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

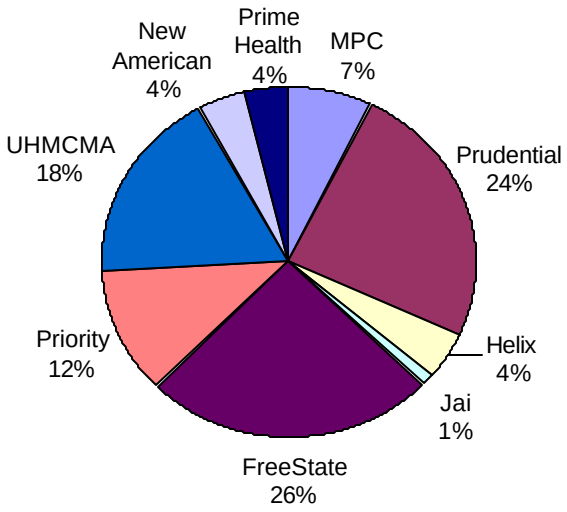
Before awarding a contract to participate in the HealthChoice program, the Department requires each MCO applicant to establish that it is qualified and capable of delivering the full HealthChoice MCO benefit package to its enrollees consistent with program standards. The Department verifies each successful 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

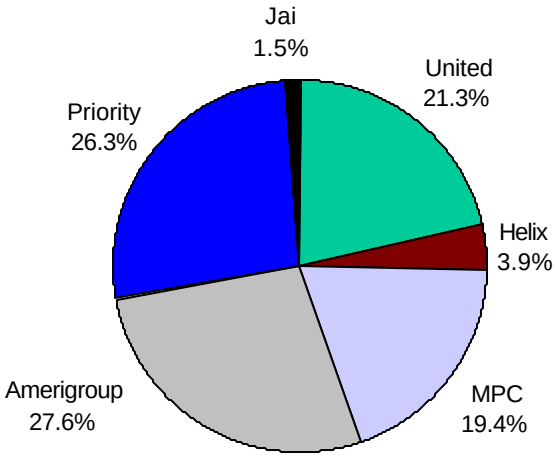
Consistent with its enabling statute and program regulations, the HealthChoice program contracts with "all willing and qualified" MCOs in a non-competitive selection process. An applicant still must demonstrate that it meets solvency, access, quality, and data requirements, and has sufficient provider 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

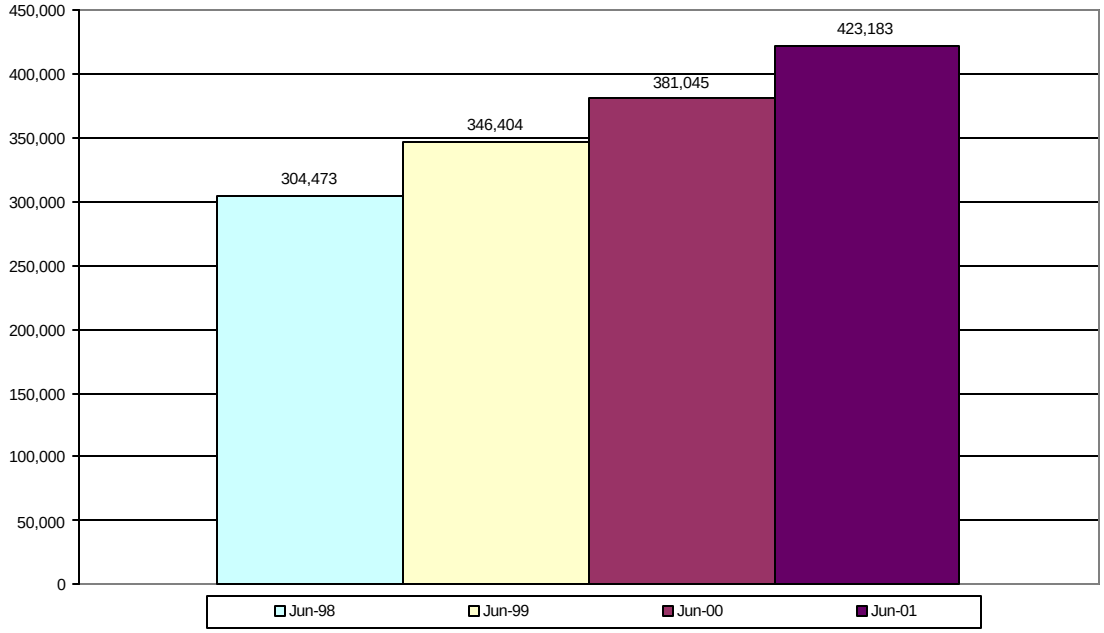
It has always been expected that, consistent with other states' experiences, some HealthChoice MCOs would be more successful than others over time, and that these would be the plans that would continue to participate. In fact, compared to the experience of Medicaid managed care programs in other states, 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

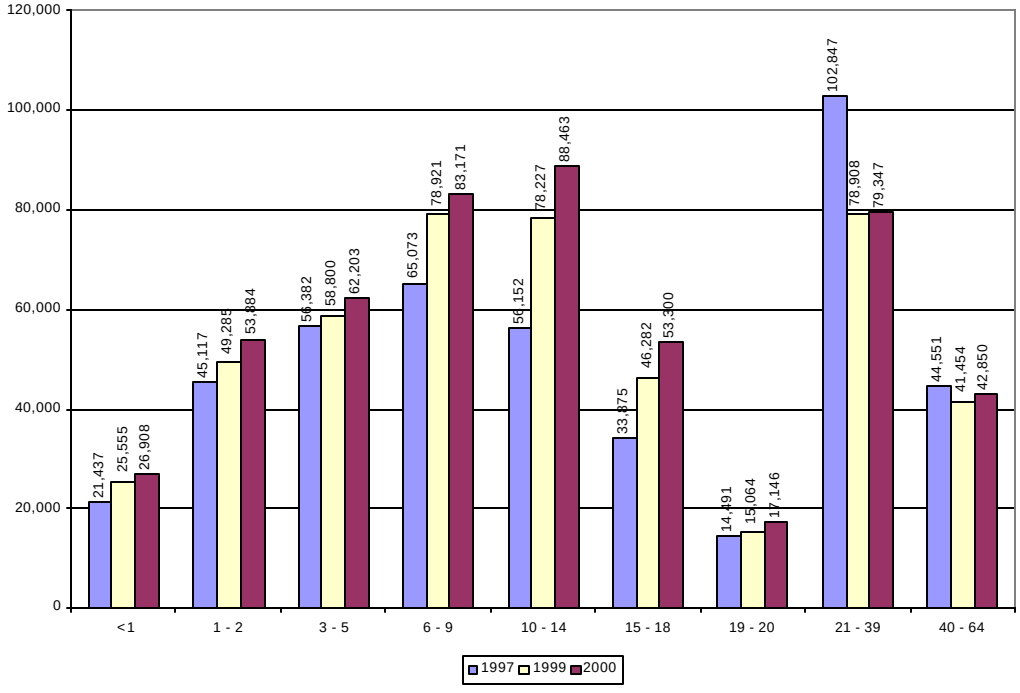
[6] Population totals in Figure II-3 are based on point-in-time enrollment. Population totals in Figure II-4 and II-5 are based on individuals with eligibility during the year. The totals in these charts, therefore, will not balance.

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.

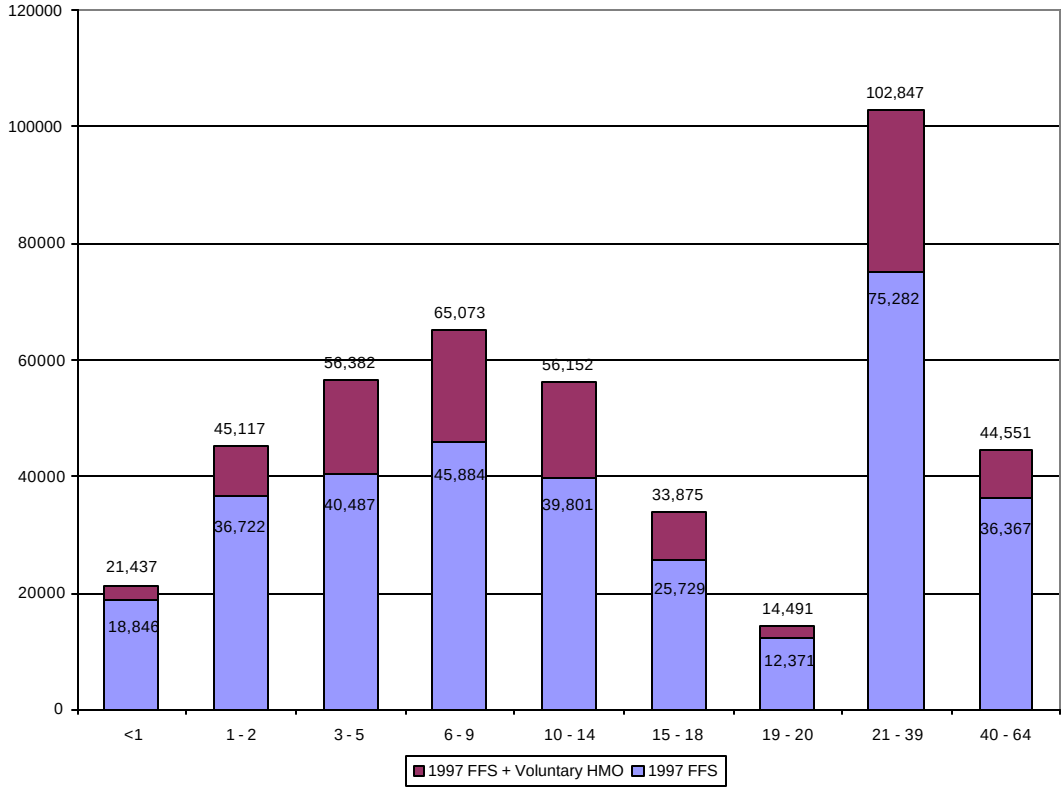
Welfare Reform. The implementation of welfare reform may explain another shift in the composition of the HealthChoice population. Between 1997 and 2000, the total number of enrollees ages 21-39 decreased by 23 percent, or 23,500 individuals. This is the only age group in which a significant decrease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