IV. BUILD ON STRENGTHS OF MARYLAND'S HEALTH CARE DELIVERY SYSTEM

The HealthChoice program was able to build on the existing health care delivery system in Maryland. Prior to HealthChoice, there was broad Medicaid participation by the physician community, a strong public health infrastructure, and a committed and long-standing cadre of "safety net" providers. In addition, its enrollees had access to world-renowned medical teaching facilities. Rather than allocating resources to recruit and develop a provider network, the program was able to allocate its resources to expanding services and developing management tools and techniques to assure quality-of-care for enrollees.

As mentioned earlier, there has been tremendous growth and demographic shifts in the HealthChoice program. An important part of the evaluation is to understand how these changes as well as others have impacted Maryland's health care delivery system over the years.

- *Are there adequate provider networks to serve HealthChoice enrollees?* To address this question, this section will compare information from HealthChoice provider files with actual program enrollments.

- *Can physicians serve the HealthChoice population without experiencing financial losses?* Fee schedules for Medicaid and selected MCOs are compared with Medicare fee schedules.

- *What has been the effect of HealthChoice on hospital utilization rates and lengths of stay?* Data from the Health Services Cost Review Commission (HSCRC) is examined to assess changes in hospital patterns among Medicaid recipients.

- *Has HealthChoice adversely impacted graduate medical education in Maryland?* The special provisions to protect institutions with a role in training physicians are examined.

- *Has HealthChoice maintained its relationships with traditional community or safety-net providers?* The effects of HealthChoice on Federally Qualified Health Centers (FQHCs) and local health departments (LHDs) are discussed. In addition, the changing roles of LHDs are examined.

PROVIDER NETWORK ADEQUACY

Overview

The assessment of the adequacy of HealthChoice provider networks can be approached in a number of ways. One approach is to examine retrospectively whether the networks were able to deliver services to eligible enrollees. Based on encounter data, the percentage of enrollees receiving services increased for ambulatory services and well-child visits from 1997 to 2000 even with the dramatic enrollee growth. While this is a very positive finding, many enrollees still do not receive any well-child or ambulatory services. Without being able to determine how many enrollees are not accessing services due to lack of provider participation, it is hard to determine by encounter data alone whether or not the network is adequate.

In addition to encounter data, the primary care provider (PCP) to enrollee ratios can be compared to the guidelines in HealthChoice regulations as a way to measure network adequacy. The advantage of this measurement tool is that it allows us to proactively assess potential network deficiencies.

Methods and Limitations

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

This section of the evaluation analyzes HealthChoice provider capacity based on provider network files submitted through September 30, 2001. Although this is the best information available, a number of problems still exist with the data, including:

- *Providers in multiple MCOs.* Physicians can, and do, contract with more than one HealthChoice MCO. Due to subtle differences in how the name or other information was recorded, a provider may be listed multiple times, which would overstate capacity.

- *Providers in multiple locations.* Physicians can, and do, practice at multiple sites. A physician who practices at multiple locations may appear in the provider directory more than once. This also can lead to overstating capacity.

- *Inconsistent updating of provider data.* The accuracy of any consolidated provider analyses rests upon the quality of data submitted by the individual MCOs. A number of factors can reduce the accuracy of provider data. For example, a provider may end active participation in the MCO or decide to close its practice to new enrollees and fail to inform the MCO; or an MCO can fail to inform the Department when a provider retires or passes away. In each of these examples, the capacity of provider networks would be overstated. Conversely, if an MCO fails to update its submissions with providers who have been added to its network, the provider data will understate capacity.

- *<u>Replacement of MCO provider information by the Department's fee-for-service provider files.</u>* The Department's information system currently is programmed to search for provider matches from its fee-for-service provider files. If it finds a match based on provider name, address, telephone number, provider type, tax ID, and license number, it will replace the updated provider data submitted by the MCOs. This also can lead to inaccuracies in the provider data.

Recognizing these problems with provider data and the accuracy of the provider network directories, a number of steps where taken to mitigate any overstatement of capacity; specifically:

- *<u>Providers were unduplicated by license number.</u>* MCOs are required to include license numbers for their participating providers (physicians, nurse practitioners, etc.). To address the problem of providers in multiple MCOs and/or multiple locations, the analysis only counts unique provider license numbers.

- *<u>Network estimates are adjusted for inconsistent updating.</u>* The inconsistent updating of provider files has led to inaccuracies in the provider directories. The Department has embarked on a process of regularly sampling listed providers to assess the overall accuracy of provider files. Initial samples and calls indicate that provider files overstate participation in HealthChoice by roughly 15 percent. Thus, to account for this apparent over-reporting of provider data, once provider files are unduplicated, they are further reduced by 15 percent. The Department is continuing to update this adjustment factor through on-going calls to providers' offices.

The cleaned-up provider data was distributed across local access areas (LAAs) based on the zip code of the provider's location (the process of unduplicating providers focused on including only the first office location).

HealthChoice regulations establish a ratio of one physician to every 200 enrollees as a general standard for assessing an individual MCO's capacity within a given LAA. HealthChoice regulations further recognize that the one to 200 standard is not appropriate for all physicians (e.g., FQHC physicians who traditionally serve a high Medicaid population). To account for these high volume physicians, the regulations also set an absolute limit of one provider per 2,000 enrollees.

In the analysis presented here, two capacity estimates were developed: 1) 200 enrollees per unduplicated PCP and 2) 500 enrollees per unduplicated PCP. It should also be noted that the regulatory guidelines apply to a particular MCO. The analysis presented looks at an unduplicated count of all HealthChoice PCPs. By not allowing a single provider who contracts with several MCOs to be counted multiple times, the evaluation applies a higher standard than outlined in the regulations.

Figure IV-1: MCO Capacity Analysis - All MCOs < 15%

	Total PCPs	Total PCPs	Total PCPs	Enrollment	Excess Capacity	Excess Capacity
Local Access Area	06/30/01	Multiplied by 200	Multiplied by 500	7/10/01	Difference @ 200*	Difference @ 500*
Allegany	56	9520	23800	7983	1537	15817
Anne Arundel North	97	16490	41225	12043	4447	29182
Anne Arundel South	117	19890	49725	7440	12450	42285
Balto City SE/Dundalk	148	25160	62900	16388	8772	46512
Balto City East	224	38080	95200	29631	8449	65569
Balto City N. Central	77	13090	32725	12813	277	19912
Balto City N. East	49	8330	20825	14651	-6321	6174
Balto City N. West	112	19040	47600	16742	2298	30858
Balto City South	53	9010	22525	13661	-4651	8864
Balto City West	180	30600	76500	36249	-5649	40251
Balto Cnty East	89	15130	37825	12112	3018	25713
Balto Cnty North	180	30600	76500	6484	24116	70016
Balto Cnty N. West	77	13090	32725	15908	-2818	16817
Balto Cnty S. West	125	21250	53125	13792	7458	39333
Calvert	33	5610	14025	4233	1377	9792
Caroline	9	1530	3825	3698	-2168	127
Carroll	52	8840	22100	5878	2962	16222
Cecil	26	4420	11050	6985	-2565	4065
Charles	63	10710	26775	8283	2427	18492
Dorchester	18	3060	7650	3614	-554	4036
Frederick	39	6630	16575	8117	-1487	8458
Garrett	15	2550	6375	3878	-1328	2497
Harford East	27	4590	11475	4446	144	7029
Harford West	49	8330	20825	7259	1071	13566
Howard	114	19380	48450	7754	11626	40696
Kent	13	2210	5525	1627	583	3898
Montgomery-Sil Spr	112	19040	47600	6970	12070	40630
Montgomery-Mid Cnty	116	19720	49300	11929	7791	37371
Montgomery-North	58	9860	24650	20063	-10203	4587
Prince Geo N East	74	12580	31450	5785	6795	25665
Prince Geo N West	119	20230	50575	35115	-14885	15460
Prince Geo S East	40	6800	17000	4866	1934	12134
Prince Geo S West	40	6800	17000	15514	-8714	1486
Queen Anne's	7	1190	2975	2209	-1019	766
Somerset	14	2380	5950	2711	-331	3239
St. Mary's	45	7650	19125	5921	1729	13204
Talbot	32	5440	13600	2332	3108	11268
Washington	74	12580	31450	9889	2691	21561
Wicomico	45	7650	19125	9354	-1704	9771
Worchester	22	3740	9350	4086	-346	5264
Total	2840	482800	1207000	418413	64387	788587

Findings

When the conservative standard of 200 enrollees per PCP is adjusted downward by 15 percent to account for poor updating, fifteen LAAs have capacity deficits. The area with the greatest deficit is the Eastern Shore, with seven of the nine LAAs having capacity deficits. If the more liberal capacity standard of 500 enrollees per PCP is used with a 15 percent adjustment downwards, however, no LAA across the State shows a capacity deficit.

Figure IV-2: Local Access Areas with Excess Capacity

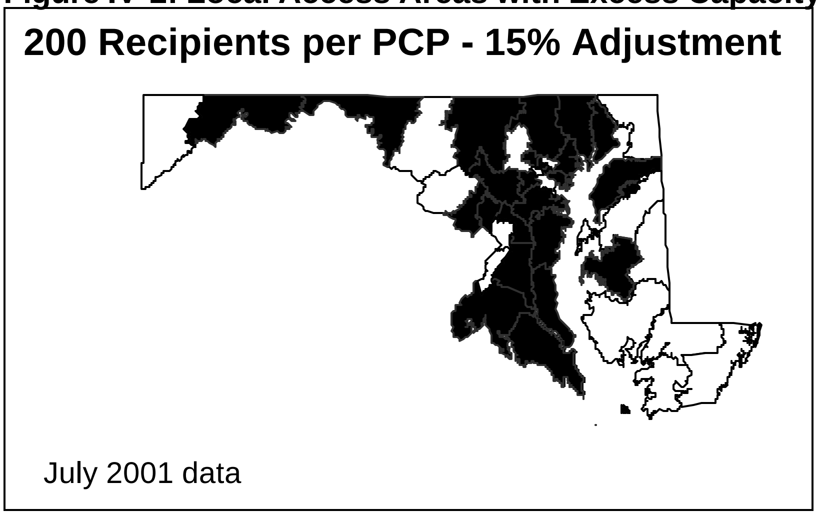
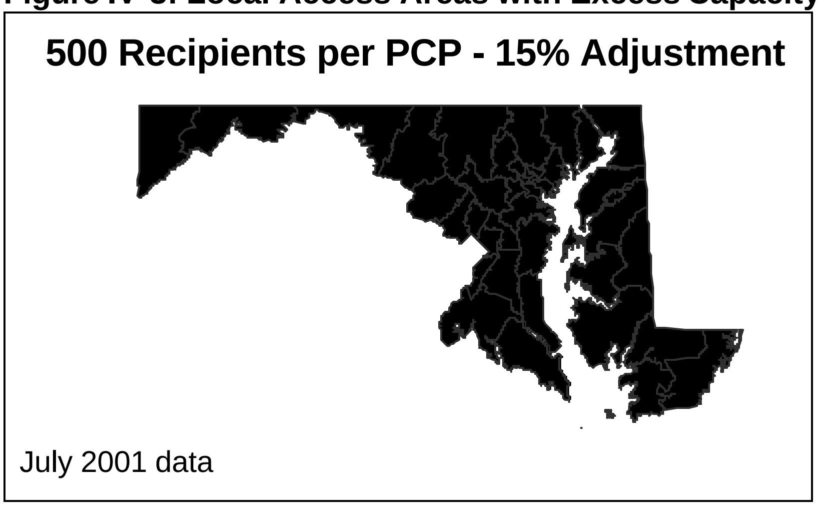


Figure IV-3: Local Access Areas with Excess Capacity



Conclusion

Based on a capacity standard of 500 enrollees to one PCP, the provider networks are adequate to serve the current HealthChoice population. While a number of the LAAs have capacity to absorb significant growth in enrollment, several of them can only absorb small enrollment growth, if any at all. Putting additional stress on the provider networks will cause considerable instability in the program, which will affect both access and quality of services.

Of immediate concern is the Eastern Shore. The lack of participating providers on the Eastern Shore is not unique to Medicaid or HealthChoice. Historically, the Eastern Shore has had less overall provider capacity relative to the rest of the State.[1] The stress on the Eastern Shore's provider network, however, is much more pronounced now than ever before due to the dramatic expansion of covered children from 1990 to 2000 (from 12 percent of the population under 18 years in 1990 to 29 percent of the population under 18 years in 2000).

Direct discussions with providers and stakeholder groups confirmed the Department's finding: although the provider network analysis demonstrates an adequate network, a number of providers are under stress as the patient load continues to increase from year-to-year while reimbursement rates continue to remain low compared to Medicare.

During the past year the Department has worked to develop a formal network adequacy plan. The plan should not only improve the State's ability to monitor and proactively act on potential PCP network adequacy problems, but also meet the requirements of the proposed federal managed care regulations published in August 2001. In addition, the Department has begun to take steps on creating a specialty care capacity plan. Other components of the Departmental Network Adequacy Plan are compared to network adequacy standards suggested by PricewaterhouseCoopers[2] on the following table:

Figure IV-4: Comparison of Network Adequacy Plan

PricewaterhouseCoopers Standard	Status	DHMH Response
Access and Availability		
PCP to Member Ratio	Complete	
For Each Provider Type, Including PCPs, Determine the following: Number and Percentage that serve Medicaid patients; Number and Percentage that accept New Medicaid Patients	Partially Complete	PCPs completed, Certain specialists to be completed over next year
Provider Turnover by Provider Type (Including PCPs)	Complete	
MCO has a process in place to evaluate and adjust the aggregate number of providers needed and their distribution among different specialties as the network expands	Partially Complete	Phase I requires MCO to submit corrective action plans in response to identified problems. A formal evaluation of existing MCO network adequacy systems, has been added to the 01 Systems Performance Review
MCO is in compliance with state standards regarding the maximum travel and distance times to PCPs and specialists. If no standards, MCO has method for determining geographic access needs based on distance, travel times and means of transportation.	Scheduled for 3/30/02	DHMH has purchased Geo-Access Software and is scheduled to implement its use during the first quarter of 2002. Note: The Department intended to hire an FTE to perform these duties, but is now under a hiring freeze.
MCO has method of ensuring that medical care is accessible 24 hours a day, 7 days a week for emergency services, post-stabilization services and urgent care services	Completed - Tracked through Customer Service*	This is tracked.
MCO has a process for ensuring that some providers offer evening (5 p.m. to 9 p.m.) or weekend hours.	Completed- Tracked through Customer Service*	This is tracked.

[1]"Rural Health in Maryland: Setting an Agenda in a Time of Change," Maryland State Office of Rural Health, 1997.
[2]"Assessing the Adequacy of Medicaid Managed Care Provider Networks," PricewaterhouseCoopers LLP, May 2001.

MCO is in compliance with the state's standards regarding appointment wait times. If not state standard exists, MCO has method for determining and tracking appointment wait times.	Completed - Tracked through Customer Service*	This is tracked.
MCO has process for communicating the appointment waiting time standards to affiliated providers and the MCO has in place mechanisms for complying.	Completed - Tracked through Systems Performance	MCOs are required to communicate wait time standards in their provider manuals. DHMH regulates the template for these manuals as well as approves all modifications prior to printing. Also monitored via enrollee satisfaction surveys.
The percentage of enrollees for specific age categories who had an ambulatory or preventive care encounter during the year is evaluated. Inpatient procedures, hospitalizations, emergency rooms visits, mental health and chemical	Scheduled for 3/30/02	DHMH is currently doing ad-hoc reviews of select ambulatory and preventative encounter frequencies by geographic area. Current efforts will be enhanced and formalized in Phase II so that this analysis is done quarterly.
MCO allows women direct access to a women's health specialist within the MCO's network for women's routine and preventative services.	Reviewing	This issue is addressed in draft federal regulations. The Department will come into compliance with federal requirements.
MCO identifies providers whose facilities are accessible to people with disabilities.	Added to CY 01 Systems Performance	DHMH will review each MCO's current processes for tracking and monitoring ADA accessible offices and providers.
The number of Perinatal Care Level II and Level III facilities is evaluated.	Not in Current Plan	Not in network plan because Maryland does not have a problem in this area.
MCO is in compliance with the state's standards regarding the availability of translators in American Sign Language. If no state standard exists, MCO has method for ensuring the availability of ASL translators.	Tracked through Customer Service*	Currently tracked – Communication Barriers.
MCO is in compliance with the state's standards regarding the availability of TDD services. If no state standard exists, MCO has method for ensuring the availability of TDD services.	Completed - Tracked through Customer Service*	Currently tracked – Communication Barriers.
Network Quality	**Status**	**DHMH Response**
State has process for ensuring the MCOs have relationships with public health, education and social services agencies.	Completed	Monitored through MOU with LHDs
State evaluates MCO's credentialing and recredentialing process for all providers, including institutional providers.	Tracked through Systems Performance	DHMH has enhanced its standard review of MCO credentialing procedures to include reviewing a random sample of charts to ensure compliance with procedures and to perform an assessment of MCO credentialing turnaround rates.
% of providers who receive initial orientation to the plan and ongoing training from the plan.	Partially Completed	MCOs are required to give new providers a HealthChoice provider manual.
MCO has procedures in place to timely identify and furnish care to pregnant women.	Completed	This is already required in MCO regs and monitored via health risk assessment data.
MCO has procedure in place to timely identify individuals with complex and serious medical conditions, assess the conditions identified and identify appropriate medical procedures to address and monitor them.	Under consideration for 02 Systems Performance	
MCO has process for ensuring that all Members identified with complex and serious medical conditions are assigned to a care manager.	Added to 01 Systems Performance	DHMH will be assessing each MCO's procedures for referral to case management, protocols and qualifications for case management and case management operating policies.
Cultural Compliance		
MCO has process for identifying significant sub-populations within enrolled populations that may experience special barriers in accessing health services such as the homeless or certain ethnic groups	Tracked through Customer Service*	DHMH is in process of adding specific code that will point to Office Access area to monitor other barriers unique to special populations.
Ratio of providers who speak language other than English to enrollees is evaluated	Tracked through Customer Service*	Currently tracked.
MCO has process for ensuring that the plan has sufficient bilingual capacity among staff and makes arrangements for interpreter services	Tracked through Customer Service*	Currently tracked. HealthChoice Management is also responsible for ensuring that MCOs meet regulatory requirements of printing materials in other languages.
MCO offers cultural competency training that educates providers re: medical conditions particular to the racial, ethnic, and socio-economic factors of the populations served.	Reviewing new BBA regulations.	

*DHMH's September 1 Network Adequacy Plan formalizes the relationship between the Chiefs of the Customer Service Hotlines and HealthChoice Management. Following any routine review of complaint or inquiry trends, the Hotline Chiefs are now formally required to request that the Chief, HealthChoice Management conduct a formal investigation should a trend in data be indicated.

PHYSICIAN REIMBURSEMENT AND MEDICAID FFS PARTICIPATION

Medicaid Physician Payments

An allocation for provider reimbursement rates is included in the MCO capitation rates and is based on fee-for-service data. The Medicaid physician fees, which account for a portion of the rates, have not been increased in ten years. There has been growing concern by many stakeholders that the physician fees are too low to maintain provider practices and to ensure adequate provider participation.

Background

In provider forums held across the State, insufficient physician reimbursement was repeatedly cited as the number one problem with provider participation (see Public Perceptions section in Chapter III). To assess the significance of this issue, it also is necessary to examine the existing Medicaid physician reimbursement rate structure for the fee-for-service program because:

- It still serves around 100,000 individuals; and
- An MCO's ability to increase provider rates is restricted by the capitation rates provided by the State, which are tied to the fee-for-service rates by federal regulations through 2001.

Concerns about physician reimbursement also stem from Maryland Medicaid's historic approach to physician fee increases. Unlike hospital payments, that the Health Resources Cost Review Commission (HSCRC) adjusts annually, and some other service payments, the reimbursement rates for providers have been static for the last decade. The last major increases of Medicaid physician fees in Maryland occurred in 1991, coinciding with the implementation of Maryland Access to Care (MAC), Medicaid's relatively unsophisticated primary care case management program. Even in this instance, only certain procedure codes were raised. Much of the following analysis is based upon a September 2001 report to the General Assembly, as requested in Ch. 702, 2001 Maryland Laws (HB 1071) on the current Medicaid fee schedule.

Maryland Medicaid Fee-for-Service Rates Compared to Medicare

For a meaningful assessment of the adequacy of physician fees paid by the Medical Assistance program, a point of comparison is needed. Medicare rates are an obvious choice as Medicare fees are determined based on the resource-based, relative-value scale (RBRVS) methodology, which relates payments to the level of resources and skills used in providing services. This system of setting procedure-specific reimbursement levels is well established and is widely accepted by government agencies, physicians, and many private health insurers.

To compare Maryland Medicaid fee-for-service rates with Medicare rates, the two programs' procedure codes had to be reconciled. Of the 4,300 Maryland codes, 3,800 (88 percent) are standard CPT codes, which could be matched with Medicare equivalents. Figure IV- 5 compares Medicaid payment rates for some common procedures with their Medicare counterparts. For these procedures, Medicaid rates range from 16 to 61 percent of Medicare rates. Overall, Maryland Medicaid's fee-for-service reimbursement rates average only about 36 percent of the amount paid by Medicare for the same procedures.

Figure IV-5: Comparison of Medicaid and Medicare Payments Selected Procedures

Procedures Used for Survey of MCOs Fees as of 4/1/2001				
Procedure Code	**Procedure Description**	**Medicare Fee**	**Medicaid Fee**	**Ratio Medicaid to Medicare**
99203	Office Visit New Extended	$91.62	$37.00	40%
99204	Office Visit New Comprehensive	$133.06	$48.00	36%
99205	Office Visit New Complicated	$167.95	$50.00	30%
99211	Office Visit Established Minimal	$19.99	$10.00	50%
99212	Office Visit Established Moderate	$36.09	$20.00	55%
99213	Office Visit Established Extended	$50.67	$31.00	61%
99214	Office Visit Established Comprehensive	$79.08	$38.00	48%
99215	Office Visit Established Complicated	$117.40	$45.00	38%
99222	Initial Hospital Visit Moderate	$117.67	$24.50	21%
99223	Initial Hospital Visit Comprehensive	$161.00	$25.00	16%
99231	Hospital Visit Subsequent Minimal	$36.05	$14.50	40%
99232	Hospital Visit Subsequent Moderate	$57.52	$16.00	28%
99233	Hospital Visit Subsequent Comprehensive	$81.65	$20.00	24%

HealthChoice MCO and Medicaid Fee-for-Service Rates Compared to Medicare

Most, although not all, HealthChoice MCO physician contracts incorporate a schedule of payment rates that have been developed as percentages (generally slightly over 100 percent) of the current Medicaid fee-for-service rates for each procedure.

Figure IV- 6 shows how Maryland's Medicaid fee-for-service rates compare to several MCO physician payment rates, as well as Medicare rates. The data show a great deal of variation in physicians' fees from MCO to MCO. MCO A pays 105 percent of the fee-for-service rate for each of the procedures listed. MCO B, however, applies a different percentage to the fee-for-service rate for almost every procedure listed. The MCO B rates range from 100 percent of fee-for-service (for an extended office visit with an established patient) to 295 percent of fee-for-service (for moderate or comprehensive initial hospital visits). The rates MCO B pays are significantly higher than those paid by MCO A, but still are substantially lower than Medicare.

Figure IV-6: Comparison of Medicaid, MCO and Medicare Fees

Procedure Code	Procedure Description	Medicaid Fee	MCO A	MCO B	Medicare Fee
99203	Office Visit New Extended	$37.00	$38.85	$56.32	$91.62
99204	Office Visit New Comprehensive	$48.00	$50.40	$81.77	$133.06
99205	Office Visit New Complicated	$50.00	$52.50	$103.16	$167.95
99211	Office Visit Esab Minimal	$10.00	$10.50	$12.30	$19.99
99212	Office Visit Estab Moderate	$20.00	$21.00	$22.19	$36.09
99213	Office Visit Estab Extended	$31.00	$32.55	$31.00	$50.67
99214	Office Visit Estab Comprehensive	$38.00	$39.90	$48.59	$79.08
99215	Office Visit Estabished Complicated	$45.00	$47.25	$72.11	$117.40
99222	Initial Hosp Visit Moderate	$24.50	$25.73	$72.20	$117.67
99223	Initial Hosp Visit Comprehensive	$25.00	$26.25	$98.75	$161.00
99231	Hosp Visit Subsequent Minimal	$14.50	$15.23	$22.12	$36.05
99232	Hosp Visit Subsequent Moderate	$16.00	$16.80	$35.27	$57.52
99233	Hosp Visit Subsequent Comprehensive	$20.00	$21.00	$50.08	$81.65

Findings and Conclusions

As was mentioned at the beginning of this section, physicians throughout the State repeatedly identified insufficient reimbursement as their most significant concern. The Medicaid fee-for-service population declined dramatically with the formation of HealthChoice; at the same time, the number of participating physicians declined by 4 percent statewide between 1998 and 2000. The rate of decline was much higher in underserved areas (e.g., 23 percent in Caroline County).

The impact of further attrition is likely to become increasingly significant, particularly in counties where the provider networks already are under stress. As physicians stop participating, the program becomes more dependent on a smaller number of physicians, who individually must provide more services if the Medicaid population's needs are to be met.

Regardless of future enrollment growth, declines in physician participation will cause the remaining physicians to see an increase in the Medicaid portion of their practices. The increase in HealthChoice enrollment since 1997 only exacerbates the problem of physician practices with increasing shares of financially unattractive Medicaid patients.

HOSPITALS

Overview

Maryland hospitals play an important role in the provision of services to Medicaid enrollees. In addition, for over 20 years, Maryland has operated a unique hospital payment system.

Maryland's commitment to its hospitals is explicitly stated in the HealthChoice regulations, which require MCOs to pay the Maryland Health Services Cost Review Commission (HSCRC) approved rates. A basic premise of managed care is that savings can be achieved by reducing unnecessary hospital utilization either by avoiding preventable admissions through better patient intervention, or by reducing hospital lengths of stay. Hospital utilization per enrollee, therefore, was expected to decline under HealthChoice. In addition, it was thought that managed care may affect the pattern of hospitalizations within the Medicaid program, diverting admissions away from higher cost hospitals that historically served the Medicaid population and towards lower cost hospitals.

In response to the formation of HealthChoice, Maryland hospitals developed a number of strategies. Three hospital groups formed their own MCOs, while a fourth group of hospitals funded the formation of an MCO managed by an outside contractor. Others contracted on either a risk or non-risk basis with MCOs. Currently, there are three hospital based MCO programs, accounting for about half of the total HealthChoice enrollment.

This section of the evaluation examines whether there have been any significant changes in the distribution of inpatient hospital services, in the percent of individuals with an admission, or in average length of stay for FY 1997 and CY 2000.

Data Limitations

As discussed in Chapter VI, the HealthChoice encounter data for inpatient hospital services is estimated to be approximately 70 percent complete and inconsistent across MCOs. As a result, it is not an acceptable source of data to analyze inpatient patterns. An alternative source of data was provided by the HSCRC, which requires regular submission of hospital discharge data for its hospital rate-setting process. The HSCRC data were deemed to be a better source of complete data for the purposes of this evaluation.

Analysis of inpatient patterns would ideally break out HealthChoice enrollees from the fee-for-service population. Unfortunately, data elements that distinguish between fee-for-service and HealthChoice populations are unreliable, so all Medicaid admissions were analyzed. HealthChoice is a statewide program that enrolls the vast majority of Medicaid enrollees and any significant shifts in patterns of inpatient care can reasonably be attributed to the HealthChoice program. In FY

1997 Medicaid fee-for-service admissions are used in the analysis and in CY 2000 all Medicaid admissions are used. These data exclude the Medicaid recipients who were enrolled in the voluntary HMO program in FY 1997. This was a much healthier population, which may make the FY 1997 admission rates look higher than they actually were.

Figure IV-7: All Medicaid Admissions - Statewide (HSCRC Data)[3]

Hospital	FY 1997 MA Market Share	CY 1998 MA Market Share	CY 2000 MA Market Share	Hospital	FY 1997 MA Market Share	CY 1998 MA Market Share	CY 2000 MA Market Share
Johns Hopkins Hospital	11.62%	12.82%	10.75%	Carroll County General Hospital	1.13%	0.97%	1.40%
University Of Maryland	7.81%	7.98%	7.87%	Union Hospital Of Cecil County	1.08%	0.68%	1.20%
Mercy Medical Center Inc	6.29%	7.57%	6.52%	Sacred Heart Hospital	1.07%	1.08%	0.51%
Prince George's Hospital Center	6.14%	5.93%	6.91%	Howard County General Hospital	1.03%	0.73%	0.56%
Sinai Hospital	5.01%	5.34%	5.18%	Memorial Hospital Of Easto	1.01%	1.50%	1.61%
Johns Hopkins Bayview Medical Center	4.63%	4.98%	4.24%	Church Hospital	0.93%	0.69%	0.00%
Maryland General Hospital	3.74%	3.83%	4.26%	Doctors Community Hospital	0.84%	0.83%	0.75%
St. Agnes Healthcare	3.58%	2.94%	2.01%	Calvert County Memorial Hospital	0.84%	1.02%	0.82%
Franklin Square Hospital	3.52%	2.98%	4.53%	Montgomery General Hospital	0.77%	0.82%	0.74%
Harbor Hospital Center	3.09%	3.79%	3.27%	Memorial Hospital Of Cumberland	0.76%	0.75%	1.20%
Peninsula Regional Medical Center	2.83%	2.67%	3.12%	Civista Medical Center	0.74%	0.69%	0.97%
Union Memorial Hospital	2.56%	2.47%	3.05%	Northwest Hospital Center	0.71%	0.43%	0.97%
Liberty Medical Center	2.39%	2.07%	0.00%	Dorchester General Hospital	0.68%	0.26%	0.50%
Holy Cross Of Silver Spring	2.26%	2.88%	4.42%	Good Samaritan Hospital	0.54%	0.57%	0.89%
Southern Maryland Hospital	2.05%	1.94%	1.26%	Garrett County Hospital	0.54%	0.45%	0.47%
Washington County Hospital	2.04%	2.34%	2.09%	Suburban Hospital	0.48%	0.43%	0.45%
Shady Grove Hospital	1.90%	1.48%	2.11%	Kent & Queen Anne Hospital	0.34%	0.17%	0.42%
Frederick Memorial Hospital	1.69%	1.87%	1.54%	James L. Kernan Hospital	0.33%	0.44%	0.30%
Washington Adventist Hospital	1.60%	1.15%	2.57%	Johns Hopkins Oncology Center	0.33%	0.36%	0.42%
Anne Arundel Medical Center	1.60%	1.87%	2.09%	Upper Chesapeake Med. Ctr.	0.18%	0.18%	0.31%
Bon Secours Hospital	1.47%	1.39%	1.60%	Fort Washington Hospital	0.09%	0.08%	0.05%
Laurel Regional Hospital	1.37%	1.28%	1.07%	Atlantic General Hospital	0.03%	0.03%	0.07%
Greater Baltimore Medical Center	1.29%	0.49%	0.70%	Edward W. Mc Cready Hospital	0.03%	0.04%	0.07%
North Arundel Hospital	1.28%	1.24%	1.37%	Healthsouth Chesapeake Rehab Center	0.02%	0.02%	0.01%
St. Joseph Hospital	1.27%	1.38%	1.03%	The New Children Hospital	0.02%	0.01%	0.00%
St. Mary Hospital	1.21%	1.13%	0.83%	Eastern Neuro Rehab Hospital	0.01%	0.03%	0.01%
Harford Memorial Hospital	1.14%	0.92%	0.89%	**Total**	**100.00%**	**100.0%**	**100.00%**

Findings

- *Hospitals that historically served Medicaid enrollees continue to serve Medicaid enrollees at similar levels.* Hospitals have either the same or higher Medicaid admission levels as they had under fee-for-service. Although the number of admissions per Medicaid enrollee declined, the significant growth in enrollment counteracted the effect of decreasing admissions per enrollee. Overall, there was little change in the distribution of Medicaid admissions across Maryland hospitals.

- *The percentage of individuals with a hospital admission declined*. An analysis of the overall rate of inpatient admissions in Maryland found that admissions declined by 24 percent, from 23.93 percent in FY 1997 to 18.16 percent in CY 2000. For Baltimore City residents, there was a 20 percent decline, from 27.69 percent in FY 1997 to 22.27 percent in CY 2000. In the rest of the State, where the Medicaid enrollment growth has been greatest,

[3] Figure IV-7 FY 1997 data includes MA fee-for-service and MA voluntary HMO program for that year.

the admission rate declined by 27 percent, from 22.17 percent in FY 1997 to 16.25 percent in CY 2000.

Many women become eligible for Medicaid because they are pregnant. Not surprisingly, approximately 40 percent of admissions were classified as obstetric or neonatal in FY 1997, and 45 percent in CY 2000. Analysis of such predictable admissions does not provide meaningful insights into the success of managed care practices. Therefore, an analysis of non-OB and non-neonatal admissions was conducted to examine admissions which could be most affected by managed care--through better access to appropriate primary care. The percentage of individuals with admissions for non-pregnancy related services declined by 29 percent from 14.29 percent in FY 1997 to 10.15 percent in CY 2000. The decline in admissions not related to pregnancy is greater than the decline in admissions overall.

- *Average length of stay declined.* Statewide, average length of stay declined 12 percent for all admissions from 4.94 days in FY 1997 to 4.37 days in CY 2000. There was a similar decline in average length of stay for admissions for Medicaid recipients in Baltimore City and in the rest of the State.

  The average length of stay was higher in an analysis of the non-obstetric and non-neonatal admissions. Their average length of stay declined by 15 percent from 6.01 days in FY 1997 to 5.19 days in CY 2000.

Conclusions

Hospitals that historically served Medicaid patients continue to serve Medicaid patients under HealthChoice. Although there has been an overall decline in the admission rate per person, expansions in Medicaid enrollment have resulted in the maintenance of pre-HealthChoice levels of inpatient admissions. Some hospitals have even experienced an increase in admissions. As a result, the patterns of Medicaid hospital admissions have changed very little across the state.

The admission rates per enrollee and the lengths of stay for Medicaid enrollees have decreased, both in the whole Medicaid population and in the non-obstetric and non-neonatal Medicaid population. These findings together suggest that HealthChoice has had an overall positive effect on hospitalization, by reducing inpatient days, while at the same time ensuring that the admissions levels of hospitals that have historically served the Medicaid population have remained steady.

GRADUATE MEDICAL EDUCATION

Background

Graduate medical education (GME) plays an important role in the health care environment in Maryland. Baltimore is the home of two major academic medical centers, the University of Maryland Medical System and Johns Hopkins University. There also are fourteen other teaching hospitals in Maryland. Inpatient hospital rates for teaching hospitals in Maryland include an amount for GME. Prior to HealthChoice, the Medicaid program reimbursed teaching hospitals for GME as a component of the rates set by the Health Services Cost Review Commission (HSCRC).

When the HealthChoice program started in 1997, the amount Medicaid paid teaching hospitals for GME payments was included in the MCO capitation payments. There was concern among some of the teaching hospitals that MCOs would shift their patients to lower-cost hospitals. Therefore, they requested separate payments to ensure the continued support of graduate medical education at pre-HealthChoice levels. Beginning in July 1998, the GME payments were carved-out of the capitation payments to MCOs and set aside in a separate GME pool.

The intent of the carve-out was to:

- Maintain the historic amount of Medicaid funding for graduate medical education;
- Create a level playing field so that the added cost of GME would not be a financial disincentive for MCOs to admit patients to teaching hospitals; and
- Encourage teaching programs to promote primary care and innovative training programs.

Under the all-payer hospital rate system in Maryland, MCOs are unable to negotiate hospital rates independently. The GME carve-out was designed so that the hospital rates from the MCOs, in addition to the payments from the GME pool, would allow teaching hospitals to be competitive based on cost while continuing to receive funding for their teaching efforts.

The GME payments to teaching hospitals are based on the inflation-adjusted FY 1995 GME expenditures. For FY 1999 and FY 2000, $24 million was carved out of MCO capitation payments to create a GME payment pool. In CY 2001, the GME carve-out increased to $27 million and in CY 2002, it will be increased to $31 million.

In order to measure whether there was any impact upon admissions to teaching hospitals as a result of the carve-out, HSCRC data on inpatient hospital admissions were reviewed. Again, because data factors to separate services provided under fee-for-service Medicaid from HealthChoice are not reliable, the analysis includes data for all Medicaid funded services.

An analysis of data for all of Maryland's 16 teaching hospitals shows that Medicaid admissions increased for all but two teaching hospitals (Greater Baltimore Medical Center and St. Agnes) from FY 1997 to CY 2000. Most teaching hospitals actually maintained or gained Medicaid market share. The two academic medical centers, Johns Hopkins University and the University of Maryland Medical System, account for over half of all GME revenues. Johns Hopkins University experienced an increase in Medicaid market share in CY 1998 compared to FY 1997, but a decrease in CY 2000. The University of Maryland Medical System experienced an increase in market share in both CY 1998 and CY 2000 when compared to FY 1997.

Conclusion

The data indicate that the implementation of HealthChoice has had no negative impact upon Medicaid admissions to teaching hospitals. It is not possible to conclude if the GME carve-out was necessary (the market share of both academic medical centers was up in CY 1998, before the carve-out occurred) or whether the carve-out prevented drops in market share. The identified changes in Medicaid market share seem to relate to geographic and demographic shifts in Medicaid enrollment and the hospital networks of the participating MCOs.

Figure IV-8: All Medicaid Admissions to Teaching Hospitals (HSCRC Data)

Hospital	FY 1997 MA Market Share	CY 1998 MA Market Share	CY 2000 MA Market Share
Franklin Square Hospital	3.52%	2.98%	4.53%
Good Samaritan Hospital	0.54%	0.57%	0.89%
Greater Baltimore Medical Center	1.29%	0.49%	0.70%
Harbor Hospital Center	3.09%	3.79%	3.27%
Holy Cross Of Silver Spring	2.26%	2.88%	4.42%
James L. Kernan Hospital	0.33%	0.44%	0.30%
Johns Hopkins Bayview Medical Center	4.63%	4.98%	4.24%
Johns Hopkins Hospital	11.62%	12.82%	10.75%
Maryland General Hospital	3.74%	3.83%	4.26%
Mercy Medical Center Inc	6.29%	7.57%	6.52%
Prince George's Hospital Center	6.14%	5.93%	6.91%
Sinai Hospital	5.01%	5.34%	5.18%
St. Agnes Healthcare	3.58%	2.94%	2.01%
Suburban Hospital	0.48%	0.43%	0.45%
University Of Maryland	7.81%	7.98%	7.87%
Union Memorial Hospital	2.56%	2.47%	3.05%
Total	62.88%	65.45%	65.35%

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

Background

Federally Qualified Health Centers (FQHCs) are non-profit organizations that receive grant funding from the Public Health Service to provide primary and preventive health care services to people living in medically underserved communities. The FQHCs in Maryland include community health centers, migrant health centers, and a community-based organization dedicated to providing healthcare to homeless populations.

FQHCs historically have played an important role as providers in the Medicaid program. Statewide, approximately one-third of FQHC patients are covered by Medicaid.[4] In addition, prior to the implementation of HealthChoice, one FQHC operated an HMO in the HMO voluntary program, with 15,000+ enrollees. With the transition to HealthChoice, the Department was interested in maintaining FQHCs as providers in the program to ensure continuity of care for their existing patient base and to preserve their existence as safety net providers.

FQHCs in HealthChoice

There has been substantial activity since the inception of the program with regard to FQHC reimbursement. There are currently 12 FQHCs in Maryland. Seven of the FQHCs have ownership interest in one of the MCOs and all of the FQHCs have at least one MCO contract.

Historically and in accordance with federal requirements, FQHCs were eligible for Medicaid reimbursement rates that were based on their reasonable costs of providing services. As a result, the reimbursement rates that FQHCs received for providing services to the Medicaid population were much higher than the rates paid to private physicians from the Medicaid fee schedule for comparable services. In this way, FQHCs are in a similar position as teaching hospitals that are reimbursed for their graduate medical education costs; they have a broader role in the health care system that Medicaid has taken special steps to finance.

An important caveat, though, is that FQHCs historically took responsibility for providing transportation services, but in 1993 Medicaid shifted the transportation responsibility to the local health departments. The local health departments were provided grants for ensuring transportation services, and FQHCs were no longer compensated for the costs of transportation.

Changes in both federal and state regulations regarding FQHC reimbursement have made the transition to HealthChoice complex. Federal legislation initially allowed for the phase-out of cost-based reimbursement and then reinstated cost-related payment provisions through a prospective payment methodology. Legislation on the state level supported enhanced payments for FQHCs. As a

[4] Data from federal FY 1997 – FY 1999 Maryland State Profile at http://stateprofiles.hrsa.gov/

result of this legislative activity, the approach that the HealthChoice program has taken to FQHC reimbursement has evolved since 1997.

When HealthChoice was initially implemented, the program required MCOs to pay FQHCs a cost-related rate, which FQHCs were expected to negotiate with the MCOs. In 1998, as directed by State legislation, an FQHC supplemental payment methodology was implemented. If an FQHC requested supplemental payments and the Department determined that MCO reimbursement to the FQHC was below its reasonable costs, the Department would supplement the MCO payment and deduct the supplemental payment from the Department's capitated payment to the MCO. The FQHCs believed that this mechanism created a disincentive for the MCOs to contract with them.

In 1999, an FQHC Viability Committee was established to examine the viability of FQHCs within HealthChoice and to address reimbursement issues. Based on recommendations from that committee and in accordance with new federal regulations, beginning in January 1, 2001, a new reimbursement mechanism for FQHCs was implemented. FQHCs were paid a market rate for each service by the MCOs and then received a supplemental payment from the Department to bring their total reimbursement level for each visit even with their reasonable costs. In CY 2001, $5.3 million was withheld from the MCO capitation rates and put into a supplemental pool for Departmental payments, and in CY 2002, $5.5 million will be placed into a supplemental pool.

To assess the impact of the HealthChoice program on the number of visits to FQHCs made by Medicaid enrollees, visits were compared between FY 1997 and CY 2001. The CY 2001 utilization data are based on projections provided by each FQHC for the purposes of receiving supplemental payments. The CY 2001 projections exclude mental health and dental services provided by FQHCs. In FY 1997, FQHCs had 107,000 Medicaid visits,[5] including mental health and dental visits. Based on the FQHCs' projections, the number of visits made in CY 2001 is estimated to be 126,000. When looking at the number of FQHC visits per 1,000 Medicaid enrollees, the volume of services is virtually unchanged from FY 1997 to CY 2001. However, the FY 1997 data include mental health and dental visits, but the CY 2001 data do not, suggesting that there may have been an increase in the number of FQHC visits per person.

Conclusion

After several changes in reimbursement methodology, the HealthChoice program assures that FQHCs are reimbursed their full cost-based rates, while eliminating any disincentive MCOs have to contract with them because of their high costs. Current projections by FQHCs demonstrate that the number of visits to FQHCs by

[5]This number includes an estimate of 32,000 for Total Health Care, who was providing services under the voluntary HMO program at that time. The estimate for FY 1997 assumes the same level of Medicaid services as CY 2001, which was projected at 32,000 by Total Health Care. The estimate for FY 1997 may be high given the significant growth in Medicaid enrollment since the inception of the HealthChoice program.

Medicaid enrollees is at least similar to, if not greater than before HealthChoice implementation. This may be due to an expansion in Medicaid enrollment and expanded services offered by FQHCs.

LOCAL HEALTH DEPARTMENTS

Background

The local health departments (LHDs) in Maryland are administrative units of the Community Health Administration of DHMH. They represent a strong public health network and have historically played an important role in the provision of public health services to vulnerable populations. Their sensitivity to regional issues and their experience working directly with clients have made them key partners in the HealthChoice program.

LHDs and HealthChoice

New roles were created for the LHDs under HealthChoice. They were given responsibility and funding for the following new functions:

- Outreach and care coordination for non-compliant patients;
- Ombudsman services; and
- Eligibility and enrollment for the Maryland Children's Health Program (MCHP).

LHDs also continued to have responsibility for Healthy Start case management and transportation for Medicaid enrollees, functions that they had coordinated prior to the implementation of HealthChoice. In addition, some LHDs also provide clinical services to HealthChoice enrollees.

Outreach and Care Coordination for Non-compliant Patients and Ombudsman Services

LHDs are responsible for contacting non-compliant HealthChoice enrollees that the MCOs are unable to bring into care. Before referring a client to the LHD, MCOs must first demonstrate that they have not been able to successfully contact the client despite several attempts. Upon referral from an MCO, the LHD is responsible for trying to contact the client (by phone or home visit, if needed), working with the client to link him/her to care, and informing the MCO about the resolution of the referral.

Under HealthChoice, LHDs were given the role of serving as ombudsman for enrollees. The ombudsman is responsible for assisting the Department in investigating enrollee complaints against MCOs. The LHD is expected to resolve disputes through enrollee or MCO education, through mediation, or by advocating for the enrollee through the MCO internal grievance and appeal process. Safeguards were established to ensure that a LHD does not serve as ombudsman for a complaint that involves its own staff.

Through their outreach and ombudsman roles, LHDs helped 129 per 1,000 HealthChoice enrollees in FY 2001, up from 96 per 1,000 in FY 1999. They are a local source of assistance for consumers in linking them to the appropriate case management services, finding providers willing to serve them, coordinating care, and problem solving. They assist MCOs in finding hard to reach clients or with non-compliant cases. Many of their contacts are face to face with HealthChoice clients or by phone. Some LHDs provide the Department with more detailed information on the number and type of outreach and educational contacts. Statewide, more specific information on the type of LHD contacts is not available.

Figure IV-9: Rate of Referral to Local Health Departments for Outreach, Care Coordination, and Ombudsman Services per 1000 MCO Enrollees by Source of Referral and Year

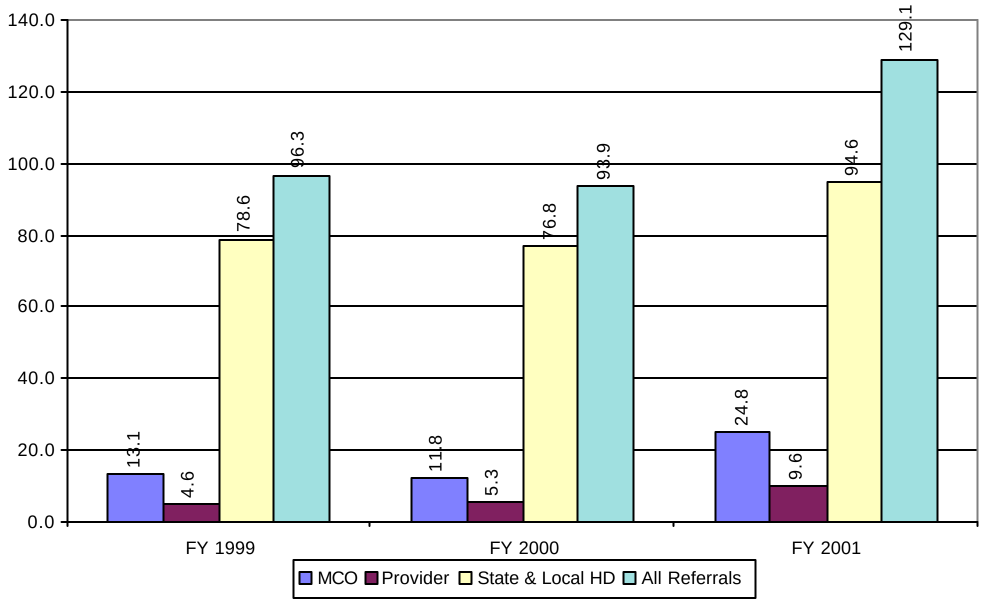
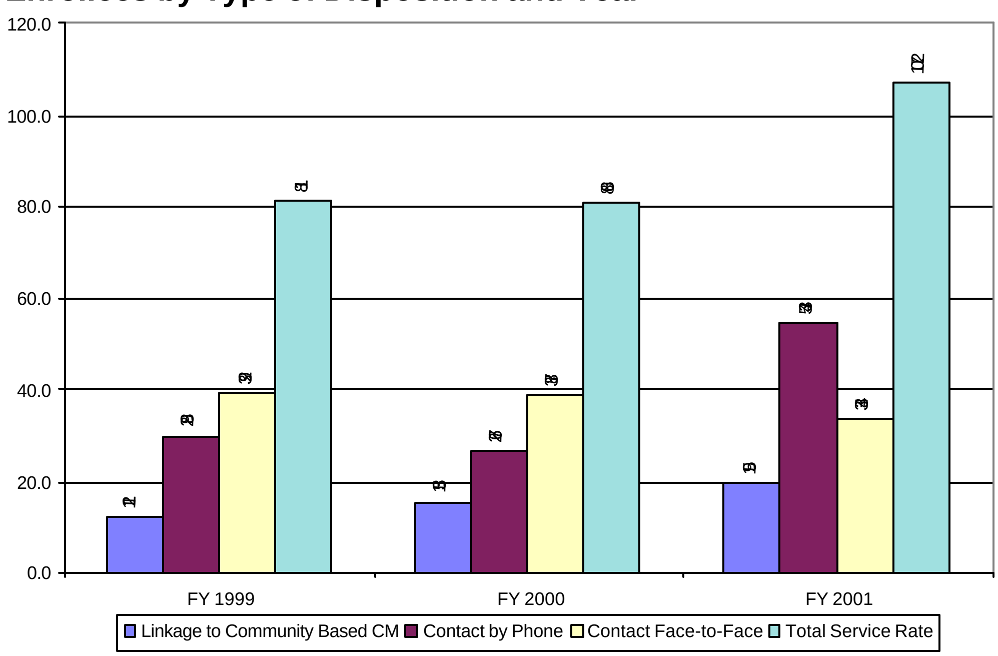


Figure IV-10: Disposition Rate for Referrals to Local Health Departments for Outreach, Care Coordination, and Ombudsman Services per 1000 MCO Enrollees by Type of Disposition and Year



Eligibility and Enrollment for the Maryland Children's Health Program (MCHP)

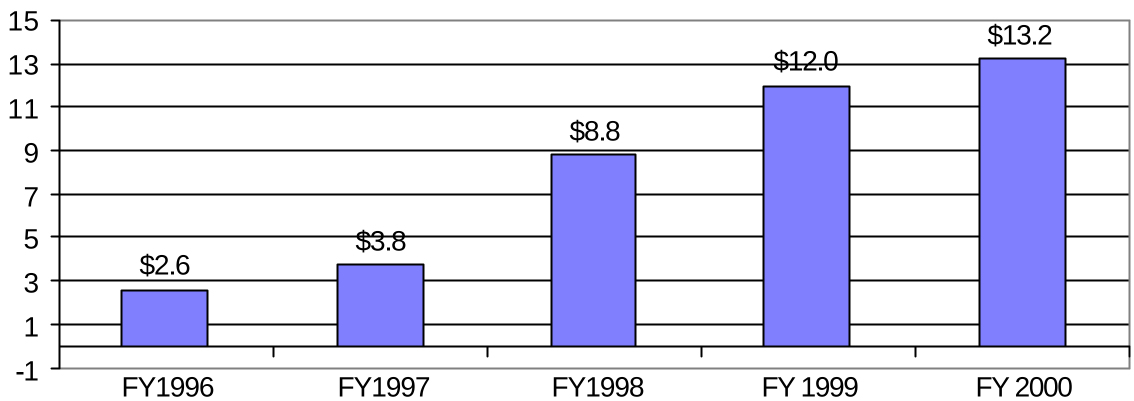
LHDs also have primary responsibility for determining eligibility and processing enrollment forms for the MCHP, which started in July 1998. Prior to HealthChoice, all local health departments conducted initial processing of Medicaid applications for pregnant women and children, making them a logical partner in this process.

LHDs have been a critical part of the success of MCHP. From July 1, 1998 through November 26, 2001, the LHDs have enrolled 93,766 beneficiaries. Feedback from enrollees indicates that they are very happy with the efficiency of the eligibility process for MCHP through the LHDs.

Funding

Grants to the LHDs to support the provision of their new or expanded functions (outreach and care coordination, ombudsman and eligibility) increased from $2.6 million in FY 1996 to $13.2 million in FY 2000. LHDs began receiving funds for HealthChoice outreach in FY 1997. Much of the increase in funding to the LHDs over this period is related to the MCHP expansion. These figures do not include grants that LHDs receive for transportation services, the claims paid for Healthy Start Case Management Services, or clinical services provided by LHDs to HealthChoice enrollees.

Figure IV-11: Grants to Local Health Departments



Healthy Start Case Management.

Healthy Start is a targeted case management program which addresses perinatal health with the goal of reducing infant mortality and low birth weight deliveries. Since 1989, LHDs have been providing specialized case management services to high-risk pregnant woman and children under the age of two through this program. The responsibility for these services has remained constant under the HealthChoice program, however, they now coordinate efforts with the MCOs to identify individuals who would benefit from the program.

Transportation

The local health departments maintained responsibility for coordinating a majority of the transportation services under the HealthChoice program. They receive grant funding to provide non-emergency transportation to and from medically necessary covered services for HealthChoice enrollees and their guardians/attendants, who have no other means of transportation available. Consumers and FQHCs continue to express concern over the apparent lack of emergency transportation services. During the public forums, many stakeholders expressed dissatisfaction with the non-emergency transportation program under HealthChoice. Transportation is provided only by the Local Health Departments. Prior to HealthChoice, FQHCs also provided transportation services. Providers perceive the lack of convenient transportation as a reason for missed appointments and they complain about the difficulty in obtaining cross-jurisdictional transportation. Consumers would like the program to: (1) provide transportation services on demand, (2) transport other family members, in addition to the enrollee and guardian (e.g., other children in the family), (3) provide more timely service, (4) provide transportation in lieu of taking public transport, and (5) allow for more flexibility in crossing jurisdictional lines.

Clinical Services

Historically, many LHDs provided clinical services to Medicaid enrollees. Under HealthChoice some LHDs sought contracts with MCOs to be care providers. The Department recently surveyed the 24 LHDs to assess their role as providers of clinical services for HealthChoice. Twenty LHDs completed the survey. Thirteen out of 20 LHDs have one contract with an MCO, the most frequently contracted services being HIV case management and substance abuse treatment. Those LHDs who do not contract with MCOs cite the payment rates and required contract addendum[6] as deterrents.

Discussion

The LHDs assume a significant role in the HealthChoice program by providing vital services to the enrollees. They have absorbed new responsibilities for outreach, care coordination, and MCHP eligibility. LHDs play a unique role in the HealthChoice program as a locally available resource for HealthChoice consumers.

[6] When signing contracts as health care providers, LHDs are required to use a standard addendum which addresses, in part, indemnification and risk allocation.

HISTORIC PROVIDER PROTECTIONS

Overview

Historically, Maryland has been very successful in assuring access to Medicaid providers (particularly for primary care and hospital services). Maryland's success is not only due to the services provided to Medicaid enrollees by institutions (e.g., hospital outpatient departments) and public providers (e.g., community health centers), but is also the result of high private practitioner participation in the Medicaid program. Prior to the implementation of HealthChoice, 75 percent of the Maryland Access to Care (MAC) patients were enrolled with private practitioners.

Under the HealthChoice program, the MCOs had a strong economic incentive to contract with the providers who had historically served the Medicaid population. By including historic Medicaid providers in their own network, an MCO could enhance their own market share. Despite that incentive, when Maryland began to plan for the implementation of HealthChoice, Medicaid providers raised significant concerns that they would not be able to contract with MCOs and would lose their Medicaid patient base. This concern prompted the legislature and the Department to establish contracting protections for historic Medicaid providers.

In order to be considered an historic provider, a provider was required to satisfy three criteria. The provider had to:

- Meet the definition of a "health care provider" under the Medicaid program;
- Demonstrate a history of service to the Medicaid population; and,
- Meet certain quality of care standards.

If a provider was approved as an historic provider and was unable to secure a contract with any of the MCOs proposing to serve the area of the state in which that provider's practice was located, the Department would assign the provider to one of the MCOs serving that area. Under this provision, MCOs were required to offer a contract with terms that were substantially equivalent to the MCOs' contracts with similarly qualified providers in the same or similar practice categories.

Findings

There were 12,000 active physician providers in the Medicaid program prior to HealthChoice. During the transition, only 51 providers (of all types) sought assistance under the historic provider protections. These findings demonstrate overall that providers did not have difficulty securing MCO contracts, although the findings do not allow us to draw conclusions about the number of patients referred to the providers. Of the 51 providers who sought assistance, ten were approved as historic providers and assigned to an MCO. The remaining 41 either did not meet the requirements of an historic provider or did not complete the application process.

Figure IV-12: Number of Applications for Historic Provider Protections

Provider Type	Number of Applications	Number of Approved Applications
Addictions	9	3
DME/S	20	3
HIV Case Management	1	0
Home Health	2	1
Hospice	1	0
Laboratory	3	1
Mental Health	2	0
Physician	11	1
Physical Therapy/Occup. Therapy	1	1
Podiatrist	1	0
Total	51	10
DHMH Administrative files, data collected through November 1997		