

HealthChoice Evaluation Update

February 2005

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. The Department continues to monitor HealthChoice via a variety of measures. This document provides a brief update on HealthChoice program performance. The measures include both key measures that were part of the 2002 HealthChoice Evaluation, as well as several new measures that were not a part of the original evaluation. This update focuses on HealthChoice performance trends for the four-year period, CY 2000-CY 2003.

As of December 2003, HealthChoice enrollment stood at 470,463, or roughly 9 percent of the population of the State of Maryland. This is an increase of about 15 percent from January 2000. 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. HealthChoice enrollment accounts for 80 percent of all Medicaid enrollment. At present, HealthChoice enrollees are served by seven managed care organizations (MCOs). Six of the HealthChoice MCOs have participated in the program since 1999, with the seventh approved in 2003.

Key Findings

This evaluation update demonstrates continued progress by the HealthChoice program. Between CYs 2000 and 2003 HealthChoice improved access to health services in a number of important areas. These increases occurred even as the number of HealthChoice enrollees continued to grow.

- The percentage of enrollees receiving an ambulatory care visit increased from 60 percent to 68 percent
- The percentage of children receiving a well-child visit increased from 38 percent to 46 percent
- The percentage of children receiving a dental visit increased from 34 percent to 43 percent (over the three-year period 2001 to 2003)
- The percentage of one-year-olds receiving a lead screening increased from 43 percent to 47 percent (over the three-year period 2001 to 2003)

New analyses in this report also yielded other encouraging findings:

- Children in foster care enrolled in HealthChoice are receiving services at a higher rate than other HealthChoice children and experience stable MCO enrollment.
- An examination of several preventive services found little indication of racial disparities in HealthChoice with regard to the percentage of enrollees receiving services.

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

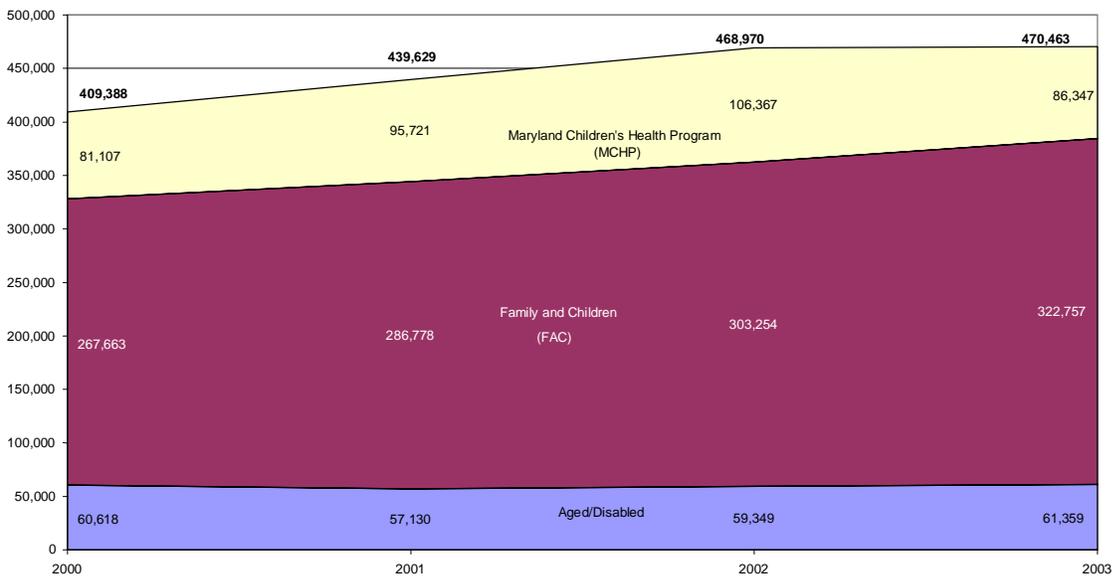
- Through care management, the MCOs have maintained the level of avoidable hospital admissions for individuals with asthma and diabetes.

The rate of emergency department (ED) utilization continues to increase, despite expectations that managed care would reduce overall ED use. Between CYs 2000 and 2003, the percentage of the HealthChoice population receiving an ED service increased from 14 percent to 20 percent. This is consistent with national trends.

Enrollment

The HealthChoice program continues to experience a growth in enrollment. In December of 2000, there were about 410,000 enrollees in HealthChoice. By December 2003, this number rose to just over 470,000.

Figure 1: HealthChoice Enrollment by Coverage Group

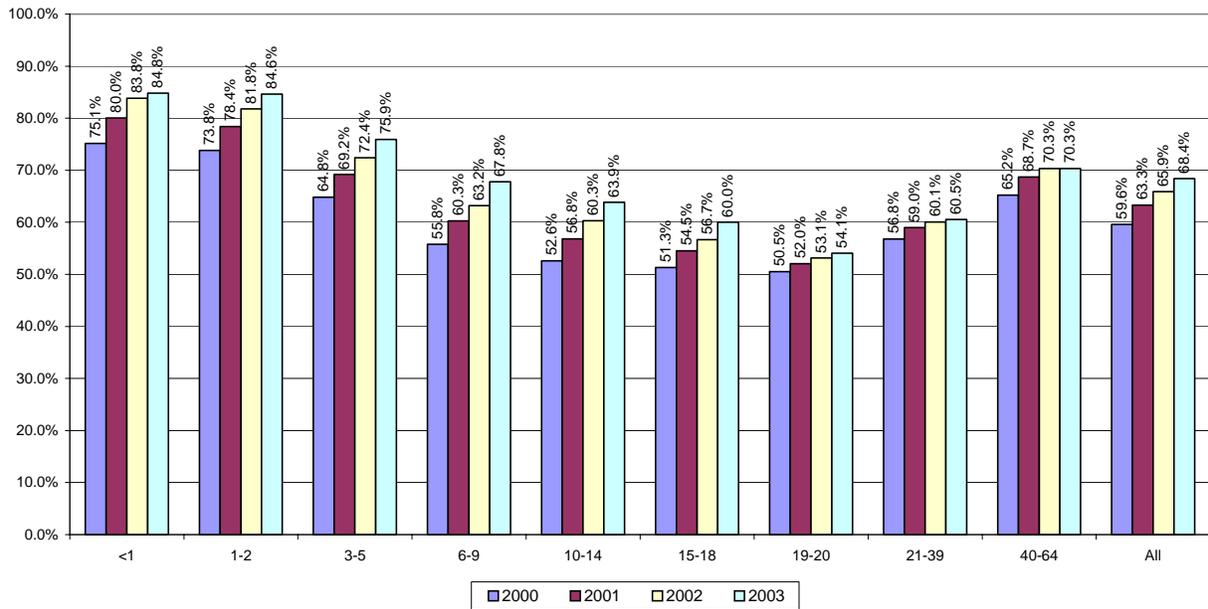


Ambulatory Visits

Ambulatory visits are defined as any time an enrollee 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.

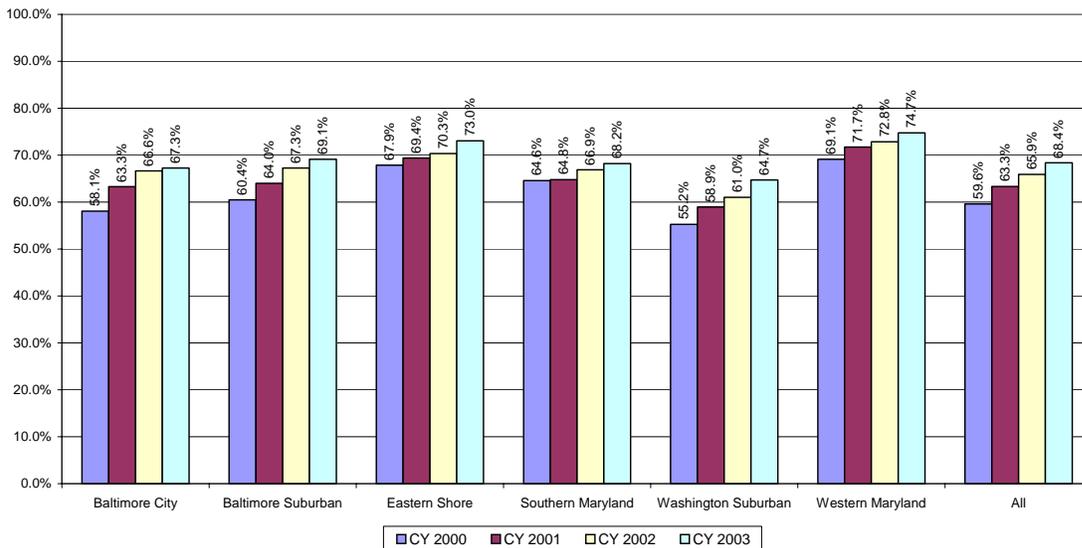
The HealthChoice program has been successful in increasing access to ambulatory care for all enrollees, particularly for children under the age of 15. Since CY 2000, the overall percentage of individuals receiving an ambulatory visit has increased from 59.6 percent to 68.4 percent (Figure 2). The increase was greatest for children aged 0-14 and smallest for individuals aged 19-39. In FY 1997, prior to the implementation of HealthChoice, the percentage of individuals accessing an ambulatory visit was 57.8 percent.

Figure 2: Percentage of the Population Receiving Ambulatory Care Service by Age²



The percentage of individuals receiving an ambulatory service has increased in every region of the State, with the greatest improvements in Baltimore City and the surrounding Baltimore Suburban region (Figure 3)³. Access to ambulatory services for the SSI/Disabled population has also increased (Figure 4), from 63.5 percent in CY 2000 to 71.2 percent in CY 2003.

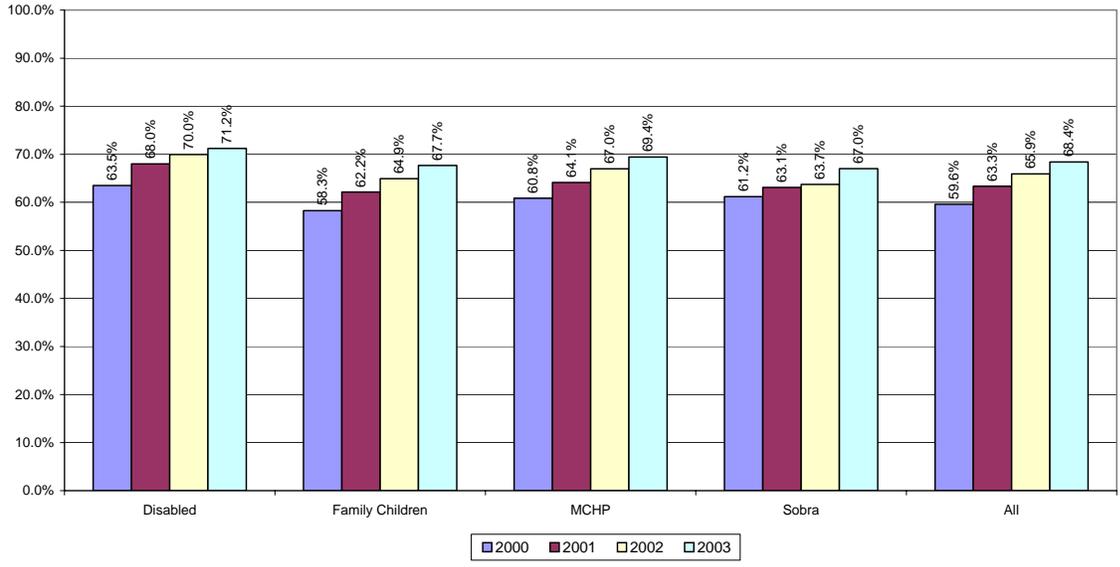
Figure 3: Percentage of the Population Receiving Ambulatory Care Service by Region



² The ambulatory care measure, as well as ER and well-child measures, are based on a population of HealthChoice enrollees with any period of enrollment.

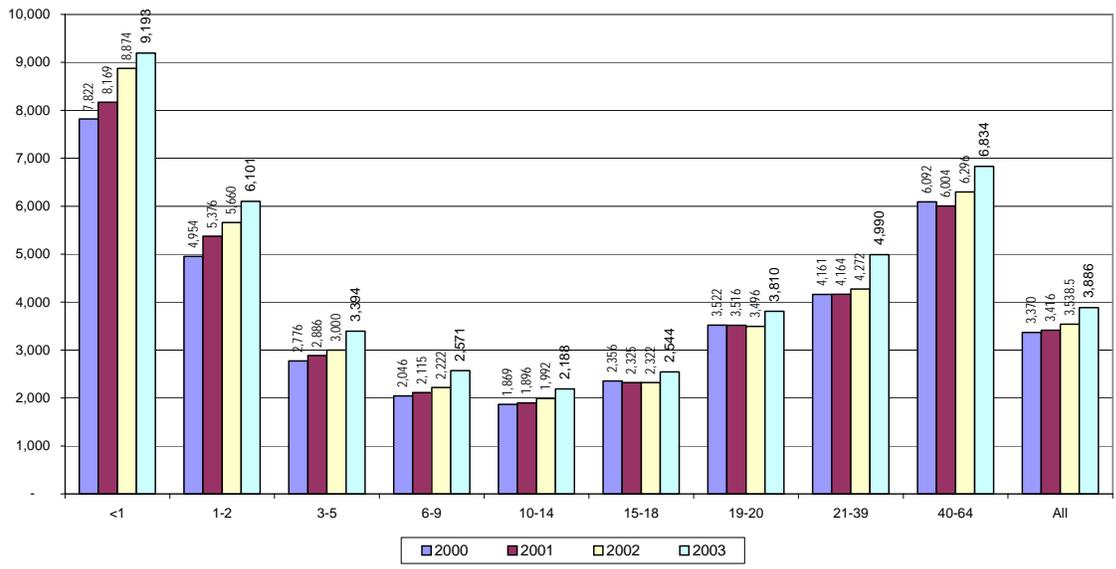
³ The “Baltimore Suburban” region includes Anne Arundel, Carroll, Harford, Howard, and Baltimore Counties.

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



Overall, between CYs 2002 and 2003 the number of ambulatory visits enrollees received registered a noticeable increase after having remained relatively static between CYs 2000 and 2002 (Figure 5). The most notable increase was for those children aged two and under – visit rates have increased by roughly 20 percent since CY 2000.

Figure 5: Volume of Ambulatory Care Visits per Thousand Members per Year by Age



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 State uses to report Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) services for federal reports, and includes clinic services in an outpatient department (OPD) that are accompanied by an appropriate diagnosis code. Well-child visits are a subset of all ambulatory visits.

Although well-child visits are a subset of ambulatory visits, they are unique because of their 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 show that HealthChoice has been successful in increasing the percentage of children who receive such services. The percentage of the population receiving a well-child service increased across all ages between CYs 2000 and 2003, from 37.8 percent to 46.0 percent (Figure 6). These increases were observed across the State, with consistent increases in the Baltimore and Washington Suburban regions (Figure 7).

Figure 6: Percentage of Children Receiving a Well-Child Service by Age

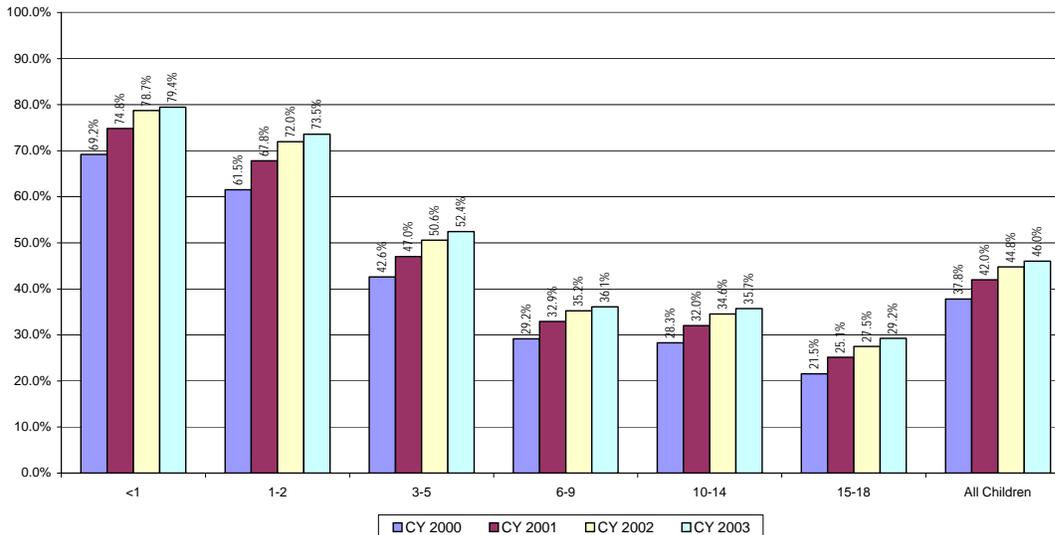
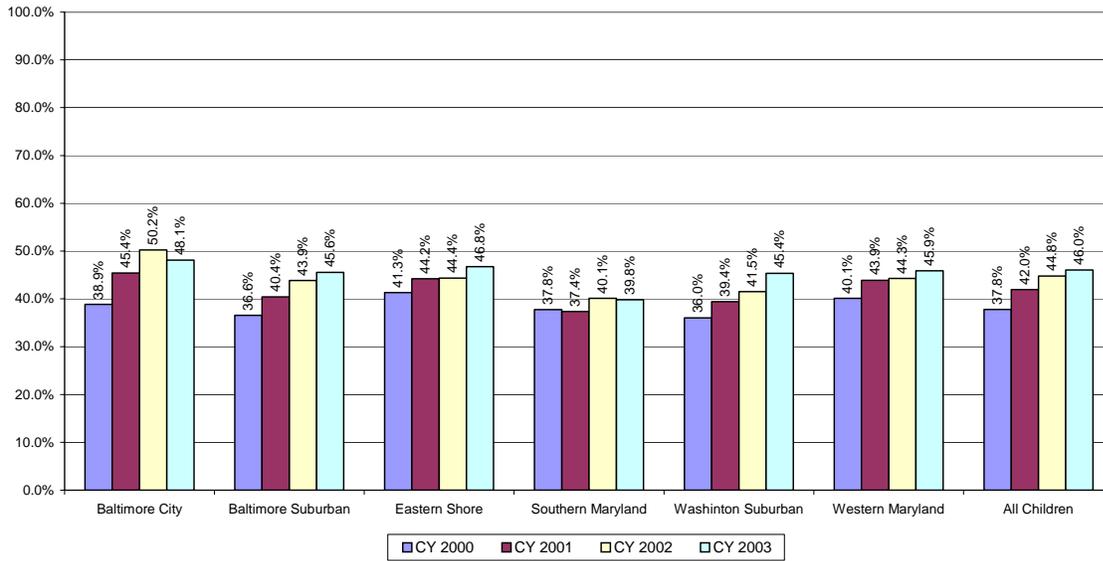
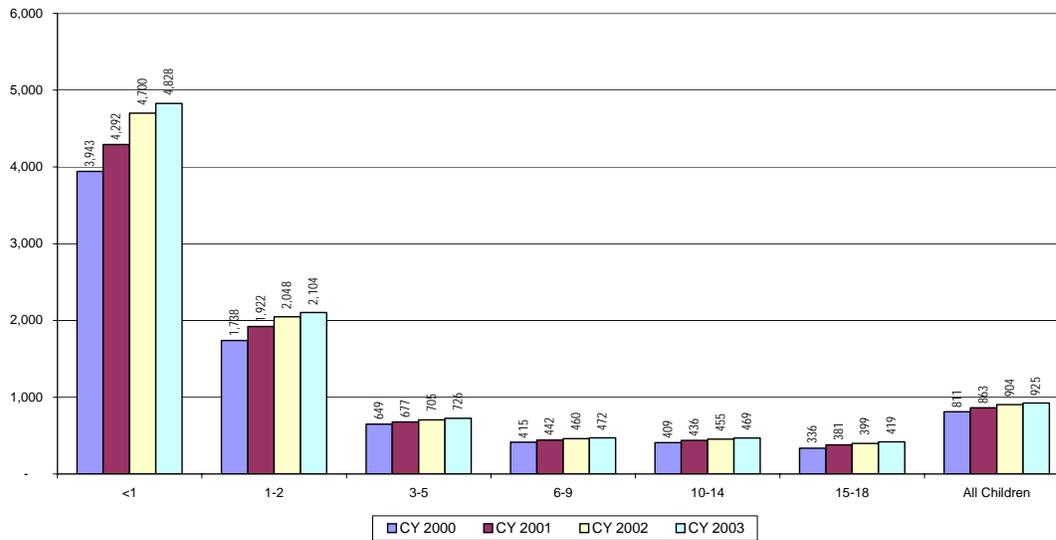


Figure 7: Percentage of Children Receiving a Well-Child Service by Region



The number of children receiving a well-child visit continues to make marginal gains overall, with significant increases for children under one and notable increases for children under 2 (Figure 8).

Figure 8: Volume of Well-Child Visits per Thousand Members per Year by Age



Dental Services

Dental care is a mandated health benefit for children through age 20 under federal EPSDT requirements. Though rates of access to dental services have always been low, access has dramatically 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 in the Department’s annual report to the General Assembly (www.dhmf.state.md.us/mma/html/reppubs.html).

Between CYs 2001 and 2003 the percentage of children ages 4-20 with 320 days of enrollment who had at least one dental visit increased from 33.6 percent to 43.2 percent (Figure 9). The 43.2 percent access rate for CY 2003 was more than double the access rate under the fee-for-service (FFS) program in FY 1997 (19.9 percent). Although access rates had remained static during CYs 2001 and 2002, the CY 2003 data showed noticeable increases across all age groups and regions within the State (Figure 10).

Figure 9: Percentage of Children Receiving a Dental Visit by Age

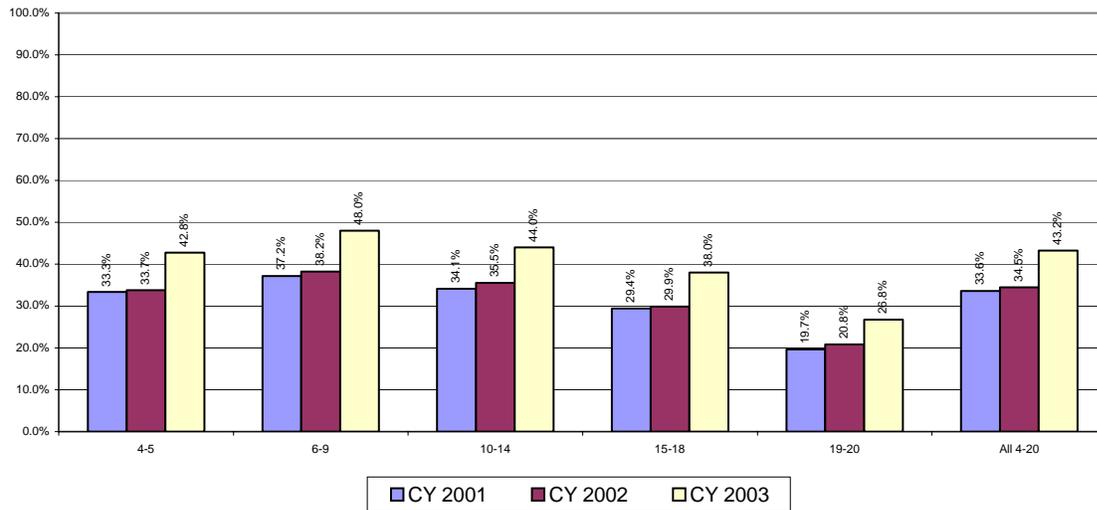
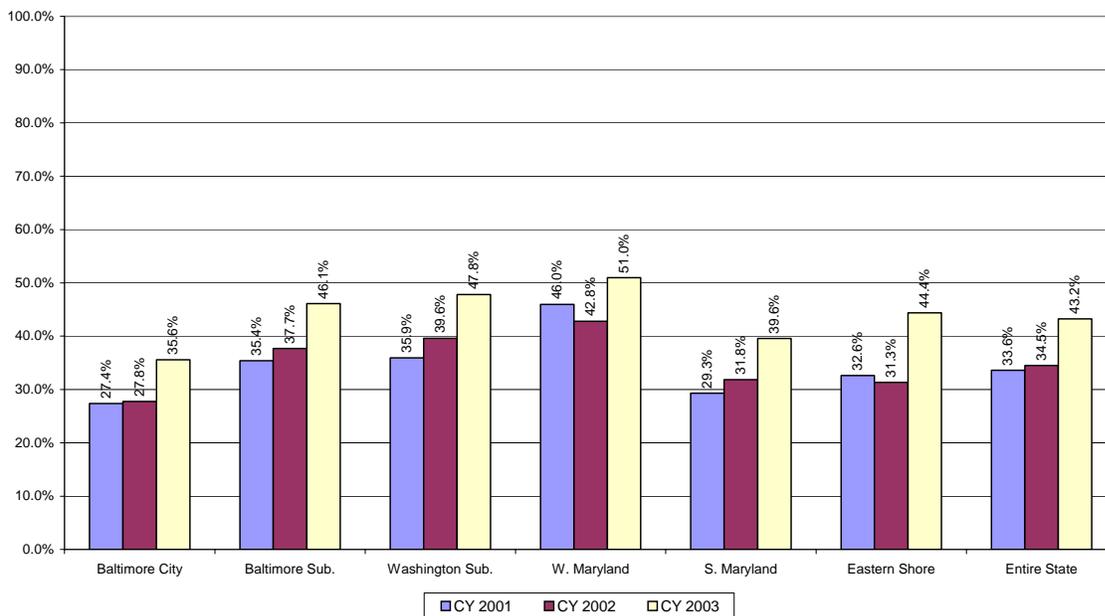


Figure 10: Percentage of Children Receiving a Dental Visit by Region



Lead Screening

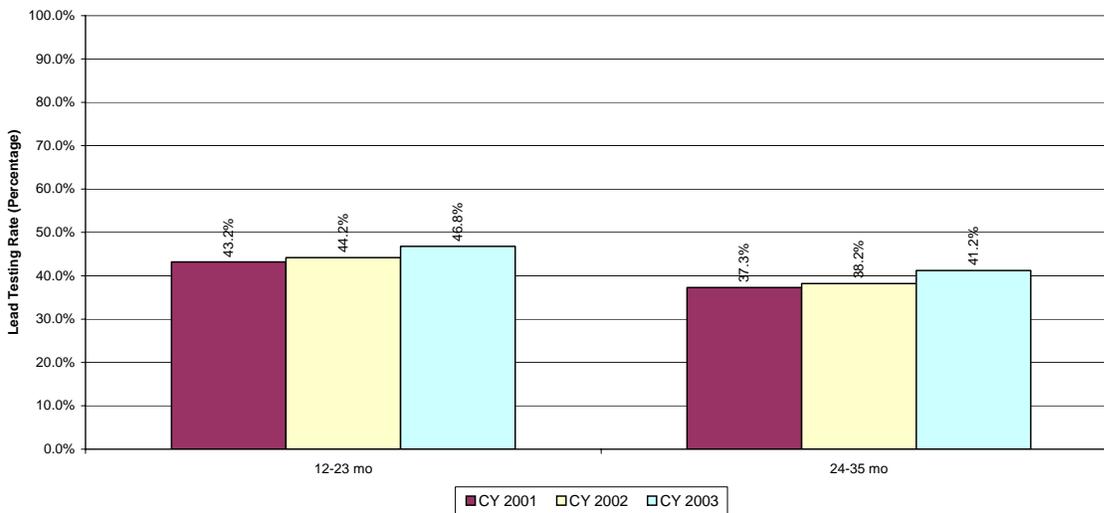
Lead is one of the greatest environmental hazards for children in Maryland. Children are at greatest risk from birth to age six while their neurological systems are developing. Sustained exposure to lead can cause long-lasting neurological damage or death. Effects of sustained exposure include learning disabilities, shortened attention span, irritability, and lowered IQ.⁴

Maryland has developed a Plan to Eliminate Childhood Lead Poisoning by 2010.⁵ One goal of the State Plan is to ensure that young children receive appropriate lead risk screening and blood lead testing. Specifically, Maryland is seeking to improve the rate of blood lead testing among Medicaid children between the ages of 12 and 36 months.

In HealthChoice, lead screening rates are reported for those children enrolled continuously in the same MCO for at least 90 days. The statewide data in Figure 11 show that nearly 47 percent of children between the ages of 12 and 23 months received a lead screening in CY 2003, an increase of over three percentage points since CY 2001. For children aged 24 to 35 months the CY 2003 screening rate was just over 41 percent, an increase of 4 percentage points since CY 2001.

In Baltimore City, an identified high-risk area,⁶ the HealthChoice lead screening rate exceeds fifty percent (Figure 12). The Baltimore City screening rates have increased since CY 2001, although at a lower rate than the statewide increase.

Figure 11: HealthChoice Children Receiving a Lead Screening by Age (Statewide)⁷



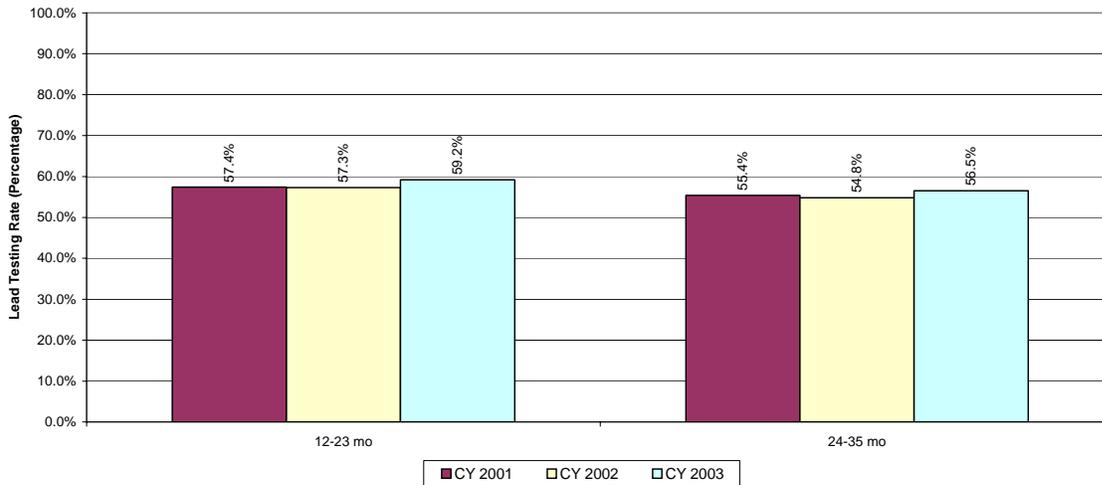
⁴ <http://www.mde.state.md.us/Programs/LandPrograms/LeadCoordination/index.asp>

⁵ http://www.mde.state.md.us/assets/document/2010_Elimination_Plan.pdf

⁶ *ibid*

⁷ Sources: MDE Childhood Lead Registry/Maryland Medicaid Management Information Systems II
Age shown as of 12/31/2003 for HealthChoice Enrollees

Figure 12: HealthChoice Children Receiving a Lead Screening by Age (Baltimore City)



Emergency Department Visits

There is a general consensus that, unlike ambulatory care and well-child visits, emergency department (ED) use should decrease under managed care. This consensus is based on assumptions that ED services are expensive, and inappropriate except for true emergencies, and that effective controls capable of restricting emergency department use to appropriate circumstances are implicit in a managed care system of care.

For purposes of the HealthChoice Evaluation, therefore, ED visits have been defined as visits that did not lead to hospitalization. These types of ED visits are most likely to be sensitive to managed care controls.

The patterns of ED use under HealthChoice are contrary to the theory that managed care would depress ED use. Overall, ED use increased each of the years examined. These increases occurred across all age groups and most regions, although there were concentrated increases in Baltimore City and the surrounding suburbs. ED access and utilization rates have remained static in some regions. The percentage of enrollees receiving an ED visit increased from 13.7 percent in CY 2000 to 20.0 percent in CY 2004 (Figure 13). The analysis shows that ED use increased most among young children and those over the age of 21, and among enrollees in Baltimore City (Figures 13 and 14).

Figure 13: Percentage of Population Receiving an Emergency Department Service by Region

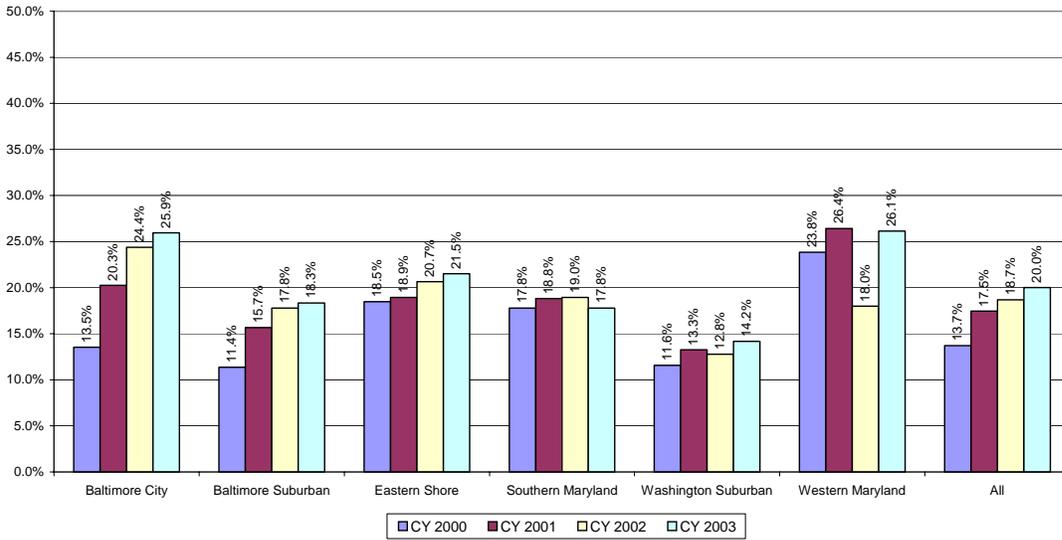
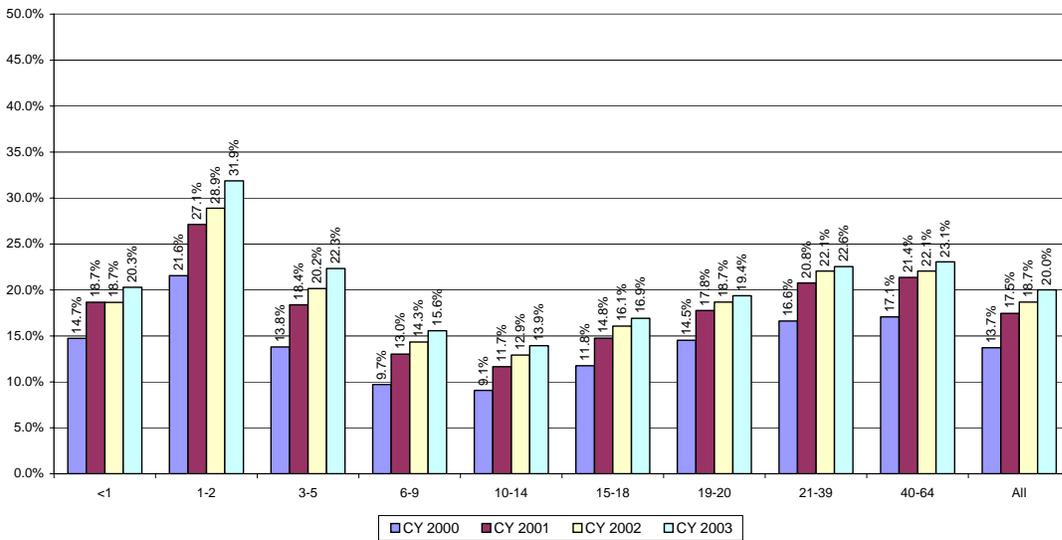


Figure 14: Percentage of Population Receiving an Emergency Department Service by Age



It is difficult to assess the meaning of the increase in ED use. The regional concentration of the increase suggests that this is not a statewide phenomenon. In addition, the simultaneous increase in the rate of ambulatory visits suggests provider network issues are not the source of growth in ED utilization. The Baltimore regions experienced consistent and comparatively strong growth in ambulatory access and utilization between CYs 2000 and 2003.

- The steady increase in ED use may be indicative of any number of the following issues:
- Maryland is experiencing what has been a national trend in increased ED use.^{8,9&10}

⁸ Cunningham, Peter, and Jessica May. "Issue Brief: Insured Americans Drive Surge in Emergency Department Visits," Center for Studying Health System Change, October 2003.

⁹ Manning, Joe. 2004. "State Tackles Emergency Room Misuse." *Milwaukee Journal Sentinel*, January 31, 03D.

- Increased service availability as a result of hospital expansions of ED and outpatient facilities and the accompanying community outreach.
- EDs are open 24-hours.
- There are no financial penalties for Medicaid recipients to use EDs.
- Problematic ED claims submissions in CY 2000.
 - Analyses of encounter data completeness for CY 2000 indicates that some MCOs had poor ED claims submissions in CY 2000. These problems were exclusive to CY 2000 and only pertain to the upward trend in reported ED access observed between CYs 2000 and 2001.

An additional analysis of ED utilization will be undertaken in an effort to better understand the increase in use. The analysis will include an examination of the primary diagnoses associated with the ED visits as well as an examination of the preventive service utilization of ED users. Existing research has shown that individuals who receive preventive services from private practice physicians are less likely to receive services in an ED.¹¹

Using HEDIS to Measure Program Performance

One limitation of the original HealthChoice evaluation was that access and utilization measures contained in the report were defined specifically for the HealthChoice evaluation and were not based on standard or universal measures. In an effort to address this limitation, the Department has opted to base the preventive services measures contained in this section on the National Committee on Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS). HEDIS was originally designed to allow employers to compare the performance of private health plans that were competing to provide insurance for their employees. HEDIS has since been expanded to monitor Medicaid and Medicare participating health plans. HEDIS is currently the most commonly used and recognized set of performance measures for managed care programs in both the public and private sectors.

In HealthChoice, participating health plans supply the information on whether or not the member received the particular service. Health plans can gather this information from members' medical charts or from administrative records or both. The accuracy of this information is independently checked by an outside organization. HEDIS data are reported on a plan-by-plan basis, and those data can be found in the DHMH annual HEDIS report.¹²

A limitation of the audited HEDIS measures is that the data cannot be broken down to measure regional or demographic differences, such as racial variations or how other age group definitions fared. Therefore, instead of using the HEDIS reported measures, the Department

¹⁰ Reinart, Sue. 2004. "Survey Reveals Many ER Visits Avoidable." *The Patriot Ledger*, July 3, 1.

¹¹ Johns, William and Mary Rimsza. 2004. "The effects of Access to Pediatric Care and Insurance Coverage on Emergency Department Utilization." *Pediatrics* 113:3

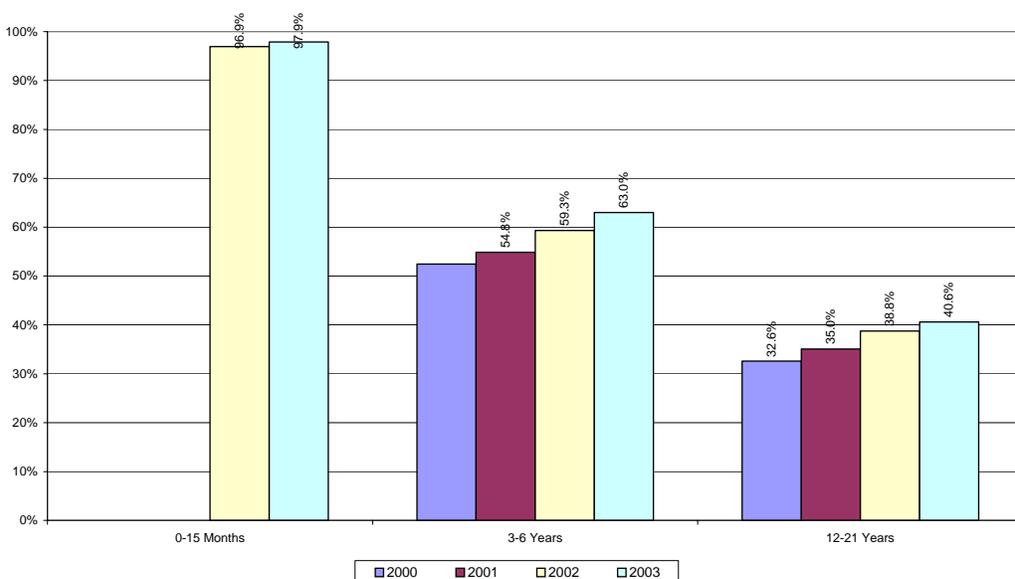
¹² The HEDIS annual report is available online at www.dhmd.state.md.us/mma/healthchoice/html/CY2003.htm.

calculated the measures using plan submitted encounter data analyzed according to HEDIS data specifications.¹³ Specifically, the Department focused on measuring preventive visits.

Well-Child Services

Access to HEDIS-defined well-child services has steadily increased between CYs 2000 and 2003 (Figure 15).¹⁴ Improvement rates were the strongest for children between the ages of 3 and 6. Although the actual rates differ (resulting from different visit definitions and age criteria) from the well-child access measure on page 6, the trends are the same. Both approaches to the measurement of well-child access reveal steady increases each year.

Figure 15: Infant, Child and Adolescent Access to Well-Child Services by Age¹⁵
(HEDIS definition (320 days minimum enrollment) calculated using encounter data)



Adult Preventive Services

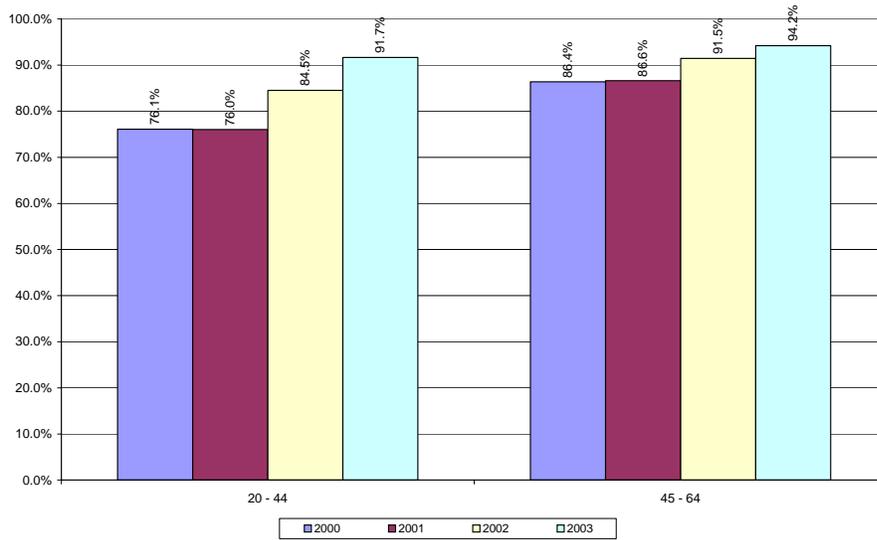
As with children’s access to well-child services, adult access to preventive services has also increased during the same time period. In CY 2003, well over 90 percent of enrollees aged 20-64 received a preventive service (Figure 16). The upward trend mimics the trend observed in the ambulatory visit analysis on pages 2 through 4.

¹³ The HEDIS measures presented in this document are calculated using MMIS II encounter data and therefore may not precisely match the HEDIS results reported in the DHMH annual report.

¹⁴ HEDIS-defined well-child measures differ from the well-child measure presented in a prior section of this report (pp. 5-6). HEDIS well-child measures are specific to certain age groups and limited to enrollees with continuous enrollment. The previously cited well-child measures include children of all ages and with any period of program enrollment. As a result of these differences, the results of the measures differ.

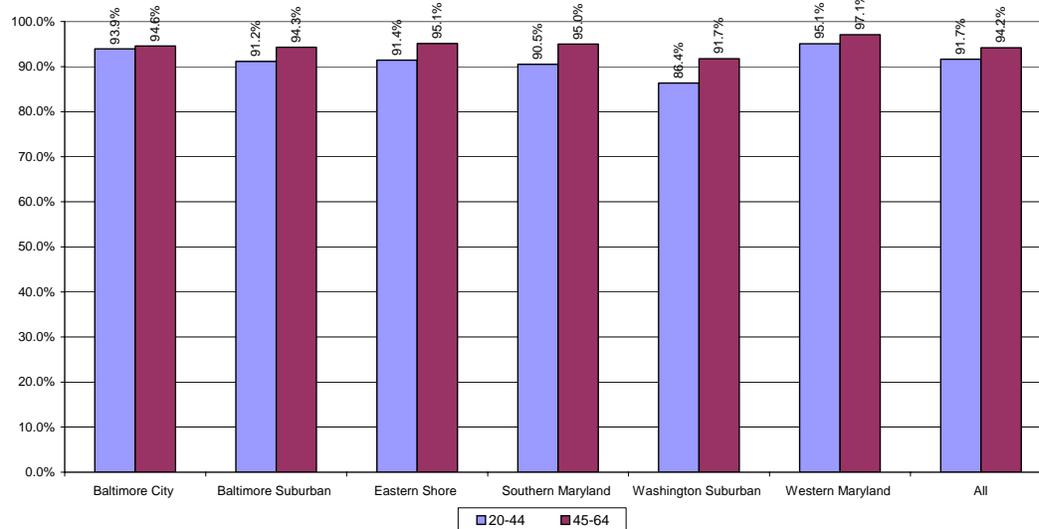
¹⁵ Data for infants aged 0-15 months was not available for CY 2000 or 2001.

Figure 16: Adult Access to Preventive/Ambulatory Services
(HEDIS definition (320 days minimum enrollment) calculated using encounter data)



There is very little variation across the State with regard to adult access to preventive/ambulatory care (Figure 17).

Figure 17: Adult Access to Preventive/Ambulatory Services by Region (CY 2003)
(HEDIS definition (320 days minimum enrollment) calculated using encounter data)



Racial/Ethnic Disparities

There is a large body of published reports that ethnic and racial minorities experience a lower quality of health care services, and are less likely to receive routine medical procedures and quality care as compared to white Americans.¹⁶ Maryland legislators passed House Bill 883,

¹⁶ Smedley BD, Stith AY, Nelson AR, eds. 2002. *Unequal treatment: confronting racial and ethnic Disparities in Health Care*. Washington, DC: National Academies Press.

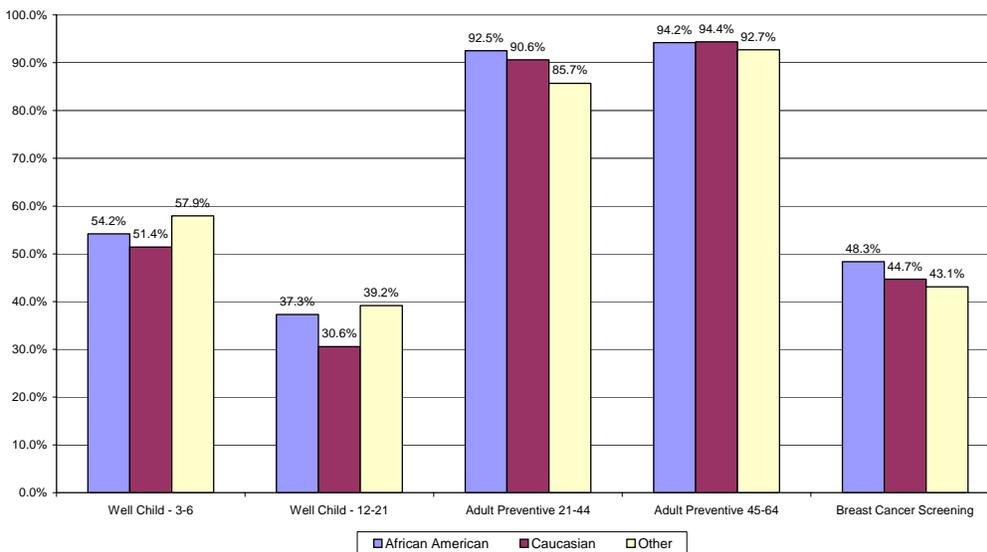
the Health Care Services Disparities Prevention Act of 2003 which directed the Department to develop and implement a plan to reduce health care disparities based on race, gender, ethnicity and poverty. In recognition of this goal, HEDIS-defined preventive service measures were examined according to enrollee race.¹⁷

Although predominately African American and Caucasian, the HealthChoice program does encompass an increasingly diverse population. Since 1997, the proportion of the population that is African American and Caucasian has declined slightly and the proportion of all other enrollees has increased by nearly fifty percent. Even with that population growth, African Americans (57 percent) and Caucasians (30 percent) still account for nearly 90 percent of the HealthChoice population. As a result, the data presented will focus on those populations.

The data presented in Figure 18 reveal a rather confounding finding – counter to the well-documented findings that racial and ethnic minorities tend to experience diminished access to preventive health services, the data in Figure 18 show that there are few differences with regard to access. Where disparities are found, they are equally likely to show that the Caucasian population experienced reduced access relative to the African American population. These measures should continue to be closely monitored.

It is important to note that the measures presented in Figure 18 are not the only access measures the Department monitors. In these measures, only enrollees meeting strict enrollment requirements are examined. Enrollees had to have been continuously enrolled in a single MCO for at least 320 days in CY 2003. Measures that do not include such stringent minimum enrollment requirements may not reveal such levels of parity.

Figure 18: Access to Preventive Services (HEDIS Definition) by Race
(HEDIS definition (320 days minimum enrollment) calculated using encounter data)



¹⁷ Current enrollment data do not differentiate between race and ethnicity. As such, it is not possible to accurately reflect the number of Hispanic enrollees in HealthChoice. Roughly 90 percent of enrollees are identified as either African American or Caucasian. The “Other” category includes Hispanics, Asian/Pacific Islanders, Native Americans and enrollees with no designated race.

Foster Care

Following the HealthChoice Evaluation in 2001, additional utilization analyses were performed on the services accessed by the foster care population. The analyses found that the majority of services provided to children in foster care were delivered through the fee-for-service (FFS) program (about 75 percent) and not through the MCOs in FYs 2001, 2002 and 2003. The majority of the FFS expenditures were for mental health services and mental health related pharmacy. Specialty mental health services are carved out of MCOs and paid on a FFS basis for all enrollees. During FY 2003, children in foster care received, on average, about ten MCO covered services per year as compared to 43 FFS-based services.

Most of the FFS-based services were for non-preventive services. As such, it is still important to consider access to and utilization of preventive services under HealthChoice for children in foster care. Children in foster care tend to be high utilizers of health services. When compared to other HealthChoice children, children in foster care are more likely to access well-child services across all ages (Figure 19). Additionally, children in foster care receive a higher volume of well-child services (Figure 20).

Figure 19: Percentage of Children Receiving a Well-Child Service by Age (Foster Care and HealthChoice)

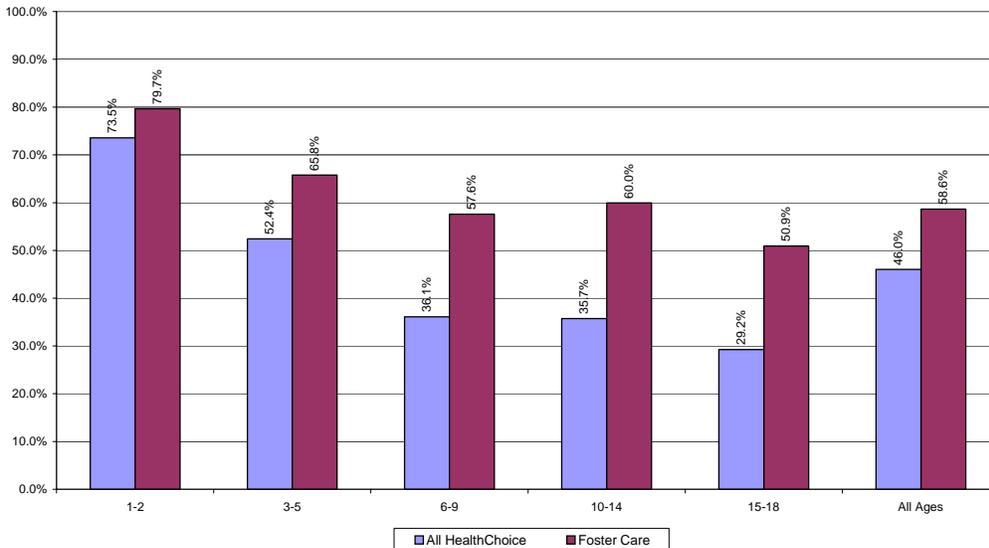
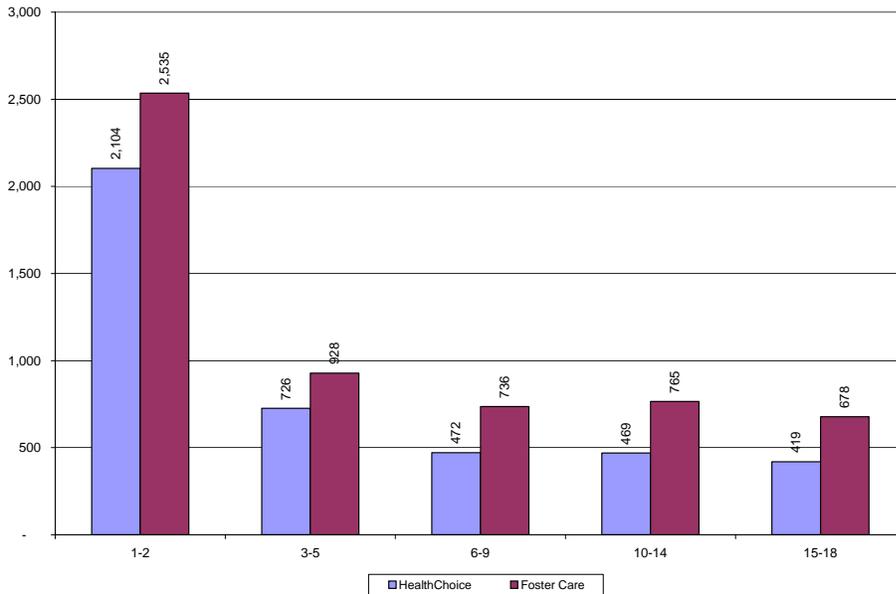
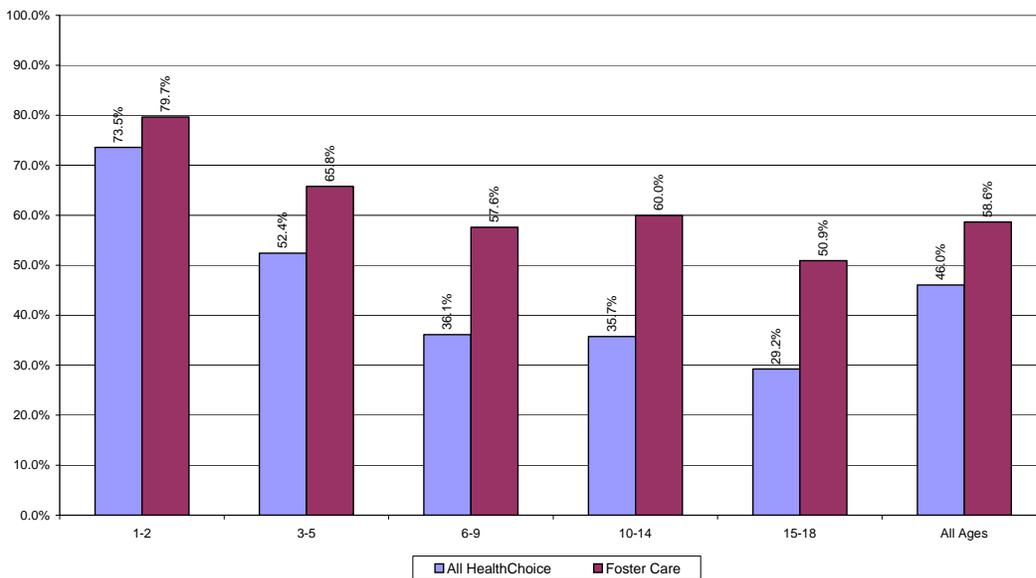


Figure 20: Volume of Well-Child Services per Thousand Member Years by Age (Foster Care and HealthChoice)



The pattern of increased access and utilization for children in foster care can also be found in the larger category of ambulatory visits. Children in foster care are more likely to receive an ambulatory visit than the larger HealthChoice population (Figure 21).

Figure 21: Percentage of Children Receiving a Well-Child Service by Age (Foster Care and HealthChoice)



Many children are enrolled in HealthChoice prior to entering foster care. An examination of data from CY 2003 showed that nearly 55 percent of children in foster care had been enrolled in Medicaid prior to entering the foster care system and over half of children in foster care have been in foster care for at least 24 months. Despite initial concerns that children in foster care

change MCOs frequently, 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. However, more children in foster care are auto-assigned to MCOs. Enrollment data show that nearly 40 percent of children in foster care who were new to HealthChoice were auto-assigned compared to only about 13 percent of comparably aged MCHP children.

The findings from this analysis of children in foster care suggest that the current delivery model facilitates access to both FFS and MCO services for children in foster care. Children in foster care access both preventive and non-preventive services at higher rates than the general HealthChoice population.

Asthma and Diabetes

Avoidable hospital admissions are preventable admissions if proper ambulatory care is 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 physician (PCP). Avoidable hospital admissions may rise when health care needs are not met by the primary health care system.

Avoidable admissions include conditions whose onset can be prevented (such as through immunization), acute illnesses that could be controlled in ambulatory settings, and chronic diseases that can be managed in outpatient settings.¹⁸ Two chronic conditions that should be managed through the outpatient setting are asthma and diabetes.

To understand how the MCOs were managing the care of individuals with asthma and diabetes, the Department calculated the rate of avoidable hospital admissions for CYs 2002 and 2003. The study population includes those HealthChoice enrollees who have been diagnosed with diabetes or asthma according to HEDIS specifications.^{19, 20 & 21} The rate of diabetes-related avoidable admissions remained constant in CYs 2002 and 2003 (Table 1). The asthma avoidable admissions rate increased slightly from CYs 2002 to 2003, but this increase should be interpreted with caution (Table 2). A thorough analysis of year-to-year changes will require more than two years of data.

¹⁸ *ibid*

¹⁹ The study population was limited to those meeting the HEDIS enrollment criteria (320 days of continuous eligibility and enrollment as of Dec 31, with no more than one gap in enrollment of up to 45 days).

²⁰ Enrollees were defined as having asthma if they met or exceeded at least one of the following utilization thresholds of medical care services in the measurement year: 1) Four asthma dispensing events (i.e., an asthma medication was dispensed on four different occasions); 2) One emergency department (ED) visit based on the visit codes below with asthma (ICD-9 code 493) as the principal diagnosis; 3) One acute inpatient discharge based on the visit codes below with asthma (ICD-9 code 493) as the principal diagnosis; 4) Four ambulatory care visits with asthma (ICD-9 code 493) as one of the listed diagnoses and at least two asthma medication-dispensing events

²¹ Enrollees were defined as diabetic if they met or exceeded at least one of the following: 1) One dispensed insulin or oral hypoglycemic/antihyperglycemic event; 2) One ED visit with a diabetes diagnosis; 3) One inpatient visit with a diabetes diagnosis; or 4) Two ambulatory care visits with a diabetes diagnosis

Table 1: Diabetes Admissions per Thousand Members per Year (enrollees ages 21-64)

	CY 2002	CY 2003
Diabetes-related hospital admissions	370	363
Avoidable diabetes-related hospital admissions	30	30

Table 2: Asthma Admissions per Thousand Members per Year (enrollees ages 5-20)

	CY 2002	CY 2003
Asthma-related hospital admissions	87	87
Avoidable asthma-related hospital admissions	48	51

Currently, there are no national standards or acceptable rates for avoidable hospital admissions to compare against. The Department, therefore, will monitor the trends across MCOs to determine whether there are any discernable admission trends. The Department also evaluates HEDIS performance measures to determine how well the MCOs are managing the care of individuals with diabetes and asthma. A summary of these measures is available in the annual HEDIS report (the asthma HEDIS measure was implemented in 2004, and therefore will be reported next year). The annual HEDIS report is available at: <http://www.dhmf.state.md.us/mma/healthchoice/html/CY2003.htm>

Quality of Care

During CY 2004, the Department conducted a variety of quality assurance activities. These activities included the annual systems performance review (EQRO), the Consumer Assessment of Health Plans Survey (CAHPS), and use of Health Employer Data and Information Set (HEDIS) based measures. In addition, the HealthChoice consumer report card and the Value-Based Purchasing Initiative were updated. The report card and the Purchasing Initiative synthesize performance results from HEDIS, CAHPS, the systems performance review, and encounter data analyses.

Ten quality measures were included in the CY 2003 Value-Based Purchasing Initiative (Table 3). MCOs' performance on these ten measures was compared to compliance levels (or targets) set by the Department for each measure. Two of the measures, practitioner turnover and childhood immunization status, were added in 2003. In future years, other measures may be added to the set of ten or may be rotated with measures in the set.

Reports on the 2002-2003 HealthChoice quality assurance activities are available by request and are posted online at <http://www.dhmf.state.md.us/mma/healthchoice/html>

Conclusion

This update of key measures from the HealthChoice Evaluation indicates that HealthChoice continues to improve access to care. Overall, the percentage of HealthChoice enrollees who receive services continues to increase. While the upward trend in ED utilization is a concern, there is no evidence that access to care is declining. The data also show that the children in foster care access services at higher rates than the general population. Access to

dental services and lead screening continues to improve, and there is little indication that racial minorities that are continuously enrolled (for at least 320 days) are experiencing diminished access to services.

Based on these findings, the Department will continue to monitor trends in ED utilization and focus on identifying reasons behind increased ED use. The Department also will continue to monitor avoidable hospitalizations for enrollees with asthma or diabetes. Multiple quality assurance activities will continue in CY 2004 and beyond, and the Department anticipates that HealthChoice will continue to demonstrate overall improvements in access to care.