Analysis of Options to Ensure Continuity of Care: A Report to the Maryland Health Benefit Exchange Board of Trustees

Prepared by The Hilltop Institute and
the Continuity of Care Advisory Committee

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Introduction

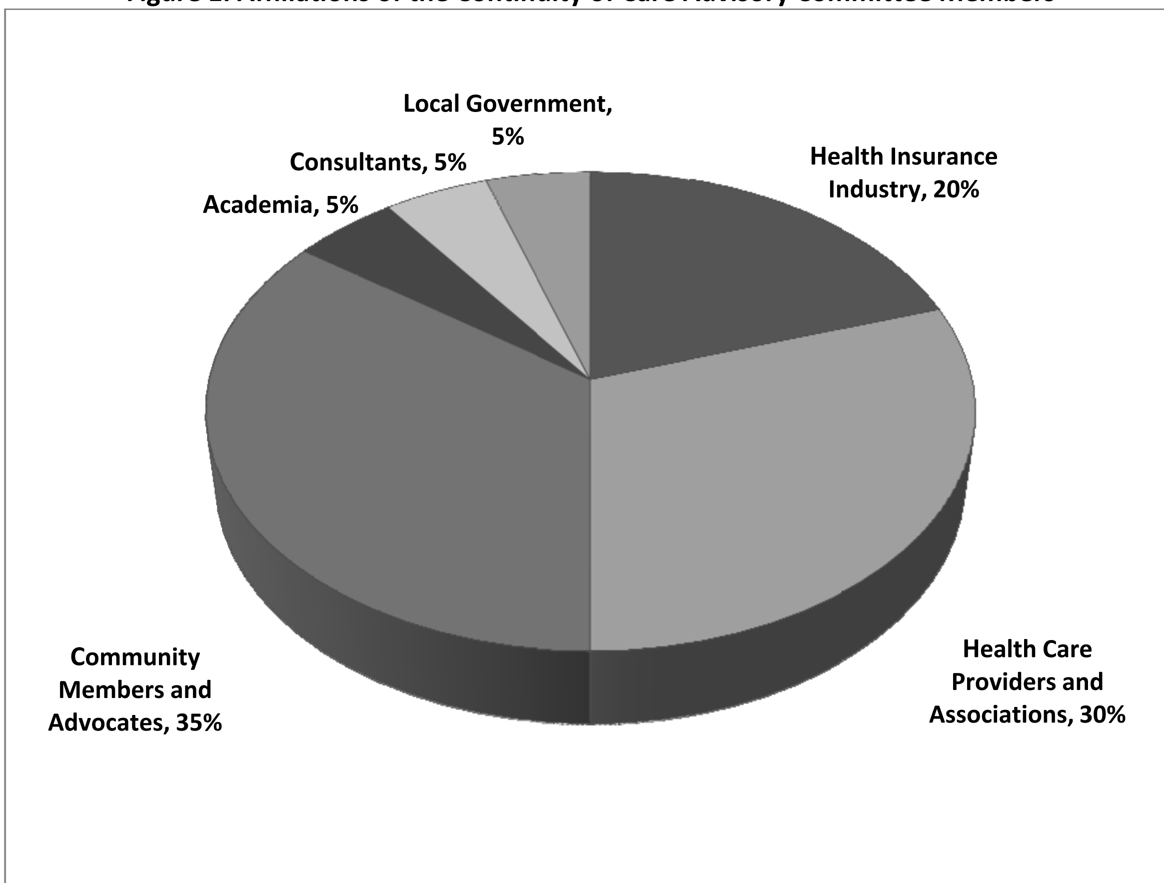
The Maryland Health Benefit Exchange Act of 2012 requires the Maryland Health Benefit Exchange (MHBE) to conduct a study and report findings and recommendations to the Governor and General Assembly on "the establishment of requirements for continuity of care in the State's health insurance markets (2012, Md. Laws, Ch. 152)." To meet this legislative charge, MHBE established the Continuity of Care Advisory Committee in the fall of 2012 and issued a request for proposal (RFP). The RFP sought a consultant to conduct a study evaluating options for continuity of care provisions to assist beneficiaries who may transition between coverage under Medicaid/the Maryland Children's Health Program (MCHP) and qualified health plans (QHPs) offered through MHBE. MHBE contracted with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to conduct this study and provide staff support to the Continuity of Care Advisory Committee. The Committee, consultant, and the public worked collaboratively to develop a set of options and considerations for the MHBE Board of Trustees.

The purpose of this report is to present the results of the study and summarize the Committee's discussions and written comments to help guide the MHBE Board as it makes recommendations to the Governor and General Assembly. This report first provides an overview of the Committee, followed by background information on continuity of care and existing policies in Maryland and other states. This overview is followed by a description of Hilltop's study and findings. The report concludes with a description of policy options and a summary of the potential advantages and disadvantages of each option.

Continuity of Care Advisory Committee

The Committee is a non-voting body charged with using an open and transparent process to collect and review perspectives related to continuity of care from key stakeholders in Maryland and to discuss specific policy options to address these issues. It held five public meetings (October 3, October 15, November 5, November 13, and November 29, 2012) that included presentations by Hilltop, discussions by the Committee members, and opportunities for public comment. The Committee is composed of 20 members selected by the MHBE Board to represent a broad array of stakeholders in Maryland. Members have the following affiliations: health care providers and associations, health insurance industry, local government, consultants, academia, and community members and advocates. See Appendix A for the full list of Committee members.

Figure 1. Affiliations of the Continuity of Care Advisory Committee Members



Background

The Affordable Care Act (ACA), signed into law in 2010, requires states to either establish a Health Insurance Exchange by 2014 or participate in the federally facilitated Exchange. Exchanges are new marketplaces for individuals and small businesses to purchase health insurance. The ACA also allows states to expand Medicaid coverage to individuals with household income up to 138 percent of the federal poverty level (FPL). The federal government will offer subsidies to individuals with household income between 138 and 400 percent of the FPL to purchase QHPs offered in the Exchange. Maryland has decided to proceed with the Medicaid Expansion and is quickly moving forward with implementing its Exchange.

Because eligibility for Medicaid and Exchange subsidies are based on FPL status, individuals may transition between eligibility for the two programs as their income and household composition change. Everyday life changes, including job changes, marriage, divorce, having children, incarceration and re-entry, and changes in income, will affect eligibility for these programs (Farley Short, Swartz, Namrata, & Graefe, 2011). “Significant changes in family income from one year to the next are common even in normal economic times (Farley Short et al., 2011, p. 5),” especially for individuals with low income.

National estimates anticipate high rates of transition between Medicaid and QHPs offered in Exchanges; 35 percent of adults with household income below 200 percent of the FPL are estimated to have at least one income-related transition within six months; 50 percent are estimated within one year (Sommers &

Rosenbaum, 2011). This process of transitioning eligibility between Medicaid and Exchanges is commonly referred to as "churning." National estimates also suggest that individuals newly eligible for Exchanges may have pent-up demand for services and complicated health care needs (Ingram, McMahon, & Guerra, 2012). Thus, "churning between [Medicaid and Exchanges] can cause disruptions in insurance coverage that can affect health care access and can contribute to high administrative costs (Hwang et al., 2012, p. 1214)." This can pose problems to continuity of care, especially for individuals with serious acute or chronic medical and mental health conditions. Churning may make it difficult to maintain treatment regimens because of the two programs' differing provider networks, benefits design, drug formularies, utilization management practices, and cost-sharing requirements.

MHBE is tasked with examining continuity of care policy options to mitigate the impact of churning/transitioning between Medicaid and QHPs offered in MHBE. Both Medicaid and health plans in Maryland's commercial market currently have policies and programs to assist beneficiaries as they transition into and out of health plans, and other states have also developed such policies. The following sections provide an overview of these policies.

Existing Continuity of Care Policies in Maryland

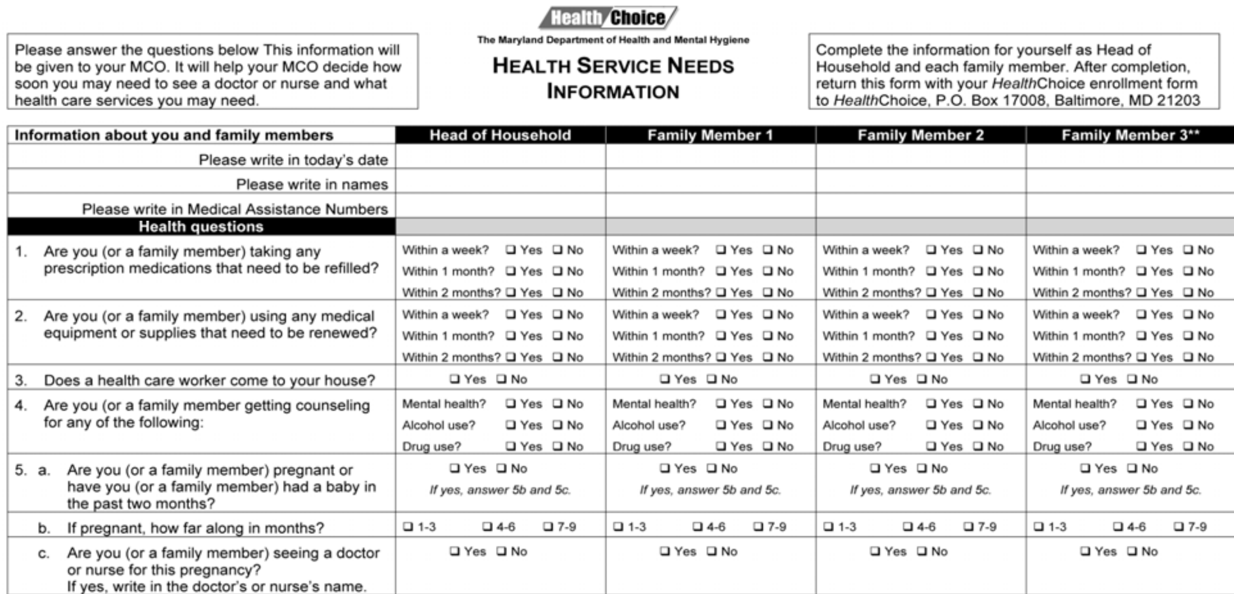
Maryland Medicaid

Maryland Medicaid has two policies that help ensure continuity of care for enrollees in transition: the health risk assessment and self-referral programs.

Health Risk Assessment

The Medicaid enrollment broker is required to conduct outreach and education, enroll eligible recipients, assist new enrollees with selecting a managed care organization (MCO) and primary care provider, and conduct a health risk assessment. The Medicaid enrollment broker administers the health risk assessment to new beneficiaries at the time of enrollment, and the assessment asks questions about the health service needs of the head of household and other household members (Maryland Department of Health and Mental Hygiene [DHMH], 2012). The information from the risk assessment is then transmitted to the MCO, which uses the information to take appropriate action for new enrollees with special or immediate health care needs (COMAR 10.09.63.03). Figure 2 displays the questions on the Maryland Medicaid health risk assessment.

Figure 2. Maryland Medicaid Health Risk Assessment Form



HealthChoice

The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Please answer the questions below This information will be given to your MCO. It will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your *Health*Choice enrollment form to *Health*Choice, P.O. Box 17008, Baltimore, MD 21203

Information about you and family members	Head of Household	Family Member 1	Family Member 2	Family Member 3**
Please write in today's date				
Please write in names				
Please write in Medical Assistance Numbers				
Health questions				
1. Are you (or a family member) taking any prescription medications that need to be refilled?	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No
2. Are you (or a family member) using any medical equipment or supplies that need to be renewed?	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No	Within a week? ❑ Yes ❑ No Within 1 month? ❑ Yes ❑ No Within 2 months? ❑ Yes ❑ No
3. Does a health care worker come to your house?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
4. Are you (or a family member getting counseling for any of the following:	Mental health? ❑ Yes ❑ No Alcohol use? ❑ Yes ❑ No Drug use? ❑ Yes ❑ No	Mental health? ❑ Yes ❑ No Alcohol use? ❑ Yes ❑ No Drug use? ❑ Yes ❑ No	Mental health? ❑ Yes ❑ No Alcohol use? ❑ Yes ❑ No Drug use? ❑ Yes ❑ No	Mental health? ❑ Yes ❑ No Alcohol use? ❑ Yes ❑ No Drug use? ❑ Yes ❑ No
5. a. Are you (or a family member) pregnant or have you (or a family member) had a baby in the past two months?	❑ Yes ❑ No *If yes, answer 5b and 5c.*	❑ Yes ❑ No *If yes, answer 5b and 5c.*	❑ Yes ❑ No *If yes, answer 5b and 5c.*	❑ Yes ❑ No *If yes, answer 5b and 5c.*
b. If pregnant, how far along in months?	❑ 1-3 ❑ 4-6 ❑ 7-9	❑ 1-3 ❑ 4-6 ❑ 7-9	❑ 1-3 ❑ 4-6 ❑ 7-9	❑ 1-3 ❑ 4-6 ❑ 7-9
c. Are you (or a family member) seeing a doctor or nurse for this pregnancy? If yes, write in the doctor's or nurse's name.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

** If you need additional space for extra family members, please call the *Health*Choice Enrollment Line at 1-800-977-7388

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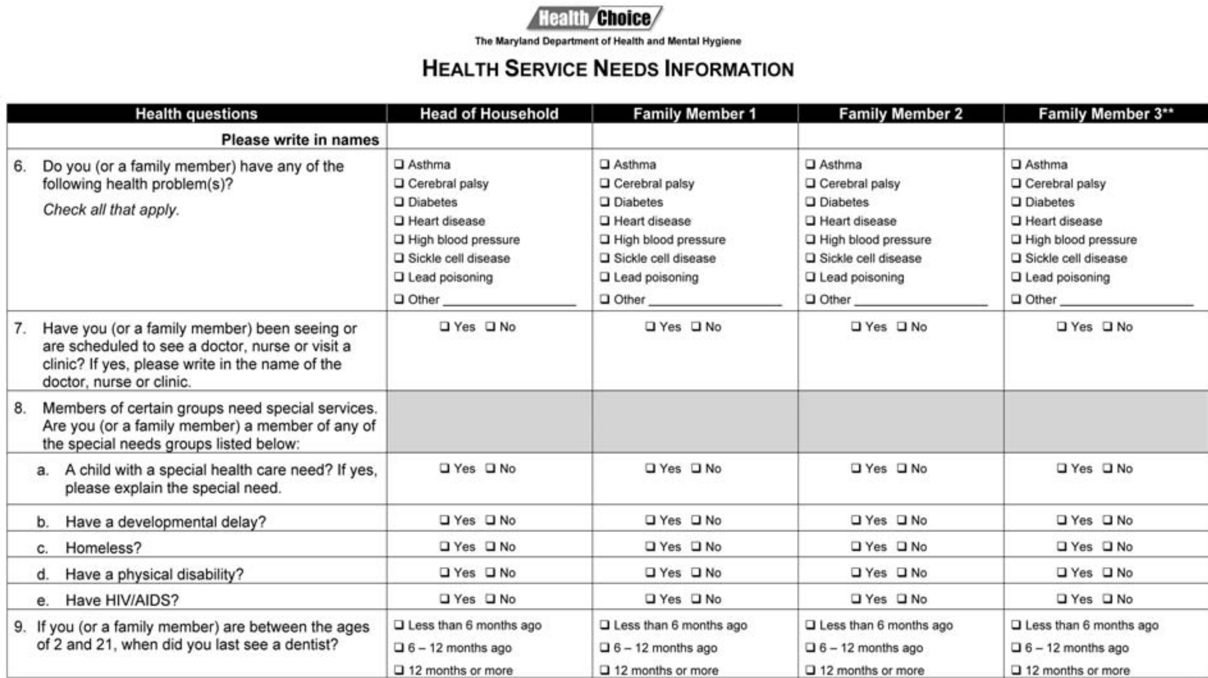

HealthChoice

The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Health questions	Head of Household	Family Member 1	Family Member 2	Family Member 3**
Please write in names				
6. Do you (or a family member) have any of the following health problem(s)? *Check all that apply.*	❑ Asthma ❑ Cerebral palsy ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Sickle cell disease ❑ Lead poisoning ❑ Other ______	❑ Asthma ❑ Cerebral palsy ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Sickle cell disease ❑ Lead poisoning ❑ Other ______	❑ Asthma ❑ Cerebral palsy ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Sickle cell disease ❑ Lead poisoning ❑ Other ______	❑ Asthma ❑ Cerebral palsy ❑ Diabetes ❑ Heart disease ❑ High blood pressure ❑ Sickle cell disease ❑ Lead poisoning ❑ Other ______
7. Have you (or a family member) been seeing or are scheduled to see a doctor, nurse or visit a clinic? If yes, please write in the name of the doctor, nurse or clinic.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
8. Members of certain groups need special services. Are you (or a family member) a member of any of the special needs groups listed below:				
a. A child with a special health care need? If yes, please explain the special need.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
b. Have a developmental delay?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
c. Homeless?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
d. Have a physical disability?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
e. Have HIV/AIDS?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
9. If you (or a family member) are between the ages of 2 and 21, when did you last see a dentist?	❑ Less than 6 months ago ❑ 6 – 12 months ago ❑ 12 months or more	❑ Less than 6 months ago ❑ 6 – 12 months ago ❑ 12 months or more	❑ Less than 6 months ago ❑ 6 – 12 months ago ❑ 12 months or more	❑ Less than 6 months ago ❑ 6 – 12 months ago ❑ 12 months or more

** If you need additional space for extra family members, please call the *Health*Choice Enrollment Line at 1-800-977-7388

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Self-Referral

Maryland Medicaid also allows MCO enrollees to self-refer for certain services from out-of-network providers. The Medicaid MCO must reimburse the out-of-network provider at the Medicaid rate. The following services are eligible for self-referral (COMAR 10.09.65.20):

- Family planning services
- School-based health center services
- Pregnancy-related services initiated prior to MCO enrollment
- Initial medical exams for children in state-supervised care
- One annual diagnostic and evaluation visit for enrollees living with HIV/AIDS
- Renal dialysis in a Medicare-certified facility
- An initial medical exam for a newborn in a hospital
- Substance abuse treatment services
- Emergency services

Maryland Commercial Market

The Maryland commercial health insurance market also has policies and standards for continuity of care. These include requirements in the Maryland insurance code, National Committee for Quality Assurance (NCQA) accreditation standards, and health-plan initiated policies.

Maryland Insurance Code

The Maryland Insurance Code has requirements for the extension of benefits for certain health plans in certain circumstances. Certain health plans are required to (MD Insurance Code Ann. §15-833):

- Pay covered benefits for individuals who are totally disabled when the coverage terminates up to the lesser of 12 months or the date the individual ceases to be totally disabled
- Pay a claim in progress on the date coverage terminates up to the lesser of the release from care from the physician or 12 months
- Pay covered benefits for individuals confined in a hospital on the date coverage terminates up to the lesser of the discharge date or 12 months
- Provide covered vision benefits if contacts/glasses ordered prior to the termination date, if the individual receives the glasses/lenses within 30 days
- Provide covered dental benefits for a course of treatment for at least 90 days after termination if the treatment began before the termination date and requires two or more separate visits

NCQA Accreditation Standards

All health plans offered within MHBE are required to be accredited. The NCQA health plan accreditation standards include a set of standards for continuity and care coordination and require all NCQA-accredited plans to (NQCA, 2012):

- Collect and analyze data to identify and prioritize opportunities to improve coordination of medical care
- Perform annual action to improve coordination on at least two of the opportunities identified
- Notify members affected by the termination of a practitioner or a practice group in general, family, and internal medicine, at least 30 days prior to termination, and help them select a new practitioner
- If a practitioner's contract is discontinued, continue treatment through the current period of active treatment for chronic or acute medical condition up to 90 days or through the postpartum period for members in their second or third trimester
- Help a member transition to other care, if necessary, when benefits end, including offering to educate members about alternatives for continuing care and how to obtain care if the covered benefits are exhausted while a member still needs care

Health Plan-Initiated Policies

Finally, health plans may initiate their own continuity of care programs. For example, CareFirst provides a Transition of Care Program to new enrollees. This program allows members and covered dependents to request to continue to receive care from an out-of-network physician for up to 90 days following the date of enrollment, and the benefits are paid at the in-network level (CareFirst, n.d.). The program applies to certain unstable and serious medical conditions that require a limited course of treatment or follow-up care. Examples of conditions that may qualify for the program include (CareFirst, n.d.):

- Pregnancy (beyond 24 weeks)
- Bone fractures
- Recent heart attack
- Other acute trauma or surgery
- Joint replacement
- Newly diagnosed cancer

Lessons from Other States

In addition to the policies currently in place in Maryland, other states have implemented various transition of care policies in their pre-ACA marketplaces. While not an exhaustive list of all transition policies in other states, the following paragraphs provide some examples for illustrative purposes.

Other States with Pre-ACA Exchanges

Prior to the enactment of the ACA, both Massachusetts and Utah established Exchange-like health insurance marketplaces. While Utah has not yet developed any continuity of care policies, Massachusetts has developed policies to assist beneficiaries as they transition between Medicaid and the state's Exchange (Ingram et al., 2012). The receiving MCO is required to provide transition plans for enrollees who are pregnant, have significant health care needs or complex medical conditions, are hospitalized or receiving ongoing care at the time of transition, and/or have prior authorization for services from the relinquishing MCO (Ingram et al., 2012).

Prior Authorization

Minnesota's Medicaid program requires the receiving MCO to cover services that were previously authorized by the relinquishing MCO (Ingram et al., 2012). However, the receiving MCO may require the enrollee to see an in-network provider for these services (Ingram et al., 2012).

Out-of-Network Providers

California requires commercial health plans to provide the continuation of services from an out-of-network provider under certain circumstances at the request of an enrollee. Health plans must provide for the continuation of services for out-of-network providers, if requested, for the following conditions and time frames (Calif. Health & Safety Code § 1373.96):

- The duration of an acute condition.
- The time period necessary to complete a course of treatment and to arrange for safe transfer to a covered provider for a serious chronic condition. Plans are not required to continue such services for more than 12 months.
- All stages of a pregnancy, which include all three trimesters and the immediate postpartum period.
- The duration of a terminal illness. Continuation of services may be required for more than 12 months.
- The care of a child aged 0 through 36 months. Plans are not required to continue such services for more than 12 months.
- A surgery or procedure that was authorized by the relinquishing plan as part of a documented course of treatment and has been recommended and scheduled to occur within 180 days from the plan transition.

For purposes of continuing treatment with the out-of-network provider during the transition period, the plan may require the non-enrolled provider to accept the terms, conditions, and payment rates that it would offer to in-network providers who offer similar services and are practicing within a similar geographic area (Calif. Health & Safety Code § 1373.96). If the non-enrolled provider does not agree to these terms, neither the plan nor the provider is required to continue services for the enrollee. California also requires the enrollee's cost sharing during the period of continued services with the out-of-network provider to be the same as would be required if the provider were contracted with the plan (Calif. Health & Safety Code § 1373.96). This policy does not require a plan to cover services or provide

benefits that are not otherwise covered under the terms and conditions of the plan contract (Calif. Health & Safety Code § 1373.96).

Health Risk Assessments

Florida requires Medicaid MCOs to contact new members at least twice, if necessary, within 90 days of enrollment to schedule an appointment with a primary care provider to conduct a health risk assessment (Florida Agency for Health Care Administration, 2006). The MCOs are also required to contact new members within 30 calendar days of enrollment to request the member to authorize the release of medical records to the plan (Florida Agency for Health Care Administration, 2006). The MCO must use the health risk assessments and released medical records to identify members who need to make a primary care appointment or obtain prenatal and pregnancy-related services (Florida Agency for Health Care Administration, 2006).

Transition Plans

New Jersey requires Medicaid MCOs to provide immediate transition planning for any new enrollee identified as having complex or chronic medical needs (New Jersey Department of Health and Human Services, 2007). Transition planning must be completed within a timeframe appropriate to the enrollee's condition, but no later than 10 business days from the effective date of enrollment or within 30 days after the complex or chronic health condition is identified (New Jersey Department of Health and Human Services, 2007). The transition plan should provide a brief, interim plan to ensure uninterrupted services until a more detailed plan of care is developed (New Jersey Department of Health and Human Services, 2007). Minnesota's Medicaid program also requires the relinquishing MCO to develop transition plans for beneficiaries with mental health and chemical dependency needs (Ingram et al., 2012).

Notification Requirements

New Jersey requires Medicaid MCOs to provide transitioning individuals with an explanation of the terms of enrollment in the contractor's plan, disenrollment procedures, time frames, default procedures, enrollee's rights and responsibilities, and other pertinent information to the transition process (New Jersey Department of Health and Human Services, 2007). Notifications should include information on how to obtain continued services during a transition from one plan to another, when applicable (New Jersey Department of Health and Human Services, 2007).

Analysis of the Transition Population

Hilltop first conducted an analysis to estimate the size of the population expected to transition or churn between Medicaid and MHBE. Using the eligibility data in the Maryland Medicaid Management Information System (MMIS2), Hilltop analyzed the rate of turnover in eligibility in fiscal year (FY) 2011.[1] Looking at both a 6-month and 12-month time span, Hilltop classified beneficiaries into four categories:

- Those who were continuously enrolled in Medicaid
- Those who were newly enrolled in Medicaid
- Those who lost eligibility
- Those who gained and then lost eligibility

The latter three groups are considered to be the transition population. Please note that the analysis could not identify the reasons the individuals lost eligibility; they may lose eligibility for reasons other than changes in FPL status. Table 1 presents the transition rate for the first six months of FY 2011 by Medicaid eligibility group. The first row, labeled "All Medicaid," presents the transition rate for the entire Medicaid population, and the subsequent rows present the rates for the following eligibility groups likely to participate in MHBE:

- Families and children.
- Children in foster care.
- Children enrolled in the Maryland Children's Health Program (MCHP), Maryland's Children's Health Insurance Program (CHIP), which covers children in households with income up to 250 percent of the FPL.
- Children enrolled in MCHP Premium, which is an expansion program that covers children in households with income up to 300 percent of the FPL.
- Women enrolled in the Family Planning Program, which, in FY 2011, was a limited benefit program offering family planning services to women losing Medicaid eligibility after pregnancy-related Medicaid eligibility. This program covers women with household income up to 200 percent of the FPL.
- Individuals enrolled in the Medicaid Expansion program, which offers full Medicaid coverage to parents and caretaker relatives with household income up to 116 percent of the FPL.
- Individuals enrolled in the Primary Adult Care (PAC) program, which offers limited primary care and outpatient benefits to non-pregnant, non-disabled, childless adults with household income up to 116 percent of the FPL.[2]

[1] FY 2011 is used as the analysis period because claims are still being processed for FY 2012, while the claims submitted for FY 2011 are substantially complete.
[2] As Maryland is moving forward with the Medicaid Expansion option under the ACA, PAC enrollees will receive full Medicaid benefits starting January 1, 2014.

The columns in Table 1 present the number and percentage of the Medicaid population with continuous eligibility over six months, those who gained eligibility within the six-month period, those who lost eligibility, and those who gained and then lost eligibility within the time period. Small cells were suppressed to zero to protect individual privacy. Children in foster care and MCHP were the most likely to maintain continuous coverage during the six-month time period. Individuals enrolled in the limited benefit programs—PAC and Family Planning—were the least likely to maintain continuous Medicaid coverage, and thus were more likely to churn. Among the coverage groups likely to transition between Medicaid and MHBE, 81 percent maintained continuously eligibility in six months.

Table 1. Churn Rate, 6-Month Population, FY 2011

	Continuous	%	Gained Eligibility	%	Lost Eligibility	%	Gained/ Lost	%	Total
All Medicaid	**840,198**	**82.2%**	**106,829**	**10.5%**	**71,108**	**7.0%**	**4,142**	**0.4%**	**1,022,277**
Family and Children	310,778	81.5%	42,579	11.2%	26,800	7.0%	1,225	0.3%	381,382
Foster Children	16,088	92.9%	650	3.8%	574	3.3%	0	0.0%	17,318
MCHP	77,207	85.0%	7,465	8.2%	6,032	6.6%	147	0.2%	90,851
MCHP Premium	16,535	84.3%	1,663	8.5%	1,384	7.1%	39	0.2%	19,621
Family Planning	10,065	65.4%	2,957	19.2%	2,336	15.2%	26	0.2%	15,384
Medicaid Expansion	169,185	82.2%	23,431	11.4%	12,436	6.0%	718	0.3%	205,770
PAC	39,677	67.0%	12,599	21.3%	6,825	11.5%	96	0.2%	59,197
Sum of Groups Likely to Transition to/from MHBE	**639,535**	**81.0%**	**91,344**	**11.6%**	**56,387**	**7.1%**	**2,257**	**0.3%**	**789,523**

Table 2 presents the same data as Table 1, but the period of analysis is extended to 12 months. By extending the analysis to 12 months, the rate of turnover in eligibility increased for all coverage groups. Again, children in foster care and MCHP were the most likely to maintain continuous coverage, and enrollees in the limited benefit programs—PAC and Family Planning—were the most likely to have turnover in eligibility. Among the coverage groups likely to transition between Medicaid and MHBE, 67 percent maintained continuously eligibility in 12 months.

Table 2. Churn Rate, 12-Month Population, FY 2011

	Continuous	%	Gained Eligibility	%	Lost Eligibility	%	Gained/ Lost	%	Total
All Medicaid	**779,870**	**69.0%**	**203,733**	**18.0%**	**131,436**	**11.6%**	**15,824**	**1.4%**	**1,130,863**
Family and Children	290,078	68.6%	79,664	18.9%	47,509	11.2%	5,307	1.3%	422,558
Foster Children	15,394	85.3%	1,359	7.5%	1,268	7.0%	32	0.2%	18,053
MCHP	71,916	73.6%	13,890	14.2%	11,323	11.6%	591	0.6%	97,720
MCHP Premium	15,216	71.9%	2,920	13.8%	2,703	12.8%	323	1.5%	21,162
Family Planning	7,487	39.0%	6,678	34.8%	4,914	25.6%	137	0.7%	19,216
Medicaid Expansion	160,464	70.3%	43,894	19.2%	21,160	9.3%	2,656	1.2%	228,174
PAC	31,818	43.3%	26,591	36.2%	14,696	20.0%	428	0.6%	73,533
Sum of Groups Likely to Transition to/from MHBE	**592,373**	**67.3%**	**174,996**	**19.9%**	**103,573**	**11.8%**	**9,474**	**1.1%**	**880,416**

Finally, Table 3 compares the rates of churn for the populations measured at 6 months and 12 months. As would be expected, the proportion of coverage groups with continuous coverage declined from 6 months to 12 months. Conversely, the proportion gaining eligibility, losing eligibility, or gaining and then losing eligibility increased.

Table 3. Comparison of 6-Month and 12-Month Churn Rates, FY 2011

	Continuous		Gained Eligibility		Lost Eligibility		Gained/Lost	
	6 Months	12 Months	6 Months	12 Months	6 Months	12 Months	6 Months	12 Months
All Medicaid	**82.2%**	**69.0%**	**10.5%**	**18.0%**	**7.0%**	**11.6%**	**0.4%**	**1.4%**
Family and Children	81.5%	68.6%	11.2%	18.9%	7.0%	11.2%	0.3%	1.3%
Foster Children	92.9%	85.3%	3.8%	7.5%	3.3%	7.0%	0.0%	0.2%
MCHP	85.0%	73.6%	8.2%	14.2%	6.6%	11.6%	0.2%	0.6%
MCHP Premium	84.3%	71.9%	8.5%	13.8%	7.1%	12.8%	0.2%	1.5%
Family Planning	65.4%	39.0%	19.2%	34.8%	15.2%	25.6%	0.2%	0.7%
Medicaid Expansion	82.2%	70.3%	11.4%	19.2%	6.0%	9.3%	0.3%	1.2%
PAC	67.0%	43.3%	21.3%	36.2%	11.5%	20.0%	0.2%	0.6%
Sum of Groups Likely to Transition to/from MHBE	**81.0%**	**67.3%**	**11.6%**	**19.9%**	**7.1%**	**11.8%**	**0.3%**	**1.1%**

Analysis of Selected Sub-Populations Requiring Continuity of Care

With input from the Committee, Hilltop analyzed the rate of turnover in Medicaid eligibility for selected populations and conditions that may require continuity of care when transitioning between Medicaid/MCHP and MHBE. Both Hilltop and the Committee recognize that the populations selected are not an all-inclusive list of populations or treatments that may require continuity. The Committee believes the guiding principles for determining the need for continuity of care are when continuity 1) improves patient outcomes, 2) improves patient compliance with treatment, and 3) makes accessing care more convenient and feasible for patients in these populations. With the limited amount of time for analysis, the Committee decided to focus on populations measurable within the Medicaid data with serious chronic conditions or within a prescribed course of treatment. These include:

- Pregnancy
- Hospitalization
- Individuals receiving treatment for chemotherapy, radiation therapy, and dialysis
- Individuals receiving organ transplants
- Individuals with ongoing care needs as identified by durable medical equipment (DME), home health services, and prescription medications for management of chronic diseases
- Individuals receiving mental health and substance abuse services

Hilltop identified these sub-populations through diagnosis codes, procedure codes, and other coding on Medicaid claims. The claims data were analyzed to determine the service utilization within each category of the churn population. Tables 4 through 6 present the percentage of beneficiaries in the 6-month churn population with the selected conditions listed above; Tables 7 through 9 present the results for 12-month population. Each set of tables consists of one table for those losing coverage, one table for those gaining coverage, and one table for those gaining and subsequently losing coverage. In each table, the top summary row indicates the prevalence of the above conditions among the entire Medicaid population, and the subsequent rows present the results for coverage groups likely to participate in MHBE. The last column in each table shows the percentage that did not have any of the specified conditions for analysis (though these individuals may have other health conditions that were not measured). Percentages of interest are emphasized with bold font. Small cells were suppressed to zero to protect individual privacy.

Table 4. Distribution of Selected Conditions among the 6-Month Population Losing Eligibility

Eligibility Category	Pregnancy	Prescriptions	HIV/AIDS	Mental Health	Substance Abuse	Dialysis	Chemotherapy	Radiation	Transplant	Hospitalizations	Home Health	DME	None of the Measured Conditions	Total People in Category
All Medicaid (including groups not listed)	**1.7%**	**28.7%**	**0.6%**	**9.4%**	**2.7%**	**0.3%**	**0.5%**	**0.2%**	**0.1%**	**6.2%**	**1.1%**	**3.2%**	**63.7%**	**71,108**
Family Planning*	7.4%	**18.3%**	0.0%	1.4%	0.6%	0.0%	0.0%	0.0%	0.0%	2.9%	0.0%	0.0%	77.9%	2,336
Family and Children	0.9%	**27.3%**	0.2%	5.9%	1.5%	0.0%	0.1%	0.0%	0.0%	1.5%	0.1%	1.1%	69.5%	26,800
Foster Children	0.0%	**30.1%**	0.0%	20.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.1%	61.3%	574
MCHP	0.0%	**23.6%**	0.0%	5.9%	0.4%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	1.0%	73.2%	6,032
MCHP Premium	0.0%	**31.7%**	0.0%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	65.0%	1,384
Medicaid Expansion	0.8%	**29.2%**	0.1%	5.4%	1.2%	0.0%	0.0%	0.0%	0.0%	1.6%	0.0%	1.1%	68.1%	12,436
PAC*	0.2%	**40.2%**	1.2%	11.5%	8.9%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	0.7%	55.3%	6,825
Sum of Groups Likely to Transition to/from MHBE	**1.0%**	**28.6%**	**0.3%**	**6.5%**	**2.1%**	**0.0%**	**0.1%**	**0.0%**	**0.0%**	**1.4%**	**0.1%**	**1.0%**	**68.0%**	**56,387**

*Enrollee's last coverage group in the time period is presented. Services outside of the scope of the limited benefit PAC and Family Planning programs, such as hospitalizations, occurred when the individual was enrolled in prior eligibility categories.

**Percentages represent the proportion of the eligibility category that has each condition. Because members may have multiple conditions, the percentages do not sum to 100 percent horizontally.

- Among the six-month population losing eligibility likely to transition, 68 percent had none of the measured conditions.
- Prescriptions were the most frequent (28.6 percent), followed by mental health (6.5 percent).
- The remaining conditions were infrequent among this population.

Table 5. Distribution of Selected Conditions among the 6-Month Population Gaining Eligibility

Eligibility Category	Pregnancy	Prescriptions	HIV/AIDS	Mental Health	Substance Abuse	Dialysis	Chemotherapy	Radiation	Transplant	Hospitalizations	Home Health	DME	None of the Measured Conditions	Total People in Category
All Medicaid (including groups not listed)	**4.8%**	**26.6%**	**0.3%**	**7.1%**	**2.5%**	**0.1%**	**0.3%**	**0.1%**	**0.1%**	**17.6%**	**0.9%**	**1.7%**	**56.7%**	**106,829**
Family Planning*	**67.7%**	**40.3%**	0.0%	2.1%	0.9%	0.0%	0.0%	0.0%	0.0%	**11.1%**	0.0%	0.5%	**27.4%**	2,957
Family and Children	3.7%	**28.3%**	0.2%	5.0%	1.6%	0.0%	0.1%	0.0%	0.0%	**23.9%**	1.2%	1.6%	**52.9%**	42,579
Foster Children	0.0%	**31.8%**	0.0%	**21.2%**	2.0%	0.0%	0.0%	0.0%	0.0%	**17.1%**	2.5%	2.0%	**51.1%**	650
MCHP	0.4%	**23.4%**	0.0%	4.5%	0.2%	0.0%	0.0%	0.0%	0.0%	**15.6%**	0.9%	1.5%	**63.4%**	7,465
MCHP Premium	0.0%	**27.2%**	0.0%	4.9%	0.0%	0.0%	0.0%	0.0%	0.0%	**11.4%**	0.0%	2.2%	**64.0%**	1,663
Medicaid Expansion	3.9%	**27.5%**	0.2%	4.5%	1.1%	0.0%	0.1%	0.0%	0.0%	**15.8%**	0.4%	1.3%	**59.5%**	23,431
PAC*	0.3%	**25.8%**	0.4%	**12.4%**	**8.2%**	0.0%	0.0%	0.0%	0.0%	**1.6%**	0.0%	0.2%	**65.2%**	12,599
Sum of Groups Likely to Transition to/from MHBE	**5.0%**	**27.7%**	**0.2%**	**5.9%**	**2.2%**	**0.0%**	**0.1%**	**0.0%**	**0.0%**	**17.4%**	**0.8%**	**1.3%**	**56.5%**	**91,344**

*Enrollee's last coverage group in the time period is presented. Services outside of the scope of the limited benefit PAC and Family Planning programs, such as hospitalizations, occurred when the individual was enrolled in prior eligibility categories.

**Percentages represent the proportion of the eligibility category that has each condition. Because members may have multiple conditions, the percentages do not sum to 100 percent horizontally.

- Among the six-month population gaining eligibility likely to transition, 56.5 percent had none of the measure conditions.
- Prescriptions were the most frequent (27.7 percent), followed by hospitalizations (17.4 percent).
- Pregnancy, mental health, and substance abuse were less frequent but occurred disproportionately among certain coverage groups.
- The remaining conditions were infrequent among this population.

Table 6. Distribution of Selected Conditions among the 6-Month Population Gaining then Losing Eligibility

Eligibility Category	Pregnancy	Prescriptions	HIV/AIDS	Mental Health	Substance Abuse	Dialysis	Chemotherapy	Radiation	Transplant	Hospitalizations	Home Health	DME	None of the Measured Conditions	Total People in Category
All Medicaid (including groups not listed)	**8.1%**	**9.9%**	**0.8%**	**5.9%**	**2.2%**	**0.4%**	**1.1%**	**0.3%**	**1.0%**	**32.5%**	**0.5%**	**1.4%**	**57.6%**	**4,142**
Family Planning*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	26
Family and Children	1.0%	**10.7%**	0.0%	**5.0%**	1.8%	0.0%	0.0%	0.0%	0.0%	15.2%	0.0%	0.0%	74.0%	1,225
Foster Children**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0
MCHP	0.0%	**8.8%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	87.1%	147
MCHP Premium**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0%	39
Medicaid Expansion	0.0%	**10.0%**	0.0%	3.1%	0.0%	0.0%	0.0%	0.0%	0.0%	4.7%	0.0%	0.0%	83.8%	718
PAC*	0.0%	**28.1%**	0.0%	**13.5%**	0.0%	0.0%	0.0%	0.0%	0.0%	17.7%	0.0%	0.0%	54.2%	96
Sum of Groups Likely to Transition to/from MHBE	**0.9%**	**11.2%**	**0.0%**	**4.7%**	**1.5%**	**0.0%**	**0.0%**	**0.0%**	**0.2%**	**10.9%**	**0.0%**	**0.8%**	**77.3%**	**2,257**

*Enrollee's last coverage group in the time period is presented. Services outside of the scope of the limited benefit PAC and Family Planning programs, such as hospitalizations, occurred when the individual was enrolled in prior eligibility categories.

**Percentages represent the proportion of the eligibility category that has each condition. Because members may have multiple conditions, the percentages do not sum to 100 percent horizontally.

- Among the six-month population gaining then losing eligibility likely to transition, 77.3 percent had none of the measure conditions.
- Prescriptions were the most frequent (11.2 percent), followed by hospitalizations (10.9 percent) and mental health (4.7 percent).
- The remaining conditions were infrequent among this population.

Table 7. Distribution of Selected Conditions among the 12-Month Population Losing Eligibility

Eligibility Category	Pregnancy	Prescriptions	HIV/AIDS	Mental Health	Substance Abuse	Dialysis	Chemotherapy	Radiation	Transplant	Hospitalizations	Home Health	DME	None of the Measured Conditions	Total People in Category
All Medicaid (including groups not listed)	**2.5%**	**39.3%**	**0.8%**	**13.5%**	**4.3%**	**0.4%**	**0.6%**	**0.3%**	**0.2%**	**9.1%**	**1.4%**	**4.8%**	**52.0%**	**131,436**
Family Planning	6.5%	**20.1%**	0.0%	1.5%	0.4%	0.0%	0.0%	0.0%	0.0%	3.9%	0.0%	0.3%	**77.4%**	4,914
Family and Children	1.5%	**40.0%**	0.2%	9.1%	2.2%	0.0%	0.1%	0.0%	0.0%	3.2%	0.2%	2.3%	**56.6%**	47,509
Foster Children	0.6%	**42.1%**	0.0%	**28.8%**	1.2%	0.0%	0.0%	0.0%	0.0%	3.2%	1.3%	3.5%	**48.1%**	1,268
MCHP	0.2%	**36.0%**	0.0%	8.6%	0.6%	0.0%	0.0%	0.0%	0.0%	1.0%	0.1%	2.0%	**60.0%**	11,323
MCHP Premium	0.0%	**46.0%**	0.0%	11.0%	0.6%	0.0%	0.0%	0.0%	0.0%	0.9%	0.5%	3.6%	**50.1%**	2,703
Medicaid Expansion	1.6%	**41.8%**	0.2%	9.0%	1.9%	0.0%	0.1%	0.0%	0.0%	3.3%	0.2%	2.2%	**55.0%**	21,160
PAC	0.1%	**51.2%**	1.4%	**17.1%**	**14.6%**	0.0%	0.0%	0.0%	0.0%	1.6%	0.0%	1.3%	**42.7%**	14,696
Sum of Groups Likely to Transition to/from MHBE	**1.4%**	**40.8%**	**0.4%**	**10.1%**	**3.6%**	**0.0%**	**0.1%**	**0.0%**	**0.0%**	**2.7%**	**0.2%**	**2.0%**	**55.4%**	**103,573**

*Enrollee's last coverage group in the time period is presented. Services outside of the scope of the limited benefit PAC and Family Planning programs, such as hospitalizations, occurred when the individual was enrolled in prior eligibility categories.

**Percentages represent the proportion of the eligibility category that has each condition. Because members may have multiple conditions, the percentages do not sum to 100 percent horizontally.

- Among the 12-month population losing eligibility likely to transition, 55.4 percent had none of the measured conditions.
- Prescriptions were the most frequent (40.8 percent), followed by mental health (10.1 percent).
- The remaining conditions were infrequent among this population.

Table 8. Distribution of Selected Conditions among the 12-Month Population Gaining Eligibility

Eligibility Category	Pregnancy	Prescriptions	HIV/AIDS	Mental Health	Substance Abuse	Dialysis	Chemotherapy	Radiation	Transplant	Hospitalizations	Home Health	DME	None of the Measured Conditions	Total People in Category
All Medicaid (including groups not listed)	**6.7%**	**43.7%**	**0.4%**	**10.9%**	**4.3%**	**0.1%**	**0.4%**	**0.1%**	**0.1%**	**21.6%**	**1.2%**	**3.9%**	**42.4%**	**203,733**
Family Planning	**80.7%**	**56.8%**	0.3%	4.5%	1.8%	0.0%	0.6%	0.0%	0.0%	**31.9%**	0.3%	1.4%	**14.7%**	6,678
Family and Children	5.1%	**46.5%**	0.2%	7.9%	2.4%	0.0%	0.2%	0.0%	0.1%	**28.9%**	1.5%	4.0%	**38.8%**	79,664
Foster Children	0.0%	**46.7%**	0.0%	**30.8%**	3.5%	0.0%	0.0%	0.0%	0.0%	**20.2%**	3.5%	4.6%	**37.4%**	1,359
MCHP	0.6%	**40.5%**	0.0%	6.3%	0.4%	0.0%	0.0%	0.0%	0.0%	**17.5%**	1.1%	4.1%	**49.0%**	13,890
MCHP Premium	0.0%	**44.9%**	0.0%	7.4%	0.4%	0.0%	0.0%	0.0%	0.0%	**13.3%**	0.4%	4.4%	**47.2%**	2,920
Medicaid Expansion	5.3%	**46.5%**	0.2%	7.7%	1.8%	0.0%	0.2%	0.0%	0.1%	**20.1%**	0.6%	3.5%	**43.7%**	43,894
PAC	0.4%	**46.1%**	0.9%	**19.8%**	**15.3%**	0.0%	0.0%	0.0%	0.0%	**1.4%**	0.1%	1.0%	**45.8%**	26,591
Sum of Groups Likely to Transition to/from MHBE	**6.8%**	**46.3%**	**0.3%**	**9.6%**	**4.0%**	**0.0%**	**0.2%**	**0.0%**	**0.1%**	**21.4%**	**1.0%**	**3.3%**	**41.1%**	**174,996**

*Enrollee's last coverage group in the time period is presented. Services outside of the scope of the limited benefit PAC and Family Planning programs, such as hospitalizations, occurred when the individual was enrolled in prior eligibility categories.

**Percentages represent the proportion of the eligibility category that has each condition. Because members may have multiple conditions, the percentages do not sum to 100 percent horizontally.

- Among the 12-month population gaining eligibility likely to transition, 41.1 percent had none of the measure conditions.
- Prescriptions were the most frequent (46.3 percent), followed by hospitalizations (21.4 percent).
- Pregnancy, mental health, and substance abuse were less frequent but occurred disproportionately among certain coverage groups.
- The remaining conditions were infrequent among this population.

Table 9. Distribution of Selected Conditions among the 12-Month Population Gaining then Losing Eligibility

Eligibility Category	Pregnancy	Prescriptions	HIV/AIDS	Mental Health	Substance Abuse	Dialysis	Chemotherapy	Radiation	Transplant	Hospitalizations	Home Health	DME	None of the Measured Conditions	Total People in Category
All Medicaid (including groups not listed)	**9.4%**	**22.5%**	**0.7%**	**8.2%**	**3.1%**	**0.6%**	**1.3%**	**0.4%**	**0.8%**	**29.7%**	**0.6%**	**2.5%**	**50.5%**	**15,824**
Family Planning	**53.3%**	**41.6%**	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	0.0%	**30.7%**	0.0%	0.0%	31.4%	137
Family and Children	2.5%	**25.7%**	0.0%	6.9%	2.3%	0.0%	0.0%	0.0%	0.2%	**15.6%**	0.3%	1.4%	61.5%	5,307
Foster Children	0.0%	**0.0%**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	71.9%	32
MCHP	0.0%	**22.7%**	0.0%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	**4.1%**	0.0%	0.0%	71.4%	591
MCHP Premium	0.0%	**33.4%**	0.0%	8.7%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**	0.0%	4.0%	63.5%	323
Medicaid Expansion	1.1%	**23.6%**	0.0%	5.1%	1.7%	0.0%	0.0%	0.0%	0.0%	**7.7%**	0.0%	1.7%	70.1%	2,656
PAC	0.9%	**47.0%**	3.0%	**20.8%**	**14.7%**	0.0%	0.0%	0.0%	0.0%	**15.7%**	0.0%	0.0%	42.1%	428
Sum of Groups Likely to Transition to/from MHBE	**2.6%**	**26.3%**	**0.3%**	**7.0%**	**2.5%**	**0.0%**	**0.2%**	**0.0%**	**0.2%**	**12.3%**	**0.3%**	**1.6%**	**63.3%**	**9,474**

*Enrollee's last coverage group in the time period is presented. Services outside of the scope of the limited benefit PAC and Family Planning programs, such as hospitalizations, occurred when the individual was enrolled in prior eligibility categories.

**Percentages represent the proportion of the eligibility category that has each condition. Because members may have multiple conditions, the percentages do not sum to 100 percent horizontally.

- Among the 12-month population gaining then losing eligibility likely to transition, 63.3 percent had none of the measure conditions.
- Prescriptions were the most frequent (26.3 percent), followed by hospitalizations (12.3 percent) and mental health (7.0 percent).
- The remaining conditions were infrequent among this population.

The following paragraphs summarize the trends within each selected sub-population.

No Measured Conditions

The majority of the Medicaid population losing (or gaining and then losing) coverage had none of the specified medical conditions during either the 6-month or 12-month time period. Those newly gaining coverage, however, were more likely to have the specified medical conditions, which is expected since Medicaid coverage is often obtained when an individual is seeking care, such as during an office or emergency department (ED) visit or hospitalization episode.

Pregnancy

Pregnancy was one of the conditions for eligibility for the Family Planning program. Because of this, over two-thirds of the 6-month Family Planning enrollment group gaining coverage—and over 80 percent of the 12-month group gaining coverage—experienced a pregnancy during the measurement period. Pregnancy was also more common among the Families and Children and the Medicaid Expansion coverage groups. Maintaining provider continuity for pregnancy services would thus be an issue for these populations. Among the overall population likely to transition between Medicaid and MHBE, pregnancy was relatively infrequent.

Hospitalizations

Hospitalizations were the most common among the population newly gaining Medicaid coverage, occurring among 17 percent of the 6-month measurement group and 21 percent of the 12-month group. PAC is an exception, as hospitalization is not a covered benefit for this population. The Families and Children coverage group had some of the highest rates of hospitalizations, possibly because hospitals may help individuals who are unable to pay for services apply for Medicaid. It should also be noted that hospitalization is a broad category that does not require a particular diagnosis, so a high hospitalization rate, compared with the other services measured, is expected, and hospitalizations are a major component of costs to the Medicaid program.

Chemotherapy, Radiation, Organ Transplant, Dialysis, and HIV/AIDS

Chemotherapy, radiation, organ transplant, dialysis, and HIV/AIDS had comparatively low rates among the churn populations. These conditions were so infrequent that percentages were often suppressed to zero to protect the privacy of individuals. These conditions and services were most common among eligibility groups unlikely to participate in MHBE, including individuals in coverage groups for people with disabilities receiving Supplemental Security Income (SSI) and individuals dually edible for Medicare and Medicaid.

DME, Home Health, and Prescription Drug Services

DME, home health, and prescription drug services were selected for analysis because they indicate ongoing health care needs. Prescription drugs were the most common among the selected conditions across all population and time periods. Appendix B contains a list of chronic disease indications and drugs prescribed to treat those indications, along with the numbers of enrollees in the 12-month measurement group using those drugs. Common conditions include allergies, depression, diabetes, anti-

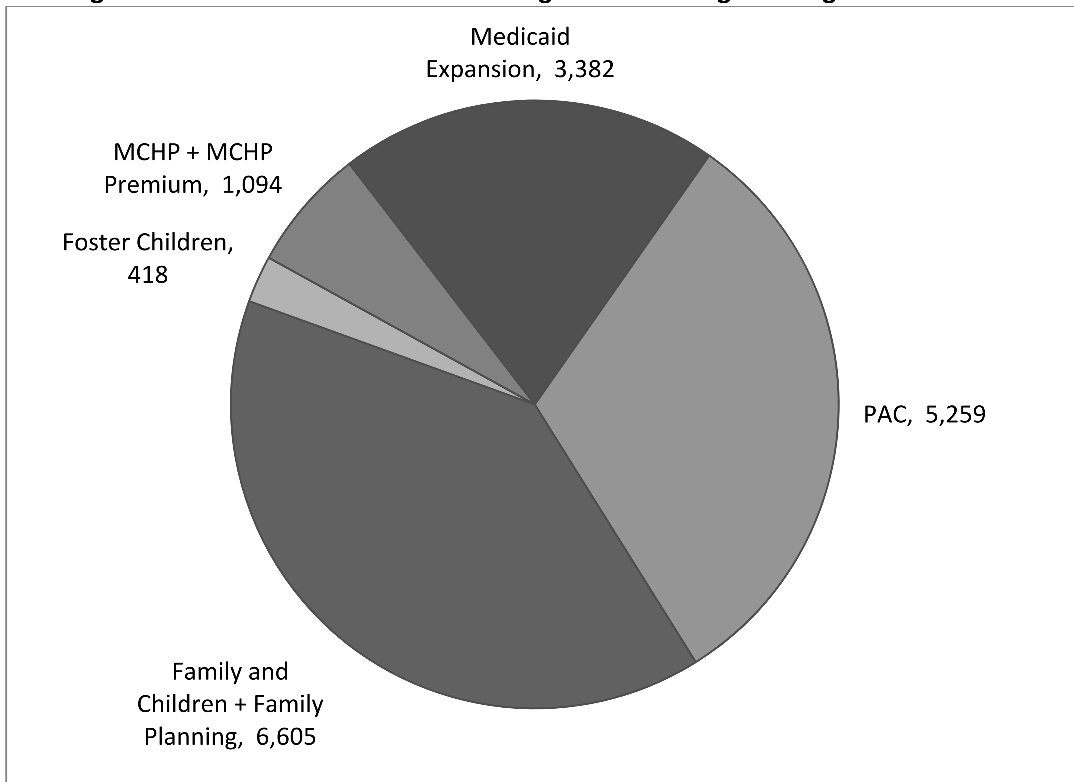
drug abuse, heart conditions, and respiratory conditions. DME is more commonly used than home health, although both are much less frequently used than prescriptions. Home health was the least common service among these groups.

Mental Health

Although they were more likely than other coverage groups to have continuous coverage, children in foster care have the highest rates of mental health service use. Approximately 30 percent of foster children losing coverage and gaining coverage had mental health conditions in the 12-month study group. Foster children in the six-month study group also had high rates of mental health utilization. Mental health service use was also more frequent among the PAC population: approximately 12 percent of the 6-month group and 20 percent of the 12-month group used these services.

Although children in foster care had the highest rate of mental health service utilization, they are a small percentage of the overall population receiving mental health services. Figure 3 presents the number of enrollees identified with mental health conditions among the 12-month group gaining coverage. Of the 16,758 people who used mental health services, the Families and Children coverage group made up about 40 percent and the PAC group made up about 31 percent.

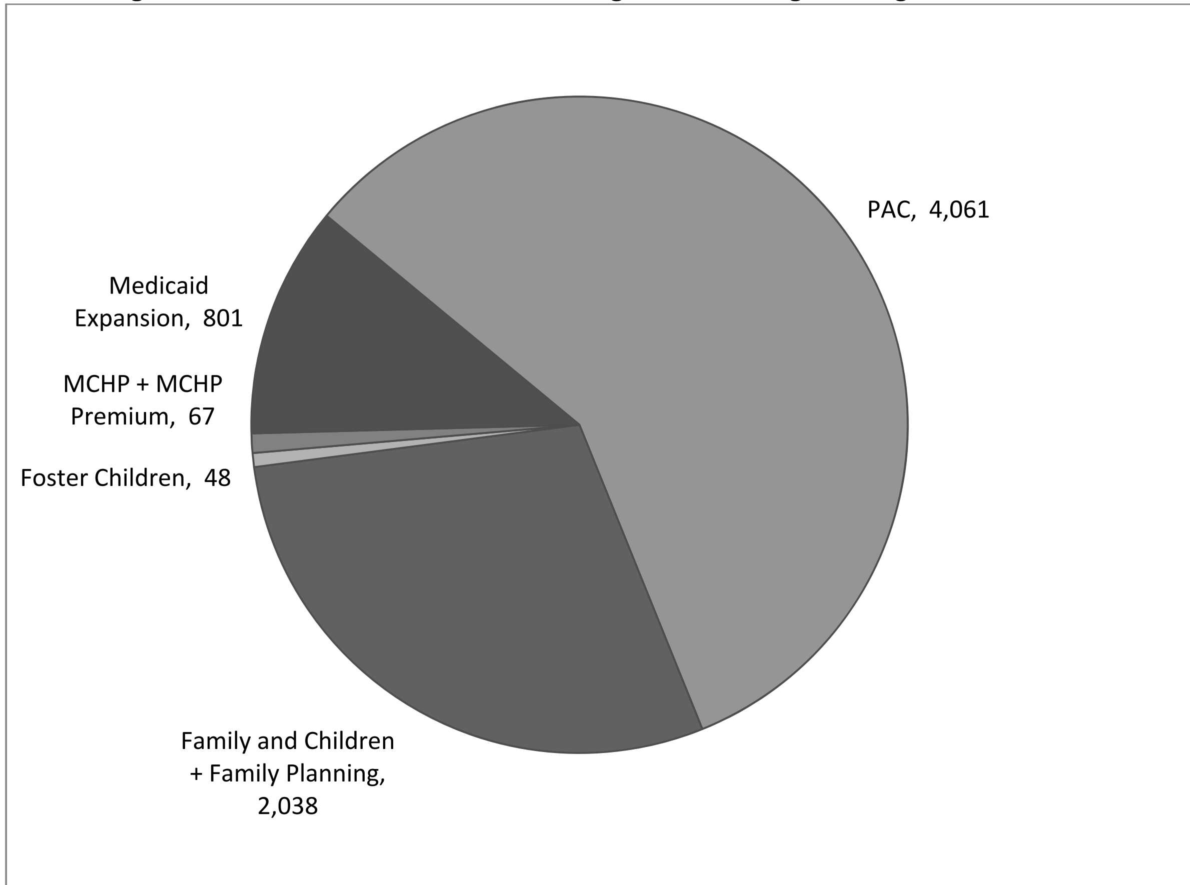
Figure 3. Mental Health Services among Those Gaining Coverage in 12 Months



Substance Abuse

Substance abuse services were most common among PAC enrollees. Roughly 15 percent of PAC enrollees in the 12-month churn population and 9 percent in the 6-month population used substance abuse services. PAC also represented the majority of substance abuse service users in the churn population. Figure 4 shows that nearly 60 percent of the 7,015 enrollees using substance abuse services are in the PAC enrollment group.

Figure 4. Substance Abuse Services among Those Gaining Coverage in 12 Months



Analysis of Service Costs for the Churn Population

This section of the report discusses the cost impact of each of the selected conditions and how they can be managed between plans during periods of transition. Hilltop engaged an actuarial consultant, Optumas, to conduct an analysis of the health services costs for these particular conditions and services. Optumas used data from its nationwide database of commercial insurance and Medicaid claims, as well as data from Hilltop on the prevalence of churn in the Maryland Medicaid population. Optumas calculated the ratio of the annual cost of each of these individual conditions to the total population health care cost (i.e., the share of annual health spending attributable to each condition and service). It then applied Hilltop's rates of churn for those Medicaid eligibility groups who were likely to experience transitions into and out of MHBE, in order to allocate a share of those total costs per condition to the plan membership likely to churn. Optumas performed separate analyses for the transition from Medicaid to MHBE coverage, and from MHBE to Medicaid coverage.

The goal of this analysis was to calculate a percentage adjustment to health plan premiums to account for the movement of people with the specified health care needs into and out of the plans. According to Optumas, costs would accrue to plans because policies to maintain continuity for specified periods would require plans to pay potentially different rates to out-of-plan providers. To account for differences in provider payments among those in the churn population who would maintain continuity of care with providers who did not participate in the receiving plans' network, Optumas applied a further adjustment based on its proprietary data. Finally, this adjustment factor was further adjusted to account for different time periods that could be applied to transition policies, such as 90 days or 6 months (to estimate coverage for pregnancy through postpartum). The ultimate result of the analysis was a percentage adjustment to the per member per month (PMPM) payments for the members in Medicaid or MHBE health plans for the out-of-network services related to the selected conditions.

Optumas provided the committee with a low estimate, a "best" estimate of the most likely scenario, and a high estimate. The results from the alternative scenarios and a more detailed explanation of the methodology used by Optumas are included in Appendix C. There were relatively small differences (in the estimated effects among the different scenarios), so Tables 10 and 11 display the "best" estimate from Optumas.

Table 10 summarizes Optumas' estimates of the effects of transfers from Medicaid to the MHBE population. This analysis assumes a policy of continuation of coverage for three months, except for pregnancy, which is assumed to last an average of six months even if the coverage policy specifies continuation of coverage until delivery.

The condition with the highest adjustment factor is mental health, followed by DME, substance abuse, and pregnancy. The adjustment to the PMPM is 0.0100 percent for mental health, 0.0041 percent for DME, 0.0029 percent for substance abuse, and 0.0022 percent for pregnancy. The adjustment factor for DME is relatively high because of the high percentage of providers expected to be out of network for the receiving plan, and the high payment differential for those out-of-network providers. Other conditions with substantial costs are prescription drugs, home health, and chemotherapy. The remaining conditions are less costly, and therefore have less financial consequences. Summed together, the conditions result in a combined PMPM percentage adjustment of 0.024 percent. In the lower right portion of Table 10 is an illustration of the impact of this adjustment to a hypothetical plan premium of $300 per month, showing that the impact of the churn policies is about 7 cents.

Table 10. Estimates of PMPM Cost by Optumas for Transfers from Medicaid to MHBE

	Percentage of Total Service Costs	Churn Rate	Percentage of Providers Not in Network	Reimbursement Differential for Providers Not in Network	Months of Coverage	Total Impact
Pregnant Women	14.02%	3.69%	22%	4%	6	0.0022%
Prescriptions	8.16%	7.52%	10%	13%	3	0.0017%
HIV	0.35%	11.36%	25%	31%	3	0.0008%
Mental Health	2.74%	6.78%	25%	31%	3	0.0100%
Substance Abuse	3.87%	10.05%	25%	31%	3	0.0029%
Dialysis	0.42%	9.86%	25%	31%	3	0.0008%
Chemotherapy	1.22%	5.01%	25%	31%	3	0.0012%
Radiation Therapy	0.61%	7.66%	25%	31%	3	0.0009%
Transplants	0.05%	6.13%	22%	4%	3	0.0000%
Hospitalizations	19.18%	3.42%	22%	0%	3	0.0000%
Home Health	1.09%	3.49%	40%	31%	3	0.0012%
DME	2.72%	4.79%	40%	31%	3	0.0041%
					All Combined	0.024%
					Original Capitation Rate	$ 300.00
					Adjusted Capitation Rate	$ 300.07
					PMPM Impact	$ 0.07

*Churn rates represent the proportion of the population with the condition leaving Medicaid coverage for the Exchange.

Table 11 displays Optumas' estimates of the effects of transfers from MHBE to Medicaid. Optumas assumed slightly lower rates of churn into the Medicaid population than into MHBE as shown in Table 10. In this model, the condition with the greatest impact is substance abuse, followed by DME, mental health, and pregnancy. Among the members transitioning to Medicaid, substance abuse adds 0.0048 percent to costs, DME adds 0.0029 percent, mental health adds 0.0023 percent, and pregnancy adds 0.0021 percent. The net impact of these conditions on the cost to Medicaid plans from members moving from MHBE is 0.015 percent. This represents a change of about 5 cents, for a hypothetical $300 monthly capitation payment.

Table 11. Estimates of PMPM Cost by Optumas for Transfers from MHBE to Medicaid

	Percentage of Total Service Costs	Churn Rate	Percentage of Providers Not in Network	Reimbursement Differential for Providers Not in Network	Months of Coverage	Total Impact
Pregnant Women	18.69%	3.32%	22%	3%	6	0.0021%
Prescriptions	8.16%	6.76%	10%	10%	3	0.0014%
HIV	0.26%	10.22%	25%	25%	3	0.0004%
Mental Health	2.42%	6.10%	25%	25%	3	0.0023%
Substance Abuse	3.36%	9.05%	25%	25%	3	0.0048%
Dialysis	0.01%	8.87%	25%	25%	3	0.0000%
Chemotherapy	0.29%	4.51%	25%	25%	3	0.0002%
Radiation Therapy	0.03%	6.89%	25%	25%	3	0.0000%
Transplants	0.17%	5.52%	22%	3%	3	0.0000%
Hospitalizations	21.32%	3.08%	22%	0%	3	0.0000%
Home Health	1.09%	3.14%	40%	25%	3	0.0009%
DME	2.72%	4.31%	40%	25%	3	0.0029%
					All Combined	0.015%
					Original Capitation Rate	$ 300.00
					Adjusted Capitation Rate	$ 300.05
					PMPM Impact	$ 0.05

*Churn rates represent the proportion of the population with the condition leaving Medicaid coverage for the Exchange.

Policy Options

Based on Committee discussions and suggestions and a review of continuity of care policies in Maryland and other states, Hilltop developed a range of policy options for the Committee to review. The options, which were set within the Committee scope defined by MHBE, are intended to provide a range for consideration and could be implemented in isolation or in combination with other options. Committee members and the public were given the opportunity to provide verbal and written comments on these options. Appendix D provides the full text of the written public comments submitted to the Committee. Beneath each option is a summary of the potential advantages and disadvantages discussed by the Committee.

As the MHBE Board is reviewing these options, it should be noted that the health plan rate filings are due March 1, 2013, for dental and vision plans and April 1, 2013, for medical plans. Due to this short time frame, policy options with a rate impact could not likely be implemented in the first year of enrollment. Some Committee members also wanted to note that national standards on continuity of care for Exchanges have not been developed, and the Board should keep abreast of national policies as they become available. Some Committee members also wanted to highlight that the Board consider the consumer's perspective. The continuity of care approach selected should not create barriers and should be culturally and linguistically appropriate. The transition process should not increase racial/ethnic and other health disparities.

1. Maintain current continuity/transition of care policies; implement no new policies.

<u>Potential Advantages</u>

- Some committee members felt that this is the best approach because national NCQA guidelines currently exist for both Medicaid and commercial health plans. These are well-established, nationally-vetted processes that are currently working.
- The analysis presented in this report suggests a relatively low rate of churn between Medicaid and QHPs, suggesting that MHBE consider waiting until it is operational to address continuity of care issues.
- Several committee members recommended that MHBE adopt this approach in the first year and then re-evaluate and modify, if necessary, depending on Maryland's experience and any federal guidance that emerges. This option could be combined with Option 7, and continuity could be revisited when the true scope of the problem is known.
- Similarly, it was noted that any new policy would impose a cost on payers, and there may not be enough information at this time to warrant the additional cost.

<u>Potential Disadvantages</u>

- Some committee members felt that the current standards are not adequate, and without additional protections and a more proactive approach, vulnerable populations in particular may fall through the cracks. These vulnerable populations include:
    - Individuals with lower income, who are have lower health literacy and are less familiar with commercial insurance
    - Individuals in treatment for complex medical and mental health conditions

    - Racial and ethnic minorities, individuals with disabilities, and other vulnerable populations encountering compounding health disparities

- Current policies in the commercial market may be insufficient for the special situation that enrollees transitioning from Medicaid to commercial health plans will be facing because they were developed for employees transitioning from one employer-sponsored plan to another.
- This approach is not proactive and does not account for "potential" problems with continuity of care.
- This approach does not address chronic disease and ambulatory care-sensitive conditions, which are factors that plague patients and providers and lead to higher costs throughout the health care system.

2. Prior authorization policies

a. New health plan accepts prior authorization determination from relinquishing health plan for certain treatments.

Potential Advantages

- It was offered that this option could work only if there are clear sets of criteria for prior authorization across health plans, but would be problematic if there is wide variation in criteria.

Potential Disadvantages

- Many committee members expressed concern about this option because it does not place any time limitations on the acceptance of the prior authorization.
- Blanket acceptance of prior authorization without time limits can be problematic since prior authorizations generally have built-in time or treatment limits. Acceptance without such limits could cause services to be extended longer than intended.
- Implementation would be difficult because health plans have different standards for prior authorization, cover different services, require different cost-sharing, and have different provider networks and payment structures.
- Another implementation challenge is that there is no current process for identifying patients for transfer of preauthorized services, and the patients would have to initiate the coordination of their services.
- It may be difficult for the receiving health plan to honor the limitations placed by the relinquishing health plan. For example, if prior authorization were allowed for 12 visits by the relinquishing plan, it would be difficult for the accepting plan to determine how many visits the patient has already received.
- There was concern about disputes between the relinquishing and accepting plans about paying for these services.

b. New health plan accepts prior authorization determination from relinquishing health plans for certain treatments for a specified period of time.

Potential Advantages

- Many committee members felt that this option was preferable over Option 2a because it provides the opportunity to reassess patients' needs while minimizing disruptions in coverage and additional aggravation for patients who are already sick.

- Some committee members felt that this option would work if it were only applicable to certain acute conditions for a limited period of time because it would prevent disruption of treatment for critical conditions. A limited timeframe would allow for adequate review by the new plan, as well as a smooth transition to the new plan's requirements. One set of criteria offered suggested that:
    - The time limit should be no longer than 90 calendar days, which would be adequate to prevent disruption of immediately needed care.
    - The CareFirst list of services that require prior authorizations could potentially be used as a guideline for conditions where prior authorizations could be transferred.[3]
- A second set of criteria offered suggested that:
    - The time limit should be the lesser of 60 days or the previously authorized time.
    - It should only cover outpatient services determined to be medically necessary by the relinquishing health plan.
    - Services should only be provided by in-network providers.
    - The new plan should not be required to cover services not already in the plan.
- A third set of criteria offered suggested that pregnant women be covered through delivery and the postpartum visit.
- A fourth set of criteria offered suggested that:
    - Any list of conditions developed for prior authorization should ensure that the benefits are reflective of the needs of beneficiaries, especially racial and ethnic minorities and other vulnerable populations.
    - Care for newborn children through age three should be covered.

Potential Disadvantages

- National standards have not yet been developed, and any standards that the state creates may not be consistent with future national standards.
- Implementation may be difficult because the plans have different cost-sharing requirements, benefits, provider networks and payments, and preauthorization criteria.
- Another implementation challenge is that there is no process to identify patients for transfer of preauthorized services between relinquishing and new health plans, and the patients would have to initiate the coordination of their services.

3. New health plan allows enrollees within specified courses of treatment to receive care from out-of-network providers for a specified amount of time.

Potential Advantages

- Many committee members supported this option.

[3] These may be found at https://provider.carefirst.com/wps/portal/Provider/ProviderLanding?WCM_GLOBAL_CONTEXT=/wcmwps/wcm/connect/Content-Provider/CareFirst/ProviderPortal/Generic/Tab/mprInNetwork&WT.z_from=providerQuicklinks

- It was noted that NCQA has defined standards for commercial carriers on this issue, and this would be appropriate under those current standards.
- Some felt that this option is the cornerstone for achieving continuity of care, and the other policy options are complementary.
- This process is already in place in the commercial market and it is working, and Medicaid has a similar process in its self-referral program.
- This process is easily and simply explained in each carrier's benefits guide and/or website.
- Some felt that this is a good approach to minimize disruptions in care and additional aggravation for patients who are already sick.
- Some committee members felt that this option may be appropriate with specified criteria. One set of criteria offered suggested that:
    - There should be a time limit that provides coverage through the acute episode of care and up to a maximum of 90 days or through delivery in the case of pregnancy.
    - It should only cover a limited course of treatment.
    - The new plan should not be required to cover services not already in the plan.
- A second set of criteria offered suggested that the providers be paid the receiving plan's rate.
- A third set of criteria suggested that this option should allow out-of-network care for specified conditions in addition to the specified courses of treatment.
- A fourth set of criteria suggested that this option require in-network cost-sharing for these out-of-network services.

Potential Disadvantages

- Several committee members expressed concern that out-of-network providers are not contractually obligated to continue care and must be willing to accept patients through transition. Payment differentials would likely affect providers' willingness to participate.
- Reimbursement rates for out-of-network providers may be costly to the health plan.
- This option may be burdensome or confusing if implemented in a manner that does not follow national NCQA standards.

4. Formal notification of their transition options is provided to enrollees.

Potential Advantages

- Some committee members felt that this may be an appropriate option if such notification requirements are integrated into existing health plan benefit materials.
- Similarly, some felt that this would be effective if culturally and linguistically appropriate.
- Navigators and Assistors could potentially be used to review the notifications and help members with the benefit materials from different plans.

Potential Disadvantages

- Some committee members felt that notification requirements are not adequate to protect consumers, particularly if there is no aggressive outreach to educate consumers about their

options. Several committee members felt that human assistance would be needed, especially for racial and ethnic minorities and other vulnerable populations.

- There was concern that this option is too patient-dependent and many do not understand health insurance.
- If notification requirements are not integrated into existing health plan benefit materials, such notices may be confusing and impose costly requirements with little benefit.
- Formal letters that describe complex insurance rules may be frightening to individuals.

5. Both Medicaid and QHPs conduct health risk assessments for new enrollees

Potential Advantages

- Some committee members felt that this could be an effective method of identifying individuals who may need transition plans.
- This is currently used by the Medicaid program and it works well because it alerts the MCO that the enrollee has ongoing health care needs.

Potential Disadvantages

- Some committee members expressed concern that this process is not currently in place in the commercial market. While some carriers may voluntarily use health risk assessments for wellness and other purposes, requiring this for all members and plans could impose significant expense. There are no processes for sending, receiving, tracking, or evaluating such surveys. Implementation of this option would require human, financial, and technology resources not currently accounted for, and the new costs would be borne by the payers (individual enrollees, federal government, and state government).
- Many enrollees may not require such assessments, and transition issues should be limited to ongoing treatment for acute episodes. It was suggested that there may need to be a way to target those in most need of assistance without doing risk assessments for everyone.
- Written materials are often difficult for enrollees to understand.
- Response rates would likely be low, especially if responses were mail-in only or completed without human assistance. There is no way to require members to complete such surveys, and members should not be subject to penalties if they choose not to do so.
- Such assessments may be hindered by a lack of information, such as proper addresses.
- It was mentioned that health risk assessments are a good tool in general, but it is not clear if they will be a useful tool for continuity of care.
- Health risk assessments may take a significant amount of time to fill out, and accuracy may be an issue for individuals with limited health literacy.
- Individuals in employer-sponsored plans may be hesitant to participate in fear of implications to their employment and/or fear of disclosing certain medical problems.

6. New health plan creates transition plans for enrollees within specified courses of treatment

Potential Advantages

- None provided.

Potential Disadvantages

- Some committee members expressed concern that the new health plan would not know whether a member is "within" an ongoing course of acute treatment. The member or the member's provider would be required to identify needs for a transition plan, and there is no way to compel an out-of-network provider to comply with such requirements.
- Some committee members also expressed concern that requiring carriers to provide a transition plan would constitute a new benefit that falls outside of the scope of the essential health benefits. To the extent that providers are required to pay to develop such plans, the state may be required to subsidize that benefit for QHPs.
- Some committee members felt that transition plans, if required, may need to rest outside of the carrier, and it may be best if Navigators or Assistors handled this.

7. Future Evaluation: MHBE works with others to evaluate continuity of care as it progresses

Potential Advantages

- Many committee members felt that this is an appropriate role for MHBE, especially as it gains market experience and new federal guidance emerges.
- Several committee members suggested that this option could be combined with Option 1 to make Option 1 a more proactive approach.
- It was suggested that future evaluation study the actual transition population in more depth, including:
  - The newly-eligible Medicaid population
  - Individuals within various courses of treatment and/or with various diagnoses
  - Individuals who transition between MHBE and the outside commercial market
  - Racial and ethnic minorities
  - Other vulnerable populations
- It was also suggested that future evaluation efforts focus on identifying cases where a "transition of care" is requested and following these individuals through the transition process to identify problems from the perspective of patients, providers, health plans, and other individuals involved in the process.
- There were several suggestions that the evaluation data be reviewed periodically to develop further policy recommendations as needed.

Potential Disadvantages

- MHBE is still in the process of developing its information system, and some of the data required for such an evaluation may be housed outside of MHBE. It was noted, however, that these data will likely be accessible from the outside sources.

Other Considerations

The Committee wanted to highlight other factors that may affect continuity of care that were outside of its policy scope. The Committee wanted to bring the following issues to the attention of the Board:

Benefit Gaps

Committee members expressed concern about benefit gaps between Medicaid and QHPs offered in the exchange. QHPs will offer essential health benefits (EHBs), which must cover ten broad categories of service, and the U.S. Department of Health and Human Services provided states with ten options for selecting an EHB benchmark plan.

Maryland's proposed EHB benchmark plan is the CareFirst State of Maryland preferred provider organization (PPO) (state employee plan). The Maryland Governor's Office of Health Care Reform presented the details of the proposed EHB benchmark plan to the Committee, and, at the request of the Committee, DHMH conducted an analysis comparing Maryland Medicaid and the proposed EHB benefits. Some of the key differences in benefits are highlighted below:

- The EHB package covers infertility services; Medicaid does not.
- Medicaid offers more robust mental health and substance abuse services than the EHB. Additional services include counseling, psychiatric rehabilitative services, and methadone maintenance programs.
- Medicaid offers a more robust inpatient rehabilitation benefit than the EHB. Additional services include comprehensive physical rehabilitation and no time limits.
- The EHB covers community-based speech and occupational therapy, while Medicaid only covers these services for children. Medicaid does cover speech and occupational therapy under the home health and hospital benefit for adults.
- The EHB covers vision hardware and hearing aids for adults; Medicaid does not.
- Medicaid offers a more robust skilled nursing benefit that does not impose time limits; the EHB offers this benefit with time limits.
- Medicaid offers non-emergency medical transportation; the EHB does not.

Committee members were also concerned about differences in drug formularies between the Medicaid MCOs and QHPs. When enrollees transition between Medicaid/MCHP and QHPs, these differences in benefits could potentially cause disruptions in care and adverse health outcomes, particularly for vulnerable populations.

Cost-Sharing Differences

Committee members were also concerned about the differences in cost-sharing requirements between Medicaid/MCHP and QHPs. Medicaid/MCHP enrollees have little to no cost sharing. With the exception of the MCHP Premium and Employed Individuals with Disabilities programs, Medicaid and MCHP do not charge premiums. Medicaid and MCHP also do not charge copayments for services, with the exception of pharmacy. Currently, full benefit Medicaid enrollees pay $3 for brand-name drugs that are not on the

state's preferred drug list. For all other prescriptions, enrollees pay $1.[4] When enrollees transition from Medicaid/MCHP to QHPs offered in MHBE, they will be required to pay both monthly premiums and copayments for services. Although the ACA places limits on the amount of cost sharing for individuals with household income up to 400 percent of the FPL, cost sharing may still pose a barrier.

Basic Health Plan Option

The ACA provides states with the option of implementing a Basic Health Plan (BHP) for individuals with household income between 138 and 200 percent of the FPL (ACA §1331 d). The federal government would pay the state 95 percent of the subsidies it would have paid to those individuals in the Exchange (ACA §1331 d). The BHP option could be beneficial for continuity of care in states like Maryland that have managed care systems because the same MCOs that participate in Medicaid/MCHP could be used to offer the BHP to individuals with household income between 138 and 200 percent of the FPL (DHMH, 2012). This would allow these individuals to remain within the same provider network should their income shift between Medicaid/MCHP and MHBE eligibility (DHMH, 2012). This option could also streamline eligibility for families with children enrolled in Medicaid/MCHP programs with higher income thresholds. However, there is evidence that suggests that the rate of churning will be similar at 200 percent of the FPL, which is the upper income limit under a BHP (Graves, Curtis, & Gruber, 2011).

DHMH and Hilltop conducted a preliminary analysis of the BHP option in January 2012, and DHMH concluded that there is not enough federal guidance on the BHP option at this time to make a decision about whether it should be implemented in Maryland (DHMH & The Hilltop Institute, 2012).[5] The Committee understands that a decision on the BHP cannot be made at this time but requests that DHMH consider the benefits this option may provide for continuity of care as federal guidance is released and the state gets closer to making a decision.

Health Information Exchange

The Committee also wanted to note that electronic health records and health information technology may assist with continuity of care in the future. The Maryland Health Information Exchange is in the process of developing a proposal to send patient information to interested parties after triggering events, such as a hospital discharge or enrollment in a new health plan (DHMH, 2012). This could be a potential continuity of care resource in the future.

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[4] PAC enrollees currently have a slightly higher copayment for prescriptions, but this will revert to the standard copayment in 2014 when PAC enrollees will be eligible for full Medicaid benefits.

[5] This report may be found at http://dhmh.maryland.gov/docs/BHP%2001%2018%2012%20Report%20Analysis%20FINAL.pdf

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Appendix A. Continuity of Care Committee Membership

Continuity of Care Advisory Committee Members	
Co-Chair, Uma Ahluwalia	Montgomery County Department of Health
Co-Chair, Cynthia Demarest	Maryland Physicians Care
Angela Burden	HealthCare Access Maryland
Thomas Cargiulo	Open Society Institute–Baltimore
Vincent DeMarco	Maryland Citizens' Health Initiative
Ann Doyle	CareFirst
George Escobar	CASA de Maryland
Stacy Fruhling	People's Community Health Centers
Andrew Gaddis	Charm City Clinic
Regina Gan-Carden	Care for Your Health, Inc.
Mary Jean Herron	Health Care for the Homeless
Lena Hershkovitz	Healthy Howard, Inc.
Rochelle Howell	Parents Place of Maryland
George Leon	Leon Medical Center
Jody Luttrell	Kennedy Krieger
Thomas McLoughlin	Rural Maryland Council
Ann Mech	University of Maryland, School of Nursing
Brenda Myrick	Coventry Health Care of Delaware
K. Singh Taneja	Prince George's Hospital Center
Fredette West	Racial and Ethnic Health Disparities Coalition/African American Health Alliance
Liaisons to the Continuity of Care Advisory Committee	
George Benjamin	Maryland Health Benefit Exchange Board Liaison
Frank Kolb	Maryland Health Benefit Exchange
Megan Mason	Maryland Insurance Administration
Rebecca Pearce	Maryland Health Benefit Exchange
Tricia Roddy	Maryland Department of Health and Mental Hygiene
Susan Tucker	Maryland Department of Health and Mental Hygiene
Enrique Vidal-Martinez	Maryland Health Benefit Exchange Board Liaison

Appendix B. Chronic Prescription Drugs among 12-Month Churn Cohort, by Drug Indications

Drug Indications and Therapeutic Descriptions	Users
ADHD; narcolepsy	**3,255**
Amphetamines	2,824
Propylamine Derivatives	431
Anemia	**3,830**
Iron Preparations	3,830
Antipsychotic illness	**3,693**
Phenothiazine Derivatives	3,693
Anxiety	**13,255**
Miscellaneous Anxiolytics, Sedatives and	6,890
Tranquilizers	6,365
Asthma and other respiratory conditions	**92**
Respiratory Smooth Muscle Relaxants	92
Benign Prostatic Hypertrophy; Hypertension	**367**
a-Adrenergic Blocking Agents	367
Birth control	**8,272**
Contraceptives	8,272
Blood clotting disorders	**1,726**
Anticoagulants	1,726
Cancer	**907**
Antineoplastic Agents	907
Control of overactive bladder symptoms e.g. frequency, nocturia, and urgency	**573**
Genitourinary Smooth Muscle Relaxants	573
Depression	**18,134**
Antidepressants	18,134
Diabetes	**13,138**
Biguanides	4,032
Diabetes Mellitus	2,901
Glucosidase Inhibitors	15
Glycogenolytic Agents	187
Insulins	3,037
Ketones	47
Meglitinides	44
Sulfonylureas	2,423
Thiszolidinediones	452
Dietary agents for appetite suppression	**2,162**
Anorexigenic Agents & Respiratory and Ce	2,162
Drug abuse	**36,108**

Drug Indications and Therapeutic Descriptions	Users
Opiate Agonists	34,100
Opiate Antagonists	105
Opiate Partial Agonists	1,903
Drugs used to aid in digestion of food	**117**
Digestants	117
Drugs used to remove heavy metals from body e.g. lead	**6**
Heavy Metal Antagonists	6
Gastrointestinal disorders (e.g. nausea and vomiting, increased colon motility), slow heart rate, glaucoma	**1,928**
Miscellaneous Autonomic Drugs	1510
Parasympathomimetic Agents	418
Heart disease	**544**
Antiarrhythmic Agents	208
Cardiotonic Agents	336
Heart disease; Angina	**867**
Nitrates and Nitrites	867
Heart disease; Congestive heart failure	**786**
Mineralocorticoid (Aldosterone) Receptor	786
Heart disease; Hypertension	**7,831**
b-Adrenergic Blocking Agents	7831
Heart disease; Hypertension; Angina	**6,614**
Calcium-Channel Blocking Agents, Miscellaneous	958
Dihydropytidines	5,656
Heart disease; Kidney Disease; Diabetes	**10,266**
Angiotensin-Converting Enzyme Inhibitors	10,266
HIV	**1,437**
Antiretroviral	1,437
Hypertension, Heart failure,	**1,646**
AngiotensinII Receptor Antagonists	1,646
Hypertension, Heart failure, Angina	**693**
Direct Vasodilators	630
Vasodilating Agents, Miscellaneous	63
Karposi's sarcoma (HIV complication, liver disease, multiple sclerosis, leukemia	**31**
Interferons	31
Kidney Disease	**342**
Alkalinizing Agents	85
Phosphate removing agents	257
Liver disease; constipation	**1,055**
Ammonia Detoxicants	1,055
Lowers cholesterol	**7,816**
HMG-CoA Reductase Inhibitors	7,816

Drug Indications and Therapeutic Descriptions	Users
Lowers cholesterol and/or triglycerides	**181**
Antilipemic Agents, Miscellaneous	181
Lowers triglycerides	**794**
Fibric Acid Derivatives	794
Malaria	**478**
Antimalarials	478
May be given to stimulate appetite for weight gain	**218**
Caloric Agents	218
Migraine headaches	**1,088**
Selective Serotonin Agonists	1,088
Panic disorders, anxiety, insomnia, alcohol withdrawal, seizures	**2,843**
Benzodiazepines	2,843
Parasitic infections	**185**
Amebioides	3
Anthelmintics	182
Protozoal infections	**5,740**
Miscellaneous Antiprotozoals	5,740
Reduces cholesterol and triglycerides	**134**
Bile Acid Sequestrants	134
Respiratory Illness; erectile dysfunction	**30**
Phosphodisterase Inhibitors	30
Respiratory Illness; Urinary disease	**15**
Acidifying Agents	15
Sedative, hypnotic, anticonvulsant	**252**
Barbiturates	252
Seizures	**8,613**
Hydantoins	538
Miscellaneous Anticonvulsants	8,059
Succinimides	16
Slows heart rate; Hypertension	**2,075**
Central a-Agonists	2,075
Stimulate red blood cell production; often used in patients receiving dialysis	**192**
Hematopoietic Agents	192
Treatment of psychoses	**856**
Antimanic Agents	856
Treatment of Tuberculosis	**167**
Antituberculosis Agents	167
Treatment of Tuberculosis and Leprosy	**90**
Miscellaneous Antimycobacterials	90
Urinary disorders	**1,938**

Drug Indications and Therapeutic Descriptions	Users
Antimuscarinics (Antispasmodics)	1,938
Used for gastro intestinal disorders i.e. difficult digestion, ulcer disease, prevention of stress ulcers, and gastro esophageal reflux disease	**7,417**
Histamine H2-Antagonists	7,417
Used for gout	**19**
Uricosuric Agents	19
Used in gastrointestinal disorders	**10**
GI Drugs, Misc.	10
Used in many illness states to remove excess potassium from blood e.g. heart disease and kidney disease	**108**
Potassium removing agents	108
Used in peripheral vascular disease	**23**
Hemorrheologic Agents	23
Used in treatment of eye disorders	**186**
Mydriatics	186
Used in treatment of leukemia; used in treatment of dermatology conditions	**686**
Cell Stimulants and Proliferants	686
Used in treatment of parathyroid disorders	**22**
Parathyroid	22
Used in treatment of pituitary disorders	**175**
Pituitary	175
Used to prevent antiviral replication-(HIV, chemotherapy, Hepatitis B)	**2,552**
Nucleosides and Nucleotides	2,552
Used to stimulate thyroid gland	**2,831**
Thyroid Agents	2,831
Used to suppress thyroid gland as in hyperthyroidism	**243**
Antithyroid Agents	243
Used to treat respiratory illness and/or lung disease; used in transplants procedures; used in swelling in the brain	**16,909**
Adrenals	16,909
Used to treat respiratory conditions, liver conditions, ulcerative colitis and allergic reactions	**8,585**
Corticosteroids	8,585
Sub Total	**213,146**
Other drugs for Non-Chronic Conditions, or Unclassified	331,887
Grand Total	**545,033**

Appendix C. Actuarial Analysis

Maryland Continuity of Care Impact Review

Background:
Optumas worked with Hilltop to review the potential impact that ongoing continuity of care policy discussions could have on health plans operating in Medicaid and the Health Insurance Exchange. If implemented, the continuity of care provisions could increase the costs for a health plan because it would be required to allow, for a period of time, certain newly enrolled members to continue to receive care from providers with which it does not directly contract. Reimbursement to these non-contracted providers could be at a rate higher than typically paid by the health plans prior to the continuity of care provisions.

Methodology:
In order to estimate the potential impact of the continuity of care discussions, **Optumas** first isolated the dimensions of health plan risk that could be affected by the continuity of care provisions. These included

a) **covered conditions**: the conditions that would be continuously covered,
b) **condition prevalence**: the relative prevalence of those conditions within a typical Medicaid or Commercial Health Insurance population,
c) **condition churn rate**: the likelihood that a member with a given condition moves from one health plan to another,
d) **non-par provider likelihood**: the likelihood that a churning member's service provider is a part of another health plan's provider network,
e) **non-par provider reimbursement**: the provider reimbursement differential for contracted and non-contracted providers,
f) and **months of coverage**: the length of time for which continuity is guaranteed.

Optumas relied on multiple sources of information in order to develop reasonable assumptions for the risk dimensions listed above. These sources of information are summarized in Table 1 below.

Table 1: Analysis Components and Support

Analysis Component	Support
a) Covered Conditions	Hilltop coding logic to identify appropriate service conditions in claims data
b) Condition Prevalence	**Optumas**' review of multiple years of claims experience for Medicaid and Commercial health plans in combination with benchmarks for reasonableness
c) Condition Churn Rate	Hilltop study of churn in the Maryland Medicaid program
d) Non-Par Provider Likelihood	**Optumas**' proprietary models including typical out of network utilization for broad service categories
e) Non-Par Provider Reimbursement	HealthChoice Manual for Providers of Self-Referral and Emergency Services

	(http://mmcp.dhmh.maryland.gov/docs/SELFREFERRALMAN.Current.update.08.10.pdf) Medicaid Non-Emergency Out-of-Network Payment Study (http://www.lewin.com/~/media/Lewin/Site_Sections/Publications/OutofNetworkStudyReport.pdf)
f) Months of Coverage	Policy decision

Conclusions:
Based on its review of the dimensions of risk listed above, Optumas produced a range of potential outcomes for the impact of the continuity of care provisions to account for variability inherent in the assumptions and provided Hilltop with three scenarios: a lower scenario estimate, a best estimate, and an upper scenario estimate. A separate set of estimates were provided for a) the impact on Medicaid health plans receiving members churning out of a Health Insurance Exchange plan and b) the impact on Health Insurance Exchange health plans receiving members churning out of the Medicaid program. These are summarized in Tables 2a and 2b below.

Table 2a: Analysis Results (Including Normal MH/SA[1])

	Continuity of Care Impact (%)		
Scenario	**Lower Scenario**	**Best Estimate**	**Upper Scenario**
Medicaid Churn to Exchange	0.002%	0.026%	0.097%
Exchange Churn to Medicaid	0.002%	0.022%	0.083%

Table 2b: Analysis Results (Including Severe/Persistent MH/SA[1])

	Continuity of Care Impact (%)		
Scenario	**Lower Scenario**	**Best Estimate**	**Upper Scenario**
Medicaid Churn to Exchange	0.002%	0.024%	0.094%
Exchange Churn to Medicaid	0.001%	0.015%	0.069%

[1] Hilltop provided Optumas with two definitions for Mental Health and Substance Abuse conditions. The results in Tables 2a and 2b reflect the continuity of care impact for all conditions combined, but these tables differ based on the criteria for Mental Health and Substance abuse.

Impact of Continuity of Care

Mental Health / Substance Abuse Persistent

Medicaid to Exchange

	% of Total Service Costs	Churn Rate	Non Par Prov %	Non Par Reimb Differential	Months of Coverage	Total Impact
Pregnant Women	14.02%	3.69%	22%	4%	6	0.0022%
Prescriptions	7.35%	7.52%	10%	13%	3	0.0017%
HIV	0.35%	11.36%	25%	31%	3	0.0008%
Mental Health	2.74%	6.78%	25%	31%	3	0.0036%
Substance Abuse	3.87%	10.05%	25%	31%	3	0.0076%
Dialysis	0.42%	9.86%	25%	31%	3	0.0008%
Chemotherapy	1.22%	5.01%	25%	31%	3	0.0012%
Radiation Therapy	0.61%	7.66%	25%	31%	3	0.0009%
Transplants	0.05%	6.13%	22%	4%	3	0.0000%
Hospitalizations	19.18%	3.42%	22%	0%	3	0.0000%
Home Health	1.09%	3.49%	40%	31%	3	0.0012%
DME	2.72%	4.79%	40%	31%	3	0.0041%
				All Combined		0.024%

Original Capitation Rate	$	300.00
Adjusted Capitation Rate	$	300.07
PMPM Impact	$	0.07

Exchange to Medicaid

	% of Total Service Costs	Churn Rate	Non Par Prov %	Non Par Reimb Differential	Months of Coverage	Total Impact
Pregnant Women	18.69%	3.32%	22%	3%	6	0.0021%
Prescriptions	8.16%	6.76%	10%	10%	3	0.0014%
HIV	0.26%	10.22%	25%	25%	3	0.0004%
Mental Health	2.42%	6.10%	25%	25%	3	0.0023%
Substance Abuse	3.36%	9.05%	25%	25%	3	0.0048%
Dialysis	0.01%	8.87%	25%	25%	3	0.0000%
Chemotherapy	0.29%	4.51%	25%	25%	3	0.0002%
Radiation Therapy	0.03%	6.89%	25%	25%	3	0.0000%
Transplants	0.17%	5.52%	22%	3%	3	0.0000%
Hospitalizations	21.32%	3.08%	22%	0%	3	0.0000%
Home Health	1.09%	3.14%	40%	25%	3	0.0009%
DME	2.72%	4.31%	40%	25%	3	0.0029%
				All Combined		0.015%

Original Capitation Rate	$	300.00
Adjusted Capitation Rate	$	300.05
PMPM Impact	$	0.05

Appendix D. Written Public Comments

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Voices for Maryland's Children | www.acy.org

Ms. Uma Ahluwalia and Ms. Cyndy Demarest
Co-Chairs, Continuity of Care Advisory Committee
c/o The Maryland Health Benefit Exchange
4160 Patterson Avenue
Baltimore, MD 21215

November 16, 2012

Dear Ms. Ahluwalia and Ms. Demarest:

Advocates for Children (ACY) is submitting comments at the request of Ms. Ahluwalia in response to issues raised at the November 13, 2012 Continuity of Care meeting.

Establishing effective mechanisms to assure continuity of medical, dental and behavioral health services and to prevent churn will be particularly important for children. To further these goals, ACY strongly recommends that the Exchange consider and act upon the issues outlined below.

First, the Exchange should recommend and the State should move to establish 12 months continuous eligibility for MAGI populations. Currently, both MCHP and MCHP Premium programs require renewal at six months. While the Department of Health and Mental Hygiene has taken significant steps to simplify the renewal process, it makes no sense set up a new system where parents enrolled in the Maryland Health Benefit Exchange have different renewal dates than their children enrolled in MCHP or MCHP Premium. And, as the Hilltop slides comparing churn rates for foster children versus MCHP/MCHP Premium children illustrate, the six-month eligibility period does make a significant difference.

Second, the Exchange should determine whether the "waiting period" for MCHP/MCHP Premium applicants can be eliminated as we implement health care reform. It seems counter intuitive to require coverage and than impose a waiting period. The existence of the waiting period also raises the specter of different renewal periods among family members. It is our understanding that other states have already implemented less restrictive measures to avoid crowd out under CHIP. It also may be possible to get a waiver from CMS.

Finally, ACY strongly recommends that the Continuity of Care Advisory Committee include pediatric dental benefits in its discussion about standards for continuity of care. As Maryland is well aware, pediatric dental benefits are critical to ensuring the wellbeing of children. If we are to continue to prioritize access to dental care for children, then we must address continuity of care standards for pediatric dental just as we are considering them for medical and behavioral health services. To do otherwise is to deny their status as an essential health benefit under the Affordable Care Act and to disavow Maryland's concerted efforts to make oral health an integral part of children's health services. Relegating pediatric dental benefits to a "second class" benefit category is simply unacceptable.

Thank you for your consideration of our request. We look forward to working with the Committee as it moves forward. If you should have any questions, please feel free to contact me.

Sincerely,

Leigh Cobb
Leigh Cobb, Health Policy Director

Comments on:
Analysis of Options to Ensure Continuity of Care:
A Report to the Maryland Health Benefit Exchange Board of Trustees
Submitted 3 December 2012
Advocates for Children and Youth
Maryland Women's Coalition for Health Care Reform

Advocates for Children and Youth and the Maryland Women's Coalition for Health Care Reform are pleased to submit the following comments on the Continuity of Care Advisory Committee's draft report to the Maryland Health Benefit Exchange (MHBE) Board. We hope that these comments are helpful as the Advisory Committee and the Exchange Board consider the options for continuity of care provisions. These will be particularly important for those transitioning between coverage under Medicaid/the Maryland Children's Health Program (MCHP) and qualified health plans (QHPs) offered in MHBE. However, while other populations were not included in the Committee's report, it is worth noting that the continuity of care issues will affect others, including individuals moving between the SHOP and individual exchange, between the MHBE and the outside market, and special populations such as those leaving the prison system.

We appreciate the work of the MHBE, the Department of Health and Mental Hygiene (DHMH) and the Continuity of Care Advisory Committee to address these important issues. While public, as opposed to committee member, comment was not specifically solicited we hope that the perspective and expertise shared here by the signatories will be of use to the Board. Our shared commitment is to ensure that Maryland establishes an Exchange program that "gets it right" and assures Marylanders that, despite a change in their coverage, they will have access to all of the health care services they need.

In evaluating the committee's report, it may be useful to consider the statement in the **Health Care Reform Coordinating Council's 2010 interim report. This spoke of the "once-in-a-generation" opportunity to transform the health care landscape**. Therefore, we would encourage the Board to take a visionary approach that includes recommendations that create parity between the inside and outside markets. This approach is incorporated into Section 7. (2) of the Health Benefit Exchange Act of 2012 and is reflected in the committee's scope of work. Its charge was to provide input on "how Maryland can implement continuity of care provisions across markets."

In addition, we propose the following for the Board's consideration:

- The **needs of, and the impact on, the consumer should be the most important consideration.** While this may seem obvious, many of the options and much of the discussion during the committee meetings focused on the impact on the carriers or the MBHE as opposed to the effectiveness of the approach on consumers. While we understand the necessity to create "workable" solutions these should not be at the expense of accessible care for consumers during time periods in which they are particularly vulnerable.

- As regards the selection of the **Essential Health Benefits**, the decision has yet to be made as to the limit on carriers' ability to substitute benefits. We believe that the importance of ensuring

continuity of care argues for a **no substitution policy. Substitution of benefits by carriers would unnecessarily complicate all transition planning.**

- The MHBE Board has, in a number of other policy areas, determined that it will take a reasoned approach that includes the **collection of comprehensive data** that can be used to inform future decision-making. This approach is supported by Section 31-115 of the Health Benefit Exchange Act of 2012, which requires that carriers submit to the Exchange, the Secretary and the Commissioner in an accurate and timely manner … "(iii) data on enrollment, disenrollment, number of claims denied, and rating practices; (iv) information on cost-sharing and payments with respect to out-of-network coverage; … (vi) any other information as determined appropriate by the Secretary and the Exchange; …"

  Collecting valid data requires that the MHBE ensure the development of streamlined **disenrollment codes.** Disenrollment data must be complete and accurate to enable analysis based on issues including changes in income and affordability. **(For a discussion of the issues and recommendations see "Issue Brief: New Denial and Disenrollment Coding Strategies to Drive State Enrollment Performance")**

- We believe that **Option 2b (New health plan accepts prior authorization determinations from relinquishing plans for certain treatments for specified time period)** has some merit**.** However, we would stress the importance of a 90 day (over 60 day) and/or condition specific period. In making this recommendation we would note that clinicians have already conducted the necessary analyses to justify the treatment. Therefore, there should be a cost-saving for carriers in eliminating an initial and unnecessary second pre-authorization process. We also strongly believe that the pregnancy transitions should extend to the post partum period.

- **Option 3 (New health plan allows enrollees within specified courses of treatment to receive care from out-of-network providers for a specified period of time.)** While this is not specifically defined as "self-referral" we believe that this approach should be adopted, with in-network cost-sharing, in addition to Option 2b. Not only will this enhance a consumer's ability to retain the provider that best suits them, but it has the same benefit as Option 2b in terms of a second pre-authorization.

- We do not regard **Option 4 (formal notification is provided to enrollees of their transition options)** as optional. It must be a requirement to ensure, not only continuity of care, but for the dual goals of consumer protections and transparency.

- **Option 5 (Health Risk Assessment)** would serve the needs of providers as they determine effective preventive and treatment plans. The result would be better outcomes for patients with potential cost savings and seamless transition plans to underscore the goal of continuity of care.

- This process would be enhanced if **Option 6 (transition plans for enrollees)** is adopted. Carriers should be required, at the time of enrollment to identify any special or immediate health care services needed by the consumer. This would be greatly facilitated by a limited health risk assessment that would identify those who might require transition plans due to chronic disease, pregnancy, etc. As discussed at the November 29 meeting, both trained navigators and/or

appropriate screens on the HIX could facilitate such an assessment, which should serve to create effective treatment-specific transition plans while also ensuring patient privacy.

While the discussion at the meeting explored in-depth how such assessments might be carried out, and when, we do not believe that the challenges should be used as an excuse to circumvent a process that would benefit consumers in the long-term.

- **Option 7 (MHBE works with others to evaluate continuity of care as it progresses)** should not be considered "optional." Given the emphasis on continuity of care in both the December 23, 2011 Report to the Governor and Maryland General Assembly and in the HBEA 2012, we believe the MHBE is obligated to undertake on-going evaluation and to address issues as they arise. We feel certain it will agree that this is required to ensure that consumers have seamless transitions.

Lastly, we would **strongly suggest that the Exchange, consumer advocates, Medicaid representatives, representatives of the broader insurance market, and providers continue to have a venue to discuss these issues.** While the Advisory Committee began to delve into some interesting issues, the timeframe for the decision did not allow for full discussion of issues such as the NAIC model continuity of care standards. We believe that there still may be other options to evaluate that could promote continuity of care for *consumers*. These options include self-referral standards for certain services and ways to mitigate cost-sharing changes when consumers switch plans. For the purposes of these comments, we have focused solely on those options presented to the Advisory Committee.

We are grateful for the opportunity to submit these comments. We would be happy to provide further clarifications and/or information as would be deemed useful and we look forward to working to ensure that all Marylanders receive the full promise of health care reform, which includes the assurance that they will have access to care even as they transition between programs or plans.

Leigh Cobb, Health Policy Director, Advocates for Children and Youth lcobb@acy.org

Leni Preston, Chair, Maryland Women's Coalition for Health Care Reform leni@mdchcr.org

9 November 2012

Uma Ahluwalia
Co-Chairwoman, Continuity of Care Advisory Committee
Maryland Health Benefit Exchange
4201 Patterson Avenue
Baltimore, MD 21215

Dear Co-Chairwoman Ahluwalia:

We would like to take this opportunity to thank you and the members of the Continuity of Care Advisory Committee for your leadership in ensuring the best possible care for all in Maryland. We appreciate the information being provided by this committee, as well as the information being provided by staff of the Maryland Health Benefit Exchange and Medicaid. We are grateful that the hard work of many has made Maryland a model state for implementing provisions of the Affordable Care Act (ACA).

In particular, we applaud your committee's decision to include people living with HIV among those populations being analyzed as potential special populations in need of transition plans between the Maryland Health Benefit Exchange (MHBE) and Medicaid. We hope that you will choose to place people living with HIV on your committee's final list of special populations needing transition plans, as well as consider those patients who suffer from chronic infections such as viral hepatitis.

In your deliberations, we ask that you continue to keep in mind that strict adherence to medication treatment regimens leads to improved clinical outcomes for HIV patients. We encourage you to ensure that, as part of the transition planning, HIV patients continue to have access to the comprehensive list of drugs currently identified by the Department of Health and Mental Hygiene's drug formulary under the Maryland AIDS Drug Assistance Program (MADAP). The list of medicines covered by MADAP includes a wide range of medications used to treat HIV infection, opportunistic infections, and complications of HIV infection or related conditions, including all anti-retroviral therapies approved by the U.S. Food and Drug Administration.

To assure continuity of care across systems, we recommend the use of the Ryan White service network to inform transition plans and help minimize disruption in care.

Finally, we encourage that transition plan development be informed by current public health standards for treating HIV. Federal HIV treatment recommendations are written and frequently updated by the National Institutes of Health in recognition of the complexity of HIV treatment and ongoing advances in preferred treatment regimens.

We appreciate your consideration for the HIV/AIDS population and look forward to closely following the continuing work of the Continuity of Care Advisory Committee.

Respectfully,

Carolyn L. Massey, Chair
Jeanne Keruly, CRNP, NP, Vice-chair
Melanie Reese, Nominating Committee Chair
Leonard Sowah, MD, MPH and Carlisle Harvey, Sr., Co-chairs, Comprehensive Planning Committee
Greater Baltimore HIV Health Services Planning Council

The Greater Baltimore HIV Health Services Planning Council

Our mission is to provide comprehensive, high quality services to people living with HIV/AIDS in the greater Baltimore eligible metropolitan area (EMA) regardless of their ability to pay. The planning council will plan for and ensure access to culturally sensitive, high quality, cost-effective services in collaboration with local authorities, providers and consumers of HIV-prevention and care services. The planning council and its advisors will act in a timely and unbiased manner when setting priorities to allocate resources to people living with HIV and AIDS. For more information about the planning council, please visit: www.baltimorepc.org.

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2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM
MARYLAND CITIZENS' HEALTH INITIATIVE

December 3, 2012

Dr. Joshua Sharfstein
Health Secretary
Maryland Department of Health and Mental Hygiene

Dear Dr. Sharfstein:

Thank you so much for the opportunity to submit our comments to the committee.

On the Continuity of Care document in general:

We recommend AGAINST option 1.

Option 1 which is to maintain only current continuity of care policies that exist in the commercial marketplace is not sufficient for the special situation that enrollees transitioning from Medicaid to commercial exchange plans will be facing. Current commercial sector polices were developed for transitions of employees as a group from one employer sponsored health plan to another. The differences between two commercial plans are vastly smaller than the differences between Medicaid and any commercial plan, in terms of cost sharing and covered benefits. In this case there is no human resources department to help employees with the change either. The lower income population involved is likely to be less educated, less familiar with commercial insurance and more vulnerable, all of which argues for more proactive assistance with transitions. For persons in treatment for complex medical and mental health conditions there needs to be a more proactive approach to assuring that these persons continue with no disruption their care.

We recommend FOR option 2b and 3.

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MARYLAND CITIZENS' HEALTH INITIATIVE

Option 2b puts the responsibility on the health plan to accept the prior authorization of the prior health plan for a specified period of time. Option 3 requires that providers who may be out-of network in the receiving plan for a specified period of time. While there may be some administrative challenges to implementing such a policy the cost of not doing so will be disruptions in care and additional unnecessary aggravation for patients who are already sick.

Regarding options 4, 5 and 6, formal notification.

Formal letters, which describe complex insurance rules and say things like "your provider may not be in the network of your new plan," only serve to frighten people who are already stressed, unfamiliar with insurance, and may have limited English skills or reading skills. Human assistance is needed. This may be costly and there may need to be a way to target those in most need of assistance, without doing risk assessments for everyone, but the benefit of a proactive approach will be seen in better health outcomes and a much better consumer experience. Once again, a simple *letter* to the majority of these new insured populations may not only frustrate these Marylanders, but also discourage them from participating, as the confusion level might prevent them from enrolling – directly the opposite of the intent. We will need to be proactive and creative to make sure folks across the spectrum of our diverse population are gaining the care they desperately need.

Finally, although we recognize that this is beyond the report's scope, we urge the committee and state officials to analyze and act on pending federal regulation regarding the Basic Health Plan option. Compared to limited and complex tax subsidies to allow an individual to purchase coverage on the Exchange, the Basic Health Plan option could allow for more affordable, streamlined and continuous coverage for low-income adults. This option may especially streamline enrollment for families with children enrolled in Medicaid, MCHP and other programs. When specific federal guidance is available, we look forward to working to encourage the state to utilize a Basic Health Plan, which can improve access to quality affordable

health care for low-income Marylanders.

A basic health plan would move the line that separates Medicaid and commercial plans up to 200% of Federal Poverty Level. While this might not reduce the number of persons that move back and forth between Medicaid and commercial plans in the exchange, it would change who moves across this line to a slightly higher income population. It is hard to know for sure whether this population would have fewer special needs requiring continuity of care policies, but it is possible. The prevalence of conditions that need the additional types of services that Medicaid covers and that the Essential Health Benefits does not, is likely to be more concentrated among lower persons, e.g. specialized dental health and substance abuse services and non-medical transportation.

Once again, we thank you for the opportunity to comment, and we are always available to comment further if you see fit or have specific questions.

Sincerely,

Vincent DeMarco, President, Maryland Citizens' Health Initiative

Matthew Celentano, Deputy Director, Maryland Citizens' Health Initiative

Maryland Dental Action Coalition

Maryland Dental Action Coalition
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http://www.mdac.us/

Ms. Uma Ahluwalia and Ms. Cyndy Demarest
Co-Chairs, Continuity of Care Advisory Committee
c/o The Maryland Health Benefit Exchange
4160 Patterson Avenue
Baltimore, MD 21215

November 16, 2012

Dear Ms. Ahluwalia and Ms. Demarest:

The Maryland Dental Action Committee (MDAC) is writing to request that the Continuity of Care Advisory Committee include pediatric dental benefits in its discussion about standards for continuity of care. Pediatric dental benefits are critical to ensuring the wellbeing of children – so critical that the Affordable Care Act (ACA) specifically requires states to include pediatric dental benefits in their essential health benefits packages. While this mandate holds great promise for improving access to dental care for children, states will need to ensure that implementation policies allow for this promise to be realized. One of those key implementation policies is the development of continuity of care standards. The Committee is considering standards for medical and behavioral health services. We submit that the same consideration should be given to continuity of care standards for pediatric dental services so that we can identify ways to ensure that children have consistent access to the full range of health related services, including dental services.

Continuity of care standards are most critical when there are high rates of "churn" between plans. We are very concerned about the impact of this churn on children, especially children churning between Medicaid managed care organizations (MCOs) and qualified health plans (QHPs). As a State, we have identified pediatric dental services as a top priority in improving the delivery of services in the Maryland Medicaid program. If Maryland wants to maintain these pediatric dental services as a priority, we need to ensure that they are not disrupted for children caught in the churn between plans.

The inclusion of pediatric dental benefits in the essential health benefits package will provide some consistency for children switching plans. However, the provision of critical services could be disrupted easily by even slight differences in benefits design, medical necessity definitions, cost sharing requirements, and network composition. We think it only makes sense to consider ways to maintain access through the periods of churn for children. To assist the Committee, we have identified three services areas which should be discussed: 1) orthodontics; 2) restorative services, including endodontic treatment; and 3) oral surgical services. In each of these services areas, children could be left in coverage "limbo" if the first plan approves coverage but the second plan does not. What happens to those children mid-treatment? This is the same underlying question that the Committee is considering for people who are mid-treatment for medical and behavioral health conditions. It makes sense to ask the same basic question for pediatric dental services.

Thank you for your consideration of our request. We look forward to working with the Committee as it moves forward. If you should have any questions, please feel free to contact Penny Anderson, Executive Director of MDAC, at panderson@mdac.org or (410) 884-8294.

Sincerely,

Carol Caiazzo
Chair, Board of Directors

cc: Continuity of Care Advisory Committee; Rebecca Pearce

Optimal Oral Health for All Marylanders

UNIVERSITY *of* MARYLAND
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November 16, 2012

Uma Ahluwalia, Co-Chair, Continuity of Care Advisory Committee
Cynthia Demarest, Co-Chair, Continuity of Care Advisory Committee
Laura Spicer, Policy Analyst, Hilltop Institute
(sent electronically)

RE: ***Recommendations for Continuity of Care Protections for Individuals with Substance Use Disorders and Mental Health Conditions***

Dear Ms. Spicer and Co-Chairs Ahluwalia and Demarest:

The Drug Policy and Public Health Strategies Clinic of the University of Maryland Francis King Carey School of Law submits this letter to the Continuity of Care Advisory Committee in support of implementing specific continuity of care protections for individuals with behavioral health conditions who transition between Medicaid plans and Health Connection Plans.

As clearly illustrated by the reports and studies cited herein, individuals with mental health ("MH") conditions and substance use disorders ("SUDs") in the Medicaid population are high cost, high utilizers in all categories of health care services.[1] Studies also demonstrate that appropriate treatment for behavioral health conditions results in overall cost savings.[2] Churn between Medicaid and Qualified Health Plans ("QHPs") within the Maryland Health Connection threatens poor health outcomes for individuals with behavioral health needs, as well as increased economic costs for the insurers and the State.[3] Care coordination and transition supports for these individuals as they move between Medicaid and QHPs are vital to ensure that current treatment of chronic and acute conditions is sustained and supported, and that the costs of treatment for this population is appropriately contained.

[1] See *infra* Section IA.
[2] See *infra* Section IC.
[3] See *infra* Section IB.

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I. Individuals with Behavioral Health Needs Require Continuity of Care Protection

A. Individuals with Behavioral Health Needs Are High Cost, High Utilizers of Somatic Health Care Services

Individuals with MH conditions and SUDs are high utilizers of Medicaid-reimbursed health care services generally, and consume a disproportionate amount of somatic care in comparison to individuals without behavioral health needs.[4] In a recent study on Behavioral Health Integration, adult individuals enrolled in Maryland HealthChoice with MH conditions, SUD, or both were shown to use more **somatic services** (services separate from substance use disorder or mental health care) per enrollee in nearly every service setting than did their counterparts with neither condition.[5] For example, in FY 2011, individuals diagnosed with SUD alone had 2.3 times as many hospital inpatient admissions, 1.7 times as many hospital outpatient visits, and 2 times as many emergency room visits.[6] Furthermore, individuals categorized as having both SUD and MH conditions had 4 times as many hospital inpatient admissions, 2.9 times as many hospital outpatient visits and 4.9 times as many emergency department visits.[7]

B. Individuals with Behavioral Health Needs are Particularly Vulnerable to Churn

A recent report by the Hilltop Institute, presented as a PowerPoint presentation at the November 5, 2012 Continuity of Care Advisory Committee meeting, recognizes individuals with behavioral health needs as a measurable sub-population affected by churn.[8] In addition, the Department of Health and Mental Hygiene ("DHMH") has noted in its recommendations for further study that behavioral health is a treatment plan worth considering as a population with critical continuity of care issues.[9] In its recommendations, DHMH also notes that "Medicaid will have a more comprehensive benefit package for behavioral health services than QHPs. Gaps in services for this population could have significant consequences for their care."[10]

Hilltop and DHMH are correct in focusing on individuals with behavioral health needs as a sub-population requiring additional continuity of care protections. Citing a major study by Benjamin Sommers and Sara Rosenbaum, DHMH has recognized that individuals below 200% FPL may be the most susceptible to churn.[11] Many individuals with MH conditions and SUD

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[4] See Appendix A, Service Per Enrollee Chart ("Appendix A") (developed from "An Integrated Model for Medicaid-Financed Health Services." Recommendations delivered to Secretary Sharfstein. October 1, 2012 ("BHI Report"), Appendix XII.1, 2011 Databook, Template 9a, available at http://dhmh.maryland.gov/bhd/Documents/BH_ReportAppendices_FINAL.pdf).
[5] See BHI Report, Appendix XII.1, Template 9a; See also Appendix A.
[6] See Appendix A (figures derived by comparing service per enrollee data between populations).
[7] *Id.*
[8] See Hilltop Presentation, Nov. 5 2012 Continuity of Care Meeting, at 10, available at http://dhmh.maryland.gov/exchange/pdf/CoC%20Analysis_11052012.pdf).
[9] "Continuity of Care Issues Between the Maryland Health Benefit Exchange and Maryland Medicaid. Recommendations for further study by the Continuity of are Committee." Department of Health and Mental Hygiene (Sept. 13, 2012) ("DHMH Report"), at 6-7.
[10] *Id.* at 7.
[11] *Id.* at 6.

fall into this low income level.[12] As noted in an April 2012 Issue Brief from the Center for Health Care Strategies, "[s]mooth coverage transitions are particularly critical to minimize disruptions in services for individuals . . . with special health care needs . . . . includ[ing] those who have . . . behavioral health conditions requiring medically necessary health and related services beyond those required by the typical beneficiary."[13]

C. Sustained Treatment for Individuals with Behavioral Health Needs is Cost-Effective

Providing ongoing substance use and behavioral health services to those in need saves money. A study of enrollees in Maryland's Medicaid program from 2004-2006, conducted by Peter Fagan, PhD, Director of Research and Clinical Outcomes at Johns Hopkins Healthcare, found that substance use treatment coupled with disease care management resulted in savings due to a reduced rate of health care spending.[14]

In addition, a study by the Washington State Department of Social and Health Services completed in October 2012 found that the average Medicaid medical cost, not including the cost of behavioral health treatments, was $2,587 higher per person per year for individuals with SUD who remained untreated as compared with those who received treatment.[15] The Washington study also notes that consistent SUD treatment decreases mortality, reduces involvement with the criminal justice system, and reduces the number of hospital and emergency room stays.[16]

II. Examples of Transition Protections

A. Maryland Medicaid Provides a Model for Certain Continuity of Care Protections

Current Maryland Medicaid regulations provide numerous protections for special needs populations that can serve as a model for developing continuity of care provisions for individuals with MH conditions or SUDs within the Exchange.

As a special needs population individuals with SUD are entitled to specific protections,[17] including requirements that an MCO:

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[12] See BHI Report, Appendix 1, 2011 Databook, Template 3a. "Unique Enrollees (Aged 19-64 Years) by Service Type, FY 2011" (showing large numbers of SUD and MH enrollees in Maryland Medicaid programs).

[13] Ingram C., McMahon S.M., and Guerra V. *Creating Seamless Coverage Transitions Between Medicaid and the Exchange*, STATE HEALTH REFORM ASSISTANCE NETWORK (April 2012) ("CHCS Issue Brief""), at 2.

[14] See *Medicaid Integrated Care Management and ROI*, AcademyHealth Research Meeting (June 4, 2007), available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=633674

[15] Washington State Department of Social & Health Sciences, Aging and Disability Services Administration, *Adult Behavior Health System – Making the Case for Change* (Draft) (Oct. 23, 2012) ("Washington Study") at 5, available at http://www.dshs.wa.gov/pdf/dbhr/Draft%20Adult%20Behavioral%20Health%20System%20Document.pdf

[16] *See Id.* at 4-6.

[17] COMAR 10.09.65.04(B)(7).

- Perform a **substance abuse assessment** and provide **case management** that is both coordinated and continuous at all levels of care.[18] A case manager is assigned to an enrollee, as appropriate, at the time of his/her initial health screen.[19]

- Ensure that providers **coordinate care and communicate** with other providers at all levels of care. The MCO must identify a **special needs coordinator** to oversee management of the special needs population.[20]

- Ensure that primary care providers **provide care or appropriately refer** to specialty care for the special needs populations.[21]

- Provide **immediate access** for pregnant and postpartum women and individuals suffering from HIV or AIDS to substance abuse treatment (within 24 hours of enrollee's request) and case management services.[22]

- Permit individuals with SUD to **self-refer** to any licensed provider of SUD services at in-network rates.[23]

B. Other States and NCQA Offer Additional Models for Continuity of Care Protections

Additional models for continuity of care protections can be found in other state regulations and in NCQA's accreditation standards. In its report on transitions between Medicaid and the Exchange, DHMH cites an issue brief by the Center for Health Care Strategies ("CHCS") that analyzes several state transition policies and NCQA accreditation standards.[24] The CHCS Issue brief identified a number of specific transition provisions aimed at protecting individuals with behavioral health needs or chronic conditions including the following:

- The NCQA's 2011 accreditation standard that requires health plans to provide enrollees undergoing active treatment for a chronic medical condition access to their discontinued practitioners through the current active treatment period, or for ninety days, whichever is shorter.[25]

- A Massachusetts requirement that MCOs in the event of a change to a behavioral health provider network assure that enrollees "continue to have access to medically necessary services."[26]

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[18] COMAR 10.09.65.04(C)(4).
[19] COMAR 10.09.65.04(C)(5)(a).
[20] COMAR 10.09.65.04(C)(9).
[21] COMAR 10.09.65.04(C)(1).
[22] COMAR 10.09.65.08(F); and *see* COMAR 10.09.65.10(C)(1)(a)and (b) and (E).
[23] COMAR 10.09.67.28(I).
[24] DHMH Report, *supra* note 9, at 7.
[25] CHCS Issue Brief, *supra* note 13, at 7.
[26] *Id.* at 10.

- A Minnesota requirement that "both treatment and treatment-related room and board be covered by the relinquishing MCO" for individuals with chemical dependency or mental health disorders.[27]

In addition to specific protections for enrollees with behavioral health conditions, the CHCS Issue Brief identifies other general transition strategies used by states including: (1) requiring MCOs to craft a transition plan for special-needs enrollees to include criteria such as care management evaluation, coordination, and consultation with existing providers, and coordination and consultation with state agencies if necessary;[28] and (2) requiring relinquishing MCOs to transfer records to the receiving MCO, identify a transition coordinator to assist the flow of beneficiary movements, and, in the event of failing to provide all relevant information to the receiving MCO, cover the individual at issue for up to 30 days.[29]

Finally, the CHCS Issue Brief identified examples of states creating prior authorization protections for Medicaid enrollees. It found that Indiana, Massachusetts, Minnesota, and New Mexico all require the accepting MCO to reimburse treatment for which the patient has received a prior authorization, with varying lengths of time during which the authorization must be accepted.[30]

III. Recommendation for Continuity of Care for Behavioral Health

As demonstrated above, individuals with behavioral health needs represent a population that requires specific protections in order to ensure that such individuals receive appropriate continuity of care. Disruption of treatment for this population, whether caused by a change in provider, increased out-of network costs, additional treatment barriers such as prior authorization or other intake and transition requirements, is costly, both in terms of overall health costs to the plans and in terms of health outcomes for the population. Implementation of proven transition supports should be a priority for the Exchange in order to ensure that special populations receive the full benefits of coverage as they move between Medicaid and the Health Connection plans.

We strongly urge the Continuity of Care Advisory Committee to include in its report to the Exchange Board the following recommendations for individuals with behavioral health needs who transition between Medicaid and Health Connection plans:

1. Special Needs Assessment, Case Management and Care Coordination.

Individuals with mental health conditions or substance use disorders should be identified as a special needs population entitled to case management and care coordination services. All current Medicaid provisions relating to special needs individuals should apply to QHPs when they enroll individuals moving from Medicaid to the QHPs, including the requirement that QHPs identify a care coordinator for such individuals in transition.

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[27] *Id.* at 11-12.
[28] *Id.* at 10-11.
[29] *Id.* at 8-9.
[30] *Id.* at 8-13.

2. Seamless Coverage for 90 days or end of treatment.

Individuals with behavioral health needs should be entitled to remain with their current behavioral provider under the current treatment limitations and coverage terms, including prior authorization requirements, for a period of 90 days, or the end of treatment at that level of care, whichever is shorter. Under this requirement, patients should pay no more than the in-network cost-sharing during the transition term and should be able to access non-formulary drugs at no additional cost. Additionally, as currently provided under Medicaid for SUD, individuals with behavioral health needs should be entitled to self-refer to begin or continue medically necessary treatment for a period of 90 days following enrollment in a QHP.

3. Transition Plans.

Medicaid providers and QHP providers must provide comprehensive transition planning and care coordination for all individuals with behavioral health conditions moving between Medicaid plans and QHPs. This is particularly important for individuals with behavioral health needs as certain Medicaid behavioral health services will not be offered under the Essential Health Benefit and it will be important for transition plans and transition care coordinators to refer patients to other available resources in order to obtain an appropriate level of needed treatment and other non-medical supports.

Thank you for the opportunity to provide public comment.

Sincerely,

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*practicing pursuant to Rule 16 of the Maryland Rules

Appendix A
Service per Enrollee (Aged 19-64 Years) (2011)[31]

	HealthChoice Only				PAC Only				HealthChoice/PAC			
Service Setting	**Both HC**	**MHD HC**	**SUD HC**	**None HC**	**Both PAC**	**MHD PAC**	**SUD PAC**	**None PAC**	**Both HC/PAC**	**MHD HC/PAC**	**SUD HC/PAC**	**None HC/PAC**
Hospital Inpatient Visits (Somatic)	0.8	0.27	0.46	0.2	0	0	0	0	0.55	0.24	0.42	0.19
Hospital Outpatient Visits (Somatic)	5.19	2.85	3.07	1.81	1.66	0.8	0.8	0.64	4.12	2.61	2.54	2.17
Physician/ Professional Visits (Somatic)	23.45	13.58	12.72	8.38	5.34	4.71	3.05	3.93	14.84	11.38	11.06	9.19
Pharmacy Prescriptions	27.73	20.84	11.49	7.78	16.17	15.47	6.3	9.25	22.26	20.17	10.54	11.45
Home Health Visits	4.97	27.9	2.06	1.45	0.26	0.07	0.21	0.03	0.52	1.14	0.2	0.16
Long Term Care Billing Events	0.1	0.04	0.03	0	0.01	0.01	0	0	0.02	0.01	0.02	0.01
Emergency Department Visits (Somatic)	3.82	1.55	1.81	0.95	1.66	0.8	0.8	0.86	3.24	1.68	1.65	1.1
Emergency Department Visits (All)	4.62	1.69	1.88	0.95	2.05	0.88	1.4	0.64	4.23	1.84	1.72	1.1
Methadone	8.61	0	10.38	0	8	0	10.15	0	8.14	0	10.23	0

[31] Data has been transcribed from BHI Report Appendix XII.1, 2011 Databook, Template 9a. Some categories were omitted for relevance purposes. Each figure represents the average number of services consumed per enrollee under each program by service setting during FY 2011.