DRAFT Maryland HealthChoice Program

§1115 Waiver Renewal Application

Submitted by

The Maryland Department of Health and Mental Hygiene

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HealthChoice §1115 Waiver Renewal Application

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HealthChoice §1115 Waiver Renewal Application

Introduction

The Maryland Department of Health and Mental Hygiene (DHMH) is pleased to submit this Section 1115 waiver renewal application for the HealthChoice program. HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in 1997 under authority of a waiver through Section 1115 of the Social Security Act. This initial waiver was approved for five years. In January 2002, DHMH completed the first comprehensive evaluation of HealthChoice as part of the first 1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during the final year without managed care (fiscal year 1997). The Centers for Medicare and Medicaid Services (CMS) approved subsequent waiver renewals in 2005, 2007, and 2010. The 2010 renewal evaluation focused on the HealthChoice goals of expanding coverage to additional Maryland residents with low income, improving access to care, and improving service quality. Between waiver renewals, DHMH continually monitors HealthChoice performance on a variety of measures and completes an annual evaluation for HealthChoice stakeholders. This renewal period will focus on the changes to the program required under the Affordable Care Act (ACA).

This renewal application includes the following sections:

- A discussion of recent changes to the waiver
- A description of special initiatives in the next renewal period
- A list of requested changes in the next renewal period
- A list and description of the requested waiver and expenditure authorities
- A description of DHMH's public input process
- An evaluation report of the demonstration

Recent Changes to the Waiver

During the last renewal period, DHMH focused on improving access to dental and pregnancy-related services and the behavioral health integration process. DHMH received bonus payments from CMS for implementing initiatives to increase Medicaid enrollment.

Dental Services

Maryland convened a broad array of stakeholders to improve dental access and outcomes for children, pregnant women, and adults enrolled in the Rare and Expensive Case Management Program (REM) program. As a result, several changes were made to the program to improve dental access. DHMH increased dental fees for preventive and diagnostic services. Dental services were carved out of the managed care organization (MCO) benefit package in July 2009 and are now administered by a single statewide administrative services organization (ASO). In

addition, DHMH implemented a fluoride varnish program in medical offices to serve children aged 9 through 36 months. Because of these efforts, the Maryland Healthy Smiles Program received the highest ranking in the nation for providing dental services to low-income participants from The Pew Center for the States in 2010 and 2011.

Family Planning Program

In 2008, CMS required the Family Planning Program to perform annual active redeterminations and to reduce the upper income limit from 250 percent to 200 percent of the federal poverty level (FPL). Beginning in January 2012, Maryland expanded eligibility for the Family Planning Program to include all women less than 51 years of age with household income up to 200 percent of the FPL. It previously only covered women losing pregnancy-related Medicaid eligibility 60 days postpartum for no more than five years.

Accelerated Certification of Eligibility Process

DHMH implemented a procedure for prioritizing Medicaid applications for pregnant women, the Accelerated Certification of Eligibility (ACE) process. This process has alleviated barriers to access to prenatal care by granting temporary eligibility in cases where there is insufficient documentation to make an eligibility determination. Temporary eligibility is granted while the case worker completes the case work within 30 days. These procedures assist the State in meeting Governor O'Malley's initiative to decrease infant mortality in Maryland. The program also collaborates with public health officials at DHMH to implement various strategies that support the Governor's initiative to reduce infant mortality.

REM

During the last waiver renewal, Medicaid expanded access to benefits for individuals in the Rare and Expensive Case Management (REM) program. Specifically, the State asked for waiver approval from CMS to allow individuals receiving private duty nursing or home health aide services through the REM benefit expansion to remain in the REM program after becoming eligible for Medicare. To qualify, individuals must continue to meet the eligibility diagnosis criteria for REM. Should an individual no longer meet the diagnostic criteria for REM, that individual is disenrolled from REM just as other REM beneficiaries are subject to disenrollment. DHMH plans to continue offering this expanded benefit package to REM enrollees during the next waiver period.

Increased Community Services Program

DHMH has been operating the Increased Community Services (ICS) Program since 2009. This innovative program removes the barrier that now prevents certain individuals from moving into the community. Specifically, the ICS program allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300 percent of SSI. Individuals in the ICS program are an expansion population under the HealthChoice waiver. This population is

currently capped at 30 individuals. Seven individuals are currently participating in the program. Although small, the ICS program plays an integral role in allowing these individuals to live in the community. DHMH plans to continue to operate this program during the next waiver period. The program will continue to be limited to 30 individuals; however, the eligibility criteria will be updated for consistency with the federal rules under the Money Follows the Person Demonstration. Specifically, eligibility will be available to an individual who:

- Resides (and has resided for a period of not less than 90 consecutive days) in a nursing facility. Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day nursing home stay requirement; and
- Is receiving Medicaid benefits for nursing home services furnished by such nursing facility.

CHIPRA Bonus Payments

Maryland received three performance bonus payments from CMS, authorized under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Bonus payments are granted to states that implemented at least five CMS-identified initiatives known to promote enrollment and retention in coverage for children and have demonstrated a significant increase in Medicaid enrollment among children. Maryland's first bonus payment was $10.5 million for federal fiscal year (FFY) 2010, and the bonus payment was $28.0 million for FFY 2011. Maryland's payment will be $36.5 million for FFY 2012. FFY 2013 will be the last year that states can qualify for bonus payments.

A Look at the Next Renewal Period

Improving Quality of Care

The HealthChoice program works to improve the quality of health services delivered. DHMH has an extensive system for quality measurement and improvement that uses nationally recognized performance standards. Quality activities include the External Quality Review Organization (EQRO) Systems Performance Review, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, the value-based purchasing (VBP) program, the Healthcare Effectiveness Data and Information Set (HEDIS) quality measures, a provider satisfaction survey, a HealthChoice consumer report card, annual Performance Improvement Projects (PIPs), and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provider compliance review.[1] As Maryland is pursing the Medicaid expansion under the ACA, DHMH will be reviewing these performance standards to make sure that they more completely represent the new adult populations.

[1] These reports may be found at https://mmcp.dhmh.maryland.gov/healthchoice/SitePages/CY%202011.aspx.

Behavioral Health Integration

Due to the correlation between mental health and substance use disorders, DHMH began a Behavioral Health Integration stakeholder process in 2011. As part of the fiscal year (FY) 2012 budget, the Maryland General Assembly asked DHMH to convene a workgroup and provide recommendations "to develop a system of integrated care for individuals with co-occurring serious mental illness and substance abuse issues." In making this request, the Maryland General Assembly recognized the current need for improved coordination in Maryland's approach to individuals with behavioral health conditions.

The process began with Phase 1 in 2011 and involved collaborative work between DHMH, a consultant, and stakeholders in order to assess the strengths and weaknesses in Maryland's current system. While noting the strengths in the current system, including generally good access in each service domain (mental health, substance use treatment, and somatic care), the resulting report reached five conclusions: (1) benefit design and management across the domains are poorly aligned; (2) purchasing and financing are fragmented; (3) care management is not coordinated; (4) performance and risk are lacking; and (5) care integration needs improvement.

Phase 2 of the process began in early 2012 as DHMH and stakeholders set out to develop a broad financing model to better integrate care across the service domains. Between March and September 2012, DHMH held a series of public stakeholder meetings to inform the selection of a financing model. DHMH accepted comments in writing and in 24 public meetings. After review of the various options, a cross-disciplinary leadership steering committee within DHMH offered its recommendation that Maryland pursue a transformative behavioral health carve-out that combines treatment for specialty mental illness and substance use disorders under the management of a single ASO. On April 12, 2013, Secretary Sharfstein announced the decision to move forward with establishing a performance-based carve-out for substance abuse and mental health services.

In order to implement this model, DHMH will develop a robust Request for Proposals to select an ASO to administer the new carve-out, as well as design the related policy changes in the existing program for MCOs. It is our goal to implement the new system in 2015. As we have done to date, we will continue to collaborate with stakeholders to develop:

- Performance measures
- Shared savings models
- Network adequacy policies
- Quality standards
- Access to care standards
- A financing approach that complements emerging clinical models of integration

Maryland Multi-Payer Patient-Centered Medical Home Program

A patient-centered medical home (PCMH) is a model of care delivery that encourages teamwork and care coordination among clinicians to offer patients better access to services and a greater role in making health care decisions. It is intended to strengthen the patient-provider relationship, as well as lower health care costs. In 2011, Maryland began a three-year pilot to test the use of a PCMH; this pilot is called the Maryland Multi-Payer Patient Centered Medical Home Program (MMPP). The MMPP provides Maryland patients with many services, such as integrated care plans, chronic disease management, medication reconciliation at every visit, and same-day appointments for urgent matters. Across the State, 52 primary and multispecialty practices and federally qualified health centers are participating in MMPP. These practices are paid through the HealthChoice MCOs and private health insurance carriers. The Maryland Health Care Commission will conduct an evaluation of MMPP to examine if health care quality and outcomes improved and costs were reduced.

Chronic Health Home

In the FY 2013 budget, the Maryland General Assembly set aside funds for the development of a chronic health home demonstration to take advantage of the opportunity in Section 2703 of the ACA. Section 2703 allows states to amend their Medicaid State Plans to offer health homes that provide comprehensive systems of care coordination for participants with two or more defined chronic conditions. Anticipated eligibility for Maryland's chronic health home services will extend to individuals diagnosed with a serious and persistent mental illness, children diagnosed with a serious emotional disturbance, or individuals diagnosed with an opioid substance use disorder along with being at-risk for another chronic condition based on tobacco, alcohol, or other non-opioid substance use.

The sites of care include psychiatric rehabilitation programs (PRPs), mobile treatment (MT) services, and opioid maintenance therapy (OMT) programs. Maryland will require interested sites to enroll as Medicaid providers, receive health home accreditation, and demonstrate capabilities to comply with data collection, reporting, and other technological activities. Providers will receive payments per member per month for performing care management activities related to preventive and health promotion, coordination of care, disease self-management, discharge planning, and patient monitoring, among other activities. Maryland will evaluate providers based on a combination of monitoring hospital and emergency department (ED) admissions, cost savings, HEDIS measures, and other measures to be defined further in the State Plan Amendment. DHMH officially uploaded the chronic health home State Plan Amendment to the CMS system on April 8, 2013, and final submission will be dependent upon CMS feedback.

State Innovation Grant

In February 2013, CMS awarded Maryland with a State Innovation Model (SIM) design award of up to $2.4 million for design activities to occur between April and September 2013. The SIM initiative is providing funding to support the development and testing of state-based models for

multi-payer health care delivery and payment system transformation. Maryland is seeking to create a model that integrates patient-centered primary care with innovative community health initiatives. Funds will be used to design a statewide, multi-payer Community-Integrated Medical Home (CIMH) program. The design phase will engage public and private payers and local health improvement coalitions to create a comprehensive plan, establish a governance structure for CIMH, set program standards, and collect baseline data. It is anticipated that these design activities will form a SIM Model Testing grant submission in the spring of 2013. DHMH is leading this initiative, and it will require significant involvement from the Medicaid program.

Covering New Populations

Under the ACA, Maryland will expand its Medicaid program to offer coverage to individuals with incomes up to 138 percent of FPL.[2] Maryland received guidance from The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) on how the ACA would impact enrollment into the Medicaid program and the Maryland Health Benefit Exchange (MHBE). [3] In July 2010, The Hilltop Institute developed a financial model forecasting the fiscal and enrollment effects of Maryland's implementation of the ACA. This model's fiscal estimates were limited to State general funds. The most recent iteration of the model, published in July 2012 for the MHBE, was an expanded analysis to further assess the impact of ACA implementation on Maryland's economy (Fakhraei, 2012).

Pertinent to this evaluation, this model projects a substantial increase in Medicaid enrollment resulting from the expansion of eligibility to 138 percent of the FPL. Between 2014 and 2020, Maryland is estimated to have 187,276 newly eligible individuals enrolled in Medicaid. This represents 73.8 percent of individuals projected to be newly eligible. A significant share of newly eligible individuals will be shifting from the Primary Adult Care (PAC) program (Fakhraei, 2012). Hilltop's economic model projects State costs for the Medicaid expansion to be $123 million through 2020. Overall, Maryland's implementation of the ACA is projected to save between $504 and $840 million towards the State budget and lower the unemployment rate to 3.7 percent (Fakhraei, 2012).

Table 1 presents enrollment projections by components of ACA implementation (Medicaid expansion, the Medicaid "woodwork" effect[4], and the MHBE). By 2020, 471,019 individuals are projected to have new Medicaid or MHBE-based coverage. Conversely, 390,352 individuals are projected to remain uninsured – representing 6.3 percent of Maryland's total population (Fakhraei, 2012).

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[2] The new federal eligibility rules include a 5 percent income disregard, raising the eligibility maximum from 133 to 138 percent FPL.

[3] See http://www.hilltopinstitute.org/publications/MarylandHealthCareReformSimulationModel-July2012.pdf. To view detailed estimates, go to http://www.hilltopinstitute.org/publications/SimulationModelProjections-July2012.pdf.

[4] The "woodwork" effect is comprised of individuals currently eligible but not enrolled in Medicaid, but are likely to enroll with Maryland's implementation of ACA. For these individuals, the federal match rate is 50 percent.

Table 1. Total New Medicaid and Exchange Coverage

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Medicaid Expansion (Includes PAC Participants)	90,639	112,285	119,634	126,996	133,201	138,999	143,207
Medicaid "Woodwork" Effect	11,046	23,117	32,301	40,150	41,793	42,956	44,069
Exchange (138 - 200% FPL) with Subsidy	37,452	42,308	45,088	49,859	55,823	61,336	67,249
Exchange (200 - 400% FPL) with Subsidy	67,289	77,937	84,888	96,245	108,691	119,423	131,508
Exchange (Above 400%) without Subsidy	34,023	41,038	44,240	51,903	60,066	66,974	74,829
Small Business Health Options Program (SHOP)	8,469	8,553	10,107	10,138	10,141	10,137	10,157
Total New Medicaid and Exchange Coverage	**248,918**	**305,238**	**336,258**	**375,291**	**409,715**	**439,825**	**471,019**

Request to Waive Title XIX Requirements: New Provisions

1. New Childless Adult Population

With the implementation of Health Care Reform, DHMH will no longer need to operate the PAC program. Rather, childless adults under the age of 65 and with incomes up to 138 percent of the FPL will receive full Medicaid benefits. Because the ACA explicitly permits states to cover this childless adult population, Maryland will no longer have to use budget neutrality savings from the HealthChoice 1115 waiver to receive federal matching dollars. This population will remain covered under the HealthChoice 1115 waiver because services will be provided through HealthChoice MCOs. Accordingly, DHMH seeks to move this new childless adult population under the waiver and to remove the PAC program as an expansion population.

2. Pregnant Women

Despite the ACA option of lowering the income limit to 185 percent of the FPL, DHMH will continue to cover pregnant women with income up to 250 percent of the FPL. Women with incomes between 138 and 250 percent of the FPL will receive health care coverage through qualified health plans. Once pregnant, women within these income groups will receive their services through Medicaid. Eligibility will continue through 60 days of postpartum care and includes full Medicaid benefits and dental services.[5]

DHMH considered offering premium assistance to pregnant woman in order to help them maintain provider continuity of care. To meet the pending deadline of January 1, 2014, however, Maryland has decided it cannot pursue a premium assistance program for pregnant women. This

[5] Dental services will discontinue after giving birth.

decision was also influenced by the lack of final federal rules and Maryland's need to finalize eligibility system programming changes. DHMH will cover pregnant women who are not eligible for or receiving advanced premium tax credits.

Maryland does not anticipate needing any specific waivers to cover pregnant women. But if the final federal rules do not match the current eligibility rules programmed into our system, we may need to seek waiver authority in the future.

3. Family Planning Program

DHMH requests that the Maryland Family Planning Program be accorded one additional transition year—from January 1, 2014, to January 1, 2015— to convert income limits to the modified adjusted gross income (MAGI).

Eligibility determinations for the Family Planning Program will be made outside of the Maryland Health Insurance Exchange (HIX). For the Family Planning Program to operate outside of HIX and be converted to MAGI by October 2013, DHMH anticipates substantial changes to the current eligibility system of record. In addition, the program application and outreach materials must reflect the new eligibility rules, and DHMH must train current eligibility staff on these new rules. These changes will require a significant level of effort by the operations and eligibility staff. As you may know, staff resources are severely limited as Maryland prepares to implement the broader health reform changes that become effective in January 2014. Accordingly, additional time is needed to accomplish the MAGI conversion for the Family Planning Program.

4. Breast and Cervical Cancer Program

Maryland is requesting permission to continue providing coverage to women who are currently receiving coverage under the federal Breast and Cervical Cancer Prevention and Treatment Act. The program serves women with incomes up to 250 percent of the FPL. As of March 2013, 479 women were enrolled in the program. Any new applicants who are not enrolled in the program on January 1, 2014, will not be found to be eligible. Medicaid will now be covering childless adults up to 138 percent of the FPL, and individuals between 138 percent and 400 percent of the FPL will be eligible for new advanced premium tax credits and cost sharing subsidies through the Exchange. Additionally, insurers in the individual and group markets will be prohibited from imposing pre-existing condition exclusions. In short, DHMH will no longer cover new enrollees but the provisions in the ACA provide individuals served under the Breast and Cervical Cancer Program with other alternatives. Maryland, however, does not want to discontinue Medicaid coverage for women currently in active treatment programs for breast and cervical cancer. So for continuity of care issues, Maryland will grandfather-in existing enrollees.

5. Alternative Benefit Package

Maryland is seeking a waiver to proposed 42 C.F.R §440.345. Specifically, Maryland is requesting that its existing Medicaid benefit package be deemed to meet the alternative benefit

plan standards under the Secretary-approved coverage option, without having to supplement benefits from the essential health benefit (EHB) benchmark options.

The proposed rules (42 C.F.R. §440.345) indicate that states will be required to offer EHBs to the newly eligible Medicaid expansion population. This is very problematic for several reasons. Prior to this guidance, Maryland had intended to offer the existing Medicaid State Plan benefit package to the newly eligible population, and Medicaid had planned and budgeted accordingly. In comparing the State Plan services to the EHB benchmark options, Maryland found that the benchmark covers services beyond the State Plan (some of which are ineligible for federal financial participation under the Hyde Amendment). Supplementing coverage will present a series of challenges. For services that are not presently covered, Medicaid would need to enroll new providers, set reimbursement rates, design claims and payment rules, incorporate those rules into Medicaid systems, determine whether the services should be delivered through managed care, and, if the services are delivered in managed care, incorporate the cost of those services into capitation rates. This is not an exclusive list of activities that Medicaid would have to complete in order to realize coverage for new services. There will be a large administrative burden in expanding the benefit package.

Further, the guidance suggests that the policy only applies to the newly eligible category of adults. This creates a situation in which the higher income expansion population would receive a more generous benefit package than the existing populations. These disparities in coverage will create a churn point of covered services within Medicaid. This means that states will likely have to expand coverage for all adult populations to prevent benefit churn. There would be a significant financial cost to states to expand benefits for all adults, as new benefits for the existing population are ineligible for the enhanced matching offered under the ACA for the newly eligible expansion population. This would have a major impact on the State Medicaid budget. Therefore, Maryland is requesting that its existing Medicaid benefit package be deemed to meet the alternative benefit plan standards under the Secretary-approved coverage option, without having to supplement benefits from the EHB benchmark options. The Secretary has already approved the State Plan benefit package as adequate for the existing low-income Medicaid populations. Thus, it should be adequate for the newly eligible population.

Request to Waive Title XIX Requirements

The following table summarizes the current waiver provisions and whether or not DHMH is requesting to continue these provisions in the next renewal period.

Current Terms and Conditions	Keep / Remove
Demonstration Population 13 (PAC)	Remove
Demonstration Population 14 (Family Planning) • Waiver to Section 1902(a)(10(B) – to allow the State to offer limited benefit • Waiver to Section 1902(a)(34) - to exempt the State from extending eligibility prior to the date of application • Waiver to Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53 – to the extent necessary to enable the State to not assure transportation to and from providers • Waiver to Section 1902(a)(17) – to extent necessary to allow the State to not include parental income when determining a minor's (an individual age 18 and below) eligibility	Keep
Demonstration Population 15 (Increased Community Services) • Allow the program to be capped at 30 individuals	Keep
REM Benefits – Include expenditures for benefits not under the State Plan and allow individuals receiving private duty nursing and shift home health aide services who become Medicare eligible to stay on the program if they continue to meet the REM diagnostic eligibility criteria until age 65 • Waiver to Section 1902(a)(10)(B) – to enable the State to provide benefits specified in the STCS to Demonstration participants in the Rare and Expensive Case Management program which are not available to other individuals under the Medicaid State plan.	Keep
Do not require the MCO to: 1. Provide an enrollee with the disenrollment rights required by sections 1903 (m)(2)(A)(vi) and 1932(a)(4) of the Act, when the enrollee is automatically re-enrolled into the enrollee's prior MCO after an eligibility lapse of no more than 120 days. 2. Enforce the requirement that an enrollee's verbal appeal be confirmed in writing as specified in sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 42 CFR 438.402(b)(3)(ii) and 42 CFR 438.406(b)(1) 3. Send a written notice of action for a denial of payment [as specified in 42 CFR 438.400(b)(3)] when the	Keep: 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. Currently, DHMH does not require that appeals be submitted in writing and neither the DHMH nor the MCOs require a signature. In order to maintain

Current Terms and Conditions	Keep / Remove
beneficiary has no liability, as required by sections 1903(m)(2)(A)(xi) and 1932(b)(4) of the Act and in regulations at 438.404(c)(2)	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. 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.
Reasonable promptness Section 1902(a)(8) Providing Medical Assistance Section 1902(a)(10)(A)(ii)(XIV) – 6-month waiting period for CHIP kids	Remove: DHMH will not require children to wait 6-months after dropping employer-sponsored coverage to gain eligibility
Freedom of Choice Section 1902(a)(23)(A) – to enable the State to restrict freedom of choice of provider, other than for family planning services, for children with special needs, as identified in section 1932(a)(2)(A)(i-v) of the Act, who are participants in the Demonstration To enable the State to require that all populations participating in the Demonstration receive outpatient mental health services from providers with the public mental health system.	Keep
Retroactive Eligibility Section 1902(a)(34) To exempt the State from extending eligibility prior to the date of application to optional targeted low-income children, except for infants under age 1 described in subsection 1902(a)(10)(A)(i)(IV), or children described in subsections 1902(a)(10)(A)(i)(VI) or 1902(a)(10)(A)(i)(VII)	Keep: Currently, there is no retroactivity coverage or fee-for-service period for MCHP Premium. MCHP Premium coverage begins once a child is enrolled in an MCO. As of January 1, 2014, the fee-for-service period will be effective on the first day of the month in which the child is found eligible for MCHP Premium until the

Current Terms and Conditions	Keep / Remove
	child is enrolled in an MCO. Retroactivity coverage will not be available for this population.
Presumptive Eligibility Option Section 1902(a)(47) insofar as it incorporates sections 1920 and 1920A To permit the State for provide presumptive eligibility for pregnant women and children using a method for determining presumptive eligibility that is not in accordance with sections 1920 and 1920A.	Keep: DHMH will continue to operate the ACE process for pregnant women

Public Process and Indian Consultation Requirements

DHMH engaged stakeholder participation and provided public notice of this renewal application per the requirements in 45 C.F.R. §431.408. DHMH provided a 30-day public notice and comment period on April 19, 2013, through May 19, 2013. This notice was published in *The Maryland Register* and on the DHMH website.

In addition to publishing these notices, DHMH conducted two public hearings on the renewal application. The first hearing was held on April 25, 2013, in Baltimore subsequent to the Maryland Medicaid Advisory Committee (MMAC) meeting. The second hearing was held on May 9, 2013, in Annapolis. During these hearings, DHMH presented the renewal application and accepted comments from stakeholders.

Beyond these requirements, DHMH continually engages stakeholder consultation on the HealthChoice program through the MMAC. The MMAC meets monthly and receives reports on regulatory and waiver changes, including amendments to the 1115 waiver. Annually, the MMAC provides feedback on the HealthChoice evaluation report. The MMAC also provides extensive input and feedback on the evaluation outline submitted to CMS.

Evaluation

This section serves as the evaluation required for the renewal request and seeks to address:

- Coverage and access to care
- The extent to which HealthChoice provides a medical home and continuity of care
- The quality of care delivered to participants
- Program financing and budget neutrality
- Special topics, including dental services, behavioral health care, services provided to children in foster care, reproductive health services, REM program, and racial/ethnic disparities in utilization
- Access and quality of care under the PAC program

As with previous HealthChoice evaluations and renewal applications, this renewal application was conducted collaboratively by DHMH and The Hilltop Institute at the University of Maryland, Baltimore County (UMBC).

Overview of the HealthChoice Program

The HealthChoice managed care program currently enrolls over 80 percent of the State's Medicaid and the Maryland Children's Health Program (MCHP) population. Participants in HealthChoice choose one of eight MCOs and a primary care provider (PCP) from the MCOs' network to oversee their medical care. The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include:

- Families with low income that have children
- Families receiving Temporary Assistance for Needy Families (TANF)
- Children younger than 19 years eligible for MCHP
- Children in foster care
- Low income women who are pregnant or less than 60-days postpartum
- Individuals receiving SSI who are younger than 65 years and ineligible for Medicare

Not all Maryland Medicaid beneficiaries are enrolled in HealthChoice MCOs. Groups ineligible for MCO enrollment include:

- Medicare beneficiaries
- Individuals aged 65 years and older
- Individuals in a "spend-down" eligibility group who are only eligible for Medicaid for a short period of time

- Individuals who are continuously enrolled in a long-term care facility or an institution for mental illness for over 30 days
- Individuals residing in an intermediate care facility for the mentally retarded
- Those enrolled in the Employed Individuals with Disabilities program
- Refugees and certain categories of aliens

Additional populations covered under the HealthChoice waiver include individuals in the Family Planning, REM, and PAC programs. HealthChoice-eligible individuals with certain diagnoses may choose to receive care on a fee-for-service (FFS) basis through the REM program. Family Planning and PAC are both limited benefit packages under the waiver. REM and Family Planning are further discussed in Section IV of this report, and PAC is included in Section V.

HealthChoice participants receive the same comprehensive benefits as those available to Maryland Medicaid participants through the FFS system. Services in the MCO benefit package include, but are not limited to:

- Inpatient and outpatient hospital care
- Physician care
- Clinic services
- Laboratory and x-ray services
- EPSDT services for children
- Prescription drugs, with the exception of mental health and HIV/AIDS drugs, which are provided under the FFS system
- Substance abuse treatment services
- Durable medical equipment and disposable medical supplies
- Home health care
- Vision services
- Dialysis
- The first 30 days of care in a nursing home

Some services are carved out of the MCO benefit package and instead are covered by the Medicaid FFS system. These include:

- Specialty mental health care, which is administered by the DHMH Mental Hygiene Administration
- Dental care for children, pregnant women, and adults in the REM program

- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Education Plan or Individualized Family Service Plan
- Therapy services (occupational, physical, speech, and audiology) for children
- Personal care services
- 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
- Services covered under 1915(c) home and community-based services waivers

Section I. Coverage and Access

Two of the goals of the HealthChoice program are to expand coverage to additional residents with low income through resources generated from managed care efficiencies and to improve access to health care services for the Medicaid/MCHP population. This section of the report addresses Maryland's progress in achieving these coverage and access goals. Coverage is examined through several enrollment measures. Access to care is measured by provider network adequacy, ambulatory care service utilization, ED service utilization, and enrollee survey results.

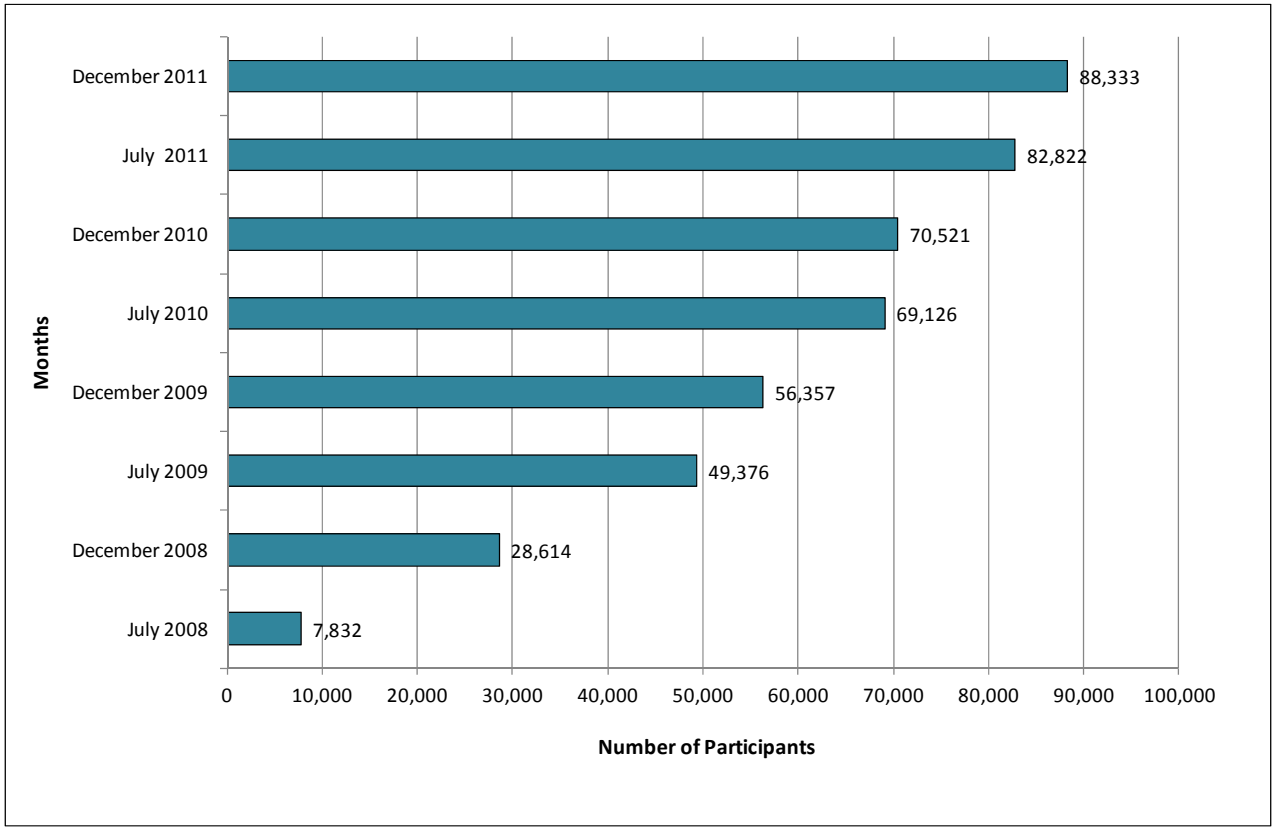
Are More Marylanders Covered?

Major Expansion Initiatives

Maryland has recently engaged in several efforts to increase Medicaid enrollment. Legislation and grant awards have increased DHMH's capacity to enroll uninsured children and adults in programs for which they might be eligible. The most successful of these expansion efforts was the increase in income eligibility for families in Medicaid. Effective July 1, 2008, Maryland expanded the eligibility thresholds for parents and caretaker relatives of children enrolled in Medicaid or MCHP from approximately 40 percent of the FPL to 116 percent of the FPL.

The eligibility expansion occurred at the same time that the economy slipped into recession, resulting in a dramatic increase in enrollment. Figure 1 presents the monthly enrollment in this parent expansion program beginning in July 2008. Enrollment increased from 7,832 participants in July 2008 to 88,333 participants in December 2011.

Figure 1. Enrollment in the Parent Expansion Program, July 2008 – December 2011



Health Choice Enrollment

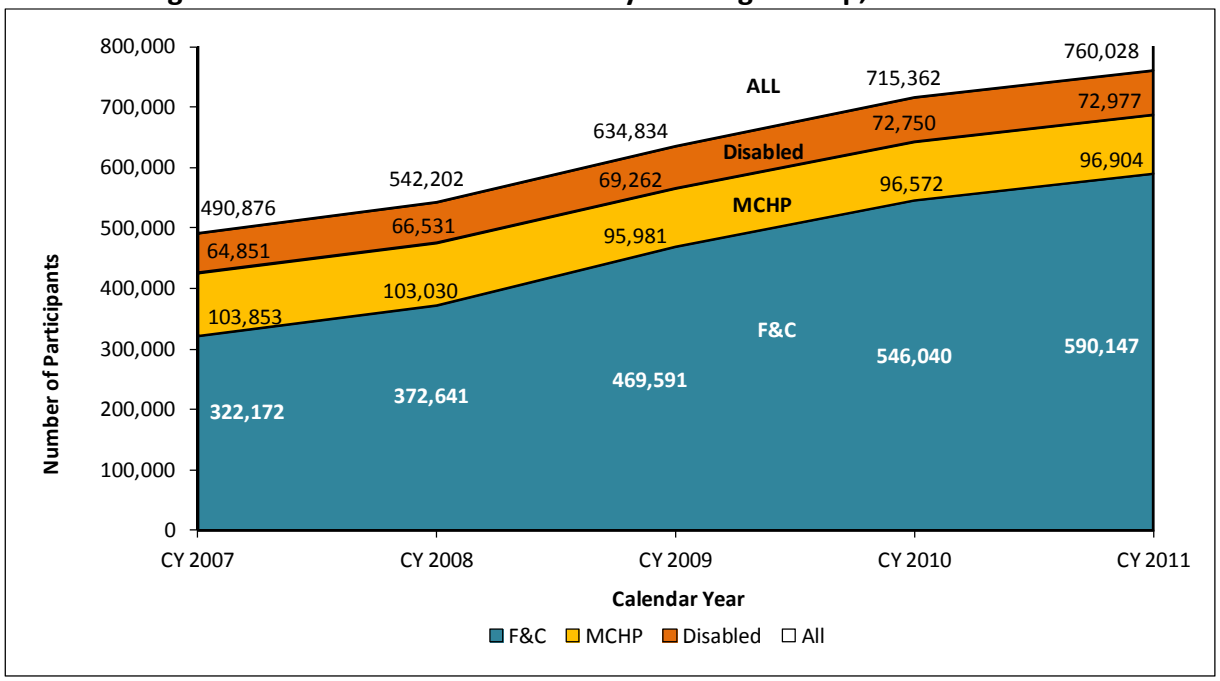
There are several methods available for measuring HealthChoice enrollment. One methodology is to count the number of individuals with any period of enrollment during a given calendar year (CY), including individuals who were only enrolled for a very short period of time. Another method is to count individuals who were enrolled at a certain point in time. Although this yields a smaller number, it provides a snapshot of typical program enrollment on a given day. Unless specified otherwise, the enrollment data in this section of the report use the point-in-time methodology to reflect enrollment as of December 31 of the measurement year.[6]

The overall HealthChoice population grew by nearly 55 percent between CY 2007 and CY 2011 (Figure 2). Most of the enrollment increase occurred between CY 2008 and CY 2009 when HealthChoice grew by more than 17 percent (92,632 new participants). A key factor in this enrollment growth was the expansion of Medicaid eligibility in July 2008. Figure 2 displays HealthChoice enrollment by coverage group between CY 2007 and CY 2011. As of December 31 of each year, most HealthChoice participants were eligible in the families, children, and pregnant women (F&C) category. Overall, F&C enrollment grew by 83 percent between CY

[6] Enrollment data are presented for individuals aged 0 through 64 years. Age is calculated as of December 31 of the measurement year.

2007 and CY 2011. Individuals with disabilities composed the smallest eligibility category in each of the years under review.[7]

Figure 2. HealthChoice Enrollment by Coverage Group, CY 2007–CY 2011



Enrollment Growth

National enrollment in Medicaid reached an all-time high of 52.6 million by June 2011 (Kaiser Commission on Medicaid and the Uninsured, 2012). According to the Kaiser Commission on Medicaid and the Uninsured, Maryland was one of ten states that accounted for 60 percent of Medicaid enrollment growth between June 2010 and June 2011, and Maryland experienced the seventh highest growth rate of all 50 states and the District of Columbia (2012).

Table 2 shows the percentage of Maryland's population enrolled in HealthChoice between CY 2007 and CY 2011. These data are presented for individuals enrolled in HealthChoice as of December 31 and for individuals with any period of HealthChoice enrollment. The percentage with any period of HealthChoice enrollment remained at 11 percent between CY 2007 and CY 2008 and increased to 15 percent by CY 2011.

[7] Individuals who are covered under both Medicare and Medicaid programs are not enrolled in HealthChoice.

Table 2. HealthChoice Enrollment as a Percentage of the Maryland Population, CY 2007 – CY 2011

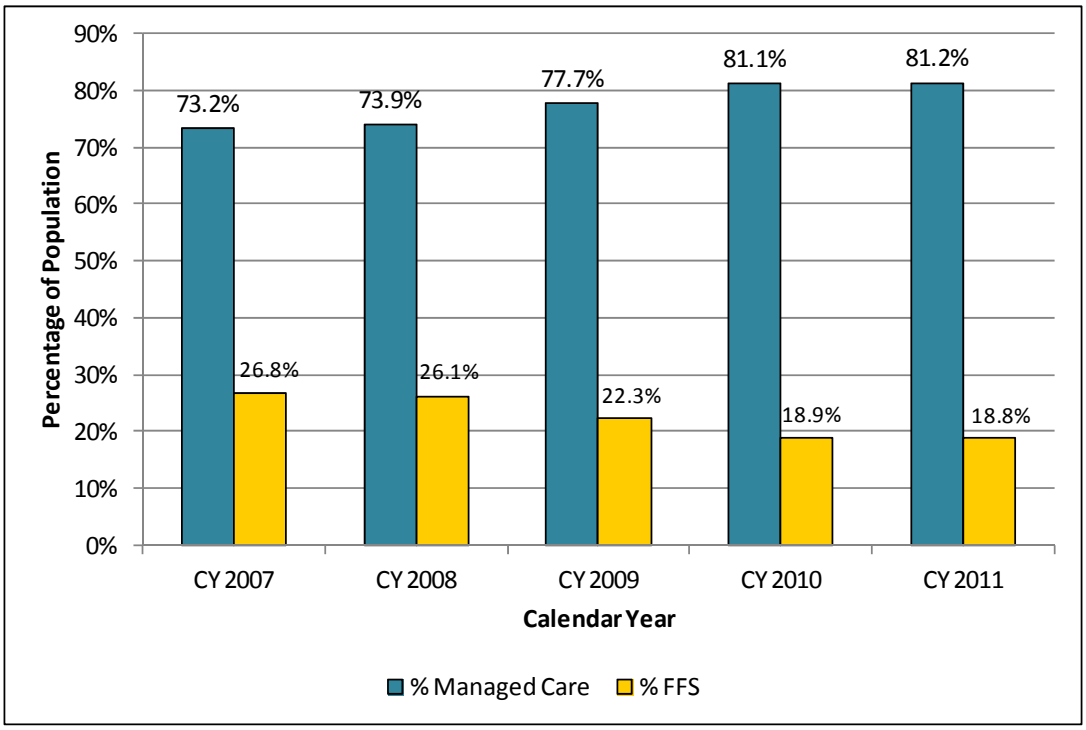
	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Maryland Population	5,634,242	5,658,655	5,699,478	5,773,552	5,828,289
Individuals Enrolled in HealthChoice for Any Period of Time During Year					
HealthChoice Population	623,299	654,412	743,098	832,684	893,084
% of Population in HealthChoice	11.1%	11.6%	13.0%	14.4%	15.3%
Individuals Enrolled in HealthChoice as of December 31					
HealthChoice Population	490,876	542,202	634,834	715,362	760,028
% of Population in HealthChoice	8.7%	9.6%	11.1%	12.4%	13.0%

* Maryland Population Data Source: United States Census Bureau, 2012; Maryland, Department of Planning, 2010

Are More Maryland Medicaid /MCHP Participants Covered Under Managed Care?

One of the original goals of the HealthChoice program was to enroll most individuals in Medicaid and MCHP into managed care. Figure 3 presents the percentage of Maryland Medicaid/MCHP participants who were enrolled in managed care (including both HealthChoice and PAC MCOs) as compared with FFS enrollment. Between CY 2007 and CY 2011, managed care enrollment increased from 73.2 percent to 81.2 percent.

Figure 3. Percentage of Medicaid/MCHP Participants in Managed Care versus FFS, CY 2007 – CY 2011



Does the Covered Population Access Care?

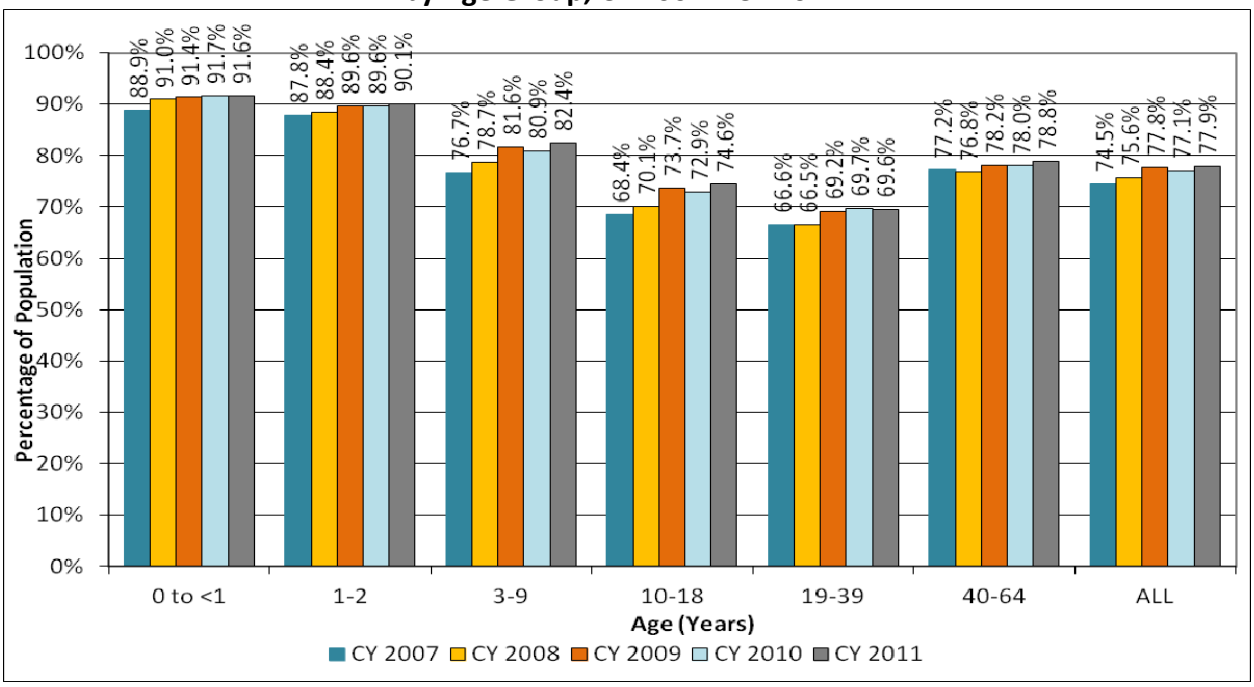
With this increased enrollment, it is important to maintain access to care. This section of the report examines ambulatory care, ED visits, and network adequacy to evaluate access to care. It also discusses results from the CAHPS survey.

Ambulatory Care Visits

DHMH monitors ambulatory care utilization as a measure of access to care. An ambulatory care visit[8] is defined as a contact with a doctor or nurse practitioner in a clinic, physician's office, or hospital outpatient department by an individual enrolled in HealthChoice at any time during the measurement year. In this section of the report, ambulatory care visits are measured using MCO and FFS data.

Figure 4 presents the percentage of HealthChoice participants who received an ambulatory care visit during the calendar year by age group. Overall, the ambulatory care visit rate increased from 74.5 percent in CY 2007 to 77.9 percent in CY 2011, and the rate increased for all age groups during the measurement period.

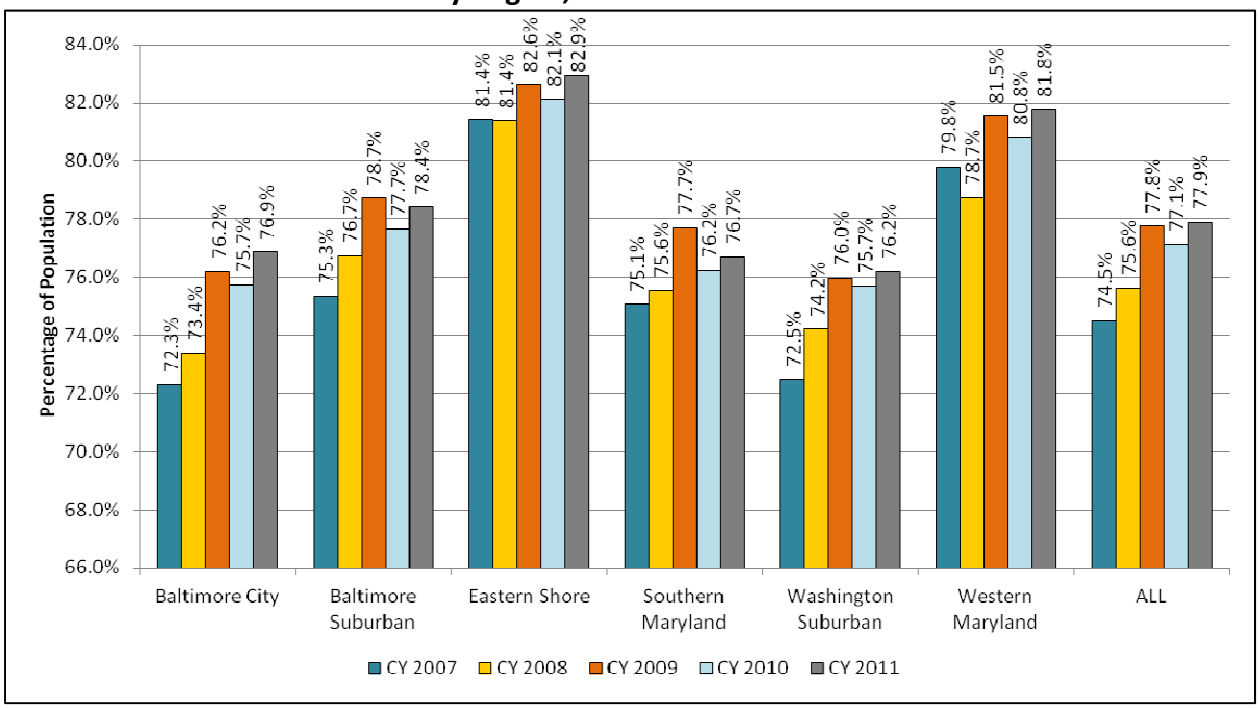
Figure 4. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Age Group, CY 2007 – CY 2011



[8] This definition excludes ED visits, hospital inpatient services, substance abuse treatment, mental health, home health, x-rays, and laboratory services.

Figure 5 presents the percentage of the HealthChoice population receiving an ambulatory care visit by region. The visit rate increased within each region between CY 2007 and CY 2011, and the Eastern Shore region had the highest percentage each year of the study period.

Figure 5. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Region, CY 2007 – CY 2011



ED Utilization

The primary role of the ED is to treat seriously ill and injured patients. Ideally, 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 and preventive care, thereby reducing the need for emergency services. To assess overall ED utilization, DHMH measures the percentage of individuals with any period of enrollment who visited an ED at least once during the calendar year. This measure excludes ED visits that resulted in an inpatient hospital admission.

Figure 6 presents ED use by coverage group. Overall, ED use among HealthChoice participants increased by 4.3 percentage points between CY 2007 and CY 2011. Participants with disabilities were more likely to utilize ED services than any other coverage group.

Figure 6. Percentage of the HealthChoice Population with at Least One ED Visit by Coverage Group, CY 2007 – CY 2011

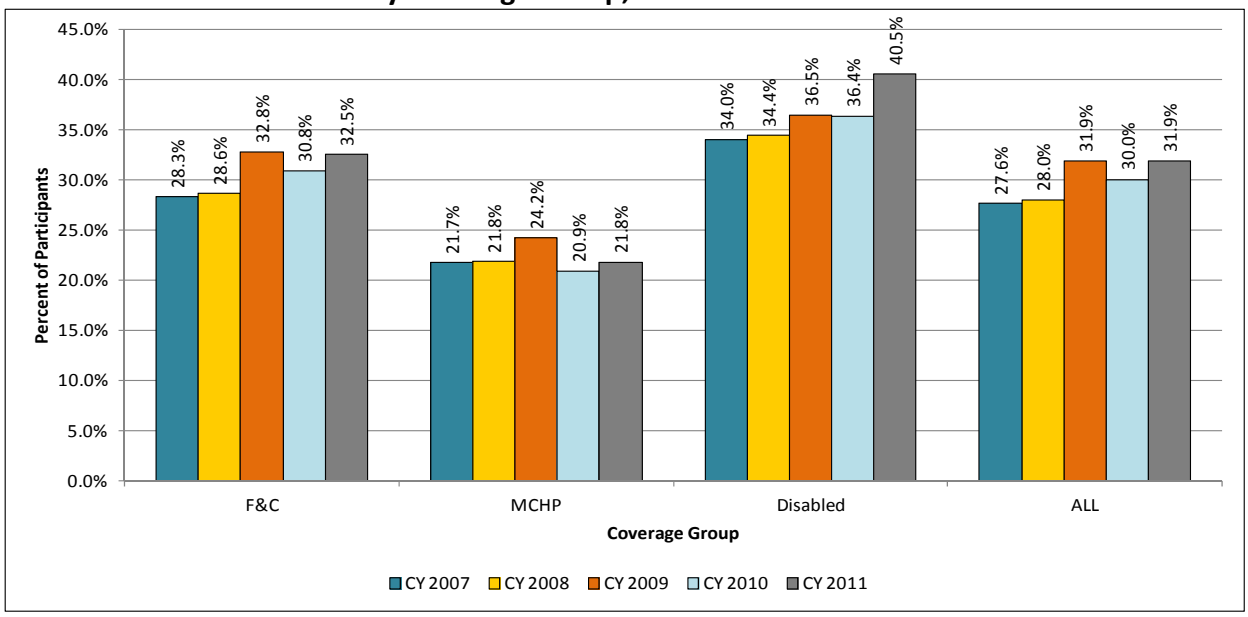
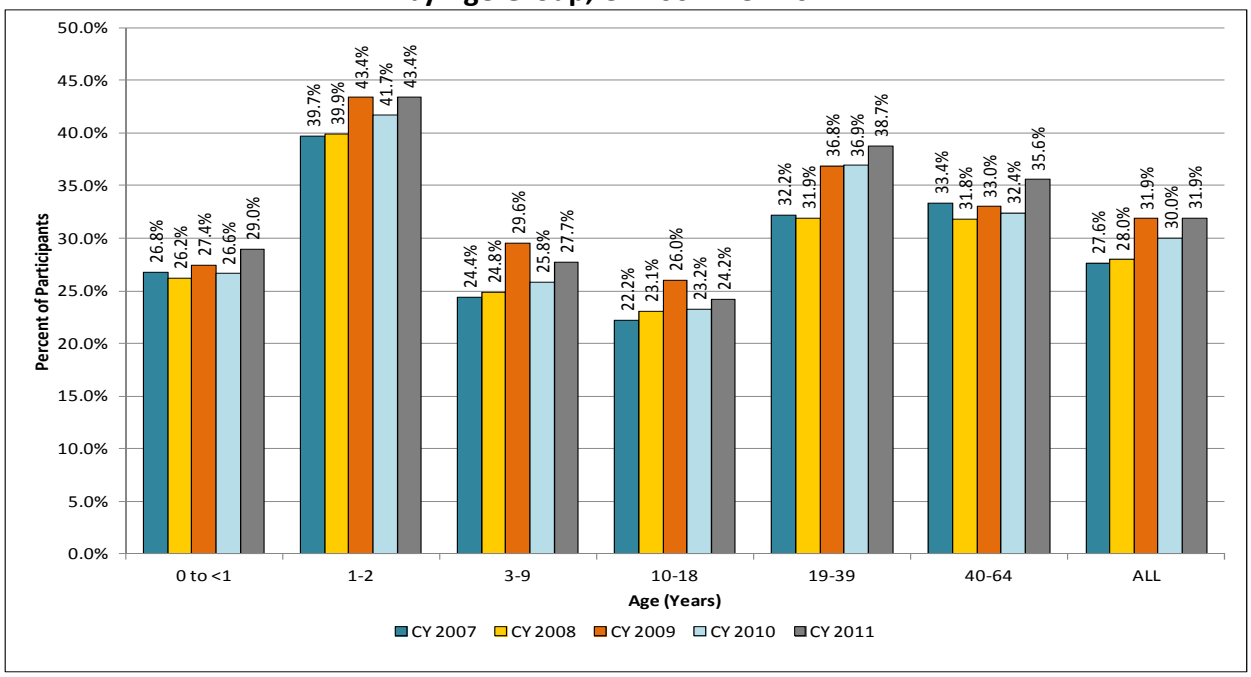


Figure 7 presents ED utilization by age group. Children aged 1 and 2 years consistently had the highest ED utilization throughout the evaluation period.

Figure 7. Percentage of the HealthChoice Population with at least One ED Visit by Age Group, CY 2007 – CY 2011



Are Provider Networks Adequate to Ensure Access?

One method of measuring enrollee access to care is to examine provider network adequacy. This section of the report examines PCP and specialty provider networks.

PCP Network Adequacy

HealthChoice requires every enrollee to have a PCP, and each MCO must have enough PCPs to serve its enrollee population. HealthChoice regulations require a ratio of 1 PCP to every 200 participants within each of the 40 local access areas (LAAs) in the State. Because some PCPs traditionally serve a high volume of HealthChoice participants at some of their sites (e.g., Federally Qualified Health Center [FQHC] physicians), the regulations permit DHMH to approve a ratio of 2,000 adult participants per high-volume provider and 1,500 participants aged 0 to 21 years per high-volume provider. DHMH assesses network adequacy periodically throughout the year to pinpoint potential network inadequacies and work with the MCOs to resolve capacity issues.

Table 3 shows PCP network adequacy as of September 2012. Two capacity estimates are presented: 200 participants per PCP and 500 participants per PCP. Although regulatory requirements apply to a single MCO, this analysis aggregates data from all seven HealthChoice MCOs. The analysis does not allow a single provider who contracts with multiple MCOs to be counted multiple times; thus, it applies a higher standard than that in regulation.

Table 3.PCP Capacity by Local Access Area, as of September 2012

	Total PCPs			Enrollment	Excess Capacity	
Local Access Area	September, 2012	Multiplied by 200	Multiplied by 500	September, 2012	Difference 200:1 Ratio	Difference 500:1 Ratio
Allegany	68	13,600	34,000	12,625	975	21,375
Anne Arundel North	218	43,600	109,000	29,582	14,018	79,418
Anne Arundel South	210	42,000	105,000	16,590	25,410	88,410
Baltimore City SE/Dundalk	235	47,000	117,500	26,108	20,892	91,392
Baltimore City East	389	77,800	194,500	30,907	46,893	163,593
Baltimore City N. Central	95	19,000	47,500	13,528	5,472	33,972
Baltimore City N. East	102	20,400	51,000	27,211	-6,811	23,789
Baltimore City N. West	248	49,600	124,000	23,908	25,692	100,092
Baltimore City South	85	17,000	42,500	19,620	-2,620	22,880
Baltimore City West	382	76,400	191,000	41,456	34,944	149,544
Baltimore County East	235	47,000	117,500	25,828	21,172	91,672
Baltimore County North	316	63,200	158,000	15,600	47,600	142,400
Baltimore County N. West	133	26,600	66,500	31,977	-5,377	34,523
Baltimore County S. West	179	35,800	89,500	23,822	11,978	65,678
Calvert	60	12,000	30,000	9,085	2,915	20,915
Caroline	35	7,000	17,500	7,562	-562	9,938
Carroll	99	19,800	49,500	13,500	6,300	36,000
Cecil	73	14,600	36,500	15,618	-1,018	20,882
Charles	94	18,800	47,000	16,237	2,563	30,763
Dorchester	28	5,600	14,000	7,270	-1,670	6,730
Frederick	104	20,800	52,000	20,229	571	31,771
Garrett	21	4,200	10,500	4,918	-718	5,582
Harford East	33	6,600	16,500	7,787	-1,187	8,713
Harford West	93	18,600	46,500	15,756	2,844	30,744
Howard	157	31,400	78,500	21,050	10,350	57,450
Kent	24	4,800	12,000	3,060	1,740	8,940
Montgomery-Silver Springs	201	40,200	100,500	48,901	-8,701	51,599
Montgomery-Mid County	224	44,800	112,000	15,247	29,553	96,753
Montgomery-North	122	24,400	61,000	34,111	-9,711	26,889
Prince George's N East	106	21,200	53,000	19,071	2,129	33,929
Prince George's N West	184	36,800	92,000	65,885	-29,085	26,115
Prince George's S East	67	13,400	33,500	12,785	615	20,715
Prince George's S West	77	15,400	38,500	30,802	-15,402	7,698
Queen Anne's	24	4,800	12,000	5,478	-678	6,522
Somerset	31	6,200	15,500	4,772	1,428	10,728
St. Mary's	78	15,600	39,000	12,694	2,906	26,306
Talbot	47	9,400	23,500	4,611	4,789	18,889
Washington	131	26,200	65,500	23,786	2,414	41,714
Wicomico	70	14,000	35,000	20,252	-6,252	14,748
Worchester	36	7,200	18,000	7,162	38	10,838
Total	**5,114**	**1,022,400**	**2,557,000**	**786,391**	**236,409**	**1,770,609**

Based on a standard enrollee-to-PCP ratio of 500:1, provider networks in each LAA are more than adequate. However, 14 LAAs do not meet the stricter 200:1 ratio: two in Baltimore City,

one in Baltimore County, one in Harford County, two in Montgomery County, two in Prince George's County, one in Garrett County, and five on the Eastern Shore. Between March 2011 and September 2012, the number of PCPs participating in HealthChoice increased from 4,661 to 5,114, a 9.7 percent increase. The Washington Suburban region[9] experienced the greatest increase.

Specialty Care Provider Network Adequacy

In addition to ensuring PCP network adequacy, DHMH requires MCOs to provide all medically necessary specialty care. If an MCO does not have the appropriate in-network specialist needed to meet the enrollee's medical needs, then the MCO must arrange for care with an out-of-network specialist and compensate the provider. Regulations for specialty care access require each MCO to have an in-network contract with at least one provider statewide in the following medical specialties: allergy, dermatology, endocrinology, infectious disease, nephrology, and pulmonology. Additionally, each MCO must include at least one in-network specialist in each of the 10 regions throughout the State for the following eight core specialties: cardiology, otolaryngology (ENT), gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology.

DHMH regularly monitors compliance with these specialty care access standards. As of September 2012, all seven MCOs met specialty coverage requirements for the core and major medical specialties.

CAHPS Survey Results

DHMH uses the CAHPS survey to measure enrollee satisfaction with their medical care (WB&A Market Research, 2012; WB&A Market Research, 2010; WB&A Market Research, 2008). Two CAHPS survey measures relate to access: "getting needed care" and "getting care quickly." "Getting needed care" measures:

- How often it was easy to get appointments with specialists
- How often is was easy to get care, tests, or treatments through their health plans

"Getting care quickly" measures:

- When participants needed care right away, how often they received care as soon as they thought they needed it
- Not counting the times they needed care right away, how often participants received an appointment for health care at a doctor's office or clinic as soon as they thought they needed it

[9] The Washington Suburban region encompasses the following LAAs: Frederick, Montgomery-Silver Springs, Montgomery-Mid County, Montgomery-North, Prince George's N East, Prince George's N West, Prince George's S East, and Prince George's S West.

The survey responses for these two measures are always, usually, sometimes, or never. In CY 2011, the percentage of adult HealthChoice members who responded that they were "usually" or "always" successful in getting needed care was 71 percent, and 79 percent of adult members responded that they were "usually" or "always" successful in getting care quickly (Table 4). Both of these percentages are lower than the CY 2011 National Committee for Quality Assurance (NCQA) Quality Compass benchmark.

Table 4. Percentage of Adult HealthChoice Participants Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2007 – CY 2011

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Getting Needed Care - Percentage of members who responded "Usually" or "Always"					
HealthChoice	73%	74%	74%	72%	71%
NCQA Quality Compass Benchmark	75%	76%	75%	76%	76%
Getting Care Quickly - Percentage of members who responded "Usually" or "Always"					
HealthChoice	80%	82%	80%	80%	79%
NCQA Quality Compass Benchmark	80%	80%	79%	81%	80%

In CY 2011, 79 percent of parents and guardians of children enrolled in HealthChoice responded "usually" or "always" getting needed care for their children, and 87 percent responded "usually" or "always" getting care quickly (Table 5). Both of these percentages are the same as the CY 2011 NCQA benchmark.

Table 5. Percentage of Parents/Guardians of Child HealthChoice Participants Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2007 – CY 2011

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Getting Needed Care - Percentage of members who responded "Usually" or "Always"					
HealthChoice	80%	76%*	74%	77%	79%
NCQA Quality Compass Benchmark	82%	79%*	79%	79%	79%
Getting Care Quickly - Percentage of members who responded "Usually" or "Always"					
HealthChoice	79%	89%*	88%	88%	87%
NCQA Quality Compass Benchmark	78%	86%*	87%	87%	87%

*Due to significant changes in the 2009 CAHPS 4.0H Survey (CY 2008), comparison to previous years is not appropriate.

Parents or guardians of children with chronic conditions in HealthChoice were also surveyed (Table 6). In CY 2011, 80 percent responded "usually" or "always" getting needed care for their children, which was a percentage point lower than the NCQA benchmark of 81 percent. Ninety percent reported "usually" or "always" getting care quickly, the same as the NCQA benchmark. National benchmarks for this population were available beginning in CY 2011.

Table 6. Percentage of Parents/Guardians of Children with Chronic Conditions in HealthChoice Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly, CY 2007 – CY 2011

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Getting Needed Care - Percentage of members who responded "Usually" or "Always"					
HealthChoice	77%	75%*	75%	78%	80%
NCQA Quality Compass Benchmark**					81%
Getting Care Quickly - Percentage of members who responded "Usually" or "Always"					
HealthChoice	79%	90%*	90%	91%	90%
NCQA Quality Compass Benchmark**					90%

*Due to significant changes in the 2009 CAHPS 4.0H Survey (CY 2008), comparison to previous years is not appropriate.
**NCQA Quality Compass Benchmarks were available for children with chronic conditions beginning in CY 2011.

Section I Summary

This section of the report discussed the HealthChoice program's progress in achieving its goals of expanding coverage and improving access to care. Related to coverage, Maryland expanded Medicaid eligibility for parents and caretaker relatives of children enrolled in Medicaid or MCHP in July 2008. By December 2011, 88,333 new parents and caretaker relatives were covered under HealthChoice. The overall HealthChoice population grew by nearly 55 percent between CY 2007 and CY 2011. By CY 2011, 15 percent of the State population was enrolled in HealthChoice. With these expansion activities and increased enrollment, it is important to maintain access to care and ensure program capacity to provide services to a growing population. Regarding PCP networks, there are several areas in the State that do not meet conservative network adequacy standards. The specialist network standards were met across all MCOs and regions in the State. Looking at service utilization as a measure of access, the percentage of participants receiving an ambulatory care visit increased since CY 2007, with nearly 78 percent of participants receiving a visit in CY 2011. Although CAHPS survey results indicate that most participants report that they usually or always receive needed care and receive care quickly, ED visits also increased, suggesting that there is still room for improvement in access to care.

Section II. Medical Home

One of the goals of the HealthChoice program is to ensure patient-focused, comprehensive, and coordinated care by providing each member with a medical home. HealthChoice participants choose one of seven MCOs and a PCP from the MCOs' network to oversee their medical care and provide a medical home. This section of the report discusses the extent to which HealthChoice provides participants with a medical home by assessing appropriate service utilization and continuity of care.

Appropriate Service Utilization

This section addresses whether participants could identify with and know how to navigate a medical home. With a greater understanding of the resources available to them, participants should be able to seek care in an ambulatory care setting before resorting to using the ED or letting a condition progress to the extent that it warrants an inpatient admission.

Appropriateness of ED Care

A fundamental goal of managed care programs such as HealthChoice is the delivery of the right care at the right time in the right setting. One widely used methodology to evaluate this goal in the ED setting is based on classifications developed by researchers at the New York University Center for Health and Public Service Research (NYU). The algorithm categorizes emergency visits as follows:

1. *Non-emergent*: Immediate care was not required within 12 hours based on patient's presenting symptoms, medical history, and vital signs
2. *Emergent but primary care treatable*: Treatment was required within 12 hours, but it could have been provided effectively in a primary care setting (e.g., CAT scan or certain lab tests)
3. *Emergent but 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., asthma flare-up)
4. *Emergent, ED care needed, not preventable/avoidable*: Ambulatory care could not have prevented the condition (e.g., trauma or appendicitis)
5. *Injury*: Injury was the principle diagnosis
6. *Alcohol-related*: The principal diagnosis was related to alcohol
7. *Drug-related*: The principal diagnosis was related to drugs
8. *Mental-health related*: The principal diagnosis was related to mental health
9. *Unclassified*: The condition was not classified in one of the above categories by the expert panel

ED visits that fall into categories 1 through 3 may be indicative of problems with access to primary care. Figure 8 presents the distribution of all ED visits by NYU classification for CY 2011 for individuals with any period of HealthChoice enrollment. In CY 2011, 51.8 percent of all ED visits were for potentially avoidable conditions, meaning that the visit could have been avoided with timely and quality primary care. Participants in the F&C and MCHP coverage groups had higher rates of potentially avoidable visits than participants in the disabled coverage group.

ED visits in categories 4 (emergent, ED care needed, not preventable/avoidable) and 5 (injury) are the least likely to be prevented with access to primary care. These two categories accounted for 26.5 percent of all ED visits in CY 2011. Adults aged 40 through 64 years had more ED visits related to category 4 than other age groups. Children aged 3 through 18 years had more injury-related ED visits compared to other age groups. The inpatient category in Figure 8, which is not a part of the NYU classification, represents ED visits that resulted in a hospital admission. Participants with disabilities had a much higher rate of ED visits that led to an inpatient admission than the F&C and MCHP coverage groups.

Figure 8. Classification of ED Visits by HealthChoice Participants, CY 2011

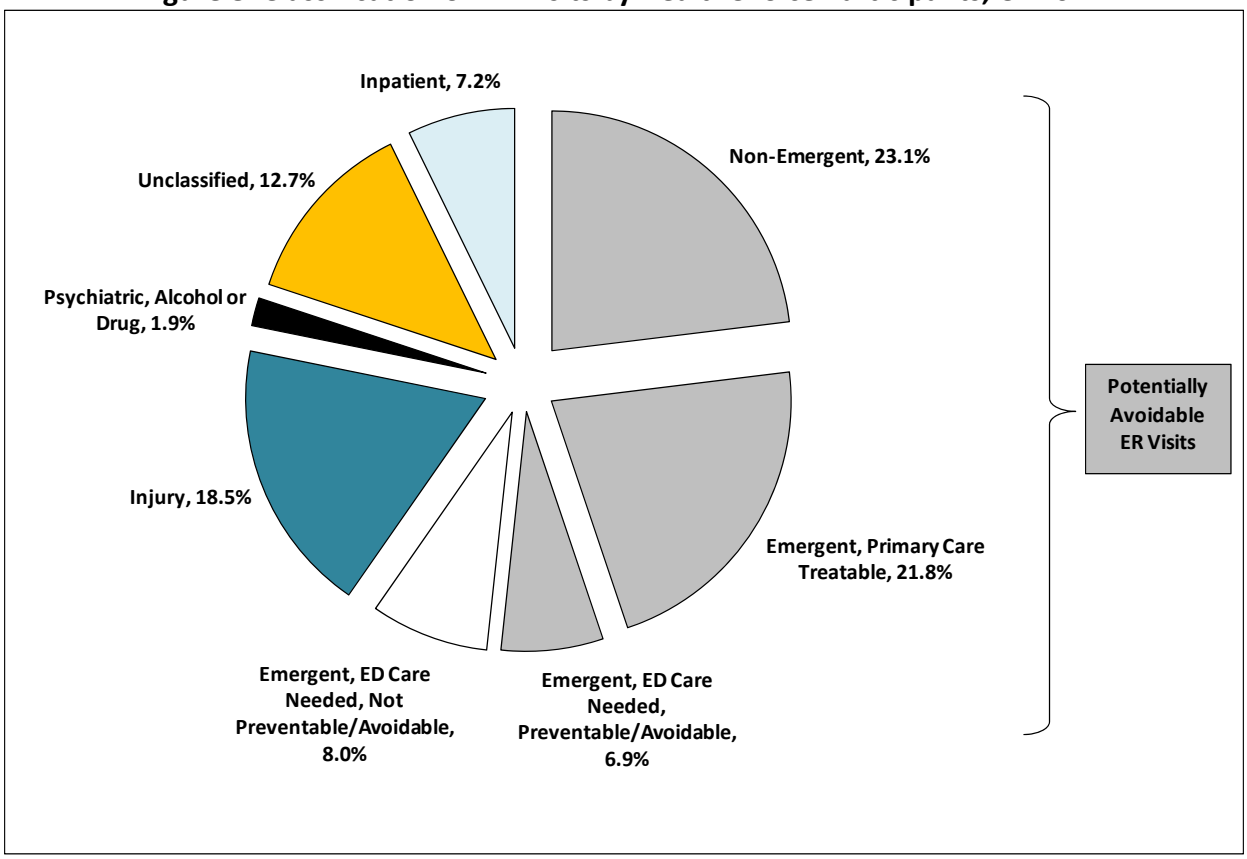
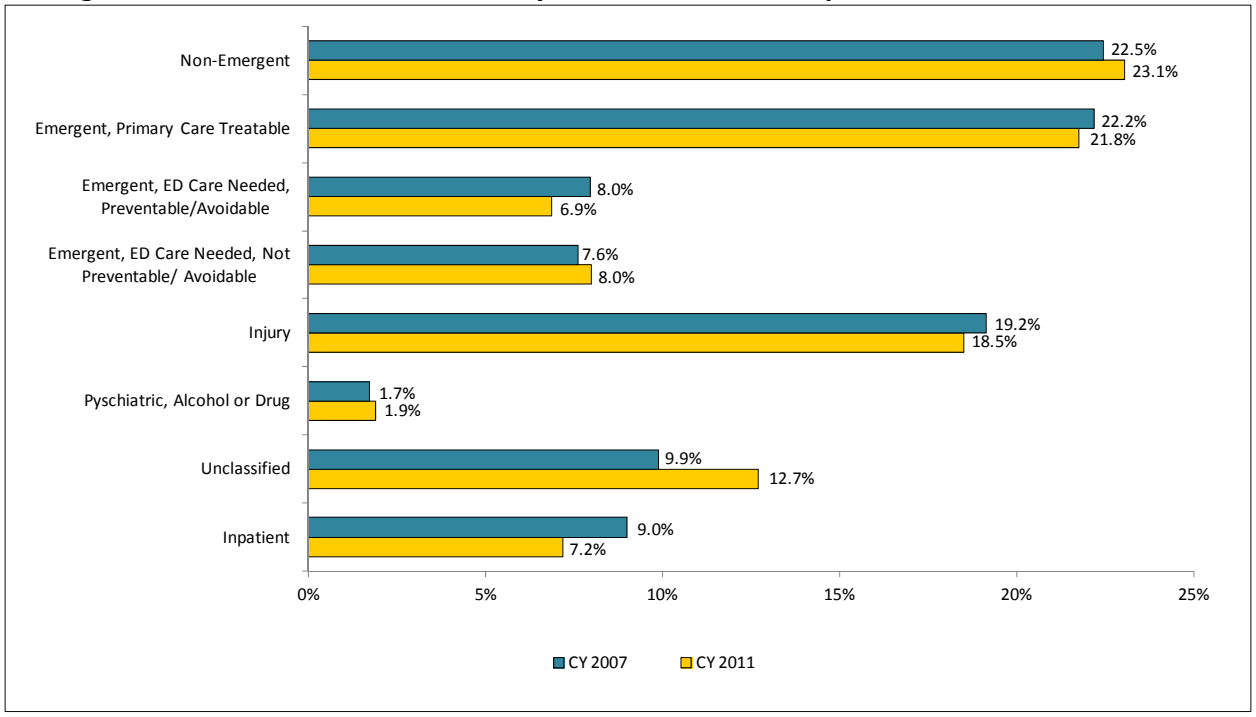


Figure 9 compares the ED visit classifications for CY 2007 with classifications for CY 2011. The data show that potentially avoidable ED visits decreased during the evaluation period, from 52.7 percent to 51.8 percent.

Figure 9. Classification of ED Visits by HealthChoice Participants, CY 2007 and CY 2011



Ambulatory Care Sensitive Hospitalizations

Ambulatory care sensitive hospitalizations (ACSHs), also referred to as preventable or avoidable hospitalizations, are hospital admissions considered preventable if proper 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. DHMH monitors avoidable asthma and diabetes admission rates by using a combination of HEDIS enrollment criteria and Agency for Healthcare Research and Quality (AHRQ) clinical criteria to identify participants[10] with a hospital admission who had a primary diagnosis of asthma or short-term diabetes with complications.[11]

Table 7 presents the rate of diabetes-related admissions for participants aged 21 through 64 years and asthma-related admissions for participants aged 5 through 20 years. The avoidable admission rate for diabetes increased from 22 admissions per 1,000 members in CY 2007 to 24 admissions per 1,000 members in CY 2011, with the highest rate occurring in CY 2010 with 26 admissions. The avoidable admission rate for asthma, however, decreased from 49 admissions per 1,000 members in CY 2007 to 36 admissions per 1,000 members in CY 2011. Overall, the admission rate for both measures decreased between CY 2010 and CY 2011.

[10] Individuals had to be continuously enrolled for 320 days during the calendar year and enrolled as of December 31, with no more than one gap in enrollment of up to 45 days.
[11] Participants with gestational diabetes are excluded.

Table 7. Potentially Avoidable Asthma- and Diabetes-Related Admissions per One Thousand Members, CY 2007 – CY 2011

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Diabetes (Participants Aged 21 – 64 Years)					
Number of Diabetes-Related Avoidable Hospital Admissions	188	182	258	331	364
Rate per 1,000 HEDIS-Eligible Adults with Diabetes	22	21	24	26	24
Asthma (Participants Aged 5 – 20 Years)					
Number of Asthma-Related Avoidable Hospital Admissions	330	290	381	392	389
Rate per 1,000 HEDIS-Eligible Children with Asthma	49	39	43	40	36

Does the Waiver Provide Continuity of Care?

In addition to looking at appropriate service utilization, medical homes may be examined by assessing continuity of care. If individuals frequently change MCOs, then it may be difficult to establish a medical home. However, it should be noted that many physicians contract with multiple MCOs. Table 8 presents the percentage of the HealthChoice population enrolled in one or more MCOs over a three-year period. In each evaluation period, between 83 and 88 percent of participants remained within the same MCO over a three-year period, indicating that most participants do not change MCOs frequently and thus have a greater opportunity to establish a medical home. However, this rate dropped 4.6 percentage points between CY 2007 (87.8 percent) and CY 2011 (83.2 percent). This drop may be explained by a CMS-required change that allowed all new HealthChoice participants to change their MCO for any reason within 90 days of initial enrollment. Previously, only participants who were auto-enrolled could change MCOs.

Table 8. Percentage of the HealthChoice Population Enrolled in One or More MCOs, Three-Year Look Back

Number of MCOs	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
1	87.8%	87.3%	86.9%	85.2%	83.2%
2	11.5%	12.0%	12.4%	13.9%	15.5%
3 or More	0.6%	0.8%	0.7%	0.9%	1.3%

Section II Summary

This section of the report addressed the extent to which HealthChoice provides participants with a medical home by assessing appropriateness of service utilization and continuity of care. In reviewing appropriateness of care, potentially avoidable ED visits and asthma- and diabetes-related ACSHs decreased during the study period. In reviewing continuity of care, most participants (at least 83 percent) did not change MCOs across multiple years.

Section III. Quality of Care

Another goal of the HealthChoice program is to improve the quality of health services delivered. DHMH has an extensive system for quality measurement and improvement that uses nationally recognized performance standards. Quality activities include the External Quality Review Organization (EQRO) annual report, the CAHPS survey of consumer satisfaction, the value-based purchasing (VBP) program, and the Healthcare Effectiveness Data and Information Set (HEDIS) quality measurements. HEDIS data are validated by nationally certified HEDIS vendors to ensure that all plan participants have collected data using identical methodology. This process allows appropriate comparisons across health plans. DHMH also reviews a sample of medical records to ensure that MCOs meet EPSDT standards. This section of the report presents highlights of these quality improvement activities related to preventive care and care for chronic conditions.

Preventive Care

HEDIS Childhood Measures

DHMH uses HEDIS measures to report childhood immunization and well-child visit rates. Immunizations are evidence-based interventions that safely and effectively prevent severe illnesses, such as polio and hepatitis (HealthcareData Company, LLC, 2012). The HEDIS immunization measures include the percentage of two-year-olds who received the following immunizations on or before their second birthday: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (Hib); three hepatitis B; one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines. HEDIS calculates a rate for each vaccine and nine different combination rates. Immunization combination two includes all of these vaccines except the four PCV, while combination three includes each of the above listed vaccines with its appropriate number of doses. DHMH compares health plan rates against immunization combination two and combination three.

The HEDIS well-child measures include the following:

- The percentage of 15-month-old infants who received at least five well-child visits with a PCP
- The percentage of children aged three to six years who received at least one well-child visit
- The percentage of adolescents aged 12 to 21 years who received at least one well-care visit

Table 9 compares HealthChoice with the national HEDIS mean for the immunization and well-child measures. HealthChoice performed above the national HEDIS mean across all measures from CY 2007 through CY 2011. Within the HealthChoice program:

- The percentage of two-year-old children receiving immunization combination two increased by nearly 2 percentage points during the measurement period
- The percentage of two-year-old children receiving immunization combination three increased by 5.6 percentage points during the measurement period
- The percentage of 15-month-old infants who received at least five well-child visits increased by almost 3 percentage point during the measurement period
- The percentage of children aged three to six years who received at least one well-child visit increased by about 8 percentage points during the measurement period
- The percentage of adolescents aged 12 to 21 years who received at least one well-care visit increased by 14.1 percentage points during the measurement period

Table 9. HEDIS Immunizations and Well-Child Visits: HealthChoice Compared with the National HEDIS Mean, CY 2007 - CY 2011

HEDIS Measures	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Childhood Immunizations - Combination 2					
HealthChoice	80.6%	81.9%	80.2%	79.9%	82.5%
National HEDIS Mean	72.3%	73.7%	74.3%	74.1%	74.5%
Childhood Immunizations - Combination 3					
HealthChoice	74.1%	76.9%	76.0%	76.3%	79.7%
National HEDIS Mean	65.6%	67.6%	69.4%	69.9%	70.6%
Well Child Visits - 15 Months of Life					
HealthChoice	82.1%	83.2%	83.2%	82.4%	85.0%
National HEDIS Mean	70.2%	75.4%	75.8%	76.3%	77.9%
Well Child Visits – 3- to 6-year-olds					
HealthChoice	77.1%	76.8%	81.8%	80.7%	85.0%
National HEDIS Mean	65.3%	69.7%	71.6%	71.9%	72.0%
Well-Care Visits - Adolescents					
HealthChoice	52.9%	54.7%	62.6%	62.8%	67.0%
National HEDIS Mean	42.0%	45.9%	47.7%	48.1%	49.7%

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Review

The EPSDT program is a required package of benefits for all Medicaid participants under the age of 21 years. The purpose of EPSDT is to ensure that children receive appropriate age-specific physical examinations, developmental assessments, and mental health screenings periodically to identify any deviations from expected growth and development early. Maryland's EPSDT program aims to support access and increase the availability of quality health care. The goal of the EPSDT review is to examine whether EPSDT services are provided to HealthChoice beneficiaries in a timely manner. The review is conducted annually to assess HealthChoice provider compliance with the following five EPSDT components:

- *Health and developmental history*: A personal and family medical history helps the provider determine health risks and provide appropriate anticipatory guidance and laboratory testing.
- *Comprehensive physical exam*: The exam includes vision and hearing tests, oral assessment, nutritional assessment, and measurements of head circumference and blood pressure.
- *Laboratory tests*: These tests involve assessing the risk factors related to heart disease, anemia, tuberculosis, lead exposure, and sexually transmitted diseases.
- *Immunizations*: Providers who serve HealthChoice participants must offer immunizations according to DHMH's recommended childhood immunization schedule.
- *Health education/anticipatory guidance*: Maryland requires providers to discuss at least three topics during a visit, such as nutrition, injury prevention, and social interactions. Referrals for dental care are required after a patient turns two years old.

During the evaluation period, provider compliance declined or remained the same for four of the five EPSDT components. However, between CY 2009 and CY 2010, provider compliance increased from 2 to 4 percentage points in all components of the EPSDT assessment except the comprehensive physical exam (Table 10) (Delmarva Foundation, 2011; Delmarva Foundation, 2007). The decline in provider compliance with the comprehensive physical exam is partly explained by the addition of body mass index (BMI) calculation and graphing into the scoring of this component (Delmarva Foundation, 2011).

Table 10. HealthChoice MCO Aggregate Composite Scores for Components of the EPSDT Review, CY 2006 – CY 2010

EPSDT Components	CY 2006	CY 2007	CY 2008	CY 2009	CY 2010
Health and Developmental History	90%	81%	85%	86%	89%
Comprehensive Physical Exam	96%	91%	92%	93%	88%
Laboratory Tests/ At Risk Screenings	78%	74%	78%	80%	82%
Immunizations	94%	93%	93%	85%	89%
Health Education/ Anticipatory Guidance	90%	88%	89%	88%	90%

Childhood Lead Testing

DHMH is a member of Maryland's Lead Poisoning Prevention Commission, which advises Maryland executive agencies, the General Assembly, and the Governor on lead poisoning prevention in the State. Maryland's Plan to Eliminate Childhood Lead Poisoning includes a goal of ensuring that young children receive appropriate lead risk screening and blood lead testing. As part of the work plan for achieving this goal, DHMH provides the MCOs with quarterly reports on children who received blood lead tests and children with elevated blood lead levels so that these children may receive appropriate follow-up. DHMH also includes blood lead testing measures in several of its quality assurance activities, including the VBP and managing-for-results programs.

As part of the EPSDT benefit, Medicaid requires that all children receive a blood lead test at 12 and 24 months of age. DHMH measures the lead testing rates for children aged 12 through 23 months and 24 through 35 months who are continuously enrolled in the same MCO for at least 90 days.[12] A child's lead test must have occurred during the calendar year or the year prior. For CY 2011, the lead test measure was revised to exclude children who disenrolled from HealthChoice before their birthday. Thus, the lead testing rate for CY 2011 is not comparable to the results of prior years.

Table 11 presents the lead testing rate for children aged 12 through 23 months and 24 through 35 months between CY 2008 and CY 2011. In CY 2011, the lead testing rate was 57 percent for children aged 12 through 23 months and approximately 77 percent for children aged 24 through 35 months.

Table 11. Percentage of HealthChoice Children Aged 12–23 and 24-35 Months who Received a Lead Test During the Calendar Year or the Prior Year, CY 2008–CY 2011

	CY 2008	CY 2009	CY 2010	CY 2011*
12 - 23 Months	55.7%	55.5%	57.5%	57.4%
24 - 35 Months	76.0%	75.7%	75.6%	76.6%

***** The measure was revised in CY 2011 to exclude children who disenrolled before their birthday. Thus, CY 2011 results cannot be compared to previous years.

Breast Cancer Screening

According to the Centers for Disease Control and Prevention (CDC), mammograms are the most effective technique for detecting breast cancer early (CDC, n.d.a). The CDC reports a prevalence of breast cancer of 120.4 cases per 100,000 women (CDC, 2010). Breast cancer represents the most prevalent cancer among women (CDC, 2010). When breast cancer is detected early, women have more treatment options and a greater chance of survival (CDC, n.d.a). HEDIS assesses the percentage of women who received a mammogram within a two-year period. Although there has been recent debate over the appropriate age requirements for mammograms, HEDIS continues to utilize the 40-69 year female cohort for this measure.

Table 12 compares the percentage of women in HealthChoice who received a mammogram for breast cancer screening with the national HEDIS mean for CY 2007 through CY 2011 (HealthcareData Company, LLC, 2012). Between CY 2007 and CY 2011, the percentage of women aged 40 through 69-years[13] receiving a mammogram increased by 3.3 percentage points. Maryland performed slightly below the national HEDIS mean during the measurement period.

[12] The lead testing measures include lead tests reported in the Medicaid administrative data and the Childhood Lead Registry, which is maintained by the Maryland Department of the Environment.
[13] Maryland's HealthChoice program covers individuals through age 64 years.

Table 12. Percentage of Women in HealthChoice Receiving a Mammogram for Breast Cancer Screening Compared with the National HEDIS Mean, CY 2007 – CY 2011

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
HealthChoice	47.0%	49.0%	49.5%	48.3%	50.3%
National HEDIS Mean	50.0%	50.8%	52.4%	51.3%	50.4%

Cervical Cancer Screening

Cervical cancer is preventable and treatable, and the CDC recommends PAP tests for women who are sexually active or over the age of 21 years (CDC, n.d.c.). Because PAP screenings can detect precancerous cells early, cervical cancer can be treated or altogether avoided (CDC, n.d.c). HEDIS measures the percentage of women who received at least one PAP test within a three-year period to screen for cervical cancer.

Table 13 compares the percentage of women aged 21 to 64 years in HealthChoice who received a cervical cancer screening with the national HEDIS mean for CY 2007 through CY 2011 (HealthcareData Company, LLC, 2012). Between CY 2007 and CY 2011, the cervical cancer screening rate increased by nearly 10 percentage points. HealthChoice performed slightly below the national HEDIS mean in CY 2007 but outperformed the national HEDIS mean in the subsequent years.

Table 13. Percentage of Women in HealthChoice Aged 21-64 Years Receiving a Cervical Cancer Screening Compared with the National HEDIS Mean, CY 2007 – CY 2011

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
HealthChoice	63.2%	67.2%	68.1%	73.2%	73.1%
National HEDIS Mean	64.8%	66.0%	65.8%	67.2%	66.7%

Care for Chronic Conditions

Use of Appropriate Medications for People with Asthma

DHMH uses HEDIS measures to report the use of appropriate medications for people with asthma. Asthma is a common chronic disease that affects nearly 25 million American children and adults (CDC, 2011). In 2009, approximately 823,000 adults and children in Maryland had a history of asthma, and Medicaid spent over $10 million for asthma ED visits (Bankoski, Hess-Mutinda, McEachern, & De Pinto, 2011). The purpose of asthma medications is to prevent or reduce airway inflammation and narrowing. If appropriate asthma medications are prescribed and used correctly, asthma-related hospitalizations, ED visits, and missed school and work days decrease (CDC, n.d.d).

Table 14 compares the HealthChoice rate of appropriate medications for people with asthma with the national HEDIS mean (HealthcareData Company, LLC, 2012). Between CY 2007 and CY 2008, HEDIS included individuals aged 5 through 56 years in this measure. From CY 2009

onwards, however, HEDIS restricted the measure to individuals aged 5 through 50 years. Because of the change in the age requirement in CY 2009, a comparison to prior years is not appropriate for this measure. Throughout the study period, HealthChoice performed above the national HEDIS mean. In CY 2011, 91 percent of HealthChoice participants aged 5 through 50 years were appropriately prescribed medications for asthma treatment compared to the national HEDIS mean of 85 percent.

Table 14. Percentage of HealthChoice Members Aged 5-50 Years with Persistent Asthma who were Appropriately Prescribed Medications Compared with the National HEDIS Mean, CY 2007 – CY 2011

	CY 2007	CY 2008	CY 2009*	CY 2010	CY 2011
	Members Aged 5-56 Years		Members Aged 5-50 Years		
HealthChoice	89%	90%	90.7%	90.8%	91.2%
National HEDIS Mean	87%	89%	88.6%	88.4%	85.0%

*Due to significant changes in the specifications for the 2010 HEDIS specifications (CY 2009 data), a comparison to prior years is not appropriate.

Comprehensive Diabetes Care

Diabetes is a disease caused by the inability of the body to make or use the hormone insulin. The complications of diabetes are serious and include heart disease, kidney disease, stroke, and blindness. Screening and treatment can reduce the burden of diabetes complications. To assess appropriate and timely screening and treatment for adults with diabetes (types 1 and 2), HEDIS includes a composite set of measures, comprehensive diabetes care (CDC), that include:

- *HbA1c Testing*: The percentage of participants aged 18 through 75 years with diabetes who received at least one Hemoglobin A1c (HbA1c) test during the measurement year.
- *LDL-C Screening*: The percentage of participants aged 18 through 75 years with diabetes who received at least one low-density lipoprotein cholesterol (LDL-C) screening in the measurement year.
- *Eye Exams*: The percentage of participants aged 18 through 75 years with diabetes who received an eye exam for diabetic retinal disease during the measurement year *or* had a negative retinal exam (no evidence of retinopathy) in the year prior to the measurement year.

Table 15 compares HealthChoice with the national HEDIS mean on the CDC measures for CY 2007 through CY 2011 (DHMH, 2012; HealthcareData Company, LLC, 2012). HealthChoice consistently performed above the national HEDIS mean on eye exams throughout the study period and performed above the average for LDL-C screenings in most years. HealthChoice performed above the national average on HbA1c testing in CY 2007, but remained below the national average in subsequent years. Within the HealthChoice program:

- The percentage of participants with diabetes who received an eye exam increased by 11.3 percentage points during the measurement period.

- The percentage of participants with diabetes who received an HbA1c test increased by 2.4 percentage points during the measurement period.
- The percentage of participants with diabetes who received an LDL-C screening remained same during the measurement period; however, the estimates fluctuated between the years.

Table 15. Percentage of HealthChoice Members Aged 18–75 Years with Diabetes who had an Eye Exam, HbA1C Test, and LDL-C Screening Compared with the National HEDIS Mean, CY 2007-CY 2011

HEDIS Measures	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Eye Exam (Retinal)					
HealthChoice	59.7%	62.6%	66.6%	67.9%	71.0%
National HEDIS Mean	50.1%	52.8%	52.7%	53.1%	53.4%
HbA1c Test					
HealthChoice	78.6%	77.9%	77.1%	77.6%	81.0%
National HEDIS Mean	77.4%	80.5%	80.6%	82.0%	82.5%
LDL-C Screening					
HealthChoice	75.6%	76.5%	74.9%	74.3%	76.4%
National HEDIS Mean	70.9%	74.1%	74.2%	74.7%	75.0%

Section III Summary

This section of the report discussed the HealthChoice goal of improving quality and focused on preventive care and care for chronic conditions. Regarding preventive care for children, HealthChoice well-child visit and immunization screening rates increased during the study period and were consistently higher than the national HEDIS mean. However, the EPSDT record review shows that provider compliance with EPSDT screening components decreased slightly during the evaluation period, suggesting that this is an area requiring improvement. Regarding preventive care for adults, rates of cervical and breast cancer screening improved during the study period. From CY 2008 to CY 2010, the cervical cancer screening rate exceeded the national HEDIS mean, while the breast cancer screening rate continued to fall below the national average although it has improved over the evaluation period. Colorectal cancer screening rates improved during the study period, but remained low. This section also examined the quality of care for chronic conditions, namely diabetes and asthma. The percentage of participants receiving appropriate asthma medications remained the same from CY 2009 to CY 2011, and HealthChoice performed above the national HEDIS mean. For participants with diabetes, rates of eye exams steadily improved during the evaluation period and were consistently higher than the national HEDIS mean. The HbA1c testing and LDL-C screening rates increased between CY 2010 and CY 2011, but the HbA1c testing rate remained below the national average while the LDL-C screening rate was higher than the national average in CY 2011.

Section IV. Special Topics

This section of the report discusses several special topics, including services provided under the dental and mental health carve-outs, services provided to children in foster care, reproductive health services, services provided to individuals with HIV/AIDS, the REM program, and access to care for racial and ethnic minorities.

Dental Services

EPSDT mandates dental care coverage for children younger than 21 years. Children enrolled in Maryland Medicaid, however, historically utilized these services at a low rate. Before Maryland implemented HealthChoice in 1997, only 14 percent of children enrolled in Medicaid for any period of time received at least one dental service, which was below the national average of 21 percent (Academy of Pediatrics State Medicaid Report).

In an effort to increase access to oral health care and service utilization, the Secretary of DHMH convened the Dental Action Committee (DAC) in June 2007. The DAC consisted of a broad-based group of stakeholders concerned about children's access to oral health services. The DAC reviewed dental reports and data and presented its final report to the DHMH Secretary on September 11, 2007.[14] Key recommendations from the report included increased reimbursement for Medicaid dental services and the institution of a single dental ASO. The reforms recommended by the DAC have been supported and, to a great degree, implemented by DHMH to effectively address the barriers to dental care access previously experienced in the State. Expanded access to dental care also has been achieved through initiatives of the Medicaid program and the Office of Oral Health. These include:

- Increasing dental provider payment rates in 2008, with plans to increase rates further as the budget allows.
- Implementing an ASO in July 2009 to oversee Medicaid dental benefits for pregnant women, children, and adults in the REM program (the Maryland Healthy Smiles program).
- Authorizing EPSDT-certified medical providers (pediatricians, family physicians, and nurse practitioners), after successful completion of an Office of Oral Health training program, to receive Medicaid reimbursement for fluoride varnish treatment and oral assessment services provided to children between 9 and 36 months of age. By September 2012, 392 unique EPSDT-certified providers administered over 64,000 fluoride varnish treatments.
- Allowing public health dental hygienists to perform services within their scope of practice without on-site supervision and prior examination of the patient by a dentist.

[14] Dental Action Committee. (2007). Access to Dental Services for Medicaid Children in Maryland. http://fha.dhmh.maryland.gov/oralhealth/docs1/DAC_report.pdf

This change permits public health dental hygienists to provide services outside of a dental office, e.g., in schools and Head Start centers.[15]

Maryland's current oral health achievements are a direct result of the State's progress in implementing the 2007 DAC recommendations, which called for increasing access to oral health services through changes to Maryland Medicaid and expansion of the public health dental infrastructure. In 2010 and 2011, the Pew Center on the States named Maryland a national leader in improving dental care access for Marylanders with low income, especially those who are Medicaid-eligible or uninsured. As Maryland is the only state to meet seven of the eight dental policy benchmarks, the Pew Center ranked it first in the nation for oral health (Pew Center on the States, 2011). CMS also recognized Maryland's improved oral health service delivery by requesting Maryland to share its story at its national quality conference in August 2011, including its story and achievements in its best practices guide for states and their governors through the Medicaid State Technical Assistance Team (MSTAT) process. In addition, Maryland was invited to present in the inaugural *CMS Learning Lab: Improving Oral Health through Access* web seminar series.

DHMH continually monitors a variety of measures of dental service utilization, published in the Annual Oral Health Legislative Report. One measure is closely modeled on the HEDIS measure for Medicaid children's dental service utilization. The HEDIS measure counts the number of individuals receiving dental services based on two criteria: 1) an age range from 2 through 21 years; and 2) Medicaid enrollment of at least 320 days. DHMH modified the measure to include children aged 4 through 20 years. The dental service utilization rate increased by 17.1 percentage points between CY 2007 and CY 2011 (Table 16). Nevertheless, many children still do not receive the dental services they need.

Table 16. Children Aged 4 – 20 Years in Medicaid (Enrolled for at least 320 Days) Receiving Dental Services, CY 2007 – CY 2011

Calendar Year	Total Number of Participants	Participants Receiving One or More Dental Service	Percentage Receiving Service	National HEDIS Mean*
2007	263,742	130,112	49.3%	43.5%
2008	278,063	149,673	53.8%	44.2%
2009	304,907	184,563	60.5%	45.7%
2010	335,214	214,265	63.9%	47.8%
2011	363,465	241,149	66.4%	**

*National HEDIS mean is for children aged 2 – 21 years.
**National HEDIS mean data for CY 2011 are not available.

Dental care is also a benefit for pregnant women. Table 17 presents the percentage of pregnant women aged 21 years and older who received at least one dental service between CY 2007 and CY 2011. During that time period, dental service utilization increased from14.3 percent in CY

[15] Maryland Department of Health and Mental Hygiene (December 2010). *Maryland's 2010 Annual Oral Health Legislative Report.* Baltimore, MD. Retrieved from http://mmcp.dhmh.maryland.gov/docs/dentalJCRfinal10-10.pdf

2007 to 28 percent in CY 2011. Despite these improvements, dental service utilization by pregnant women remains low.

Table 17. Percentage of Pregnant Women Aged 21+ Years in Medicaid (Enrolled for at Least 90 Days) Receiving Dental Services, CY 2007 – CY 2011

Calendar Year	Total Number of Participants	Participants Receiving One or More Dental Service	Percent Receiving Service
2007	35,444	5,072	14.3%
2008	36,458	6,272	17.2%
2009	37,206	8,871	23.8%
2010	40,206	10,060	25.0%
2011	30,882	8,653	28.0%

Mental Health Services

HealthChoice participants in need of mental health services are referred to Maryland's Public Mental Health System, but they continue to receive medically necessary somatic care through their MCO. Mental health services are funded through the FFS Maryland Mental Hygiene Administration using the mental health ASO.

Table 18 presents the percentage of the HealthChoice population diagnosed with/treated for an MHD[16] by age group. The percentage of children with an MHD remained at approximately 21 percent throughout the study period. The percentage for adults decreased slightly.

Table 18. Percentage of HealthChoice Population (Any Period of Enrollment) with a Mental Health Disorder by Age Group, FY 2008 – FY 2011

Age Group (Years)	FY 2008	FY 2009	FY 2010	FY 2011
0-18	20.6%	20.6%	20.9%	21.2%
19-64	34.6%	33.6%	33.0%	32.4%
Total	**24.0%**	**24.3%**	**24.8%**	**25.1%**

Table 19 presents the regional distribution of HealthChoice participants with an MHD. Between FY 2008 and FY 2010, most HealthChoice participants with an MHD resided in Baltimore City. However, in FY 2011, the Baltimore Suburban region contained the most HealthChoice participants with an MHD with 28.5 percent, followed by Baltimore City (26.7 percent).

[16] A person was identified as having MHD if he/she had any diagnoses beginning with "290," "293," "294," "295," "296," "297," "298," "299," "300," "301," "302," "306," "307," "308," "309," "310," "311," "312," "313," "314," "315," "316" or an invoice control number (ICN) beginning with "6."

Table 19. Regional Distribution of HealthChoice Participants (Any Period of Enrollment) with a Mental Health Disorder, FY 2008–FY 2011

Region	FY 2008	FY 2009	FY 2010	FY 2011
Baltimore City	30.4%	29.3%	28.1%	26.7%
Baltimore Suburban	27.2%	27.3%	27.8%	28.5%
Washington Suburban	19.2%	19.6%	20.1%	20.7%
Western Maryland	7.1%	7.2%	7.2%	7.1%
Eastern Maryland	11.4%	11.7%	12.0%	12.2%
Southern Maryland	4.5%	4.6%	4.7%	4.7%
Total	**100%**	**100%**	**100%**	**100%**

DHMH monitors the extent to which participants with an MHD access somatic services through their MCOs. Table 20 compares the percentage of HealthChoice participants with an MHD who received a physician visit for somatic care with the percentage who received an ED visit for somatic care. Between FY 2008 and FY 2011, the percentage of participants with a physician visit for somatic care increased by 3.2 percentage points. During the same time period, the percentage of participants with an ED visit for somatic care increased by 3.5 percentage points.

Table 20. Service Utilization among HealthChoice Participants (Any Period of Enrollment) with a Mental Health Disorder, FY 2008-FY 2011

Fiscal Year	HealthChoice Participants with a MHD	Percent with a Physician visit for Somatic Care	Percent with an ED visit for Somatic Care
2008	125,487	87.5%	42.7%
2009	142,619	89.0%	44.9%
2010	166,088	90.1%	47.0%
2011	183,669	90.7%	46.2%

Substance Use Disorder Services

Substance use disorder (SUD) services are currently provided under the HealthChoice MCO benefit package. Table 21 shows the percentage of HealthChoice participants diagnosed with/treated for an SUD by age group. The percentage of children aged 0 through 18 years with an SUD remained at approximately 1 percent throughout the study period. The percentage for adults decreased slightly.

Table 21. Percentage of HealthChoice Participants (Any Period of Enrollment) with a Substance Use Disorder by Age Group, FY 2008–FY 2011

Age Group (Years)	FY 2008	FY 2009	FY 2010	FY 2011
0-18	1.0%	1.0%	1.1%	1.0%
19-64	14.3%	13.0%	13.1%	12.4%
Total	**4.2%**	**4.4%**	**5.0%**	**4.9%**

Table 22 presents the regional distribution of HealthChoice participants with an SUD. In FY 2011, the majority of participants with an SUD (38.2 percent) lived in Baltimore City. This is a 9 percentage point decrease from FY 2008 when 47.3 percent of participants with a SUD resided in Baltimore City.

Table 22. Regional Distribution of HealthChoice Participants (Any Period of Enrollment) with a Substance Use Disorder, FY 2008–FY 2011

Region	FY 2008	FY 2009	FY 2010	FY 2011
Baltimore City	47.3%	43.4%	41.1%	38.2%
Baltimore Suburban	23.7%	24.9%	25.9%	26.5%
Washington Suburban	10.8%	11.1%	11.3%	12.1%
Western Maryland	5.9%	6.4%	6.3%	6.1%
Eastern Maryland	9.2%	10.9%	11.5%	12.1%
Southern Maryland	3.0%	3.2%	3.9%	4.9%
Total	**100%**	**100%**	**100%**	**100%**

DHMH also monitors the extent to which participants with an SUD access somatic care services. Table 23 compares the percentage of HealthChoice participants with an SUD who received a physician visit for somatic care compared to the percentage who received an ED visit for somatic care. Between FY 2008 and FY 2011, the percentage of participants with a physician visit for somatic care or an ED visit for somatic care increased by less than a percentage point.

Table 23. Service Utilization among HealthChoice Participants (Any Period of Enrollment) with a Substance Use Disorder, FY 2008 - FY 2011

Fiscal Year	HealthChoice Participants with SUD	Percentage with a Physician visit for Somatic Care	Percentage with an ED visit for Somatic Care
2008	22,103	91.3%	66.9%
2009	25,784	91.9%	68.4%
2010	33,278	92.0%	68.6%
2011	36,238	92.0%	67.6%

Table 24 shows the number and percentage of HealthChoice participants with an SUD and at least one methadone replacement therapy. Between FY 2008 and FY 2011, the percentage of participants with at least one methadone replacement therapy increased by 1.5 percentage points.

Table 24. Number and Percentage of HealthChoice Participants (Any Period of Enrollment) with a Substance Use Disorder and at Least One Methadone Replacement Therapy, FY 2008 – FY 2011

Fiscal Year	HealthChoice Participants with a SUD	Number of Participants with a MHD and Methadone Replacement Therapy	Percentage of Total Participants with MHD
2008	22,103	4,400	19.9%
2009	25,784	5,207	20.2%
2010	33,278	6,809	20.5%
2011	36,238	7,754	21.4%

Behavioral Health Integration Efforts

The number of HealthChoice participants with a dual-diagnosis of mental health and substance use disorder increased from 13,717 in FY 2008 to 22,407 in FY 2011. Table 25 presents the number of participants in FY 2008 through FY 2011 with a dual-diagnosis, MHD only, SUD only, or none of these diagnoses.

Table 25. Number of HealthChoice Participants (Any Period of Enrollment) with a Dual Diagnosis of Mental Health Disorder and Substance Use Disorder, FY 2008 – FY 2011

	HealthChoice Participants			
Fiscal Year	Both	MHD Only	SUD Only	None
2008	13,717	111,770	8,386	388,808
2009	16,201	126,418	9,583	434,242
2010	21,309	144,779	11,969	492,038
2011	22,407	161,262	13,831	535,177

Access to Care for Children in Foster Care

This section of the report examines service utilization for children in foster care with any period of enrollment in HealthChoice during the calendar year.[17] The section also compares service utilization for children in foster care with other HealthChoice children. Unless otherwise stated, all of the measures presented include children aged 0 through 21 years and include their use of FFS and MCO services.

[17] This analysis *excludes* children in the subsidized adoption population.

Figure 10 displays the percentage of children in foster care with any period of enrollment that had at least one ambulatory care visit in CY 2007 and CY 2011 by age group. During the evaluation period, the overall rate decreased by a percentage point, from 75.5 percent to 74.5 percent. Utilization was highest for the youngest children and lowest for the oldest children.

Figure 10. Percentage of Children in Foster Care Receiving at Least One Ambulatory Care Visit by Age Group, CY 2007 and CY 2011

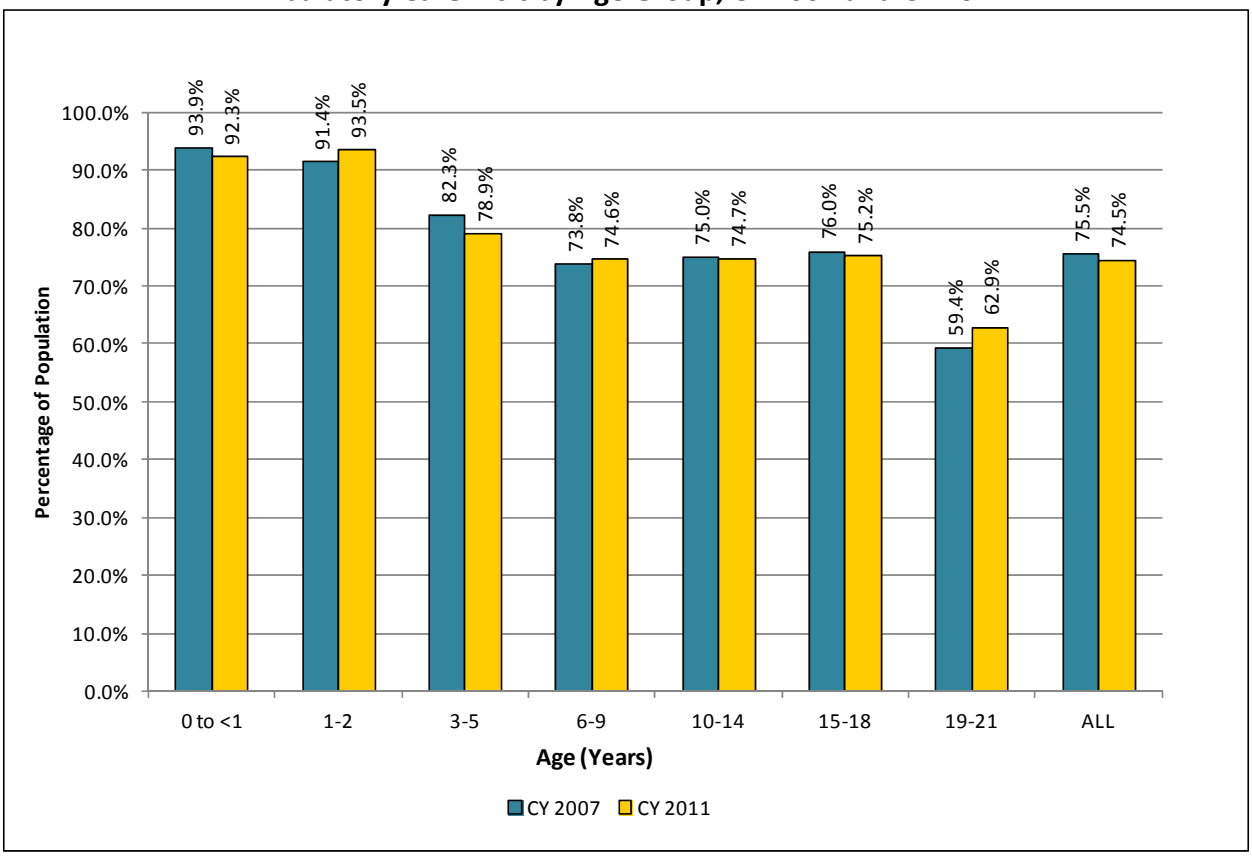


Figure 11 compares the ambulatory care visit rate for children in foster care with the rate for other children enrolled in HealthChoice in CY 2011. Overall, 74.5 percent of children in foster care and 79.2 percent of other HealthChoice children received at least one ambulatory care visit. For the youngest age groups and the oldest age groups, children in foster care accessed ambulatory care services at higher rates than other children in the HealthChoice program.

Figure 11. Percentage of Children in Foster Care vs. HealthChoice (Non-Foster) Children Receiving at Least One Ambulatory Care Visit by Age Group, CY 2011

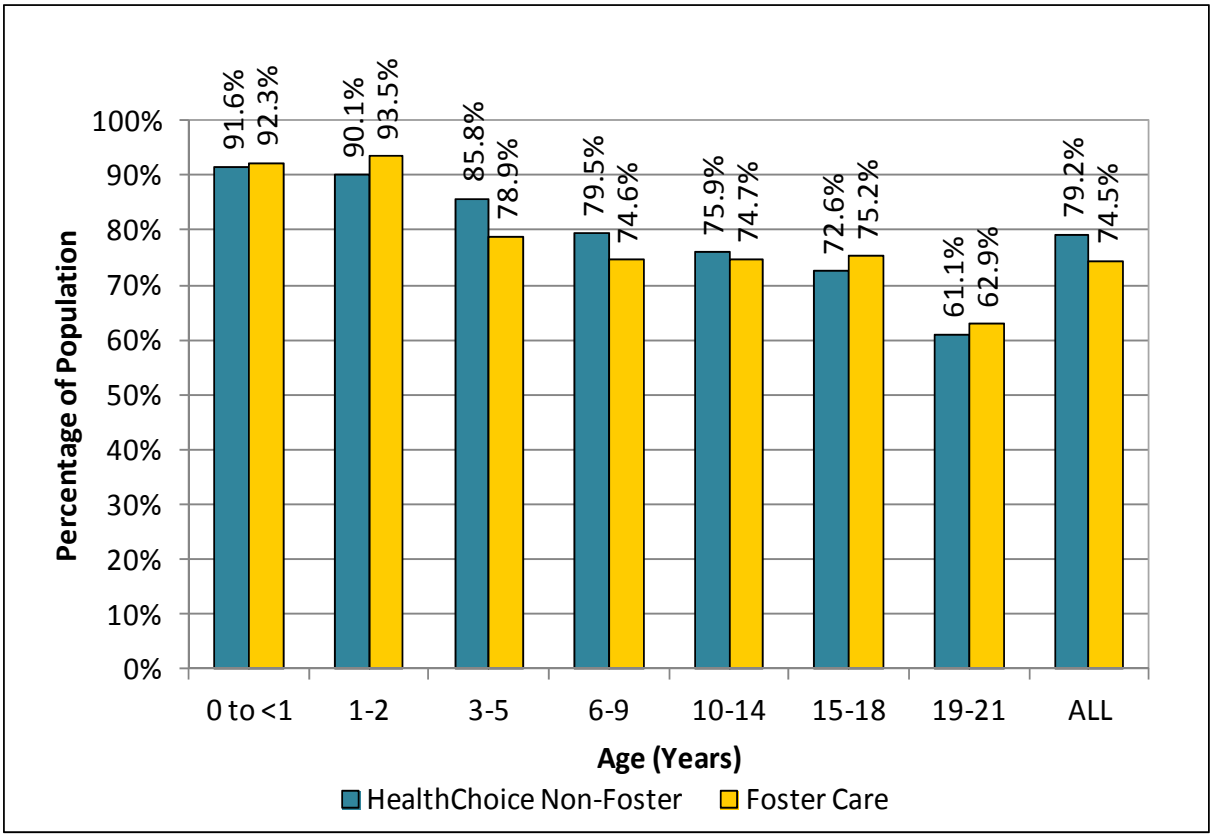


Figure 12 displays the percentage of children in foster care receiving at least one MCO outpatient ED visit in CY 2007 and CY 2011 by age group. The overall rate increased by 4.1 percentage points during the evaluation period. Children aged 1 through 2 years and those aged 19 through 21 years had the highest rates of ED utilization across the study period.

Figure 12. Percentage of Children in Foster Care Receiving at Least One MCO Outpatient ED Visit by Age Group, CY 2007 and CY 2011

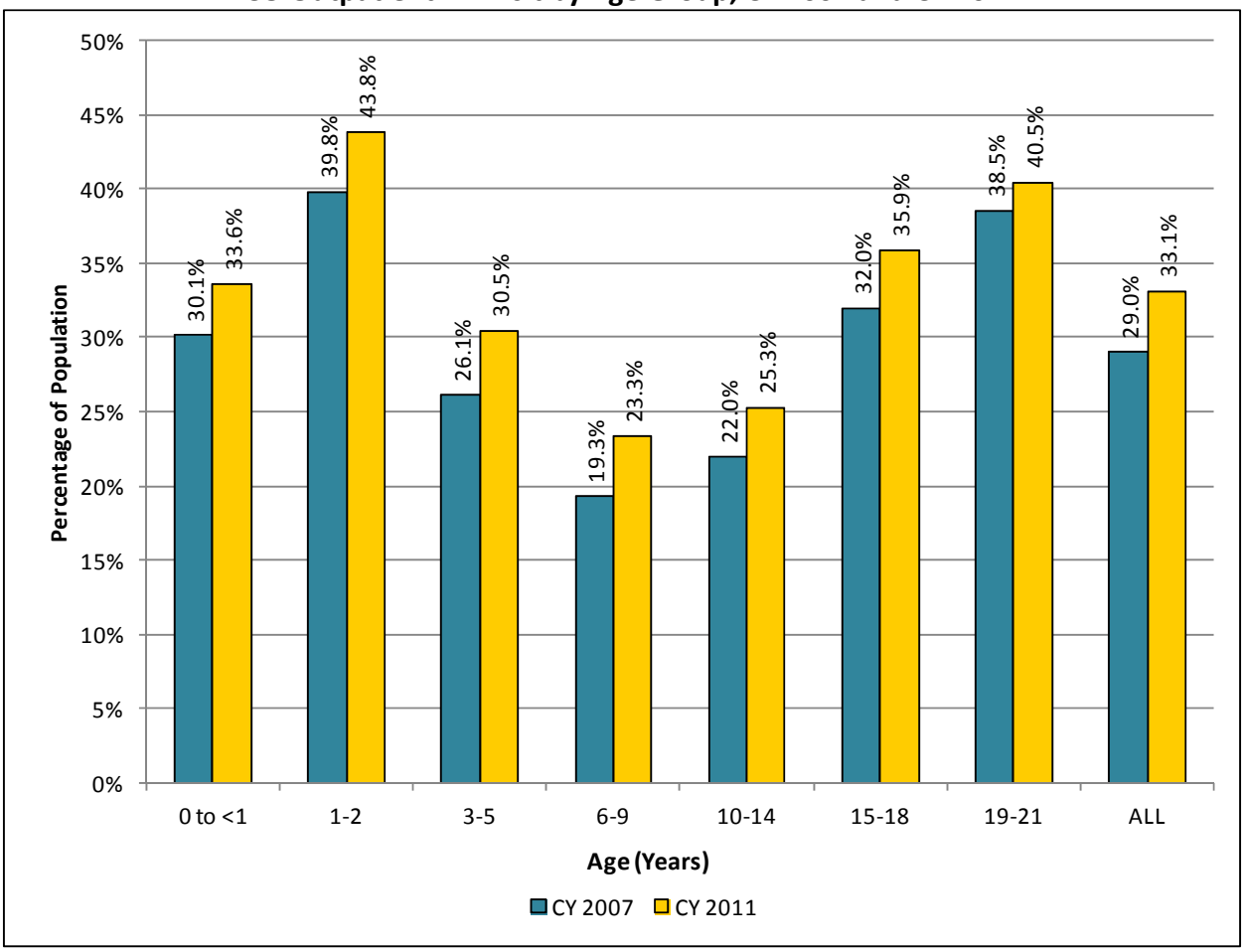


Figure 13 compares the MCO outpatient ED visit rate in CY 2011 for children in foster care to the rate of other children enrolled in HealthChoice. Overall, children in foster care visited the ED at a higher rate than other children in HealthChoice. Children aged 1 through 2 years had the highest ED visit rate across both groups of children. Please note that children often enter the foster care system through cases of abuse, which may account for their higher rate of ED utilization.

Figure 13. Percentage of Children in Foster Care vs. HealthChoice (Non-Foster) Children Receiving at Least One MCO Outpatient ED Visit by Age Group, CY 2011

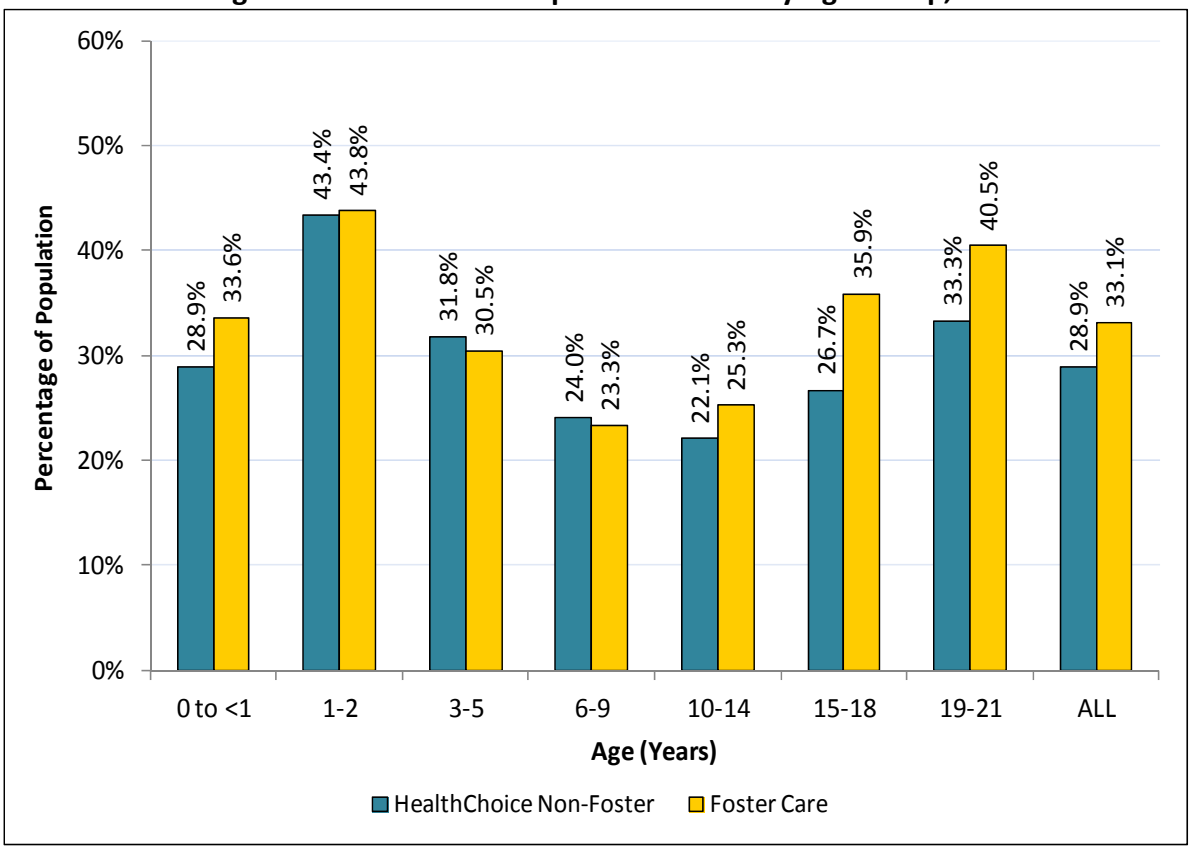


Figure 14 compares the dental utilization rate of children in foster care aged 4 to 20 years with any period of enrollment in Medicaid to the rate of other children in Medicaid in CY 2011. Overall, children in foster care had a higher dental visit rate (64.7 percent) than other Medicaid children (57.9 percent).

Figure 14. Percentage of Children Aged 4-20 Years (Any Period of Enrollment) in Foster Care in Medicaid vs. Children in Medicaid (Non-Foster) Receiving at Least One Dental Visit by Age Group, CY 2011

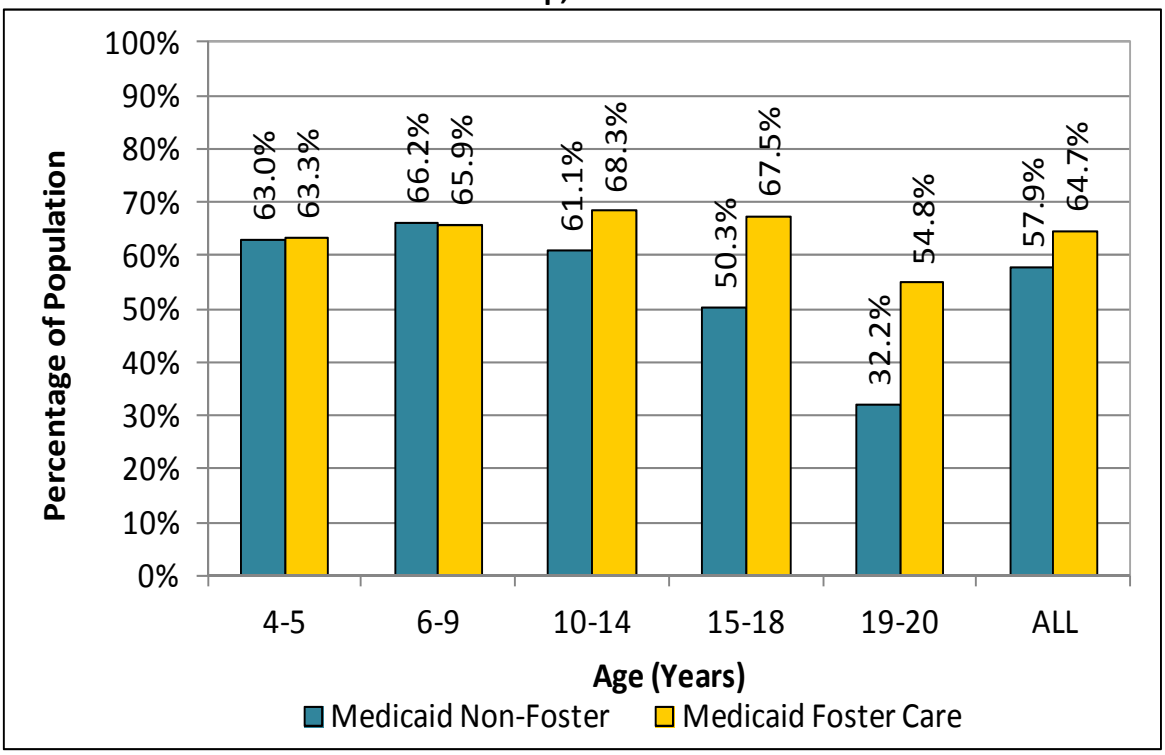
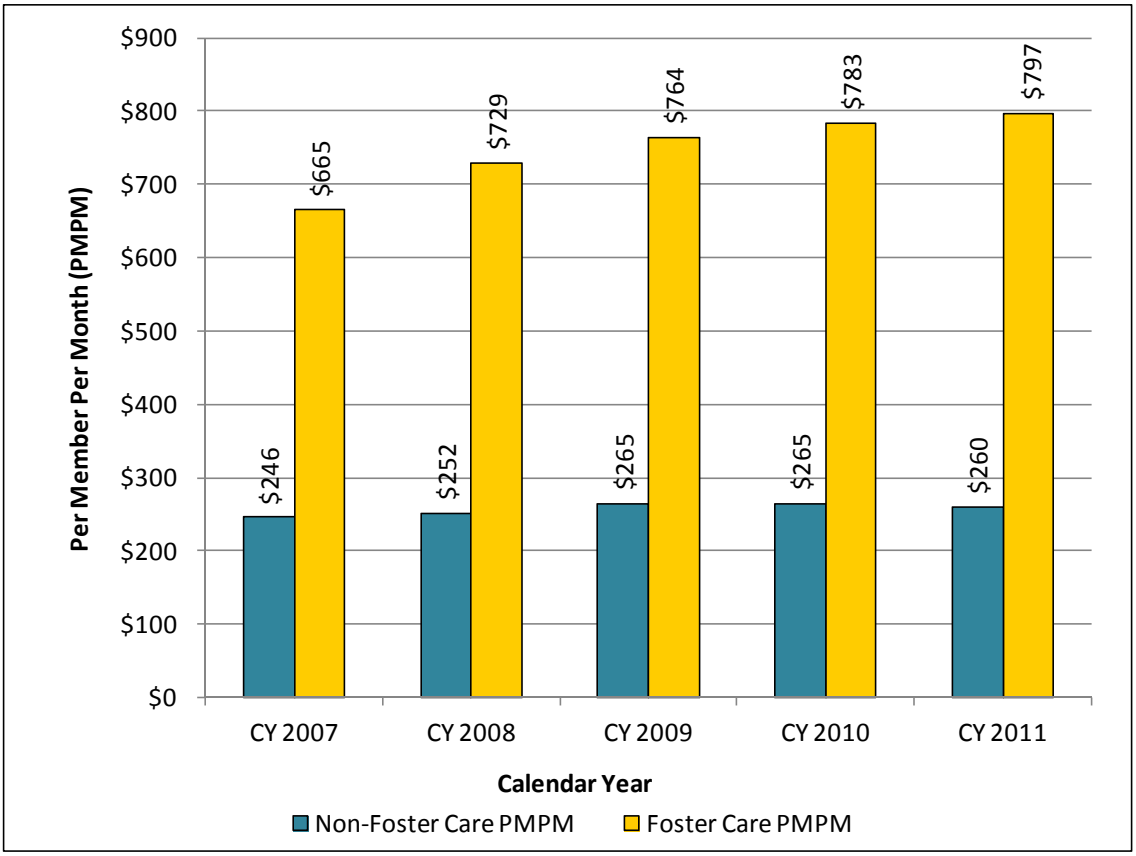


Figure 15 compares the per member per month (PMPM) cost for children in foster care with other children in Health Choice. The PMPM includes carve-out specialty mental health services and dental services. The PMPM for foster children rose considerably between 2007 and 2011, while the PMPM for non-foster children remained at a similar level. The PMPM for foster children is approximately three times greater than it is for non-foster children.

Figure 15. PMPM for Foster Children vs. Health Choice (Non-Foster) Children, CY 2007 – CY 2011



Reproductive Health

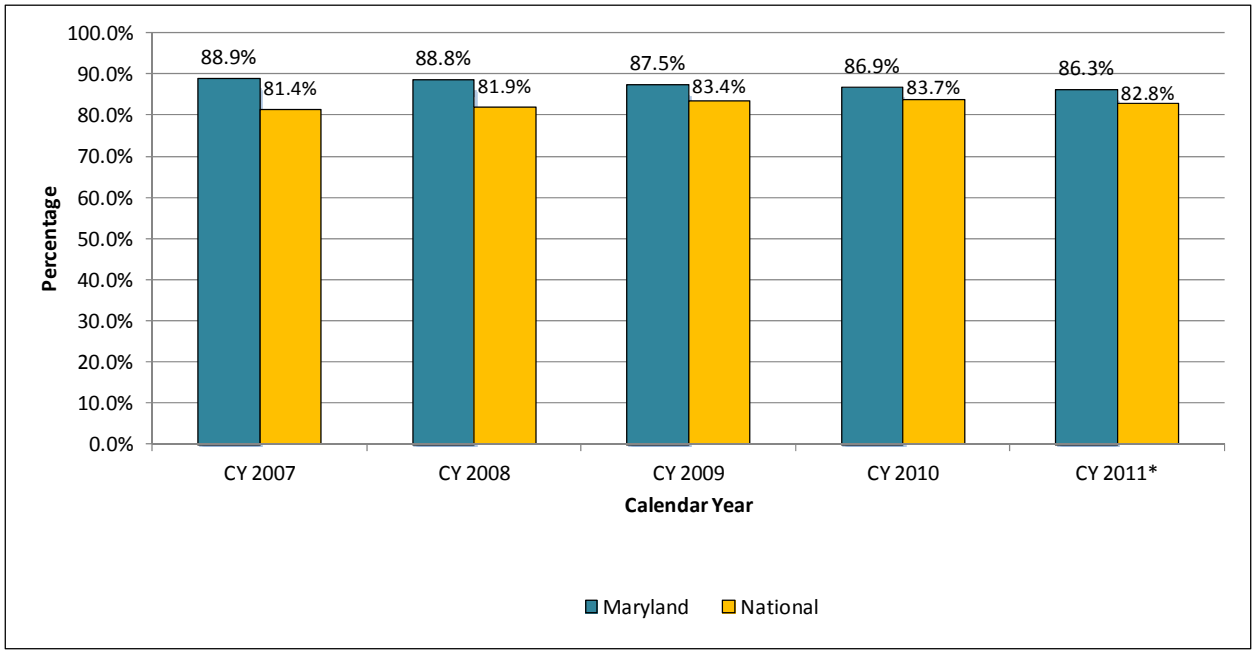
This section of the report focuses on reproductive health services provided under HealthChoice. HEDIS prenatal measures are presented first, followed by a discussion of the Family Planning Program.

Timeliness of Ongoing Prenatal Care

HEDIS measures the timeliness of prenatal care and the frequency of ongoing prenatal care to determine the adequacy of care during pregnancy. The earlier a woman receives prenatal care, the more likely health conditions that could affect her health or the health of the newborn will be identified and managed.

Timeliness of care considers the percentage of deliveries for which the mother received a prenatal care visit in the first trimester *or* within 42 days of HealthChoice enrollment.[18] Figure 16 compares HealthChoice performance on this measure with the national HEDIS mean for CY 2007 through CY 2011 (HealthcareData Company, LLC, 2012). Utilization of prenatal care decreased by 2.6 percentage points during the study period, from 88.9 percent in CY 2007 to 86.3 percent in CY 2011. HealthChoice consistently outperformed the national HEDIS mean during the study period by 3 to 8 percentage points.

Figure 16. HEDIS Timeliness of Prenatal Care, Maryland Compared with the National HEDIS Mean, CY 2007 – CY 2011



[18] HEDIS requires continuous enrollment 43 days prior to and 56 days after delivery.

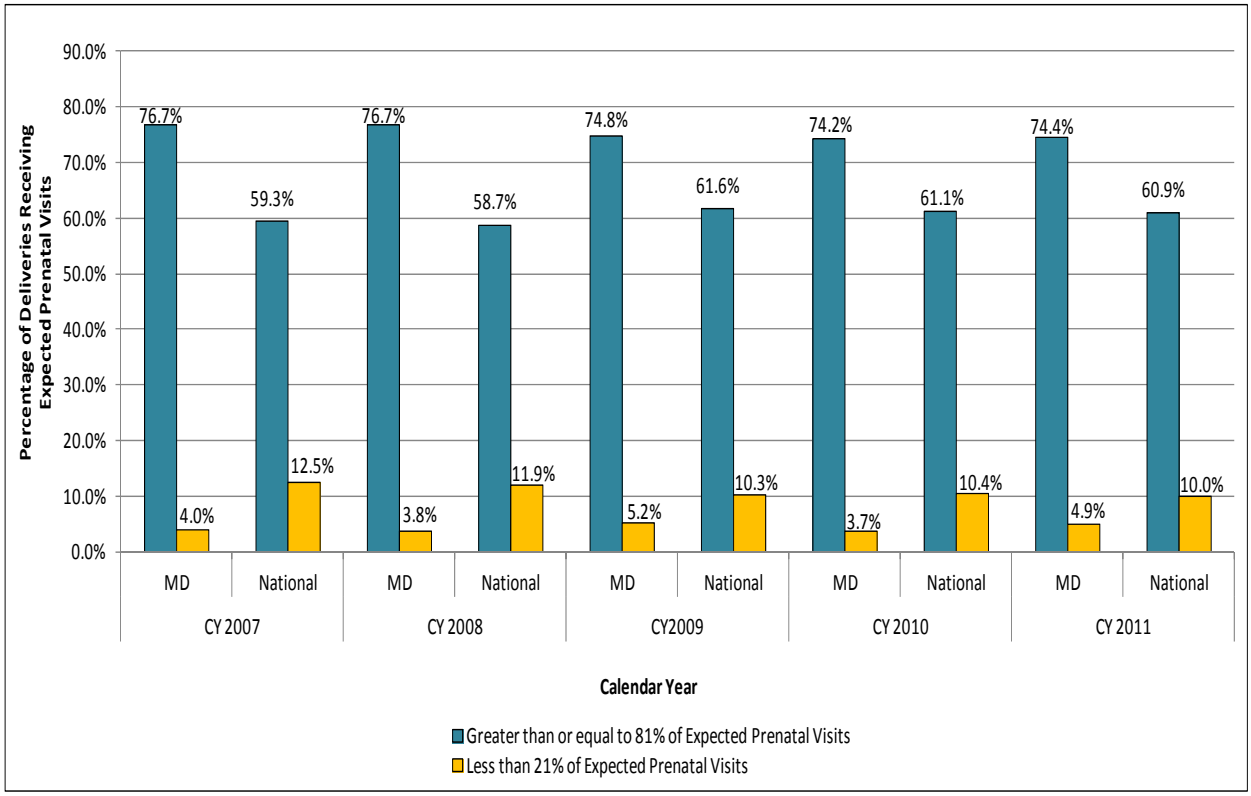
Frequency of Ongoing Prenatal Care

The frequency of ongoing prenatal care measure considers the percentage of recommended[19] prenatal visits received. DHMH uses this measure to assess MCO performance in providing appropriate prenatal care. The measure calculates the percentage of deliveries that received the expected number of prenatal visits. This measure accounts for gestational age and time of enrollment, and women must be continuously enrolled 43 days prior to and 56 days after delivery.

The first aspect of this measure assesses the percentage of women that received more than 80 percent of expected visits; therefore, a higher score is preferable. This rate decreased by 2.3 percentage points during the study period, from 76.7 percent in CY 2007 to 74.4 percent in CY 2011 (Figure 17) (HealthcareData Company, LLC, 2012). The second aspect of this measure assesses the percentage of women who received less than 21 percent of expected visits; therefore, a lower score is preferable. Estimates of this measure for the study period increased slightly—by nearly a percentage point—from 4 percent in CY 2007 to 4.9 percent in CY 2011. In sum, Maryland consistently outperformed the national HEDIS means in both instances, although the performance over the study period declined slightly.

[19] The American College of Obstetricians and Gynecologists recommends a visit once every 4 weeks during the first 28 weeks of pregnancy, once every 2 to 3 weeks during the next 7 weeks, and weekly for the remainder of the pregnancy, for a total of about 13 to 15 visits.

Figure 17. Percentage of Deliveries Receiving the Expected Number of Prenatal Visits ≥ 81 Percent or < 21 Percent of Recommended Visits, Maryland Compared with the National HEDIS Mean, CY 2007 – CY 2011



The Family Planning Program

The Family Planning Program provides family planning office visits—which include physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and permanent sterilization services—to women who are not eligible for Medicaid. During the study period, the Family Planning Program only enrolled postpartum women. Eligibility for the Program was expanded in 2012 to cover women younger than 51 years of age with household income below 200 percent of the FPL.

Tables 26 and 27 present the percentage of total Medicaid participants in the Family Planning Program and the percentage of Family Planning participants who received at least one service between CY 2007 and CY 2011. These data are presented for women who were enrolled in Family Planning for any period of time during the calendar year and women who were enrolled continuously for 12 months.

The number of women with any period of enrollment in the Family Planning Program decreased by 66.3 percent between CY 2007 and CY 2011 (Table 25). This decline in enrollment may be attributable to several significant changes made in CY 2008 in response to new CMS terms and conditions. CMS required the Program to perform annual active redeterminations in order to

reduce the upper income limit from 250 to 200 percent of the FPL and no longer enroll women with other third-party insurance that included family planning benefits. The July 2008 Medicaid expansion also increased the number of women who continue to be eligible for full Medicaid coverage after delivery, thus decreasing the number of women enrolled in the limited benefit Family Planning Program.

Table 26 shows that, during the evaluation period, the percentage of women with any period of enrollment in the Program who utilized at least one family planning service ranged between 14.2 and 19.4 percent. As Table 27 displays, the rate of women enrolled in the Program for the entire 12 months increased from 13 percent in CY 2007 to 23.9 percent in CY 2011.

Table 26. Percentage of Family Planning Participants (Any Period of Enrollment) with at least One Corresponding Service, CY 2007-CY 2011

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Number of Participants	62,469	52,094	38,132	25,920	21,070
Number with at least 1 Service	8,898	9,040	6,798	4,642	4,097
Percentage with at least 1 Service	14.2%	17.4%	17.8%	17.9%	19.4%

Table 27. Percentage of Family Planning Participants (12-Month Enrollment) with at least One Corresponding Service, CY 2007-CY 2011

	CY 2007	CY 2008	CY 2009	CY 2010	CY 2011
Number of Participants	21,216	14,731	7,433	1,886	1,737
Number with at least 1 Service	2,754	2,306	1,057	488	415
Percentage with at least 1 Service	13.0%	15.7%	14.2%	25.9%	23.9%

Services for Individuals with HIV/AIDS

DHMH continuously monitors service utilization for HealthChoice participants with HIV/AIDS. This section of the report presents the enrollment distribution of HealthChoice participants with HIV/AIDS by race/ethnicity, as well as measures of ambulatory care service utilization, outpatient ED visits, CD4 testing, and viral load testing. CD4 testing is used to determine how well the immune system is functioning in individuals diagnosed with HIV. The viral load test monitors the progression of the HIV infection by measuring the level of immunodeficiency virus in the blood.

Table 28 presents the percentage of participants with HIV/AIDS by race/ethnicity for CY 2007 and CY 2011. Across the study period, Blacks and Whites composed about 95 percent of the HIV/AIDS population, and the Black-to-White ratio was about 8 to 1.

Table 28. Percentage of HealthChoice Participants (Any Period of Enrollment) with HIV/AIDS by Race/Ethnicity, CY 2007 and CY 2011

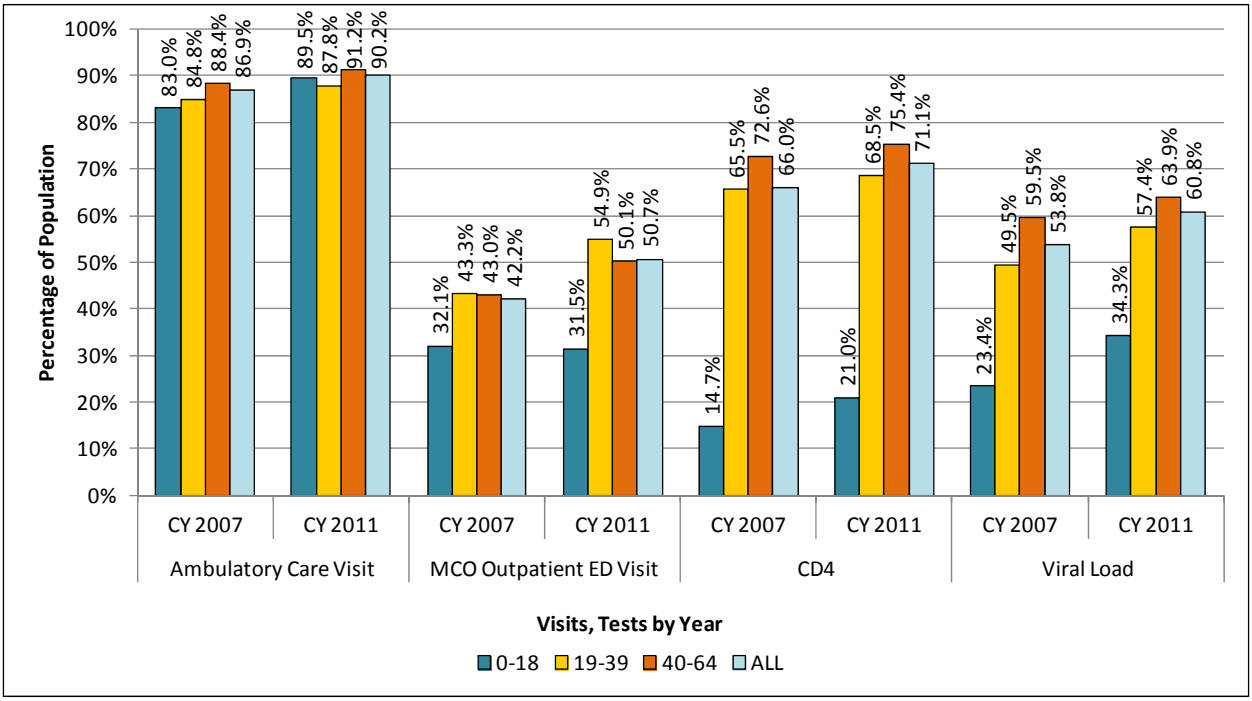
	CY 2007		CY 2011	
Race/Ethnicity	**Number of Participants**	**Percentage of Total**	**Number of Participants**	**Percentage of Total**
Asian	8	0.2%	18	0.4%
Black	3,390	84.9%	3,521	84.1%
White	435	10.9%	471	11.3%
Hispanic	43	1.1%	49	1.2%
Other	117	2.9%	126	3.0%
ALL	**3,993**	**100%**	**4,185**	**100%**

Figure 18 shows service utilization by participants with HIV/AIDS in CY 2007 and CY 2011 by age group. The overall percentage of participants with HIV/AIDS with an ambulatory care visit increased from 86.9 percent in CY 2007 to 90.2 percent in CY 2011. This rate increased for all age groups. Similarly, the percentage of participants with an MCO outpatient ED visit increased by 8.5 percentage points during the study period. This rate increased for all age groups, except children aged 0 through 18 years, for which it reduced marginally.

Figure 18 also presents the percentage of individuals with HIV/AIDS who received CD4 testing in CY 2007 and CY 2011. The overall rate increased from 66 percent in CY 2007 to 71.1 percent in CY 2011. Individuals aged 40 through 64 years had the highest rates of CD4 testing during the study period. Individuals aged 0 to 18 years demonstrated the largest increase in CD4 testing rates: 6.3 percentage points.

Finally, Figure 18 presents the percentage of individuals with HIV/AIDS who received viral load testing during the study period. This measure increased from 53.8 percent in CY 2007 to 60.8 percent in CY 2011. Individuals aged 0 through 18 showed the largest increase in utilization, 10.9 percentage points.

Figure 18. Percentage of HealthChoice Participants with HIV/AIDS who Received an Ambulatory Care Visit, MCO Outpatient ED Visit, CD4 Testing, and Viral Load Testing by Age Group, CY 2007 and CY 2011



REM Program

The REM program provides case management services to Medicaid participants who have one of a specified list of rare and expensive medical conditions and require sub-specialty care. In order to be enrolled in REM, an individual must be eligible for HealthChoice, have a qualifying diagnosis, and be within the age limit for that diagnosis. Examples of qualifying diagnoses include: HIV/AIDS, cystic fibrosis, quadriplegia, muscular dystrophy, chronic renal failure, and spina bifida. REM participants do not receive services through an MCO. The REM program provides the standard FFS Medicaid benefit package and some expanded benefits, such as medically necessary private duty nursing, shift home health aide, and adult dental services. This section of the report presents data on REM enrollment and service utilization.

REM Enrollment

Table 29 presents REM enrollment by age group and sex for CY 2007 and CY 2011. In both years, the majority of REM participants were male children aged 0 through 18 years. The gender distribution differs from the HealthChoice population, which has a higher percentage of females (about 57 percent in CY 2011).

Table 29. REM Enrollments by Age Group and Sex, CY 2007 and CY 2011

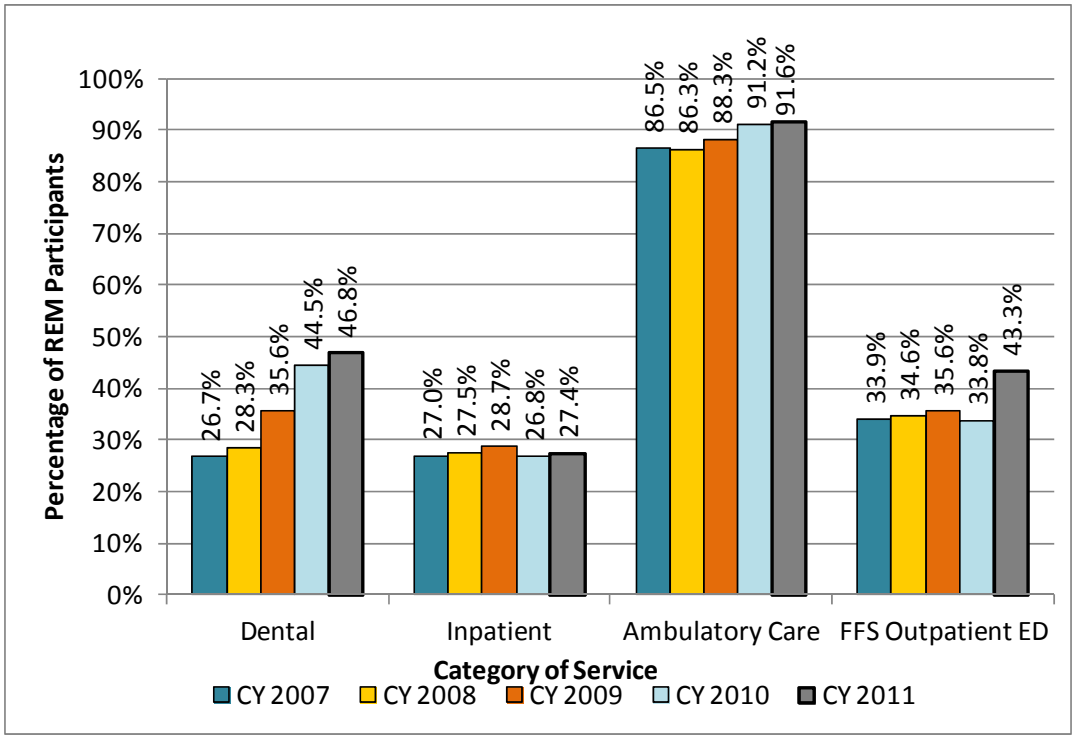
	CY 2007		CY 2011	
Age Group (Years)	Number of Participants	Percentage of Total	Number of Participants	Percentage of Total
0-18	2,961	74.5%	3,139	70.3%
19-64	1,013	25.5%	1,327	29.7%
Total	**3,974**	**100.0%**	**4,466**	**100.0%**
Female	1,778	44.7%	1,977	44.3%
Male	2,196	55.3%	2,489	55.7%
Total	**3,974**	**100.0%**	**4,466**	**100.0%**

REM Service Utilization

Figure 19 presents the percentage of REM participants who received at least one dental, inpatient, ambulatory care, and FFS outpatient ED visit between CY 2007 and CY 2011.[20] The dental, inpatient, and ambulatory care visits measures serve as indicators of access to care. The percentage of participants with a dental visit increased markedly during the study period, from 26.7 percent in CY 2007 to 46.8 percent in CY 2011. The ambulatory care utilization rate increased by 5.1 percentage points during the study period, and inpatient service utilization increased slightly. The percentage of participants who had a FFS outpatient ED visit was steady for four years before the sudden increase of 9.5 percentage points between CY 2010 and CY 2011.

[20] The analysis includes participants who were in the REM program for any period during the calendar year and received FFS dental, inpatient, ambulatory care, and outpatient ED services. Inpatient service includes services occurred in acute, chronic, hospice and rehab facilities.

Figure 19. Percentage of REM Participants (Any Period of Enrollment) with at least One Dental, Inpatient, Ambulatory Care, and FFS Outpatient ED Visit, CY 2007-CY2011



Racial/Ethnic Disparities

Racial and ethnic disparities in health care are nationally recognized issues. DHMH is committed to improving health services utilization among racial and ethnic groups through its managing-for-results program. This section of the report presents enrollment trends among racial and ethnic groups and assesses disparities within several measures of service utilization.

Enrollment

Table 30 displays HealthChoice enrollment by race/ethnicity. Enrollment increased within each racial/ethnic group between CY 2007 and CY 2011. However, this growth did not occur uniformly across all categories. The Hispanic and Other racial/ethnic categories increased by 43 percent and 59 percent, respectively. The Asian category experienced the most growth, increasing by 76 percent. The percentage of participants in the Black category decreased from 54 percent in CY 2007 to 50.3 percent in CY 2011, while the percentage of participants in the White category increased from 28 percent in CY 2007 to 29.3 percent in CY 2011.

Table 30. HealthChoice Enrollment by Race/Ethnicity, CY 2007 and CY 2011

	CY 2007		CY 2011	
	Number of Participants	Percentage	Number of Participants	Percentage
Asian	14,600	2.3%	25,694	3.1%
Black	336,450	54.0%	418,692	50.3%
White	174,711	28.0%	243,692	29.3%
Hispanic	68,799	11.0%	98,617	11.8%
Other	28,739	4.6%	45,803	5.5%
Total	**623,299**	**100.0%**	**832,498**	**100.0%**

Ambulatory Care Visits

Figure 20 shows the percentage of children aged 0 through 20 years who received at least one ambulatory care visit across all racial/ethnic groups during the study period. This rate increased for all racial/ethnic groups during the evaluation period. Hispanics had the highest rate in both CY 2007 (83.8 percent) and CY 2011 (88.1 percent), and Blacks had the lowest rate across the study period.

Figure 20. Percentage of HealthChoice Participants Aged 0-20 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2007 and CY 2011

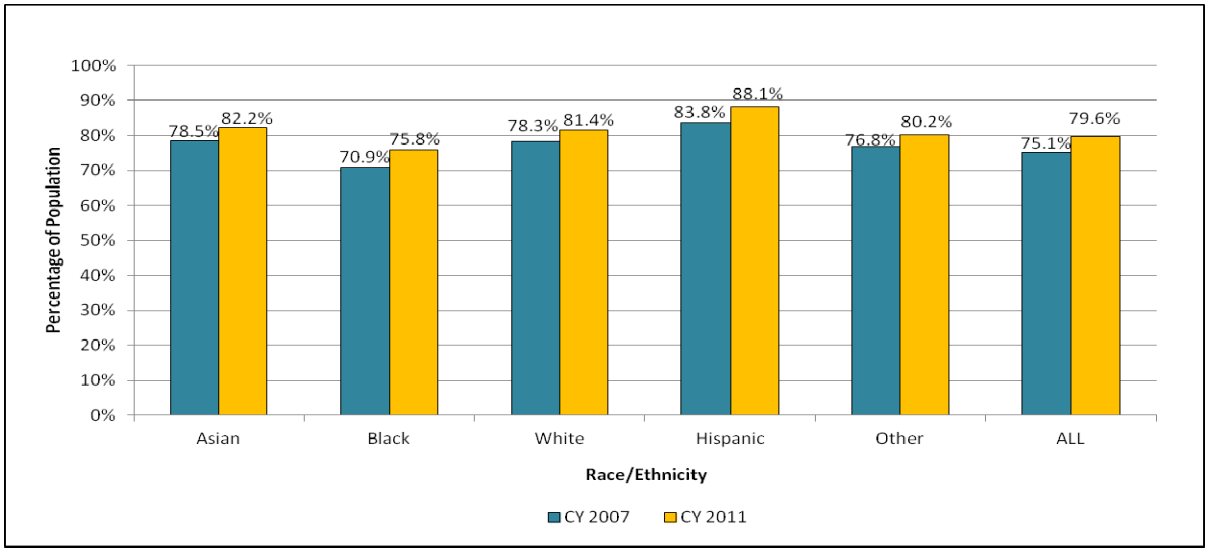
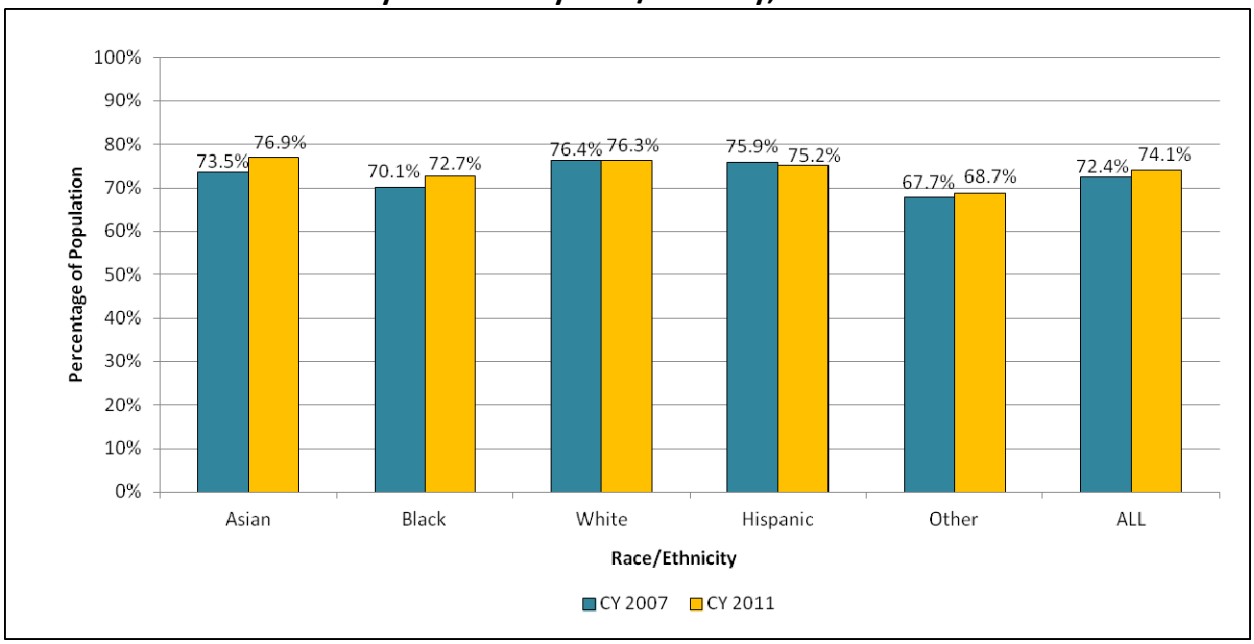


Figure 21 presents the percentage of adults aged 21 through 64 years who received at least one ambulatory care visit in CY 2007 and CY 2011. The ambulatory care visit rate improved for all racial/ethnic groups except Hispanics and Whites. The Asian racial/ethnic group experienced the greatest increase during the evaluation period (3.4 percentage points).

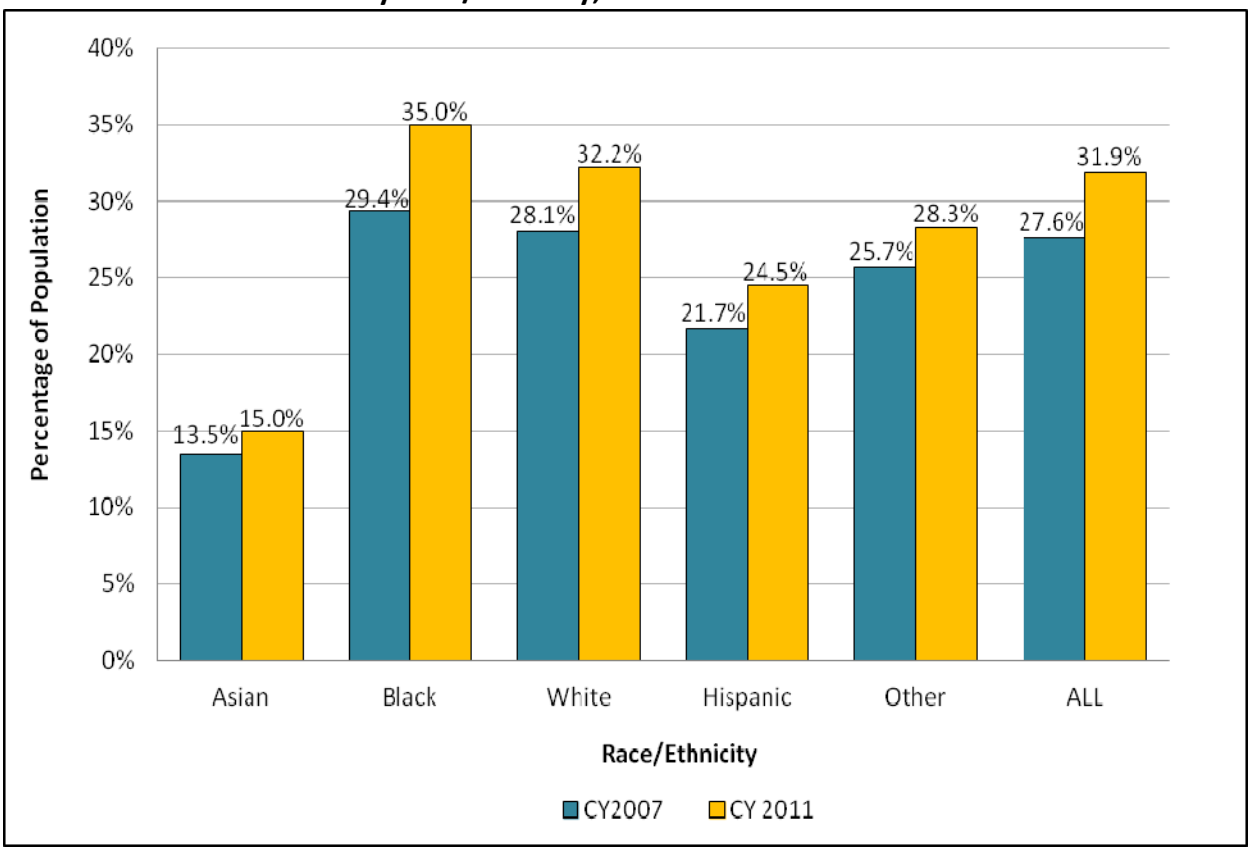
Figure 21. Percentage of HealthChoice Participants Aged 21-64 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2007 and CY 2011



ED Visits

Figure 22 displays the percentage of HealthChoice participants aged 0 through 64 years who had at least one ED visit by race/ethnicity in CY 2007 and CY 2011. Blacks had the highest ED visit rate, but each racial/ethnic group experienced an increase during the study period. Asians had the lowest rate across the study period.

Figure 22. Percentage of HealthChoice Participants Aged 0-64 Receiving an ED Visit by Race/Ethnicity, CY 2007 and CY 2011



Section IV Summary

This section of the report provided an overview of several special HealthChoice initiatives and programs. Some of the highlights of these special topics include:

- Dental services for children, pregnant women, and adults in the REM program were carved out of the MCO benefit package on July 1, 2009. These services are administered by an ASO. Maryland has made improvements in children's dental service utilization and dental provider reimbursement.
- The percentage of participants with an MHD remained at approximately 25 percent between FY 2008 and FY 2011. The percentage of participants with an SUD ranged between 4.2 and 5 percent during the same time period. Both populations have similar rates of physician visits for somatic care, but participants with a SUD had a higher ED visit rate (67.6 percent) than participants with an MHD (46.2 percent) in FY 2011.
- In CY 2011, children in foster care had a lower rate of ambulatory care service utilization compared with other children in HealthChoice, as well as a higher rate of MCO outpatient ED visits.

- Measures of access to prenatal care services declined slightly during the study period, but Maryland outperformed the national HEDIS means in CY 2010.
- Due to program changes required by CMS, enrollment in the Family Planning Program decreased by 66 percent between CY 2007 and CY 2011 (using the any period of enrollment methodology).
- Ambulatory care service utilization, CD4 testing, and viral load testing improved for participants with HIV/AIDS during the study period. ED utilization by this population also increased during the study period.
- The REM program provides case management, medically necessary private duty nursing, and other expanded benefits to participants who have one of a specified list of rare and expensive medical conditions. The majority of REM participants are children (70 percent) and male (56 percent).
- Regarding racial and ethnic disparities in access to care, Black children have lower rates of ambulatory care visits than other children. Among the entire HealthChoice population, Blacks also have the highest ED utilization rates. DHMH will continue to monitor these measures to reduce disparities between racial/ethnic groups.

Section V. PAC Access and Quality

Implemented in July 2006, the PAC program offers limited benefits to childless adults aged 19 years and older who are not eligible for Medicare or Medicaid and whose incomes are at or below 116 percent of the FPL. The PAC program replaced the Maryland Pharmacy Assistance and Maryland Primary Care program. Participants must choose from one of five PAC MCOs and a participating PCP. Each MCO in the PAC program offers the following services:

- Primary care services, including visits to the doctor or clinic
- Family planning services
- Routine annual gynecological visits
- Prescriptions
- Certain over-the-counter medications with a doctor's order
- Some x-ray and laboratory services
- Diabetes-related services, including vision care and podiatry
- Mental health services provided by an enrollee's PCP
- Community-based substance abuse services (effective January 1, 2010)
- Outpatient ED facility services (effective January 1, 2010)

Additionally, participants may receive specialty mental health services through the FFS system. As a result of the Medicaid expansion option in the ACA, the PAC program will transition into a categorically eligible Medicaid population by January 2014. This section of the report analyzes a variety of PAC enrollment and service utilization performance measures.

PAC Enrollment

This section presents PAC enrollment from CY 2007 through CY 2011. The number of individuals with any period of enrollment in PAC increased by 164 percent during the study period: from 31,278 participants in CY 2007 to 82,647 participants in CY 2011.

Figure 23 presents the percentage of PAC participants with any period of enrollment by race/ethnicity for CY 2007 through CY 2011. Across the study period, Blacks and Whites composed around 95 percent of the PAC population, with the Black-to-White ratio almost 2 to 1 during the first two years of the study period. However, since CY 2009, this ratio has been decreasing.

Figure 23. PAC Enrollment (Any Period of Enrollment) by Race/Ethnicity, CY 2007-2011

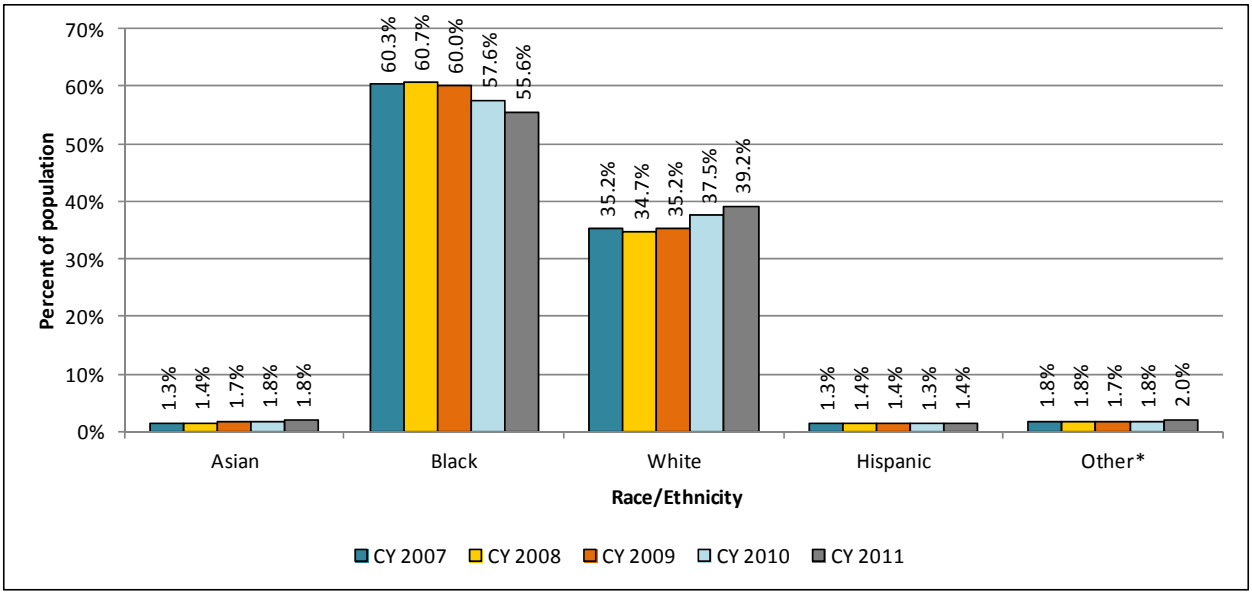
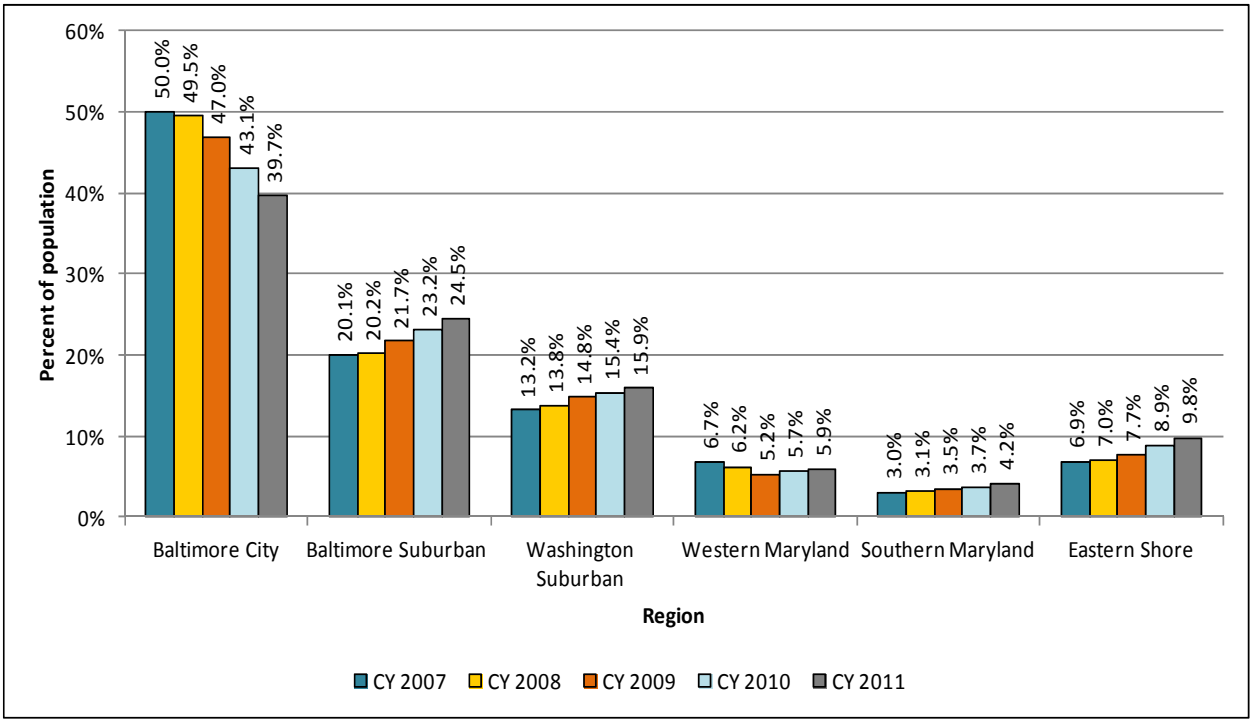


Figure 24 presents PAC enrollment by region from CY 2007 through CY 2011. Enrollment was concentrated in the densely populated areas of the State, with more than 80 percent residing in three regions: Baltimore City, Baltimore Suburban, and Washington Suburban.

Figure 24. PAC Enrollment (Any Period of Enrollment) by Region, CY 2007-2011



PAC Service Utilization

In order to provide a more accurate review of PAC enrollee service utilization, this section of the report includes only those who were enrolled in the PAC program for the entire year, except in the mental health and substance use disorder services sections.

Ambulatory Care Visits

Figure 25 presents the percentage of PAC participants who had at least one ambulatory care visit between CY 2007 and CY 2011 by race/ethnicity. The percentage of participants with an ambulatory care visit increased by 19.4 percentage points, from 55.0 percent in CY 2007 to 74.4 percent in CY 2011. Hispanic participants experienced the greatest increase (over 28 percentage points), followed by the Black, Asian, and Other categories, with increases around 20 percentage points. The number of Asians with an ambulatory care visit increased each year from CY 2007 to CY 2011, unlike the remaining racial/ethnic groups, which experienced a drop in CY 2011.

Figure 25. Percentage of PAC Participants (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Race/ Ethnicity, CY 2007-CY 2011

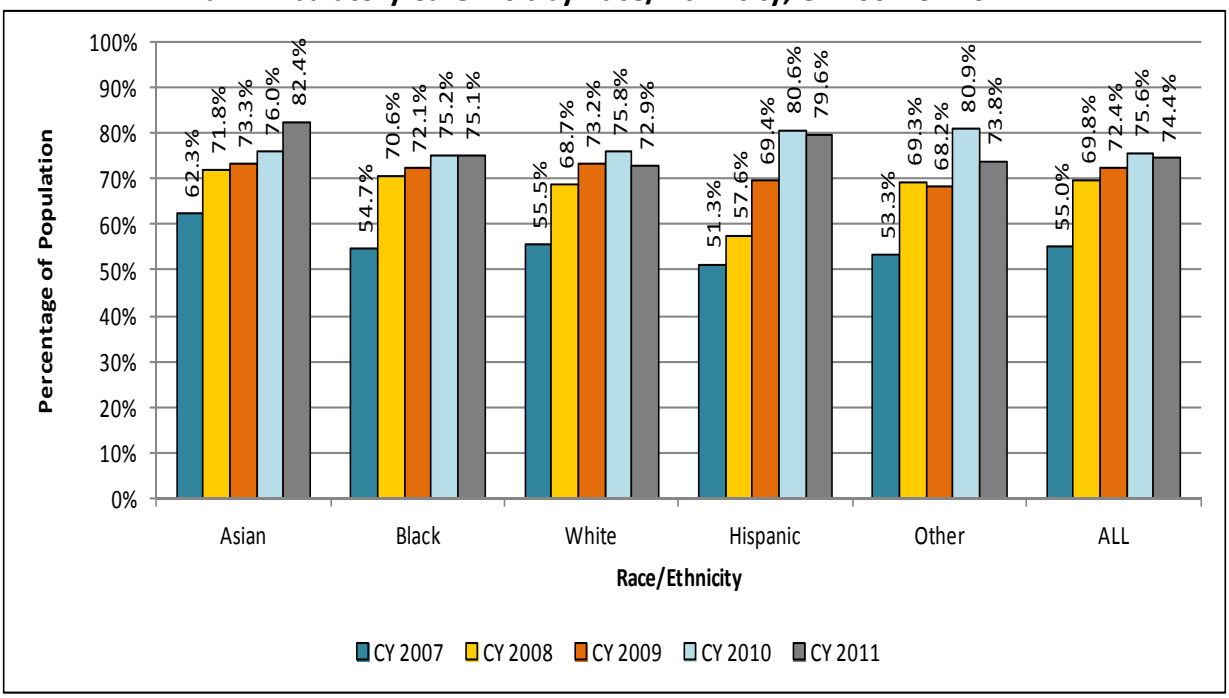
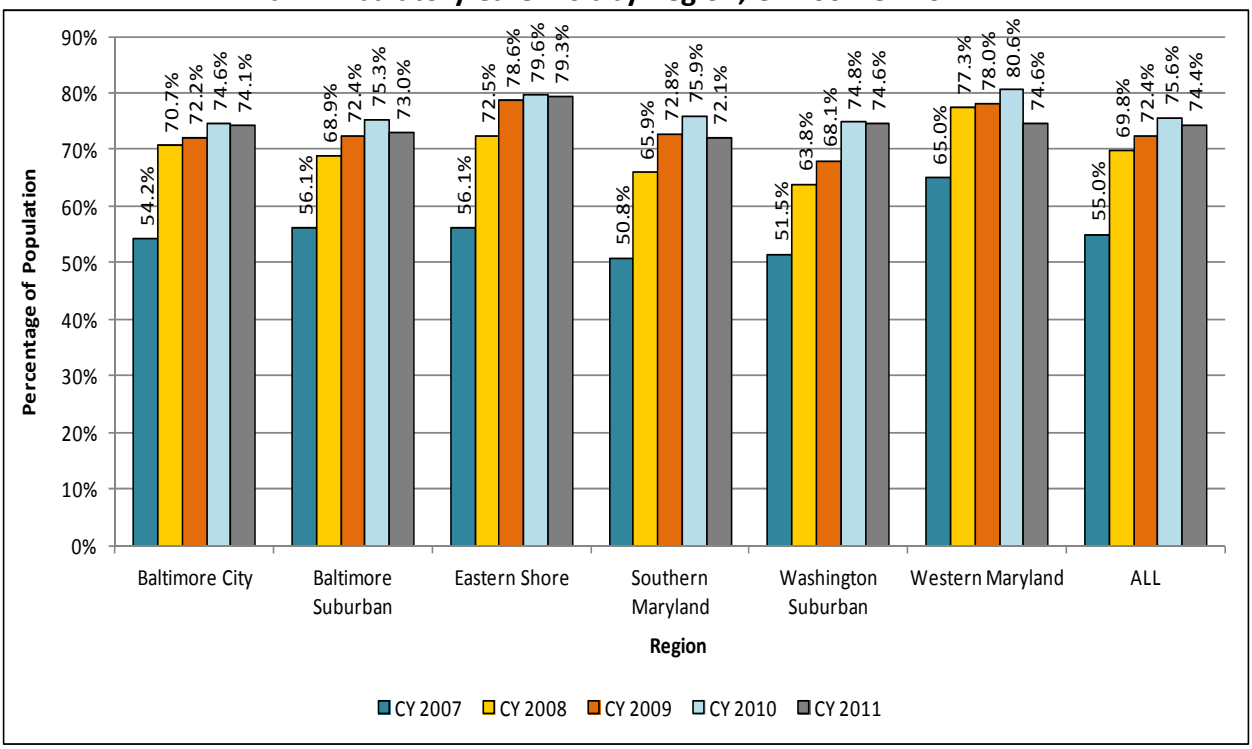


Figure 26 shows the ambulatory care visit rate also increased within each region. The Eastern Shore and Washington Suburban regions experienced the greatest increase (23 percentage points), followed by Southern Maryland and Baltimore City (21.3 and 19.9 percentage points, respectively).

Figure 26. Percentage of PAC Participants (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Region, CY 2007-CY 2011



Mental Health Services

Mental health services are carved out of the PAC MCO benefit package and are managed by an ASO. Table 31 shows the percentage of PAC participants with an MHD by region between FY 2008 and FY 2011. Overall, the percentage of PAC participants with an MHD decreased from 41.4 percent in FY 2008 to 38.3 percent in FY 2011.

Table 31. Percentage of PAC Participants (Any Period of Enrollment) with a Mental Health Disorder by Region, FY 2008 – FY 2011

Region	FY 2008	FY 2009	FY 2010	FY 2011
Baltimore City	38.2%	39.8%	35.2%	36.3%
Baltimore Suburban	47.8%	48.0%	43.1%	43.1%
Washington Suburban	39.9%	38.5%	33.0%	33.6%
Western Maryland	41.8%	41.3%	43.5%	43.4%
Eastern Maryland	44.8%	45.1%	40.0%	39.2%
Southern Maryland	43.3%	41.1%	39.4%	38.1%
Total	**41.4%**	**41.9%**	**37.8%**	**38.3%**

Table 32 shows the percentage of PAC participants with an MHD who also accessed physician and ED somatic care services. The percentage of participants with at least one physician visit increased by 5.6 percentage points over the study period. The percentage of participants with an ED visit increased by nearly 33 percentage points, from 8.6 percent in FY 2008 to 41.3 percent in FY 2011.

Table 32. Service Utilization among PAC Participants (Any Period of Enrollment) with a Mental Health Disorder, FY 2008 – FY 2011

Fiscal Year	PAC Participants with an MHD	Percentage with a Physician Visit for Somatic Care	Percentage with an ED Visit for Somatic Care
2008	9,044	71.6%	8.6%
2009	10,003	73.7%	9.6%
2010	13,969	76.9%	30.3%
2011	19,133	77.2%	41.3%

Substance Use Disorder Services

Table 33 shows the percentage of PAC participants with an SUD by region between FY 2008 and FY 2011. Throughout the evaluation period, the Baltimore City region had the largest percentage of participants with an SUD. Overall, the percentage of PAC enrollees with an SUD increased steadily over the study period.

Table 33. Percentage of PAC Participants (Any Period of Enrollment) with a Substance Use Disorder by Region, FY 2008 – FY 2011

Region	FY 2008	FY 2009	FY 2010	FY 2011
Baltimore City	22.9%	22.6%	33.9%	38.1%
Baltimore Suburban	10.8%	11.0%	26.8%	32.4%
Washington Suburban	5.2%	6.3%	11.8%	16.3%
Western Maryland	3.3%	5.0%	20.3%	28.5%
Eastern Maryland	4.9%	6.5%	19.8%	25.0%
Southern Maryland	7.2%	5.6%	15.0%	25.1%
Total	**14.6%**	**15.1%**	**26.3%**	**31.1%**

Table 34 shows the percentage of PAC participants with an SUD who also accessed somatic physician and ED services. The percentage of participants with at least one physician visit decreased from 87.2 percent in FY 2008 to 68.3 percent in FY 2011. The percentage of participants with an ED visit increased from 13.7 percent in FY 2008 to 43.5 percent in FY 2011. The number of participants enrolled with an SUD, the increase in ED visits for somatic care, and the decrease in the overall percentage of PAC participants with an SUD accessing somatic care can be attributed to the addition of outpatient substance abuse services and coverage for ED facility charges to the PAC benefit in January 2010.

Table 34. Service Utilization among PAC Participants (Any Period of Enrollment) with a Substance Use Disorder, FY 2008 – FY 2011

Fiscal Year	PAC Participants with a SUD	Percentage with a Physician Visit for Somatic Care	Percentage with a ED Visit for Somatic Care
2008	3,191	87.2%	13.7%
2009	3,595	89.0%	15.4%
2010	9,729	72.3%	34.2%
2011	15,519	68.3%	43.5%

Table 35 presents the number and percentage of PAC participants with an SUD and at least one methadone replacement therapy service. Between FY 2010 and FY 2011, the percentage of participants with at least one methadone replacement therapy increased from 3.3 percent to 29.4 percent.

Table 35. Number and Percentage of PAC Participants (Any Period of Enrollment) with a Substance Use Disorder and at least One Methadone Replacement Therapy, FY 2008 – FY 2011

Fiscal Year	PAC Participants with a SUD	Number of Participants with a SUD and Methadone Replacement Therapy	Percentage of Total Participants with SUD
2008	3,191	37	1.2%
2009	3,595	57	1.6%
2010	9,729	321	3.3%
2011	15,519	4,566	29.4%

Prescription Drug Use

Table 36 presents the percentage of PAC participants who filled a prescription in CY 2007 and CY 2011 by the number of prescriptions filled per person. The percentage of participants who filled a prescription increased from 69.5 percent in CY 2007 to 83.2 percent in CY 2011.

Table 36. Percentage of PAC Participants (12 Months of Enrollment) with a Prescription by Number of Prescriptions, CY 2007 and CY 2011

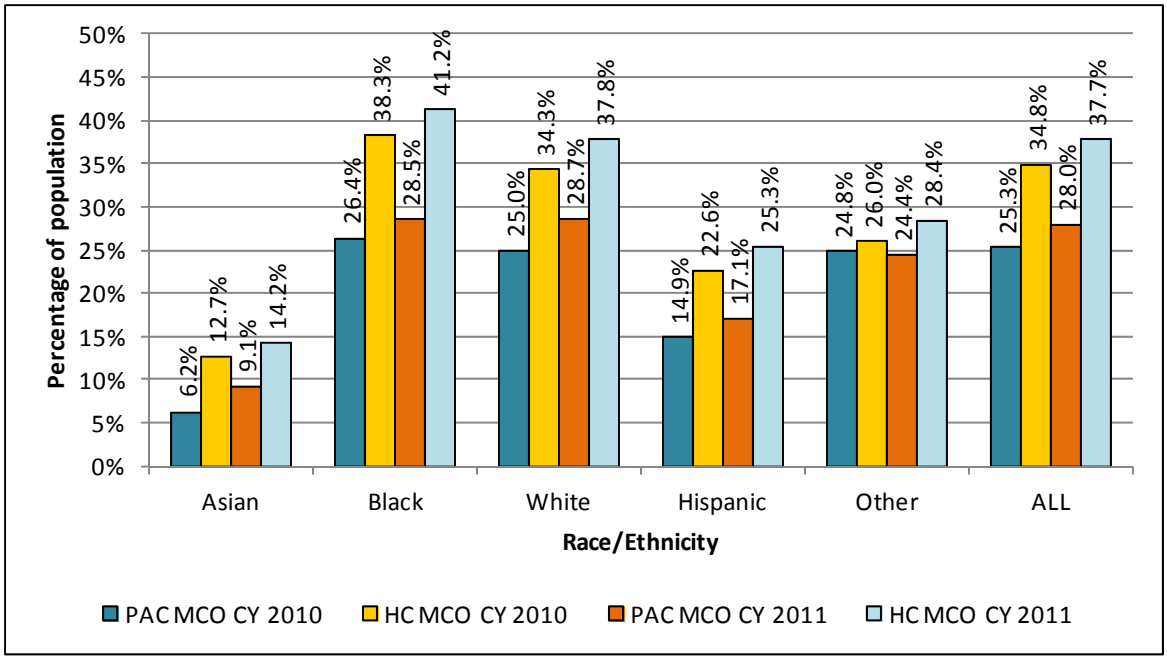
	CY 2007		CY 2011	
Number of Prescriptions	Number of Participants	% with Prescription	Number of Participants	% with Prescription
0	5,002	30.5%	3,627	16.8%
1	624	3.8%	864	4.0%
2	702	4.3%	1,024	4.7%
3	486	3.0%	810	3.7%
4	503	3.1%	699	3.2%
5-10	1,926	11.8%	3,027	14.0%
11-20	2,160	13.2%	3,720	17.2%
21-30	1,406	8.6%	2,424	11.2%
31-40	1,020	6.2%	1,660	7.7%
41-50	756	4.6%	1,195	5.5%
51 or More	1,803	11.0%	2,566	11.9%
ALL	**16,388**	**100.0%**	**21,616**	**100.0%**

ED Visits

On January 1, 2010, Maryland added outpatient ED visits to the PAC benefit package. Figure 27 compares the percentage of PAC participants who had at least one outpatient ED visit in CY 2010 and CY 2011 with the percentage of HealthChoice participants aged 19 to 64 years with an ED visit in those years. These data are presented by race/ethnicity.

In both years, outpatient ED utilization rates among HealthChoice participants were nearly 10 percentage points higher than PAC participants. Among all racial/ethnic groups, Blacks had a higher rate of ED use for both the PAC and HealthChoice populations, except in CY 2011 when Whites in the PAC population had a slightly higher utilization rate (28.7 percent) than Blacks (28.5 percent).

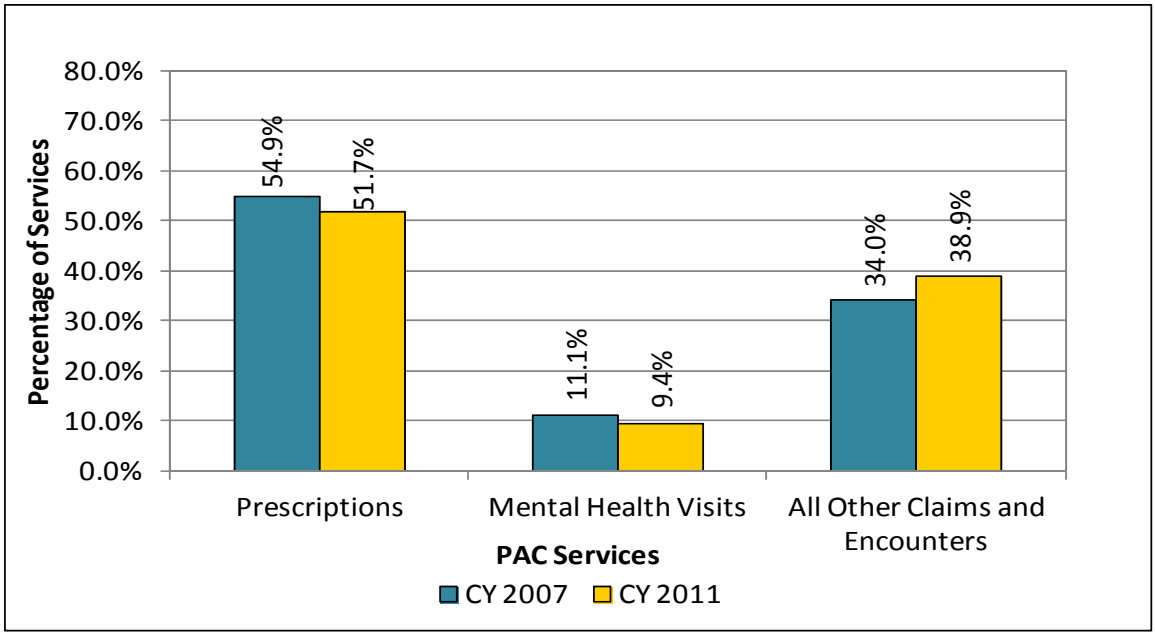
Figure 27. PAC Population vs. HealthChoice Population (Any Period of Enrollment) Receiving an Outpatient ED Visit by Race/Ethnicity, CY 2010–CY 2011



Composition of Total PAC Services

Figure 28 presents the overall composition of services (categorized as prescriptions, mental health, and all other services) provided under the PAC program in CY 2007 and CY 2011. Across the study period, prescriptions accounted for over half of all PAC services. Mental health visits accounted for 9.4 percent of the services in CY 2011, a 1.7 percentage point decrease from CY 2007. The "all other services" category increased by about 5 percentage points between CY 2007 and CY 2011.

Figure 28. Comparison of Total Services Provided in PAC, CY 2007 and CY 2011



PAC HEDIS Measures

In CY 2008, DHMH began using HEDIS to assess quality and service utilization in the PAC program. The PAC HEDIS measures include breast cancer screening, cervical cancer screening, and comprehensive diabetes care. Table 37 compares the PAC HEDIS measures with the national HEDIS means for CY 2008 through CY 2011 (HealthcareData Company LLC, 2012).

The breast cancer screening measure assesses the percentage of women aged 40 through 69 years who received at least one mammogram for breast cancer screening within a two-year period. Overall, about 41 percent of women enrolled in PAC received a mammogram in CY 2011, an increase of 8.7 percentage points over CY 2008.

The cervical cancer screening measure is reported for women aged 21 through 64 years who received a PAP test within a three-year period. The rate increased by 5.4 percentage points between CY 2008 and CY 2011. It should be noted that this measure examines participants' experiences during the measurement year and the two years prior to the measurement year. PAC was not in existence for three years when these measures were conducted, which may explain why the PAC scores are lower than the national HEDIS means.

The CDC measure assesses the percentage of participants with diabetes (types 1 and 2) who received HbA1c testing, eye exams, and LDL-C screening. Between CY 2008 and CY 2011, the HbA1c testing rate, the eye exam rate, and the LDL-C screening rates increased. PAC CDC rates are below national averages, but CY 2011 was the first year in the measurement period when the LDL-C screening rate surpassed the national HEDIS mean.

Table 37. PAC HEDIS Measures Compared with the National HEDIS Means, CY 2008–CY 2011

	CY 2008		CY 2009		CY 2010		CY 2011	
HEDIS Measures	**PAC**	**National HEDIS Mean**	**PAC**	**National HEDIS Mean**	**PAC**	**National HEDIS Mean**	**PAC**	**National HEDIS Mean**
Breast Cancer Screening	32.1%	50.8%	38.4%	52.4%	41.7%	51.3%	40.8%	50.4%
Cervical Cancer Screening	39.1%	66.0%	42.0%	65.8%	42.7%	67.2%	44.5%	66.7%
CDC – HbA1c Testing	75.2%	80.5%	77.0%	80.6%	76.7%	82.0%	81.6%	82.5%
CDC – Eye Exam	35.1%	52.8%	44.8%	52.7%	40.5%	53.1%	40.7%	53.4%
CDC – LDL-C Screening	73.0%	74.1%	72.6%	74.2%	72.8%	74.7%	76.2%	75.0%

Section V Summary

PAC is a limited benefit program for adults with low income who are not eligible for Medicare or the full Medicaid benefit package. Overall, PAC enrollment increased by 164 percent during the study period. DHMH measured PAC ambulatory care, MHD and SUD services, and prescription drug utilization between CY 2007 and CY 2011. During the study period, ambulatory care and prescription utilization increased, as did the use of physician visits and ED visits for somatic care by PAC participants with an MHD. The percentage of PAC participants with an SUD and an ED visit for somatic care increased over the study period, while the percentage with a physician visit decreased. On January 1, 2010, Maryland added outpatient ED visits to the PAC benefit package. In CY 2011, 28 percent of PAC participants had at least one ED visit, which is a 2.7 percentage point increase from CY 2010. DHMH began using PAC HEDIS measures in CY 2008. PAC performance on these measures improved during the study period but remained lower than the national HEDIS means except for the LDL-C screening rate in CY 2011.

Conclusion

HealthChoice is a mature managed care program that provides services to 15 percent of Marylanders. The information presented in this renewal application provides strong evidence that HealthChoice has been successful in achieving its stated goals related to coverage and access to care, providing a medical home to participants, and improving quality of care. As with any program, there are areas that need improvement to ensure that the growing number of participants have access to quality care. DHMH is committed to working with CMS and other stakeholders to identify and address necessary programmatic changes upon renewal of this waiver.

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