

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.