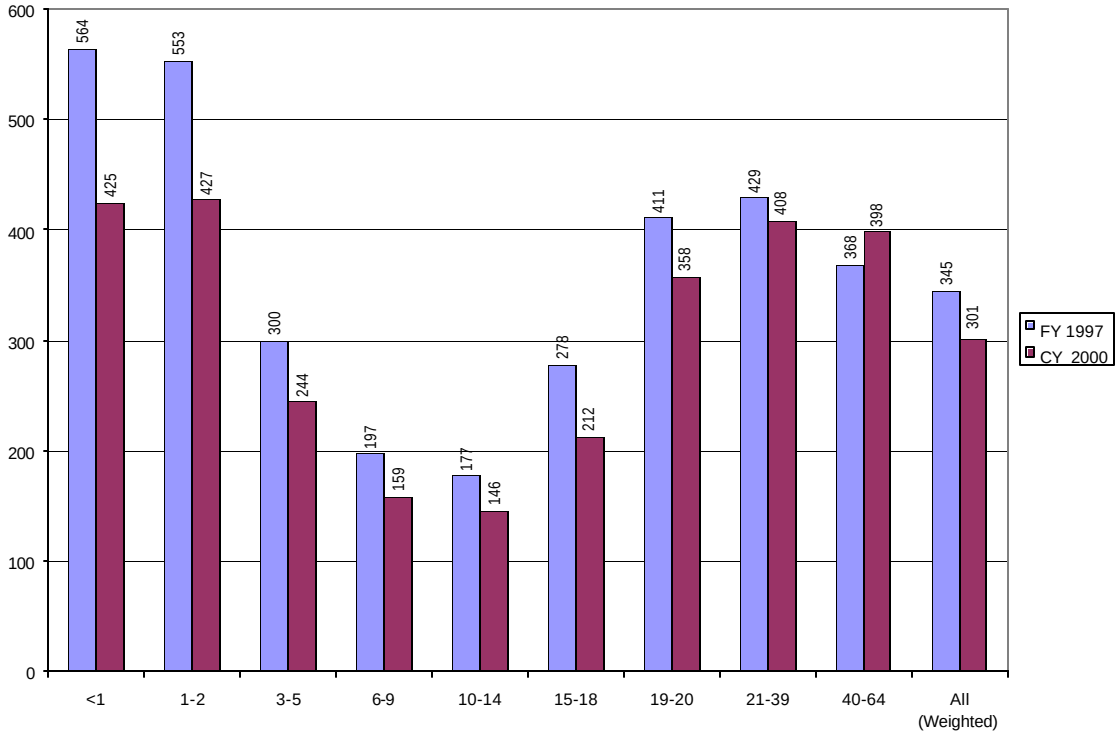
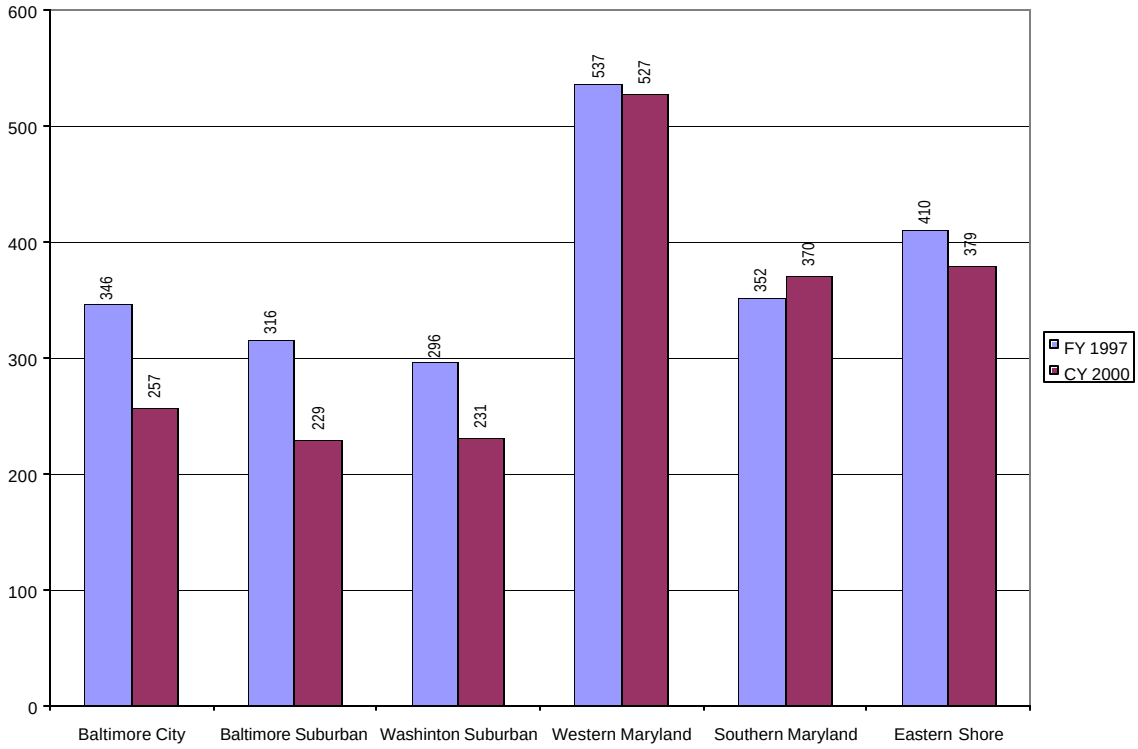


Figure III-13: Emergency Room Visits per Thousand Annualized by Region



Discussion

Overall, the declines in emergency room use through the encounter data analysis are a positive finding for the HealthChoice program. It is also important to look at the emergency room experience in light of other utilization trends. Reductions in emergency room use were most dramatic for children under age two. It is encouraging that this is the same age group that experienced the most substantial improvement in access and service delivery for ambulatory and well child services. This may be an indication that HealthChoice MCOs have been successful in directing young children to more appropriate sites for care.

The regional nature of the reductions in emergency room use is also an interesting finding. A combination of local factors may account for this. For example:

Emergency Room Costs Are Lower in Rural Hospitals. Because emergency room visits are less costly in rural hospitals than in urban and suburban hospitals, MCOs have less financial incentive to divert patients in from emergency rooms in rural hospitals.

Alternatives to Emergency Rooms May Be Less Available in Rural Areas. Emergency rooms in more rural parts of the State may play a different role in local delivery systems. Urgent care centers and primary care sites with extended hours may be less available. Given the lower costs (relative to urban and suburban areas) of emergency room visits generally, there would be less financial incentive for MCOs to establish alternative acute care delivery sites in rural areas. In these areas patients may perceive emergency rooms as the most accessible source of urgent specialty care services available locally.

UTILIZATION BY COVERAGE CATEGORY

Introduction

The HealthChoice population is comprised of several distinct coverage groups. Enrollment in these groups is determined by a host of factors including age, income level, pregnancy and disability. Enrollees in these distinct groups are likely to have differing needs and utilization patterns. For example, individuals with Supplemental Security Income (SSI)/Disabled eligibility who have coverage due to their disability are likely to use more services than children with MCHP coverage whose eligibility is based on income. This section will examine those patterns. It is important to note, however, that the MCHP program did not exist in FY 1997 so there is no pre-period for comparison.

Findings

As expected, there is a high degree of variation in utilization among different HealthChoice coverage groups. The SOBRA group (comprised for purposes of this analysis only of pregnant women)[7] consistently experiences higher ambulatory visits per thousand than the other eligibility categories. SOBRA enrollees had 7,376 visits per thousand in CY 2000 as compared to 5,004 for the Disabled/SSI group, 3,025 for the Family and Children group, 2,734 for MCHP and 3,667 for the HealthChoice population as a whole. This same pattern existed in FY 1997 where the SOBRA group had 10,506 visits per thousand as compared to 5,269 for the Disabled/SSI group, 3,729 for the Family and Children group and 4,301 for the population as a whole.

When the 1997 experience is compared with the CY 2000 experience by eligibility category some interesting patterns emerge. In CY 2000 the percentage of the population who received an ambulatory service clustered around 60 percent for all coverage groups, with a high of 63.5 percent among the SSI/disabled and a low of 58.3% among the Families and Children group. In FY 1997 there was still a clustering around 60 percent, but the high was at 71.2 percent for the SOBRA enrollees and the low was 56.2 percent for the Family and Children group. The data show that the percentage of the population receiving service increased for every coverage group except for SOBRA.

The SOBRA results should also be interpreted carefully for two reasons. First, they are by far the smallest distinct population with fewer than 20,000 enrollees in FY 1997 and fewer than 30,000 in CY 2000, thus the rates of service calculation may be more volatile. Second, since that eligibility category is linked specifically to pregnancy, enrollees may receive a higher volume of pre-

[7] Pregnant women's children whose Medicaid eligibility is based on their mother's eligibility through SOBRA are, for purposes of this analysis, included in the Families and Children eligibility category.

HealthChoice enrollment fee-for-service visits, which are not included in this study, as compared to other coverage groups.

Figure III-14: Percentage of the Population Receiving Ambulatory Care Service by Coverage Category

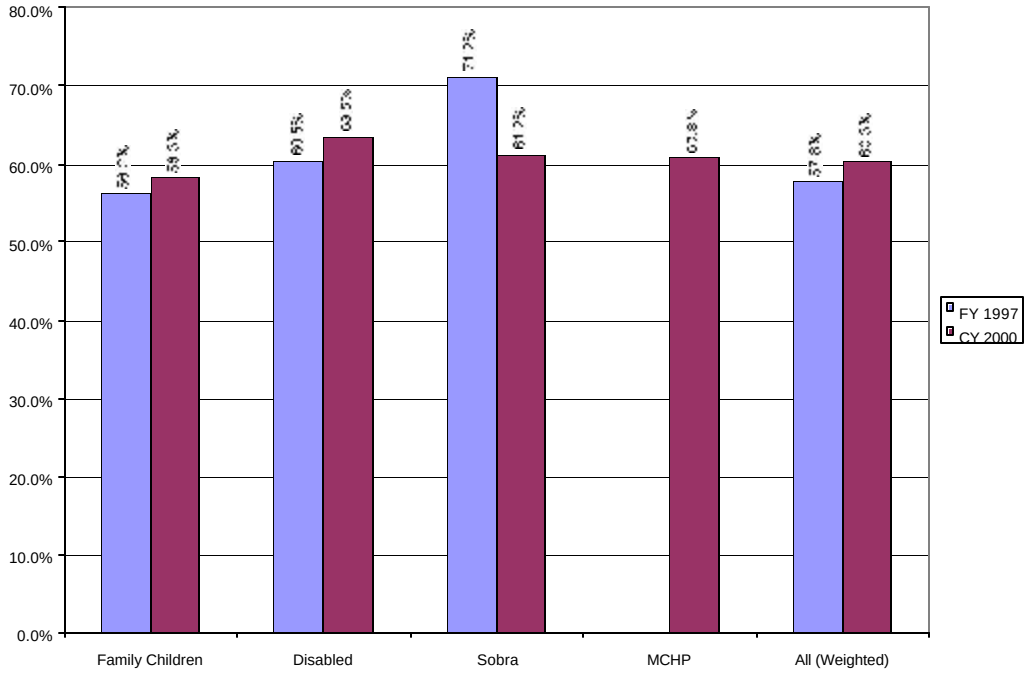
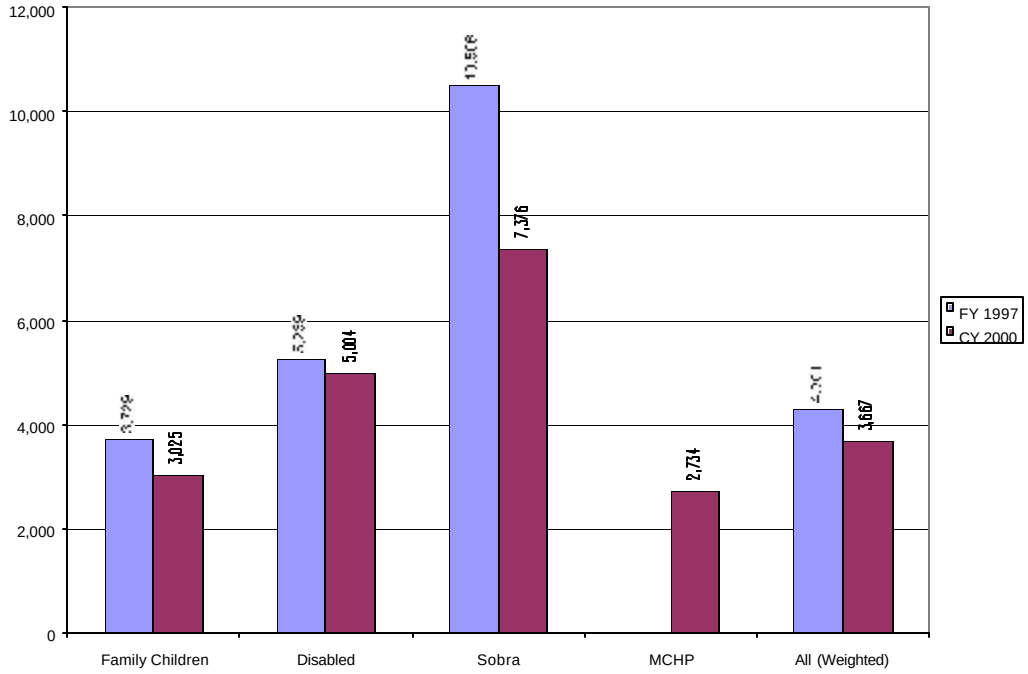


Figure III-15: Ambulatory Care Visits per Thousand Annualized by Coverage Category



The utilization patterns for well child visits reveals some very intriguing trends not necessarily captured by the earlier aggregate discussion. When compared by coverage group, the well child visits per thousand increases for all categories when compared to FY 1997. The Family and Children group saw visits increase from 912 in FY 1997 to 928 in CY 2000. For the SSI/disabled group visits rose from 446 to 491. The MCHP group, with no period for comparison, was at 569 visits. The percentage of the population receiving service followed a similar trend, increasing for every group when compared to FY 1997 levels.

Figure III-16: Percentage of Children Receiving a Well Child Service by Coverage Category

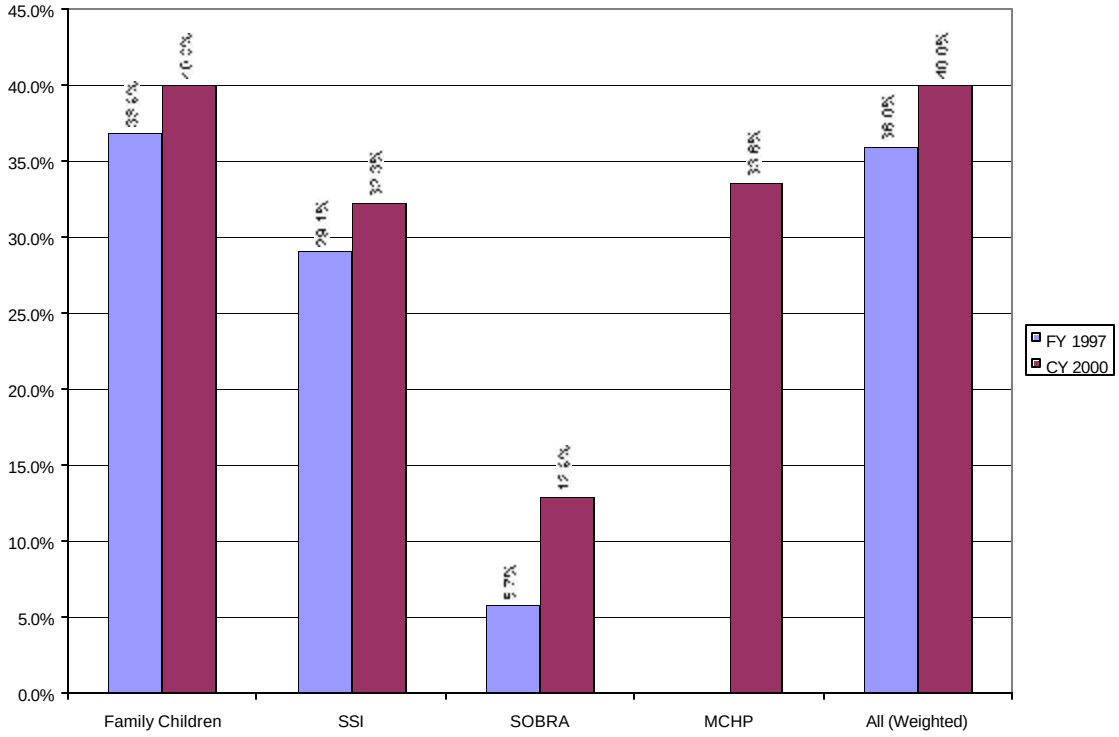


Figure III-17: Well Child Visits per Thousand Annualized by Coverage Category

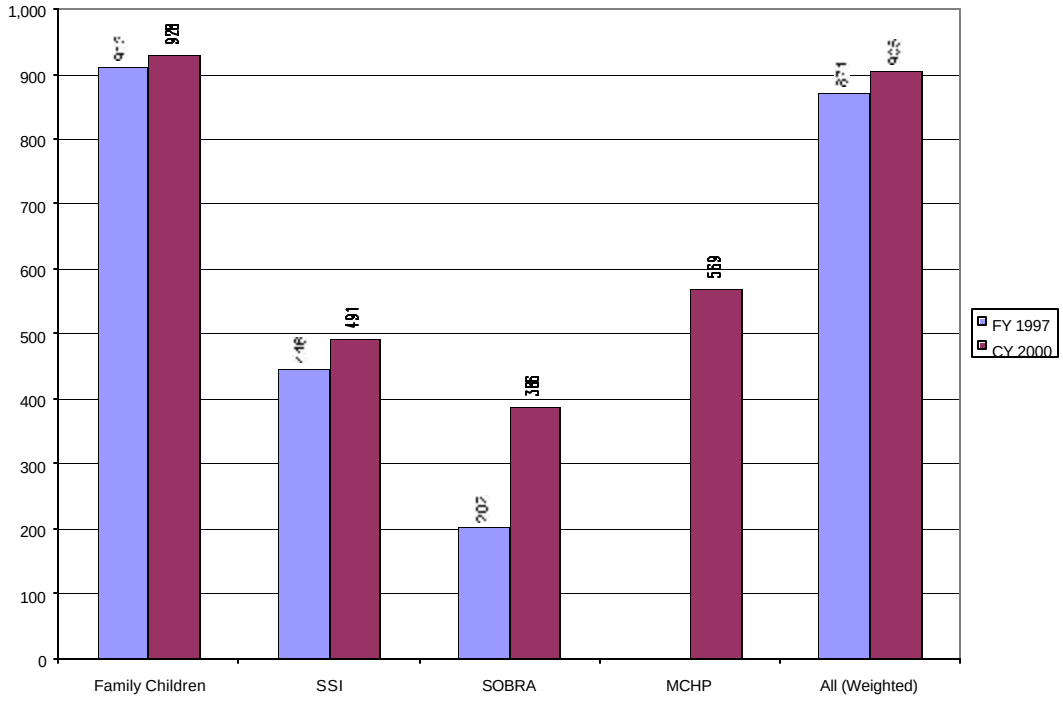


Figure III-18: Percentage of Population Receiving an Emergency Room Service by Coverage Category

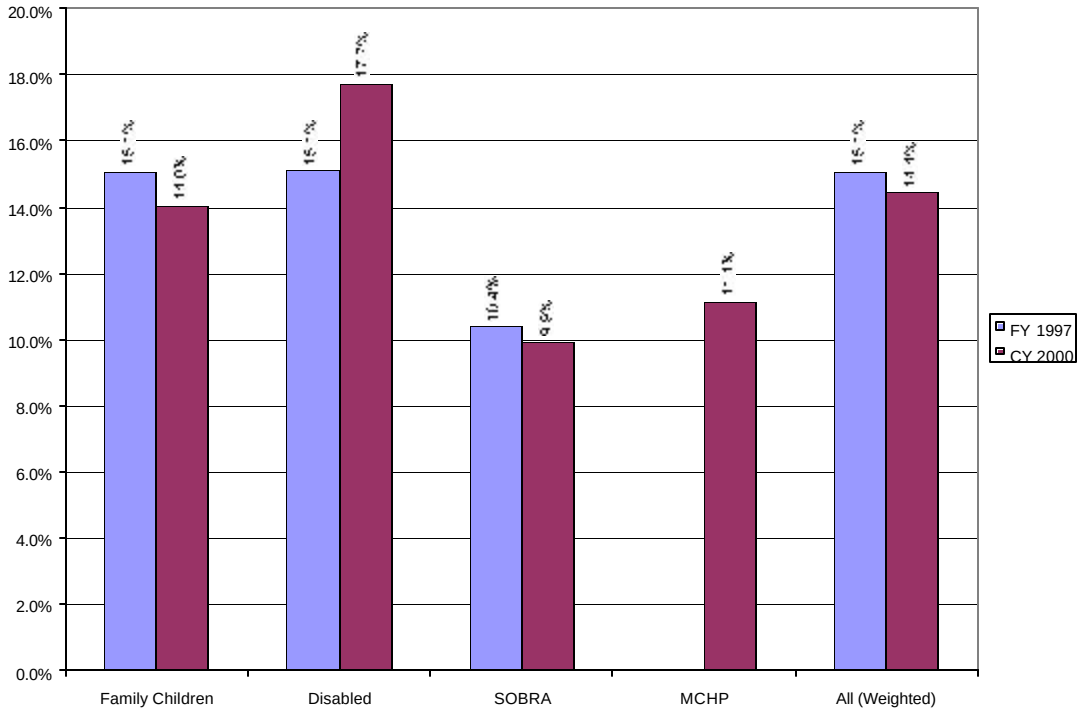
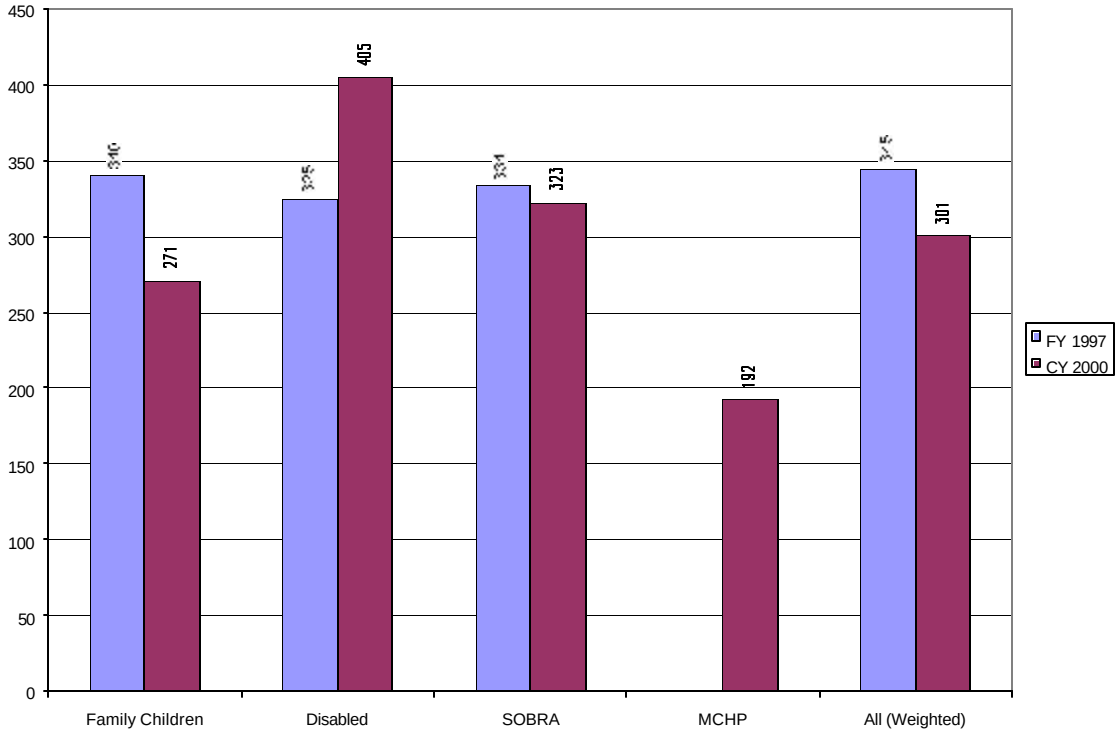


Figure III-19: Emergency Room Visits per Thousand Annualized by Coverage Category



Discussion

These variations are what would be expected based on the composition of the coverage groups. One would expect the disabled and pregnant women to use a higher volume of ambulatory services than those enrolled in Family and Children and MCHP. The MCHP population, with a higher income threshold and largely adolescent population, would be expected to use fewer ambulatory services.

The Families and Children population have higher well child service utilization than do any other group. This can be explained, however, by considering that the Disabled and MCHP populations are more heavily adolescent than is Family and Children. Therefore, the high volume of well child services used by those aged two and under has a far greater impact on the overall utilization rates for that coverage group.

The prior discussion regarding the impact of the demographic shifts that have occurred under the HealthChoice program also become evident in the study. As shown, well child visits per thousand increased for every coverage group under HealthChoice. The collective rate, however, is below that of FY 1997. This is a direct result of the MCHP population utilizing services at a volume below that of the Family and Children group. Due to the size of the MCHP population, their

impact on overall utilization rates gives the impression that visits per thousand has declined under HealthChoice.

SUBPOPULATION ANALYSIS - CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Overview

Special Needs Children. Serving special needs children has been a primary goal of the HealthChoice program from its inception. Children with special health care needs are identified in program regulations as a special needs population. The Department also established the Special Needs Advisory Committee at the outset of the program to provide regular feedback and guidance on issues related to special needs children.

Special Needs Children – Categories. The challenge for the evaluation with regards to this HealthChoice subpopulation is how to define and examine it in a way that yields useful insights. Clearly, both a child in foster care and a child enrolled in the REM program have special health care needs, but the nature of their special needs are likely to be very different. Rather than attempt a "one size fits all" analysis of special needs children, the evaluation groups together a series of analyses to examine the provision of care to specific categories of special needs children. The analyses include:

- *Services to foster care children.* The experience of children in foster care is compared to the overall HealthChoice population and the experience of children in foster care pre-HealthChoice. This analysis relies primarily on claims and encounter data.

- *Services to SSI-eligible children.* The experience of children who are eligible for SSI is compared to the overall HealthChoice population and the experience of SSI children before the HealthChoice program was implemented. This analysis relies primarily on claims and encounter data.

- *Services to children enrolled in the REM program.* The composition (e.g., by age, eligibility category, etc.) and utilization patterns of REM enrollees (who are predominantly children) is compared to that of the overall HealthChoice population. Since services provided to REM enrollees are in effect "carved-out" of the HealthChoice benefit package for which MCOs are responsible, the analysis of REM utilization is based entirely on providers' fee-for-service claims.

- *Therapies analysis.* Using encounter and claims data, this analysis looks at the effect that the carve-out of occupational, physical and speech therapies had on access and utilization of these services.

- *Other analyses.* In addition to the analyses presented here, the Department has previously conducted other targeted studies of special needs children. These studies concerned:

- *Services to children with sickle cell disease.* This study, conducted in 1998, used chart reviews and pharmacy data to examine the provision of prophylactic penicillin for children in HealthChoice. It found that compliance with the standard of prescribing prophylactic penicillin was similar before and after implementation of the HealthChoice program.

- *Services to children with cerebral palsy.* In November 1997, in response to concerns raised by the special needs advisory committee, the Department conducted chart reviews and interviews of families of children with cerebral palsy during the early days of the HealthChoice program. The study found that children with cerebral palsy selected for this review received good quality preventive care and continued to receive the specialty care services that had been prescribed to them prior to enrollment in an MCO. More specifically, it found that:

  - Eighty percent of children with cerebral palsy remained with the same PCP they had prior to HealthChoice;

  - The subjects of the review were receiving good quality preventive health care, including immunizations and lab tests;

  - In general, the children studied continued to receive the specialty services ordered prior to their HealthChoice enrollment;

  - MCOs reported that after a child in the sample became enrolled in an MCO, 80 percent of services and therapies ordered prior to enrollment continued to be authorized ; and

  - MCOs reported that new treatment plans were developed for 61 percent of sampled enrollees.

Considered together, the analyses described above provide an instructive picture of service delivery to special needs children in the HealthChoice program.

Foster Care Children

Overview. Children in foster care are particularly vulnerable and they often have "unique and complex health issues."[8] They are at increased risk for acute and chronic medical conditions, behavioral and emotional problems, developmental delays, and mental health and substance abuse conditions.[9,10] Foster care children, therefore, generally require a heightened level of health services.

Although health problems are prevalent among foster care children, there are significant barriers to providing the health care services that are needed to address these problems. Recognized barriers to care for this population include: multiple placements; large caseloads; incomplete health records; lack of training of foster parents, health care providers, and caseworkers; Medicaid enrollment difficulties and delays; service limitations of Medicaid managed care; medical consent problems; and inadequate coordination of services.[2,11,12] In Maryland, the health care of foster care children is managed by two systems, the Department of Health and Mental Hygiene and the Department of Human Resources, which creates challenges for care coordination.

Foster care children are included in the HealthChoice program. They were not eligible, however, for either of Maryland's earlier managed care programs – MAC or voluntary HMOs. By comparing utilization data for ambulatory care services and well child visits, the experience of children identified as being in foster care can be contrasted with that of all children in the HealthChoice population. It is also useful to examine the percentage of all HealthChoice foster children who have been enrolled in more than one MCO as compared to the percentage of all children enrolled in more than one MCO.

The analysis is complicated by the fact that foster care children have longer periods of fee-for-service eligibility than most HealthChoice children do. Foster care children are given 60 days to select a MCO, whereas other HealthChoice enrollees are given 21 days to choose a MCO. Foster care children are allowed

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[8] Kaye, N.; Horvath, J; Booth, M. Monitoring the Quality of Health Care Provided to Children in Foster Care. Technical Report. Portland, ME: National Academy for State Health Policy; May 1998.

[9] Silver, J.A.; Amster, B.J.; Haecker, T. Young Children and Foster Care: A Guide for Professionals. Baltimore, MD, Paul H. Brookes Publishing Company.

[10] Health Conditions, Utilization and Expenditures of Children in Foster Care. U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation; September 2000.

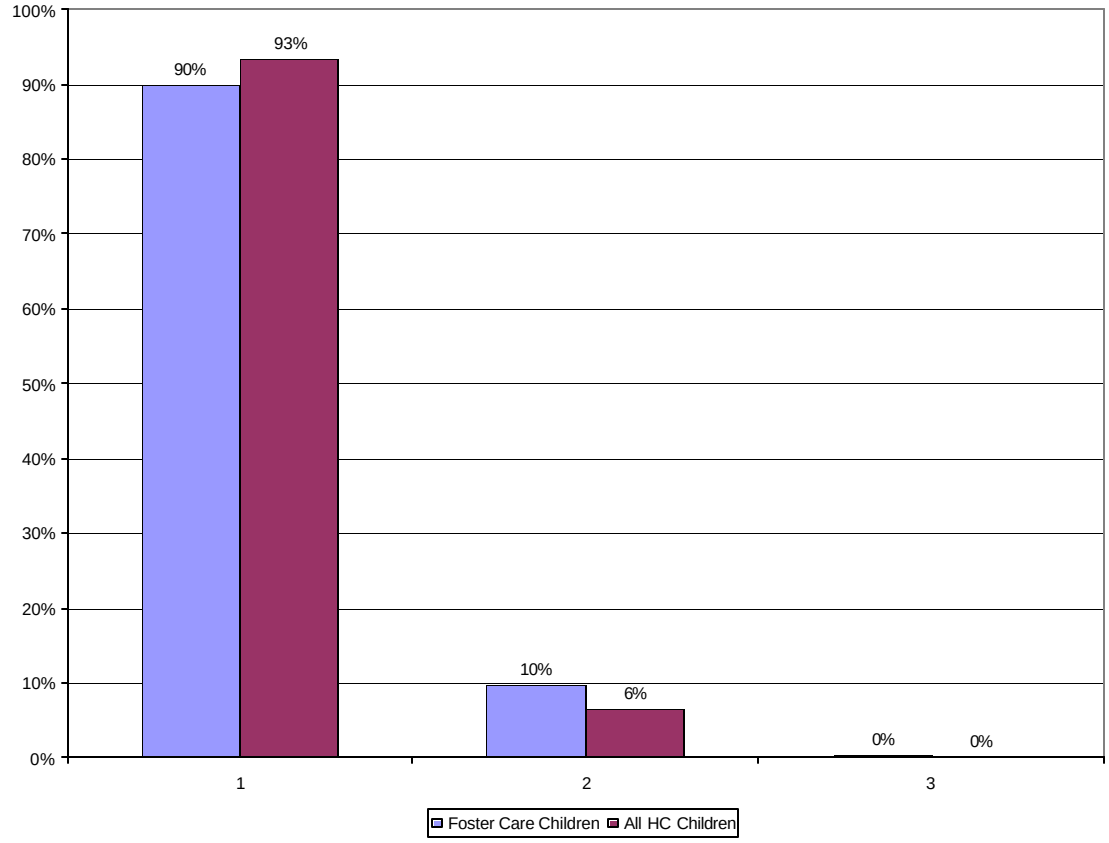
[11] Battistelli, E.S. The Health Care of Children in Out-of-Home Care: A Survey of State Child Welfare Commissioners. CWLA Press; 1998.

[12] Code Blue: Health Services for Children in Foster Care. Sacramento, CA: California State University Institute for Research on Women and Families; 1998.

the additional time for MCO selection in order to give the foster care workers time to work with the foster parents to choose a MCO. In addition, there are often delays in processing eligibility applications for foster care children, which results in longer fee-for-service periods once eligibility is completed since eligibility is back-dated to entry into foster care. The analysis presented in this report considers only services provided to foster care children who are MCO-enrolled. As a result data representing services delivered to foster care children do not include any utilization occurring during a period of time that is longer than it is for the rest of the HealthChoice population. The period of time following a foster care child's application for Medicaid benefits and before the child's MCO enrollment is significant not only because it lasts so long, but also because of when it occurs. For foster care children, the period before encounter data can be collected coincides with the two months immediately following their entry into foster care. During this period, any services received by foster care children are paid for through fee-for-service. For example, within five working days of a placement, a foster care child is required to have at minimum a partial health exam, and within 60 days of entering care, a foster care child must receive a comprehensive physical examination. Initial examinations for foster care children often occur during the fee-for-service period, and are therefore not reflected in MCO encounter data.

Findings. The experience of foster care children receiving MCO services contrasts with the overall HealthChoice experience. First of all, foster care children are slightly more likely to experience enrollment in multiple MCOs over the course of the year: ten percent of foster care children experience multiple enrollments, but just six percent of children in the general HealthChoice population do. Foster care children spend longer periods of time enrolled in fee-for-service before enrolling in a MCO.

Figure III-20: Percentage of Children Enrolled in One or More MCOs - CY 1999



According to MCO encounter data, the percentage of foster care children receiving an ambulatory service has declined, from 64 percent in FY 1997 to 59 percent in CY 2000. The trend for foster care children is the opposite of the ambulatory care utilization trend of the general HealthChoice population, in which the percentage of children receiving an ambulatory care service increased between FY 1997 and CY 2000. The percentage of foster care children who received a well child visit also declined from 44 percent to 40 percent, again in contrast to the general HealthChoice population.

An analysis of fee-for-service utilization for foster care children enrolled in HealthChoice MCOs indicates that there is a significant level of service being provided through fee-for-service before the children are enrolled in MCOs or carved-out services. This finding indicates that the above encounter data analysis represents just a portion of the range of services provided to foster care children, and that a more comprehensive analysis of this issue is warranted.

Figure III-21: Percentage of Foster Care Children Receiving an Ambulatory Service

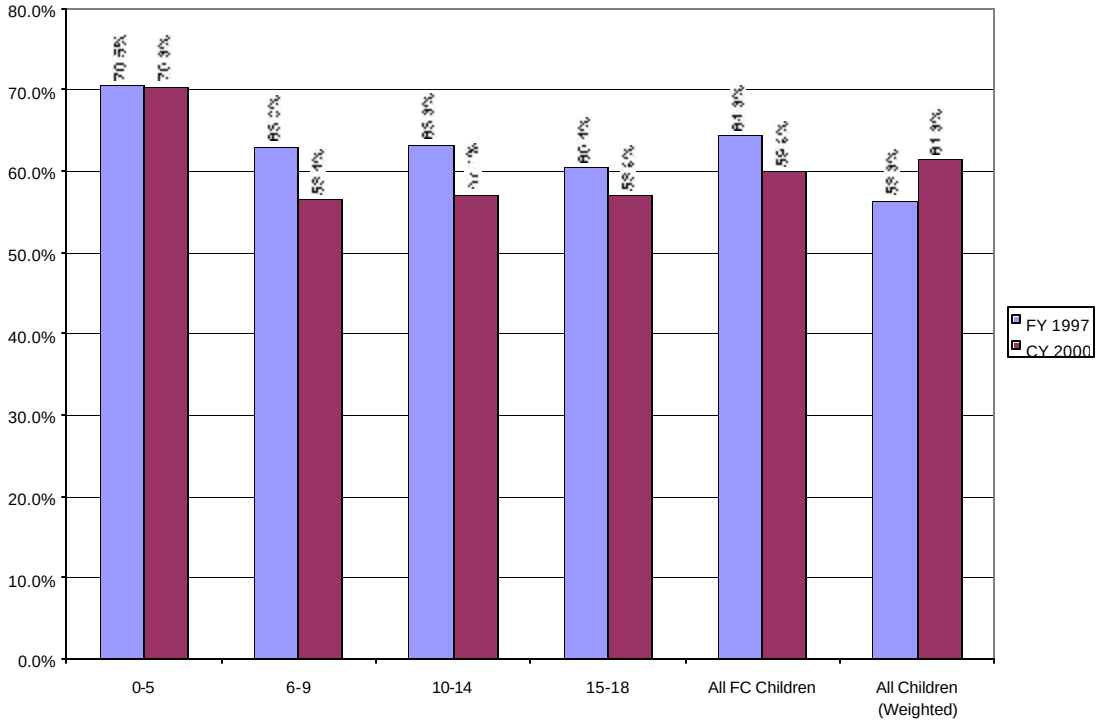
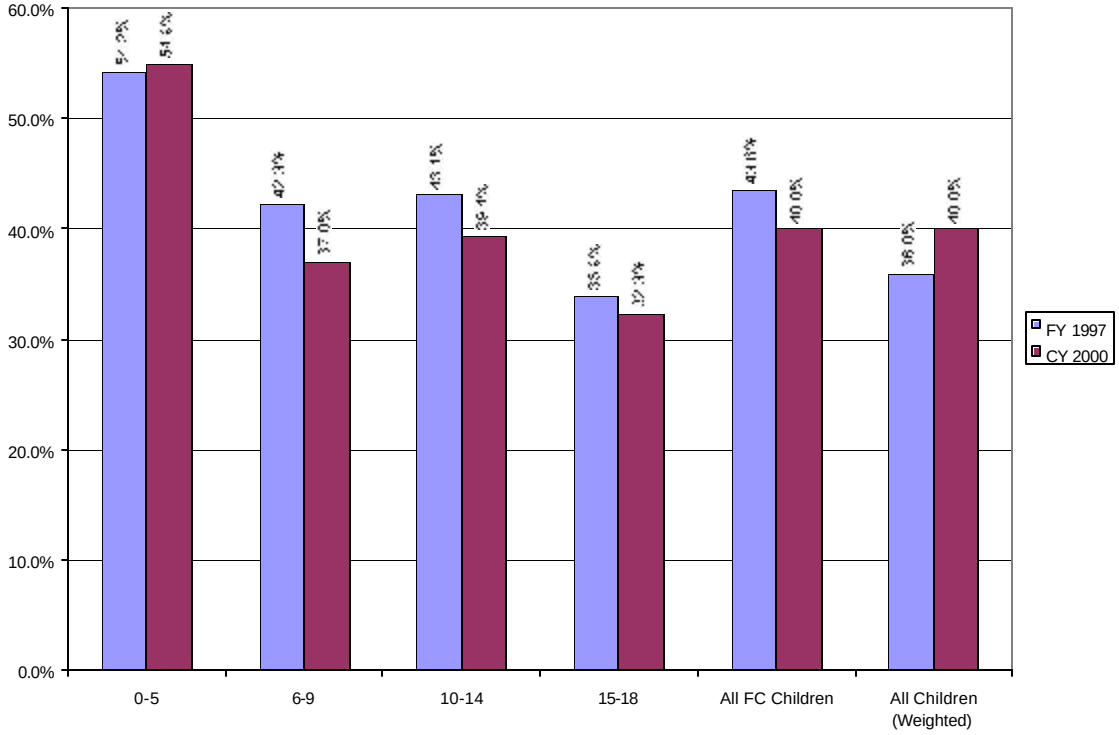


Figure III-22: Percentage of Foster Care Children Receiving a Well Child Service



Discussion Several factors may account for the disparity in services provided to foster care children through the MCO:

- Foster care children spend longer periods of time in fee-for-service before being enrolled in a MCO and therefore the encounter data do not provide a complete picture of service utilization.

- Because foster care children are more transient than the general population, common managed care practices, such as assigning a child to one primary care provider, present greater barriers to care.

- MCOs cannot perform the same direct outreach activities when targeting foster care children that they have used with the general population. Instead, MCOs must outreach to foster care children through foster care caseworkers at local departments of social services. This makes it challenging for MCOs to get foster care children into needed services because they often have difficulties finding the children.

- Rules and practices that are unique to foster care children (such as determining responsibility for choosing a PCP or MCO for the child) add additional barriers to making service arrangements.

  The instability of foster care children's residential arrangements may also understate their actual utilization of services. Foster care children entering HealthChoice have longer periods of fee-for-service eligibility than most HealthChoice children. It is possible that a significant number of foster care children received services after coming into foster care and becoming Medicaid-eligible, but before enrolling in HealthChoice. The encounter data analysis does not capture services provided to foster care children during the transitional period before HealthChoice enrollment, when the child would access health care services through fee-for-service Medicaid. Thus, foster care children may be receiving as many services, if not more, than the general population. This is an area in which continued study is needed.

SSI-Eligible Children.

Overview. Like children in foster care, children who are eligible for SSI benefits eligibility are a HealthChoice subpopulation that is distinctly different from the HealthChoice population as a whole. By definition, children eligible for SSI have an identified disability. They have more health problems and need more services than the general population. This assumption is borne out by the large number SSI children enrolled in the REM program.

SSI Children in MCOs. The number of SSI eligible children in HealthChoice has remained relatively constant, from approximately 12,000 to 13,000 from FY 1997 to CY 2000. The percent of the eligible SSI population receiving an ambulatory visit has increased from 58 percent in FY 1997 to 61 percent in CY 2000, an increase that is very similar to that noted for the overall HealthChoice population. Similar to the trends observed in the general HealthChoice population, these increases were most dramatic among children under age two. With regard to well child visits the percentage of SSI children receiving a visit increased from 29 percent in FY 1997 to 32 percent in CY 2000. This rate of increase was equivalent to that experienced by all children in the program. It is possible that some ambulatory visits are not coded as well child visits since physicians for most disabled children may find a medical condition even during a well child visit.

Figure III-23: Percentage of SSI Children Receiving an Ambulatory Service

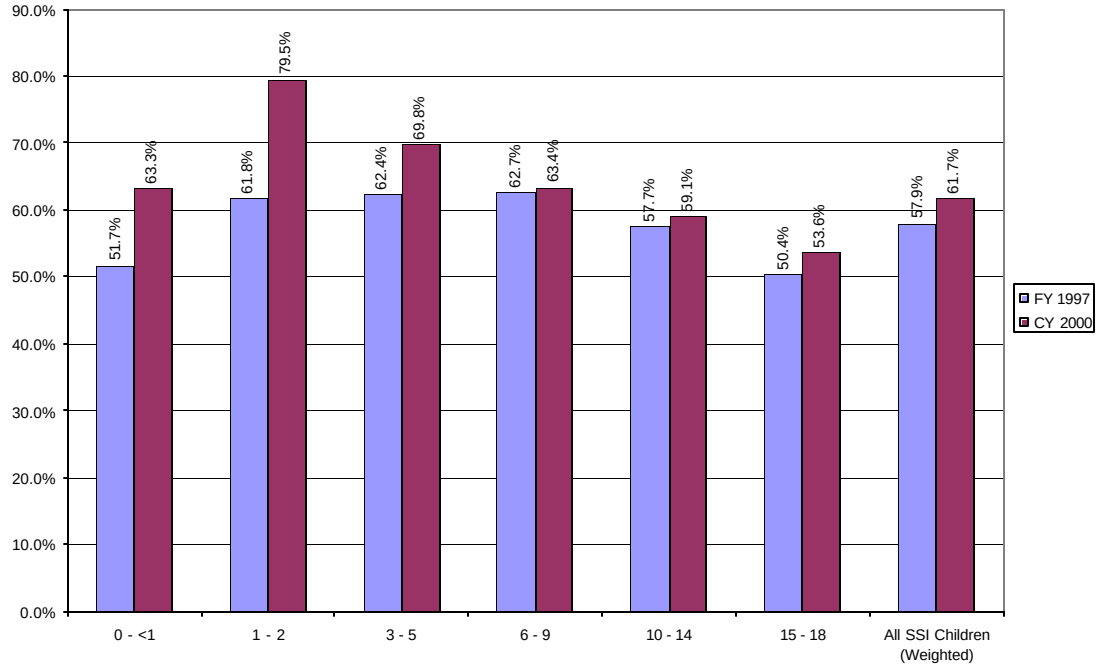
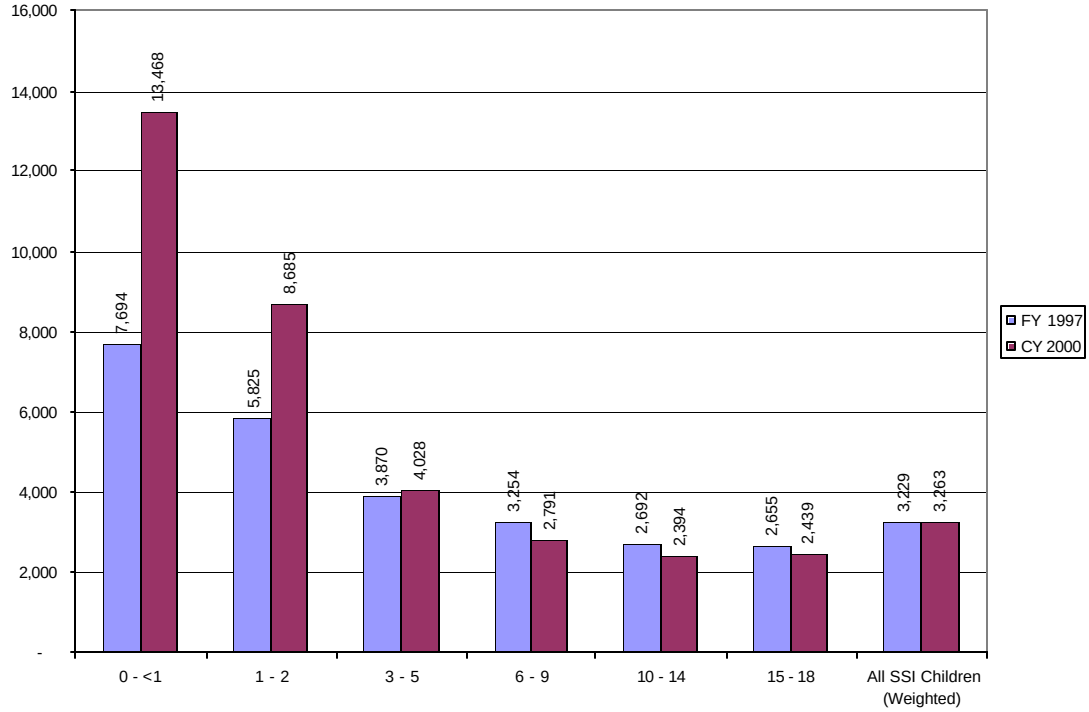
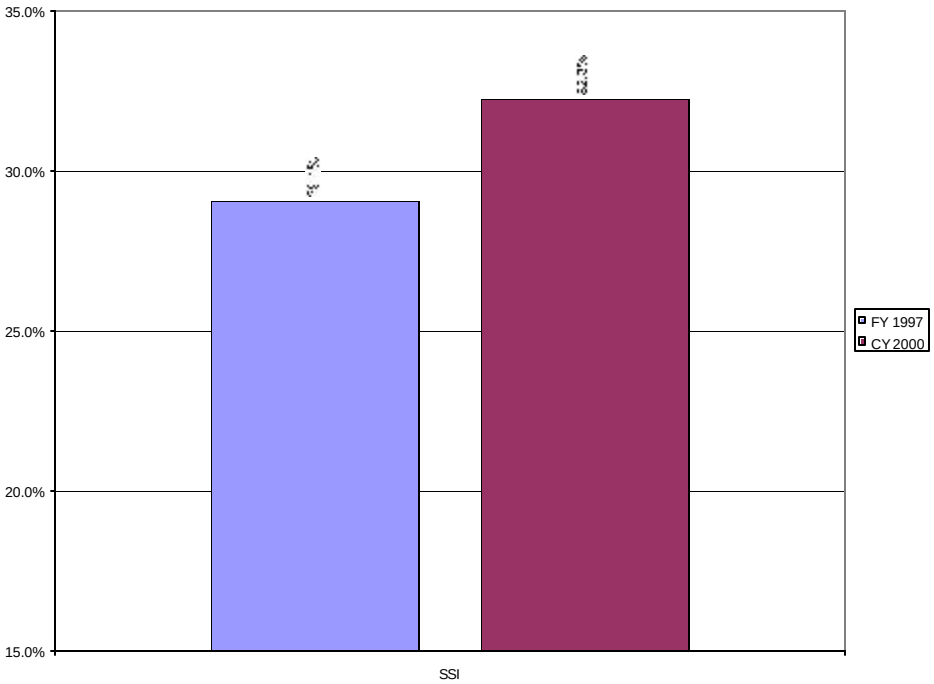


Figure III-24: Ambulatory Visits per Thousand Annualized, by Age



SSI children enrolled in MCOs did experience marginal increases in ambulatory visits per thousand, a trend that contrasts with what was observed in the general population. Well child visits per thousand also increased slightly for SSI children enrolled in HealthChoice MCOs, rising from 446 to 491.

Figure III-25: Percentage of SSI Children Receiving a Well Child Service



SSI Children – MCO and REM Combined. In most of the analyses in this evaluation that compare experience before and after HealthChoice implementation, measures based on CY 2000 encounter data are compared to fee-for-service data from FY 1997. These comparisons ignore the fact that the utilization of individuals in the REM program is not captured by encounter data (encounter data does not include carved-out services) utilization for the REM population is in the FY 1997 fee-for-service data. Because the REM population is very small compared to overall HealthChoice enrollment (less than 1 percent), in most of the analyses presented, the 'missing' REM population has no significant effect.

This is not the case for children with SSI eligibility. In CY 2000, the REM population accounted for nearly 10 percent of SSI children enrolled in HealthChoice. Failure to account for the REM population, therefore, can skew comparisons of services utilization by SSI children before and after the implementation of HealthChoice. This is especially important since, as the following section shows, REM enrollees use significantly more services than SSI children do. Although there is no methodology for removing the REM population from the FY 1997 data, theoretical adjustments can be made to the CY 2000 data in an effort to assess their impact on utilization rates.

As the following tables show, combining the utilization of the CY 2000 SSI children with that of the FY 2000 REM children demonstrates that these children receive a higher volume of service under HealthChoice. Overall, 65 percent of SSI/REM children received an ambulatory visit in CY/FY 2000 as compared to 58 percent in FY 1997[13]. With respect to visits per thousand, the SSI/REM children received 3,740 in CY/FY 2000 as opposed to 3,229 in FY 1997.

[13] REM data was calculated based on fiscal year as opposed to calendar year. All other methodologies were the same.

Figure III-26: Percentage of SSI/REM Children Receiving an Ambulatory Care or Well Child Service

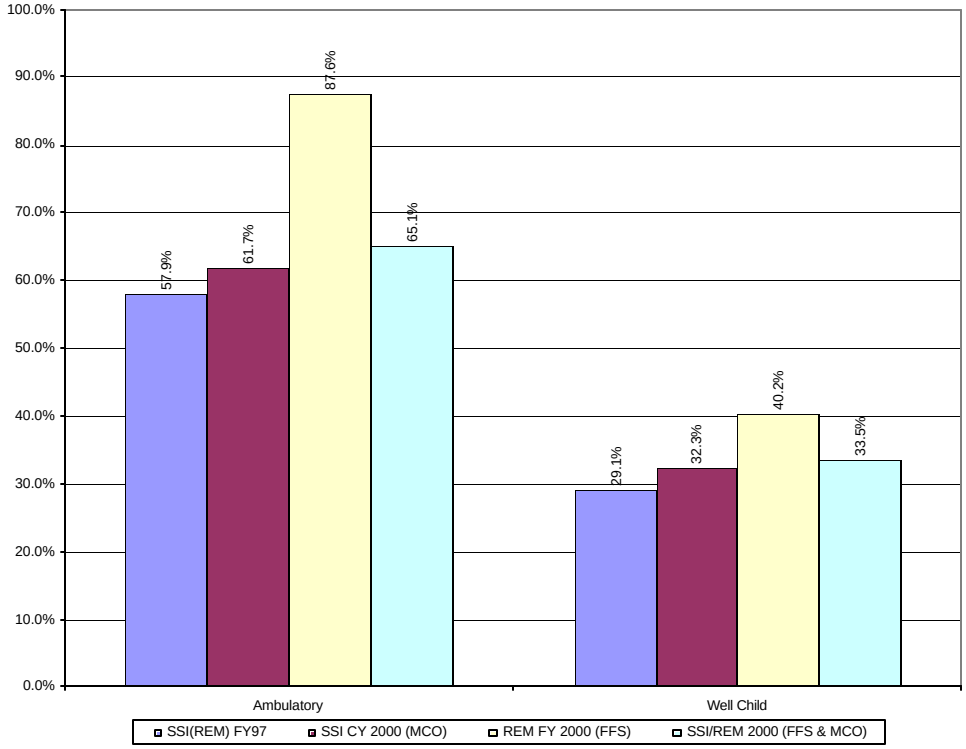
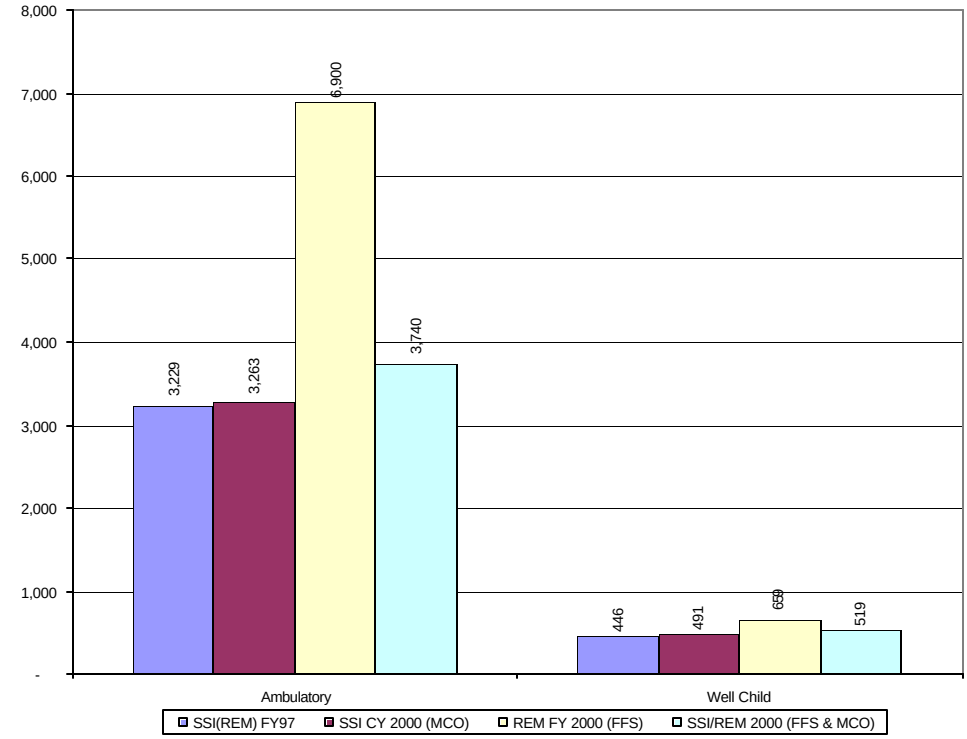


Figure III-27: Ambulatory Visits per Thousand Annualized



Discussion. Although the SSI population has remained relatively constant over the evaluation period, the carve-out of the REM program has had a noticeable impact. In FY 1997, approximately 10 percent of the SSI child population was comprised of future REM enrollees. The result would be seemingly depressed levels of service use among CY 2000 SSI children. The combination of SSI and REM data, as presented in the tables above, demonstrates the impact of merging the two populations.

The examination of this data suggests that the HealthChoice program has been successful at service delivery for special needs children. Special needs children, as defined by SSI and REM eligibility, have had improved access to care, including preventive services. Furthermore, these children have seen increases in the level of services they receive with the greatest increases among those below the age of five.

Rare and Expensive Case Management

Introduction. The REM program is a carve-out of HealthChoice created to provide intensive case management services to a select group of individuals with rare, expensive, and chronic medical conditions. The specific goals of REM case management are: 1) to facilitate access to quality health care through a varied provider network, 2) to promote coordination of services, and 3) to optimize the REM enrollee's functional ability and quality of life. To be eligible for the REM program, the individual must qualify for HealthChoice and, in addition, meet specific diagnostic and age criteria. REM enrollees receive medical care on a fee-for-service basis from Maryland Medicaid providers. The REM program is administered by the Department through a contractual relationship with the Center for Health Program Development and Management (the Center) at University of Maryland, Baltimore County (UMBC).

The REM program has experienced a number of changes over time. Initially, the REM Unit at the Center employed some of its own case managers. As of December 31, 1998, all direct case management responsibilities were transitioned to five private agencies selected through a competitive bid process. There were also changes with regard to the qualifying diagnoses. During the first year of the program (FY 1998), 138 ICD-9 codes covering 10 condition types qualified for the REM program. This list was expanded to cover 31 condition types in FY 1999 as new ICD-9 codes were added to the list and others were dropped. For some conditions, the age eligibility criteria also changed. Finally, the mandatory enrollment requirement was eliminated in FY 2000 to allow people to stay in MCOs if they choose.

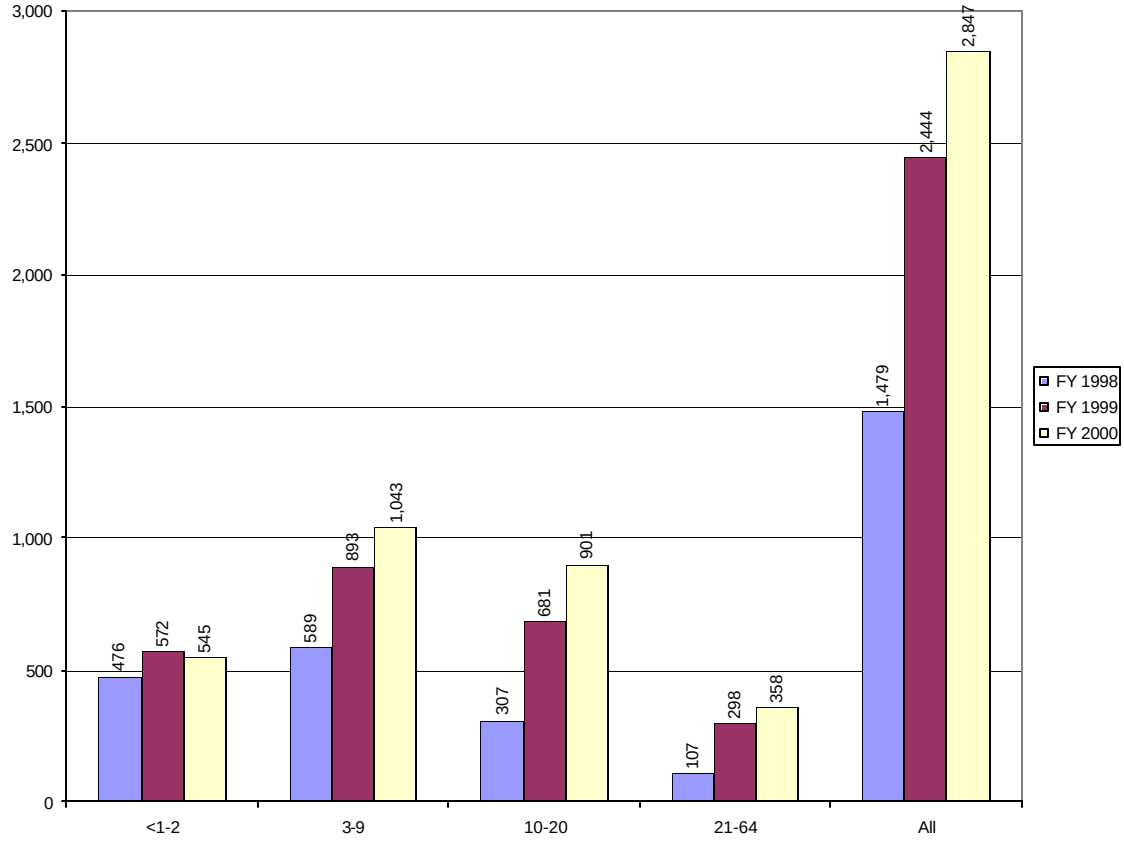
Methodology. Although the methodology used to calculate services utilization by the REM population is the same as for the other measures presented in this section, there are two caveats that merit consideration. First, the time frames for

comparisons (i.e., FY 1997 for Medicaid fee-for-service, CY 2000 for HealthChoice, and FY 2000 for REM) do not match precisely. The data available for the REM population were based on claims data for FY 2000. The data available for the fee-for-service population in FY 1997 are based on FY 1997 claims data, which includes claims for services provided to REM-eligible individuals. The data available for the HealthChoice population were based on encounter data from CY 2000 and did not include the REM-eligible individuals. Second, the measures of service utilization expressed herein are appropriate to summarize the data of large populations. The REM population, however, is made up of less than three thousand people. Since the majority of the REM population is children under the age of 21, those in the 21 to 64 age range were aggregated in order to increase the sample size for extrapolation to visits per thousand.

The REM Population. Like the HealthChoice program as a whole, Rare and Expensive Case Management is in its fourth year of operation. During the first year 1,479 individuals were enrolled in REM. Enrollment increased 65 percent to 2,444 members in FY 1999. This large enrollment increase has been attributed to intensive outreach efforts, the qualifying diagnoses, and the expansion of age eligibility for some diagnostic conditions. There were 2,847 REM enrollees in FY 2000, representing a 16 percent increase from FY 1999. The majority of the REM enrollees were children under age 21. In FY 2000, 87 percent of the REM enrollees are children under the age of 21. This represented a small decline from the 92 percent in FY 1998. Some of the changes in the distribution of the REM enrollees by age group are due to programmatic changes made with regard to age eligibility criteria for a number of diagnoses.

The percentage of REM enrollees in the Families and Children eligibility category declined from 48 percent in FY 1998 to 34 percent in FY 2000, and the percentage of REM enrollees in the Disabled eligibility category grew from 50 percent to 59 percent during the same period. REM enrollees eligible through MCHP increased from three percent in FY 1999 to six percent in FY 2000. For all three years, less than two percent of REM enrollees were in the “Other” eligibility category.

Figure III-28: Changes in REM Population 1998 to 2000



REM Ambulatory Care Visits. Overall, the REM population in FY 2000 had a higher percentage of individuals with ambulatory care visits than the HealthChoice population in CY 2000 and the fee-for-service population in FY 1997. Within the REM population in FY 2000, 83.2 percent of the enrollees received health care services compared to 60.3 percent of the MCO-enrolled HealthChoice population in CY 2000, and 57.8 percent of the fee-for-service population in FY 1997. The REM population in FY 2000 had a higher percentage of ambulatory care visits in all age groups compared to the other two populations.

There were large differences in the number of ambulatory care visits per thousand among the three populations. Overall, the REM population in FY 2000 received 6,664 visits per thousand compared to 3,367 visits per thousand for the HealthChoice population in CY 2000 and 4,301 visits per thousand for the fee-for-service population in FY 1997. The REM population in FY 2000 had more ambulatory care visits per thousand in all age groups than the other two populations. The higher utilization of ambulatory care visits for the REM population, however, was expected because this is a targeted population with chronic conditions that are likely to have higher levels of service needs.

Figure III-29: Percentage of REM Population Receiving an Ambulatory Service by Age

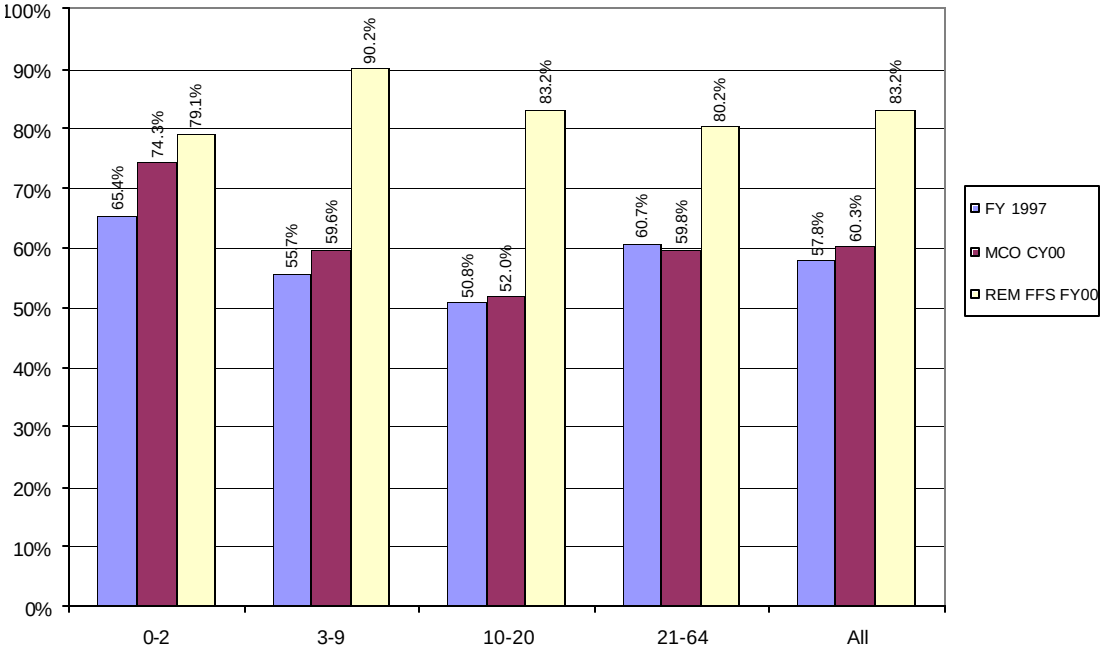
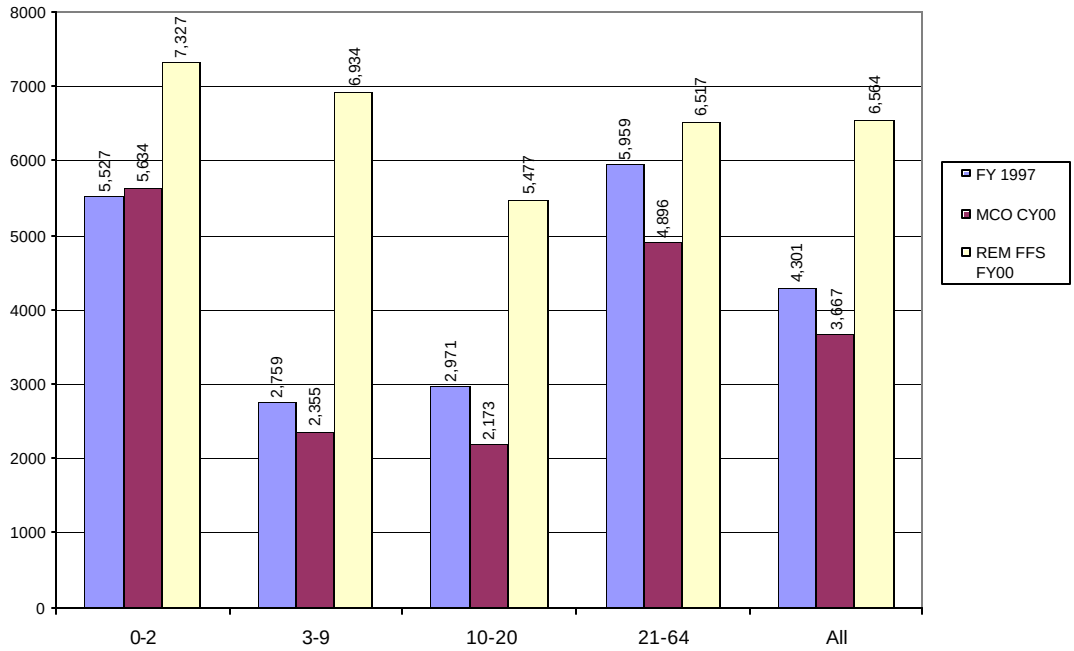


Figure III-30: Ambulatory Visits of REM Population per Thousand Annualized by Age



REM Well Child Visits. The percentage of children receiving well child visits was slightly higher for the REM population compared to the other two populations. For FY 2000, 39.4 percent of children enrolled in REM had well child visits, compared to 40.0 percent of children enrolled in HealthChoice MCOs for CY 2000, and 36.0 percent of children in the fee-for-service population for FY 1997.

The number of well child visits per thousand, however, was slightly lower for the REM population than for the other two populations. In FY 2000, the REM population had 726 visits per thousand, as compared to 905 visits per thousand for the MCO-enrolled HealthChoice population in CY 2000, and 871 visits per thousand for the fee-for-service population in FY 1997. For all three populations, the largest number of well child visits per thousand was for children aged 0-2. For those aged three to 18, the number of well child visits dropped sharply for all populations.

The utilization of well child visits were expected to be about the same for the all three populations since the children were treated according to the same periodicity schedule for well child care. The slightly higher percentage of REM children receiving well child visits may be attributable to case managers' reminders. A possible explanation for the smaller number of well child visits per thousand for REM children is the likelihood that a substantial number of visits for periodic preventive care also address a disease issue. Under these circumstances, the PCP would code the service as a "sick" visit rather than a "well child" visit.

Figure III-31: Percentage of REM Population Receiving a Well Child Service by Age

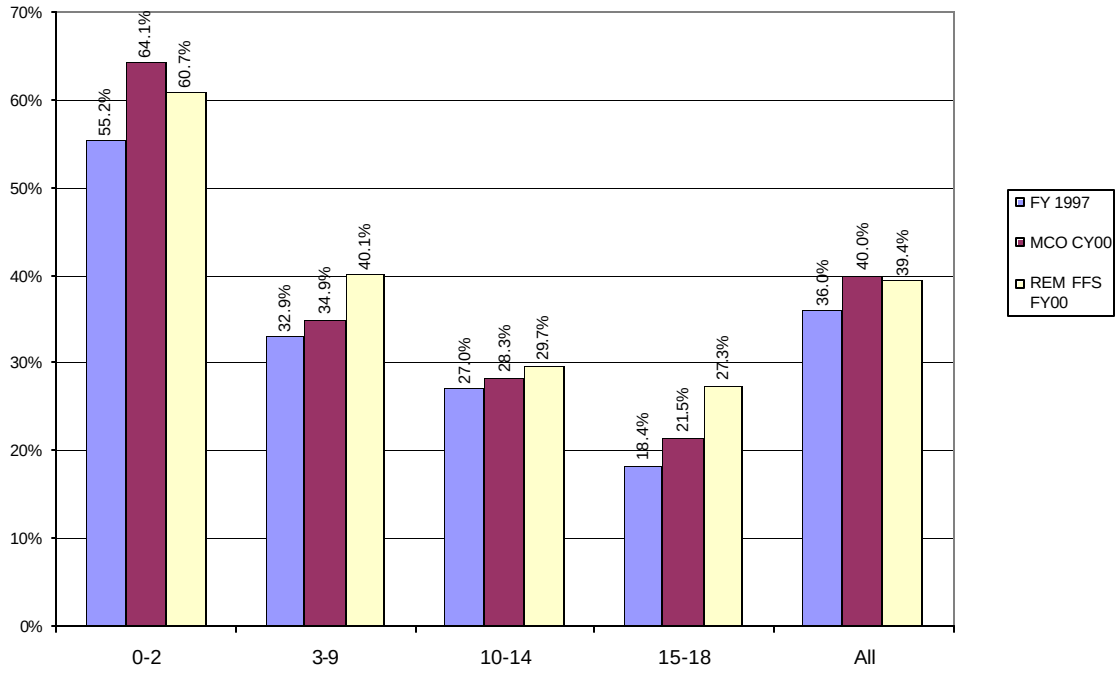
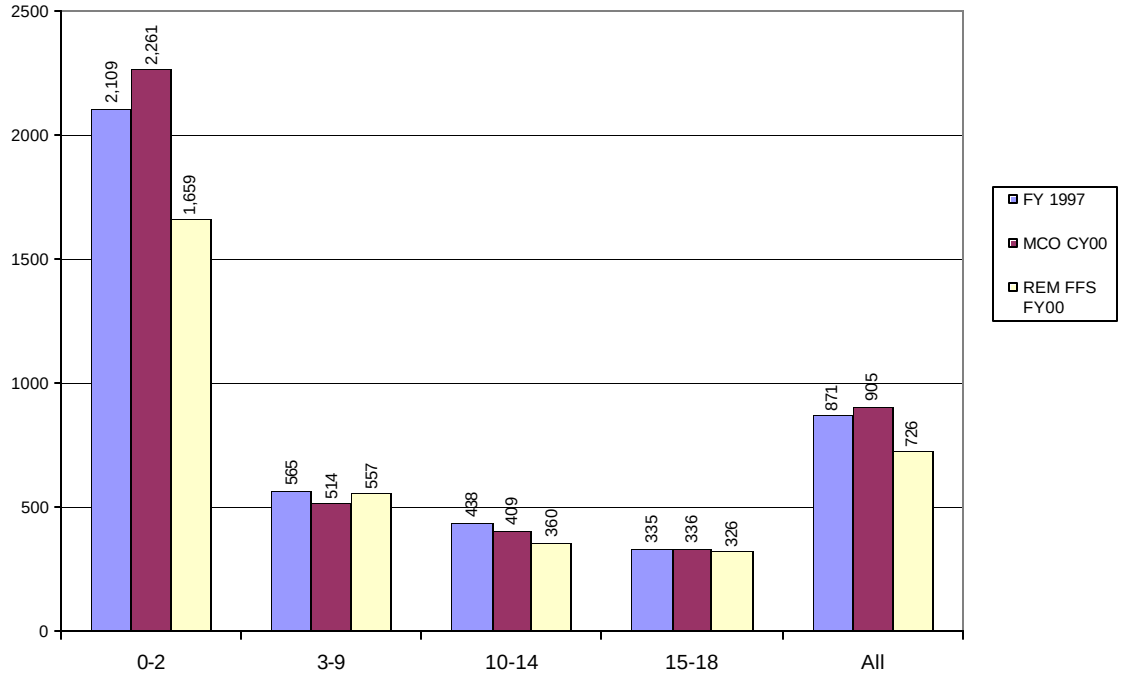


Figure III-32: Well Child Visits per Thousand Annualized by Age



REM ER Visits. Overall, a higher percentage of REM population had ER visits compared to the other two populations. Within the REM population in FY 2000, 21.7 percent of the enrollees had an ER visit compared to 14.4 percent in the MCO-enrolled HealthChoice population in CY 2000, and 15.1 percent in the fee-for-service population in FY 1997. The REM population also had higher numbers of ER visits per thousand. The REM population in FY 2000 had 398 ER visits per thousand compared to 301 ER visits per thousand for the MCO-enrolled HealthChoice population in CY 2000, and 346 ER visits per thousand for the fee-for-service population in FY 1997. Within the REM population, those in the 21-64 age group had the highest percentage of ER visits and the highest number of ER visits per thousand. For the other populations, the 0-2 age group had the highest percentage of ER visits and the highest number of visits per thousand. The REM population may be at a higher risk for emergency services compared to the general HealthChoice population.

Figure III-33: Percentage of REM Population Receiving an Emergency Room Service by Age

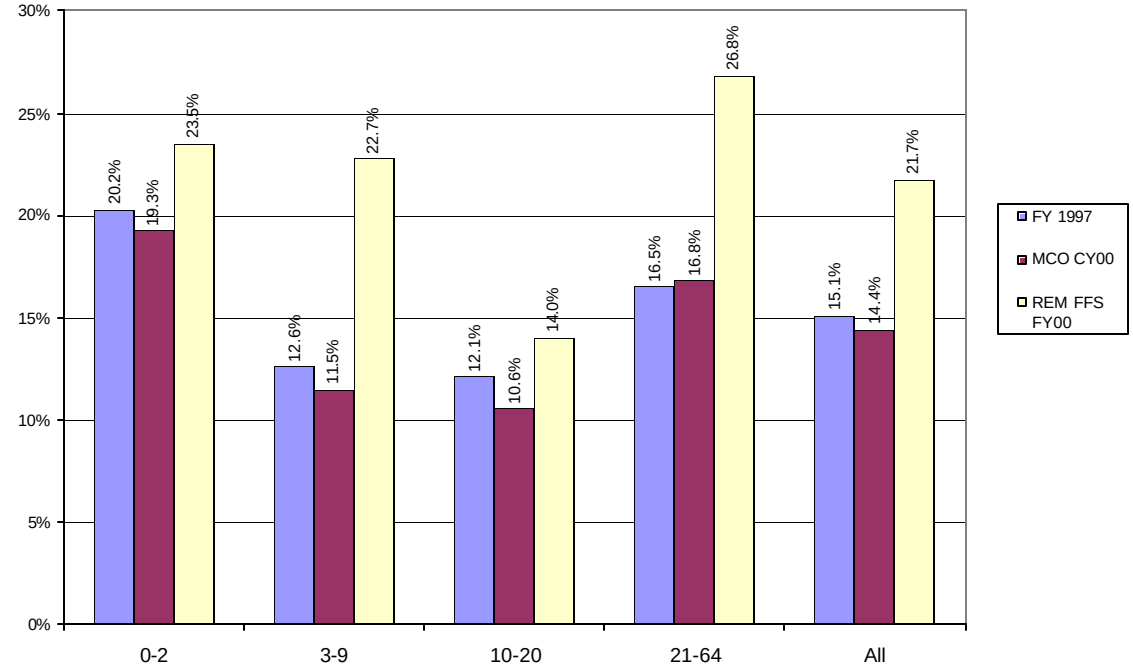
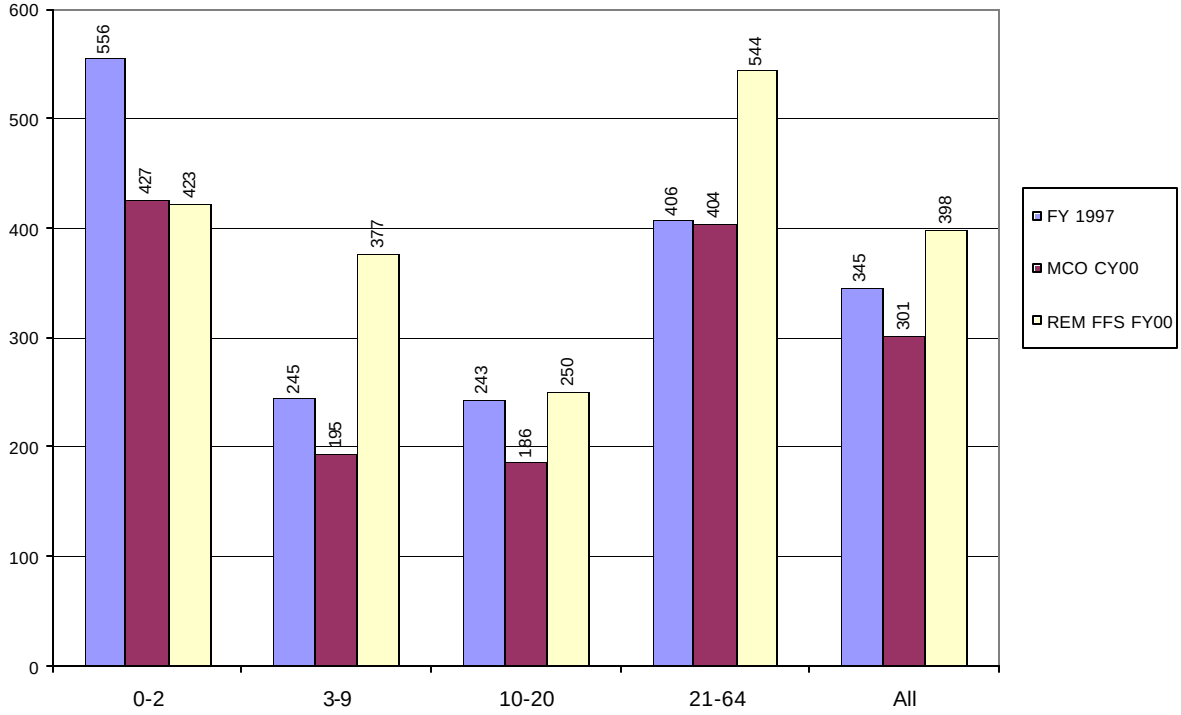


Figure III-34: Emergency Room Visits per Thousand Annualized by Age



The utilization patterns for the REM program were consistent with what would be expected from a chronically ill, high-risk population that would potentially benefit from intensive case management. Overall, a higher percentage of the REM population in FY 2000 received ambulatory care visits, ER visits, and well child

visits compared to the MCO-enrolled HealthChoice population in CY 2000 and the fee-for-service population in FY 1997.

The REM Cohort Study. The previous discussion considered the REM population relative to the HealthChoice population overall. Not surprisingly, the REM population used services at a considerably higher rate than the general HealthChoice population. This section will focus on how individuals within the REM program have fared over time.

- *Introduction*. In FY 2000, a cohort design was used to study the cost and utilization in the REM program. In this study, 450 REM enrollees were found to have two years of continuous enrollment in the MAC program (FY 1996 and FY 1997) and two years of continuous enrollment in the REM program (FY 1998 and FY 1999). Continuous enrollment was defined as less than six months break between MAC disenrollment date and REM enrollment date, and no more than three months break in enrollment during any program year.

- *Findings.* The results from this study show that the total medical cost was lower in FY 1999 than in FY 1997 and the average per member per month (PMPM) medical cost declined from $3,044 in FY 1997 to $2,907 in FY 1999 (case management cost not included). Compared to FY 1997, both the medical cost and service utilization for the REM cohort in FY 1999 were lower in six of the eight claim types, including dental, home health, inpatient hospital, long-term care, outpatient, and physician services. Two areas of increases in medical cost and service utilization were in pharmacy and special services. Since REM enrollees are by definition a chronically ill population that includes many individuals with degenerative diseases, it is expected that the need for medication and special services would increase over time. Many of the service provisions under special services address educational needs, which are likely to reduce duplication of services and lead to early detection and treatment of symptoms. It is hoped that the shift to increased utilization of pharmacy and special services would lead to further decline in medical cost in the long run by reducing complications and the use of inpatient and ER services.

Occupational Therapy, Physical Therapy, Speech Therapy and Audiology Services.

Introduction. At present, HealthChoice MCOs are not responsible for providing physical therapy, occupational therapy, speech therapy or, audiology to enrollees less than 21 years old. When the HealthChoice program was implemented, these services were an MCO responsibility, and MCOs could require enrollees to access them through in-plan providers. HealthChoice regulations were changed

in 1998 to allow special needs children the flexibility of being able to access "medical services such as physical therapy, occupational therapy, or speech therapy" by self-referral under certain circumstances. MCOs would then have to reimburse the self-referred providers of these services at applicable Medicaid fee-for-service rates. Effective November 1999, the regulations were changed again to create a carve-out for physical therapy, occupational therapy, speech therapy, and audiology services.

Except when delivered as part of an inpatient hospital stay, medically necessary physical therapy, speech therapy, occupational therapy, and audiology services may be accessed by enrollees under 21 years old through any willing Medicaid provider, who then looks directly to the Department for reimbursement on a fee-for-service basis. To assess the effectiveness of this 'carve-out' a study was conducted to examine the pattern of therapy service utilization and provider networks before HealthChoice, during HealthChoice, and after the carve-out of therapy services.

Methodology. As the purpose of this analysis is to examine what happened when a set of services was removed from the HealthChoice benefit package, it uses a different methodology than many of the other analyses in this evaluation. The population selected for this study consisted of children less than 21 years of age that were HealthChoice eligible in FY 1997 and HealthChoice enrolled from FY 1998 through FY 2001. In addition, these children must be receiving one or more of the following services: 1) occupational therapy (OT), 2) physical therapy (PT), 3) speech therapy (ST), and 4) audiology services (AU).

The study uses fee-for-service claims from FY 1997 and FY 2001. Encounter files from FY 1998 to FY 2000 are used to capture MCO services utilization. Three time periods were defined:

- *Fee-for-service period.* The fee-for-service period is FY 1997 (7/1/1996 through 6/30/1997).

- *HealthChoice period.* The HealthChoice period consists of FY 1998, FY 1999, and FY 2000 (from 7/1/97 through 10/31/1999). During the HealthChoice period, the program's capitation payments to MCOs included therapy services, which were part of the benefit package for which MCOs were responsible at that time. A small subset of the HealthChoice population, however, was enrolled in the Rare and Expensive Case Management program (REM) rather than in MCOs. Services for the REM population were paid on a fee-for-service basis by the Medicaid program. Thus, the HealthChoice period included both MCO and fee-for-service payments.

- *Therapy carve-out (fee-for-service) period.* The carve-out of therapy services became effective on November 1, 1999. The time period

covering November 1, 1999 through April 30, 2001 made up the therapy carve-out (fee-for-service) period.

There are two caveats that merit consideration. The first relates to the count of the number of providers during the different time periods. It is important to note that many of the therapists provide services through agencies that bill using only one provider number per discipline. Thus, the number of different providers billing for service may be an underestimate of the true number of individual providers. This was, however, true for the entire study period and did not differentially affect one year. The second relates to changes in the eligibility criteria for the REM enrollees in FY 1999. REM children with cerebral palsy (ICD-9 codes 343.0 and 343.2) could choose to leave MCOs and be enrolled in Medicaid fee-for-service. This choice was selected by 373 children in FY 1999 and 166 children in FY 2000 and would likely impact the number of children being served in MCO versus fee-for-service settings.

Occupational Therapy and Physical Therapy - Findings. There appears to be a small declining trend in the percentage of children receiving therapy services over the years. The number of children receiving occupational and physical therapy services increased following the implementation of HealthChoice, from 1,264 in FY 1997 to a high of 1,763 in FY 1998, although the population of children enrolled in HealthChoice decreased in FY 1998. After the carve-out, the number of children receiving occupational and physical therapy services appeared to have declined to roughly 1,000 children receiving services. The average number of occupational and physical therapy services increased from 5.4 in FY 1997 to a high of 9.7 in FY 1999, and then dropped to 8.3 after the carve-out. It is important to note that the utilization of occupational therapy, physical therapy, speech therapy, and audiology services during the carve-out years all represent full-year estimates based on partial-year data. The claims data for FY 2001 were still being updated at the time of this study, and the utilization numbers were likely to be underestimated.

Speech Therapy and Audiology Services - Findings. The number of children receiving speech therapy and audiology services declined after implementation of the HealthChoice program, from 3,692 in FY 1997 to a low of 3,022 in FY 1998. After the carve-out, 2,029 children received speech therapy and audiology services. Utilization did not return to the pre-HealthChoice level. The average number of speech therapy and audiology services decreased from 3.3 visits in FY 1997 to 2.7 visits in FY 1998 and then increased after the carve-out to an average of 5.2 visits. Many more children received speech therapy/audiology services than children that received occupational or physical therapy services. The average number of occupational or physical therapy services received per child per year was higher than the average number of speech therapy/audiology services per child.

Provider Network. A number of findings were suggestive of provider shifts. First, physician claims increased for occupational/physical therapy and speech therapy/audiology services during HealthChoice years then declined after the therapy carve-out. Second, Special Services claims for occupational/physical therapy and speech therapy/audiology services were lower during HealthChoice years but increased after the therapy carve-out. This may be due to therapists billing under their own provider number rather than through a physician after the therapy carve-out. Third, the number of providers increased during HealthChoice years then decreased after the therapy carve-out. In general, the number of providers was likely to be underestimated, assuming that multiple individual therapists practiced in professional groups, with all providers in the group billing under a single provider number. To the extent that this assumption is valid, however, group billing should not affect claims experience in one year more than in another. Finally, there were fewer fee-for-service providers in FY 2000 and FY 2001 than there were in FY 1997.

Discussion. The analysis of therapy services before and after their removal from the HealthChoice benefit package indicates that the strategy of "carving-out" specific services was unwise. With respect to both occupational/physical therapy and speech therapy/audiology services, the number of children receiving services declined following the carve-out. Although carve-outs are sometimes suggested for specific services as a way of improving access, this carve-out appears to have the opposite effect. Several reasons may account for this. First, Medicaid rates for community-based therapy services are quite low; MCOs may pay higher rates to secure a broader network of providers. Second, some enrollees may be confused about whether these therapies are carved out, whether they have coverage for them, or how and where they can access these services.

SUBPOPULATION ANALYSIS - INDIVIDUALS WITH CHRONIC ILLNESS

Overview

The preceding analyses focused on the utilization and experience of special needs children. Individuals with long-term chronic illness are another sub-population meriting special analysis. These individuals are likely to have great need for services. In some managed care systems, individuals with chronic illness have been viewed as patients to avoid. They are, therefore, the type of population that the risk adjustment mechanism used in HealthChoice was intended to address. Risk adjusted capitation is designed to ensure that MCOs are paid more for individuals with poorer health status.

Subpopulations of Individuals with Chronic Illness

Subpopulations Identified. This section looks at three separate subpopulations, of individuals with chronic illness. The targeted subpopulations include:

- *Individuals with diabetes*. The utilization patterns of individuals with diabetes before and after implementation of the HealthChoice program are compared below. This subpopulation is interesting in that its size has remained relatively constant since HealthChoice was implemented at the beginning of FY 1998.

- *Individuals with asthma.* Like those of individuals with diabetes, the utilization patterns of individuals with asthma are compared before and after the beginning of the HealthChoice program. Unlike individuals with diabetes, however, the individuals with asthma subpopulation has grown markedly since 1997.

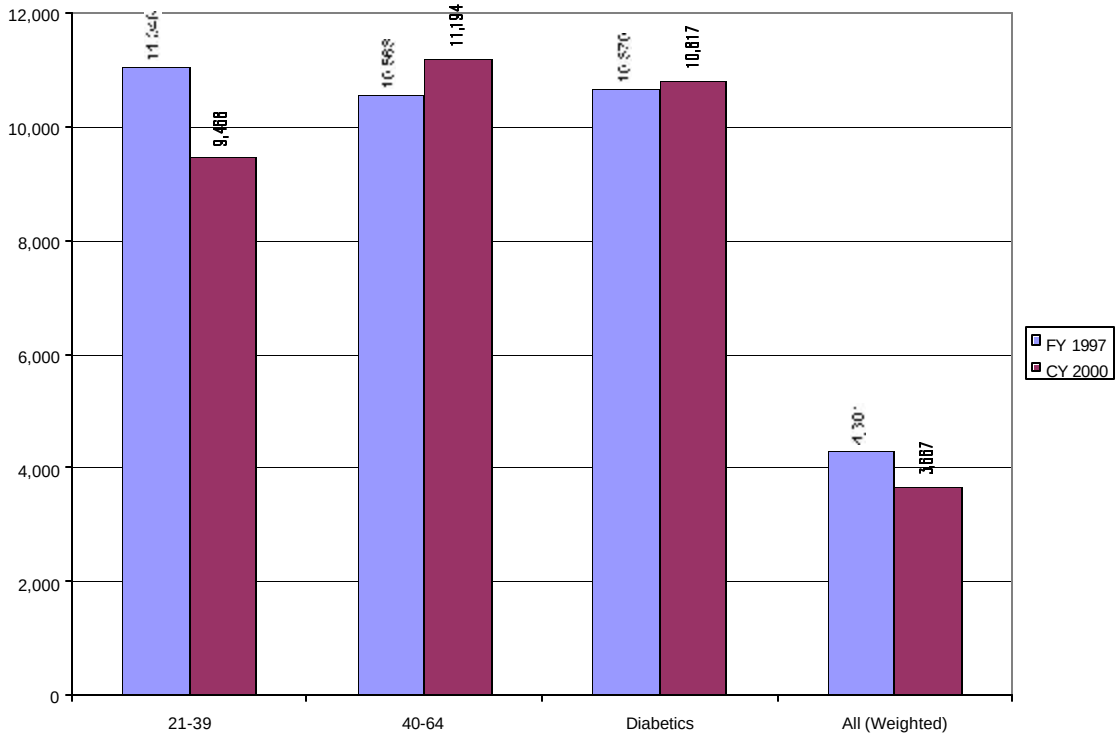
- *Individuals with HIV/AIDS*. Since the implementation of the HealthChoice program, two separate, medical records-based reviews were conducted to assess services to individuals with HIV/AIDS. The results of those studies are reviewed and analyzed below.

Individuals with Diabetes. Diabetes is a long-term chronic condition that affects primarily adult HealthChoice enrollees. In view of demographic differences in HealthChoice enrollment in FY 1997 and CY 2000 (i.e., the disproportionate increase in children, especially adolescents, enrolled in HealthChoice), HealthChoice utilization data for diabetes may be more comparable to pre-HealthChoice utilization data than other measures are. The percentage of HealthChoice-eligible individuals with a diagnosis of diabetes on a physician encounter was 2.1 percent in FY 1997 and 1.5 percent in CY 2000. The diabetic population is predominantly age 21 and older. Because the number of diabetics under age 21 enrolled in HealthChoice is too small to provide reliable estimates,

results for that age group are not presented. The regional distribution of individuals age 21 and older with diabetes closely mirrors that of the general population. The analysis of diabetes focuses on the number of ambulatory visits per thousand.[14]

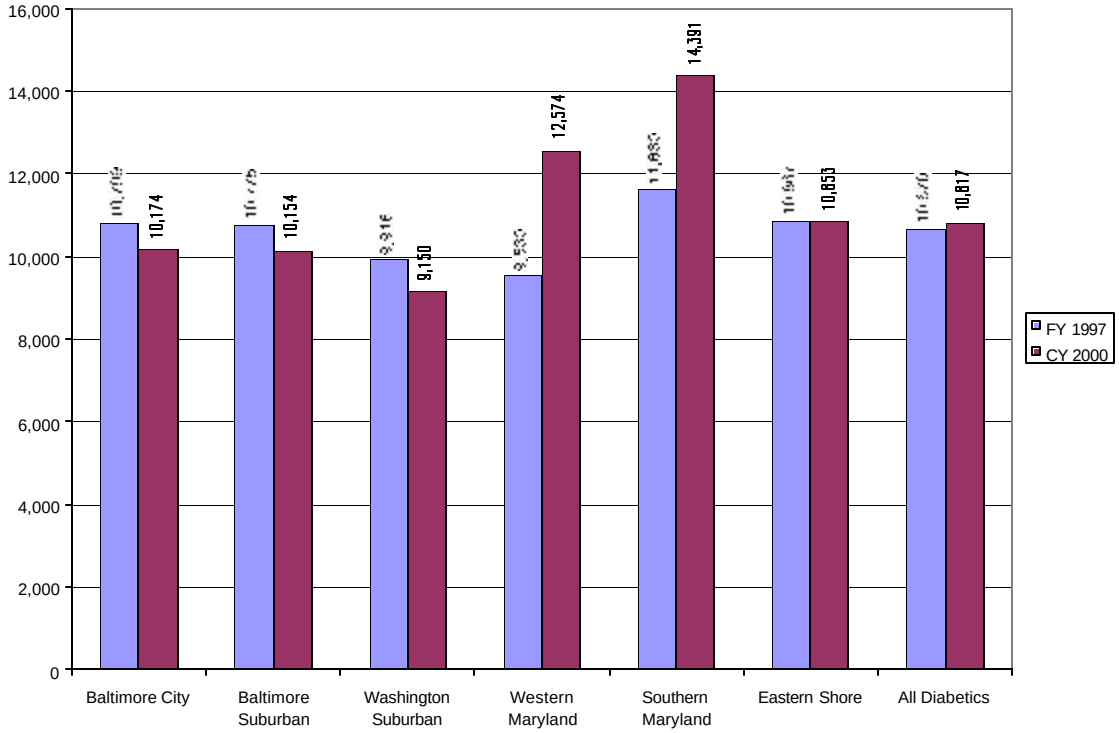
- *Findings.* Overall, service use by individuals with diabetes has remained virtually unchanged before and after HealthChoice implementation. The average number of visits per thousand increased by just over 1 percent (10,670 in FY 1997 to 10,817 in CY 2000). While overall utilization by individuals with diabetes was essentially unchanged, an analysis of the data by age presents a slightly different picture. Among those individuals ages 21-39 with diabetes, service use was down (from 11,408 in FY 1997 to 9,468 in CY 2000). Those declines were offset by increases among individuals aged 40-64 with diabetes (10,566 in FY 1997 to 11,194 in CY 2000).

Figure III-35: Ambulatory Care Visits for Diabetics per Thousand Annualized by Age



[14] Since individuals with diabetes are identified by a diagnosis associated with a visit, it would be inappropriate to examine the percentage who had a visit.

Figure III-36: Ambulatory Care Visits for Diabetics per Thousand Annualized by Region



- *Discussion.* Utilization patterns of individuals with diabetes were virtually unchanged between FY 1997 and CY 2000. For individuals with a chronic condition, managed care has not led to measurable reductions in the amount of care (as measured by the number of visits). It should also be noted that prior to the introduction of HealthChoice, Maryland operated the Diabetes manage d care program, which provided additional services for individuals with diabetes who enrolled in the program. The program served approximately 2,500 individuals in 1997. It is reasonable to conclude, therefore, that a portion of the HealthChoice diabetic population was already being served through a managed care system of care before the HealthChoice program was implemented.

Individuals with Asthma. Like diabetes, asthma is a chronic condition that requires regular and close monitoring. Unlike diabetes, however, the experience of this population before and after the implementation of HealthChoice is considerably different. The number of individuals with an asthma diagnosis grew by 48 percent from FY 1997 to CY 2000, and the adolescent proportion of the individuals with asthma population became significantly greater. This increase in adolescent asthma mirrors the growth in the overall HealthChoice adolescent population resulting from the MCHP expansion, as discussed earlier.

- *Findings.* The population consisting of individuals with asthma is located predominately in the city and suburban regions, and is spread across most

age groups. It experienced the same growth as the overall HealthChoice population, but there was less decline in utilization by individuals with asthma than in the overall HealthChoice population. Utilization declined in the urban/suburban regions, and increased slightly in the rural regions. The improved access in rural areas is significant, given that the HealthChoice subpopulation of individuals with asthma is growing at a faster rate there than in urban areas. With respect to ER visits, utilization by this population has declined at a rate similar to that experienced by the overall HealthChoice population.

Figure III-37: Ambulatory Visits for Asthmatics per Thousand Annualized by Age

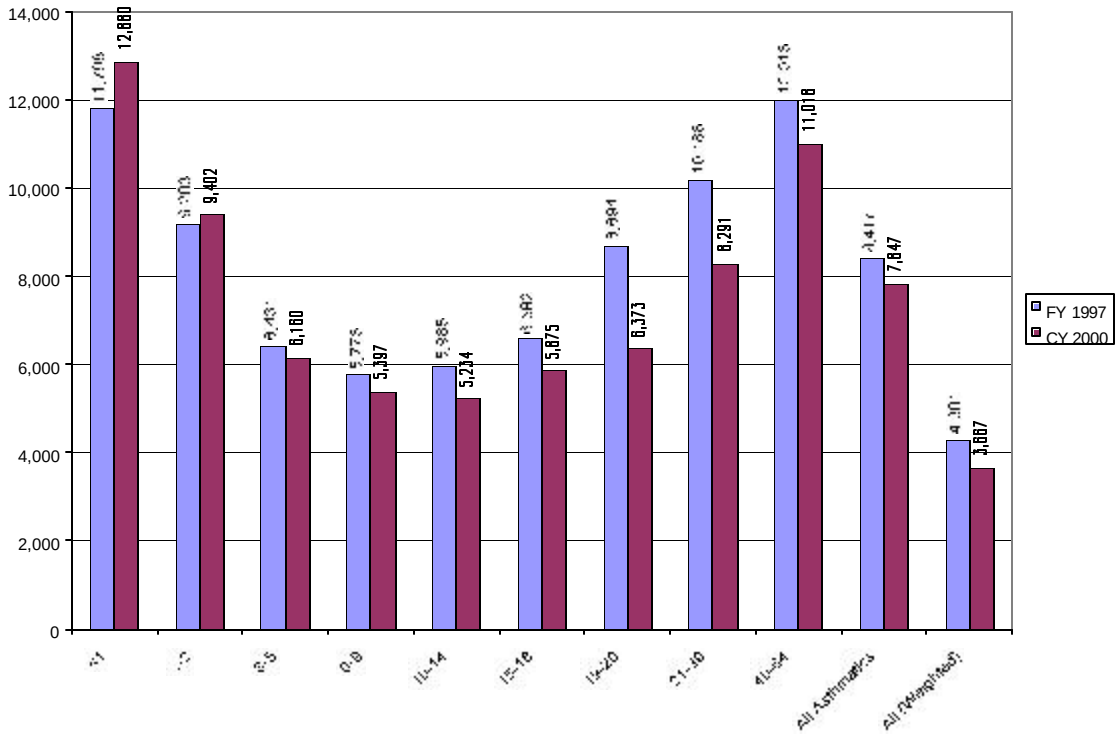


Figure III-38: Ambulatory Visits for Asthmatics per Thousand Annualized by Region

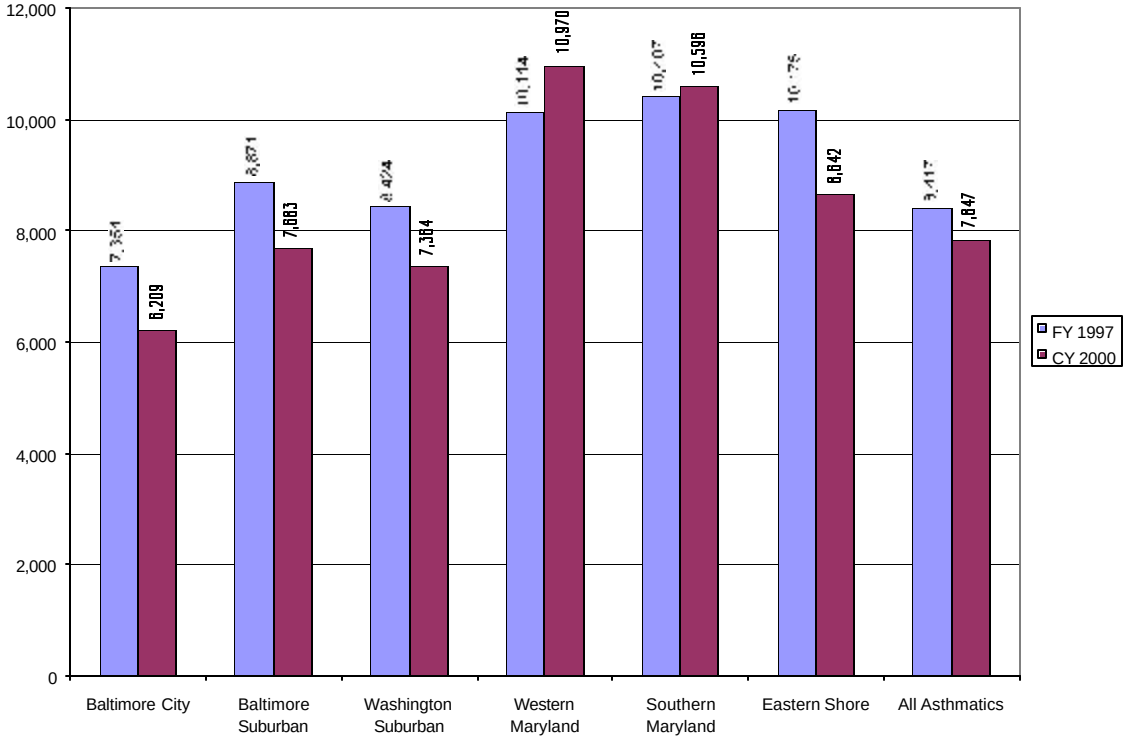
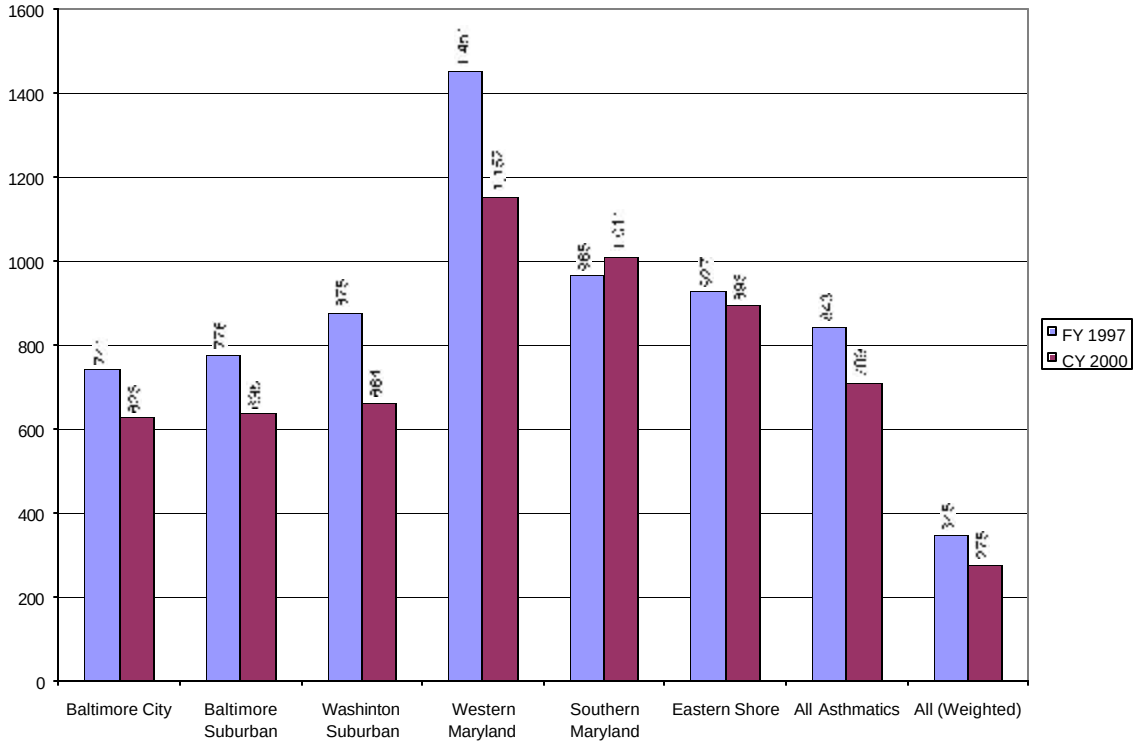


Figure III-39: Emergency Room Visits for Asthmatics per Thousand Annualized by Age



Discussion. The decline in services utilization may be indicative of a combination of factors, including:

- Managed care disease management practices that have reduced utilization;

- General changes in the treatment of asthma that may have led to overall reductions in the number of visits required by asthmatics. For example, better management of asthmatics through new pharmaceuticals;

- The substantial entry into HealthChoice of MCHP-eligible adolescents has added to the program's preexisting Medicaid population a substantial number of children with higher incomes and perhaps less acute conditions that require fewer services than HealthChoice-enrolled children in the "Family and Children" Medicaid eligibility category; and

- Pediatric asthma is one of the quality indicators monitored by the State's contracted External Quality Review Organization (EQRO). The EQRO's calendar year 2000 Annual Quality of Care Audit determined that HealthChoice MCOs had seen improvement of three of the four tracked quality indicators for pediatric asthma including, confirmation of diagnosis, annual health assessment, and the prescribing of quick relief medication.

SUBPOPULATION ANALYSIS - INDIVIDUALS WITH HIV/AIDS

Background

Special Needs Populations. During the HealthChoice planning process, the Department carefully considered the potential impact of the program on enrollees with specific and significant health care needs. As a result, several patient categories were designated as special needs populations. The Department has required each MCO applicant, as a condition of its approval to participate in HealthChoice, to demonstrate specifically its ability to identify and meet the unique health care needs of members of each special needs populations designated in program regulations.[1] Individuals with HIV/AIDS are one of the special needs populations recognized by the program.

HealthChoice Program's Special Provisions for Individuals with HIV/AIDS. The special provisions for enrollees with HIV/AIDS, as provided in the program's regulations, include:

- Access to case management services;
- The option of accessing one diagnostic evaluation service (DES) assessment per year by self-referral to an out-of-plan provider;[2]
- Access to substance abuse treatment services within 24 hours of request;
- Access to clinical trials;
- Access to providers with appropriate clinical credentials; and
- A plan of care, updated annually.

AIDS Capitation Enhancement. The Department also paid enhanced capitation rates for patients with AIDS, in recognition that service utilization for this category of enrollees would far exceed that of enrollees with less resource-intensive health conditions.

[1] Since its initial implementation, the HealthChoice program has recognized seven special needs populations. These are: children with special health care needs, individuals with a physical disability, individuals with a developmental disability, pregnant and postpartum women, individuals who are homeless, individuals with HIV/AIDS, and individuals with a need for substance abuse treatment. See COMAR 10.09.65.08 - .11.

[2] An MCO's responsibility to provide additional DES assessments through its network providers is limited only by medical necessity.

Discussion and Findings

Services Provided to Individuals with HIV/AIDS. This evaluation will present the findings of two studies of services provided to individuals in the HIV and AIDS populations enrolled in HealthChoice. The Delmarva Foundation for Medical Care, Inc. (Delmarva) conducted a study for the Department as part of a planned HealthChoice quality improvement project, and the Maryland State AIDS Administration conducted an independent review at the onset of the program. Data from both of these studies address some of the provisions in the HealthChoice regulations that assign special responsibilities to MCOs with regard to their enrollees with HIV/AIDS.

- *Delmarva study.* As a part of the Department's annual Quality of Care Audit, Delmarva conducted several quality improvement studies for the HealthChoice program. The HealthChoice regulations specify that quality improvement audits be conducted on special needs populations. Influenza (flu) immunizations for enrollees with HIV/AIDS were selected as a key clinical indicator for one of the quality improvement studies.

  The Delmarva study sought to improve flu immunization rates, by examining immunization rates in 1998 to comparable rates in 2000. During the first year, each MCO was required to develop baseline data and implement an intervention strategy aimed at increasing flu immunization rates for its members with HIV and AIDS. Interventions were executed during the 1999 flu season. In 2000, MCOs conducted a re-measurement of the data. The data collected through medical record abstraction show much higher rates of immunization than the medical encounter data reported by MCOs. Provider billing and reimbursement practices may contribute to this difference.

  The data collected illustrates that flu immunization rates among enrollees with HIV/AIDS increased from 24 percent in 1997 to 43 percent in 2000. This marked increase suggests that the intervention may have contributed to the increase in the number of immunizations administered. Six of the seven MCOs improved their immunization rates during the audit period.

  Delmarva also looked at the rate of PCP (pneumocystis carinii pneumonia) prophylaxis antibiotic use in the out patient setting with HIV and AIDS patients. The baseline study occurred from October 1997 through September 1998. A re-measurement was done from July of 1999 through June of 2000. The data showed an increase in the rate of prophylactic antibiotic use from 25 percent to 67 percent in this population.

- *AIDS Administration study during transition period.* The Maryland State AIDS Administration conducted a separate evaluation of the impact of the HealthChoice program on people living with AIDS (not including enrollees

with HIV disease who did not meet the CDC definition of AIDS), supported by a grant from the Kaiser Family Foundation and the Department. They examined services provided during the transition period July 1997 to December 1998 as recorded in 1,064 patient records**.** It is important to note that this study begins during the six-month transition period to HealthChoice and may not accurately reflect what is happening now.

The AIDS Administration transition study reported the following results:

- *CD4 and Viral Load Testing*. Only 68 percent of AIDS patients enrolled for more than six months had their CD4 test results and viral load testing recorded every 6 months as recommended by the Public Health Service. More than 95 percent had at least one CD4 and viral load test result recorded during the course of the study.

- *Antiretroviral therapy*. More than 95 percent of AIDS patients with CD4 counts less than or equal to 200 or viral loads greater than 20,000 and enrolled more than 6 months had been prescribed antiretroviral therapy.

- *PCP prophylaxis*. More than 95 percent of AIDS patients with CD4 counts less than or equal to 200 and enrolled for more than 90 days had been given PCP prophylaxis, as recommended by the Public Health Service.

- *Syphilis test*. Nearly one-half of AIDS patients enrolled for more than 90 days were tested for syphilis.

- *Pap test*. Forty percent of female AIDS patients who were enrolled for more than 12 months received a pap test.

- *Tuberculosis.* Sixty percent of AIDS patients enrolled for more than 90 days received a TB test and had the results read.

- *Flu Vaccine.* Approximately 70 percent of AIDS patients enrolled for more than 90 days were offered a flu vaccine.

- *Case management and care plan.* Approximately 50 percent of AIDS patients enrolled for more than 90 days had documentation of case management and a plan of care.

- *DES.* Sixty percent of AIDS patients enrolled for more than 90 days had DES assessments offered and completed.

For many of these indicators, the AIDS Administration reported variations in the results across MCOs.

Conclusion

It is difficult to draw definitive conclusions about health care services offered to HIV/AIDS patients since the beginning of the HealthChoice program. Treatment options have changed significantly during the past several years, especially with the introduction of HAART (highly active antiretroviral therapy). Because of the complexity of HIV treatment, any change in the number of visits gives little indication whether the treatment provided met the standards of care. Therefore, pre- and post-HealthChoice utilization data are not presented as they have been in other sections of this evaluation.

Both studies conducted provide limited data. The AIDS Administration transition period study looks at one period in time with no comparison to pre-HealthChoice or other programs. The records studied by the AIDS Administration reflected care provided during a time of transition in the program, and may not relate to 2001 MCO provider networks. The Delmarva audit produced information on only two areas of care to the HIV and AIDS populations over three years. The limitations of both studies make it difficult to draw conclusions about how HIV and AIDS patients are being served in the HealthChoice program.

SUBPOPULATION ANALYSIS - PREGNANT WOMEN

Prenatal Care

Discussion. Pregnant women are a large population within Medicaid. There were approximately 23,000 births to Medicaid women in FY 2000, over 25 percent of all births statewide. Studying this population and related services utilization, however, has been one of the most challenging aspects of the evaluation for a number of reasons:

- *Delayed MCO enrollment.* Many women become eligible for Medicaid because they are pregnant. As a result, many are not enrolled in a HealthChoice MCO until midway through or late in pregnancy.

- *Decreasing fee-for-service deliveries.* In 1997, the last year before the HealthChoice program was implemented, most pregnant Medicaid-enrolled women's deliveries occurred under the fee-for-service system. By FY 1999 and FY 2000, however, only 20 percent of Medicaid deliveries were paid on a fee-for-service basis. Many of these pregnant women (including undocumented women) did not apply for Medicaid coverage until the time of delivery. The data showed that women who deliver on a fee-for-service basis have poorer outcomes than women enrolled in HealthChoice when they deliver do. This population represents a growing proportion of all Medicaid fee-for-service deliveries from FY 1997 to FY 2000.

- *Prenatal care adequacy*. Measuring the adequacy of prenatal care services is difficult, as the length of enrollment varies significantly in. For women enrolled for the duration of pregnancy, neither fee-for-service nor encounter data indicate the gestational age at which the pregnancy was confirmed. This limits the ability to assess how many services are appropriate for each pregnant woman.

- *Challenges of data collection and interpretation*. Coding practices for prenatal services may have changed with the transition to capitated managed care. Whereas physicians might have billed for each service individually during the pre-HealthChoice period, the more recent use of global codes and procedure codes representing a range of units of service (e.g. "4-6 visits") complicate measurement of similar services. Finally, because the collection of encounter data from out-of-network providers is highly problematic, encounter data for maternity-related services can be expected to be incomplete to the extent that pregnant women may opt to self-refer to out-of-network providers for services covered by the MCOs.

Conclusion. Given these limitations, the Department is not able to present data on the volume of prenatal care provided under HealthChoice. Because of its

importance to the HealthChoice program, prenatal care is an area that the Department will continue to study and evaluate.

Birth Outcomes

Background. The Department was able to complete a study of birth outcomes using linked Medicaid and Vital Statistics data. The Department linked Vital Statistics Administration birth and death certificate data with Medicaid eligibility and demographic information for 1997 through 2000 to measure the proportion of low birth weight deliveries and the number of neonatal deaths. Low birth weight deliveries are babies weighing less than 2500 grams or 5.5 pounds at birth. Neonatal deaths are deaths that occur during the first 28 days of life. This measure better represents the impact of prenatal health on early outcomes than infant mortality, which includes post-neonatal deaths that are more likely to be associated with social and environmental factors).

Analyzing Birth Outcomes Data. The birth outcome analysis differs from other sections of the evaluation in several ways. The data in this analysis are from Vital Statistics, a statewide database. Therefore, it is possible to compare outcomes over time and with the non-Medicaid population in Maryland. Medicaid births to women enrolled in HealthChoice MCOs are shown separately from Medicaid births to women who are not enrolled in MCOs for whom the birth is paid fee-for-service. Most of the Medicaid fee-for-service births are to women who are found to be Medicaid-eligible very late in their pregnancy, or become Medicaid-eligible only after they arrive at the hospital to deliver.

Birth Outcomes and Race. Both outcomes – low birth weight and neonatal deaths – bear a strong correlation to the mother's race. The analysis below presents the results separately for African Americans and whites. While the proportion of other races (Hispanic, Asian, etc.) in the Medicaid population is growing, the overall number of Medicaid births to pregnant women of other races remains relatively small, and therefore will not be presented here. HealthChoice and Medicaid fee-for-service are presented separately for FY 1998 – FY 2000. The FY 1997 data, however, shows all Medicaid births.

- *Low birth weight - African Americans.* The statewide, non-Medicaid rate of low birth weight deliveries dropped from 13.6 percent in FY 97 to 13.0 percent in FY 2000. The HealthChoice low birth weight rate is slightly lower, but rising from 12.6 percent in FY 1998 to 12.9 percent in FY 2000. As expected, the Medicaid fee-for-service rate is the highest, increasing from 13.9 percent in FY 1997 to 18.4 percent in FY 2000.

- *Low birth weight - whites:* The statewide, non-Medicaid rate of low birth weight deliveries was stable at 6.1 percent in FY 1997 and 6.2 percent in FY 2000. The HealthChoice rate of low birth weight deliveries is higher than the non-Medicaid rate, but trending downward from 8.0 percent in FY

1998 to 7.4 percent in FY 2000. As expected, the Medicaid rate of low birth weight deliveries for fee-for-service births is the highest, increasing from 7.7 percent in FY 1997 to 12.9 percent in FY 2000.

- *Conclusion.* From 1997 through 2000, comparing Medicaid and non-Medicaid low birth weight deliveries statewide, the composite (HealthChoice and fee-for-service) Medicaid rate is always higher than the non-Medicaid rate, and there is essentially no change in the gap between the two groups. The pattern of low birth weight deliveries consistently illustrates, however, that women enrolled in HealthChoice have better outcomes than their Medicaid fee-for-service counterparts. This may be related to late or inadequate prenatal care for a significant number of Medicaid women who deliver fee-for-service. The FY1997 Medicaid fee-for-service data includes all Medicaid births, including women who in subsequent years would be enrolled in a MCO and those who enroll very late in their pregnancy.

  Substantial racial disparities continue to persist. The proportion of low birth weight deliveries among African Americans is consistently worse than that of whites in all categories (Medicaid fee-for-service, HealthChoice, and non-Medicaid). Nevertheless, African Americans who deliver while enrolled in HealthChoice consistently have better outcomes than African Americans who deliver outside of Medicaid or in Medicaid fee-for-service.

Neonatal Mortality and Race. The analysis below compares statewide data measuring neonatal mortality in FY 1997 through FY 2000 for African Americans and whites covered by Medicaid fee-for-service or HealthChoice MCO enrollment, or not covered by Medicaid.

- *Neonatal mortality - African Americans.* The statewide, non-Medicaid neonatal mortality rate increased slightly from 12.5 per 1,000 live births in FY 1997 to 12.8 per 1,000 live births in FY 2000. The HealthChoice rate increased slightly from 6.2 per 1,000 live births in FY 1998 to 6.8 per 1,000 live births in FY 2000. This is lower than the Medicaid fee-for-service rate, which increased from 7.2 per 1,000 live births in FY 1997 to 13.7 per 1,000 live births in FY 2000.

- *Neonatal mortality - whites.* The statewide, non-Medicaid neonatal mortality rate declined from 3.4 per 1,000 live births in FY 1997 to 3.2 per 1,000 live births in FY 2000. The HealthChoice MCO rate is higher and trending slightly upwards from 3.5 per 1,000 live births in FY 1998 to 4.2 per 1,000 live births in FY 2000. The Medicaid fee-for-service rate has extreme fluctuations, but, overall, declines from 2.8 per 1,000 live births in FY 1997 to 1.3 per 1,000 live births in FY 2000.

- *Findings.* For three of the four evaluation years, the overall Medicaid neonatal mortality rate is lower (better) than the non-Medicaid neonatal mortality rate. When shown by race, African Americans experience substantially higher rates of neonatal mortality than each of the three comparison populations: Medicaid fee-for-service, HealthChoice MCO, and non-Medicaid. But again, African Americans enrolled in HealthChoice MCOs have fewer neonatal deaths African American women whose deliveries are covered by Medicaid fee-for-service or African American women not covered by Medicaid.

- *Discussion/Conclusions.* Neonatal deaths are rare events compared to other events measured in this evaluation. As a result, breaking down the number of neonatal deaths by race, region, or coverage group over four years may lead to interpretations that do not represent trends but rather outlier events. The methodology we employed to match Medicaid eligibility and Vital Statistics data for deliveries yielded a 92 percent match, which, although quite high compared to other states, still excludes a number of deliveries. Further analysis is planned to understand the gaps between the data sets. Meanwhile, drawing conclusions based on this analysis will require examining the issue over a longer time span, so that real trends can be detected rather than random changes.

SUBPOPULATION ANALYSIS: OTHER

In addition to special needs children, chronically ill populations, individuals with HIV/AIDS and pregnant women, other subpopulation analyses can provide interesting insights into the larger HealthChoice program, specifically the health care delivery system. Two specific subpopulations are addressed in this section: individuals who are auto-assigned to MCOs, and individuals in different racial and ethnic groups.

Individuals Enrolled by Auto-Assignment

Background. One aspect of providing a medical home is to allow eligible families and individuals to enroll in an MCO of their choice and then select an appropriately credentialed provider from the MCO's network to serve as the Primary Care Provider (PCP) who oversees their medical care. Under HealthChoice, a new enrollee has 21 days to voluntarily select an MCO (Individuals in state supervised care have 60 days). Enrollees who do not select an MCO within the specified time period are auto-assigned to one. The State prohibits MCOs from using direct marketing techniques to influence potential enrollees. In an effort to help enrollees make better informed enrollment choices, the State contracts with a private firm to enroll beneficiaries into an MCO. The "enrollment broker" is responsible for providing enrollees with neutral advice about plan offerings and provider networks. The Department and its enrollment broker consider voluntary selection important. According to tracking reports compiled by the Department, the portion of enrollees who are auto-assigned has dropped from 42 percent at the beginning of the program in FY 1998 and 26 percent in CY 1999 to a low of 23 percent in CY 2000. This section examines the differences in utilization experienced by auto-assigned and voluntarily assigned families and individuals[3]. The infant population was excluded from the analysis because coding methodologies may portray infants as auto-assigned if they are automatically placed in the mother's MCO.

Findings. Enrollees that voluntarily choose an MCO are more likely to receive an ambulatory visit than are those auto-assigned. In CY 2000, 62 percent of the voluntary population received an ambulatory visit, compared to 56 percent of the auto-assigned population. With regard to ER services, 15 percent of the auto-assigned received a visit in CY 2000 as compared to 12 percent of the voluntary population. For children above age 1, assignment appears to have no measurable impact on the utilization of well child services. In CY 2000, 36 percent of auto-assigned enrollees received a well child visit, as compared to approximately 34.5 percent for the voluntary population. The results were similar for the volume of services provided, with auto-assigned enrollees receiving 692

[3] For the purposes of this analysis Voluntary and Auto Assignment determinations were based on enrollee status at initial enrollment. Further discussion of the methodology chosen can be found in the Technical Appendix at the end of this chapter.

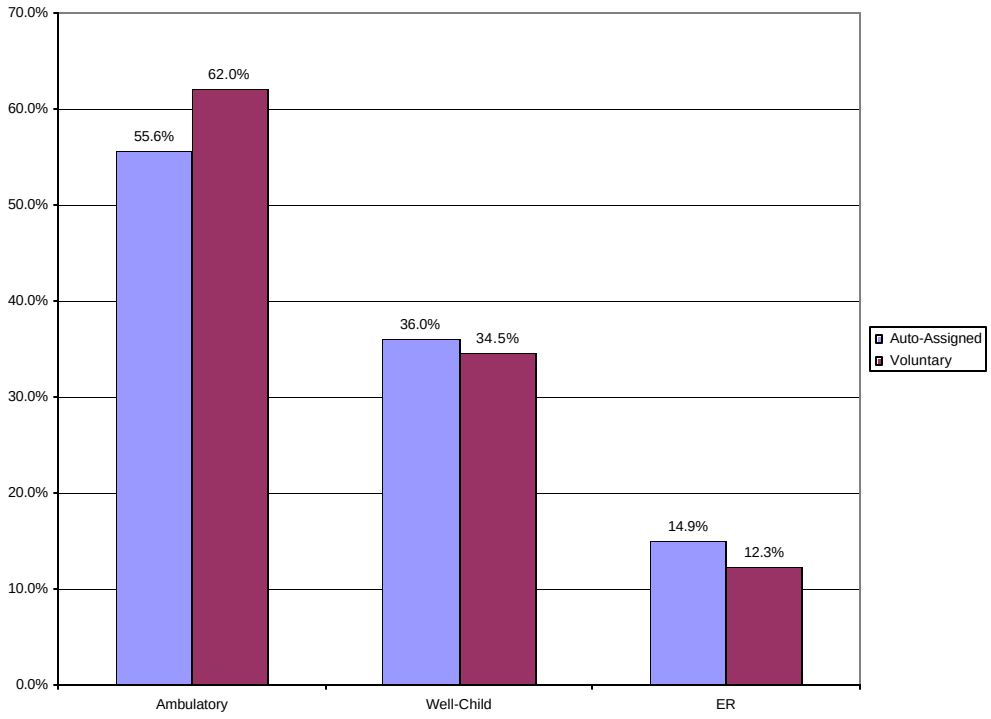
visits per thousand and the voluntarily assigned enrollees receiving 611 visits per thousand.

The voluntary population uses a higher volume of ambulatory services than auto-assigned enrollees do. In CY 2000 the voluntary population received 3,566 ambulatory visits per thousand. Among the auto-assigned population, the visits per thousand rate was 2,899.

Disparities between services provided to voluntarily assigned and auto-assigned enrollees exist across all age groups,[4] with the greatest difference among those aged 19-64. Overall, voluntary enrollees averaged 18 percent more ambulatory visits per thousand, and 16 percent fewer ER visits, than did the auto-assigned

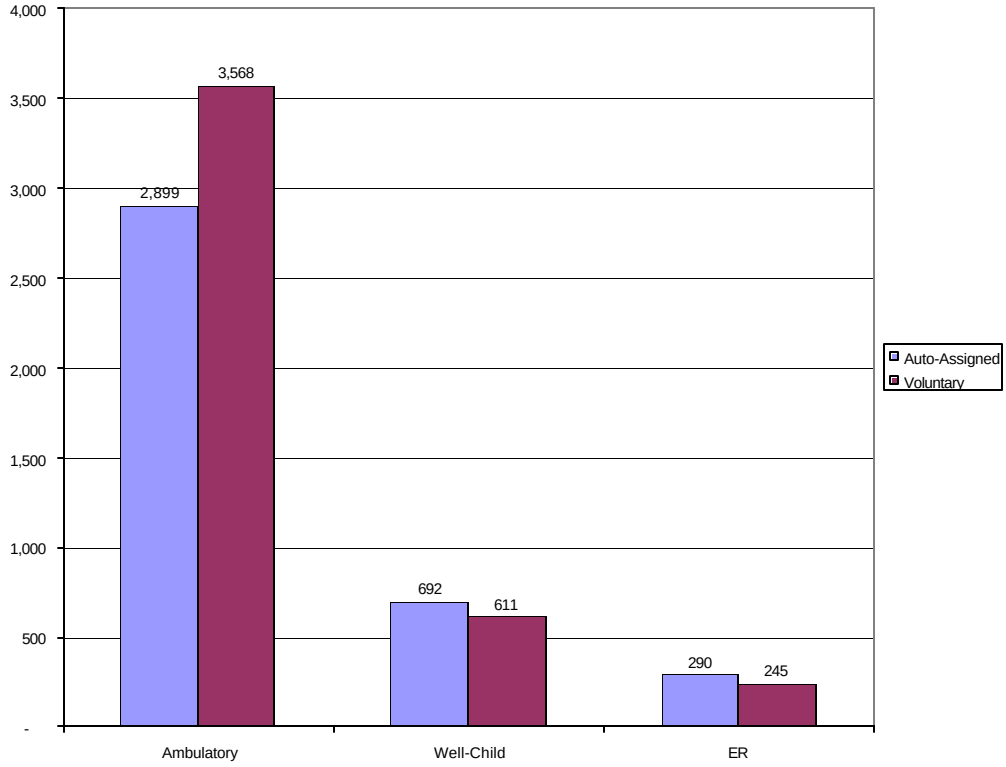
Some providers feel they have been financially harmed by auto-assignment, reporting that often an auto-assigned enrollee continues to seek care from the same providers they used before being enrolled in HealthChoice rather than from the MCO-affiliated provider designated their PCP. This results in administrative and fiscal burdens for Federally Qualified Health Centers (FQHCs) and other providers. Representatives from these groups, however, believe that allowing patients to remain with their original provider encourages ongoing patient-provider relationships, which ensure access and continuity of care.

Figure III-40: Percentage of Population Receiving an Ambulatory, Well Child and Emergency Room Service, Auto Assigned vs. Voluntary



[4] Those aged <1 are excluded from this study due to coding methodologies that may list them as auto-assigned when assigned to the mother's MCO.

Figure III-41: Ambulatory, Well Child and Emergency Room Visits per Thousand Annualized: Auto Assigned vs. Voluntary



Discussion. These data demonstrate differing patterns of utilization among the auto-assigned and the voluntarily enrolled populations. The data further show consistencies across all age groups. What the data cannot show, however, is the extent to which auto-assignment is the cause of lower health care utilization or the whether those that are auto-assigned are either healthier or are less motivated seekers of health care. For the same reasons that the enrollment broker is not able to encourage enrollees to select their plan, the MCOs may not be able to get the patients into care. These reasons include bad address information, enrollee confusion or a disinterest on the part of the consumer. It is noteworthy that despite the causes for not choosing a plan, the percentage of auto-assigned enrollees who receive some health care services is about 90 percent of the rate of those who chose an MCO. Even more significant is the fact that as many auto-assigned as voluntarily enrolled children received well-child services.

Individuals in Racially and Ethnically Diverse Populations

Introduction. The HealthChoice program encompasses a racially and ethnically diverse population. African Americans account for 58 percent of the HealthChoice population, Caucasians 31 percent, Hispanic, Asian, and others account for the remaining 11 percent. Considerable research and literature have documented the historical trends of racial disparities in access to and utilization of health care. This section of the evaluation focuses on what the available data

shows regarding the existence of such disparities in Maryland. Specific attention has been paid to the African American and Caucasian populations as they represent nearly 90 percent of the program population.

Findings. The data show that both under the previous FFS system and under HealthChoice African Americans received the fewest visits and had the lowest percent of enrollees receiving service of all racial and ethnic categories studied.

In FY 1997 53.9 percent of African Americans received an ambulatory visit compared to 63.3 percent for Caucasians and 57.8 percent for the population as a whole. In CY 2000 56.2 percent of African Americans received an ambulatory visit compared to 64.8 percent for Caucasians and 60.3 percent for the population as a whole.

Although access to care improved for both African Americans and Caucasians, the increase in access for African Americans grew by 4 percent as compared to 2 percent growth for Caucasians.

In FY 1997, 34.7 percent of African American enrollees received a well child visit as compared to 37.6 percent among Caucasians. By CY 2000, that gap was erased with 37 percent of both groups receiving a well child visit. Although a gap in the volume of visits has persisted from FY 1997 through CY 2000 that gap has narrowed slightly. In FY 1997, African Americans received 781 well child visits per thousand and Caucasians received 946. In CY 2000, African Americans received 737 well child visits per thousand and Caucasians received 832. That represents a 40 percent decline in the gap versus FY 1997.

Figure III-42: Population Distribution

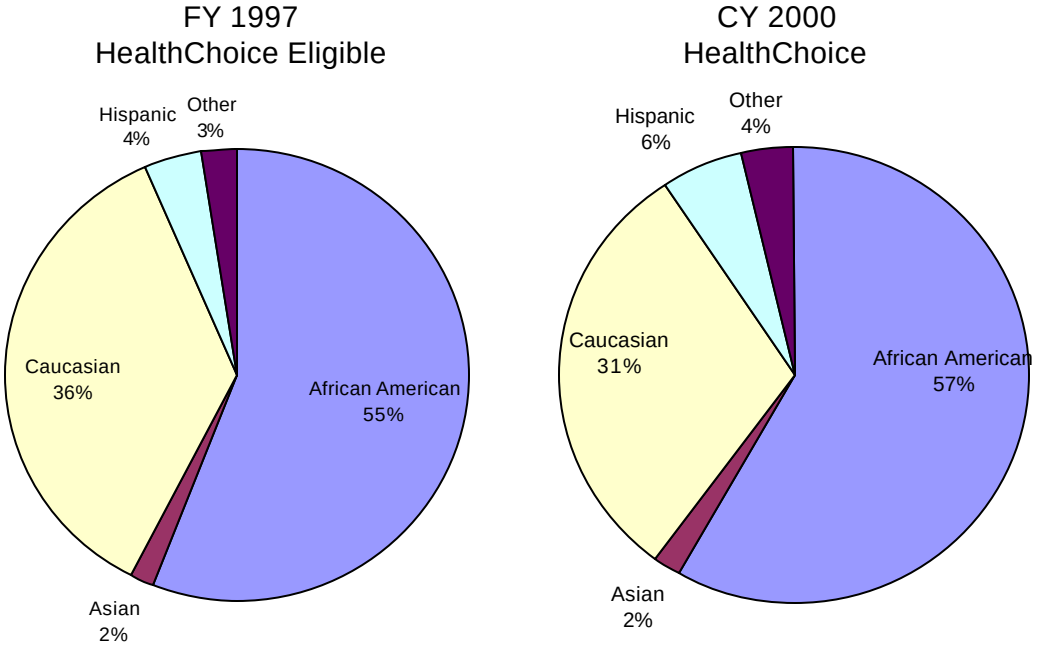


Figure III-43: Percentage of the Population Receiving Ambulatory Care Service, by Race

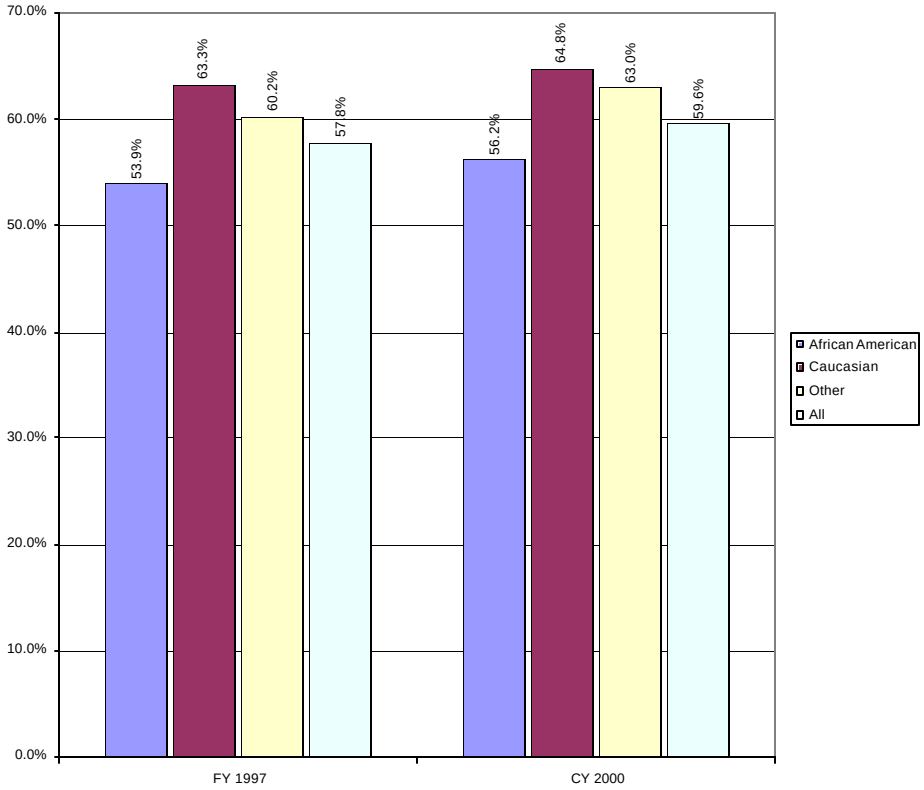
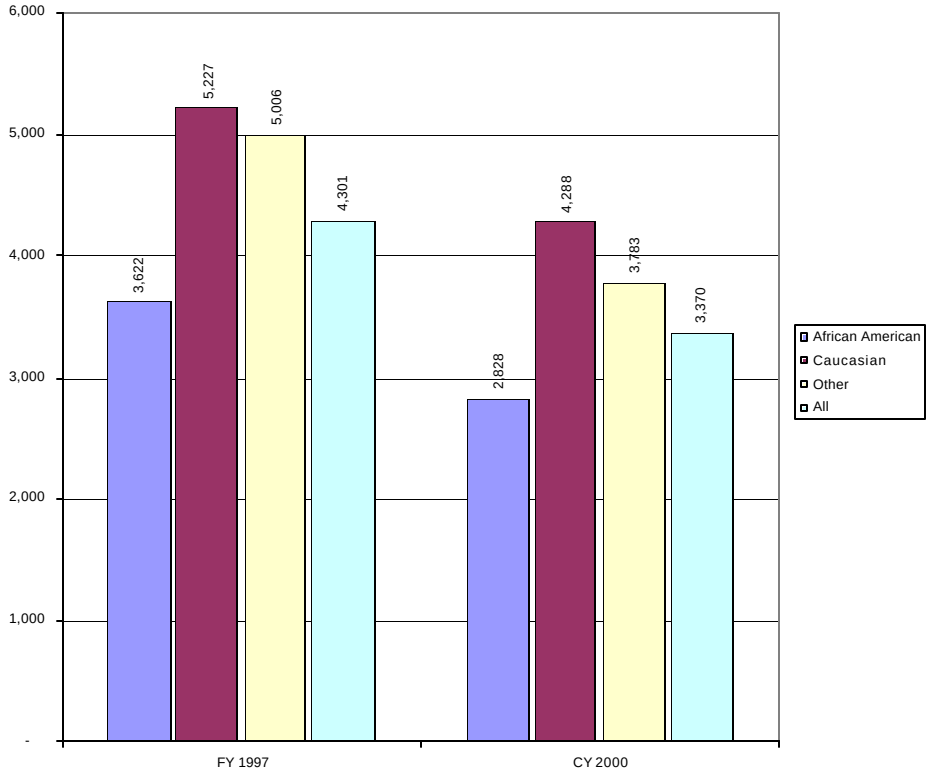


Figure III-44: Ambulatory Care Visits per Thousand Annualized, by Race



Discussion. While the gains observed for the HealthChoice population have occurred across all racial and ethnic groups, the disparities in access and utilization that existed prior to the HealthChoice program continue to persist. These disparities existed across coverage categories and region. Observed trends in access and utilization do indicate that these disparities are narrowing. In critical areas such as the percentage of the population receiving either an ambulatory or a well child visit the improvements for African Americans has out-paced the improvement for Caucasians.

UTILIZATION OF SPECIFIC SERVICES

Overview

The analyses thus far in this chapter have, in general, examined utilization according to a standard set of measures (ambulatory visits, well child visits, emergency room visits) that are then broken down and compared in various ways (by age, by region, etc). Another way to consider whether the HealthChoice program has achieved its goals is to examine the provision of individual services delivered to enrollees and how the patterns of utilization for those services have changed over time. This section examines a number of services important to the HealthChoice population. Specifically:

Dental Services. Dental services are a key HealthChoice service. The importance of dental services is underscored by the fact that the legislature has mandated specific utilization targets for dental care for children. This section examines dental services for children and adults according to several different methods.

Pap Smears. Pap smears are an important preventive service for women, with well-established expectations for frequency. This section examines pap smears pre and post HealthChoice and some of the data issues that complicate that analysis.

Mammography. Mammography, like the pap smear, is a universally recognized preventive service for women. This section will examine mammography for women.

Outpatient Department Services (OPD). Outpatient departments in hospitals are rate regulated by the HSCRC and, as such, are a relatively expensive provider of ambulatory services. OPD services are interesting to examine as they are a service where changes in usage patterns would be expected.

Specialty Consults. Access to specialty services is a major concern of the HealthChoice program. By looking at a narrowly defined specialty service, this analysis provides insights into access to specialty care.

Substance Abuse. Substance abuse treatment is another service that has been a high priority for the legislature and the Department. This section details the efforts to monitor and assess substance abuse treatment performance.

Lead Screening. Lead testing is an important public health activity that has long term public health implications. The Department has made early lead screening an important priority. This section details the efforts made in that regard.

Mental Health. Mental health services are evaluated by the Mental Hygiene Administration in a separate document.

Dental Services

The first of our analyses of specific service areas is dental services, which will be discussed in two sections, covering dental services for children under age 21 and dental services for pregnant women and adults.

Dental Services for Children – Background. Dental services for children under age 21 is a federally mandated Medicaid coverage that MCOs must provide as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. In spite of the recognized importance of children receiving periodic preventive dental services as well as medically necessary palliative and acute dental services, the actual rate at which dental services have been delivered to children in the Medicaid population has historically been problematic. In 1998, the General Assembly addressed the issue of dental access by passing Senate Bill 590, which became effective on October 1, 1998. It established the Office of Oral Health and allowed the Department to offer oral health services to pregnant women enrolled in MCOs. It also required the Department to establish a five-year oral health care plan that sets targets for MCOs as to enrollee access to oral health services. The base for these targets is the rate of dental service use by Medicaid-covered children in FY 1997, when 14 percent[5] of Maryland's Medical Assistance recipients under 21 years of age received any oral health service. The plan's target for the first year of the five-year plan, CY 2000, was 30 percent, with annual increases to 40 percent in CY 2001, 50 percent in CY 2002, 60 percent in CY 2003, until a level of 70 percent is reached in 2004.

In July 2000, the Department increased the fee schedule for oral health services, which raised most rates by 300 percent, on average, for services delivered on a fee-for-service basis. Although rates are higher now than in the past, Medicaid dental fees are still significantly lower than community rates. Although MCOs are not required to pay their oral health providers at Medicaid rates, many use the Medicaid fee schedule as the basis for their own fee schedules.

To assess the program's progress in reaching its oral health goals, CY 2000 dental utilization rates for children enrolled in HealthChoice were compared to the rate at which children accessed dental services through Maryland's Medicaid fee-for-service program during FY 1997, the final year before implementation of HealthChoice.

MCOs are required to develop and maintain an adequate network of oral health providers who can deliver the full scope of oral health services. HealthChoice regulations specify network capacity and geographic access standards for oral

[5] The 14 percent utilization rate is based on services provided to a child with any period of Medicaid eligibility. This statistic does not take into account any minimum enrollment period.

health providers. They require MCOs to maintain an oral health provider to enrollee ratio no higher than one to 2000. In addition, MCOs must ensure that enrollees have access to an oral health provider within a 30 minute or 10 mile radius for urban areas and a 30 minute or 30 mile radius for rural areas.

Dental Services for Children – Findings.

- *Program Performance.* Since 1999, the Department has produced semiannual information about children's access to dental services, which is reported to the MCOs and the Oral Health Advisory Committee. The Department has used the following criteria for assessing the program's performance in providing access to dental services for HealthChoice children. The semiannual report is based on an examination of dental services utilization data from children who:

  - Are between 3 and 20 years old (inclusive);
  - Was enrolled in one MCO for at least 90 days; and
  - Has received one or more dental services during the year.

  Using these measures, the overall utilization percentage across all HealthChoice MCOs was 24.3 percent in CY 2000, as compared to 21.3 percent for CY 1999, and 18.3 percent in FY 1997. There was an increase in the percentage of children receiving dental services in all age groups and in all regions of the State.

Figure III-45: Percentage of Children Age 3-20 with = 90 Days of Enrollment Receiving Dental Services by Age

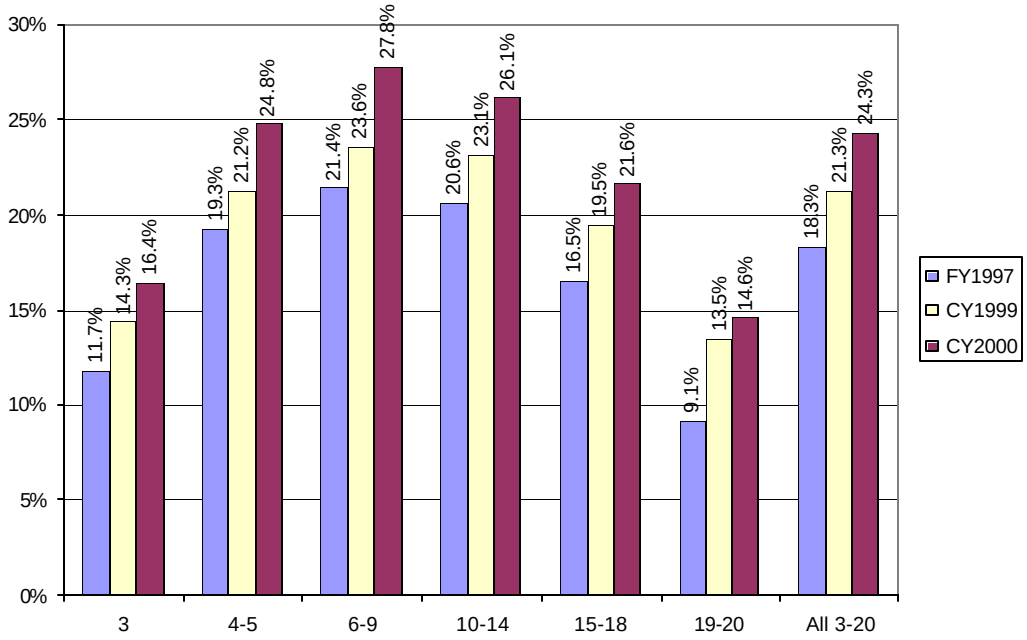
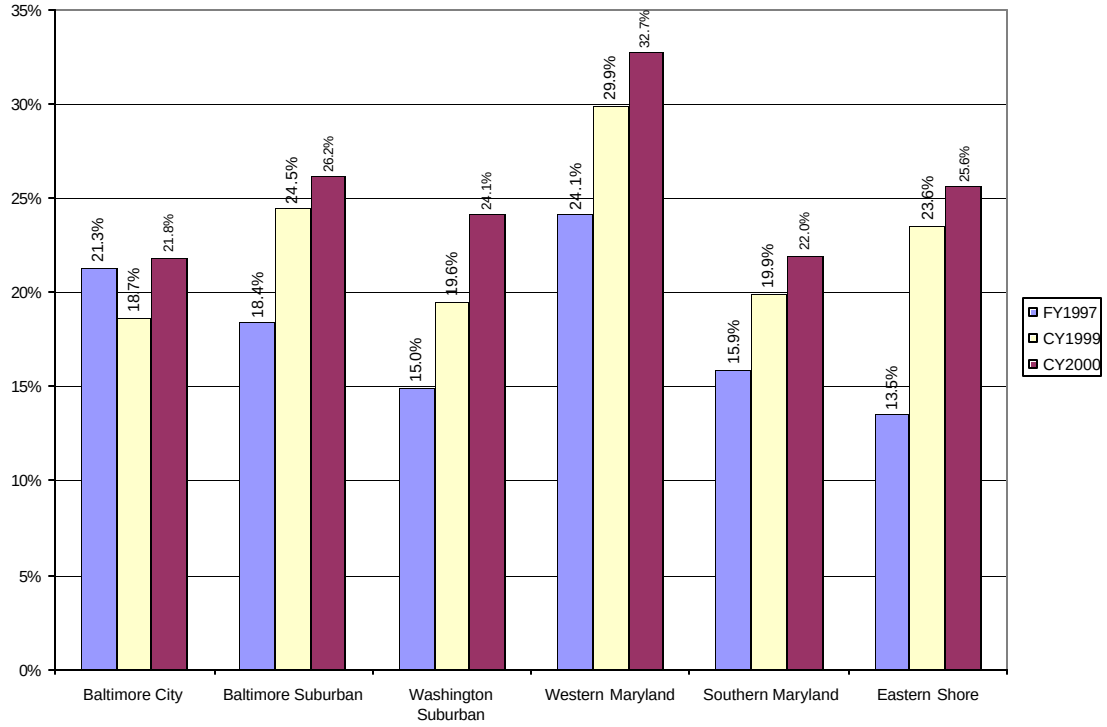


Figure III-46: Percentage of Children Age 3-20 with = 90 Days of Enrollment Receiving Dental Services by Region



➢ *Volume and Type of Services*. In addition to analyzing the percentage of children who access dental services, the data were analyzed to review the type and volume of services received in each category. The percentage of children ages 3-20 enrolled for at least 90 days who have accessed any dental services increased significantly between FY 1997 and FY 2000. The greatest increase in service utilization was in diagnostic and preventive services; with more modest increases found in restorative services.

Figure III-47: Dental Access by Type of Service for Children age 3-20 with = 90 Days of Enrollment

	FY 1997		CY 2000	
	Services per Child	Children Receiving Services	Services Per Child	Children Receiving Services
Diagnostic	2.3	14.9%	2.6	22.4%
Preventive	2.9	13.6%	2.8	20.1%
Restorative	3.2	5.0%	3.3	7.5%
Endodontics	2.0	1.1%	1.8	1.9%
Surgical	2.2	2.4%	2.1	3.0%
Orthodontic	5.4	0.4%	2.9	0.7%
Adjunctive	1.7	3.9%	1.6	3.6%
Other	1.1	0.1%	1.5	0.6%
Total	2.6	18.3%	2.7	2.46%

- *MCO Plan Performance.* In an effort to assess the performance of individual HealthChoice MCOs, the Department recently performed an additional analysis of the dental utilization data. This analysis used a measure closely modeled on the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) measure for Medicaid children's dental services utilization. The HEDIS Medicaid children's dental services measure for CY 2000 differs from our existing criteria in age range and in minimum number of days of enrollment in a year. For the additional measure, the HEDIS minimum of 365 days enrolled with a gap of no more than 45 days during the year has been employed here (320-day measure). The HEDIS methodology uses an age range from 4 through 21. The Department modified the age range to 4 to 20 years because the Maryland Medicaid program only requires dental coverage through age 20. Both measures use "any service delivered" to indicate that a child is receiving dental services. For CY 2000, the overall percentage utilization across all HealthChoice MCOs using the HEDIS criteria was 29.3 percent compared to 25.9 percent for CY 1999 and 19.9 percent in FY 1997.

Figure III-48: Percentage of Children Age 4-20 with = 320 Days of Enrollment Receiving Dental Services by Age

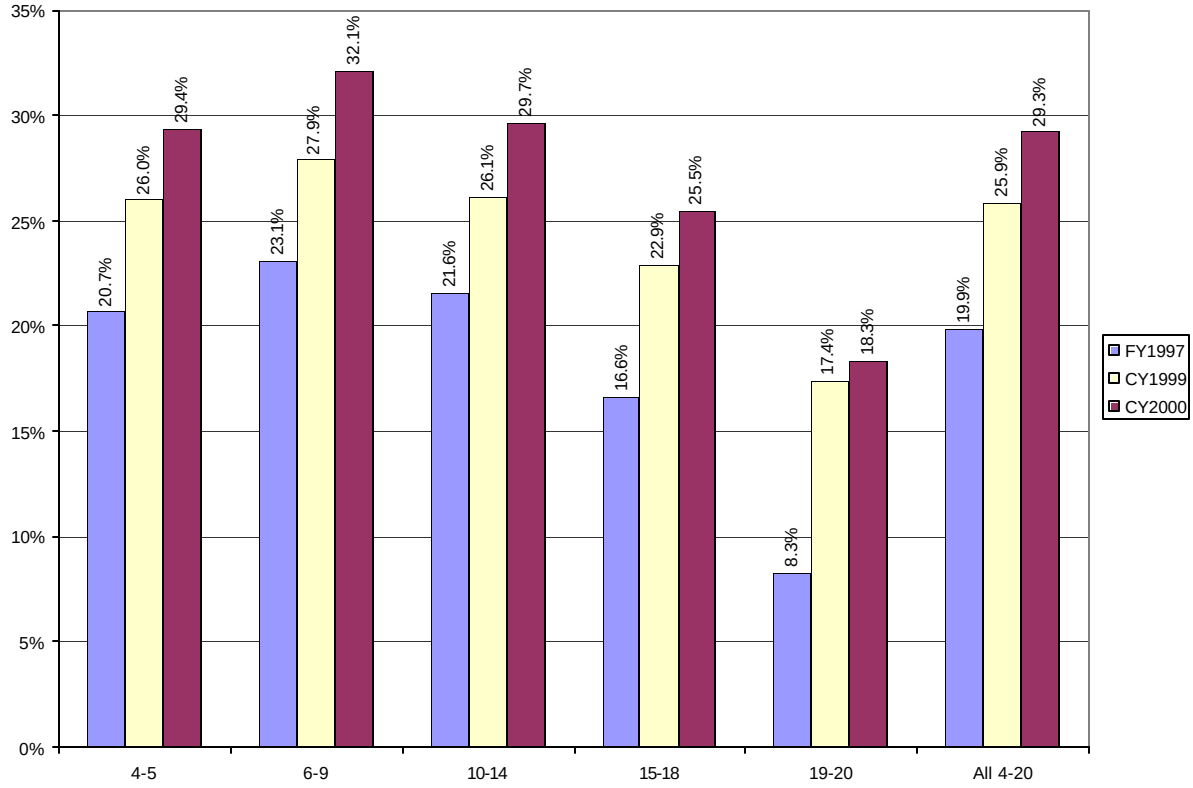
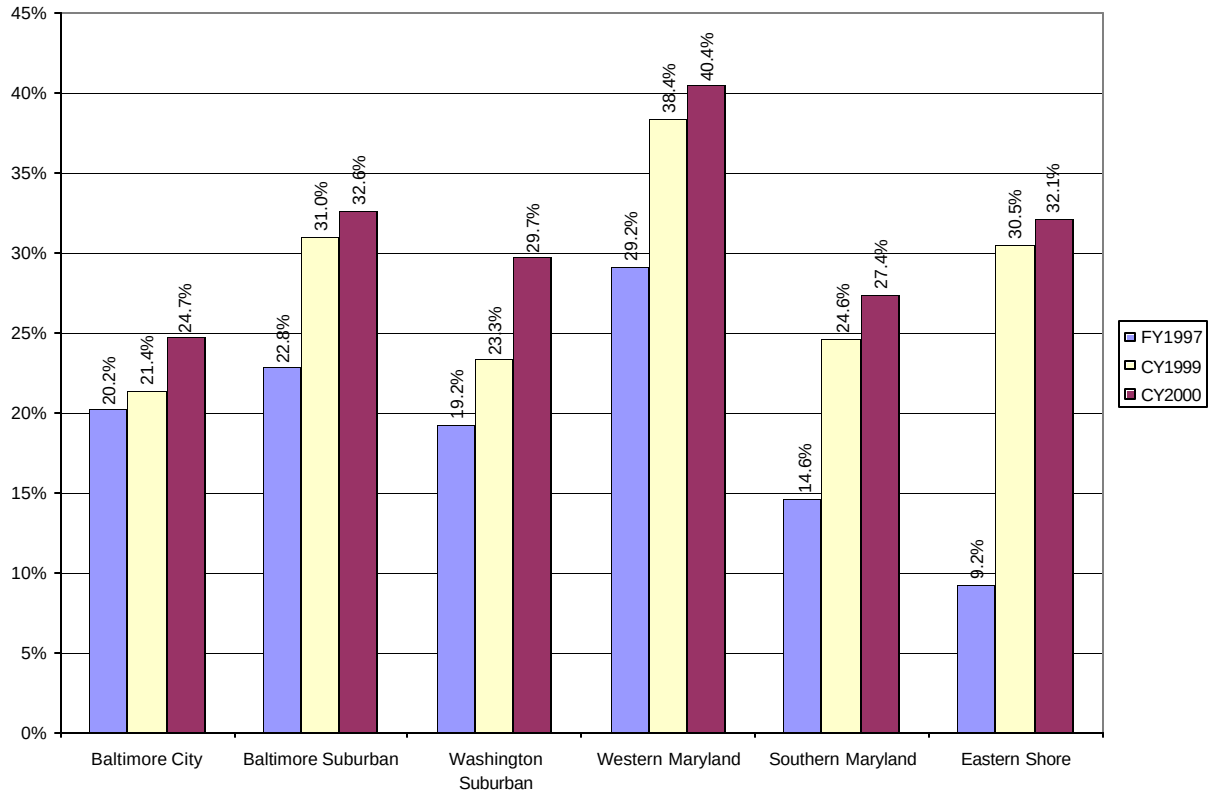


Figure III-49: Percentage of Children Age 4-20 with = 320 Days of Enrollment Receiving Dental Services by Region



Dental Utilization - Pregnant Women and Other Adults.

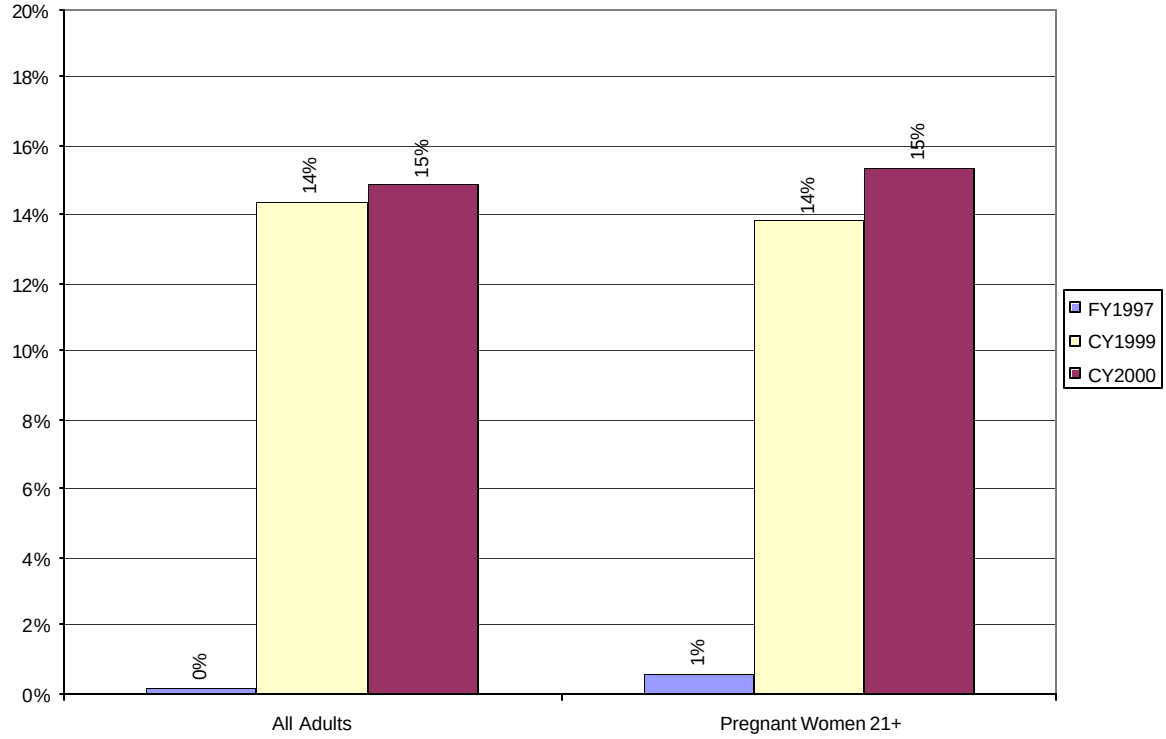
- *Dental services for pregnant women.* Senate Bill 590 also required that dental services be extended to include all pregnant women enrolled in HealthChoice. For CY 2000, dental services utilization by pregnant women was 15.4 percent for CY 2000 for pregnant women who were:

  - Age 21 or older;
  - Enrolled in an MCO for at least 90 days; and
  - Received any dental service during the year.

  The 15.4 percent dental services utilization by pregnant women in CY 2000 compares favorably to the utilization rate of 13.8 percent for this population in CY 1999. The comparable rate for pregnant women age 21 and over reported in the fee-for-service system was less than 1 percent for FY 1997, when Medicaid did not cover adult dental services. (There is no HEDIS measure for dental services for pregnant women.)

➢ *Dental services for adults other than pregnant women*. Neither Senate Bill 590 (1998) nor the HealthChoice program requires the provision of dental services to adults other than pregnant women. As provided in program regulations and contract, however, MCOs offering adult dental services are afforded preferential assignment of auto-enrolled families and individuals. As a result, all HealthChoice MCOs offer adult dental benefits. The Department's recent analysis demonstrates that 14.9 percent of adults enrolled in HealthChoice for at least 90 days received at least one dental service in CY 2000, as compared to 14.2 percent in CY 1999 and less than one percent in FY 1997.

Figure III-50: Percentage of Adults and Pregnant Women Receiving Dental Services



Dental Networks As of September 2001, there were approximately 485 oral health providers participating in the HealthChoice program. This represents an approximately 35 percent decrease in the number of oral health providers as compared to last year. Some of this decrease can be attributed to FreeState Health Plan exiting the HealthChoice program. Their enrollees were transitioned to other participating MCOs, but not all of FreeState's providers were re-contracted by other MCOs. The overall statewide ratio of MCO-contracted oral health providers to adult and children enrollees is 1:808,[2] which is within the

[2] The ratio of oral health providers to enrollees was calculated using CY 2000 data. Enrollees over the age of one are included in the analysis. The estimated count of providers comes from the HealthChoice Provider Listings.

COMAR-defined ratio of 1:2000. The table below shows the regional breakout of oral health providers in Maryland.

The table illustrates the total number of oral health providers affiliated with a HealthChoice MCO as of September 2001. Providers are counted only once, even if they are in the provider networks of multiple MCOs. Some oral health providers may not be accepting new referrals, or may limit the number of new referrals than they accept. These numbers also do not reflect the availability of specialists, such as pediatric dentists who are trained to treat very young children.

Figure III-51: MCOs Dental Network Providers

Total number of unduplicated dental providers				
	Aug 00	**Sept 01**	**% Change**	**Counties**
Baltimore Metropolitan Area	322	243	-25%	Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, Howard
Montgomery/Prince George's	267	212	-21%	Montgomery, Prince George's
Southern Maryland	14	11	-21%	Calvert, Charles, St. Mary's
Western Maryland	26	11	-58%	Allegany, Garrett, Washington, Frederick
Eastern Shore	19	8	-58%	Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester
Total	**648**	**485**	**-35%**	**24 Jurisdictions**

Discussion. There have been significant improvements in access to dental services since FY 1997. Some of the largest gains have been in rural areas of the State and probably correspond to the Eastern Shore and Western Maryland pilot projects established as a result of SB 590 (1998). Access to dental care has been a historic Medicaid problem. In spite of the significant improvements in children's access to these services, access to dental services continues to be cited by most stakeholders, including consumers, as a problem.

Pap Tests and Screening Mammography

Overview. A key goal of the HealthChoice program is to provide prevention-oriented care. Pap tests and screening mammography are widely recognized as preventive services with demonstrated benefits. Although encounter data can be used to measure the extent to which these services are being delivered limitations in both the MCO-submitted encounter data and in the fee-for-service data collected before the implementation of HealthChoice mean that any findings must be considered with great caution.

Lab services, including pap tests, are commonly subcontracted by MCOs to third party providers. MCOs may have less complete encounter data for services that are subcontracted than for services they provide directly. For most other quality measures (lead screening, pap smears, etc.), the limitations of lab data make encounter data analysis difficult at best. Unfortunately, the screening mammography measure is only appropriate for a small segment of the HealthChoice population: women over age 40, particularly those over age 50. It should also be noted that some MCOs subcontract for radiology services, which suggests that these services may be under-reported as well.

Findings. Encounter data shows a marked increase in the provision of pap tests in all regions of the State, as well as among all relevant age groups. There were increases in screening mammography utilization in nearly all regions of the State, but with declines in Southern Maryland, and among women ages 40-50. These declines resulted in a slight overall decrease in access to mammography services.

The Behavioral Risk Factor Surveillance Survey (BRFSS), conducted by the State under the direction of the Centers for Disease Control and Prevention (CDC), yields a significantly higher percentage of Medicaid enrollees receiving pap tests than reflected by HealthChoice encounter data. The BRFSS and encounter data results do, however, show similar trends.

Figure III-52: Percentage of Women Receiving a Pap Test by Age

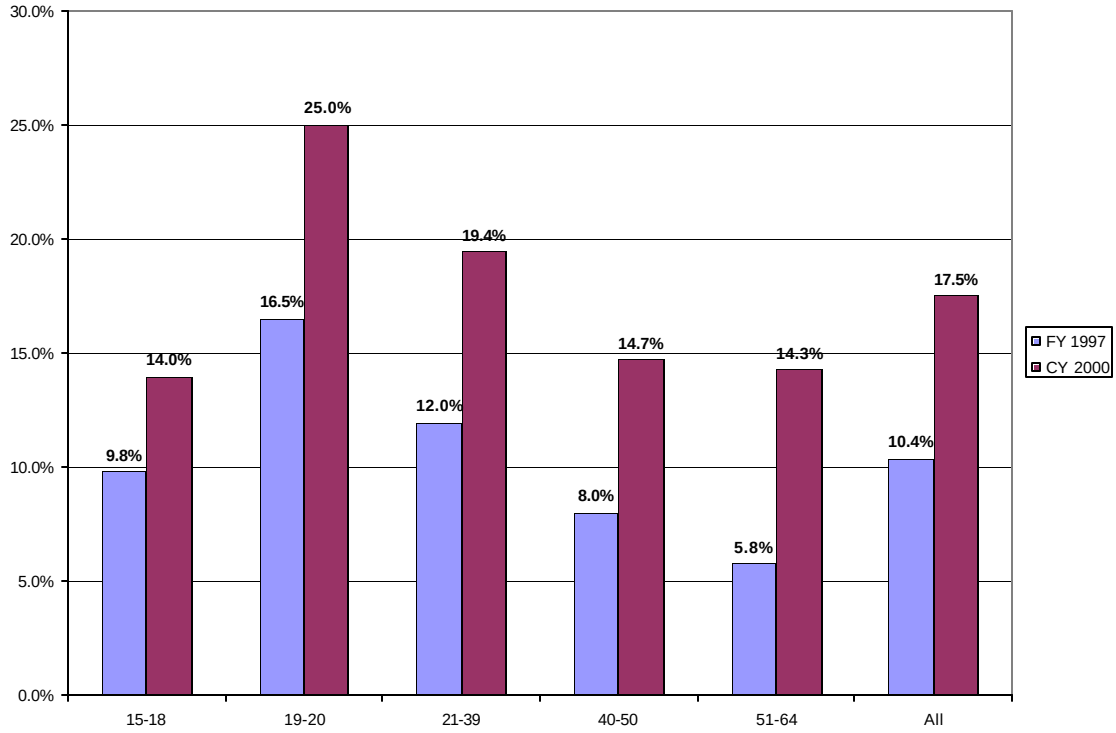


Figure III-53: Percentage of Women Receiving a Pap Test by Region

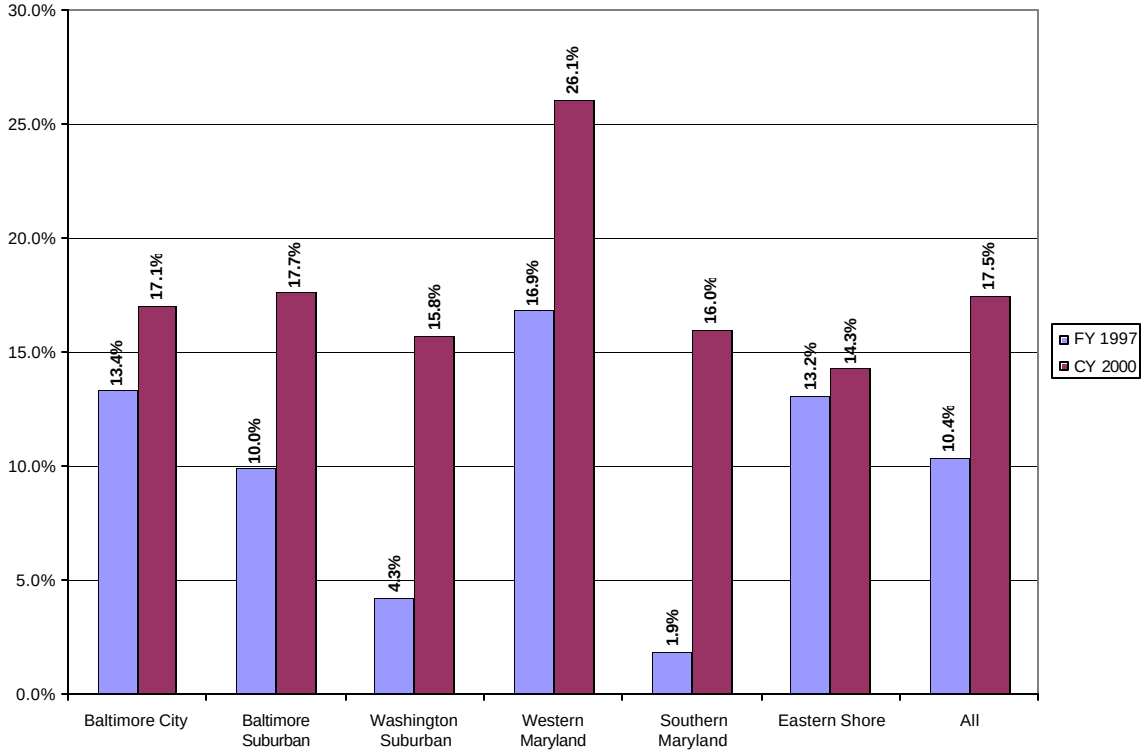


Figure III-54: Percentage of Women Receiving a Screening Mammography by Age

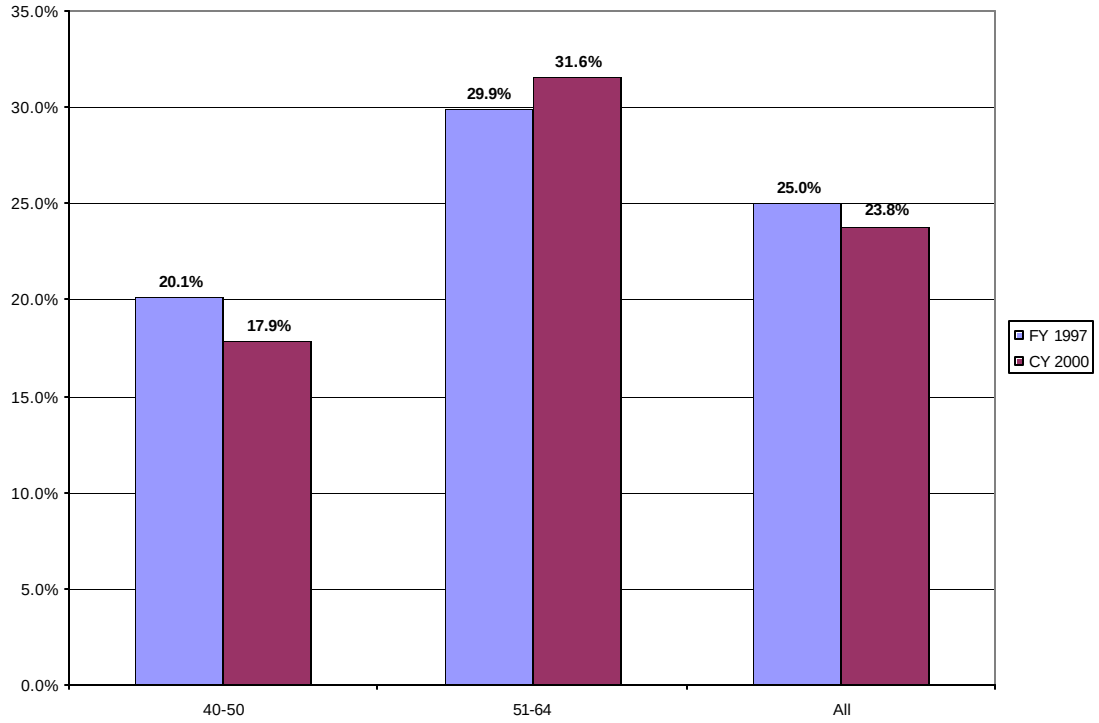
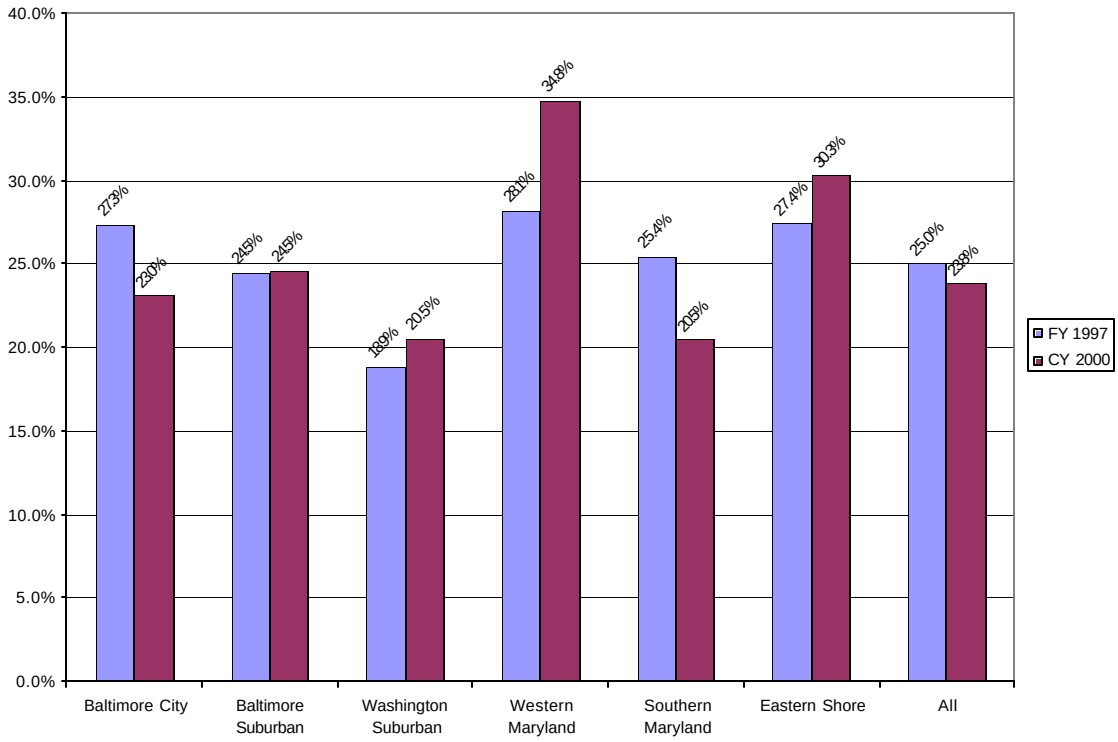


Figure III-55: Percentage of Women Receiving a Screening Mammography by Region



Discussion. Although the BRFSS reports results that are considerably higher than those encounter data indicates, there are factors that explain these differences. As previously discussed, there are known limitations to the completeness of the encounter data, especially for pap smears. The BRFSS data are self-reported, and there are no medical records available to substantiate answers supplied by the survey respondents. It is well established in research literature that self-reported survey data tend to show much higher results than confirmed data sources (e.g., administrative data or chart reviews). Moreover, this is particularly true for preventive services for which the medical establishment, public health officials, and the media have publicized their importance.

Interestingly, encounter data on pap smears, though limited, may actually be more complete than the corresponding claims data from FY 1997. It is unlikely that the widespread regional discrepancies observed in FY 1997 resulted from varying practice patterns. The more plausible explanation is the billing practices of State labs. State labs were instructed to bill Medicaid as appropriate. The data indicates that these billing practices may not have been implemented consistently across the State.

Considered together, the analyses of pap smears and mammography are mildly encouraging. Data limitations in both the pre-HealthChoice and HealthChoice data sources, however, make it unwise to draw any definitive conclusions.

Outpatient Departments

Introduction. One way of viewing the provision of a medical home is to assess the level of services in physician offices rather than the level of services provided in other settings. This section focuses on the rate at which patients were seen in a physician office as compared to an outpatient department (OPD) for FY 1997 (Medicaid fee-for-service) and in CY 2000 (HealthChoice). The relative use of physician versus OPD services is not simply a practice decision. In Maryland, OPDs are reimbursed according to rates set by the Health Services Cost Review Commission (HSCRC), at a considerably higher level than fees commonly paid for physician office visits. MCOs therefore have a strong financial incentive to shift care out of OPD settings, especially for services (such as primary care) that can be provided successfully in office settings. The following section details the findings from a study of the site of service for the Ambulatory Visit study conducted for this evaluation.

Findings. In general, OPD use is regionally concentrated in both FY 1997 and CY 2000 with the greatest use of OPDs occurring in Baltimore City. During this time period, there was a marked decline in the percentage of ambulatory care visits performed in an OPD setting. In FY 1997, 13 percent of all ambulatory visits took place in an OPD. That rate fell to slightly more than 3 percent in CY

2000. The decline in the rate of ambulatory visits taking place in an OPD was greatest among individuals under age 20; it was consistent among races and across all regions of the state.

Proportionally, the declines in Baltimore City were less than in other regions. The proportion of visits in an OPD declined by 64 percent in the City, and by an average of 75 percent in the rest of the State.

Although adults tend to access care through OPDs more often than other groups, OPD utilization by adults still has declined. Enrollees ages 21-64 experienced an overall OPD utilization decline of 53 percent, as opposed to the average decline of 81 percent among all other ages.

Figure III-56: Percentage of the Population Receiving an Ambulatory Care Service in Outpatient Departments by Age

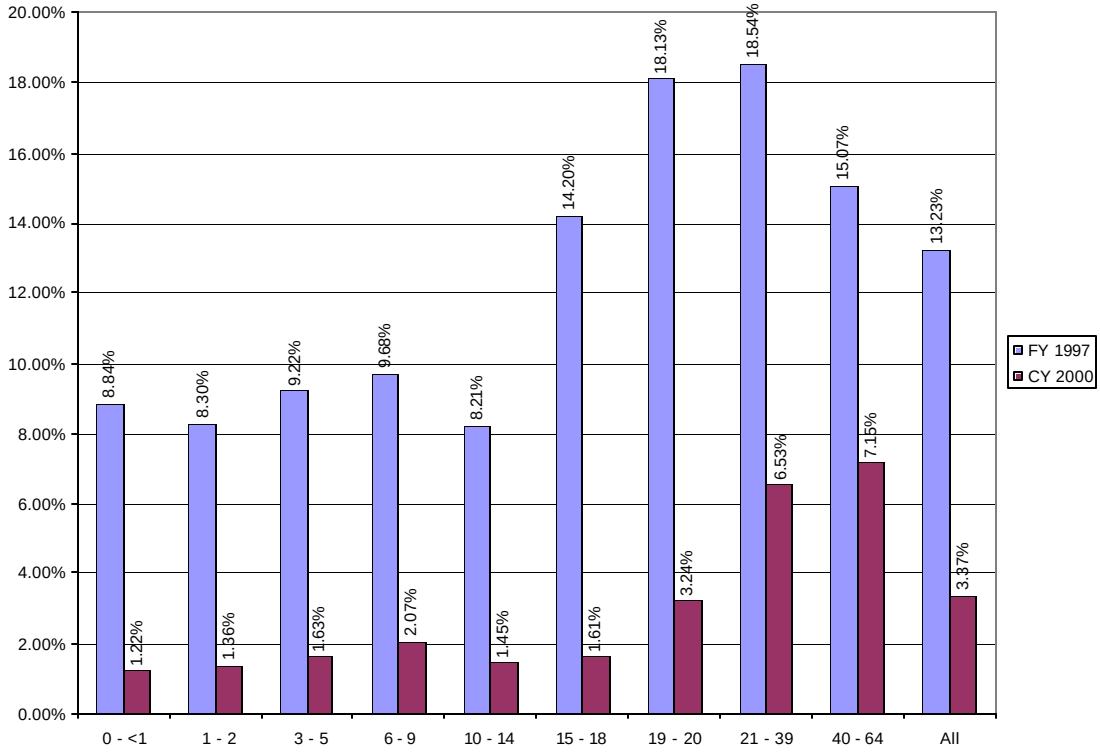
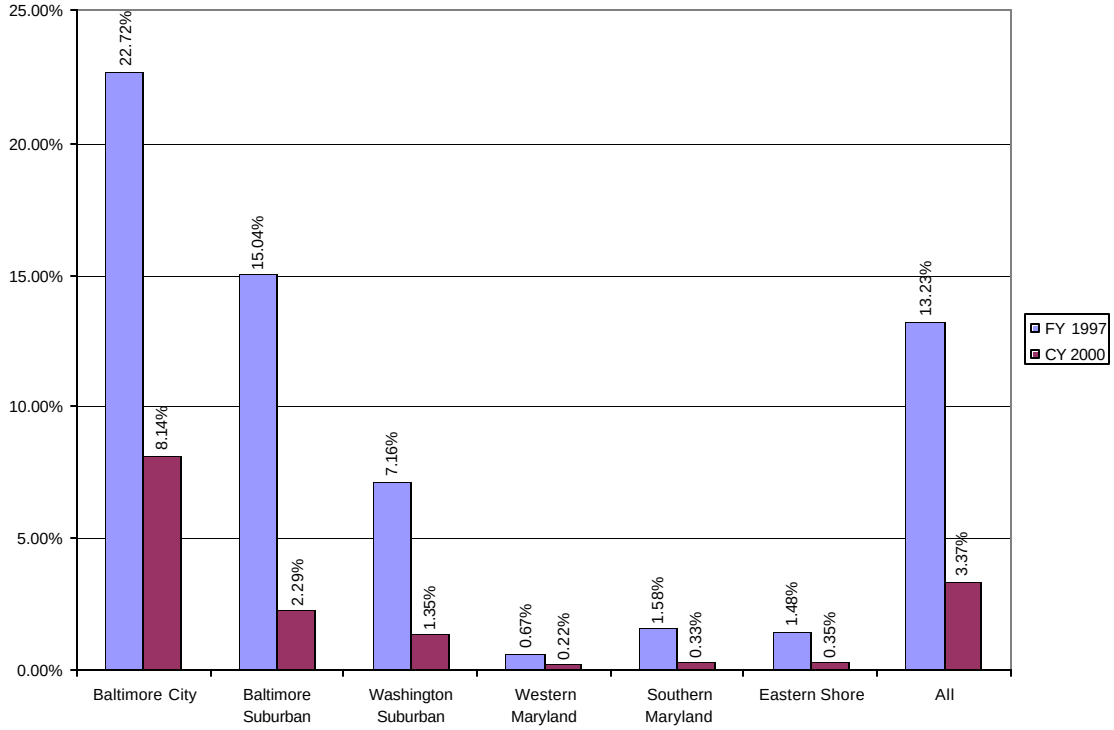


Figure III-57: Percentage of the Population Receiving an Ambulatory Care Service in Outpatient Departments by Region



Discussion. The declining OPD utilization rates discussed above indicate that HealthChoice MCOs have made significant progress toward reducing the use of relatively high-cost OPDs for ambulatory services.

Physician Consultations

Introduction. The accessibility and utilization of specialty services are important components of a medical home and prevention oriented care. Due to existing data limitations it is not possible to analyze services provided by specialists because of incomplete provider information in encounter data. Because of these limitations a proxy analysis of physician consults[6] was performed as a measure of access to specialty care.

This analysis measures only a narrowly defined set of specialty services, those for which a provider requested a consult from another provider. As such, it is only a limited measure of access to specialty care. It does not examine specialty services provided in hospital outpatient departments, nor does it consider the volume of services provided by specialists overall. In the absence of better provider specialty information, however, it does provide useful, albeit limited, insights into the availability of specialty care to HealthChoice enrollees.

[6] Consults were defined by CPT code.

Findings. Access to and use of consultation services (as proxied by billing codes) has increased slightly under HealthChoice. In FY 1997, 4.6 percent of enrollees received a consult service as compared to 6 percent in CY 2000. The volume of services increased from 86 per thousand in FY 1997 to 110 per thousand in CY 2000. The largest increases were among 40 to 64-year-olds, and among those living in Western Maryland. For the 40-64 age group, visits per thousand increased from 200 in FY 1997 to 343 in CY 2000; the percentage receiving a service climbed from 11.4 percent to 16.6 percent. In Western Maryland, visits per thousand increased from 114 in FY 1997 to 192 in CY 2000; the percentage receiving a service climbed from 6.2 percent to 9.9 percent. There has also been a measurable increase in the volume of consultations received by individuals in the SSI eligibility category. The volume of visits have nearly doubled for the SSI population since the implementation of HealthChoice, with 272 visits per thousand in CY 2000 as compared to 149 in FY 1997.

Figure III-58: Percentage of the Population Receiving a Physician Consult by Age

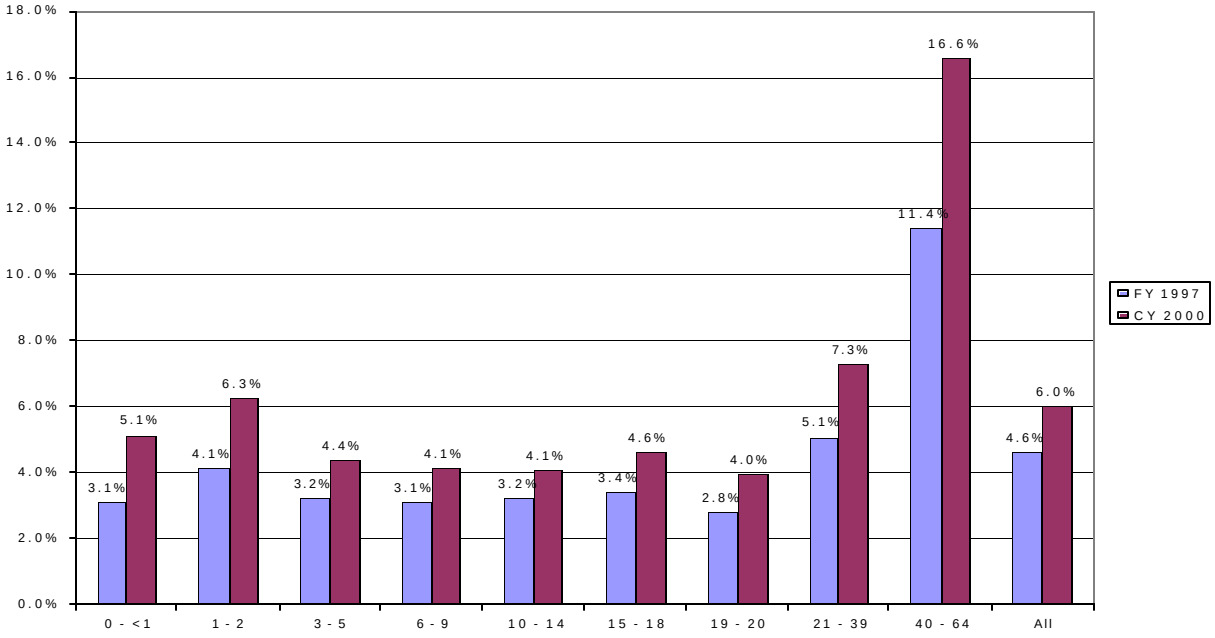


Figure III-59: Percentage of the Population Receiving a Physician Consult by Region

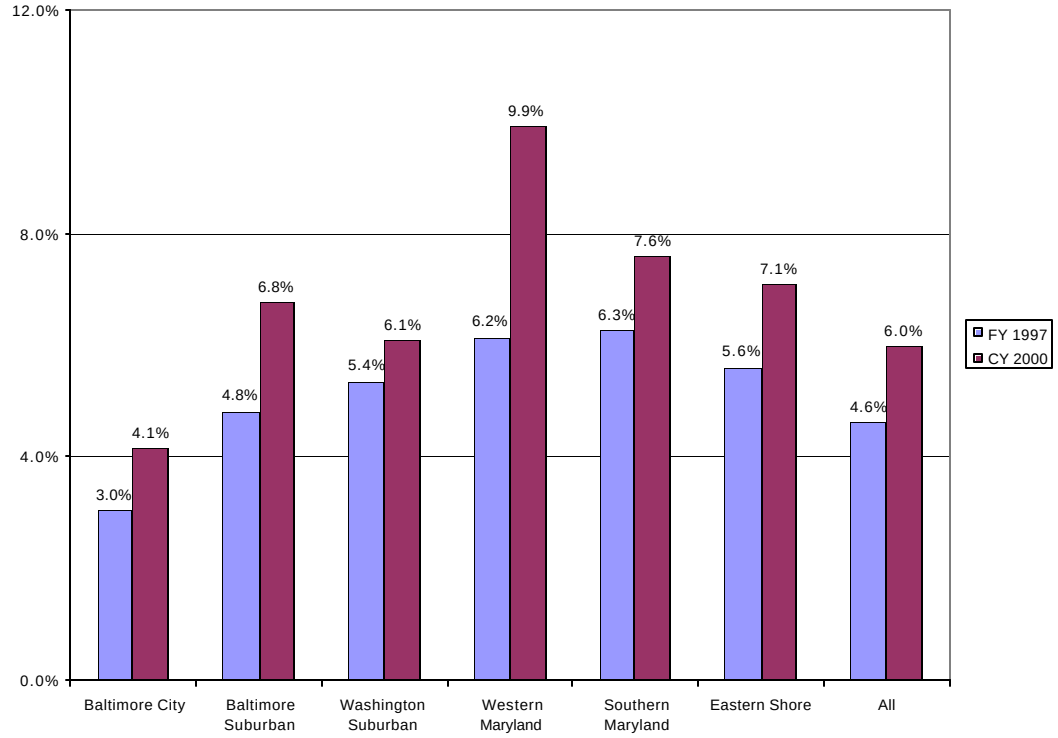


Figure III-59: Percentage of the Population Receiving a Physician Consult by Coverage Category

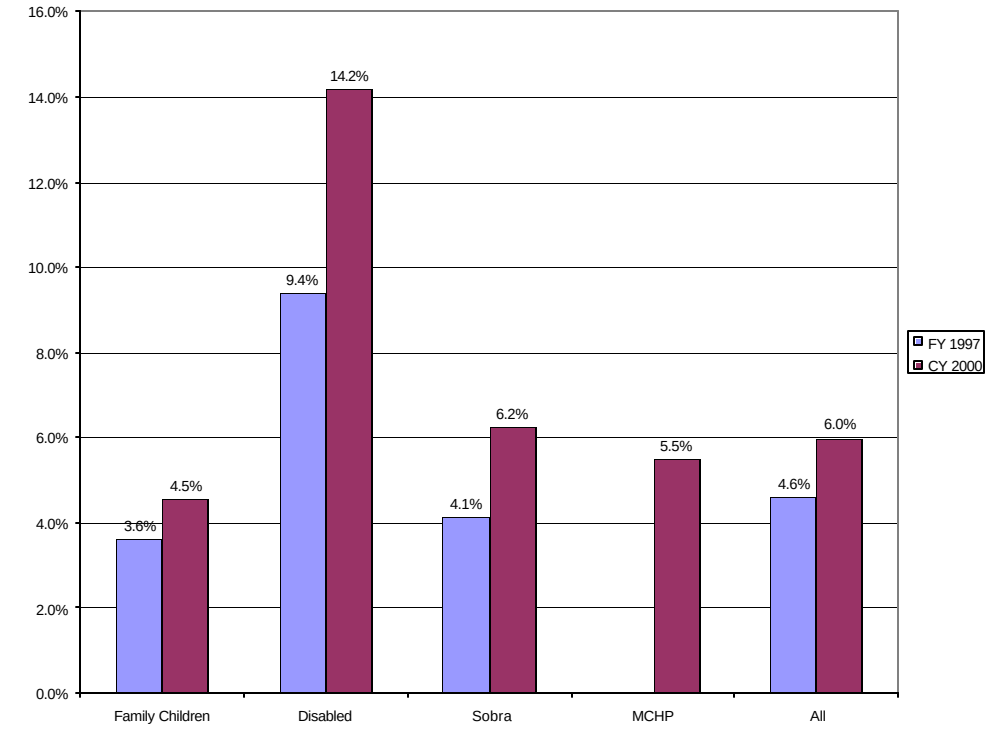


Figure III-60: Physician Consults per Thousand Annualized by Age

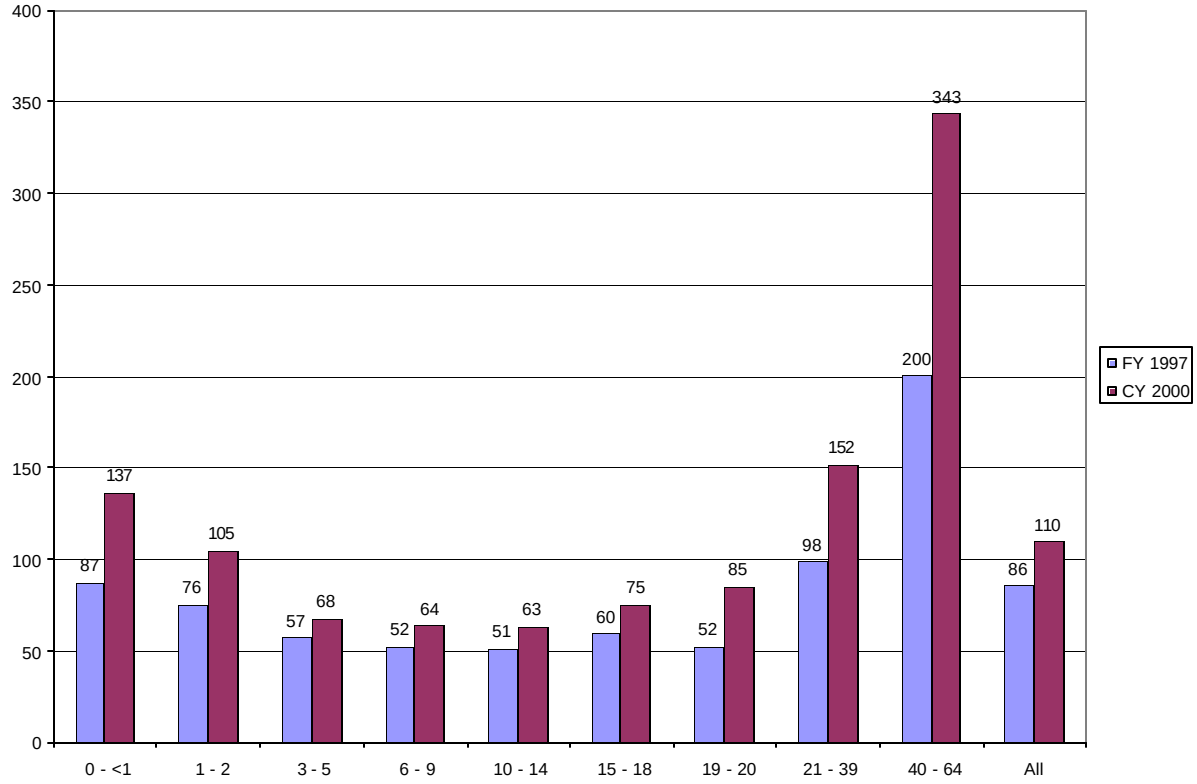


Figure III-61: Physician Consults per Thousand Annualized by Region

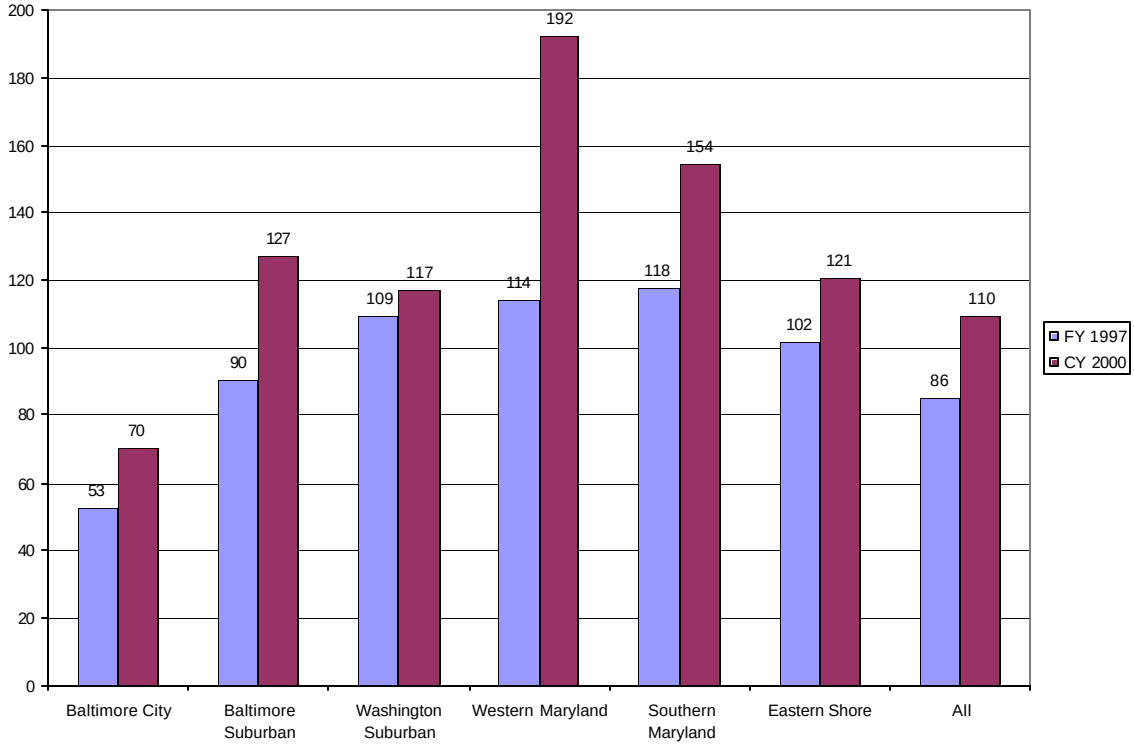
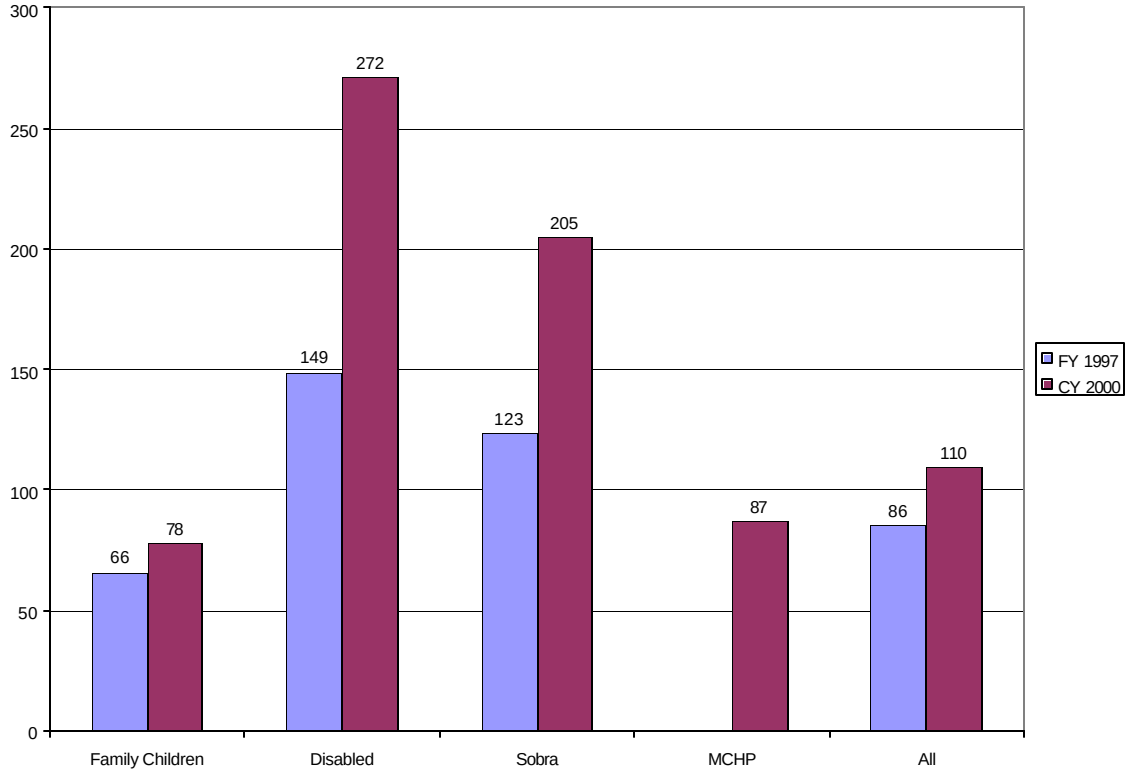


Figure III-62: Physician Consults per Thousand Annualized by Coverage Category



Discussion. Since the HealthChoice program was implemented, access to physician consults and the number of such services has increased as compared to the FY 1997 fee-for-service experience. Both in percentage of the population receiving a consult and with respect to the number of consults provided per thousand are greater than in FY 1997.

While these increases are encouraging they should be interpreted carefully. The analysis does not measure outpatient department (OPD) specialty consults, and there was a decline in OPD care. The decline in OPD usage (discussed in the previous section) coupled with the increase in physician consults may indicate a shift to specialty physicians practicing in the community rather than in hospitals. These services are relatively more important in urban/suburban areas. These analyses should also be considered in light of the fact that access to specialty services was frequently cited as a problem in consumer and provider forums, particularly in rural areas. One possible interpretation is that serious problems with access to specialty care existed prior to HealthChoice, and the dramatic increase in enrollment has served to highlight those problems.

Substance Abuse Treatment

Overview. Since implementation of the HealthChoice program, there have been concerns about access to substance abuse treatment services for HealthChoice enrollees. These concerns were based on provider complaints about barriers to contracting, slow payment from MCOs, and complaints that HealthChoice enrollees were not receiving substance abuse treatment. In the Summer of 2000, the Department provided to the Lieutenant Governor's Task Force on Drug Treatment an analysis comparing, for years before and after the HealthChoice program was implemented:

- The number of individuals diagnosed with substance abuse;
- The number of individuals treated for substance abuse; and
- The number of substance abuse treatment services received.

The pre-HealthChoice analysis was based on fee-for-service data. For time periods after HealthChoice implementation, the analysis was based a combination of encounter data and fee-for-service data. Limitations in the quality and completeness of encounter data made it impossible to draw definitive conclusions from the analysis. Still, when compared to the pre-HealthChoice period, the analysis showed, for time periods after HealthChoice began:

- Fewer individuals were diagnosed with a substance abuse problem;
- Fewer individuals diagnosed with a substance abuse problem received any service;
- Among those who entered treatment, fewer services were received; and
- The overall volume of services declined significantly.

In response, the Medicaid Drug Treatment Workgroup (the Workgroup), composed of the Department, the HealthChoice MCOs, behavioral health organizations (BHOs), substance abuse treatment providers, and advocates developed a Substance Abuse Improvement Initiative (the Initiative), which was implemented in January 2001. The Initiative had three primary goals:

- To improve access to substance abuse treatment services for HealthChoice enrollees;
- To expand the network of substance abuse treatment providers; and
- To improve the timeliness of payments from MCOs to substance abuse treatment providers.

The Initiative created standard authorization protocols and uniform treatment plan forms across MCOs. At the same time, the Workgroup developed a plan for evaluating the first nine months of the Initiative (January 2001 – September 2001). In October 2001, the Department began the evaluation of the Initiative based on the criteria, measures, and data sources developed by the Workgroup.

Because of the lag in data submission for these two sources, the Department's analysis of access measures that rely on encounter and claims data will not be complete until Spring 2002. The final evaluation of the Initiative will be completed in April 2002. The discussion below is based on data available at the time of this report, from sources other than encounter and claims data. Consequently, the findings reported below should be considered preliminary in nature.

MCO/BHO/Provider Contacts and Consumer Call Volume.

- *MCO, BHO, and provider contacts*. A separate tracking system was established to collect complaints and other calls from providers, MCOs and BHOs. This supplemented the Department's existing hotlines, which receive calls from both providers and consumers but not MCOs/BHOs. The tracking system was designed to capture specific information related to the Initiative. The Department encouraged providers and MCOs/BHOs to document their complaints using this tracking system. Because of the changes in the way the Department collected information on complaints from providers and MCOs/BHOs, there is no comparable information prior to the Initiative.

    - *Providers*. During the nine-month period of the Initiative, a total of 87 calls were received from 29 different providers. Most occurred in the first three months and were related to startup issues such as understanding the Initiative and eligibility issues. The six complaints about the contracting process all came in during this time. The major ongoing complaint from providers that remained unresolved over time was prompt payment, accounting for 36 of the 87 complaints from providers.

    - *MCO/BHOs.* During the same nine-month period, a total of 24 calls were received from MCOs and BHOs. Almost half of the 24 calls from MCOs and BHOs were made to report that a provider either refused to treat an enrollee or would not coordinate care with the MCO/BHO.

- *Consumer Contacts.* The Department did not need to create a new and different tracking system to monitor consumer complaints. Data from the existing hotline for HealthChoice enrollees was analyzed for the number and type of calls. From 2000 to 2001, the number of consumer calls

concerning substance abuse treatment declined from 162 to 105. Of the 105 calls received from consumers, almost half were requests for assistance in finding treatment. The second most common issue related to a provider refusing to treat due to MCO/BHO payment problems, all of which related to one provider. Twelve of the 105 calls from consumers related to general problems with substance abuse treatment providers.

Provider Contracting. The Department separately surveyed substance abuse treatment providers and MCOs to assess whether there has been an expansion of substance abuse treatment providers in MCO networks since the beginning of the Substance Abuse Improvement Initiative.

- *Provider survey*. In December 2001, the Department conducted a telephone survey of 290 ADAA-certified providers[7] to determine whether they had contracts with HealthChoice MCOs, the number of contracts, the number of new contracts since January 2001, and what they perceived as barriers to contracting with MCOs. Over half (149 or 51 percent) of the surveyed providers responded.

  - *Percentage of treatment providers with MCO contracts.* According to the survey, 48 percent of providers who responded reported having a contract with at least one MCO by the end of the Initiative period, up from 46 percent in December 2000.

  - *Number of MCO contracts per participating provider.* Providers with at least one MCO contract reported having on average 4 contracts with MCOs. The total number of MCO contracts held by the surveyed providers increased by 28 percent.

  - *Providers' contracting issues.* About 17 percent of providers reported that they are currently in contract negotiations with one or more MCOs. Of the 52 percent of providers who reported that they do not have MCO contracts, about half (49 percent) responded that they would be interested in contracting with MCOs. When asked about barriers to contracting with MCOs, 27 percent of providers cited administrative burdens, 23 percent cited payment issues, 19 percent of providers reported no contact with MCOs, and 17 percent cite lack of response from MCOs.

- *MCO survey.* In August 2001, and again in November 2001, the Department asked the six HealthChoice-participating MCOs to submit reports listing all substance abuse treatment providers in their networks and the effective dates of the corresponding MCO-provider contracts in effect as of December 31, 2000 and as of September 30, 2001. In

[7] Excludes providers who work solely in prisons, universities, or other settings unrelated to Medicaid recipients.

addition, the MCOs were asked whether they had refused to contract with any substance abuse treatment providers or if providers had denied their offer for a contract.

All six MCOs reported having expanded their network of treatment providers during the evaluation period. The number of contracts has grown from 225 to 264, an overall increase of 17 percent. (This contract count is not unduplicated by provider; some providers may have negotiated contracts with several MCOs.) On an MCO by MCO basis, the expansion of treatment provider panels range from a 7 to 45 percent increase. Only one MCO reported having refused to contract with a treatment provider; two MCOs reported having had contract offers rejected by treatment providers.

According to both providers and MCOs, there has been an expansion in the number of MCO contracts with substance abuse treatment providers. The provider survey suggests that the number of providers with at least one contract has increased marginally (2 percent), but the number of contracts has increased more substantially (28 percent). The MCO survey demonstrates that relative to the December 31, 2000 baseline, all MCOs have made some progress in expanding their networks. Both MCOs and providers report that they have additional contracts that are currently being finalized.

Timeliness of Payments. The Department assessed the timeliness of MCOs' payments to substance abuse treatment providers by collecting quarterly information from MCOs and tracking complaints from providers. MCOs report quarterly on the percentage of all provider claims paid within thirty days. In CY 2001, MCOs began separate reporting of the number of claims for substance abuse treatment services that were paid within thirty days.

- *Standard: 80 percent timely payment.* In the first quarter of CY 2001, only two of the five MCOs reporting met the standard of paying 80 percent of substance abuse treatment claims within 30 days. In the second and third quarters of CY 2001, the five MCOs reported having met or exceeded the standard of 80 percent of claims paid within 30 days.

- *Provider complaints.* According to the provider call tracking log, 16 provider complaints were registered regarding the timeliness of payment in the first three months of the Initiative. The number of complaints declined in April and May and increased to 19 complaints in each of the three final months of the Initiative evaluation period (July – September, 2001). Although timeliness of payments was a more frequent complaint to the Department's provider hotline, the overall volume of complaints was relatively low (36 complaints over the nine-month period).

Data from the quarterly reports provided by four MCOs about claims payment suggest MCO improvement in making timely payments to providers. This has not, however, resulted in a decline in provider complaints about timely payment.

Stakeholder Perspectives on Substance Abuse Treatment. In addition to the Department's analysis of the Initiative, stakeholder perspectives were gathered by an independent consulting firm, the Lewin Group[8]. Providers, MCOs/BHOs, Maryland Health Partners, the Department, and consumers were asked about access to substance abuse treatment services, coordination of care, and their experiences with Medicaid before and after the implementation of HealthChoice. The stakeholders were also asked about the opportunities and challenges of proposed carve-out models.

The text set out in the box below is excerpted from the Lewin Group's report, as presented to the Medicaid Drug Treatment Workgroup on January 3, 2002.

Providers & MCOs:

Access: Thirteen outpatient and inpatient treatment providers were interviewed across a range of treatment settings in rural as well as urban environments. Provider concerns included the following: providers are devoting more resources to administrative activities than pre-HealthChoice. Enhanced provision of Intensive Outpatient (IOP) services and reimbursement for methadone maintenance by MCOs is highly valued. BHOs are perceived as more restrictive with authorizations for inpatient detoxification than MCOs that manage substance abuse benefits in-house. Having to deal with multiple MCOs with different standards is viewed as a burden, e.g. inconsistency in MCO application of ASAM criteria for treatment approval. Restricted access to high level treatment, inpatient detoxification in particular, is an issue for some providers, though not all. Some providers, who are less dependent on Medicaid revenues, feel it isn't worth billing the MCOs because of the administrative hassle.

Providers expressed mixed reviews regarding access. Providers with the most concerns tended to be more heavily reliant on Medicaid as a source of income, treat more complex cases or service specialized population, e.g. adolescents. Providers are more likely to express concerns regarding inpatient detoxification. On the other hand, providers believe that access to methadone maintenance has improved.

Coordination: The dually diagnosed population was cited as too difficult for MCOs and providers due to insufficient system resources and a lack of coordination. Providers and MCOs reported a need for greater coordination of care among substance abuse, mental health and somatic treatment.

Improvement Initiative: Providers and MCOs often described the original implementation of HealthChoice as difficult, but improved due to better communication and relationship building. Most providers and MCOs report that areas addressed in the Initiative were working better, but acknowledged that it would take time to resolve all issues. A number of providers questioned

[8] The Lewin Group's work was funded by the Open Society Institute and was presented to the Medicaid Drug Treatment Workgroup on January 3, 2002.

moving to another model and indicated that they preferred to continue working with HealthChoice. MCOs believed the improved communication among all substance abuse stakeholders has contributed to an improved service delivery system. MCOs indicated that differences in provider network capacity in rural versus urban areas remains a challenging issue.

Consumer Focus Groups:

Focus groups with pregnant and post-partum women were held in Baltimore City and on the Eastern Shore. Key perceptions or observations included: if a woman was no longer pregnant, in jail or involved with child protective services, she had more difficulty getting into care – with waiting times from two to six weeks. Women felt they had to exaggerate the severity of their drug problem or indicate they were still actively using even when clean to obtain treatment. Women stated a need for better education as to what services were available and how to access them. Participants wanted more wrap-around services to assist them with housing, transportation, and day care. Participants asked for more opportunities to offer feedback and input into system issues.

Other Stakeholders:

On certain issues, stakeholders voiced conflicting views. For instance, while some stakeholders valued increased reimbursement for IOP and methadone maintenance services, other were concerned that these improvements were at the expense of reduced utilization of and expenditures for high-end services. Similarly, the benefits of improved accountability came at the expense of increased administrative costs for providers/organizations. Finally, data sharing potential for program improvements resulted in heightened concerns for patient confidentiality.

All Stakeholders:

Interviews with all stakeholders revealed a set of consistent themes:

- Inadequacy of current substance abuse treatment funding;
- Limited coordination and collaboration between substance abuse and mental health treatment;
- Importance of continuing enhanced benefits (available under HealthChoice but not fee-for-service, such as IOP for non-pregnant women); and
- Need for a comprehensive statewide strategic plan for substance abuse treatment.

Coordination of Care. Although not specifically addressed as a goal of the Initiative, advocates, MCOs, and providers alike have expressed concerns regarding lack of coordination of substance abuse and mental health services. The measures used to evaluate the Initiative do not specifically address this important issue.

Conclusion. Based on these preliminary analyses, the Initiative appears to have made progress towards some of its goals. The size of the substance abuse provider network has expanded significantly over the course of the nine-month Initiative, and barriers to contracting appear to have been resolved. The preliminary findings on timeliness of payment suggest a more mixed picture. The impact of the Initiative on access to treatment services will be reported in April of

2002. At that time, the Department will be able to more fully assess the success of the Initiative.

Lead Testing

Background. Blood lead testing is essential to the detection of elevated lead levels, especially lead poisoning, which generally lacks obvious symptoms at onset. Children covered by Medicaid have a statistically higher risk of these conditions than other children. Children living in certain locations (e.g., Baltimore City) are also at higher risk for the condition. Since 1992, federal requirements have included universal blood lead testing as part of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) standards for one- and two-year-olds. All HealthChoice primary care providers serving children must agree to comply with all EPSDT standards. Further, Maryland law requires universal lead screening of children under age six who live in "areas of highest risk" in the State (such as Baltimore City) or who are covered by Medicaid. Maryland law also requires medical labs in the State to report all blood lead test results for children under the age of 18 to the Maryland Department of the Environment (MDE) for inclusion in its Childhood Lead Registry (CLR).

Data Sources.

- *MDE Childhood Lead Registry and HealthChoice eligibility data.* To present a valid comparison of the proportion of one- and two-year-olds receiving lead testing before and after the implementation of HealthChoice, several data sources were used. Although the Childhood Lead Registry is the most complete source of blood lead testing data statewide, the laboratory results do not differentiate between Medicaid and non-Medicaid children. The Department has been able to match Lead Registry data for CY 1998 through CY 2000 with HealthChoice eligibility records, enabling HealthChoice children to be analyzed separately from the non-Medicaid population. The linked data make it possible to identify the percentage of HealthChoice-enrolled one- and two-year-olds receiving blood lead tests during the year.

- *Data limitations.* Unfortunately, Childhood Lead Registry data are not available for a pre-HealthChoice comparison. Instead, FY 1997 Medicaid fee-for-service claims data for laboratory lead testing are used. Please note that post-HealthChoice encounter data for subcontracted services such as lab services tend to be more incomplete.

Findings. Comparing FY 1997, CY 1999, and CY 2000 testing rates, fee-for-service claims for FY 1997 show that 22 percent of one-year olds and 18 percent of two-year olds received blood lead tests during FY 1997, the fiscal year immediately preceding implementation of HealthChoice. The linked data for CY

1999 shows nearly the same results, with 21 percent of one-year olds and 18 percent of two-year olds receiving testing. This compares to a statewide (Medicaid and non-Medicaid combined) average of 28 percent of one-year olds and 23 percent of two-year olds receiving lead testing during CY 1999. By CY 2000, further improvement was seen in the linked rates, with 28 percent of one year olds and 23 percent of two-year olds being tested.

An examination of whether two to three-year old children currently enrolled in HealthChoice had ever received lead testing was also completed. This analysis used both encounter data and the Childhood Lead Registry to assess whether a child had a documented lead test in either data set.[9] The analysis showed that more than half of currently enrolled children had received a lead test at some point in their lifetimes. In Baltimore City, the percentage of two- to three-year old children who had ever been tested was close to 70 percent.

Conclusions. For FY 1997 through CY 2000 (i.e., in every year for which utilization data were examined) lead testing for one- and two-year-olds in Medicaid, and later the HealthChoice program, were, in absolute terms, too low. However, a comparison of FY 1997 fee-for-service claims data to CY 2000 Childhood Lead Registry-HealthChoice linked data showed that 27 percent more one-year-olds and 28 percent more two-year olds received lead screens in CY 2000 than in FY 1997. Furthermore, an analysis of lifetime lead testing of two- to three-year olds demonstrated that more than half of the currently enrolled children in the target age group have been tested at least once. While Childhood Lead Registry data for the pre-HealthChoice period were not available for comparison, these results suggest that positive steps have been made toward achieving higher utilization under HealthChoice than under the fee-for-service Medicaid program.

[9] Because of a data lag, neither of these sources is complete, but the combination of the two sources provides a relatively complete picture of the prevalence of lead testing among two- to three-year-olds.

PUBLIC PERCEPTIONS

Stakeholder Feedback (Consumers, Providers, and other Stakeholders)

Gathering information and input from HealthChoice consumers, providers, and those participating in the program in other capacities are important tools for gauging the program's effectiveness and shortcomings. Is the program working for consumers and providers? In what ways is the program is falling short? How could HealthChoice do a better job of meeting various stakeholder needs? The Department has sought to answer these questions on an ongoing basis through the use of routinely collected quantitative information and, more recently, through extensive collection of qualitative data at forums, focus groups, and hearings with numerous stakeholder and constituency groups.

Ongoing Quantitative Monitoring Efforts

As part of its ongoing quality and performance monitoring efforts, the Department operates a telephone hotline for consumers and providers, conducts annual or biannual consumer and provider satisfaction surveys, and collects enrollment data on the incidence of enrollees changing MCOs. Each of these activities provides timely, ongoing information on various aspects of consumer satisfaction with the HealthChoice program.

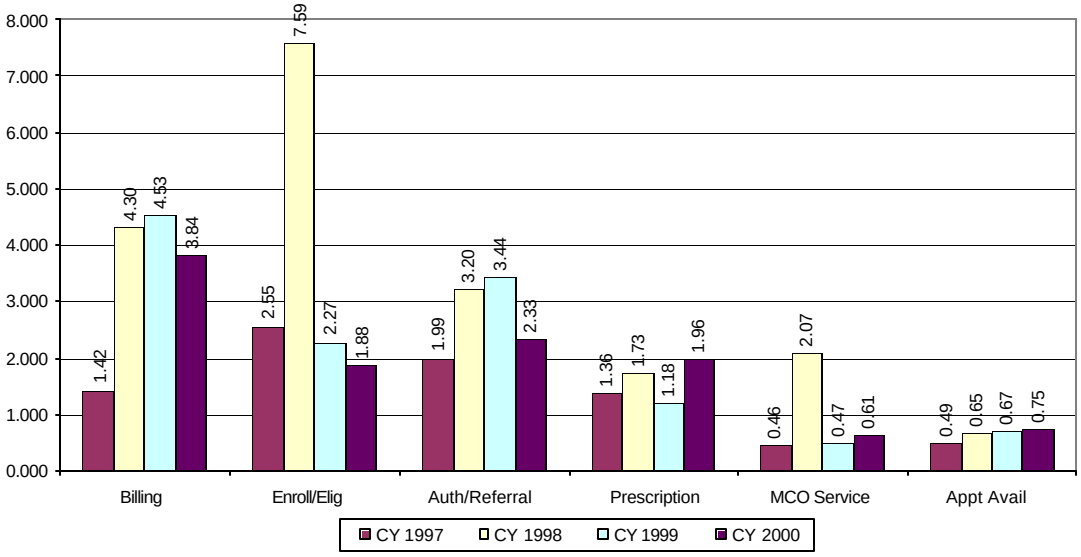
Consumer Complaints – Enrollee Action Line. The Enrollee Action Line is a statewide, customer service, telephone hotline operated by the Department's Division of HealthChoice Customer Relations. Enrollee Action Line, or "hotline" staff field questions and complaints from HealthChoice enrollees during normal business hours; enrollees may leave messages after hours.

- *Background*. Hotline staff can usually answer questions and inquiries - simple requests for information - during the consumer's call. A call is a "complaint" if it involves medical care or access to care issues requiring staff intervention with MCOs, local health departments, or other groups to be resolved. Less than five percent of hotline calls are recorded as complaints. Most hotline calls are informational requests that are handled during the call. A discussion of trends and changes in the rate of various types of complaints over the course of the program is presented below.

  In the past, the Department grouped complaints into five categories: billing, enrollment, access, treatment and "other". More recently, the Department has expanded the number of complaint categories to twelve in order to understand the nature of many of the access and treatment complaints. Currently, complaints are grouped into the following categories: billing; enrollment and eligibility; authorization and referral; prescription medications; MCO services; appointment availability; PCP

assignment; care management; quality of care; provider service; office access; and a small number of complaints that fall outside these categories, labeled "other." Because the number of complaints falling into the latter six categories has been quite small, only data from the six leading complaint categories are presented here.

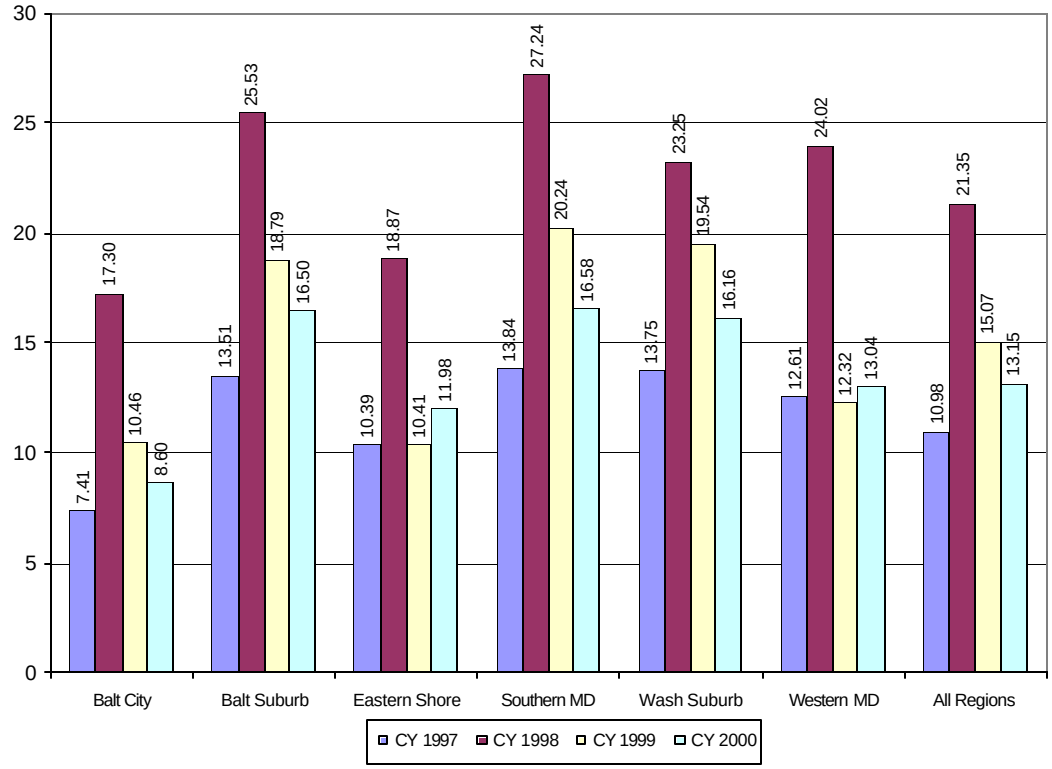
Figure III-63: Enrollee Action Line Complaint Rate per Thousand Enrollees by Reason and Year



➢ *Findings*. Since the program's inception, administrative issues have generated the most complaints, followed by access to specialty care and problems related to medications. In CY 1998, the first full year of the program, Enrollment/eligibility and MCO service complaints were disproportionately high relative to other years. The MCO service complaint category includes problems with an MCO's internal grievance process, telephone customer service, nurse hotline or other MCO administrative staff, and MCO failure to provide outreach services when requested by the PCP. It is likely that these spikes in enrollment/eligibility and MCO service complaints in 1998 are attributable to two factors. First, there continued to be a substantial number of enrollees changing MCOs throughout the entire first year of the HealthChoice program. Second, the implementation of the MCHP program in July 1998, which brought in 35,000 new children in its first six months, also is likely to be partly responsible. The higher rate of billing and enrollment complaints, relative to other issues over the course of the program is probably related to the program's complex eligibility rules and requirements. The level of prescription-related complaints, which increased in CY 2000, may reflect a disconnect between the MCOs and their Pharmacy Benefit Managers (PBMs) that could delay a PBM's timely recognition of enrollee beneficiaries. The increased level of pharmacy complaints in CY 2000 may also reflect

issues surrounding formulary drugs, the practitioners' lack of familiarity with the formulary, and consumer discontent with generic substitutions.

Figure III-64: Enrollee Action Line Complaint Rate per Thousand Enrollees by Region and Year



- *Complaints by region*. Analysis of overall complaint data by region also shows that during the first four years of the program, the rate of complaints in most regions has declined. The Eastern Shore, which experienced an overall increase in complaints during the last two years, is an exception. Over the last four years, the complaint rate generally has been lower in Baltimore City and on the Eastern Shore than the statewide average. In contrast, Baltimore County, Southern Maryland, and the Washington Suburban regions have experienced consistently higher than average overall complaint rates during this four year period, particularly in the last two years. It is unclear why this is the case in these three areas.

- *Discussion.* On average, the Enrollee Action Line receives over 100,000 calls each year. Of these, the number that are categorized as complaints is small (roughly 5,000 in CY 1999 and CY 2000). The low volume of complaints relative to inquiries may be attributable to the fact that most hotline calls do not involve immediate medical issues, access to care issues, or a denial of services. Rather, most involve more general questions about eligibility or enrollment or simply the need for more

education and information on how to negotiate the MCO and HealthChoice systems.

Overall, the proportion of HealthChoice enrollees contacting the hotline (26 percent) for any reason, while significant, is not large relative the program's total enrollment. Information from consumer focus groups and forums suggests that a larger proportion of HealthChoice consumers could benefit from the services provided by the Enrollee Action Line. It is possible that only one quarter of consumers call the hotline because only a small number are aware that the hotline is a resource available to them. Moreover, it is also possible that more consumers do not call because they have little confidence in the Department's and the hotline's ability to actually resolve their issues to their satisfaction. Finally, it may be that a number of consumer questions, problems and complaints are resolved by the MCOs themselves.

It is difficult to draw conclusions from this complaint data that can be generalized to the entire HealthChoice population. In order to gain additional insight on this topic, the Department probed this issue in the consumer focus groups. Additional information can be found in subsequent sections on consumer input.

Consumer Satisfaction Survey

Overview. The Consumer Assessment of Health Plans Survey (CAHPS) is the primary tool for assessing consumer satisfaction and experiences with care in the commercial, Medicaid, and Medicare markets. Different survey instruments are used for adult and child Medicaid enrollees. Given a valid survey sample and a sufficient response rate, CAPHS results are comparable among the different state Medicaid programs and between Medicaid and commercial populations.

Consumers report a high level of satisfaction with HealthChoice; however, there have been concerns about the validity of this information because of survey sampling problems and low response rates. In 1998, the Medicaid adult consumer satisfaction survey had a response rate of 30 percent (2,727 returned surveys), with most of the responses coming from two rural counties. In 1999, the survey had a response rate of 22 percent (2,204 returned surveys). The chart below describes the results of the 1999 Medicaid adult CAHPS conducted in Maryland.

Figure III-65: 1999 Consumer Assessment of Health Plans Survey (CAHPS) Results

	HealthChoice	MD Commercial Plans	National CAHPS***
Getting Needed Care*	78%	75%	74%
Getting Care Quickly*	85%	77%	78%
Personal Doctor	75%	NA	73%
How Well Doctors communicate	87%	89%	89%

*Indicates composite measures
**The National CAHPS percentages are derived only from those plans reporting CAHPS as part of HEDIS.

Discussion. Although CAHPS satisfaction scores for the HealthChoice program are in line with those of other states' Medicaid and commercial managed care programs, the shortcomings of the HealthChoice data make such comparisons inappropriate. The 1998 HealthChoice CAHPS sample was highly skewed towards enrollees in two counties, and in both 1998 and 1999, the survey response rate was unacceptably low. Efforts are currently underway to conduct a methodologically sound survey that will yield reliable results. Results will be available in early 2002. Given the concerns with the validity of the information from the consumer satisfaction survey, the Department has used consumer forums to get a better sense of current satisfaction with the program.

Provider Satisfaction Survey

Overview. The Department conducted Provider Satisfaction Surveys in 1998 and 1999. The results are reported below. In each of these years, the Department mailed surveys to a sample of participating physicians. In 1998, the physician satisfaction survey had a response rate of 31 percent (387 returned surveys). In 1999 the response rate dropped to 11 percent.

Discussion. The majority of providers surveyed are satisfied with many aspects of the HealthChoice program, and the percentage of surveyed providers who express satisfaction was higher in 1999 than in 1998 for each category. Notably, drug formularies received the lowest rating in 1998 and the second lowest rating in 1999. This is consistent with the findings from the provider forums, discussed below. The number of physicians who participated in this survey was very small, and there are no comparable measures from the period prior to HealthChoice. Information gathered at provider forums offers a more current and detailed perspective on provider experiences in the program**.**

Annual Right to Change

Overview. The proportion of enrollees electing to change MCOs during their annual right to change period is in some respects a measure of enrollee satisfaction with their plan. In general, once a HealthChoice enrollee has selected an MCO, they remain with that plan for one year. Once a year, in the month of the anniversary of their enrollment, enrollees may elect to change plans. It is important to note, however, that HealthChoice enrollees may also change MCOs at any time during the year for cause. "Cause" is defined in the program's Operational Protocol to include: transportation hardship (e.g., the enrollee has moved, and now lives a great distance from his or her provider); dissatisfaction with auto-assignment; desire to keep all family members in the same MCO; change in foster care placement; and, in certain circumstances, the enrollee's PCP no longer participating in the enrollee's MCO.

Discussion. The proportion of enrollees who exercise their annual right to change may be a useful proxy for consumer satisfaction. For instance, the relative rate of enrollee-initiated changes among the plans could be used to identify a problem with a particular plan. In Maryland to date, only a small proportion (1.66 percent in CY 1999 and 1.97 percent in CY 2000) of enrollees who are eligible to change MCOs during their annual right-to-change period elect to do so. (Data from the state's previous enrollment broker for CY 1997 and CY 1998 were not available. Hence, only data from the latter years of the program are presented here.) Firm conclusions are difficult to draw from this low percentage. However, the small number of enrollees who choose to switch plans during their annual right to change may indicate that enrollees are largely satisfied with their MCO plans.

The Department also examined disenrollments for cause – namely, change due to transportation hardship, change in order to keep the family in one MCO, and change because of dissatisfaction with auto-assignment. In all of these cases both the volume and rate of consumer switching declined between CY 1999 and CY 2000.

Switching due to a transportation hardship – usually because a family moves – declined from 5,331 (15.24 per 1,000 HealthChoice enrollees) in CY 1999 to 4,663 (12.11 per 1,000 HealthChoice enrollees) in CY 2000. Similarly, changing MCOs to maintain all family members' enrollment in the same plan also decreased from (28.33 per 1,000 HealthChoice enrollees) to (25.4 per 1,000 HealthChoice enrollees) between CY 1999 and CY 2000. Finally, switching plans because of dissatisfaction with auto-assignment followed the same pattern. While the overall number of individuals who were auto-assigned dropped between CY 1999 and CY 2000, the percentage of the enrollees who were auto-assigned and changed plans declined as well (from 15.5 percent in CY 1999 to 7.6 percent in CY 2000).

It is unlikely, however, that the decreased incidence of enrollees changing plans is related to consumer satisfaction. The number of enrollees switching plans due to transportation hardship occurs when people move from one jurisdiction to another. This is likely to be related to larger workforce and demographic issues. Moreover, the number of enrollees who change MCOs to maintain the continuity of family members' enrollment in a single MCO is likely to decrease as the program ages. This is because, as it matures, consumers become more familiar with the program, and, most importantly, they establish and retain a primary care provider with whom they are comfortable. Drawing clear conclusions as to why there has been a decline in the number of enrollees changing MCOs after auto-assignment is not currently possible.

Public Input - Community Forums, Focus Groups, Meetings with Stakeholders and Public Hearings.

As part of the evaluation, the Department initiated a broad, multi-faceted public input process, soliciting feedback about the performance of HealthChoice from consumers, providers and other stakeholder groups. Altogether, the Department conducted over 80 meetings across all regions of the State. The major findings of the different stakeholder groups are briefly described below. Consumer input was gathered through several mechanisms:

- *Consumer focus groups – HealthChoice parents:* The first mechanism for soliciting input was a series of 17 meetings across the State with focus groups composed of parents of children enrolled in HealthChoice. Some of the HealthChoice parents were also HealthChoice enrollees themselves. Each focus group was composed of seven to ten participants. These groups provided the Department with an opportunity for lengthy, in-depth dialogue with consumers about the program. An independent contractor facilitated these groups.

- *Community Forums:* The second mechanism used for gathering consumer input was 14 community forums attended by over 280 HealthChoice

consumers. These were larger meetings designed to solicit feedback from a broader cross section of the HealthChoice population. Consumers participating in these forums were asked about their problems and issues concerning the HealthChoice program.

- *Consumer focus groups - parents of special needs children*: The third mechanism used for gathering consumer input was three focus groups composed of the parents of children with special health care needs. A total of 36 parents, all of whom had at least one special needs child enrolled in a HealthChoice MCO, participated in these groups, which were also facilitated by an independent contractor.

Findings - Summary of General Comments Across All Consumer Groups, Forums and Meetings. In general, many participants described themselves as satisfied with the coverage and quality of care that they or their children, or both receive through the HealthChoice program. Participants value the health care coverage the program provides, and they typically express high praise for their primary care providers.

- *Specialty care*. Access to specialty care, however, appears to be a problem. In rural areas, participants speak of having to drive well over an hour to see a specialist. Participants in both urban and rural areas describe long waits, in some instances four to six weeks or more, to get an appointment with a specialist.

- *Dental services.* Most participants throughout the state cited an insufficient number of dental providers as a major problem with HealthChoice. A number of participants also voiced concerns about the quality of dental care received and the competency of some of the program's dental providers.

- *Pharmacy services.* Most participants, including those with special needs, are satisfied with the program's pharmacy coverage, although some consumers report frustration with physicians' lack of familiarity with MCO formularies and what consumers perceive as frequent MCO formulary drug changes. Consumers express frustration and confusion when physicians prescribe medication that is not on their MCO's formulary. For some, this situation has resulted in delays in starting medication (for example, when the pharmacist could not reach the physician to correct the problem) or paying for the prescription out-of-pocket.

- *Transportation services.* The majority of participants are unaware that HealthChoice offers transportation services. However, parents of special needs children who had used these services had many negative comments. Several cited numerous problems with scheduling and

timeliness of pickups. Several parents of special needs children reported missing appointments because drivers were late.

- *Vision services.* Participants appear pleased with the program's vision care and benefits, although parents of HealthChoice-enrolled children uniformly noted the extremely poor quality and unaesthetic appearance of the eyeglass frames.

- *Billing problems*. Billing is also a source of frustration for many HealthChoice enrollees. A substantial number of parents of HealthChoice enrolled children reported receiving bills for services. The reasons behind this are somewhat unclear. It appears that some parents are unaware of MCO emergency room policies or are simply unable or unwilling to comply with them. Additionally, program eligibility issues appear to be a likely cause of some billing errors.

- *Stigma*. Finally, some - but not all - participants report that they feel some stigma as a result of their enrollment in HealthChoice. Whether real or not, some parents of HealthChoice-enrolled children perceive that they are treated differently because they have public coverage. For the most part, these individuals report that it is the attitude and conduct of the reception and front office staff in their medical provider's office that lead to this perception - not that of providers or MCO staff.

Medical Home & Access to Care

Primary Care Provider. Most consumers report that they have a primary care provider, who they hold in high regard, and with whom they appear to have maintained a positive, ongoing relationship over a number of years. Parents are aware of their children's need for preventive services, although it is less clear the degree to which children are receiving the full range of recommended preventive care services. Some parents reported receiving reminders - mostly from their physician's office and to a lesser degree from their health plan - reminding them about scheduling or keeping appointments for preventive services.

Appointments. Most parents report the ability to make appointments for both routine and urgent care in a timely manner. Some participants in Baltimore City were less satisfied than participants in other regions with the amount of time it took them to get in to see their provider.

Carve-outs.

The majority of those who commented in detail on issues related to HealthChoice's carve-out services were parents of HealthChoice-enrolled children. It is important to keep in mind that only a very small number of parents

across all of the groups reported having children who needed speech therapy, occupational therapy, or physical therapy services. While a larger number of parents had children requiring mental health services, focus group participants and their children were not among the seriously and persistently mentally ill, nor did any of the children appear to have substance abuse issues. Virtually all of the focus group participants whose children had used the mental health system had diagnoses of attention deficit hyperactivity disorder (ADHD), attention deficit disorder (ADD), conduct disorder, or mild to severe depression. Finally, as noted previously in the substance abuse section of this document, HealthChoice consumers in the adult population – as well as providers and MCOs – report difficulty in coordinating somatic and behavioral health care services.

The impact of carve-outs, at least among young early and pre-adolescent children enrolled in HealthChoice, appears to be complicated and varies by region. Overall, consumers in certain rural regions have fewer complaints and seem pleased with both the outpatient mental health services and the occupational therapy, physical therapy and speech therapy services that their children receive. From their perspective, coordination of care for these services is less of a problem. In Southern Maryland and Western Maryland, awareness of mental health services and access to them appears to be satisfactory if not good. The picture in the state's urban and suburban communities, however, is more complicated.

Parents in urban and suburban areas reported feeling somewhat on their own with respect to mental health services. Some of these parents said that their health plan did not cover mental health services and appeared not to recognize that mental health services are, in fact, part of the HealthChoice benefit package. These parents seemed to be unaware that mental health services are offered as part of HealthChoice through the State's Administrative Services Organization (ASO). Moreover, urban and suburban parents who knew about the Maryland Health Partners (MHP) network did not report being satisfied with the access to services or the quality of care they were receiving through the network.

Specific Populations

Spanish Speaking Enrollees. In two forums conducted in Baltimore City and Silver Spring, Spanish speaking HealthChoice participants generally expressed satisfaction with the coverage and care that they are receiving through the HealthChoice program. Latino forum participants raised several issues, however, that the Department had not heard from other groups.

- *Appointment scheduling.* Latino forum participants reported long waits to schedule appointments for both urgent and preventive care, and lengthy in-office waiting times once they arrived for their appointments. It appears that many Latino enrollees seek care in clinics that schedule "block appointments," in which numerous patients are intentionally assigned

identical appointment times. Patients generally all arrive at close to the same time, and the provider sees them in the order in which they arrived. This approach means very long in-office waiting times for the majority of patients. Block appointments are very convenient and economical for the provider, as patients who are no-shows do not mean significant down time for the provider. This approach to scheduling is, however, extremely inconvenient for patients.

- *Language and office staff.* Spanish speaking enrollees also said that they had difficulty understanding their physicians, most of whom were not fluent in Spanish. While most felt that the doctors' demeanor was appropriate, Silver Spring participants felt that office staff was disrespectful, unhelpful, and unkind. In addition, Latino participants seemed unaware that their MCO could provide translation services.

- *Enrollment and re-enrollment processes*. Latino participants expressed more difficulty with the HealthChoice enrollment and re-enrollment processes than other enrollees. Participants in the Latino groups suggested that the Department indicate whether or not providers in the Provider Directory were fluent in Spanish. Additionally, they suggested that the Department print virtually all forms and letters in Spanish. Moreover, they noted that it would be helpful if the Department mailed families a letter indicating that they had in fact received re-certification and would continue to be covered by the program. Otherwise, participants said, they have no idea if their application was received, processed and accepted.

Children with Special Health Care Needs. As discussed previously, the Department contracted with an independent contractor to conduct several focus groups with parents of HealthChoice-enrolled children with special health care needs. These groups were not composed of the parents of children with very similar disease specific conditions; rather, the groups were made up of parents of children with a wide range of problems, from exclusively mental health concerns to chronic illnesses such as diabetes and brittle bone disease. With few exceptions, parents in these groups voiced mainly the same concerns as those in other groups, such as problems accessing specialty and dental care, fatigue with the number of HealthChoice MCO transitions, and struggles navigating and understanding the HealthChoice and MCO systems. Moreover, their degree of concern about these issues was also similar.

- Therapies, case management, and transportation services. Given the greater need for specialized services in this population, certain findings from the focus groups are a greater concern with respect to this population. While it is not clear whether the children in these groups actually may have needed therapy services, the apparent lack of awareness among participants that these carve-out services are available

is likely to be problematic. Moreover, many special needs parents seem unaware of the MCOs' provision of case management services. With one or two exceptions, most special needs parents do not appear to be benefiting from regular contact with a case manager concerning their child's care or progress with care. In addition, some special needs parents report having difficulty understanding and navigating the MCO and HealthChoice system. While some special needs parents note that they received a great deal of written information from their MCOs, they found it more confusing than helpful. Finally, in contrast to parents of children without special needs, parents of special needs children, as discussed earlier in the public input section, had a greater awareness of and more experience with HealthChoice transportation services.

Children under Age One

The Department also conducted a focus group with mothers of children under one, who had been enrolled in HealthChoice during their pregnancy. The purpose of this group was assessing whether consumers were experiencing problems accessing care for their newborns. While this is clearly an important issue for providers, consumers do not appear to experience problems getting their child assigned to a PCP, making timely appointments, or receiving recommended care.

Administrative Issues

Administrative Burden. Consumers complain of "administrative burden" with both the Medicaid program and their MCO. The parents of children enrolled in HealthChoice through the Maryland Children's Health Program (MCHP) are more likely to have experience with employer-based managed care plans. Such experience helps MCHP parents navigate MCO rules concerning referrals, emergency room use, and provider networks. Managed care policies and processes may be more confusing to lower income parents, particularly those with special needs children who use services frequently.

Application Process.

- *Mail and local health department processes.* Many MCHP parents who enrolled their children in HealthChoice entirely through the mail were very pleased with the process. These parents reported enrollment to be smooth, easy and relatively quick. Parents who enrolled at the local health department had similarly positive comments.

- *Department of Social Services.* Lower income participants who were simultaneously seeking enrollment in other social service programs, however, reported less satisfaction and greater frustration with the process. Because they were also applying for other forms of assistance in

addition to HealthChoice, these individuals enrolled through their local Department of Social Services (DSS). Typically long waits, long forms, detailed questions, and harried staff were characteristic of these individuals' enrollment experiences, particularly in Baltimore City and Baltimore County. Notably, this was not the case in Western or Suburban Maryland. It is important to mention that the Department and DSS have recently reduced the application form down to six pages for those applying for multiple programs. Thus perhaps consumers will find the application process for multiple programs less time consuming and onerous in the future.

- *Spanish Language Application and Outreach*. Many participants felt that outreach efforts and the application process targeted at the Hispanic population should be sure to incorporate Spanish-language outreach, application, and education materials. Specifically, participants suggested that reapplication materials be sent to Spanish-speaking families in Spanish.

MCO Transitions. A majority of participants expressed their fatigue with the program's numerous MCO transitions and the frequency with which providers dropped out of the program. Consumers discussed how these events threatened continuity of care. The MCO transitions were perceived as extremely disruptive. Many participants expressed a desire for greater program stability.

Enrollee Hotlines. Most consumers indicate that they have little experience calling the MCO and Enrollee Action line numbers on the back of their MCO cards. It is unclear whether and to what extent this is because they assume a call to a hotline will not resolve their issue or because they have not had problems necessitating a call. Those who have called a hotline have trouble remembering which hotline (their MCO's or the Department's) they contacted. Moreover, those who reported calling experiencing mixed results. Many enrollees seem to find other HealthChoice parents the best source of information, as these individuals may have experience working through similar problems.

Program Changes Suggested by Consumers. Several changes suggested by consumers were discussed or alluded to above - namely, fewer transitions, greater provider retention, additional dentists and specialists, improved communication and information concerning the availability or advisability of certain HealthChoice services, efficient transportation services, and greater availability of Spanish language materials. Several consumers, particularly working parents, wished that the program could be expanded to provide coverage for them. Several also recommended that the program further relax rules concerning the requirement that participants remain in their chosen MCO for one year.

Advocates

In addition to face-to-face meetings with consumers, the Department held a centralized meeting with advocacy organizations. An independent contractor facilitated the meeting. In general, advocates raised serious concerns about the HealthChoice program.

Medical Home. Advocates said that HealthChoice had failed to provide a medical home. They were concerned that historic provider relationships had been disrupted and that auto-assignment of patients had been devastating. They said that the complexity of the system with different MCOs and different rules had led to confusion for consumers.

Provider Issues. They expressed concerns about the adequacy of the provider network, particularly regarding dentists and specialists, and issues about the inaccuracy of the provider directory.

Carve-outs. Various advocacy groups had differing opinions about carve-outs. Some said that carve-outs added to the complexity of the program and were confusing for patients. Some suggested that carve-outs afforded consumers greater access and, therefore, more services should be carved out or self-referred. One participant expressed a positive experience with access-to-care under the mental health carve-out.

Case Management. Advocates also said that HealthChoice was not providing sufficient case management services. Some said that MCOs do not have enough case management staff and thus only respond to urgent situations. Many advocates stated that MCOs only do administrative case management, rather than helping enrollees and providers to coordinate a broad range of medical, social, and educational services.

Vulnerable Populations. In general, advocates expressed strong concerns about access to care for vulnerable populations. In particular, advocates raised concerns about the following populations: pregnant women, adolescents, immigrants, children in foster care and kinship care, and HIV/AIDS patients.

Department's Performance. They expressed mixed feelings about the Department's performance and responsiveness to their concerns. When asked about working with the Department, some advocates stated that the Department is accessible, but not always responsive. Some said that Department staff was trying to make the program work, but they were under-funded and under-staffed. Others believe that the Department is obstructionist. Some advocates stated that the Department was in alliance with MCOs because they want managed care to work to the exclusion of listening to other options and suggestions.

Enrollee Complaints. Several advocates said that they believed that consumers do not call the Department's complaint line when they have problems. Advocates were concerned about denials of care and believed that consumers were not being notified when a service was denied.

Program Changes Suggested by Advocates. Advocates recommended the following changes for the HealthChoice program:

- Increase funding.
- Eliminate HealthChoice, and replace it with a primary care case management (PCCM) program.
- Phase in PCCM where networks are falling apart.
- Stop administrative case management.
- Allow chronic and disabled enrollees to go to wherever needed.
- Invest in better computer system.
- Provide efficient case coordination.
- Maximize federal funding opportunities.
- Enhance and create a more visible role for local health departments.
- Study best practices.
- Collaborate with Health Care for All.
- Correct disconnect with eligibility and access between the Department of Human Resources and the Department.
- Improve coordination with all departments (Department of Human Resources, Maryland State Department of Education, and Department of Juvenile Justice).
- Better educate consumers about the program, its rules and requirements.
- Carve out the foster care and kinship care populations.
- Become more proactive in monitoring care and enforcing standards of care at the provider level.

- Simplify all monitoring in order to encourage provider participation in networks.

- Institute real-time claims payment.

- Recruit and retain providers.

Provider Forums

A total of individual 184 providers participated in 20 discussion group meetings held throughout the State. Nine of these meetings were regional meetings for physicians; five were regional meetings for office managers. The Department conducted one centralized meeting for each of the following provider groups: advanced practice nurses, school-based health clinics, pharmacists, dentists, FQHCs and hospitals. In total, over 200 people participated in these meetings.

Findings – all provider groups. Below we have summarized the main findings across all of the provider groups broken down by (1) reimbursement and administrative followed by (2) issues related to medical care. Subsequently, we provide more detailed information about the findings for several specific provider groups when opinions in these groups differed sufficiently from those articulated in the majority of provider groups. Specifically, a more detailed discussion of the findings from the groups with office managers, school-based health clinics, advanced practice nurses, pharmacists, dentists and federally qualified health centers are provided below.

- *Reimbursement and administrative issues.*

  - *Reimbursement rates.* The leading concern for the majority of providers is the low reimbursement rates in Maryland's Medicaid and HealthChoice programs. Many blame low reimbursement for provider withdrawals and insufficient provider networks**.** Physicians displayed a thorough understanding of the current rate structure compared to Medicare rates. Moreover, the majority felt that Maryland Medicaid rates are too low to maintain provider participation in the program. There were important exceptions, however. PCPs who receive capitated payments report satisfaction with their payment rates. In addition, several physicians noted that HealthChoice EPSDT rates are actually higher than the commercial rate.

  - *Administrative burdens*. All provider groups – physicians, advanced practice nurses, hospitals, pharmacists, school-based health clinics, dentists, and Federally Qualified Health Centers (FQHCs) cited the administrative burdens of participating in the program.

Specially, they mentioned: the administrative hassles of working with several MCOs (referrals, preauthorization, and formularies); eligibility verification; newborn eligibility and assignment issues; long telephone waiting times for MCO and Department staff; paperwork volume required to comply with EPSDT and other quality oversight requirements; educating patients on how the program works; educating patients about appropriate use of emergency rooms; and outreach and care coordination for patients.

- *Timely payment*. Both physicians and office managers noted problems with timeliness of payment and hassles associated with submitting claims. Although some providers stated that the timeliness of payments had improved, others continue to identify this as a problem. Several providers recommended that MCOs and MHP accept electronic claims and that the Department establish a process to reconcile payment issues.

- *Auto-assignment*. Some providers were concerned that auto-assignment had resulted in a lack of continuity of care for HealthChoice enrollees. In particular, FQHCs were concerned that auto-assignment resulted in loss of their historic patients.

- *Provider directories.* A majority of providers were concerned about inaccurate MCO and MHP provider directories. They expressed a need to have an accurate provider directory available on the Internet.

➢ *Care issues.*

- *Primary care – medical home.* Many providers acknowledged that HealthChoice had resulted in greater access to primary care. Most view the physician or clinic as patient's medical home, and most physician providers believed that they have furnished a medical home for their patients. Some hospital participants believed that the establishment of a medical home was one of the more successful aspects of the program. Other hospital participants, however, believed that emergency room utilization was increasing – a possible indication that the appropriate level-of-care may not be taking place at the PCP level – and that the large number of plan transitions did not support the conclusion that HealthChoice has provided a medical home for patients.

  Some health officers echoed these statements, also citing alleged increases in emergency room use, and a lack of preventive care as evidence that the program had failed to create a medical home. In contrast, some local health department staff stated that more

people are better served and that for primary care a medical home was created.

- *Specialty care access and coordination*. Numerous providers in various provider groups voiced concerns about access to specialty care, mental health services, dental services and coordination of care among different providers. Many also voiced concerns about the lack of consistency between different MCO formularies.

- *Case management.* Coordination with carve-out services was believed to be difficult. Most providers stated that they believed that the burden for case management was on the provider and not on the MCO**.** Many said that they thought the program's case management requirements should be better defined. Several local health department staff believed case management should be locally provided.

Findings – Specific Provider Groups. This portion of the chapter sets forth more detailed information about the findings, as drawn from specific provider groups when the group's opinion differed significantly from those articulated in the majority of provider groups.

➢ *Office managers.*

- *Administrative issues – eligibility, network information*. Office managers cited problems with eligibility verification, auto-assignment, and newborn issues. They reported having to spend considerable time trying to determine whether patients were HealthChoice-eligible. In addition, they felt frustrated by their inability to obtain accurate network provider information from the MCOs.

- *Formulary.* Office managers cited the desirability of establishing one prescription drug formulary for all Medicaid consumers. They want a simple regulatory system that is uniform across the entire Medicaid program.

- *Prompt payment.* Office managers stated that the MCOs should pay providers on time and that the Department should fine those MCOs that failed to do so.

- *Transportation, case management, appointments, and inappropriate ER use.* Office managers believed that they were spending too much time arranging for transportation and case management services for HealthChoice clients. They felt strongly that HealthChoice consumers should be more responsible about

keeping appointments and using the emergency room appropriately.

- *Frustration.* Finally, office managers expressed frustration that they are responsible for various activities that are integral to the provision of high quality, comprehensive patient care, yet few take the time to listen to and address their concerns.

➢ *School-based health clinics.*

- *Limitations on number and type of services; reimbursement.* Staff at school-based health clinics expressed frustration at the limitations placed on the services for which they can receive reimbursement. They want the state to change the regulations that limit the number of times their clinics can see a child. They say that they are providing many services to the Medicaid population but are not being reimbursed. They report that under HealthChoice, only two percent of their clinic costs are covered as compared to forty percent under the MAC program.

- *Appropriateness as care-delivery site; dental services.* School-based health clinic providers feel strongly that they are perhaps the best place for HealthChoice enrolled children to receive timely services. They believe that some children experience long waiting times before getting in to see their PCP, and that some PCPs have problems locating their clients. Because of their proximity to many HealthChoice children, school-based health clinics state that they have little problem locating clients and assisting them to get in for timely care. Moreover, clinic directors believe that they can provide better care to the non-English speaking HealthChoice population than many of these individuals are currently receiving. Clinic directors also report that they are providing dental services to elementary school children, many of whom have serious dental issues, and they believe that they should be reimbursed for the provision of these services. Clinic directors also stated that coordination between mental health and substance abuse services is problematic for many children and adolescents enrolled in HealthChoice.

- *School-based health clinics as MCO subcontractors, PCPs.* School-based clinics wanted the Department to help them obtain service contracts with MCOs. Most importantly, however, they wanted the Department to allow them to become primary care providers. This, they believed, would be a step toward eliminating some of the existing problems with HealthChoice.

- *Advanced practice nurses.*

  - *PCP classification; increased reimbursement.* Like school-based health clinic administrators, the central issue for advanced practice nurses is their desire to be classified as Primary Care Providers, as was the case under the Maryland Access to Care (MAC) program. The nurses echoed many of the concerns and comments articulated by the preceding groups. Like others, they believe that provider reimbursement for Medicaid and HealthChoice should be raised to Medicare levels, and they articulate the same concerns and recommendations as other providers with respect to Medicaid eligibility, drug formularies, and other administrative issues.

  - *Expanded benefits; consumer education; financial disclosure by MCOs; limitation of pharmaceutical industry profits.* Several advanced practice nurses recommended that HealthChoice institute the following changes: provide consumers with transportation both on weekends and on short notice; better educate consumers so that they fully understand all of their options within the HealthChoice program; require MCO payment of tooth extractions for both adults and children; require MCO provision of financial information detailing how HealthChoice funds are spent; and finally, institute a cap on the profits that pharmaceutical companies are permitted to make on the sale of drugs to the Medicaid program.

- *Pharmacists.* Pharmacists reiterated the problems expressed by both consumers and physicians with varying and constantly changing MCO drug formularies. They also expressed frustration with their inability to verify enrollee eligibility during nights and weekends—the very times when enrollees are most likely to fill prescriptions. They believe that MCOs' and the Department's Eligibility Verification System (EVS) are inaccessible on weekends and after hours during the week.

- *Dentists.*

  - *Access – payment rates*. Dentists expressed extreme frustration with the access to dental care under HealthChoice. Dentists acknowledge the low number of providers who choose to participate in the program and cite the Department's low dental reimbursement rates as one of the leading reasons. While they acknowledged that dental rates have increased relative to the State's MAC program, they note that rates paid by HealthChoice MCOs continue to be lower than those of neighboring state

Medicaid programs, and they note that the MCO that paid the highest dental rates is no longer participating in the program.

- *Other administrative issues.* Other administrative issues that are problematic for many dentists include the perception of a high turnover rate among MCO dental benefit managers or vendors in recent years. Increased paperwork is also a problem. A number of dental providers said that the timeliness of provider payments had improved and was no longer as problematic as it had been in the past.

- *Broken appointments; transportation; dental specialty access.* In terms of care issues, dentists cited the high proportion of appointment no-shows – 40 to 50 percent in the HealthChoice population – as a problem. Many acknowledged that transportation was a tremendous problem for their HealthChoice patients, and that many had to travel large distances in order to get to their offices. Several dentists noted that while some children seemed to be getting preventive dental care and cleanings, many that should were not getting cavities filled. In addition, several dentists cited problems finding dental specialists for their patients.

- *Dental education.* Interestingly, several dental providers pointed to a lack of awareness concerning dental hygiene and the need for better dental education in the HealthChoice population as an issue. Some noted that because Medicaid had failed to cover adult dental services for so long, many parents were uninformed about important aspects of routine oral health care and thus failed to set an appropriate example for their children. Several also noted the relationship between good dental care and workplace opportunities in later life, saying that adults often have trouble finding private sector jobs if their mouth looks particularly bad.

- *Federally Qualified Health Centers*

  - *Historic provider relationship.* The most important and central concern that FQHCs have with the HealthChoice program is a disruption in the relationship between historic providers and Medicaid patients that they state has occurred as a result of HealthChoice.

  - *Financial resources.* A second major concern and one that is also unique to the FQHCs is the movement away from presumptive eligibility and its reported negative effect on clinic finances. Moreover, clinic financing has been further stressed because directors report that they have had to hire more administrative staff in order to participate in the HealthChoice program. These financial stresses, in turn, have increased clinic directors' concerns about their ability to continue to have sufficient resources to adequately serve the uninsured.

  - *Translation services.* Clinics also report having problems surrounding translation services. Many FQHCs report having a large non-English speaking population. Some clinics reported they are unable to obtain adequate translation services from MCOs. Others note that they are unable to obtain reimbursement for the translation services they must provide for their non-English speaking consumers .

  - *Mental health, substance abuse treatment services.* They also raised concerns about mental health services. Clinic directors reported little coordination, overall, between somatic and mental health services. In addition, they reported that their clinics were currently providing a significant number of mental health and substance abuse treatment services in-house, which they believed was quite beneficial for HealthChoice recipients.

  - *Transportation services.* Several FQHC providers mentioned problems with HealthChoice transportation services. They noted that transportation often stopped at the county line, a problem in suburban Maryland where Prince George's County residents sought care from Montgomery County providers and vice versa. The program's transportation services typically will only take the patient. This is a problem for a mother who has a sick child and other children, they said. Moreover, they stated that HealthChoice transportation services required consumers to arrange for their rides at least 72 hours in advance, which is particularly difficult if an individual needs urgent or specialty care. FQHCs noted that they

were continuing to provide transportation services to consumers and wanted to be reimbursed for this.

- *Consumer education.* FQHCs also noted that HealthChoice and the MCOs' systems have been very complicated for patients to understand and negotiate. This, in turn, has placed an increased educational burden on clinic staff, who must take the time to explain various program and MCO rules and requirements.

- *Dental services – reimbursement.* Additionally, the FQHCs uniformly felt that dental services were under-funded, and that the dental benefits package should be expanded to include crowns, bridges and periodontal work, the need for which is particularly acute in the HealthChoice adult population.

- *Provider funding.* In addition to many of the aforementioned concerns, clinic directors also echoed many of the issues raised by other provider groups, namely the program's inadequate provider funding and a desire to see rates raised to levels comparable to Medicare. FQHCs also raised many of the same concerns with respect to eligibility, administrative issues as other groups discussed above.

Program Changes Suggested by Providers.

➢ *Reimbursement.*

- Increase rates.
- Acceptance by MCOs and mental health providers (MHPs) of electronic claims (this would help with lost claims concerns).
- Clearly define a "clean" claim.
- Timely payment to providers by MCOs and MHP; otherwise MCOs and MHP should be required to pay.
- Reimburse providers for legitimate services regardless of the consumer's MCO or PCP.
- Establish an appeals process for disputed claims by DHMH.
- Services should not be bundled.

➢ *Patient Care.*

- Increase number of providers, especially specialists (in certain geographic areas and especially for dental and mental health services).

- Permit consumers to receive care from out-of-state specialty providers (e.g., as done by MPC in Western MD but not by Priority Partners on the Eastern Shore or in Western Md.)
- Improve coordination of care between MHP and the PCP
- Allow mothers to choose the MCO and the PCP for newborns
- Allow DSS workers or foster parents to choose the PCP for foster care children
- Improve coordination between the health care system and the educational system
- Improve education of HealthChoice consumers by MCOs
- Consumers need to take responsibility for keeping appointments and not abusing the system. This should include fines.
- Make generic drugs mandatory, and require enrollees to pay for the less expensive over the counter drugs.

➢ *Administration*.

- Do not expand MCHP unless the provider network is in place.
- Simplify EVS –swipe card would be ideal.
- MCO manuals must be accurate and on-line.
- MCOs must simplify the referral process.
- Increased supervision of MCOs by DHMH
- Eliminate the requirement for a physician to contact a patient three times.
- Determine if the consumer wishes to stay with their PCP before auto-assignment.
- Improve the responsiveness of the provider hot line.
- Carve out dental and pharmacy benefits.
- Define case management, who receives it, which entity is responsible for providing it, and ensure that the services are provided; the Department should do this.
- Establish a statewide Medical Assistance pharmacy formulary, and a statewide durable medical equipment and lab contractor.
- Establish uniform rules that the MCOs must comply with (e.g., audits).
- Provide pharmacists with feedback, when appropriate, on consumers' prescription drug histories.
- Allow advanced practice nurses and school-based health clinics to be PCPs.
- Some support for use of dental hygienists in the schools and dental students in the local health departments, or in other county locations.
- Update physicians DEA numbers (DHMH).

MCOs

The Department held one central meeting with MCO directors, facilitated by an independent contractor. In addition, Department staff conducted site visits at several MCO offices.

MCO directors stated that they believed that HealthChoice had created a medical home. They expressed frustrations about unreasonably high expectations of the program. They felt that even their successes were viewed as failures, pointing to dental care as the prime example. MCOs said the program needs adequate funding and stability. Several MCOs said that the Department should be a purchaser – articulating a set of realistic, achievable, measurable, and coherent goals for the program, and then step back to work in partnership with the MCOs in order to achieve these goals. In contrast, several MCOs stated the Department is too often highly reactive to outside comments and functions as a "micro-manager" with a regulatory mindset. Some MCOs believed that the Department is too advocacy based.

Care Issues. MCOs stated that there had been improvements with access to care, but there were concerns about the provider networks. While they believe a medical home has been created, they cite a difficulty with changing patient behavior such as inappropriate emergency room use.

They believe that their role as case managers is not understood and, like many providers, said there was no common definition of case management. Through site visits to the MCOs, the Department met and talked with many MCO case managers. Most MCOs case manage specific populations, such as pregnant women, asthmatics, diabetics, and special needs children. In addition, they have general case management processes and tools for other low-risk populations, as well as outreach and heath education programs. When asked about the disconnect between the consumers' comments that they had not received case management and the MCOs' case management activity, they thought it may be because consumers did not have a recent contact with a case manager, may not know the term "case manager," or that the Department failed to speak with individuals who were in active case management with a MCO.

- *Program changes suggested by MCOs*

  - Increase funding.
  - Increase program stability.
  - Provide leadership and direction with realistic expectations.
  - Expand coverage.
  - Eliminate ESI.
  - Provide Departmental assistance for provider issues and networks.
  - Re-assess of carve-outs.
  - Re-think timing on risk adjustment.

- Provide leadership, direction and collaboration on public health issues.
- Formalize strategic planning with MCOs.
- DHMH should be more aware of what MCOs do.
- Create formal process to review and reduce administrative burdens.

Public Hearings

A series of five regional public hearings were conducted in September and October 2001 as part of the Comprehensive HealthChoice Evaluation process. Approximately 153 people attended the hearings, and 78 people testified. Notices for the public hearings were mailed to over 400 public officials, statewide and local advisory/advocacy groups, and the HealthChoice managed care organizations (MCOs). Notices were also published in the Maryland General Assembly's weekly interim hearing schedule.

A few of the speakers at the public hearings prefaced their remarks by noting positive changes they have witnessed since the implementation of the HealthChoice program; including improved access to care through expanded eligibility and a broader benefit package, and the presence of a medical home for consumers.

Much of the testimony, however, referenced concerns about the program. Speakers were not satisfied with the level of provider participation in the program. Different groups from different regions noted a lack of all types of providers - PCPs, pediatricians, specialists, and especially dentists. Speakers also demonstrated widespread agreement with previously noted concerns about reimbursement rates and the overall administrative burden associated with HealthChoice. Other concerns raised consistently throughout the public hearings included poor coordination between mental health, substance abuse, and somatic health care; timeliness of payment; barriers to care for foster care children; difficulties with drug formularies; lack of case management, and problems with auto-assignment.

Conclusions

While various constituencies have differing, sometimes conflicting perspectives on the performance of the HealthChoice program, there are several common themes that emerge from the Department's extensive dialogue with consumers, physicians and other direct providers, MCOs, hospitals, local health departments, and advocates. All of these groups concur that funding, - physician fees in particular - the adequacy of provider networks, and network stability are the major challenges facing the HealthChoice program today.

Different groups express differing levels of satisfaction with the HealthChoice program. Interestingly, those who are most pleased with the program overall are the consumers. The Department went to considerable lengths to ensure that participants in a majority of the focus groups were selected and recruited at random. The Department recognizes that not all HealthChoice consumers are satisfied with the care that they receive and the health outcomes that result.

IV. BUILD ON STRENGTHS OF MARYLAND'S HEALTH CARE DELIVERY SYSTEM

The HealthChoice program was able to build on the existing health care delivery system in Maryland. Prior to HealthChoice, there was broad Medicaid participation by the physician community, a strong public health infrastructure, and a committed and long-standing cadre of "safety net" providers. In addition, its enrollees had access to world-renowned medical teaching facilities. Rather than allocating resources to recruit and develop a provider network, the program was able to allocate its resources to expanding services and developing management tools and techniques to assure quality-of-care for enrollees.

As mentioned earlier, there has been tremendous growth and demographic shifts in the HealthChoice program. An important part of the evaluation is to understand how these changes as well as others have impacted Maryland's health care delivery system over the years.

- *Are there adequate provider networks to serve HealthChoice enrollees?* To address this question, this section will compare information from HealthChoice provider files with actual program enrollments.

- *Can physicians serve the HealthChoice population without experiencing financial losses?* Fee schedules for Medicaid and selected MCOs are compared with Medicare fee schedules.

- *What has been the effect of HealthChoice on hospital utilization rates and lengths of stay?* Data from the Health Services Cost Review Commission (HSCRC) is examined to assess changes in hospital patterns among Medicaid recipients.

- *Has HealthChoice adversely impacted graduate medical education in Maryland?* The special provisions to protect institutions with a role in training physicians are examined.

- *Has HealthChoice maintained its relationships with traditional community or safety-net providers?* The effects of HealthChoice on Federally Qualified Health Centers (FQHCs) and local health departments (LHDs) are discussed. In addition, the changing roles of LHDs are examined.

PROVIDER NETWORK ADEQUACY

Overview

The assessment of the adequacy of HealthChoice provider networks can be approached in a number of ways. One approach is to examine retrospectively whether the networks were able to deliver services to eligible enrollees. Based on encounter data, the percentage of enrollees receiving services increased for ambulatory services and well-child visits from 1997 to 2000 even with the dramatic enrollee growth. While this is a very positive finding, many enrollees still do not receive any well-child or ambulatory services. Without being able to determine how many enrollees are not accessing services due to lack of provider participation, it is hard to determine by encounter data alone whether or not the network is adequate.

In addition to encounter data, the primary care provider (PCP) to enrollee ratios can be compared to the guidelines in HealthChoice regulations as a way to measure network adequacy. The advantage of this measurement tool is that it allows us to proactively assess potential network deficiencies.

Methods and Limitations

Under HealthChoice regulations, MCOs are required to regularly submit information on their provider networks to the Department. Submission elements include provider name, license number, specialty, location, phone number, and whether the provider is open to new patients. These submissions are used both for creating provider directories and for calculating the total number of providers, both program-wide, by local access area, and by MCO.

This section of the evaluation analyzes HealthChoice provider capacity based on provider network files submitted through September 30, 2001. Although this is the best information available, a number of problems still exist with the data, including:

- *Providers in multiple MCOs.* Physicians can, and do, contract with more than one HealthChoice MCO. Due to subtle differences in how the name or other information was recorded, a provider may be listed multiple times, which would overstate capacity.

- *Providers in multiple locations.* Physicians can, and do, practice at multiple sites. A physician who practices at multiple locations may appear in the provider directory more than once. This also can lead to overstating capacity.

- *Inconsistent updating of provider data.* The accuracy of any consolidated provider analyses rests upon the quality of data submitted by the individual MCOs. A number of factors can reduce the accuracy of provider data. For example, a provider may end active participation in the MCO or decide to

close its practice to new enrollees and fail to inform the MCO; or an MCO can fail to inform the Department when a provider retires or passes away. In each of these examples, the capacity of provider networks would be overstated. Conversely, if an MCO fails to update its submissions with providers who have been added to its network, the provider data will understate capacity.

- *Replacement of MCO provider information by the Department's fee-for-service provider files.* The Department's information system currently is programmed to search for provider matches from its fee-for-service provider files. If it finds a match based on provider name, address, telephone number, provider type, tax ID, and license number, it will replace the updated provider data submitted by the MCOs. This also can lead to inaccuracies in the provider data.

Recognizing these problems with provider data and the accuracy of the provider network directories, a number of steps where taken to mitigate any overstatement of capacity; specifically:

- *Providers were unduplicated by license number.* MCOs are required to include license numbers for their participating providers (physicians, nurse practitioners, etc.). To address the problem of providers in multiple MCOs and/or multiple locations, the analysis only counts unique provider license numbers.

- *Network estimates are adjusted for inconsistent updating.* The inconsistent updating of provider files has led to inaccuracies in the provider directories. The Department has embarked on a process of regularly sampling listed providers to assess the overall accuracy of provider files. Initial samples and calls indicate that provider files overstate participation in HealthChoice by roughly 15 percent. Thus, to account for this apparent over-reporting of provider data, once provider files are unduplicated, they are further reduced by 15 percent. The Department is continuing to update this adjustment factor through on-going calls to providers' offices.

The cleaned-up provider data was distributed across local access areas (LAAs) based on the zip code of the provider's location (the process of unduplicating providers focused on including only the first office location).

HealthChoice regulations establish a ratio of one physician to every 200 enrollees as a general standard for assessing an individual MCO's capacity within a given LAA. HealthChoice regulations further recognize that the one to 200 standard is not appropriate for all physicians (e.g., FQHC physicians who traditionally serve a high Medicaid population). To account for these high volume physicians, the regulations also set an absolute limit of one provider per 2,000 enrollees.

In the analysis presented here, two capacity estimates were developed: 1) 200 enrollees per unduplicated PCP and 2) 500 enrollees per unduplicated PCP. It

should also be noted that the regulatory guidelines apply to a particular MCO. The analysis presented looks at an unduplicated count of all HealthChoice PCPs. By not allowing a single provider who contracts with several MCOs to be counted multiple times, the evaluation applies a higher standard than outlined in the regulations.

Figure IV-1: MCO Capacity Analysis - All MCOs < 15%

	Total PCPs	Total PCPs	Total PCPs	Enrollment	Excess Capacity	Excess Capacity
Local Access Area	06/30/01	Multiplied by 200	Multiplied by 500	7/10/01	Difference @ 200*	Difference @ 500*
Allegany	56	9520	23800	7983	1537	15817
Anne Arundel North	97	16490	41225	12043	4447	29182
Anne Arundel South	117	19890	49725	7440	12450	42285
Balto City SE/Dundalk	148	25160	62900	16388	8772	46512
Balto City East	224	38080	95200	29631	8449	65569
Balto City N. Central	77	13090	32725	12813	277	19912
Balto City N. East	49	8330	20825	14651	-6321	6174
Balto City N. West	112	19040	47600	16742	2298	30858
Balto City South	53	9010	22525	13661	-4651	8864
Balto City West	180	30600	76500	36249	-5649	40251
Balto Cnty East	89	15130	37825	12112	3018	25713
Balto Cnty North	180	30600	76500	6484	24116	70016
Balto Cnty N. West	77	13090	32725	15908	-2818	16817
Balto Cnty S. West	125	21250	53125	13792	7458	39333
Calvert	33	5610	14025	4233	1377	9792
Caroline	9	1530	3825	3698	-2168	127
Carroll	52	8840	22100	5878	2962	16222
Cecil	26	4420	11050	6985	-2565	4065
Charles	63	10710	26775	8283	2427	18492
Dorchester	18	3060	7650	3614	-554	4036
Frederick	39	6630	16575	8117	-1487	8458
Garrett	15	2550	6375	3878	-1328	2497
Harford East	27	4590	11475	4446	144	7029
Harford West	49	8330	20825	7259	1071	13566
Howard	114	19380	48450	7754	11626	40696
Kent	13	2210	5525	1627	583	3898
Montgomery-Sil Spr	112	19040	47600	6970	12070	40630
Montgomery-Mid Cnty	116	19720	49300	11929	7791	37371
Montgomery-North	58	9860	24650	20063	-10203	4587
Prince Geo N East	74	12580	31450	5785	6795	25665
Prince Geo N West	119	20230	50575	35115	-14885	15460
Prince Geo S East	40	6800	17000	4866	1934	12134
Prince Geo S West	40	6800	17000	15514	-8714	1486
Queen Anne's	7	1190	2975	2209	-1019	766
Somerset	14	2380	5950	2711	-331	3239
St. Mary's	45	7650	19125	5921	1729	13204
Talbot	32	5440	13600	2332	3108	11268
Washington	74	12580	31450	9889	2691	21561
Wicomico	45	7650	19125	9354	-1704	9771
Worchester	22	3740	9350	4086	-346	5264
Total	2840	482800	1207000	418413	64387	788587

Findings

When the conservative standard of 200 enrollees per PCP is adjusted downward by 15 percent to account for poor updating, fifteen LAAs have capacity deficits. The area with the greatest deficit is the Eastern Shore, with seven of the nine LAAs having capacity deficits. If the more liberal capacity standard of 500 enrollees per PCP is used with a 15 percent adjustment downwards, however, no LAA across the State shows a capacity deficit.

Figure IV-2: Local Access Areas with Excess Capacity

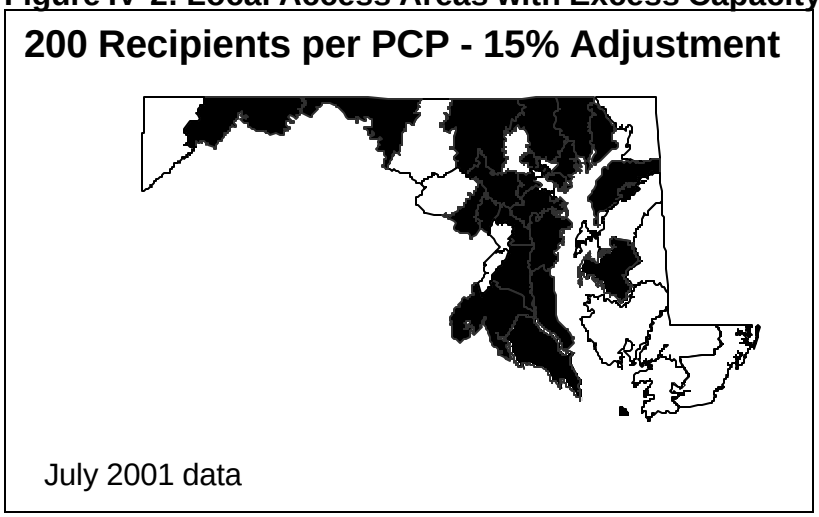
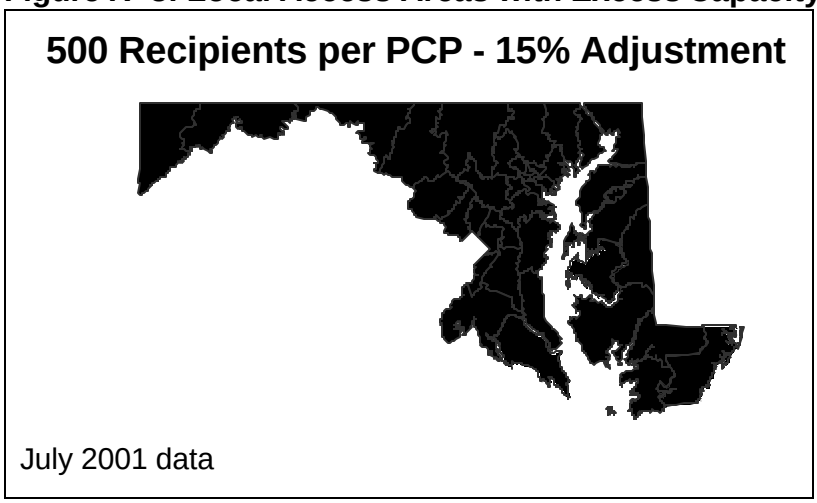


Figure IV-3: Local Access Areas with Excess Capacity



Conclusion

Based on a capacity standard of 500 enrollees to one PCP, the provider networks are adequate to serve the current HealthChoice population. While a number of the LAAs have capacity to absorb significant growth in enrollment, several of them can only absorb small enrollment growth, if any at all. Putting additional stress on the provider networks will cause considerable instability in the program, which will affect both access and quality of services.

Of immediate concern is the Eastern Shore. The lack of participating providers on the Eastern Shore is not unique to Medicaid or HealthChoice. Historically, the Eastern Shore has had less overall provider capacity relative to the rest of the State.[1] The stress on the Eastern Shore's provider network, however, is much more pronounced now than ever before due to the dramatic expansion of covered children from 1990 to 2000 (from 12 percent of the population under 18 years in 1990 to 29 percent of the population under 18 years in 2000).

Direct discussions with providers and stakeholder groups confirmed the Department's finding: although the provider network analysis demonstrates an adequate network, a number of providers are under stress as the patient load continues to increase from year-to-year while reimbursement rates continue to remain low compared to Medicare.

During the past year the Department has worked to develop a formal network adequacy plan. The plan should not only improve the State's ability to monitor and proactively act on potential PCP network adequacy problems, but also meet the requirements of the proposed federal managed care regulations published in August 2001. In addition, the Department has begun to take steps on creating a specialty care capacity plan. Other components of the Departmental Network Adequacy Plan are compared to network adequacy standards suggested by PricewaterhouseCoopers[2] on the following table:

Figure IV-4: Comparison of Network Adequacy Plan

PricewaterhouseCoopers Standard	Status	DHMH Response
Access and Availability		
PCP to Member Ratio	Complete	
For Each Provider Type, Including PCPs, Determine the following: Number and Percentage that serve Medicaid patients; Number and Percentage that accept New Medicaid Patients	Partially Complete	PCPs completed, Certain specialists to be completed over next year
Provider Turnover by Provider Type (Including PCPs)	Complete	
MCO has a process in place to evaluate and adjust the aggregate number of providers needed and their distribution among different specialties as the network expands	Partially Complete	Phase I requires MCO to submit corrective action plans in response to identified problems. A formal evaluation of existing MCO network adequacy systems, has been added to the 01 Systems Performance Review
MCO is in compliance with state standards regarding the maximum travel and distance times to PCPs and specialists. If no standards, MCO has method for determining geographic access needs based on distance, travel times and means of transportation.	Scheduled for 3/30/02	DHMH has purchased Geo-Access Software and is scheduled to implement its use during the first quarter of 2002. Note: The Department intended to hire an FTE to perform these duties, but is now under a hiring freeze.
MCO has method of ensuring that medical care is accessible 24 hours a day, 7 days a week for emergency services, post-stabilization services and urgent care services	Completed - Tracked through Customer Service*	This is tracked.
MCO has a process for ensuring that some providers offer evening (5 p.m. to 9 p.m.) or weekend hours.	Completed- Tracked through Customer Service*	This is tracked.

[1] "Rural Health in Maryland: Setting an Agenda in a Time of Change," Maryland State Office of Rural Health, 1997.
[2] "Assessing the Adequacy of Medicaid Managed Care Provider Networks," PricewaterhouseCoopers LLP, May 2001.

MCO is in compliance with the state's standards regarding appointment wait times. If not state standard exists, MCO has method for determining and tracking appointment wait times.	Completed - Tracked through Customer Service*	This is tracked.
MCO has process for communicating the appointment waiting time standards to affiliated providers and the MCO has in place mechanisms for complying.	Completed - Tracked through Systems Performance	MCOs are required to communicate wait time standards in their provider manuals. DHMH regulates the template for these manuals as well as approves all modifications prior to printing. Also monitored via enrollee satisfaction surveys.
The percentage of enrollees for specific age categories who had an ambulatory or preventive care encounter during the year is evaluated. Inpatient procedures, hospitalizations, emergency rooms visits, mental health and chemical	Scheduled for 3/30/02	DHMH is currently doing ad-hoc reviews of select ambulatory and preventative encounter frequencies by geographic area. Current efforts will be enhanced and formalized in Phase II so that this analysis is done quarterly.
MCO allows women direct access to a women's health specialist within the MCO's network for women's routine and preventative services.	Reviewing	This issue is addressed in draft federal regulations. The Department will come into compliance with federal requirements.
MCO identifies providers whose facilities are accessible to people with disabilities.	Added to CY 01 Systems Performance	DHMH will review each MCO's current processes for tracking and monitoring ADA accessible offices and providers.
The number of Perinatal Care Level II and Level III facilities is evaluated.	Not in Current Plan	Not in network plan because Maryland does not have a problem in this area.
MCO is in compliance with the state's standards regarding the availability of translators in American Sign Language. If no state standard exists, MCO has method for ensuring the availability of ASL translators.	Tracked through Customer Service*	Currently tracked – Communication Barriers.
MCO is in compliance with the state's standards regarding the availability of TDD services. If no state standard exists, MCO has method for ensuring the availability of TDD services.	Completed - Tracked through Customer Service*	Currently tracked – Communication Barriers.
Network Quality	**Status**	**DHMH Response**
State has process for ensuring the MCOs have relationships with public health, education and social services agencies.	Completed	Monitored through MOU with LHDs
State evaluates MCO's credentialing and recredentialing process for all providers, including institutional providers.	Tracked through Systems Performance	DHMH has enhanced its standard review of MCO credentialing procedures to include reviewing a random sample of charts to ensure compliance with procedures and to perform an assessment of MCO credentialing turnaround rates.
% of providers who receive initial orientation to the plan and ongoing training from the plan.	Partially Completed	MCOs are required to give new providers a HealthChoice provider manual.
MCO has procedures in place to timely identify and furnish care to pregnant women.	Completed	This is already required in MCO regs and monitored via health risk assessment data.
MCO has procedure in place to timely identify individuals with complex and serious medical conditions, assess the conditions identified and identify appropriate medical procedures to address and monitor them.	Under consideration for 02 Systems Performance	
MCO has process for ensuring that all Members identified with complex and serious medical conditions are assigned to a care manager.	Added to 01 Systems Performance	DHMH will be assessing each MCO's procedures for referral to case management, protocols and qualifications for case management and case management operating policies.
Cultural Compliance		
MCO has process for identifying significant sub-populations within enrolled populations that may experience special barriers in accessing health services such as the homeless or certain ethnic groups	Tracked through Customer Service*	DHMH is in process of adding specific code that will point to Office Access area to monitor other barriers unique to special populations.
Ratio of providers who speak language other than English to enrollees is evaluated	Tracked through Customer Service*	Currently tracked.
MCO has process for ensuring that the plan has sufficient bilingual capacity among staff and makes arrangements for interpreter services	Tracked through Customer Service*	Currently tracked. HealthChoice Management is also responsible for ensuring that MCOs meet regulatory requirements of printing materials in other languages.
MCO offers cultural competency training that educates providers re: medical conditions particular to the racial, ethnic, and socio-economic factors of the populations served.	Reviewing new BBA regulations.	

*DHMH's September 1 Network Adequacy Plan formalizes the relationship between the Chiefs of the Customer Service Hotlines and HealthChoice Management. Following any routine review of complaint or inquiry trends, the Hotline Chiefs are now formally required to request that the Chief, HealthChoice Management conduct a formal investigation should a trend in data be indicated.

PHYSICIAN REIMBURSEMENT AND MEDICAID FFS PARTICIPATION

Medicaid Physician Payments

An allocation for provider reimbursement rates is included in the MCO capitation rates and is based on fee-for-service data. The Medicaid physician fees, which account for a portion of the rates, have not been increased in ten years. There has been growing concern by many stakeholders that the physician fees are too low to maintain provider practices and to ensure adequate provider participation.

Background

In provider forums held across the State, insufficient physician reimbursement was repeatedly cited as the number one problem with provider participation (see Public Perceptions section in Chapter III). To assess the significance of this issue, it also is necessary to examine the existing Medicaid physician reimbursement rate structure for the fee-for-service program because:

- It still serves around 100,000 individuals; and
- An MCO's ability to increase provider rates is restricted by the capitation rates provided by the State, which are tied to the fee-for-service rates by federal regulations through 2001.

Concerns about physician reimbursement also stem from Maryland Medicaid's historic approach to physician fee increases. Unlike hospital payments, that the Health Resources Cost Review Commission (HSCRC) adjusts annually, and some other service payments, the reimbursement rates for providers have been static for the last decade. The last major increases of Medicaid physician fees in Maryland occurred in 1991, coinciding with the implementation of Maryland Access to Care (MAC), Medicaid's relatively unsophisticated primary care case management program. Even in this instance, only certain procedure codes were raised. Much of the following analysis is based upon a September 2001 report to the General Assembly, as requested in Ch. 702, 2001 Maryland Laws (HB 1071) on the current Medicaid fee schedule.

Maryland Medicaid Fee-for-Service Rates Compared to Medicare

For a meaningful assessment of the adequacy of physician fees paid by the Medical Assistance program, a point of comparison is needed. Medicare rates are an obvious choice as Medicare fees are determined based on the resource-based, relative-value scale (RBRVS) methodology, which relates payments to the level of resources and skills used in providing services. This system of setting procedure-specific reimbursement levels is well established and is widely accepted by government agencies, physicians, and many private health insurers.

To compare Maryland Medicaid fee-for-service rates with Medicare rates, the two programs' procedure codes had to be reconciled. Of the 4,300 Maryland codes, 3,800 (88 percent) are standard CPT codes, which could be matched with Medicare equivalents. Figure IV-5 compares Medicaid payment rates for some common procedures with their Medicare counterparts. For these procedures, Medicaid rates range from 16 to 61 percent of Medicare rates. Overall, Maryland Medicaid's fee-for-service reimbursement rates average only about 36 percent of the amount paid by Medicare for the same procedures.

Figure IV-5: Comparison of Medicaid and Medicare Payments Selected Procedures

Procedures Used for Survey of MCOs Fees as of 4/1/2001				
Procedure Code	**Procedure Description**	**Medicare Fee**	**Medicaid Fee**	**Ratio Medicaid to Medicare**
99203	Office Visit New Extended	$91.62	$37.00	40%
99204	Office Visit New Comprehensive	$133.06	$48.00	36%
99205	Office Visit New Complicated	$167.95	$50.00	30%
99211	Office Visit Established Minimal	$19.99	$10.00	50%
99212	Office Visit Established Moderate	$36.09	$20.00	55%
99213	Office Visit Established Extended	$50.67	$31.00	61%
99214	Office Visit Established Comprehensive	$79.08	$38.00	48%
99215	Office Visit Established Complicated	$117.40	$45.00	38%
99222	Initial Hospital Visit Moderate	$117.67	$24.50	21%
99223	Initial Hospital Visit Comprehensive	$161.00	$25.00	16%
99231	Hospital Visit Subsequent Minimal	$36.05	$14.50	40%
99232	Hospital Visit Subsequent Moderate	$57.52	$16.00	28%
99233	Hospital Visit Subsequent Comprehensive	$81.65	$20.00	24%

HealthChoice MCO and Medicaid Fee-for-Service Rates Compared to Medicare

Most, although not all, HealthChoice MCO physician contracts incorporate a schedule of payment rates that have been developed as percentages (generally slightly over 100 percent) of the current Medicaid fee-for-service rates for each procedure.

Figure IV-6 shows how Maryland's Medicaid fee-for-service rates compare to several MCO physician payment rates, as well as Medicare rates. The data show a great deal of variation in physicians' fees from MCO to MCO. MCO A pays 105 percent of the fee-for-service rate for each of the procedures listed. MCO B, however, applies a different percentage to the fee-for-service rate for almost every procedure listed. The MCO B rates range from 100 percent of fee-for-service (for an extended office visit with an established patient) to 295 percent of fee-for-service (for moderate or comprehensive initial hospital visits). The rates MCO B pays are significantly higher than those paid by MCO A, but still are substantially lower than Medicare.

Figure IV-6: Comparison of Medicaid, MCO and Medicare Fees

Procedure Code	Procedure Description	Medicaid Fee	MCO A	MCO B	Medicare Fee
99203	Office Visit New Extended	$37.00	$38.85	$56.32	$91.62
99204	Office Visit New Comprehensive	$48.00	$50.40	$81.77	$133.06
99205	Office Visit New Complicated	$50.00	$52.50	$103.16	$167.95
99211	Office Visit Esab Minimal	$10.00	$10.50	$12.30	$19.99
99212	Office Visit Estab Moderate	$20.00	$21.00	$22.19	$36.09
99213	Office Visit Estab Extended	$31.00	$32.55	$31.00	$50.67
99214	Office Visit Estab Comprehensive	$38.00	$39.90	$48.59	$79.08
99215	Office Visit Estabished Complicated	$45.00	$47.25	$72.11	$117.40
99222	Initial Hosp Visit Moderate	$24.50	$25.73	$72.20	$117.67
99223	Initial Hosp Visit Comprehensive	$25.00	$26.25	$98.75	$161.00
99231	Hosp Visit Subsequent Minimal	$14.50	$15.23	$22.12	$36.05
99232	Hosp Visit Subsequent Moderate	$16.00	$16.80	$35.27	$57.52
99233	Hosp Visit Subsequent Comprehensive	$20.00	$21.00	$50.08	$81.65

Findings and Conclusions

As was mentioned at the beginning of this section, physicians throughout the State repeatedly identified insufficient reimbursement as their most significant concern. The Medicaid fee-for-service population declined dramatically with the formation of HealthChoice; at the same time, the number of participating physicians declined by 4 percent statewide between 1998 and 2000. The rate of decline was much higher in underserved areas (e.g., 23 percent in Caroline County).

The impact of further attrition is likely to become increasingly significant, particularly in counties where the provider networks already are under stress. As physicians stop participating, the program becomes more dependent on a smaller number of physicians, who individually must provide more services if the Medicaid population's needs are to be met.

Regardless of future enrollment growth, declines in physician participation will cause the remaining physicians to see an increase in the Medicaid portion of their practices. The increase in HealthChoice enrollment since 1997 only exacerbates the problem of physician practices with increasing shares of financially unattractive Medicaid patients.

HOSPITALS

Overview

Maryland hospitals play an important role in the provision of services to Medicaid enrollees. In addition, for over 20 years, Maryland has operated a unique hospital payment system.

Maryland's commitment to its hospitals is explicitly stated in the HealthChoice regulations, which require MCOs to pay the Maryland Health Services Cost Review Commission (HSCRC) approved rates. A basic premise of managed care is that savings can be achieved by reducing unnecessary hospital utilization either by avoiding preventable admissions through better patient intervention, or by reducing hospital lengths of stay. Hospital utilization per enrollee, therefore, was expected to decline under HealthChoice. In addition, it was thought that managed care may affect the pattern of hospitalizations within the Medicaid program, diverting admissions away from higher cost hospitals that historically served the Medicaid population and towards lower cost hospitals.

In response to the formation of HealthChoice, Maryland hospitals developed a number of strategies. Three hospital groups formed their own MCOs, while a fourth group of hospitals funded the formation of an MCO managed by an outside contractor. Others contracted on either a risk or non-risk basis with MCOs. Currently, there are three hospital based MCO programs, accounting for about half of the total HealthChoice enrollment.

This section of the evaluation examines whether there have been any significant changes in the distribution of inpatient hospital services, in the percent of individuals with an admission, or in average length of stay for FY 1997 and CY 2000.

Data Limitations

As discussed in Chapter VI, the HealthChoice encounter data for inpatient hospital services is estimated to be approximately 70 percent complete and inconsistent across MCOs. As a result, it is not an acceptable source of data to analyze inpatient patterns. An alternative source of data was provided by the HSCRC, which requires regular submission of hospital discharge data for its hospital rate-setting process. The HSCRC data were deemed to be a better source of complete data for the purposes of this evaluation.

Analysis of inpatient patterns would ideally break out HealthChoice enrollees from the fee-for-service population. Unfortunately, data elements that distinguish between fee-for-service and HealthChoice populations are unreliable, so all Medicaid admissions were analyzed. HealthChoice is a statewide program that enrolls the vast majority of Medicaid enrollees and any significant shifts in patterns of inpatient care can reasonably be attributed to the HealthChoice program. In FY

1997 Medicaid fee-for-service admissions are used in the analysis and in CY 2000 all Medicaid admissions are used. These data exclude the Medicaid recipients who were enrolled in the voluntary HMO program in FY 1997. This was a much healthier population, which may make the FY 1997 admission rates look higher than they actually were.

Figure IV-7: All Medicaid Admissions - Statewide (HSCRC Data)[3]

Hospital	FY 1997 MA Market Share	CY 1998 MA Market Share	CY 2000 MA Market Share	Hospital	FY 1997 MA Market Share	CY 1998 MA Market Share	CY 2000 MA Market Share
Johns Hopkins Hospital	11.62%	12.82%	10.75%	Carroll County General Hospital	1.13%	0.97%	1.40%
University Of Maryland	7.81%	7.98%	7.87%	Union Hospital Of Cecil County	1.08%	0.68%	1.20%
Mercy Medical Center Inc	6.29%	7.57%	6.52%	Sacred Heart Hospital	1.07%	1.08%	0.51%
Prince George's Hospital Center	6.14%	5.93%	6.91%	Howard County General Hospital	1.03%	0.73%	0.56%
Sinai Hospital	5.01%	5.34%	5.18%	Memorial Hospital Of Easto	1.01%	1.50%	1.61%
Johns Hopkins Bayview Medical Center	4.63%	4.98%	4.24%	Church Hospital	0.93%	0.69%	0.00%
Maryland General Hospital	3.74%	3.83%	4.26%	Doctors Community Hospital	0.84%	0.83%	0.75%
St. Agnes Healthcare	3.58%	2.94%	2.01%	Calvert County Memorial Hospital	0.84%	1.02%	0.82%
Franklin Square Hospital	3.52%	2.98%	4.53%	Montgomery General Hospital	0.77%	0.82%	0.74%
Harbor Hospital Center	3.09%	3.79%	3.27%	Memorial Hospital Of Cumberland	0.76%	0.75%	1.20%
Peninsula Regional Medical Center	2.83%	2.67%	3.12%	Civista Medical Center	0.74%	0.69%	0.97%
Union Memorial Hospital	2.56%	2.47%	3.05%	Northwest Hospital Center	0.71%	0.43%	0.97%
Liberty Medical Center	2.39%	2.07%	0.00%	Dorchester General Hospital	0.68%	0.26%	0.50%
Holy Cross Of Silver Spring	2.26%	2.88%	4.42%	Good Samaritan Hospital	0.54%	0.57%	0.89%
Southern Maryland Hospital	2.05%	1.94%	1.26%	Garrett County Hospital	0.54%	0.45%	0.47%
Washington County Hospital	2.04%	2.34%	2.09%	Suburban Hospital	0.48%	0.43%	0.45%
Shady Grove Hospital	1.90%	1.48%	2.11%	Kent & Queen Anne Hospital	0.34%	0.17%	0.42%
Frederick Memorial Hospital	1.69%	1.87%	1.54%	James L. Kernan Hospital	0.33%	0.44%	0.30%
Washington Adventist Hospital	1.60%	1.15%	2.57%	Johns Hopkins Oncology Center	0.33%	0.36%	0.42%
Anne Arundel Medical Center	1.60%	1.87%	2.09%	Upper Chesapeake Med. Ctr.	0.18%	0.18%	0.31%
Bon Secours Hospital	1.47%	1.39%	1.60%	Fort Washington Hospital	0.09%	0.08%	0.05%
Laurel Regional Hospital	1.37%	1.28%	1.07%	Atlantic General Hospital	0.03%	0.03%	0.07%
Greater Baltimore Medical Center	1.29%	0.49%	0.70%	Edward W. Mc Cready Hospital	0.03%	0.04%	0.07%
North Arundel Hospital	1.28%	1.24%	1.37%	Healthsouth Chesapeake Rehab Center	0.02%	0.02%	0.01%
St. Joseph Hospital	1.27%	1.38%	1.03%	The New Children Hospital	0.02%	0.01%	0.00%
St. Mary Hospital	1.21%	1.13%	0.83%	Eastern Neuro Rehab Hospital	0.01%	0.03%	0.01%
Harford Memorial Hospital	1.14%	0.92%	0.89%	**Total**	**100.00%**	**100.0%**	**100.00%**

Findings

- *Hospitals that historically served Medicaid enrollees continue to serve Medicaid enrollees at similar levels.* Hospitals have either the same or higher Medicaid admission levels as they had under fee-for-service. Although the number of admissions per Medicaid enrollee declined, the significant growth in enrollment counteracted the effect of decreasing admissions per enrollee. Overall, there was little change in the distribution of Medicaid admissions across Maryland hospitals.

- *The percentage of individuals with a hospital admission declined*. An analysis of the overall rate of inpatient admissions in Maryland found that admissions declined by 24 percent, from 23.93 percent in FY 1997 to 18.16 percent in CY 2000. For Baltimore City residents, there was a 20 percent decline, from 27.69 percent in FY 1997 to 22.27 percent in CY 2000. In the rest of the State, where the Medicaid enrollment growth has been greatest,

[3] Figure IV-7 FY 1997 data includes MA fee-for-service and MA voluntary HMO program for that year.

the admission rate declined by 27 percent, from 22.17 percent in FY 1997 to 16.25 percent in CY 2000.

Many women become eligible for Medicaid because they are pregnant. Not surprisingly, approximately 40 percent of admissions were classified as obstetric or neonatal in FY 1997, and 45 percent in CY 2000. Analysis of such predictable admissions does not provide meaningful insights into the success of managed care practices. Therefore, an analysis of non-OB and non-neonatal admissions was conducted to examine admissions which could be most affected by managed care--through better access to appropriate primary care. The percentage of individuals with admissions for non-pregnancy related services declined by 29 percent from 14.29 percent in FY 1997 to 10.15 percent in CY 2000. The decline in admissions not related to pregnancy is greater than the decline in admissions overall.

- *Average length of stay declined.* Statewide, average length of stay declined 12 percent for all admissions from 4.94 days in FY 1997 to 4.37 days in CY 2000. There was a similar decline in average length of stay for admissions for Medicaid recipients in Baltimore City and in the rest of the State.

  The average length of stay was higher in an analysis of the non-obstetric and non-neonatal admissions. Their average length of stay declined by 15 percent from 6.01 days in FY 1997 to 5.19 days in CY 2000.

Conclusions

Hospitals that historically served Medicaid patients continue to serve Medicaid patients under HealthChoice. Although there has been an overall decline in the admission rate per person, expansions in Medicaid enrollment have resulted in the maintenance of pre-HealthChoice levels of inpatient admissions. Some hospitals have even experienced an increase in admissions. As a result, the patterns of Medicaid hospital admissions have changed very little across the state.

The admission rates per enrollee and the lengths of stay for Medicaid enrollees have decreased, both in the whole Medicaid population and in the non-obstetric and non-neonatal Medicaid population. These findings together suggest that HealthChoice has had an overall positive effect on hospitalization, by reducing inpatient days, while at the same time ensuring that the admissions levels of hospitals that have historically served the Medicaid population have remained steady.

GRADUATE MEDICAL EDUCATION

Background

Graduate medical education (GME) plays an important role in the health care environment in Maryland. Baltimore is the home of two major academic medical centers, the University of Maryland Medical System and Johns Hopkins University. There also are fourteen other teaching hospitals in Maryland. Inpatient hospital rates for teaching hospitals in Maryland include an amount for GME. Prior to HealthChoice, the Medicaid program reimbursed teaching hospitals for GME as a component of the rates set by the Health Services Cost Review Commission (HSCRC).

When the HealthChoice program started in 1997, the amount Medicaid paid teaching hospitals for GME payments was included in the MCO capitation payments. There was concern among some of the teaching hospitals that MCOs would shift their patients to lower-cost hospitals. Therefore, they requested separate payments to ensure the continued support of graduate medical education at pre-HealthChoice levels. Beginning in July 1998, the GME payments were carved-out of the capitation payments to MCOs and set aside in a separate GME pool.

The intent of the carve-out was to:

- Maintain the historic amount of Medicaid funding for graduate medical education;
- Create a level playing field so that the added cost of GME would not be a financial disincentive for MCOs to admit patients to teaching hospitals; and
- Encourage teaching programs to promote primary care and innovative training programs.

Under the all-payer hospital rate system in Maryland, MCOs are unable to negotiate hospital rates independently. The GME carve-out was designed so that the hospital rates from the MCOs, in addition to the payments from the GME pool, would allow teaching hospitals to be competitive based on cost while continuing to receive funding for their teaching efforts.

The GME payments to teaching hospitals are based on the inflation-adjusted FY 1995 GME expenditures. For FY 1999 and FY 2000, $24 million was carved out of MCO capitation payments to create a GME payment pool. In CY 2001, the GME carve-out increased to $27 million and in CY 2002, it will be increased to $31 million.

In order to measure whether there was any impact upon admissions to teaching hospitals as a result of the carve-out, HSCRC data on inpatient hospital

admissions were reviewed. Again, because data factors to separate services provided under fee-for-service Medicaid from HealthChoice are not reliable, the analysis includes data for all Medicaid funded services.

An analysis of data for all of Maryland's 16 teaching hospitals shows that Medicaid admissions increased for all but two teaching hospitals (Greater Baltimore Medical Center and St. Agnes) from FY 1997 to CY 2000. Most teaching hospitals actually maintained or gained Medicaid market share. The two academic medical centers, Johns Hopkins University and the University of Maryland Medical System, account for over half of all GME revenues. Johns Hopkins University experienced an increase in Medicaid market share in CY 1998 compared to FY 1997, but a decrease in CY 2000. The University of Maryland Medical System experienced an increase in market share in both CY 1998 and CY 2000 when compared to FY 1997.

Conclusion

The data indicate that the implementation of HealthChoice has had no negative impact upon Medicaid admissions to teaching hospitals. It is not possible to conclude if the GME carve-out was necessary (the market share of both academic medical centers was up in CY 1998, before the carve-out occurred) or whether the carve-out prevented drops in market share. The identified changes in Medicaid market share seem to relate to geographic and demographic shifts in Medicaid enrollment and the hospital networks of the participating MCOs.

Figure IV-8: All Medicaid Admissions to Teaching Hospitals (HSCRC Data)

Hospital	FY 1997 MA Market Share	CY 1998 MA Market Share	CY 2000 MA Market Share
Franklin Square Hospital	3.52%	2.98%	4.53%
Good Samaritan Hospital	0.54%	0.57%	0.89%
Greater Baltimore Medical Center	1.29%	0.49%	0.70%
Harbor Hospital Center	3.09%	3.79%	3.27%
Holy Cross Of Silver Spring	2.26%	2.88%	4.42%
James L. Kernan Hospital	0.33%	0.44%	0.30%
Johns Hopkins Bayview Medical Center	4.63%	4.98%	4.24%
Johns Hopkins Hospital	11.62%	12.82%	10.75%
Maryland General Hospital	3.74%	3.83%	4.26%
Mercy Medical Center Inc	6.29%	7.57%	6.52%
Prince George's Hospital Center	6.14%	5.93%	6.91%
Sinai Hospital	5.01%	5.34%	5.18%
St. Agnes Healthcare	3.58%	2.94%	2.01%
Suburban Hospital	0.48%	0.43%	0.45%
University Of Maryland	7.81%	7.98%	7.87%
Union Memorial Hospital	2.56%	2.47%	3.05%
Total	62.88%	65.45%	65.35%

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

Background

Federally Qualified Health Centers (FQHCs) are non-profit organizations that receive grant funding from the Public Health Service to provide primary and preventive health care services to people living in medically underserved communities. The FQHCs in Maryland include community health centers, migrant health centers, and a community-based organization dedicated to providing healthcare to homeless populations.

FQHCs historically have played an important role as providers in the Medicaid program. Statewide, approximately one-third of FQHC patients are covered by Medicaid.[4] In addition, prior to the implementation of HealthChoice, one FQHC operated an HMO in the HMO voluntary program, with 15,000+ enrollees. With the transition to HealthChoice, the Department was interested in maintaining FQHCs as providers in the program to ensure continuity of care for their existing patient base and to preserve their existence as safety net providers.

FQHCs in HealthChoice

There has been substantial activity since the inception of the program with regard to FQHC reimbursement. There are currently 12 FQHCs in Maryland. Seven of the FQHCs have ownership interest in one of the MCOs and all of the FQHCs have at least one MCO contract.

Historically and in accordance with federal requirements, FQHCs were eligible for Medicaid reimbursement rates that were based on their reasonable costs of providing services. As a result, the reimbursement rates that FQHCs received for providing services to the Medicaid population were much higher than the rates paid to private physicians from the Medicaid fee schedule for comparable services. In this way, FQHCs are in a similar position as teaching hospitals that are reimbursed for their graduate medical education costs; they have a broader role in the health care system that Medicaid has taken special steps to finance.

An important caveat, though, is that FQHCs historically took responsibility for providing transportation services, but in 1993 Medicaid shifted the transportation responsibility to the local health departments. The local health departments were provided grants for ensuring transportation services, and FQHCs were no longer compensated for the costs of transportation.

Changes in both federal and state regulations regarding FQHC reimbursement have made the transition to HealthChoice complex. Federal legislation initially allowed for the phase-out of cost-based reimbursement and then reinstated cost-related payment provisions through a prospective payment methodology. Legislation on the state level supported enhanced payments for FQHCs. As a

[4] Data from federal FY 1997 – FY 1999 Maryland State Profile at http://stateprofiles.hrsa.gov/

result of this legislative activity, the approach that the HealthChoice program has taken to FQHC reimbursement has evolved since 1997.

When HealthChoice was initially implemented, the program required MCOs to pay FQHCs a cost-related rate, which FQHCs were expected to negotiate with the MCOs. In 1998, as directed by State legislation, an FQHC supplemental payment methodology was implemented. If an FQHC requested supplemental payments and the Department determined that MCO reimbursement to the FQHC was below its reasonable costs, the Department would supplement the MCO payment and deduct the supplemental payment from the Department's capitated payment to the MCO. The FQHCs believed that this mechanism created a disincentive for the MCOs to contract with them.

In 1999, an FQHC Viability Committee was established to examine the viability of FQHCs within HealthChoice and to address reimbursement issues. Based on recommendations from that committee and in accordance with new federal regulations, beginning in January 1, 2001, a new reimbursement mechanism for FQHCs was implemented. FQHCs were paid a market rate for each service by the MCOs and then received a supplemental payment from the Department to bring their total reimbursement level for each visit even with their reasonable costs. In CY 2001, $5.3 million was withheld from the MCO capitation rates and put into a supplemental pool for Departmental payments, and in CY 2002, $5.5 million will be placed into a supplemental pool.

To assess the impact of the HealthChoice program on the number of visits to FQHCs made by Medicaid enrollees, visits were compared between FY 1997 and CY 2001. The CY 2001 utilization data are based on projections provided by each FQHC for the purposes of receiving supplemental payments. The CY 2001 projections exclude mental health and dental services provided by FQHCs. In FY 1997, FQHCs had 107,000 Medicaid visits,[5] including mental health and dental visits. Based on the FQHCs' projections, the number of visits made in CY 2001 is estimated to be 126,000. When looking at the number of FQHC visits per 1,000 Medicaid enrollees, the volume of services is virtually unchanged from FY 1997 to CY 2001. However, the FY 1997 data include mental health and dental visits, but the CY 2001 data do not, suggesting that there may have been an increase in the number of FQHC visits per person.

Conclusion

After several changes in reimbursement methodology, the HealthChoice program assures that FQHCs are reimbursed their full cost-based rates, while eliminating any disincentive MCOs have to contract with them because of their high costs. Current projections by FQHCs demonstrate that the number of visits to FQHCs by

[5]This number includes an estimate of 32,000 for Total Health Care, who was providing services under the voluntary HMO program at that time. The estimate for FY 1997 assumes the same level of Medicaid services as CY 2001, which was projected at 32,000 by Total Health Care. The estimate for FY 1997 may be high given the significant growth in Medicaid enrollment since the inception of the HealthChoice program.

Medicaid enrollees is at least similar to, if not greater than before HealthChoice implementation. This may be due to an expansion in Medicaid enrollment and expanded services offered by FQHCs.

LOCAL HEALTH DEPARTMENTS

Background

The local health departments (LHDs) in Maryland are administrative units of the Community Health Administration of DHMH. They represent a strong public health network and have historically played an important role in the provision of public health services to vulnerable populations. Their sensitivity to regional issues and their experience working directly with clients have made them key partners in the HealthChoice program.

LHDs and HealthChoice

New roles were created for the LHDs under HealthChoice. They were given responsibility and funding for the following new functions:

- Outreach and care coordination for non-compliant patients;
- Ombudsman services; and
- Eligibility and enrollment for the Maryland Children's Health Program (MCHP).

LHDs also continued to have responsibility for Healthy Start case management and transportation for Medicaid enrollees, functions that they had coordinated prior to the implementation of HealthChoice. In addition, some LHDs also provide clinical services to HealthChoice enrollees.

Outreach and Care Coordination for Non-compliant Patients and Ombudsman Services

LHDs are responsible for contacting non-compliant HealthChoice enrollees that the MCOs are unable to bring into care. Before referring a client to the LHD, MCOs must first demonstrate that they have not been able to successfully contact the client despite several attempts. Upon referral from an MCO, the LHD is responsible for trying to contact the client (by phone or home visit, if needed), working with the client to link him/her to care, and informing the MCO about the resolution of the referral.

Under HealthChoice, LHDs were given the role of serving as ombudsman for enrollees. The ombudsman is responsible for assisting the Department in investigating enrollee complaints against MCOs. The LHD is expected to resolve disputes through enrollee or MCO education, through mediation, or by advocating for the enrollee through the MCO internal grievance and appeal process. Safeguards were established to ensure that a LHD does not serve as ombudsman for a complaint that involves its own staff.

Through their outreach and ombudsman roles, LHDs helped 129 per 1,000 HealthChoice enrollees in FY 2001, up from 96 per 1,000 in FY 1999. They are a

local source of assistance for consumers in linking them to the appropriate case management services, finding providers willing to serve them, coordinating care, and problem solving. They assist MCOs in finding hard to reach clients or with non-compliant cases. Many of their contacts are face to face with HealthChoice clients or by phone. Some LHDs provide the Department with more detailed information on the number and type of outreach and educational contacts. Statewide, more specific information on the type of LHD contacts is not available.

Figure IV-9: Rate of Referral to Local Health Departments for Outreach, Care Coordination, and Ombudsman Services per 1000 MCO Enrollees by Source of Referral and Year

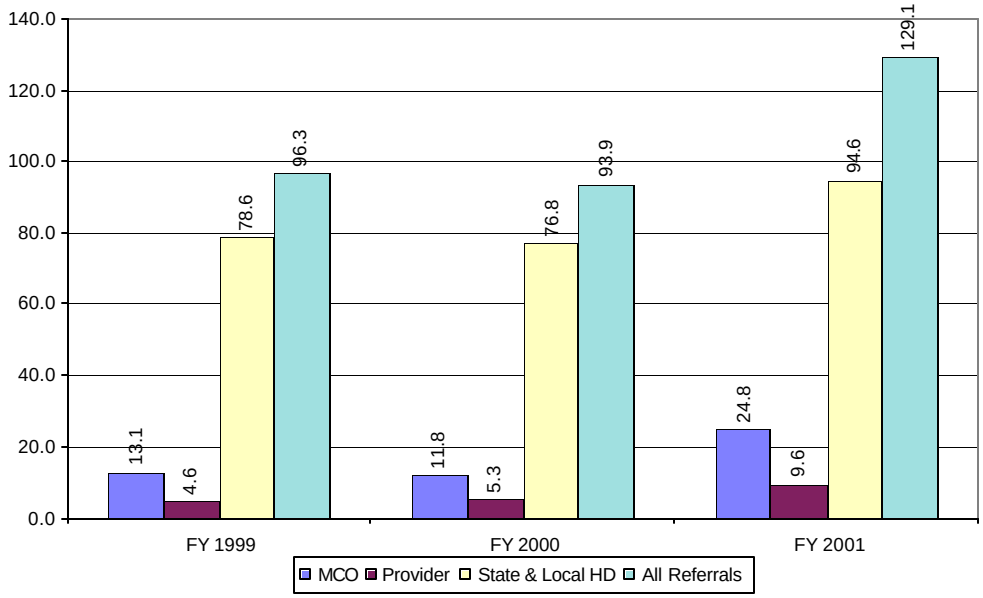
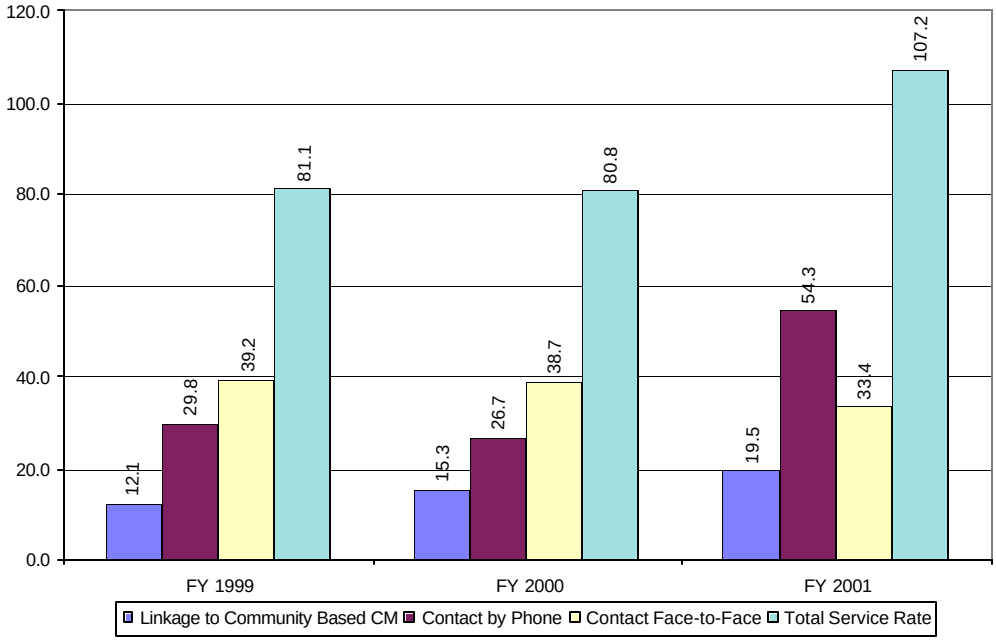


Figure IV-10: Disposition Rate for Referrals to Local Health Departments for Outreach, Care Coordination, and Ombudsman Services per 1000 MCO Enrollees by Type of Disposition and Year



Eligibility and Enrollment for the Maryland Children's Health Program (MCHP)

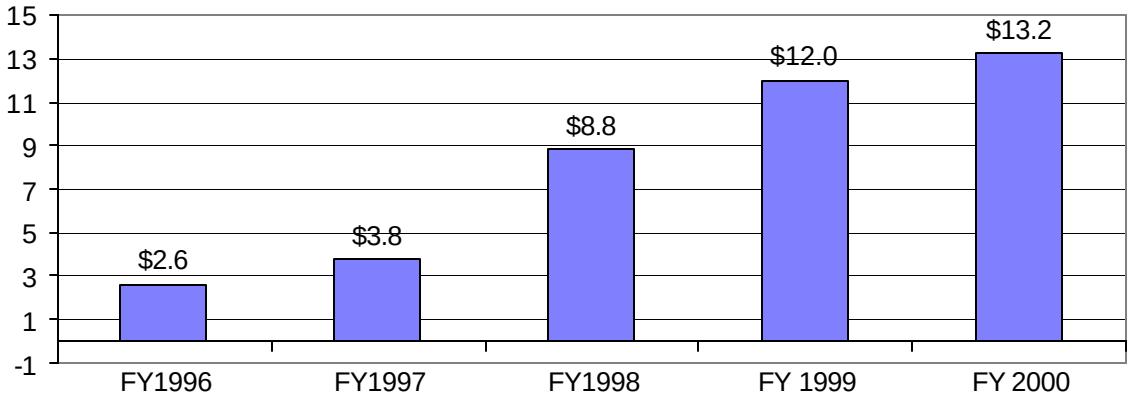
LHDs also have primary responsibility for determining eligibility and processing enrollment forms for the MCHP, which started in July 1998. Prior to HealthChoice, all local health departments conducted initial processing of Medicaid applications for pregnant women and children, making them a logical partner in this process.

LHDs have been a critical part of the success of MCHP. From July 1, 1998 through November 26, 2001, the LHDs have enrolled 93,766 beneficiaries. Feedback from enrollees indicates that they are very happy with the efficiency of the eligibility process for MCHP through the LHDs.

Funding

Grants to the LHDs to support the provision of their new or expanded functions (outreach and care coordination, ombudsman and eligibility) increased from $2.6 million in FY 1996 to $13.2 million in FY 2000. LHDs began receiving funds for HealthChoice outreach in FY 1997. Much of the increase in funding to the LHDs over this period is related to the MCHP expansion. These figures do not include grants that LHDs receive for transportation services, the claims paid for Healthy Start Case Management Services, or clinical services provided by LHDs to HealthChoice enrollees.

Figure IV-11: Grants to Local Health Departments



Healthy Start Case Management.

Healthy Start is a targeted case management program which addresses perinatal health with the goal of reducing infant mortality and low birth weight deliveries. Since 1989, LHDs have been providing specialized case management services to high-risk pregnant woman and children under the age of two through this program. The responsibility for these services has remained constant under the HealthChoice program, however, they now coordinate efforts with the MCOs to identify individuals who would benefit from the program.

Transportation

The local health departments maintained responsibility for coordinating a majority of the transportation services under the HealthChoice program. They receive grant funding to provide non-emergency transportation to and from medically necessary covered services for HealthChoice enrollees and their guardians/attendants, who have no other means of transportation available. Consumers and FQHCs continue to express concern over the apparent lack of emergency transportation services. During the public forums, many stakeholders expressed dissatisfaction with the non-emergency transportation program under HealthChoice. Transportation is provided only by the Local Health Departments. Prior to HealthChoice, FQHCs also provided transportation services. Providers perceive the lack of convenient transportation as a reason for missed appointments and they complain about the difficulty in obtaining cross-jurisdictional transportation. Consumers would like the program to: (1) provide transportation services on demand, (2) transport other family members, in addition to the enrollee and guardian (e.g., other children in the family), (3) provide more timely service, (4) provide transportation in lieu of taking public transport, and (5) allow for more flexibility in crossing jurisdictional lines.

Clinical Services

Historically, many LHDs provided clinical services to Medicaid enrollees. Under HealthChoice some LHDs sought contracts with MCOs to be care providers. The Department recently surveyed the 24 LHDs to assess their role as providers of clinical services for HealthChoice. Twenty LHDs completed the survey. Thirteen out of 20 LHDs have one contract with an MCO, the most frequently contracted services being HIV case management and substance abuse treatment. Those LHDs who do not contract with MCOs cite the payment rates and required contract addendum[6] as deterrents.

Discussion

The LHDs assume a significant role in the HealthChoice program by providing vital services to the enrollees. They have absorbed new responsibilities for outreach, care coordination, and MCHP eligibility. LHDs play a unique role in the HealthChoice program as a locally available resource for HealthChoice consumers.

[6] When signing contracts as health care providers, LHDs are required to use a standard addendum which addresses, in part, indemnification and risk allocation.

HISTORIC PROVIDER PROTECTIONS

Overview

Historically, Maryland has been very successful in assuring access to Medicaid providers (particularly for primary care and hospital services). Maryland's success is not only due to the services provided to Medicaid enrollees by institutions (e.g., hospital outpatient departments) and public providers (e.g., community health centers), but is also the result of high private practitioner participation in the Medicaid program. Prior to the implementation of HealthChoice, 75 percent of the Maryland Access to Care (MAC) patients were enrolled with private practitioners.

Under the HealthChoice program, the MCOs had a strong economic incentive to contract with the providers who had historically served the Medicaid population. By including historic Medicaid providers in their own network, an MCO could enhance their own market share. Despite that incentive, when Maryland began to plan for the implementation of HealthChoice, Medicaid providers raised significant concerns that they would not be able to contract with MCOs and would lose their Medicaid patient base. This concern prompted the legislature and the Department to establish contracting protections for historic Medicaid providers.

In order to be considered an historic provider, a provider was required to satisfy three criteria. The provider had to:

- Meet the definition of a "health care provider" under the Medicaid program;
- Demonstrate a history of service to the Medicaid population; and,
- Meet certain quality of care standards.

If a provider was approved as an historic provider and was unable to secure a contract with any of the MCOs proposing to serve the area of the state in which that provider's practice was located, the Department would assign the provider to one of the MCOs serving that area. Under this provision, MCOs were required to offer a contract with terms that were substantially equivalent to the MCOs' contracts with similarly qualified providers in the same or similar practice categories.

Findings

There were 12,000 active physician providers in the Medicaid program prior to HealthChoice. During the transition, only 51 providers (of all types) sought assistance under the historic provider protections. These findings demonstrate overall that providers did not have difficulty securing MCO contracts, although the findings do not allow us to draw conclusions about the number of patients referred to the providers. Of the 51 providers who sought assistance, ten were approved as historic providers and assigned to an MCO. The remaining 41 either did not meet the requirements of an historic provider or did not complete the application process.

Figure IV-12: Number of Applications for Historic Provider Protections

Provider Type	Number of Applications	Number of Approved Applications
Addictions	9	3
DME/S	20	3
HIV Case Management	1	0
Home Health	2	1
Hospice	1	0
Laboratory	3	1
Mental Health	2	0
Physician	11	1
Physical Therapy/Occup. Therapy	1	1
Podiatrist	1	0
Total	51	10

DHMH Administrative files, data collected through November 1997

V. VALUE AND PREDICTABILITY

This section of the evaluation assesses the HealthChoice program's success in achieving its underlying financing goals. These goals include improving the value of the health care services purchased for Medicaid beneficiaries while at the same time improving the predictability of the State's budget outlays for the Medicaid program.

The determination of purchaser value is not simply a comparison of current costs with the costs of the prior fee for service program. Rather, consistent with the other components of this evaluation, the measure of value should be based on whether or not the program's overall goals of improving access to and quality of Medicaid services were achieved at an appropriate price. The judgment of value also must be based on how successfully the program has been able to adjust to changes outside of its control, such as the enormous growth in program enrollment since the start of HealthChoice. A number of separate questions will be addressed, including:

- *Has HealthChoice complied with federal regulations?* This section will assess the HealthChoice program's compliance with federal financing regulations, which apply to both 1115 waivers and Medicaid managed care programs.

- *Has the HealthChoice program been adequately funded?* This section will consider whether the State's payments to MCOs have been adequate to achieve the State's goals of improving access and ensuring quality of care.

- *Has the program provided a stable financial platform?* This section will assess whether the State's payments to MCOs have fostered a stable financial platform for the MCOs.

- *Has the HealthChoice program led to greater budget predictability?* This section will address whether the HealthChoice program has contributed to more predictability for the State's budgeting of Medicaid expenditures.

- *What has been the effect of risk adjustment on purchaser value?* This section will discuss the unique risk-adjustment capitation rates used in Maryland and asses whether they have improved purchaser value.

- *Have the administrative costs of the HealthChoice program been reasonable?* This section will review the administrative costs of both the State and the MCOs in relation to the demands of the program and other states.

- *Have the State's overall goals for value and predictability been met?* This section will briefly summarize whether, taken together, the financial components of HealthChoice have led to improved value and predictability.

COMPLIANCE WITH FEDERAL REGULATIONS

Overview

Federal regulations impose two separate but related financing tests for the HealthChoice program, the upper payment limit (UPL) and the budget neutrality standard. These are presented first because the HealthChoice program must conform to these federally established funding parameters. If the HealthChoice program failed to meet these requirements, the Federal government could withdraw its authorization for the waiver and/or shift more financial responsibility for funding the program on to the State.

- **Upper Payment Limit Test.** Federal regulations specify that capitation rates paid to MCOs *cannot exceed* amounts that would have been paid in the fee-for-service program for the same services for an equivalent population. These regulations apply regardless of whether a State is operating a managed care program under a §1115 waiver (as is the case for HealthChoice), another type of waiver, or through the State's regular Medicaid program.

  The UPL test is conducted annually by comparing MCO payment rates to the fee-for-service equivalency amount for that particular year. In Maryland, the fee-for-service equivalency amount for CY 2001 and CY 2002 is derived based on data from the State's 1997 fiscal year, which is trended forward to the year under review.

  The State has established capitation rates for HealthChoice that have passed the federal upper payment limit test in each year of the program. For the two most recent years, capitation rates have been set at about 98 percent of the calculated upper payment limit.

- **Budget Neutrality.** Section 1115 waivers, such as HealthChoice, have an additional financial requirement that states must meet. Specifically, as part of the terms and conditions of the waiver, the State and federal government agree to a five-year spending cap for the program. The spending cap is derived from a base year period and inflated each year in accordance with previously established trend factors. In Maryland, the State used its 1996 Medicaid expenditures for the base period and agreed to an annual trend rate of a 5.5 percent increase in total costs per person through June 30, 2002.

  Because the cap is based on a per person amount, the State's dramatic increase in HealthChoice enrollment over the last several years has not affected the State's ability to comply with the cap. The budget neutrality test is different from the Upper Payment Limit test in that it includes services that are not part of the MCO capitation rate. The most significant

of these 'wrap-around' services are mental health services, care delivered under the Rare and Expensive Case Management (REM) program, and special education services provided through schools.

The determination of whether the State meets its budget neutrality test is based on the cumulative spending for the entire five-year period of the waiver. Thus overspending in one year is permissible if lower spending levels in other years offset the overspending.

Findings

Based on data submitted to the Federal Centers for Medicare and Medicaid Services, the State is complying with the Budget Neutrality requirements of the HealthChoice waiver. While the State exceeded the cap in the first two years of the demonstration, waiver spending has been under the cap since that time. By the end of the third year, spending was about two percent below the cap. Preliminary data indicate the State is likely to be further below the cap by the end of the fourth year.

Given the rise in health care costs, the State petitioned the Centers for Medicare and Medicaid Services (CMS) for an adjustment to its 5.5 percent annual inflation rate. CMS recently approved the State's request, increasing the trend rate to eight percent for the three-year waiver extension period from July 2002 to June 2005.

ADEQUACY OF PROGRAM FUNDING

Overview

This section focuses on the adequacy of payment to the MCOs. Funding adequacy needs to be measured in combination with access and quality standards. If capitation rates are not sufficient for even a mature, efficient managed care plan to provide high quality contracted services, the State will not fulfill its goal of adequate funding for the program. At the same time, if the rates paid to MCOs promote inefficient business models, then the State will be paying more than is necessary to achieve its goals.

The test for measuring funding adequacy is whether a sufficient number of MCOs have succeeded in providing contracted services while still generating a reasonable return on investment. Because Maryland's payments to MCOs take into account the health status of each plan's enrollees, an MCO's financial performance is more likely determined by the successful execution of managed care business practices than its ability to enroll individuals with better health status and lower costs.

Findings

The funding analysis examined the financial results of all the MCOs that participate or have participated in the HealthChoice program since the program's inception in July 1997. The financial results through October 2001 show that the MCOs that cover approximately 70 percent of the 2001 HealthChoice enrollment have successfully provided the contracted benefits and are profitable. In aggregate, these profitable MCOs have averaged a 3.5 percent profit during the 1997-2000 period.

Figure V-1: Financial Experience of Consistently Profitable MCOs

1997 - 2000 Cumulative Results as of December 31, 2000	
Consistently Profitable MCOs	
	1997 - 2000
Calendar Year (Reported) Basis	
PREMIUM REVENUE ($ Mil)	$ 1,117.9
MEDICAL LOSS RATIO	83.5%
ADMINISTRATIVE EXP. RATIO	13.0%
UNDERWRITING GAIN/(LOSS) ($Mil)	$ 39.5
PREMIUM SURPLUS RATIO	3.5%
OTHER REVENUE ($ Mil)	$ 17.8
INCOME/ (LOSS) **	$ 57.3
MEMBER MONTHS (Millions)	5.4
* Ratios based on Premium Revenue only, excludes investment income.	
** Excludes any adjustment for Federal Income Tax.	

The financial analysis also documented that some plans have consistently reported poor financial performance. As a result, a number of these MCOs no longer participate in the HealthChoice program. In reviewing the financial results reported by the MCOs, it is important to recognize that the full extent of the HealthChoice program's funding is affected by sub-capitated arrangements with downstream providers. Thus, if a sub-capitated provider incurred losses, those amounts would not be recorded on the MCO financial statements. MCOs made wide use of sub-capitated provider arrangements in the first two years of the HealthChoice program. Since then, the number of sub-capitated providers has been reduced dramatically at present only two of the six plans do any risk contracting, and those at only a minimal level. The reduction is due to concerns by the MCOs about these arrangements and to losses incurred by some of the providers that chose to enter into these sub-capitated arrangements.

Conclusions

The contrast between financially successful and financially unsuccessful plans does not suggest that the capitation rates have been inadequate. As the earlier discussion of plan transitions showed (Chapter One), the HealthChoice MCO experience is consistent with other Medicaid managed care programs around the country. In addition and more importantly, the HealthChoice experience is consistent with the commercial managed care industry in Maryland, which saw a significant decrease in the number of plans from 1996 to 2000 (dropping from 23 to 14).

A review of one plan that exited the market due to financial losses demonstrates the different capabilities among the MCOs. A Medicaid plan was owned by a major commercial insurer and was sold to a new Medicaid insurer in Maryland. The acquiring plan successfully managed the transition and was able to generate a positive return on its investment within the first year of the acquisition. This strongly suggests that a managed care plan's execution of its business fundamentals is an essential determinant of financial success.
When considered in the context of the other findings that cite improved access and consumer satisfaction, the State received value for the services purchased on behalf of Medicaid beneficiaries.

STABILITY OF FINANCIAL PLATFORM

Overview

As business entities, MCOs can more effectively implement the program's objectives if funding is both adequate and reasonably predictable. While the previous analysis demonstrated that funding has been adequate, controversy and uncertainty over capitation rates marked the first two years of the HealthChoice program. Specifically, amounts paid in 1998 were controversial due to the way that enrollees were assigned to the new risk-adjusted rate cells. An independent review of the rates identified this problem and other issues and concluded that, overall, the State paid close to the correct amount in the first year. It also concluded that the MCOs were paid more in the second year than they should have been. Equally important was the fact that payment rates were implemented with limited MCO involvement in the process. Furthermore, the rate-setting time periods provided only minimal notice to MCOs when rates were changed. These destabilizing outcomes eroded the financial platform for the MCOs.

Beginning with recommendations proposed by a special legislative committee on the administration of HealthChoice in September 1999, the State implemented a series of changes to promote a more stable and predictable payment process for the MCOs, including:

- Changing the capitation rate year from a State fiscal year to a calendar year. This allows more time for developing the rates and longer periods for the MCOs to react and consider the rates prior to implementation. In addition, this allows for the budget to include the appropriate amount of increase for at least one-half of the year.

- Completely revising the rate-setting process beginning with the CY 2001 rates, based on the following key attributes:

    - Open and data driven;
    - Collaborative with MCOs;
    - Provides sufficient time for MCO review and reaction prior to finalizing rates; and,
    - Provides regular feedback to MCOs to allow them to address internal MCO issues (e.g. missing encounter data submissions).

- Developing and implementing ongoing financial performance tools to enhance the State's understanding of the impact of the rates throughout the year. The primary tool is the HealthChoice Financial Monitoring Report (HFMR), which provides insight into the financial performance of individual MCOs as well as the overall program. Also, during the rate-setting process each MCO prepares templates presenting its current and

projected financial picture, enabling the MCO to show its operational activities and the impact of the rates on its financial position. Finally, the Department will be scheduling operational and financial audits of each plan by an independent CPA firm to verify the information reported in the HFMR.

Taken together, these changes have resulted in a more predictable and understandable rate-setting process for MCOs that participate in the HealthChoice program. The Department continues to try to improve the process each year. The ability to improve the process, however, is constrained by certain federal rules, particularly relating to the budget neutrality cap which incorporates the low Medicaid physician fees into the base. The upper payment limit also is based on what Medicaid would be spending fee-for-service in the absence of the waiver, a portion of which is based on the physician fee schedule, however, new Federal regulations may soon be issued to allow states to use different approaches.

BUDGET PREDICTABILITY

Overview

The health care industry in general, and Medicaid in particular, operates in an environment affected by many variables that limit its ability to forecast budgets accurately. Federal legislation, demographic trends, private sector health benefit trends, and the deployment of new medical technologies and pharmaceuticals all work together to affect the Medicaid program both in the short and long term. The recent slowing of the national and State economies, not foreseen when budget forecasts were prepared last year, further demonstrates how a change in market assumptions can upset enrollment projections and budget calculations.

The analysis of budget predictability, therefore, focuses only on the State's ability to budget appropriately with current market assumptions. The accuracy of enrollment projections is not addressed, as excess enrollment would shape the Medicaid budget regardless of the HealthChoice program.

Findings

As described above, in the initial years of HealthChoice (1998 and 1999) there was considerable volatility in State budget costs stemming from the capitation rate process and outcomes. Uncertainty over the actual level of the rates, difficulties in projecting HealthChoice enrollment mix among the rate cells, and the relatively short time period between final rate development (May) and implementation of the rates (July) resulted in a lack of predictability for the State.

Beginning with the recommendations of the Special Committee on the Administration of HealthChoice and subsequent State actions, the development and implementation of HealthChoice rates are now partially integrated into the State's budget process. After the rates are developed through the collaborative process discussed earlier, the State is able to determine the impact on the budget for the second half of the current fiscal year, and the first half of the upcoming budget year. In this way, the State budget can incorporate the MCO rate increases that will be in place for the first six months of the new fiscal year. The budget does not include a projected increase for the second half of the new budget year because the State does not want to undermine the integrity of the rate-setting process. Therefore, there is built into the budget system an anticipated deficit for the second half of the fiscal year.

RISK ADJUSTMENT'S CONTRIBUTION TO VALUE

Overview

The most innovative financial aspect of the Maryland HealthChoice program is its use of health-based risk adjustment as the basis of paying the MCOs. The risk-adjusted payment method is statistically valid and ties an MCO's capitation rates to the health status of its enrollees. MCOs that attract a sicker population will be paid more than the average capitation rate. The risk-adjusted payment method substantially reduces the incentive for MCOs to try to enroll only relatively healthy individuals--a major criticism of managed care systems. At the same time, the risk adjustment system removes the implicit penalty for plans with networks that attract a substantially sicker case mix.

Findings

The following tables demonstrate that risk adjustment has led to significant variance in the payments to participating MCOs. For enrollees in the families and children eligibility category, average MCO payments ranged from a low of 88 percent of the statewide average to a high of 106 percent of the statewide average, depending upon the case mix of the members. For the higher cost disabled population, the effect of risk adjustment on the comparative payments to the MCOs is even more dramatic, demonstrating that risk adjustment leads to payments that are more plan specific. Average MCO payments for the disabled range from a low of 77 percent of the statewide average to a high of 108 percent of the statewide average. When the entire case mix of enrollees is considered, average payments by MCO range from a low of 92 percent of the statewide average to a high of 157 percent.

Figure V-2: Effect of Risk Adjustment on Comparative Payments to MCOs

MCO	CY 2000
Plan A	0.92
Plan B	1.18
Plan C	0.99
Plan D	1.57
Plan E	1.02
Plan F	1.09
Plan G	0.93
All	1.00

Figure V-3: Effect of Risk Adjustment on Comparative Payments to Select MCOs: Family & Children Enrollees

MCO	CY 2000
Plan A	0.95
Plan B	1.04
Plan C	0.88
Plan D	1.06
All	1.00

Figure V-4: Effect of Risk Adjustment on Comparative Payments to Select MCOs: Disabled Enrollees

MCO	CY 2000
Plan A	0.92
Plan B	1.08
Plan C	0.77
Plan D	1.09
All	1.00

Conclusions

Risk adjustment significantly contributes to the State's goal of enhancing purchaser value by more appropriately distributing the HealthChoice funds among plans according to the health status of their enrollees. As a result, this system provides MCOs with the right incentives to manage the care of its population effectively by providing outreach and case management services to avoid costly hospitalization, rather than seeking ways to avoid adverse selection.

The use of risk adjustment also has contributed significantly to the ability of provider-sponsored MCOs to participate in the HealthChoice program. Provider-sponsored MCOs tend to have provider networks with large Medicaid patient bases and higher risks and costs. When the actual case mix differences among Maryland MCOs is examined using the risk-adjusted payment method, the provider-sponsored plans have a higher cost case-mix. Under the risk adjustment system, these plans are paid more to care for their patients. In contrast, a traditional age-sex rate methodology would have generated lower payments to those provider-sponsored plans. It is fair to conclude, therefore, that

the risk-adjusted payment system has been essential to the continued participation of provider-sponsored MCOs in the HealthChoice program.

ADMINISTRATIVE COSTS

Overview

States planning to implement §1115 Medicaid managed care waivers may anticipate that their administrative costs will be reduced since some administrative activities are shifted over to the MCOs. In reality, states with managed care programs are required to perform a number of additional activities not required under a fee-for-service system. These new functions include: monitoring the enrollment broker and external quality review organization (EQRO) activities; responding to complaints and grievances; ensuring prompt payments to providers; providing outreach, care coordination and ombudsmen services through local health departments; collecting, analyzing, and reporting encounter data; overseeing the MCO capitation rate-setting process; and overall monitoring of the MCOs to ensure that the State's access and quality standards are ultimately being met. The State has a financial contract with MCOs and needs to monitor those contracts to ensure that state dollars are being used appropriately and predictably.

In addition to these new functions, states must continue to operate both fee-for-service and managed care components of Medicaid. In Maryland, despite the fact that the overwhelming majority of enrollees are in MCOs, well over 60 percent of the Medicaid budget expended via the Department's fee-for-service payments. HealthChoice created many new administrative activities, but the only significant administrative activities that were transferred to the MCOs were those involving some claims payments, which is a relatively low-cost activity, and contracting with and maintaining the provider network.

It is common for administrative spending to increase for states with §1115 Medicaid managed care waivers due to managed care oversight responsibilities. A Mathematica Policy Research report, dated April 2001, stated: "All states should expect to spend more, not less, to administer a managed care program. If they do not provide additional administrative resources, their programs may not be able to operate adequately." Since Maryland's managed care program is considered a highly regulated managed care program, it is even more likely that additional funds would be required for the oversight requirements of the program.

Findings

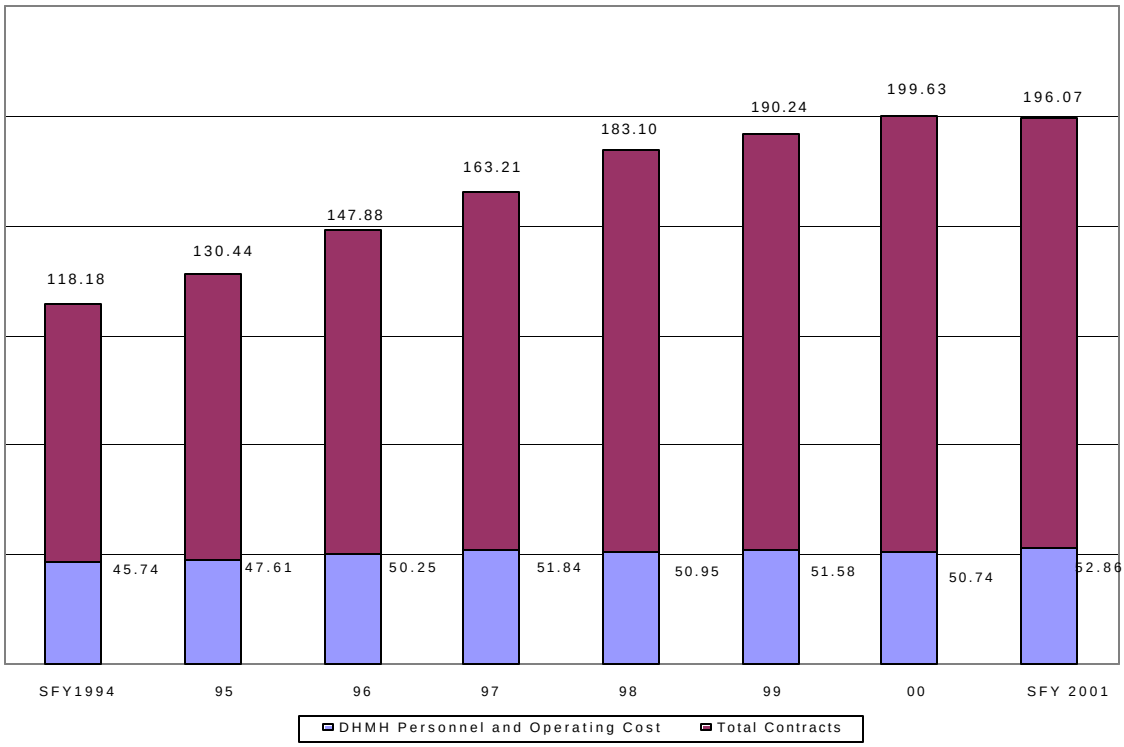
Department of Health and Mental Hygiene

Based on Medical Care Programs' expenditure data from fiscal year 1994 through 2001, the State's administrative costs have increased. The data summarize all Medicaid administrative costs and include both Department and contractor administrative costs. It is not possible to separate out "HealthChoice" administrative costs because many staff work on both Medicaid fee-for-service

and HealthChoice activities (see Chapter 2 for a discussion of Department operations).

The Department's administrative costs grew from $83 million in FY 1997 (3.5 percent of Medicaid expenditures) to $121 million in FY 2001 (4.4 percent of Medicaid expenditures). The administrative costs per person grew from $163.21in FY 1997 to $196.01 in FY 2001, a 20 percent increase. Therefore, there are no administrative savings to the State that can be passed on to the MCOs as a component of the capitation rates.

Figure V-4: Total DHMH Administrative Cost per Program Recipient



Most of the growth in costs was due to Medicaid contracts for functions such as the enrollment broker, EQRO, and rate-setting. In addition to these new contractual costs, the Department took on a number of new administrative functions. It is important to note that many of the new responsibilities were absorbed within the Department's existing administrative budget.

The Mathematica study indicated that State administrative costs ranged from 3 to 8 percent of total program costs in the five states examined (including Maryland) because of their mandatory managed care and eligibility expansions. Based on this information, Maryland's administrative expenditures appear to be similar to those in other comparable states and are considered reasonable.

Providers

In the provider forums, most providers reported new administrative costs, but they were unable to quantify these additional costs. The provider costs are attributed to pre-authorization, billing multiple entities, differing MCO formularies, medical record audits, encounter data reporting, and identifying an enrollee's PCP. In particular, providers who used to contract with one entity - the State - now contract with multiple MCOs each with own set of procedures and rules. In some cases, providers have stated that the need to add additional staff to handle the additional workload.

MCOs

Direct comparisons between MCO administrative costs and those incurred by the State for operating a fee-for-service program are not appropriate. Essential elements of the managed care model require a highly developed management infrastructure. For example, MCOs must contract with and credential a provider network and operate information systems that go far beyond routine claims processing if they are to manage effectively and coordinate care. Successful managed care plans often make substantial investments in their administrative system so that care can be delivered in the most appropriate and cost effective setting.

MCOs reported $111 million in administrative costs in calendar year 2000 and projected $118 million for calendar year 2001. These estimates are problematic, however, because MCOs have not used a uniform definition of "administrative costs". For example, services such as case management and outreach may be included in administrative or medical costs. The Department is in the process of better defining how administrative costs are to be reported in its revisions of the HFMR reporting requirements.

It is important to keep in mind that when employers or State Medicaid programs contract with managed care organizations to provide services to their members, a major part of what they are purchasing is the MCOs' management expertise. With effective management MCOs are able to provide all necessary and appropriate services to their members at a lower cost than in a fee-for-service system, even taking into account their administrative costs. In the Maryland Medicaid program, total State capitation payments to the MCOs, which cover all services, case management and administrative costs and any operating margins the MCOs may generate, are about 2 percent less than what the same services would have cost if they had been in a fee-for-service system. In addition, the MCOs generally have been able to provide higher payments to physicians than the Medicaid program pays on a fee-for-service basis. This is possible because of effective management of resources.

Because of the relatively extensive quality and access standards included in Maryland's HealthChoice program, it is likely that MCO administrative costs are higher than in most other Medicaid or commercial programs. Indeed, some of the MCOs that operate plans in other states have reported higher administrative costs in Maryland. MCOs cite some administrative burdens as barriers to efficiently managing resources.

Discussion

The administrative costs incurred by the Department and the MCOs are consistent with what would be expected under a managed care system. Managed care systems, as the name implies, require an investment in administrative systems if they are to succeed in achieving their goals. An important caveat to the need for administrative controls to manage patient care appropriately is the need to avoid overburdening the provider system with arduous tasks that do not yield returns, either in quality of care or efficiency.

OVERALL CONCLUSIONS

This section of the evaluation addresses a series of questions about whether the State's goals of improving value and predictability have been achieved. The analyses show that:

- The State has passed the two federal financing tests under HealthChoice;
- MCO funding levels appear to have been adequate to achieve the program's goals;
- Although the program initially fell short of its goals for predictability, important procedural changes implemented in late 1999 have promoted greater budget predictability for the State and participating MCOs;
- The risk-adjusted payment method contributes significantly to achieving purchaser value by more efficiently allocating funds among the MCOs; and
- Administrative costs associated with the operation of the HealthChoice program are reasonable given the rigorous quality and access requirements of the program, but should be reviewed to identify opportunities to reduce unnecessary burdens.

All of these successes were achieved against a backdrop of an unprecedented expansion in program enrollment. In spite of real challenges and difficulties, the HealthChoice program's financing structure has proved durable and has helped to advance overall program goals.

VI. HOLD MCOS ACCOUNTABLE

One of the guiding principles of HealthChoice is to hold MCOs accountable for performance and high quality care. This chapter discusses the systems in place to assure MCO accountability for both quality of care and administrative issues. The following analytic questions are addressed

- *What are the on-going quality of care review activities?* This section discusses the State's annual quality review audit, its process, results and the actions that follow.

- *What oversight is done of MCOs administrative activities?* This section will present two analyses. The first addresses MCO submission of encounter data. The second examines MCO performance with regard to prompt payment of provider claims.

- *How does the State assure that MCOs follow correct grievance and appeal procedures?* This section will review the procedures for complaints and grievances and denials of care and the State efforts to enforce those standards.

- *How does the State solicit input from stakeholders and interested parties?* This section will review and summarize the various committees and workgroups that provide ongoing oversight and guidance for the HealthChoice program.

ANNUAL QUALITY OF CARE AUDIT – FOCUSED MEDICAL RECORD REVIEWS

Overview

Federal and state regulations require that DHMH perform an annual audit of the health care delivered by each HealthChoice MCO. The Quality of Care audit must be performed by a federally qualified external quality review organization (EQRO). The audit has been conducted each year since the HealthChoice program began in July 1997. The most recent audit covered the period from January 2000 through December 2000.

The audit process can be broken into two distinct parts; first, an evaluation of each MCO's systems and operations (systems performance review); and, second, clinical care review that involves the review of medical records. The HealthChoice regulations require each MCO to meet specific performance targets of 100 for each of the 16 systems' performance standards as well as performance thresholds of 80 percent for the clinically focused studies for CY 2000.

The Quality of Care audit process currently in place for the HealthChoice program was also used for the pre-HealthChoice voluntary HMO program (25 percent of enrollees pre-HealthChoice). The biggest difference is that no EQRO type process was in place for enrollees who received care through the fee-for-service MAC program. Consequently, the audit findings cannot be used to assess how HealthChoice compares to the prior fee-for-service program.

The annual Quality of Care audit is a key management tool that the Department uses for ongoing oversight of MCO performance. As a direct result of the Quality of Care audit results for CY 1998, CY 1999, and CY 2000, the Department imposed financial penalties on MCOs related to the clinical care portion of the audit. The penalties were in the form of withholds from MCO capitation payments, so that MCOs had the opportunity to recover the money if they improved. The CY 1998 audit led the Department to impose withholds totaling more than $640,000 on five of the eight participating MCOs. As a result of the CY 1999 audit**,** the Department imposed withholds totaling more than $230,000 on four of the eight participating MCOs. The CY 2000 audit resulted in withholds of more than $272,000 against five of eight MCOs.

Findings

Systems Performance Review. As was noted earlier, the Quality of Care audit has two distinct elements. The systems performance review is, as the name implies, a review of the MCOs internal systems for assuring quality of care. MCO performance is evaluated against 18 different standards ranging from credentialing procedures, composition of the quality assurance committee, health education, and outreach programs.

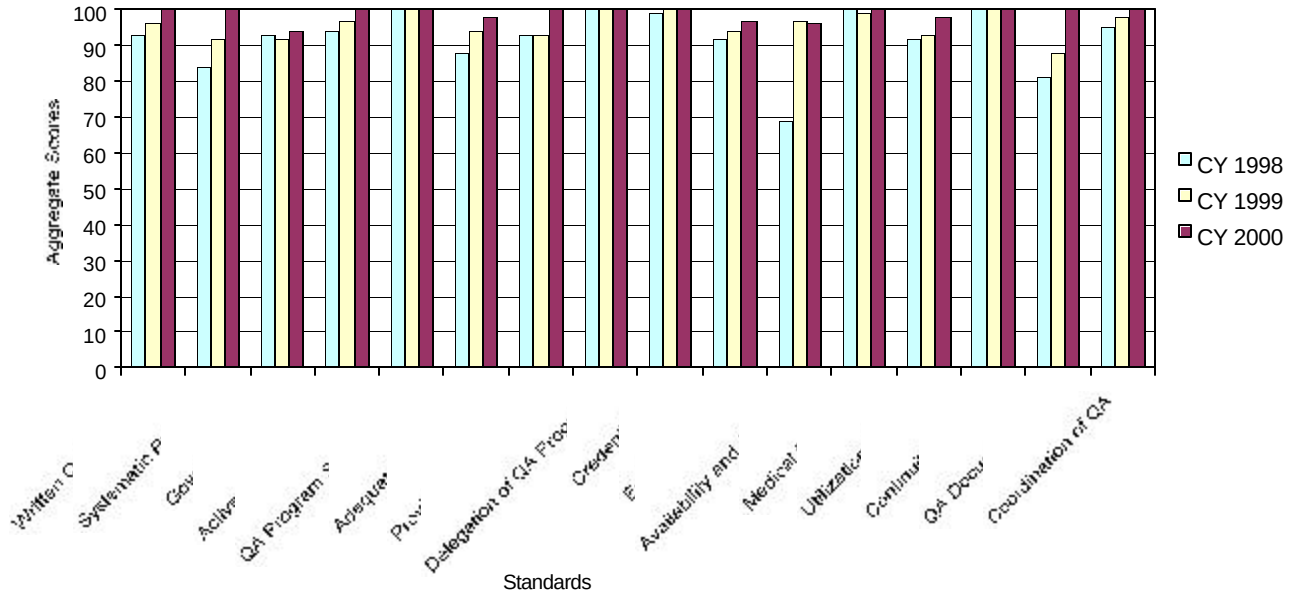
The most recent review showed that, overall, there was significant improvement in the

MCO systems performance compliance ratings. This is a continuation of the improvements in the previous two years' system performance review scores, and highlights the general improvement in review results over the past three years.

For CY 2000, the MCOs improved in 15 of the 16 standards over last year but failed to meet the minimum required score audit in five areas. In 1999, over half of the standards were lower than this year's standards. For the CY 2000 audit, all 16 of these standards require a 100 percent compliance rating in order to meet the performance threshold. Only 7 standards required 100 percent compliance rating for the CY1999 audit.

For CY 2000, the MCO aggregate availability and accessibility score decreased slightly from the previous year, to a score of 96 percent. The availability and accessibility standard assesses the policies and procedures that the MCOs have in place to insure that services are accessible and available (not the actual accessibility and availability of services). This is the only standard for which the aggregate score decreased from last year.

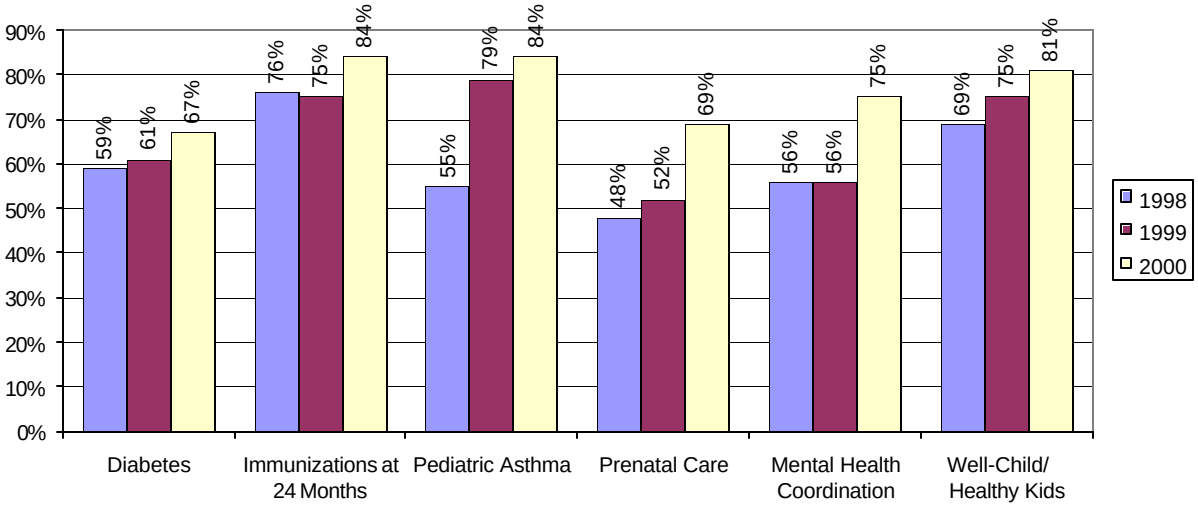
Figure VI-1: Aggregate Systems Performance Scores 1998-2000



Clinically Focused Review. The second part of the annual Quality of Care audit is clinically focused reviews. For this part of the audit, the review team pulls charts and analyzes them for compliance with specific clinical expectations.

In the most recent audit, there was a significant improvement in each of the clinically focused review areas. Figure VI-2 shows the general improvement in each of the 6 clinical areas over the past three years. The minimum score in each clinical care area for CY 2000 was 80 percent, which increased from 75 percent in CY 1999 and 70 percent in CY 1998.

Figure VI-2: Improvement Trends in Clinically Focused Reviews



The audit showed improvement in MCO performance in a number of areas. For example:

- *Immunizations.* Seven MCOs met or exceeded the performance standards for immunizations.

- *Pediatric asthma*. Six MCOs met or exceeded the performance standards.

- *Prenatal care*. Eight MCOs improved their scores in all prenatal care indicators.

- *Somatic and mental health coordination.* All eight MCOs made significant improvement across all five indicators for coordination of mental health care with primary care. Three MCOs - JAI Medical Systems, Freestate, and Maryland Physicians Care - met or exceeded the minimum standard.

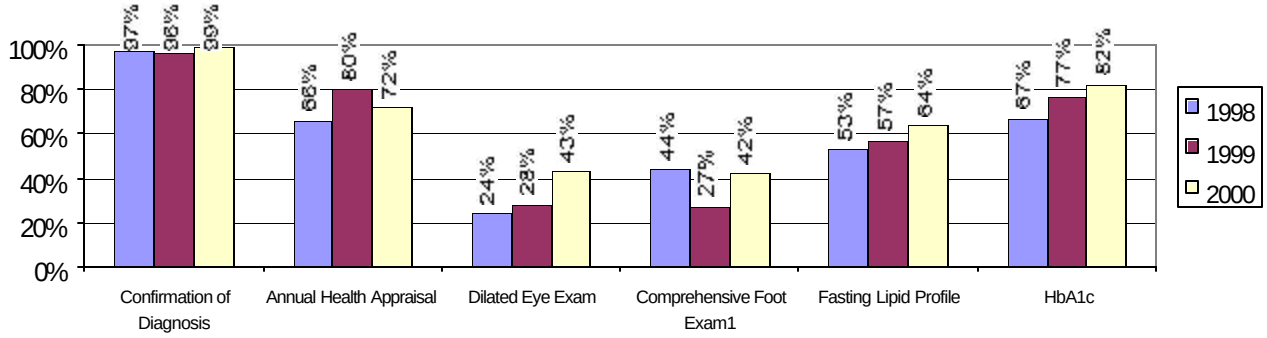
- *Healthy Kids* – All eight MCOs met or exceeded the minimum compliance rate for comprehensive physical exams for the third year.

While the audit showed progress and improvement in a number of areas, it also highlighted areas of clinical performance where MCOs need to make additional improvements to meet the State's expectations. For example:

- *Diabetes Care.* Figure VI-3 shows the six indicators used to assess the quality of diabetic care. General diabetic care and focused physician encounters improved overall, however, there was a slight decline in comprehensive annual health appraisals. Both dilated eye and comprehensive foot exams improved from CY 1999 but the scores remain relatively low. When compared to the latest national HEDIS rates for diabetic eye exams, however, the HealthChoice rate is consistent with the national rate of 41 percent. One MCO exceeded the minimum standard (80

percent) for the CY2000 audit for diabetes care.

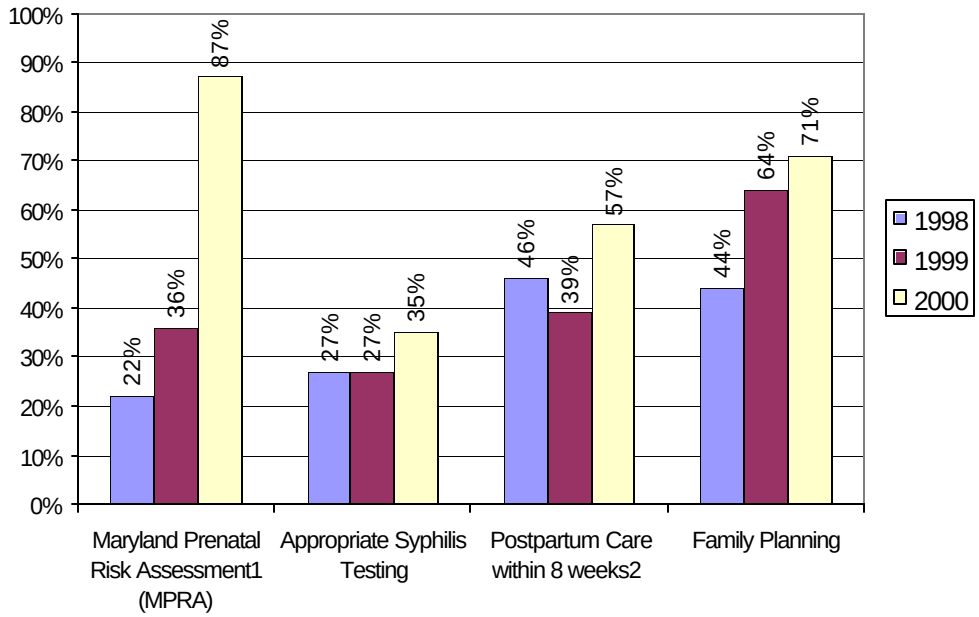
Figure VI-3: Trends in Diabetes Indicators



NOTE: CY1998 audit assessed whether a foot exam was performed; the CY 1999 and CY 2000 audits looked for five specific sub-components of diabetes care.

- *Prenatal care*. Figure VI-4 shows the individual indicators used to assess the quality of prenatal care. No MCO met the overall minimum compliance rate of 80 percent in this area. Two plans had minimum compliance rates that met or exceeded 75 percent, the minimum compliance score for this measure last year. While improvement occurred in the areas of risk assessment, syphilis testing, postpartum care, and family planning, the results indicate that these areas need continued attention.

Figure VI-4: Trends in Prenatal Indicators



NOTE: CY 1998/99 reflect MPRA only. CY 2000 reflects MPRA, ACOG, or ACOG-like risk assessment tools documentation in the medical records.
NOTE: CY 1998 reflects postpartum care scheduled within 4-6 weeks; CY 1999/2000

reflect actual visits.

Discussion

While a review of the audit findings does not yield any pre and post HealthChoice insights it does allow for an assessment of program progress. Although there have been some changes to the EQRO audit over the past three years, the measures and standards are generally consistent. The audit, therefore, serves as an important tool for assessing the clinical progress that has been made since the start of the program. The Department's use of financial penalties in the form of withholds demonstrates its commitment to the annual Quality of Care audit as part of its quality improvement strategy. The significant and measurable progress documented by the EQRO audit process demonstrates that in areas where the Department has focused real progress has been made.

Finally, it is important to highlight the important step forward the Quality of Care audit represents over Maryland's pre-HealthChoice approach to quality. The EQRO audit is a comprehensive, program-wide assessment of the delivery of health care. It is designed to hold MCOs accountable for their overall clinical performance, and to penalize MCOs that do not perform up to high standards. As such, it is a significant step forward in Maryland's approach to quality care.

MCO ENCOUNTER DATA

Overview

Encounter data is central to the Department's goal of operating the HealthChoice Program in a data driven manner. Toward this end, the Department and the MCO have been engaged in an intense collaborative effort to improve all aspects of the collection and submission of encounter data. Since March 1999, when the Encounter Data Workgroup was formed, the Department has worked extensively with the MCOs to improve the submission of encounter data. This collaborative effort has taken a number of forms including:

Group meetings with the MCOs**.** The Department has, since March 1999, regularly convened meetings of all HealthChoice MCOs (the 'Encounter Data Workgroup') to discuss and review progress on encounter data collection. Each of these meetings has included a formal presentation that reviewed the status of encounter data and presented summary findings.

Individual MCO Site Visits**.** The more than 40 individual MCO site visits conducted have been an invaluable complement to the full meetings of the MCO encounter data workgroup. Early in the process the Department realized that many, if not most, encounter data submission issues are unique to specific MCOs. Individual MCO issues range widely and include; internal MCO systems, network arrangements, payment practices and other more esoteric problems.

Aggressive Monitoring and Improved Feedback Mechanisms**.** Building on the insights gained through the group and face-to-face meetings, the Department has developed a series of tools that provide MCOs with useful feedback. Specifically these feedback tools have include:

- *Date of service graphs*. These graphs track (according to the encounter data received by the Department) the number of users over time an MCO has. The date of service graphs have proved to be a very useful feedback tool, as they allow the Department and the MCO to quickly identify 'gaps' in service delivery volume that can indicate missing or lost data. The dates of service graphs also provide a means to roughly compare performance across MCOs.

- *Data submission targets*. In the process of increasing the amount of encounter data accepted by the MMIS2 system, it was found useful to set targets for the MCOs to meet or surpass. Projection tables were developed for CY 1999 and CY 2000 for both HCFA-1500 and UB-92 record formats. These tables were based on a calculated ratio of encounters by date of service to enrollees for each month, and updated on a monthly basis.

There have been great strides made in both the quantity and the quality of encounter data

over the past few years. In the early stages of HealthChoice, the submission process was difficult and the MCOs were unprepared. From CY 1999 forward, the submission of acceptable encounter records reached a level to allow its use for rate setting, although it still required the use of a 'completion factor'.

Encounter data is imperative in rate setting and in evaluation of the program. The improvement in data submissions can be accorded to the collaboration and cooperation of the MCOs and the Department.

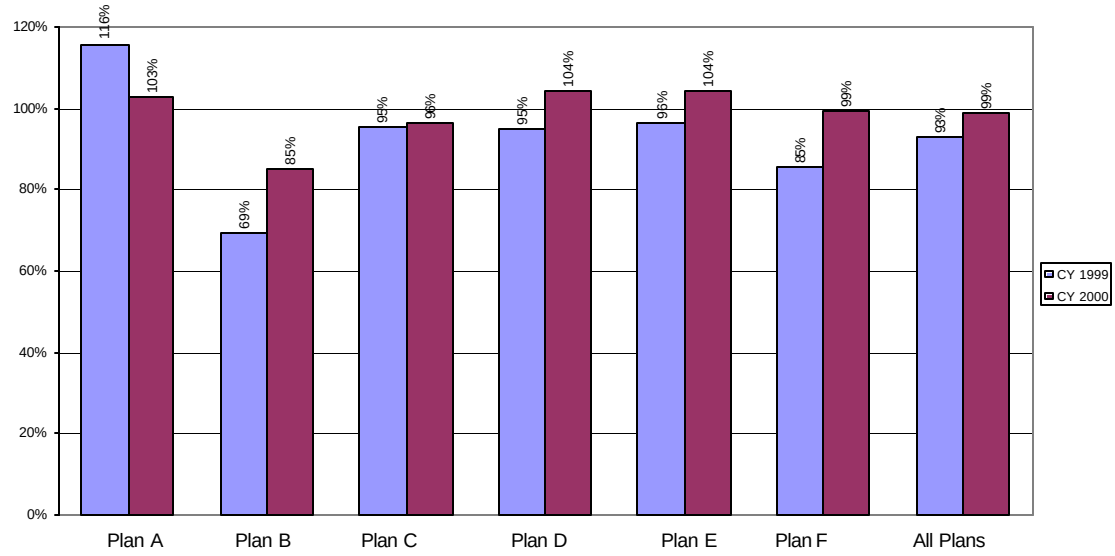
Findings

HCFA-1500. Early in the rate setting process it was determined that HCFA-1500 records were the largest factor in the assessing each enrollee's health status and, therefore, the rate cell. Given the importance of HCFA-1500s for rate setting, initial studies on volume began with HCFA encounters.

HCFA-1500 submission targets were met or surpassed by most MCOs. In calendar year 1999, five of the six MCOs were 80 percent of the target or better. In calendar 2000, all MCOs hit at least an 80 percent rate. The overall percentage for all MCOs was approximately 85 percent in CY 1999 compared to 95 percent in CY 2000. Only one MCO performed at a lower level in 2000 as compared to 1999, but this MCO also well exceeded its initial projections.

In the future, these targets will be recalculated on more current data, and the ratios and corresponding targets will increase. In addition, further studies on specific service areas of possible missing data will be undertaken.

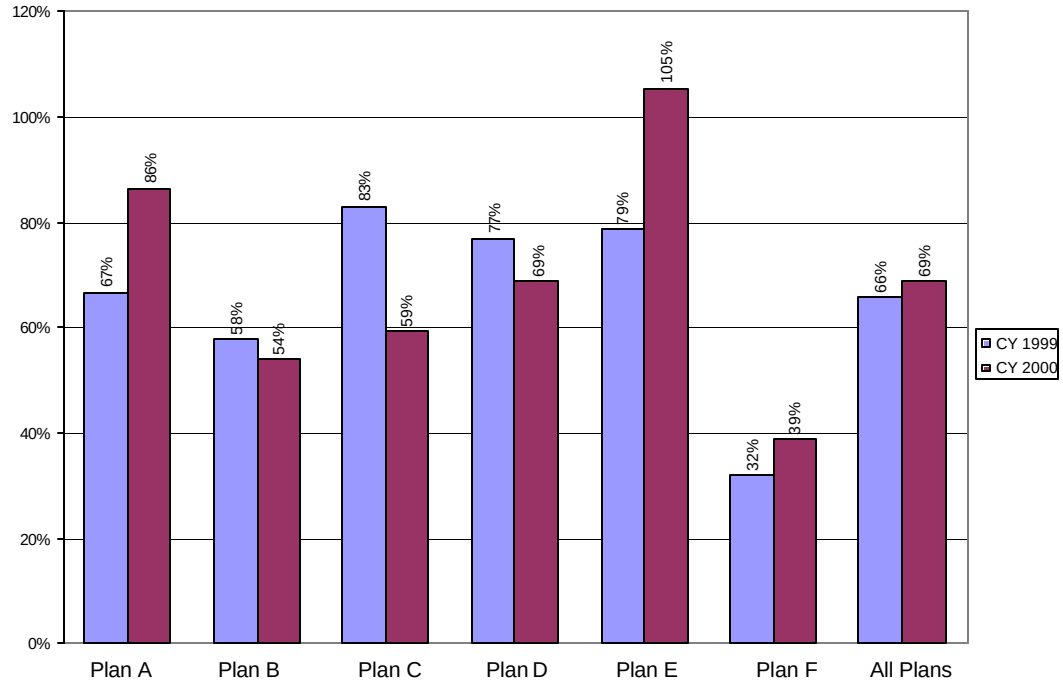
Figure VI-5: HCFA-1500 Submissions As Percent of Target CY 1999 and CY 2000



UB-92 Inpatient. The targets set for UB-92 Inpatient submissions were based on a combination of the average number of encounters per month (by month of service) and the highest average number of encounters by a single MCO. In addition, studies were undertaken that compared the maternity payments to each MCO in comparison to the hospital rate for deliveries.

Comparison of the MCO specific targets with actual MCO submissions demonstrates that there are impediments to the submissions of inpatient data. Only one MCO was able to meet and exceed the target projections for CY 2000. In contrast, one MCO was unable to meet even 50 percent rate for either CY 1999 or CY 2000. The overall average of the six MCOs was just over 60 percent for both years. Clearly, there are problems that need to be identified and solved in order to increase the level of inpatient submissions. The inpatient hospital encounters are not as important to the rate setting process as the HCFA 1500 data, as inpatient encounters are unlikely to pick up new diagnoses that have not previously been identified using HCFA 1500 data. The inpatient data is, however, important to quality oversight and monitoring of plans' performance.

Figure VI-6: UB-92 Submissions As Percent of Target CY 1999 and CY 2000



Conclusion

The improvement of encounter data submissions is an ongoing process. Both the MCOs and the Department understand the importance of this endeavor and will continue to look for ways to increase both the volume and the validity of the data.

As such, the Department must continue to improve the feedback mechanisms to the MCOs. Open communication is imperative. The Department has a fulltime specialist available to work with the MCOs to identify problems. Regular internal workgroup meetings provide an open forum for discussion of problems, identification of solutions, and development of new methods to validate data.

The MCOs need to work with their providers and outside vendors to receive as complete encounter data. The decrease in capitated contracts is causing a marked increase in the volume of data. Each MCO must provide easy methods for data to be accepted into their system and process this data within a shorter timeframe.

PROMPT PAY

Overview

One of the first concerns raised by providers in the HealthChoice program related to the lag in payment they experienced when submitting claims to MCOs. In order to respond to the providers' complaints, in 1998, the Department started to collect information from MCOs about the timeliness of claims processing activities. At that time, the Department established a standard of paying all claims within 30 days. The Department also began working with MCOs on corrective action plans to meet the new standard. Starting in the 2nd quarter of CY 2000, sanctions were imposed on MCOs that did not meet the standard of paying 80 percent of claims within 30 days in addition to the fact that interest is being paid by MCOs in accordance with State law. MCOs are able to recover these sanctions if they can demonstrate improvement over two consecutive quarters. Initially, the state required MCOs to report on all claims (paid, denied, and pending). One difficulty in addressing the issue of prompt claims paymentis that providers and MCOs have not always agreed on the definition of a clean claim. In 2001, new regulations prepared by the Maryland Insurance Administration were adopted to standardize the definition statewide. In the future, MCOs will be required use this definition when reporting claims.

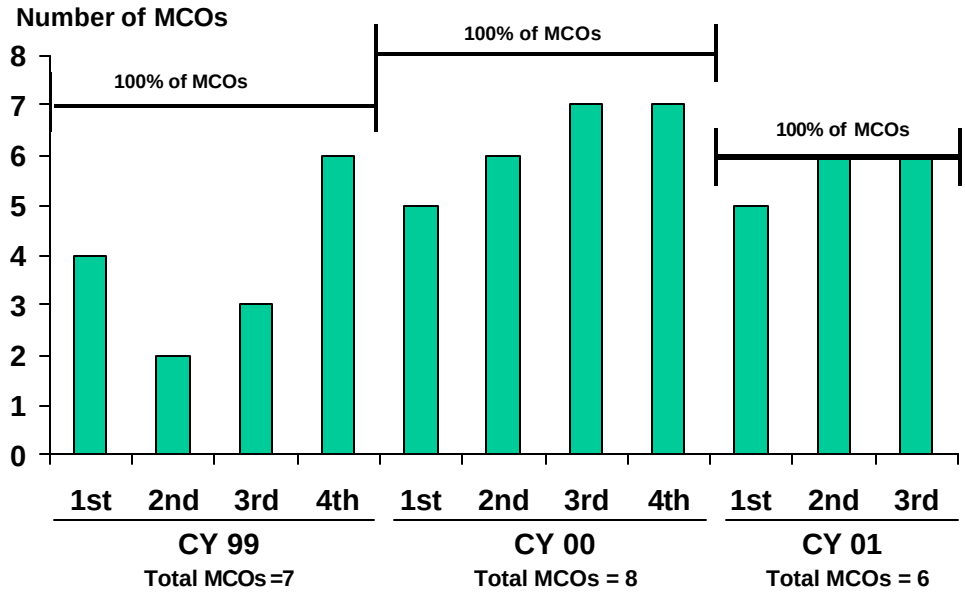
Findings

The implementation of a 30 day standard, increased monitoring by the Department, and the threat of sanctions appear to have improved claims processing times. Chart 88 shows the steady progress that MCOs have made towards meeting the 80 percent timeliness standard. Although the data used to monitor progress on this initiative is self-reported by the MCOs, the Department believes the data to be representative because some MCOs reported that they were below the 80 percent standard and, as a result, incurred sanctions.

In CY 2000, $16,645 in sanctions were withheld from MCOs, however, withholds were refunded if the MCOs achieved a passing score for two consecutive quarters. This did occur in CY 2000. There were no withholds for the 4th quarter of CY 2000 or the 1st quarter of CY 2001 due to a management decision to give MCOs an opportunity to adjust to the membership/provider changes that occurred due to the FreeState and PrimeHealth exits.

The timeliness of payment of professional claims has improved more rapidly than payment to institutional providers. In addition, some MCOs have been better than others at paying providers in a timely manner**.** In the 3rd quarter of CY 2001**,** the latest quarter for which data were available, all of the MCOs exceeded the 80 percent standard and some had paid close to 100 percent of their claims within 30 days.

Figure VI-7: Compliance with Prompt Pay, By Quarter



COMPLAINT AND GRIEVANCE PROCESS

Overview

HealthChoice enrollees have numerous opportunities to complain about or appeal an MCO decision to deny, reduce or terminate benefits. Many enrollees, however, may not fully understand how to use the MCO's internal appeal and grievance process or be aware that they do not need to exhaust the MCO appeal process before seeking help from the Department's HealthChoice Enrollee Action Line.

Enrollees currently receive information about the MCO's internal complaint and grievance process, as well as the Department's HealthChoice Enrollee Action Line, at the time of enrollment. Information about the Department's line is in a pamphlet that is widely distributed through various means including DSS, LHDs, the Enrollment Broker, and advocacy groups. The HealthChoice Enrollee Action Line's toll-free number is also on all MCO identification cards. The MCOs are required to outline their internal complaint and grievance process in their MCO Member Handbook that is sent to everyone upon entry into HealthChoice and the provider manuals that the MCOs issue. Despite these efforts to educate enrollees, the Department continues to hear that HealthChoice enrollees do not know how to appeal when services have been denied, reduced, or terminated.

In April 2000, the HealthChoice internal appeal processes were significantly revised to assure that consumers were given complete and timely information regarding their appeal rights. When an enrollee makes a complaint to the Department and the problem is not resolved within ten days, he/she is informed of his/her right to appeal to the Office of Administrative Hearings. This change resulted in a slight increase in appeals and the need to hire additional staff within the Department to handle such appeals in a timely manner.

The MCOs are required to inform consumers in writing when a service is reduced, denied, or terminated. The Department has received requests to standardize and strengthen the adverse action notices distributed by MCOs and to place a greater emphasis on monitoring whether MCOs are sending such notices to affected enrollees.

Discussion

Monitoring the MCOs' processes for informing consumers of service reduction, denial or termination has been problematic. The Department's effort to monitor this process began in the fall of 1999 when it worked with the MCOs to develop eleven specific elements that an MCO denial letter must contain. Beginning in June 2000, the Department required the MCOs to send to the Department a copy of every denial letter issued. Over the last year, the Department received 1,672 MCO denial letters.

It has become clear that some of the MCO denial letters do not consistently contain all the required elements or have other deficiencies. The Department sought to improve the denial letters by instituting letter-review as part of the EQRO process. That review,

however, has not been completed. The Department recognizes that it needs to more effectively monitor the denial process at the MCO level.

WORKGROUPS AND COMMITTEES

Overview

There are several standing HealthChoice Committees that advise the Department of Health and Mental Hygiene on the effectiveness of their assigned program components and make recommendations to improve program quality and efficiency.

Medicaid Advisory Committee. The Medical Care Advisory Committee, implemented under Section 1902 (a) (22) of the Social Security Act was reconstituted as the Maryland Medicaid Advisory Committee under section 15-103 (a) (27) (1) of the Annotated Code of Maryland in 1997 (SB 750). The Maryland Medicaid Advisory Committee improves and maintains the quality of the HealthChoice Program by assisting the Department of Health and Mental Hygiene with the implementation, operation and evaluation of the Program. The Maryland Medicaid Advisory Committee meets on a monthly basis and selected members participate on other standing HealthChoice committees/workgroups developed to focus on specific elements of the HealthChoice Program.

Medical Review Panel for the Rare and Expensive Case Management. The Medical Review Panel for the Rare and Expensive Case Management Program (REM) was developed in January 1998. The mission of the Panel is to review and recommend changes to the conditions appropriate for determining eligibility into the REM Program. The work of the Panel includes examining the REM diagnoses eligibility list and developing a service complexity tool. The Medical Review Panel meets on a monthly basis and will begin meeting quarterly beginning in 2002

Special Needs Children Advisory Council. The Department established the Special Needs Children Advisory Council (SNCAC) in April 1997. The mission of this Advisory Council is to provide information, consult with, and to advise the Deputy Secretary for Health Care Financing at the Department of Health and Mental Hygiene on the administration and delivery of care for special needs children through the HealthChoice program. The Advisory Council reviews available data related to special needs children to identify problems, suggest improvements, and make recommendations as appropriate. The SNCAC meets on a bi-monthly basis.

Oral Health Advisory Committee. The Oral Health Advisory Committee is a task force formed by the Health Secretary to examine the provision of dental services for Medicaid-eligible individuals. The Committee, which started in May 1998, is comprised of representatives from dental professional organizations, Medicaid, academia, public health agencies, consumer groups, and managed care organizations. The main purpose of the Committee is to increase access to dental services for Medicaid-eligible patients in accordance with the utilization targets established in statute by the 1998 Maryland General Assembly (SB 590). The OHAC meets on a monthly basis.

Medicaid Drug Treatment Workgroup. The Medicaid Drug Treatment Workgroup was

formed to examine access and coordination of substance abuse treatment services for Medicaid enrollees. Some of the goals of the workgroup include: providing accessible substance abuse treatment services through a self-referral process; expanding the network of substance abuse providers; and assuring treatment providers are paid in a timely manner.

Other *ad Hoc* Workgroups. In addition to the committees and workgroups mentioned above, there are other *ad hoc* groups that meet regularly on specific HealthChoice related issues. For example, there is a HealthChoice enrollment steering committee, encounter data workgroup, focusing on improving the submission of encounter data, and a newborn care coordination taskforce, which is dedicated to addressing all issues related to newborn enrollment and access to care.

Findings

The work of these committees is very important to the continued improvements in the HealthChoice program. For example, a number of recommendations have been developed through the work of these committees, which have resulted in significant improvements to the HealthChoice Program. However, there have been concerns expressed through various forums about the continuous changes to the Program and the impact some of the changes have had on enrollees, providers, and MCOs. Also, the lack of communication and education of enrollees and providers regarding the new policies is a concern. The lack of time given to implement the changes, as well as the continuous policy changes made to the Program were identified as a burden on the plans, as well as their provider networks. In addition, both advocates and providers have expressed concern about the lack of focus and resolution of some issues.

VII. SUMMARY AND RECOMMENDATIONS

INTRODUCTION

The comprehensive evaluation of the HealthChoice program has demonstrated that the program has made progress in meeting its originally stated goals. It also has been the platform for a major expansion under the Maryland Children's Health Program (MCHP). We have reached this conclusion about the program based on the following key findings:

The Medicaid HealthChoice program serves a much larger and different population than before and was the platform for a major program expansion.

- Since HealthChoice began, over 100,000 individuals have been added to the Medicaid rolls. The decline in adults and rapid growth in children in the program are due to changes in the welfare program and the implementation of the Maryland Children's Health Program in 1998.

- Statewide, the percentage of Maryland children enrolled in Medicaid has grown from 12.7 percent of all Maryland children in 1990 to 22.2 percent in 2000. On the Eastern Shore, the percentage of children served by Medicaid has more than doubled, from 12.4 percent in 1990 to 28.7 percent in 2000. One reason these significant program expansions could occur is that MCOs pay higher rates to physicians than the fee-for-service Medicaid program. Because of the low Medicaid physician fee schedule, it is questionable whether the previous fee-for-service system would have been able to support these major program expansions.

HealthChoice has helped more people, particularly children, access health care services overall. Although the number of services per person has decreased, the implications of this are unclear.

- Access to care has increased compared to before HealthChoice, even with the significant increase in the number of people served under HealthChoice.
- Individuals who enroll in Medicaid stay on Medicaid longer than before. The number of enrollees who maintain a full year of eligibility within the year increased from 41.8 percent in FY 1997 to 48.5 percent in CY 2000.
- The percentage of children who receive well-child visits is up from 36.0 percent in FY 1997 to 40.0 percent in CY 2000. The largest increase is for newborns, increasing from 54.5 percent in FY 1997 to 69.2 percent in CY 2000. Looking at well-child visits addresses some of the problems of comparability that complicate

the examination of all ambulatory visits since well-child visits should be provided to all children regardless of the child's health status.

- The percentage of individuals who access any ambulatory service has increased from 57.8 percent in FY 1997 to 60.3 percent CY 2000. The greatest increase is for newborns, increasing from 61.3 percent in FY 1997 to 75.1 percent in CY 2000.

- The number of well-child services is up from 871 per thousand members in FY 1997 to 905 per thousand members in CY 2000. For newborns, the number of ambulatory services is up from 6,526 visits per thousand members in FY 1997 to 7,822 visits per thousand members in CY 2000.

- Overall emergency room use is down in terms of the percentage of people who have an emergency room visit (15.2 percent in FY 1997 versus 14.4 percent in CY 2000) and in the number of visits per thousand (345 in FY 1997 versus 301 in CY 2000).

- In general, the number of services individuals use has decreased except for newborns and well-child visits, as described above. Overall, the number of ambulatory services are down from 4,301 visits per thousand members in FY 1997 to 3,667 visits per thousand members in CY 2000. The implications of this are unclear. This might indicate that people are not receiving needed medical services. For example, it is possible that some patients with special health needs have encountered barriers to reaching all the services they need or that enrollees are confused by the complexity of the system. However, the decreases in service utilization may also be because:

    - There is a very different case mix in CY 2000 compared to FY 1997, which is healthier (current MCO population includes more higher income children and the voluntary HMO population which was not included in the 1997 pre-HealthChoice utilization data).

    - It is possible that care is being properly managed and enrollees are receiving timely interventions and less inappropriate care.

    - Although encounter data from CY 2000 is good, it is incomplete compared to the FY 1997 claims data. We have estimated that it may be 5-10 percent incomplete, which may contribute to the appearance of decreased utilization.

- HealthChoice has made significant progress in improving access to dental services, although access measures still fall short of the legislatively mandated targets. In CY 2000, for children between ages three and twenty enrolled in Medicaid for more than 90 days, 24 percent accessed dental services, up from 18 percent in FY 1997. The legislated targets start at 30 percent for CY 2000 and increase to 40 percent in CY 2001, 50 percent in CY 2002, 60 percent in CY 2003

and 70 percent in CY 2004. Areas that have lower access rates compared to the statewide average include Baltimore City and Southern Maryland.

- Although overall access to care has improved for children in SSI, some populations of special needs children may not be equally well served by HealthChoice.
  - Compared to the previous fee-for-service system, the encounter data analysis shows fewer children in foster care received outpatient services under HealthChoice and the number of services they received decreased. This analysis does not include important data on utilization of services before foster care children are enrolled in an MCO and therefore drawing conclusions is impossible. This is currently being studied further by the Department.
  - SSI eligible children have had improved access to care, including preventive services. Overall, 65 percent of SSI children (including some children enrolled in the Rare and Expensive Case Management [REM] Program who receive services on a fee-for-service basis) received an ambulatory visit in CY/FY 2000, an increase from 58 percent in FY 1997. The level of services they received increased slightly: SSI/REM children received 3,740 visits per thousand in CY/FY 2000 compared to 3,229 per thousand in FY 1997.

Overall, HealthChoice saved money relative to what would have been spent on the fee-for-service delivery system, and has added value to the program for consumers and providers.

- HealthChoice has met the two federal cost effectiveness requirements:
  - MCO costs have been under the Federal Upper Payment Limit; and
  - Although HealthChoice exceeded the budget neutrality cap of 5.5 percent in first two years, it was about 2 percent below the cap after the third year. Preliminary numbers indicate that it will be further under the cap after the fourth year.
- The first four years of HealthChoice demonstrate that most MCOs were able to generate profits each year, suggesting that rates in the past have been adequate. This does not address losses that some downstream risk providers experienced.
- The higher administrative costs of HealthChoice are associated with the benefits of the MCOs' care management systems and establishment of medical homes for enrollees. New care management functions such as outreach mandates, enrollee education responsibilities, and case management efforts created new administrative burdens for MCOs and providers. Plans believe that increased administrative burdens hinder their ability to adequately manage expenses.
- Risk adjusted rate setting methods contribute significantly to achieving purchaser value by more efficiently allocating funds among the MCOs according to the health status of their enrollees.

- MCOs have sufficient primary care providers (PCPs) to serve their enrolled population, including the 100,000 additional HealthChoice participants, at least partially due to the higher physician fees paid by the MCOs.
- The change in the number of MCOs participating in the HealthChoice program (initially eight, currently six) is similar to the magnitude of MCO withdrawals in other states.

Improvements in access may be threatened by diminishing numbers of physicians willing to participate in HealthChoice.

- Concern is greatest in the Eastern Shore, Southern Maryland, and Western Maryland due to the dramatic growth in the proportion of children served by Medicaid and the numbers of physicians available to absorb program growth.
- Physicians have left HealthChoice or are threatening to leave because of inadequate reimbursement from MCOs, even though most MCOs' physician payments are greater than the Medicaid fee-for-service schedule.

The evaluation demonstrates that to date HealthChoice has made progress in advancing the goal of providing access to high quality care to all enrollees. However, progress has not been uniform across the range of populations served and health needs addressed by HealthChoice. Changes are needed in order to continue HealthChoice's progress and to promote the stability of the program. The evaluation findings can be used to address long-standing challenges that have the potential to significantly affect the program.

RECOMMENDATIONS

Despite this progress, there are areas of concern. It is clear that maintaining and continuing further improvements will require a stable managed care program in the future. The remainder of this report identifies recommended changes to the HealthChoice program to encourage program stability, establish a regular process to identify program priorities, and identify specific program improvements.

ESTABLISH A LONG-TERM PRIORITY SETTING PROCESS

As has been referenced in a number of studies, including the Mathematica Policy Research study on the HealthChoice program, one of the biggest lessons learned about the HealthChoice program is that too much was attempted in too little time. The program was implemented with inadequate time to prepare and plan for the significant changes in the health care system. Subsequently, a number of changes have been made to the program through legislative, regulatory, and programmatic processes. As the program continues to mature, it needs a more reasonable pace of change. HealthChoice costs in FY 2001 were about $1.6 billion which represents roughly half of all Medicaid and MCHP expenditures. Any changes to the program need to be made in the context of the State's long-term goals and a realistic assessment of how much change our enrollees, providers, and MCO partners can absorb. Implicit in this is a process to establish and maintain priorities and achievable goals.

The Department, MCOs, providers, enrollees, and advocates have participated in numerous projects to improve the HealthChoice program during the first years of the program. However, as the program matures, it is critical that all stakeholders invest their limited resources in the same strategic priority areas.

➢ Recommendations

- The evaluation has identified several areas for program improvements, which we recommend to serve as the priorities of the HealthChoice program beginning in CY 2002. Implementation of selected HealthChoice evaluation recommendations will begin in CY 2002. Other HealthChoice evaluation recommendations will be implemented in subsequent years as part of a multi-year process.

- The Department recommends an annual process to review and establish strategic priorities for the HealthChoice program. To the extent possible, the Department would implement the subsequent changes one time a year in order to promote program stability and ease administrative burden. This process would begin with the Department proposing an annual list of priorities for CY

2003 and each year beyond. The Maryland Medicaid Advisory Committee would comment on the items and would set the order by which the different priorities would be addressed. During the summer of each year, the Maryland Medicaid Advisory Committee would receive input from the established advisory committees, MCOs, and other stakeholders from the program on the list of priorities. With this input, the Advisory Committee would recommend a prioritized list of issues by the end of September of each year for the Department to address in the upcoming year. The Department can then develop work plans and be able to implement strategies to address the issues prior to the beginning of the calendar year.

MAINTAIN THE CURRENT MCO-BASED CAPITATED PROGRAM, BUT DEVELOP A BACK-UP MANAGED CARE SYSTEM

The Department believes that improvements under the HealthChoice program are largely due to the establishment of a medical home and the care management systems of the MCOs. The evaluation findings suggest that this model has made progress and that there is no compelling evidence to recommend a significant programmatic shift away from HealthChoice. The evaluation found that important issues need to be addressed, and the number of services per person has decreased, although the implications of this are unclear. However, the quantitative data and direct input from consumers and providers does not suggest that the HealthChoice program should be eliminated.

While implementing a risk-based MCO model has allowed Maryland to achieve its quality improvement and cost-containment goals, program stability has been a challenge. During the last three years, management has been concerned about maintaining a statewide program, especially in rural areas of the State. During this time, two MCOs have withdrawn from HealthChoice and two have changed ownership. Six MCOs currently remain in HealthChoice. Four of these six MCOs cover 94 percent of the total HealthChoice membership, and two serve patients in all parts of the state while another operates in 23 of the 24 jurisdictions.

Currently, in the event that a region is left with less than two MCOs, the Department is required to return to a fee-for-service (FFS) system. Having a fee-for-service Medicaid card does not guarantee that a enrollee will receive needed health care services or that those services will have the same sort of quality protections and support services offered under managed care. In addition, while the State would be able to provide some care management components like concurrent review and pre-authorization, it currently lacks the managed care infrastructure needed to contain costs effectively and provide the types of quality oversight activities that are available in a managed care environment.

As a result, neither program management nor program stakeholders have been willing to endorse the fee-for-service model as the appropriate alternative to the MCO model. Both seek a more satisfactory alternative. Given the current situation, the State needs to develop a better contingency plan should MCOs leave the program.

The Department believes it is critical to develop the infrastructure to implement a back-up program which would provide another high-quality mechanism for serving HealthChoice enrollees if MCOs are not available in an area of the State or if it is determined that other populations would be better served outside of an MCO. This program needs to provide a primary care provider for each enrollee, and provide better "management" within the FFS system to address quality of care issues and help control health care costs.

The National Academy for State Health Policy's 2000 survey of Medicaid managed care programs indicates that most enrollees of exiting MCOs did not revert to FFS, but were

enrolled in another MCO or Primary Care Case Management (PCCM) program. As of May 2001, thirty-two states operated PCCM programs, either alone or in conjunction with risk-based managed care programs. In addition, a back-up program, such as a PCCM program, would allow the Department the flexibility to manage specific populations outside of MCOs, if in the future it is determined that a population is not well served by the MCOs, or in certain geographic areas where enrolling in an MCO is not an option.

In general under PCCM programs developed by other states, the state maintains a network of participating providers and assigns each enrollee to a primary case manager, usually a primary care physician. In most states, the patient's primary care physician receives a small payment each month for serving as the patient's first point of contact for all health care needs, whether the physician sees that patient in that month or not. The physician serves as the "gatekeeper," making referrals to other services as appropriate. To the physician, the crucial difference between the PCCM model and the current risk-based managed care model is that the purchaser of the health care - in this case the State or its contractor - pays the physician directly rather than paying an intermediary organization like an MCO or HMO and works with the physician directly to assure proper case management.

PCCM models vary across states depending on the needs of their specific populations, and their internal capabilities and resources. A PCCM program always has at least the ability to pay claims and to establish a network of providers. Where they usually differ is the intensity of care management programs offered, if at all. Some states decide to outsource all the functions of its PCCM program, while others manage them entirely in-house or outsource only pieces.

Fundamentally, two different PCCM models exist today. These models are commonly referred to as either "Phase I" or "Phase II" PCCM programs. The earliest PCCM programs were "Phase I" programs. In general, states operating "Phase I" PCCM programs pay claims and establish some utilization controls such as preauthorization of high cost services and post-payment review of hospital services. They do not collect comprehensive quality data, and they do not supply information to providers to help them manage care for their patients. These states rely heavily on the primary care case manager to coordinate care. The Maryland Access to Care (MAC) program, which preceded HealthChoice, was a "basic" or "Phase I" PCCM program. Although this model did improve the use of primary care and preventive services, it did not help to control health care costs.

States with "Enhanced" or "Phase II" PCCM programs generally supplement physician case management activities with the analysis of encounter or claims data. They also perform utilization management and develop or subcontract for sophisticated internal infrastructures to oversee the quality-of-care and service provided. Through these mechanisms, they are better able to control costs and provide case management than "Phase I" PCCM programs.

How Maryland decides to structure its back-up program will depend on the Department's resources and capabilities. For instance, the Department's Medicaid Management Information System has state-of-the-art capabilities to process claims. Therefore, it is not likely that the Department will need to seek a vendor for claims processing under the back-up program.

There are two important caveats, however, to the recommendation to develop a back-up "Phase II" PCCM program. As previously stated, the Maryland provider community is under stress and participation in the program is an issue. Some providers suggest that they will discontinue their relationships with Medicaid unless fees are increased and/or the administrative burdens of program participation are significantly reduced. Given the significant administrative responsibilities for primary care physicians under a back-up managed care program, physician reimbursement rates must be increased in order to be able to recruit an adequate provider network.

Also mentioned previously, the infrastructure of an appropriate contingency program is very similar to the infrastructure of a risk-based managed care organization. Maryland providers were accustomed to a "Phase I" PCCM program and may assume that any newly proposed model would be similar to their pre-HealthChoice Maryland Access to Care (MAC) experience. Providers may initially support the creation of such a back-up program. However, once fully educated on the concept and the State's intent, providers may not be as supportive. Without incurring additional administrative expenses upfront and providing additional funding for providers, Department management will be challenged to create an appropriately managed back-up program. For example, the Maryland Medicaid Information System (MMIS) will need to be programmed to allow enrollees to be linked with primary care providers rather than MCOs.

Even if additional administrative funding and a provider fee increase is approved, the Department will still need to pursue and rely on its current interim short term contingency models in order to be able to respond to any potential stability issue that may result from an MCO exit or significant provider network change while a back-up program is being developed.

- **Recommendation**

  The Department should develop a back-up care management program:

  - With input from stakeholders, plan a back-up program which includes linkage with a primary care provider; comprehensive care management and disease management programs; active quality assurance activities; and cost-containment efforts such as utilization control; and

  - By January 1, 2004, reprogram MMIS to allow for the implementation of such a model.

IMPROVE PROVIDER NETWORKS

One of the biggest challenges in the HealthChoice program is maintaining an adequate network of providers willing to see HealthChoice patients. As the evaluation findings identified, low physician reimbursement is the primary reason providers are not willing to participate. In addition, the Department lacks the information to effectively monitor and enforce MCOs' network capacity standards. The following recommendations are being made to support and strengthen the provider networks within the HealthChoice program.

Physician Reimbursement

During the evaluation process, HealthChoice stakeholders strongly supported an increase in physician reimbursement. The Joint Chairmen's Report establishes a process for annually setting reimbursement rates for Medicaid and makes recommendations for a multi-year process for increasing fees.[1] The fee increases would first be applied to approximately 200 medical procedures that comprise Evaluation and Management (E and M) services. E and M services are most often office visits provided by either a primary care physician or a specialist, and also include consultations and visits to patients in hospitals and nursing facilities. The prioritization of E and M services ensures that the new resources will have the greatest impact. The increased fees would cover all of the practice and malpractice expenses and most of the work component of physician services.

If there is a Medicaid physician fee increase, increased payments must reach physicians. Currently, the evaluation findings and the Department's on-going monitoring efforts suggest that most MCOs pay physicians on average more than the Medicaid fee schedule. In some cases, MCOs pay higher amounts in certain areas or for certain specialties.

➢ **Recommendation**

If the Medicaid fee schedule is increased under a budget initiative, the Department should monitor and make sure that the appropriate amount of the increased capitation payments related to this fee increase is passed on to physicians. The method for monitoring the levels of MCO pass-throughs to physicians includes the following:

- MCOs would be required to pay network physicians at least 100 percent of the new fee schedule for E and M services;

[1] "Report on the Maryland Medical Assistance Program and Maryland Children's Health Program—Reimbursement Rates Fairness Act." DHMH, September 2001.

- If an MCO wants to use the new resources to increase other physician fees rather than pay the new fee schedule for E and M services, it could request a waiver from the Department. The Department would approve a waiver if an MCO demonstrates that at least an equivalent amount of total dollars would be paid to physicians; and,

- An MCO wishing to use new resources will periodically provide the Department with its physician fee schedule for all procedure codes to demonstrate compliance with the above requirement.

Improve Provider Data and Ultimately Improve the Directory

The Provider Network Directory, PND, is a tool used to identify participating HealthChoice providers and their MCO affiliation. Unfortunately, the Provider Network Directory is not very accurate. Inaccuracies include duplicate provider entries, incorrect provider data, incorrect provider MCO affiliation status and missing information. There are various reasons for the inaccuracies. They include a faulty computer-editing program used to compile the provider data from the MCOs, inconsistent provider updates from the MCOs, and a burdensome and time-consuming provider update process.

The Department, MCOs, and providers have recently focused on improving the accuracy and the completeness of the information on providers who participate in the HealthChoice program. Accurate provider network data will allow the Department to more effectively monitor network capacity, improve the information enrollees use in the selection of their primary care providers, and improve the quality of the encounter data.

➢ Recommendations

The Department should implement the following multi-faceted plan to address this issue and ultimately improve provider data:

- *Perform Manual Clean Up*. This project, initiated in November 2001, will verify provider data by contacting the providers directly and making changes to the Provider Network Directory file. The manual clean project will focus on primary care physician data by geographic area. It is estimated that this project will be completed in March 2002.

- *Develop New Provider Network Directory Edit Program.* The existing Provider Network Directory edit program overrides certain data submitted by the MCOs with provider data from the Medicaid Fee-For-Service file. The Department is working to redevelop the edit program to eliminate the overriding of data and to improve the overall compilation of provider data. This project will be completed by October 2002.

- *Develop Methodology to Sanction MCOs for Failure to Submit Accurate Data*. MCOs are required to submit weekly updates to the provider file. Overall, most of the MCOs are very cooperative in the Provider Network Directory process. However, there are instances where the MCOs are inconsistent in submitting data, which has a direct impact on the accuracy of the Provider Network Directory. The Department will develop a methodology to sanction MCOs for failure to submit accurate data in an effort to encourage the MCOs to maintain compliance with the Provider Network Directory process. These sanctions should be implemented after October 2002 to allow the Department to complete the actions in the previous bullets.

- *Eliminate Provider Duplicates.* This is an ongoing process by which duplicate providers are identified and MCOs are requested to submit the appropriate data to eliminate the duplications.

  The process to improve the provider network data is a collaborative process that requires participation by the Department, MCOs and the providers.

Plan to Monitor and Enforce MCO Network Adequacy

In general, the evaluation found that HealthChoice MCOs have sufficient primary care providers (PCPs) to serve their enrolled population. This finding has been supported by consumer forums and by the lack of complaints in this area. However, the evaluation also found that PCP provider networks are under stress in certain areas of the State. In addition, consumers are worried about access to specialty care in rural areas, and many stakeholders believe that low physician fees will soon lead to PCP and specialty access problems throughout the State.

The Department developed a Network Adequacy Plan in CY 2001. The first phase of the Network Adequacy Plan was implemented by the Department in September 2001. This first phase has a methodology for on-going monitoring of PCP networks so that PCP shortage areas can be identified and acted on at an early stage. While the plan represents a step forward, the Department will need to use the results of its analysis to take corrective actions against MCOs.

The second phase of the Network Adequacy Plan (to be implemented in CY 2002) would concentrate on developing and implementing more rigorous methodologies to analyze access to specialty care. Currently, the Department analyzes specialty networks when an MCO applies to enter the HealthChoice program, and thereafter uses consumer, local health department and provider complaints to identify problems with MCO specialty networks. Through the use of these mechanisms, it has become clear that most access complaints during the life of the HealthChoice program have focused on the lack of available specialists, especially in rural areas. Lack of access to specialty care in rural areas was identified as a key concern by stakeholders during the public forums.

Given concerns about network stability and access to high-quality comprehensive care for HealthChoice enrollees, it is critical for the Department to develop more sophisticated tools to allow for timely and accurate assessment of specialty provider networks. The Department can find no state that has developed provider to member ratio standards for specialists or geographic access requirements for specialists. This is in part because geographic standards must be sophisticated enough to account for the fact that specialty physicians are not evenly distributed throughout the State. Nevertheless, it has become clear that access standards for certain common physician specialists should be developed.

The components of the Departmental Network Adequacy Plan, both existing and those planned for future phases, have been compared to network adequacy standards suggested by PricewaterhouseCoopers.[2] This information is included in the findings section of this report. It should be noted, however, that regardless of the sophistication of the Department network analysis and enforcement activities, MCOs will only be able to attract and retain physicians if they have the financial resources to increase physician payment rates.

➢ **Recommendations**

To monitor and enforce MCO network adequacy, the Department should fully implement its new Network Adequacy Plan. This includes:

- Developing specialty care standards and a methodology for implementing and enforcing these standards. The first step will be to establish network standards for certain commonly used specialists; and

- Continuing to identify geographic areas where there may be potential problems with access to care, and work with the MCOs to improve networks in problem areas.

Streamline administrative burdens for direct service providers and establish better mechanisms for communicating with HealthChoice providers

Since the beginning of the HealthChoice program, direct service providers have asked for help with a number of administrative problems: ensuring that MCO claims are paid in a timely manner; easily verifying that a HealthChoice enrollee is eligible, which MCO they are in, and the identity of their primary care provider; ensuring that they would be paid for care received by sick newborns even when they were seen out of network; reducing the reliance

[2]. "Assessing the Adequacy of Medicaid Managed Care Provider Networks." PricewaterhouseCoopers L.L.P., May 2001.

on chart reviews as part of the HealthChoice quality assurance process; and streamlining credentialing processes across all MCOs. These issues will be addressed below along with a recommendation for a future process to determine the impact of proposed new requirements on providers.

Timely Claims Payment

The Department received calls from providers immediately after program implementation concerning timely payment of claims by MCOs. The Department immediately set up procedures to handle individual billing complaints from providers and established quarterly reports from MCOs concerning the percentage of bills paid in a timely manner. In addition, the Department began to sanction MCOs when they did not pay at least 80 percent of claims within 30 days. Through these mechanisms and through the hard work of MCOs, MCO claims payment has improved dramatically.

As a result of recent legislation, the Maryland Insurance Administration (MIA) will be implementing regulations to define clean claims and monitor HMO (including HealthChoice MCOs) compliance with timely payment of clean claims. The MIA will also be monitoring MCO payment of interest on clean claims that are not paid within 30 days.

- **Recommendation**

  Rather than duplicating efforts, the Department should utilize the information collected by the MIA to monitor and apply corrective actions for MCO claims payment performance.

Eligibility Verification

Providers have asked for one phone number to call to find out if an enrollee is eligible for Medicaid, which MCO they are in, and the name of the enrollee's primary care provider. Currently, providers call two phone numbers – the Maryland Medicaid Eligibility Verification System to see if the patient is eligible and what MCO they are in – and then the MCO phone line for information on who is the PCP. This adds to their administrative burden.

- **Recommendation**

  The State already has funding to replace the current EVS system as part of its efforts to become HIPAA compliant. The new system should include the capability to automatically route the call to the MCO's eligibility phone line. This linkage would result in a provider making only one call and getting both PCP information and client eligibility information at the same time. Specifically, this means that after calling the State's EVS system and hearing the patient is eligible and in a certain MCO, the doctor's office could push a button to automatically dial-up the MCO eligibility verification line which provides PCP information. This line would then give the caller the name of the enrollee's primary care provider.

Newborn Care

The evaluation demonstrated that newborns are more likely to access care under HealthChoice than under the previous fee-for-service system. In addition, newborns received more well child and ambulatory care visits under HealthChoice. This good news is tempered by the fact that the Program still has progress to make in order to meet its high standards for newborn care.

➢ Recommendations

In order to make sure that mothers of newborns know where to take their newborn for care and that appropriate newborn care is paid for by the MCO, the following new and on-going initiatives are recommended:

- The Department should support and monitor the MCO Newborn Care Coordinator Initiative. In this initiative, the MCOs hired Newborn Care Coordinators by September 1, 2001 to provide information and assistance to providers serving newborns. This includes facilitating payment for newborn care to out-of-network providers. Protocols for the newborn coordinators have been developed and the list of coordinators and their phone numbers have been distributed to doctors and other newborn providers throughout the State. Both the Department and the MCOs are currently tracking the volume and types of calls being received by this new staff. Additional efforts are currently underway to explain the availability of the Newborn Care Coordinators to providers throughout the State. After 6 months, the Department should evaluate this initiative to determine if it is meeting its performance objectives, including but not limited to: expediting eligibility; facilitating PCP selection; coordinating and authorizing in-network care; coordinating with ancillary provider networks; and facilitating the resolution of claims;

- The Department should continue to track newborn issues raised on the HealthChoice Enrollee Action Line;

- The Department should periodically monitor how quickly hospitals submit information on newborn's births to the Department. Hospitals that do not submit the forms in an expeditious manner should be required to submit corrective action plans. The Department should give hospitals, and other appropriate stakeholders, a new flyer to be given to new moms prior to leaving the hospital reinforcing that the newborn has coverage from birth and giving the mother important information and phone numbers to call if she needs assistance;

- The Department should periodically audit through its already established quality assurance audit how quickly MCOs issue MCO cards to newborns. If there is a delay in issuing these cards, MCOs should submit corrective action plans; and,

- The Local Health Departments and MCOs should continue to educate pregnant women regarding the importance of selecting a doctor for the newborn during pregnancy and the enrollment process that assigns the newborn to his or her mother's MCO.

Reducing Unnecessary Administrative Burdens Associated with Quality Assurance Activities

During the early years of the Program, the Department and its contractors relied almost exclusively on chart reviews to determine if high quality health care services were being delivered by MCOs. Pulling charts is an administrative burden for providers. However, it was necessary because the Department did not have the appropriate administrative data (encounter data and HEDIS data) to use to see if adequate care was being delivered. At this point, the Department has other tools to assist in monitoring quality of care.

➢ **Recommendation**

The Department should develop a quality assurance process that relies more on administrative data rather than chart reviews. The exception to this recommendation should be chart reviews to monitor the provision of high quality, well-child care (since three quarters of the population served under HealthChoice are children) and focused reviews for certain special populations. In addition, administrative data collected by the Department will include audited chart reviews conducted by the MCOs and validated by the External Quality Review Organization to meet HEDIS requirements.

Streamlining Credentialing Processes

Each MCO has established procedures and protocols for credentialing providers to participate in its network. These separate procedures and protocols make it difficult for providers that want to participate in multiple MCOs.

➢ **Recommendation**

The Department should establish an MCO and provider workgroup to determine how to streamline and potentially standardize or centralize the MCO provider credentialing process.

Future Provider Communication Model

During the initial years of the HealthChoice Program, it has become clear that providers want more input into and information about the HealthChoice Program. It also has become increasingly clear that current communication methodologies such as program transmittals, provider handbooks and even the internet, are insufficient.

➢ **Recommendations**

- The Department should work collaboratively with the MCOs to develop a HealthChoice provider manual. This manual should be distributed to all HealthChoice providers in writing and should also be placed on the web. It should be updated as program policy and procedures change. While this manual will consolidate most of the Department's and MCOs' communications to providers, individual MCOs may provide additional information to providers concerning such issues as provider billing procedures;

- Provider transmittals for the HealthChoice program should be placed on the web; and,

- The Department, in collaboration with MCOs and provider organizations such as the Maryland Chapter of the American Academy of Pediatrics, the Maryland Hospital Association, and the Medical and Chirurgical Faculty, should convene regional meetings on a periodic basis to relay updated program information to providers and their office managers. These meetings will also provide an avenue for the Department to receive providers' and office managers' input on issues. MCO staff should be available at these meetings to address issues and concerns.

QUALITY OF CARE AND STRATEGIES TO IMPROVE PROGRAM PERFORMANCE

In order to make sure that HealthChoice enrollees receive accessible and quality health services, the Department has established a number of on-going monitoring efforts, including:

- Annual quality of care audit
- Prompt pay reviews
- MCO grievance and appeal systems review
- Analysis of results of MCO operations (encounter date, HEDIS, DUR, etc)
- Review of MCO financial utilization and management (HFMR)
- Review of MCO financial stability (MIA reviews)

Although the Department has been monitoring many important aspects of MCO performance, there has been no centralized or coordinated approach to assessing and improving overall MCO performance. The Department is also concerned about the amount of administrative burden placed on the MCOs and providers in order to comply with all of these efforts.

In recognition of the need for a more defined and coordinated assessment of MCO performance, a need to streamline and reduce the administrative burden placed on MCOs and direct service providers by the Department's numerous monitoring efforts, and the need for a more flexible approach in order to meet the new federal requirements as a result of the Balanced Budget Act of 1997, the Department has been developing a Value Based Purchasing Strategy to be implemented beginning in calendar year 2002.

Value Based Purchasing is an approach to health benefits purchasing that seeks to reward contractors based on their performance on a comprehensive range of dimensions. These dimensions are defined as administration, cost, access and quality of care, and member satisfaction. Measured together, MCO performance in these dimensions defines "value". Taking the approach of monitoring through a defined set of comprehensive performance measures will streamline and consolidate HealthChoice monitoring efforts.

- **Recommendations**

  The Department, in collaboration with stakeholders, should:

  - Define the set of performance measures that represent key indicators of success in each major dimension of MCO performance;

- Develop targets for each measure based on existing data, such as national benchmarks, established baselines, or an accepted methodology based on self-improvement programs such as the federal Quality Improvement System for Managed Care (QISMC); and,

- Create a system of financial incentives and disincentives to encourage MCOs to improve performance.

PROGRAM IMPROVEMENTS FOR CONSUMERS

Based on the evaluation findings, a number of recommendations are being made to improve consumer access to care under HealthChoice:

Auto-Assigned Enrollees' Right to Change MCOs

In numerous public forums, providers, local health departments, enrollees and advocates have stated publicly that the program has disrupted the enrollee's medical home. This is mostly related to the enrollee not making a choice during the initial enrollment period. Although 80 percent of HealthChoice enrollees choose an MCO, the remaining 20 percent are auto-assigned. Currently, auto-assigned patients can change to follow their historic provider, but only if they call within 60 days of the auto-assignment.

MCOs support an annual lock-in period because they have to spend resources to outreach to enrollees; if an enrollee leaves in less than a year, the resources invested may yield little benefit to that MCO. One year is also the standard in the private managed care market place.

- **Recommendation**

  The Department recommends that any new enrollee who has been auto-assigned to an MCO be allowed to change MCOs once at any time during the first year (not just within 60 days of the auto-assignment), in addition to his or her annual right to change, and the right-to-change for cause. The one exception should be enrollees in the middle of a hospital stay. These enrollees should wait until discharge in order to change MCOs.

Case Management

When the HealthChoice Program was developed, high expectations were established for the level of case management services to be delivered to special populations. It was assumed that case management would save money in the long-term and that MCOs would automatically provide the service even though no additional money (with the exception of funding for case management services to individuals with HIV/AIDS) was included in the rates. Numerous populations were targeted for case management, including:

- Individuals with HIV/AIDS
- Individuals with physical disabilities
- Individuals with developmental disabilities
- Pregnant and postpartum women
- Individuals in need of substance abuse treatment
- Children with special health care needs

- Individuals who are homeless.

According to the HealthChoice regulations, special populations are to receive necessary services through MCO provider networks that include primary care providers and all necessary specialty providers. Under this model, except in the case of individuals with HIV/AIDS (where case management is to be universally offered), it is assumed that the enrollee's PCP will take the lead in determining whether specialty care is necessary and seek help from MCO case managers to coordinate these specialty referrals when necessary and appropriate. Case managers within the MCO are to work with enrollees and their PCPs and specialists to develop a case management plan and make sure needed services are delivered in a timely manner.

Under the regulations, if an MCO (through its providers or case managers) works with a member of the above mentioned special populations and is unable to get the member to comply with the care plan, the MCO can seek assistance from grant-funded local health department staff. The LHD staff will help locate and attempt to get the individual back into care.

During the evaluation, the Department conducted numerous consumer forums. In the course of these forums, it became clear that many consumers were confused about how to appropriately use the health care system. In addition, it became clear that most consumers did not know if they had received services from MCO case managers or that case management services were available. Although consumers did not complain about the lack of case management or request access to case management, other stakeholders such as advocates and providers have expressed concern about the lack of such services.

In follow up to these meetings, the Department held site visits at MCOs to meet with case management staff to determine the source of the confusion. These site visits included the opportunity to sit with individual case managers and watch them interact with clients. During these meetings, it became clear that MCOs are providing case management to high-risk HealthChoice enrollees. In particular, most MCOs have case management programs for pregnant women, newborns, and individuals with conditions that can be improved through disease management protocols (such as children with asthma and sickle cell anemia and adults with diabetes and heart disease).

In addition, MCOs have case managers that work with individuals who have high medical costs or who utilize the health care system inappropriately (such as going to emergency rooms for primary care). Most of these case management interactions are via telephone, although MCOs did have outreach staff go to the patient's home when necessary. MCO staff also explained how they utilized local health department staff for non-compliant patients and expressed concern over the HealthChoice policy which requires them to continue to serve patients who refuse case management while continuing to use the health system inappropriately.

The Department has been trying to determine possible reasons for the disconnect between the case management services they witnessed being provided and hearing enrollees state that they did not have a case manager within their MCO. It could be that the:

- Consumer forums did not include individuals who had received case management services (only high-risk patients receive active case management and this population may have been less likely to attend a consumer forum); and,

- Consumers do not know what case managers do and therefore do not recognize that they have received such services (e.g., - case managers in MCOs often explain to consumers that they are trying to help the doctor make sure that they get necessary health services and therefore consumers do not know they are MCO staff).

High-quality case management is expensive, resulting in the need to utilize case management resources in the most efficient manner. When the HealthChoice program was implemented, no additional funding was added beyond the grants given to local health departments for care coordination for non-compliant populations and the direct reimbursement for HIV/AIDS case management that was placed in the MCO capitation rates.

- **Recommendations**

  A case management workgroup composed primarily of LHD and MCO case management staff should be formed to make recommendations regarding:

  - Whether the HealthChoice regulations identify the most appropriate special populations;

  - The actual scope of case management within the MCOs;

  - The difference between the case management functions that are the responsibility of the MCOs and those that are the responsibility of the Local Health Departments;

  - The best methods for identifying populations in need of case management services and educating providers and consumers;

  - Best practices within MCOs in the area of disease management (a systematic program to improve the health status of members with a specific chronic condition through member education and empowerment, collaboration with treating physicians and other health care providers, and coordination with community based organizations and other available resources);

- Protocols and procedures to ensure that MCO case management staff, local health department administrative care coordinators, and other targeted case management staff do not waste scarce resources by duplicating efforts; and,

- The feasibility of utilizing the local health department Administrative Care Coordinators/Ombudsman grants to provide intensive case management services for certain enrollees who require more intensive assistance in order to comply with treatment.

Foster Care

The evaluation data indicated that foster care children received fewer well-child and ambulatory services in MCOs than they had in the fee-for-service system prior to HealthChoice. This information did not take into account the large number of services reimbursed through Medicaid fee-for-service that foster care children receive prior to entry into an MCO. State rules require foster care children to receive comprehensive physicals shortly after entry into foster care. Since foster care workers are required by the Department of Human Resources to coordinate MCO placement with the child's foster care parent, HealthChoice regulations allow children in State-supervised care to have 60 days (instead of 30 days) to choose an MCO. Therefore, many of the foster care physicals are completed prior to entry into HealthChoice and are not recorded in the MCO encounter data.

Even though the data on foster care children may not be complete, stakeholders agree that these children represent one of the most vulnerable populations in HealthChoice. Therefore, system barriers to assuring that these children receive high-quality comprehensive health care services should be addressed through the following strategies.

➢ Recommendations

- An expert panel (which includes representatives from the Department of Human Resources, the Local Departments of Social Services (DSS), the Department of Health and Mental Hygiene, foster care parents, providers, and other key stakeholders) should be convened to develop a comprehensive list of system improvements to serve the health needs of this population. For example, a mechanism should be developed to allow MCOs to have addresses of the foster care parents associated with each child.

- The process for determining eligibility for foster care children needs to be expedited, as has been proposed in Baltimore City. After testing and, if necessary, improving the new Baltimore City process, it should be implemented on a statewide basis.

- Training should be implemented for DSS foster care workers, foster care parents and resource providers for children in out-of-home placements so that they can assist in making sure children receive needed health services.

- The Department should apply for a federal waiver amendment to allow children enrolled in the State-only foster care eligibility coverage group to be enrolled in HealthChoice MCOs. This will affect approximately 600 children who are currently not eligible for HealthChoice.

Complaint and Grievance Process

HealthChoice enrollees have numerous opportunities to complain about or appeal an MCO decision to deny, reduce or terminate benefits. However, many enrollees may not fully understand how to use the MCO's internal appeal and grievance process or be aware that they do not need to exhaust the MCO appeal process before seeking help from the Department's HealthChoice Enrollee Action Line.

Enrollees currently receive information about the MCO's internal complaint and grievance process, as well as the Department's HealthChoice Enrollee Action Line, at the time of enrollment. Information about the Department's line is in a pamphlet that is widely distributed through various means including DSS, LHDs, the Enrollment Broker, and advocacy groups. The HealthChoice Enrollee Action Line's toll-free number is also on all MCO identification cards. The MCOs are required to outline their internal complaint and grievance process in their MCO Member Handbook that is sent to everyone upon entry into HealthChoice. Despite these efforts to educate enrollees, the Department continues to hear cases where HealthChoice enrollees do not know how to appeal when services have been denied, reduced, or terminated.

In April 2000, the Program's internal appeal processes were significantly revised to assure that consumers were given complete and timely information regarding their appeal rights. When an enrollee's problem is not resolved within ten days, they are informed of their right to appeal. This change resulted in a slight increase in appeals and the need to hire additional staff within the Department to handle such appeals in a timely manner.

The Department has received requests to standardize and strengthen the adverse action notices distributed by MCOs and to place a greater emphasis on monitoring whether MCOs are sending such notices to affected enrollees.

➢ Recommendations

In partnership with the Enrollment Broker, the local health departments, community-based groups, providers, and the MCOs, the Department should:

- Increase efforts to educate and inform enrollees of the HealthChoice Enrollee Action Line;

- Ensure that consumer education materials, such as member handbooks, discuss the consumer's right to receive prior written notice from the MCO of any adverse action, their right to disagree with the proposed adverse action, and their right to continue receiving ongoing disputed care until the issue is resolved through the appeal and hearing process;

- Require MCOs to provide adverse action notices and if necessary, use a sample notice developed by the Department as a template; and,

- Enhance efforts to monitor MCO compliance with the standard appeal and grievance processes.

Transportation

Maryland Medicaid provides funds to grantees (most often local health departments) and asks them to arrange or provide non-emergency transportation to and from medically necessary covered services for Medicaid enrollees (and when necessary their guardians/ attendants). Transportation is only to be provided for those enrollees who have no other means of transportation available. The FY 2001 appropriation for the Transportation grant program was $20,467,890.

It is clear from public forums that Medicaid enrollees and their providers, including MCOs, would like a more generous transportation benefit. Consumers want:

- Immediate and private versus scheduled and shared ride services;
- Transport of other family members in addition to the enrollee and attendant; and,
- Transportation provided in lieu of being required to use public transport.

Providers are concerned that the lack of convenient transportation is a reason for missed appointments and non-compliance with treatment regimens. Both consumers and providers complain about difficulty in obtaining cross-jurisdictional transportation when an MCO specialty provider is not locally available.

- **Recommendation**

  The Department should develop a proposal to:

  - Retain the scheduled transportation system, but modify it to support enrollees' visits to scheduled appointments within or outside their jurisdiction;

  - Increase program oversight of grantees through such mechanisms as consumer surveys and encourage local health departments to pool resources and efforts when providing regional transportation;

- In collaboration with stakeholders, study whether provider network issues in rural areas (particularly the Eastern Shore) as well as other areas justify a reallocation of transportation funding; and,

- Continue to use complaint hotlines to monitor that transportation services are provided appropriately.

IMPROVE THE DELIVERY OF SPECIAL SERVICES

The HealthChoice program was implemented with a number of services carved-out, meaning the MCOs are not responsible for providing or paying for these services. The major carve-out was specialty mental health services. In addition, from the beginning, the program carved out health-related special education services; long-term care services such as personal care and medical day care services, and services provided in ICF-MRs; Healthy Start case management services for pregnant women and high-risk children under two years; Developmental Disability waiver services; abortion services; and viral load testing used in treatment of HIV/AIDS. Although protease inhibitors for individuals with HIV/AIDS were initially carved out of the MCO service package, once the program had cost experience and data, these services were included back in the MCO service package. Two years after the implementation of the waiver, physical therapy, speech therapy, occupational therapy, and audiology services were carved out of the program. Since that time, no additional services have been carved out.

Carve-outs are difficult to handle in a managed care system. They are complicated to explain to providers and enrollees who expect the MCO to provide or coordinate all necessary health care services. In addition, they require providers in different systems to communicate with each other for the welfare of the patient. For example, it has been especially challenging to make sure primary care providers and specialty mental health providers know the services and prescriptions each of them are providing for an individual enrollee. This is also true for the health-related special education and the therapy services. Most primary care providers do not know the full range of services provided to children in their practice. This may have an impact on quality of care.

Carve-outs must be carefully thought out because the unintended consequences can be negative for HealthChoice enrollees. As explained in the findings section of the report, there was actually a decline in access to physical therapy and occupational therapy services after these services were carved out of the MCO service package, although there was an increase in speech therapy services. This was in part because the fee-for-service provider network for these services was weak, especially outside of the Baltimore metropolitan area. The following three areas have been recommended by certain stakeholders for possible carve-out from the HealthChoice program: dental care, substance abuse treatment, and all services delivered to pregnant women enrolled in the SOBRA expansion group.

In addition, some stakeholders have recommended that mental health services be carved back into HealthChoice. A decision to do this would have consequences for the entire specialty mental health system since that system also serves low income, uninsured and underinsured Marylanders. The specialty mental health system has undergone a separate evaluation which will be appended to this evaluation.

Dental

The HealthChoice evaluation found that access to dental services has improved since the implementation of HealthChoice. The Department continues to encourage the use of best practices learned from those MCOs that have met the established targets or have made significant improvement in utilization rates. MCO strategies for increasing access to oral health services to children include the following:

- Bonuses to oral health providers for new patients;
- Paying oral health providers to offset revenue losses for missed appointments;
- Extended school-based clinic hours;
- Expediting or eliminating authorization and referral procedures; and,
- Financial incentives, transportation, and service reminders for enrollees.[3]

Despite this fact, some stakeholders believe that progress has not been rapid enough, especially in light of the high utilization goals established by the General Assembly. This has led some stakeholders to request a carve-out of dental services. Other stakeholders have questioned whether the goals included in State law are realistic given the high-risk nature of the Medicaid population and the reluctance of dental providers to participate in any health insurance program, much less the Medicaid program. They also question whether carving out dental services would improve access. However, all agree that more children enrolled in HealthChoice should access dental services.

The potential repercussions of a dental carve-out must be considered. First, it will threaten the program's progress in the area of adult dental services, which is not provided under the Medicaid program, but all the MCOs offer as an extra benefit. When the program was implemented, the Department required MCOs to provide adult dental benefits if they wanted to receive auto-assignments under the program. Due in large part to this requirement, all MCOs are providing this extra service. If dental services were not included as part of the MCO service package, it is highly unlikely that MCOs would continue to contract with dental benefit plans on behalf of their adult members. Therefore, an important enhanced service offered under the program would in all likelihood be eliminated.

Second, the State should carefully consider whether a carve-out would result in higher dental utilization rates. In the past, in large part due to low payment rates, most dental providers in Maryland did not participate in the fee-for-service Medicaid dental program. If the State were to revert to the fee-for-service Medicaid program, it is probable that there still would be a shortage of dental providers. If the State were to contract with another dental benefit provider, significant time and effort would be spent bidding out and re-contracting for this service. In addition, this could disrupt the network of providers that service children currently enrolled in the program.

[3] "FY2001 Annual Report on Access to Dental Services in the HealthChoice Program." DHMH, October 1, 2001.

➢ **Recommendations**

- The Department should continue to increase funding for dental care to meet the utilization goals established by the legislature;

- If dental utilization does not improve significantly based on the Department's new funding for CY 2001 and subsequent years, the Department should consider alternatives for the delivery of dental services;

- The Department should develop a system to monitor and enforce MCO dental network adequacy;

- The Department should develop a dental accountability plan to enforce the legislatively mandated utilization targets. This includes monitoring MCO dental fees and actual expenditures for dental services and outreach to encourage use of dental services. The Department should implement financial sanctions for those MCOs that do not meet the required target of 40 percent for CY 2001;

- The Department should study the utilization goals established in State law to determine if they have been achieved by other state Medicaid programs and to see how they compare to other national benchmarks for dental care for low income populations. As part of this investigation, other state Medicaid agencies with higher dental utilization rates should be studied to determine the factors that contributed to their success;

- The Department should perform annual on-site visits with MCOs to review their strategies for meeting the utilization targets and to share successful strategies from other states; and,

- As recommended earlier, the Department should establish an MCO and provider workgroup to determine how to streamline and potentially standardize or centralize the MCO provider credentialing process.

Substance Abuse

In the summer of 2000, at the request of the Drug Treatment Task Force, the Department formed the Medicaid Drug Treatment Workgroup, a working committee comprised of representatives from DHMH, the MCOs and their Behavioral Health Organizations (BHOs), providers and advocates. The Workgroup's task was to answer two questions:

➢ Are the MCOs appropriately serving HealthChoice enrollees with substance abuse needs?
➢ If not, should substance abuse be carved out, and what model should be used?

After months of study, the Workgroup made two recommendations. The first was to implement a Substance Abuse Improvement Initiative (SAII) for enrollees in HealthChoice. This initiative provides enhanced access to substance abuse services for HealthChoice enrollees and opportunities for expansion of provider networks. The main components of the SAII are enrollee self-referral for substance abuse treatment to any willing treatment provider even if the provider is not part of the MCO/BHO network, prompt payment of claims, and expansion of MCO/BHO provider networks.

The second recommendation was simultaneously to design a carve-out of substance abuse services from the HealthChoice program, with the intention of implementing it if the new improvement initiative was not successful. The evaluation of the Substance Abuse Improvement Initiative is to be completed in April 2002. The Workgroup is currently in the process of designing the carve-out model and devising a timeline for implementing the carve-out, should this option be chosen.

SOBRA Pregnant Women

Prior to the implementation of the HealthChoice program, women who gained Medicaid eligibility because they were pregnant (SOBRA pregnant women) were not allowed to enroll in the voluntary HMO program. When HealthChoice was implemented, the State decided to enroll these women in MCOs as long as they enrolled in the Medicaid program before 32 weeks gestation. At the same time, the program required MCOs to allow women who enrolled during their pregnancy to continue to receive prenatal care from their prenatal care provider (even out-of-network) as long as she began to receive the care prior to enrolling in the MCO. The goal was to maintain continuity of care throughout the pregnancy. The State also acknowledged that some pregnant women are non-compliant with prenatal care requirements and therefore, even after implementation, the State continued to provide Healthy Start case management services for high-risk pregnant women through local health departments.

Some MCOs have had a problem with costs associated with SOBRA moms and their newborns. They have stated that it is difficult to have an impact on a woman's pregnancy when she enrolls late in pregnancy. It has been suggested that the State consider carving this population out of HealthChoice. This would mean that they would have to choose an MCO for the baby after birth.

The potential problems of this proposal are that the Department might have a difficult time assuring access to obstetrical care during the prenatal period. Most MCOs do pay physicians more for this care than Medicaid pays on a fee-for-service basis. In addition, babies born to SOBRA pregnant women who are not enrolled in MCOs would need to choose an MCO following the birth. Therefore, they would be in the fee-for-service Medicaid program for at least the first two months of life. They might establish relationships with providers that might then have to be changed when the mother selects the baby's MCO. In addition, they will not get assistance from MCOs in finding providers to see their babies. This is a concern because the evaluation found that newborns enrolled in

MCOs got many more ambulatory services than newborns received prior to the implementation of HealthChoice. Finally, pediatricians may be concerned about accepting Medicaid fee-for-service payment rates for newborn care. This may lead to a reduction of services for newborns of SOBRA pregnant women if these women are not allowed to enroll in an MCO.

- **Recommendation**

  The Department does not recommend a carve-out of SOBRA pregnant women at this time. However, it should reconsider whether the 32-week gestation period is the appropriate cut-off period for entry into MCOs. The Department should conduct further study of general HealthChoice prenatal care delivery, including services for SOBRA pregnant women.

STRATEGIES TO ESTABLISH A MORE STABLE MANAGED CARE SYSTEM

As described in the findings section, the Medicaid program has experienced several plan transitions and operational challenges in recent years. In order to focus on stabilizing the HealthChoice program and developing longer-term relationships with the MCOs, the recommendations below have been developed.

Future Rate-Setting Model

The HealthChoice evaluation process has examined the historical financial performance of the Program and of the MCOs over the past four years. The evaluation found that most of the MCOs were able to generate profits through 2001. The MCOs, however, have projected that future medical expenses will increase faster than the trends projected by the actuary. There also is general concern about the inadequacy of 1997 physician fee-for-service data as a component of the baseline for rate-setting.

- **Recommendation**

  Given MCO projections of rapid increases in medical expenses and issues with the current baseline for setting capitation rates, the Department should establish a new method for establishing the baseline for the rate-setting process. This model will better reflect the MCOs' costs and market trends. Operational and financial audits should be used to confirm that MCO costs are accurate and reasonable.

Two-Year Rate Setting Process

The Department's current rate-setting process is very collaborative, but labor intensive. During more than eight months of every year, the Department, MCOs, and other HealthChoice stakeholders devote a great deal of time and resources to the rate-setting process. This annual process by nature introduces volatility and instability into the Program.

- **Recommendation**

  - The rate-setting process eventually should be switched to a biennial schedule, with a trend factor applied for the second year based on a predetermined formula. This would allow the Department to better maximize its critical resources and the MCOs to engage in longer-term business planning. It would also free up more time for the Department, MCOs, and other stakeholders to work on other priorities.

- Enrollee risk adjustments would take place every year based on the latest health information, and interim adjustments would account for any fee-for-service or hospital rate increases as currently required by regulation. A two-year rate-setting process would allow the Program to work towards maintaining longer-term, more stable relationships with the MCOs.

MCO Exit Notice Requirements

Effective February 1, 2002, HealthChoice regulations will allow MCOs to terminate their contracts at any time if they provide 120 days of advance notice. There is a second provision that allows MCOs to exit the market at the start of a new rate year with only 90 days notice (by October 1) to the Department. These timeframes do not allow sufficient time for preparation of exits and transitions. In addition, there are financial costs associated with plan exits, such as the costs associated with re-enrolling individuals across the remaining MCOs. The Department typically is faced with absorbing these costs.

➢ Recommendation

- MCOs should only be allowed to exit by giving at least 180 days of advance notice between contract periods, or 90 days advance notice at the beginning of a rate year. This would guarantee longer periods of time to prepare for exits and transitions, and would enhance continuity of care.

- The Department should investigate and make recommendations regarding an equitable formula for sharing the costs of the exits with the exiting MCO.

Larger Service Areas

Currently, when MCOs have network or financial problems in certain local access areas, they are able to institute freezes on enrollment. This system tends to result in instability and service disruptions particularly in areas with higher-risk populations.

➢ Recommendation

In order to address this situation, larger service areas should be established. This would discourage plans from freezing in or withdrawing from certain local access areas based on localized medical loss ratios. Operationally, local access areas would continue to exist for enrollee PCP and MCO assignment purposes based on zip code clusters and geographical access standards. In addition, MCOs would still have to meet the time and distance standards included in the regulations for access to primary care and other services.

Federal Waiver Amendment to Allow HealthChoice to Continue in Areas Where There is Only One MCO

The current waiver requires at least two MCOs in each local access area. As plan exits have occurred over the past several years, this provision has threatened to create barriers to access in certain regions of the State where plan participation is limited. The Department believes that allowing enrollees a choice of providers within a MCO is adequate to assure choice and preferable to a fee-for-service system with no medical home or managed care infrastructure. Keeping HealthChoice in operation in areas with only one MCO improves access to services and increases program stability. This change will require reprogramming of the Medicaid Management Information System.

➢ **Recommendation**

The Department should request an amendment to the federal waiver so that HealthChoice may continue to operate in areas where there is only one MCO as long as there is an adequate provider network. This will maintain choice of provider. The Department should develop a reasonable timeline for implementation.

Cost-Containment and Reduced Administrative Burdens

The Mercer actuaries determined that per person costs for the HealthChoice population if there had been no waiver would have increased by 4.1 percent between FY 1997 and FY 1998, and by 8.3 percent between CY 2001 and CY 2002. This accelerating rate of increase accompanied by the administrative complexity of the HealthChoice Program hinders the Department's ability to effectively manage costs.

During September and October 2001, the Department met with MCOs individually to discuss their ideas on cost-containment. Opportunities for improvement that were identified include:

- Maximizing third-party recoveries;
- Reducing administrative requirements;
- Coordinating and reducing overlaps of on-site audits; and,
- Reducing ancillary costs through collective purchasing in areas such as pharmacy, lab, and radiology, as well as surgery centers.

➢ **Recommendations**

- The Department, in collaboration with the MCOs, should identify cost-containment initiatives and develop implementation plans that would begin in CY 2002; and,

- The Department should streamline regulatory reporting by MCOs by coordinating the audit requirements and compliance standards of the

Department, MIA, and HSCRC. As such, MCOs will be held accountable for providing high quality care while overall regulatory reporting requirements are reduced.

CONCLUSION

Managed care has been adopted in both the commercial insurance industry and in Medicaid programs nationwide as a means of controlling health care costs and improving quality of care through the promotion of appropriate utilization of health services. The comprehensive evaluation of Maryland's HealthChoice Medicaid managed care program has found that HealthChoice has been successful in meeting the dual goals of improving access to appropriate health care while controlling health care costs. As such, the HealthChoice program should continue as the health service delivery system for the majority of Maryland's Medicaid enrollees. Despite the successes of the program, the evaluation does identify areas for improvement within HealthChoice. Informed by the evaluation findings and input from stakeholders, the Department has outlined recommendations to improve HealthChoice. Legislation is not needed to implement any of the proposed changes. Collaboration among the Department, other state and local agencies, MCOs, providers, advocates, consumers, and other stakeholders has been and will continue to be central to the successful prioritization and implementation of the Department's recommendations.

APPENDIX 1

Legislative and Regulatory Changes In HealthChoice

In the years following its enactment of the program's enabling legislation, the Maryland General Assembly has continued to update the HealthChoice program through legislative action and oversight of the Department's regulatory functions. The following is a chronological list of program changes:

1998 Program Changes

- *MCHP.* Enabling legislation for the Maryland Children's Health Program (MCHP) authorized enrollment in HealthChoice of children under age 19 and pregnant women with income too high for Medicaid but not over 200 percent of the federal poverty line (FPL). Because this first phase of MCHP is a Medicaid expansion program, MCHP enrollees receive the same benefits provided to Medicaid-eligible children enrolled in HealthChoice.
- *Dental services.* Legislation enacted requiring a five-year Oral Health Care Program, and establishing specific utilization targets, to expand dental services under HealthChoice.
- *Substance abuse treatment.* Department promulgates regulations requiring MCOs to use standard assessment instruments (POSIT/ASI and ASAM) for comprehensive substance abuse assessments and placement appraisals. Use of standard instruments would improve the accuracy and appropriateness of enrollees' assessment results and treatment placements, and would facilitate monitoring of substance abuse identification and treatment referrals from plan to plan.
- *Therapy services carve-out.* As was noted above, regulatory changes occurred to give occupational therapy, physical therapy, speech therapy, and audiology services to limited self-referral status in July 1998, and then, as of November 1999, to carve out these services from the benefit package for which MCOs are responsible. As a result, children enrolled in HealthChoice can access these medically necessary services through any Medicaid provider, who then submits a fee-for-service claim to the Medicaid program for direct reimbursement.
- *Other changes.* Other program changes in 1998 concerned: MCO payments to FQHCs (legislation requiring the Department to enforce the FQHCs' "reasonable cost of services" rate); GME regulations (creating a mechanism outside of capitation rates for reimbursing graduate medical education costs); regulations requiring timely encounter data submission by MCOs (within 60 days of receipt from a provider); and legislation requiring MCOs to develop and submit comprehensive outreach plans for improving enrollees' access to health care services.

1999 Program Changes

- *Capitation payment rates.* In the first year, the State's implementation of the risk-adjusted payment system resulted in a higher level of payments to MCOs than originally anticipated. Therefore in FY1999 a freeze of intermin rates was coupled with a new process that was implemented for the period beginning in January 2001. Regulations effecting this change were granted emergency status by the Maryland General Assembly's Administrative, Executive, and Legislative Review (AELR) Committee, which required that a committee be established to address capitation rates issues for FY 2000. The Department shifted the program's future rate-setting schedule from a fiscal year to calendar year basis, and proposed new rates for the 14-month period beginning November 1, 1999.
- *Other changes.* The responsibility for obtaining stop-loss insurance for excess hospital inpatient costs was shifted to the MCOs, as the Department all but eliminated its role as a source from which MCOs could purchase such coverage. The Joint Chairmen's Report on the FY 2000 budget recognized the Department's efforts (including a two percent hospital rate discount for prompt payment) to encourage MCOs to provide working capital advances to hospitals, and urged the Department to continue such efforts.

2000 Program Changes

- *MCHP expansion.* The General Assembly passed legislation expanding MCHP eligibility to include children with family income up to 300 percent of the FPL and pregnant women with income up to 250 percent of the FPL. Pregnant women gaining MCHP eligibility under this legislation became eligible for enrollment in a HealthChoice MCO as part of the MCHP Medicaid expansion component. Children with family income over 200 but not more than 300 percent of the FPL became eligible for a new program component called MCHP Premium, implemented July 1, 2001. MCHP Premium enrollees are required to pay a flat rate premium, which is assessed on a per-family, not per-child, basis.

  MCHP Premium has two premium levels, based on family income. An eligible individual whose family income is above 200 but not more than 250 percent of the FPL pays an amount equal to 2 percent of the annual income of a family of two at 200 percent of the FPL; an individual with family income above 250, but not more than 300 percent of the FPL pays an amount equal to 2 percent of the annual income of a family of two at 250 percent of the FPL.

  MCHP Premium provides "private option" premium assistance to enable parents to secure private health insurance coverage for their eligible children under an employer-sponsored health benefits plan only. If qualifying employer-sponsored coverage is not available, an eligible child is enrolled in a HealthChoice MCO with access to the same benefits as Medicaid-eligible HealthChoice enrollees.

- *Other changes.* The General Assembly enacted legislation aimed at maintaining continuity of care by allowing enrollees to disenroll from their MCO if their assigned PCP leaves the MCO. Another law enacted during the 2000 legislative session expanded Maryland Insurance Administration (MIA) oversight of MCOs' downstream risk arrangements, and required MCOs to comply with National Association of Insurance Commissioners' risk-based capital standards.

2001 Program Changes

- *MCO and provider continuity.* The General Assembly addressed provider continuity again in 2001 with legislation requiring that an individual disenrolled from the program who then is re-enrolled within 120 days must be re-assigned to the same MCO and the same PCP. The legislation also requires an MCO withdrawing from the program to provide enrollees at least 30 days prior written notice. The MCO must also provide the Department with a list of reassigned enrollees and their PCPs
- *Provider directories - dissemination.* The General Assembly also passed legislation during the 2001 session requiring the Department to maintain a written directory and an electronic database, updated monthly, of all available providers participating in HealthChoice. Consistent with its pre-existing practice, the Department distributes the written version of the directory to new enrollees and on request. The Department implemented its electronic provider directory in June 2001. It allows the user to search for a PCP or other provider by name, provider type, location, or MCO. However there continue to be numerous problems with information posted on the Department's website, and the Department is actively working to clean up the information in the provider directory.
- *Newborn issues.* The Department has launched a number of new initiatives to address identified problem areas affecting newborns born to HealthChoice enrollee mothers. Each MCO was required to establish a newborn coordinator to facilitate access issues immediately following the birth, assignment of the PCP, billing issues for providers and the receipt of a MCO card for the newborn. An on-going newborn workgroup was established with MCOs, providers, advocates and the Department. [Shelby – please help here]
- *Other changes.* The 2001 General Assembly also acted: to require a study of fee-for-service rates adequacy and an annual rate-setting process to assure provider participation; to compel the submission of encounter data by MCOs that are leaving the program (to avoid negative financial impact on remaining MCOs); and requiring that fines collected from MCOs be deposited in a non-lapsing fund to be used as financial incentives to reward MCOs that meet or exceed performance targets.

Federal Changes

In addition to the legislative and regulatory changes at the State level, there have been changes at the federal level which affect HealthChoice. Welfare reform resulted in a decline in the number of adults served by HealthChoice.

APPENDIX 2: COMPARISONS TO OTHER STATES

Overview

An understanding of how well enrollees fare in Maryland in terms of the number and type of services delivered compared to Medicaid/SCHIP recipients in other states is important to an analysis of the success of HealthChoice. It is difficult, however, to make direct comparisons between Medicaid programs in different states. The relative independence of each state in designing and operating its Medicaid program adds to the inherent differences in the demographics and health status of the Medicaid population.

Each state's Medicaid program is unique, as is the extent to and manner in which managed care has been incorporated into the program. Some states have a capitated system throughout the state, others have a primary care case management program, and still others mix the two to varying degrees. There is also wide variability across states and within some states regarding whether managed care enrollment is voluntary or mandatory.

State Children's Health Insurance Program (SCHIP). An additional variable between states is a result of the federal SCHIP program, which affords states a great deal of flexibility in their use of available funds. The SCHIP population is necessarily different from the Medicaid population, at least with respect to participants' average income level. Eligibility rules under SCHIP vary from state to state. A state may elect to serve children in families with income up to 150 percent of the Federal Poverty Line (FPL), but some state programs include children in households with income of up to 300 percent of the FPL. Another variable, whether or not a state includes the SCHIP-eligible population in its Medicaid managed care program, can also make it difficult to compare the Medicaid managed care programs of different states.

Data Sources

In addition to programmatic differences, differences in data collection methodology pose a significant barrier to meaningful comparisons among states.

Encounter Data. The majority of utilization measures for the HealthChoice program are based on encounter data, a type of administrative data. As noted earlier, Maryland has worked hard to develop reliable encounter data, and Maryland's encounter data is now recognized as being among the best in the country.[1]

Many states, unable to use their own encounter data, rely on other types of data for information about their programs. These data sources include claims, chart

[1] Rate-setting Forum 1.

reviews, a blend of claims or encounter data and chart reviews, and surveys. Survey data is a common method of program evaluation. While surveys provide a rich source of certain types of information, comparing administrative data to survey data can be problematic. Extensive studies have shown that very different results are obtained when using administrative data than when using survey data to measure health care utilization. For the measures and the population studied here, surveys are likely to over-report service utilization.[2]

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Data. Another source of data for states derives from the Form HCFA-416. The Centers for Medicare and Medicaid Services (formerly HCFA) require states to submit Form HCFA-416, which contains basic information regarding Medicaid children's participation in the EPSDT Program, in order to measure the Program's performance annually. HCFA-416 data is reported differently across the states and from year to year, which limits its usefulness as a source of data for comparisons between states or across time. For example, how children participating in the program are counted as defined by HCFA has changed year to year.

Specific practices with respect to reporting EPSDT data using HCFA-416 data in Maryland make the use of this data at this time particularly problematic. Prior to the implementation of the HealthChoice program in 1997, approximately 80,000 children were voluntarily enrolled in HMOs. The HMOs were not required to report encounter data. Form HCFA-416 instructions allowed the EPSDT Program to assume that each HMO enrolled child received at least one EPSDT screening service per year. This may have resulted in a higher participation rate than what may actually have occurred. We have not used HCFA-416 as a source of data in this review because of its known inconsistencies year to year in Maryland. The encounter data analysis presented in the comprehensive review uses a consistent methodology before and after HealthChoice and represents information on actual utilization, rather than making assumptions about utilization.

HEDIS Data. The Health Plan Employer Data and Information Set (HEDIS) —is a tool developed by the National Committee for Quality Assurance to collect data about the performance of health plans. HEDIS requires health plans to measure and collect data in a standardized way so that purchasers and consumers have the information they need to make reliable and valid comparisons between plans. Using HEDIS, health plans can report specific measures using a blend of data sources (administrative data, claims data, audited medical records and other sources). This type of blended data analysis allows plans to fill in the gaps that may exist when using only administrative or encounter data. Therefore, it is likely

[2] See, for example, S. Newell, et al., "Accuracy of patients' recall of Pap and cholesterol screening," Am J Public Health (September 2000): 1431-5; J.A. Bowman, R. Sanson-Fisher, and S. Redman, "The accuracy of self-reported Pap smear utilization," Soc Sci Med (April 1997): 969-76.

that the blended data analysis will result in higher numbers than an analysis using only encounter data.

HEDIS can be used to evaluate Medicaid managed care plans, but differences in state programs, such as the population served and enrollment procedures make the use of HEDIS as a benchmark to evaluate the service provided to Medicaid enrollees problematic.[3] In 1998 a demonstration project was begun to create a national Medicaid HEDIS database using 1997 as the base year. By November 1998, when data collection for the Medicaid HEDIS pilot year ended, 18 states had pledged participation. Concerns about administrative burdens (on states and on plans) and a reluctance to change existing reporting requirements may have impeded states' willingness to commit to the entire Medicaid HEDIS measurement set.[4]

Currently in Maryland, the Department collects and reviews HEDIS data. The MCOs and the Department continue to work toward a comprehensive data collection and reporting strategy which will meet federal and state requirements, minimize duplication of effort, and produce data that are meaningful and useful. HEDIS is a critical component of this strategy. An auditor has been hired this year and is currently working with the MCOs to establish operating and data collection procedures. At this point, the Department is completing its first audit of MCO HEDIS Reports. Audited HEDIS data for Maryland's Medicaid managed care program were therefore not available at the time of the evaluation.

Despite the barriers to and limitations of data comparisons among states with the data sources currently available, we gathered data from sources that were most comparable to our data for the following measures: ambulatory care visits, well child visits, number of ER visits, Pap test rate, and dental services. The results are displayed and analyzed below.

Findings – Ambulatory Visits

The comparisons for this measure are presented in two parts, as some states report number of visits per enrollee per year, while others report the percent of the eligible population receiving service.

Visits Per Person Per Year.

- *Maryland.* As is discussed in the Utilization Analysis section of this report, the number of visits per person per year in HealthChoice declined from 4.3 in 1997 to 3.67 in 2000. Maryland data includes any time a recipient saw a

[3] L. Partridge and C.I. Szlyk, National Medicaid HEDIS Database/Benchmark Project, Pilot-Year Experience and Benchmark Results, February, 2000, p.2.

[4] See National Medicaid HEDIS Database/Benchmark Project, note 3 above, page 5.

provider in an ambulatory setting, but it is an unduplicated count per enrollee per day, and both male and female adults are included.

- Wisconsin used data from a variety of sources, including HEDIS measures, collected from Medicaid HMOs in 1999 to calculate a rate of 3.00 visits per eligible year.[5] The data reported for Wisconsin reflects only primary care visits for HMO enrollees, whereas the analysis of Maryland data reflects all physician visits.

- Ohio reported 2.59 visits per person per year, which was calculated using statewide encounter data.[6] This number includes primary care and specialist visits. By the end of 1999, the year this data was collected in Ohio, there were only seven counties in Ohio in which managed care enrollment was mandatory for Medicaid recipients. Enrollment was voluntary in nine counties.

- Tennessee used encounter data to calculate the rate of 7.6 visits.[7] This rate includes visits to primary care providers and specialists, but the report does not specify that this rate represents an unduplicated count per enrollee per day. Additionally, Tennessee's results were calculated for female enrollees only. Both of these factors are likely to inflate the reported rate.

Percentage of Eligible Population Receiving Service.

- *Maryland.* In 2000, 56.8 percent of HealthChoice-enrolled adults ages 21-39 received an ambulatory care visit, and 65.2 percent of adults ages 40-64 received an ambulatory care visit.

- *Colorado.* reported between 44 and 45 percent of all adults (20-64) receiving an ambulatory visit according to 1998 HEDIS data.[8]

- Arizona. Based on calculations using encounter data, Arizona reported the highest percentage of adults receiving an ambulatory visit - 78.7 percent.[9]

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[5] Wisconsin Medicaid HMO Comparison Report: 1998/1999, Wisconsin Department of Health and Family Services, page 36.

[6] Ohio Medicaid Managed Care Plan 1999 Statewide Progress Report (dated October 3, 2000).
[7] TennCare Report on Women's Health Issues (December, 2000), pages 65, 69.

[8] Health Plan Employer Data and Information Set (HEDIS): A Comprehensive Performance Report of Colorado Medicaid Health Plans, December 1999, page 7 (Summary of HEDIS Measure Results).

[9] Health Plan Performance Measures, Adult and Adolescent Indicators: Results and Analysis. Report produced by the Arizona Health Care Cost Containment System (AHCCCS), Office of Medical Management, using data from October 1, 1998 – September 30, 1999, page 47.

The measure of ambulatory care visits for adults could be sensitive to differences in eligibility criteria. States have flexibility in determining which adults will receive coverage in their program. A more restrictive set of eligibility criteria is likely to lead to a sicker population (indicated by a higher proportion of SSI-eligible enrollees), and hence a higher rate of services utilization.

FINDINGS - WELLCHILD VISITS

Maryland. Maryland 's 2000 rate - 61.5 percent of enrollees ages 1-2 receiving a well child visit - is an improvement over the 1997 rate of 55.6 percent. For children ages 3-5, Maryland's rate improved from 37.8 percent in 1997 to 42.6 percent in 2000. For children ages 6-9 and 10-14, rates increased slightly to 29.2 percent and 28.3 percent, respectively, in 2000. The rate for adolescents ages 15-18 improved slightly to 21.5 percent receiving a well care visit.

Other States.

- *Wisconsin* (excluding the Milwaukee area) reports that 84.2 percent of children ages 0-5 received a well child visit, while 28.2 percent of children ages 6-14 and 19.4 percent of adolescents ages 15-20 received a visit.[10] Data for this measure was collected from a variety of sources, including HEDIS measures, from Medicaid HMOs in 1999. In the Milwaukee area, the reported utilization rate for well child visits was 69.3 percent for children ages 0-5, 35.2 for children ages 6-14, and 22.7 for ages 15-20.

- *Massachusetts* HEDIS data for 1998 was used to calculate rates of 73.1 percent for children ages 3-6, 78.2 percent for children ages 8-9, 57.5 percent for children ages 10-11, and 45.4 percent for adolescents ages 12-21.[11]

- *Colorado.* Colorado's Medicaid program reports that for children ages 3-6, 35.36 percent received at least one well child visit with a primary care provider during 1997.[12] Colorado reported that 6.93 percent of Medicaid members aged 12-21 years received at least one comprehensive well care visit with a primary care provider during the 1997 reporting year. A closer examination of individual plan results reveals that this average was not weighted for plan enrollment, and is heavily influenced by the low percentages reported for Colorado's Primary Care Physician Program and the Unassigned Fee-For-Service programs.[13]

[10] See note 5 above, pages 24-25.

[11] MassHealth Managed Care HEDIS 1999 Report (Reporting Year 1998), page 16.

[12] See note 8 above at page 35 (Table 13).

[13] See note 8 above at page 37 (Table 14).

- *Minnesota*. Minnesota Medicaid officials first attempted to calculate a utilization rate for well child visits using encounter data. The result (27 percent of enrolled children overall) was thought to be too low to be accurate, so they proceeded with chart abstraction. The results were that 66.3 percent of children ages 1-2, 55.7 percent of children ages 2-6, 37.2 percent of children ages 6-15, and 40.2 percent of adolescents ages 15-21 received a well child visit in 1998.[14]

- Tennessee. Tennessee's reported results of 84 percent for children less than 5 years old, 67 percent for children ages 5-12, and 57 percent for adolescents ages 13-17 were calculated from responses to a telephone survey of a random sample of enrollees under age 22, stratified by age and plan.[15] As noted above, comparisons between survey data and administrative data are notoriously unreliable.[16] For a utilization measure taken in this population, survey data is likely to over-estimate utilization when compared to claims data or chart reviews.[17]

- Arizona. Arizona's reported rate of 44.5 percent for children ages 3-6 reflects children who were continuously enrolled (with no more than one break in enrollment of no more than 31 days) with one managed care plan during the reporting year of October 1, 1999 through September 30, 2000 and who received at least one well child visit during the reporting year.[18] Thirty-one percent of enrolled adolescents ages 11-15 received a well care visit, and 18.4 percent of adolescents ages 16-20 received a well care visit during the most recent year.[19] These notes are based on HEDIS

[14] 1999 External Quality Review Study Child and Teen Checkups Participation Rate Review Final Report: August 2000. "Using administrative (encounter) data for 1998, DHS calculated the C&TC participation rate to be 27 percent, which is below the goal set by HCFA and below the national average." (Executive Summary, p.1).

[15] Early, Periodic, Screening, Diagnosis and Testing (EPSDT): Knowledge, Attitudes and Health Care Utilization of TennCare Enrollees, produced by the Division of Health Care Services Evaluation, Bureau of Health Assessment and Evaluation, Metropolitan Health Department of Nashville and Davidson County, page 10.

[16] See note 2 above.

[17] See, for example, P.G. McGovern, N. Lurie, K.L. Margolis, and J.S. Slater, "Accuracy of self-report of mammography and Pap smear in a low-income urban population," American Journal of Preventive Medicine (April 1998): 201-8; E.D. Paskett et al., "Validation of self-reported breast and cervical cancer screening tests among low-income minority women," Cancer Epidemiology Biomarkers and Prevention (September 1996): 721-6.

[18] Arizona Health Care Cost Containment System Pediatric Performance Indicators Results and Analysis for Reporting Period October 1, 1999 –– September 30, 2000, p. 14.

[19] See note 9 above.

data for a selected group of recipients who were continuously enrolled during the reporting year.[20]

- *Medicaid HEDIS*. The National Medicaid HEDIS Database/Benchmark Project has published results for 1997 (pilot year) and 1998.[21] For children ages 3-6, they report a benchmark (which is the mean of all plans reporting) of 60 percent receiving one or more well care visits with a primary care provider in 1997 and 51 percent in 1998. Adolescent well care was not a benchmark measure in 1997. For 1998, 27 percent of member ages 12-21 had at least one comprehensive well care visit with a primary care or OB/GYN practitioner during the reporting year.

Data is particularly difficult to compare for the well child measure due to the varying age breaks used from state to state, and the significant impact that this consistency can have on the data. For instance, Wisconsin and Tennessee both report a utilization percentage of children ages 0-5 receiving a well child visit. Their results, 69.3 percent for Milwaukee, 84.2 percent for the rest of the state of Wisconsin, and 84 percent for Tennessee, are difficult to compare to the other states because they combine the under two age group with the next oldest age group. The likelihood of a child receiving a well child visit correlates the age of the child, and EPSDT standards vary according to age. The greatest difference in the recommended number of visits is for children 15 months and younger versus those older than 15 months. Thus, including enrollees younger than 15 months old with other enrollees is likely to artificially inflate the overall rate.

Maryland's rate for children receiving a well child visit for ages 3-5 is lower than most of the states reported here, although it is higher than Colorado and only a few percentage points below the latest Medicaid HEDIS benchmark.

EMERGENCY ROOM VISITS

Maryland. HealthChoice program reports 301 emergency room visits that do not result in hospital admission per 1000 member years.

Other States.

- *Colorado.* Colorado's rate of 456 visits per 1000 member years was calculated using HEDIS data for the reporting year 1997.[22] This measure, like Maryland's, includes only visits that did not result in hospital admission. The reported rate reflects the Colorado Medicaid average but was not weighted according to plan enrollment.

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[20] See note 18 at page i.

[21] See note 3 above. For 1998, see National Medicaid HEDIS Database/Benchmark Project: Benchmarks for Measurement Year 1998 at http://medicaid.aphsa.org/research%1998benchmarks.htm.

[22] See note 8 above at 40 (Table 16).

- *Wisconsin.* Wisconsin reported 710 visits per 1000 member years, based on 1999 data from Medicaid HMOs.[23]
- *New York.* New York reported 357 visits per 1000 member years for the Medicaid managed care population.[24]

- *Tennessee. Tennessee* reported 509 visits per 1000 member years for TennCare Medicaid Managed Care in 1996.[25]

National Data.

- *National Hospital Ambulatory Medical Care Survey (NAMCS)* NHAMCS reports 378 emergency room visits per 1000 member years. This estimate is based on a sample, and includes visits (approximately 12.9 percent of the total) that resulted in a hospital admission.[26] This is an estimate for the entire population, not just Medicaid recipients.

- Medicaid HEDIS benchmarks were 456 visits per 1000 member years in 1997 and 504 visits per 1000 member years in 1998.[27]

When compared to five other states, an overall national survey, and the Medicaid HEDIS benchmarks for two years, Maryland's 301 ER visits per 1000 member years is the lowest.

DENTAL SERVICES

Maryland. In 2000, 29.3 percent of the population ages 4-20 received a dental visit, a significant increase over the 19.9 percent receiving service in 1997.

- Wisconsin. Wisconsin reported 22.1 percent receiving service, which includes all dental visits for all ages, but only in Milwaukee County.

- Oregon. Oregon reported a rate of 65.3 percent for children ages 1-17.[28] This rate is based on data obtained through a telephone survey.

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[23] See note 5 above at 34 (Graph 2.12).

[24] New York State Report 1997 Medicaid Managed Care (New York State Department of Health SPARCS data for upstate and the City).

[25] TennCare 1996 Medicaid payer data.

[26] L.F. McCaig and C.W. Burt , "National Hospital Ambulatory Medical Care Survey: 1999 Emergency Department Summary. Advance data from vital and health statistics; number 320," Hyattsville, Maryland: National Center for Health Statistics. 2001.

[27] See Medicaid HEDIS Benchmarks, notes 3 and 21 above.

- Tennessee. Tennessee's results are close behind Oregon's, reporting 65 percent for ages 5-12 and 59 percent for ages 13-17.[29] This data was also obtained through a telephone survey.

- California. In California 36 percent of children are estimated to have received a dental service in 1999, based on a 10 percent sample of enrollees in a combination fee for service and managed care system in 1999.[30]

- Connecticut. Connecticut's Medicaid program reported 34 percent of children received dental services within the managed care program.[31]

- Massachusetts. Massachusetts reported that in 1998 42 percent of all MassHealth members (both children and adults) used any dental service.[32] This information was reported by a Special Legislative Commission on Oral Health in February of 2000. The Commission found that data was not available to comprehensively evaluate the oral health status of its residents, so the Commission used information available from community studies, survey results from the Behavioral Risk Factor Surveillance System, cancer mortality statistics, and national data.[33]

- Arizona. In Arizona 43.5 percent of children in the Medicaid managed care program received any dental service during the period October of 1999 through September of 2000.[34]

The results for both Oregon and Tennessee, the two states reporting the highest percent of the population receiving a dental service, were obtained through a telephone survey. As noted above, telephone survey data has been shown to be unreliable when compared to administrative data and, for this population and

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[28] J.B. Mitchell, S.G. Haber, and G. Khatutsky, "The Impact of the Oregon Health Plan on Beneficiary Satisfaction and Access to Care," (Health Economics Research, Inc. October 12, 1999), page 26.

[29] See note 15 above.

[30] R. Almeida, I. Hill, and G. Kenney, Does SCHIP Spell Better Dental Care Access for Children? An Early Look at New Initiatives. The Urban Institute, July 2001.

[31] See note 29 above. For reporting year October, 1998 – September, 1999.

[32] "The Oral Health Crisis in Massachusetts: Report of the Special Legislative Commission on Oral Health, (February 2000), page iii.

[33] See note 32 above, p. 3.

[34] See note 18 above, page 52.

level of utilization, survey data tends to overestimate utilization when compared to administrative data.[35]

PAP TESTS

- In Maryland, 16.1 percent of individuals 15-20 years old and 17.5 percent of adults 21-64 years old with 12 months of continuous enrollment received a Pap test during the reporting year. Maryland's encounter data is not complete enough to conduct comparable utilization analysis for years prior to 2000. The percentages reported for one year in Maryland can be multiplied by three to get a rough estimate of the percent of the population that would have received a Pap test during three years. This yields 48.1 percent of women ages 15-20 and 52.4 percent of women ages 21-64 estimated to have received a Pap test during a three-year period if the data were available.

- The rate reported for Massachusetts is 79 percent.[36] More than 75 percent of the MassHealth managed care members were enrolled in the primary care case management plan as of December 1999. The percent receiving service was calculated by counting the number of women ages 21-64 that received a Pap test during the 1999 reporting year or the two previous years.

- Similarly, Arizona reported that 57.2 percent of the eligible population received one or more Pap tests in a three-year period.[37]

- In Wisconsin, a higher percentage of Medicaid HMO enrollees living in the rest of the state (41.1 percent of 15-20 year-olds, 46.0 percent of those age 21 and older) received a Pap test than of those living in Milwaukee County (36.1 percent of 15-20 year-olds, 37.4 percent of those 21 and older).[38]

- Tennessee reports 117.84 Pap tests per 1000 female member years (for women ages 21-64).[39] Converting this measure to 11.78 tests per 100 female member years renders it easier to compare to other states' reports. This measure, one of the few reported by Tennessee using encounter data, is low compared to other states.

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[35] See note 2 above.

[36] HEDIS 2000 Report for MassHealth Managed Care (data for calendar year 1999).

[37] See note 9 above, page 15.

[38] See note 5 above, page 32.

[39] TennCare Report on Women's Health Issues (December 2000), page 83.

- Medicaid HEDIS benchmarks: The percentage of women ages 21-64 who received one or more Pap tests during the reporting year or the two years prior to the reporting year was 63 percent for 1997 and 60 percent for 1998.[40]

CONCLUSION

The diversity of program design, population demographics, data sources, and calculation methods make it impossible to definitively compare the performance of Maryland's HealthChoice program with any other state's publicly-funded managed care program in order to draw conclusions about the relative value of the program. While we have tried to present the most comparable measures available, this is by no means an exhaustive study. The more important comparison, as has been the focus of this evaluation, is to measure progress over time, because we know how reliable our encounter data is and we can be sure that we are measuring the same things the same way year to year.

Despite the barriers and limitations to meaningful comparisons between states, conclusions can be drawn from the above analysis. First, very few states have yet been able, as Maryland has, to do a comprehensive and reliable analysis of service utilization using encounter data. Second, states report a broad range of values for these five measures.

[40] See Medicaid HEDIS Benchmarks, notes 3 and 21 above.