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.

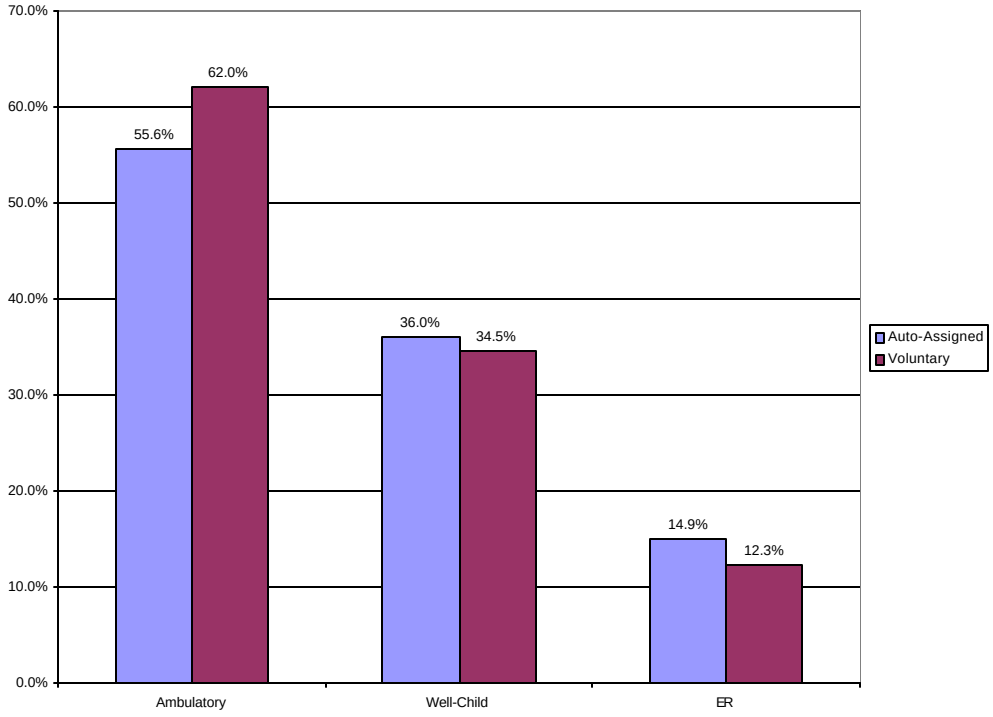
visits per thousand and the voluntarily assigned enrollees receiving 611 visits per thousand.

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

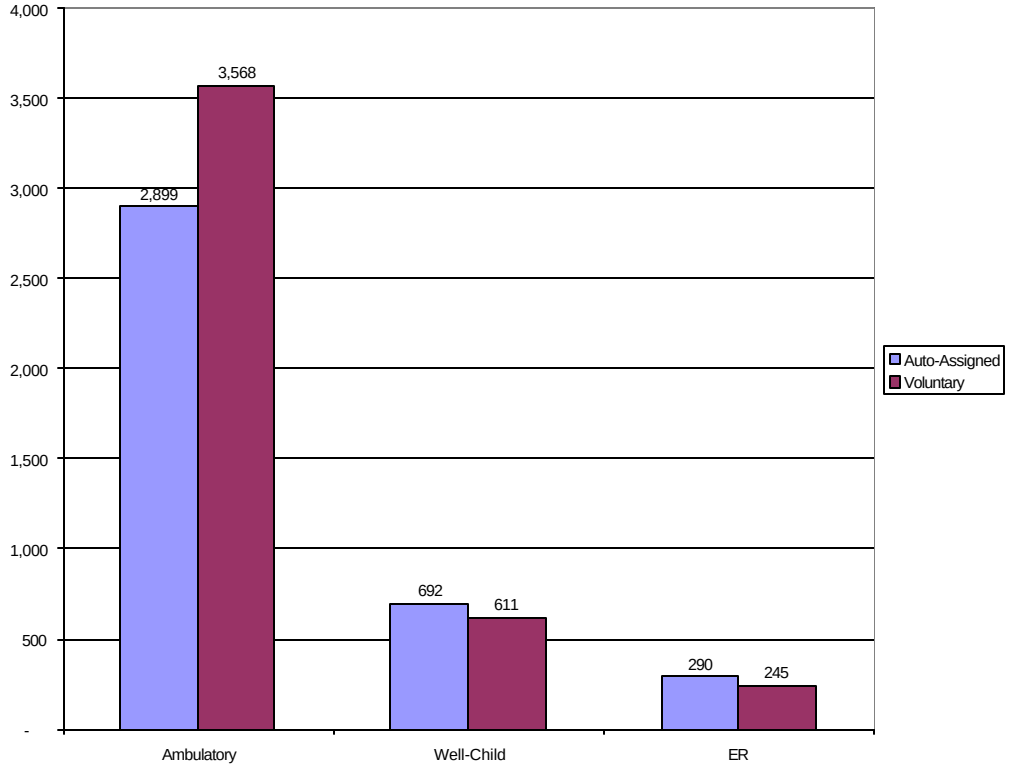
Some providers feel they have been financially harmed by auto-assignment, reporting that often an auto-assigned enrollee continues to seek care from the same providers they used before being enrolled in HealthChoice rather than from the MCO-affiliated provider designated their PCP. This results in administrative 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

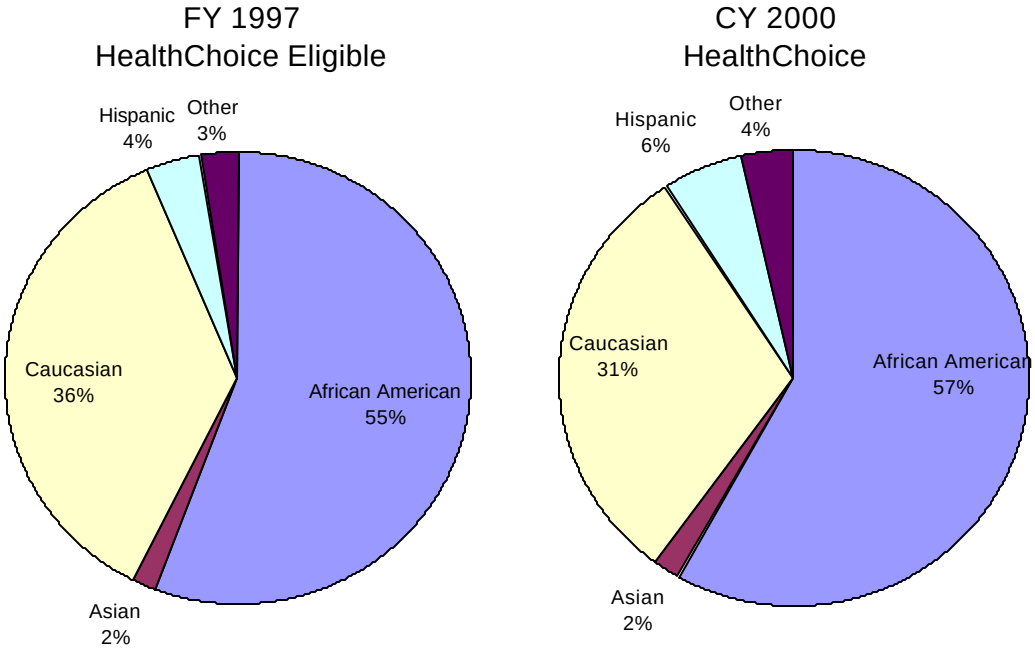


Figure III-43: Percentage of the Population Receiving Ambulatory Care Service, by Race

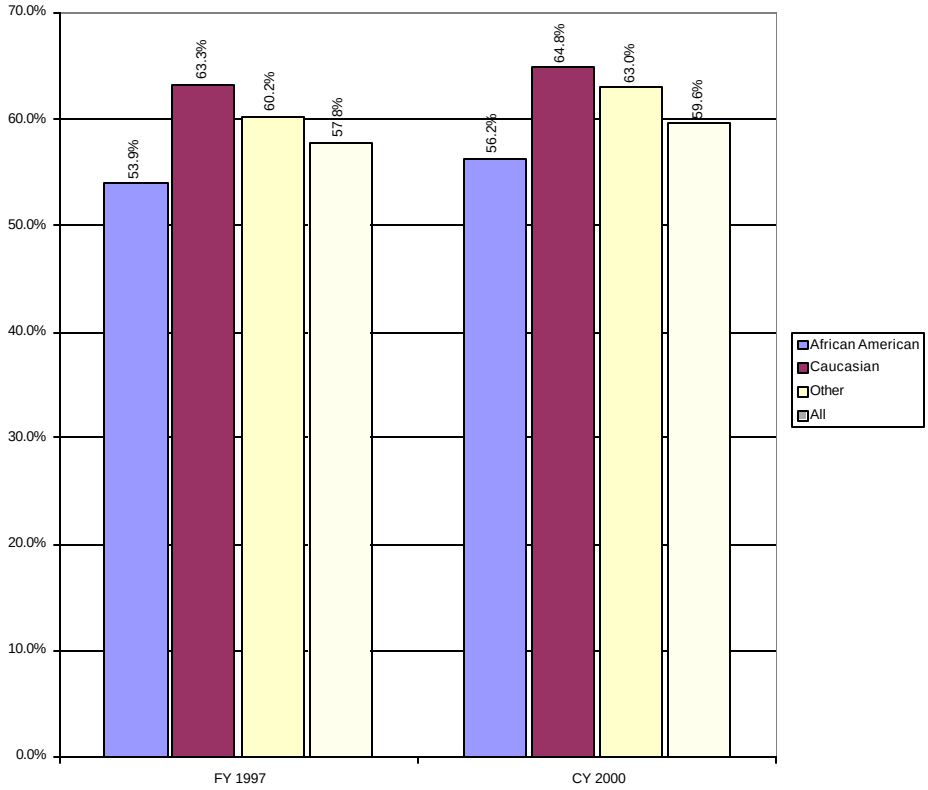
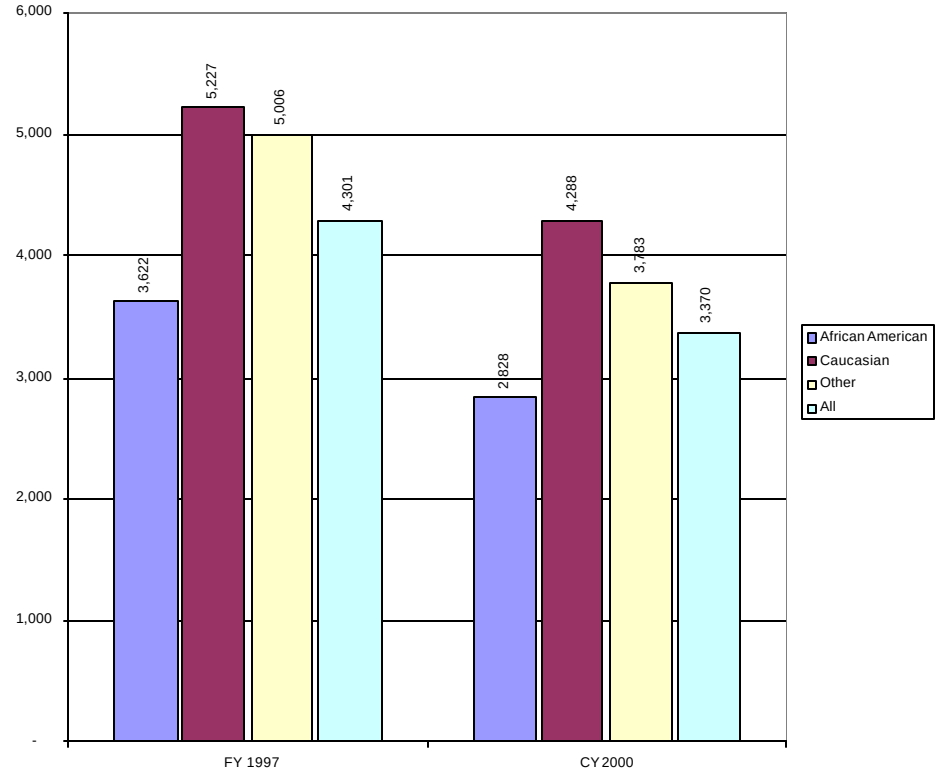


Figure III-44: Ambulatory Care Visits per Thousand Annualized, by Race



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

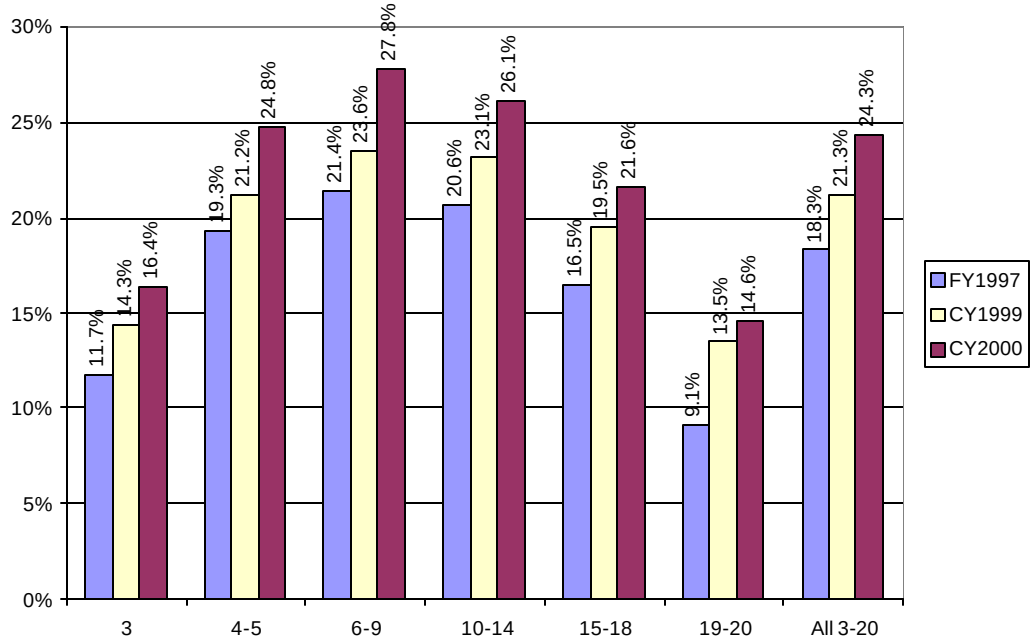
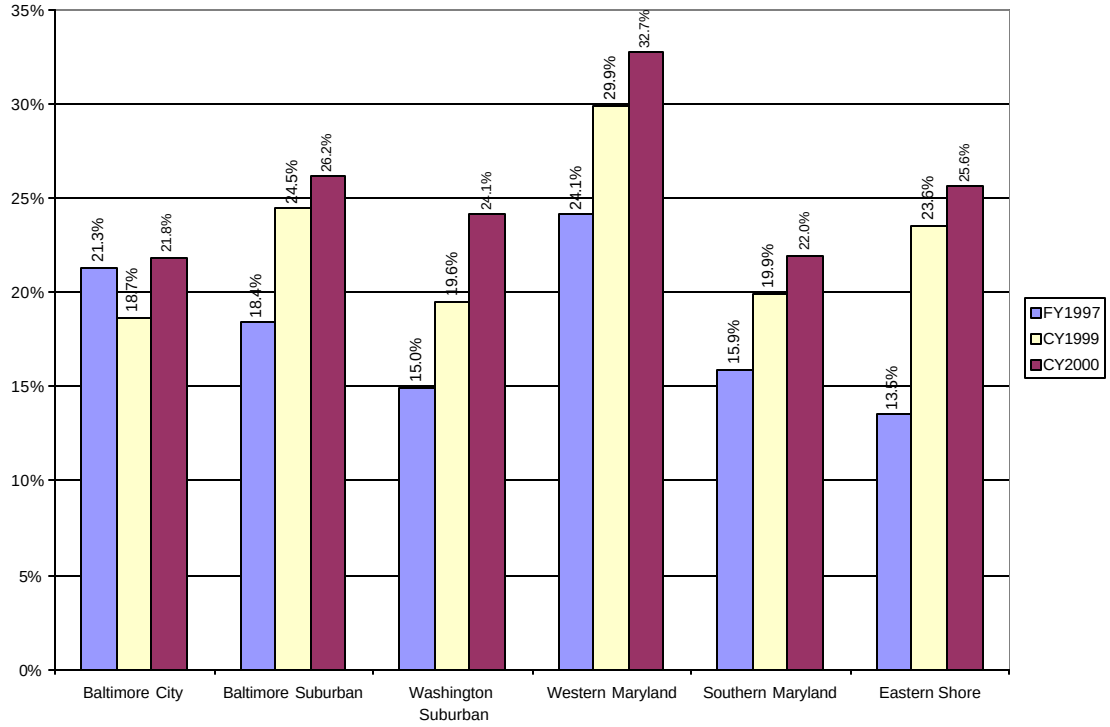


Figure III-46: Percentage of Children Age 3-20 with 90 Days of Enrollment Receiving Dental Services by Region



➢ *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

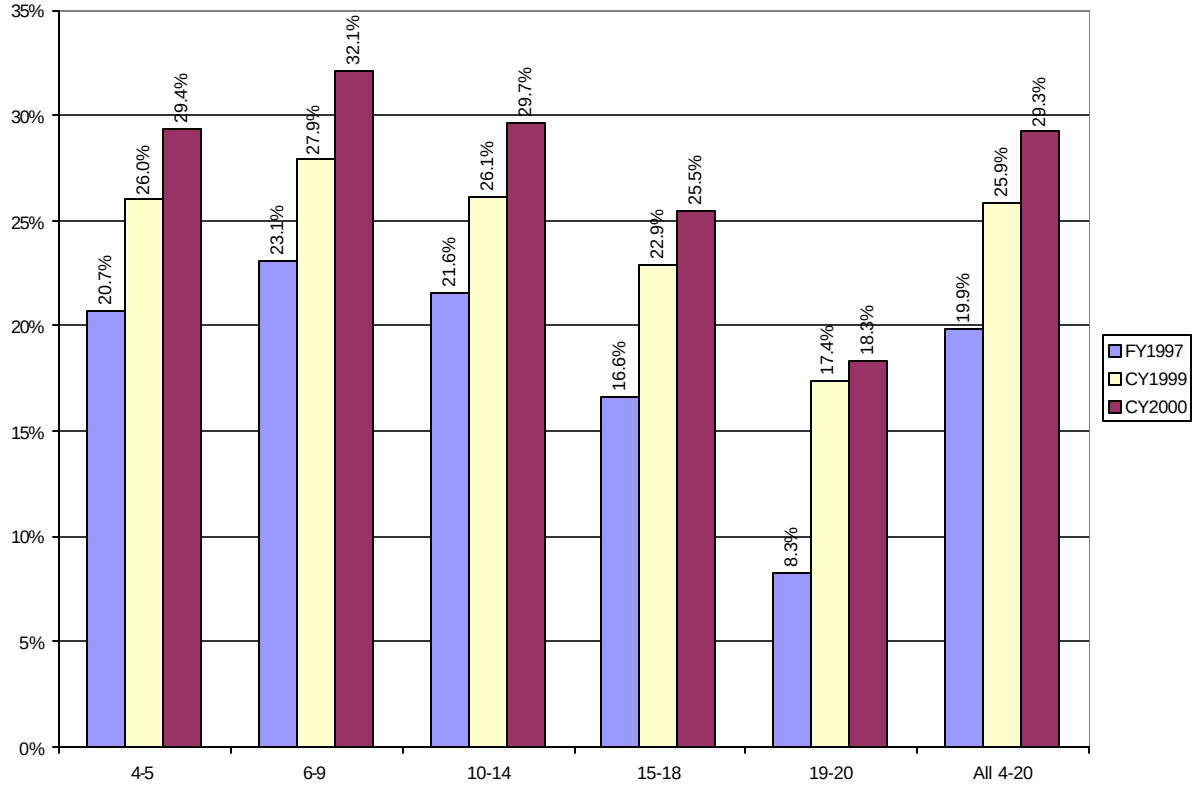
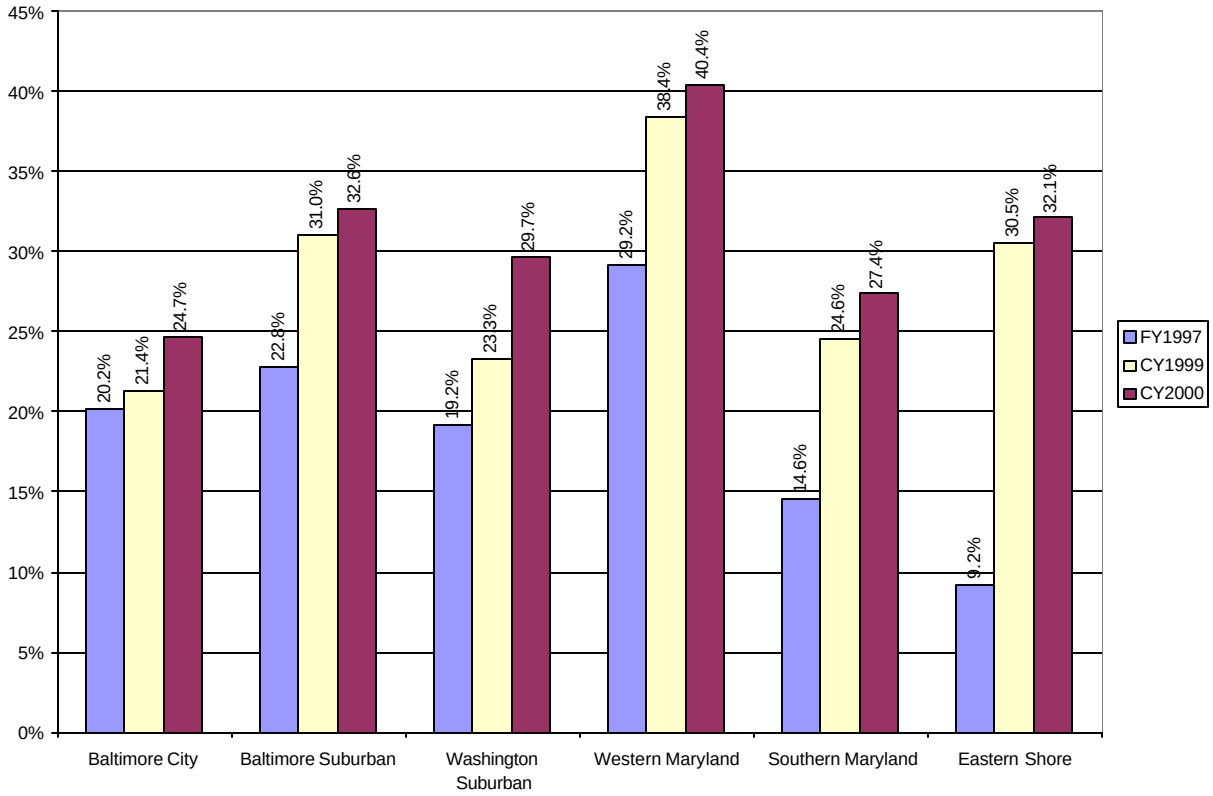


Figure III-49: Percentage of Children Age 4-20 with 320 Days of Enrollment Receiving Dental Services by Region



Dental Utilization - Pregnant Women and Other Adults.

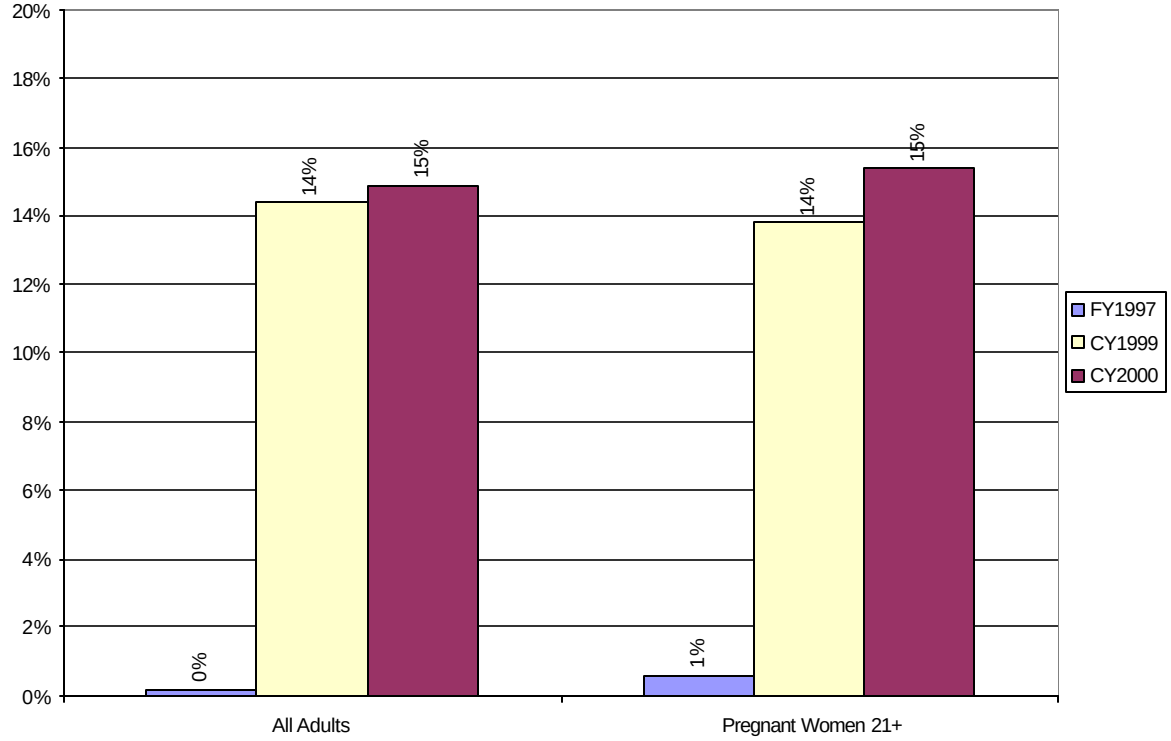
- *Dental services for pregnant women.* Senate Bill 590 also required that dental services be extended to include all pregnant women enrolled in HealthChoice. For CY 2000, dental services utilization by pregnant women was 15.4 percent for CY 2000 for pregnant women who were:

  - 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

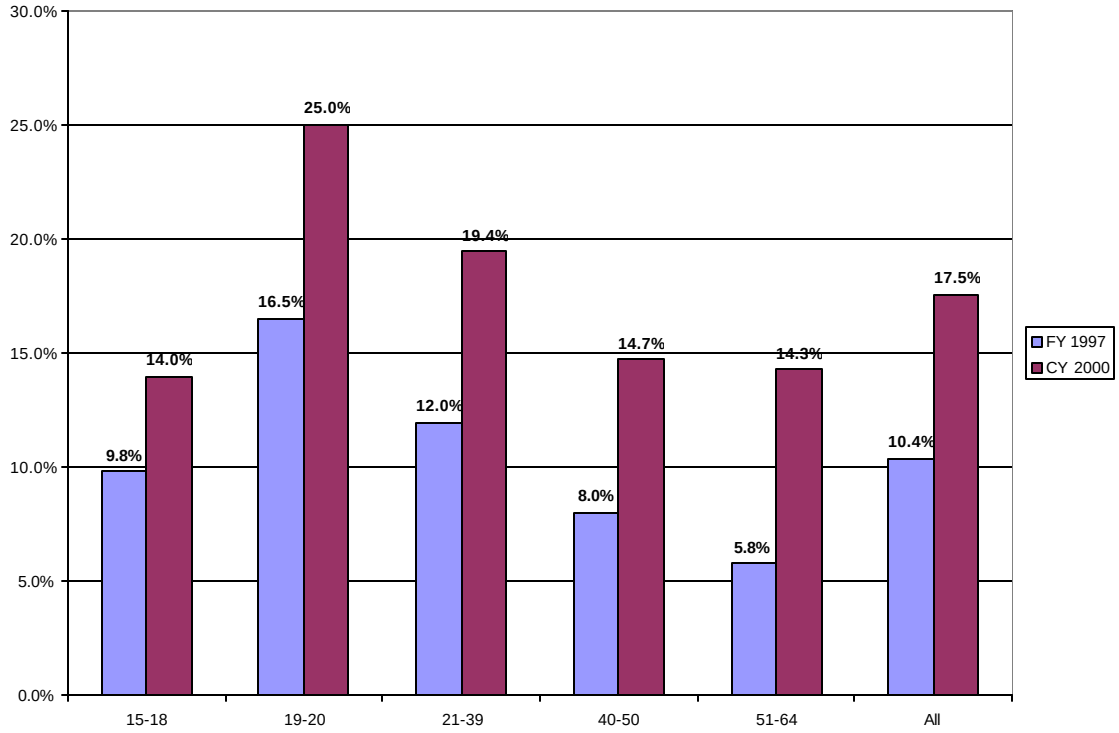


Figure III-53: Percentage of Women Receiving a Pap Test by Region

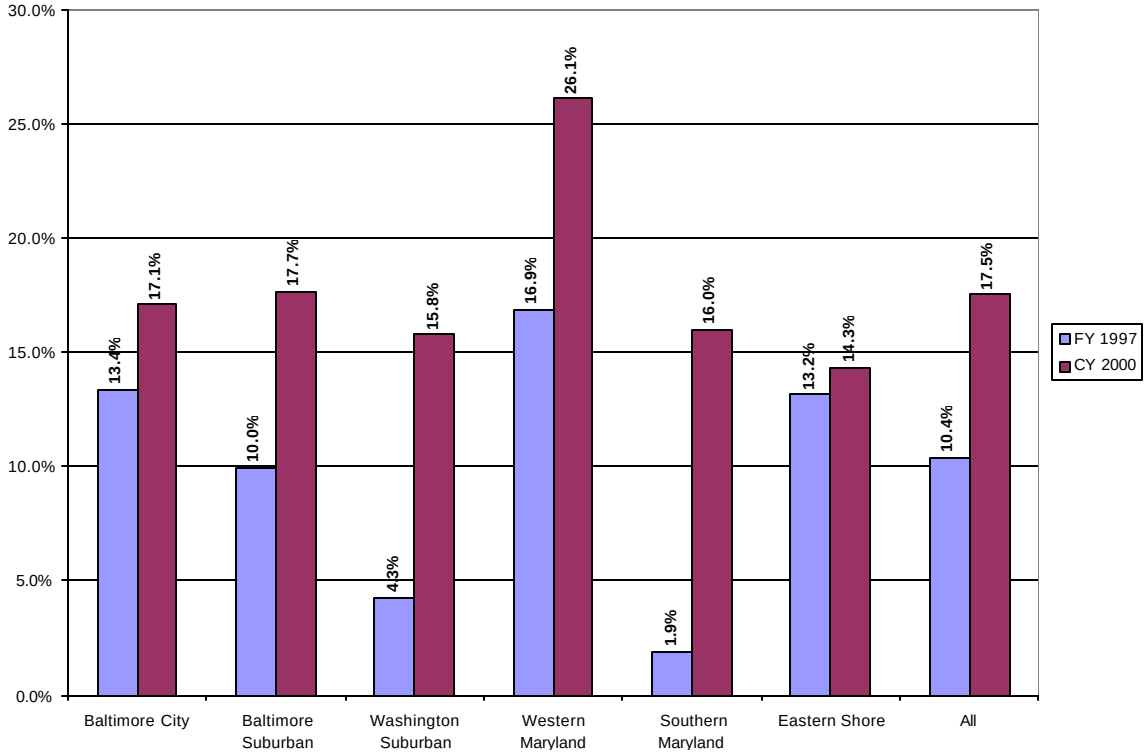


Figure III-54: Percentage of Women Receiving a Screening Mammography by Age

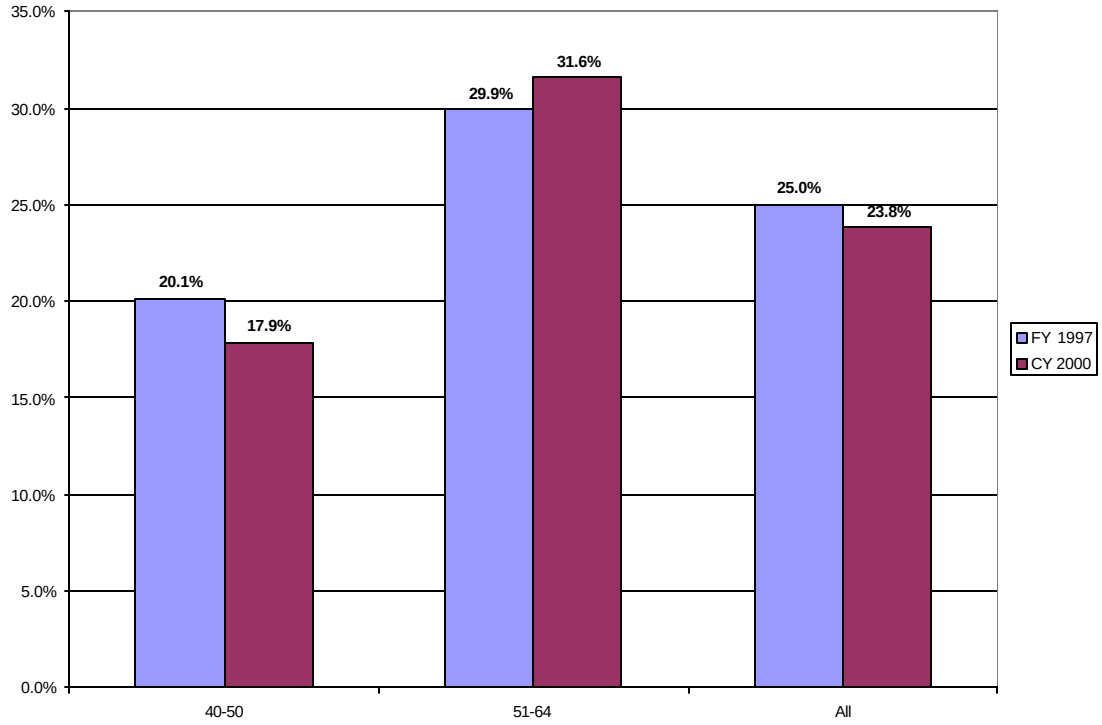
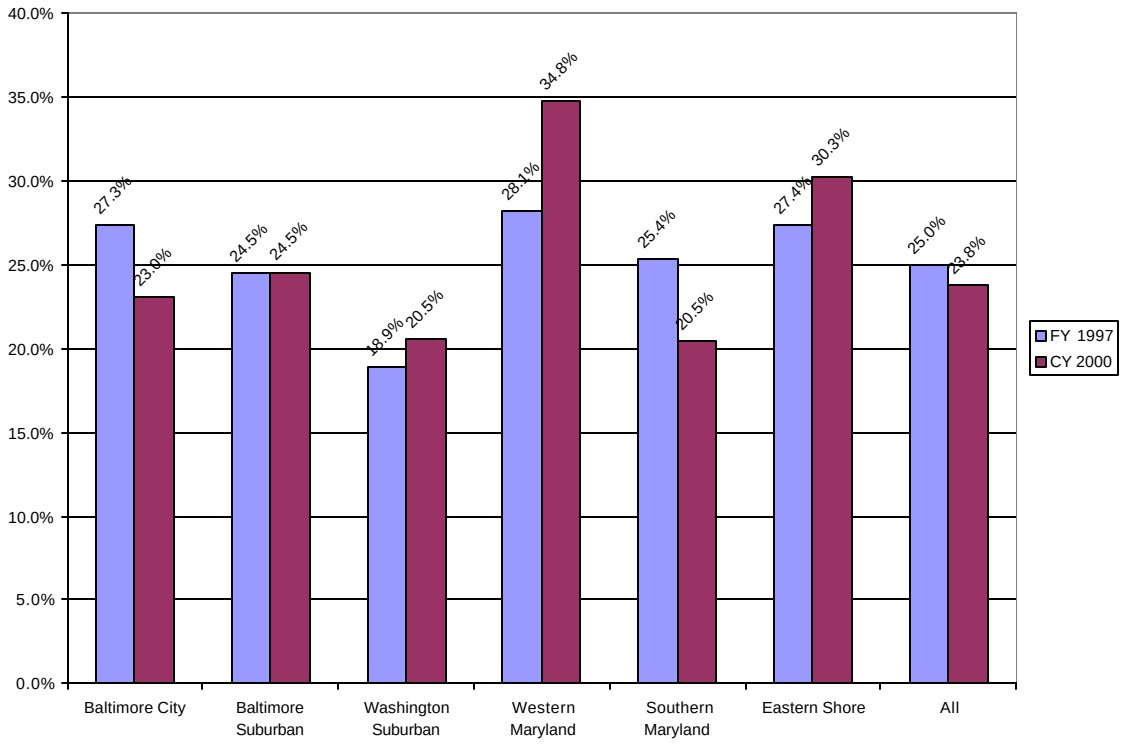


Figure III-55: Percentage of Women Receiving a Screening Mammography by Region



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

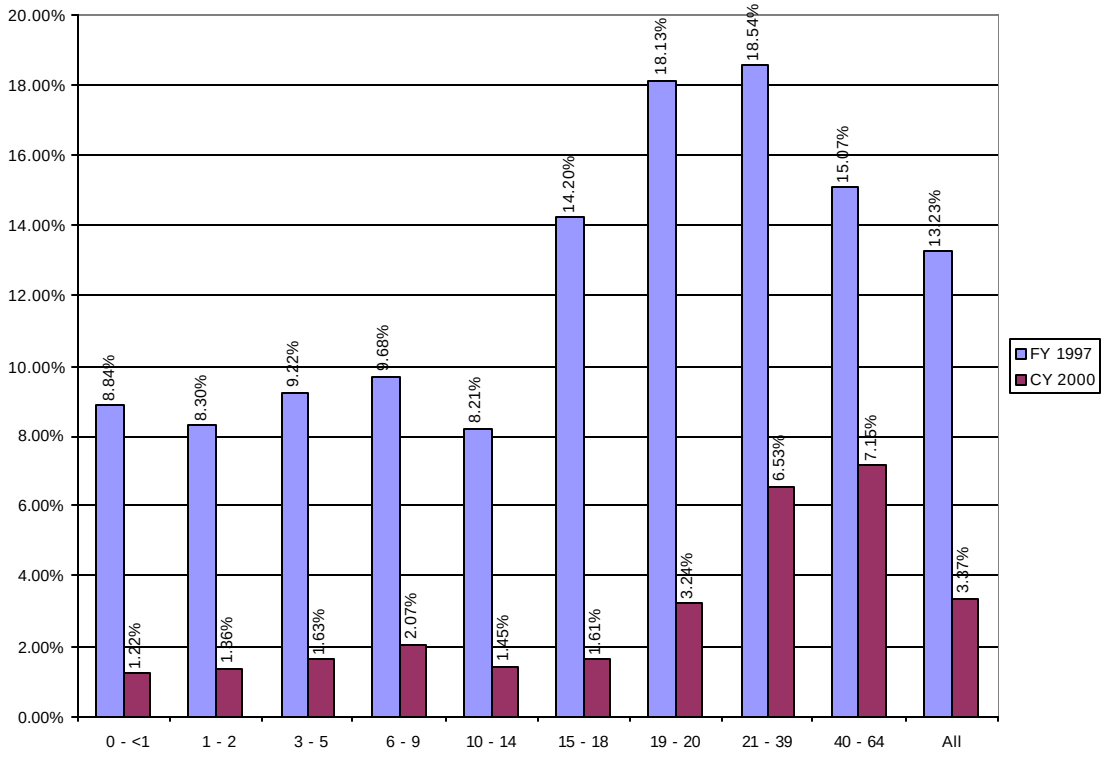
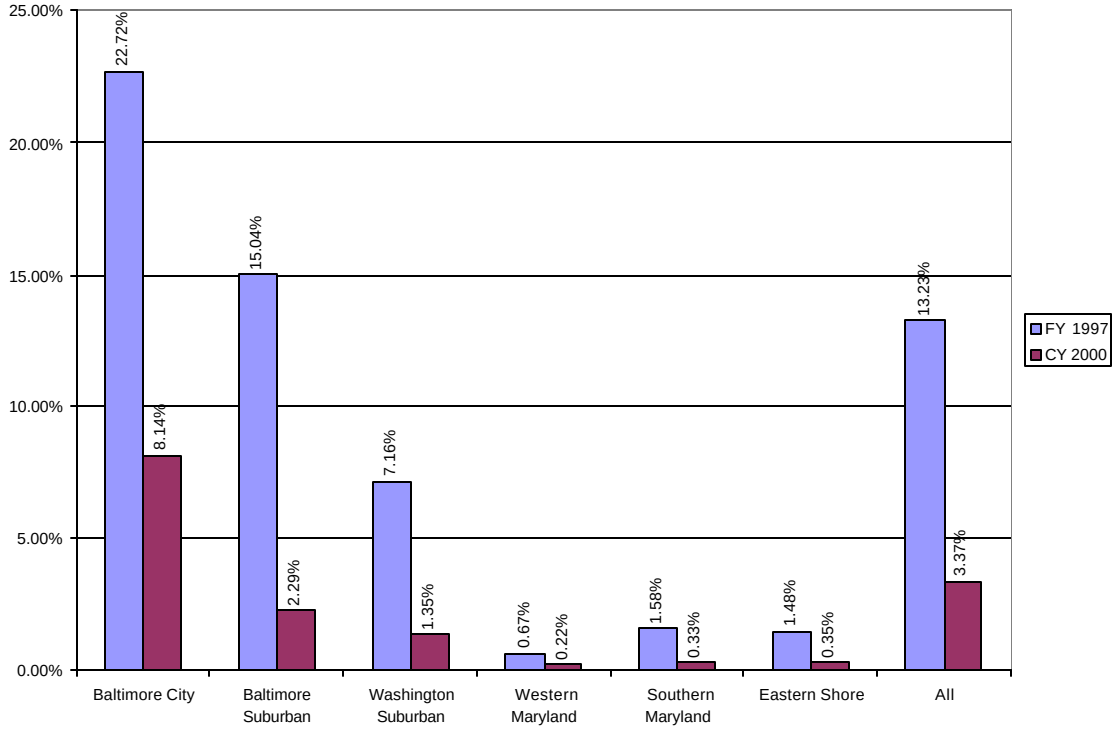


Figure III-57: Percentage of the Population Receiving an Ambulatory Care Service in Outpatient Departments by Region



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

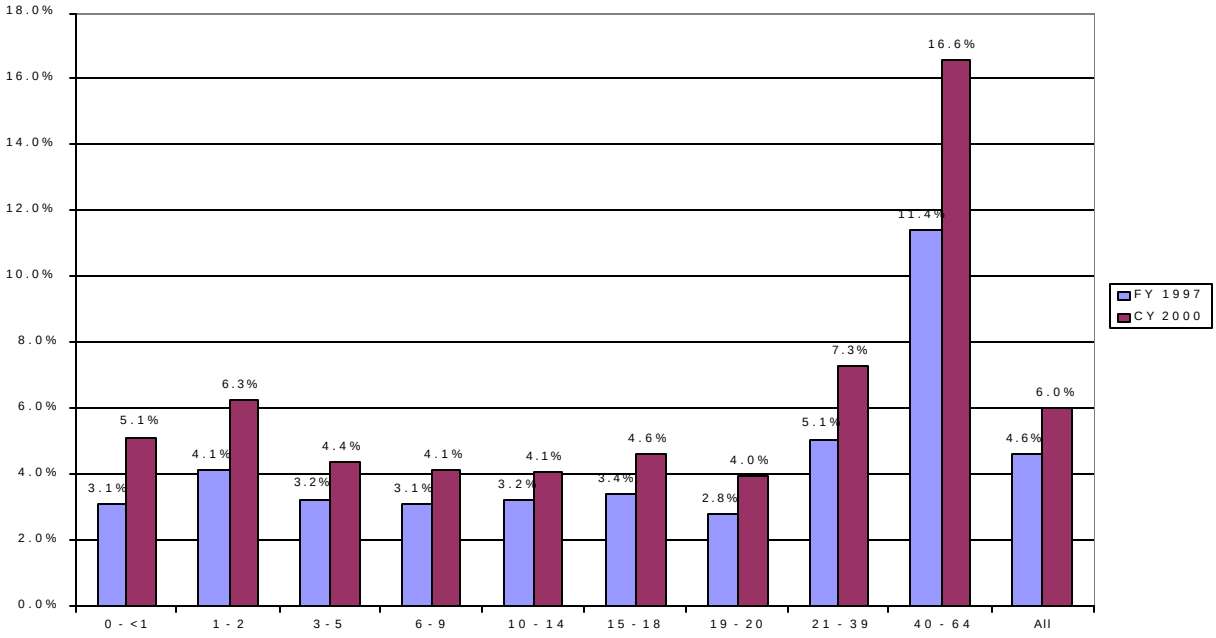


Figure III-59: Percentage of the Population Receiving a Physician Consult by Region

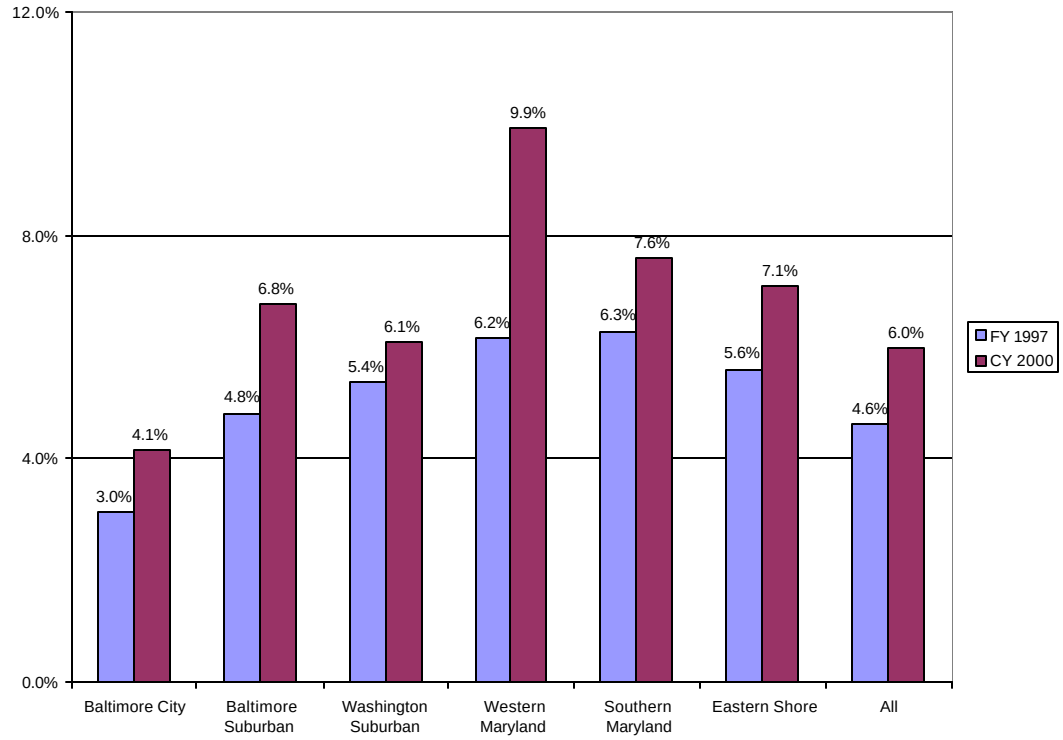


Figure III-59: Percentage of the Population Receiving a Physician Consult by Coverage Category

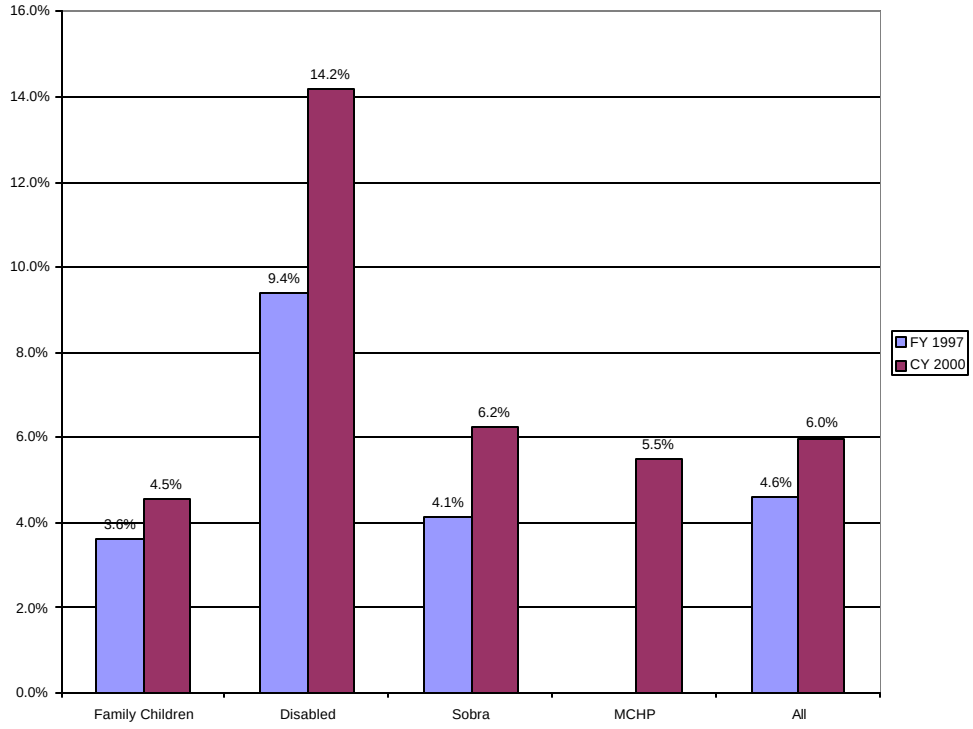


Figure III-60: Physician Consults per Thousand Annualized by Age

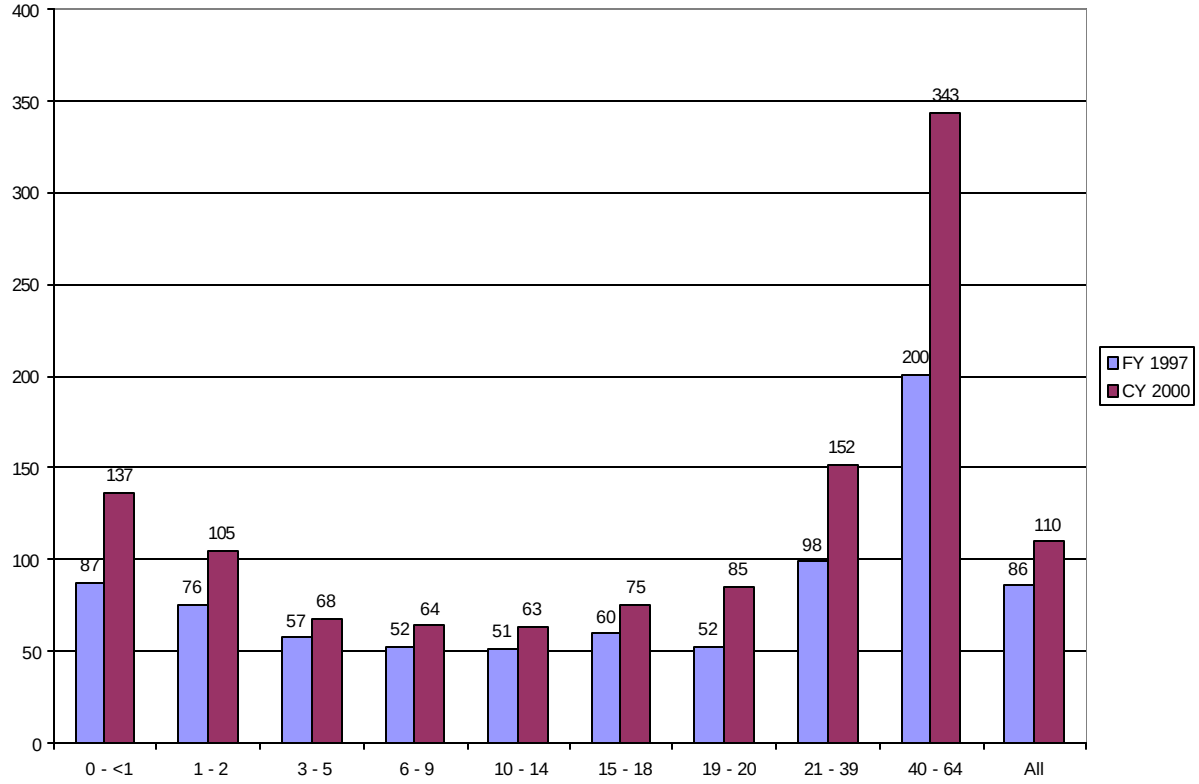


Figure III-61: Physician Consults per Thousand Annualized by Region

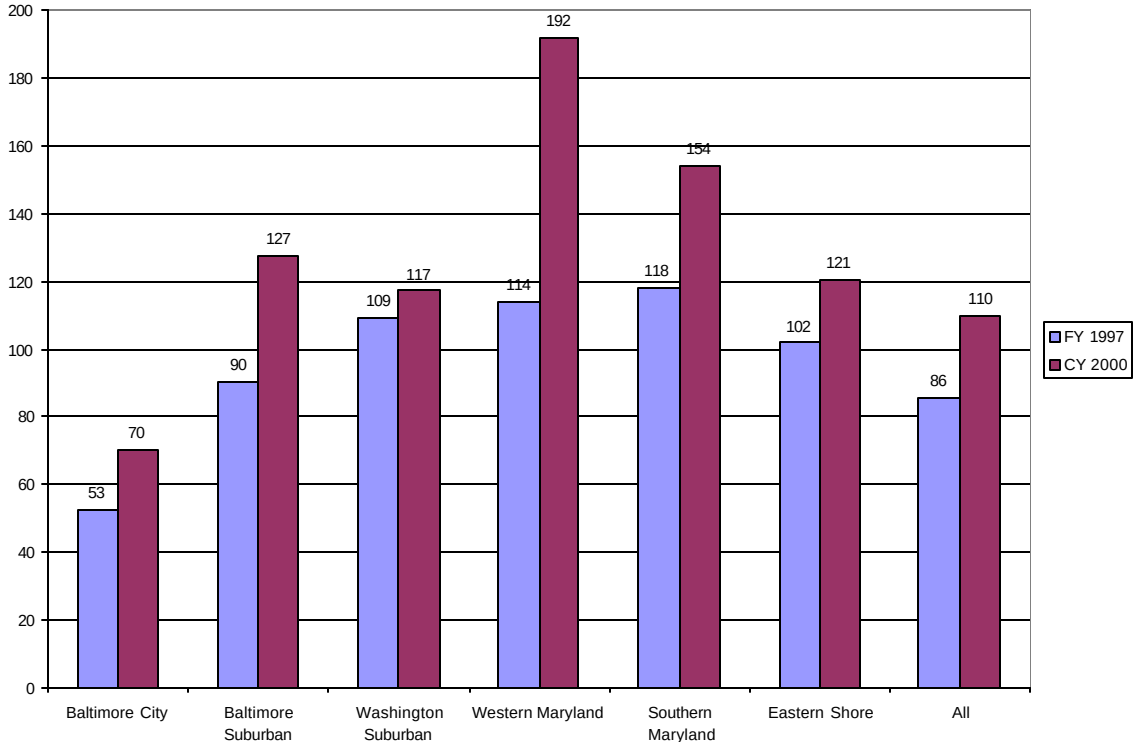
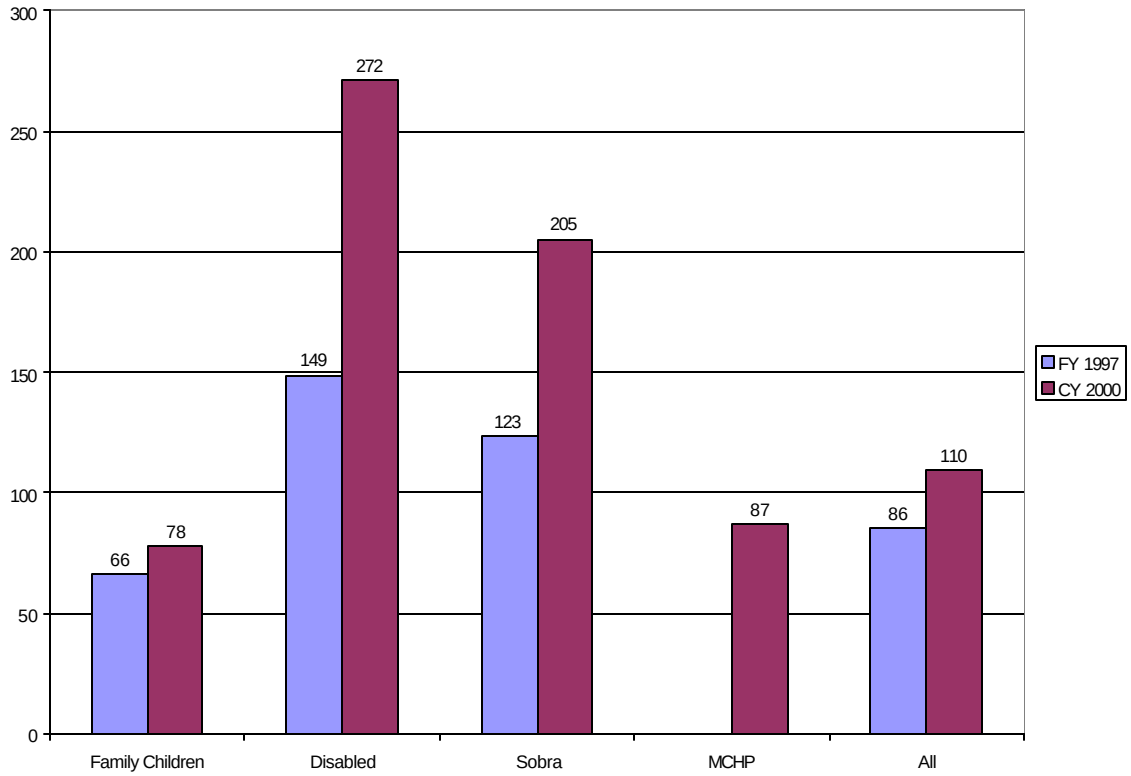


Figure III-62: Physician Consults per Thousand Annualized by Coverage Category



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.