

HealthChoice Evaluation Update

January 2004

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 HealthChoice¹. 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 based on several key measures that were part of the HealthChoice Evaluation. The 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 2000- CY 2002.

This evaluation update provides evidence that HealthChoice continued to show progress between CY 2000 and CY 2002 and HealthChoice improved access to care for its enrollees. Increases in access to health services occurred even as the number of HealthChoice enrollees continued to grow. Access to care steadily improved in a variety of areas, including ambulatory care, well-child visits, substance abuse treatment, dental services, and lead testing. This update also showed that emergency room (ER) utilization had increased between CY 2000 and CY 2002. This was an unexpected trend – the Department had anticipated that ER utilization would decrease under managed care.

HealthChoice Facts

HealthChoice enrolls 80% of Medicaid beneficiaries (over 470,000 Marylanders).

- Since CY 1999, average total HealthChoice enrollment has increased by about 7% per year, from just over 355,000 enrollees in CY 1999 to over 455,000 enrollees in CY 2002.
- HealthChoice absorbed significant enrollment growth, primarily from Maryland Children's Health Program (MCHP) expansions in 1998 and 2001.
- HealthChoice enrollees include low-income children, pregnant women, families receiving Temporary Cash Assistance (TCA), individuals receiving Supplemental Security Income (SSI) benefits, and foster children.
- The average length of enrollment in HealthChoice is about 9 months.
- Enrollees receive their health services through seven HealthChoice managed care organizations (MCOs). The seventh MCO was added to the program in 2003.

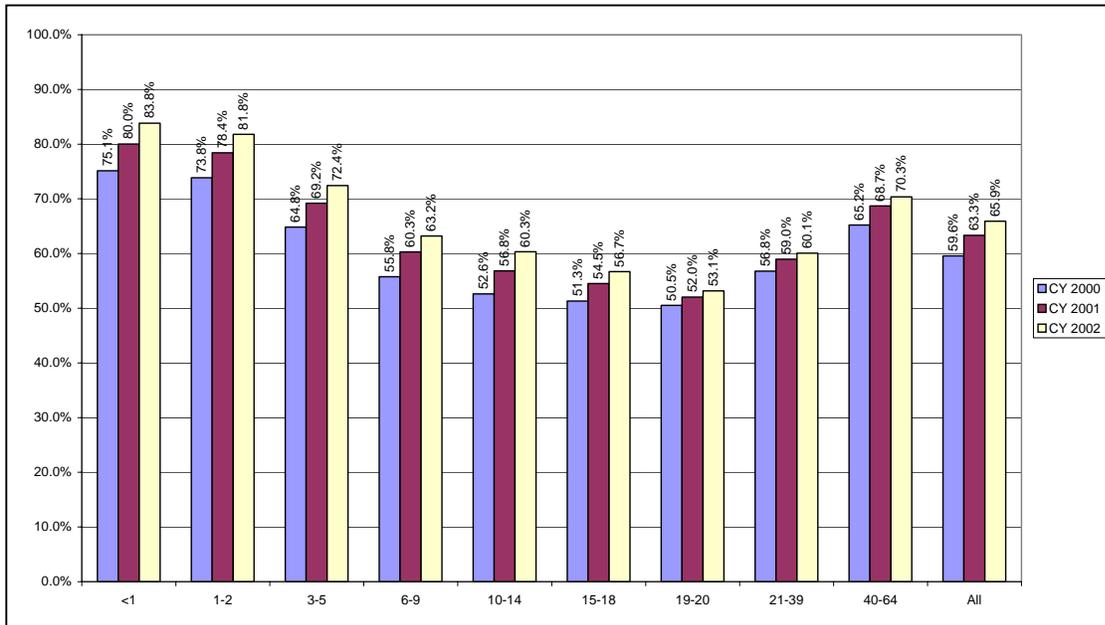
¹ HealthChoice Evaluation (Jan 2002) is available online at www.dhmd.state.md.us/mma/healthchoice/hcevalpres.html.

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 (all ages) receiving an ambulatory visit has increased from 59.6% to 65.9% (Figure 1). In FY 1997, prior to the implementation of HealthChoice, the percentage of individuals accessing an ambulatory visit was 57.8%.

Figure 1: Percentage of the Population Receiving Ambulatory Care Service by Age²

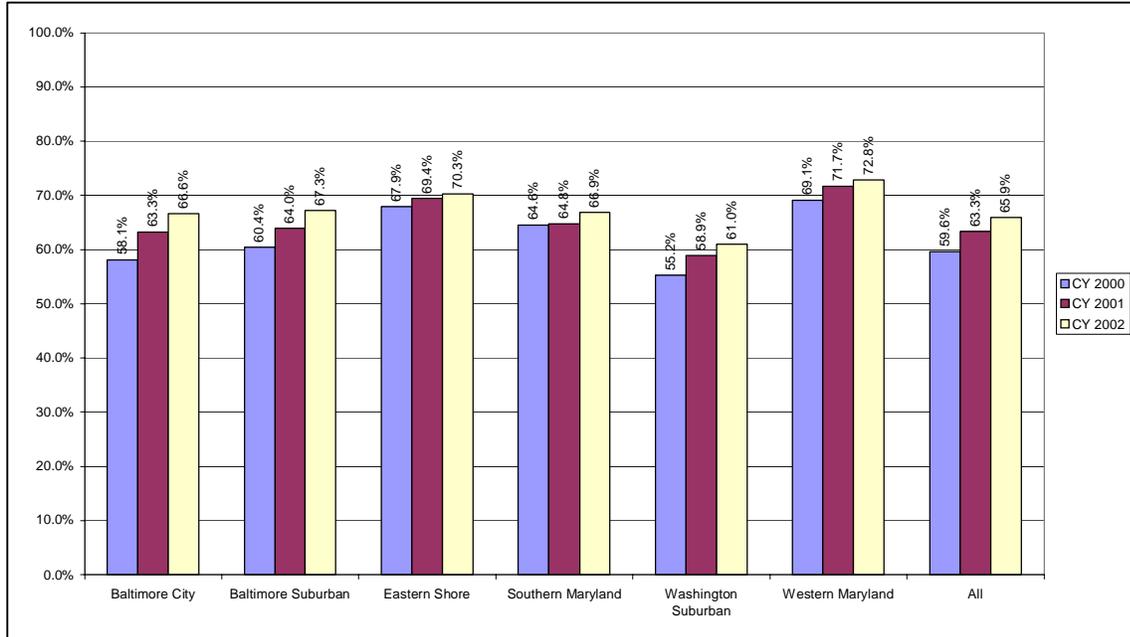


When the Department compared access rates between coverage groups, the Disabled category had the highest rate of access. In CY 2000, 63.5% of disabled individuals (all ages) accessed an ambulatory care service; in CY 2002 the rate of access had grown to 70.0%. The majority of individuals in the Disabled category are SSI eligible. Access to ambulatory services for the SSI population increased from 73.4% in CY 2000 to 76.9% in CY 2002 for adult SSI enrollees and from 64.9% in CY 2000 to 65.8% in CY 2002 for child SSI enrollees.

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

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 2)³.

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



Well-Child Visits

Well-child visits are defined by one comprehensive measure, which includes well-child visits, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and preventive services. This measure includes what the Department uses to report EPSDT services for federal reports, and includes clinic services in an outpatient setting that are accompanied by an appropriate diagnosis code. Well-child visits are a subset of all ambulatory visits.

Well-child visits are unique because they should take place 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 receiving a well-child service increased across all ages between CY 2000 and CY 2002. Overall, the access rate increased from 37.8% in CY 2000 to 44.8% in CY 2002 (Figure 3). These increases were observed across the State, with the greatest increases in Baltimore City, which now has the highest access rate of any region (Figure 4).

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

Figure 3: Percentage of Children Receiving a Well-Child Service by Age

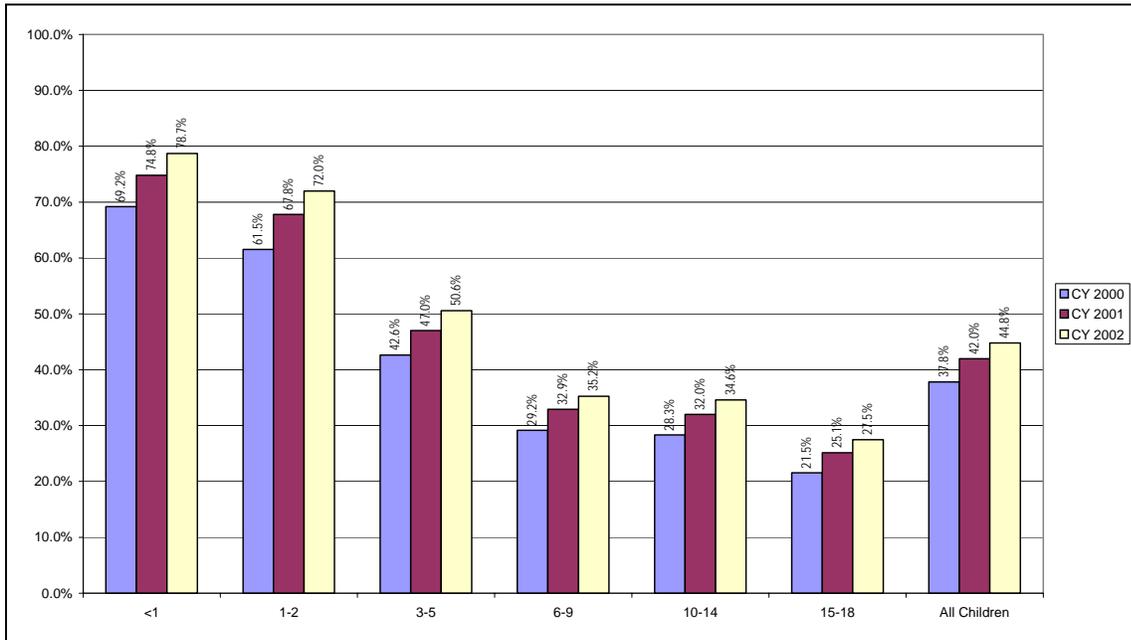
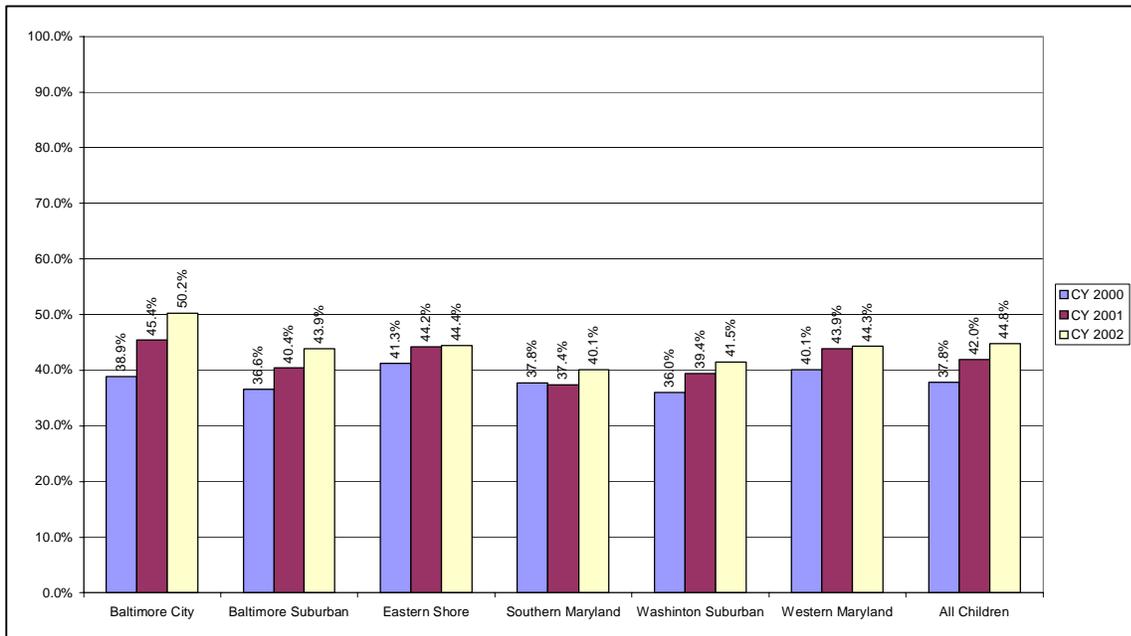


Figure 4: Percentage of Children Receiving a Well Child Service by Region



Dental Services

Dental care is a mandated health benefit for children through age 20 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 in the Department's annual report to the General Assembly (www.dhmmh.state.md.us/mma/html/reppubs.html).

The Department's measure of overall access to dental services is defined as the percentage of children aged 4-20 who received any dental service. Between CY 2000 and CY 2002 the percentage of children accessing any dental service increased from 28.7% to 34.5%⁴ (Table 1). The rate of access in FY 1997, prior to the implementation of HealthChoice, had been 19.9%.

Table 1: Number of Children Receiving Any Dental Services
Children ages 4-20, Enrolled for at least 320 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
FY 1997	88,638	17,637	19.9%
CY 1999	122,756	31,742	25.9%
CY 2000	132,399	38,056	28.7%
CY 2001	142,988	48,066	33.6%
CY 2002	194,351	67,029	34.5%

Access to restorative, diagnostic, and preventive dental services had also improved (Table 2). The most notable improvements in access occurred between FY 1997 and CY 2001. For example, the rate of access to restorative services increased from 6.6% to 10.8% between FY 1997 and CY 2001. The rates of access to restorative, diagnostic, and preventive services remained relatively static between CY 2001 and CY 2002.

Table 2: Percentage of Children Receiving Dental Services by Type of Service
Children ages 4-20, enrolled for at least 320 days

Year	Diagnostic	Preventive	Restorative
FY 1997	19.6%	18.1%	6.6%
CY 2000	27.3%	24.6%	9.3%
CY 2001	31.7%	29.1%	10.8%
CY 2002	31.7%	29.1%	10.3%

⁴ Based on enrollment of children ages 4-20 years with at least 320 days of enrollment in one MCO and an enrollment gap of no more than 45 days. Prior to CY 2001, these data included individuals enrolled in any MCO for at least 320 days.

Emergency Room Visits

Unlike ambulatory care and well-child visits, emergency room (ER) use was expected to decrease under managed care. This expectation was based on assumptions that the high cost of ER services makes them inappropriate except for ‘true’ emergencies, and that effective controls capable of restricting ER use to appropriate circumstances are inherent in a managed care system.

ER visits that result in hospitalization are more likely to be the result of ‘true’ emergencies. For purposes of the HealthChoice Evaluation, therefore, ER visits have been defined as visits that did not lead to hospitalization. These types of ER visits are most likely to be sensitive to managed care controls.

The actual patterns of ER use under HealthChoice run contrary to the theory that managed care would reduce ER use. Overall, ER use increased for each of the years examined. These increases occurred across all age groups and across most regions. ER utilization rates remained static in some regions, increased markedly in others (Baltimore City and Baltimore Suburban) and declined noticeably in Western Maryland. The percent of the population accessing an ER service increased from 13.7% in CY 2000 to 18.7% in CY 2002 (Figure 5). The analysis showed that ER use increased most among young children and those over the age of 21 (Figure 6).

Figure 5: Percentage of Population Receiving an Emergency Room Service by Region

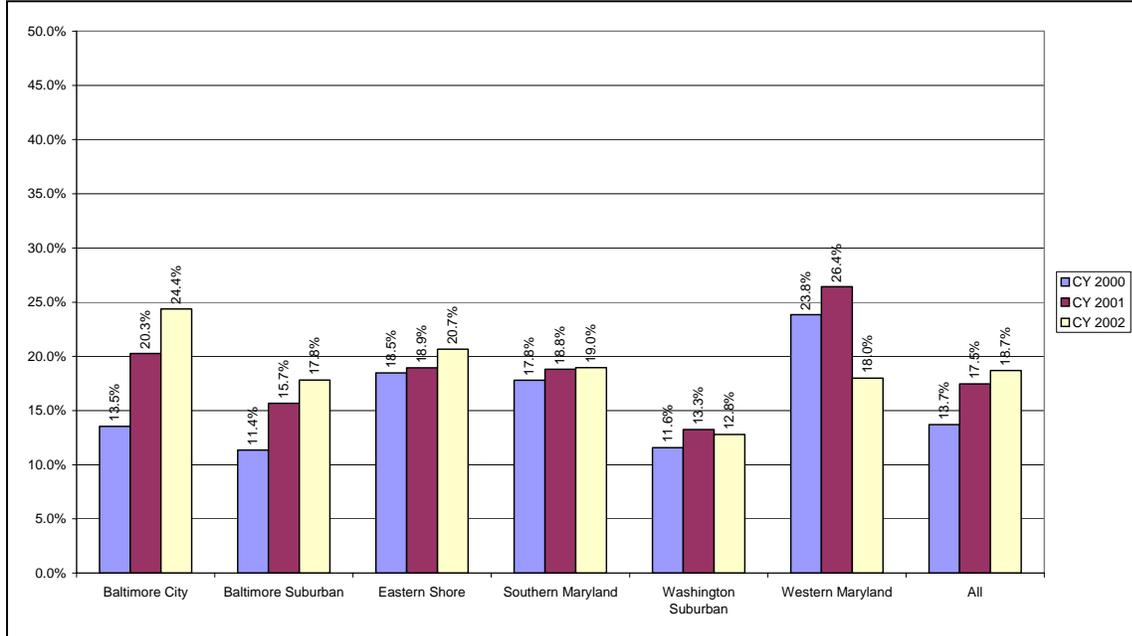
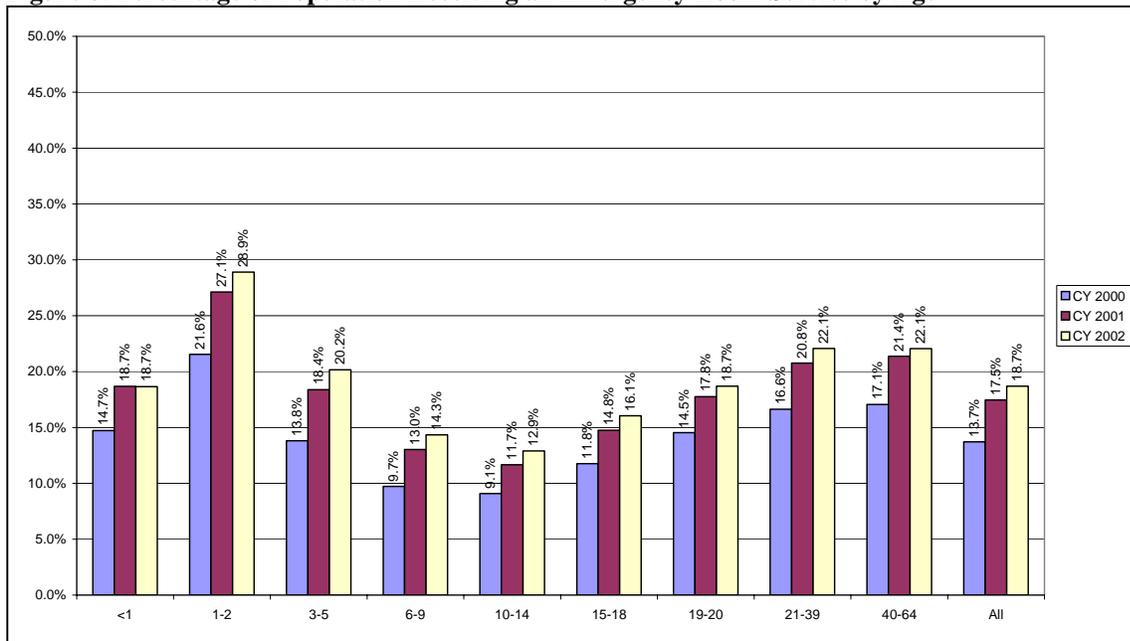


Figure 6: Percentage of Population Receiving an Emergency Room Service by Age



It is difficult to assess the meaning of the increase in ER use. The regional concentration of the increase suggests that this is not a Statewide phenomenon. In addition, the simultaneous increases in the rate of ambulatory visits suggests provider network issues are not the source of growth in ER utilization. The Baltimore regions experienced consistent and comparatively strong growth in ambulatory access and utilization between CY 2000 and CY 2002.

The steady increase in ER use may be indicative of any number of the following items:

- Maryland could be experiencing what has been a State and national trend in increased ER use⁵.
- Increased service availability as a result of hospital expansions of ER and outpatient facilities and the accompanying community outreach and marketing.
- Problematic ER claims submissions in CY 2000, causing ER visits to be under-reported.
- Disproportionate concentration of Family and Children and SSI/Disabled enrollees in Baltimore City. Both populations tend to use more ER services than do other coverage groups and comprise 85 percent of all enrollees in Baltimore as compared to 66 percent elsewhere.
- Some providers may be instructing patients to seek after-hours care in ERs (especially in Baltimore City and rural areas, and areas where there are no urgent care centers)

⁵ Cunningham, Peter, and Jessica May. "Issue Brief: Insured Americans Drive Surge in Emergency Department Visits," Center for Studying Health System Change, October 2003.

Maryland Health Care Commission and Maryland Health Services Cost Review Commission Report of the Joint Workgroup on Emergency Department Utilization, "Trends in Maryland Hospital Emergency Department Utilization: An Analysis of Issues and Recommended Strategies to Address Crowding," April 2002.

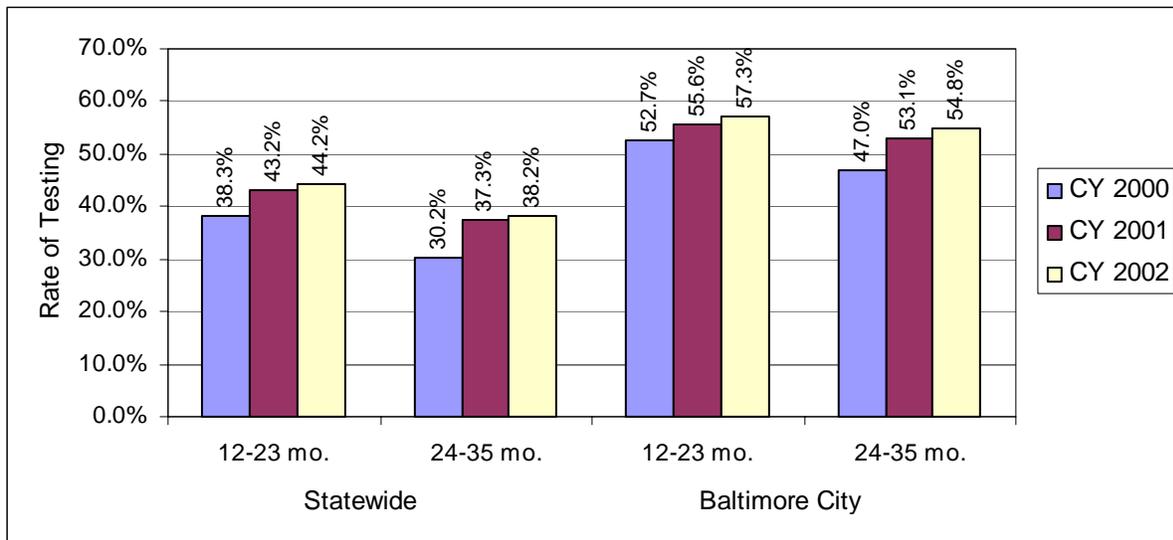
Lead Testing

The percentage of the age-defined⁶ population receiving a lead test has grown steadily between CY 2000 and CY 2002, both statewide and in Baltimore City (Figure 7). In order to calculate these rates, the Department merges HealthChoice eligibility, encounter and Medicaid fee-for-service data with Childhood Lead Registry data from the Maryland Department of the Environment.

The statewide rate of lead testing for children aged 12-23 months increased from 38.3% in CY 2000 to 44.2% in CY 2002. For children aged 24-35 months, the rate of testing increased from 30.2% in CY 2000 to 38.2% in CY 2002.

The rate of lead testing in Baltimore City for children aged 12-23 months increased from 52.7% in CY 2000 to 57.3% in CY 2002. For children aged 24-35 months, the rate of testing increased from 47.0% in CY 2000 to 54.8% in CY 2002.

Figure 7: Percentage of Population Receiving a Lead Test by Age, Statewide and Baltimore City⁷



Substance Abuse Services

In response to a 2000 report to the Lieutenant Governor's Task Force showing a significant decline in substance abuse treatment compared to the year before the implementation of HealthChoice (FY 1997), the Medicaid Drug Treatment Workgroup, composed of MCOs,

⁶ According to federal EPSDT requirements, children in Medicaid are required to receive blood lead testing at ages one (12-23 months) and two (24-35 months).

⁷ Based on children aged 12-23 months or 24-35 months as of December 31 of the measurement year, who were enrolled 90 or more days in a single MCO. CY 2001 and CY 2002 rates reflect decision rule (adopted in 2003) that lead tests must occur on or before the last MCO enrollment date in the last MCO in which the child was enrolled for at least 90 days.

providers, advocates, and state and local health department staff, implemented a Substance Abuse Improvement Initiative in January 2001. Since that time, HealthChoice has demonstrated positive trends in diagnosing substance abuse and bringing more adults into treatment (Table 3).

Table 3: Proportion of Adults Diagnosed with Substance Abuse Who Received Treatment

	CY2000	CY2001	CY2002
HC Enrolled Population Adults 21+	134,299	128,343	135,148
HC Adults Diagnosed with a Substance Abuse Disorder	9,701	11,342	12,583
Substance Abuse Prevalence (Proportion Diagnosed/Total HC Enrolled)	7.2%	8.8%	9.3%
Number of HC Adults Diagnosed with Sub Abuse who received Treatment	6,610	8,831	8,995
Proportion of HC Adults Diagnosed with Sub Abuse who received Treatment	68.1%	77.9%	71.5%

The percentage of the total adult HealthChoice population receiving any substance abuse treatment has increased compared to CY 2000, from about 5% in CY 2000 to approximately 7% in CY 2002. The rate of individuals receiving medication-assisted treatment (e.g. methadone, LAMM) increased from 1.1% in CY 2000 to 2.9% in CY 2002, and the rate of individuals receiving counseling services increased from 3.4% in CY 2000 to 3.7% in CY 2002. The duration of medication-assisted treatment per person has increased in the same time period, from 18.2 weeks in CY 2000 to 22.6 weeks in CY 2002, and from 12.8 counseling visits in CY 2000 to 13.1 counseling visits in CY 2002.

Foster Care

Following the HealthChoice Evaluation in 2001, the Department performed additional analyses of utilization by the foster care population. The analyses found that the majority (approximately 60%) of services provided to foster children were delivered outside the MCOs. In addition, disproportionately more (approximately 75%) was spent in fee-for-service than in HealthChoice in both FY 2001 and FY 2002. Mental health and pharmacy, including mental health pharmacy, were the largest categories contributing to fee-for-service expenditures.

The percentage of foster children receiving mental health services (excluding those children who received mental health pharmacy only) increased between FY 2000 and FY 2002, from 30.4% to 33.6%. The increase in utilization of mental health services is consistent with recent increases in the average age of the foster care population.

Quality of Care

During CY 2003, 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, two new quality strategies were implemented, the HealthChoice consumer report card and the Value-Based Purchasing Initiative. The report card

and the Purchasing Initiative synthesized performance results from HEDIS, CAHPS, the systems performance review, and encounter data analyses.

Based on the CAHPS, all MCOs received high satisfaction ratings from their enrollees. In addition, the Maryland average HEDIS score improved for 15 of the 16 measures.

Eight quality measures were included in the CY 2002 Value-Based Purchasing Initiative (Table 4). MCOs' performance on these eight measures was compared to compliance levels (or targets) set by the Department for each measure. Each measure's target was tied to a system of incentives and disincentives. Based on CY 2002 data, four MCOs were eligible for incentives - three for performance on the well-child visits measure and one for performance on the prenatal care measure. However, in 2002 the General Assembly redirected all the money that had been set aside for incentives. MCOs' incentive amounts, therefore, were used to offset any disincentives.

Table 4: CY 2002 Value-Based Purchasing Performance Measures

Performance Measure	2002 Target
Claims adjudication within 30 days	Neutral: 80% - 100% Disincentive: <80%
Well-child visits for children ages 3-6	Incentive: >68% Neutral: 53% - 68% Disincentive: <53%
Dental services for children ages 4-20	Incentive: >50% Disincentive: <50%
Ambulatory care services	SSI adults: Incentive: >84% Neutral: 70% - 84% Disincentive: <70%
	SSI children: Incentive: >77% Neutral: 63% - 77% Disincentive: <63%
Timeliness of prenatal care	Incentive: >87% Neutral: 68% - 87% Disincentive: <68%
Cervical cancer screening for women ages 21-64	Incentive: >77% Neutral: 42% - 77% Disincentive: <42%
Lead tests for children ages 12-23 months	Incentive: >53% Neutral: 36% - 53% Disincentive: <36%
Eye exams for diabetics	Incentive: >61% Neutral: 42% - 61% Disincentive: <42%

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

Provider Networks

The HealthChoice Evaluation provided analysis on the adequacy of primary care provider (PCP) networks. In general, the evaluation found that MCOs have adequate PCP networks. The evaluation also acknowledged the need to develop methodologies for monitoring the adequacy of specialty care networks, and develop specialty network access standards.

Over the past two years the Department has focused on developing specialty care standards and a methodology for enforcing these standards. In February 2004, new HealthChoice regulations establishing specialty network standards become effective. These regulations identify 14 major specialty areas in which MCOs are required to have at least one provider contract. The regulations also identify 8 core specialty areas in which MCOs are required to have at least one provider contract in each of the 10 specialty care regions in which they serve. Based on discussions and research, the Department is unaware of any other state Medicaid managed care program that has incorporated specialty network standards as rigorous as these.

Conclusion

This update of several 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 ER use is a concern, there is no evidence that enrollees are using ER as a substitute for ambulatory care. The Department will continue to monitor trends in ER utilization and focus on identifying reasons behind increased ER use. 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 while controlling costs.