

HealthChoice Evaluation

March 2006

Introduction

HealthChoice, Maryland's Medicaid managed care program, was implemented in 1997. In January 2002, the Maryland Department of Health and Mental Hygiene (the Department) completed a comprehensive evaluation of HealthChoice.¹ The evaluation found that HealthChoice had been successful in improving access while controlling costs, and had served as a platform for major program expansion.

Since completing the HealthChoice Evaluation, the Department has continued to monitor a variety of HealthChoice performance measures. This document provides a brief update on how HealthChoice is performing. The original HealthChoice Evaluation compared performance in Fiscal Year (FY) 1997, prior to the implementation of HealthChoice, to performance in Calendar Year (CY) 2000. This update focuses on HealthChoice performance for CY 2001 through CY 2004.

HealthChoice Facts

- HealthChoice enrolls approximately 70% of Medicaid beneficiaries (over 483,000 Marylanders).²
- Since CY 2000, average total HealthChoice enrollment has increased by about 15%, from just over 409,000 enrollees in CY 2000 to over 483,000 enrollees in CY 2004.
- HealthChoice enrollees include low-income children, pregnant women, families receiving Temporary Cash Assistance (TCA), individuals receiving Supplemental Security Income (SSI) benefits, and children in foster care. Some of the groups excluded from HealthChoice are Medicare recipients and individuals in nursing facilities for more than 30 days.
- Enrollees receive their health services through seven HealthChoice managed care organizations (MCOs).

Key Findings

This update demonstrates continued progress by the HealthChoice program. Between CY 2001 and CY 2004 HealthChoice improved access to health services in a number of important areas including ambulatory care, well-child visits, dental services, and lead testing. Increases in access occurred even as the number of HealthChoice enrollees continued to grow. Access rates have shown the greatest improvement for children.

- The percentage of enrollees receiving an ambulatory care visit increased from 63.3 percent to 69.5 percent.
- The percentage of children receiving a well-child visit increased from 42 percent to 49.2 percent.
- The percentage of children receiving a dental visit increased from 34.5 percent to 43.7 percent.

¹ HealthChoice Evaluation (January 2002) and subsequent updates are available online at www.dhmd.state.md.us/mma/healthchoice/hcevalpres.html.

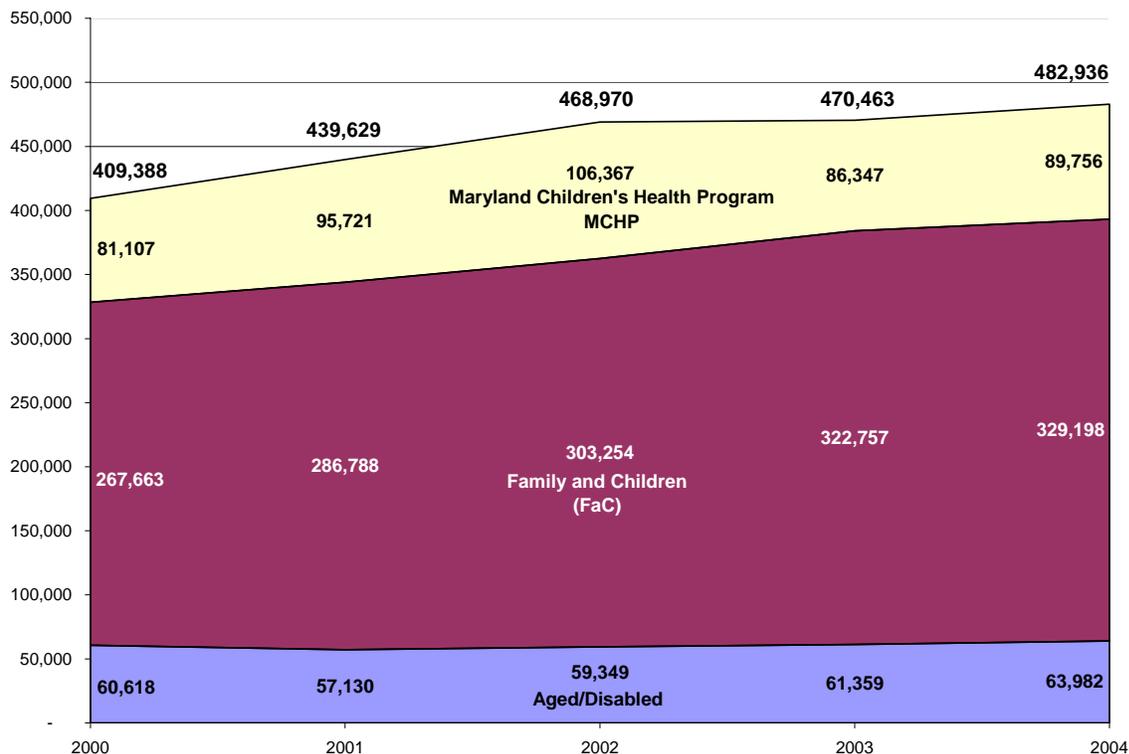
² Maryland: Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, as of December 31, 2004. <http://new.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcpr04.pdf>

- The percentage of one-year-olds receiving lead testing increased from 43 percent to 49 percent.
- After increasing in the early years of HealthChoice, emergency department (ED) utilization has stabilized. Approximately one-quarter of all ED visits were for the delivery of non-emergent care, but only a small proportion of HealthChoice enrollees (approximately six percent) account for non-emergent ED use.
- An examination of rates of access to several preventive services found little indication of racial or ethnic disparities in access to care under HealthChoice. HealthChoice has alleviated disparities in access to well-care services that existed under the fee-for-service Medicaid program.
- Children in foster care receive services, including preventive services, at higher rates than other HealthChoice children.
- The level of avoidable hospital admissions for individuals with asthma and diabetes has registered slight declines.

HealthChoice Enrollment

The HealthChoice program continues to experience growth in enrollment. In December of 2000, there were approximately 409,000 enrollees in HealthChoice. By December 2004, this number rose to just under 483,000 (Figure 1). The majority of enrollees continue to be in the Family and Children category (this includes TANF or temporary assistance to needy families, foster care children, and SOBRA pregnant women and children in families with incomes higher than TANF and lower than MCHP).

Figure 1: HealthChoice Enrollment by Coverage Group

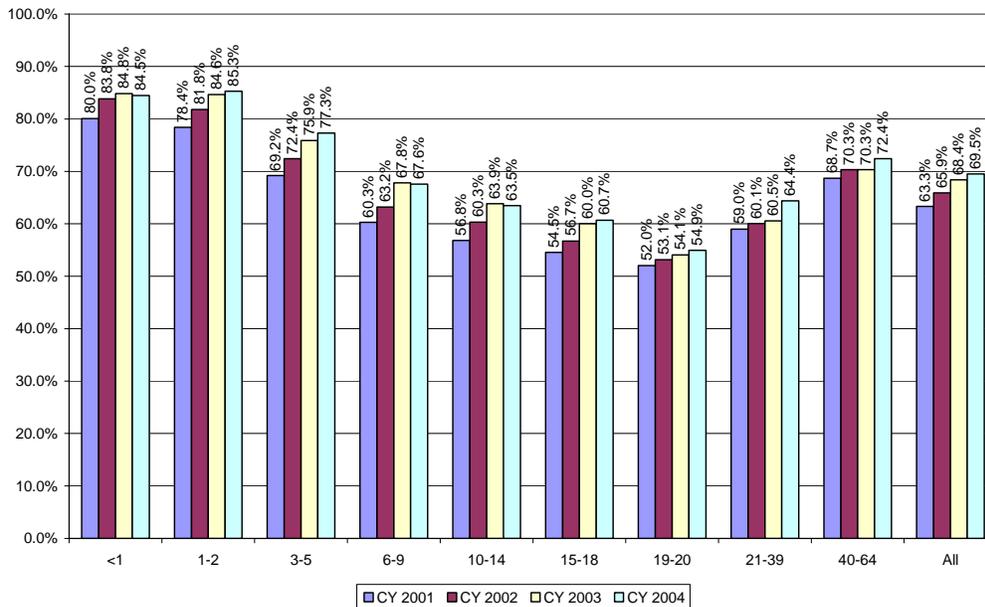


Ambulatory Visits

Ambulatory visits are defined as any time an enrollee (with any period of enrollment) has contact with a doctor or a nurse practitioner in an ambulatory setting. Ambulatory visits are reported as an unduplicated count that may not exceed one per day. The Department uses this measure to look at overall access to care, measuring the percentage of the population that had any contact with a health care provider.

The HealthChoice program has been successful in increasing access to ambulatory care for all enrollees, particularly for children under the age of 15. Since CY 2001, the overall percentage of individuals receiving an ambulatory visit has increased from 63.3 percent to 69.5 percent (Figure 2). In FY 1997, prior to the implementation of HealthChoice, the percentage of individuals accessing an ambulatory visit was 57.8 percent. Increases have been the greatest for children aged 1 through 14 and smallest for individuals aged 19 through 20.

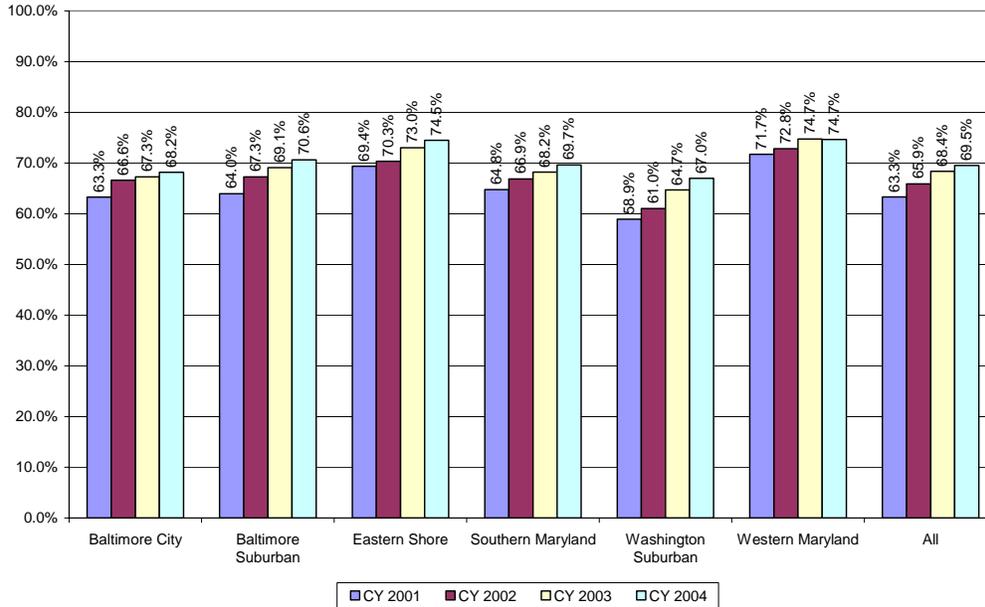
Figure 2: Percentage of the Population Receiving Ambulatory Care Service by Age³



The percentage of individuals receiving an ambulatory service has increased in every region of the State, with the greatest improvements in the Washington Suburban region as well as Baltimore City and the surrounding Baltimore Suburban region (Figure 3 below).

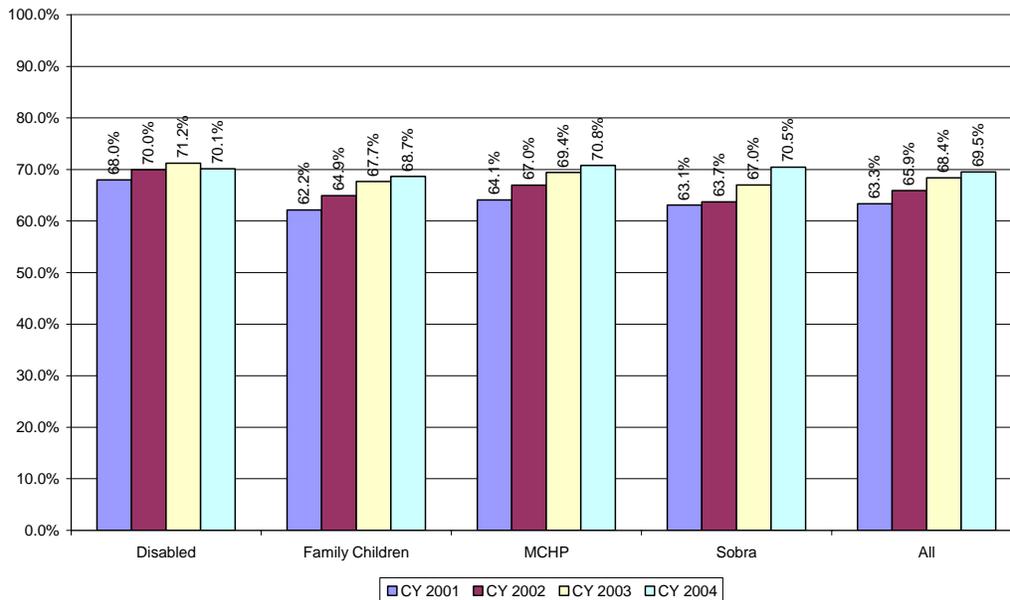
³ The ambulatory care, well-child, and ED measures are based on a population of HealthChoice enrollees with any period of enrollment.

Figure 3: Percentage of the Population Receiving Ambulatory Care Service by Region



Access to ambulatory services has improved for all HealthChoice coverage groups, with the SOBRA (pregnant women and children in families with incomes higher than TANF and lower than MCHP) and MCHP groups realizing the greatest improvements (Figure 4).

Figure 4: Percentage of the Population Receiving Ambulatory Care Service by Coverage Group



Overall, the number of ambulatory visits per thousand has steadily increased since CY 2001. On average, the HealthChoice population has experienced a one-half visit increase. The

most notable increases in the number of visits were for those children aged two and under; visit rates have increased by roughly 15 percent since CY 2001.

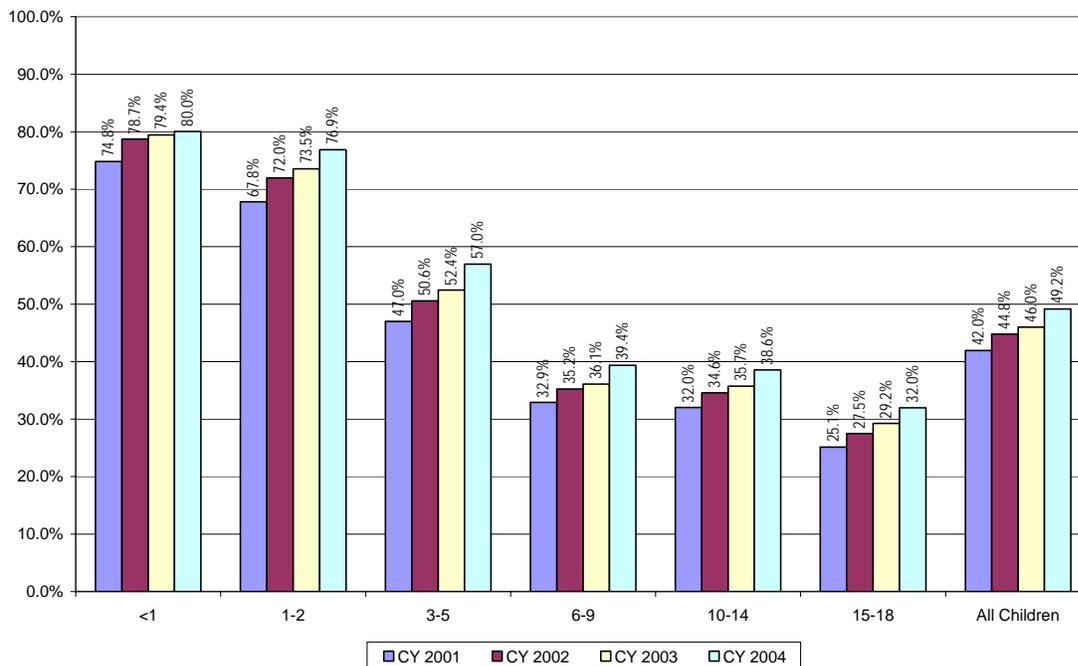
Well-Child Visits

Well-child visits are defined by one comprehensive measure, inclusive of well-child visits, EPSDT, and preventive services. This measure includes what the Department uses to report EPSDT services for federal reports. Well-child visits are a subset of all ambulatory visits.

Although they are a subset of ambulatory visits, well-child visits are unique because they are provided according to a prescribed periodicity schedule. HealthChoice regulations stipulate that MCOs must notify parents/guardians of pending well-child visits and make efforts to ensure that scheduled visits occur.

Well-child services are essential to the provision of comprehensive, prevention-oriented care, and the data suggest that HealthChoice has been successful in increasing the percentage of children who receive such services. The percentage of the population (with any period of enrollment) receiving a well-child service increased across all ages between CY 2001 and CY 2004. Overall, the access rate increased from 42 percent in CY 2001 to 49.2 percent in CY 2004 (Figure 5). These increases were observed across the State.

Figure 5: Percentage of Children Receiving a Well-Child Visit by Age



The number of well-child visits per thousand annualized member months continues to make marginal gains overall, with the most significant increases for children under one.

Dental Services

Dental care is a mandated health benefit for children up to age 21 under Medicaid EPSDT requirements. Though rates of access to dental services have been low for a number of years, access has steadily improved under HealthChoice. The Department closely monitors access to dental services through a variety of measures. A detailed description of dental access under HealthChoice is available at www.dhmm.state.md.us/mma/html/reppubs.html.

Between CY 2001 and CY 2004 the overall rate of access to dental services increased from 33.6 percent to 43.7 percent (Figure 6). The 43.7 percent access rate for CY 2004 was more than double the access rate under the fee-for-service program in FY 1997 (19.9 percent). Although access rates remained static during CY 2001 and CY 2002, rates increased noticeably in CY 2003 and those gains were maintained through CY 2004. Gains were registered across all age groups and across all regions within the State (Figures 6 and 7).

Figure 6: Percentage of Children Receiving a Dental Visit by Age

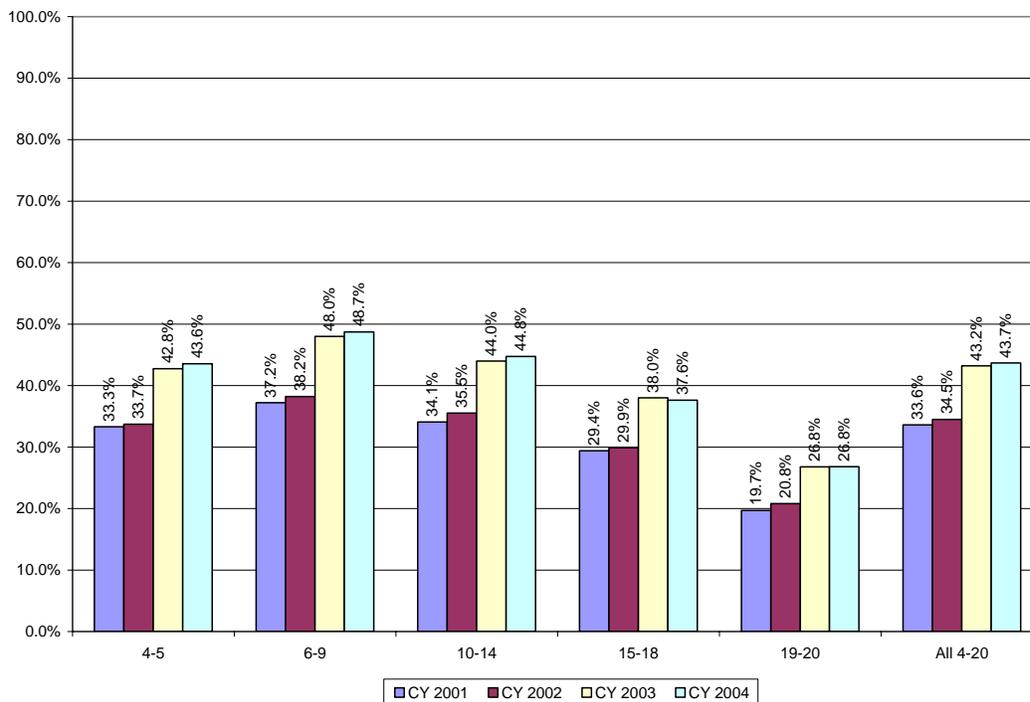
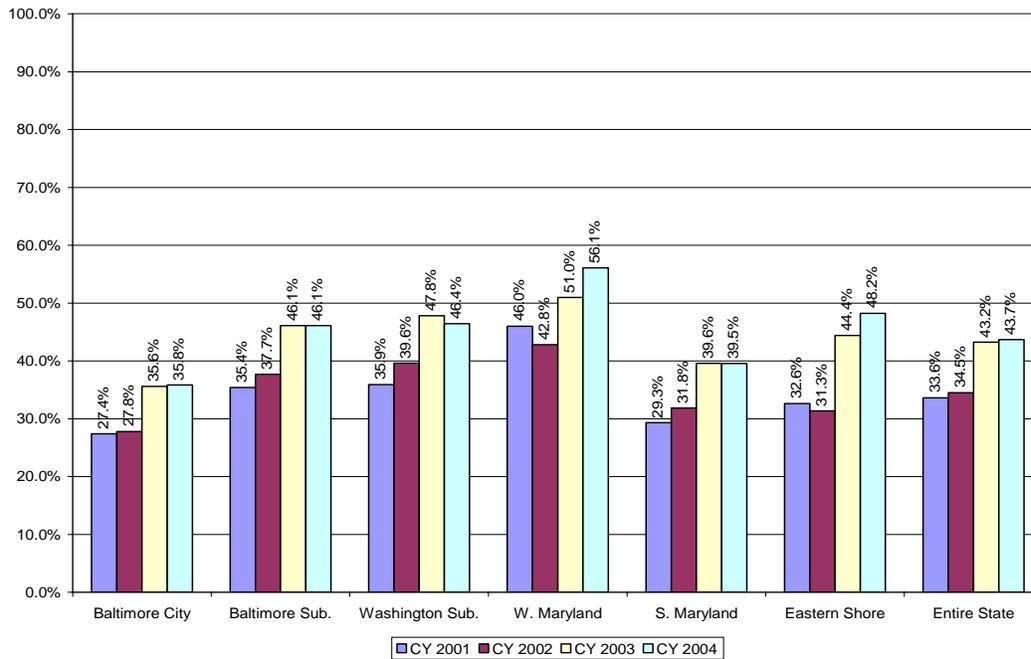


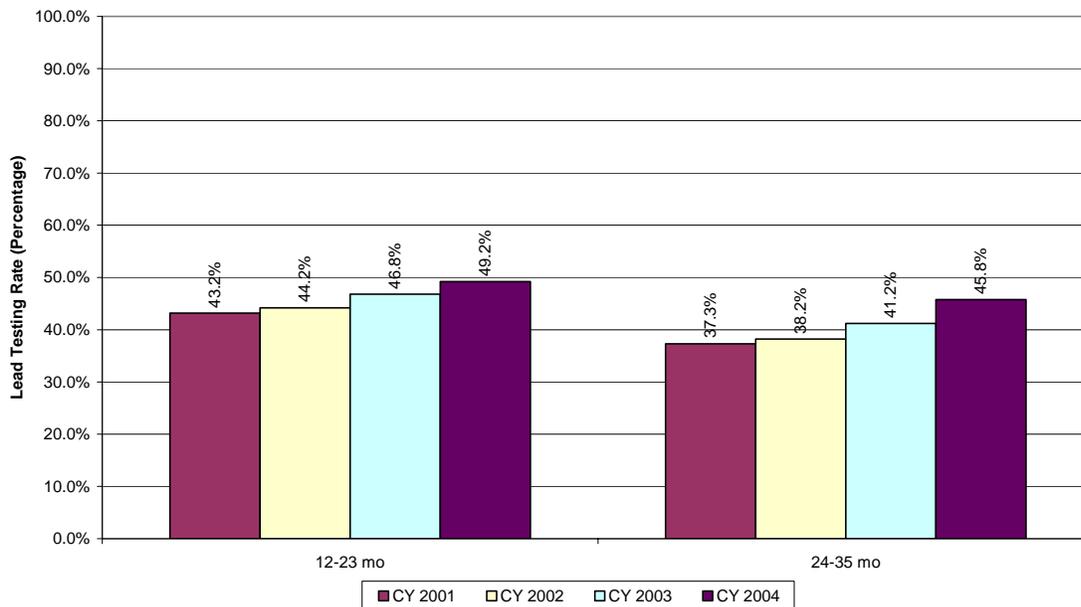
Figure 7: Percentage of Children Receiving a Dental Visit by Region



Lead Testing

Maryland has developed a Plan to Eliminate Childhood Lead Poisoning by 2010. One goal of the State plan is to ensure that young children receive appropriate lead risk screening and blood lead testing. All one- and two-year-olds enrolled in Medicaid are required to receive lead testing.

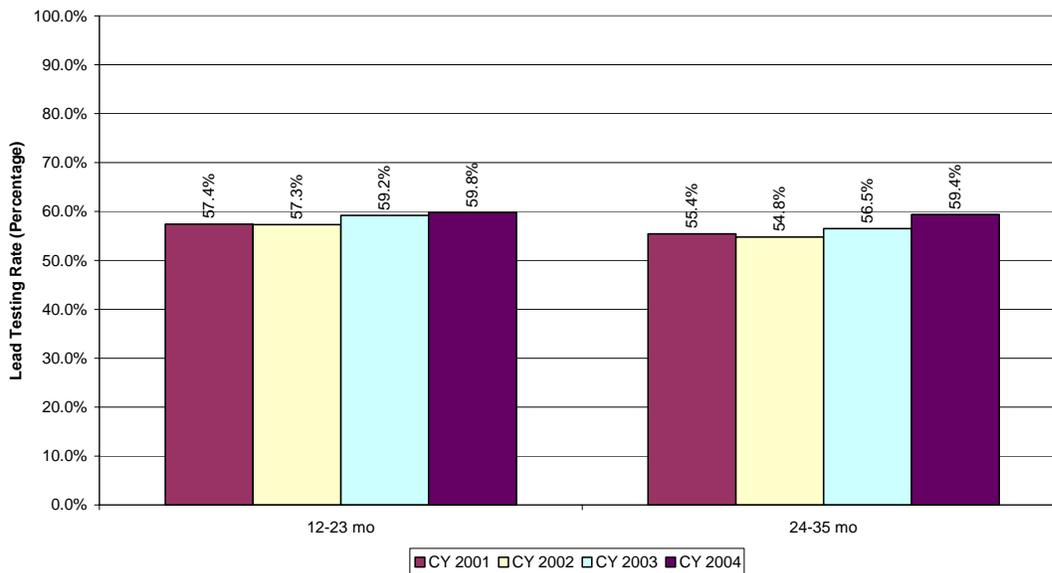
Figure 8: HealthChoice Children Receiving Lead Testing by Age (Statewide)⁴



⁴ Lead testing rates are reported for those children enrolled continuously in the same MCO for at least 90 days.

Figure 8 above shows that in HealthChoice, nearly 50 percent of children between the ages of 12 and 23 months received lead testing in CY 2004, an increase of six percentage points since CY 2001.⁵ For children aged 24 to 35 months the CY 2004 lead testing rate was nearly 46 percent, an increase of over 8 percentage points since CY 2001.

Figure 9: HealthChoice Children Receiving Lead Testing by Age (Baltimore City)



In Baltimore City, an identified high-risk area, the HealthChoice lead testing rate is close to 60 percent (Figure 9).⁶ The testing rates in Baltimore City have increased since CY 2001 although at a rate smaller than for the statewide data.

Emergency Department Visits

During the early years of HealthChoice, emergency department (ED) visit rates increased.⁷ This ran counter to expectations. There is general consensus that, unlike ambulatory care and well-child visits, ED use should decrease under managed care. This is based on assumptions that a managed care system is capable of promoting ambulatory care and restricting ED use to appropriate circumstances. For example, MCOs have disease management programs in place to encourage enrollees to access preventive care in order to manage their chronic conditions.

Recent analysis shows that after initially increasing in the early years of HealthChoice, ED use under HealthChoice has remained relatively static since CY 2001 (Figures 10 and 11). Slight increases among certain populations or regions have been countered by slight decreases elsewhere. Overall, the level of ED use was similar in CY 2004 and CY 2001.

⁵ Sources: MDE Childhood Lead Registry/Maryland MMIS II. Age shown as of 12/31.

⁶ *ibid*

⁷ ED visits are defined as visits that do not lead to hospitalizations.

Figure 10: Percentage of Population Receiving an Emergency Department Service by Region

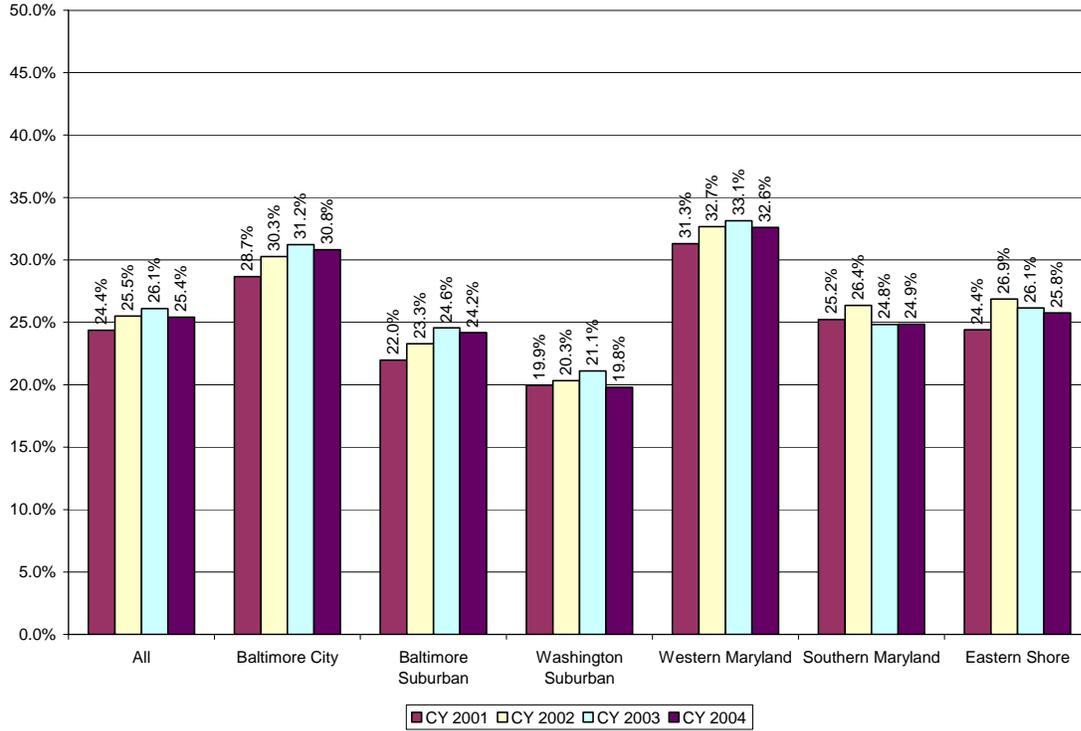


Figure 11: Percentage of Population Receiving an Emergency Department Service by Age

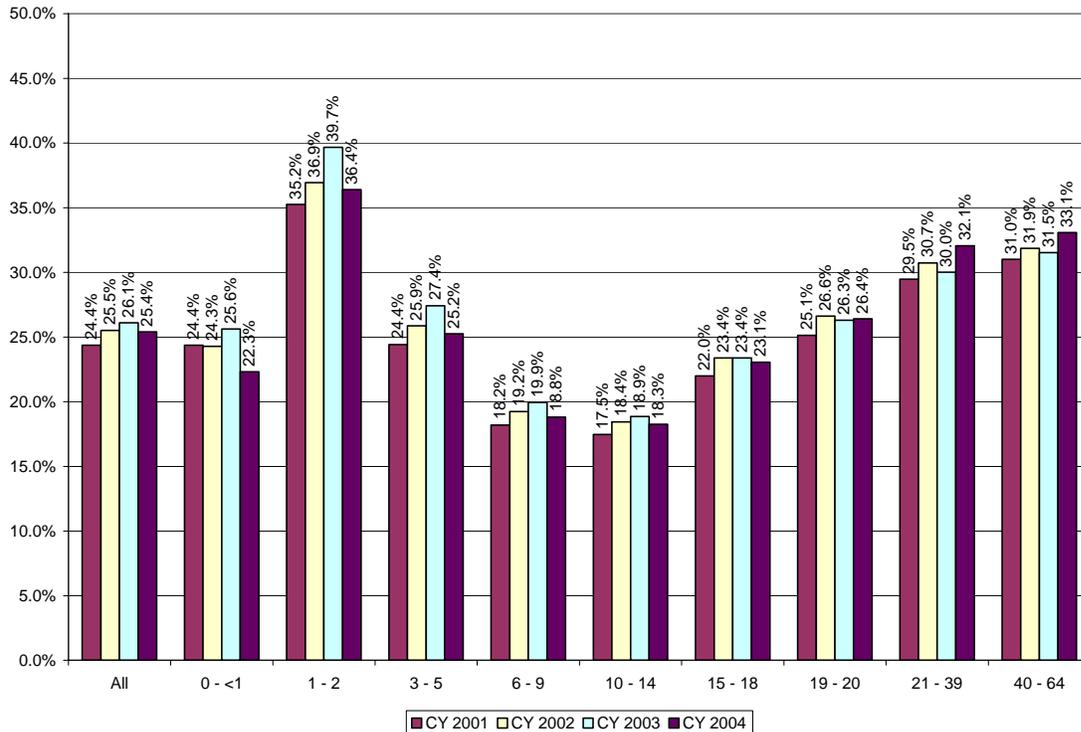
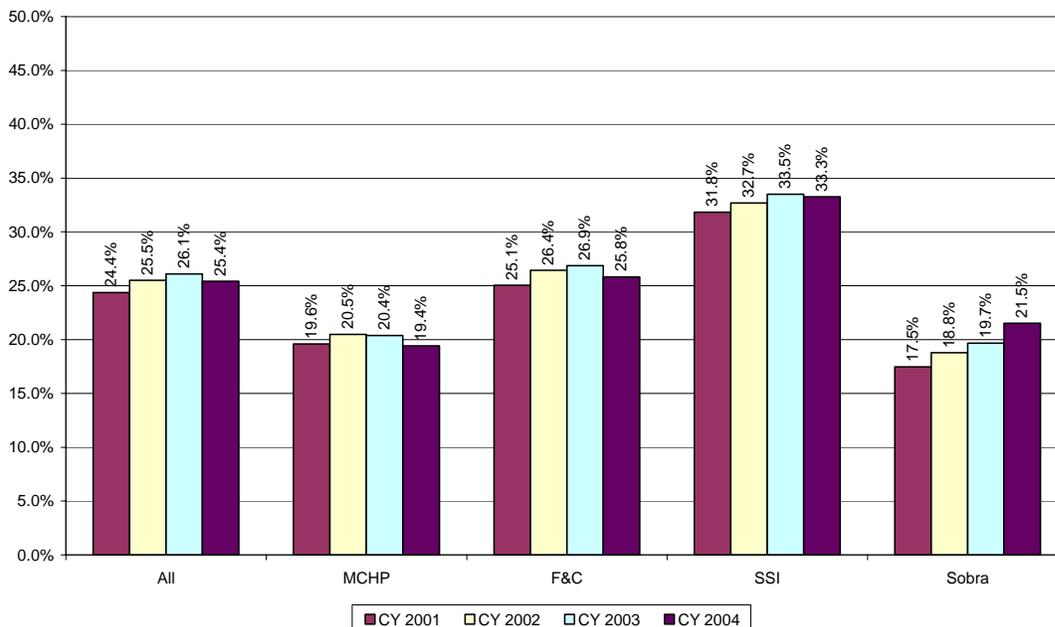


Figure 12 shows that enrollees with disabilities in the SSI coverage group are more likely to receive an ED visit than enrollees in other coverage groups. Further analysis of this is needed.

Figure 12: Percentage of Population Receiving an Emergency Department Visit by Coverage Group

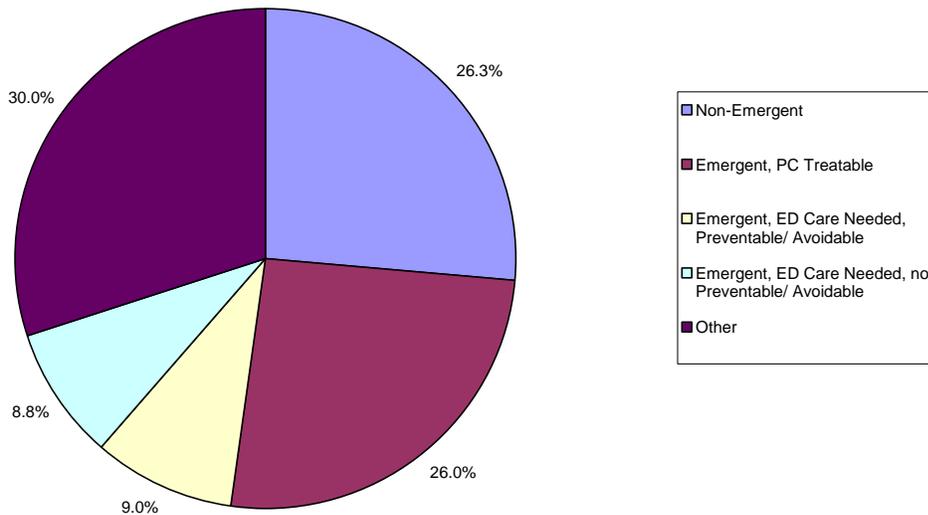


Recent analysis examined primary diagnoses associated with ED visits and preventive service utilization by ED users. For the purposes of this analysis, HealthChoice ED utilization has been categorized according to a methodology established by the New York University (NYU) Center for Health and Public Service Research. This categorization helps identify appropriateness of ED use. Figure 13 below shows the CY 2003 breakdown of ED visits by 1) non-emergent, 2) emergent but primary care treatable, 3) emergent but preventable/avoidable, 4) emergent, ED care needed, not preventable/avoidable, and 5) other.⁸ Non-emergent care should be accessed in settings other than the ED. From CY 2000 through CY 2004 there was very little year-to-year variation in the proportion of ED visits falling in each category. In addition, little variation by region was found.

As shown below in Figure 13, a minority of ED visits appeared to be for non-emergent care (26 percent of ED visits, just over 75,000 visits out of 286,000 total ED visits in CY 2003). The percentage of ED visits classified as non-emergent remained relatively static (ranging between 25 and 26 percent) during the 2001 through 2004 time period. Thirty percent of visits fell into an “other” category which included visits related to injury, mental health, or substance abuse. It is not currently possible to determine whether those visits were emergent or avoidable.

⁸ Billings, J et al. Emergency Department Use: The New York Story. *The Commonwealth Fund Issue Brief*. November 2000, p.2.

Figure 13: Classification of HealthChoice Emergency Department Visits – CY 2003



The analysis found that the majority of HealthChoice enrollees seeking ED care do so for emergent care. Among users of the ED, 62 percent sought emergent care and 38 percent sought non-emergent care in CY 2003. Only a small proportion of the HealthChoice population accounts for all non-emergent ED care. When viewed from the perspective of the overall HealthChoice population, only about six percent of HealthChoice enrollees (approximately 37,000 individuals in CY 2003) used an ED for non-emergent care in a given year. This rate varied little from CY 2001 through CY 2004.

In an effort to better understand whether certain demographic characteristics influence ED use, individuals who used an ED for non-emergent care were compared with those who had sought truly emergent care. In the period from CY 2001 through CY 2004 there was little distinction between those enrollees who sought non-emergent care in an ED and those who sought emergent care.

Access to Care Under HealthChoice for Racial or Ethnic Minority Groups

HealthChoice covers a large proportion of children from population groups that have historically experienced health care disparities. Nearly three-quarters of HealthChoice enrollees are racial or ethnic minorities, compared to more than one-third of all State residents. Approximately 30 percent of Maryland’s children receive their health care through Medicaid as compared to about 10 percent of the adult population. In several Maryland counties and Baltimore City, child enrollment exceeds 40 percent. In all, over 70 percent of HealthChoice enrollees are aged 18 or below in a State where that age group accounts for only one-quarter of the population.⁹

As the data in Table 1 show, among children ages three through six enrolled in Maryland Medicaid in 1997, white children were more likely than other children (with the exception of the

⁹ United States by State: TM-P019. Percent of Persons Under 18 Years: 2000

relatively small Asian population) to receive well-child services as defined by HEDIS.¹⁰ Among adolescents ages 12 to 21, white and African-American adolescents were more likely to receive services as compared to Hispanic adolescents (Table 2). The disparities in access evident under the fee-for-service Medicaid program in 1997 were mostly eliminated by 2001 under HealthChoice. Data from 2004 show that access rates for children from minority groups have surpassed the access rates for similarly aged white children. Beyond the elimination of evident disparities, the data in Tables 1 and 2 also repeat the findings shown above that access to well-child services increased noticeably for all children under HealthChoice. Access rates for African-American children have increased by more than 30 percent and rates for Hispanic children have increased by nearly 60 percent since 1997. The increases in access for adolescents are comparable to those for children, with access for Hispanic adolescents more than doubling.

Table 1: Well-Child Access Rates for Children aged 3-6 Years: 1997, 2001-2004

	1997	2001	2002	2003	2004
Asian	47.68%	48.86%	53.48%	56.08%	57.27%
African-American	40.74%	48.34%	52.11%	53.88%	55.04%
Hispanic	38.86%	51.78%	56.57%	60.30%	61.98%
White	41.19%	45.21%	48.34%	50.90%	52.40%

Table 2: Well-Child Access Rates for Adolescents aged 12-21 Years: 1997, 2001-2004

	1997	2001	2002	2003	2004
Asian	24.05%	24.76%	30.78%	33.01%	34.17%
African-American	22.61%	29.41%	32.4%1	33.48%	34.35%
Hispanic	17.35%	31.41%	33.50%	36.83%	38.93%
White	20.43%	24.45%	26.21%	27.64%	28.29%

The data from these well-child measures clearly indicate that the State has made significant progress with regard to disparities in access to preventive services, especially for Hispanic children and adolescents. HealthChoice has clearly demonstrated progress in alleviating disparities in well-child care and in increasing access to care for all children. However, well-child services represent only a sample of the health care services provided to HealthChoice enrollees and further analysis is needed.

Access for Children in Foster Care

The State continues to monitor service delivery to children in foster care given their special needs, and findings are positive. An analysis of enrollment data for CY 2003 showed that 90 percent of children in foster care were enrolled in only one MCO during that year, virtually identical to the rate of other HealthChoice children. This indicates that children in foster care have stable MCO enrollment, and HealthChoice provides them with a medical home.

An examination of CY 2004 HealthChoice utilization data shows that children in foster care tend to be high utilizers of health services. When compared to other children in

¹⁰ The HEDIS definition of well-child care differs from the well-child measures presented in a prior section of this report with regard to enrollee age and procedure codes used to identify a well-child visit.

HealthChoice, children in foster care are more likely to access ambulatory and well-child services across all ages (Figures 14 and 15).

Figure 14: Percentage of Children Receiving an Ambulatory Service by Age (Foster Care and HealthChoice)

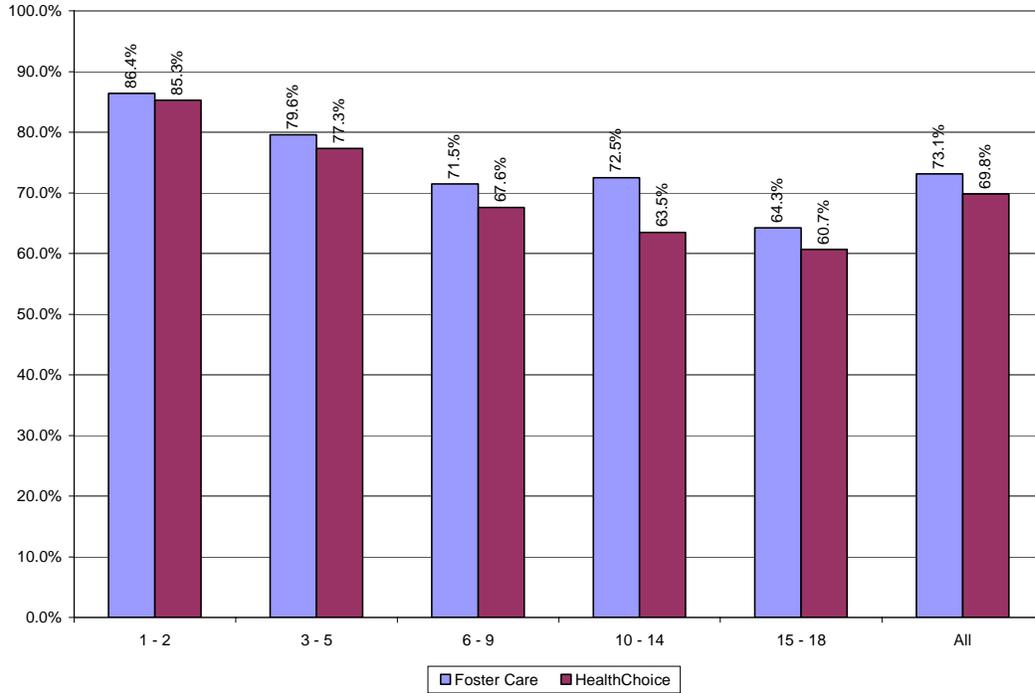
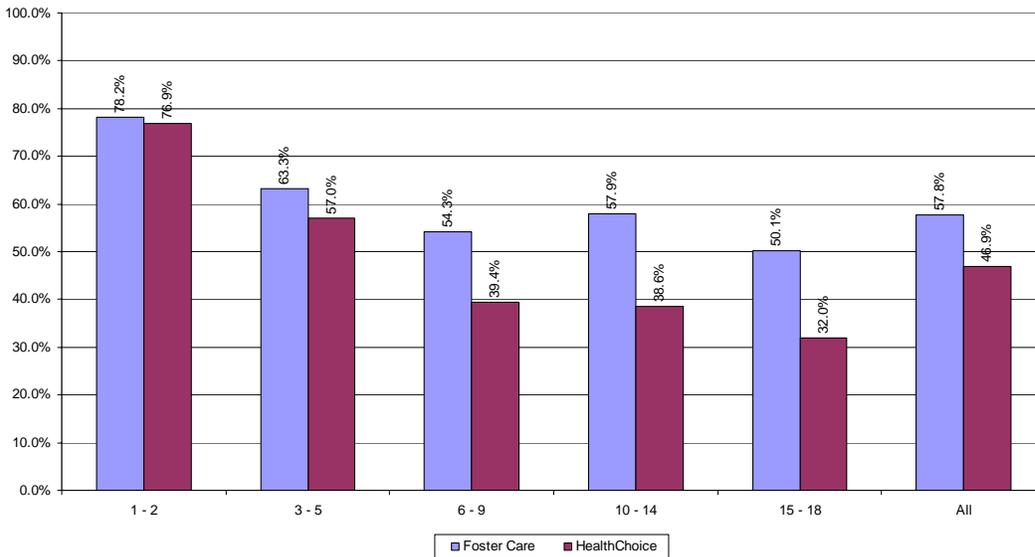
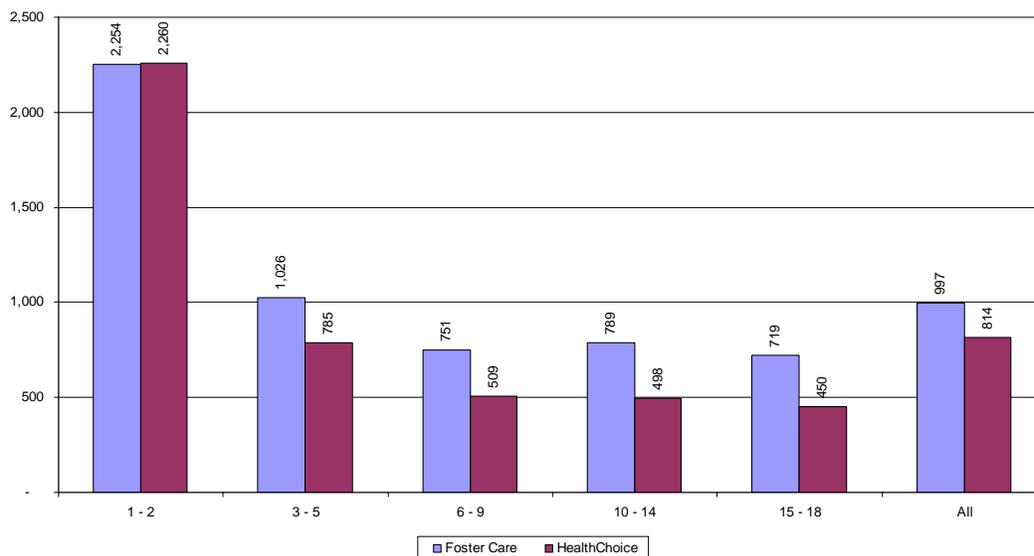


Figure 15: Percentage of Children Receiving a Well-Child Service by Age (Foster Care and HealthChoice)



Additionally, children in foster care receive a higher volume of well-child services (Figure 16).

Figure 16: Volume of Well-Child Services by Age (Foster Care and HealthChoice)



In addition to the increases in access to well-child care through the MCO, further analysis of utilization of services by children in foster care (based on FY 2001 through 2003 data) found that the majority of services provided to these children were delivered through the fee-for-service program (about 75 percent). In Maryland’s Medicaid program, certain services are carved out of the MCOs and paid separately on a fee-for-service basis. During FY 2003, children in foster care received, on average, about ten MCO covered services per year as compared to 43 fee-for-service services. The majority of the fee-for-service expenditures were for mental health care, health-related special education services and mental health related pharmacy, all of which are carved out from the MCOs. Analysis of fee-for-service drug use found that in FY 2004, 35 percent of children in foster care under age 18 received a prescription for a mental health drug. This rate was several times greater than the general child population in HealthChoice.

These findings suggest that the current delivery model facilitates access to both HealthChoice MCO services and fee-for-service for children in foster care, and that children’s case workers get them into care. Children in foster care access both preventive and non-preventive services at higher rates than the general HealthChoice population. This is consistent with national findings showing that children in foster care tend to have higher health and mental health needs.

Access for HealthChoice Enrollees with Asthma and Diabetes

Avoidable hospital admissions refer to admissions that could have been prevented if ambulatory care was provided in a timely and effective manner. High rates of avoidable hospital admissions have been found to be associated with poor access to care, poverty, and the lack of a primary care provider (PCP). Asthma and diabetes are two chronic conditions that can be managed through the outpatient setting. Hospital admissions for these conditions should be avoided through effective outpatient management.

The Department measured avoidable asthma and diabetes inpatient admission rates for CY 2002 through CY 2004. The rates of diabetes- and asthma-related avoidable admissions both declined from CY 2002 to CY 2004 (Tables 3 and 4, respectively).

Table 3: Diabetes Admissions per Thousand Members per Year (enrollees ages 21-64)

	CY 2002	CY 2003	CY 2004
Number of Diabetes-related avoidable hospital admissions	204	213	176
Rate per thousand of avoidable Diabetes-related hospital admissions	29	30	24

Table 4: Asthma Admissions per Thousand Members per Year (enrollees ages 5-20)

	CY 2002	CY 2003	CY 2004
Number of Asthma-related hospital admissions	533	626	566
Rate per thousand of avoidable asthma-related hospital admissions	48	48	43

Currently, there are no national standards or acceptable rates for avoidable hospital admissions. The Department will continue to monitor the trends across MCOs. The Department also continues to evaluate asthma and diabetes care as part of its HealthChoice quality strategy.

Assuring Quality of Care

Each year the Department conducts a variety of quality assurance activities. These activities include the annual systems performance review (EQRO), the Consumer Assessment of Health Plans Survey of consumer satisfaction (CAHPS), and measures of access and quality from the Health Employer Data and Information Set (HEDIS). In addition, the Healthy Kids Program reviews a sample of medical records from all MCOs as part of the EQRO to assure that preventive care standards were met. In CY 2005 all seven plans exceeded the minimum 80% compliance rate and demonstrated improvement in the five preventive care components evaluated by the Healthy Kids Program.

The HealthChoice consumer report card and the Value-Based Purchasing Initiative were updated in fall 2005. The report card and the Value-Based Purchasing Initiative synthesize performance results from HEDIS, CAHPS, and encounter data analyses. Eleven quality measures were included in the CY 2004 Value-Based Purchasing Initiative. MCOs' performance on these eleven measures was compared to compliance levels (or targets) set by the Department for each measure. In future years, other measures may be added to or rotated.

MCO performance continues to improve over time. Reports on the 2005 HealthChoice quality assurance activities are available by request and are posted online at <http://www.dhmd.state.md.us/mma/healthchoice/html/CY2004.htm>.

CONCLUSION

The Department has worked closely with the MCOs to improve access to high quality care and create a prevention-oriented delivery system. Overall, the percentage of HealthChoice enrollees who receive services has steadily increased over the past four years. Access to dental services and lead screening continues to improve. Although ED utilization has not decreased under HealthChoice as expected, it has stabilized in recent years and there is no evidence that access to care is declining elsewhere. This update shows that HealthChoice continues to improve access to care for special populations, including children from racial and ethnic minority groups, children in foster care, and individuals with diabetes and asthma.

The Department will continue to monitor access to care, including trends in ED utilization and asthma and diabetes-related avoidable admissions. A companion report to the HealthChoice Evaluation Update will examine prevalence of and treatment for substance abuse and co-occurring substance abuse and mental illness. Multiple quality assurance activities will continue in CY 2006 and beyond, and the Department anticipates that HealthChoice will continue to demonstrate overall improvements in access to services.