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

Table of Contents

Introduction 1
Recent Changes to §1115 Waiver 1
A Look at the Next Renewal Period: Improving Quality of Care 3
A Look at the Next Renewal Period: Covering New Populations 4
Public Process and Indian Consultation Requirements 5
Request to Waive Title XIX Requirements 6
Request Special Exceptions to Provisions of the Balanced Budget Act (BBA) 7
Evaluation 9
Overview of the HealthChoice Program 9
Section I. Coverage and Access 12
Are More Marylanders Covered? 12
Are More Maryland Medicaid Enrollees Covered Under Managed Care? 17
Are Provider Networks Adequate to Ensure Access? 18
Does the Covered Population Access Care? 23
Section I. Summary 26
Section II. Medical Home 27
Appropriate Service Utilization 27
Does the Waiver Provide Continuity of Care? 31
Section II. Summary 31
Section III. Quality of Care: Is the Right Care Delivered? 32
Preventive Care 32
HEDIS Childhood Measures 32
Breast Cancer Screening 36
Cervical Cancer Screening 37
Care for Chronic Conditions 38
Section III. Summary 40
Section IV. Financing 41
Physician Fee Changes 41

Dental Fee Increases 42
Budget Neutrality 42
Trend Factor 43
Changes in Medicaid Eligibility Groups 43
Section IV. Summary 44
Section V. Special Topics 45
Dental Services 45
Mental Health Services 48
Reproductive Health 50
REM Program 56
Substance Abuse Treatment Workgroup 59
Racial/Ethnic Disparities 60
Section V. Summary 64
Section VI. PAC Access and Quality 66
PAC Enrollment 66
PAC Service Utilization 68
Section VI. Summary 72
Conclusion 72

List of Figures and Tables

Figures

1. Monthly Enrollment of Parents Aged 18 Years and Older in the Medical Assistance for Families Program, July 2008 – May 2010 13

2. HealthChoice Enrollment by Coverage Group, CY 2004 – CY 2009 16

3. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Age Group, CY 2004 – CY 2008 24

4. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Region, CY 2004 – CY 2008 24

5. Percentage of the HealthChoice Population with at Least One ED Visit by Coverage Group, CY 2004 – CY 2008 25

6. Percentage of the HealthChoice Population with at least One ED Visit by Age Group, CY 2004 – CY 2008 26

7. Classification of ED Visits by HealthChoice Enrollees, CY 2008 29

8. Classification of ED Visits by HealthChoice Enrollees, CY 2004 and CY 2008 30

9. HealthChoice Children Receiving a Lead Test During the Calendar Year by Age Group, CY 2004 – CY 2007 35

10. Percentage of HealthChoice Enrollees with a PRP Service, CY 2004 – CY 2008 49

11. HEDIS Timeliness of Prenatal Care, Maryland Compared with the HEDIS Medicaid National Average, CY 2004 – CY 2008 51

12. HEDIS Percentage of Ongoing Prenatal Care at > 80 Percent or ≤ 21 Percent of Recommended Visits, Maryland Compared with the HEDIS Medicaid National Average, CY 2004 – CY 2008 52

13. Percentage of HealthChoice Children Aged 4-20 Years Receiving a Dental Visit by Race/Ethnicity, CY 2004 and CY 2008 61

14. Percentage of HealthChoice Enrollees Aged 0 -20 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2004 and CY 2008 61

15. Percentage of HealthChoice Enrollees Aged 21 - 64 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2004 and CY 2008 62

16. Percentage of HealthChoice Enrollees Receiving an ED Visit by Race/Ethnicity, CY 2004 and CY 2008 63

17. Percentage of Pregnant HealthChoice Women with Gestational Diabetes by Race/Ethnicity, CY 2004 and CY 2008 64

18. Percentage of PAC Enrollees (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Race/ Ethnicity, CY 2007 and CY 2008 69

19. Percentage of PAC Enrollees (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Region, CY 2007 and CY 2008 69

20. Percentage of PAC Enrollees (12 Months of Enrollment) with a Specialty Mental Health Visit by Region, CY 2007 and CY 2008..... 70

Tables

1. HealthChoice Enrollment as a Percentage of the Maryland Population, CY 2004 – CY 2009 17

2. Number of Medicaid Enrollees in Managed Care versus FFS, CY 2006 – CY 2009 17

3.PCP Capacity by Local Access Area, as of January 2009..... 19

4. Percentage of PCPs Continuing to Practice in the HealthChoice Program, CY 2004 – CY 2008 20

5. Percentage of Adult HealthChoice Enrollees Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly Compared with the NCQA Quality Compass Benchmark, CY 2004 – CY 2008 22

6. Percentage of Parents/Guardians of Child HealthChoice Enrollees Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly Compared with the NCQA Quality Compass Benchmark, CY 2004 – CY 2008 22

7. Percentage of Parents/Guardians of Children with Chronic Conditions in HealthChoice Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly, CY 2004 - CY 2008 23

8. Individuals with ED or Inpatient Visits and Ambulatory Care Visits, CY 2004 – CY 2008 27

9. Asthma- and Diabetes-Related Admissions per One Thousand Members, CY 2004 – CY2008 31

10. Percentage of HealthChoice Population Enrolled in One or More MCOs, CY 2004 – CY 2008 31

11. HEDIS Immunizations and Well-Child Visits: HealthChoice Compared with the National HEDIS Medicaid Average, CY 2004 – CY 2008 33

12. HealthChoice MCO Aggregate Composite Scores for Components of the EPSDT Review, CY 2005 – CY 2008..... 34

13. Percentage of Women in HealthChoice Receiving a Mammogram for Breast Cancer Screening Compared with the National HEDIS Medicaid Average, CY 2004 – CY 2008 36

14. Percentage of Women in HealthChoice Receiving a Cervical Cancer Screening Compared with the National HEDIS Medicaid Average, CY 2004 – CY 2008 37

15. Percentage of HealthChoice Members Aged 5-56 Years with Persistent Asthma who were Appropriately Prescribed Medications Compared with the National HEDIS Medicaid Average, CY 2005 – CY 2008 39

16. Percentage of HealthChoice Members Aged 18–75 Years with Diabetes (Type 1 and Type 2) who had an Eye Exam (Retinal) Performed Compared with the National HEDIS Medicaid Average, CY 2004 – CY 2008 40

17. Requested Capitation Rates and Trend Factors for the Next Renewal Period 44

18. Children Aged 4- 20 Years (Enrolled for at least 320 Days) Receiving Dental Services, CY 2004 – CY 2008 45

19. Percentage of Pregnant Women Aged 21+ Years (Enrolled for at Least 90 Days) Receiving Dental Services, CY 2004 – CY 2008..... 48

20. Percentage of PRP Enrollees with at Least One MCO Ambulatory Care Visit and One MCO Outpatient ED Visit, CY 2004 – CY 2008 49

21. Percentage of Pregnant HealthChoice Women with at Least One MCO Outpatient ED Visit by Gestational Diabetes Status, CY 2004 and CY 2008..... 53

22. Percentage of Pregnant HealthChoice Women with at Least One MCO Ambulatory Care Visit by Gestational Diabetes Status, CY 2004 and CY 2008..... 53

23. Percentage of Pregnant HealthChoice Women with at Least One MCO Outpatient ED Visit and One MCO Ambulatory Care Visit by Gestational Diabetes Status, CY 2004 and CY 2008 54

24. Percentage of Medicaid Enrollees in Family Planning and Percentage with at Least One Family Planning Service, CY 2004 – CY 2009 55

25. REM Enrollment by Race/Ethnicity and Age Group, CY 2004 and CY 2008 56

26. REM Enrollment by Sex and Region, CY 2004 and CY 2008.....57

27. Average Annual Medicaid Cost per REM Enrollee, CY 2004 – CY 2008.....57

28. Percentage of REM Population with a PDN Service, CY 2004 and CY 2008..... 58

29. Number of PDN Services Provided to REM Enrollees, CY 2004 and CY 2008 58

30. Average Annual PDN Costs for REM Enrollees with a PDN Service, CY 2004 – CY 2008... 58

Table 31. Percentage of REM Enrollees with At Least One ED Visit by Use of PDN Services, CY 2004 and CY 2008 59

32. HealthChoice Enrollment by Race/Ethnicity, CY 2004 and CY 2008..... 60

33. PAC Enrollment by Race/Ethnicity, Age Group, Sex, and Region, CY 2007 and CY 2008... 67

34. PAC Enrollment by Number of Months of Enrollment, CY 2007 - CY 2009 68

35. Percentage of PAC Enrollees (12 Months of Enrollment) with a Prescription by Number of Prescriptions, CY 2007 and CY 2008 71

36. PAC HEDIS Measures Compared with the National HEDIS Medicaid Average, CY 2008....72

HealthChoice §1115 Waiver Renewal Application

Introduction

HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in 1997 under authority of Section 1115 of the Social Security Act. In January 2002, the Maryland Department of Health and Mental Hygiene (DHMH) completed the first comprehensive evaluation of HealthChoice as part of the 1115 waiver renewal. The 2002 evaluation examined the performance of HealthChoice by comparing service use during the program's initial years with utilization during the final year without managed care (fiscal year 1997). A second renewal was approved in 2005. In November 2007, DHMH conducted another comprehensive renewal evaluation, which focused on guiding principles for a mature program and demonstrated how the program had progressed since the first evaluation. These evaluations found that HealthChoice had successfully improved access to care while controlling costs and had served as a platform for major program expansion. These evaluations also identified areas that needed improvement to ensure that enrollees had access to care. Between these renewal evaluations, DHMH has continued to monitor HealthChoice performance on a variety of measures and, each year, completes an annual evaluation for HealthChoice stakeholders.

Recent Changes to §1115 Waiver

During the last renewal period, DHMH primary focus has been on: expanding access to Medicaid for parents and caretakers; increasing the number of services provided under the Primary Adult Care (PAC) program; improving access to dental, substance abuse, and pregnancy-related services; and breaking down barriers that now prevent the elderly and individuals with disabilities from living in the community.

Medicaid Expansion

Effective July 1, 2008, Maryland expanded eligibility for parents and caretaker relatives from approximately 40 percent of the federal poverty level (FPL) to 116 percent of the FPL. As a part of this effort, Maryland streamlined eligibility requirements to reduce barriers to enrollment. These changes included removing the face-to-face interview requirement and eliminating asset thresholds for parents. Coupled with the impact of the economic downturn, Maryland is covering 150,000 new persons, of which roughly 63,000 are new parents and caretaker relatives.[1] Maryland legislation also incrementally expanded the PAC program benefits, although budget constraints have prevented the full implementation of the childless adult expansion. In January 2010, however, community-based substance abuse and outpatient emergency department (ED) services were added to the PAC benefit package.

Dental Services

Maryland involved a broad stakeholder group to improve dental access and outcomes for children, pregnant women, and adults enrolled in the Rare and Expensive Case Management

[1] The increase is even greater after adjusting for the enrollment decline in the Family Planning program.

(REM) program. Several innovative practices were implemented to improve dental access including:

- Increased dental fees for preventive and diagnostic (and certain endodontic and surgical) codes to the 50th percentile of the American Dental Association's South Atlantic region charges.
- Contracted with a single statewide administrative service organization to (1) eliminate barriers to and provide incentives for provider participation; (2) leverage existing medical and dental provider resources; and (3) expand the dental safety net to each local jurisdiction to ensure every Maryland child has a dental home.
- Implemented a physician fluoride varnish program in medical offices serving children ages 9 – 36 months.

There are 200 new dentists now participating in the program and preliminary utilization percentages suggest improved access to dental care over previous years.

Substance Abuse Services

In 2008, Maryland developed a Substance Abuse Treatment Workgroup to improve access to substance abuse treatment. As a result of the workgroup's efforts, in January 2010, substance abuse services were added to the PAC benefit and rates for HealthChoice and PAC providers were increased. DHMH improved the procedures for self-referred services, including making the self-referral process less administratively burdensome for providers. DHMH also eased provider burdens by creating clear billing instructions, streamlining credentialing, and conducting several provider training sessions.

Pregnancy-Related Services

In December 2009, DHMH developed new procedures for prioritizing Medicaid applications for pregnant women. It implemented an accelerated eligibility determination process in the local departments of social services.[2] Applications are screened and the eligibility process is accelerated to enable pregnant women to receive prenatal care services as soon as possible. The procedures were implemented to assist the state in meeting Governor O'Malley's initiative to decrease infant mortality in Maryland. The program is also collaborating with public health officials at DHMH to implement various strategies that support the Governor's initiative to reduce infant mortality.

Increasing Community Services Program

Last September the Centers for Medicare and Medicaid Services (CMS) approved DHMH's request to operate the Increasing Community Services (ICS) Program. This innovative program strips away the barrier that now prevents individuals from moving into the community. Specifically, the ICS program allows individuals in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them

[2] DHMH already was operating an accelerated eligibility process for pregnant women in local health departments.

to keep income up to 300 percent of SSI. The ICS program is an expansion population and is currently capped at 10 individuals. Two individuals are now participating in the program.

It is too early to tell whether the initiatives implemented to improve access to dental, substance abuse, and pregnancy related services are working. As more complete data become available, DHMH will evaluate further the effectiveness of these changes. The ICS program is meeting its goal of serving individuals in the community. More evaluative work, however, needs to be completed. This includes evaluating the participants' satisfaction with the program and the quality of community services provided.

A Look at the Next Renewal Period: Improving Quality of Care

DHMH is continuing to explore opportunities on how to best improve quality of care. A comprehensive strategy will include improving the coordination of care for enrollees, increasing the number of providers participating in the program, and streamlining eligibility to promote earlier entry into care. Some initiatives are described below.

Electronic Health Records

One initiative involves encouraging providers to use the state's electronic health exchange. The initiative also involves working diligently to give providers whatever assistance is required to help them secure certain federal financial incentives. These incentives are offered to enable providers to purchase and ultimately use electronic health records.

Medical Home Model

Another initiative is implementing a patient-centered medical home model. A key component of such a model is the use of electronic health records. This is a key project for the Maryland Quality and Cost Council, which Governor O'Malley established. Our objective is to include some physicians who have a Medicaid patient population. DHMH also plans on expanding this pilot and focusing on different physicians by applying to participate in the new Medicaid Health Home for Enrollees with Chronic Conditions Demonstration afforded through the Patient Protection and Affordability Act (PPACA).

Streamlining Eligibility

A third initiative involves streamlining the eligibility process. Maryland received $988,177 from the Department of Health and Human Services (HHS) to increase access to Medicaid for uninsured children. The grant will be used to further streamline eligibility through the development of an online screening and application tool. This effort will set the stage for increased system interoperability and ease of access for potential enrollees as Maryland implements the health care reform provisions under PPACA.

Increasing Provider Participation

A fourth initiative is ensuring access to care for our recipients. The growing number of enrollees has put an increasing strain on providers. Certain underserved areas are experiencing challenges

in physician network adequacy. Immediate attention must be given to obstetric providers. DHMH recently froze enrollment in three counties – Wicomico, Worcester and Somerset – for both Amerigroup and United due to a lack of obstetric provider contracts in those areas. Likely such provider network issues will only increase when Medicaid is expanded in 2014 to parents and childless adults who have incomes below 133 percent of the FPL. Building a strong provider network is the first step to ensuring individuals who have health insurance actually receive care.

ED Diversion

A final, ongoing initiative is evaluating opportunities to improve primary care access and avoid unnecessary ED visits. CMS awarded Maryland a two-year $1.78 million grant to create ED diversion pilots. The two pilots – one in Baltimore City and the second in Montgomery County – focus on redirecting patients to community care providers rather than continuing the inappropriate use of EDs. The target population includes Medicaid fee-for-service, Medicaid managed care, and the uninsured. A comprehensive evaluation is being conducted on these two pilots. If these pilots are successful, DHMH will explore opportunities to replicate them across the state.

In addition to these initiatives, DHMH plans to focus on reducing racial and ethnic health care disparities. A first step in doing so is categorizing our evaluation data by race. We plan to partner with DHMH's Office of Minority Health and Health Disparities and the HealthChoice managed care organizations to identify interventions and projects that will further reduce racial disparities.

A Look at the Next Renewal Period: Covering New Populations

DHMH has two outstanding waiver requests focused on expanding access to care. Discussions with CMS have been favorable and DHMH anticipates initial approval during the summer of 2010. If approved, DHMH requests to continue these waivers during the next renewal cycle. The two proposals are described below.

- Pharmacy Discount Program. Maryland's proposal would allow low-income Maryland residents (with incomes at or below 300 percent of the FPL) to purchase prescription drugs at a cost equal to the Medicaid payment rate, minus the average federal and supplemental drug rebate amounts and an additional Medicaid contribution equal to two percent of the Medicaid payment rate. Maryland is seeking to promote better health outcomes by extending access to affordable pharmacy coverage to a new population.
- MHIP Premium Assistance. DHMH proposes providing premium assistance to those Maryland Health Insurance Plan (MHIP) individuals whose incomes are at or below 200 percent of the FPL. MHIP is a state-managed health insurance plan for Maryland residents who are unable to obtain health insurance from other sources. The health care reforms implemented under PPACA will eventually change how MHIP operates, but many of these reforms are not fully implemented until 2014. In the meantime, MHIP will continue to play a key role in providing access to health care insurance.

DHMH is also seeking two additional changes that will have a positive impact on access to care. DHMH requests that these proposals be considered as soon as possible rather than waiting for approval in July 1, 2011, the start of the next renewal period. The changes include:

- Expanding Family Planning Services. DHMH is proposing to increase the income threshold for family planning services from 200 percent of the FPL to 250 percent of the FPL. Prior to the current renewal period, the Maryland Family Planning Program provided up to five years of family planning services to qualified women. Such women were eligible previously for Medical Assistance due to a pregnancy and had incomes up to 250 percent of the FPL. This income threshold mirrored that of the income eligibility threshold for pregnant women. During the last renewal cycle, based on the Bush Administration's policy position, a change was made to decrease the income threshold to 200 percent of the FPL. Raising the income level to the highest income level established for pregnant women under our State Plan is consistent with the family planning provisions under PPACA. At this time, however, Maryland does not have the general funds to move the program under its State Plan and serve all eligible women (not just women who were covered under Medicaid because of a pregnancy). Additionally, DHMH requests that enrollees' eligibility status does not have to be actively redetermined each year.
- Expanding Access to the REM Program. DHMH proposes to continue serving individuals in the REM program who become Medicare-eligible and are below age 65 years. Currently, once individuals become Medicare-eligible they are disenrolled from the HealthChoice program, including REM. When these individuals transfer to the fee-for-service program, they are no longer eligible to receive private duty nursing services. This service is not covered under the State Plan, and it plays an integral role in keeping persons out of facilities and in the community. This option reinforces DHMH's goal of increasing the proportion of persons receiving community-based long-term care services. These individuals are categorically eligible for Medicaid and, therefore, would not be considered an expansion population. DHMH estimates that 16 individuals annually will take up this option.

Lastly, another major project is implementing the Medicaid requirements under PPACA. DHMH will need to work with CMS to determine how the budget neutrality terms will change because the childless adult population will be considered a categorically eligible population and not an expansion population under the 1115 HealthChoice Waiver.

Public Process and Indian Consultation Requirements

DHMH has engaged stakeholders primarily through consultation with the Maryland Medicaid Advisory Committee (MMAC). Annually, the MMAC provides feedback on the HealthChoice evaluation. Also, monthly updates are provided that report on regulatory and waiver changes, including amendments to the 1115 waiver. The public process for the renewal also included the MMAC providing extensive input and feedback on the evaluation outline submitted to CMS.

In July, DHMH will review and discuss the full application with the MMAC. DHMH hopes to identify opportunities to improve the program over the next waiver period. DHMH will also post the renewal application on its web site for public comment and place a public notice in the Maryland Registrar.

The American Recovery and Reinvestment Act require states to implement additional protections for American Indians. DHMH has made efforts to implement the consultation and cost-sharing protection provisions. American Indian children have never been required to pay a premium. Also, DHMH contacted the Native American Lifelines, Maryland's only Indian Health Services provider, to provide feedback and input on waivers and programmatic policy changes. To foster an ongoing relationship with the provider, an invitation was extended for a member of the agency to serve on the MMAC. Currently, DHMH is providing technical assistance for the Native American Lifelines to become a Medicaid provider.

Request to Waive Title XIX Requirements

Besides the proposals discussed above and the budget neutrality terms, DHMH is not requesting any changes to the HealthChoice 1115 terms and conditions. This includes the waivers to Title XIX requirements for the PAC (Demonstration Population 13) and Family Planning (Demonstration Population 14) programs, which are described below.

Title XIX Requirements Not Applicable to Demonstration Populations 13 and 14:

Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable the State to provide a limited benefit package to enrollees in a limited benefit program.

To enable the State to provide a benefit package consisting only of approved family planning services to women in Demonstration Population 14.

Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics **Section 1902(a)(15)**

To enable the State to establish reimbursement levels to these clinics for a limited benefit package provided to PAC program participants, which is different from reimbursement levels established by the prospective payment system.

To enable the State to establish reimbursement levels to these clinics that would compensate them solely for family planning services rendered only to women enrolled in Demonstration Population 14.

Retroactive Eligibility **Section 1902(a)(34)**

To exempt the State from extending eligibility prior to the date of application for Demonstration Populations 13 and 14.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) **Section 1902(a)(43)**

To exempt the State from furnishing or arranging for EPSDT services for Demonstration Population 13 who are ages 19 or 20, and for Demonstration Population 14.

Title XIX Requirements Not Applicable to Demonstration Population 13 only:

Freedom of Choice **Section 1902(a)(23)**

To enable the State to restrict freedom-of-choice of provider for enrollees in a limited benefit program.

Cost Sharing and Denial of Service **Section 1902(a)(14) as it would otherwise enforce 1916(e)**

To enable the State to allow pharmacy providers to deny service to enrollees for failure to pay the required cost sharing for pharmacy services.

Additionally, Maryland has requested to deny service to enrollees for failure to pay the required cost sharing for pharmacy services in its Pharmacy Discount Program Amendment, which is currently under review by CMS.

Request Special Exceptions to Provisions of the Balanced Budget Act (BBA)

DHMH also asks that the following components of the BBA be waived to maintain the continuity of the HealthChoice program.

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

Children under 19 years of age who are—

Eligible for SSI under title XVI

(iii) In foster care or other out-of-home placement

(iv) In foster care or adoption assistance

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

§ 438.56 (g) *Automatic reenrollment: Contract requirement.*

If the State plan so specifies, the contract must provide for automatic reenrollment of a recipient who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

To maintain continuity of care the state requires that individuals who lose Medicaid eligibility for a period of 120 days or less be automatically reenrolled in an MCO.

§ 438.402 (b)(3) *General Requirements:*

(ii) The enrollee or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

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

§ 438.406 *Handling of grievances and appeals.*

(b) Special requirements for appeals

(1)… must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.

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

Evaluation

This report serves as a request for an additional extension of the HealthChoice waiver and seeks to address:

- Coverage and access to care under HealthChoice
- The extent to which HealthChoice provides a medical home and continuity of care
- The quality of care delivered to enrollees
- Program financing and budget neutrality
- Special topics, including dental services, reproductive health services, mental health care, substance abuse treatment services, and racial/ethnic disparities in utilization
- Access and quality of care under Maryland's signature PAC program

As with the 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 population. The program also enrolls children in the Maryland Children's Health Program (MCHP). Participants in the program choose one of seven managed care organizations (MCOs) and a primary care provider from the MCOs' network to oversee their medical care. The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs are:

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

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

- Medicare beneficiaries[3]
- Individuals aged 65 years and older

[3] DHMH has requested to allow REM enrollees who become Medicare-eligible and are below age 65 years to remain under the HealthChoice Waiver.

- Individuals in a "spend-down" eligibility group who are only eligible for Medicaid for a short period of time
- Individuals who are continuously enrolled over 30 days in a long-term care facility or an institution for mental illness
- Individuals residing in an intermediate care facility serving the mentally retarded (ICF-MR)
- Individuals enrolled in the Employed Individuals with Disabilities program

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 basis through the REM program. Family Planning and the PAC programs are both expansion programs under the waiver. REM and Family Planning are described in Section V of this report, and PAC is included in Section VI.

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

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

Some services are carved out of the MCO benefit package and instead are covered by the Medicaid FFS system. A key carve-out service is specialty mental health care, which is administered by the DHMH Mental Hygiene Administration. Another key carve-out service is dental care for children, pregnant women, and REM adults. Dental services were carved out in

2009 in response to recommendations by Maryland's Dental Action Committee.[4] Other carved-out services include:

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

[4] The dental service carve-out is described in more detail in Section V of this evaluation.

Section I. Coverage and Access

The goals of the current HealthChoice demonstration include expanding coverage to additional low-income residents through resources generated from managed care efficiencies and improving access to health care services for the Medicaid population. This section of the report addresses Maryland's progress in achieving these coverage and access goals by discussing major expansion initiatives, new and innovative outreach activities, and program enrollment. Access to care is measured by provider network adequacy, enrollee survey results, and ambulatory care service utilization.

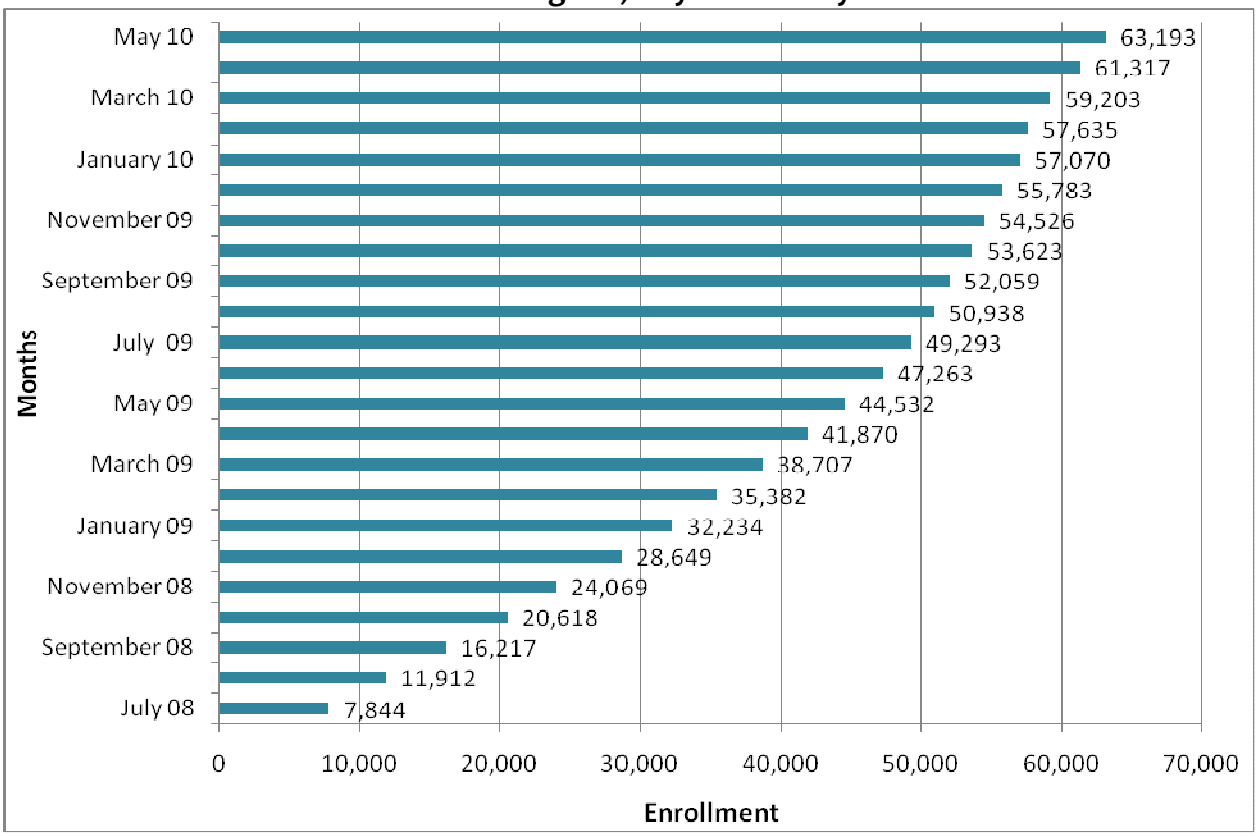
Are More Marylanders Covered?

Major Expansion Initiatives

During the last three years, Maryland has engaged in several efforts to encourage increased enrollment in Medical Assistance. Legislation coupled with federal and private grants have increased the capacity of DHMH to enroll uninsured children and adults in programs for which they might be eligible. The most successful expansion effort was increasing the income eligibility threshold for families under Medicaid.

Effective July 1, 2008, Maryland altered its Medical Assistance eligibility regulations governing the calculation of household income to expand Medical Assistance eligibility for parents and caretaker relatives of children enrolled in Medicaid or MCHP. Under the "Medical Assistance for Families" program, the maximum household income for this population effectively increased from approximately 40 percent to 116 percent of the FPL. Enrollment in the Medical Assistance for Families program increased dramatically from 7,844 enrollees in July 2008 to 63,193 enrollees in May 2010. Figure 1 presents monthly enrollment of parents in the Medicaid Expansion between July 2008 and May 2010.

Figure 1. Monthly Enrollment of Parents Aged 18 Years and Older in the Medical Assistance for Families Program, July 2008 – May 2010



Outreach Initiatives

During the demonstration period, Maryland pursued some innovative outreach strategies to enroll eligible individuals into Medicaid and the Maryland's Children's Health Program (MCHP). These strategies include the implementation and evaluation of the Kids First Act and activities supported by a Children's Health Insurance Program Reauthorization Act (CHIPRA) Outreach Grant. The Kids First Act was enacted by the Maryland Legislature and signed into law by Governor O'Malley in May 2008. This law mandated outreach initiatives in Medicaid and MCHP programs based on information from state income tax forms. For tax years 2008 and 2009, the law required taxpayers to report, without penalty, "the presence or absence of health care coverage," for each dependent child for whom an exemption is claimed. Upon receipt of this information, the Comptroller is required to send a Medicaid/MCHP application and enrollment instructions to taxpayers who indicate dependent children without health care coverage and report income within Medicaid/MCHP financial eligibility limits (300 percent of the FPL).

The Kids First Express Lane Eligibility Act, passed in April 2010, requires the Comptroller's office to send information from tax returns to DHMH "for the purpose of determining eligibility of a dependent child of the taxpayer" for Medicaid and MCHP. The bill requires DHMH to "enter into an interagency agreement that allows the sharing of information from the income tax return of a taxpayer" for the purpose of eligibility determination. The bill also requires the Comptroller to provide notice of this information sharing with income tax returns, and this notice

must have a check box allowing individuals to opt into information sharing between the two agencies.

The Robert Wood Johnson Foundation recently awarded DHMH a State Health Access Reform Evaluation (SHARE) grant to evaluate whether the tax form is a reliable source of information to support identification and enrollment of Medicaid/CHIP-eligible children. DHMH, in partnership with The Hilltop Institute, will conduct the Kids First Act evaluation over the next two years. As of September 2009, there were 379,096 dependents identified through the tax form as NOT having health care coverage (27.6 percent of the 1.4 million dependents reported by Maryland taxpayers). However, this number could potentially include some children who actually were insured.

In 2009, the Maryland General Assembly also passed House Bill 500, Baltimore City – Medical Assistance Programs – Eligibility and Enrollment Information Mailings to Students. This legislation required DHMH to work with the Maryland State Department of Education and the Baltimore City school lunch program to implement outreach to families who receive free and reduced lunch but are not enrolled in Medicaid or MCHP. DHMH will evaluate the effectiveness of the outreach by determining if the individuals who submitted applications are subsequently enrolled in the following months. Based on the results of the outreach, the effort may be implemented in other areas of the state. Unlike the Kids First Act, DHMH will have the capacity to avoid sending applications to persons who are already enrolled in or known to the system. If implemented statewide, this process to streamline eligibility also has the potential to increase the number of children enrolled in HealthChoice during the next renewal cycle.

In addition to the Kids First Act and the Baltimore City school lunch initiatives, DHMH was awarded a CHIPRA Outreach Grant in September 2009 from the CMS to enhance outreach and enrollment activities in Maryland. DHMH is using these funds to create a web-based platform that will screen and enroll applicants into Medical Assistance programs, including Families and Children, MCHP, and the PAC program. The enrollment system is based on an enterprise service bus platform called One-e-App and promises to increase Medicaid enrollment by using cutting-edge information technology to increase the access and efficiency of the application process. Similar systems currently operate in Arizona, Indiana, and California, where they have demonstrated a positive impact on outreach and enrollment.

Maryland's system will include "assisted" and "public" versions. Under the assisted version, users may access the system at a variety of community locations, hospitals, and federally qualified health centers (FQHCs) with the help of a trained assistor. Under the public access model, users may access the system online from any location. In developing the system, DHMH has collaborated with community leaders, local health departments, and other state agencies to ensure that it links with existing information systems and programs. DHMH expects to launch a pilot system in Howard County this summer followed by a statewide rollout this fall. Once operational, the system will be incorporated into DHMH's current outreach and enrollment initiatives, including the Kids First Act and Baltimore school lunch mailings. DHMH plans to incorporate information on the new enrollment system into future Kids First Act and school lunch mailings, as well as provide information at various community locations, including local health and social service offices.

HealthChoice Enrollment

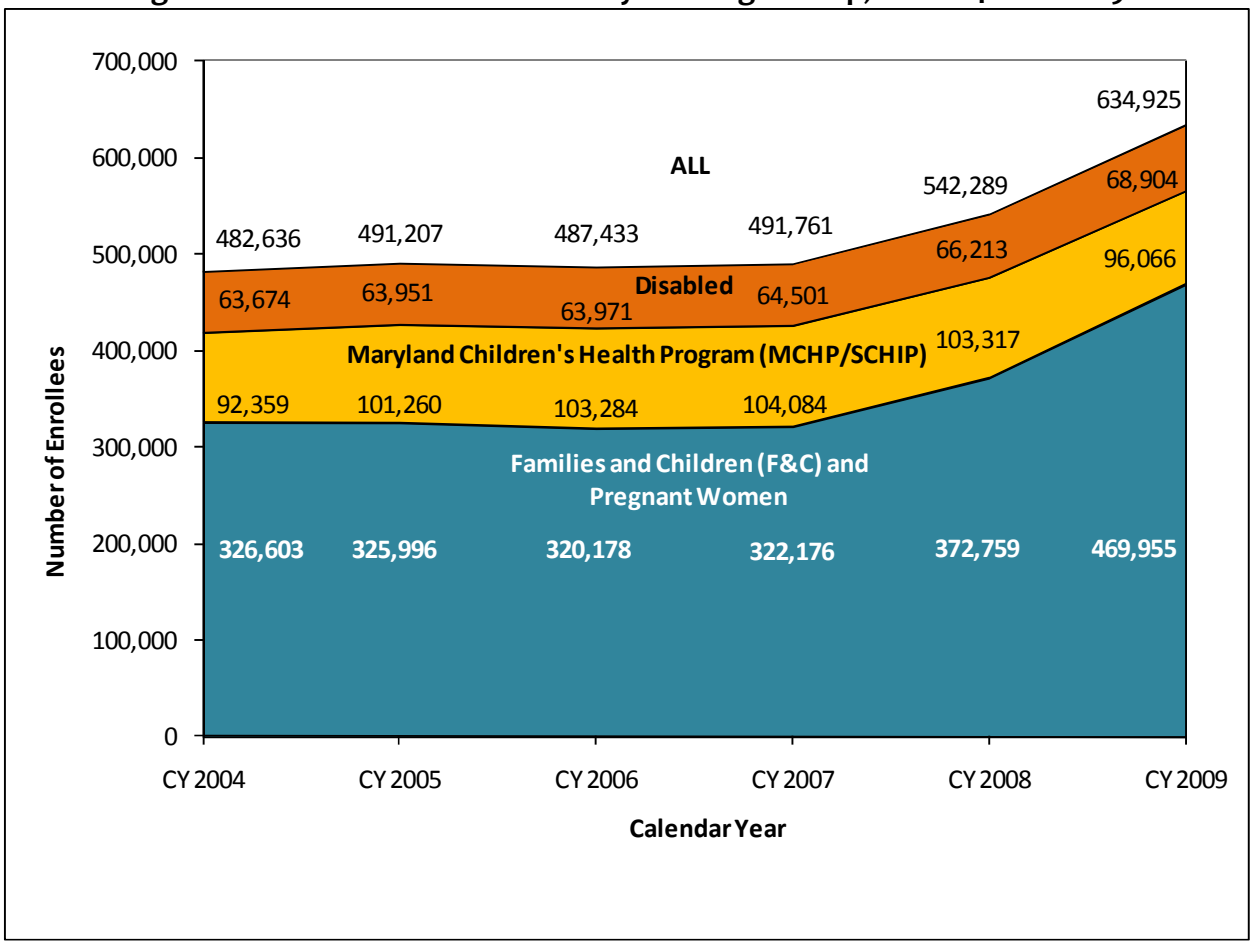
Given the recent program expansion and outreach initiatives, DHMH is continually monitoring HealthChoice enrollment. There are several methods available for measuring HealthChoice enrollment. One methodology is to count individuals with any period of enrollment during a given calendar year (CY), including individuals who were enrolled only for a very short time. Another method is to count individuals enrolled at a certain point in time. Although this yields a smaller number, it provides a snapshot of typical enrollment in the program on a given day. Unless specified otherwise, enrollment data presented in this section of the report are derived using the point-in-time methodology to reflect enrollment as of December 31 of the measurement year.[5]

The HealthChoice population grew by nearly 32 percent between CY 2004 and CY 2009, increasing by 152,289 individuals during that time period (Figure 2).[6] Most of the enrollment increase between CY 2004 and CY 2009 occurred during the last year of the period, when HealthChoice grew by more than 17 percent, adding 92,636 new enrollees. 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 2004 and CY 2009. As of December 31 of each year, most HealthChoice enrollees were eligible in the families, children, and pregnant women (F&C) category. Overall, F&C enrollment grew by more than 143,000 enrollees between CY 2004 and CY 2009, an increase of 44 percent. Individuals with disabilities comprised the smallest eligibility category in each of the years under review.[7]

[5]Enrollment data are presented for enrollees aged 0 through 64 years. Age is calculated as of December 31 of the measurement year. Enrollment counts include some Maryland residents with out-of-state mailing addresses.
[6] The increase is even greater after adjusting for the enrollment decline in the Family Planning program.
[7] Individuals who are covered under both Medicare and Medicaid programs are not enrolled in HealthChoice.

Figure 2. HealthChoice Enrollment by Coverage Group, CY 2004 – CY 2009



Enrollment Growth

From June 2008 to June 2009, economic conditions deteriorated significantly, as demonstrated by the national rise in unemployment from 5.5 to 9.5 percent. At the same time, Medicaid enrollment in the United States increased by 7.5 percent, representing an additional 3.3 million monthly enrollees during the course of that year. Total enrollment reached 46.9 million by June 2009. According to the Kaiser Family Foundation, Maryland had the highest rate of increased Medicaid enrollment experienced by any state during this time period.[8] Increased enrollment of this magnitude in a single year is unparalleled since the state-by-state implementation of Medicaid programs in the years following federal enactment of Title XIX of the Social Security Act.

Table 1 shows the percentage of Maryland's population enrolled in HealthChoice between CY 2004 and CY 2009. These data are presented for individuals enrolled in HealthChoice as of December 31 and for individuals with any period of HealthChoice enrollment. The percentage of the Maryland population with any period of HealthChoice enrollment remained at approximately 11 percent between CY 2004 and CY 2007 and increased to 13 percent by CY 2009.

[8] http://kff.org/medicaid/upload/8050.pdf

Table 1. HealthChoice Enrollment as a Percentage of the Maryland Population, CY 2004 – CY 2009

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009
Maryland Population[9]	5,542,659	5,582,520	5,602,017	5,612,196	5,634,242	5,699,478
	Individuals Enrolled in HealthChoice as of December 31					
HealthChoice Population	482,636	491,207	487,433	490,761	542,289	634,925
% of Maryland Population in HealthChoice	8.7%	8.8%	8.7%	8.7%	9.6%	11.1%
	Individuals Enrolled in HealthChoice for Any Period of Time					
HealthChoice Population	609,754	617,339	624,311	623,356	654,513	743,187
% of Maryland Population in HealthChoice	11.0%	11.1%	11.1%	11.1%	11.6%	13.0%

Are More Maryland Medicaid Enrollees Covered Under Managed Care?

One of the original goals of the HealthChoice program was to enroll most individuals into managed care. Table 2 presents the percentage of Maryland Medicaid beneficiaries who were enrolled in managed care (including both HealthChoice and PAC MCOs) as compared to FFS enrollment for CY 2006 through CY 2009. Enrollment in Medicaid increased steadily between CY 2006 and CY 2009, by approximately 22 percent. During the same time period, the proportion of FFS to overall Medicaid enrollment decreased from 27.1 percent in CY 2006 to 21.0 percent in CY 2009. By CY 2009, nearly 80 percent of Medicaid enrollees were under managed care.

Table 2. Number of Medicaid Enrollees in Managed Care versus FFS, CY 2006 – CY 2009

Enrollment Type	CY 2006	CY 2007	CY 2008	CY 2009
Health Choice	487,433	490,761	542,289	634,925
FFS	188,520	184,953	194,995	178,762
PAC	20,342	27,223	23,797	37,129
Total Medicaid Enrollees[10]	696,295	703,937	761,081	850,816
% Managed Care	72.9%	73.7%	74.4%	79.0%
% FFS	27.1%	26.3%	25.6%%	21.0%

[9] Maryland Department of Planning. (2010, March). Retrieved June 21, 2010 from http://www.mdp.state.md.us/msdc/Pop_estimate/Estimate_09/county/table1a.pdf

[10] This includes all FFS, MCO, PAC, and partial benefit enrollees.

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 primary care provider (PCP) and specialty provider networks. Enrollee satisfaction survey results pertaining to provider network adequacy are also presented.

Primary Care Provider Network Adequacy

HealthChoice requires every enrollee to have a PCP, and each MCO must have enough PCPs to serve its enrollee population. As a general standard for assessing an individual MCO's capacity, HealthChoice regulations require a ratio of 1 PCP to every 200 enrollees within each of 40 local access areas (LAAs) within the state. The 1 to 200 standard is inappropriate for PCPs who traditionally serve a high Medicaid population (e.g., FQHC physicians). To account for these high volume physicians, the regulations permit DHMH to approve a ratio of 1 provider per 2,000 enrollees. MCOs are required to regularly submit information on their provider networks to DHMH. Submission elements include provider name, license number, specialty, location, phone number, and whether the provider is open to new patients. These submissions are used both for creating provider directories and for monitoring the total number of providers program-wide, within LAAs and MCOs.

The review of PCP to enrollee ratios allows DHMH to assess potential network deficiencies and work with the MCOs to correct any capacity issues as they arise. Table 3 shows PCP network adequacy for files submitted through January 1, 2009. Two capacity estimates are presented: 200 enrollees per unduplicated PCP and 500 enrollees per unduplicated PCP. While regulatory requirements apply to a single MCO, the analysis presented identifies an unduplicated count of all HealthChoice PCPs. The analysis does not allow a single provider who contracts with several MCOs to be counted multiple times; this applies a higher standard than that in regulation.

Table 3.PCP Capacity by Local Access Area, as of January 2009

	Total PCPs			Enrollment	Excess Capacity	
Local Access Area	January 2009	Multiplied by 200	Multiplied by 500	January 2009	Difference 200:1 Ratio	Difference 500:1 Ratio
Allegany	61	12,200	30,500	10,127	2,073	20,373
Anne Arundel North	184	36,800	92,000	18,689	18,111	73,311
Anne Arundel South	190	38,000	95,000	10,743	27,257	84,257
Baltimore City SE/Dundalk	246	49,200	123,000	18,462	30,738	104,538
Baltimore City East	488	97,600	244,000	27,127	70,473	216,873
Baltimore City N. Central	85	17,000	42,500	12,652	4,348	29,848
Baltimore City N. East	98	19,600	49,000	19,911	-311	29,089
Baltimore City N. West	251	50,200	125,500	18,365	31,835	107,135
Baltimore City South	77	15,400	38,500	15,474	-74	23,026
Baltimore City West	375	75,000	187,500	35,258	39,742	152,242
Baltimore County East	198	39,600	99,000	15,993	23,607	83,007
Baltimore County North	279	55,800	139,500	9,251	46,549	130,249
Baltimore County N. West	113	22,600	56,500	20,484	2,116	36,016
Baltimore County S. West	177	35,400	88,500	16,446	18,954	72,054
Calvert	53	10,600	26,500	6,408	4,192	20,092
Caroline	25	5,000	12,500	5,381	-381	7,119
Carroll	90	18,000	45,000	8,767	9,233	36,233
Cecil	57	11,400	28,500	10,699	701	17,801
Charles	80	16,000	40,000	10,851	5,149	29,149
Dorchester	32	6,400	16,000	5,544	856	10,456
Frederick	79	15,800	39,500	13,411	2,389	26,089
Garrett	18	3,600	9,000	4,342	-742	4,658
Harford East	24	4,800	12,000	5,415	-615	6,585
Harford West	84	16,800	42,000	10,942	5,858	31,058
Howard	137	27,400	68,500	12,697	14,703	55,803
Kent	19	3,800	9,500	2,310	1,490	7,190
Montgomery-Silver Springs	174	34,800	87,000	30,693	4,107	56,307
Montgomery-Mid County	189	37,800	94,500	9,993	27,807	84,507
Montgomery-North	93	18,600	46,500	22,611	-4,011	23,889
Prince George's N East	94	18,800	47,000	11,072	7,728	35,928
Prince George's N West	162	32,400	81,000	44,543	-12,143	36,457
Prince George's S East	50	10,000	25,000	8,049	1,951	16,951
Prince George's S West	62	12,400	31,000	20,823	-8,423	10,177
Queen Anne's	30	6,000	15,000	3,576	2,424	11,424
Somerset	21	4,200	10,500	3,752	448	6,748
St. Mary's	55	11,000	27,500	8,822	2,178	18,678
Talbot	47	9,400	23,500	3,154	6,246	20,346
Washington	110	22,000	55,000	15,586	6,414	39,414
Wicomico	66	13,200	33,000	14,422	-1,222	18,578
Worchester	32	6,400	16,000	5,247	1,153	10,753
Total	4,705	941,000	2,352,500	548,092	392,908	1,804,408

Based on a capacity standard of 500 enrollees to one PCP, provider networks in each LAA are more than adequate. However, there are a few areas where the conservative standard of 200

enrollees per PCP is not met: two in Baltimore City, one in Montgomery County, two in Prince Georges County, one in Garrett County, and two on the Eastern Shore. The Washington Suburban region had the largest PCP capacity deficits in 2008. Two Prince Georges County LAAs had capacity deficits of more than 8,000 enrollees at the conservative 200 enrollees per PCP level. In addition, the county as a whole had a net capacity deficit of more than 10,000 enrollees. One Montgomery County LAA had a capacity deficit of more than 4,000 enrollees. However, the county as a whole had excess capacity at the conservative 200 enrollees per PCP level.

Primary Care Provider Retention

Retaining PCPs within the HealthChoice program allows enrollees to establish relationships with their providers and facilitates continuity of care and the provision of a medical home. The retention rate is calculated by matching the license numbers of PCPs who provided services in a given year with those who provided services in the following year. The retention rate is presented as the percentage of PCPs who provided services in year two who also provided services in year one. Table 4 displays the PCP retention rate for CY 2004 through CY 2008. The data show an improvement in the retention rate between the CY 2004 – 2005 and CY 2005 – 2006 measurement periods. The retention rate, however, decreased by nearly 2 percentage points between CY 2005 and CY 2008.

Table 4. Percentage of PCPs Continuing to Practice in the HealthChoice Program, CY 2004 – CY 2008

Time Period	Number of PCPs[11]	Retention Rate
CY 2004 – 2005	3,225	81.3%
CY 2005 – 2006	3,612	87.6%
CY 2006 – 2007	3,626	86.7%
CY 2007 – 2008	3,907	85.9%

Specialty Care Provider Network Adequacy

In addition to ensuring PCP network adequacy, the MCOs are required to provide all medically necessary specialty care. If an MCO does not have a specialist in network, the MCO must pay an out-of-network provider. Following the 2002 HealthChoice evaluation, DHMH worked with a stakeholder group to develop standards for specialty care access. These standards were implemented in regulation in February 2004. The HealthChoice regulations mandate that each MCO have an in-network contract with at least one provider statewide in the following specialties: allergy, dermatology, endocrinology, infectious disease, nephrology, and pulmonology. Each MCO must also include at least one in-network specialist in each of the ten regions throughout the state for the following eight core specialties: cardiology, otolaryngology (ENT), gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology.

[11] Please note that providers were unduplicated by license number. If an individual provider has multiple license numbers, he or she is counted for each license number.

As of March 2010, all MCOs met the statewide standard for allergy, dermatology, endocrinology, infectious disease, nephrology, and pulmonology specialists. One MCO did not meet the regional in-network requirement for ENTs. DHMH is requiring this MCO to submit a corrective action plan for the in-network ENTs it lacks. Meanwhile, the MCO is making out-of-network specialists and specialists in neighboring regions available to their enrollees.

CAHPS Survey Results[12]

DHMH uses the Consumer Assessment of Healthcare Providers and Services (CAHPS) survey to measure HealthChoice members' satisfaction with their medical care. Two CAHPS survey measures relate to access: "getting needed care" and "getting care quickly." "Getting needed care" is defined as obtaining health care from doctors and specialists through health plans. "Getting care quickly" is defined as receiving treatments and appointments as soon as they were needed. The survey responses for these two measures were "always," "usually," "sometimes," or "never."

In CY 2008, the percentage of adult HealthChoice members who responded that they were "usually" or "always" successful in "getting needed care" was 74 percent, a 2 percentage point increase from CY 2006. However, HealthChoice performance for this measure is lower than the CY 2008 National Committee for Quality Assurance (NCQA) Quality Compass benchmark of 76 percent. In contrast, 82 percent of adult members responded that they were "usually" or "always" successful in "getting care quickly," which is higher than the CY 2008 national benchmark of 80 percent.

[12] WBA Market Research. (2009, October). State of Maryland HealthChoice Adult and Child Populations, CAHPS® 2009 4.0H Adult and Child Medicaid Survey Results – Executive Summary. WBA Market Research. Retrieved May 25, 2010, from http://dhmh.maryland.gov/mma/healthchoice/pdf/2008/Executive_Summary_Adult_Child_CAHPS.pdf
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The Myers Group. (2007). 2007 Maryland Medicaid Managed Care, CAHPS® 4.0H Adult and 3.0H Child Satisfaction Surveys – Executive Summary. The Myers Group. Retrieved May 25, 2010, from http://dhmh.maryland.gov/mma/healthchoice/pdf/CY2006/2007CAHPSExecSummary.pdf
The Myers Group. (2006). *CAHPS® 2006 Medicaid Adult Survey, Project Numbers 42582-42600, Final Report*. Snellville, GA: The Myers Group, p1-1 & 1-4. The Myers Group. (2006). *CAHPS® 2006 Medicaid Child with CCC Measurement Set Survey General Population and CCC Reports, Project Numbers 62583-62601, Final Report*. Snellville, GA: The Myers Group, p1-1 & 1-6 to 1-7.

Table 5. Percentage of Adult HealthChoice Enrollees Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly Compared with the NCQA Quality Compass Benchmark, CY 2004 – CY 2008

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
Getting Needed Care - Percentage of Members who Responded "Usually" or "Always"					
HealthChoice	72%	72%	72% **	73%	74%
NCQA Quality Compass Benchmark	75%	N/A	N/A	75%*	76%
Getting Care Quickly - Percentage of Members who Responded "Usually" or "Always"					
HealthChoice	79%	79%	82%	80%	82%
NCQA Quality Compass Benchmark	74%**	81%	N/A	80%	80%

*Due to significant changes in the 2007 CAHPS 4.0H Survey, comparing CY 2006 results to previous years is not appropriate.
**Because this rate has not been recalculated to adjust for survey changes, it cannot be compared to rates in the same or subsequent years.

In CY 2008, the percentage of parents and guardians of children enrolled in HealthChoice responding "usually" or "always" "getting needed care" for their children was 76 percent, which is lower than the national benchmark of 79 percent. Eighty-nine percent of the parents and guardians surveyed responded "usually" or "always" "getting care quickly" for their children, which is higher than the CY 2008 national benchmark of 86 percent. Due to changes in the 2009 CAHPS survey, a comparison to data from previous years would not be appropriate.

Table 6. Percentage of Parents/Guardians of Child HealthChoice Enrollees Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly Compared with the NCQA Quality Compass Benchmark, CY 2004 – CY 2008

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
Getting Needed Care - Percentage of Members who Responded "Usually" or "Always"					
HealthChoice	81%	81%	80%	80%	76%*
NCQA Quality Compass Benchmark	79%	79%	N/A	82%	79%*
Getting Care Quickly - Percentage of Members who Responded "Usually" or "Always"					
HealthChoice	80%	80%	80%	79%	89%**
NCQA Quality Compass Benchmark	79%	79%	N/A	78%	86%**

*Due to significant changes in the 2009 CAHPS 4.0H Survey, a comparison to previous years would not be appropriate.
**Because the composite was revised in the 2009 survey, a comparison to previous years would not be appropriate.

The parents or guardians of children with chronic conditions in HealthChoice were also surveyed. In CY 2008, 75 percent responded "usually" or "always" "getting needed care" for their children. Ninety percent of the sample reported "usually" or "always" "getting care quickly." National benchmarks for this population are not available. Due to changes in the 2009 CAHPS survey, a comparison to data from previous years would not be appropriate.

Table 7. Percentage of Parents/Guardians of Children with Chronic Conditions in HealthChoice Responding "Usually" or "Always" Getting Needed Care and Getting Care Quickly, CY 2004 - CY 2008

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
Getting Needed Care - Percentage of Members who Responded "Usually" or "Always"					
HealthChoice	78%	78%	76%	77%	75%*
Getting Care Quickly - Percentage of Members who Responded "Usually" or "Always"					
HealthChoice	78%	79%	79%	79%	90%**

*Due to significant changes in the 2009 CAHPS 4.0H Survey, a comparison to previous years would not be appropriate.
**Because the composite was revised in the 2009 survey, a comparison to previous years would not be appropriate.

Does the Covered Population Access Care?

This section of the report looks at ambulatory care and ED visits to evaluate access to care.

Ambulatory Care Visits

DHMH monitors utilization (e.g., the percentage of the covered population receiving at least one ambulatory care service during the measurement year) as a proxy for access to care. An ambulatory care visit 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. This definition excludes ED visits, hospital inpatient services, substance abuse treatment, mental health, home health, x-rays, and laboratory services. An ambulatory care visit is reported as an unduplicated count that may not exceed one visit per day. In this section of the report, ambulatory care visits are measured using MCO encounter data only and exclude FFS ambulatory care visits. Overall, the ambulatory care visit rate increased from 69.8 percent in CY 2004 to 74.4 percent in CY 2008. Figure 3 presents the percentage of HealthChoice enrollees who received at least one ambulatory care service by age. Overall, ambulatory care visits have increased for all age groups since CY 2004.

Figure 3. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Age Group, CY 2004 – CY 2008

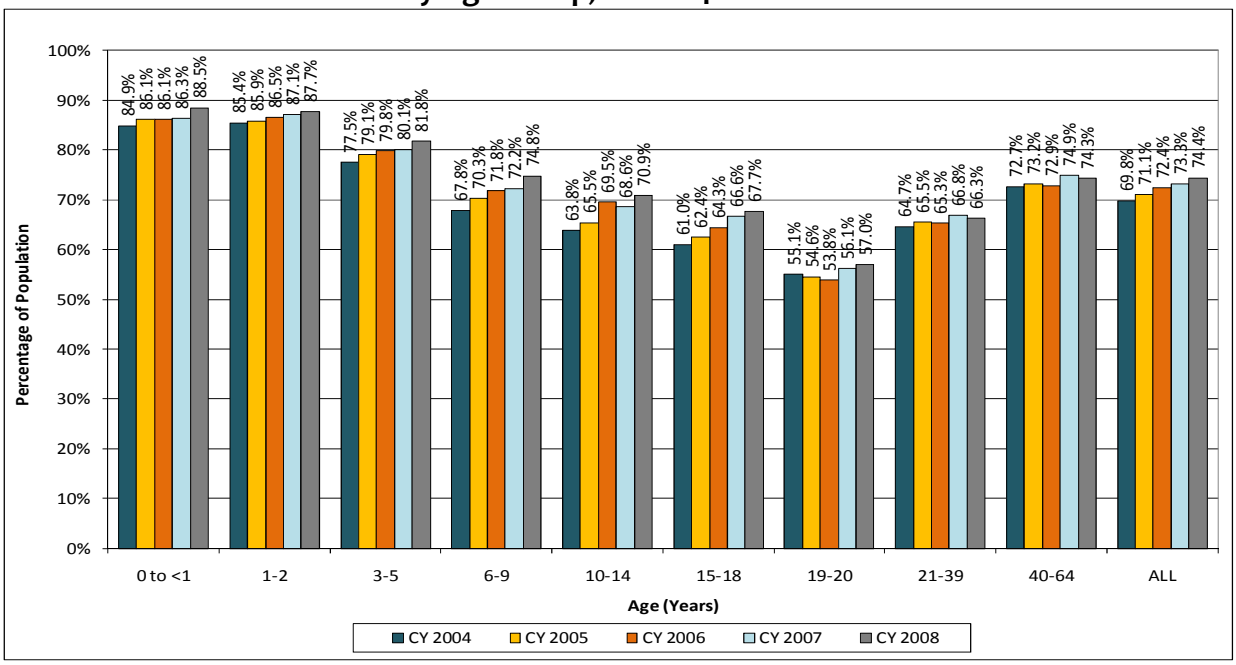
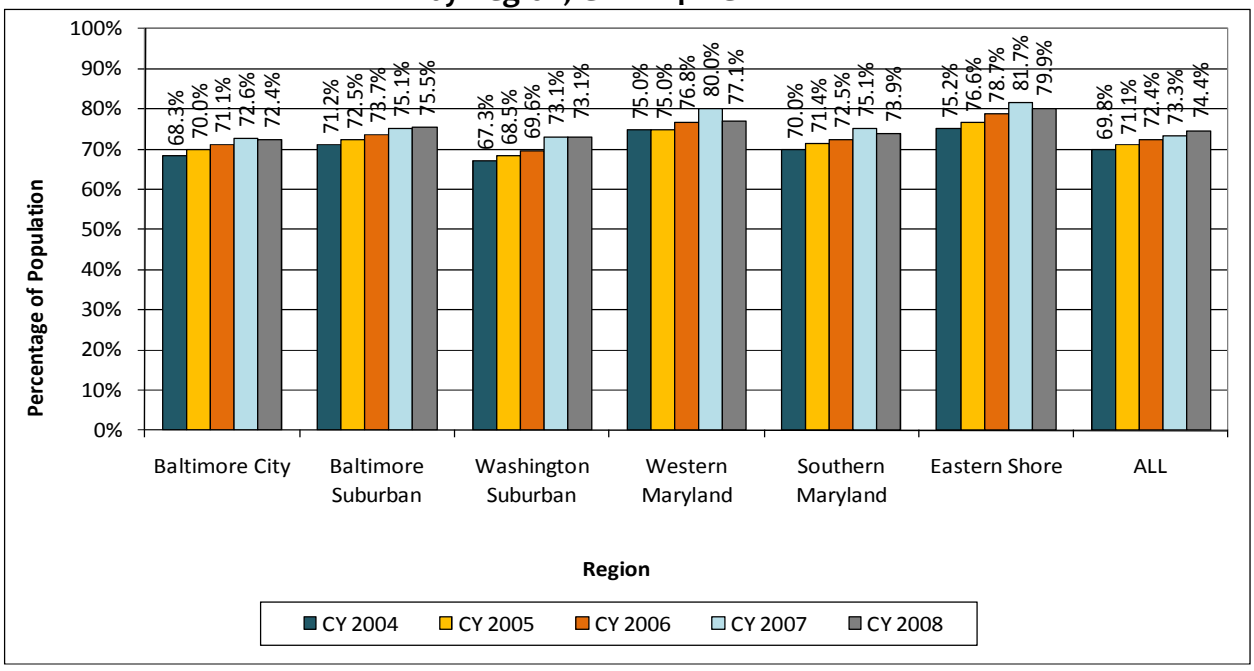


Figure 4 displays the percentage of HealthChoice enrollees receiving an ambulatory care service by region. Visits for all regions increased steadily over the study period. However, Baltimore Suburban was the only region that experienced an increase in service utilization in CY 2008 (from 75.1 percent in CY 2007 to 75.5 percent in CY 2008).

Figure 4. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Region, CY 2004 – CY 2008



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. Studies have shown a steady rise in ED utilization nationwide.[13] 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 in HealthChoice who visited an ED at least once during the calendar year. This measure excludes ED visits that resulted in an inpatient hospitalization.

Figure 5 presents overall ED use by coverage group. On the whole, ED use among HealthChoice enrollees increased by approximately 4 percentage points by the conclusion of the evaluation period. Enrollees with disabilities were more likely to utilize ED services than any other coverage group. The F&C coverage group also experienced an increase in utilization between CY 2007 and CY 2008.

Figure 5. Percentage of the HealthChoice Population with at Least One ED Visit by Coverage Group, CY 2004 – CY 2008

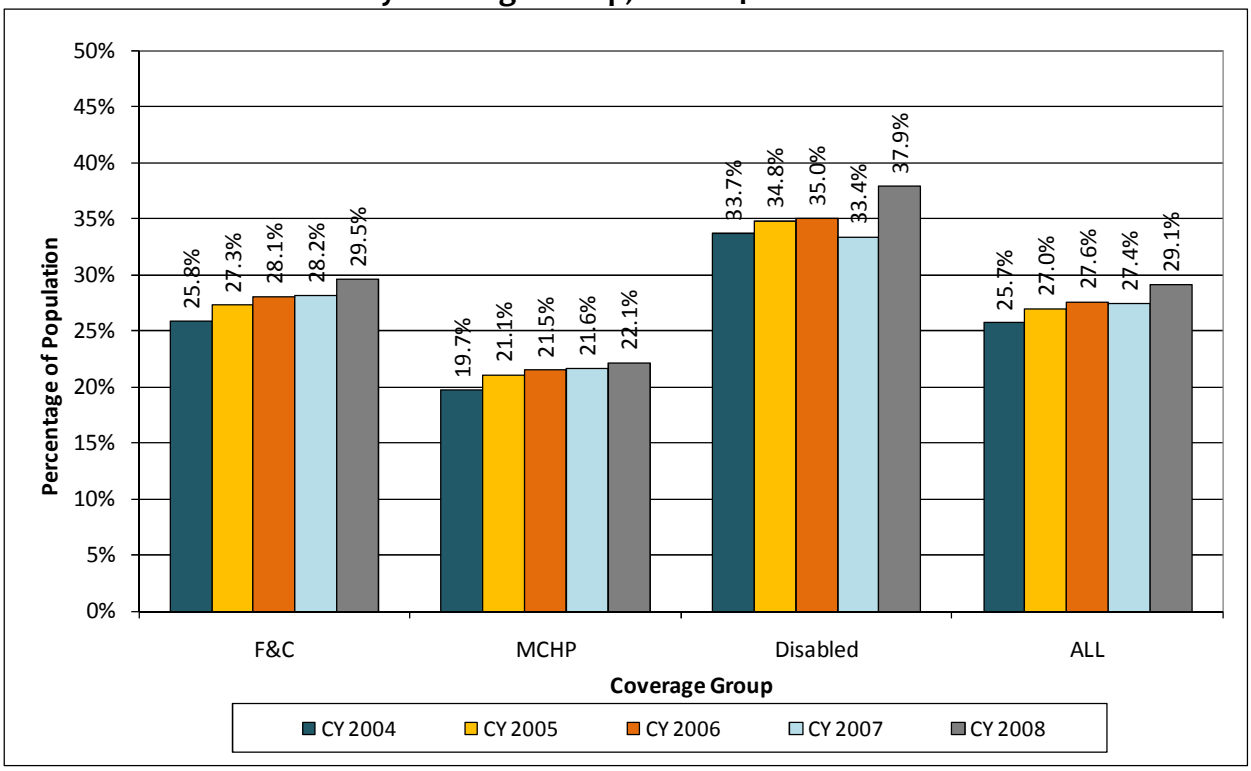
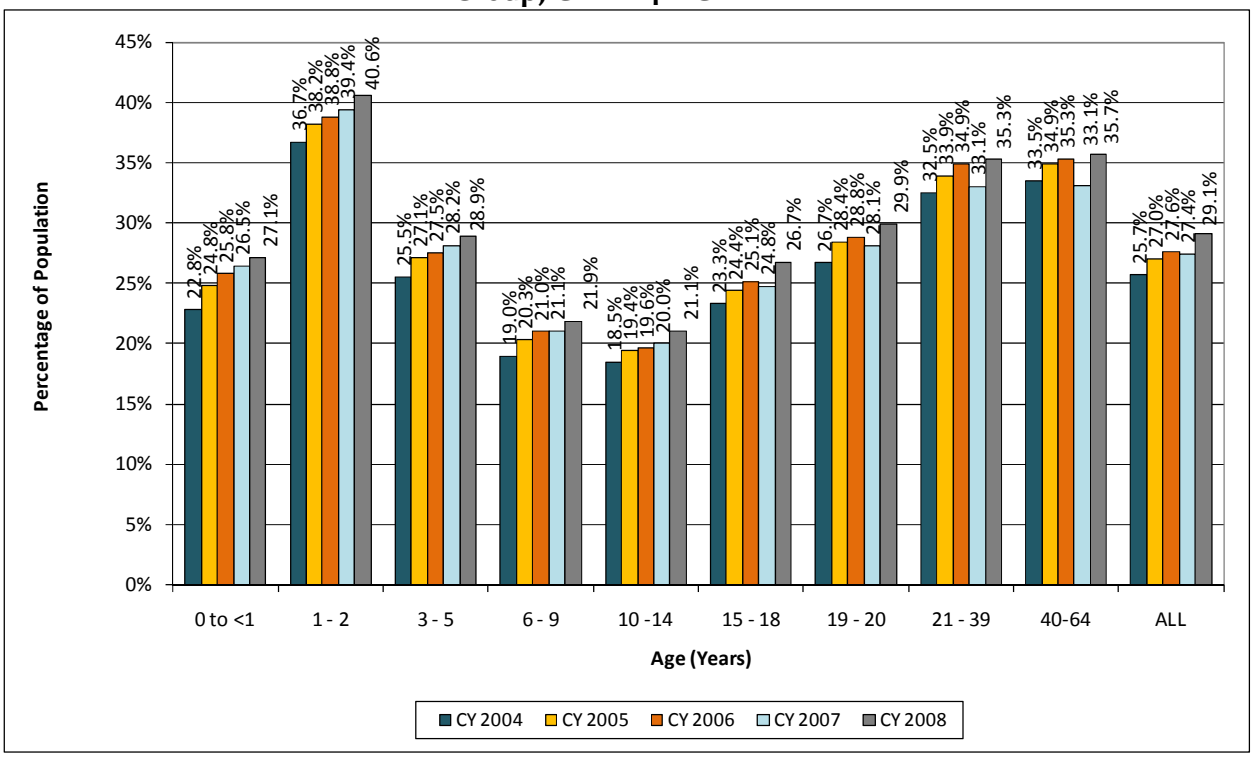


Figure 6 presents ED utilization by age group. Children aged 1 and 2 years consistently had the highest ED utilization throughout the evaluation period, followed by adults aged 21 through 64

[13] Maryland Health Care Commission. (2007). *Use of Maryland Hospital Emergency Departments: An Update and Recommended Strategies to Address Crowding*. Retrieved June 23, 2010, from http://mhcc.maryland.gov/hospital_services/acute/emergencyroom/ed_crowding_122006_report.pdf

years. The percentage of enrollees under the age of 21 years who accessed the ED increased markedly over the evaluation period.

Figure 6. Percentage of the HealthChoice Population with at least One ED Visit by Age Group, CY 2004 – CY 2008



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 May 2010, 63,193 new parents and caretaker relatives were covered under HealthChoice. At the same time, DHMH embarked upon two new outreach initiatives to enroll eligible Maryland residents. With these expansion activities and increased enrollment, it is important to maintain access to care and ensure that the program has the capacity to provide services to a growing population. Looking at provider networks, there are a few areas in the state that do not meet conservative PCP and specialist network adequacy standards. However, CAHPS survey results indicate that most enrollees report that they usually or always receive needed care and receive needed care quickly. Looking at service utilization, the percentage of enrollees receiving an ambulatory care visit increased during the demonstration period. ED visits also increased during the same time period.

Section II. Medical Home

One of the goals of the HealthChoice program is to provide patient-focused, comprehensive, and coordinated care by providing each member with a medical home. HealthChoice enrollees 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 enrollees with a medical home by assessing appropriate service utilization and continuity of care.

Appropriate Service Utilization

This section addresses whether enrollees could identify with and know how to navigate a medical home. With a greater understanding of the resources available to them, enrollees should be able to seek care in an ambulatory setting before resorting to the ED or letting an ailment exacerbate to the extent that it could warrant an inpatient admission. In Table 8 below, enrollees with at least one ED visit and enrollees with at least one inpatient admission are compared across CY 2004 through CY 2008.

While the ED visit rate increased by CY 2008, the majority of enrollees seen in the ED (88.3 percent) also received ambulatory care visits. The same trend is observed for enrollees who had an inpatient admission. About 94 percent of enrollees with an inpatient admission in CY 2008 also had an ambulatory care visit during the same year. There is an upward trend in the proportion of enrollees who were either admitted to a hospital or had an ED visit and accessed care in an ambulatory setting. This suggests that the majority of enrollees who are either admitted to a hospital or use the ED have access to somatic care outside of these settings.

Table 8. Individuals with ED or Inpatient Visits and Ambulatory Care Visits, CY 2004 – CY 2008

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
ED					
Number of enrollees with an ED visit	156,781	166,720	172,514	171,051	190,292
Number of enrollees with an ED visit who had an ambulatory care visit	135,976	145,085	151,719	150,345	167,978
Percent of enrollees with an ED visit who had an ambulatory care visit	86.7%	87.0%	88.0%	87.9%	88.3%
Inpatient					
Number of enrollees with an inpatient visit	59,705	61,922	65,041	64,497	66,529
Number of enrollees with an inpatient visit who had an ambulatory care visit	55,290	57,610	60,940	60,425	62,673
Percent of enrollees with an inpatient visit who had an ambulatory care visit	92.6%	93.0%	93.7%	93.7%	94.2%

Appropriateness of Emergency Department 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 the classifications developed by researchers at the New York University Center for Health and Public Service Research (NYU). This methodology 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 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 principal 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 7 presents the distribution of all ED visits by NYU classification for CY 2008 for individuals with any period of HealthChoice enrollment. In CY 2008, 53 percent of all ED visits among enrollees were for potentially avoidable conditions, meaning that the visit could have been avoided with timely and quality primary care.[14] Enrollees in the F&C and MCHP coverage groups had higher rates of potentially avoidable visits than enrollees with disabilities.

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 26.1 percent of all ED visits in CY 2008. Adults and infants 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 9, which is not part of the NYU classification, represents ED visits that resulted in a hospital admission. Enrollees with disabilities had a much higher rate of ED visits that lead to an inpatient admission than the F&C and MCHP coverage groups.

[14] This figure combines categories 1 through 3: non-emergent, emergent but primary care treatable, and emergent but preventable/avoidable.

Figure 7. Classification of ED Visits by HealthChoice Enrollees, CY 2008

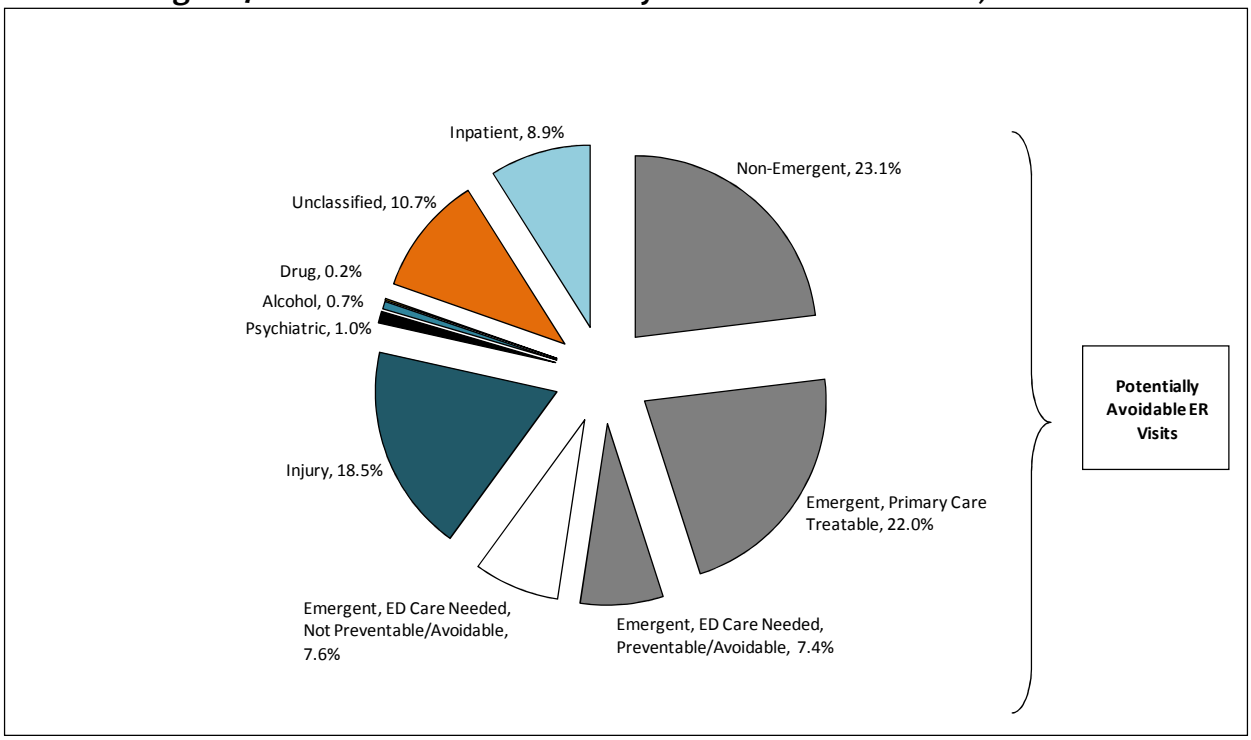
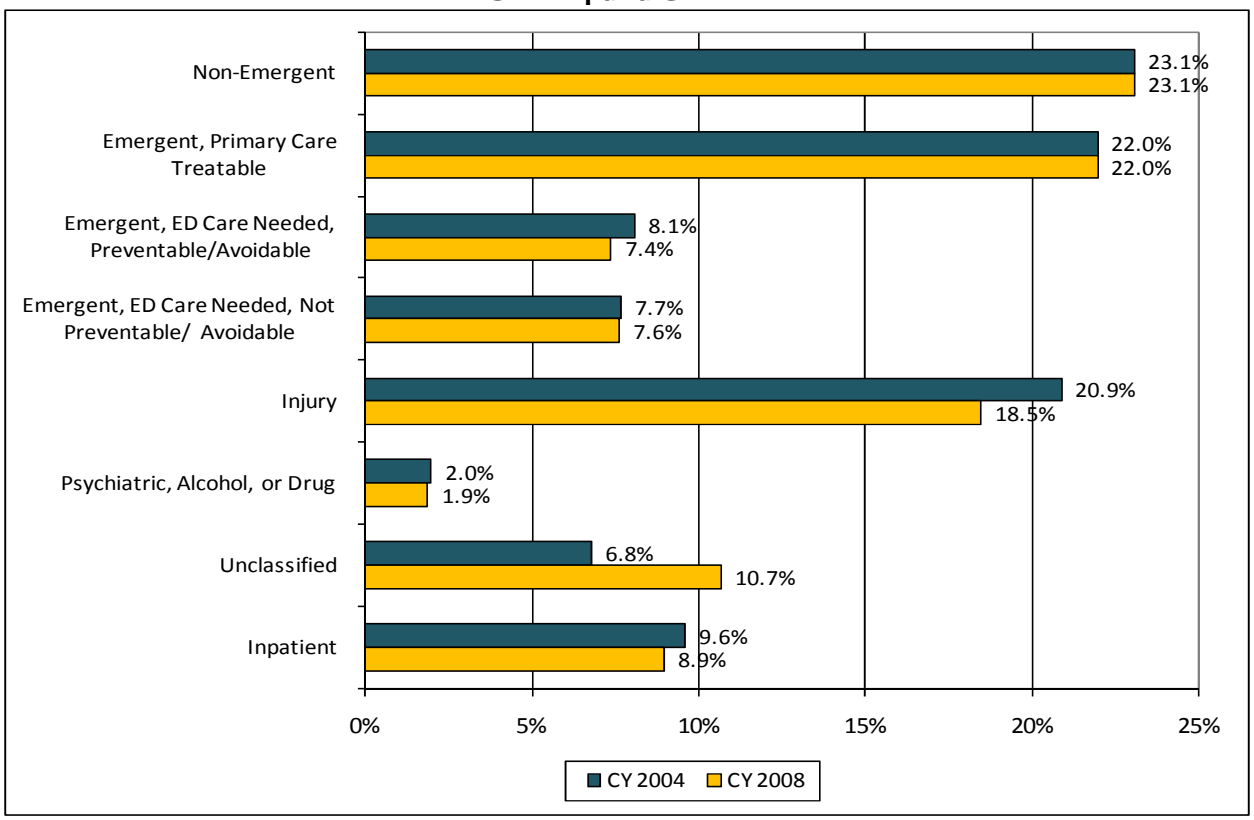


Figure 8 compares ED visit classifications for CY 2004 with classifications for CY 2008. The data show that potentially avoidable ED visits decreased during the evaluation period, whereas ED visits leading to an inpatient admission increased slightly.

Figure 8. Classification of ED Visits by HealthChoice Enrollees, CY 2004 and CY 2008



Ambulatory Care Sensitive Hospitalizations

Ambulatory care sensitive hospitalizations (ACSHs), also referred to as preventable or avoidable hospitalizations, are hospital admissions that are 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 enrollees[15] with any hospital admission who had a primary diagnosis of asthma or short-term diabetes with complications. Table 9 presents the rate of diabetes-related admissions for enrollees aged 21 through 64 years and asthma-related admissions for enrollees aged 5 through 20 years. The avoidable admission rates for both asthma and diabetes improved during the measurement period. The avoidable admission rate for diabetes decreased from 24 admissions per 1,000 members in CY 2004 to 21 admissions per 1,000 members in CY 2008.

[15] To be included, enrollees 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.

The avoidable admission rate for asthma decreased from 55 admissions per 1,000 members in CY 2004 to 39 admissions per 1,000 members in CY 2008.

Table 9. Asthma- and Diabetes-Related Admissions per One Thousand Members, CY 2004 – CY2008

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
Diabetes (Enrollees Aged 21 – 64 Years)					
Number of Diabetes-Related Avoidable Hospital Admissions	178	199	204	188	182
Rate per 1,000 HEDIS-Eligible Adults with Diabetes	24	25	25	22	21
Asthma (Enrollees Aged 5 – 20 Years)					
Number of Asthma-Related Avoidable Hospital Admissions	279	257	275	330	290
Rate per 1,000 HEDIS-Eligible Children with Asthma	55	46	44	49	39

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, it may be difficult to establish a medical home. Table 10 presents the percentage of the HealthChoice population who were enrolled in more than one MCO during the calendar year. In each year of the evaluation period, approximately 97 percent of enrollees remained within one MCO, indicating that most enrollees do not change MCOs and thus have greater opportunity to establish a medical home.

Table 10. Percentage of HealthChoice Population Enrolled in One or More MCOs, CY 2004 – CY 2008

Number of MCOs	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
1	96.8%	96.9%	97.0%	97.3%	96.8%
2 or More	3.2%	3.1%	3.0%	2.7%	3.2%

Section II. Summary

This section of the report sought to address the extent to which HealthChoice provides enrollees with a medical home by assessing the appropriateness of service utilization and continuity of care. Looking at appropriateness of care, nearly 90 percent of enrollees who had an ED visit and 94 percent who had an inpatient admission in CY 2008 also received an ambulatory care visit. This suggests that these enrollees have access to care in an appropriate setting outside of the hospital and may explain, at least in part, why potentially avoidable ED visits and asthma- and diabetes-related ACSHs decreased during the evaluation period. Looking at continuity of care, most enrollees (97 percent) do not change MCOs within the year.

Section III. Quality of Care: Is the Right Care Delivered?

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. DHMH also reviews a sample of medical records to ensure that EPSDT standards are met. 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[16]

DHMH uses HEDIS measures to report childhood immunization rates and well-child visits. Immunizations are a proven method to safely and effectively prevent severe illnesses, such as polio and hepatitis. The HEDIS immunization measures include the percentage of two-year-old children who have received the following immunizations in their lifetime: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (Hib); three hepatitis B; one chicken pox (VZV); and four pneumococcal conjugate vaccines. Rates for two separate combinations of these vaccines are measured.

The American Academy of Pediatrics recommends well-child visits according to an age-based periodicity schedule: six well-child visits for children from birth through 12 months, annual check-ups for children aged 2 to 6 years, and annual check-ups for adolescents aged 12 to 21 years. 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 11 compares the HealthChoice program with the national HEDIS Medicaid average on the immunization and well-child measures. HealthChoice performed above the national HEDIS Medicaid average across all measures and all years during the study period. Within the HealthChoice program:

- The percentage of two-year-old children receiving immunization combination two increased by 12.3 percent (9 percentage points) during the measurement period

[16] HealthcareData Company, LLC. (2009, September). *Statewide Executive Summary, HealthChoice and Primary Adult Care Organizations, HEDIS® 2009.* Mechanicsburg, PA: HealthcareData Company, LLC., p. 12-16.

- The percentage of children receiving immunization combination three increased by 51.0 percent (26 percentage points) during the measurement period
- The percentage of 15-month-old infants who received at least five well-child visits increased by 2.5 percent (2 percentage points) during the measurement period
- The percentage of children aged three to six years who received at least one well-child visit increased by 5.5 percent (4 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 5.8 percent (3 percentage points) during the measurement period

Table 11. HEDIS Immunizations and Well-Child Visits: HealthChoice Compared with the National HEDIS Medicaid Average, CY 2004 – CY 2008

HEDIS Measures	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008[17]
Childhood Immunizations – Combination 2					
HealthChoice	73%	77%	78%	81%	82%
National HEDIS Medicaid Average	63%	70%	73%	72%	74%
Childhood Immunizations – Combination 3					
HealthChoice	n/a	51%	68%	74%	77%
National HEDIS Medicaid Average	n/a	43%	61%	66%	68%
Well-Child Visits – 15 Months of Life					
HealthChoice	81%	82%	85%	82%	83%
National HEDIS Medicaid Average	64%	68%	73%	70%	75%
Well-Child Visits – 3 to 6 Year-Olds					
HealthChoice	73%	70%	77%	77%	77%
National HEDIS Medicaid Average	62%	63%	67%	65%	70%
Well-Care Visits - Adolescents					
HealthChoice	52%	52%	59%	53%	55%
National HEDIS Medicaid Average	39%	41%	44%	42%	46%

Early and Periodic Screening, Diagnosis, and Treatment Review

The EPSDT program is a required package of services and benefits for all Medicaid enrollees under the age of 21 years. The purpose of EPSDT is to ensure that children receive proper somatic health, mental health, and developmental care to curtail the development of or increase

[17]National Committee for Quality Assurance. (2009). *Medicaid HEDIS 2009 Audit Means, Percentiles and Ra*tios [Microsoft Excel]. Washington, DC.

in illness and disability. Maryland's EPSDT program aims to support access and increase 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 and measures HealthChoice provider compliance with the following five EPSDT components:

- Health and developmental history: A personal and family medical history helps the provider to determine health risks. It is recommended that providers use a comprehensive, standard, age-appropriate history form.
- 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 risk factors related to heart disease, anemia, tuberculosis, lead exposure, and sexually transmitted diseases (STDs)/HIV.
- Immunizations: Providers with HealthChoice patients must offer immunizations according to DHMH's recommended childhood immunization schedule
- Health education/anticipatory guidance: Providers are required 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.

Overall, provider compliance for laboratory tests, immunizations, and health education/anticipatory guidance decreased by one percentage point during the measurement period (Table 12). Compliance with recording a health and developmental history for HealthChoice patients dropped from 89 percent in CY 2005 to 85 percent in CY 2008. Finally, provider compliance with comprehensive physical exams decreased from 95 percent in CY 2005 to 92 percent in CY 2008. Between CY 2007 and CY 2008, however, provider compliance improved on all five measures.

Table 12. HealthChoice MCO Aggregate Composite Scores for Components of the EPSDT Review, CY 2005 – CY 2008

	CY 2005	CY 2006	CY 2007	CY 2008
EPSDT Components				
Health and developmental history	89%	90%	81%	85%
Comprehensive physical exam	95%	96%	91%	92%
Laboratory tests	79%	78%	74%	78%
Immunizations	94%	94%	93%	93%
Health education/anticipatory guidance	90%	90%	88%	89%

Childhood Lead Testing

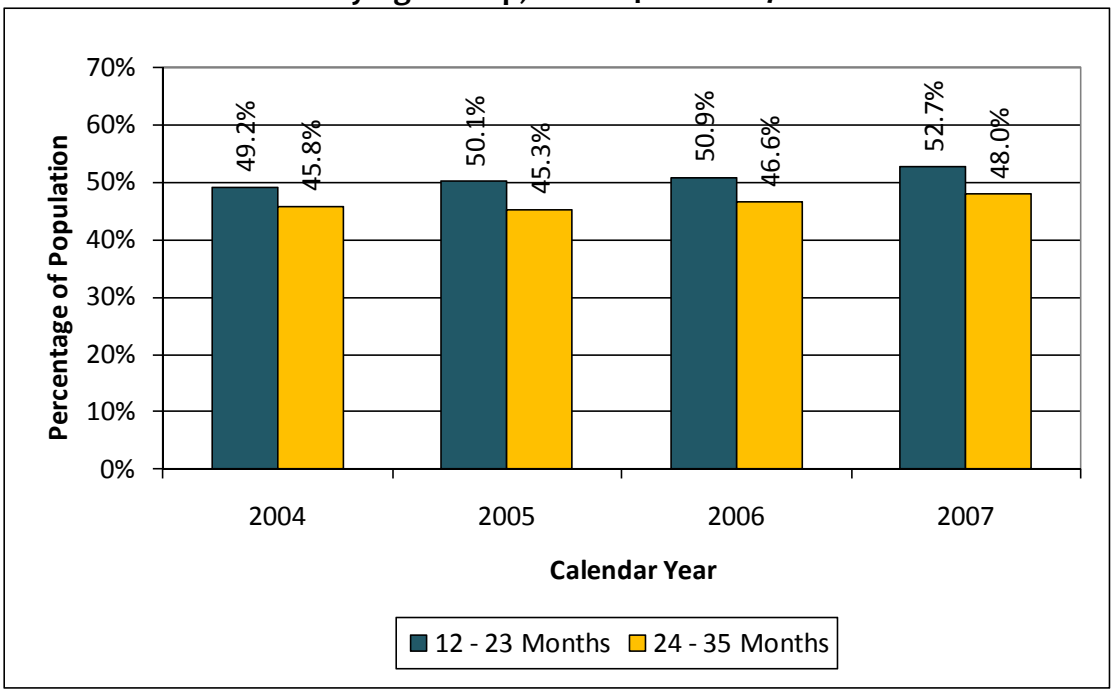
DHMH is a member of the Lead Poisoning Prevention Commission, which advises Maryland executive agencies, the General Assembly, and the governor on lead poisoning prevention in the state. Maryland's *Plan to Eliminate Childhood Lead Poisoning by 2010* includes a goal of

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 have 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 (MFR) 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.[18] In prior years, DHMH calculated this rate for lead tests occurring during the calendar year only. In CY 2008, however, DHMH changed the specifications to include lead tests occurring during the calendar year *or the prior calendar year* to more closely align the measure with the new HEDIS lead screening in children measure. Because of this change, the CY 2008 lead testing rate is not comparable to the CY 2004 through CY 2007 rates. Therefore, the new measure is presented separately.

Figure 9 shows that between CY 2004 and CY 2007, the lead testing rate for children aged 12 through 23 months increased by 7.1 percent (3.5 percentage points), and the rate for children aged 24 through 35 months increased by 4.8 percent (2.2 percentage points).

Figure 9. HealthChoice Children Receiving a Lead Test During the Calendar Year by Age Group, CY 2004 – CY 2007



Using the new measure, which calculates the percentage of children receiving a lead test in CY 2007 or CY 2008, 53.9 percent of children aged 12 through 23 months and 50.1 percent of

[18] The lead 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.

children aged 24 through 35 months received at least one blood lead test in CY 2008. These percentages will serve as the baseline for measuring performance of the new measure going forward. The lead testing rate for children enrolled in Medicaid is higher than the rate for children statewide. In 2008, 45.2 percent of one-year-old children and 35.5 percent of two-year-old children statewide received a lead test.[19]

Breast Cancer Screening[20]

According to the U.S. Preventive Services Task Force, mammograms are the most effective technique for detecting breast cancer. Among American women, breast cancer is the most prevalent type of cancer. When breast cancer is detected early, women have more treatment options and a greater chance of survival. HEDIS assesses the percentage of women who received a mammogram within a two-year period. During CY 2004 and CY 2005, HEDIS included women aged 50 through 69 years in this measure. In CY 2006, however, the measure was expanded to include women aged 40 through 69 years. Although there has been recent debate over the age requirements for mammogram, HEDIS continues to include this measure.

Table 13 compares the percentage of women in HealthChoice who received a mammogram for breast cancer screening with the HEDIS Medicaid national average for CY 2004 through CY 2008. Because of the change in the age requirement in CY 2006, a comparison to prior years is not appropriate for this measure. Between CY 2006 and CY 2008, the percentage of women aged 40 through 69 years receiving a mammogram increased by 11.4 percent (5 percentage points). However, in CY 2008, HealthChoice performance for this measure remained below the national HEDIS Medicaid average of 51 percent.

Table 13. Percentage of Women in HealthChoice Receiving a Mammogram for Breast Cancer Screening Compared with the National HEDIS Medicaid Average, CY 2004 – CY 2008

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008[21]
	Women Aged 50-69 Years		Women Aged 40-69 Years		
HealthChoice	52%	55%	44%*	47%	49%
National HEDIS Medicaid Average	54%	54%	49%*	50%	51%

*Due to significant changes in the specifications for the 2007 HEDIS measurement year, a comparison to prior years would not be appropriate

[19] Maryland Department of the Environment (2009, June). *Childhood Blood Lead Surveillance in Maryland. Annual Report 2008 Supplementary Data Tables: Supplement* #3. Retrieved May 3, 2010, from http://www.mde.state.md.us/assets/document/LeadCoordination/LeadrptCLR2008supplement_3.pdf

[20] HealthcareData Company, LLC. (2009, September). *Statewide Executive Summary, HealthChoice and Primary Adult Care Organizations, HEDIS® 2009*. Mechanicsburg, PA: HealthcareData Company, LLC., p.25.

[21] National Committee for Quality Assurance. (2009). *Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios* [Microsoft Excel]. Washington, DC.

Cervical Cancer Screening[22]

Cervical cancer is a preventable and treatable cancer. The American Cancer Society recommends Pap tests for women who are sexually active or over the age of 21 years. Through the use of Pap tests, precancerous lesions can be detected early and cervical cancer can be treated or altogether avoidable. HEDIS measures the percentage of women who have received at least one Pap test within a three-year period to screen for cervical cancer. During CY 2004 and CY 2005, HEDIS included women aged 18 through 64 years in this measure. In CY 2006, however, the measure was restricted to women aged 21 through 64 years.

Table 14 compares the percentage of women in HealthChoice who received a cervical cancer screening with the HEDIS Medicaid national average for CY 2004 through CY 2008. Because of the change in the age requirement in CY 2006, a comparison to prior years is not appropriate for this measure. Between CY 2006 and CY 2008, the percentage of women in HealthChoice who received a Pap test for cervical cancer screening increased by 8.1 percent (5 percentage points). The HealthChoice CY 2008 rate, 67 percent, was one percentage point higher than the national HEDIS Medicaid average of 66 percent.

Table 14. Percentage of Women in HealthChoice Receiving a Cervical Cancer Screening Compared with the National HEDIS Medicaid Average, CY 2004 – CY 2008

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008[23]
	Women Aged 18-64 Years		Women Aged 21-64 Years		
HealthChoice	62%	59%	62%*	63%	67%
National HEDIS Medicaid Average	64%	65%	66%*	65%	66%

*Due to significant changes in the specifications for the 2007 HEDIS measurement year (CY 2006), a comparison to prior years would not be appropriate

Cervical Cancer Screening Performance Improvement Project[24]

DHMH requires the HealthChoice MCOs to conduct performance improvement projects (PIPs) that focus on both clinical and non-clinical areas over a three-year period. The purpose of PIPs is to examine the quality improvement process used by the MCOs and to apply modifications that improve health care outcomes. In CY 2007, DHMH implemented the cervical cancer screening PIP. The Delmarva Foundation is required to oversee and evaluate each MCO's PIPs. The Delmarva Foundation assesses the PIPs using the following 10-step process devised by CMS:

1. Assess the study methodology
2. Review the study question(s)

[22] HealthcareData Company, LLC. (2009, September). *Statewide Executive Summary, HealthChoice and Primary Adult Care Organizations, HEDIS® 2009.* Mechanicsburg, PA: HealthcareData Company, LLC., p.26.
[23] National Committee for Quality Assurance. (2009). *Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios* [Microsoft Excel]. Washington, DC.
[24] Delmarva Foundation. (2009, January). Medicaid Managed Care Organization Performance Improvement Projects, Annual Report 2008. Maryland Department of Health and Mental Hygiene. Retrieved on May 25, 2010, from http://dhmh.maryland.gov/mma/healthchoice/pdf/2009/2008-MD-PIP-Annual-Report-FINAL.pdf

3. Review the selected study indicator(s)
4. Review the identified study population
5. Review the sampling methods
6. Review the data collection procedures
7. Assess improvement strategies
8. Review data analysis and interpretation of study results
9. Assess whether improvement is real improvement
10. Assess sustained improvements

The Delmarva Foundation rates the MCOs on each of these steps. The ratings are "met," "partially met," "unmet," or "not applicable". For Steps 1 through 8 of the cervical cancer screening PIP, all of the MCOs received a "met" rating, meaning that all of the required components were addressed. For Steps 9 and 10, each MCO received a "not applicable" rating because the most recent report assesses data from CY 2007, the baseline year of data collection and justification for the cervical cancer screening PIP. The following list contains examples of interventions used by the HealthChoice MCOs for the cervical cancer screening PIP:

- Distributed educational information at community events
- Mailed educational information to health plan members
- Created a database to identify members who have not received a cervical cancer screening
- Made outreach calls to members in need of a screening
- Developed incentive programs for members, such as gift cards, to promote screenings
- Distributed lists of patients in need of a screening to PCPs
- Created partnerships with lab vendors to acquire PAP smears

Care for Chronic Conditions

Use of Appropriate Medications for People with Asthma[25]

DHMH uses HEDIS measures to report the use of appropriate medications for people with asthma. Asthma is a common and expensive disease that affects more than 30 million American children and adults. In Maryland, in 2007, approximately 740,000 adults and children had a history of asthma, of which about 75,000 were enrolled in Medicaid.[26] The purpose of asthma medications is to prevent or reduce airway inflammation and narrowing. If a patient's asthma

[25] HealthcareData Company, LLC. (2009, September). *Statewide Executive Summary, HealthChoice and Primary Adult Care Organizations, HEDIS® 2009.* Mechanicsburg, PA: HealthcareData Company, LLC., p.19.
[26]De Pinto, C., McEachern, Y., Hess-Mutinda, R., & Nwachukwu, L . (2010*). Maryland Asthma Surveillance Report 2008*. Baltimore, MD: Maryland Asthma Control Program, Family Health Administration, Maryland Department of Health and Mental Hygiene.

medications are prescribed and used appropriately, asthma-related hospitalizations, ED visits, and missed school and work days decrease.

Table 15 compares the HealthChoice rate of appropriate medications for people with asthma with the HEDIS Medicaid national average. Because DHMH began reporting this measure in CY 2005, data are not available for CY 2004. Between CY 2005 and CY 2008, the percentage of HealthChoice members aged 5 through 56 years with asthma who were appropriately prescribed medications increased by 3.4 percent (3.0 percentage points). HealthChoice performed slightly above the HEDIS Medicaid national average each year during the measurement period.

Table 15. Percentage of HealthChoice Members Aged 5-56 Years with Persistent Asthma who were Appropriately Prescribed Medications Compared with the National HEDIS Medicaid Average, CY 2005 – CY 2008

	CY 2005	CY 2006	CY 2007	CY 2008[27]
HealthChoice	87%	88%	89%	90%
National HEDIS Medicaid Average	86%	87%	87%	89%

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). The CDC measures include:

- HbA1c Screening: The percentage of enrollees 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 HealthChoice enrollees aged 18 through 75 years with diabetes who received at least one low-density lipoprotein cholesterol (LDL-C) screening. In CYs 2004 and 2005, HEDIS measured LDL-C screenings occurring within a two-year time period. In CY 2006, however, HEDIS reduced the measurement period to one year.
- Eye Exams: The percentage of HealthChoice enrollees aged 18 through 75 years with diabetes who received an eye exam for diabetic retinal disease during the measurement year *or* a negative retinal exam (no evidence of retinopathy) in the year prior to the measurement year.

Table 16 compares HealthChoice with the HEDIS Medicaid national average on the CDC measures for CY 2004 through CY 2008. HealthChoice performed above the HEDIS Medicaid national average across all years for both the eye exam and LDL-C measures. HealthChoice also performed at the same level or above the HEDIS Medicaid national average on the HbA1c screening measure each year except CY 2008. Within the HealthChoice program:

[27] National Committee for Quality Assurance. (2009). *Medicaid HEDIS 2009 Audit Means, Percentiles and Ra*tios [Microsoft Excel]. Washington, DC.

- The percentage of enrollees with diabetes who received an eye exam increased by 34 percent (16 percentage points) during the measurement period.
- The percentage of enrollees with diabetes who received an LDL-C screening increased by 4 percent (3 percentage points) between CY 2006 and CY 2008. Because the specifications changed in CY 2006, a comparison to prior years would not be appropriate.
- The percentage of enrollees with diabetes who received an HbA1c screening decreased by 3 percent (2 percentage points) during the measurement period.

Table 16. Percentage of HealthChoice Members Aged 18–75 Years with Diabetes (Type 1 and Type 2) who had an Eye Exam (Retinal) Performed Compared with the National HEDIS Medicaid Average, CY 2004 – CY 2008

HEDIS CDC Measures	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008[28]
Eye Exams					
HealthChoice	47%	55%	59%	60%	63%
National HEDIS Medicaid Average	44%	47%	51%	50%	53%
HbA1c Screening					
HealthChoice	80%	80%	78%	79%	78%
National HEDIS Medicaid Average	75%	76%	78%	77%	81%
LDL-C Screening	**2-Year Measurement Period for LDL-C Screening**		**1-Year Measurement Period for LDL-C Screening**		
HealthChoice	87%	84%	74%*	76%	77%
National HEDIS Medicaid Average	78%	81%	71%	71%	74%

*Due to significant changes in the specifications for the 2007 HEDIS measurement year, a comparison would not be appropriate for prior years.

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 childhood immunization rates increased during the evaluation period and were consistently higher than the national HEDIS Medicaid average. Childhood blood lead testing rates also improved during the same period. However, the EPSDT record review shows that provider compliance with five EPSDT components decreased 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 evaluation period. This section also examined the quality of care for chronic conditions, namely diabetes and asthma. The rate of enrollees receiving appropriate asthma medications improved during the evaluation period and HealthChoice performed higher than the national HEDIS Medicaid average. For enrollees with diabetes, rates of eye exams and LDL-C screening improved, while the rate of HbA1c screening decreased slightly during the evaluation period.

[28] National Committee for Quality Assurance. (2009). *Medicaid HEDIS 2009 Audit Means, Percentiles and Ratios* [Microsoft Excel]. Washington, DC.

Section IV. Financing

This section of the report discusses several aspects of the financing of the HealthChoice program, including provider fee changes, budget neutrality, and trend factors.

Physician Fee Changes

Maryland law has directed DHMH to establish a process whereby the physician FFS reimbursement rates for the Medicaid and MCHP programs are established in a manner that ensures provider participation. The law further stipulates that, in order to develop the rate-setting process, DHMH should take into account the Resource-Based Relative Value Scale methodology that is used in the federal Medicare program and American Dental Association (ADA) Current Dental Terminology (CDT-3) codes.

In 2005, the Maryland Legislature created the Maryland Health Care Provider Rate Stabilization Fund. The revenues for this fund are from a tax imposed on MCOs and health maintenance organizations (HMOs). The Rate Stabilization Fund allocates funds annually to the Medical Assistance Program for increasing and maintaining physician fees.

DHMH used the Medicare physician payment methodology as a benchmark for increasing physician fees in 2006, 2007, 2008, and 2009. Medicare fees are based on the Resource-Based Relative Value Scale methodology, which relates payments to the resources and skills that physicians use to provide services. CMS annually updates the Medicare fee schedule.

For 2006, DHMH increased fees for procedures commonly performed by obstetricians, neurosurgeons, orthopedic surgeons, and emergency medicine physicians. For FY 2007, DHMH increased fees for procedures that are primarily used for anesthesiology, general surgery, digestive surgery, ear, nose, and throat (ENT), allergy/immunology, dermatology, and radiation oncology procedures. For FY 2008, DHMH increased fees for Evaluation and Management (E&M) procedures, obstetric anesthesia, neonatology, radiology, psychiatry, and vaccine administration procedures. In addition, procedures with the lowest fees were raised to a minimum of 50 percent of Medicare fees.

DHMH implemented another fee increase for FY 2009. As indicated above, fees for many procedures, including orthopedic, obstetric/gynecology, neurosurgery, ENT, and emergency medicine were set in previous years at 100 percent of their corresponding Medicare fee. Medicare fees in general did not increase substantially during the 2006 to 2008 period. However, updates in procedure relative value units (RVUs) led to Medicare fee decreases for many procedures, which caused Maryland Medicaid fees for some of these procedures to exceed Medicare fees. At the same time, Medicaid fees for some procedures were at 50 percent of Medicare fees. Therefore, DHMH increased the lowest Medicaid fees and re-balanced any Medicaid fees that were higher than Medicare fees. In addition, separate fees for different sites of service were established so that Medicaid fees would have site of service differentials for facilities (e.g., hospitals) and non-facilities (e.g., offices).

Medicaid fees that were higher than Medicare fees were reduced to their corresponding Medicare fee levels by site of service, and the lowest fees were raised to 78.6 percent of their

corresponding Medicare fees by site of service. The exceptions to this methodology were that, as directed by Maryland law, fees for procedures in four specialties (orthopedic, obstetric/gynecology, neurosurgery, and emergency medicine) were set equal to 100 percent of Medicare fees, and fees for four obstetric procedures (normal and cesarean delivery procedures) were maintained at their FY 2008 levels, which are higher than their corresponding Medicare fees.

Additionally, rate stabilization funds were used to increase MCO capitation rates to reflect the costs of the physician fee increases. To ensure that the MCOs use these funds to raise their physician fees, DHMH requires MCOs to pay their network physicians at least 100 percent of the Medicaid physician fee schedule. Furthermore, DHMH reviews the physician fee schedule of each MCO to monitor compliance with this requirement.

DHMH allocated $30.0 million total funds in FY 2006, $25.2 million total funds in FY 2007, $32.8 million total funds in FY 2008, and $9.0 million total funds in FY 2009 for increasing Medicaid physician fees. Due to budgetary constraints, the FY 2009 increase was reduced by $3.08 million total funds. Physician fees also were reduced to achieve an $11.5 million total funds reduction in payment for FY 2010. DHMH is planning to keep FY 2011 physician fees at the same level as FY 2010 fees.

Dental Fee Increases

Effective March 1, 2004, MCOs were required to reimburse their contracted providers at the ADA's then-current 50th percentile of charges for 12 restorative procedures. At the same time, Medicaid increased FFS rates to ADA's 50th percentile levels for the same restorative procedures.

Senate bill (SB) 545 of the 2008 session of the Maryland General Assembly allocated $7 million in state funds ($14 million total funds) for increasing dental fees in FY 2009. The rate increase targeted 12 high-volume preventive procedures and went into effect on July 1, 2008. Maryland Medicaid dental fees in FY 2009 were, on average, 61 percent of ADA's 50th percentile of charges in the Mid-Atlantic region.

Effective July 1, 2009, an administrative service organization (ASO), Doral Dental (now DentaQuest), coordinated provision of dental services for children, pregnant women, and adult enrolled in REM through the FFS program. Fees for some dental procedures were increased effective July 1, 2009 to coincide with the provision of dental services through the ASO. After these adjustments, Maryland Medicaid dental fees in FY 2010 were, on average, 64 percent of ADA's 50th percentile of charges in the Mid-Atlantic region.

Budget Neutrality

Section 1115 waivers require states to demonstrate that actual expenditures do not exceed certain cost thresholds, *i.e.*, they may not exceed what the costs of providing those services would have been under a traditional Medicaid FFS program. Appendix 1 shows that HealthChoice has met this condition and generated savings for both the state and federal governments. In short, the

overall HealthChoice savings is expected to total $4.7 billion by the end of Demonstration Year 14.

Governor O'Malley and the Legislature ranked health care reform as a top priority for the citizens of Maryland. A key part of their reform effort used Medicaid to expand health care coverage for parents and childless adults. On July 1, 2008, the income threshold for parents increased from 40 percent of the FPL to 116 percent of the FPL. The reform effort also used a portion of Maryland's §1115 waiver savings to increase benefits to childless adults served under the PAC program.[29] The increased benefits include community substance abuse and outpatient emergency services in FY 2010.

Over the next three years, DHMH plans to continue to operate two additional expansion programs -- Increasing Community Services (ICS) and Family Planning. DHMH is requesting, however, to expand the number covered under the Family Planning Program through various eligibility changes. Additionally, DHMH has proposed two new expansion populations -- the Pharmacy Discount and MHIP Premium Programs.

The upcoming renewal will include the impact of the PPACA legislation, which will include broad changes to the Medicaid program in coverage, funding, access, and quality. DHMH is requesting technical assistance from CMS to determine how the budget neutrality terms will change as the PAC population moves from an expansion to a categorically-eligible population.

Trend Factor

Under its current terms and conditions, HealthChoice has a trend factor of 6.95 and 6.86 percent in the last year of the renewal period. HealthChoice expenses have grown on average 6.0 percent annually between Demonstration Years 1 and 11. DHMH expects these trends to continue over the next four years. [30] Maryland does not foresee any significant changes that will result in lower costs in the short-term. Expenses may actually increase if state funding allows for provider reimbursement increases. Based on historical trends, a trend factor of 6.0 percent is both reasonable and sound.

Changes in Medicaid Eligibility Groups

DHMH is not requesting any changes to the Medicaid Eligibility Groups (MEGs). Additionally, DHMH is asking that the requested 6.0 percent trend factor be applied across all the MEGs (Table 17).

[29] Maryland still needed to provide the state costs to operate the program. The 1115 savings provided Maryland the authority to expand coverage and benefits to a population otherwise not covered under Medicaid.
[30] Demonstration Year 12 is not comparable because the parent expansion significantly skewed the membership mix.

Table 17. Requested Capitation Rates and Trend Factors for the Next Renewal Period

Medicaid Eligibility Group	Capitation PMPM	Trend Factor
TANF Adults	$693.11	6.0 %
TANF Children	$373.06	6.0 %
SSI/BD Adults	$1,635.84	6.0 %
SSI/BD Children	$1,482.55	6.0%
Medically Needy Adults	$4,054.98	6.0 %
Medically Needy Children	$1,875.82	6.0 %
SOBRA Adults	$3,128.02	6.0%
SOBRA Children	$451.79	6.0 %

Section IV. Summary

This section of the report demonstrated that DHMH has met the budget neutrality condition required for §1115 waivers and has generated savings for both the state and federal governments. Based on an analysis of historical expenditures for the HealthChoice populations, DHMH is requesting a trend factor of 6.0 percent for the next renewal period.

Section V. Special Topics

This section of the report discusses several special topics, including services provided under the dental and mental health carve-outs, reproductive health services and initiatives, the REM program, the Substance Abuse Treatment Workgroup, and access to care for racial and ethnic minorities.

Dental Services

EPSDT mandates dental care coverage for children younger than 21 years. Medicaid-enrolled children in Maryland, however, historically have utilized these services at a low rate. Before Maryland implemented the HealthChoice Medicaid program in 1997, only 14 percent of Maryland children enrolled in Medicaid for any period of time received at least one dental service, which was below the national average of 21 percent.[31]

To assess the performance of individual HealthChoice MCOs, DHMH uses a measure closely modeled on the HEDIS measure for Medicaid children's dental services 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) enrollment of at least 320 days. DHMH has modified the measure to include children aged 4 through 20 years. Dental service utilization by children enrolled in Medicaid has improved substantially under HealthChoice, with utilization increasing 180 percent from 19.9 percent in 1997 to 55.7 percent in 2008 (Table 18). Nevertheless, many children still do not receive the dental services they need.

Table 18. Children Aged 4- 20 Years (Enrolled for at least 320 Days) Receiving Dental Services, CY 2004 – CY 2008

	Total Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service	HEDIS National Medicaid Average
CY 2004	213,324	93,154	43.7%	42.7%
CY 2005	227,572	104,188	45.8%	41.0%
CY 2006	223,936	103,561	46.2%	42.5%
CY 2007	216,885	111,791	51.5%	43.5%
CY 2008	243,076	135,403	55.7%	n/a

According to the Pew Report, "*The Cost of Delay,*" dental coverage for Medicaid-enrolled children was sporadic in 2007, with only 38.1 percent nationally receiving dental care.[32] Pew

[31] Academy of Pediatrics State Medicaid Report for Federal FY 1996 - Analysis of HCFA National Data for Medicaid Children's Dental Services Utilization.

[32] Pew's national Medicaid utilization rate was measured in children ages 1-18. Pew Center on the States. 2010. The Cost of Delay: State Dental Policies Fail One in Five Children. http://www.pewcenteronthestates.org/uploadedFiles/Cost_of_Delay_web.pdf

reported that Maryland has made tangible improvements to its children's dental care program since the February 2007 death of Deamonte Driver.[33]

In an effort to increase access to oral health care and service utilization, in June 2007, DHMH Secretary John Colmers convened the Dental Action Committee (DAC), consisting 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.[34] 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, instituted 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 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. Nearly 300 providers have been trained and enrolled with DentaQuest to provide fluoride varnish as of June 2010.
- Permitting public health program-employed dental hygienists to perform services within their scope of practice without on-site supervision and prior examination of the patient by a dentist. This change allows public health dental hygienists to provide services outside of a dental office, e.g., in schools and Head Start centers.[35]

Of the eight benchmarks by which Pew assesses state oral health programs in *The Cost of Delay*, Maryland meets six, including CDC-established minimum staffing requirements. One benchmark that Maryland does not satisfy[36] is the state's utilization rate for dental services to children, which is below the national average. It is important to note, however, that the 2007 measurement was made before the DAC initiatives were fully implemented. According to

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[33] For the story of Deamonte Driver, see Otto, M. "For Want of a Dentist" *The Washington Post* (Wednesday, February 28, 2007) http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html

[34] Dental Action Committee. (2007).Access to Dental Services for Medicaid Children in Maryland. http://www.fha.state.md.us/pdf/oralhealth/DAC_Final_Report.pdf

[35] DHMH. (2009). Maryland's 2009 Annual Oral Health Legislative Report. http://www.dhmh.state.md.us/reports/pdf/oct09/FHA/132504_HB70_JCRp82_MA_FHA_Oral percent20Health percent20Final.pdf

[36] The other benchmark that Pew found Maryland had not met calls for the state to "authoriz[e] new primary care dental providers" as a way of developing "innovative workforce models to expand the number of qualified dental providers." Pew Center on the States. (2010). The Cost of Delay: State Dental Policies Fail One in Five Children. http://www.pewcenteronthestates.org/uploadedFiles/Cost_of_Delay_web.pdf

Maryland's 2009 Annual Oral Health Legislative Report,[37] capacity and accessibility has improved more recently. As of July 2008, there were approximately 743 dentists enrolled as providers (HealthChoice provider directories). The July 2008 dentist count is a point-in-time count of providers. It increased by the end of 2008 due to several provider outreach activities. The overall statewide ratio of dentists listed in the HealthChoice provider directories to HealthChoice enrollees under age 21 years was 1:679 in July 2008. As of June 2010, there were 942 dental providers operating in over 1,700 locations enrolled with DentaQuest, and provider enrollment efforts are continuing. DentaQuest is required to have a dentist to enrollee ratio of 1:1,000 after the first year of the program, 1:750 after year two, and 1:500 after year three. DentaQuest is within the required ratio and has had success enrolling new providers due to increased rates, a streamlined credentialing process, and simplified billing procedures.

DHMH is also working with the Maryland State Dental Association, University of Maryland Dental School, and the Public Justice Center (among others) to brand and market the new Medicaid dental program and encourage additional dental providers to participate. For example, "Access to Care Day" was held in connection with the Maryland State Dental Associations' annual organizational meeting in Ocean City, Maryland on September 24, 2009, as part of the association's partnership with DHMH in provider recruitment. Dentists had the opportunity to openly discuss the Maryland Healthy Smiles Dental Program with DentaQuest representatives, DHMH, and members of the DAC. Free continuing education credits and training in pediatric dentistry were provided to the dentists who attended this session. DHMH is continuing to work with the DAC to make access to dental care and a dental home a reality for all of Maryland's Medicaid-insured children.

[37] http://www.dhmh.state.md.us/reports/pdf/oct09/FHA/13-2504_HB70_JCRp82_MA_FHA_Oral%20Health%20Final.pdf

Dental Services for Pregnant Women

Dental care is a mandated benefit for pregnant women under a 1998 state law.[38] Table 19 presents the percentage of pregnant women aged 21 years and older who received at least one dental service during the period of CY 2004 through CY 2008. During that time period, dental service utilization increased from 14.5 percent in CY 2004 to 20.6 percent in CY 2008. Despite these improvements, dental service utilization by pregnant women remains low. This is an issue that the new dental ASO seeks to address.

Table 19. Percentage of Pregnant Women Aged 21+ Years (Enrolled for at Least 90 Days) Receiving Dental Services, CY 2004 – CY 2008

	Total Number of Enrollees	Enrollees Receiving One or More Dental Service	Percent Receiving Service
CY 2004	21,412	3,102	14.5%
CY 2005	23,088	3,354	14.5%
CY 2006	20,756	3,187	15.4%
CY 2007	19,968	3,603	18.0%
CY 2008	20,749	4,280	20.6%

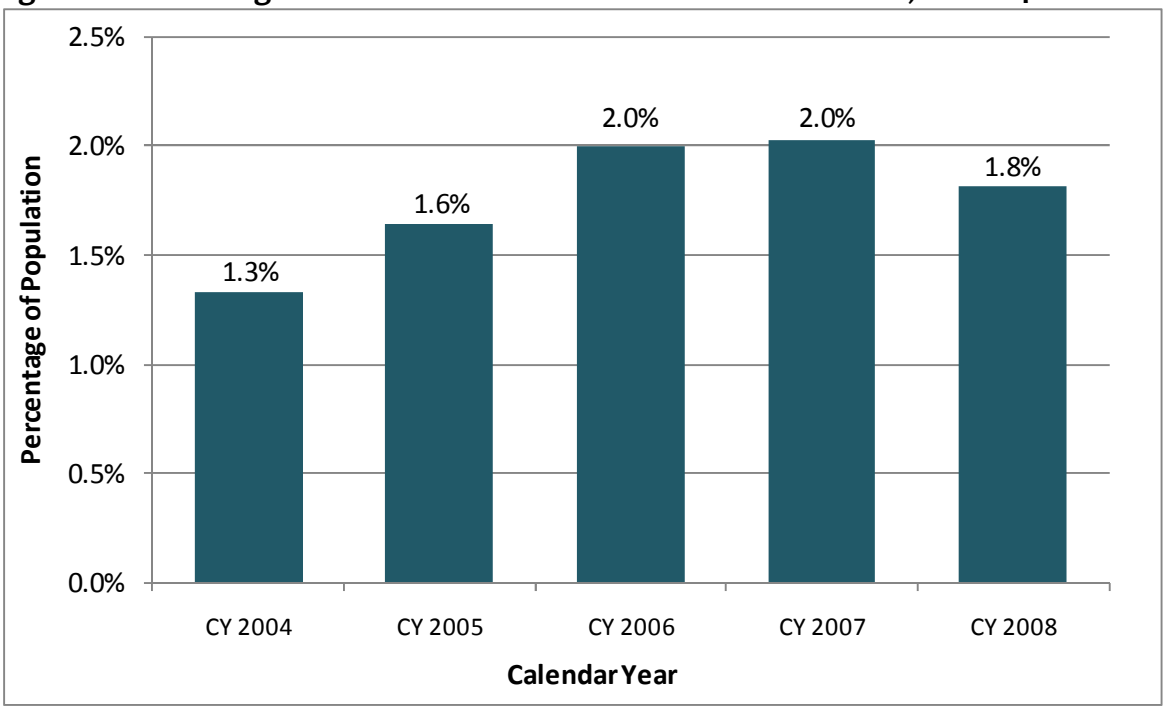
Mental Health Services

HealthChoice enrollees in need of specialty mental health services are referred to Maryland's Public Mental Health System but continue to receive medically necessary somatic care through their MCO. The Public Mental Health System provides psychiatric rehabilitation program (PRP) services, which are a collection of supports to individuals that aid in the transition between a serious illness episode (e.g., an inpatient stay) and return to optimal functioning in the community. A PRP provides extensive support services in a structured environment for adults with severe and persistent mental illness (SPMI). PRP services provide either general or intense support services in a non-residential setting. General support services offer face-to-face visits with a staff person, at least once a week, and on-call staff are available to the consumer 24 hours a day and 7 days a week. In contrast, intensive support services offer face-to-face interaction with staff at least 40 hours a week, and a treatment provider is on call 24 hours a day and 7 days a week. A PRP may include enrollment in a residential rehabilitation program (RRP). RRPs are PRPs certified to provide housing for their clients with appropriate staffing and operation of those residences.[39]

Figure 10 presents the percentage of HealthChoice enrollees who utilized PRP services from CY 2004 through CY 2008. PRP service utilization increased each year between CY 2004 and CY 2007 and declined between CY 2007 and CY 2008.

[38] SB 590 (Ch. 113 of the Acts of 1998).
[39] COMAR §10.21.22

Figure 10. Percentage of HealthChoice Enrollees with a PRP Service, CY 2004 – CY 2008



DHMH monitors MCO service utilization by PRP enrollees to ensure that these individuals have access to somatic care. The PRP population tends to be sicker than the general HealthChoice population. While approximately 40 percent of the PRP enrollees had an outpatient ED visit, nearly 90 percent of these individuals also had an ambulatory care visit within the same calendar year (Table 20).

Table 20. Percentage of PRP Enrollees with at Least One MCO Ambulatory Care Visit and One MCO Outpatient ED Visit, CY 2004 – CY 2008

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
Number of PRP Enrollees	6,444	8,085	9,634	9,941	9,842
Number of PRP Enrollees with an MCO Outpatient ED Visit	2,627	3,316	3,881	3,704	4,214
Percentage of PRP Enrollees with an MCO Outpatient ED Visit	40.8%	41.0%	40.3%	37.3%	42.8%
Number of PRP Enrollees with an MCO Outpatient ED Visit and MCO Ambulatory Care Visit	2,309	2,849	3,389	3,279	3,720
Percentage of PRP Enrollees with an MCO Outpatient ED Visit and MCO Ambulatory Care Visit	87.9%	85.9%	87.3%	88.5%	88.3%

Reproductive Health

Reproductive health is linked intrinsically to the future. In addition to the importance of preconception, pregnancy, and postnatal care, a newborn's health is largely dependent on its mother's general health during childhood, adolescence, and adulthood, including her family and personal medical history, nutrition, environment, lifestyle, and access to health care. These determinants of maternal health throughout the lifecycle have a profound effect on future generations.[40] This section of the report focuses on reproductive health services provided under HealthChoice. HEDIS prenatal measures are presented first, followed by measures related to gestational diabetes. Discussions of the family planning program and a new statewide initiative to improve prenatal service utilization and pregnancy outcomes conclude this section.

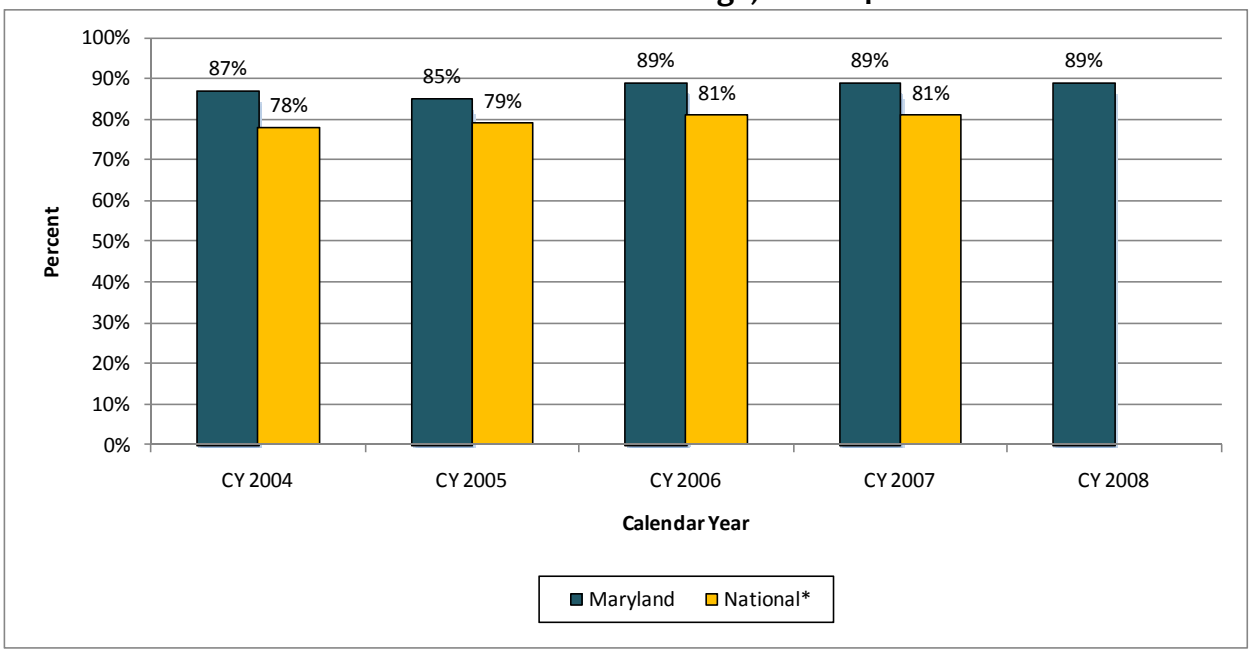
Timeliness of Ongoing Prenatal Care

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 enters prenatal care, the more likely that health conditions that could affect her health or the health of the newborn might 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 enrollment.[41] Figure 11 compares HealthChoice performance on this measure with the HEDIS Medicaid national average for CY 2004 through CY 2008. HealthChoice enrollee utilization of prenatal care remained relatively stable from CY 2004 through CY 2008, at approximately 88 percent. HealthChoice consistently outperformed the HEDIS Medicaid national average during the study period, by 6 to 9 percentage points.

[40] *United Nations Population Information Network (POPIN) UN Population Division, Department of Economic and Social Affairs, with Support from the UN Population Fund (UNFPA): Guidelines On Reproductive Health,* http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html

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

Figure 11. HEDIS Timeliness of Prenatal Care, Maryland Compared with the HEDIS Medicaid National Average, CY 2004 – CY 2008



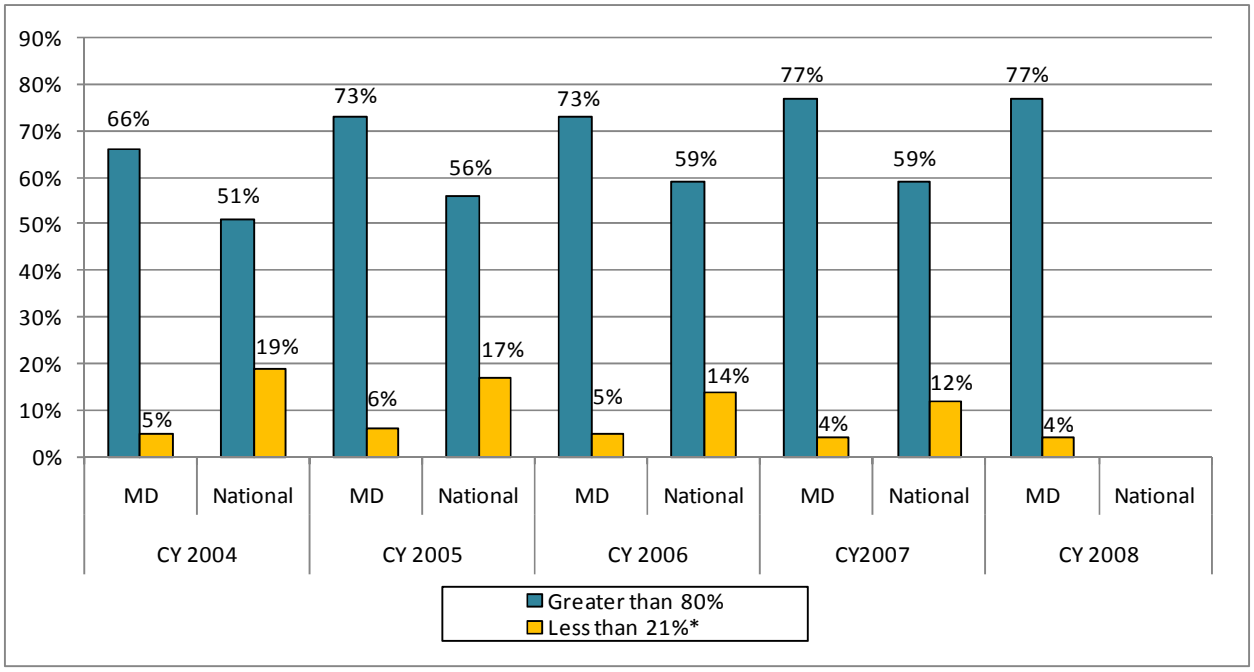
*HEDIS CY 2008 data are not available.

Frequency of Ongoing Prenatal Care

The frequency of ongoing prenatal care considers the percentage of recommended[42] prenatal visits received. DHMH uses the HEDIS frequency of ongoing prenatal care 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. HealthChoice performance on this measure steadily increased and outperformed the HEDIS Medicaid national average during the study period (Figure 12). The first aspect of this measure assesses the percentage of women who received more than 80 percent of expected visits; therefore, a higher score is preferable. This rate increased from 66 percent in CY 2004 to 77 percent in CY 2008. 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. The percentage of women receiving less than 21 percent of expected visits improved, decreasing from 5 percent in CY 2004 to 4 percent in CY 2008. In sum, both measures show an improvement in the percentage of women receiving prenatal care, and Maryland outperformed the HEDIS Medicaid national average in both instances.

[42] According to the American College of Obstetricians and Gynecologists, the recommended numbers of visits are once every four 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. This total to about 13 to 15 visits.

Figure 12. HEDIS Percentage of Ongoing Prenatal Care at > 80 Percent or ≤ 21 Percent of Recommended Visits, Maryland Compared with the HEDIS Medicaid National Average, CY 2004 – CY 2008



*HEDIS CY 2008 data are not available.

Gestational Diabetes

When diabetes occurs only during pregnancy and resolves after delivery of the infant, it is called gestational diabetes. Research has shown that women who experience gestational diabetes are more likely than women who do not to develop diabetes later in life. In addition, infants born to mothers with gestational diabetes are often larger, creating difficulties in the delivery process. If there is poor maternal glucose control during pregnancy, there can be temporary glucose control problems for the newborn, as well as an increased risk that the newborn also will develop diabetes later in life.[43]

The percentage of pregnant women in HealthChoice with gestational diabetes increased from 5.4 percent in CY 2004 to 6.6 percent in CY 2008.Table 21 presents the percentage of pregnant women with and without gestational diabetes who had at least one ED visit. ED visits may occur in pregnancy due to issues relating to the pregnancy, but gestational diabetes is likely to be a factor that contributes to ED use. Among pregnant HealthChoice enrollees, women with gestational diabetes visited the ED more frequently than women without the gestational diabetes in both CY 2004 and CY 2008.

[43] http://diabetes.niddk.nih.gov/dm/pubs/gestational/

Table 21. Percentage of Pregnant HealthChoice Women with at Least One MCO Outpatient ED Visit by Gestational Diabetes Status, CY 2004 and CY 2008

	All Pregnant Women	Pregnant Women with an MCO Outpatient ED Visit	Percentage of Pregnant Women with an MCO Outpatient ED Visit	All Pregnant Women	Pregnant Women with an MCO Outpatient ED Visit	Percentage of Pregnant Women with an MCO Outpatient ED Visit
	CY 2004			CY 2008		
With Gestational Diabetes	1,913	625	32.7%	2,386	963	40.4%
Without Gestational Diabetes	33,873	9,213	27.2%	33,827	11,650	34.4%
ALL	35,786	9,838	27.5%	36,213	12,613	34.8%

The percentage of pregnant women with gestational diabetes who had at least one ambulatory care visit through an MCO exceeded that of pregnant women without gestational diabetes in both calendar years (Table 22). The difference between the groups was 10.6 and 7.3 percentage points in CY 2004 and CY 2008, respectively.

Table 22. Percentage of Pregnant HealthChoice Women with at Least One MCO Ambulatory Care Visit by Gestational Diabetes Status, CY 2004 and CY 2008

	All Pregnant Women	Pregnant Women with MCO Ambulatory Care Visit	Percentage of Pregnant Women with MCO Ambulatory Care Visit	All Pregnant Women	Pregnant Women with MCO Ambulatory care Visit	Percentage of Pregnant Women with MCO Ambulatory Care Visit
	CY 2004			CY 2008		
With Gestational Diabetes	1,913	1,807	94.5%	2,386	2,235	93.7%
Without Gestational Diabetes	33,873	28,434	83.9%	33,827	29,229	86.4%
ALL	35,786	30,241	84.5%	36,213	31,464	86.9%

Pregnant women with gestational diabetes were more likely to have an MCO outpatient ED and ambulatory care visit than pregnant women without gestational diabetes. However, they were nearly as likely as pregnant women without gestational diabetes to have both an MCO outpatient ED and ambulatory care visit (Table 23). This suggests that pregnant women with gestational diabetes have similar access to somatic care as pregnant women without gestational diabetes in the HealthChoice program.

Table 23. Percentage of Pregnant HealthChoice Women with at Least One MCO Outpatient ED Visit and One MCO Ambulatory Care Visit by Gestational Diabetes Status, CY 2004 and CY 2008

	CY 2004		CY 2008	
	With Gestational Diabetes	Without Gestational Diabetes	With Gestational Diabetes	Without Gestational Diabetes
Percent of Pregnant Women with an MCO Outpatient ED Visit and MCO Ambulatory Care Visit	97.4%	94.9%	98.4%	95.5%
Pregnant Women with an MCO Outpatient ED Visit and MCO Ambulatory Care Visit	609	8,739	948	11,128
Pregnant Women with an MCO Outpatient ED Visit	625	9,213	963	11,650

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 with household income up to 200 percent of the FPL who lose Medicaid coverage after a pregnancy-related period of Medicaid eligibility.

Table 24 presents the percentage of total Medicaid enrollees in the Family Planning Program and the percentage of Family Planning enrollees who received at least one service for CY 2004 through CY 2009. 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 as of December 31. Between CY 2004 and CY 2009, the number of women with any period of enrollment in the Family Planning Program decreased by 46 percent, from 70,665 enrollees to 38,173 enrollees. During the same time period, the number of women who were enrolled in Family Planning as of December 31 decreased by 71 percent, from 56,058 enrollees to 16,245 enrollees. This decline in enrollment may be attributable to several significant changes that were made in CY 2008 in response to new CMS terms and conditions. The Program was required to perform annual active redeterminations, reduce the upper income limit from 250 percent of the FPL to 200 percent of the FPL, and was no longer allowed to 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. During the evaluation period, the percentage of individuals with any period of Family Planning Enrollment who utilized at least one family planning service remained between 25 and 28 percent.

Table 24. Percentage of Medicaid Enrollees in Family Planning and Percentage with at Least One Family Planning Service, CY 2004 – CY 2009

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	CY 2009
	Individuals Enrolled in Family Planning on December 31					
Number of Family Planning Enrollees	56,058	53,171	46,342	36,922	27,969	16,245
Number of Total Medicaid Enrollees	685,613	694,898	696,295	703,937	761,081	850,816
Percentage of Total Medicaid Enrollees in Family Planning	8.2%	7.7%	6.7%	5.2%	3.7%	1.9%
	Individuals Enrolled in Family Planning for Any Period of Time					
Number of Family Planning Enrollees	70,665	72,625	69,849	62,469	52,094	38,173
Number of Family Planning Enrollees with at Least 1 Service	18,094	18,103	17,230	16,216	14,422	9,845
Percentage of Family Planning Enrollees with at Least 1 Service	25.6%	24.9%	24.7%	26.0%	27.7%	25.8%

The Maryland Babies Born Healthy Initiative

The Maryland Babies Born Healthy Initiative is a statewide effort to remediate health conditions and environmental factors that contribute to low-birth weight and infant mortality in Maryland. Birth outcomes of concern include high and increasing rates of prematurity, low birth weight, and high infant mortality rates, especially among Black and Hispanic women. More than 42 percent of statewide cases of infant mortality occur in Baltimore City and Prince George's County.[44] Focal projects supported by the Babies Born Healthy Initiative include:

- A partnership between the University of Maryland and Johns Hopkins University to support local high-risk obstetrics in underserved communities throughout the state through telemedicine and onsite high-risk perinatal consultation
- In Baltimore City, expansion of Planned Parenthood, Inc.'s preconception and prevention services to include preventive/screening services to detect risk factors associated with adverse birth outcomes, counseling/educational services, outreach and support, and a public information campaign to increase community awareness of infant mortality and low birth weight, as well as to promote the new services
- In Prince George's County, re-opening a health department comprehensive women's care center and supporting the partnership of the health department and the local FQHC, Greater Baden Medical Center, to improve access to chronic disease management for women of child-bearing age and to outreach to women at risk of poor pregnancy outcomes and provide them preconception/interconception and family planning services[45]

Improving access to care for women at high risk of poor birth outcomes is crucial to reducing infant mortality and morbidity. Substantial gains in Medicaid enrollment of low-income mothers

[44]Based on preliminary 2007 data. DHMH. 2008. Joint Chairmen's Report: Status of Infant Mortality Programs. http://www.dhmh.state.md.us/reports/pdf/jan09/FHA/105_FHA+MHHD_infant_mortality.pdf

[45] Joint Chairmen's Report: Status of Infant Mortality Programs. http://www.dhmh.state.md.us/reports/pdf/jan09/FHA/105_FHA+MHHD_infant_mortality.pdf

in families with dependent children resulted from expanded Medicaid eligibility beginning in FY 2009. More women of child-bearing age now have access to comprehensive well women care, including family planning, prenatal, perinatal, postnatal care, and all other HealthChoice-covered services. Moreover, their access to general preventive care services before pregnancy may mean better health status entering pregnancy, which expectably will improve pregnancy outcomes.

REM Program

The REM program provides case management services to Medicaid enrollees who have one of a specified list of rare and expensive medical conditions and who 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 conditions include: HIV/AIDS, cystic fibrosis, quadriplegia, muscular dystrophy, chronic renal failure, and spina bifida. REM enrollees do not receive services through an MCO. In addition to the standard FFS Medicaid benefit package, REM enrollees receive some expanded benefits, such as medically necessary private duty nursing, and shift home health aide services. Adults also receive dental services. This section of the report presents data on REM enrollment, costs, and service utilization.

REM Enrollment and Costs

Table 25 presents REM enrollment by race/ethnicity and age group for CY 2004 and CY 2008. During the evaluation period, the number of individuals enrolled in REM increased from 3,901 to 4,064. In both CY 2004 and CY 2008, more than 80 percent of REM enrollees were in the Black and White racial/ethnic groups. Children aged 0 through 18 years made up the majority (roughly 75 percent) of the REM population in both years.

Table 25. REM Enrollment by Race/Ethnicity and Age Group, CY 2004 and CY 2008

	CY 2004		CY 2008	
Race/Ethnicity	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
Black	2,117	54.3%	2,146	52.8%
Asian	81	2.1%	84	2.1%
White	1,303	33.4%	1,264	31.1%
Hispanic	185	4.7%	283	7.0%
Other*	215	5.5%	287	7.1%
Total	3,901	100.0%	4,064	100.0%
Age Group (Years)	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
0-18	3,020	77.4%	3,030	74.6%
19-64	881	22.6%	1,034	25.4%
Total	3,901	100.0%	4,064	100.0%

Males accounted for approximately 55 percent of REM enrollment in both CY 2004 and CY 2008 (Table 26). More than 80 percent of REM enrollees resided in the following three regions: Baltimore City, Baltimore Suburban, and Washington Suburban.

Table 26. REM Enrollment by Sex and Region, CY 2004 and CY 2008

	CY 2004		CY 2008	
Sex	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
Female	1,780	45.6%	1,816	44.7%
Male	2,121	54.4%	2,248	55.3%
Total	3,901	100.0%	4,064	100.0%
Region	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
Baltimore City	1,190	30.5%	1,202	29.6%
Baltimore Suburban	1,032	26.5%	1,103	27.1%
Eastern Shore	374	9.6%	357	8.8%
Southern Maryland	140	3.6%	153	3.8%
Washington Suburban	969	24.8%	1,057	26.0%
Western Maryland	180	4.6%	176	4.3%
Out of State	16	0.4%	16	0.4%
Total	3,901	100.0%	4,064	100.0%

Table 27 presents the average annual Medicaid cost per REM enrollee between CY 2004 and CY 2008. The average annual Medicaid cost per REM enrollee increased by 52 percent during the evaluation period, from $51,383 in CY 2004 to $78,117 in CY 2008.

Table 27. Average Annual Medicaid Cost per REM Enrollee, CY 2004 – CY 2008

	Total Number of REM Enrollees	Total REM Costs	Average Cost per REM Enrollee
CY 2004	3,901	$200,445,909	$51,383
CY 2005	3,921	$220,409,285	$56,213
CY 2006	3,988	$248,492,969	$62,310
CY 2007	3,979	$280,553,414	$70,509
CY 2008	4,064	$317,467,213	$78,117

Private Duty Nursing in REM

Private duty nursing (PDN) is a service provided to enrollees in the REM program. The percentage of REM enrollees receiving a PDN service increased from 9.7 percent in CY 2004 to 14.9 percent in CY 2008 (Table 28). Although the total number of REM enrollees increased by 4.0 percent (163 individuals), the percentage of enrollees using a PDN service increased by 53.6 percent (5.2 percentage points).

Table 28. Percentage of REM Population with a PDN Service, CY 2004 and CY 2008

CY 2004			CY 2008		
Number of REM Enrollees	Number with a PDN Service	Percentage with a PDN Service	Number of REM Enrollees	Number with a PDN Service	Percentage with a PDN Service
3,901	380	9.7%	4,064	604	14.9%

Over the evaluation period, the percentage of REM enrollees using more than 300 PDN services increased from 41.8 percent in CY 2004 to 53.3 percent in CY 2008 (Table 29).

Table 29. Number of PDN Services Provided to REM Enrollees, CY 2004 and CY 2008

	CY 2004		CY 2008	
Number of PDN Services	Number of REM Enrollees	Percent with PDN Services	Number of REM Enrollees	Percent with PDN Services
1-50	54	14.2%	49	8.1%
51-100	27	7.1%	33	5.5%
101-200	49	12.9%	62	10.3%
201-300	91	23.9%	138	22.8%
301 or More	159	41.8%	322	53.3%
ALL	380	100.0%	604	100.0%

Table 30 presents the average annual cost of PDN services for REM enrollees who utilized a PDN service during the calendar year. The average annual cost of PDN services per REM enrollee increased from $82,676 in CY 2004 to $110,788 in CY 2008 (a 39.3 percent increase).

Table 30. Average Annual PDN Costs for REM Enrollees with a PDN Service, CY 2004 – CY 2008

	Number of REM Enrollees with a PDN Service	Total PDN Costs	Average PDN Cost per REM Enrollee With a PDN Service
CY 2004	380	$31,416,714	$82,676
CY 2005	435	$37,578,919	$86,388
CY 2006	468	$44,131,456	$94,298
CY 2007	555	$54,916,336	$98,948
CY 2008	604	$66,915,725	$110,788

One of the goals of providing PDN services is to reduce REM enrollees' dependence on the ED. The percentage of REM enrollees with an ED visit and a PDN service decreased from 62.6 percent in CY 2004 to 59.8 percent in CY 2008 (Table 31). However, the percentage of REM enrollees with an ED visit and without a PDN service was 46.7 percent in CY 2008, a 3.6 percentage point increase from CY 2004.

Table 31. Percentage of REM Enrollees with At Least One ED Visit by Use of PDN Services, CY 2004 and CY 2008

	CY 2004			CY 2008		
	Total REM Enrollees	REM Enrollees with an ED Visit	Percentage of REM Enrollees with an ED Visit	Total REM Enrollees	REM Enrollees with an ED Visit	Percentage of REM Enrollees with an ED Visit
With PDN	380	238	62.6%	604	361	59.8%
Without PDN	3,521	1,519	43.1%	3,460	1,615	46.7%
ALL	3,901	1,757	45.0%	4,064	1,976	48.6%

Substance Abuse Treatment Workgroup

In the summer of 2008, the Secretary of DHMH, John Colmers, convened a Substance Abuse Treatment Workgroup to identify action-oriented and practical recommendations to improve the substance abuse treatment system in Maryland with a focus on the services provided through Maryland Medicaid. The renewed focus on improving substance abuse treatment came in the context of a Medicaid expansion for families and a planned expansion of the PAC program for childless adults. At the time, it was understood that while the state worked to provide more help to those most in need, the recession in the U.S. economy would increase the number of people who qualify for assistance. It was also understood that approximately 8 percent of HealthChoice and PAC enrollees aged 13 through 64 years have been diagnosed with a substance abuse disorder, and that the projected growth in enrollment heightened the need for a more responsive and efficient Medicaid substance abuse treatment system.

The Secretary asked individuals with diverse experiences and expertise to comprise the Substance Abuse Treatment Workgroup. The Workgroup was divided into four subgroups to focus on particular aspects of the treatment system:

- Eligibility Subcommittee: To facilitate enrollment in the Medicaid program for individuals in need of treatment
- Administrative Subcommittee: To reduce barriers to care within the existing system
- Data Subcommittee: To improve substance abuse-related data analysis and quality monitoring
- Services and Rates Subcommittee: To recommend appropriate covered services and reimbursement rates for those services

The final consensus report is attached to this evaluation as Appendix 2, which includes the recommendations offered by each subcommittee. While DHMH provided staff to assist each subcommittee, the final product does not necessarily represent the views of DHMH or a final plan of action. Instead, the recommendations were the product of a collaborative effort among many stakeholders in the Medicaid substance abuse treatment system, including representatives from the HealthChoice MCOs, treatment providers, advocates, the Alcohol and Drug Abuse Administration (ADAA), the Mental Hygiene Administration, and the Medicaid program. The Maryland Medicaid Program has subsequently implemented many of the recommendations.

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 initiatives such as the managing-for-results (MFR) program, which uses ambulatory care visits to monitor racial/ethnic disparities. This section of the report presents enrollment trends among racial and ethnic groups and assesses disparities within several measures of service utilization.

Racial/Ethnic Enrollment

Table 32 displays HealthChoice enrollment by race/ethnicity. Enrollment increased within each racial/ethnic category between CY 2004 and CY 2008. However, this growth did not occur uniformly across all categories: new enrollees were disproportionately from the Hispanic, Asian, and Other[46] groups. The percentage of HealthChoice enrollees in the Black and White racial/ethnic categories decreased from 85 percent in CY 2004 to 81 percent in CY 2008. During the same time period, enrollees in the Hispanic category grew by 42.8 percent from 52,590 in CY 2004 to 75,093 in CY 2008.

Table 32. HealthChoice Enrollment by Race/Ethnicity, CY 2004 and CY 2008

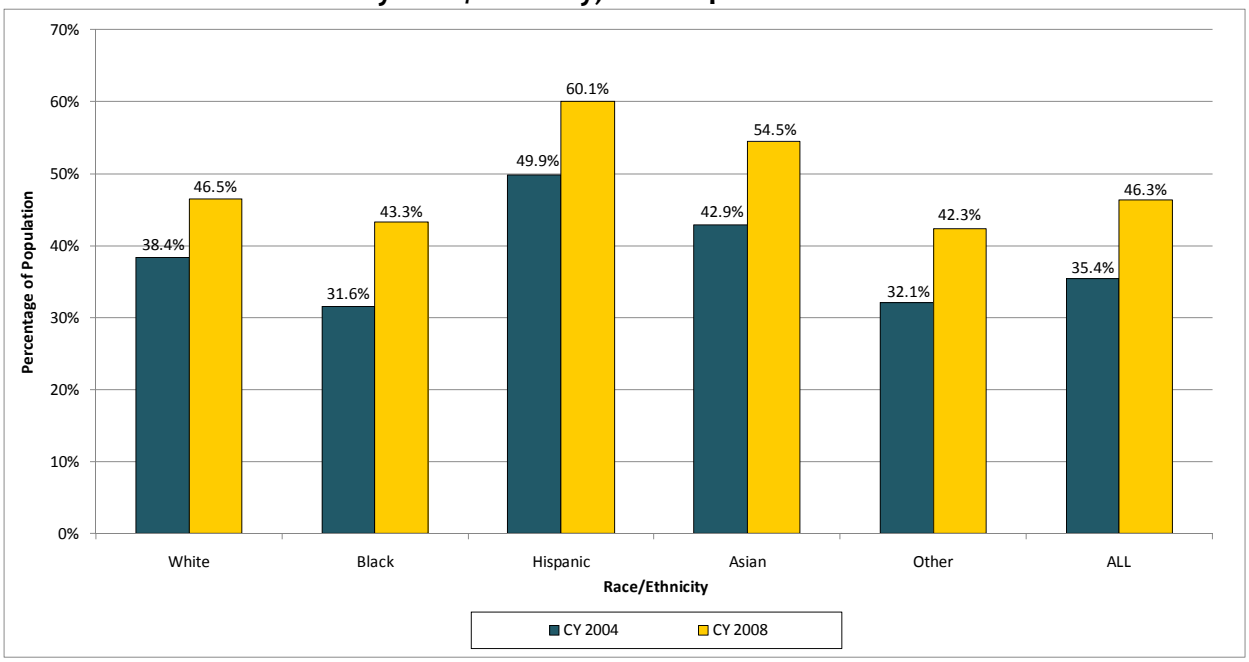
	CY 2004		CY 2008	
	Number of Enrollees	Percent	Number of Enrollees	Percent
White	180,988	29.7%	185,275	28.3%
Black	339,578	55.7%	344,948	52.7%
Hispanic	52,590	8.6%	75,093	11.5%
Asian	13,920	2.3%	15,983	2.4%
Other	22,678	3.7%	33,214	5.1%
Total	609,754	100.0%	654,513	100.0%

Dental Visits by Race/Ethnicity

The percentage of children aged 4 through 20 years who received at least one dental visit increased across all racial/ethnic groups during the study period (Figure 13). Hispanics consistently had the highest rate of dental visits, increasing from 49.9 percent in CY 2004 to 60.1 percent in CY 2008. While Blacks had a lower dental visit rate than the other racial/ethnic groups, they experienced the greatest improvement across the study period, with the percentage of children receiving at least one dental visit increasing by 37 percent (11.7 percentage points).

[46] The Other racial/ethnic category includes Native American, Pacific Islands/Alaskan, and enrollees with no designated race.

Figure 13. Percentage of HealthChoice Children Aged 4-20 Years Receiving a Dental Visit by Race/Ethnicity, CY 2004 and CY 2008



Ambulatory Care Visits by Race/Ethnicity

Figure 14 shows that the percentage of children aged 0 through 20 years who received at least one ambulatory care visit increased across all racial/ethnic groups during the study period. Although Hispanics had the highest percentage in both CY 2004 (79.1 percent) and CY 2008 (85.2 percent), Asians experienced the greatest improvement, increasing from 73.2 percent in CY 2004 to 80.2 percent in CY 2008. Blacks had the lowest ambulatory care visit rate among children during the study period.

Figure 14. Percentage of HealthChoice Enrollees Aged 0 -20 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2004 and CY 2008

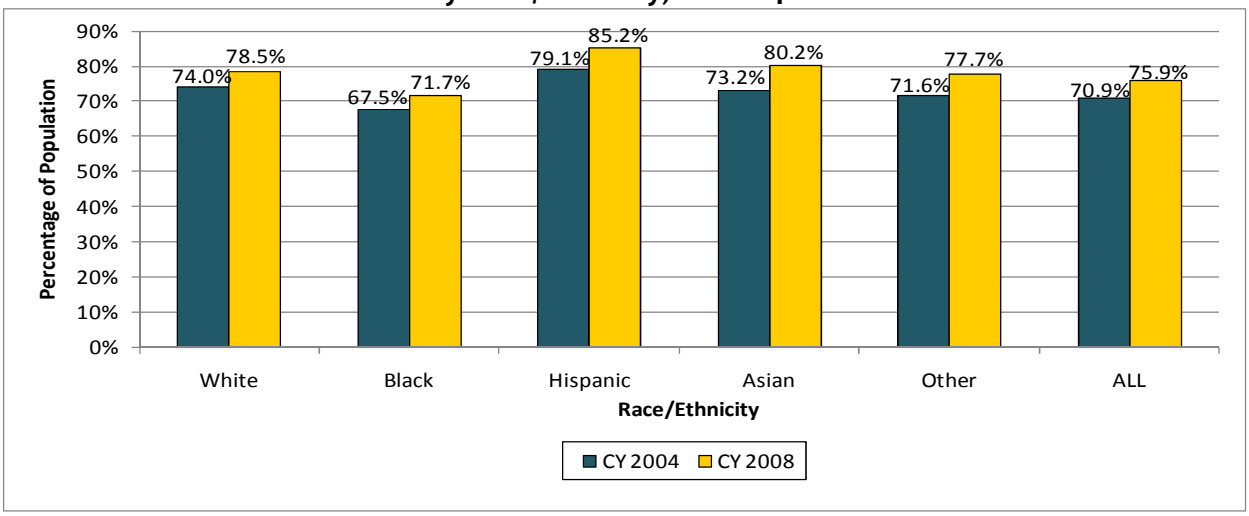
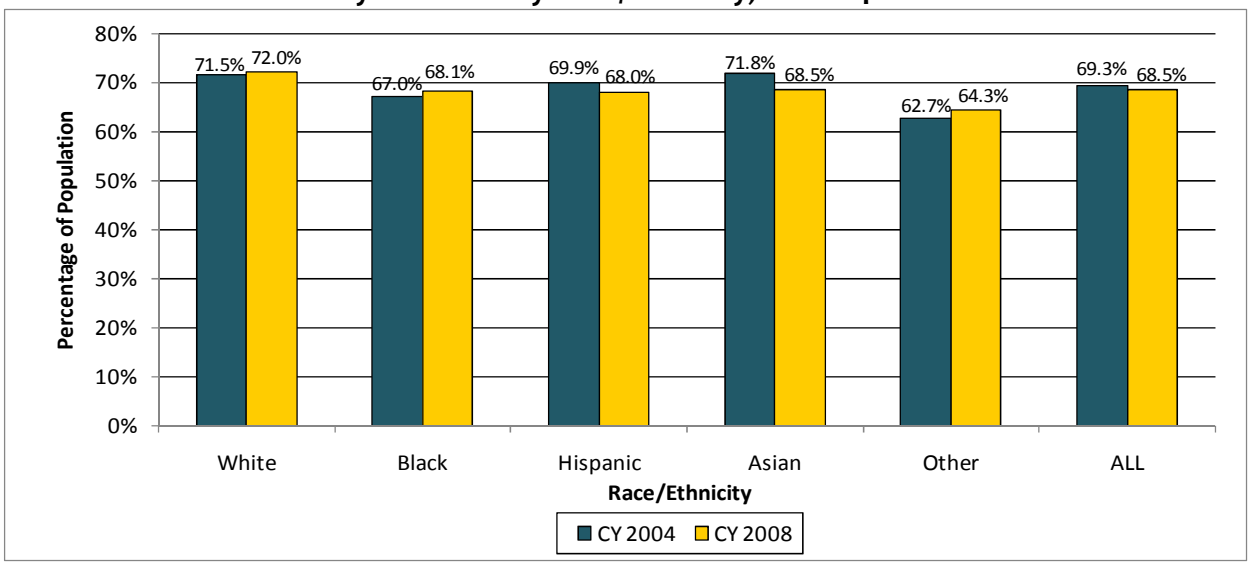


Figure 15 presents the percentage of adults aged 21 through 64 years who received at least one ambulatory care visit. The ambulatory care visit rate improved for all racial/ethnic groups except Hispanics and Asians. The Other racial/ethnic group experienced the greatest improvement during the study period (1.6 percentage points), but had the lowest overall rate (64.3 percent). Unlike the increase observed in the ambulatory care rate for children, the overall ambulatory care rate for adults decreased between CY 2004 and CY 2008.

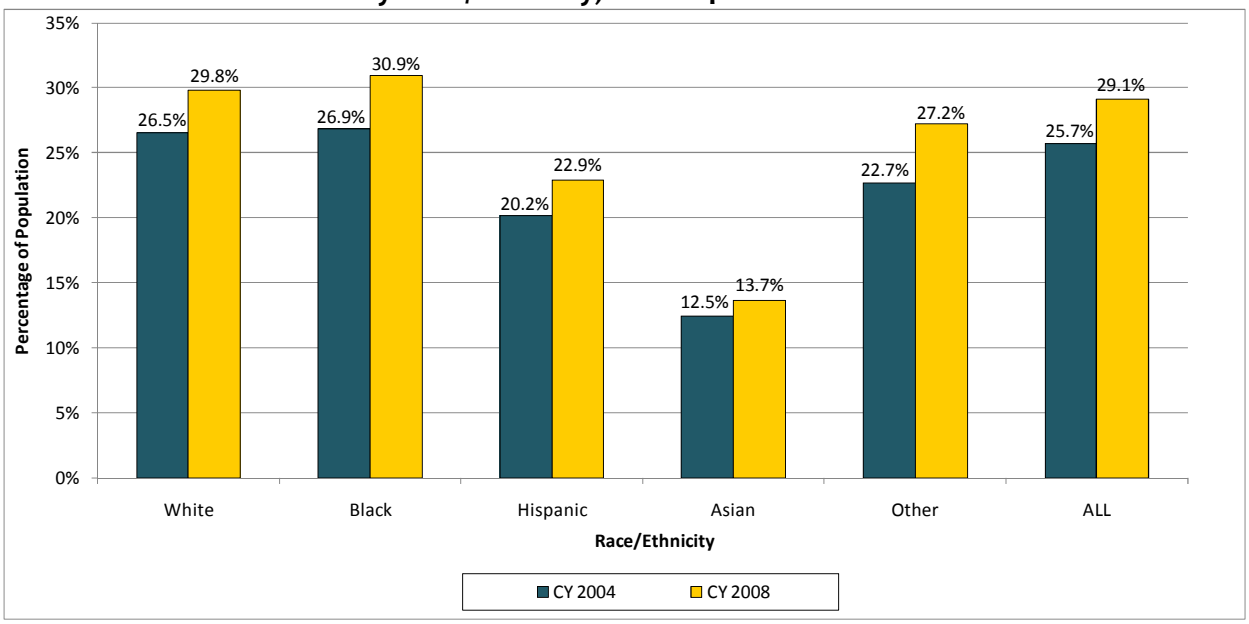
Figure 15. Percentage of HealthChoice Enrollees Aged 21 - 64 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2004 and CY 2008



ED Visits by Race/Ethnicity

Figure 16 displays the percentage of HealthChoice enrollees receiving an ED visit by race/ethnicity in CY 2004 and CY 2008. Blacks had the highest ED visit rate, but each racial/ethnic group experienced an increase during the study period. Asians had the lowest increase (1.2 percentage points), while the Other racial/ethnic group had the highest increase (4.5 percentage points).

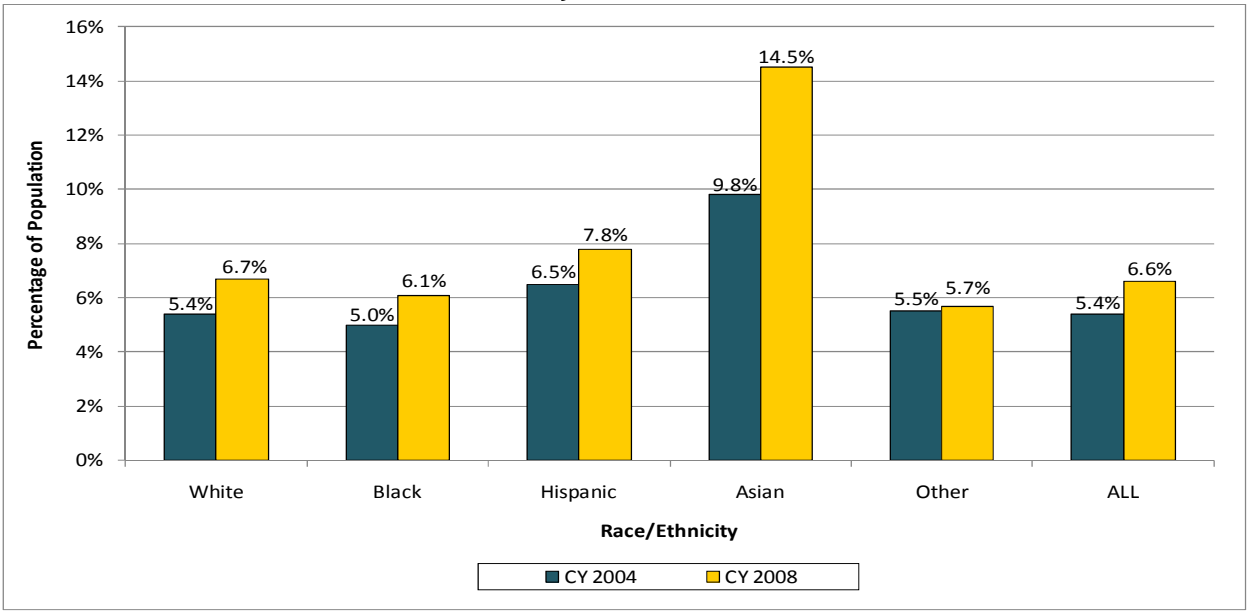
Figure 16. Percentage of HealthChoice Enrollees Receiving an ED Visit by Race/Ethnicity, CY 2004 and CY 2008



Gestational Diabetes by Race/Ethnicity

The percentage of women with gestational diabetes in HealthChoice increased across all racial/ethnic groups between CY 2004 and CY 2008. Asians had the highest increase over the study period (4.7 percentage points), while the Other racial/ethnic group had the lowest increase (0.2 percentage points).

Figure 17. Percentage of Pregnant HealthChoice Women with Gestational Diabetes by Race/Ethnicity, CY 2004 and CY 2008



Section V. 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 and pregnant women were carved out of the MCO benefit package on July 1, 2009. These services are now administered by an ASO, which has been successful in recruiting more dentists to participate in Medicaid. The ASO also administers dental benefits for adults in the REM program. Maryland also has made improvements in children's dental service utilization and dental provider reimbursement.
- HealthChoice enrollees who access carved-out specialty mental health services are also receiving ambulatory care services through their MCOs.
- Maryland has implemented some initiatives to improve rates of prenatal care, and measures of access to prenatal care services among HealthChoice enrollees improved over the evaluation period.
- Due to program changes required by CMS, enrollment in the Family Planning Program decreased by 46 percent between CY 2004 and CY 2009 (using the any period of enrollment methodology).
- The REM program provides case management, medically necessary private duty nursing, and other expanded benefits to enrollees who have one of a specified list of rare and expensive medical conditions. The majority of REM enrollees (roughly 75 percent) are children. Between CY 2004 and CY 2008, the annual average cost of Medicaid services per REM enrollee increased by 52.0 percent, and utilization of REM PDN services increased by 53.6 percent.

- In 2008, DHMH convened a Substance Abuse Treatment Workgroup composed of individuals with diverse expertise to make recommendations for improvement to the substance abuse treatment system in Maryland, with a focus on services provided through Medicaid. Substance abuse services were added to the PAC benefit package, and provider rates were increased.
- Regarding racial and ethnic disparities in access to care, Blacks have lower rates of dental and ambulatory care visits for children and higher rates of ED use. Asians have the highest rate of gestational diabetes. DHMH will continue to monitor ED utilization, gestational diabetes, and preventive services measures to ensure that the disparities between racial/ethnic groups are reduced.

Section VI. PAC Access and Quality

The PAC program was implemented in July 2006. PAC is a limited benefit program that serves 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 programs. To participate, enrollees 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 and gynecological services
- 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
- Primary mental health services through an enrollee's PCP
- Community-based substance abuse services (effective January 1, 2010)
- Outpatient ED services (effective January 1, 2010)

During the 2007 HealthChoice renewal, Maryland received CMS approval to phase in additional services to the PAC program. Community-based substance abuse services and outpatient ED services were added to the PAC benefit package in January 2010. Specialty and outpatient hospital services will be phased in as funding allows. Additionally, enrollees may access FFS specialty mental health care through DHMH's Mental Hygiene Administration. This section analyzes a variety of PAC enrollment and service utilization performance measures. The measures presented in this report will provide a baseline for future evaluation of the PAC program. As a result of PPACA, the PAC program will transition into a categorically eligible population in January 2014.

PAC Enrollment

This section presents PAC enrollment measures. Table 33 presents the number of individuals with any period of enrollment in a PAC MCO for CY 2007 through CY 2009. Overall enrollment increased 55.7 percent during the study period, increasing from 31,028 enrollees in CY 2007 to 48,299 enrollees in CY 2009. Across the study period, Blacks and Whites comprised more than 95 percent of the PAC population, and the Black-to-White ratio was almost 2 to 1. PAC eligibility is available to adults aged 19 and older. Individuals covered by Medicare are not eligible for PAC. The majority of the PAC population fell in the 40 through 64 year age range throughout the study period. The ratio of women to men enrolled in PAC was roughly 1 to 1 in CY 2007 and CY 2008, but the proportion of women increased in CY 2009. Enrollment was concentrated in the densely populated areas of the state, with more than 80 percent of PAC enrollees residing in three regions: Baltimore City, Baltimore Suburban, and Washington Suburban.

Table 33. PAC Enrollment by Race/Ethnicity, Age Group, Sex, and Region, CY 2007 and CY 2008

	CY 2007		CY 2008		CY 2009	
Race/Ethnicity	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
Asian	404	1.3%	609	1.4%	817	1.7%
Black	18,749	60.4%	25,736	60.8%	29,132	60.3%
White	10,941	35.3%	14,713	34.8%	16,952	35.1%
Hispanic	421	1.4%	581	1.4%	672	1.4%
Other*	513	1.7%	702	1.7%	726	1.5%
Total	31,028	100.0%	42,341	100.0%	48,299	100.0%
Age Group (Years)	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
19-20	588	2.0%	954	2.3%	1,402	2.9%
21-39	10,876	35.1%	15,618	36.9%	18,146	37.6%
40-64	19,564	63.1%	25,769	60.9%	28,751	59.5%
Total	31,028	100.0%	42,341	100.0%	48,299	100.0%
Sex	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
Male	15,083	48.6%	21,196	50.1%	22,296	46.2%
Female	15,945	51.4%	21,145	49.9%	26,003	53.8%
Total	31,028	100.0%	42,341	100.0%	48,299	100.0%
Region	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**	**Number of Enrollees**	**Percent of Total**
Baltimore City	15,985	51.5%	21,258	50.2%	22,900	49.6%
Baltimore Suburban	5,793	18.7%	8,283	19.6%	10,302	19.9%
Washington Suburban	4,161	13.4%	5,866	13.9%	7,184	14.5%
Western Maryland	2,040	6.6%	2,624	6.2%	2,515	5.9%
Southern Maryland	928	3.0%	1,326	3.1%	1,695	3.1%
Eastern Shore	2,101	6.8%	2,966	7.0%	3,694	7.1%
Out of State	20	0.1%	18	0.0%	9	0.0%
Total	31,028	100.0%	42,341	100.0%	48,299	100.0%

Table 34 presents PAC enrollment months for CY 2007 through CY 2009. In CY 2007, more than 52 percent of individuals were enrolled for 12 months. The percentage of individuals with 12 months of enrollment declined to nearly 27 percent in CY 2009 (12,908 out of 48,299). One hypothesis for the difference between CY 2007 and CY 2009 enrollment is that the Medicaid parent expansion, which began in July 2008, encouraged more adults to enroll in the full-benefit Medicaid program.

Table 34. PAC Enrollment by Number of Months of Enrollment, CY 2007 - CY 2009

	CY 2007		CY 2008		CY 2009	
Months of Enrollment	Number of Enrollees	Percent of Total	Number of Enrollees	Percent of Total	Number of Enrollees	Percent of Total
1	2,141	6.9%	2,376	5.6%	3,603	7.5
2	1,388	4.5%	4,944	11.7%	4,469	9.3
3	1,377	4.4%	3,027	7.2%	4,134	8.6
4	1,923	6.2%	3,033	7.2%	3,423	7.1
5	1,880	6.1%	2,964	7.0%	3,319	6.9
6	1,921	6.2%	3,553	8.4%	3,645	7.5
7	1,610	5.2%	2,869	6.8%	3,088	6.4
8	875	2.8%	2,846	6.7%	3,277	6.8
9	528	1.7%	2,571	6.1%	2,918	6.0
10	502	1.6%	1,959	4.6%	2,181	4.5
11	514	1.7%	897	2.1%	1,334	2.8
12	16,369	52.8%	11,302	26.7%	12,908	26.7
Total	31,028	100.0%	42,341	100.0%	48,299	100.0%

PAC Service Utilization

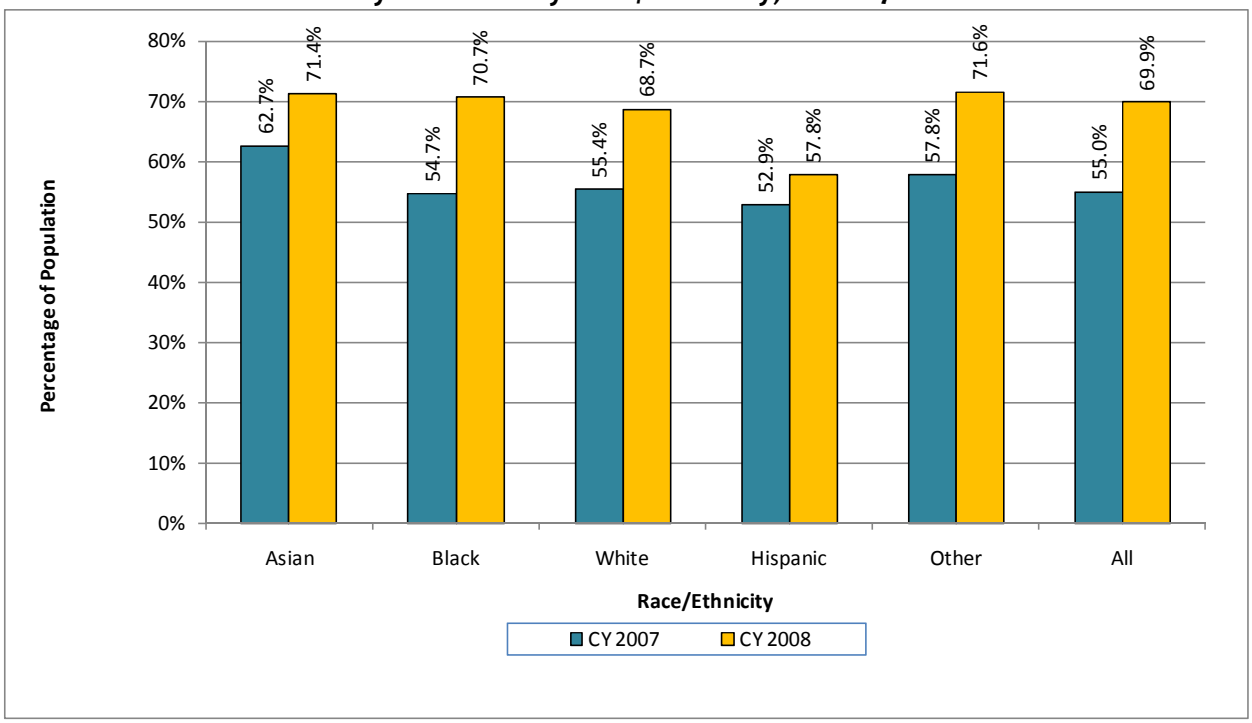
In order to provide a more complete picture of service utilization for individuals enrolled in the PAC program, this section of the report will focus on PAC service utilization for individuals who were enrolled in the PAC program for the entire year.

Ambulatory Care Visits Among PAC Enrollees[47]

Figure 18 presents the percentage of PAC enrollees with 12 months of enrollment in a PAC MCO who had at least one ambulatory care visit during CY 2007 and CY 2008 by race/ethnicity. Ambulatory care service utilization increased across all racial/ethnic groups between CY 2007 and CY 2008. The number of Black, White, and Other enrollees with at least one ambulatory care visit increased by more than 13 percentage points during the evaluation period. Asian and Hispanic groups experienced a growth in their rates by 8.7 and 4.9 percentage points, respectively. Overall, the percentage of PAC enrollees who had an ambulatory care visit increased by 14.9 percentage points, from 55.0 percent in CY 2007 to 69.9 percent in CY 2008.

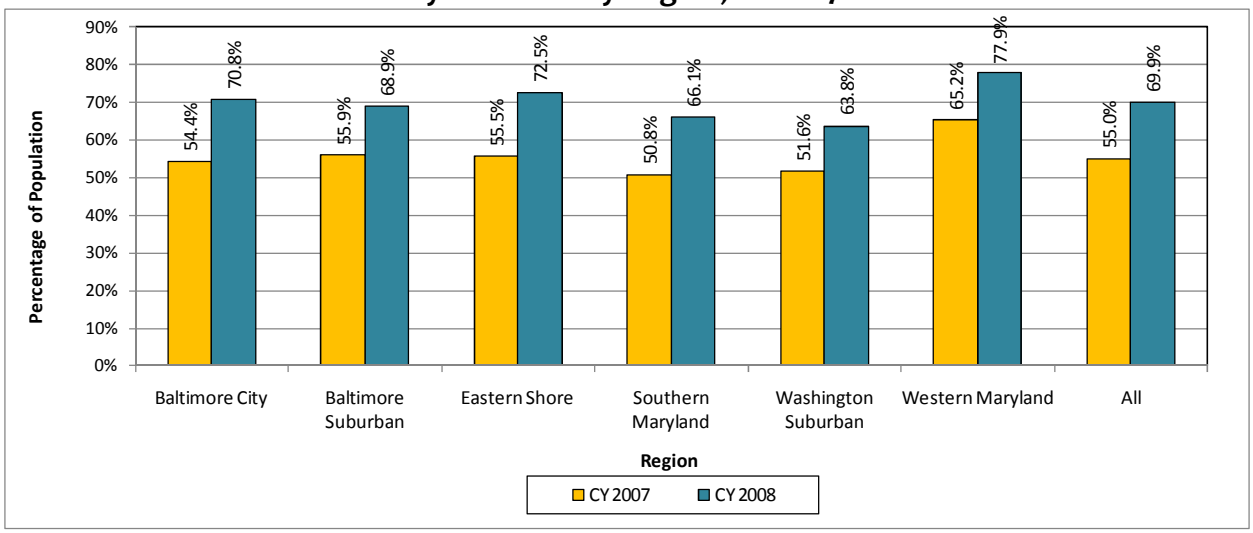
[47] An ambulatory care visit is reported as an unduplicated count that may not exceed one visit per person per provider per day. This definition excludes ED visits, substance abuse treatment, mental health, home health, x-rays, and laboratory services.

Figure 18. Percentage of PAC Enrollees (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Race/ Ethnicity, CY 2007 and CY 2008



The ambulatory care visit rate increased within each region during the evaluation period (Figure 19). The Eastern Shore region experienced the greatest increase –17 percentage points– followed by Baltimore City and Southern Maryland –16.4 and 15.3 percentage points, respectively.

Figure 19. Percentage of PAC Enrollees (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Region, CY 2007 and CY 2008



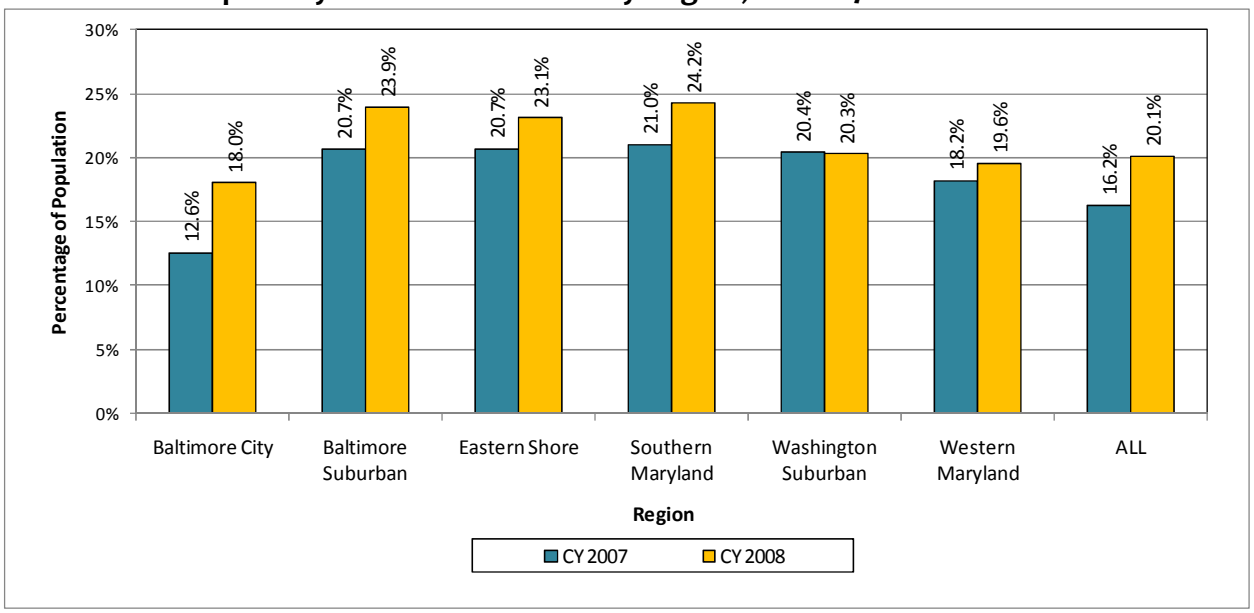
Similar increases in the number of enrollees with an ambulatory care visit were observed across age groups and in both genders between CY 2007 and CY 2008.

Specialty Mental Health Services Among PAC Enrollees

Specialty mental health services are carved out of the PAC managed care benefit package and are administered by an ASO run by the Mental Hygiene Administration. Specialty mental health services are defined as any mental health service other than those provided by a PCP and are measured as one visit per provider per person per day.[48]

Figure 20 shows the percentage of individuals with 12 months of enrollment in a PAC MCO who had at least one specialty mental health visit by region in CY 2007 and CY 2008. The percentage of enrollees who accessed specialty mental health services increased in five out of the six Maryland regions in CY 2008. Between CY 2007 and CY 2008, the number of PAC enrollees residing in the Baltimore Suburban, Eastern Shore, Western Maryland, and Southern Maryland regions with a mental health visit increased by 1 to 3 percentage points. The percentage of PAC enrollees in Baltimore City with a specialty mental health visit increased from 12.6 percent in CY 2007 to 18.0 percent in CY 2008. In contrast, the Washington Suburban rate remained stable during the study period. Overall, the percentage of PAC enrollees who had a specialty mental health visit increased from 16.2 percent in CY 2007 to 20.1 percent in CY 2008.

Figure 20. Percentage of PAC Enrollees (12 Months of Enrollment) with a Specialty Mental Health Visit by Region, CY 2007 and CY 2008



Prescription Drug Use Among PAC Enrollees

On July 1, 2006, PAC replaced the Maryland Pharmacy Assistance Program, and the Pharmacy Assistance enrollees were transitioned into PAC. Table 35 presents the percentage of PAC enrollees who filled a prescription during the year by the number of prescriptions filled per person. Prescription drug use varied among PAC enrollees in CY 2007 and CY 2008. The

[48] Specialty mental health services were identified for any PAC enrollee who had any FFS claim with an invoice control number (ICN) beginning with the numeral 6. These visits were identified for individuals with 12 months of enrollment in the PAC program during CY 2007 and CY 2008.

percentage of enrollees that filled at least one prescription decreased by 7.3 percentage points during the evaluation period.

Table 35. Percentage of PAC Enrollees (12 Months of Enrollment) with a Prescription by Number of Prescriptions, CY 2007 and CY 2008

	CY 2007		CY 2008	
Number of Prescriptions	Unduplicated Enrollee Count	Percent of Total	Unduplicated Enrollee Count	Percent of Total
0	4,421	27.0%	3,871	34.3%
1	524	3.2%	239	2.1%
2	588	3.6%	294	2.6%
3	432	2.6%	282	2.5%
4	466	2.8%	252	2.2%
5	341	2.1%	224	2.0%
6	348	2.1%	218	1.9%
7	299	1.8%	203	1.8%
8	308	1.9%	178	1.6%
9	246	1.5%	185	1.6%
10	271	1.7%	182	1.6%
11-20	2,392	14.6%	1,601	14.2%
21-30	1,455	8.9%	1,021	9.0%
31-40	1,225	7.5%	775	6.9%
41-50	866	5.3%	559	4.9%
51 or More	2,187	13.4%	1,218	10.8%
ALL	16,369	100.0%	11,302	100.0%

PAC HEDIS Measures

In CY 2008, DHMH began using HEDIS measures 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 36 compares the CY 2008 PAC HEDIS measures with the national HEDIS Medicaid average.

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, 32 percent of women enrolled in PAC received at least one mammogram in CY 2008. This rate is lower than the national HEDIS Medicaid average of 51 percent. Because PAC is a limited benefit program, one should be careful when comparing it to the national averages for enrollees who receive full Medicaid benefits.

The HEDIS cervical cancer screening measure is reported for women aged 21 through 64 years who received a Pap test within a three-year period. Overall, 23 percent of women enrolled in PAC received a cervical cancer screening during the measurement period. This percentage is lower than the national HEDIS Medicaid average of 66 percent. It is worth noting that this measure examines enrollees' experience during the measurement year and the two years prior to

the measurement year. At the time this measure was conducted, PAC had not been in existence for three years. This may explain why the PAC scores are lower than the general Medicaid scores.

The HEDIS CDC measures assess the percentage of enrollees with diabetes (type 1 and 2) who receive HBA1c testing, eye exams, and LDL-C screening. PAC performed similar to the national HEDIS Medicaid average across many of the CDC measures with some exceptions. Of note, PAC scored 18 percentage points lower than the national HEDIS Medicaid average on the eye exam measure.

Table 36. PAC HEDIS Measures Compared with the National HEDIS Medicaid Average, CY 2008

HEDIS Measures	PAC	National HEDIS Medicaid Average
Breast Cancer Screening	32%	51%
Cervical Cancer Screening	39%	66%
CDC –HBA1c Testing	75%	80%
CDC –Eye Exam	35%	53%
CDC –LDL-C Screening	73%	74%

Section VI. Summary

PAC is a limited benefit program for adults with low income who are not eligible for Medicare or Medicaid. This section presented PAC enrollment and service utilization measures, and these data will serve as the baseline for evaluating the PAC program going forward. Overall PAC enrollment increased by 55.7 percent during the study period, increasing from 31,028 enrollees in CY 2007 to 48,299 enrollees in CY 2009. DHMH has measured PAC ambulatory care, mental health service, and prescription drug utilization for CY 2007 and CY 2008. Utilization of ambulatory and mental services increased during the study period. While the percentage of PAC enrollees who filled at least one prescription dropped from CY 2007 to CY 2008, nearly 66 percent of PAC enrollees filled a prescription in CY 2008. CY 2008 was the first year that DHMH began using PAC HEDIS measures, so trend data are not available. PAC performed lower than the national HEDIS Medicaid average for the CY 2008 HEDIS measures.

Conclusion

HealthChoice is a mature program that provides services to over half a million 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 enrollees, and improving quality of care. As with any program, there are areas that need to be improved to assure that enrollees have access to care. DHMH is committed to working with CMS and other stakeholders to identify and address necessary programmatic changes upon renewal of this waiver.