

I. INTRODUCTION AND PURPOSE OF THE EVALUATION

The implementation of the Maryland HealthChoice program began in July 1997; by January 1998 all eligible individuals were enrolled. HealthChoice represented a major change in Maryland's approach to service delivery for most Medicaid recipients. It replaced a mixed model delivery system--consisting of fee-for-service primary care case management and capitated Health Maintenance Organization (HMO) voluntary enrollment--with a mandatory system of enrollment in managed care organizations (MCOs). Under HealthChoice, all eligible families and individuals are required to enroll in a managed care organization (MCO) that has been approved by the Department of Health and Mental Hygiene (the Department). The MCOs are responsible for developing a network that can provide those services for its enrollees.

Over the last four years, the Department has worked with the MCOs to improve the program by measuring and monitoring performance. The Department has always maintained a continuous improvement mindset with HealthChoice, however, it has never performed a comprehensive evaluation of HealthChoice. In recent years, HealthChoice has received scrutiny from a variety of sources – providers, MCOs, advocates, legislators, and researchers.

Much of this scrutiny is a result of the tension between the need to control costs without compromising care during a period of general rising health care costs. This tension is not unique to Maryland as both the commercial insurance market and the federal Medicare program face similar concerns.

The HealthChoice program was in its fourth year when the Department embarked on an extensive evaluation that would assess the program's success relative to its original goals and stakeholders' expectations. To accomplish its goals, the evaluation uses a mix of quantitative data (such as encounter data and Health Services Cost Review Commission data) and qualitative data sources (such as community forums and focus groups). The evaluation presents the findings from these different data sources together in order to provide a broad and comprehensive picture of the overall performance of the HealthChoice program.

The evaluation is structured around HealthChoice's original program goals. These were to:

- Develop a patient focused system featuring a medical home;
- Create comprehensive, prevention-oriented systems of care;
- Build on the strengths of Maryland's existing health care delivery system;
- Hold managed care organizations accountable for delivering high-quality care; and
- Achieve better value and predictability for State dollars.

MEASURING PROGRAM PERFORMANCE

In conducting this evaluation, the Department was not only interested in learning how HealthChoice compares to its predecessor, the Maryland Access to Care (MAC) primary care case management program that the State operated on a non-risk, fee-for-service basis from 1991 to 1997, but also how HealthChoice has changed over the years.

Under the MAC program, each enrollee either chose or was assigned to a primary care provider (designated the enrollee's "primary medical provider" (PMP)), who would be responsible for coordinating that enrollee's care. The MAC program was limited, however, in its care management process (such as utilization review and disease management) because it lacked the necessary infrastructure to provide these services for high-risk MAC enrollees. In addition, PMPs were not required to assure access to appropriate specialty care. Unlike the PMPs on which the MAC program relied, HealthChoice MCOs receive a predetermined capitated payment each month in exchange for providing medically necessary covered services to each of their enrollees. This gives MCOs a financial incentive to implement and use care management processes to control costs and improve quality. There was no comparable incentive under the MAC program.

Many of the analyses presented in this evaluation compare FY 1997 fee-for-service claims for individuals (mostly MAC program participants) who would be HealthChoice-eligible under current program eligibility rules to CY 2000 MCO encounters by HealthChoice enrollees.

To the extent possible, the evaluation attempts to place the Maryland experience in context of other states' Medicaid managed care programs. It is difficult, however, to make meaningful comparisons between HealthChoice program data and Medicaid managed care program data collected by other states. This difficulty is primarily due to differences in program designs, populations covered, benefits provided, and means of collecting and analyzing data, along with the inability to adjust for these differences. Appendix 2 presents a discussion of these difficulties, and includes the results of reviews and analyses of other states' Medicaid managed care programs. These are compared, to the extent possible, to similar measures employed by the HealthChoice program.

PLANNING AND DESIGNING THE EVALUATION

The first step in designing the evaluation included identifying performance standards and outlining data sources. The Department used existing data sources whenever possible to avoid duplication of efforts and to minimize the cost of performing the evaluation. To complement and validate the evaluation's quantitative data, as well as to fill any gaps in data sources, the Department collected additional qualitative data through community forums, focus groups, and interviews.

Public Input

An outline of the evaluation, specifying topic areas, analytic questions, and data sources, was first shared with stakeholders in January 2001. Subsequently, the Department held a series of stakeholder meetings to review the outline and discuss its approach. In an effort to improve attendance, these stakeholder meetings (open to all interested persons) were held on the site of and immediately following the Medicaid Advisory Committee's standing meetings.

Expert Consultation

At several points during the evaluation process, the Department consulted with a group of independent experts familiar with Medicaid, managed care, and program evaluation. The experts reviewed the evaluation plan, and commented on the evaluation's methodology, analyses, and findings. Their background and knowledge helped the Department to ensure its analyses were comprehensive and provided the Department with valuable insights and context for the findings.

CHALLENGES TO EVALUATING THE HEALTHCHOICE PROGRAM

The Department faced several significant challenges in conducting its evaluation of the HealthChoice program. While the evaluation is an extensive analysis of quantitative and qualitative data sources, drawing conclusions about whether the program has been successful is difficult due to several limiting factors. The most significant factors limiting this evaluation can be categorized as follows:

- *Changes to the HealthChoice population.* As will be discussed in Chapter II, the HealthChoice population underwent two public policy changes that have led to dramatic changes in the HealthChoice population. The first of these changes, welfare reform, significantly reduced the number of adults eligible for the program. The second change, the establishment of the Maryland Children's Health Program (MCHP), dramatically expanded the number of children served, particularly between the ages of 6 and 18. These two changes resulted in a greater proportion of children enrolled in the HealthChoice program. The health needs of adults and children vary

considerably, causing them to access very different services. In addition, among the Medicaid-eligible population, children tend to be healthier than adults and, therefore, have a lower utilization rate of services. Together, these effects render comparisons of pre-and post HealthChoice performance problematic. The demographic changes are addressed in the analyses by presenting totals that are weighted by age to account for the changed population mix.

- *Pre-HealthChoice voluntary HMO program.* It is important to note that the population enrolled during FY 1997 in Maryland's voluntary Medicaid managed care program (roughly 100,000 individuals), representing a healthier population, is not included in the FY 1997 fee-for-service comparison group. The HMOs participating in this program during FY 1997 did not submit usable encounter data to the Department. As a result, the data required to include FY 1997 Medicaid HMO enrollees in the evaluation's comparison population are missing. Because the voluntarily enrolled individuals for whom utilization data are unavailable tended to be healthier than the MAC population, the FY 1997 comparison data reflect the higher utilization rates of a sicker population and therefore overstate the utilization of the 1997 comparison group.¹
- *Lack of consistent comparison tools.* A number of tools to measure and monitor HealthChoice's performance were first implemented with HealthChoice in 1998, such as the external quality review organization (EQRO). Our ability to evaluate these measures with the 1997 fee-for-service comparison group, therefore, is limited. While these tools are discussed in this report and provide valuable insights into the progress of HealthChoice over time, they do not offer any opportunity to assess pre-and post HealthChoice performance.
- *Limited cross-state comparisons.* Generally a good way to measure the performance of any state program is to compare it to other states. Although Maryland examined the experiences of other states, comparative analysis is fraught with difficulty as Medicaid populations vary from state to state. States also use different types of data sources to measure performance. Actual encounter data provide the most valid source. Maryland's encounter data are considered among the best in the country and are used extensively in this report. States that have not been as successful in collecting encounter data rely on other sources (such as

¹ The Department, through its contractor, the UMBC Center for Health Program Development and Management, retained the actuarial firm of William H. Mercer, Inc. to provide assistance in setting HealthChoice capitation rates for CY 2001. In this capacity, Mercer conducted analyses to assess the relative services costs for individuals enrolled in the voluntary, capitated HMO program as compared to the fee-for-service "MAC" primary care case management program. Mercer's analysis indicated that individuals enrolled in the voluntary HMO program had a case mix that was 16 percent less costly than individuals enrolled in the MAC program.

telephone surveys) to evaluate their programs. The difficulties of making comparisons between disparate data sets is discussed in more detail in Appendix 2.

ORGANIZATION OF THE EVALUATION

The HealthChoice evaluation is organized in seven chapters:

Chapter I: Introduction

Chapter I discusses the evaluation's purpose and design, identifies challenges, and explains the organization of the document.

Chapter II: Background and Demographic Changes

Chapter II discusses the history of the HealthChoice program, including major legislative changes. It also reviews plan transitions and consolidations that have occurred in HealthChoice and place them in the context of large Medicaid and health care industry trends. Finally, Chapter II reviews changes in the HealthChoice-eligible population from 1997 to the present. A particular focus of the discussion is the increasing role of public-funded health insurance in providing health care access to children.

Chapter III: Medical Home and Comprehensive Care

Chapter III combines two of the original program goals, medical home and comprehensive care, into one discussion to allow for a more consistent presentation. The chapter presents extensive quantitative and qualitative analysis to assess the HealthChoice program's success in providing enrollees with a medical home and assuring comprehensive care. The chapter addresses a range of topics, including:

- *Changes in enrollee eligibility.* How do enrollee eligibility patterns compare before and after the implementation of HealthChoice?
- *Service utilization trends.* How has the utilization of specific services, such as ambulatory visits, well child visits and emergency room visits changed since the start of HealthChoice?
- *Service utilization for subpopulations.* What is the service utilization for sub-groups of HealthChoice, such as special needs children, individual with chronic conditions and different racial and ethnic groups?
- *Specific service analysis.* What has been the utilization experience for specific, important services, such as dental service, mammography, and substance abuse treatment?

- *Public perceptions.* Based on qualitative sources, how is the HealthChoice program viewed by those who it serves and those who provide services?

Chapter IV: Build on the Strengths of Maryland’s Existing Healthcare System

Chapter IV will assess the degree to which the HealthChoice program has been able to perform its mission while complementing key and longstanding aspects of the health care delivery system. Specific analyses will look at provider networks and the stresses upon them; changes in hospital service patterns; and, the role of safety net provider such as federally qualified health centers (FQHCs) and local health departments.

Chapter V: Provide Value and Predictability

Chapter V examines and discusses the financing of the HealthChoice program. Topics addressed include the program’s success in meeting federal requirements, the adequacy of program funding during the first four years, the effect of risk-adjustment on capitation rates and plan performance, and the administrative costs of operating HealthChoice.

Chapter VI: Hold Managed Care Organizations Accountable

This chapter reviews some of the key activities and systems that have been used to hold MCOs accountable for their performance. Specifically, the EQRO process, efforts to improve encounter data, and prompt pay requirement are reviewed.

Chapter VII: Summary and Recommendations

Based on the evaluation’s findings, Chapter VII makes recommendations for the HealthChoice program moving forward.