

Maryland HealthChoice Program

**§1115 Waiver Renewal
Application**

Submitted by

**The Department of Health and Mental
Hygiene**

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<i>I.</i>	<i>APPLICATION FOR HEALTHCHOICE RENEWAL</i>	<i>1</i>
	A) BACKGROUND	1
	B) 2008 1115 WAIVER RENEWAL REQUESTS	18
	C) CONCLUSION	20
<i>II.</i>	<i>MCO PROVIDER NETWORKS AND REIMBURSEMENT</i>	<i>21</i>
	A) MCO PARTICIPATION	21
	B) PROVIDER NETWORK ADEQUACY	22
	C) ESTABLISHING CAPITATION RATES	29
	D) CONCLUSION	34
<i>III.</i>	<i>SERVICE UTILIZATION EXPERIENCE</i>	<i>35</i>
	A) GENERAL UTILIZATION	35
	B) PREVENTIVE SERVICES	42
	C) APPROPRIATENESS OF CARE	53
	D) SELECTED SERVICES	58
	E) SPECIAL POPULATIONS	78
	F) CONCLUSION	90
<i>IV.</i>	<i>PUBLIC INPUT</i>	<i>91</i>
	A) MECHANISMS FOR GAINING PUBLIC INPUT	91
	B) MECHANISMS FOR PROVIDING FEEDBACK TO THE PUBLIC	98
<i>V.</i>	<i>BUDGET NEUTRALITY</i>	<i>99</i>
	A) COMPLIANCE WITH BUDGET NEUTRALITY REQUIREMENTS	99
	B) TREND FACTOR MUST INCREASE	99
	C) CHANGE IN MEDICAID ELIGIBILITY GROUPS (MEGS)	100
<i>VI.</i>	<i>CONCLUSION</i>	<i>101</i>
<i>VII.</i>	<i>FUNDING QUESTIONS</i>	<i>102</i>

I. APPLICATION FOR HEALTHCHOICE RENEWAL

A) BACKGROUND

1) Overview

HealthChoice is Maryland's statewide mandatory Medicaid managed care program, operated under authority of section 1115 of the Social Security Act. Maryland's original 1115 waiver was approved by the Health Care Financing Administration [since renamed the Centers for Medicare and Medicaid Services (CMS)] in October of 1996 and the demonstration was implemented in June 1997. Maryland's first extension was implemented in June 2002. CMS approved a second three-year extension of the State's 1115 waiver in June 2005. The evaluation within this renewal application shows HealthChoice experience for calendar years 2002 through 2006, the period from the original HealthChoice evaluation through the most recent year of available data.

Over 480,000 individuals, approximately 75 percent of the State's Medicaid population, are enrolled in HealthChoice. HealthChoice enrollees include both Medicaid and Maryland Children's Health Program (MCHP – Maryland's State Children's Health Insurance Program) populations. HealthChoice participants choose one of seven managed care organizations (MCOs), as well as a primary care provider (PCP) from the MCO's network to oversee their medical care.

The original goals for Maryland's HealthChoice demonstration were to control the rapidly rising costs of Medicaid and to improve coordination of care. The program was developed on the basis of several guiding principles:

- Providing a patient-focused system with a medical home for all beneficiaries;
- Building on the strengths of the current Maryland health care system;
- Providing comprehensive, prevention-oriented systems of care;
- Holding Managed Care Organizations (MCOs) accountable for high quality care; and
- Achieving better value and predictability for State expenditures.

The Department released the first HealthChoice evaluation in 2002. Since then, the Department has continued to monitor HealthChoice performance on a variety of measures and completes an evaluation update each year. It is important to show trends over time for certain measures. In addition, measures must evolve to assess the effectiveness and quality of an established program. The Department submitted another evaluation to CMS as part of its 2005 1115 waiver renewal. The 2005 evaluation incorporated additional guiding principles for a mature program:

- Demonstrating stability and predictability;
- Promoting appropriate service utilization through:
 - Promoting evidence-based care and quality measurement, and
 - Managing for results (pay-for-performance); and

- Alleviating disparities and assuring access to care for vulnerable populations.

The current application for the 2008 1115 waiver renewal builds on these past efforts and incorporates new analyses. The evaluation: 1) demonstrates how the waiver program has improved since the completion of the original evaluation; and 2) shows that a mature and established waiver program can be expected to meet certain goals and objectives that would not be demonstrable or achievable for a relatively young or recently implemented program.

As with the initial HealthChoice Evaluation released in January 2002, this evaluation was conducted collaboratively by the Maryland Department of Health and Mental Hygiene and the Center for Health Program Development and Management at the University of Maryland, Baltimore County.

Chapter I of this renewal application presents an overview of HealthChoice, including who is covered, what services are provided, findings and recommendations from the 2002 evaluation, and recommendation implementation activities. Subsequent chapters of this evaluation present the program performance measures relevant to the guiding principles noted above.

2) Who Enrolls in HealthChoice MCOs

The groups of Medicaid eligible individuals who enroll in HealthChoice MCOs are:

- Low-income families with children;
- Families receiving Temporary Cash Assistance (TCA)
- Children under age 19 eligible for the Maryland Children's Health Program (MCHP);
- Pregnant and postpartum women;
- Supplemental Security Income (SSI) beneficiaries under age 65 who are not also eligible for Medicare; and
- Children in foster care.

Not all Maryland Medicaid recipients are enrolled in HealthChoice MCOs. Groups who are not eligible for HealthChoice enrollment include:

- Medicare recipients;
- Individuals aged 65 or over;
- Individuals who are eligible for Medicaid for only a temporary period under a spend-down category;
- Individuals who are continuously enrolled over 30 days in a long term care facility or an institution for mental diseases; and
- Individuals institutionalized in an intermediate care facility for mentally retarded persons (ICF-MR).

3) Additional Populations Covered Under the HealthChoice 1115 Waiver

Rare and Expensive Case Management Program

The Rare and Expensive Case Management (REM) program is included under the HealthChoice 1115 waiver, but is a carve-out from the HealthChoice MCOs. REM was designed to provide case management services to Medicaid recipients who have one of a specified list of rare and expensive medical conditions and who require sub-specialty care. In order to be enrolled into REM, a Medicaid recipient must be eligible for HealthChoice, have a qualifying diagnosis, and be within the age limit for that diagnosis. In addition to the standard Medicaid fee-for-service benefits package, a REM participant is eligible for some expanded benefits.

Eligibility for REM is determined by the Department's REM Intake Unit. A HealthChoice MCO remains responsible for the recipient's care until enrollment in the REM program occurs. Once the recipient is determined REM-eligible, and consents to go into REM, he or she is disenrolled from the HealthChoice MCO and the recipient's care is coordinated by a REM case manager. A REM eligible individual may elect to remain in an MCO.

Currently there are approximately 3,500 REM enrollees. Slightly more than 80 percent are children. REM enrollment has increased by approximately four percent annually. In an effort to control rising costs, several initiatives were developed in recent years. These included streamlining case management administrative functions, developing new case management payment methodologies, and freezing levels of case management reimbursement. The Department seeks to continue the REM program in the next renewal cycle.

Maryland Primary Adult Care (PAC) Program

The Department implemented the Primary Adult Care (PAC) program in July 2006. PAC provides primary care, prescription drugs, and certain office- and clinic-based mental health services to low-income adults (age 19 and older), whose incomes are below 116 percent of the federal poverty level (FPL) and are not eligible for Medicaid or Medicare. PAC is a managed care model, similar to HealthChoice. Individuals eligible for PAC chose from one of three participating PAC MCOs and select a PCP.

Enrollment in PAC is currently approximately 28,000. This is close to the Department's original projections. PAC has expanded primary care services to approximately 20,000 low income individuals in Maryland. The other 8,000 were eligible for primary care under a small, capped State-only Maryland Primary Care Program that no longer exists. PAC's managed care model has been effective at providing added value for enrollees; all participating MCOs currently offer basic dental benefits as extra services which are not part of the PAC service package and which are not built into MCO capitation rates. The MCOs also waive the co-pays imposed by the Department in an effort to encourage utilization among enrollees.

In addition, PAC has expanded access for women who could previously only access post-partum family planning benefits. While a smaller percentage of the population, the PAC program allows continued access to services outside of the traditional contraceptive services provided through the Family Planning Program for women who meet the stricter income guidelines of PAC.

One of the important outcomes of PAC has been its role in expanding access to buprenorphine therapy Statewide, but particularly in Baltimore City. Buprenorphine is used to treat heroin and opiate addiction and can be managed in a primary care office setting. It represents a major advancement in the treatment of heroin and opiate addiction. A series of reports by the UMBC Center for Health Program Development and Management have shown that the expansion of buprenorphine as a strategy for battling opioid (e.g., heroin) addiction is cost-effective. Overall, the reports indicate that expanding opioid maintenance therapy (OMT) does have the potential to save the publicly financed health care system money by reducing heroin-associated morbidity in Medicaid and other insured and uninsured populations. The reports are available at <http://www.chpdm.org/publications/behaviorialHealth.htm>.

The Baltimore City Health Department and Baltimore Substance Abuse Systems have introduced the Buprenorphine Initiative to bring together substance abuse treatment centers, community health centers, and primary care physicians to fight heroin and opiate addiction in Baltimore City. The three major components of the project are recruiting physicians to prescribe buprenorphine, drug treatment, and extended buprenorphine therapy. PAC supports the Initiative by providing a mechanism for coverage of the buprenorphine itself, as well as primary care physician services. During the first year of PAC (state fiscal year (SFY) 2007), buprenorphine was the top PAC MCO drug in terms of dollars spent. Buprenorphine accounts for five percent of all PAC MCO pharmacy costs and approximately three percent of total pharmacy costs under PAC.¹

The Legislature recently passed SB 6 during the 2007 Special Session. The legislation requires the Department to expand benefits to the PAC population. Under this renewal period, the increased benefits include specialty physician and emergency services in SFY 2010 and outpatient hospital services in SFY 2011. The Department, therefore, seeks to continue and expand benefits under PAC in the next renewal cycle. The Department's budget neutrality information reflects these expansions.

Employed Individuals with Disabilities

The Department implemented the Employed Individuals with Disabilities program (EID) in April 2006. EID allows individuals with disabilities with incomes up to 300 percent of the FPL to work and earn income and assets above traditional Medicaid thresholds. This allows individuals to work without losing their Medicaid benefits. Individuals must pay an enrollment fee of \$75 for each six months of coverage.

¹ Certain pharmacy expenditures are carved-out of the MCO benefit package and provided on a FFS basis.

Enrollment in EID is lower than expected – currently approximately 160 compared to an estimated 1,500. To improve enrollment, the Department is utilizing Medicaid Infrastructure Grant (MIG) money to improve outreach efforts and acquire technical assistance in enhancing the program for enrollees. Among the improvements are redesigning the premium and disability requirements.

EID has provided the impetus for the Department to work with its sister agencies to implement a State-specific process for determining applicants' disability status. This is an important change to the existing Medicaid disability determination process, and may have positive effects that reach far beyond EID to the larger Medicaid population. The Department seeks to continue the EID program in the next renewal cycle.

Family Planning Program

The covered services related to family planning include family planning office visits which include physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and permanent sterilization. Maryland seeks to continue administering its Family Planning Program as it currently exists. A letter of support from the Mid-Atlantic Association of Community Health Centers (MACHC) is attached as Appendix I.

Appendix II shows all Family Planning Program services approved by CMS under the current demonstration. The spreadsheet shows the code, the description of the service, and indicates a check mark for whether that service receives 90 percent federal financial participation (FFP), 90 percent with a V25 code, or 50 percent FFP (indicated by a check mark in the FMAP column). The last column shows the year which the code was approved by CMS.

Eligibility criteria are described in COMAR 10.09.58.01. Pregnant women are eligible if they have lost Medicaid coverage after their pregnancy related period of eligibility, and do not otherwise qualify for Medicaid. The structure of MMIS-II ensures that women are not in the Family Planning Program if they are eligible for Medicaid or any other Medical Assistance program. An individual cannot have two open eligibility coverage groups in MMIS-II. The most comprehensive benefit is weighted the highest, so the lowest coverage group is closed and the highest coverage group is kept open. Women must show proof of U.S. citizenship and identity consistent with the federal Deficit Reduction Act, be residents of Maryland, and have family income that meets Medicaid eligibility requirements for pregnant women under COMAR 10.09.11 (250 percent of the FPL). This allows all women who met the financial eligibility for coverage of pregnancy under Medicaid to be eligible for the Family Planning Program, if they meet all other criteria. Women are not eligible once they have a permanent sterilization procedure.

Women become initially eligible for the Family Planning Program two months after the pregnancy ends. To become eligible, women must have filed an application for coverage of pregnancy with a local department of social services (LDSS) or local health department (LHD), and must have been determined eligible by the LDSS or LHD. MMIS-II closes the Medicaid coverage group two months after the pregnancy ends,

opens the Family Planning Program coverage group, and issues the Family Planning Program card. MMIS-II generates monthly reports of pregnancy coverage group closures and Family Planning Program openings which are used by the Department to monitor monthly enrollment. Women receive an initial notice of their eligibility for the Family Planning Program. The notice explains the services covered under the program, the eligibility criteria, the renewal process for continuation of eligibility, and provides resource numbers for helping finding providers or to answer questions.

The Department has an active redetermination process for the second, third, fourth, and fifth years of eligibility for the Family Planning Program. Each month, the Department sends out renewal packets to women who are due to have eligibility end within 90 days. A financial review is a mandated requirement for continued eligibility in the Family Planning Program. The Department's renewal worksheet is used to calculate total monthly countable income. The renewal worksheet requests information on the household, earned family income, deductions, and other health insurance. As in Medicaid, women are able to have other insurance and maintain eligibility for the Family Planning Program. This is essential to the core mission of making family planning services available to women after their Medicaid-covered pregnancy ends, given that many private insurance plans do not offer comprehensive coverage of contraceptives. When a third party insurer is responsible for payment of a service that is offered under the Family Planning Program, we cost avoid these claims. In order to maintain eligibility, women must send back the completed renewal worksheet with a signed and dated rights and responsibilities page, demonstrating they continue to meet all financial and technical criteria for eligibility. The Department tracks all renewal mailings and their status by county.

Both the initial notice and renewal packets include resources for non-covered primary care referrals. This includes information on the importance of regular visits and sick care, and locations and contact information on community health centers that offer primary care and dental on a sliding fee scale. In the renewal period, information on the PAC program will be sent in all initial and renewal packets. Some women on the Family Planning Program may be eligible for PAC, which has lower income standards.

The Medicaid administration collaborates with the Family Health Administration (FHA) which administers Title X. Both are housed in the Department of Health and Mental Hygiene. These programs share the goals of promoting the health of mothers, infants, and children. A memorandum of understanding (MOU) between Medicaid and the FHA is attached (Appendix III). The MOU covers topics related to administration and policy, reimbursement and contract monitoring, confidentiality and data exchange, recipient outreach and referral, training and technical assistance, provider capacity, systems integration, and quality assurance activities. The FHA also helps link women to health care services that are not covered under the Family Planning Program.

The Department uses monthly reports to monitor the Family Planning Program. Much of this information is shared with CMS through quarterly and annual reports. In the first quarter of State fiscal year 2008, average enrollment was approximately 40,500 women.

Approximately 18,500 women received services in the quarter. To date, approximately 11 percent of women who were sent renewal notices in the quarter have responded and been approved for continuation on the program. Some additional women have not yet come upon their 90 day deadline for response to the renewal, and may still be approved.

In the next renewal period, the Department intends to continue monitoring enrollment and service utilization through monthly reports. In addition, the Department plans on administering a mailed consumer satisfaction survey through the eligibility renewal packet. The survey will ask women about their experiences accessing family planning services. It will also ask about their experiences accessing non-covered primary care services. Women will not be required to complete the survey as a condition of continued eligibility. As another component of evaluation in the next renewal cycle, the Department will also assess the proportion of women who move from the Family Planning Program to PAC. Many women in the Family Planning Program will have incomes too high to qualify for PAC. However, because PAC offers a more comprehensive benefit package, the Department seeks to maximize the number of potentially eligible women who apply for PAC.

4) Previous Populations Covered Under the HealthChoice 1115 Waiver

The Department discontinued two pharmacy programs previously covered under the HealthChoice 1115 Waiver as a result of the federal Medicare Prescription Drug, Improvement and Modernization Act. That Act changed the way dual-eligibles (those receiving both Medicare and Medicaid) and others receive prescription drug services. On Jan. 1, 2006, dual-eligibles began receiving their prescription drug benefits through private prescription drug plans under Medicare Part D, not state Medicaid programs.

Maryland Pharmacy Discount Program

The Pharmacy Discount Program, which began on July 1, 2003, allowed Medicare recipients with incomes up to 175 percent of the FPL to purchase Medicaid formulary drugs at 65 percent of the Medicaid price. This program was terminated effective January 1, 2006 so that enrollees could receive prescriptions from the Medicare Part D drug benefit. Legislation from the General Assembly's 2005 session required the Department to apply to CMS to change this program to serve non-Medicare populations with incomes below 200 percent of the FPL. The Department submitted a waiver request to CMS to reconfigure the program. However, CMS denied the request.

Maryland Pharmacy Assistance Program

The Maryland Pharmacy Assistance Program (MPAP) was a federally approved Medicaid waiver program that helped low-income Maryland residents pay for Medicaid covered drugs. The program was not limited to the elderly or disabled. All Medicare enrollees were disenrolled from this program effective January 1, 2006 to receive prescriptions from the Medicare Part D drug benefit. Effective July 1, 2006, MPAP was combined with the Maryland Primary Care program to create PAC. Between July and September 2006, all non-Medicare MPAP enrollees were transitioned to PAC.

5) Covered Services

HealthChoice enrollees receive the same comprehensive benefits as those available to Maryland Medicaid enrollees through the fee-for-service system. Services in the MCO benefit package include but are not limited to:

- Inpatient and outpatient hospital care;
- Physician care;
- Laboratory and x-ray services;
- First 30 days of nursing home care;
- Home health care;
- Durable medical equipment and disposable medical supplies;
- Most services for children under early and periodic screening, diagnosis, and treatment program (EPSDT);
- Clinic services;
- Dialysis;
- Substance abuse treatment services;
- Vision;
- Prescription drugs, with the exception of mental health drugs and HIV/AIDS drugs; and
- Dental care for children and pregnant women.

Some services are carved out of the MCO benefit package and are covered under Medicaid fee-for-service. A key carve-out service is specialty mental health services, which are administered by the DHMH Mental Hygiene Administration's Public Mental Health System. Other carved out services include:

- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP);
- Therapy services (occupational, physical, speech, and audiology) for children;
- Personal care services;
- Medical day care services for adults or children;
- Long term care services after the first 30 days of care (individuals in long term care facilities for more than 30 days are disenrolled from HealthChoice);
- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS;
- HIV/AIDS drugs and specialty mental health drugs; and
- Services covered under 1915(c) home and community based services waivers.

5) MCO Reimbursement

Capitation Payments

Payment is made to an MCO for each enrollee at a fixed capitation rate. The HealthChoice capitation rate-setting methodology is based on Adjusted Clinical Group (ACG) assignment utilizing an enrollee's past Medicaid claims history. If there is insufficient data on which to base an ACG assignment, the Department will assign the enrollee to a geo-demographic rate cell, which reflects the enrollee's age, county of residence, eligibility group, and gender. Individual MCO risk scores are applied to these geo-demographic rate cells for enrollees over age 1 based on historical analyses of subsequent ACG assignments. By grouping recipients on the basis of past utilization, the program targets higher payments for sicker enrollees. There are two general eligibility categories: "Families and Children" and "Disabled". Special payment categories include a single supplemental payment for maternity, delivery and low-birth weight costs, and monthly payment rates applicable specifically for enrollees under age one, enrollees with HIV, and enrollees with AIDS. The Department sets rates annually, and may adjust rates during the year, called the "mid-year adjustment", due to policy or reimbursement rate changes, or hospital trends that vary from what was included in the rates.

Cost Containment

In recent years, the Department has had to implement cost containment measures in the Medical Assistance Program. In general, cost containment efforts targeted a one percent reduction in overall MCO payments. Other cost containment measures included reducing reimbursements by \$2 million in 2004 to account for increased collections from third parties and carving-out HIV drugs to leverage the Department's higher drug manufacturer rebates. Each year the MCO rates are determined to be actuarially sound even after taking into consideration cost containment.

6) Program Improvements

2002 HealthChoice Evaluation

In 2002 the Department completed an evaluation of the HealthChoice program. The evaluation was designed with extensive input from a variety of stakeholders, including consumers, providers, MCOs, advocates, and the Maryland General Assembly. Using a mix of quantitative and qualitative data sources, as well as public input and expert consultation, the evaluation provided a comprehensive picture of the overall performance of the HealthChoice program over a period of time.

The evaluation produced a number of findings and recommendations. Key findings were that HealthChoice:

- Served as the platform for a major program expansion, of over 100,000 new enrollees (MCHP);
- Helped more people, particularly children, access health services overall, although the number of services per person decreased;

- Saved money relative to fee-for-service and added value for consumers and providers; and
- Specialty physician participation could be threatened if fees were not increased.

The evaluation also provided multiple recommendations for improving HealthChoice. A selection of the Department's implementation activities are as follows:

- Improve provider networks.

Implementation activities:

- One of the State's most significant efforts to improve HealthChoice is the implementation of physician fee increases. Adequate physician fees are essential to attract and maintain providers who serve Medicaid recipients. In SFY 2003, Maryland increased physician reimbursement rates by \$50 million. Since SFY 2006, DHMH has added an additional annual increase to physician fees each year. In SFY 2006, \$30 million was allocated for physician fee increases, with an additional \$57 million allocated in SFY 2007. DHMH works with a stakeholder group to determine which specialties or procedures codes are to be targeted each year. Currently all Medicaid physician fees are at least 50 percent of Medicare reimbursement rates. Many are substantially higher. The Department's goal is to increase all physician fees to 100 percent of Medicare reimbursement rates.
- The Department has designed and implemented specialty standards for MCO network adequacy. The standards are published in regulation and require 1) for eight core specialties, each MCO must contract with at least one of each specialist in each of ten regions throughout the State, and 2) for an additional 6 major specialties, each MCO must contract with at least one of each specialist statewide.
- Additional activities include implementation of a newborn coordinator position at each MCO, streamlining payment policies with MIA rules, and utilizing better mechanisms for communication with providers, such as posting transmittals on the web.

- Promote increased quality of care and improved program performance.

Implementation activities:

- The Department implemented a Value-Based Purchasing Initiative in 2002 and a consumer report card in 2003. DHMH is in the preliminary stages of designing a physician level pay for performance program, and has sought out technical assistance from national experts in this field. Implementation could begin in calendar year 2009.

- Improve the program for consumers.

Implementation activities:

- The Department implemented a recommendation to allow new auto-assigned enrollees to change MCOs once during the first year. The Department subsequently revised this policy to allow all enrollees to

change MCOs once within the first 90 days of initial enrollment in an MCO, in order to comply with federal managed care regulations.

- The Department has collaborated with the Department of Human Resources (DHR) on several different initiatives to improve access to services for children in foster care. Analysis subsequent to the 2002 evaluation found that children in foster care utilize health services at higher rates than the general population of children in HealthChoice. This is not surprising given that foster children as a population tend to have higher health needs. Moreover, children in foster care receive approximately 80 percent of their services outside of MCOs, in the fee-for-service system. This is due primarily to high levels of mental health utilization, but also due to use of other carve-out services and the longer period of fee-for-service prior to MCO enrollment. Currently, the Secretaries of DHMH and DHR are co-chairing an advisory group to further address needed system improvements.
- The Department worked with MCOs, local health departments, and advocacy groups to design methods of educating enrollees about the HealthChoice Enrollee Action Line (HEAL). One result is that enrollees receive a magnet with the HEAL telephone number in their enrollment packets.
- The Department recently reminded providers that all HealthChoice enrollees are entitled to receive an emergency 72-hour supply of medication while awaiting prior authorization or approval to dispense a non-formulary or non-preferred medication. In addition, the Department has instructed MCOs to only make changes in their formularies according to a set quarterly schedule, and place all up to date formulary information on the Department web site.
- The Consumer Report Card implemented in 2003 also provides enrollees with information on MCO performance in key areas of interest. The report card is provided to all new enrollees and those who have reached their Annual Right to Change (ARC) date. This allows for increased consumer awareness in determining the MCO that will best suit the needs of their families.
- In response to recommendations from the Special Needs Children Advisory Committee (SNCAC), the Department worked with a group of stakeholders to develop outreach materials for families of children with special health care needs. The materials were designed to educate families about special Medicaid programs and services, and how to access them. The group produced a tri-fold brochure that is distributed in all enrollment packets, as well as five detailed brochures on HealthChoice, fee-for-service, home and community based services waiver programs, mental health, and EPSDT. The detailed brochures are available on the Medicaid website and are distributed by community-based organizations.

- Improve the delivery of special services.

Implementation activities:

- The Department has undertaken a variety of efforts to improve access to dental care for children, including significantly increasing fees for twelve restorative dental procedure codes in 2004. Despite improvement under HealthChoice, utilization of oral health services has remained low. In an effort to increase oral health access and utilization, the Secretary convened the Dental Action Committee (DAC) in June 2007. The DAC was comprised of a broad-based group of stakeholders concerned about children's access to oral health services. The DAC focused its efforts and recommendations on four topic areas: (1) Medicaid reimbursement and alternative models, (2) provider participation, capacity, and scope of practice, (3), public health strategies, and (4) oral health education and outreach. The DAC reviewed dental reports and data to develop a comprehensive series of recommendations, building on past dental initiatives, lessons learned, and best practices from other states. The DAC's final report was presented to the Secretary in September 2007. The DAC recommends several changes to the Medicaid program. In order to streamline the Medicaid process for providers and recipients, the DAC recommends a single statewide dental vendor, an Administrative Services Only (ASO) provider. The DAC further recommends increasing dental reimbursement rates to the 50th percentile of the American Dental Association's South Atlantic region charges for all dental codes. The Department is committed to fully and carefully reviewing the DAC's recommendations and working with the DAC on recommended strategies to make access to dental care a reality for all children.
 - The Department has continued to monitor the Substance Abuse Improvement Initiative (SAII) which was developed with the Medicaid Drug Treatment Workgroup. In recent months, substance abuse providers and advocates have asked for a renewed focus on this area. The Department has agreed to examine compliance with the SAII and to meet with MCOs concerning their responsibility for providing substance abuse treatment services. In addition, the Department has agreed to work with MedChi, Maryland's state medical society, to increase access to buprenorphine treatment.
- Maintain the current MCO-based capitated program, and establish strategies to stabilize the managed care system.
- Implementation activities:*
- The Department implemented the recommendations to base rate-setting on actual MCO expenditures, implemented recommendations regarding MCO planning and participation, including incentives to encourage statewide participation by MCOs, and streamlined regulatory reporting requirements prior to implementation. Almost six years after the publication of the original HealthChoice evaluation, the program has

matured into a stable program and has continued to have at least two MCOs in each area of the State.

7) Monitoring Access and Quality Improvement

The Department has an extensive system for evaluating and improving MCO performance. Each component of the approach is aimed either at measuring the actual performance of the MCO or determining whether or not the MCO has the necessary infrastructure to provide high-quality care. Before the Department approves an MCO for participation in HealthChoice, the MCO must undergo an extensive application process and must meet operational and financial standards. After joining HealthChoice, MCOs are evaluated according to a variety of quality standards. Quality activities include:

- Value-Based Purchasing, a coordinated performance measurement initiative designed to use incentives and disincentives to hold MCOs accountable for performance.
- Select Healthcare Effectiveness Data and Information Set (HEDIS) measures, which allow the State to make comparisons of HealthChoice to national performance benchmarks.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, a national survey administered to enrollees to determine consumers' perceptions of the care and services they have received from their MCOs.
- Provider satisfaction survey.
- Annual Systems Performance Review conducted by an External Quality Review Organization (EQRO). This includes reviews of MCO policies, processes, and systems performance (i.e., MCO infrastructure).
- Encounter data collection and analysis to measure trends in health services utilization and access to care.
- Consumer Report Card, a tool for consumers to use when selecting an MCO to allow them to compare MCOs based on several categories.
- Healthy Kids medical record reviews.
- Monitoring of enrollee and provider hotlines.
- Performance improvement projects focusing on clinical or non-clinical areas as determined by the Department.

The quality initiatives blend the use of nationally recognized standards and Maryland-specific measures to create a comprehensive assessment of program quality to improve service delivery and health outcomes. The measures evaluate several areas including: general utilization, preventive services, appropriateness of care, measures of specific services (e.g. dental and mental health), and special populations. The Department is submitting a separate Quality Plan detailing the quality policies and procedures for monitoring quality within the HealthChoice program.

In addition, the provider network requirements guarantee that enrollees have timely access to care. The Department's regulations address specialty as well as primary care, and are more advanced than other states' network requirements.

Standards have been established as part of all the quality and access activities. If an MCO does not meet an established standard, it must submit and follow-up with a corrective action plan. The MCO may also be subject to financial or enrollment sanctions.

8) Population Growth and Enrollee Demographics

The HealthChoice population has continued to grow. In 2002, HealthChoice covered approximately 468,000 Marylanders. After increasing by more than 20,000 by 2005, enrollment decreased slightly in 2006. Most program growth has been among the Families and Children population, although the rate of growth is higher among the disabled population (Figure I-2).

Figure I-1: HealthChoice Enrollment, 2002 to 2006

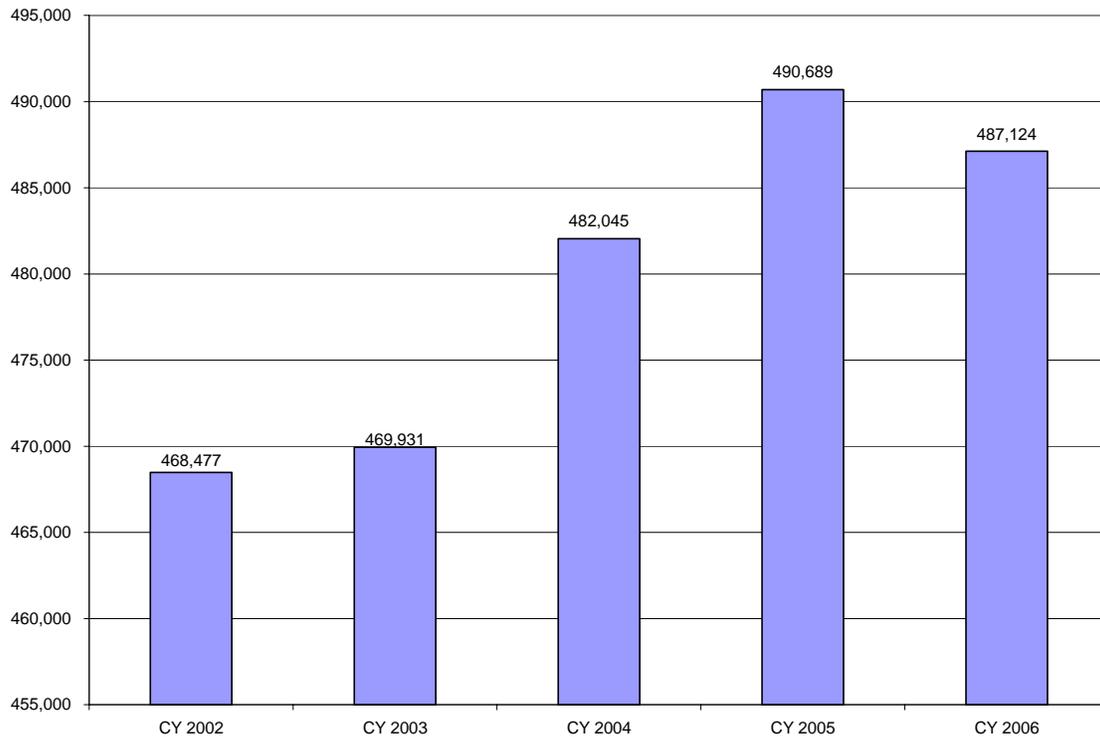
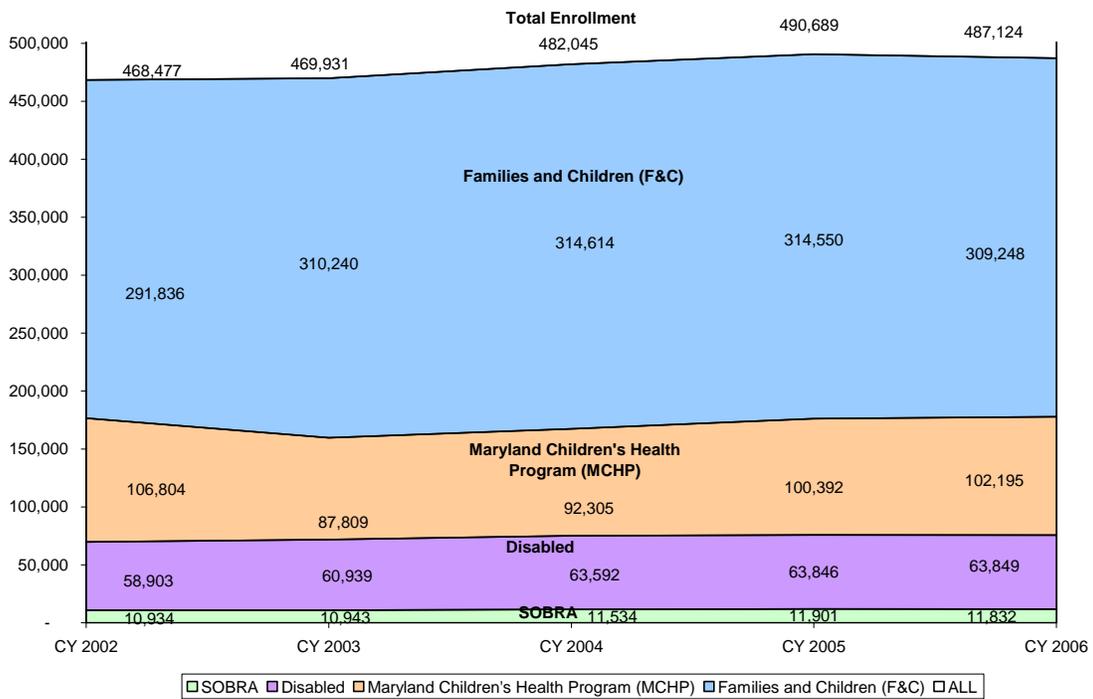
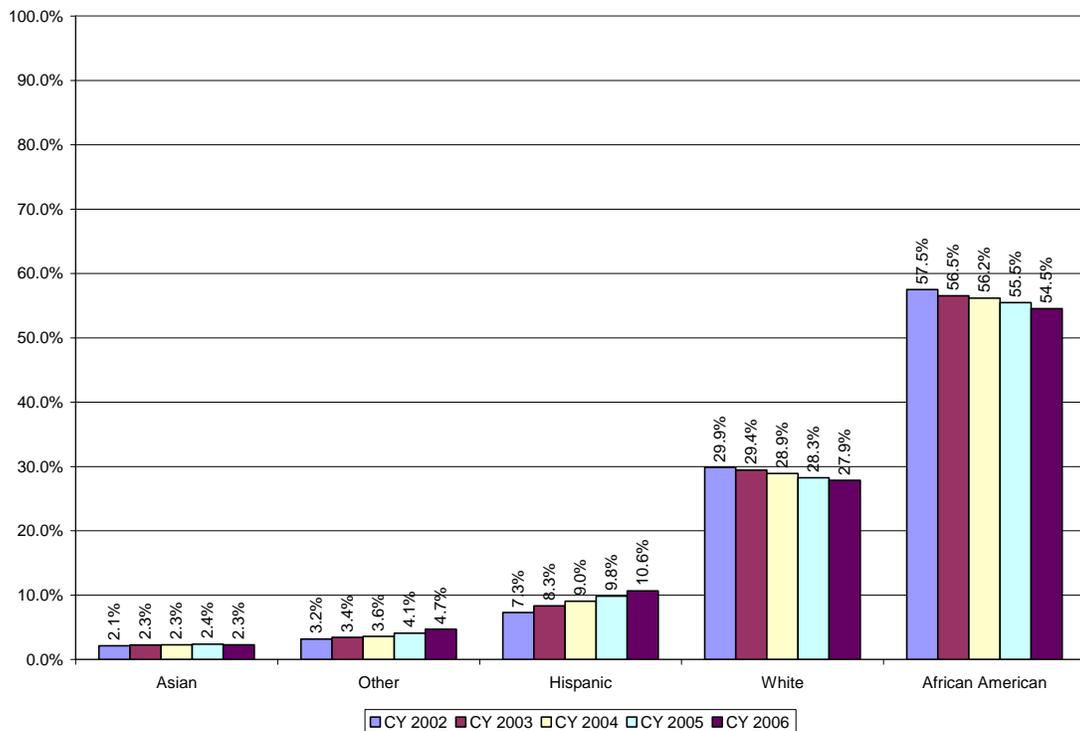


Figure I-2: HealthChoice Enrollment by Coverage Group, 2002 to 2006



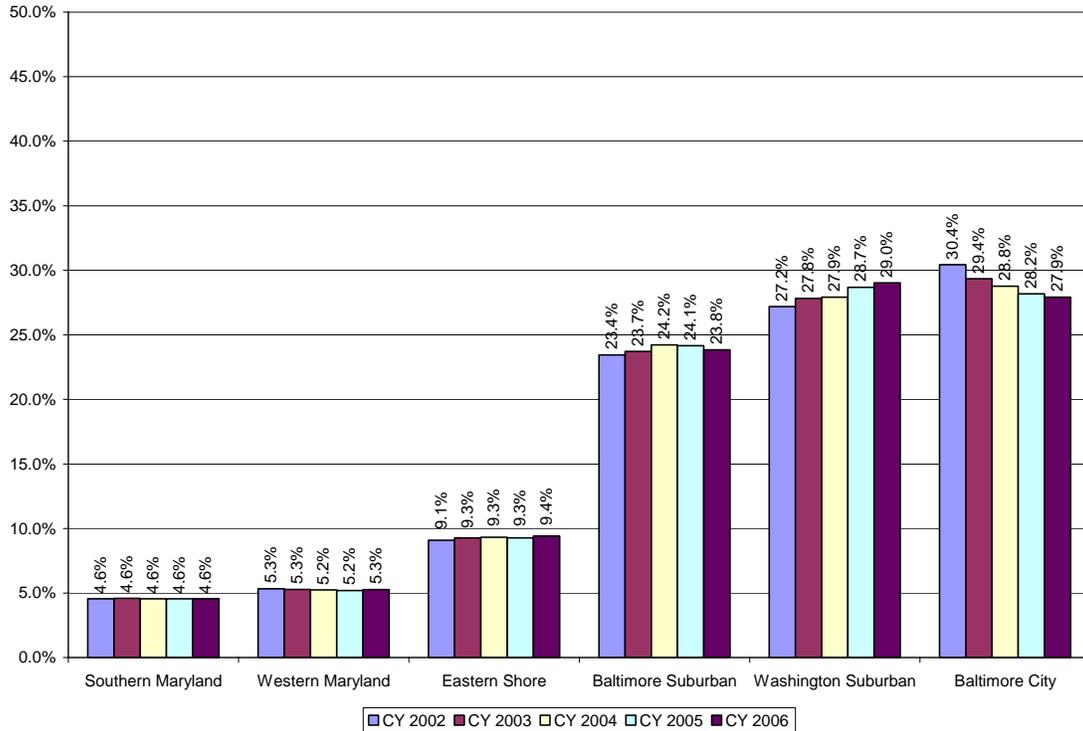
Over half of all HealthChoice enrollees are African American and Whites are just under 30 percent of the population. The racial and ethnic distribution of enrollees has remained fairly stable over time. Both African Americans and Whites experienced slight decreases in enrollment numbers and proportion of the population from 2002 to 2006, while Hispanics experienced a three percentage point increase over the five-year period (Figure I-3).

Figure I-3: HealthChoice Enrollment by Race and Ethnicity, 2002 to 2006



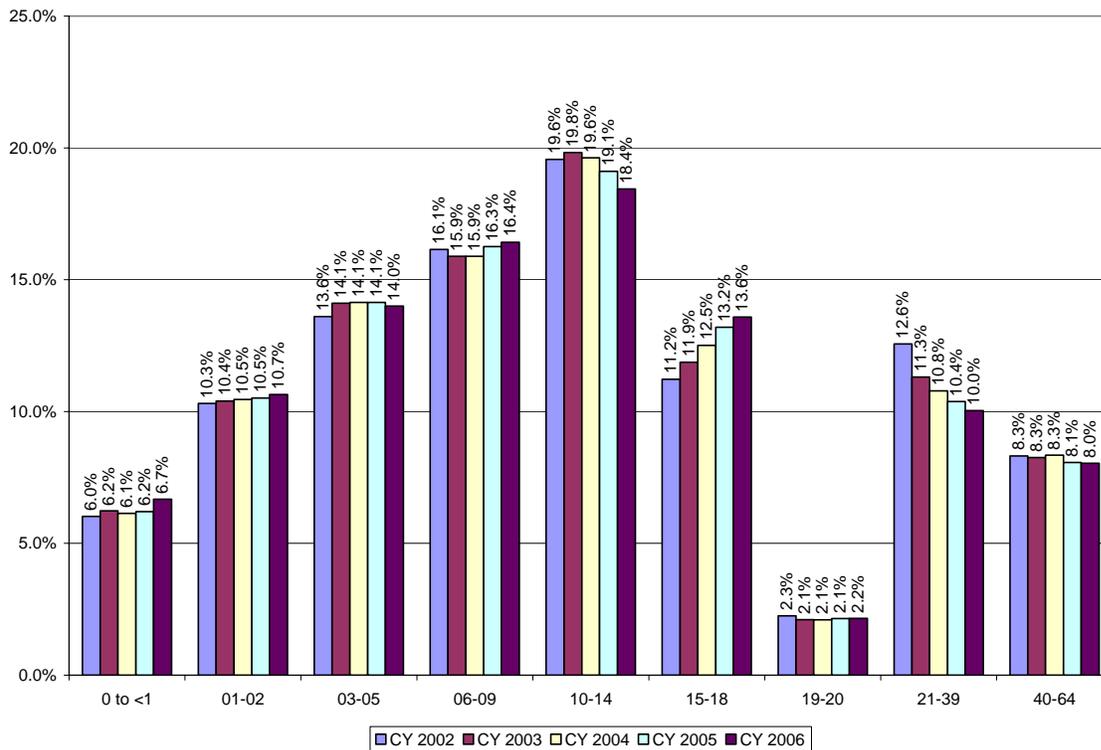
Enrollment distribution among regions remained relatively stable from 2002 to 2006. Over 80 percent of enrollees live in the Baltimore City, Washington Suburban, and Baltimore Suburban regions. The Washington Suburban regions experienced a slight growth in enrollment over the five year period, while Baltimore City experienced a slight decline in enrollment numbers and proportion of the population (see Figure I-4).

Figure I-4: Percentage of HealthChoice Enrollment by Region, 2002 to 2006



The distribution of enrollment by age group remained relatively stable among children ages nine and below. Teenagers ages 15 through 18 experienced an increase in enrollment from 2002 to 2006, while adults ages 21 through 39 experienced an enrollment decrease in numbers and proportion of the population (Figure I-5).

Figure I-5: Percentage of HealthChoice Enrollment by Age Group, 2002 to 2006



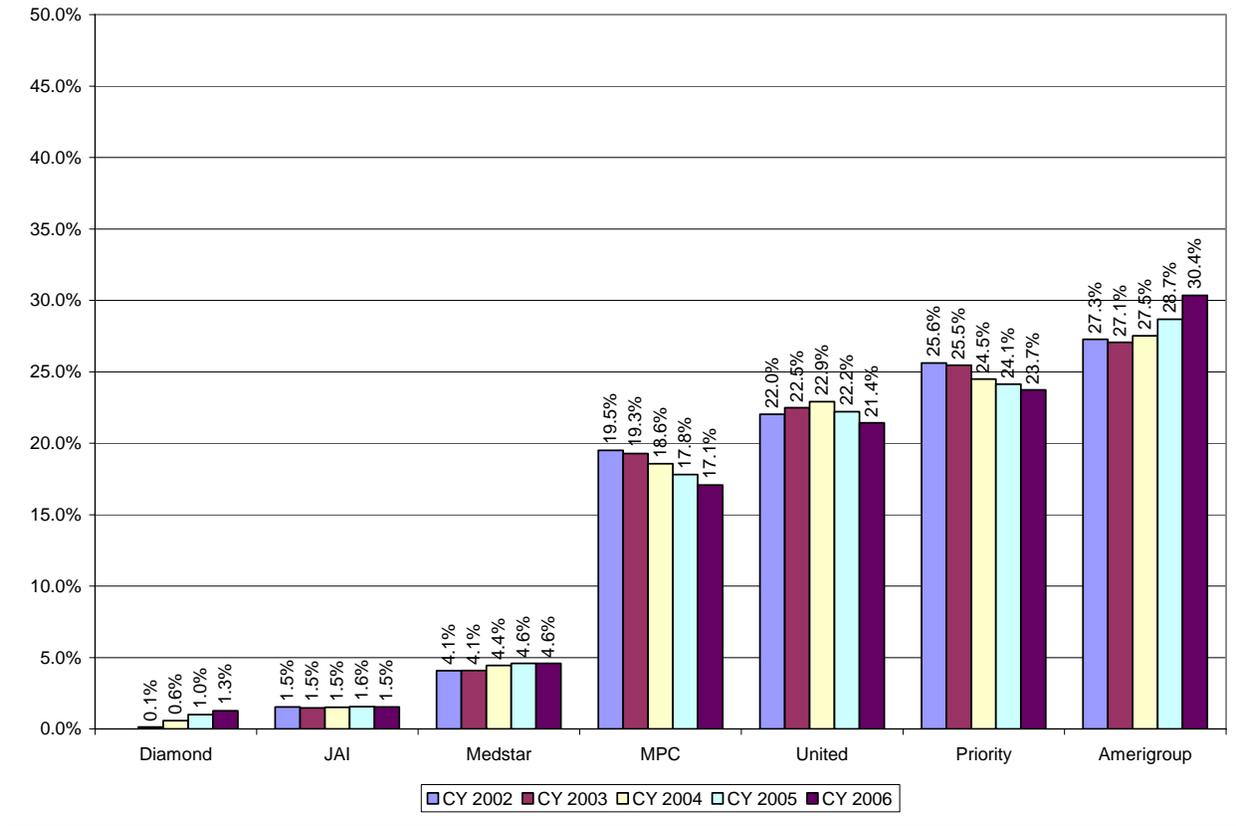
9) MCO Contracting

Seven managed care organizations (MCOs) currently participate in the HealthChoice program. Diamond Plan from Coventry Health Care is the newest MCO, having joined HealthChoice in 2003. Four MCOs operate on a statewide basis, defined as having a service area that covers at least 20 of the 24 jurisdictions in Maryland. All HealthChoice MCOs are for-profit organizations. Five serve public insurance enrollees only, while two serve both public insurance enrollees and commercial members. Three MCOs are provider-sponsored and three participate in the PAC program.

Figure I-6 shows the percentage of HealthChoice enrollment by MCO.² Enrollment numbers and proportion of the population in MPC and Priority Partners has decreased consistently since 2002, while Amerigroup's share of the population has increased. Diamond Plan's enrollment has increased each year since they joined the program in 2003, but still remains low.

² Beneficiaries enrolled as of December 31 of each year.

Figure I-6: Percentage of HealthChoice Enrollment by MCO, 2002 to 2006



B) 2008 1115 WAIVER RENEWAL REQUESTS

1) Special Funding Authority through the Demonstration

Primary Adult Care (PAC) Program

The PAC program provides primary and preventive care, outpatient mental health services, and prescription drugs to uninsured adults (age 19 or older) whose incomes are below 116 percent of the FPL. The State received approval for the waiver during the last renewal and will continue operating the program. Prior to implementing PAC, individuals received pharmacy assistance only. The program was implemented on July 1, 2006 and currently there are more than 28,000 enrollees.

Enrollment has been increasing and the State is requesting that the program be approved for the current extension period. On November 19, 2007, Governor O'Malley signed into law the Working Families and Small Business Coverage Act. Part of this law phases in an expansion of PAC services beginning in SFY 2010. Under this renewal period, the increased benefits include specialty physician and emergency services in SFY 2010 and outpatient hospital services in SFY 2011. The Department, therefore, seeks to continue and expand benefits under PAC in the next renewal cycle. The Department's budget neutrality information reflects these expansions.

Employed Individuals with Disabilities (EID) Program

The EID program provides Medicaid coverage for individuals with disabilities who wish to increase their income by returning to work. This program serves individuals with incomes up to 300 percent of the FPL. To date enrollment has been lower than estimated at only 160 enrollees since April 2006 implementation. However, through its Medicaid Infrastructure Grant, the State is implementing several outreach efforts to increase enrollment and will continue to operate the program during the next renewal period.

Family Planning Program

The Family Planning Program provides medical services related to family planning for women who were eligible for Medicaid while pregnant (250 percent of the FPL) but who lost their coverage after delivery. Coverage for family planning services continues for a maximum of five years. The State is requesting that the program be approved for the current extension period.

2) Special Exceptions to Provisions of the Balanced Budget Act

The Department asks that the following components of the BBA be waived to maintain the continuity of the HealthChoice program.

- **§ 438.50 (d) (3) – Limitations on enrollment** *The State must provide assurance that, in implementing the State plan managed care option, it will not require the following groups to enroll in an MCO or PCCM:*

Children under 19 years of age who are—

- (i) Eligible for SSI under title XVI**
- (iii) In foster care or other out-of-home placement**
- (iv) In foster care or adoption assistance**

With the continuation of the waiver, we request that these children remain in HealthChoice. Existing HealthChoice regulations allow eligibility of children under 19 years of age who are Medicaid eligible due to receipt of SSI or foster care. As shown in the following Evaluation Chapter, enrolling children in HealthChoice has substantially increased utilization of care. Children in foster care are given expanded time frames for selecting an MCO and have additional parameters for accessing care.

- **438.56 (g) Automatic reenrollment: Contract requirement.**
If the State plan so specifies, the contract must provide for automatic reenrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.
To maintain continuity of care the State requires that individuals who lose Medicaid eligibility for a period of 120 days or less be automatically reenrolled in an MCO.

- **§ 438.402 (b)(3) General Requirements:**
(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

Currently, the Department does not require that appeals be submitted in writing and neither the Department nor the MCOs require a signature. In order to maintain continuity of care, we request the provision be waived. Requiring written appeals and signatures would delay processing and resolution of grievances, as well as deter enrollees from filing appeals.

- **§ 438.406 Handling of grievances and appeals.**
(b) Special requirements for appeals
(1)... must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

Currently, at the time the inquiry is made to the MCO, the MCO representative completes the appeal form for the enrollee; no enrollee signature is required. In order to maintain continuity of care, we request the provision be waived. Requiring written appeals and signatures would delay processing and resolution of grievances, as well as deter enrollees from filing appeals.

The Department also requests that the timeframe of the demonstration year follow the same calendar of the State fiscal year. This means that the first demonstration year in the renewal cycle would begin July 1, 2008. Accordingly, the Department also requests a one-month extension for the current waiver period.

C) CONCLUSION

This chapter provides an overview of HealthChoice goals, population, services, and history. The waiver has provided the platform for enrollment growth, and has provided the vehicle for several program expansions. Chapter One discusses the recommendations from the first comprehensive HealthChoice evaluation and resulting program improvements. Chapter One also specifies the specific waiver requests for the next renewal cycle.

II. MCO PROVIDER NETWORKS AND REIMBURSEMENT

This section evaluates the stability and predictability of HealthChoice on three dimensions: MCO participation, provider networks, and capitation rate setting. An environment of stability and predictability is important to attract and maintain provider and MCO participation. This in turn promotes continuity of care, enabling enrollees to fully benefit from the intended model of a medical home and prevention-oriented care. The participation of providers and MCOs depends on adequate reimbursement and policies which are not administratively burdensome.

HealthChoice is ten years old. The implementation of HealthChoice in 1997 represented a major change in Maryland's Medicaid service delivery. In its early years, HealthChoice had to cope with historically low physician fees, manage the transition of 98,000 enrollees when a major MCO exited the market, and absorb a major population expansion with the implementation and explosive growth of MCHP. In 2002 the Department produced a comprehensive evaluation of HealthChoice to respond to concern that efforts to control cost growth would compromise access to high quality health care.

In recent years, HealthChoice has experienced much less turbulence. Although HealthChoice continues to evolve to deal with challenges such as access to dental care and inappropriate emergency department use, the program has benefited from stability and predictability across many dimensions.

A) MCO PARTICIPATION

MCOs contract with the State to provide the program's benefit package to their assigned enrollees, in a manner consistent with program policies. MCOs assemble provider networks with adequate capacity to offer the full range of covered health care services required by the MCO's enrollees. MCOs supplement their in-network provider capacity when necessary by reimbursing out-of-network specialists. Since the inception of the HealthChoice program in 1997, the Department has maintained contracts with MCOs in sufficient number and with sufficient capacity to sustain the program's statewide service.

MCO participation has stabilized after some departures during the early years of HealthChoice. In 1997, the program contracted with nine MCOs. Four of the original MCOs have withdrawn from the program, but there have been no departures since April 2001. Two new MCOs have joined the program, one in 1999 and the second in 2003. The seven MCOs currently participating in the HealthChoice program are:

- Amerigroup Maryland, Inc.;
- Diamond Plan;
- Helix Family Choice, Inc.;
- Jai Medical Systems;
- Maryland Physicians Care;

- Priority Partners; and
- United Health Care.

Five of the seven MCOs listed above have participated in the HealthChoice program since its beginning.

B) PROVIDER NETWORK ADEQUACY

The Department evaluates provider network adequacy by assessing the capacity and coverage of primary care provider (PCP) and specialty physician networks within the HealthChoice program. As a further measure of stability, this evaluation measures PCP retention.

1. Primary Care Providers

HealthChoice requires every enrollee to have a PCP, which provides the medical home. Each MCO must have enough PCPs to serve its enrollee population. For PCPs, HealthChoice requires a ratio of one primary care physician to every 200 enrollees as a general standard for assessing an individual MCO's capacity within each of 40 local access areas (LAAs). The one to 200 standard is inappropriate for primary care physicians who traditionally serve a high Medicaid population (e.g., FQHC physicians). To account for these high volume physicians, the regulations permit the Department to approve a ratio of one provider per 2,000 enrollees.

MCOs are required to regularly submit information on their provider networks to the Department. Submission elements include provider name, license number, specialty, location, phone number, and whether the provider is open to new patients. These submissions are used both for creating provider directories and for monitoring the total number of providers program-wide, by the LAAs, and by MCO.

Review of PCP to enrollee ratios allows the Department to assess potential network deficiencies and work with the MCOs to correct any capacity deficiencies as they arise.

Figure II-1 shows PCP network adequacy for files submitted through January 1, 2007. Two capacity estimates are presented: 200 enrollees per unduplicated PCP and 500 enrollees per unduplicated PCP. While regulatory requirements apply to a single MCO, the analysis presented looks at an unduplicated count of all HealthChoice PCPs. The analysis in Figure II-1 does not allow a single provider who contracts with several MCOs to be counted multiple times; this applies a higher standard than that in regulation.

Figure II-1: PCP Capacity Analysis by Local Access Area, as of January 2007

Local Access Area	Total PCPs	Capacity at 200:1 Ratio	Capacity at 500:1 Ratio	Enrollment	Excess Capacity at 200:1 Ratio	Excess Capacity at 500:1 Ratio
Allegany	58	11,600	29,000	8,322	3,278	20,678
Anne Arundel North	164	32,800	82,000	15,871	16,929	66,129
Anne Arundel South	168	33,600	84,000	9,126	24,474	74,874
Balto City SE/Dundalk	438	87,600	219,000	26,441	61,159	192,559
Balto City East	105	21,000	52,500	12,640	8,360	39,860
Balto City N. Central	90	18,000	45,000	19,072	-1,072	25,928
Balto City N. East	211	42,200	105,500	17,498	24,702	88,002
Balto City N. West	87	17,400	43,500	13,886	3,514	29,614
Balto City South	242	48,400	121,000	17,138	31,262	103,862
Balto City West	337	67,400	168,500	33,922	33,478	134,578
Balto Cnty East	195	39,000	97,500	15,030	23,970	82,470
Balto Cnty North	246	49,200	123,000	8,359	40,841	114,641
Balto Cnty N. West	103	20,600	51,500	19,369	1,231	32,131
Balto Cnty S. West	169	33,800	84,500	15,002	18,798	69,498
Calvert	51	10,200	25,500	5,280	4,920	20,220
Caroline	19	3,800	9,500	4,667	-867	4,833
Carroll	74	14,800	37,000	7,527	7,273	29,473
Cecil	54	10,800	27,000	8,894	1,906	18,106
Charles	67	13,400	33,500	9,727	3,673	23,773
Dorchester	31	6,200	15,500	4,625	1,575	10,875
Frederick	70	14,000	35,000	11,043	2,957	23,957
Garrett	15	3,000	7,500	3,739	-739	3,761
Harford East	34	6,800	17,000	5,019	1,781	11,981
Harford West	81	16,200	40,500	10,175	6,025	30,325
Howard	139	27,800	69,500	11,070	16,730	58,430
Kent	21	4,200	10,500	2,047	2,153	8,453
Montgomery-Sil Spr	158	31,600	79,000	25,629	5,971	53,371
Montgomery-Mid Cnty	164	32,800	82,000	9,002	23,798	72,998
Montgomery-North	95	19,000	47,500	18,000	1,000	29,500
Prince Geo N East	102	20,400	51,000	9,784	10,616	41,216
Prince Geo N West	176	35,200	88,000	41,183	-5,983	46,817
Prince Geo S East	38	7,600	19,000	6,893	707	12,107
Prince Geo S West	68	13,600	34,000	19,138	-5,538	14,862
Queen Anne's	19	3,800	9,500	2,772	1,028	6,728
Somerset	21	4,200	10,500	3,198	1,002	7,302
St. Mary's	53	10,600	26,500	7,338	3,262	19,162
Talbot	53	10,600	26,500	2,830	7,770	23,670
Washington	111	22,200	55,500	13,276	8,924	42,224
Wicomico	59	11,800	29,500	12,106	-306	17,394
Worcester	37	7,400	18,500	4,228	3,172	14,272
Total	4,423	884,600	2,211,500	490,866	393,734	1,720,634

Based on a capacity standard of 500 enrollees to one PCP, provider networks in each LAA are more than adequate. However, there are a few areas where the conservative

standard of 200 enrollees per PCP is not met: one in Baltimore City, two in Prince Georges County, Garrett County, and two on the Eastern Shore. Capacity on the Eastern Shore has improved since the 2002 evaluation; previously seven LAAs did not meet the conservative standard. Capacity has also improved in Garrett County since the 2002 evaluation.

Two Prince Georges County LAAs have capacity deficits of more than 5,000 enrollees at the conservative 200 enrollees per PCP level. The net capacity for Prince George's county is only 198 enrollees. However, each of the counties surrounding Prince George's has excess capacity at the conservative 200 enrollees per PCP level.

Figure II-2: Local Access Areas with Excess Capacity

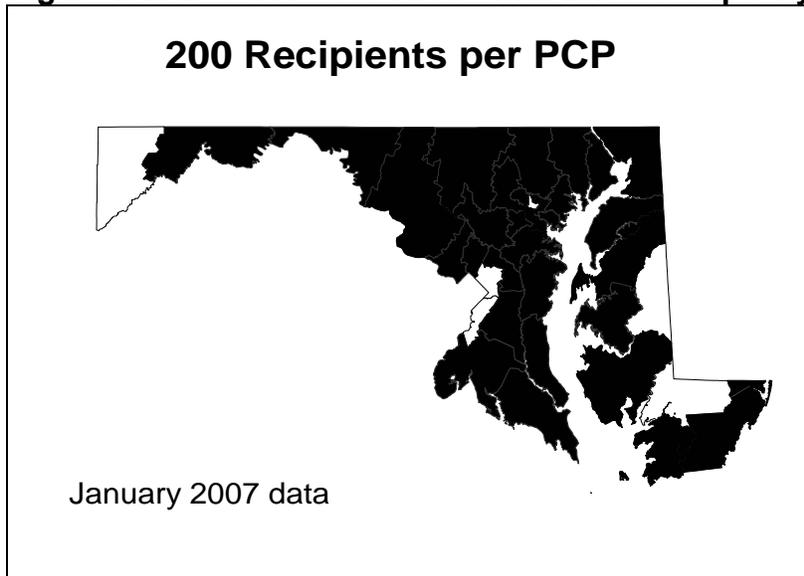
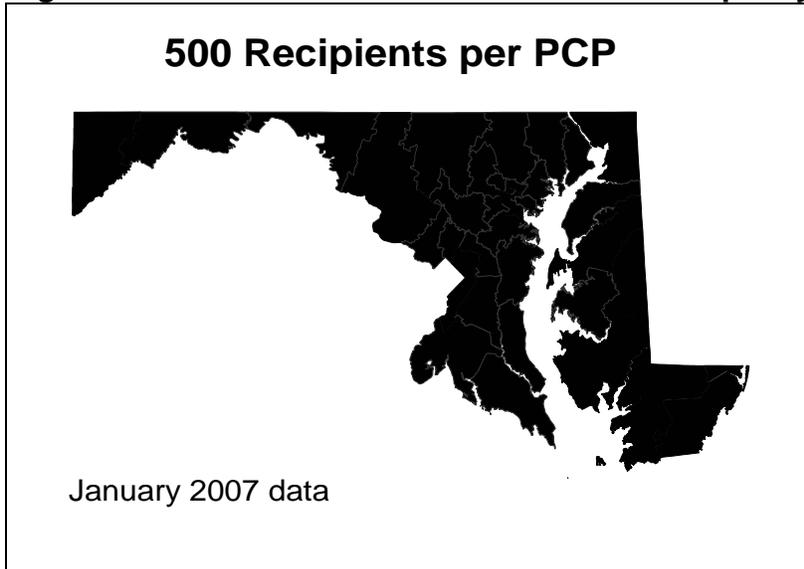


Figure II-3: Local Access Areas with Excess Capacity



Networks have improved significantly over the life of HealthChoice. From June 2001 to January 2007, the total number of HealthChoice enrollees increased by 17 percent. However, the total number of primary care providers increased by 56 percent over the same time period. In 2002, in response to the initial HealthChoice evaluation, the Governor and the Legislature appropriated \$50 million in additional funds (\$25 million in State funds) to increase physician fees. In order to strengthen access to PCPs and office-based specialty providers, the funds were used to improve evaluation and management procedure codes.

The physician fee increase and resulting growth rate of PCPs resulted in improved network adequacy. As measured by the conservative 200 enrollee to PCP standard, only six LAAs had capacity deficits in January 2007, while in 2002 sixteen LAAs had capacity deficits.

Figure II-4: Total PCP and Enrollment Comparison, 2001 to 2007

	Total PCPs	Enrollment	PCP to Enrollee Ratio
June 2001	2,840	418,413	147:1
January 2007	4,423	490,866	111:1
2001 to 2007 Change	1,583	72,453	
2001 to 2007 % Change	56%	17%	

2. Primary Care Provider Retention

PCP retention allows enrollees to establish relationships with their providers and facilitates continuity of care and the provision of a medical home. The retention rate is calculated by matching the license numbers of PCPs who provided services in year one with those who provided services in year two.³ The retention rate is presented as the percent of PCPs who provided services in year two who also provided services in year one.

Figure II-5: Primary Care Provider Retention Rate

Time Period	Retention Rate
CY02-CY03	89%
CY03-CY04	87%
CY04-CY05	83%
CY05-CY06	89%

Figure II-5 displays the data for the PCP retention rate, by year, from CY02 to CY06. The retention rate returned to its starting point of 89 percent in CY06, after decreasing in the two previous years. These decreases may have been due to actions taken by the Department in CY04 to correct inaccuracies in the PCP files. The CY06 retention rate incorporates the improved record keeping practices and therefore provides a more accurate representation of the PCP retention rate.

³ An alternative would have been to measure retention for any PCP in the network, regardless of whether or not that PCP actually provided services to any HealthChoice enrollees during the year. The Department chose to apply a more stringent and more meaningful standard by measuring retention among those PCPs who have provided care to at least one enrollee in the program.

3. Specialty Care Providers

MCOs are required to provide all medically necessary specialty care. If an MCO does not have a specialist in network the MCO must pay an out-of-network provider. Following the 2002 HealthChoice evaluation, the Department worked with a stakeholder group to develop standards for specialty care access. These standards were implemented in regulation in February 2004. The HealthChoice regulations mandate that each MCO have an in-network contract with at least one provider statewide in the following specialties: Allergy, Dermatology, Endocrinology, Infectious Disease, Nephrology, and Pulmonology. For eight specialties, each MCO must include at least one in-network specialist in each of ten regions throughout the State. These eight core specialties are: Cardiology, Otolaryngology (ENT), Gastroenterology, Neurology, Ophthalmology, Orthopedics, Surgery, and Urology.

As of October 2007, all MCOs met the statewide standard for Allergy, Dermatology, Endocrinology, Infectious Disease, Nephrology, and Pulmonology specialists. All but one MCO met the regional in-network requirement for the eight core specialties. The Department is requiring this MCO to submit a corrective action plan for the three in-network specialists it lacks. Meanwhile, the MCO is making out-of-network specialists and specialists in neighboring regions available to its enrollees.

In 2005, the Legislature passed SB 836, the "Maryland Health Care Provider Rate Stabilization Fund." The bill requires the Department to increase fee-for-service physician fees and capitation payments to MCOs so that they reimburse physicians at least the fee-for-service rates. In SFY 2006, this fund allowed Medicaid to increase fees to 100 percent of Medicare fees for the 1,600 procedure codes most commonly used by OB/GYNs, neurosurgeons, orthopedic surgeons, and emergency medicine physicians. In SFY 2007, the Department increased fees for anesthesiology and procedures performed by ENTs, general surgeons, dermatologists, allergists/immunologists, and digestive system surgeons. The Department targeted these fees for increases based on stakeholder recommendations. In SFY 2008, again based on stakeholder recommendations, the Department increased evaluation and management codes to a minimum of 80 percent of Medicare fees and raised all other procedure codes to a minimum of 50 percent of Medicare fees. Based on stakeholder concerns, the Department also specifically targeted fee increases for the following services: evaluation and management procedures performed in hospital outpatient departments, three neonatology procedures (99294, 99296, and 99299), psychiatry, radiology, vaccine administration, and obstetric anesthesia procedures. These efforts should help strengthen Medicaid and HealthChoice specialty networks throughout the State.

The Department assesses the PCP and specialty networks on a quarterly basis and produces reports for each MCO. The Department addresses any network inadequacies with the MCOs. Specialty access on the Eastern Shore continues to be a challenge for the HealthChoice program, as it is for commercial insurers as well.

4. Dental Networks

As mentioned throughout this evaluation, in an effort to increase oral health access and utilization, the Secretary of DHMH convened the Dental Action Committee (DAC) in June 2007. The DAC was comprised of a broad-based group of stakeholders concerned about children’s access to oral health services. One of the topic areas focused on by the DAC was provider participation, capacity, and scope of practice.

MCOs are required to develop and maintain an adequate network of dentists who can deliver the full scope of oral health services. HealthChoice regulations (COMAR 10.09.66.05 and 10.09.66.06) specify the capacity and geographic standards for dentists. They require that the dentist to enrollee ratio be no higher than 1 to 2,000 for each MCO. In addition, each MCO must ensure that enrollees have access to a dentist within a 30-minute or 10-mile radius for urban areas and a 30-minute or 30-mile radius for rural areas. Through the toll-free HealthChoice Enrollee Action Line, DHMH monitors access via enrollee complaints.

As of July 2007, there were approximately 964 dentists enrolled as providers in the HealthChoice program (listed in the HealthChoice provider directories). This represents an approximately five percent increase in the number of participating dentists listed in the directory as compared to last year (Figure II-6). The overall statewide ratio of dentists (listed in HealthChoice provider directories) to HealthChoice enrollees under age 21 was 1 to 410 in June 2007, compared to 1 to 439 in June 2006. Recently, concerns have been raised about the accuracy of MCOs’ dental provider directories. The Department required the MCOs to contact and confirm the accuracy of the directory information and submit the corrected information to the Department. The Department continues to increase its monitoring efforts on MCOs’ dental networks.

Figure II-6: Dentists Participating in HealthChoice

Region ⁴	Dentists Listed in HealthChoice Provider Directories ⁵		Percent Change (2006-2007)
	July 2006	July 2007	
Baltimore Metro	453	497	+10%
Montgomery/ Prince George’s	360	356	-1%
S. Maryland	39	40	+3%
W. Maryland	55	57	+4%
E. Shore	45	50	+11%
Unduplicated Total ⁶³	918	964	+5%

⁴ Baltimore Metro includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Southern Maryland includes Calvert, Charles, and St. Mary’s Counties. Western Maryland includes Allegany, Garrett, Washington, and Frederick Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne’s, Somerset, Talbot, Wicomico, and Worcester Counties.

⁵ Some dentists may not be accepting new referrals and many dentists limit the number of new referrals that they accept. These numbers only reflect the availability of general practitioners.

⁶ The unduplicated total is different than the total in each geographic region because it is possible for a dentist to have multiple sites.

According to the Maryland State Board of Dental Examiners, there are a total of 4,033 dentists licensed and actively practicing in Maryland. The figure below shows how many pediatric and general dentists are practicing in the State, and indicates how many dentists participate with HealthChoice, as of July 2006. In the two far right columns in Figure II-7 below, the number of dentists billing includes two default provider numbers that can be used by MCOs when submitting copies of their claims data to the Department. In SFY 2007, the default provider numbers were used for approximately seven to eight percent of all HealthChoice dental services. This large proportion of services could represent a significant number of additional dental providers. Further, clinics with multiple dentists are only counted once. The total of these two columns, therefore, most likely undercounts the total number of providers.

Figure II-7: Active Dentists and Dentists Participating in HealthChoice, July 2006

REGION ⁷	Total Active Dentists	Active General Dentists	Active Pediatric Dentists	Dentists in HealthChoice Directory ⁸² (% of Total Active Dentists)	Dentists Billing ≥One Service to HealthChoice (% of Total Active Dentists)	Dentists Billing ≥\$10,000 to HealthChoice (% of Total Active Dentists)
Baltimore Metro	1,780	1,403	56	453 (25.4%)	308 (17.3%)	161 (9.0%)
Montgomery/Prince George's	1,619	1,294	47	360 (22.2%)	216 (13.3%)	117 (7.2%)
S. Maryland	158	129	5	39 (24.7%)	28 (17.7%)	14 (8.9%)
W. Maryland	262	207	6	55 (21.0%)	41 (15.6%)	28 (10.7%)
E. Shore	214	173	4	45 (21.0%)	43 (20.1%)	25 (11.7%)
Other					25 (N/A)	5 (N/A)
TOTAL	4,033	3,206	118	918 (22.8%)	661 (16.4%)	350 (8.7%)

More than 661 dentists billed one or more service to HealthChoice and more than 350 dentists billed \$10,000 or more to the HealthChoice program in 2006. This represents approximately 16 percent and nine percent respectively, of the total active, licensed dentists in the State. As mentioned above, dentists whose encounters are submitted under the default provider number, and dentists whose encounters are submitted under a single group practice number are not counted here. Therefore, this understates the percentage of dentists participating in HealthChoice. Within Maryland, several areas have been designated as a Dental Health Professional Shortage Areas (HSPA). Regions designated as HPSAs are portions of the Eastern Shore, Western Maryland, Southern Maryland and all of Baltimore City. Pediatric dentists are rare in the State and

⁷ Baltimore Metro includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Western Maryland includes Allegany, Garrett, Washington, and Frederick Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

⁸ Includes Dentists listed in the HealthChoice directory as of July 2006. The total is different than the total in each geographic region because it is possible for a dentist to have multiple sites.

account for only three percent of the total number of active dentists in Maryland (Figure 8).

In certain regions, dental services are also provided through community clinics, which are known as Federally Qualified Health Centers (FQHC), and/or the local health departments. Figure II-8 provides a count of available FQHC providers as of July 2006 and July 2007. It is important to note that not all of these community clinic providers have contracts with MCOs, and they offer varying levels of oral health services. The counts of FQHC sites represent sites approved for the provision of dental services by the Federal Health Resources and Services Administration (HRSA), however not all HRSA-approved FQHC sites currently provide full services.

Figure II-8: Community Clinic Dental Providers⁹

Region ¹⁰	FQHC Provider Sites (HRSA-Approved)		Local Health Department Provider Sites	
	July 2006	July 2007	July 2006	July 2007
Baltimore Metro	5	6	5	6 ¹¹
Montgomery/ Prince George's	2	2	2	2
S. Maryland	0	0	0	0
W. Maryland	1	1	4	4
E. Shore	5	6	1	1
Total	13	15	12	13

The Department is committed to fully and carefully reviewing the DAC's recommendations and working with the DAC on recommended strategies to improve access to dental care for children, including strengthening dental provider networks.

C) ESTABLISHING CAPITATION RATES

1. Background

The Department's capitation rate-setting goals are to establish capitation rates that 1) maximize value for public expenditures, and 2) allow MCOs to generate a reasonable return on investment while providing all required services to enrollees. HealthChoice has a sophisticated rate-setting system that incorporates historic MCO expenditures, enrollee health status and prior service utilization, and geographic and demographic data. HealthChoice was one of the first Medicaid managed care programs in the country to incorporate diagnostic-based risk adjustment into its rate-setting structure.

⁹ Community clinic providers may also be counted in HealthChoice provider directories (in Table 1 above) if they contract with MCOs.

¹⁰ Baltimore Metro includes Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties. Southern Maryland includes Calvert, Charles, and St. Mary's Counties. Western Maryland includes Allegany, Garrett, Washington, and Frederick Counties. The Eastern Shore includes Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties.

¹¹ Harford County dental clinic is currently undergoing renovations and does not yet provide oral health services to the public. The clinic will begin providing services once renovations are complete.

Maryland's system has served as a model for successfully implementing risk-based capitation payment structures in other states.

The HealthChoice rate-setting process is collaborative, and encourages MCO participation and sharing of data and analysis. The Department holds monthly rate-setting meetings with MCOs between February and August each year. As the HealthChoice rate-setting process has matured, the openness of the process in addition to the willingness of the Department to make necessary adjustments to the methodology has contributed to the creation of actuarially sound rates, which is necessary for a stable managed care program.

Rates are developed annually and are effective January 1. Mid-year adjustments to the HealthChoice rates, triggered by regulatory changes (e.g. significant changes to regulated hospital charges, Medicaid provider fee increases, etc.) have been developed and implemented on a timely basis as needed.

Most HealthChoice recipients who have adequate previous Medicaid experience are assigned to a rate cell based on this experience as well as their eligibility category. Those who have little or no previous Medicaid experience are assigned to an MCO-specific risk-adjusted rate cell that incorporates age, sex, and geography (with the exception of pregnant mothers in the SOBRA program, individuals diagnosed with HIV or AIDS, and newborns). HealthChoice recipients are assigned to new risk-adjusted cells on an annual basis.

2. Rate Setting Improvements Over Time

2001 Rate Setting

During the first four years of the program, HealthChoice recipients were assigned a risk score based on their pre-HealthChoice fee-for-service (FFS) claims experience. In CY 2001, the Department began to use MCO encounter data to calculate enrollees' risk scores. Determining risk scores based on encounter data had the result of improving the quantity and quality of the encounter data submitted to the Department and significantly reducing the use of sub-capitated arrangements by MCOs. As a result, Maryland has a reliable source of data about the services provided to HealthChoice enrollees. These data are used for a variety of quality monitoring and evaluation activities.

In 2001, the Department established a new incentive payment to promote statewide MCO participation. This helped stabilize the HealthChoice program after one major MCO exited the market and helped ensure that enrollees would continue to have a choice of providers. The incentive provides a bonus payment for MCOs operating in 20 of the 24 jurisdictions in Maryland. One MCO expanded its network statewide immediately following the implementation of this incentive. In recent years, portions of the incentive payment have been redirected to MCOs with more members in rural areas and to provide greater payment incentives for MCO quality improvement.

2002 Rate Setting

The rate-setting process in CY 2002 was very consistent with 2001. Although the encounter data used to create risk assignments continued to improve, it was still necessary to apply a completion factor to risk-adjusted rate cells. An additional incentive payment was created in 2002 to assist MCOs with the costs associated with Hepatitis C that were not incorporated in the base period.

2003 Rate Setting

CY 2003 was an important year in the establishment of HealthChoice rates. Prior to 2003, the base used to establish HealthChoice rates was developed using FFS experience. The last year of FFS experience available to develop rates was SFY 1997. When 2002 HealthChoice rates were developed, the difference between the mid-point of the base period and the payment period was sixty-six months. The longer the span between base period and payment period, the less credible the process becomes due to having to apply longer periods of estimated trend as well as changes in the program that are difficult, if not impossible, to adjust for in the base (e.g. MCHP expansion).

Given the on-going issues involving encounter data, the decision was made to develop a new HealthChoice base using a financial reporting instrument known as the HealthChoice Financial Monitoring Report (HFMR). A rudimentary version of this report had been created early in the HealthChoice program. The initial version of the report reflected the MCOs' cost and utilization experience by rate cell and category of service at the statewide level. The overall results reflect the MCOs' HealthChoice member months, revenues, and medical expenses as reported in the quarterly and annual filings to the Maryland Insurance Administration (MIA).

To use the HFMR for rate-setting purposes, several enhancements needed to be made to the report, including:

1. The report needed to reflect MCO experience on a "Date of Service" or "Incurred" basis. Insurance filings reflect the current incurred period as well as any changes/adjustments to prior reporting periods.
2. More detailed description of administrative expenses. During the annual independent review of the final HFMR, administrative expenses are reviewed and certain expenses are disallowed as eligible HealthChoice expenses. The Department also established guidelines for capturing the medical case management component.
3. Financial projections to assist the State in evaluating current and future MCO specific and overall HealthChoice financial performance.

To monitor regional changes in costs over time, the MCOs provide their experience in eight separate regions of the state. The HFMR report is submitted twice a year by the MCOs. The preliminary report reflects CY experience on an incurred basis reported as of March 31 of the following year. The final annual HFMR report reflects the CY experience on an incurred basis reported as of September 30 of the following year.

The final HFMR submissions of each MCO are independently reviewed by an auditing agency. This annual review is crucial. Besides the added credibility this review brings to the rate-setting process, there is also the benefit to the Department of having an unbiased financial evaluation of each MCO. In addition to independent reviews of each final HFMR report, the unpaid reserves of each MCO are independently evaluated by an actuarial firm.

The consolidated and independently reviewed CY 2000 HFMR (reported as of September 30, 2001) was the base used for 2003 HealthChoice rates. This change reduced the time from the mid-point of the base period to the mid-point of the payment period from sixty-six months in 2002 to thirty-six months in 2003. No adjustment was made to the MCOs' risk-adjusted rate cells for encounter data shortfalls. In addition to the statewide incentives, the State added an additional \$2 million to support the administrative burden regarding HIPAA implementation.

Changes in Recent Years

Additional refinements have been made to the HealthChoice rate-setting methodology since 2003. In 2004, MCO specific rates were developed for the age/gender rate cells based on an analysis which demonstrated that some MCOs consistently attracted either sicker or healthier new members. In 2005, additional analysis indicated that within the HIV/AIDS populations, certain MCOs had a higher mix of enrollees with Hepatitis C. To fairly compensate plans (on a budget neutral basis), HIV and AIDS rate cells were risk adjusted based on the relative mix of the Hepatitis C population in each MCO within each of these rate cells. Also in 2005, the delivery rate cell and the less than age one capitation rate cell were further sub-divided into very-low and normal birth-weight rate cells.

3. Rate Setting Results

From a rate-setting perspective, the period from 2002 through 2005 has been one of stability and predictability. The overall underwriting, or profit, results for this period are shown in Figure II-9. CY 2005 is the most recent available year of audited data.

Figure II-9 HealthChoice Underwriting Results: 2002 – 2005

<u>Calendar Year</u>	<u>U/W Gain/(Loss) in Millions</u>	<u>% of Net Revenues</u>
2002	\$1.1	0.1%
2003	\$29.4	2.2%
2004	\$25.6	1.8%
2005	\$58.4	3.7%

When each year is observed at the MCO level, it clearly indicates improved financial stability across MCOs from 2002 to 2005. The following table illustrates by calendar year the number of plans reporting underwriting gains, losses, or a breakeven (B/E) position. Breakeven is defined in the table as plus or minus 0.5 percent underwriting margin.

Figure II-10 HealthChoice Underwriting Results by MCO: 2002 – 2006

<u>Calendar Year</u>	<u>MCOs Reporting Gains</u>	<u>MCOs Reporting B/E</u>	<u>MCOs Reporting Losses</u>
2002	3	1	2
2003	5	0	2 ¹²
2004	6	0	1
2005	7	0	0

Given that the base period reflects the aggregate MCO financially reviewed results, one objective of the current rate-setting methodology is that inefficiencies of individual MCOs should not be included in the base. One benchmark that is currently targeted each year is that MCOs in aggregate achieve reasonable third party liability recoveries. Failure to do so results in a downward adjustment to the base.

The strength of the financial stability of the HealthChoice program was clearly indicated by a recent analysis presented to the MCOs during the 2008 rate-setting process. A new efficiency test looking at MCO outliers was conducted using the 2005 base period. The 2005 average combined ratio (medical expense ratio plus administration expense ratio) for all MCOs was 96.3 percent. The highest combined ratio of any individual MCO was 97.6 percent. A combined ratio difference of 1.3 points between the mean combined ratio and the highest MCO combined ratio is further evidence of the stability of the program.

4. Trends Over Time

The financial stability of the HealthChoice program for this evaluation period (2002 – 2006) is significantly better than the prior evaluation period. Early indications are positive for the next period. The overall (and individual) improved financial performance has had a positive effect in the development of future rates. Figure II-11 below illustrates the annualized trends used by the actuary for the last three rate-setting periods:

Figure II-11: Annualized 36 Month Medical Expense Trends, 2006 - 2008

<u>Rate Setting Year / Base Year</u>	<u>Overall Annualized 36 Month Trends</u>
CY 2006 / 2003	+ 7.9%
CY 2007 / 2004	+ 6.6%
CY 2008 / 2005	+ 5.9%

Although trends are not the only component in developing future rates, lower trends are a direct influence in lowering future rates. This is important to maintain the cost of the HealthChoice program within budget caps as determined by CMS. The more MCO capitation costs are controlled (as well as wraparound costs associated with HealthChoice individuals), the more flexibility the State has to increase provider fees and possibly expand coverage for the uninsured under the waiver.

¹² One of two plans reporting underwriting losses due to start up as new MCO.

D) CONCLUSION

Chapter Two discusses MCO provider networks and reimbursement. It demonstrates that while there are specific areas for improvement, overall HealthChoice provider access appears to be good. The Department will continue monitoring and improving provider networks in the next renewal cycle. This chapter also provides an overview of Maryland's sophisticated MCO capitation rate-setting system. HealthChoice has demonstrated stability in provider participation and MCO reimbursement. The Department seeks to continually improve the rate-setting process.

III. SERVICE UTILIZATION EXPERIENCE

HealthChoice is designed to provide comprehensive, prevention-oriented care through a patient-focused system with a medical home for all beneficiaries. The Department continually evaluates service utilization through annual reports and special studies. Complete, valid encounter data are essential to these monitoring efforts. This chapter builds on annual analyses by looking at five specific areas of utilization. They are: A) General Utilization, B) Utilization of Preventive Services, C) Appropriateness of Care, D) Selected Services, and E) Special Populations. This approach combines encounter data measures with nationally recognized HEDIS measures. HEDIS is a standardized, nationally-used set of measures. The use of HEDIS allows the Department to compare HealthChoice performance to national Medicaid performance.¹³

A) GENERAL UTILIZATION

1. 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 a hospital outpatient department, clinic, or physician office. Ambulatory visits are reported as an unduplicated count that may not exceed one per day. The Department uses this measure to look at overall utilization as an indicator of access to care, measuring the percentage of the population that had any contact with an ambulatory health care provider.

Utilization of ambulatory care has increased for all enrollees under HealthChoice, particularly for children and adolescents. Since CY 2002, the overall percentage of individuals receiving an ambulatory visit has increased among all age groups under age 19. Access for adults improved from CY 2002 through CY 2006 as well. Access for enrollees age 19 through 20 increased from CY 2002 to CY 2004, but then dropped to CY 2002 levels in CY 2006. The overall HealthChoice rate rose from approximately 67 percent in CY 2002 to approximately 72 percent in CY 2006 (Figure III-1).

Figure III-2 below shows the percentage of individuals receiving an ambulatory service has increased in every region of the state over the five-year period, with the greatest improvements occurring in the Washington Suburban region and Eastern Shore.

¹³ National averages for HEDIS are not yet available for 2006.

Figure III-1: Ambulatory Care by Age, 2002 through 2006

Percent of the Population Receiving at Least One Ambulatory Care Service by Age Group

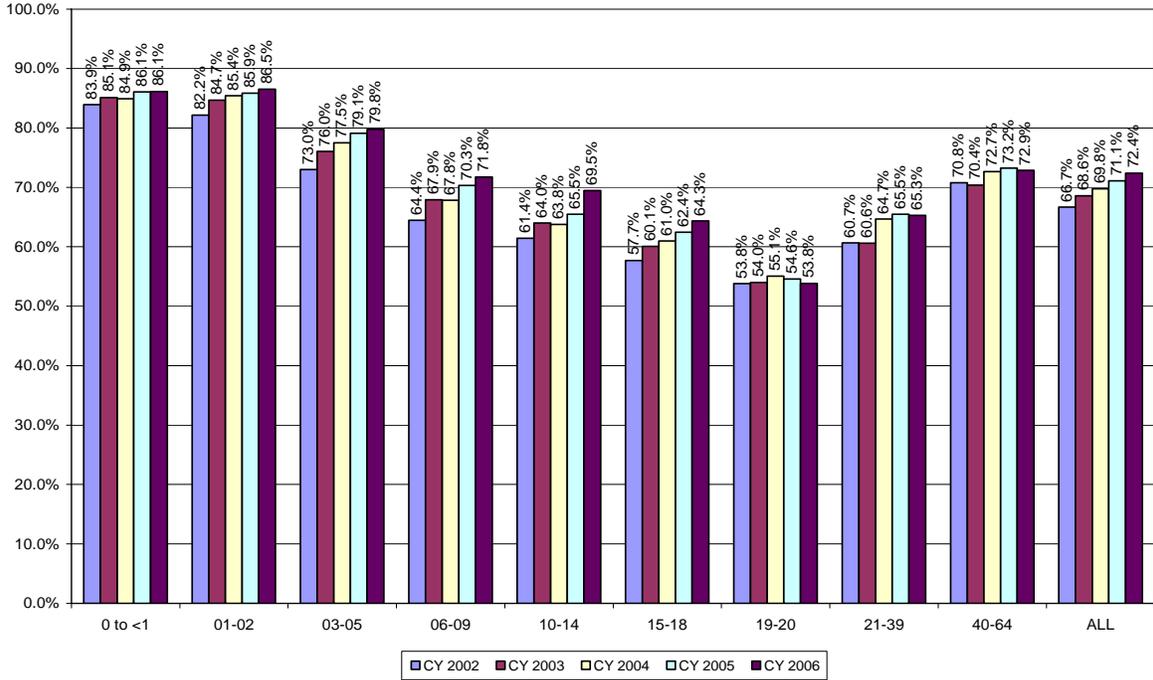
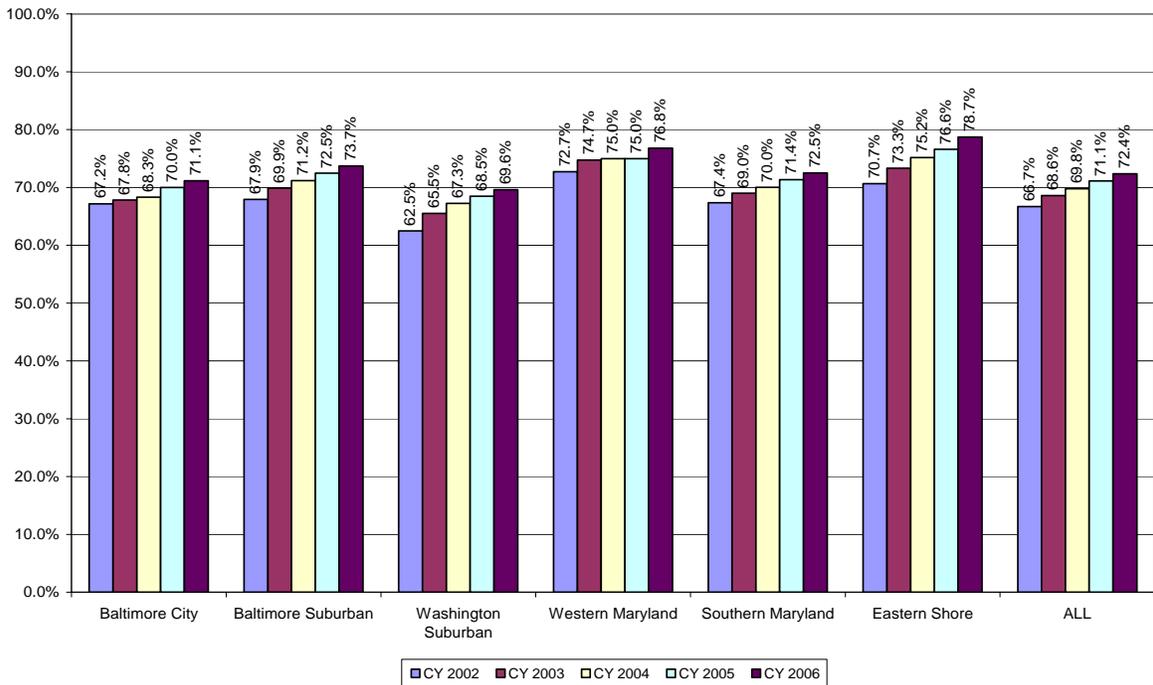


Figure III-2: Ambulatory Care by Region, 2002 through 2006

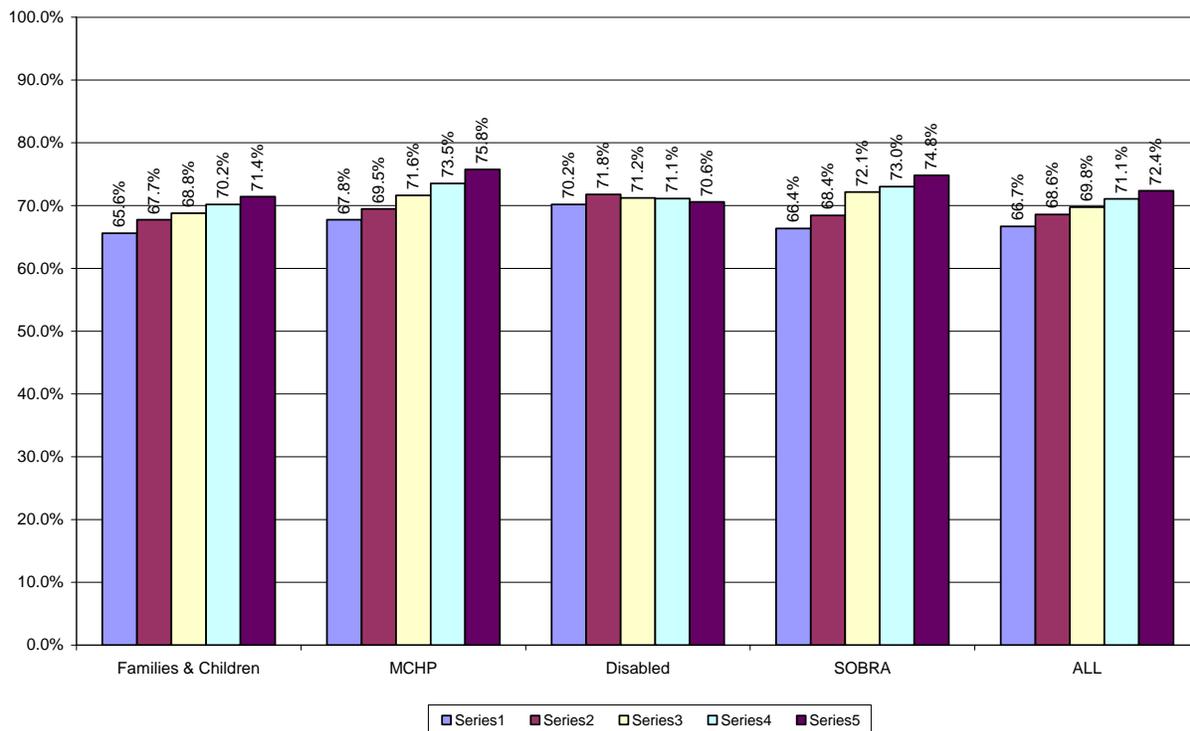
Percent of the Population Receiving at Least One Ambulatory Care Service by Region



Utilization of ambulatory services has increased for all HealthChoice coverage groups, although improvements for enrollees with disabilities have been small and have not followed a consistent upward trend. The SOBRA (pregnant women and children in families with incomes higher than TANF and lower than MCHP), family and children, and MCHP coverage groups realized improvements of greater than five percentage points between CY 2002 and CY 2006, surpassing the slight percentage increase for enrollees with disabilities (Figure III-3).

Figure III-3: Ambulatory Care by Coverage Group, 2002 through 2006

Percent of the Population Receiving at Least One Ambulatory Care Service by Coverage Group



2. Adult Preventive and Ambulatory Care Utilization

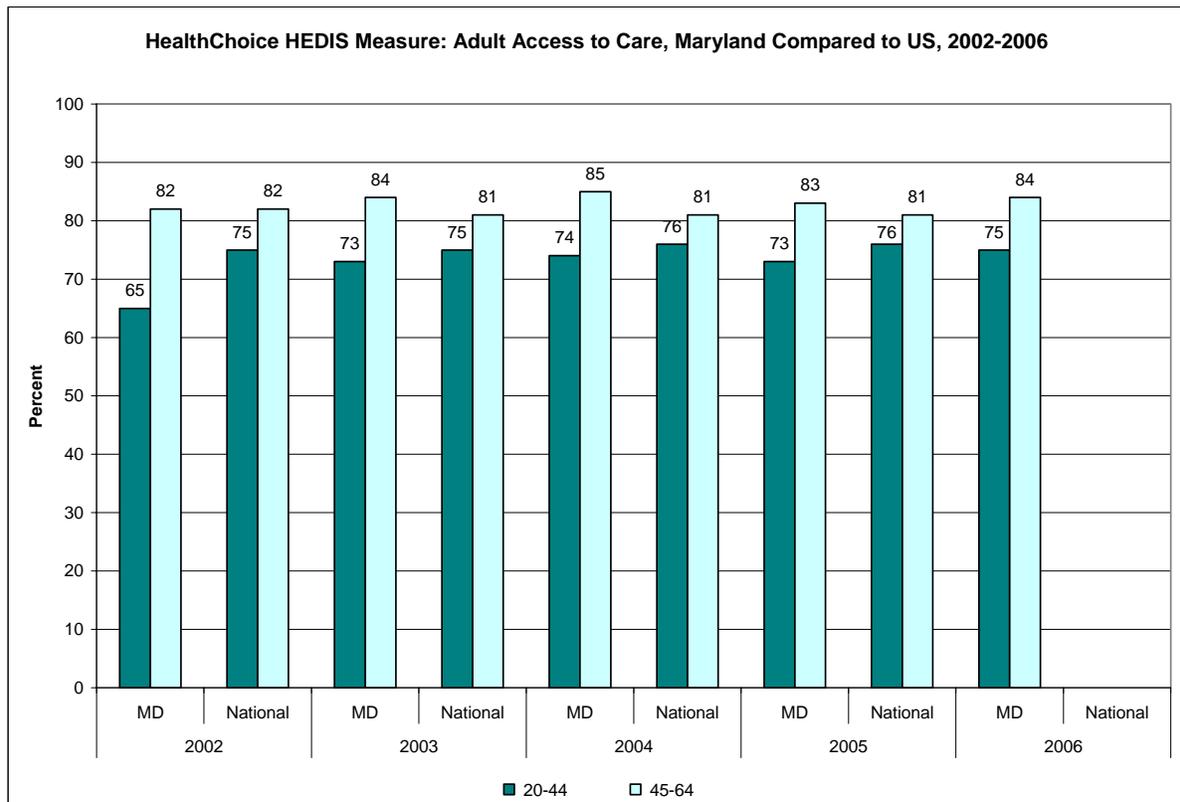
In addition to measuring utilization by age as shown in Figure III-1, the Department uses HEDIS measures to report adults' utilization of preventive or ambulatory health services. HEDIS has the benefit of allowing the Department to compare HealthChoice to Medicaid programs nationwide. The HEDIS measure of adult access to care presented in Figure III-4 below differs from the measure in Figure III-1 above in that HEDIS looks at utilization only for individuals who were continuously enrolled during the calendar year, as opposed to individuals with any period of enrollment. Utilization rates are lower when analyzed for any period of enrollment. This is because the population in the analysis includes individuals who 1) are in the MCO for only a short period of time due to turnover in eligibility or enrollment, and 2) are new to the MCO, and the MCO has not

yet had a chance to link the individual to care. MCOs have less opportunity to manage the care of these populations. HEDIS also uses slightly different age breaks.

Between 2002 and 2006, the percent of enrollees age 20 through 44 receiving a preventive or ambulatory service increased from 65 percent to 75 percent, although increases were not steady throughout this time period. In 2005, the year for which the most current national Medicaid data are available, HealthChoice enrollees age 20 through 44 had a slightly lower utilization rate compared to national Medicaid HEDIS results (73 versus 76 percent).

Utilization of preventive or ambulatory services by enrollees age 45 through 64 increased a small amount between 2002 and 2006 (from 82 to 84 percent). As for adults age 20 through 44, this increase was not steady. HealthChoice enrollees age 45 through 64 utilize services at a higher rate than the national Medicaid population (83 versus 81 percent in 2005).

Figure III-4: HEDIS Measure: Adult Access to Care, Maryland Compared to the United States, 2002-2006



3. Ambulatory Care Utilization by Enrollees with Disabilities

Figure III-3 above shows ambulatory care utilization for individuals with disabilities. The Department also assesses utilization for individuals with disabilities by age. This measure looks at individuals who are continuously enrolled in one MCO for 320 days. As noted above, utilization rates are lower when analyzed for any period of enrollment versus a period of continuous enrollment. This is because MCOs have less opportunity to manage the care of these populations.

Figure III-5 below shows that in 2006, approximately 71 percent of individuals with disabilities, age zero through 20 years, received at least one ambulatory visit. This increased from approximately 66 percent in 2002. A higher percentage of adults with disabilities receive at least one ambulatory visit. Figure III-6 below shows that in 2006, almost 79 percent of adults age 21 through 64 received an ambulatory visit. This is an increase from almost 77 percent in 2002, but there were decreases from 2004 to 2006.

Figure III-5: Ambulatory Care by Enrollees Age 0 – 20 with Disabilities, 2002 through 2006

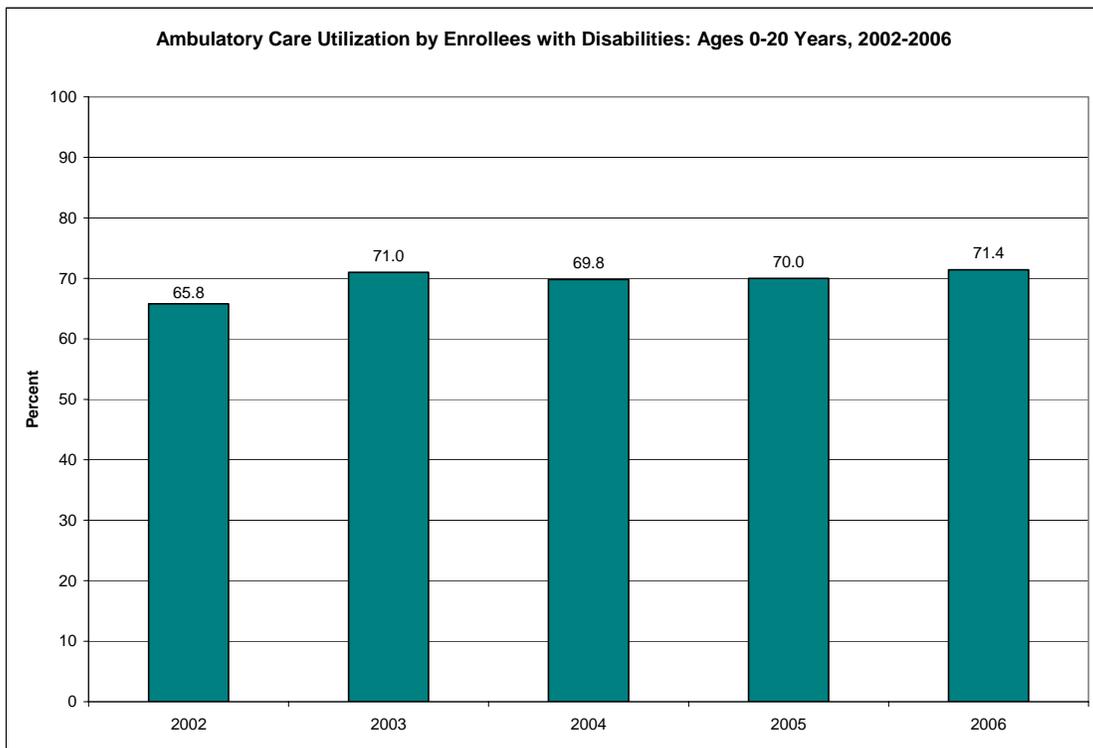
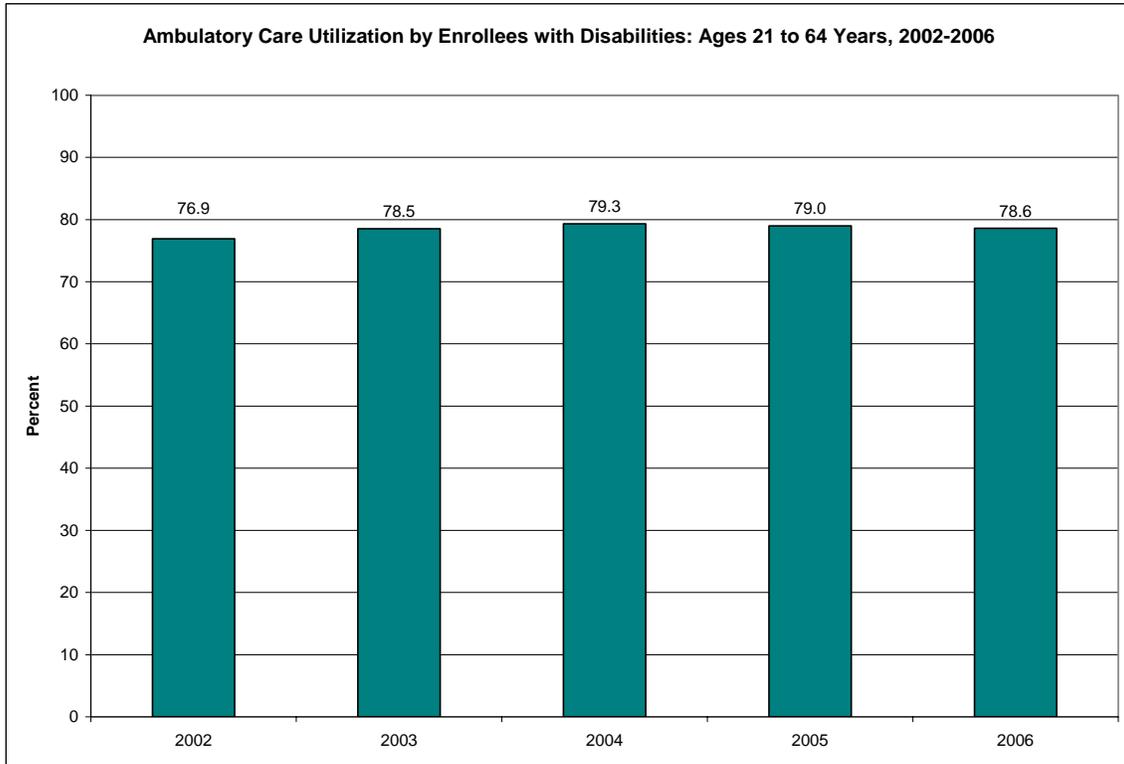


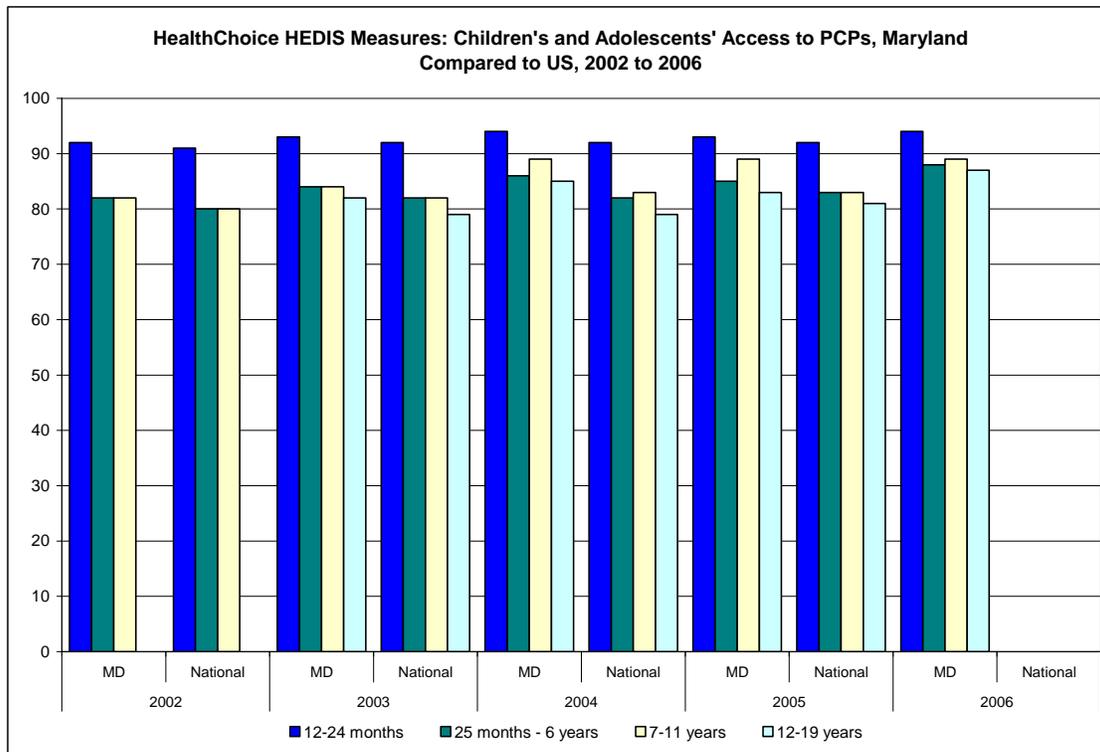
Figure III-6: Ambulatory Care by Enrollees Age 21 – 64 with Disabilities, 2002 through 2006



4. Children's and Adolescents' Access to PCPs

HEDIS assesses children's and adolescents' access to primary care providers according to four age breaks: 12 through 24 months, 25 months through six years, seven through 11 years, and 12 through 19 years. Figure III-7 shows HealthChoice performance has increased across each age group between 2002 and 2006 (2003 was the first year of available data for the oldest age group). The highest rate in 2006 was 94 percent, for the youngest age group. The lowest rate in 2006 was 87 percent, for the oldest age group. HealthChoice has outperformed national Medicaid HEDIS scores each year across all age groups.

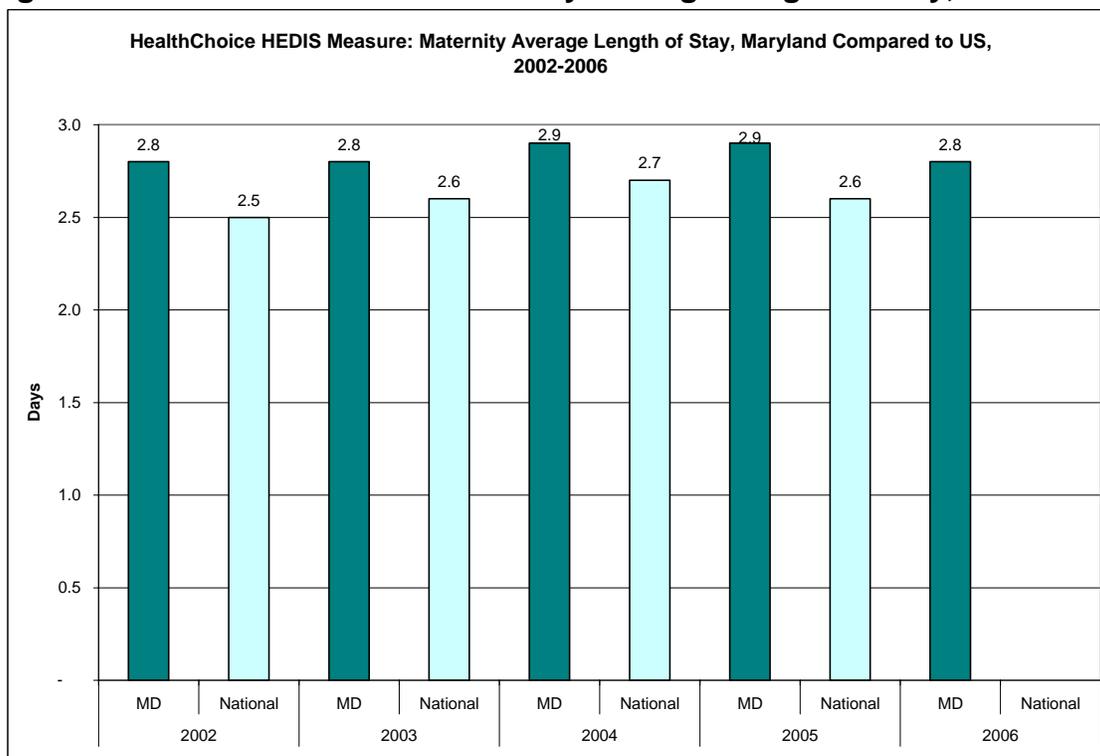
Figure III-7: HEDIS Measure: Children's and Adolescents' Access to PCPs, 2002 through 2006



5. Maternity ALOS

The average length of stay for maternity care has remained stable over the period of 2002 through 2006, between 2.8 and 2.9 days (Figure III-8). This has been consistently slightly higher than the national Medicaid average.

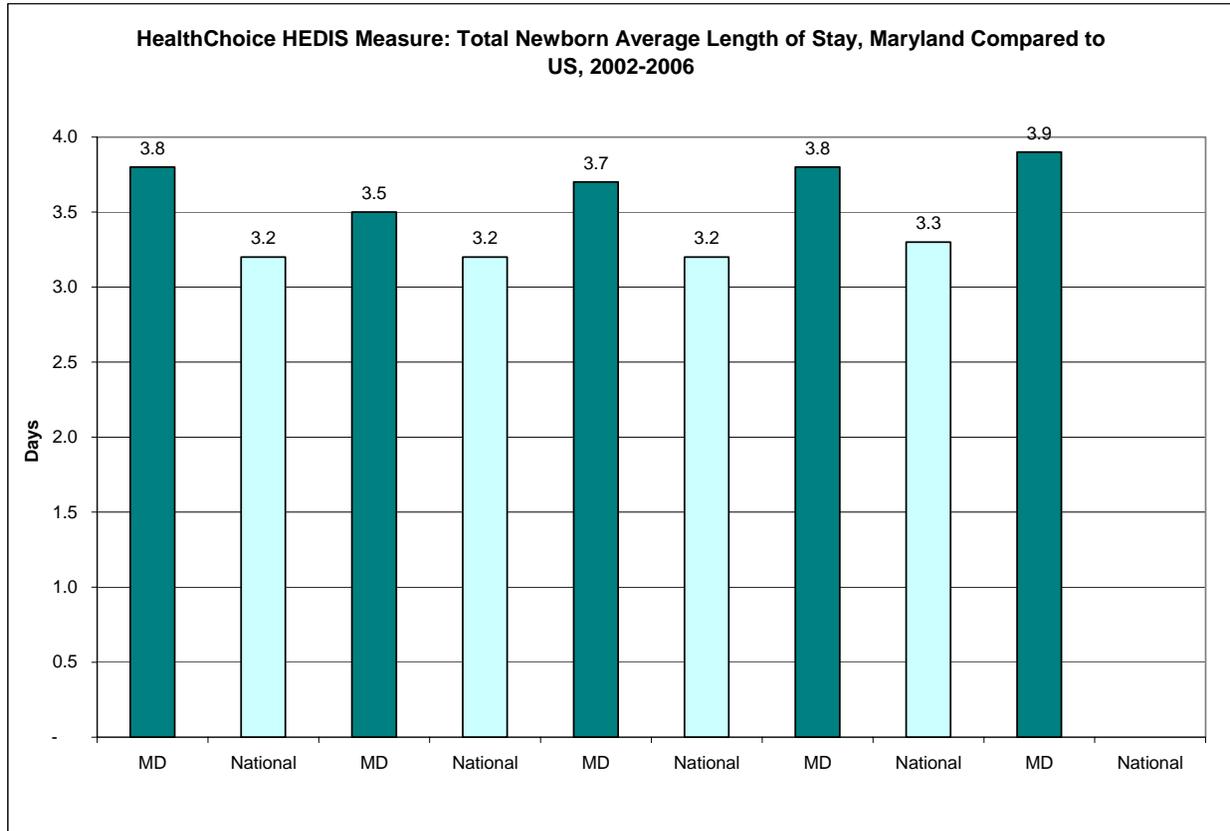
Figure III-8: HEDIS Measure: Maternity Average Length of Stay, 2002 - 2006



6. Births ALOS

The average length of stay for newborns had only a slight increase from 3.8 days in 2002 to 3.9 days in 2006 (Figure III-9). In 2003 there was a low of 3.5 days. This remains slightly higher than the national Medicaid average.

Figure III-9: HEDIS Measure: Newborn Average Length of Stay, 2002 through 2006



B) PREVENTIVE SERVICES

HealthChoice was designed to provide comprehensive, prevention-oriented care. Therefore, the assessment of preventive service delivery is central to evaluating HealthChoice. Preventive service measures are a subset of general utilization measures and include an array of services provided to both children and adults. Children's utilization of preventive care is measured through well-child visits, immunizations, and lead testing. Adult preventive care is measured through breast and cervical cancer screening and access to prenatal care. All three adult preventive measures are for services delivered to women. Over 70 percent of adult HealthChoice enrollees are female. Other measures in this evaluation are inclusive of both males and females.

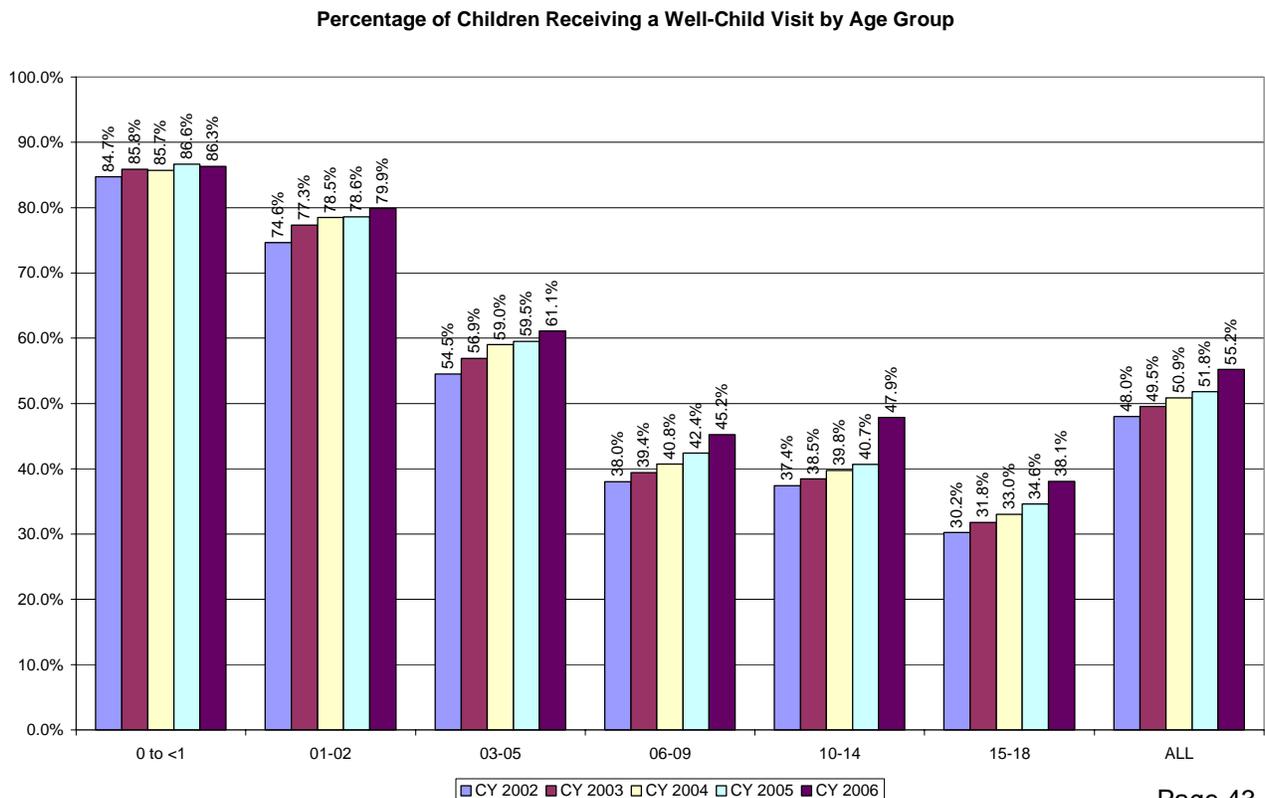
1. Well-Child Visits

Well-child visits are defined by EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) standards. Well-child visits are a subset of ambulatory visits. Like the ambulatory visit measure, the well-child visit measure includes children with any period of enrollment. Well-child visits are unique because they are provided according to a prescribed periodicity schedule. HealthChoice regulations stipulate that MCOs must notify parents or guardians of pending well-child visits and make efforts to ensure that scheduled visits occur.

Analysis of well-child visits addresses some of the challenges of comparability that complicate the examination of all ambulatory visits. Individuals with poorer health status can be expected to utilize ambulatory services at higher rates. In contrast, well-child services should be provided to all children according to the periodicity schedule and should not be affected by the child's health status.

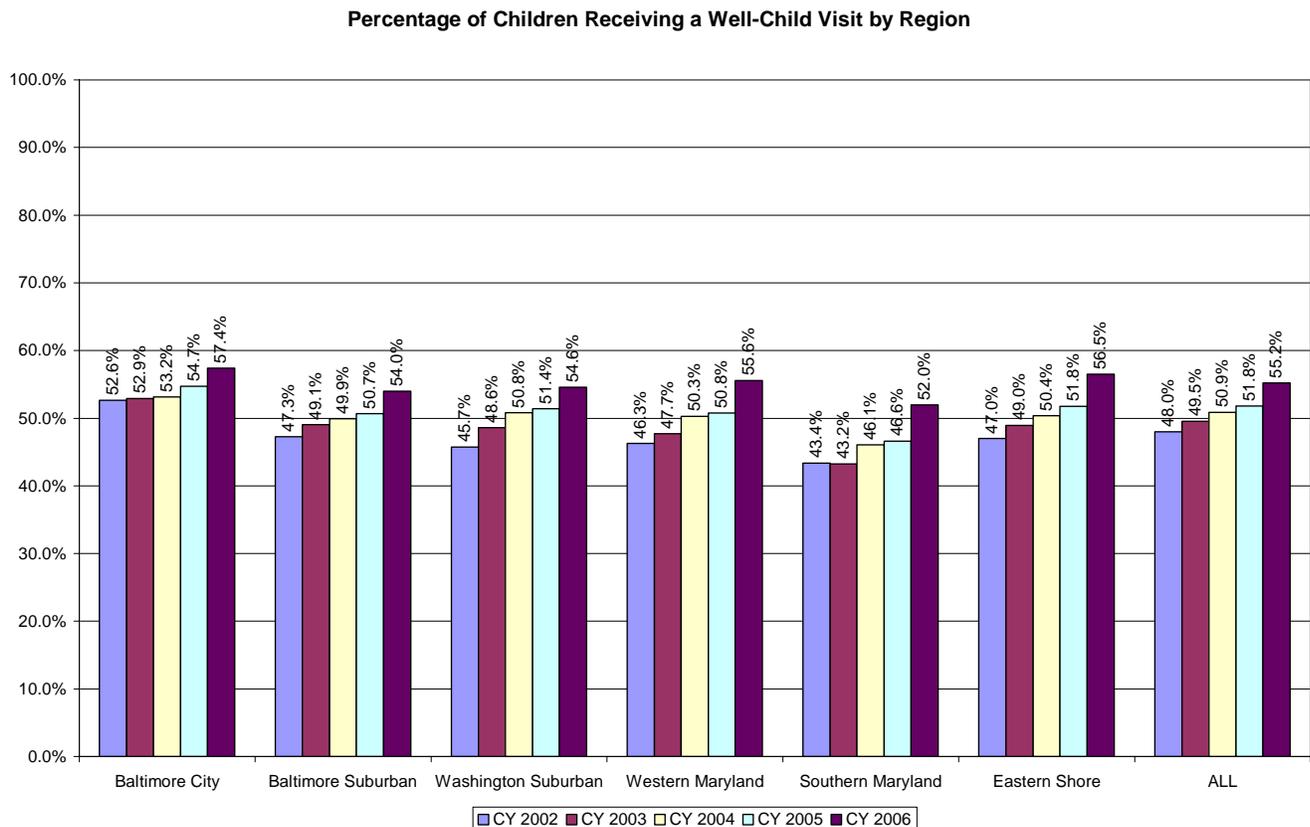
The data show that HealthChoice has been successful in increasing the percentage of children who receive such services. The percentage of the population receiving a well-child service increased across all age groups between CY 2002 and CY 2006. Overall, the utilization rate increased from 48 percent in CY 2002 to approximately 55 percent in CY 2006. Each age group experienced an increase of greater than five percentage points, except the zero to under one age group, which already had the highest access rate. The largest increase of greater than ten percentage points occurred for ages 10 through 14 (Figure III-10).

Figure III-10: Well-Child by Age, 2002 through 2006



All regions experienced increases in the percentage of well-child visits by more than five percentage points over the five-year period. The Washington Suburban, Western Maryland, Southern Maryland, and Eastern Shore regions had the highest increases, of more than approximately 9 percentage points (Figure III-11).

Figure III-11: Well-Child by Region, 2002 through 2006



In addition to measuring well-child visits by age as shown in Figure III-10, the Department also uses HEDIS measures to report children’s utilization of well-child visits. As mentioned above, the use of HEDIS allows the Department to compare HealthChoice to Medicaid programs nationwide. However, criteria for HEDIS measures differ from the Department’s criteria for other measures. HEDIS looks at utilization only for individuals with continuous enrollment, as opposed to any period of enrollment. Utilization rates are lower when analyzed for any period of enrollment, because the MCOs have less opportunity to manage the care of these populations. HEDIS also uses different age breaks.

The Department reports the HEDIS measure for well-child visits for children ages zero through 15 months. The American Academy of Pediatrics recommends six well-child visits for this age group. Figure III-12 shows the percentage of infants receiving five or more well-child visits steadily increased between 2002 and 2006 (from 75 to 85 percent). HealthChoice performance remains well above national Medicaid HEDIS

results (82 versus 68 percent in 2005). Only two percent of infants did *not* receive well-child visits in 2006. This is lower than the most recently available national Medicaid HEDIS results (Figure III-13).

Figure III-12: HEDIS Measure: Well Child Visits First 15 Months, 2002-2006

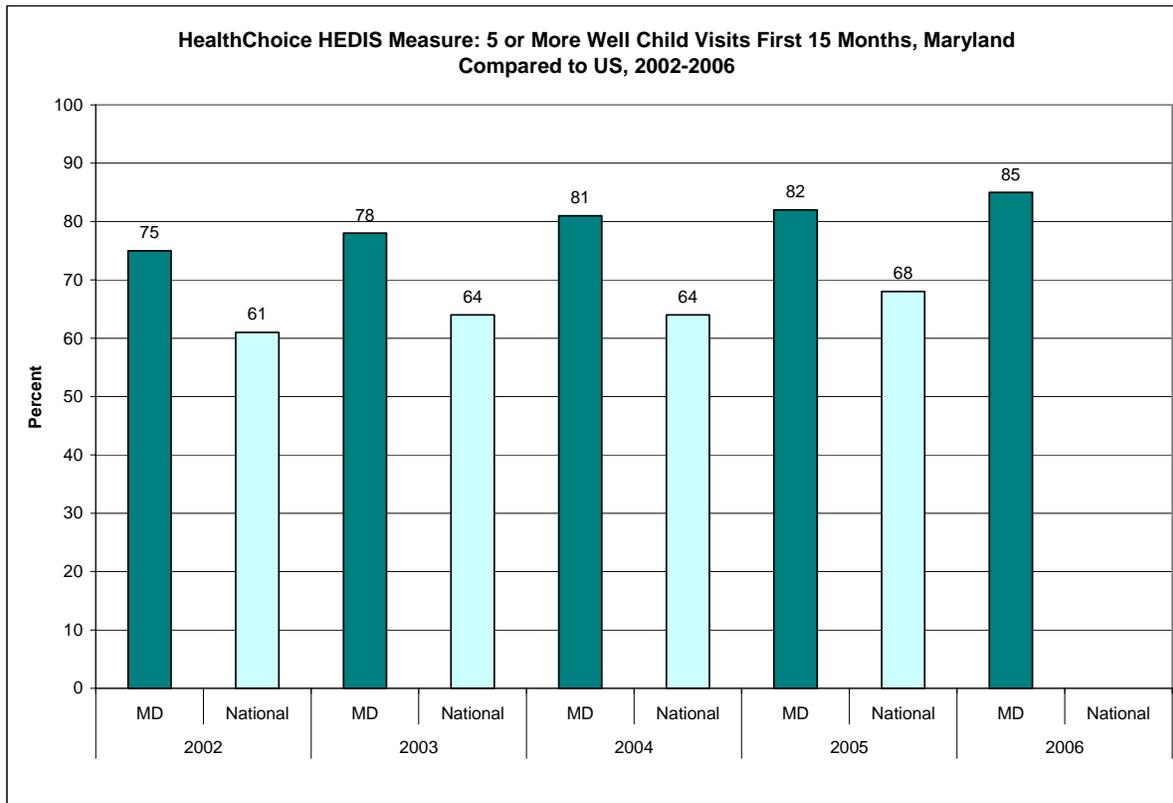
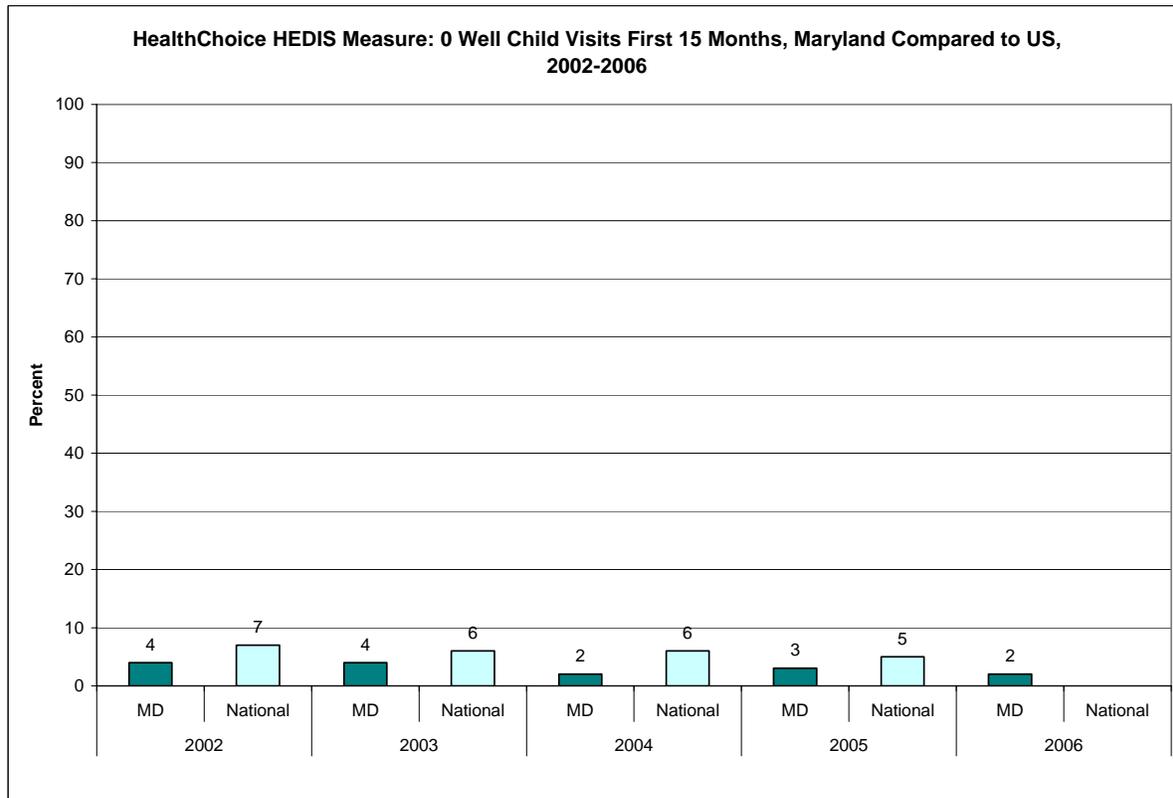
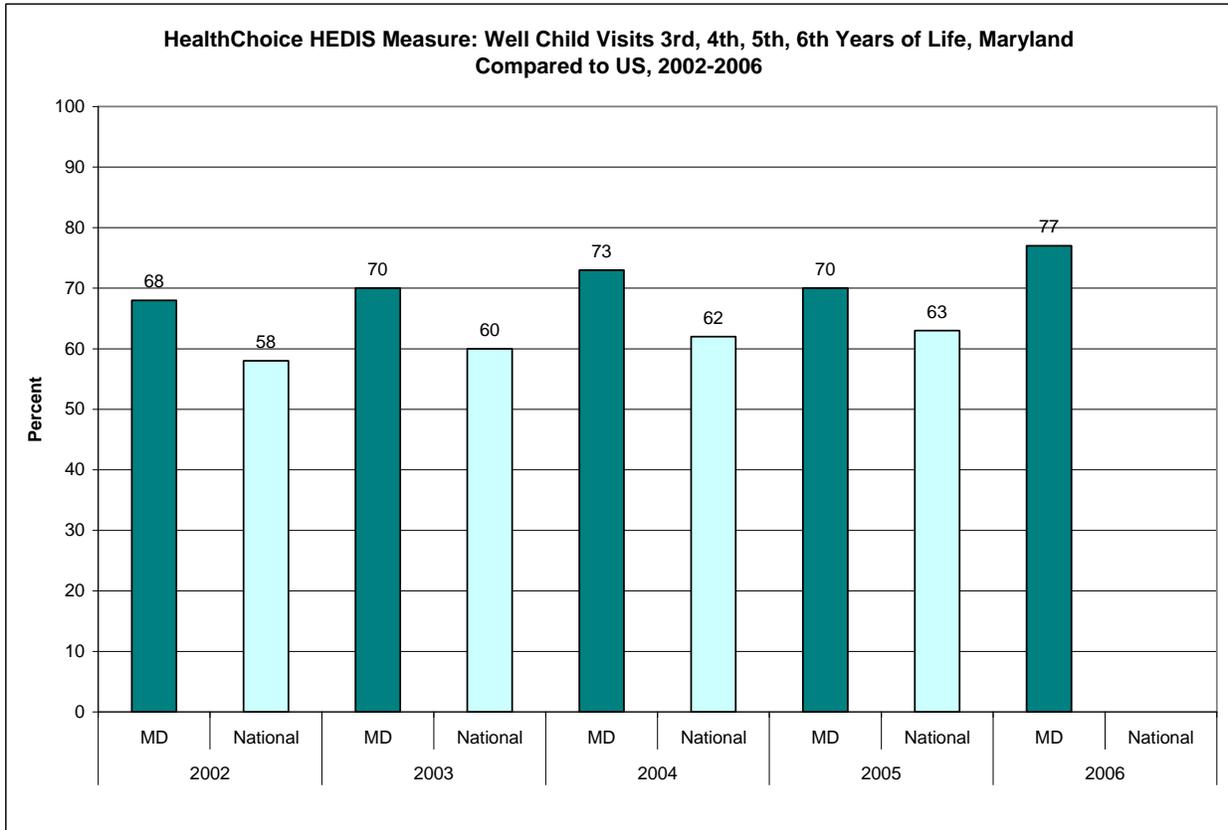


Figure III-13: HEDIS Measure: No Well-Child First 15 Months, 2002 - 2006



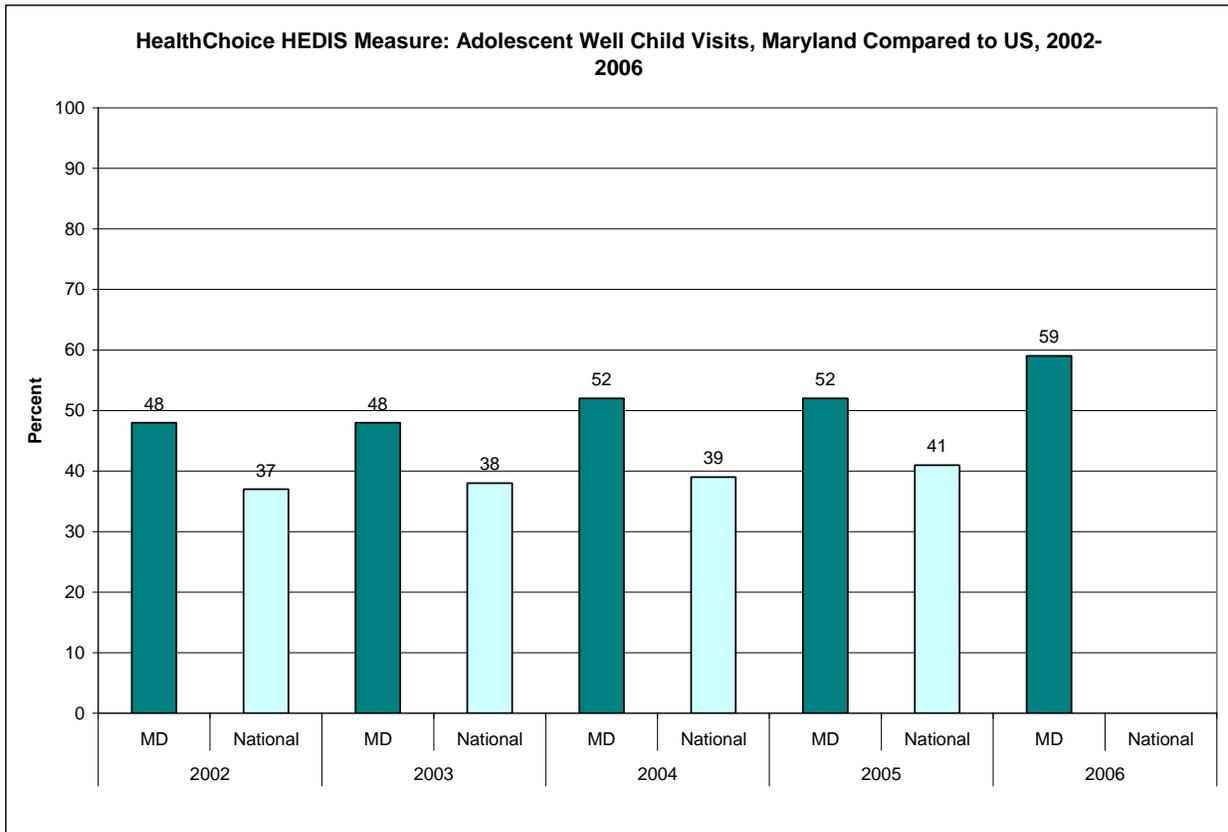
The Department reports HEDIS for well-child visits for three through six year-olds. The percentage of three through six year-olds who received a well-child visit during the year increased from 68 to 77 percent between 2002 and 2006. HealthChoice average has exceeded the national Medicaid HEDIS rate consistently (Figure III-14).

Figure III-14: HEDIS Measure: Well Child 3rd, 4th, 5th, 6th Year of Life, Maryland Compared to the United States, 2002 through 2006



The Department reports HEDIS for adolescent (ages 12 through 21) well-child visits. In 2002, 48 percent of adolescents received a well-child visit. By 2006, 59 percent of adolescents received well-child care, an increase of 11 percentage points. In contrast, the national average hovers around 40 percent and has only grown four percentage points since 2002 (Figure III-15).

Figure III-15: HEDIS Measure: Adolescent Well Child Visit, 2002 through 2006



2. Lead Testing

Maryland’s Plan to Eliminate Childhood Lead Poisoning by 2010 includes a goal of ensuring that young children receive appropriate lead risk screening and blood lead testing. The Department reports lead testing for children continuously enrolled in the same MCO for 90 days. Figure III-16 shows that in HealthChoice, approximately 51 percent of children ages 12 through 23 months received lead testing in CY 2006, an increase of over six percentage points since CY 2002. For children aged 24 through 35 months, the CY 2006 lead testing rate was approximately 47 percent, an increase of more than eight percentage points since CY 2002. Increases have been small and unsteady in recent years.

In Baltimore City, the HealthChoice lead testing rate for CY 2005 is just above 62 percent (Figure III-17) for children aged 12 through 23 months, and has increased by 5 percentage points since CY 2002. After progress for children aged 24 through 35 months between 2002 and 2005, the rate decreased between CY 2005 and CY 2006, to almost 59 percent (4 percentage points above the 2002 rate).

Figure III-16: HealthChoice Children Receiving Lead Testing by Age, Statewide 2002 through 2006

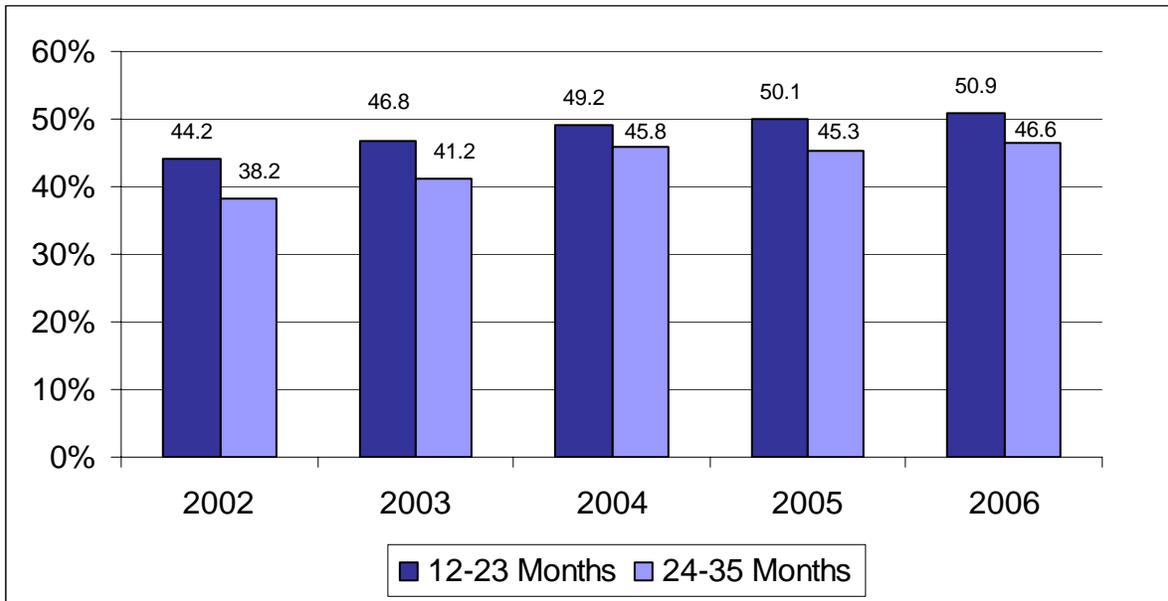
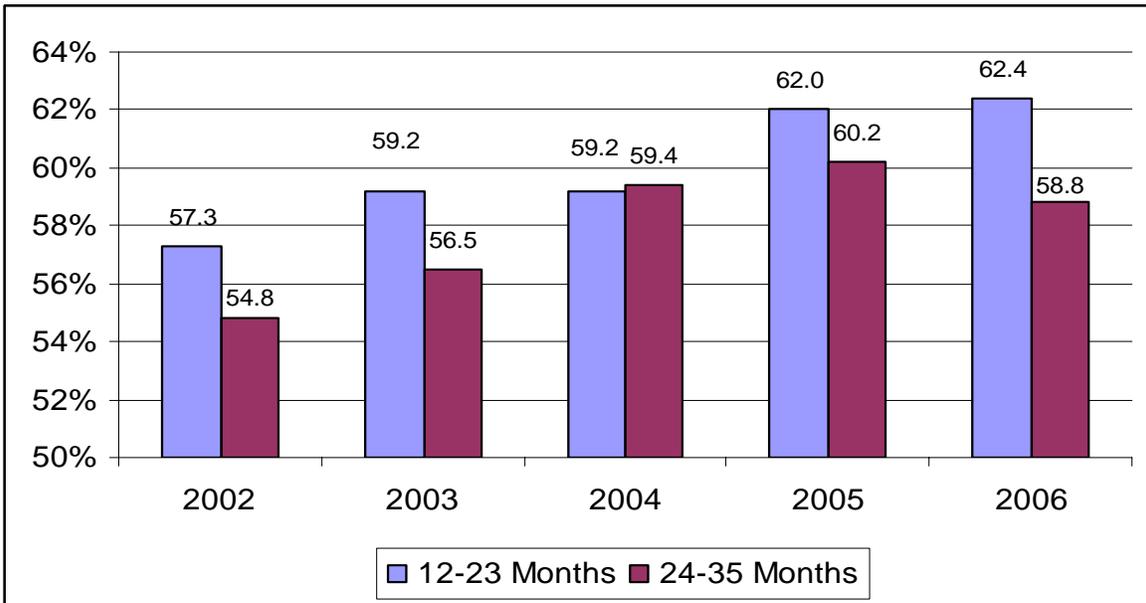


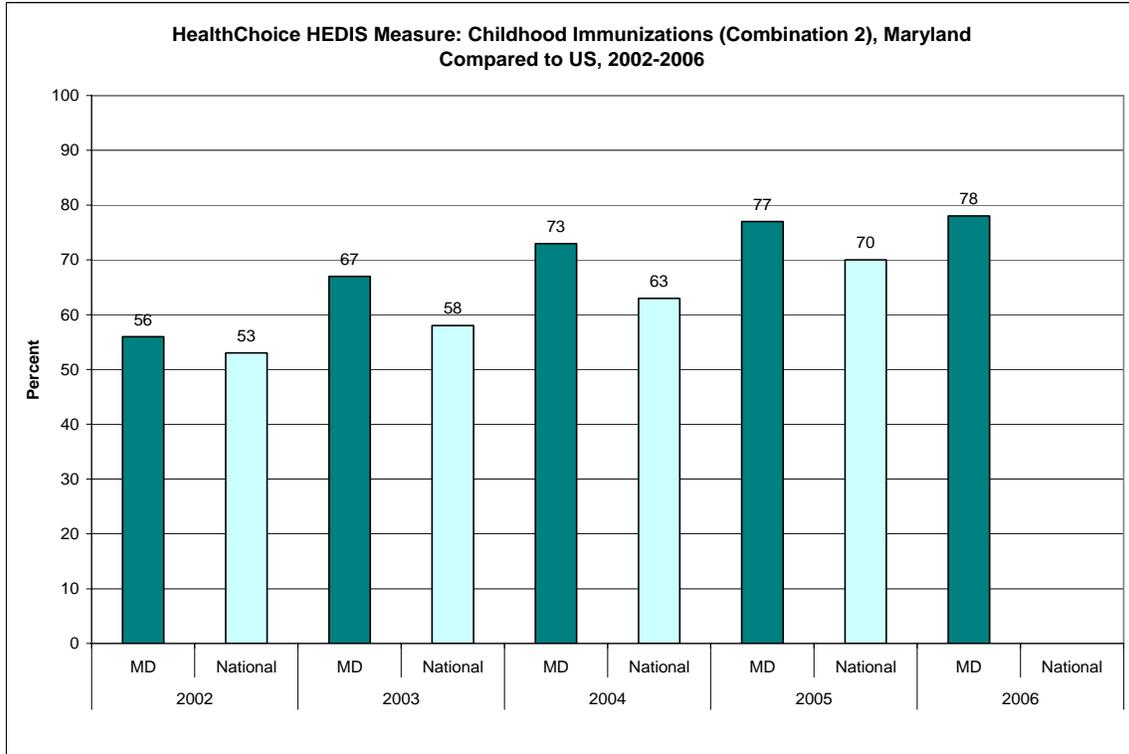
Figure III-17: HealthChoice Children Receiving Lead Testing by Age, Baltimore City 2002 through 2006



3. Childhood Immunizations

Figure III-18 below shows rates of childhood immunizations (immunization combination two) as measured according to HEDIS. The HealthChoice rate has continuously improved, from 56 percent in 2002 to 78 percent in 2006, and has remained substantially higher than national Medicaid HEDIS performance.

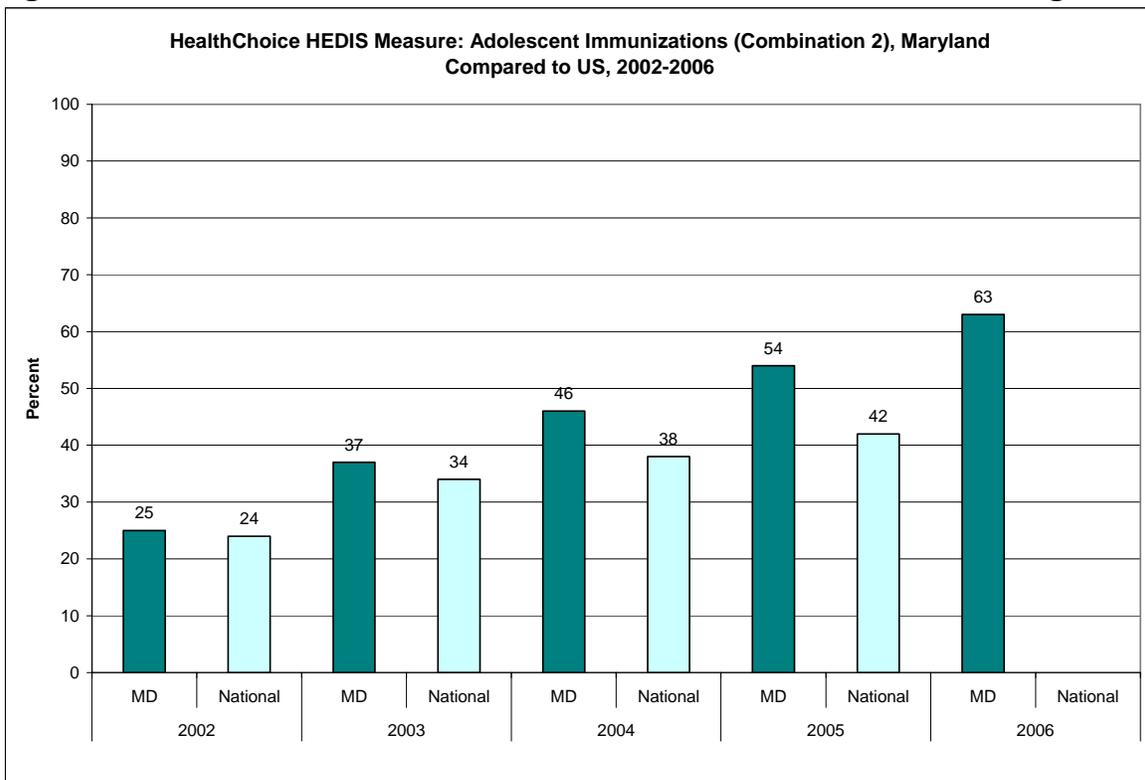
Figure III-18: HEDIS Measure: Childhood Immunizations, 2002 through 2006



4. Adolescent Immunizations

Immunization rates have improved for adolescents as well as children. The HEDIS adolescent immunization measure shows that the rate under HealthChoice improved 38 percentage points, from 25 percent in 2002 to 63 percent in 2006 (Figure III-19). The rate under HealthChoice is higher than the rate for national Medicaid HEDIS.

Figure III-19: HEDIS Measure: Adolescent Immunizations, 2002 through 2006

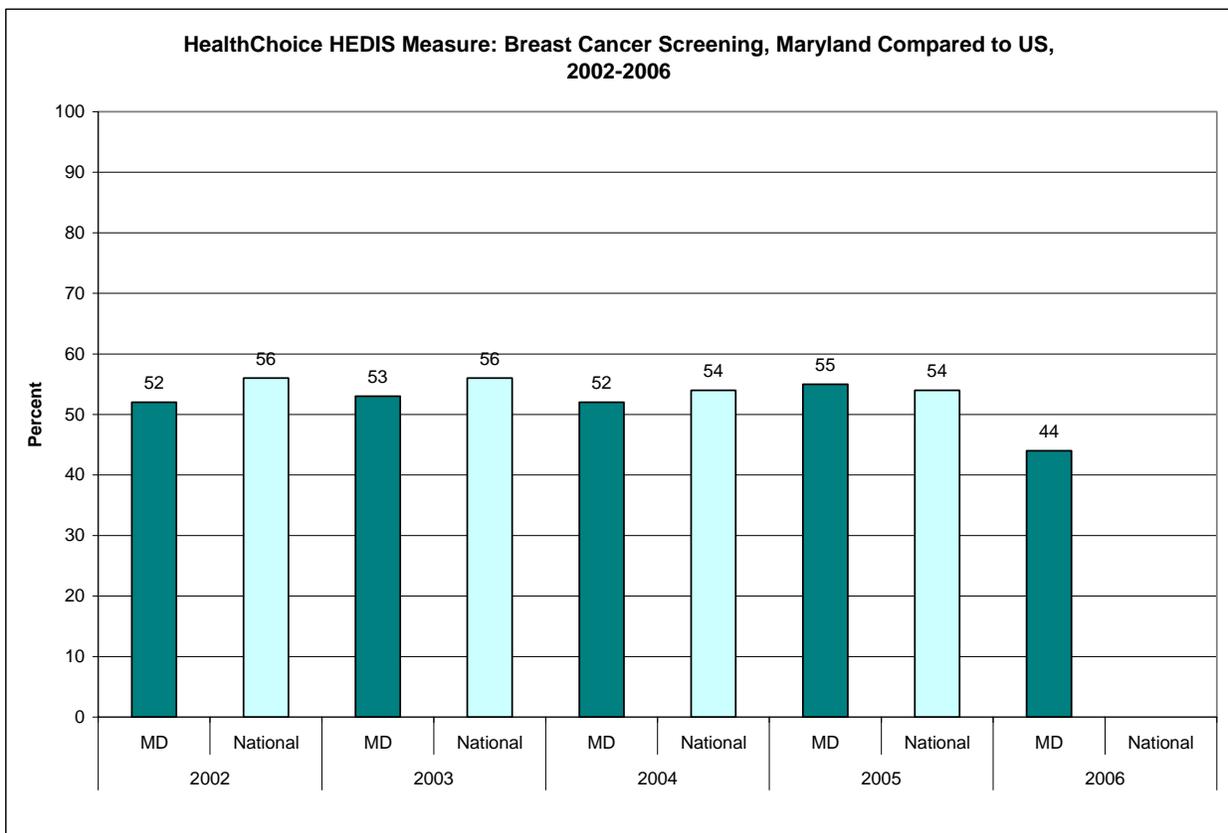


5. Breast Cancer Screening

Mammograms are an effective means of detecting breast cancer early. The Department reports this HEDIS measure for women age 52 through 69 who were continuously enrolled during the calendar year and the preceding year who had a mammogram during the reporting year or the prior year.

The percentage of women receiving mammograms increased three percentage points between 2002 and 2005 (Figure III-20). The HEDIS methodology in 2005 changed to accept administrative data only. Previous years allowed administrative data to be supplemented by medical record review. There was a significant decrease in 2006. This is most likely due to a significant change in the HEDIS methodology that year. For 2006, the age group was expanded to include women 42 through 69. Previously the measure included women 52 through 69.

Figure III-20: HEDIS Measure: Breast Cancer Screening, 2002 through 2006

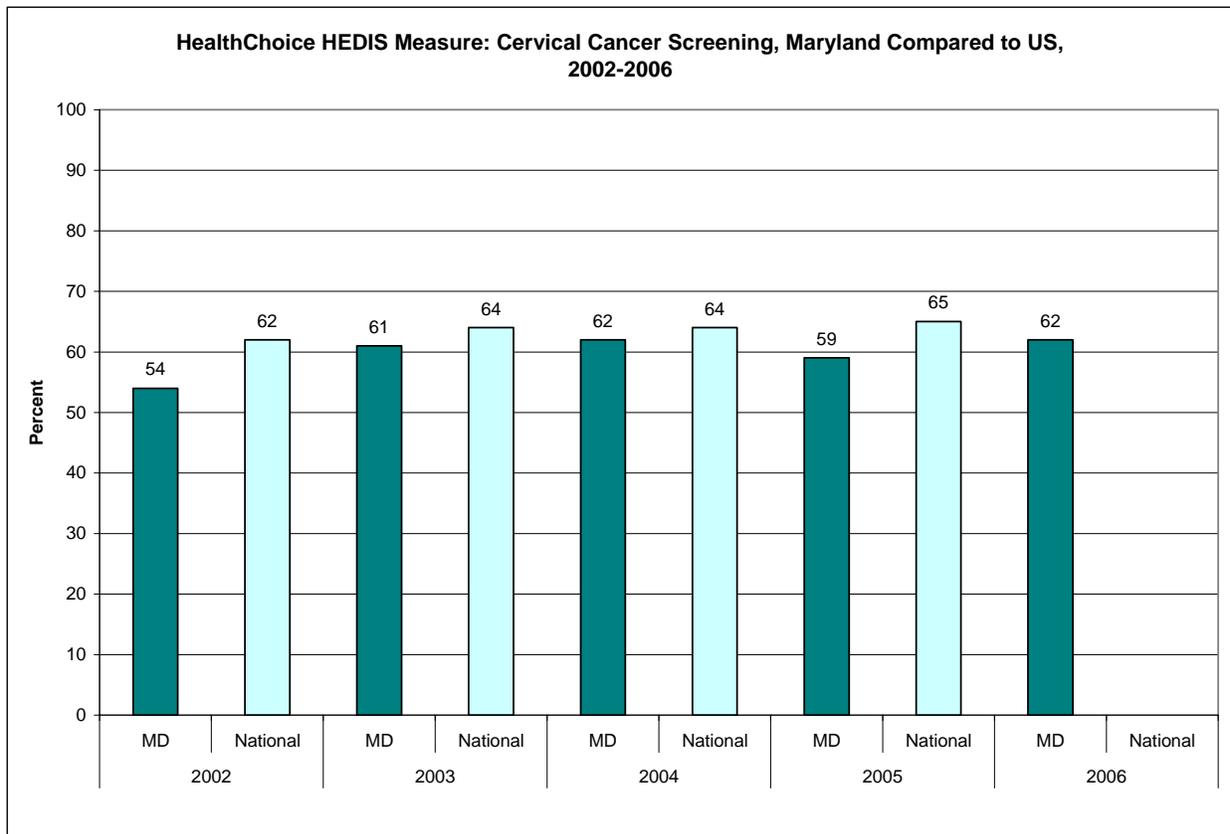


6. Cervical Cancer Screening

Cervical cancer detected in its early stages is highly curable, and Pap tests are an effective means of detecting cervical cancer early. The Department reports the HEDIS measure of cervical cancer screening for women age 21 through 64 who were continuously enrolled and who received a Pap test during the reporting year or the two prior years.

While still lower than the national Medicaid HEDIS average, HealthChoice has seen an eight percentage point increase between 2002 and 2006. This has been a larger increase than experienced nationally (Figure III-21).

Figure III-21: HEDIS Measure: Cervical Cancer Screening, 2002 through 2006

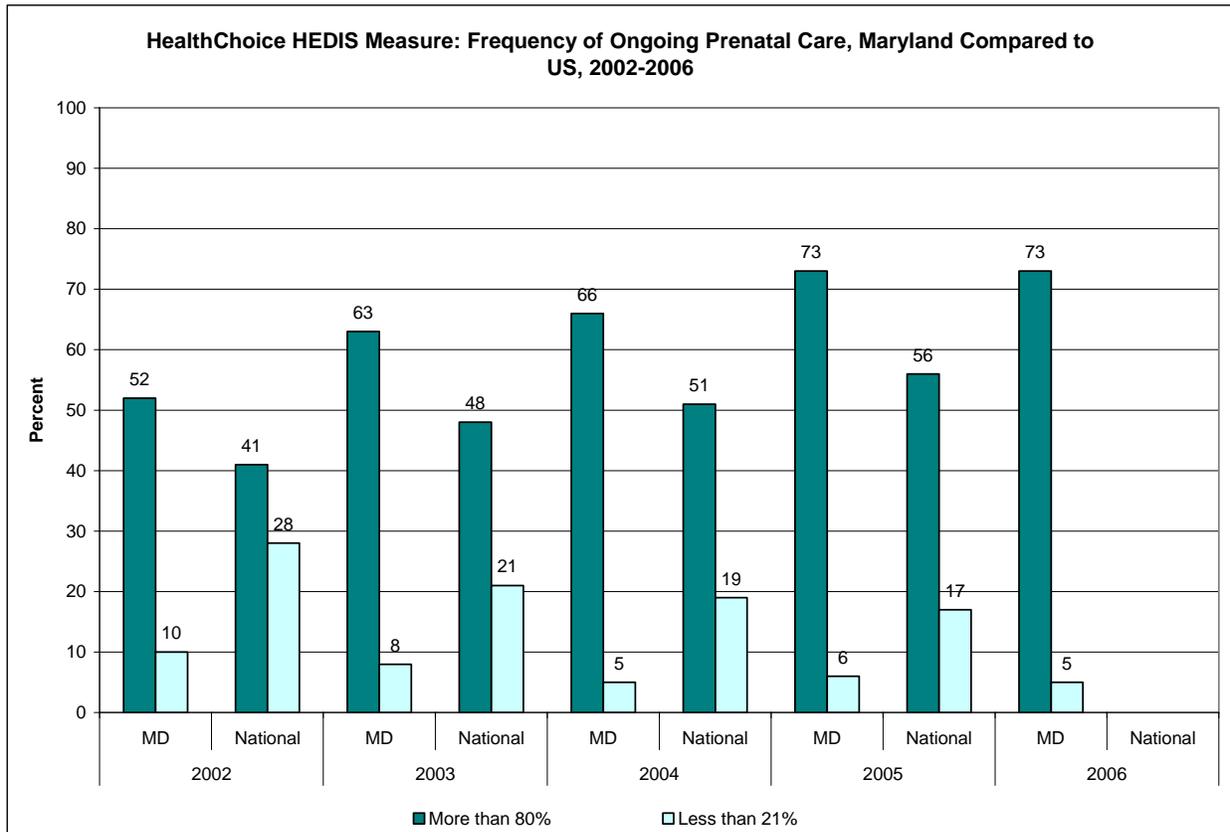


7. Frequency of ongoing prenatal care

HEDIS assesses the frequency of ongoing prenatal care by examining the percent of expected prenatal visits received, taking into account time of enrollment and gestational age. Figure III-22 shows that under HealthChoice frequency of ongoing prenatal care has increased. In 2002, 52 percent of women received greater than 80 percent of expected visits. By 2006, this increased to 73 percent of women. Rates were stable between 2005 and 2006. The rate of women who receive less than 21 percent of

expected visits has also improved, decreasing from 10 percent in 2002 to 5 percent in 2006. HealthChoice performance has consistently been better than national Medicaid, and greater improvements have been experienced in HealthChoice than nationwide.

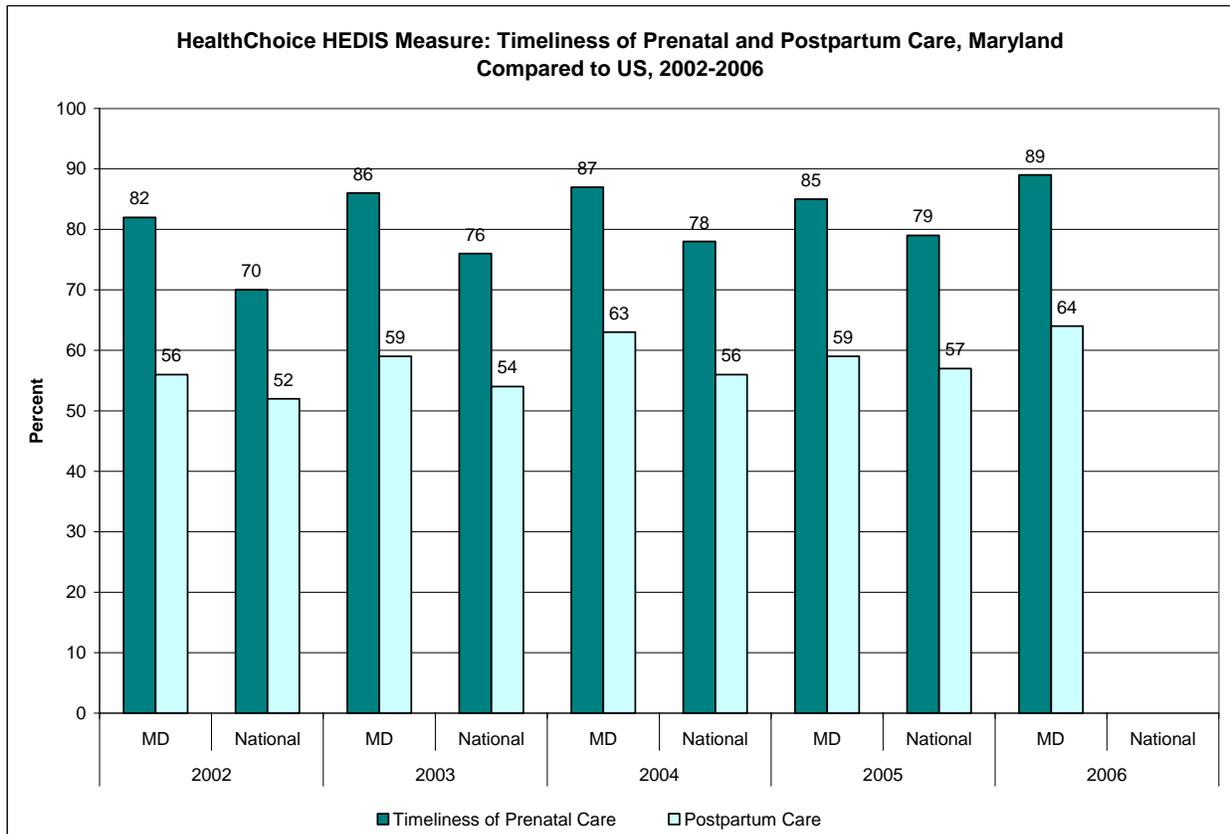
Figure III-22: HEDIS Measure: Frequency of Ongoing Prenatal Care, 2002 through 2006



8. Timeliness of prenatal and postpartum care

Utilization of early prenatal and postpartum care has increased between 2002 and 2006 under HealthChoice, as measured by HEDIS methodology (Figure III-23). For both of these measures there was a decrease from 2004 to 2005, followed by an increase in 2006. Rates of utilization for timely prenatal care increased by seven percentage points, from 82 percent in 2002 to 89 percent in 2006. The increase in utilization of timely postpartum care was similar, at eight percentage points, although the overall rate is lower than for prenatal care. Timely postpartum care increased from 56 percent in 2002 to 64 percent in 2006. For both of these measures, HealthChoice consistently outperformed national Medicaid HEDIS.

Figure III-23: HEDIS Measure: Timelines of Prenatal and Postpartum Care, 2002 through 2006



C) APPROPRIATENESS OF CARE

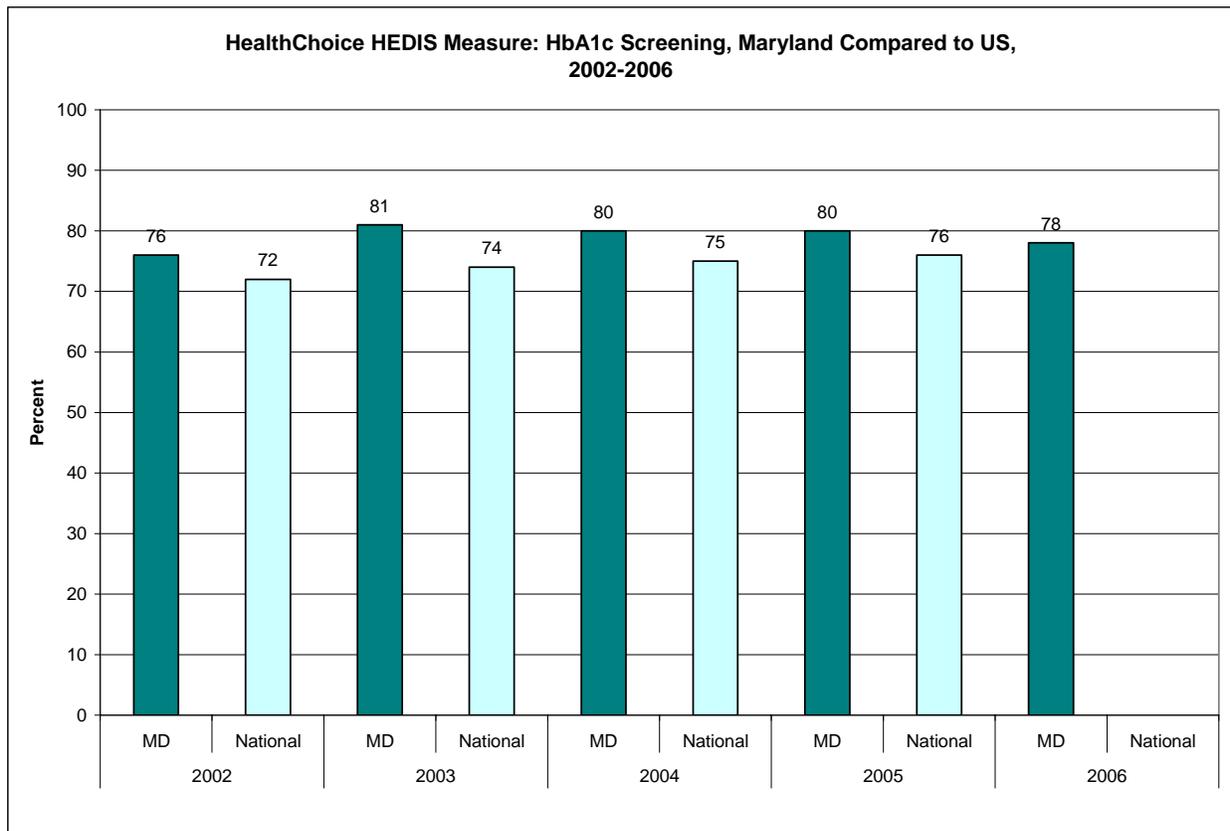
The HealthChoice evaluation is a tool to help determine if enrollees have access to high-quality care. Previous sections of this evaluation looked at HealthChoice enrollees’ rates of utilization, and more specifically at rates of preventive care utilization. Increased utilization shows that the delivery system is serving enrollees, and increases in preventive utilization show that enrollees are able to get the types of services that can help keep them well. This indicates that the system is increasingly accessible. This section of the evaluation assesses the appropriateness of the services being utilized, as an indicator that enrollees are receiving the right kind of care.

1. Comprehensive Diabetes Care

Diabetes is associated with long-term complications that affect almost every major part of the body. Effectively managing diabetes reduces the risk of complications. HEDIS looks at several parameters of diabetes management in order to determine the comprehensiveness of diabetes care.

The percent of individuals with diabetes who received appropriate HbA1c (blood glucose level) screening increased from 76 percent in 2002 to 78 percent in 2006, and continues to be above the national average (Figure III-24). However, the 2006 rate of 78 percent is a decrease from the high in 2003 of 81 percent.

Figure III-24: HEDIS Measure: HbA1c Screening, 2002 through 2006



Eye exams for individuals with diabetes are critical to maintaining eye health and avoiding blindness. Figure III-25 below shows that since 2002, the percent of HealthChoice enrollees with diabetes who had an eye exam increased 12 percentage points, from 47 to 59 percent in 2006. HealthChoice performance has consistently been above national Medicaid performance.

The percent of individuals with diabetes who had low-density lipoprotein cholesterol (LDL-C) screening has decreased between 2002 and 2006, from 78 percent to 74 percent. The percent of people screened peaked in 2004 at 87 percent. HealthChoice has consistently surpassed the national Medicaid average (Figure III-26).

Figure III-25: HEDIS Measure: Eye Exam, 2002 through 2006

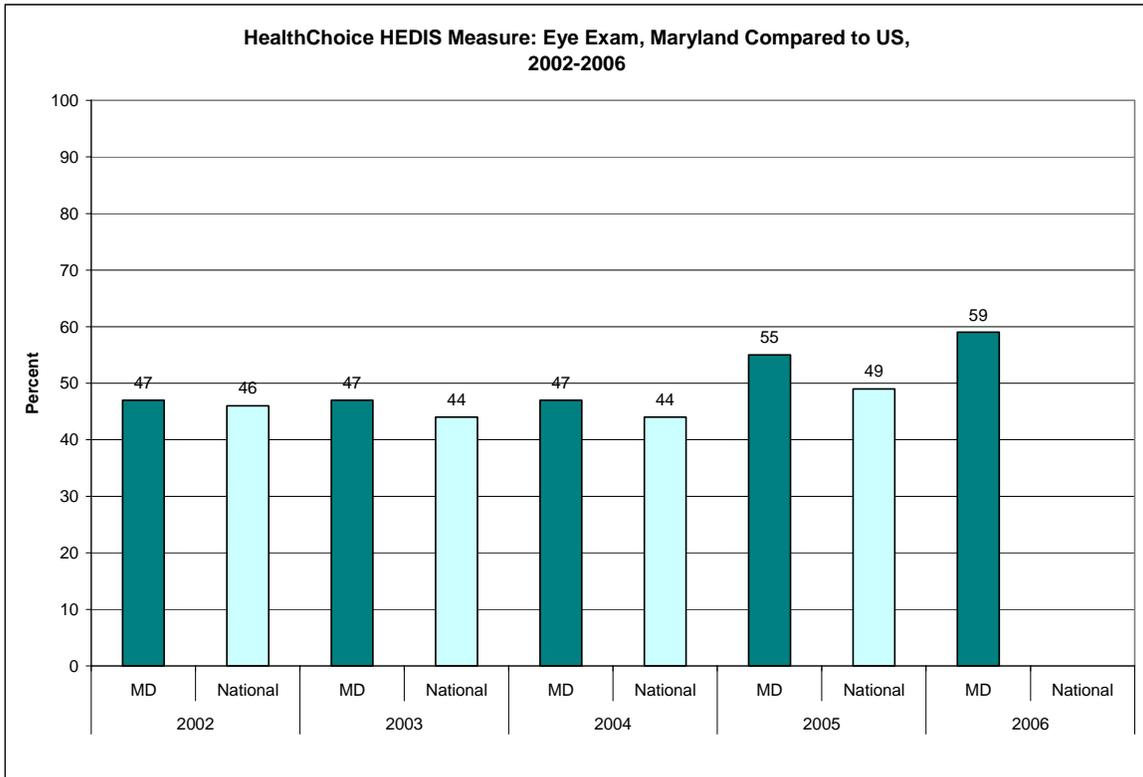


Figure III-26: HEDIS Measure: LDL-C Screening, 2002 through 2006

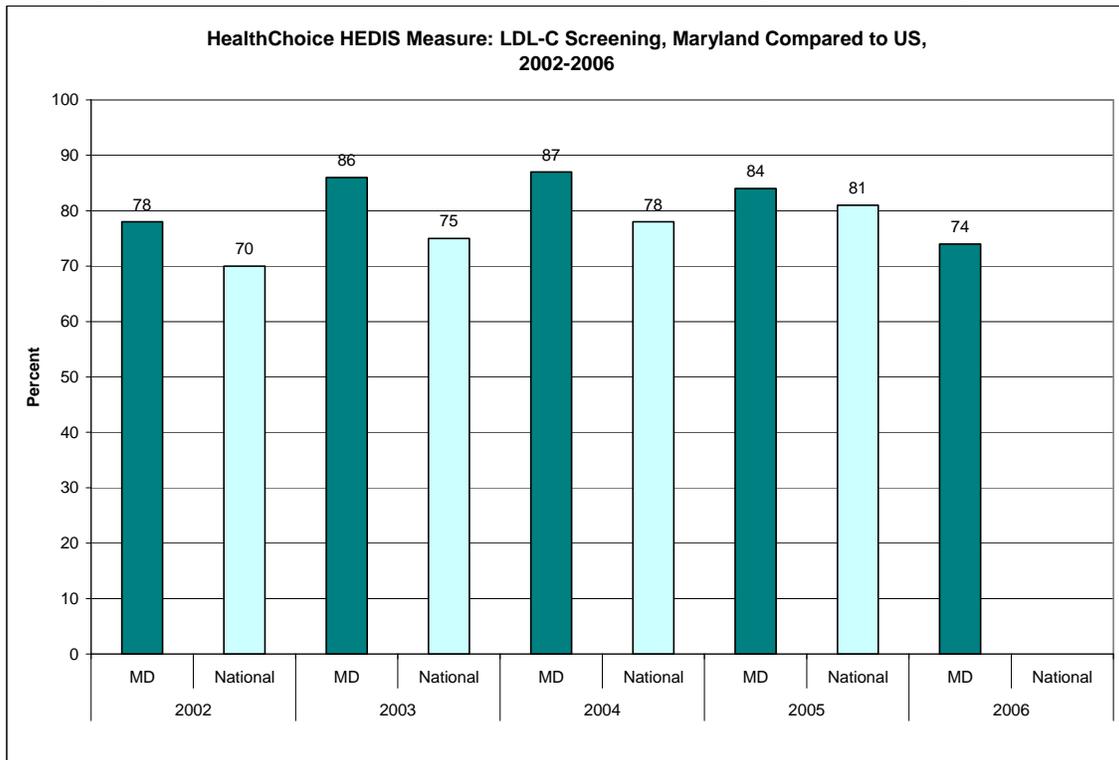
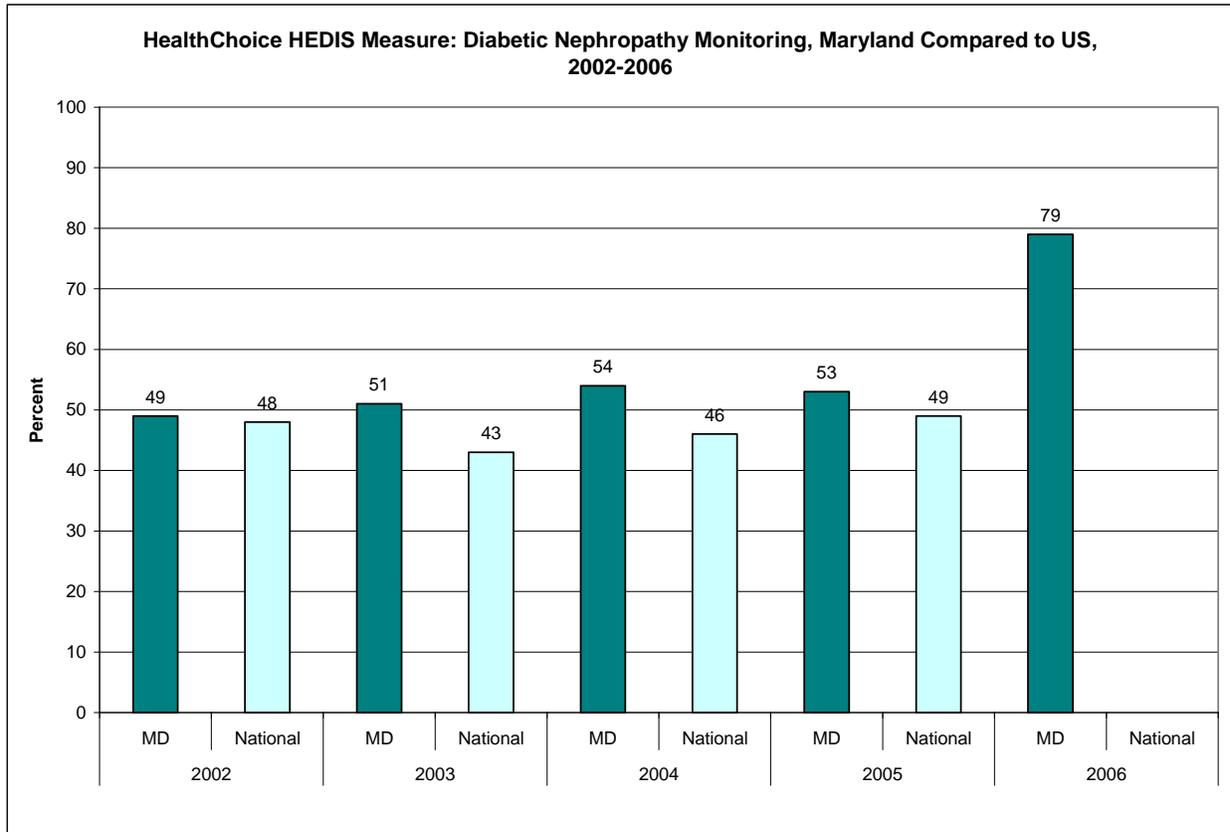


Figure III-27 below shows the increase in diabetic nephropathy monitoring between 2002 and 2006. This was a dramatic increase, from 49 percent to 79 percent. During the same time frame, HealthChoice outperformed the national Medicaid average.

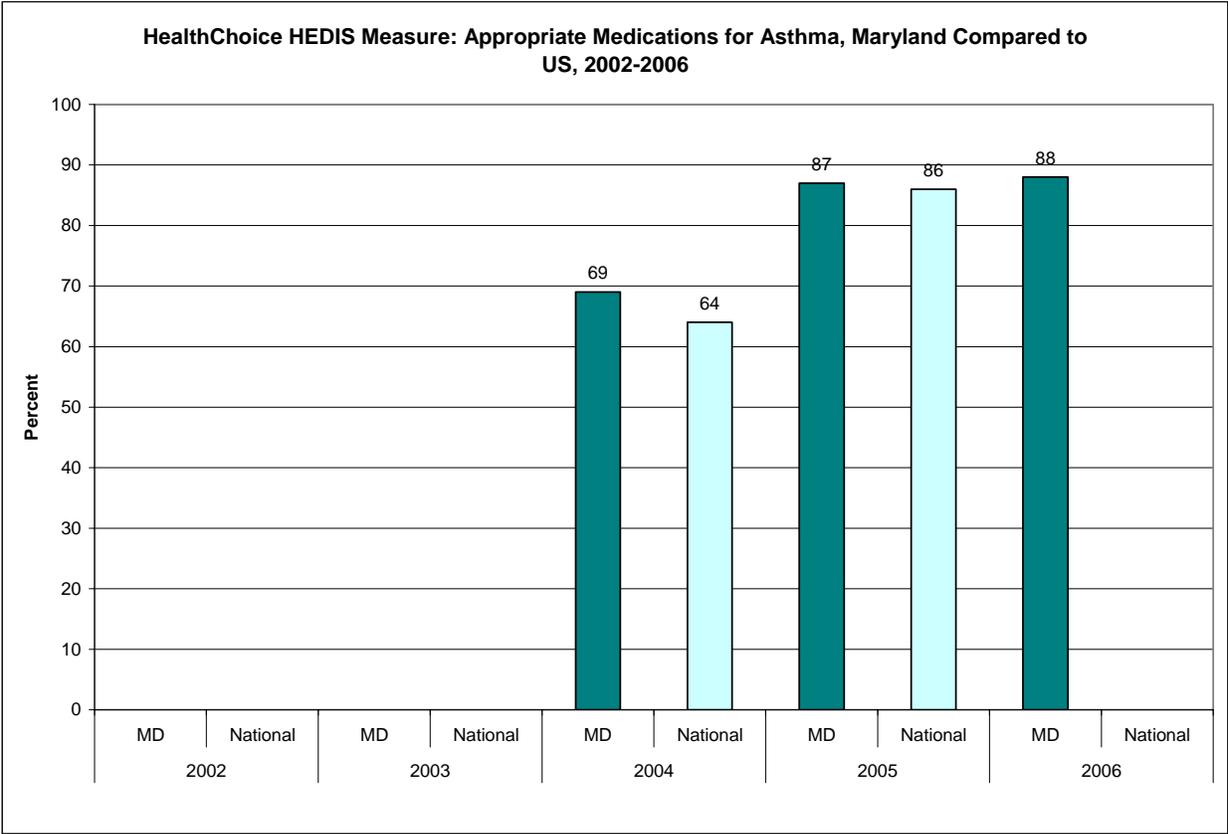
Figure III-27: HEDIS Measure: Diabetic Nephropathy Monitoring, 2002-2006



2. Appropriate Medications for Asthma

HealthChoice began reporting the HEDIS measure of the use of appropriate medications for people with asthma in 2004. For all ages analyzed, performance improved from 69 percent of enrollees with asthma using appropriate medications to 88 percent (Figure III-28). Performance does not vary greatly across age groups. The percent of enrollees in HealthChoice using appropriate medications is slightly better than for national Medicaid HEDIS.

Figure III-28: HEDIS Measure: Appropriate Medications for Asthma, 2004 through 2006



3. Ambulatory Care Sensitive Hospitalizations

Ambulatory care sensitive hospitalizations (ACSHs), also called preventable or avoidable hospitalizations, refer to admissions that could have been prevented if ambulatory care had been provided in a timely and effective manner. High numbers of avoidable hospitalizations may be indicative of problems with access to primary care services or deficiencies in outpatient management and follow-up. The number of avoidable hospitalizations may also be affected by a patient’s lack of adherence to prescribed treatment regimens.

Asthma and diabetes are two chronic conditions that can be managed through the outpatient setting. Hospital admissions for these conditions can be avoided through effective outpatient management. The Department measured avoidable asthma admission rates and avoidable diabetes¹⁴ admission rates for CY 2003 through CY 2006. The avoidable admissions rate for asthma has consistently decreased each year from CY 2003 to CY 2006, and the avoidable admissions rate for diabetes decreased from a high of 30 admissions per thousand members in CY 2003 to a low of 24

¹⁴ The measure for diabetes included only short-term complications.

admissions per thousand members in CY 2004 (Figures III-29 and 30). The diabetes rate has held constant at 25 admissions per thousand member months for the past two calendar years.

Figure III-29: Avoidable Asthma Admissions per Thousand Members per Year (Enrollees Aged 21-64)

	CY 2003	CY 2004	CY 2005	CY 2006
Rate per 1,000 HEDIS Eligible Asthma Children	66	55	46	44

Figure III-30: Avoidable Diabetes Admissions for Short-Term Complications per Thousand Members per Year (Enrollees Aged 21-64)

	CY 2003	CY 2004	CY 2005	CY 2006
Rate per 1,000 HEDIS Eligible Diabetic Adults	30	24	25	25

D) SELECTED SERVICES

1. Dental Services

In an effort to increase oral health access and utilization, the Secretary of DHMH convened the Dental Action Committee (DAC) in June 2007. The DAC was comprised of a broad-based group of stakeholders concerned about children’s access to oral health services. The DAC focused its efforts and recommendations on four topic areas: (1) Medicaid reimbursement and alternative models; (2) provider participation, capacity, and scope of practice; (3) public health strategies; and, (4) oral health education and outreach. The DAC reviewed dental reports and data to develop a comprehensive series of recommendations, building on past dental initiatives, lessons learned, and best practices from other states. The DAC’s final report was presented to the Secretary on September 11, 2007.

The DAC recommended several changes to the Medicaid program. In order to streamline the Medicaid process for providers and recipients, the DAC recommended a single statewide dental vendor, an Administrative Services Only (ASO) provider. The DAC further recommended increasing dental reimbursement rates to the 50th percentile of the American Dental Association’s South Atlantic region charges for all dental codes. The Department is committed to fully and carefully reviewing the DAC’s recommendations and working with the DAC on recommended strategies to make access to dental care a reality for all Marylanders.

Additional information is also included in the Department's October 2007 annual report to the General Assembly on access to dental care under HealthChoice.

Children

Dental care is a mandated health benefit for children up to age 21 under Medicaid EPSDT requirements. Utilization of oral health services has remained low, despite significant improvements under the HealthChoice Medicaid managed care program. Like many other states, Maryland continues to face numerous barriers in providing comprehensive oral health services to Medicaid enrollees. Barriers include low provider participation due in part to low reimbursement rates, missed appointments, and lack of awareness among enrollees about the benefits of basic oral health care. As Medicaid's population continues to increase year over year, these barriers become more pronounced.

To assess the performance of individual HealthChoice MCOs, the Department uses a measure closely modeled on the National Committee for Quality Assurance (NCQA) HEDIS measure for Medicaid children's dental services utilization. The counted number of individuals is based on two criteria: an age range from 4 through 21 years and enrollment of 320 days. The Department modified its ages to reflect 4 through 20 years because the Maryland Medicaid program only requires dental coverage through age 20. Since the inception of HealthChoice, the percent of children receiving dental services increased from almost 20 percent in 1997 to approximately 46 percent in 2006 (Figure III-31 below). As a comparison, the HEDIS national average for Medicaid was 41 percent in CY 2006.¹⁵

**Figure III-31: Number of Children Receiving 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
SFY 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 ¹⁶	142,988	48,066	33.6%
CY 2002	194,351	67,029	34.5%
CY 2003	203,826	88,110	43.2%
CY 2004	213,234	93,154	43.7%
CY 2005	227,572	104,188	45.8%
CY 2006	223,936	103,561	46.2%

This year the Department also reported utilization rates of children with any period of enrollment. Utilization rates are lower when analyzed for any period of enrollment. This

¹⁵ National Committee for Quality Assurance.

¹⁶ Starting with data for CY 2001, DHMH revised its methodology to include children enrolled in the same MCO for at least 320 days, consistent with HEDIS methodology. Prior to CY 2001, these data included individuals enrolled in any MCO for at least 320 days.

is because the population in the analysis includes children who 1) are in the MCO for only a short period of time due to turnover in eligibility or enrollment, and 2) are new to the MCO, and the MCO has not yet had a chance to link the child to care. MCOs have less opportunity to manage the care of these populations. Of the 491,646 children enrolled in HealthChoice for any period of time during CY 2006, approximately 29 percent of these children received one or more dental service (Figure III-32 which is similar to the percentage of children receiving a dental service in CY 2005 (Figure III-33)).

Figure III-32: Percentage of Children Enrolled in HealthChoice who had at Least One Dental Encounter by Age Group, Enrolled for Any Period (CY 2006)

Age Group	Total Number of Eligible Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
0-3 ¹⁷	128,599	10,109	7.9%
4-5	54,058	20,096	37.2%
6-9	96,235	40,743	42.3%
10-14	107,233	42,340	39.5%
15-18	82,028	26,458	32.3%
19-20	23,493	4,318	18.4%
Total	491,646	144,064	29.3%

Figure III-33: Percentage of Children Enrolled in HealthChoice who had at Least One Dental Encounter by Age Group, Enrolled for Any Period (CY 2005)

Age Group	Total Number of Eligible Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
0-3 ⁶	124,358	9,759	7.8%
4-5	54,297	20,487	37.7%
6-9	93,728	39,808	42.5%
10-14	109,822	43,308	39.4%
15-18	87,913	25,532	32.4%
19-20	22,186	4,220	19.0%
Total	483,304	143,114	29.6%

Type of Services

In response to the concern that while access to dental care may have increased, the level of restorative services or treatment may not be adequate, the Department examined the types of dental services that children in HealthChoice receive, including diagnostic, preventive and restorative services. Diagnostic services include evaluation services and oral exams; preventive care includes cleanings, sealants, x-rays, and fluoride treatments; and restorative care includes fillings and crowns.

¹⁷ Most newborns and infants are not expected to use dental services. As a result, the dental service rate for the 0-3 age group should be interpreted with caution.

The findings of the analysis indicate that access to any dental service, as well as access to restorative services, has improved significantly since 1997. Access to any dental service increased from almost 20 percent in SFY 1997 to approximately 46 percent in CY 2006 (Figure III-31) and access to restorative services increased from approximately six percent of all children receiving a restorative service in SFY 1997 to approximately 16 percent in CY 2006 (Figure III-34). The percentage of children receiving a restorative service remains below the anticipated need for low-income children,¹⁸ but is similar to the percentage of low-income children nationally that actually receive a restorative service.¹⁹ There has been a slight increase in restorative dental utilization since a significant 2004 fee increase on twelve restorative dental procedure codes.

Figure III-34: Percentage of Children Receiving Dental Services by Type of Service
Children ages 4-20, Enrolled for at least 320 days

Year	Diagnostic	Preventive	Restorative
SFY 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%
CY 2003	40.8%	37.9%	13.6%
CY 2004	41.0%	38.0%	13.8%
CY 2005	42.7%	39.7%	15.8%
CY 2006	43.7%	40.5%	16.4%

As noted above, utilization rates are lower when analyzed for any period of enrollment versus a period of continuous enrollment. This is because MCOs have less opportunity to manage the care of these populations. Figure III-35 below shows that for children enrolled for any period, 28 percent received a preventative or diagnostic visit in 2006. Of those receiving a preventative or diagnostic visit, approximately 27 percent received a follow-up restorative visit. The CY 2006 rates are similar to those in CY 2005.

Figure III-35: Preventive/Diagnostic Visits followed by a Restorative Visit by HealthChoice Children Enrolled for Any Period (Age 0-20)

Year	Total Enrollees	Preventative / Diagnostic Visit	Preventative / Diagnostic Visit followed by Restorative Visit
CY 2005	483,304	136,183 (28.2%)	36,001 (26.4%)
CY 2006	491,646	137,826 (28.0%)	36,675 (26.6%)

Although there has been a modest utilization increase in restorative visits since the implementation of the fee increase in 2004, barriers to receiving restorative care remain.

¹⁸ Vargas, et al. "Oral Status of Preschool Children Attending Head Start in Maryland, 2000" in Pediatric Dentistry, June 2002.

¹⁹ Macek, et al. "An Analysis of Dental Visits in US Children, by Category of Service and Sociodemographic Factors, 1996," in Pediatric Dentistry, May 2001.

Children not receiving needed restorative care may ultimately seek care in an emergency room. In CY 2006, 1,809 children with any period of enrollment visited the emergency room with a dental diagnosis (Figure III-36). For this measure, a dental diagnosis is included regardless of whether the diagnosis appeared in the primary or secondary field. Dental services provided in the ER exclude accidents, injury and poison.

Figure III-36: Emergency Room Visits with a Dental Diagnosis by HealthChoice Children Enrolled for Any Period (Age 0-20)

Year	Total Enrollees	Enrollees who had an ER visit with a Dental Diagnosis	Number of Encounters for ER Visits with a Dental Diagnosis
CY 2005	483,304	1,685	1,872
CY 2006	491,646	1,809	2,117

Pregnant Women

Prior to the implementation of HealthChoice in 1997, adult dental care was not covered under Medicaid. Starting in 1998, however, MCOs must provide dental services to pregnant women. The proportion of pregnant women 21 and over enrolled for at least 90 days receiving dental services was approximately 15 percent in CY 2006 (Figure III-37). The percentage of pregnant women 21 and over enrolled for any period receiving a dental service in 2006 was approximately 14 percent (Figure III-38). There is no comparable HEDIS measure for dental services for pregnant women.

Figure III-37: Percentage of Pregnant Women 21+ Receiving Dental Services Enrolled for at least 90 days

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 1999	17,914	2,474	13.8%
CY 2000	18,514	2,843	15.4%
CY 2001	19,644	3,109	15.8%
CY 2002	21,112	3,063	14.5%
CY 2003	21,819	4,140	19.0%
CY 2004	21,412	3,102	14.5%
CY 2005	23,088	3,354	14.5%
CY 2006	20,756	3,187	15.4%

Figure III-38: Percentage of Pregnant Women 21+ Receiving Dental Services Enrolled for Any Period

Year	Total Number of Enrollees	Enrollees Receiving \geq One dental service	Percent receiving service
CY 2005	37,559	5,010	13.3%
CY 2006	38,868	5,268	13.6%

Adults

Apart from those dental services covered for pregnant women, adult dental services are not required to be covered under HealthChoice and therefore, are not included in the MCO capitation rates. In 2005, five MCOs spent approximately \$3.9 million²⁰ to provide adult dental services. An analysis shows that approximately 10 percent of adults enrolled for at least 90 days received at least one dental service in CY 2006, when five MCOs provided an adult dental benefit (Figure III-39). The drop in the percent receiving services between 2004 and 2006 may be attributable to some MCOs scaling back the optional adult dental benefit.²¹ As of July 2007, all seven MCOs have opted to provide a limited adult dental benefit package. If the State decides to contract with an ASO provider, adults may lose these basic benefits unless additional State funding is allocated for adult dental services.

**Figure III-39: Percentage of Adults 21+Receiving Dental Services
Enrolled for at least 90 days**

Year	Total Number of Enrollees	Enrollees Receiving one or more dental service	Percent receiving service
CY 1999	111,753	16,139	14.4%
CY 2000	114,223	16,986	14.9%
CY 2001	111,694	16,795	15.0%
CY 2002	117,885	16,800	14.3%
CY 2003	116,880	21,288	18.2%
CY 2004	115,441	12,457	10.8%
CY 2005	116,266	11,093	9.5%
CY 2006	114,844	11,747	10.2%

2. Emergency Department Utilization

The primary role of the emergency department (ED) is the treatment of seriously ill and injured patients. ED visits should not occur for conditions that can be treated in an ambulatory care setting. HealthChoice was expected to lower ED use based on the premise that a managed care system is capable of promoting ambulatory care, thereby reducing the need for emergency services. MCOs provide enrollees with a medical home and implement disease management programs that encourage enrollees to access preventive care. These initiatives help enrollees manage their chronic conditions. However, during the first few years of HealthChoice, ED visit rates unexpectedly increased.²² The 2002 evaluation found that by 2001, ED use among HealthChoice enrollees had leveled off.

²⁰ This number may differ from other reported adult dental costs. Previous estimates estimated the costs based on Medicaid fee-for-service costs, not actual expenditures.

²¹ Three MCOs scaled back their adult dental package in CY 2004. Starting in CY 2006 and 2007, these MCOs, however, increased their adult dental benefit packages.

²² Emergency department (ED) visits are defined as hospital emergency department visits that do not lead to hospitalizations.

In Maryland, and across the United States, the past decade has seen substantial increases in the utilization of ED services in both the public and private sectors. In line with this trend, Maryland's HealthChoice program has experienced an increase in the volume of services provided by hospital EDs in recent years. This experience is not limited to HealthChoice. The Maryland Medicaid population served outside of HealthChoice by the fee-for-service system also has increasing rates of ED use. This trend has raised concerns about access to care and the use of the ED for problems that are non-emergent or potentially preventable with access to primary care. In October 2007 the Department completed a report to the General Assembly on ED use by all Medicaid enrollees, including both HealthChoice and fee-for-service populations. The report outlines the most common diagnoses for frequent ED users, reports rates of use by different demographic groups, and provides recommendations to reduce inappropriate ED use. The report is included as Appendix IV.

Figure III-40 indicates an increase in overall HealthChoice ED visit rates between CY 2002 and CY 2006 (from approximately 26 to 28 percent). Enrollees with disabilities in the disabled coverage groups are more likely to receive an ED visit than enrollees in any other HealthChoice coverage group. ED use by enrollees in the SOBRA eligibility category (pregnant women and children in families with incomes higher than TANF and lower than MCHP) increased steadily over the five year period. Further analysis of ED use by individuals with disabilities is shown below.

Figure III-40: Emergency Department Use by Coverage Group, 2002 through 2006

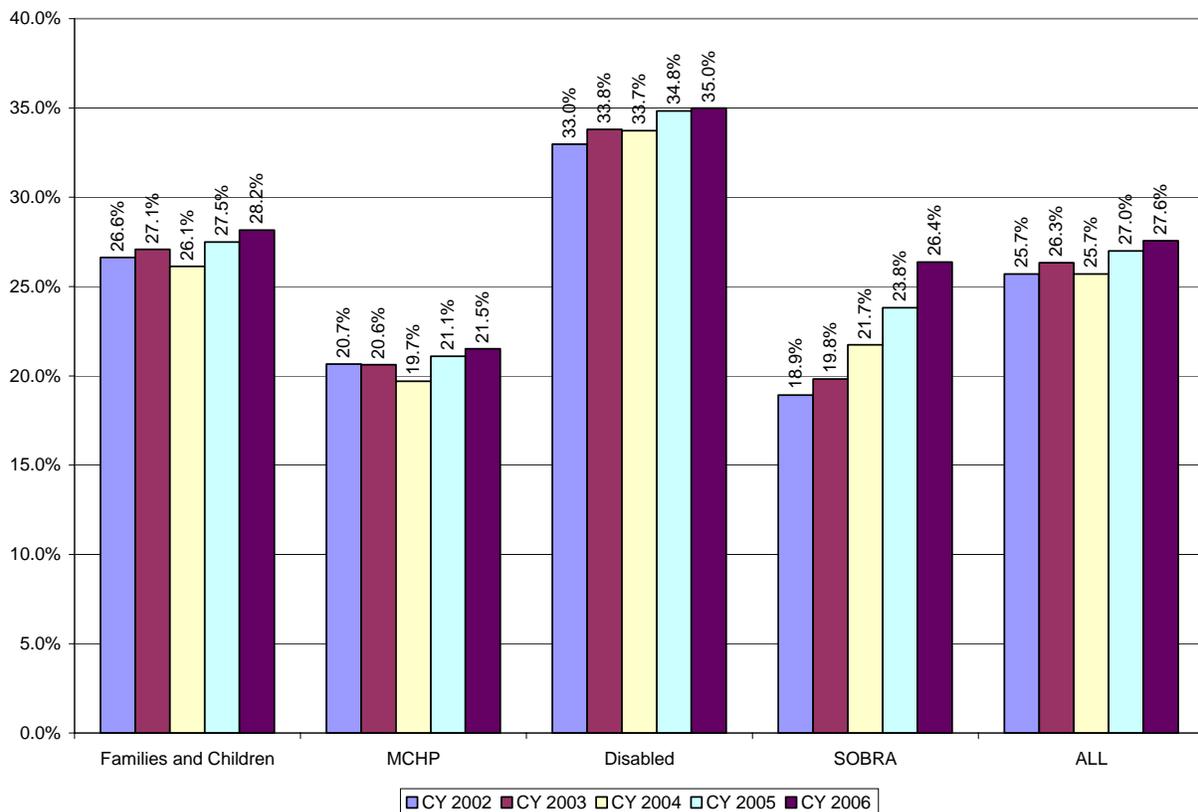
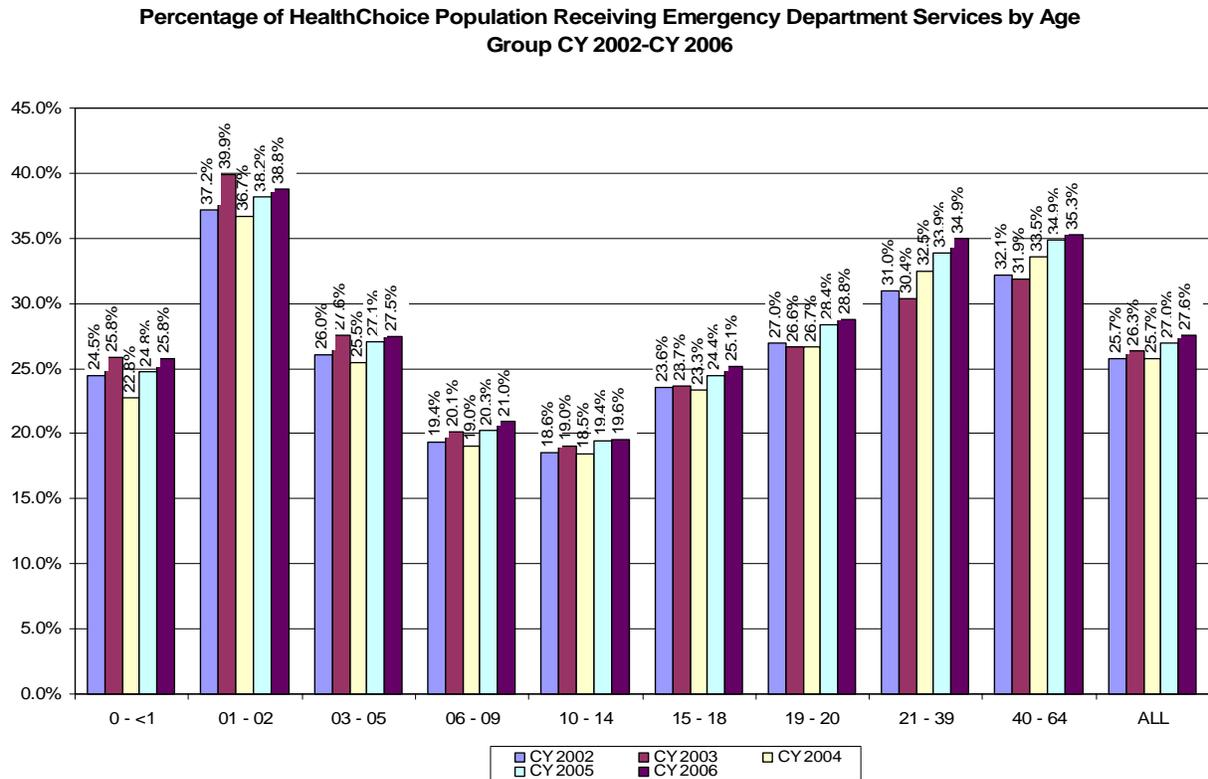


Figure III-41 shows ED use by age. Children in the one through two years age range experienced the highest ED visit rate in each of the five years studied, while children in the six through 14 age range had the lowest rate. This is consistent with national data on ED use by age.

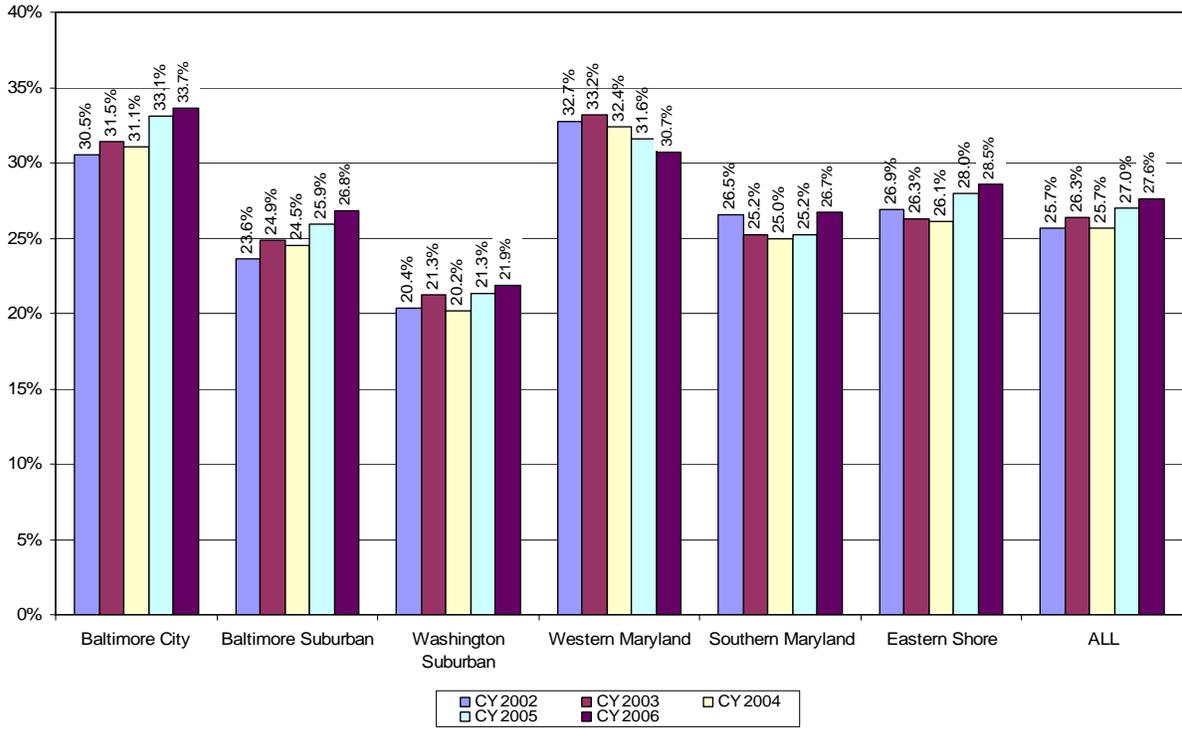
Figure III-41: Emergency Department Use by Age Group, 2002 through 2006



ED utilization increased in five out of the six regions (Figure III-42). Rates are highest in Baltimore City and Western Maryland and lowest in the Washington Suburban region.

Figure III-42: Emergency Department Use by Region, 2002 through 2006

**Percentage of HealthChoice Population Receiving Emergency Department Services by Region
CY 2002-CY 2006**



3. Appropriateness of Emergency Department Care

In recent years, there has been increased national focus on ED use among health care consumers in both the public and private sectors. A fundamental goal of managed care programs such as HealthChoice has always been the delivery of the right care at the right time in the right setting. One widely used methodology to evaluate this goal is based on the classifications developed by researchers at the New York University Center for Health and Public Service Research (NYU) in collaboration with the United Fund of New York. This methodology classifies emergency visits as follows:

- 1) *non-emergent* - immediate care not required within 12 hours based on the patient's vital signs, presenting symptoms, medical history, and age
- 2) *emergent but primary care treatable* - treatment was required within 12 hours, but it could have been provided effectively in a primary setting; e.g., CAT scan or certain lab tests
- 3) *emergent ED care needed, preventable/avoidable* - emergency care was required, but the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness, e.g., flare-ups of asthma
- 4) *emergent, ED care needed, not preventable/avoidable* - ambulatory care could not have prevented the condition; e.g., trauma or appendicitis
- 5) *injury* –injury principal diagnosis
- 6) *mental health* –mental health principal diagnosis
- 7) *alcohol-related* –alcohol-related principal diagnosis
- 8) *drug-related* –drug-related principal diagnosis
- 9) *unclassified* –conditions that could not be classified due to insufficient sample sizes available to the expert panel.

ED visits falling into categories one through three may serve as an indicator of problems with access to primary care. Overall, approximately 59 percent of all ED visits among HealthChoice enrollees were for a form of non-emergent ED care which could have been avoided or prevented with timely and quality primary care (combining *non-emergent*, *emergent but primary care treatable*, and *emergent, ED care needed, preventable/avoidable*).

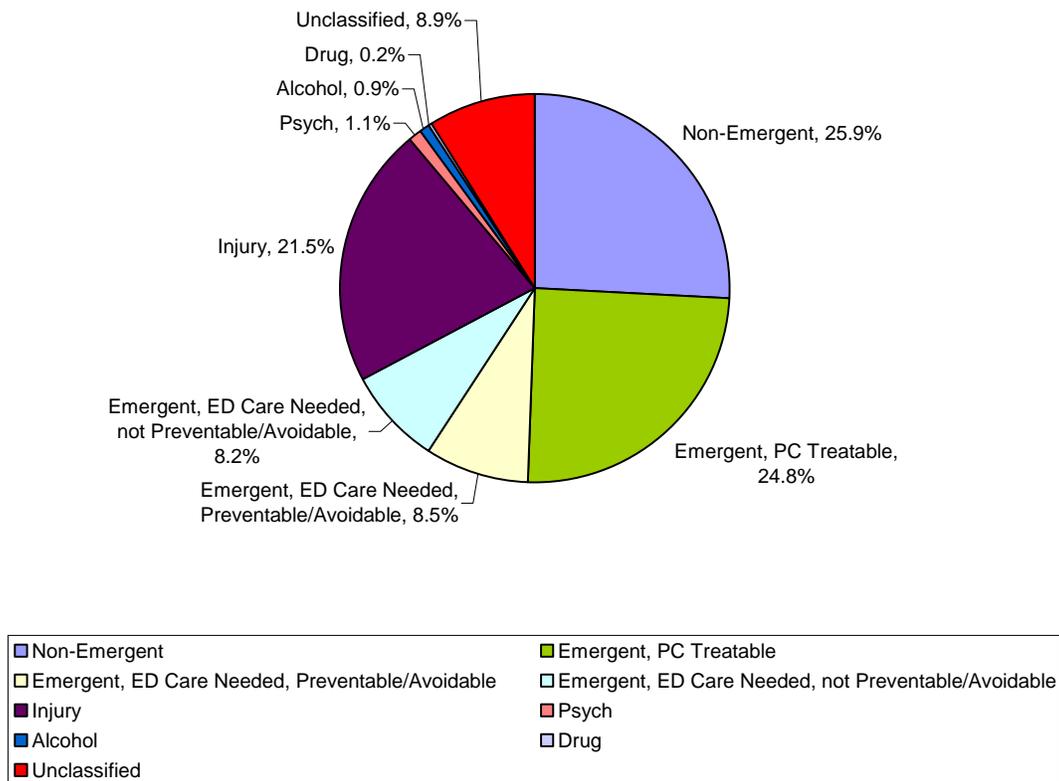
The HealthChoice rate of 59 percent is higher than the rate of approximately 47 percent for the overall Medicaid population. This is most likely due to differences in the populations. The fee-for-service population has poorer health status. It is comprised of individuals in nursing facilities, individuals eligible for Medicaid because of high medical expenditures (the “spend-down” coverage groups), individuals dually eligible for Medicare and Medicaid, and individuals in the Rare and Expensive Case Management (REM) program. Given their poorer health status, individuals outside of HealthChoice are more likely to present at the ED with truly emergent needs.

ED visits falling in categories four and five are the least likely to be prevented with access to primary care or other medical interventions. These two categories- *injury and emergent, ED care needed, non-preventable/avoidable ED visits* -- accounted for about

30 percent of all ED visits by HealthChoice enrollees. Figure III-43 below shows the analysis of ER visits for the HealthChoice population in CY 2006. This distribution has held fairly constant for the past five years.

Figure III-43: Classification of ER Visits, 2006

Classification of ER Visits for the Medicaid Population, CY 2006



4. Emergency Department Use by Individuals with Disabilities

As shown above, individuals in the disabled Medicaid coverage groups are more likely to use the ED than other Medicaid enrollees. The Department further explored ED use by individuals with disabilities. The average number of ED visits per enrollee was 1.8 for the overall HealthChoice population in 2006. It was 2.7 for individuals with disabilities. Figure III-44 shows the frequency distribution of ED visits among HealthChoice enrollees in the disabled and non-disabled coverage categories.

Figure III-44: Number of Emergency Department (ED) Visits for Disabled and Non-Disabled Enrollees in the HealthChoice Program, CY 2006

Number of Visits	Disabled		Non-Disabled	
	Frequency	Percent	Frequency	Percent
0	49,904	64.8%	401,448	73.4%
1	13,566	17.6%	92,238	16.9%
2	5,821	7.6%	30,856	5.6%
3	2,916	3.8%	11,724	2.1%
4	1,541	2.0%	5,025	0.9%
5	951	1.2%	2,383	0.4%
6	579	0.8%	1,203	0.2%
7	403	0.5%	662	0.1%
8	268	0.3%	366	0.1%
9	223	0.3%	215	0.0%
10	154	0.2%	124	0.0%
10-20	542	0.7%	296	0.1%
21-30	85	0.1%	24	0.0%
31-40	46	0.1%	5	0.0%
41-50	20	0.0%	2	0.0%
51-100	30	0.0%	3	0.0%
101+	9	0.0%	0	0.0%
ALL	77,058	100.0%	546,574	100.0%

Figure III-44 shows that most disabled and non-disabled enrollees do not use the ED at high rates. Ninety percent of individuals with disabilities and 96 percent of individuals without disabilities had two or fewer visits to the ED. However, a higher proportion of individuals with disabilities account for high-end users. Nine enrollees visited the ED on more than 100 occasions in CY 2006, and all nine enrollees were members of the disabled coverage category.

The NYU classification of the appropriateness of ED use was applied to compare the disabled and non-disabled populations. Figure III-45 shows the majority of ED visits for both the disabled and non-disabled enrollees were considered non-emergent, or potentially preventable/avoidable with access to timely and quality primary care. However, the rate of these primary care sensitive ED visits was higher among the non-disabled (60.5 percent vs. 54.7 percent).

Figure III-46 below shows a breakdown of the ED visits that fall into the “other” category in Figure III-45. The non-disabled category has a higher rate of ED visits classified as injury/poisoning, while the disabled category has a larger number of visits with a primary diagnosis of either psychological or alcohol.

Figure III-45: NYU Classification of Outpatient Emergency Department (ED) visits by Coverage Category for the HealthChoice Population, CY 2006

Coverage Category	Non-Emergent	Emergent, PC Treatable	Emergent, Preventable/Avoidable	Emergent, Not Preventable/Avoidable	Other ²³	ALL
Disabled	23.5%	22.2%	9.0%	10.8%	34.5%	100.0%
Non-Disabled	26.7%	25.5%	8.3%	7.4%	32.1%	100.0%
All HealthChoice	25.9%	24.8%	8.5%	8.2%	32.6%	100.0%

Figure III-46: Breakdown of NYU's "Other" Category, CY 2006

Coverage Category	Injury	Psychological	Alcohol	Drug	Unclassified	ALL
Disabled	18.1%	2.8%	3.1%	0.7%	9.8%	34.5%
Non-Disabled	22.4%	0.7%	0.2%	0.1%	8.7%	32.1%
All HealthChoice	21.5%	1.2%	0.9%	0.2%	8.9%	32.6%

5. Mental Health Services

Specialty mental health services are carved out of the MCO benefit package, and are administered by the DHMH Mental Hygiene Administration's (MHA) administrative service organization (ASO). MHA annually surveys clients and asks them to rate their public mental health services. The results for the SFY 2006 adult and child surveys are attached (Appendices V and VI). Specialty mental health services are defined as any mental health services other than those provided by a primary care provider. MCOs are not accountable for specialty mental health service delivery, and therefore annual MCO reports do not assess these services. However, specialty mental health services are still part of the 1115 Waiver.

The Department applied HEDIS-like criteria to fee-for-service claims and encounter data to assess two indicators of mental health care: follow-up after hospitalization for mental illness, and appropriate medication management for adults diagnosed with depression.

The first measure, follow-up after hospitalization for mental illness, assesses the percentage of discharges for enrollees ages 6 years and older who were hospitalized for treatment of mental health disorders and had a mental health visit within seven days of the discharge date or within 30 days of the discharge date. Figure III-47 below displays these percentages for each year of the evaluation period, 2002 through 2006. Performance on both components of this measure remained relatively consistent across the study period.

²³ The "other" category is comprised of ER visits that fall in the following classifications: injury/poisoning, mental health, alcohol-related, drug-related, and unclassified.

Figure III-47: HEDIS Measure: Follow-Up After Hospitalization for Mental Illness, 2002 through 2006

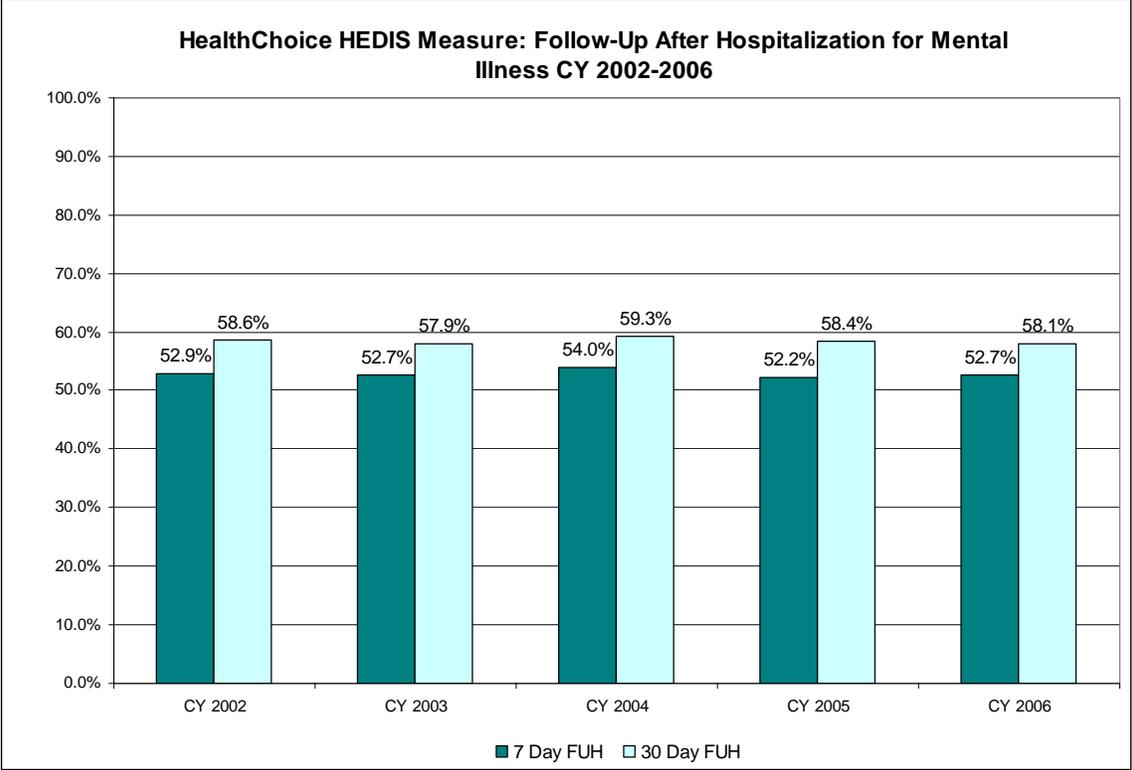


Figure III-48: HEDIS Measure: Follow-Up After Hospitalization for Mental Illness, 2002 through 2006 (National Comparison)

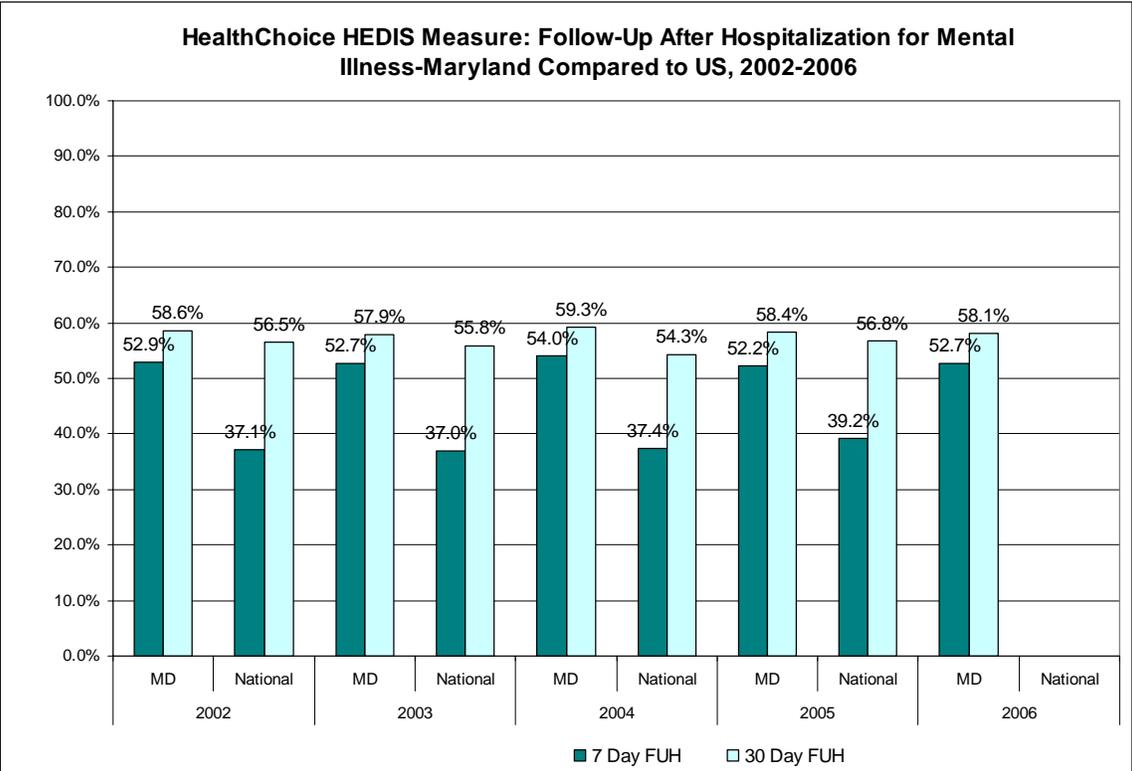


Figure III-48 above compares Maryland's performance on this indicator to national Medicaid averages. Although Maryland's performance is below 100 percent, Maryland's indices are above national averages across the study period.

The second measure, antidepressant medication management (AMM), assesses three components of the pharmacological management for adults ages 18 years and older diagnosed with depression and treated with antidepressants during the year.

The first component measures the percentage of adults diagnosed with a new episode of depression who were treated with antidepressants, and received at least three follow-up visits with a health care practitioner during the 84-day period after initial diagnosis.

The second component includes the percentage of adults diagnosed with a new episode of depression who were treated with antidepressants, and remained on the drug for the 84-day period after the initial diagnosis.

The third component of the measure assesses the percentage of adults diagnosed with a new episode of depression who were treated with antidepressants, and remained on the drug for the 180-day period after the initial diagnosis of depression.

Figure III-49 presents the results for 2003 through 2006.²⁴ Performance on the follow-up visit measure improved each year during the study period, increasing by 22 percentage points, while performance on the other two measures remained fairly stable. Some of the increase between 2003 and 2004 may be due to changes in coding practices between those years. Because local codes used in 2003 and 2004 were not picked up in this analysis, the results for the follow-up measure in 2003 and 2004 may be artificially low.

Figure III-50 compares HealthChoice performance with the national Medicaid average for this measure. For most years, Maryland performed lower than the national average for each component of this measure.

²⁴ CY 2002 is not included because HEDIS' specification for this measure includes data from the prior calendar year, i.e., the CY 2002 AMM measure would include data from May 1, 2001 through April 30, 2002.

Figure III-49: HEDIS Measure: Antidepressant Medication Management, 2003 through 2006

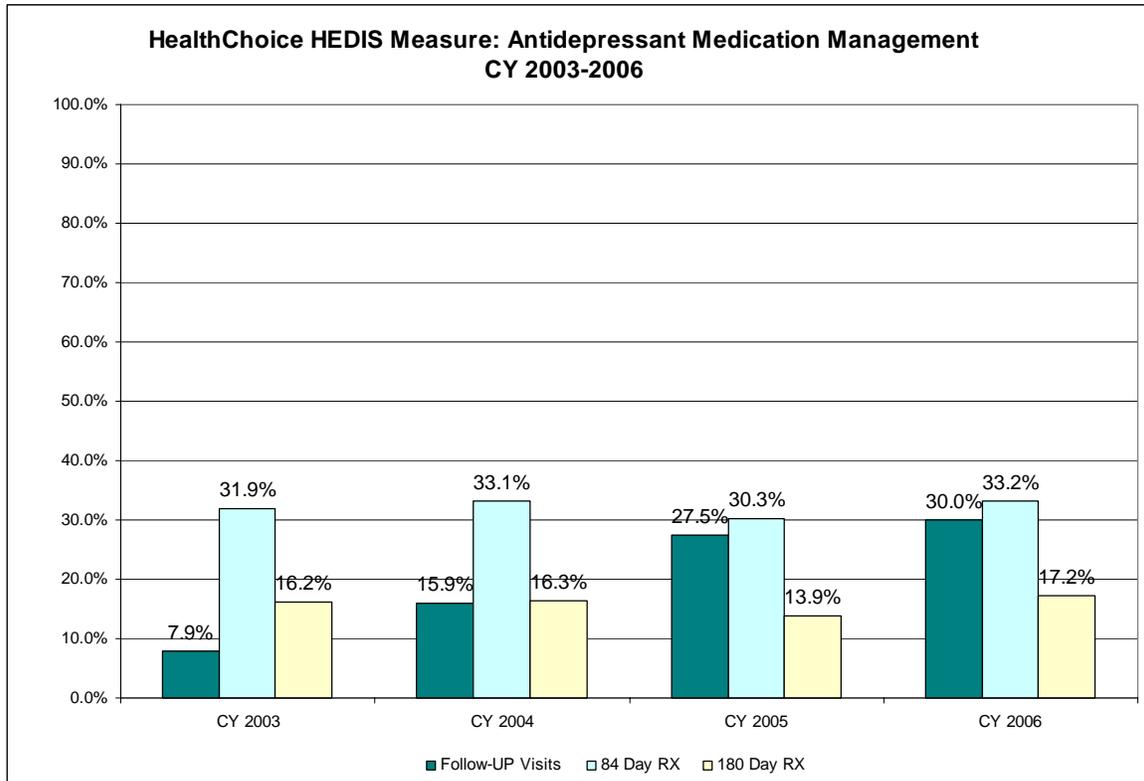
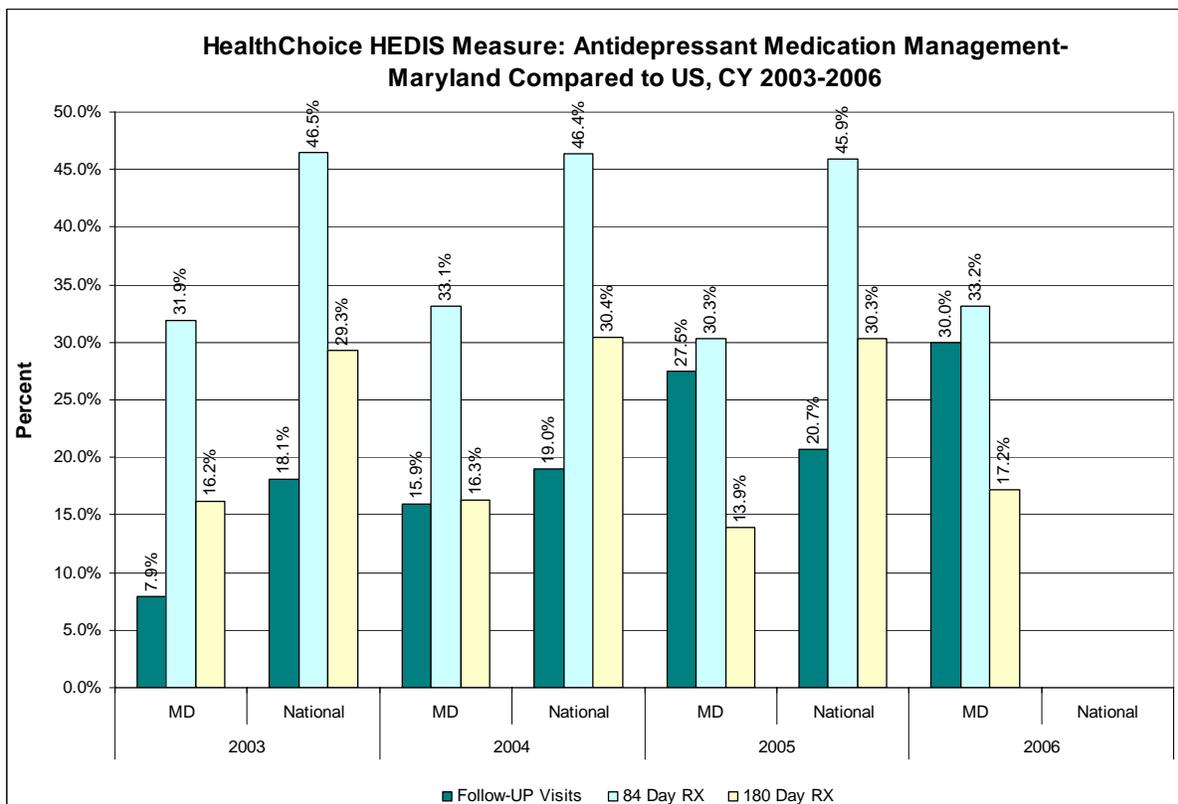


Figure III-50: HEDIS Measure: Antidepressant Medication Management, 2003 through 2006 (National Comparison)



6. Substance Use Treatment

In recent months, the Department has placed a renewed focus on substance abuse treatment under HealthChoice, at the request of substance abuse providers and advocates. The Department is committed to ensuring access to substance abuse treatment, including buprenorphine. The following analyses show the prevalence of substance use disorder among HealthChoice enrollees, the prevalence of co-occurring substance use disorder and mental illness, and substance use disorder treatment rates for both of these populations. These analyses used both fee-for-service claims and MCO encounter data. Substance use disorder was identified by substance use dependence diagnosis, substance abuse diagnosis, or treatment codes clearly identified with substance use (such as methadone). Tobacco addiction was excluded. Treatment was defined as any service with a substance use treatment code, ambiguous codes (such as therapy, but not explicitly substance use therapy) linked directly to a substance use disorder diagnosis, and buprenorphine. If an individual with substance use disorder received services that did not fall under these categories, those services were not counted as treatment.

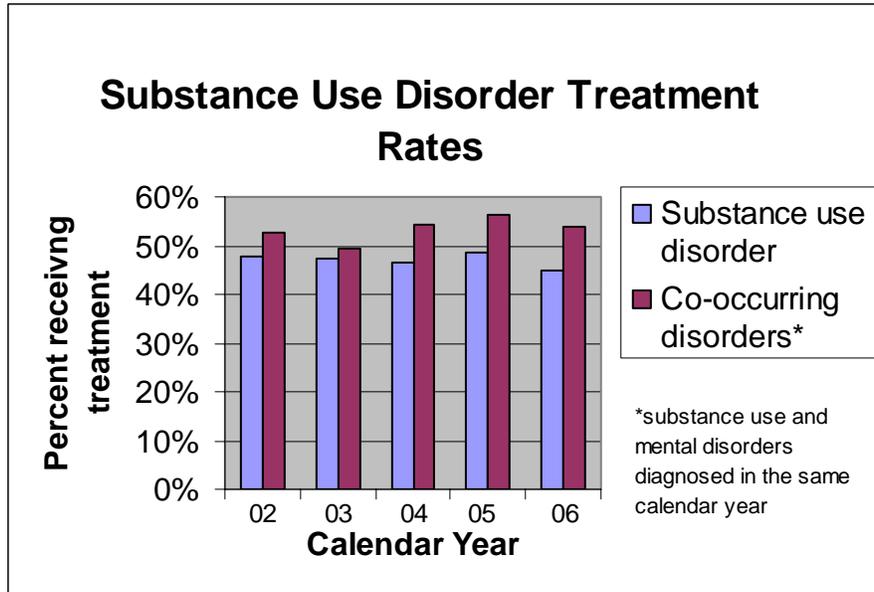
Figure III-51 shows the counts of individuals with substance use disorder, individuals with co-occurring disorders, and individuals receiving substance use treatment. This shows a rate of substance use disorder among the HealthChoice population of approximately four to five percent. This rate is consistent with national studies of the prevalence of substance use disorder.

Figure III-51: Prevalence of Substance Use Disorder, Co-Occurring Disorders, and Substance Use Treatment

	CY2002	CY2003	CY2004	CY2005	CY2006
Substance use disorder	18,415	20,499	23,907	24,819	26,170
Co-occurring disorders	6,138	7,638	9,227	10,219	10,762
Treatment for Substance Use Disorder	8,759	9,739	11,104	12,012	11,768

Figure III-52 shows the rate of substance use treatment for this population. Close to half of all individuals with substance use disorder receive substance use treatment. Individuals with co-occurring disorders experience slightly higher rates of substance use treatment. Utilization has not increased steadily between 2002 and 2006. Treatment other than specifically identified as substance use treatment, such as general primary care office visits, are not counted in these rates.

Figure III-52: Substance Use Disorder Treatment Rates



The following analyses break out substance use treatment by age, geographic region, Medicaid eligibility category, and race/ethnicity. For all of these, substance use treatment rates are higher for individuals with co-occurring disorders than for individuals with substance use disorder only. Figure III-53 shows treatment by age. Treatment rates generally increase through mid-life and decline slightly before age 65. Treatment rates for youths ages 10 to 14 have been more sporadic, with a marked low in 2003 among youths with co-occurring disorders. This may be related to the relatively low numbers of enrollees in the 10 to 14 age group.

Figure III-53: Substance Use Treatment by Age

Percent of those with Substance Use Disorders (and those with co-occurrence of substance use and mental disorders- co) Receiving at Least One Substance Use Treatment Service by Age Group

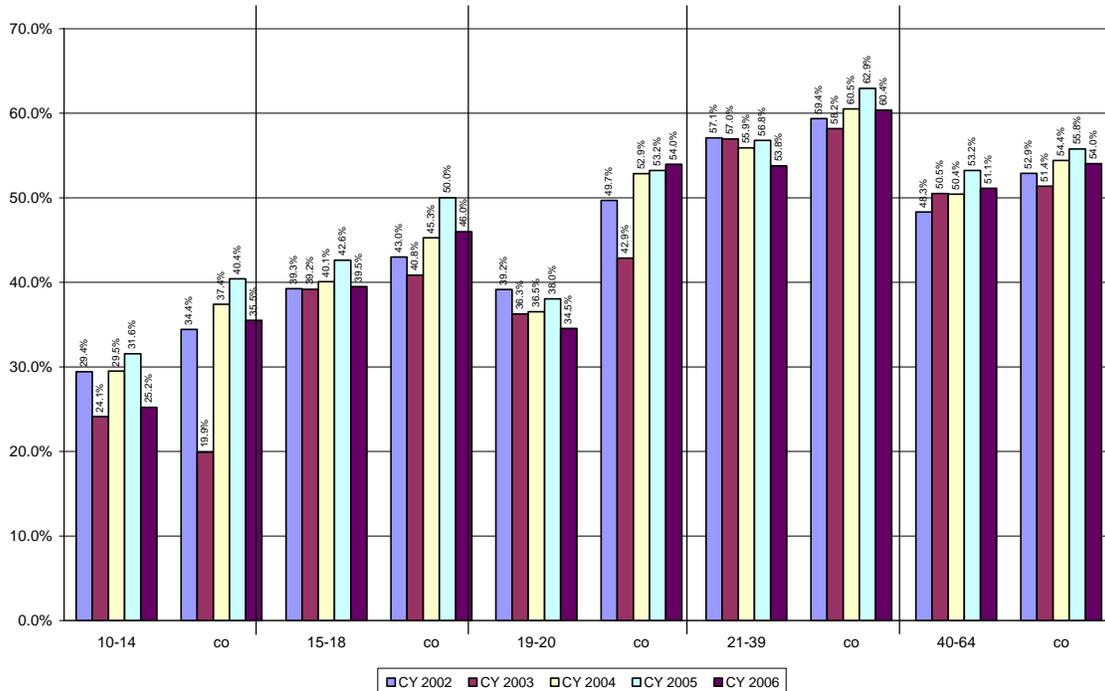
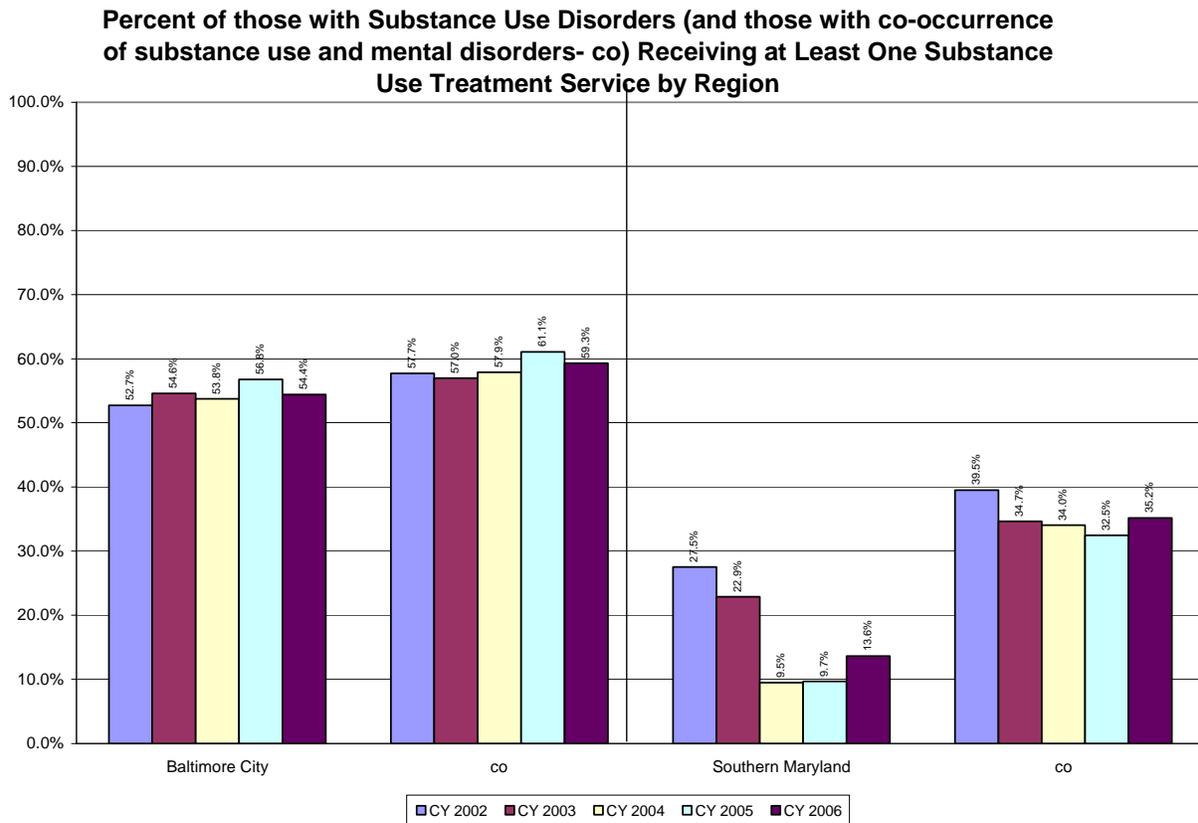


Figure III-54 shows findings for Baltimore City and Southern Maryland, which represent the two geographic extremes for treatment rates. Baltimore City experienced the highest rates, with a high of approximately 61 percent in 2005 for individuals with co-occurring disorders. Other regions generally demonstrated rates approximately 10 percentage points lower than Baltimore City. Southern Maryland experienced a low of approximately 10 percent in 2004 and 2005 for individuals with substance use disorder only.

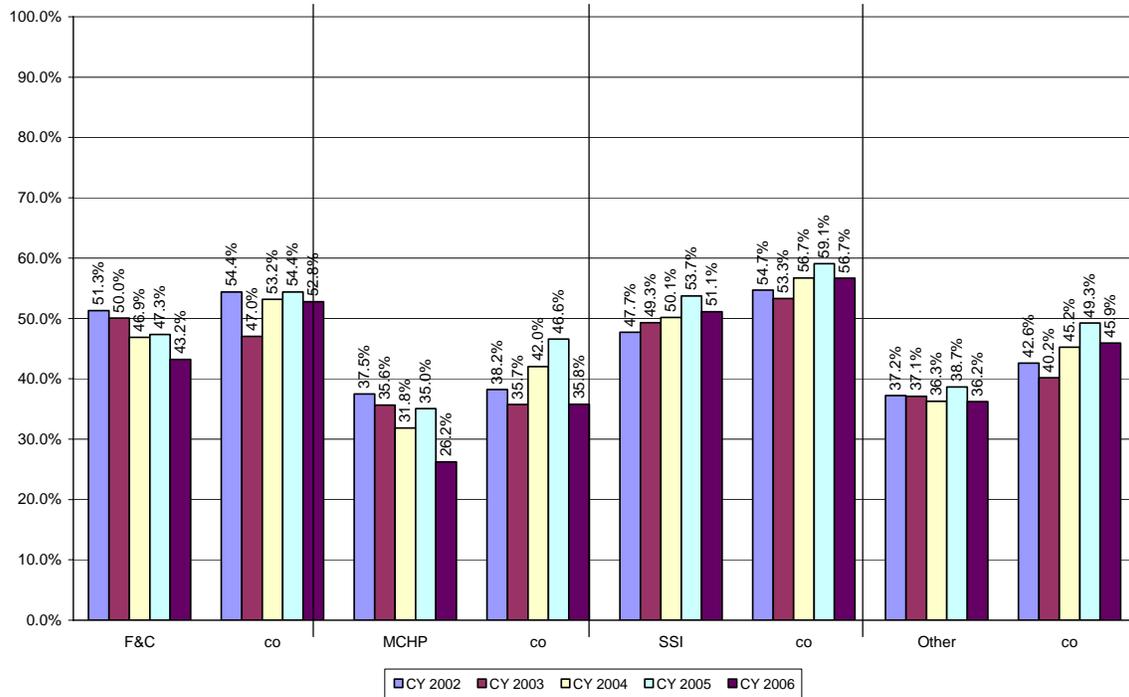
Figure III-54: Substance Use Treatment by Region



Analysis of substance use treatment by Medicaid eligibility category shows that treatment rates are highest for individuals with co-occurring disorders who are in the disabled category (Figure III-55). This follows expectations, since coverage through the disability category and presence of co-occurring disorders may indicate a higher level of severity of substance use disorder.

Figure 55: Substance Use Treatment by Coverage Group

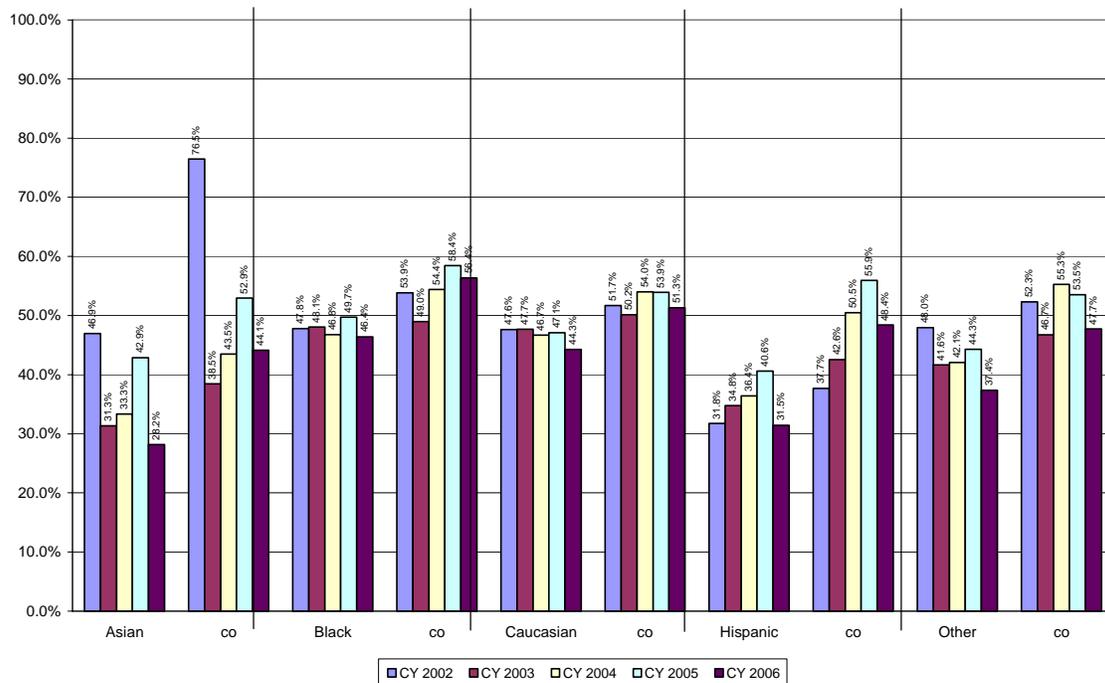
Percent of those with Substance Use Disorders (and those with co-occurrence of substance use and mental disorders- co) Receiving at Least One Substance Use Treatment Service by Eligibility Category



The last analysis of substance use treatment shows treatment rates by race and ethnicity (Figure III-56). Treatment rates are similar for African Americans and Whites, and are generally lower for Latinos and Asians. However, rates for Asians in particular vary widely over time. This may be in part to the small size of the Asian population in this analysis.

Figure III-56: Substance Use Treatment by Race

Percent of those with Substance Use Disorders (and those with co-occurrence of substance use and mental disorders- co) Receiving at Least One Substance Use Treatment Service by Race



E) SPECIAL POPULATIONS

1. Foster Care

Children in foster care are a vulnerable population and tend to have higher physical and mental health needs than the general population of children eligible for Medicaid. In recognition of this, HealthChoice includes some special provisions for children in foster care. The Department monitors rates of utilization for children in foster care, and shares findings with its sister agencies that serve foster children. These analyses examine utilization by children who were in foster care for any length of time during the year. Children in subsidized adoption are excluded.

The first set of measures examined encounter data as well as fee-for-service claims to assess utilization of ambulatory care and well-child care. Children in foster care have a two-month period of fee-for-service enrollment when they enter foster care and gain Medicaid eligibility, before they are assigned to an MCO. During this period foster children are to receive placement exams. Therefore it is important for these analyses to use fee-for-service claims so as to not underreport service utilization. Figure III-57 compares 2002 and 2006 regarding the percentage of children in foster who received at least one ambulatory visit during the year. Results are broken out by age. Utilization increased between 2002 and 2006 for all age groups to 74 percent. Utilization was higher for the youngest children.

Figure III-57: Ambulatory Care for Foster Children by Age

Percentage of HealthChoice Foster Care Enrollees Receiving an Ambulatory Visit by Age
CY2002 and CY2006

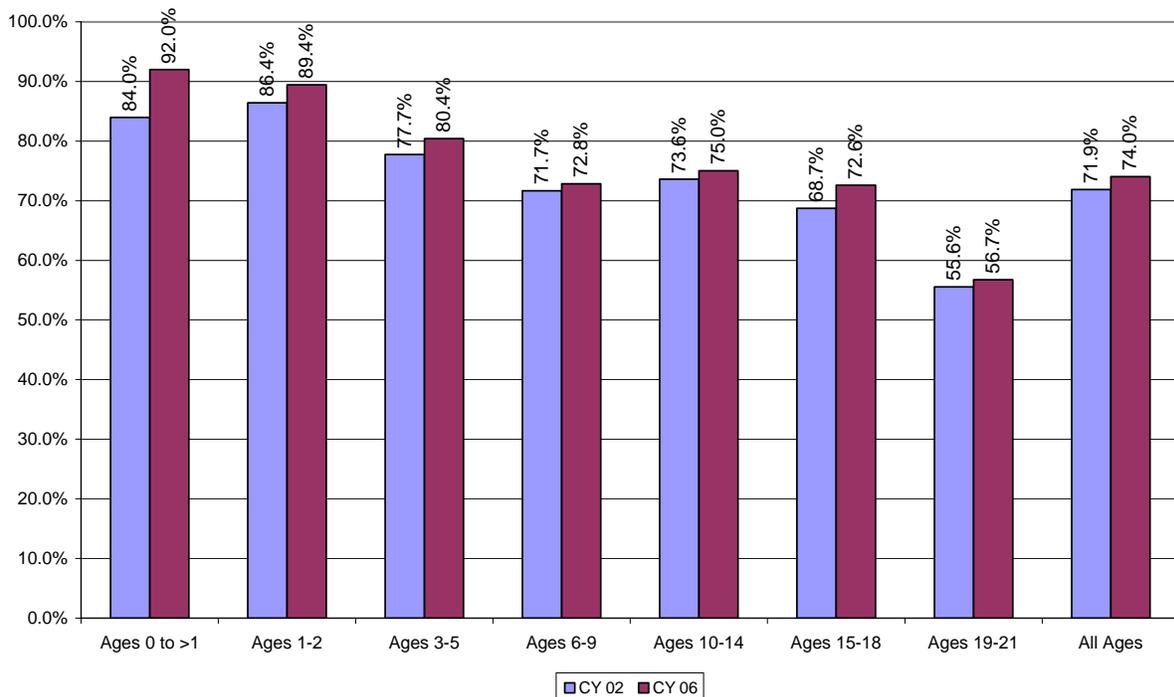


Figure III-58 compares ambulatory care utilization in 2002 and 2006, broken out by region. Approximately half of children in foster care are in Baltimore City, which was one of the three jurisdictions with the highest utilization. Utilization dropped in Western Maryland.

Figure III-58: Ambulatory Care for Foster Children by Region

Percentage of HealthChoice Foster Care Enrollees Receiving an Ambulatory Visit by Region
CY2002 and CY2006

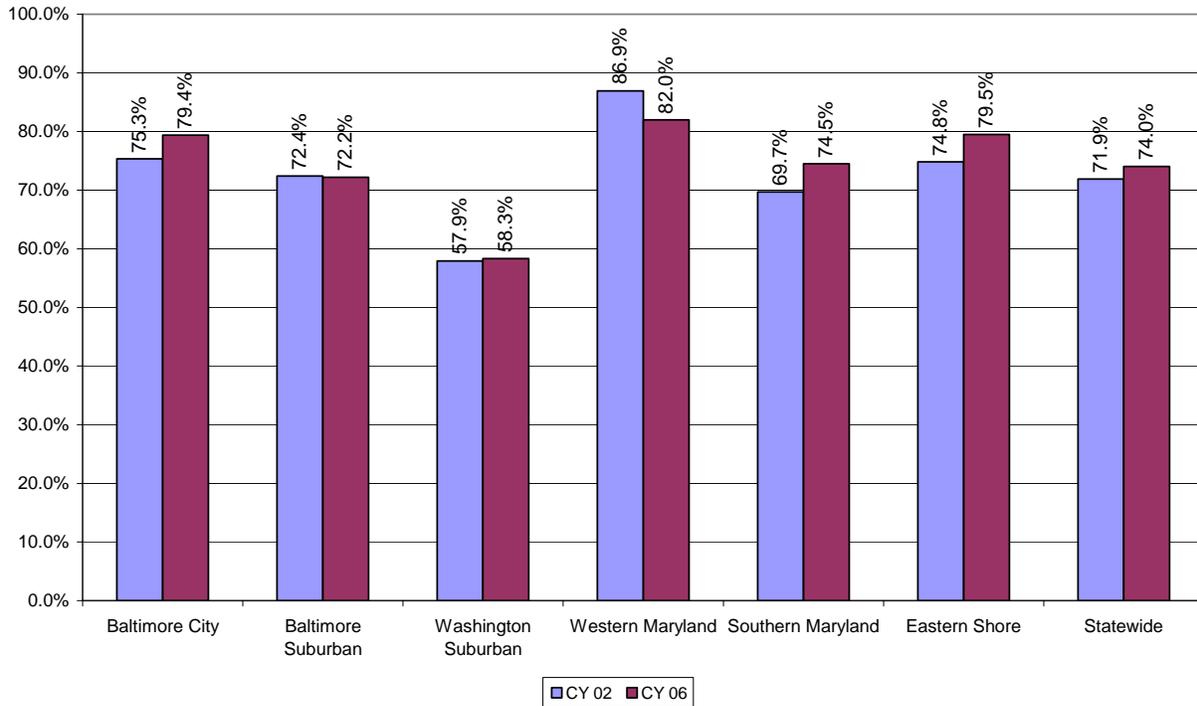


Figure III-59: Ambulatory Care for Foster Children and HealthChoice, by Age

Percentage of HealthChoice Non-Foster Care Children and Foster Care Children (Ages 0-21)
Receiving an Ambulatory Visit by Age CY2006

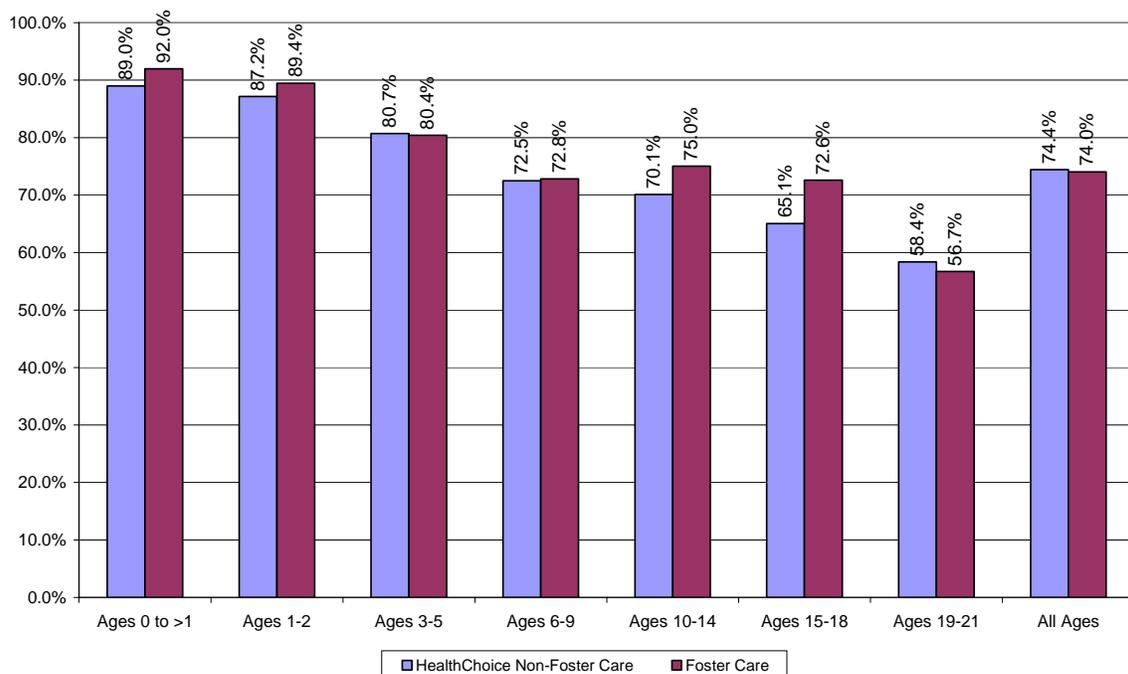
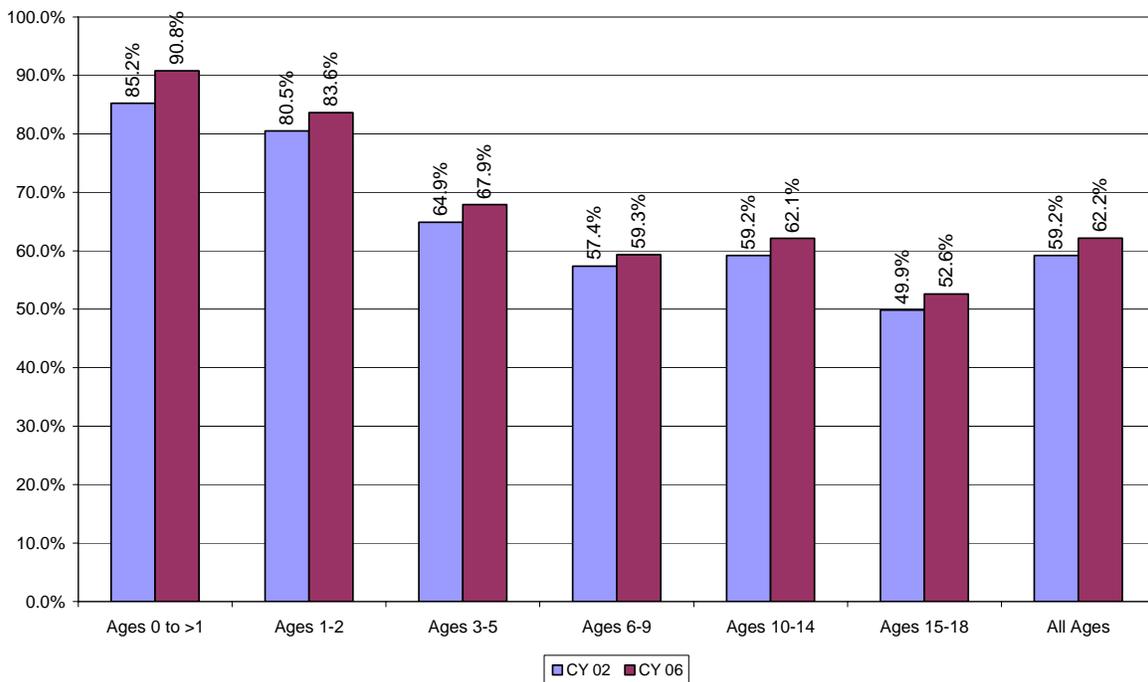


Figure III-59 above shows that when compared to the other children in HealthChoice, children in foster care utilize ambulatory care services at similar rates. The youngest foster children and adolescents utilized services at higher rates compared to other HealthChoice children.

The Department examined utilization of well-child care for children in foster care. Figure III-60 shows that rates of utilization of well-child care increased for all ages between 2002 and 2006, and is highest among the youngest children.

Figure III-60: Well-Child for Foster Children by Age

Percentage of HealthChoice Foster Care Enrollees Receiving a Well-Child Visit by Age
CY2002 and CY2006



Analysis of well-child care by geographic region shows that utilization is highest for Baltimore City, at approximately 71 percent (Figure III-61).

The comparison of children in foster care to other children in HealthChoice in Figure III-62 below shows that foster children in all other age categories except those under one have higher rates of well-child utilization compared to other children in HealthChoice.

Figure III-61: Well-Child for Foster Children by Region

Percentage of HealthChoice Foster Care Enrollees Receiving a Well-Child Visit by Region
CY2002 and CY2006

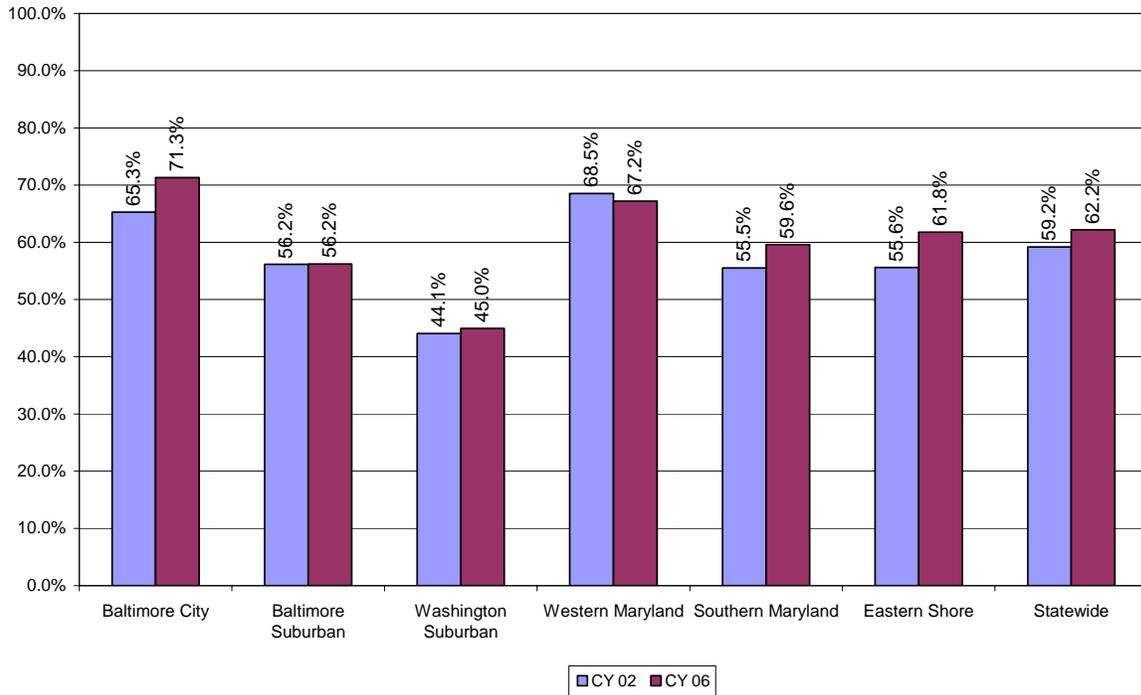
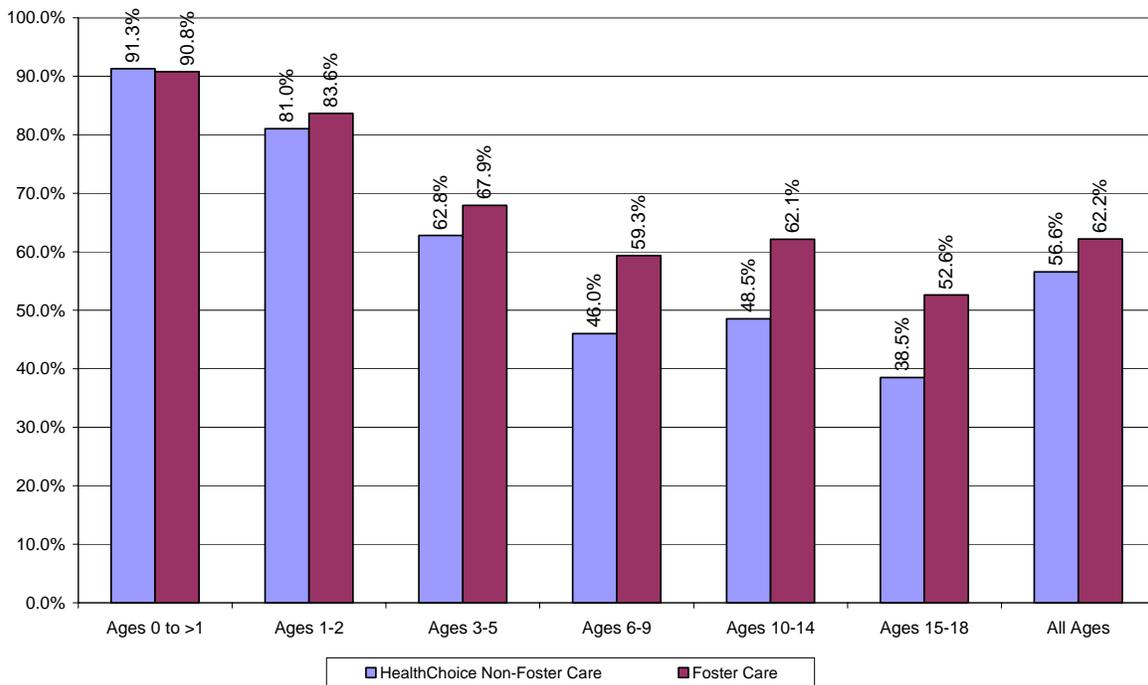


Figure III-62: Well-Child for Foster Children and HealthChoice, by Age

Percentage of HealthChoice Non-Foster Care Children and Foster Care Children (Ages 0-18)
Receiving a Well-Child Visit by Age CY 2006



ED use by foster children increased between 2002 and 2006, following general nationwide trends. Adolescents and children ages one to two years were the highest utilizers (Figure III-63). ED use increased in Baltimore City and decreased in Western Maryland between 2002 and 2006 (Figure III-64).

Figure III-63: Emergency Department Use by Foster Children, by Age

Percentage of HealthChoice Foster Care Enrollees Receiving an ED Visit by Age CY2002 and CY2006

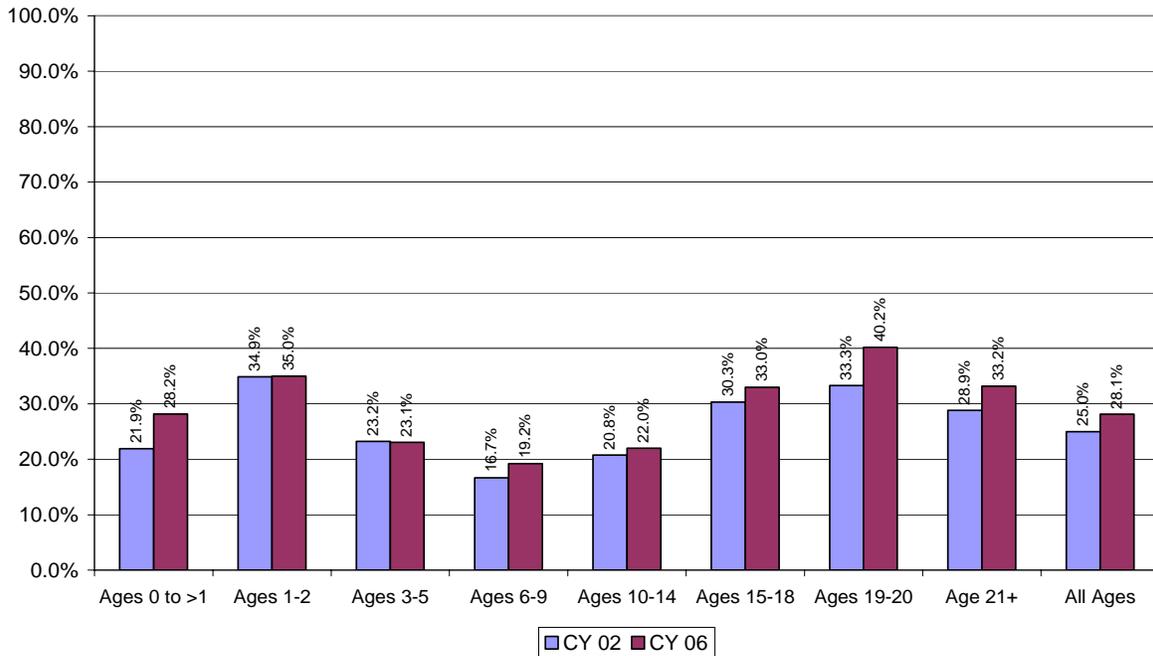
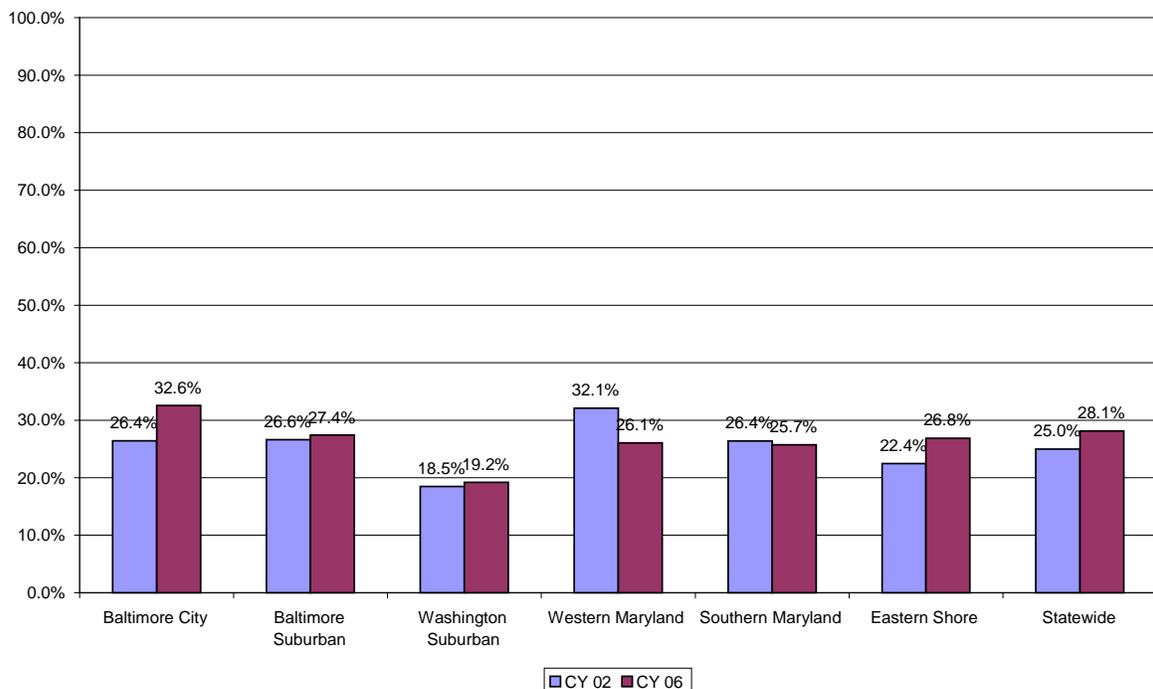


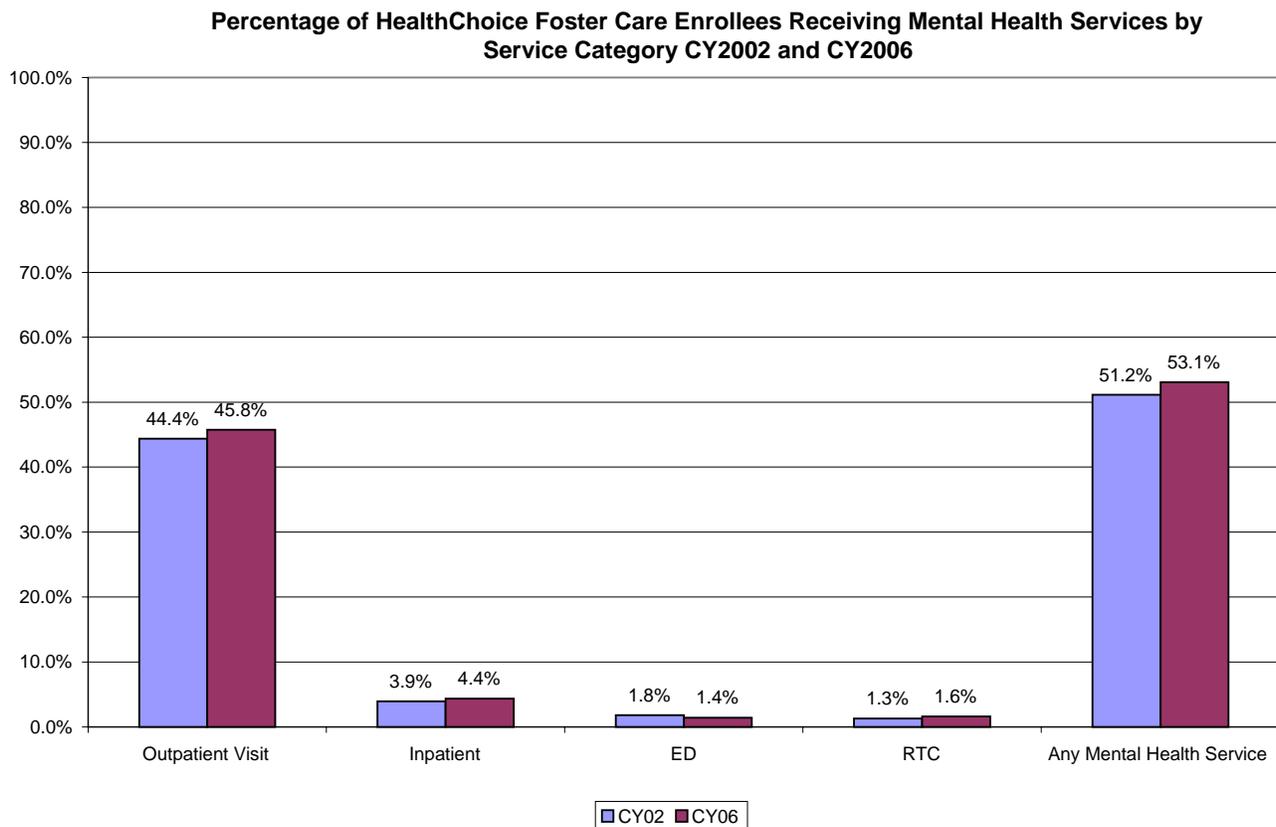
Figure III-64: Emergency Department Use by Foster Children, by Region

Percentage of HealthChoice Foster Care Enrollees Receiving an ED Visit by Region CY2002 and CY2006



Previous analyses of the foster care population have shown that foster children are high utilizers of mental health services. As for all populations in HealthChoice, mental health services are provided outside of the MCO benefit through the Public Mental Health System. Figure III-65 shows that the percentage of foster children receiving any specialty mental health service increased slightly between 2002 and 2006, and is over half the population. Most of this is accounted for in outpatient care, although six percent of children in foster care receive inpatient mental health services or have stays in residential treatment centers.

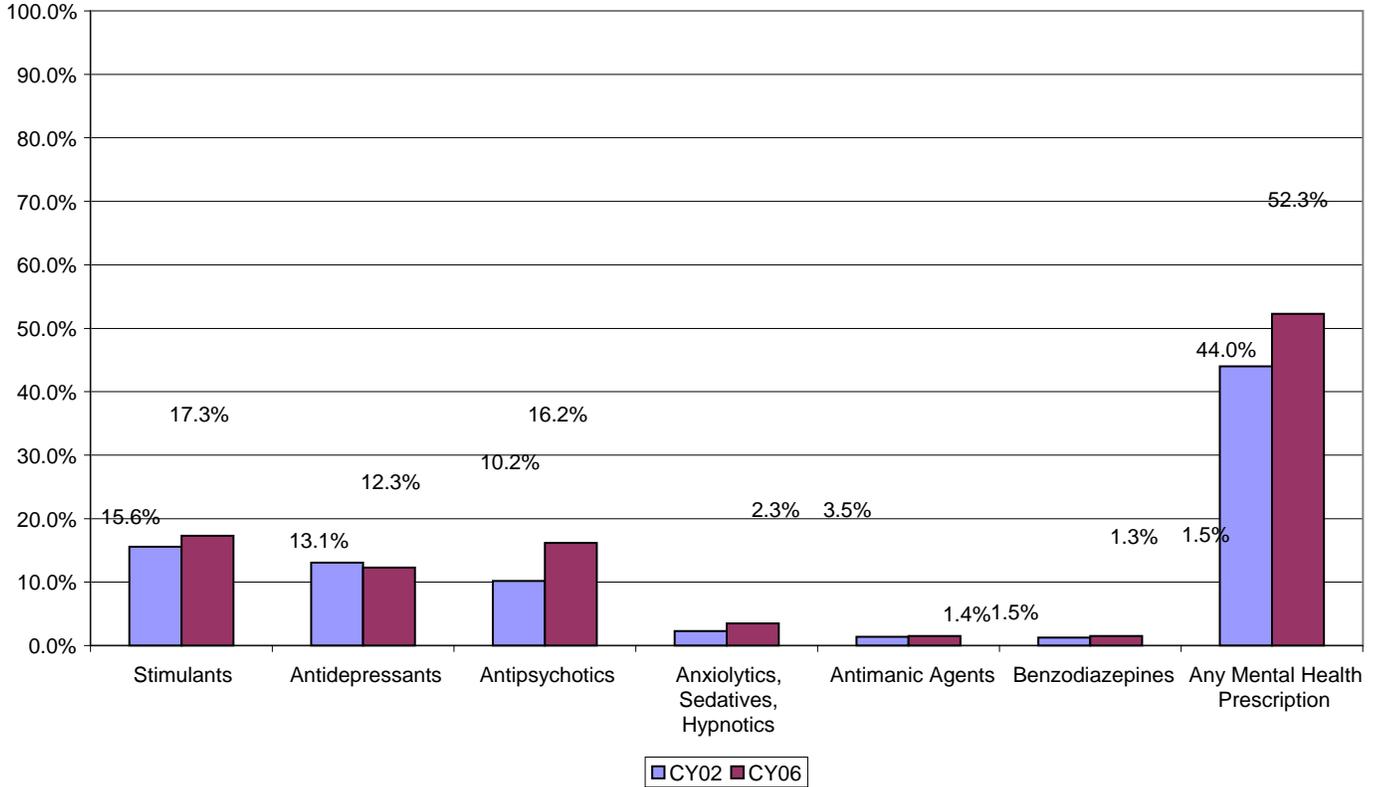
Figure III-65: Mental Health Service Utilization by Foster Children



Analysis in Figure III-66 of mental health prescription drug utilization shows that in 2006, the percentage of children receiving mental health drugs (52 percent) is almost the same as the percentage of children receiving any mental health services (53 percent). Mental health drugs use has increased between 2002 and 2006. The most common classes of mental health drugs used by foster children in 2006 were stimulants (17 percent of children), antipsychotics (16 percent of children), and antidepressants (12 percent of children).

Figure III-66: Mental Health Drug Utilization by Foster Children

Percentage of HealthChoice Foster Care Enrollees with a Mental Health Prescription by Therapeutic Class CY2002 and CY2006



2. HIV/AIDS

The Department monitors utilization for individuals with HIV/AIDS in order to ensure that individuals receive necessary services. The Department examined the distribution of individuals enrolled in HealthChoice living with HIV or AIDS compared to the distribution of the overall HealthChoice population statewide by race. Compared to the general HealthChoice population, individuals with HIV or AIDS are more likely to be white, male, and live in the Washington suburbs.

The Department looked at five measures of service utilization for individuals with HIV or AIDS. These include screening for cervical cancer, use of anti-retroviral therapy, CD4 testing, viral load testing, and utilization of ambulatory visits.

Figure III-67 shows that women with HIV or AIDS access cervical cancer screening at higher rates than other women in HealthChoice, although both groups of women are below 100 percent. The measure for women with HIV or AIDS used only encounter data, while the HEDIS measure for all women may have been supplemented with medical record review. This means that the result for women with HIV or AIDS may be understated. This measure used HEDIS standards, which looks for a cervical cancer

screen in the measurement year or two years prior. The CDC recommends that women with HIV or AIDS receive two cervical cancer screens in the year after diagnosis, and then receive annual screening.

Figure III-67: HEDIS Measure: Cervical Cancer Screening for Women with HIV/AIDS and All Women in HealthChoice

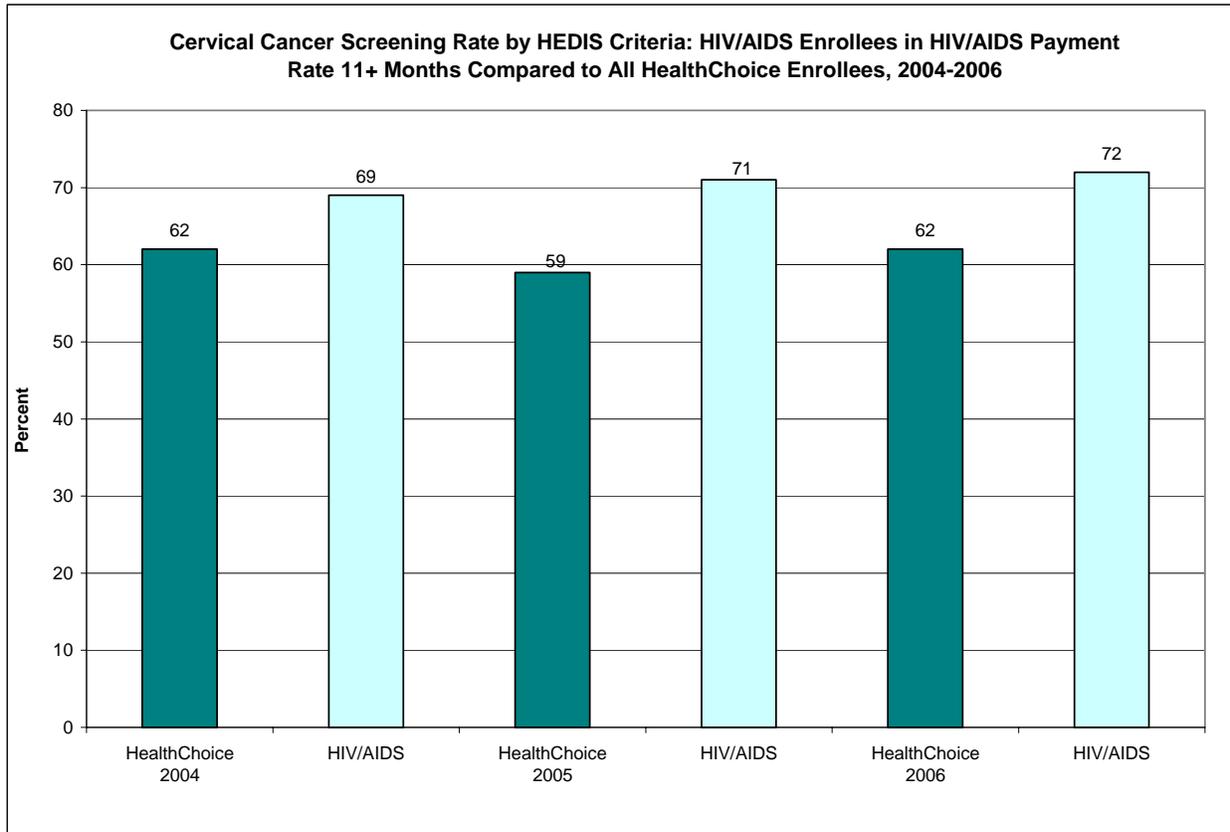


Figure III-68 shows rates of annual cervical cancer screening. These appear low and have not increased steadily.

Figure III-68: Annual Cervical Cancer Screening for Women with HIV/AIDS

Yearly Rate of Cervical Cancer Screening for Female HealthChoice Enrollees, 11 or more months in HIV/AIDS Payment Rate Cell, Aged 21 to 64

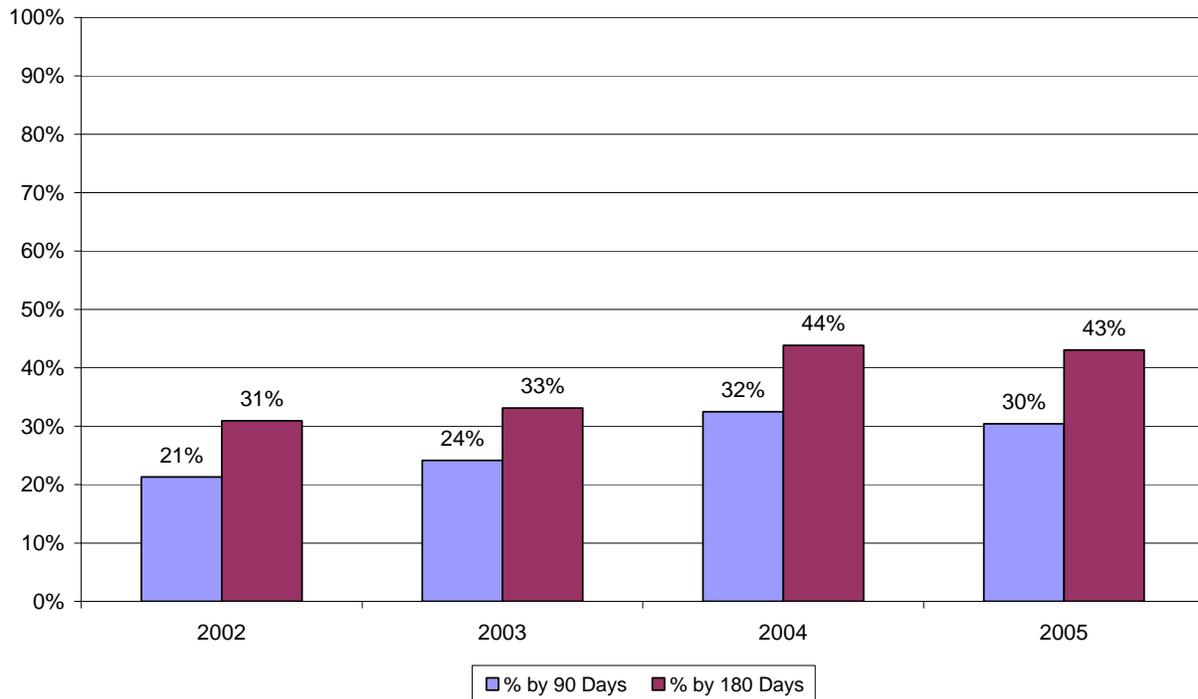
	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006
Number of Women Receiving Cervical Cancer Screening	536	516	518	556	555
Females	1495	1372	1299	1384	1424
Rate	35.9%	37.6%	39.9%	40.2%	39.0%

Rates of viral load testing were also assessed. The viral load test measures how much human immunodeficiency virus is in the blood. Viral load should be tested at diagnosis,

and then monitored every three to four months. Figure III-69 shows the percent of individuals newly enrolled into the HIV/AIDS categories in the HealthChoice capitation system who receive a viral load test within 90 and 180 days. Between 2002 and 2004 progress was made, but utilization was flat between 2004 and 2005, at 44 percent and 43 percent respectively. Findings for 2006 are not available because data for this measure are not available until 180 days into 2007 and providers and MCOs need time to submit the encounter data.

Figure III-69: Viral Load Tests for Individuals with HIV/AIDS

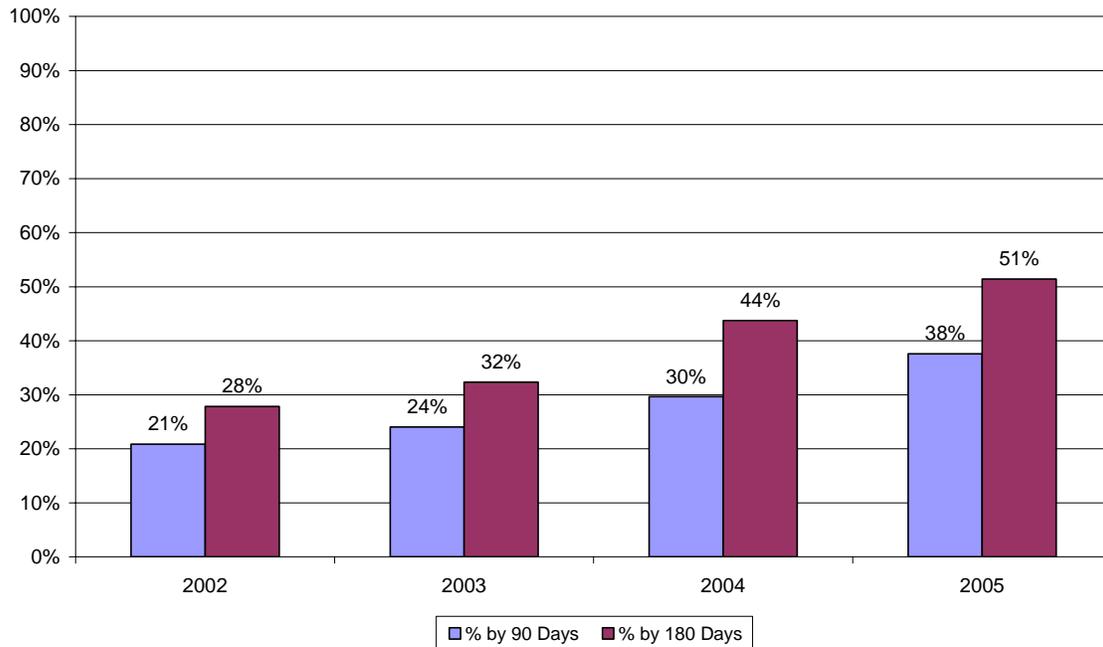
Percent of Newly Enrolled HIV/AIDS Enrollees Receiving Viral Load Test within 180 Days, CY 2002 - CY 2005



CD4 testing is used to determine how well the immune system is working in individuals diagnosed with HIV. CD4 testing should be done at diagnosis to provide a baseline, and then every three to six months depending on different factors. Figure III-70 shows the percent of individuals newly identified as having HIV or AIDS in the HealthChoice capitation system who received CD4 testing within 90 days and 180 days. Rates of CD4 testing are low, with only 51 percent of individuals receiving a CD4 test within 180 days of entering the HIV/AIDS category in the HealthChoice capitation system. Although rates have improved steadily between 2002 and 2005, significant progress remains to be made. Data for 2007 were not available to determine CD4 testing 180 days after entering the HIV/AIDS category in 2006. Findings for 2006 are not available because data for this measure is needed 180 days into 2007.

Figure III-70: CD4 Tests for Individuals with HIV/AIDS

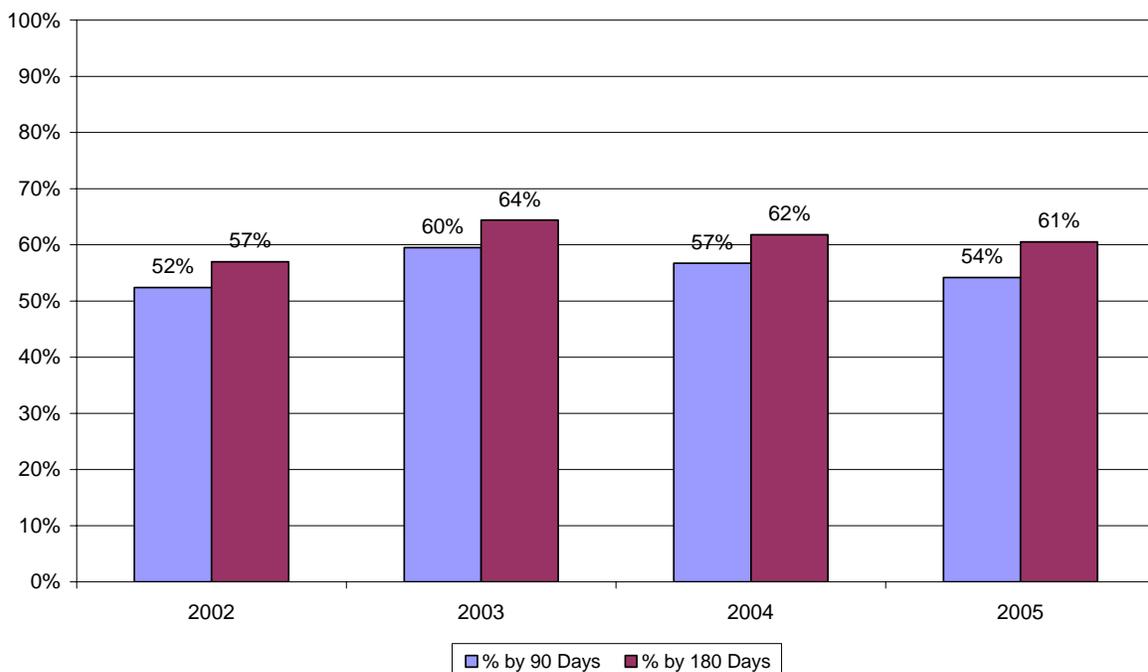
Percent of Newly Enrolled HIV/AIDS Enrollees Receiving CD4 Test within 180 Days, CY 2002 - CY 2005



The next analysis shows the percent of individuals newly identified in the HealthChoice capitation system as having HIV or AIDS, who receive anti-retroviral therapy within 90 days and 180 days of identification (Figure III-71). When to initiate anti-retroviral therapy depends on several factors, including results of viral load and CD4 tests, and symptoms. Utilization is slightly higher for 180 days, but still appears low.

Figure III-71: Anti-Retroviral Treatment for Individuals with HIV/AIDS

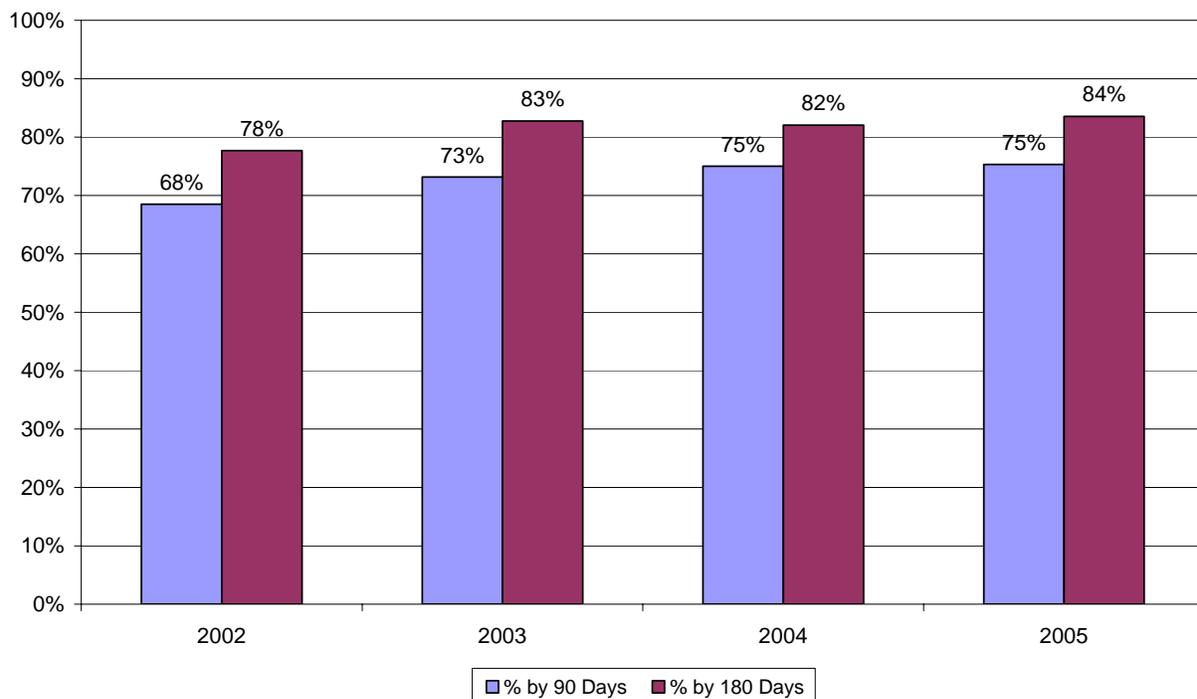
Percent of Newly Enrolled HIV/AIDS Enrollees Receiving Anti-Retroviral Treatment within 180 Days, CY 2002 - CY 2005



Lastly, the Department examined the percent of individuals newly categorized in the HIV/AIDS category in the HealthChoice capitation system who had an ambulatory visit within 90 and 180 days (Figure III-72). Subsequent to increases between 2002 and 2003, utilization has remained around 75 percent for the measure within 90 days, and around 83 percent for the measure within 180 days.

Figure III-72: Ambulatory Care for Individuals HIV/AIDS

Percent of Newly Enrolled HIV/AIDS Enrollees Receiving an Ambulatory Visit within 180 Days, CY 2002 - CY 2005



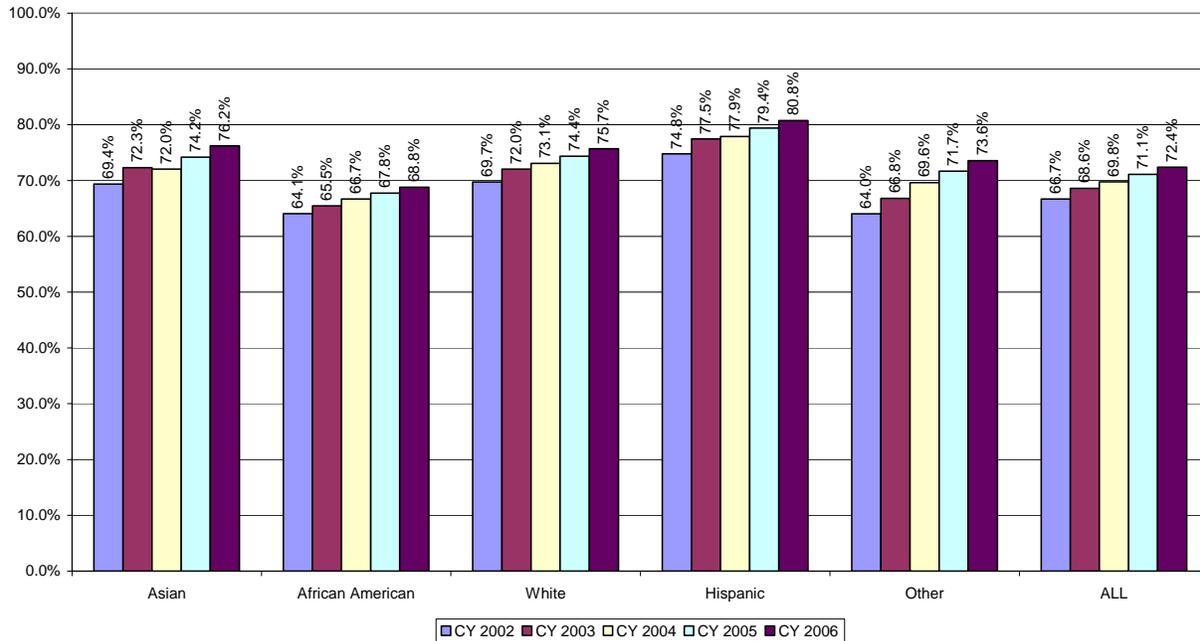
The Department will further explore service utilization for individuals with HIV or AIDS analyses based on actual diagnoses, versus identification in the capitation system. It is also possible that some individuals with HIV or AIDS may receive services through other programs, and their utilization is not showing up in Medicaid. The Department will explore this.

3. Racial and Ethnic Health Disparities

The existence of racial and ethnic disparities in access to health care is a nationally recognized issue. The Department is committed to decreasing the gap in utilization between racial and ethnic minorities and whites. The Department transmits race and ethnicity data to the MCOs through daily enrollment transactions, enabling the MCOs to address disparities. Chapter One shows HealthChoice enrollment by race and ethnicity.

Figure III-73 shows the percent of enrollees receiving at least one ambulatory service by race and ethnicity. Utilization increased for all racial and ethnic groups between 2002 and 2006. In 2006 Hispanics had the highest rate of utilization, five percentage points higher than Whites. The rate of utilization for African Americans was almost seven percentage points lower than Whites.

Figure III-73: Percent of Enrollees Receiving Ambulatory Care by Race and Ethnicity



Further analysis is needed to control for other factors that affect utilization rates, such as age and disability. For example, a population’s younger age distribution could contribute to higher rates of utilization, given that younger children are among the highest users of services. The Department will explore these issues in future analyses in order to get a better understanding of whether differences by race and ethnicity are attributable to other factors, such as age.

Analyses of special services and populations shown above also break out findings by race and ethnicity. The analysis of substance abuse treatment above shows that treatment rates are similar for African Americans and Whites, and are generally lower for Hispanics and Asians. The Department also examined the distribution of individuals enrolled in HealthChoice living with HIV or AIDS along several demographic factors, including race and ethnicity. Compared to the general HealthChoice population, individuals with HIV or AIDS are more likely to be White, male, and live in the Washington suburbs.

F) CONCLUSION

HealthChoice is a mature program in its tenth year of operation, serving close to half a million Marylanders. The data presented in this evaluation provide evidence that in most ways HealthChoice has made progress towards its goal of creating a medical home and a prevention-oriented system of care. Utilization of ambulatory care continues to increase over time, and across populations and regions. Outcomes for key indicators of preventive care, such as well-child and prenatal care, are positive, increasing, and better than national Medicaid performance. These measures are particularly meaningful for a program such as HealthChoice, whose enrollment is comprised of a high proportion of children and pregnant women. This evaluation also presents evidence that HealthChoice has promoted secondary prevention and chronic disease management. This is particularly true for asthma and diabetes management, two of the most common chronic illnesses.

Even with the gains made by HealthChoice, this evaluation shows that there are areas for improvement. Not all of the results of preventive care measures are high enough; improving rates of testing for elevated blood lead levels in young children and screening for cervical cancer in women are two areas that the Department will prioritize in the next renewal cycle. Certain services also continue to present challenges. The most notable of these are inadequate rates of dental utilization and high rates of emergency department use, particularly for non-emergent care. Both of these issues garner significant attention throughout Maryland, and present challenges nationally as well.

The next renewal cycle will also focus on access to services for special populations. This evaluation shows that some populations with special health care needs do not get all needed treatment. This appears to be the case for individuals with chronic conditions. The Department is committed to working with MCOs, providers, consumers, and its other partners to optimize access for all enrollees.

IV. PUBLIC INPUT

The Department's goal is to provide access to high-quality health care for Marylanders enrolled in HealthChoice. The Department greatly values direct input from enrollees and providers, which is essential in order to continuously improve services for enrollees. The qualitative information gathered from surveys and other mechanisms to receive public input helps the Department interpret the results of the quantitative analyses included in the previous chapter. Qualitative information combined with quantitative analysis provides a richer picture of individuals' experiences with the system.

In addition to gathering public input, the Department also recognizes the importance of reporting back to the community. This feedback loop helps the Department be responsive to concerns from stakeholders, promotes collaboration, and helps set priorities for the Department.

A) MECHANISMS FOR GAINING PUBLIC INPUT

1. Consumer Assessment of Healthcare Providers and Systems

The Department uses the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to conduct annual satisfaction surveys with HealthChoice enrollees. CAHPS is a widely used set of survey tools developed to evaluate members' satisfaction with their health plans. CAHPS covers enrollment and coverage, access to and utilization of health care, communication and interaction with providers, interaction with health plan administration, self-perceived health status, and respondent demographics. The surveys are mailed to a sample HealthChoice population with follow-up calls placed to non-respondents.

The Department contracts with an NCQA-certified Health Effectiveness Data and Information Set (HEDIS) Survey Vendor to administer the surveys and report results. This ensures that results are statistically valid and objective as well as helps enrollees feel comfortable providing honest answers.

Separate surveys are administered to adults and children. The child surveys are completed by the parent or guardian who knows the most about the child's health care. The child survey includes specific questions to measure the satisfaction of children with special health care needs.

The survey is administered to a sample of enrollees, approximately 1,400 adults per MCO and 3,500 children per MCO. It is also administered with a Spanish language option. Response rates are generally around 25 percent for the adult and child populations. The response rate for children with special needs is approximately 18 percent.

Adults

Over the past five years, general satisfaction with HealthChoice remains high; 70 percent of adult respondents are satisfied with their care and no single survey category dropped below sixty percent. Slight improvement has been recorded in respondents' satisfaction with the timeliness of care and customer service provided by their MCO. When asked, however, to rate their health care, respondents' satisfaction has declined slightly.

Children

General satisfaction with the HealthChoice Program remains high; 80 percent of respondents are satisfied with their child's care. Slight improvements have been observed regarding the timeliness of care and quality of specialists. Respondents' satisfaction with their personal doctor and the customer service provided by their MCO declined slightly, however.

Special Needs

For children with special needs, most respondents were satisfied with their care. Respondents rated all but one category of care in the mid-80's to low-90's. Satisfaction with how care is coordinated has declined over the years and currently measures at 73 percent. Respondents' satisfaction with their personal doctor also has dropped slightly for children with special needs.

MCO-specific findings are reported annually to the Department by the vendor. The findings are made available on the Department's Web site at <http://www.dhmh.state.md.us/mma/healthchoice/html/CY2006.htm>.

2. Provider Satisfaction Survey

The Department also conducts an annual primary care provider (PCP) survey to measure provider satisfaction with HealthChoice, specifically their experience with the MCOs with which they participate. The survey contains question sets covering topics such as MCOs:

- Taking appropriate and timely actions in processing claims;
- Assisting provider offices through accessible and helpful representatives;
- Maintaining an adequate network of specialist providers; and
- Providing timely authorizations.

The most recent survey was administered by mail to a random sample of PCPs from each of the MCOs. The total sample is over 5,000 providers. The response rate has been approximately six percent.

While the overall satisfaction score has decreased from 2004, significant increases have been observed in a few individual measures. Provider satisfaction scores have improved with issues related to financing, coordination of care/case management, and

utilization management. Providers also reported more canceled appointments than in previous years. Other scores have remained constant.

Findings are reported annually to the Department by a vendor. The report includes aggregate and by MCO responses from all responding providers. This information is available on the Department's Web site at:
<http://www.dhmf.state.md.us/mma/healthchoice/html/CY2006.htm>.

3. Hotlines

In addition to administering annual satisfaction surveys, the Department receives, tracks, and monitors real-time input from enrollees and providers through its hotlines.

Enrollee input is received through the Department's HealthChoice Enrollee Action Line (HEAL). The purpose of HEAL is to:

- Answer enrollee questions regarding MCO policies and/or procedures or any other issues related to or affected by HealthChoice;
- Direct enrollees to the appropriate MCO staff who can assist with the issue;
- Attempt to resolve issues by directly linking the enrollee with the MCO; and
- Refer complaints to the Department's Complaint Resolution Unit (CRU).

HEAL accommodates enrollees who do not speak English either through bilingual staff or the use of a language line service.

Calls are analyzed monthly and quarterly using an automated system for logging and tracking, enrollee complaints and grievances. This helps the Department determine if specific interventions with particular MCOs are required, or if changes in Department policies and procedures are necessary.

The Department also operates a Provider Hotline to respond to general inquiries and complaints from providers. The MCO is required to inform its providers about the Department's Provider Hotline and may not take any punitive action against providers for accessing the Provider Hotline. Similar to the HEAL, inquiry and complaint information is tracked and analyzed monthly and quarterly to determine if specific interventions with particular MCOs are required, or if changes in Department policies and procedures are necessary.

Over the last five fiscal years, the largest volume of calls from the provider and HEAL hotlines have been inquiry calls. Complaints to the CRU account for one quarter of all calls. The majority of complaints (66 percent) fall into one of the following categories: member care management, recipient billing, prescription medication authorization, and referrals to specialists. While the overall volume of calls has remained constant, there has been an increase in the number of calls related to prescriptions and care management, and a decrease in the number of calls related to durable medical equipment/durable medical supplies, provider billing, and referrals to specialists by consumers.

The Department has convened a workgroup to revise the coding system for the Inquiry and Complaint category codes. The new coding system will help provide additional detail and streamline the Department's internal coding process.

4. Comments from Maryland Medicaid Advisory Committee

The Maryland Medicaid Advisory Committee (MMAC) is charged with improving and maintaining the quality of Medicaid by assisting the Department with the implementation, operation, and evaluation of the program. The MMAC is comprised of representatives from the General Assembly, advocacy groups, consumers, providers, MCOs and sister agencies. The MMAC meets monthly.

In preparation for the HealthChoice renewal, the Department solicited input from the MMAC on prioritization of areas for improvement by reviewing drafts of the HealthChoice renewal application and evaluation. The MMAC asked the Department to address the following topics in the next renewal cycle:

- Assess whether children with special health care needs receive the routine well-child services in accordance with the periodicity schedule under EPSDT. The Department should explore options for improving rates of utilization if they appear to be low.
- Strengthen pediatric specialty networks, particularly for pediatric sub-specialists.
- Increase rates of elevated blood lead level testing for children. The Department should promote the use of and reimbursement for filter paper testing as alternative to venipuncture. Some children do not make a separate trip to the lab to have a venipuncture test. Filter paper testing can be done in a primary care office, eliminating the need for children to go to a lab.
- Promote the selection of a pediatrician for a newborn as part of prenatal care. If a newborn does not already have a pediatrician selected at the time of his or her birth, there can be delays in utilizing care.
- Explore ways to increase rates of screening for cervical cancer. The Department designates topic areas for performance improvement projects (PIPs) in which MCOs must actively work to make improvements. The next PIP topic, which commences January 2008, focuses on improving the screening rate for cervical cancer.
- Explore ways to close the racial and ethnic disparity gap in utilization, including analysis of the Hispanic population. The previous chapter includes information on utilization of ambulatory services by race and ethnicity and shows that for those services Hispanics utilize ambulatory services at higher rates than Whites.
- Explore ways to address effects of documentation issues on enrollee access to care.
- Ensure that MCOs provide 72-hour emergency supplies of medication needing prior authorization. Although this issue has been addressed previously, issues remain with the timing of the supply, and provider and enrollee awareness.

5. Regional Public Hearings

The Department held seven regional public hearings and solicited written comments to gain input from consumers in preparation for the renewal and to determine what program improvements are necessary. There were a total of 62 individuals who provided feedback, including consumers, providers, local staff, advocates, and managed care organization representatives. Overall, people expressed appreciation for the HealthChoice program in that it provides health care coverage to those who would not be able to have it otherwise. Specifically, some participants stated that the chronic disease management programs offered by MCOs in HealthChoice are beneficial.

Many concerns stem from misunderstanding, indicating a need for the Department to clarify policies. However, in many instances DHMH staff provided immediate assistance to some of those who raised concerns. Staff were present at every meeting for further discussion or to obtain the person's contact information for follow up. A summary of participants' comments is provided below

Benefits

Not surprisingly given the recent focus on improving dental services in Maryland, the greatest number of comments regarding benefits dealt with dental services. Some commenters expressed concern at the lack of participating dental providers and specialists. Others expressed concern with limitations on coverage for adults. Adult dental benefits are not mandated benefits under HealthChoice, but all MCOs have opted to cover basic adult dental care services.

Other benefits discussed included mental health and substance abuse services. Mental health services are provided outside of the MCOs through the public mental health system. Some people commented that a carve-out of mental health services leads to a lack of coordination of care between somatic and mental health services. These services are carved-out in Maryland Statute. Substance abuse services, however, are provided through the MCOs. One commenter specifically mentioned the lack of coordination between substance abuse services and mental health services. Concerns also were raised about processing times associated with prior-authorization requirements, provider enrollment, and claims payment.

There were several concerns stemming from lack of awareness of HealthChoice policies and procedures. Where possible, the Department used the opportunity to provide one-on-one assistance. One local staff person was unaware of specific guidelines regarding medical equipment. This participant relayed an experience where a recipient had to have their wheelchair repaired instead of having the program purchase a new chair. Another individual expressed concern over the one eyeglass per year limit for children. They were unaware that HealthChoice covers replacement glasses in instances where eyeglasses are lost or damaged or if the child has a significant change in vision.

It was reported that some women are unaware that they are eligible to receive care if they become pregnant while on Medicaid. It was also reported that it can take weeks to secure an appointment with a prenatal provider. After giving birth, women are disenrolled from the program after two months. A participant stated that this is not enough time to access post-partum care. Unfortunately, the State is required to end the eligibility under federal rules. However, the federal government has allowed the state to provide family planning services to women being disenrolled from the program. A participant from the Baltimore City Healthy Start program shared information on a pregnant women/STD initiative that they feel can be replicated in HealthChoice.

Some people expressed concern with the enrollment process for newborn children. A large part of the confusion seems to stem from lack of information that may result in eligibility forms being sent to the wrong places.

Provider Networks

The Department received many comments on the provider networks and the accuracy of provider directories.

Concerns about the adequacy of the provider networks were expressed by advocates for children and people with disabilities. Specific concerns regarding the provider networks included concerns that the number of providers, especially by region and specialty, are insufficient to provide adequate health care to the HealthChoice population. A number of comments focused on the number of dental providers who do not participate in HealthChoice. Some expressed difficulty in finding pediatric specialists for both dental and medical problems.

Complaints also focused on the provider directories. A number of commenters stated that published directories are often out-dated, which is a source of frustration to HealthChoice recipients seeking medical care. For example, some providers who accept MA clients are not listed as providers. In addition, some listed providers no longer participate in HealthChoice. Local health department staff are collaborating with the Department to determine the best options for updating these lists and improving communication.

MCO Management / Consumer Responsibility

A number of commenters expressed a concern regarding customer service at the MCO and provider levels. Some expressed concern that case managers represented MCO interests rather than addressing an individual's health care needs.

Providers commented that many HealthChoice recipients missed appointments, which negatively impacts their business operations. They suggested that providers respond by sometimes dropping patients who miss three or more appointments. Providers also are concerned that some recipients are abusing the prescription policies by changing doctors or MCOs.

Tracking individuals from region-to-region may remedy this concern, and the need to track individuals in general appeared in several contexts. One commenter stated that children in foster care do not access all services to which they are entitled. One barrier to getting foster care children into care is not having accurate contact information for foster families. The contact information of record is the local department of social services. A second concern expressed during the hearing was related to people moving within the State and their need to change MCOs and providers timely to ensure.

Department

Customer service at the Departmental level was discussed at public hearings. There were several concerns that the citizenship requirement posed additional burdens on recipients. It was suggested that guidance on citizenship and residency documentation would be helpful. Also, some commented that the Maryland Children's Health Program and Departments of Social Services staffs were not responsive to consumer inquiries. Participants believe that eligibility denial letters should include more detail concerning the reason for denial of eligibility and also explain fully any appeal rights. Another comment expressed that outreach for MCHP did not utilize fully other resources in helping to promote the program to target populations.

Some comments were that the hotlines are not widely publicized and, as a result, are under-utilized. Additionally, it was expressed that the hours of operation are not consumer-friendly and are a limitation to those who may not be able to call during work hours. The HEAL is open Monday through Friday from 7:30 a.m. to 5:30 p.m. with voicemail for after hours and weekends. The Provider hotline is open Monday through Friday from 8:00 a.m. to 5:00 p.m. with voicemail for after hours and weekends. All messages are returned within one working day.

Although the HealthChoice Program attempts to communicate information in a culturally appropriate manner, some commenters argued that these efforts are not sufficient for the Hispanic population. For instance, many Hispanics receiving services do not have access to a translator; the waiting list for one is long and in some cases, no translator is ever available.

Some comments suggested that the provider reimbursement rates should be increased; specifically, the vaccine reimbursement for providers and rates for substance abuse services. It should be noted that the vaccine administration fees were increased by Medicaid in July 2007 and that most vaccines are provided for free to Medicaid children by the Vaccines for Children's Program.

B) MECHANISMS FOR PROVIDING FEEDBACK TO THE PUBLIC

1. MCO Consumer Report Card

The Department reports back directly to enrollees through an MCO consumer report card. The MCO consumer report card focuses on performance measures most relevant to consumers for selecting an MCO and includes the following six categories:

- Access to Care;
- Doctor Communication and Service;
- Keeping Kids Healthy;
- Care for Kids with Chronic Conditions;
- Taking Care of Women; and,
- Diabetes Care.

MCOs are compared with each other and given an overall score of above average, average, or below average in each of the six categories. The overall score is comprised of a number of measures.

The MCO consumer report card is updated annually and is included in all initial and renewal enrollment packets. The report card is available at: http://www.dhmf.state.md.us/mma/healthchoice/html/mco_report.htm

2. Annual Presentation to the Maryland Medicaid Advisory Committee

The Department makes presentations to the MMAC on a regular cycle each year in order to keep the MMAC apprised of HealthChoice performance. Each fall, the Department devotes a MMAC meeting to the results of HealthChoice quality activities which measure individual MCO performance. The four annual MCO quality reports -- HEDIS, CAHPS, Value-Based Purchasing, and EQRO (which includes Healthy Kids Audit and the Systems Performance Review) -- are presented. These reports are available online at: <http://www.dhmf.state.md.us/mma/healthchoice/html/CY2006.htm>.

Each spring, the Department presents the results of its annual HealthChoice evaluation to the MMAC. The evaluation differs from the quality reports in that the evaluation rolls up performance for the HealthChoice program as a whole, while the quality reports break out performance by individual MCOs. The HealthChoice evaluations are available online at: <http://www.dhmf.state.md.us/mma/html/reppubs.html>.

V. BUDGET NEUTRALITY

A) COMPLIANCE WITH BUDGET NEUTRALITY REQUIREMENTS

Section 1115 waivers require states to demonstrate that actual expenditures do not exceed certain cost thresholds – i.e., they may not exceed what the costs of providing those services would have been under a traditional Medicaid fee-for-service program. Appendix VII shows that HealthChoice has met this condition as well as generated savings for both the State and Federal Government. In short, the overall HealthChoice savings is expected to total \$2.4 billion by the end of demonstration year 11.

The Governor and Legislature rank health care reform as a top priority for the citizens of Maryland. A key part of their reform effort uses Medicaid to expand health care coverage for parents and childless adults. It does so by using a portion of Maryland's 1115 waiver savings to increase benefits to childless adults served under the Primary Adult Care program. During this renewal period, the increased benefits include specialty physician and emergency services in SFY 2010 and outpatient hospital services in SFY 2011. This expansion is sustainable and allows the federal government to maintain savings at the end of the waiver renewal period.

B) TREND FACTOR MUST INCREASE

Under its current terms and conditions, HealthChoice has a trend factor of 7.1 percent, which is almost a full percentage point less than Maryland's previous trend factor of 8 percent. After allowing the program to stabilize in the first waiver period, HealthChoice expenses (excluding expansion populations) are now growing at an average of 8.2 percent per person per year, and these trends are expected to increase even more during the next waiver renewal period – the expected increases are due primarily to increased physician and dental provider fees and are necessary in order to ensure patient access to these services. In short, these provider fees will increase regardless of whether or not HealthChoice exists.

Maryland is able to increase physician fees because of 2005 legislation that taxes managed care organizations and health maintenance organizations. The legislation allocates a large portion of collected taxes to the Medicaid program and permits the Department to increase physician rates. Maryland's goal is to eventually increase physician rates to 100 percent of Medicare.

Within the last year, CMS, the U.S. Congress, and the Governor examined the low utilization of dental services for Maryland children. Based on the FY 2005 CMS 416 report, the percentage of Maryland children receiving dental services falls below the national average. The Governor and Secretary consider improving dental access for children a key priority and are reviewing recommendations from Maryland's Dental Action Committee. One key recommendation is to increase dental provider rates (specifically to the 50th percentile of charges for the American Dental Association's South Atlantic region).

The Department works diligently to control costs and establish actuarially sound capitation rates. In doing so, Maryland consults both national and statewide trends. Notwithstanding these efforts, the artificially low trend factor of 7 percent must be increased. Despite the fact that it is a full percentage point less than Maryland's previous trend factor, current average expenses are growing at nearly 8.2 percent per year. In addition, increases in physician and dental provider costs together will result in another 1 percentage point increase in expenditure trends. Based on historical trends and the unique increase in physician and dental provider costs facing Maryland, a trend factor of close to 9.2 percent is both reasonable and sound. Through continued efficiency improvements in the provision of services in the MCOs, our goal is to limit per enrollee growth in costs to 8.2 percent per year.

C) CHANGE IN MEDICAID ELIGIBILITY GROUPS (MEGS)

Because of the significant difference in per person costs between adults and children in the TANF and SOBRA MEGs, we are proposing to split them into separate adult and children MEGs for budget neutrality calculation purposes. Based on an analysis of historical expenditures for this population, the appropriate per-member per-month cap rates that correspond to the current combined adult and child TANF and SOBRA rates are \$375.50 for TANF adults, \$296.28 for TANF children, \$2,074.47 for SOBRA adults and \$454.16 for SOBRA children during demonstration year 11.

Listed by MEG, the Department is requesting the following trend factors and per-member per-month cap rates for the next three-year renewal period:

Medicaid Eligibility Groups	Description	PMPM CAP Rate DY 11	Trend Factor
1.	TANF - adults	\$375.50	8.2 percent
2.	TANF-children	\$296.28	8.2 percent
3.	SOBRA - adults	\$2,074.47	8.2 percent
4.	SOBRA - children	\$454.16	8.2 percent
5.	SSI	\$1,302.98	8.2 percent
6.	Medically needy	\$1,183.10	8.2 percent

VI. CONCLUSION

Since its inception in 1997, the HealthChoice program has proven to consistently enhance the care provided to Maryland Medical Assistance enrollees. The information presented in this renewal package provides strong evidence that HealthChoice is in fact a stable program. It has been successful in reducing program cost growth by creating a methodology for reimbursing MCOs which is predictable, yet flexible enough to accommodate changes based on population and demographic shifts. In addition, HealthChoice has increased utilization of preventive services and appropriate chronic disease treatment. It has also provided a medical home for many vulnerable individuals. As with any program, there are areas that need to be improved to assure that enrollees have access to care. The Department is committed to working with CMS and other stakeholders to identify and address necessary programmatic changes upon renewal of the waiver.

VII. FUNDING QUESTIONS

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 percent of the payments for services rendered or coverage provided. Do providers retain all of the Medicaid payments (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)? Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

Response:

State law requires that all health insurers, including HMOs and MCOs, pay a tax amounting to 2 percent of premiums. To meet standards of actuarial soundness, capitation rates paid to MCOs reflect the cost of the 2 percent premium tax. By law, the premium tax revenue from HMOs and MCOs shall go to the Maryland Health Care Rate Stabilization Fund. The fund will reduce liability insurance rates for certain health care providers, increase reimbursement rates for Medicaid providers, and, after state fiscal year 2009, will generally support the Medicaid Program. Each year Medicaid determines which physician services will be targeted for a reimbursement rate increase given the amount available from the Maryland Health Care Rate Stabilization Fund. MCOs are required to pay physicians at least 100 percent of the Medicaid fee-for-service fee schedule. When Medicaid fee-for-service rates are increased, the increase is also built into MCO capitation payments.

There are no intergovernmental transfers or certified public expenditure payments under the MCOs.

2. Section 1902(a)(2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded. Please describe whether the NFS comes from appropriations by the State Legislature, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. If any of the NFS is being provided through the use of local funds

using IGTs or CPEs, please fully describe the matching arrangement. If CPEs are used, please describe how the State verifies that the expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

Response:

As described in the response above, State law requires funds from a 2 percent tax on HMO and MCO premiums go to the Maryland Health Care Rate Stabilization Fund. The fund will reduce liability insurance rates for certain health care providers, increase reimbursement rates for Medicaid providers, and, after state fiscal year 2009, will generally support the Medicaid Program. Each year Medicaid determines which physician services will be targeted for a reimbursement rate increase given the amount available from the Maryland Health Care Rate Stabilization Fund. MCOs are required to pay physicians at least 100 percent of the Medicaid fee-for-service fee schedule. When Medicaid fee-for-service rates are increased, the increase is also built into MCO capitation payments to help fund physician services within capitation rates.

Additionally, during the 2003 legislative session, the Maryland General Assembly passed and the Governor signed into law SB 479, which created a Trauma and Emergency Medical Fund that is financed by motor vehicle registration surcharges. The Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) have oversight responsibility for the Fund. Based on the legislation, Maryland Medicaid is required to pay physicians 100 percent of the Medicare rate (the Baltimore Medicare facility rate) when they provide trauma care to Medicaid's fee-for-service and HealthChoice program enrollees. The enhanced Medicaid fee only applies to services rendered in a trauma center designated by Maryland Institute for Emergency Medical Services Systems (MIEMSS) for patients who are placed on Maryland's Trauma Registry. Initially, the enhanced Medicaid fee was limited to trauma surgeons, critical care physicians, anesthesiologists, orthopedic surgeons, and neurosurgeons. However, the passage of HB 1164 during the 2006 legislative session extends the enhanced rate to any physician, beginning July 1, 2006. MHCC and HSCRC fully cover the additional outlay of general funds that the Maryland Medicaid program incurs due to enhanced trauma fees (relevant percent of the difference between 100 percent of Medicare rates and Medicaid's current rates). MHCC pays physicians directly for uncompensated care and on-call services.

All other funds are appropriated by the Governor. There are no intergovernmental transfers or certified public expenditure payments under the MCOs.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Response:

For the Medicaid population, HealthChoice MCOs are eligible to receive a supplemental payment for serving 20 of the 24 jurisdictions across the State. For calendar year (CY) 2008, \$7.5 million has been allocated to the Statewide supplemental payment. MCOs are also eligible to receive incentive payments for meeting certain performance targets as designed in the Department's Value Based Purchasing initiative, which is a pay for performance quality initiative for HealthChoice MCOs. For CY 2008, \$2.5 million has been allocated for incentive payments, in addition to any funds collected through Value Based Purchasing sanctions. Lastly, for CY 2008 the Department has designated \$2 million to be paid to HealthChoice MCOs in a dental pool. The Department is requiring MCOs to increase dental utilization through a variety of measures. Dental utilization has historically been low. The dental pool was established to account for increases in dental utilization not built into HealthChoice capitation rates. MCOs must reach certain targets for dental utilization to receive funds from the pool.

4. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Response:

The HealthChoice capitation rate-setting methodology incorporates historic MCO expenditures, enrollee health status and prior service utilization, and geographic and demographic data. Capitation rates are certified as actuarially sound by Mercer, the Department's actuary.

Maryland has an all-payer reimbursement system for hospital services. The waiver allows Maryland to establish uniform hospital rates for all payers, including Medicare and Medicaid. The rates are established by the Health Services Cost Review Commission. The design of the all-payer waiver would never allow Medicaid payments to be more than Medicare. There are a few special hospitals (e.g., chronic hospitals) that are not under the HSCRC purview. For these hospitals, the Department pays based on Medicare's retrospective cost reimbursement principles. These rates will be used to determine capitation rates.

5. Does any public provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, other) that, in the aggregate, exceed its reasonable costs of providing services? In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.) If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations? If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Response:

No providers or contractors receive payments that exceed the reasonable costs of providing services. No capitation payments exceed the amount certified as actuarially sound.