VII. SUMMARY AND RECOMMENDATIONS

INTRODUCTION

The comprehensive evaluation of the HealthChoice program has demonstrated that the program has made progress in meeting its originally stated goals. It also has been the platform for a major expansion under the Maryland Children's Health Program (MCHP). We have reached this conclusion about the program based on the following key findings:

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

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

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

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

- Access to care has increased compared to before HealthChoice, even with the significant increase in the number of people served under HealthChoice.
- Individuals who enroll in Medicaid stay on Medicaid longer than before. The number of enrollees who maintain a full year of eligibility within the year increased from 41.8 percent in FY 1997 to 48.5 percent in CY 2000.
- The percentage of children who receive well-child visits is up from 36.0 percent in FY 1997 to 40.0 percent in CY 2000. The largest increase is for newborns, increasing from 54.5 percent in FY 1997 to 69.2 percent in CY 2000. Looking at well-child visits addresses some of the problems of comparability that complicate

the examination of all ambulatory visits since well-child visits should be provided to all children regardless of the child's health status.

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

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

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

- In general, the number of services individuals use has decreased except for newborns and well-child visits, as described above. Overall, the number of ambulatory services are down from 4,301 visits per thousand members in FY 1997 to 3,667 visits per thousand members in CY 2000. The implications of this are unclear. This might indicate that people are not receiving needed medical services. For example, it is possible that some patients with special health needs have encountered barriers to reaching all the services they need or that enrollees are confused by the complexity of the system. However, the decreases in service utilization may also be because:

    - There is a very different case mix in CY 2000 compared to FY 1997, which is healthier (current MCO population includes more higher income children and the voluntary HMO population which was not included in the 1997 pre-HealthChoice utilization data).

    - It is possible that care is being properly managed and enrollees are receiving timely interventions and less inappropriate care.

    - Although encounter data from CY 2000 is good, it is incomplete compared to the FY 1997 claims data. We have estimated that it may be 5-10 percent incomplete, which may contribute to the appearance of decreased utilization.

- HealthChoice has made significant progress in improving access to dental services, although access measures still fall short of the legislatively mandated targets. In CY 2000, for children between ages three and twenty enrolled in Medicaid for more than 90 days, 24 percent accessed dental services, up from 18 percent in FY 1997. The legislated targets start at 30 percent for CY 2000 and increase to 40 percent in CY 2001, 50 percent in CY 2002, 60 percent in CY 2003

and 70 percent in CY 2004. Areas that have lower access rates compared to the statewide average include Baltimore City and Southern Maryland.

- Although overall access to care has improved for children in SSI, some populations of special needs children may not be equally well served by HealthChoice.
  - Compared to the previous fee-for-service system, the encounter data analysis shows fewer children in foster care received outpatient services under HealthChoice and the number of services they received decreased. This analysis does not include important data on utilization of services before foster care children are enrolled in an MCO and therefore drawing conclusions is impossible. This is currently being studied further by the Department.
  - SSI eligible children have had improved access to care, including preventive services. Overall, 65 percent of SSI children (including some children enrolled in the Rare and Expensive Case Management [REM] Program who receive services on a fee-for-service basis) received an ambulatory visit in CY/FY 2000, an increase from 58 percent in FY 1997. The level of services they received increased slightly: SSI/REM children received 3,740 visits per thousand in CY/FY 2000 compared to 3,229 per thousand in FY 1997.

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

- HealthChoice has met the two federal cost effectiveness requirements:
  - MCO costs have been under the Federal Upper Payment Limit; and
  - Although HealthChoice exceeded the budget neutrality cap of 5.5 percent in first two years, it was about 2 percent below the cap after the third year. Preliminary numbers indicate that it will be further under the cap after the fourth year.
- The first four years of HealthChoice demonstrate that most MCOs were able to generate profits each year, suggesting that rates in the past have been adequate. This does not address losses that some downstream risk providers experienced.
- The higher administrative costs of HealthChoice are associated with the benefits of the MCOs' care management systems and establishment of medical homes for enrollees. New care management functions such as outreach mandates, enrollee education responsibilities, and case management efforts created new administrative burdens for MCOs and providers. Plans believe that increased administrative burdens hinder their ability to adequately manage expenses.
- Risk adjusted rate setting methods contribute significantly to achieving purchaser value by more efficiently allocating funds among the MCOs according to the health status of their enrollees.

- MCOs have sufficient primary care providers (PCPs) to serve their enrolled population, including the 100,000 additional HealthChoice participants, at least partially due to the higher physician fees paid by the MCOs.
- The change in the number of MCOs participating in the HealthChoice program (initially eight, currently six) is similar to the magnitude of MCO withdrawals in other states.

Improvements in access may be threatened by diminishing numbers of physicians willing to participate in HealthChoice.

- Concern is greatest in the Eastern Shore, Southern Maryland, and Western Maryland due to the dramatic growth in the proportion of children served by Medicaid and the numbers of physicians available to absorb program growth.
- Physicians have left HealthChoice or are threatening to leave because of inadequate reimbursement from MCOs, even though most MCOs' physician payments are greater than the Medicaid fee-for-service schedule.

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

RECOMMENDATIONS

Despite this progress, there are areas of concern. It is clear that maintaining and continuing further improvements will require a stable managed care program in the future. The remainder of this report identifies recommended changes to the HealthChoice program to encourage program stability, establish a regular process to identify program priorities, and identify specific program improvements.

ESTABLISH A LONG-TERM PRIORITY SETTING PROCESS

As has been referenced in a number of studies, including the Mathematica Policy Research study on the HealthChoice program, one of the biggest lessons learned about the HealthChoice program is that too much was attempted in too little time. The program was implemented with inadequate time to prepare and plan for the significant changes in the health care system. Subsequently, a number of changes have been made to the program through legislative, regulatory, and programmatic processes. As the program continues to mature, it needs a more reasonable pace of change. HealthChoice costs in FY 2001 were about $1.6 billion which represents roughly half of all Medicaid and MCHP expenditures. Any changes to the program need to be made in the context of the State's long-term goals and a realistic assessment of how much change our enrollees, providers, and MCO partners can absorb. Implicit in this is a process to establish and maintain priorities and achievable goals.

The Department, MCOs, providers, enrollees, and advocates have participated in numerous projects to improve the HealthChoice program during the first years of the program. However, as the program matures, it is critical that all stakeholders invest their limited resources in the same strategic priority areas.

➢ Recommendations

- The evaluation has identified several areas for program improvements, which we recommend to serve as the priorities of the HealthChoice program beginning in CY 2002. Implementation of selected HealthChoice evaluation recommendations will begin in CY 2002. Other HealthChoice evaluation recommendations will be implemented in subsequent years as part of a multi-year process.

- The Department recommends an annual process to review and establish strategic priorities for the HealthChoice program. To the extent possible, the Department would implement the subsequent changes one time a year in order to promote program stability and ease administrative burden. This process would begin with the Department proposing an annual list of priorities for CY

2003 and each year beyond. The Maryland Medicaid Advisory Committee would comment on the items and would set the order by which the different priorities would be addressed. During the summer of each year, the Maryland Medicaid Advisory Committee would receive input from the established advisory committees, MCOs, and other stakeholders from the program on the list of priorities. With this input, the Advisory Committee would recommend a prioritized list of issues by the end of September of each year for the Department to address in the upcoming year. The Department can then develop work plans and be able to implement strategies to address the issues prior to the beginning of the calendar year.

MAINTAIN THE CURRENT MCO-BASED CAPITATED PROGRAM, BUT DEVELOP A BACK-UP MANAGED CARE SYSTEM

The Department believes that improvements under the HealthChoice program are largely due to the establishment of a medical home and the care management systems of the MCOs. The evaluation findings suggest that this model has made progress and that there is no compelling evidence to recommend a significant programmatic shift away from HealthChoice. The evaluation found that important issues need to be addressed, and the number of services per person has decreased, although the implications of this are unclear. However, the quantitative data and direct input from consumers and providers does not suggest that the HealthChoice program should be eliminated.

While implementing a risk-based MCO model has allowed Maryland to achieve its quality improvement and cost-containment goals, program stability has been a challenge. During the last three years, management has been concerned about maintaining a statewide program, especially in rural areas of the State. During this time, two MCOs have withdrawn from HealthChoice and two have changed ownership. Six MCOs currently remain in HealthChoice. Four of these six MCOs cover 94 percent of the total HealthChoice membership, and two serve patients in all parts of the state while another operates in 23 of the 24 jurisdictions.

Currently, in the event that a region is left with less than two MCOs, the Department is required to return to a fee-for-service (FFS) system. Having a fee-for-service Medicaid card does not guarantee that a enrollee will receive needed health care services or that those services will have the same sort of quality protections and support services offered under managed care. In addition, while the State would be able to provide some care management components like concurrent review and pre-authorization, it currently lacks the managed care infrastructure needed to contain costs effectively and provide the types of quality oversight activities that are available in a managed care environment.

As a result, neither program management nor program stakeholders have been willing to endorse the fee-for-service model as the appropriate alternative to the MCO model. Both seek a more satisfactory alternative. Given the current situation, the State needs to develop a better contingency plan should MCOs leave the program.

The Department believes it is critical to develop the infrastructure to implement a back-up program which would provide another high-quality mechanism for serving HealthChoice enrollees if MCOs are not available in an area of the State or if it is determined that other populations would be better served outside of an MCO. This program needs to provide a primary care provider for each enrollee, and provide better "management" within the FFS system to address quality of care issues and help control health care costs.

The National Academy for State Health Policy's 2000 survey of Medicaid managed care programs indicates that most enrollees of exiting MCOs did not revert to FFS, but were

enrolled in another MCO or Primary Care Case Management (PCCM) program. As of May 2001, thirty-two states operated PCCM programs, either alone or in conjunction with risk-based managed care programs. In addition, a back-up program, such as a PCCM program, would allow the Department the flexibility to manage specific populations outside of MCOs, if in the future it is determined that a population is not well served by the MCOs, or in certain geographic areas where enrolling in an MCO is not an option.

In general under PCCM programs developed by other states, the state maintains a network of participating providers and assigns each enrollee to a primary case manager, usually a primary care physician. In most states, the patient's primary care physician receives a small payment each month for serving as the patient's first point of contact for all health care needs, whether the physician sees that patient in that month or not. The physician serves as the "gatekeeper," making referrals to other services as appropriate. To the physician, the crucial difference between the PCCM model and the current risk-based managed care model is that the purchaser of the health care - in this case the State or its contractor - pays the physician directly rather than paying an intermediary organization like an MCO or HMO and works with the physician directly to assure proper case management.

PCCM models vary across states depending on the needs of their specific populations, and their internal capabilities and resources. A PCCM program always has at least the ability to pay claims and to establish a network of providers. Where they usually differ is the intensity of care management programs offered, if at all. Some states decide to outsource all the functions of its PCCM program, while others manage them entirely in-house or outsource only pieces.

Fundamentally, two different PCCM models exist today. These models are commonly referred to as either "Phase I" or "Phase II" PCCM programs. The earliest PCCM programs were "Phase I" programs. In general, states operating "Phase I" PCCM programs pay claims and establish some utilization controls such as preauthorization of high cost services and post-payment review of hospital services. They do not collect comprehensive quality data, and they do not supply information to providers to help them manage care for their patients. These states rely heavily on the primary care case manager to coordinate care. The Maryland Access to Care (MAC) program, which preceded HealthChoice, was a "basic" or "Phase I" PCCM program. Although this model did improve the use of primary care and preventive services, it did not help to control health care costs.

States with "Enhanced" or "Phase II" PCCM programs generally supplement physician case management activities with the analysis of encounter or claims data. They also perform utilization management and develop or subcontract for sophisticated internal infrastructures to oversee the quality-of-care and service provided. Through these mechanisms, they are better able to control costs and provide case management than "Phase I" PCCM programs.

How Maryland decides to structure its back-up program will depend on the Department's resources and capabilities. For instance, the Department's Medicaid Management Information System has state-of-the-art capabilities to process claims. Therefore, it is not likely that the Department will need to seek a vendor for claims processing under the back-up program.

There are two important caveats, however, to the recommendation to develop a back-up "Phase II" PCCM program. As previously stated, the Maryland provider community is under stress and participation in the program is an issue. Some providers suggest that they will discontinue their relationships with Medicaid unless fees are increased and/or the administrative burdens of program participation are significantly reduced. Given the significant administrative responsibilities for primary care physicians under a back-up managed care program, physician reimbursement rates must be increased in order to be able to recruit an adequate provider network.

Also mentioned previously, the infrastructure of an appropriate contingency program is very similar to the infrastructure of a risk-based managed care organization. Maryland providers were accustomed to a "Phase I" PCCM program and may assume that any newly proposed model would be similar to their pre-HealthChoice Maryland Access to Care (MAC) experience. Providers may initially support the creation of such a back-up program. However, once fully educated on the concept and the State's intent, providers may not be as supportive. Without incurring additional administrative expenses upfront and providing additional funding for providers, Department management will be challenged to create an appropriately managed back-up program. For example, the Maryland Medicaid Information System (MMIS) will need to be programmed to allow enrollees to be linked with primary care providers rather than MCOs.

Even if additional administrative funding and a provider fee increase is approved, the Department will still need to pursue and rely on its current interim short term contingency models in order to be able to respond to any potential stability issue that may result from an MCO exit or significant provider network change while a back-up program is being developed.

- **Recommendation**

  The Department should develop a back-up care management program:

  - With input from stakeholders, plan a back-up program which includes linkage with a primary care provider; comprehensive care management and disease management programs; active quality assurance activities; and cost-containment efforts such as utilization control; and

  - By January 1, 2004, reprogram MMIS to allow for the implementation of such a model.

IMPROVE PROVIDER NETWORKS

One of the biggest challenges in the HealthChoice program is maintaining an adequate network of providers willing to see HealthChoice patients. As the evaluation findings identified, low physician reimbursement is the primary reason providers are not willing to participate. In addition, the Department lacks the information to effectively monitor and enforce MCOs' network capacity standards. The following recommendations are being made to support and strengthen the provider networks within the HealthChoice program.

Physician Reimbursement

During the evaluation process, HealthChoice stakeholders strongly supported an increase in physician reimbursement. The Joint Chairmen's Report establishes a process for annually setting reimbursement rates for Medicaid and makes recommendations for a multi-year process for increasing fees.[1] The fee increases would first be applied to approximately 200 medical procedures that comprise Evaluation and Management (E and M) services. E and M services are most often office visits provided by either a primary care physician or a specialist, and also include consultations and visits to patients in hospitals and nursing facilities. The prioritization of E and M services ensures that the new resources will have the greatest impact. The increased fees would cover all of the practice and malpractice expenses and most of the work component of physician services.

If there is a Medicaid physician fee increase, increased payments must reach physicians. Currently, the evaluation findings and the Department's on-going monitoring efforts suggest that most MCOs pay physicians on average more than the Medicaid fee schedule. In some cases, MCOs pay higher amounts in certain areas or for certain specialties.

➢ **Recommendation**

If the Medicaid fee schedule is increased under a budget initiative, the Department should monitor and make sure that the appropriate amount of the increased capitation payments related to this fee increase is passed on to physicians. The method for monitoring the levels of MCO pass-throughs to physicians includes the following:

- MCOs would be required to pay network physicians at least 100 percent of the new fee schedule for E and M services;

[1] "Report on the Maryland Medical Assistance Program and Maryland Children's Health Program—Reimbursement Rates Fairness Act." DHMH, September 2001.

- If an MCO wants to use the new resources to increase other physician fees rather than pay the new fee schedule for E and M services, it could request a waiver from the Department. The Department would approve a waiver if an MCO demonstrates that at least an equivalent amount of total dollars would be paid to physicians; and,

- An MCO wishing to use new resources will periodically provide the Department with its physician fee schedule for all procedure codes to demonstrate compliance with the above requirement.

Improve Provider Data and Ultimately Improve the Directory

The Provider Network Directory, PND, is a tool used to identify participating HealthChoice providers and their MCO affiliation. Unfortunately, the Provider Network Directory is not very accurate. Inaccuracies include duplicate provider entries, incorrect provider data, incorrect provider MCO affiliation status and missing information. There are various reasons for the inaccuracies. They include a faulty computer-editing program used to compile the provider data from the MCOs, inconsistent provider updates from the MCOs, and a burdensome and time-consuming provider update process.

The Department, MCOs, and providers have recently focused on improving the accuracy and the completeness of the information on providers who participate in the HealthChoice program. Accurate provider network data will allow the Department to more effectively monitor network capacity, improve the information enrollees use in the selection of their primary care providers, and improve the quality of the encounter data.

➢ Recommendations

The Department should implement the following multi-faceted plan to address this issue and ultimately improve provider data:

- *Perform Manual Clean Up*. This project, initiated in November 2001, will verify provider data by contacting the providers directly and making changes to the Provider Network Directory file. The manual clean project will focus on primary care physician data by geographic area. It is estimated that this project will be completed in March 2002.

- *Develop New Provider Network Directory Edit Program.* The existing Provider Network Directory edit program overrides certain data submitted by the MCOs with provider data from the Medicaid Fee-For-Service file. The Department is working to redevelop the edit program to eliminate the overriding of data and to improve the overall compilation of provider data. This project will be completed by October 2002.

- *Develop Methodology to Sanction MCOs for Failure to Submit Accurate Data*. MCOs are required to submit weekly updates to the provider file. Overall, most of the MCOs are very cooperative in the Provider Network Directory process. However, there are instances where the MCOs are inconsistent in submitting data, which has a direct impact on the accuracy of the Provider Network Directory. The Department will develop a methodology to sanction MCOs for failure to submit accurate data in an effort to encourage the MCOs to maintain compliance with the Provider Network Directory process. These sanctions should be implemented after October 2002 to allow the Department to complete the actions in the previous bullets.

- *Eliminate Provider Duplicates.* This is an ongoing process by which duplicate providers are identified and MCOs are requested to submit the appropriate data to eliminate the duplications.

  The process to improve the provider network data is a collaborative process that requires participation by the Department, MCOs and the providers.

Plan to Monitor and Enforce MCO Network Adequacy

In general, the evaluation found that HealthChoice MCOs have sufficient primary care providers (PCPs) to serve their enrolled population. This finding has been supported by consumer forums and by the lack of complaints in this area. However, the evaluation also found that PCP provider networks are under stress in certain areas of the State. In addition, consumers are worried about access to specialty care in rural areas, and many stakeholders believe that low physician fees will soon lead to PCP and specialty access problems throughout the State.

The Department developed a Network Adequacy Plan in CY 2001. The first phase of the Network Adequacy Plan was implemented by the Department in September 2001. This first phase has a methodology for on-going monitoring of PCP networks so that PCP shortage areas can be identified and acted on at an early stage. While the plan represents a step forward, the Department will need to use the results of its analysis to take corrective actions against MCOs.

The second phase of the Network Adequacy Plan (to be implemented in CY 2002) would concentrate on developing and implementing more rigorous methodologies to analyze access to specialty care. Currently, the Department analyzes specialty networks when an MCO applies to enter the HealthChoice program, and thereafter uses consumer, local health department and provider complaints to identify problems with MCO specialty networks. Through the use of these mechanisms, it has become clear that most access complaints during the life of the HealthChoice program have focused on the lack of available specialists, especially in rural areas. Lack of access to specialty care in rural areas was identified as a key concern by stakeholders during the public forums.

Given concerns about network stability and access to high-quality comprehensive care for HealthChoice enrollees, it is critical for the Department to develop more sophisticated tools to allow for timely and accurate assessment of specialty provider networks. The Department can find no state that has developed provider to member ratio standards for specialists or geographic access requirements for specialists. This is in part because geographic standards must be sophisticated enough to account for the fact that specialty physicians are not evenly distributed throughout the State. Nevertheless, it has become clear that access standards for certain common physician specialists should be developed.

The components of the Departmental Network Adequacy Plan, both existing and those planned for future phases, have been compared to network adequacy standards suggested by PricewaterhouseCoopers.[2] This information is included in the findings section of this report. It should be noted, however, that regardless of the sophistication of the Department network analysis and enforcement activities, MCOs will only be able to attract and retain physicians if they have the financial resources to increase physician payment rates.

- **Recommendations**

  To monitor and enforce MCO network adequacy, the Department should fully implement its new Network Adequacy Plan. This includes:

  - Developing specialty care standards and a methodology for implementing and enforcing these standards. The first step will be to establish network standards for certain commonly used specialists; and

  - Continuing to identify geographic areas where there may be potential problems with access to care, and work with the MCOs to improve networks in problem areas.

Streamline administrative burdens for direct service providers and establish better mechanisms for communicating with HealthChoice providers

Since the beginning of the HealthChoice program, direct service providers have asked for help with a number of administrative problems: ensuring that MCO claims are paid in a timely manner; easily verifying that a HealthChoice enrollee is eligible, which MCO they are in, and the identity of their primary care provider; ensuring that they would be paid for care received by sick newborns even when they were seen out of network; reducing the reliance

[2]. "Assessing the Adequacy of Medicaid Managed Care Provider Networks." PricewaterhouseCoopers L.L.P., May 2001.

on chart reviews as part of the HealthChoice quality assurance process; and streamlining credentialing processes across all MCOs. These issues will be addressed below along with a recommendation for a future process to determine the impact of proposed new requirements on providers.

Timely Claims Payment

The Department received calls from providers immediately after program implementation concerning timely payment of claims by MCOs. The Department immediately set up procedures to handle individual billing complaints from providers and established quarterly reports from MCOs concerning the percentage of bills paid in a timely manner. In addition, the Department began to sanction MCOs when they did not pay at least 80 percent of claims within 30 days. Through these mechanisms and through the hard work of MCOs, MCO claims payment has improved dramatically.

As a result of recent legislation, the Maryland Insurance Administration (MIA) will be implementing regulations to define clean claims and monitor HMO (including HealthChoice MCOs) compliance with timely payment of clean claims. The MIA will also be monitoring MCO payment of interest on clean claims that are not paid within 30 days.

- **Recommendation**

  Rather than duplicating efforts, the Department should utilize the information collected by the MIA to monitor and apply corrective actions for MCO claims payment performance.

Eligibility Verification

Providers have asked for one phone number to call to find out if an enrollee is eligible for Medicaid, which MCO they are in, and the name of the enrollee's primary care provider. Currently, providers call two phone numbers – the Maryland Medicaid Eligibility Verification System to see if the patient is eligible and what MCO they are in – and then the MCO phone line for information on who is the PCP. This adds to their administrative burden.

- **Recommendation**

  The State already has funding to replace the current EVS system as part of its efforts to become HIPAA compliant. The new system should include the capability to automatically route the call to the MCO's eligibility phone line. This linkage would result in a provider making only one call and getting both PCP information and client eligibility information at the same time. Specifically, this means that after calling the State's EVS system and hearing the patient is eligible and in a certain MCO, the doctor's office could push a button to automatically dial-up the MCO eligibility verification line which provides PCP information. This line would then give the caller the name of the enrollee's primary care provider.

Newborn Care

The evaluation demonstrated that newborns are more likely to access care under HealthChoice than under the previous fee-for-service system. In addition, newborns received more well child and ambulatory care visits under HealthChoice. This good news is tempered by the fact that the Program still has progress to make in order to meet its high standards for newborn care.

➢ Recommendations

In order to make sure that mothers of newborns know where to take their newborn for care and that appropriate newborn care is paid for by the MCO, the following new and on-going initiatives are recommended:

- The Department should support and monitor the MCO Newborn Care Coordinator Initiative. In this initiative, the MCOs hired Newborn Care Coordinators by September 1, 2001 to provide information and assistance to providers serving newborns. This includes facilitating payment for newborn care to out-of-network providers. Protocols for the newborn coordinators have been developed and the list of coordinators and their phone numbers have been distributed to doctors and other newborn providers throughout the State. Both the Department and the MCOs are currently tracking the volume and types of calls being received by this new staff. Additional efforts are currently underway to explain the availability of the Newborn Care Coordinators to providers throughout the State. After 6 months, the Department should evaluate this initiative to determine if it is meeting its performance objectives, including but not limited to: expediting eligibility; facilitating PCP selection; coordinating and authorizing in-network care; coordinating with ancillary provider networks; and facilitating the resolution of claims;

- The Department should continue to track newborn issues raised on the HealthChoice Enrollee Action Line;

- The Department should periodically monitor how quickly hospitals submit information on newborn's births to the Department. Hospitals that do not submit the forms in an expeditious manner should be required to submit corrective action plans. The Department should give hospitals, and other appropriate stakeholders, a new flyer to be given to new moms prior to leaving the hospital reinforcing that the newborn has coverage from birth and giving the mother important information and phone numbers to call if she needs assistance;

- The Department should periodically audit through its already established quality assurance audit how quickly MCOs issue MCO cards to newborns. If there is a delay in issuing these cards, MCOs should submit corrective action plans; and,

- The Local Health Departments and MCOs should continue to educate pregnant women regarding the importance of selecting a doctor for the newborn during pregnancy and the enrollment process that assigns the newborn to his or her mother's MCO.

Reducing Unnecessary Administrative Burdens Associated with Quality Assurance Activities

During the early years of the Program, the Department and its contractors relied almost exclusively on chart reviews to determine if high quality health care services were being delivered by MCOs. Pulling charts is an administrative burden for providers. However, it was necessary because the Department did not have the appropriate administrative data (encounter data and HEDIS data) to use to see if adequate care was being delivered. At this point, the Department has other tools to assist in monitoring quality of care.

➢ **Recommendation**

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

Streamlining Credentialing Processes

Each MCO has established procedures and protocols for credentialing providers to participate in its network. These separate procedures and protocols make it difficult for providers that want to participate in multiple MCOs.

➢ **Recommendation**

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

Future Provider Communication Model

During the initial years of the HealthChoice Program, it has become clear that providers want more input into and information about the HealthChoice Program. It also has become increasingly clear that current communication methodologies such as program transmittals, provider handbooks and even the internet, are insufficient.

➢ **Recommendations**

- The Department should work collaboratively with the MCOs to develop a HealthChoice provider manual. This manual should be distributed to all HealthChoice providers in writing and should also be placed on the web. It should be updated as program policy and procedures change. While this manual will consolidate most of the Department's and MCOs' communications to providers, individual MCOs may provide additional information to providers concerning such issues as provider billing procedures;

- Provider transmittals for the HealthChoice program should be placed on the web; and,

- The Department, in collaboration with MCOs and provider organizations such as the Maryland Chapter of the American Academy of Pediatrics, the Maryland Hospital Association, and the Medical and Chirurgical Faculty, should convene regional meetings on a periodic basis to relay updated program information to providers and their office managers. These meetings will also provide an avenue for the Department to receive providers' and office managers' input on issues. MCO staff should be available at these meetings to address issues and concerns.

QUALITY OF CARE AND STRATEGIES TO IMPROVE PROGRAM PERFORMANCE

In order to make sure that HealthChoice enrollees receive accessible and quality health services, the Department has established a number of on-going monitoring efforts, including:

- Annual quality of care audit
- Prompt pay reviews
- MCO grievance and appeal systems review
- Analysis of results of MCO operations (encounter date, HEDIS, DUR, etc)
- Review of MCO financial utilization and management (HFMR)
- Review of MCO financial stability (MIA reviews)

Although the Department has been monitoring many important aspects of MCO performance, there has been no centralized or coordinated approach to assessing and improving overall MCO performance. The Department is also concerned about the amount of administrative burden placed on the MCOs and providers in order to comply with all of these efforts.

In recognition of the need for a more defined and coordinated assessment of MCO performance, a need to streamline and reduce the administrative burden placed on MCOs and direct service providers by the Department's numerous monitoring efforts, and the need for a more flexible approach in order to meet the new federal requirements as a result of the Balanced Budget Act of 1997, the Department has been developing a Value Based Purchasing Strategy to be implemented beginning in calendar year 2002.

Value Based Purchasing is an approach to health benefits purchasing that seeks to reward contractors based on their performance on a comprehensive range of dimensions. These dimensions are defined as administration, cost, access and quality of care, and member satisfaction. Measured together, MCO performance in these dimensions defines "value". Taking the approach of monitoring through a defined set of comprehensive performance measures will streamline and consolidate HealthChoice monitoring efforts.

- **Recommendations**

  The Department, in collaboration with stakeholders, should:

  - Define the set of performance measures that represent key indicators of success in each major dimension of MCO performance;

- Develop targets for each measure based on existing data, such as national benchmarks, established baselines, or an accepted methodology based on self-improvement programs such as the federal Quality Improvement System for Managed Care (QISMC); and,

- Create a system of financial incentives and disincentives to encourage MCOs to improve performance.

PROGRAM IMPROVEMENTS FOR CONSUMERS

Based on the evaluation findings, a number of recommendations are being made to improve consumer access to care under HealthChoice:

Auto-Assigned Enrollees' Right to Change MCOs

In numerous public forums, providers, local health departments, enrollees and advocates have stated publicly that the program has disrupted the enrollee's medical home. This is mostly related to the enrollee not making a choice during the initial enrollment period. Although 80 percent of HealthChoice enrollees choose an MCO, the remaining 20 percent are auto-assigned. Currently, auto-assigned patients can change to follow their historic provider, but only if they call within 60 days of the auto-assignment.

MCOs support an annual lock-in period because they have to spend resources to outreach to enrollees; if an enrollee leaves in less than a year, the resources invested may yield little benefit to that MCO. One year is also the standard in the private managed care market place.

- **Recommendation**

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

Case Management

When the HealthChoice Program was developed, high expectations were established for the level of case management services to be delivered to special populations. It was assumed that case management would save money in the long-term and that MCOs would automatically provide the service even though no additional money (with the exception of funding for case management services to individuals with HIV/AIDS) was included in the rates. Numerous populations were targeted for case management, including:

- Individuals with HIV/AIDS
- Individuals with physical disabilities
- Individuals with developmental disabilities
- Pregnant and postpartum women
- Individuals in need of substance abuse treatment
- Children with special health care needs

- Individuals who are homeless.

According to the HealthChoice regulations, special populations are to receive necessary services through MCO provider networks that include primary care providers and all necessary specialty providers. Under this model, except in the case of individuals with HIV/AIDS (where case management is to be universally offered), it is assumed that the enrollee's PCP will take the lead in determining whether specialty care is necessary and seek help from MCO case managers to coordinate these specialty referrals when necessary and appropriate. Case managers within the MCO are to work with enrollees and their PCPs and specialists to develop a case management plan and make sure needed services are delivered in a timely manner.

Under the regulations, if an MCO (through its providers or case managers) works with a member of the above mentioned special populations and is unable to get the member to comply with the care plan, the MCO can seek assistance from grant-funded local health department staff. The LHD staff will help locate and attempt to get the individual back into care.

During the evaluation, the Department conducted numerous consumer forums. In the course of these forums, it became clear that many consumers were confused about how to appropriately use the health care system. In addition, it became clear that most consumers did not know if they had received services from MCO case managers or that case management services were available. Although consumers did not complain about the lack of case management or request access to case management, other stakeholders such as advocates and providers have expressed concern about the lack of such services.

In follow up to these meetings, the Department held site visits at MCOs to meet with case management staff to determine the source of the confusion. These site visits included the opportunity to sit with individual case managers and watch them interact with clients. During these meetings, it became clear that MCOs are providing case management to high-risk HealthChoice enrollees. In particular, most MCOs have case management programs for pregnant women, newborns, and individuals with conditions that can be improved through disease management protocols (such as children with asthma and sickle cell anemia and adults with diabetes and heart disease).

In addition, MCOs have case managers that work with individuals who have high medical costs or who utilize the health care system inappropriately (such as going to emergency rooms for primary care). Most of these case management interactions are via telephone, although MCOs did have outreach staff go to the patient's home when necessary. MCO staff also explained how they utilized local health department staff for non-compliant patients and expressed concern over the HealthChoice policy which requires them to continue to serve patients who refuse case management while continuing to use the health system inappropriately.

The Department has been trying to determine possible reasons for the disconnect between the case management services they witnessed being provided and hearing enrollees state that they did not have a case manager within their MCO. It could be that the:

- Consumer forums did not include individuals who had received case management services (only high-risk patients receive active case management and this population may have been less likely to attend a consumer forum); and,

- Consumers do not know what case managers do and therefore do not recognize that they have received such services (e.g., - case managers in MCOs often explain to consumers that they are trying to help the doctor make sure that they get necessary health services and therefore consumers do not know they are MCO staff).

High-quality case management is expensive, resulting in the need to utilize case management resources in the most efficient manner. When the HealthChoice program was implemented, no additional funding was added beyond the grants given to local health departments for care coordination for non-compliant populations and the direct reimbursement for HIV/AIDS case management that was placed in the MCO capitation rates.

- **Recommendations**

  A case management workgroup composed primarily of LHD and MCO case management staff should be formed to make recommendations regarding:

  - Whether the HealthChoice regulations identify the most appropriate special populations;

  - The actual scope of case management within the MCOs;

  - The difference between the case management functions that are the responsibility of the MCOs and those that are the responsibility of the Local Health Departments;

  - The best methods for identifying populations in need of case management services and educating providers and consumers;

  - Best practices within MCOs in the area of disease management (a systematic program to improve the health status of members with a specific chronic condition through member education and empowerment, collaboration with treating physicians and other health care providers, and coordination with community based organizations and other available resources);

- Protocols and procedures to ensure that MCO case management staff, local health department administrative care coordinators, and other targeted case management staff do not waste scarce resources by duplicating efforts; and,

- The feasibility of utilizing the local health department Administrative Care Coordinators/Ombudsman grants to provide intensive case management services for certain enrollees who require more intensive assistance in order to comply with treatment.

Foster Care

The evaluation data indicated that foster care children received fewer well-child and ambulatory services in MCOs than they had in the fee-for-service system prior to HealthChoice. This information did not take into account the large number of services reimbursed through Medicaid fee-for-service that foster care children receive prior to entry into an MCO. State rules require foster care children to receive comprehensive physicals shortly after entry into foster care. Since foster care workers are required by the Department of Human Resources to coordinate MCO placement with the child's foster care parent, HealthChoice regulations allow children in State-supervised care to have 60 days (instead of 30 days) to choose an MCO. Therefore, many of the foster care physicals are completed prior to entry into HealthChoice and are not recorded in the MCO encounter data.

Even though the data on foster care children may not be complete, stakeholders agree that these children represent one of the most vulnerable populations in HealthChoice. Therefore, system barriers to assuring that these children receive high-quality comprehensive health care services should be addressed through the following strategies.

➢ Recommendations

- An expert panel (which includes representatives from the Department of Human Resources, the Local Departments of Social Services (DSS), the Department of Health and Mental Hygiene, foster care parents, providers, and other key stakeholders) should be convened to develop a comprehensive list of system improvements to serve the health needs of this population. For example, a mechanism should be developed to allow MCOs to have addresses of the foster care parents associated with each child.

- The process for determining eligibility for foster care children needs to be expedited, as has been proposed in Baltimore City. After testing and, if necessary, improving the new Baltimore City process, it should be implemented on a statewide basis.

- Training should be implemented for DSS foster care workers, foster care parents and resource providers for children in out-of-home placements so that they can assist in making sure children receive needed health services.

- The Department should apply for a federal waiver amendment to allow children enrolled in the State-only foster care eligibility coverage group to be enrolled in HealthChoice MCOs. This will affect approximately 600 children who are currently not eligible for HealthChoice.

Complaint and Grievance Process

HealthChoice enrollees have numerous opportunities to complain about or appeal an MCO decision to deny, reduce or terminate benefits. However, many enrollees may not fully understand how to use the MCO's internal appeal and grievance process or be aware that they do not need to exhaust the MCO appeal process before seeking help from the Department's HealthChoice Enrollee Action Line.

Enrollees currently receive information about the MCO's internal complaint and grievance process, as well as the Department's HealthChoice Enrollee Action Line, at the time of enrollment. Information about the Department's line is in a pamphlet that is widely distributed through various means including DSS, LHDs, the Enrollment Broker, and advocacy groups. The HealthChoice Enrollee Action Line's toll-free number is also on all MCO identification cards. The MCOs are required to outline their internal complaint and grievance process in their MCO Member Handbook that is sent to everyone upon entry into HealthChoice. Despite these efforts to educate enrollees, the Department continues to hear cases where HealthChoice enrollees do not know how to appeal when services have been denied, reduced, or terminated.

In April 2000, the Program's internal appeal processes were significantly revised to assure that consumers were given complete and timely information regarding their appeal rights. When an enrollee's problem is not resolved within ten days, they are informed of their right to appeal. This change resulted in a slight increase in appeals and the need to hire additional staff within the Department to handle such appeals in a timely manner.

The Department has received requests to standardize and strengthen the adverse action notices distributed by MCOs and to place a greater emphasis on monitoring whether MCOs are sending such notices to affected enrollees.

➢ Recommendations

In partnership with the Enrollment Broker, the local health departments, community-based groups, providers, and the MCOs, the Department should:

- Increase efforts to educate and inform enrollees of the HealthChoice Enrollee Action Line;

- Ensure that consumer education materials, such as member handbooks, discuss the consumer's right to receive prior written notice from the MCO of any adverse action, their right to disagree with the proposed adverse action, and their right to continue receiving ongoing disputed care until the issue is resolved through the appeal and hearing process;

- Require MCOs to provide adverse action notices and if necessary, use a sample notice developed by the Department as a template; and,

- Enhance efforts to monitor MCO compliance with the standard appeal and grievance processes.

Transportation

Maryland Medicaid provides funds to grantees (most often local health departments) and asks them to arrange or provide non-emergency transportation to and from medically necessary covered services for Medicaid enrollees (and when necessary their guardians/ attendants). Transportation is only to be provided for those enrollees who have no other means of transportation available. The FY 2001 appropriation for the Transportation grant program was $20,467,890.

It is clear from public forums that Medicaid enrollees and their providers, including MCOs, would like a more generous transportation benefit. Consumers want:

- Immediate and private versus scheduled and shared ride services;
- Transport of other family members in addition to the enrollee and attendant; and,
- Transportation provided in lieu of being required to use public transport.

Providers are concerned that the lack of convenient transportation is a reason for missed appointments and non-compliance with treatment regimens. Both consumers and providers complain about difficulty in obtaining cross-jurisdictional transportation when an MCO specialty provider is not locally available.

- **Recommendation**

  The Department should develop a proposal to:

  - Retain the scheduled transportation system, but modify it to support enrollees' visits to scheduled appointments within or outside their jurisdiction;

  - Increase program oversight of grantees through such mechanisms as consumer surveys and encourage local health departments to pool resources and efforts when providing regional transportation;

- In collaboration with stakeholders, study whether provider network issues in rural areas (particularly the Eastern Shore) as well as other areas justify a reallocation of transportation funding; and,

- Continue to use complaint hotlines to monitor that transportation services are provided appropriately.

IMPROVE THE DELIVERY OF SPECIAL SERVICES

The HealthChoice program was implemented with a number of services carved-out, meaning the MCOs are not responsible for providing or paying for these services. The major carve-out was specialty mental health services. In addition, from the beginning, the program carved out health-related special education services; long-term care services such as personal care and medical day care services, and services provided in ICF-MRs; Healthy Start case management services for pregnant women and high-risk children under two years; Developmental Disability waiver services; abortion services; and viral load testing used in treatment of HIV/AIDS. Although protease inhibitors for individuals with HIV/AIDS were initially carved out of the MCO service package, once the program had cost experience and data, these services were included back in the MCO service package. Two years after the implementation of the waiver, physical therapy, speech therapy, occupational therapy, and audiology services were carved out of the program. Since that time, no additional services have been carved out.

Carve-outs are difficult to handle in a managed care system. They are complicated to explain to providers and enrollees who expect the MCO to provide or coordinate all necessary health care services. In addition, they require providers in different systems to communicate with each other for the welfare of the patient. For example, it has been especially challenging to make sure primary care providers and specialty mental health providers know the services and prescriptions each of them are providing for an individual enrollee. This is also true for the health-related special education and the therapy services. Most primary care providers do not know the full range of services provided to children in their practice. This may have an impact on quality of care.

Carve-outs must be carefully thought out because the unintended consequences can be negative for HealthChoice enrollees. As explained in the findings section of the report, there was actually a decline in access to physical therapy and occupational therapy services after these services were carved out of the MCO service package, although there was an increase in speech therapy services. This was in part because the fee-for-service provider network for these services was weak, especially outside of the Baltimore metropolitan area. The following three areas have been recommended by certain stakeholders for possible carve-out from the HealthChoice program: dental care, substance abuse treatment, and all services delivered to pregnant women enrolled in the SOBRA expansion group.

In addition, some stakeholders have recommended that mental health services be carved back into HealthChoice. A decision to do this would have consequences for the entire specialty mental health system since that system also serves low income, uninsured and underinsured Marylanders. The specialty mental health system has undergone a separate evaluation which will be appended to this evaluation.

Dental

The HealthChoice evaluation found that access to dental services has improved since the implementation of HealthChoice. The Department continues to encourage the use of best practices learned from those MCOs that have met the established targets or have made significant improvement in utilization rates. MCO strategies for increasing access to oral health services to children include the following:

- Bonuses to oral health providers for new patients;
- Paying oral health providers to offset revenue losses for missed appointments;
- Extended school-based clinic hours;
- Expediting or eliminating authorization and referral procedures; and,
- Financial incentives, transportation, and service reminders for enrollees.[3]

Despite this fact, some stakeholders believe that progress has not been rapid enough, especially in light of the high utilization goals established by the General Assembly. This has led some stakeholders to request a carve-out of dental services. Other stakeholders have questioned whether the goals included in State law are realistic given the high-risk nature of the Medicaid population and the reluctance of dental providers to participate in any health insurance program, much less the Medicaid program. They also question whether carving out dental services would improve access. However, all agree that more children enrolled in HealthChoice should access dental services.

The potential repercussions of a dental carve-out must be considered. First, it will threaten the program's progress in the area of adult dental services, which is not provided under the Medicaid program, but all the MCOs offer as an extra benefit. When the program was implemented, the Department required MCOs to provide adult dental benefits if they wanted to receive auto-assignments under the program. Due in large part to this requirement, all MCOs are providing this extra service. If dental services were not included as part of the MCO service package, it is highly unlikely that MCOs would continue to contract with dental benefit plans on behalf of their adult members. Therefore, an important enhanced service offered under the program would in all likelihood be eliminated.

Second, the State should carefully consider whether a carve-out would result in higher dental utilization rates. In the past, in large part due to low payment rates, most dental providers in Maryland did not participate in the fee-for-service Medicaid dental program. If the State were to revert to the fee-for-service Medicaid program, it is probable that there still would be a shortage of dental providers. If the State were to contract with another dental benefit provider, significant time and effort would be spent bidding out and re-contracting for this service. In addition, this could disrupt the network of providers that service children currently enrolled in the program.

[3] "FY2001 Annual Report on Access to Dental Services in the HealthChoice Program." DHMH, October 1, 2001.

➢ **Recommendations**

- The Department should continue to increase funding for dental care to meet the utilization goals established by the legislature;

- If dental utilization does not improve significantly based on the Department's new funding for CY 2001 and subsequent years, the Department should consider alternatives for the delivery of dental services;

- The Department should develop a system to monitor and enforce MCO dental network adequacy;

- The Department should develop a dental accountability plan to enforce the legislatively mandated utilization targets. This includes monitoring MCO dental fees and actual expenditures for dental services and outreach to encourage use of dental services. The Department should implement financial sanctions for those MCOs that do not meet the required target of 40 percent for CY 2001;

- The Department should study the utilization goals established in State law to determine if they have been achieved by other state Medicaid programs and to see how they compare to other national benchmarks for dental care for low income populations. As part of this investigation, other state Medicaid agencies with higher dental utilization rates should be studied to determine the factors that contributed to their success;

- The Department should perform annual on-site visits with MCOs to review their strategies for meeting the utilization targets and to share successful strategies from other states; and,

- As recommended earlier, the Department should establish an MCO and provider workgroup to determine how to streamline and potentially standardize or centralize the MCO provider credentialing process.

Substance Abuse

In the summer of 2000, at the request of the Drug Treatment Task Force, the Department formed the Medicaid Drug Treatment Workgroup, a working committee comprised of representatives from DHMH, the MCOs and their Behavioral Health Organizations (BHOs), providers and advocates. The Workgroup's task was to answer two questions:

➢ Are the MCOs appropriately serving HealthChoice enrollees with substance abuse needs?
➢ If not, should substance abuse be carved out, and what model should be used?

After months of study, the Workgroup made two recommendations. The first was to implement a Substance Abuse Improvement Initiative (SAII) for enrollees in HealthChoice. This initiative provides enhanced access to substance abuse services for HealthChoice enrollees and opportunities for expansion of provider networks. The main components of the SAII are enrollee self-referral for substance abuse treatment to any willing treatment provider even if the provider is not part of the MCO/BHO network, prompt payment of claims, and expansion of MCO/BHO provider networks.

The second recommendation was simultaneously to design a carve-out of substance abuse services from the HealthChoice program, with the intention of implementing it if the new improvement initiative was not successful. The evaluation of the Substance Abuse Improvement Initiative is to be completed in April 2002. The Workgroup is currently in the process of designing the carve-out model and devising a timeline for implementing the carve-out, should this option be chosen.

SOBRA Pregnant Women

Prior to the implementation of the HealthChoice program, women who gained Medicaid eligibility because they were pregnant (SOBRA pregnant women) were not allowed to enroll in the voluntary HMO program. When HealthChoice was implemented, the State decided to enroll these women in MCOs as long as they enrolled in the Medicaid program before 32 weeks gestation. At the same time, the program required MCOs to allow women who enrolled during their pregnancy to continue to receive prenatal care from their prenatal care provider (even out-of-network) as long as she began to receive the care prior to enrolling in the MCO. The goal was to maintain continuity of care throughout the pregnancy. The State also acknowledged that some pregnant women are non-compliant with prenatal care requirements and therefore, even after implementation, the State continued to provide Healthy Start case management services for high-risk pregnant women through local health departments.

Some MCOs have had a problem with costs associated with SOBRA moms and their newborns. They have stated that it is difficult to have an impact on a woman's pregnancy when she enrolls late in pregnancy. It has been suggested that the State consider carving this population out of HealthChoice. This would mean that they would have to choose an MCO for the baby after birth.

The potential problems of this proposal are that the Department might have a difficult time assuring access to obstetrical care during the prenatal period. Most MCOs do pay physicians more for this care than Medicaid pays on a fee-for-service basis. In addition, babies born to SOBRA pregnant women who are not enrolled in MCOs would need to choose an MCO following the birth. Therefore, they would be in the fee-for-service Medicaid program for at least the first two months of life. They might establish relationships with providers that might then have to be changed when the mother selects the baby's MCO. In addition, they will not get assistance from MCOs in finding providers to see their babies. This is a concern because the evaluation found that newborns enrolled in

MCOs got many more ambulatory services than newborns received prior to the implementation of HealthChoice. Finally, pediatricians may be concerned about accepting Medicaid fee-for-service payment rates for newborn care. This may lead to a reduction of services for newborns of SOBRA pregnant women if these women are not allowed to enroll in an MCO.

- **Recommendation**

  The Department does not recommend a carve-out of SOBRA pregnant women at this time. However, it should reconsider whether the 32-week gestation period is the appropriate cut-off period for entry into MCOs. The Department should conduct further study of general HealthChoice prenatal care delivery, including services for SOBRA pregnant women.

STRATEGIES TO ESTABLISH A MORE STABLE MANAGED CARE SYSTEM

As described in the findings section, the Medicaid program has experienced several plan transitions and operational challenges in recent years. In order to focus on stabilizing the HealthChoice program and developing longer-term relationships with the MCOs, the recommendations below have been developed.

Future Rate-Setting Model

The HealthChoice evaluation process has examined the historical financial performance of the Program and of the MCOs over the past four years. The evaluation found that most of the MCOs were able to generate profits through 2001. The MCOs, however, have projected that future medical expenses will increase faster than the trends projected by the actuary. There also is general concern about the inadequacy of 1997 physician fee-for-service data as a component of the baseline for rate-setting.

- **Recommendation**

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

Two-Year Rate Setting Process

The Department's current rate-setting process is very collaborative, but labor intensive. During more than eight months of every year, the Department, MCOs, and other HealthChoice stakeholders devote a great deal of time and resources to the rate-setting process. This annual process by nature introduces volatility and instability into the Program.

- **Recommendation**

  - The rate-setting process eventually should be switched to a biennial schedule, with a trend factor applied for the second year based on a predetermined formula. This would allow the Department to better maximize its critical resources and the MCOs to engage in longer-term business planning. It would also free up more time for the Department, MCOs, and other stakeholders to work on other priorities.

- Enrollee risk adjustments would take place every year based on the latest health information, and interim adjustments would account for any fee-for-service or hospital rate increases as currently required by regulation. A two-year rate-setting process would allow the Program to work towards maintaining longer-term, more stable relationships with the MCOs.

MCO Exit Notice Requirements

Effective February 1, 2002, HealthChoice regulations will allow MCOs to terminate their contracts at any time if they provide 120 days of advance notice. There is a second provision that allows MCOs to exit the market at the start of a new rate year with only 90 days notice (by October 1) to the Department. These timeframes do not allow sufficient time for preparation of exits and transitions. In addition, there are financial costs associated with plan exits, such as the costs associated with re-enrolling individuals across the remaining MCOs. The Department typically is faced with absorbing these costs.

➢ Recommendation

- MCOs should only be allowed to exit by giving at least 180 days of advance notice between contract periods, or 90 days advance notice at the beginning of a rate year. This would guarantee longer periods of time to prepare for exits and transitions, and would enhance continuity of care.

- The Department should investigate and make recommendations regarding an equitable formula for sharing the costs of the exits with the exiting MCO.

Larger Service Areas

Currently, when MCOs have network or financial problems in certain local access areas, they are able to institute freezes on enrollment. This system tends to result in instability and service disruptions particularly in areas with higher-risk populations.

➢ Recommendation

In order to address this situation, larger service areas should be established. This would discourage plans from freezing in or withdrawing from certain local access areas based on localized medical loss ratios. Operationally, local access areas would continue to exist for enrollee PCP and MCO assignment purposes based on zip code clusters and geographical access standards. In addition, MCOs would still have to meet the time and distance standards included in the regulations for access to primary care and other services.

Federal Waiver Amendment to Allow HealthChoice to Continue in Areas Where There is Only One MCO

The current waiver requires at least two MCOs in each local access area. As plan exits have occurred over the past several years, this provision has threatened to create barriers to access in certain regions of the State where plan participation is limited. The Department believes that allowing enrollees a choice of providers within a MCO is adequate to assure choice and preferable to a fee-for-service system with no medical home or managed care infrastructure. Keeping HealthChoice in operation in areas with only one MCO improves access to services and increases program stability. This change will require reprogramming of the Medicaid Management Information System.

➢ Recommendation

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

Cost-Containment and Reduced Administrative Burdens

The Mercer actuaries determined that per person costs for the HealthChoice population if there had been no waiver would have increased by 4.1 percent between FY 1997 and FY 1998, and by 8.3 percent between CY 2001 and CY 2002. This accelerating rate of increase accompanied by the administrative complexity of the HealthChoice Program hinders the Department's ability to effectively manage costs.

During September and October 2001, the Department met with MCOs individually to discuss their ideas on cost-containment. Opportunities for improvement that were identified include:

- Maximizing third-party recoveries;
- Reducing administrative requirements;
- Coordinating and reducing overlaps of on-site audits; and,
- Reducing ancillary costs through collective purchasing in areas such as pharmacy, lab, and radiology, as well as surgery centers.

➢ Recommendations

- The Department, in collaboration with the MCOs, should identify cost-containment initiatives and develop implementation plans that would begin in CY 2002; and,

- The Department should streamline regulatory reporting by MCOs by coordinating the audit requirements and compliance standards of the

Department, MIA, and HSCRC. As such, MCOs will be held accountable for providing high quality care while overall regulatory reporting requirements are reduced.

CONCLUSION

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