The Hilltop Institute

analysis to advance the health of vulnerable populations

Evaluation of the HealthChoice Program
CY 2008 to CY 2012

June 30, 2014

UMBC

AN HONORS UNIVERSITY IN MARYLAND

Evaluation of the HealthChoice Program
CY 2008 to CY 2012

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Evaluation of the HealthChoice Program
CY 2008 to CY 2012

Executive Summary

HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in 1997 under authority of Section 1115 of the Social Security Act. The HealthChoice managed care program currently enrolls more than 80 percent of the state's Medicaid population. The program also enrolls children in the Maryland Children's Health Program (MCHP), Maryland's Children's Health Insurance Program (CHIP). HealthChoice participants choose one of seven managed care organizations (MCOs) and a primary care provider (PCP) from their MCOs' network to oversee their medical care. HealthChoice enrollees receive the same comprehensive benefits as those available to Maryland Medicaid enrollees through the fee-for-service system. Since the inception of HealthChoice, the Maryland Department of Health and Mental Hygiene (DHMH) has conducted five comprehensive evaluations of the program as part of the 1115 waiver renewals. Between waiver renewals, DHMH continually monitors HealthChoice performance on a variety of measures and completes an annual evaluation for HealthChoice stakeholders. This report is the 2012 annual evaluation of the HealthChoice program. Key findings from this evaluation are presented below.

Coverage and Access

Two of the goals of the HealthChoice program are to expand coverage to additional residents with low-income through resources generated from managed care efficiencies and to improve access to health care services for the Medicaid population. Related to these goals:

- Maryland extended full Medicaid eligibility to parents and caretaker relatives of children enrolled in Medicaid or MCHP with household incomes below 116 percent of the federal poverty level in July 2008. Enrollment in this expansion program increased from 7,832 enrollees in July 2008 to 100,963 enrollees in December 2012.
- Overall HealthChoice enrollment increased by 52 percent, from 542,202 enrollees in calendar year (CY) 2008 to 824,193 enrollees in CY 2012. These totals reflect individuals who were enrolled as of December 31 of each respective year, thus providing a snapshot of typical program enrollment on a given day.
- With these expansion activities and increased enrollment, it is important to maintain access to care and ensure program capacity to provide services to a growing population. Looking at service utilization as a measure of access, the percentage of enrollees who received an ambulatory care visit increased between CY 2008 and CY 2012, with nearly 80 percent receiving a visit in CY 2012. Emergency department (ED) visits also increased during this time period, suggesting that there is still room for improvement in accessing care.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results indicate that most participants report that they usually or always receive needed care and receive care quickly, though some rates are lower than national benchmarks (WB&A Market Research, 2013; WB&A Market Research, 2011).

Medical Home

Another goal of the HealthChoice program is to provide patient-focused, comprehensive, and coordinated care by providing each member with a medical home. HealthChoice enrollees choose one of seven MCOs and a PCP from their MCOs' network to oversee their medical care. Related to this goal:

- One method of assessing the extent to which HealthChoice provides enrollees with a medical home is to measure the appropriateness of care coordination, i.e., whether enrollees can identify with and effectively navigate a medical home. With a greater understanding of the resources available to them, enrollees should be able to seek care in an ambulatory care setting before resorting to using the ED or letting an ailment exacerbate to the extent that it could warrant an inpatient admission. The rates of potentially avoidable ED visits declined between CY 2008 and CY 2012, whereas the rates of diabetes and asthma-related hospitalizations increased.

Quality of Care

Another goal of the HealthChoice program is to improve the quality of health services delivered. DHMH employs an extensive system of quality measurement and improvement that uses nationally recognized performance standards. Related to this goal:

- Breast and cervical cancer screening rates improved during the evaluation period, contributing to better preventive care for adults.
- Related to preventive care for children, HealthChoice rates for well-child and well-care visits and rates for immunization screening combination three increased during the evaluation period and were consistently higher than Medicaid national averages. Blood lead screening rates for children aged 12 to 23 months also improved.
- Between CY 2008 and CY 2011, provider compliance increased or remained constant for four of the five Early and Periodic Screening, Diagnostic, and Treatment components (Delmarva Foundation, 2013; Delmarva Foundation, 2011). Compliance with immunizations decreased by five percentage points during the evaluation period
- Regarding the quality of care for chronic conditions, the percentage of enrollees who received appropriate asthma medications slightly decreased during the evaluation period. For enrollees with diabetes, rates of eye exams and hemoglobin A1c (HbA1c) screenings steadily improved during the evaluation period. Low-density lipoprotein cholesterol

(LDL-C) screening rates, however, decreased slightly, but were still higher than the Medicaid national average in CY 2012.

Special Topics

As part of the goal of improving the quality of health services delivered, DHMH monitors the utilization of health services among vulnerable populations. Related to this goal:

- In CY 2012, children in foster care had a lower rate of ambulatory care service utilization compared with other children in HealthChoice, as well as a higher rate of MCO outpatient ED visits.
- Measures of access to prenatal care services declined slightly during the evaluation period, but Maryland outperformed the national Healthcare Effectiveness Data and Information Set (HEDIS) means in CY 2012.
- Ambulatory care service utilization, CD4 testing, and viral load testing improved for participants with HIV/AIDS during the evaluation period, while ED utilization also increased.
- Regarding racial/ethnic disparities in access to care, Black children have lower rates of ambulatory care visits than other children. Among the entire HealthChoice population, Blacks also have the highest ED utilization rates.

Primary Adult Care Program

The HealthChoice Evaluation includes a section that addresses enrollment, access, and quality of care in the Primary Adult Care (PAC) program. The PAC program offered limited benefits to childless adults aged 19 years and older who are not eligible for Medicare or Medicaid and whose incomes are at or below 116 percent of the FPL. Related to the PAC program:

- The number of individuals with any period of enrollment in PAC increased by 123 percent during the evaluation period, from 42,891 participants in CY 2008 to 95,802 participants in CY 2012. In CY 2012, roughly 80 percent of PAC participants resided in three regions: Baltimore City, Baltimore Suburban, and Washington Suburban.
- Between CY 2008 and CY 2012, the percentage of PAC participants with a substance use disorder and at least one methadone replacement therapy increased from 5.7 percent to 32.8 percent.
- DHMH began using PAC HEDIS measures in CY 2008. PAC performance on these measures improved during the evaluation period, but remained lower than the national HEDIS means.
- As a result of the Medicaid expansion option in the ACA, the PAC program transitioned into a categorically-eligible Medicaid population on January 1, 2014 (after this report's

evaluation period). Childless adults under the age of 65 years and with incomes up to 138 percent of the FPL will receive full Medicaid benefits, and services will be provided through HealthChoice MCOs.

Evaluation of the HealthChoice Program
CY 2008 to CY 2012

Introduction

HealthChoice, Maryland's statewide mandatory Medicaid managed care program, was implemented in 1997 under authority of Section 1115 of the Social Security Act. In January 2002, the Maryland Department of Health and Mental Hygiene (DHMH) completed the first comprehensive evaluation of HealthChoice as part of the first 1115 waiver renewal. The 2002 evaluation examined HealthChoice performance by comparing service use during the program's initial years with utilization during the final year without managed care (fiscal year [FY] 1997). The Centers for Medicare & Medicaid Services (CMS) approved subsequent waiver renewals in 2005, 2007, 2010, and 2013. The 2013 renewal evaluation focused on the HealthChoice goals of expanding coverage to additional Maryland residents with low income, improving access to care, and improving service quality. Between waiver renewals, DHMH continually monitors HealthChoice performance on a variety of measures and completes an annual evaluation for HealthChoice stakeholders.

This report is the 2012 annual evaluation of the HealthChoice program. The report begins with a brief overview of the HealthChoice program and recent program updates, and then addresses the following topics:

- Coverage and access to care
- The extent to which HealthChoice provides participants with a medical home
- The quality of care delivered to participants
- Special topics, including dental services, mental health care, substance use disorder services, services provided to children in foster care, reproductive health services, services for individuals with HIV/AIDS, the Rare and Expensive Case Management (REM) program, and racial and ethnic disparities in utilization
- Access and quality of care under the Primary Adult Care (PAC) program

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

Overview of the HealthChoice Program

The HealthChoice managed care program currently enrolls more than 80 percent of the State's Medicaid and Maryland Children's Health Program (MCHP) populations. Participants in HealthChoice choose one of seven managed care organizations (MCOs) and a primary care

provider (PCP) from their MCOs' network to oversee their medical care. The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include:

- Families with low income that have children
- Families that receive Temporary Assistance for Needy Families (TANF)
- Children younger than 19 years who are eligible for MCHP
- Children in foster care
- Women with low income who are pregnant or less than 60 days postpartum
- Individuals receiving Supplemental Security Income (SSI) who are younger than 65 years and not eligible for Medicare

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

- Medicare beneficiaries
- Individuals aged 65 years and older
- Individuals in a "spend-down" eligibility group who are only eligible for Medicaid for a limited period of time
- Individuals who are continuously enrolled in a long-term care facility or an institution for mental illness for more than 30 days
- Individuals who reside in an intermediate care facility for mental illness
- Individuals enrolled in the Employed Individuals with Disabilities program
- Refugees and certain categories of undocumented immigrants

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

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

- Inpatient and outpatient hospital care
- Physician care
- Clinic services

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

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

- Specialty mental health care, which is administered by the DHMH Mental Hygiene Administration
- Dental care for children, pregnant women, and adults in the REM program
- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Education Plan or Individualized Family Service Plan
- Therapy services (occupational, physical, speech, and audiology) for children
- Personal care services
- Long-term care services after the first 30 days of care (individuals in long-term care facilities for more than 30 days are disenrolled from HealthChoice)
- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS
- HIV/AIDS drugs and specialty mental health drugs
- Services covered under 1915(c) home and community-based services waivers

Recent Program Updates

Several significant changes were made to the HealthChoice program during this evaluation period. These include:

- In response to directives from CMS, several changes were made to the Family Planning Program in 2008. CMS required the program to perform annual active redeterminations

and reduce the upper income limit from 250 percent to 200 percent of the federal poverty level (FPL). Further, the program no longer enrolls women with other third party insurance that includes family planning benefits. Beginning in January 2012, Maryland expanded eligibility for the Family Planning Program to include all women with household income up to 200 percent of the FPL. It previously only covered women losing pregnancy-related Medicaid eligibility 60 days post partum.

- In 2010, Maryland began a Behavioral Health Integration stakeholder process aimed to streamline the existing disparate systems of care for the approximately 37,000 individuals with co-occurring serious mental illness and substance use issues (FY 2011). Phase 1 of this process involved collaboration among DHMH, a consultant, and stakeholders to assess the strengths and weaknesses of Maryland's current system. In early 2012, phase 2 of the process involved development of a broad financing model to better integrate care across the service domains. In 2013, DHMH announced the decision to move forward with establishing a performance-based carve-out for substance abuse and mental health services. To implement this model, DHMH will continue to collaborate with stakeholders to develop: performance measures, a shared savings model, network adequacy policies, quality standards, access to care standards, and a financing approach that complements emerging clinical models of integration.
- In 2011, Maryland began a three-year pilot program to test the use of a patient-centered medical home (PCMH), called the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP). The MMPP provides Maryland patients with many services, such as integrated care plans, chronic disease management, medication reconciliation at every visit, and same-day appointments for urgent matters. Across the State, 52 primary and multispecialty practices and federally qualified health centers (FQHCs) participate in MMPP. These practices are paid through HealthChoice MCOs and private insurance carriers.
- In FY 2013, the Maryland General Assembly set aside funds for the development of a chronic health home demonstration. Section 2703 of the Affordable Care Act (ACA) allows states to amend their Medicaid State Plans to offer health homes that provide comprehensive systems of care coordination for participants with two or more defined chronic conditions. Anticipated eligibility for Maryland's chronic health home services will include individuals diagnosed with a serious and persistent mental illness, children diagnosed with a serious emotional disturbance, and individuals diagnosed with an opioid substance use disorder who are at risk for another chronic condition based on tobacco, alcohol, or other non-opioid substance use. As of December 31, 2013, DHMH received 64 Health Home site applications and approved 57 of them, with an additional 5 pending and 2 applications denied. Approved Health Home sites include 44 Psychiatric

Rehabilitation Programs, 9 Mobile Treatment providers, and 4 opioid treatment programs.

- Under the ACA, Maryland expanded its Medicaid program to offer coverage to individuals with incomes up to 138 percent of the FPL[1]. As of the end of May 2014, over 189,000 newly eligible adults gained Medicaid coverage under the expansion. This includes nearly 96,000 PAC participants that were automatically transferred on January 1, 2014, to full Medicaid beneficiaries.

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

Section I. Coverage and Access

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

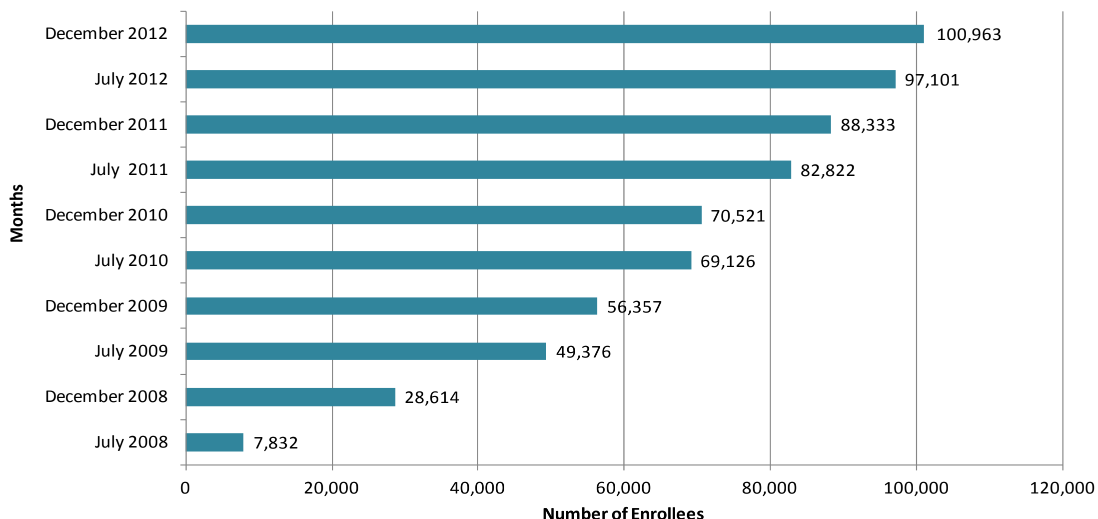
Are More Marylanders Covered?

Major Expansion Initiatives

Maryland has recently engaged in several efforts to increase Medicaid enrollment. Legislation and grant awards have increased DHMH's capacity to enroll uninsured children and adults in programs for which they might be eligible. The most successful of these expansion efforts was the increase in income eligibility for families in Medicaid. Effective July 1, 2008, Maryland expanded the eligibility thresholds for parents and caretaker relatives of children enrolled in Medicaid or MCHP from approximately 40 percent of the FPL to 116 percent of the FPL. Starting in January 2014, under the ACA, Maryland expanded its Medicaid program to individuals with incomes up to 138 percent of the FPL.

The eligibility expansion for families occurred at the same time that the economy slipped into recession, resulting in a dramatic increase in enrollment. Figure 1 presents the monthly enrollment in this parent expansion program, which began in July 2008. Enrollment increased from 7,832 participants in July 2008 to 100,963 participants in December 2012.

Figure 1. Enrollment in the Parent Expansion Program, July 2008–December 2012



HealthChoice Enrollment

HealthChoice enrollment can be measured by several methods. One methodology is to count the number of individuals with any period of enrollment during a given calendar year (CY), including individuals who were only briefly enrolled. Another method is to count individuals who were enrolled at a certain point in time. Although this yields a smaller number, it provides a snapshot of typical program enrollment on a given day. Unless specified otherwise, the enrollment data in this section of the report use the point-in-time methodology to reflect enrollment as of December 31 of the measurement year.[2]

The overall HealthChoice population grew by 52 percent between CY 2008 and CY 2012 (Figure 2). Most of the enrollment increase occurred between CY 2008 and CY 2009 when HealthChoice grew by more than 17 percent (92,632 participants). A key factor in this enrollment growth was the expansion of Medicaid eligibility in July 2008. Figure 2 displays HealthChoice enrollment by coverage group between CY 2008 and CY 2012. As of December 31 of each year, most HealthChoice participants were eligible in the families, children, and pregnant women (F&C) category. Overall, F&C enrollment grew by 75 percent during this time period. MCHP enrollment initially declined between CY 2008 and CY 2009, but it increased 2.4 percent between CY 2009 and CY 2012. Although the coverage group for individuals with disabilities grew by nearly 14 percent during the evaluation period, it was the smallest eligibility category in each year under review.

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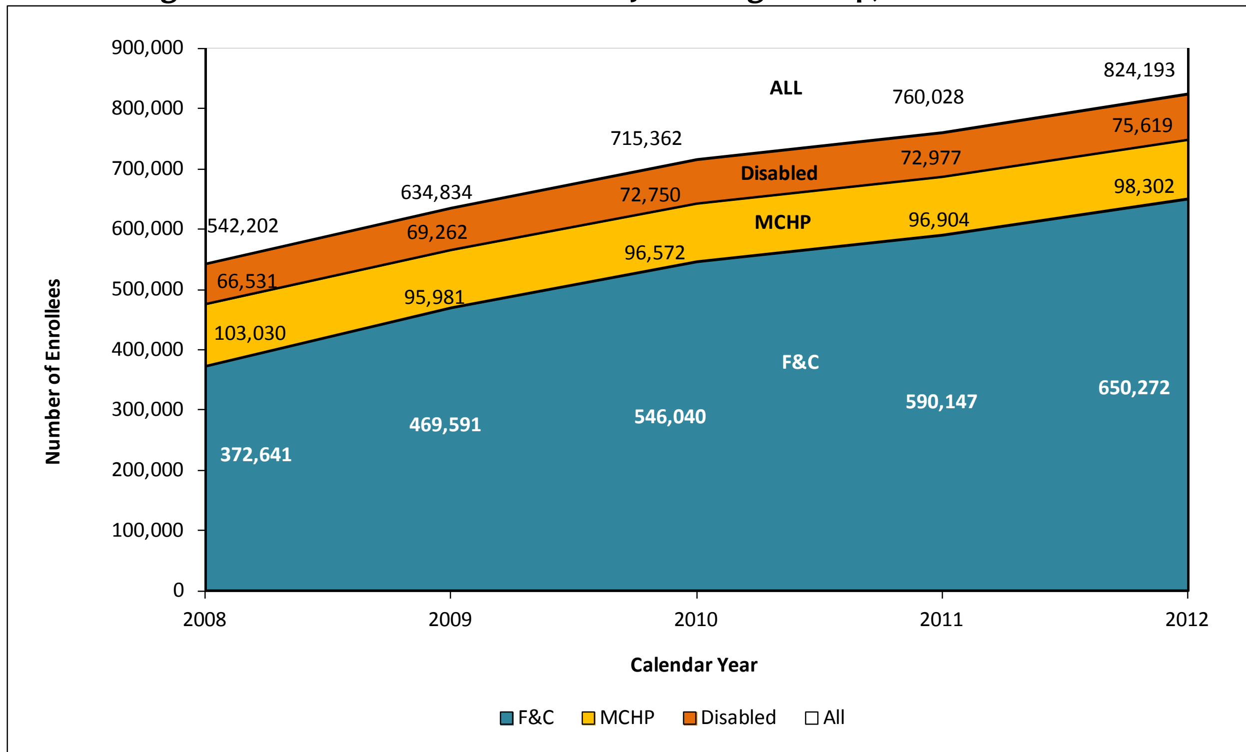
[2] Enrollment data are presented for individuals aged 0 through 64 years. Age is calculated as of December 31 of the measurement year.

Figure 2. HealthChoice Enrollment by Coverage Group, CY 2008–CY 2012



Enrollment Growth

National enrollment in Medicaid reached 54.1 million by June 2012 (Kaiser Commission on Medicaid and the Uninsured, 2013). According to the Kaiser Commission on Medicaid and the Uninsured, between June 2011 and June 2012, Maryland experienced the eighth highest growth rate in Medicaid enrollment out of all 50 states and the District of Columbia (2013). Most new Medicaid participants enroll into managed care.

Table 1 shows the percentage of Maryland's population enrolled in HealthChoice between CY 2008 and CY 2012. These data are presented for individuals enrolled in HealthChoice as of December 31 and individuals with any period of HealthChoice enrollment. The percentage with any period of HealthChoice enrollment gradually increased from approximately 12 percent in CY 2008 to nearly 16 percent in CY 2012.

Table 1. HealthChoice Enrollment as a Percentage of the Maryland Population, CY 2008–CY 2012

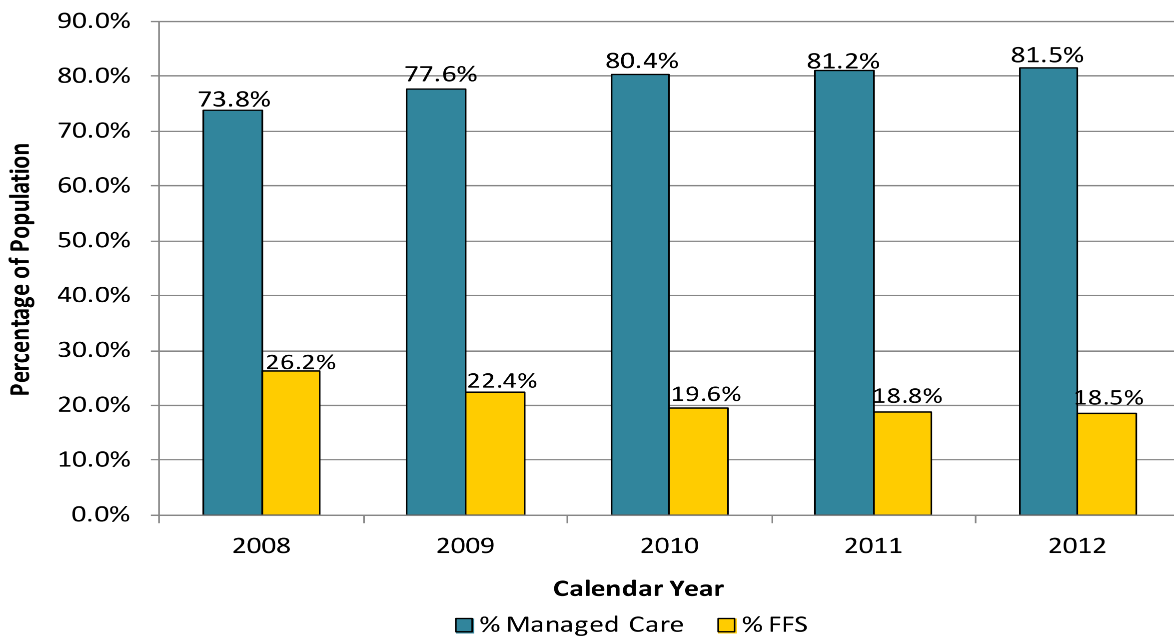
	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Maryland Population*	5,658,655	5,699,478	5,773,552	5,828,289	5,884,868
Individuals Enrolled in HealthChoice for Any Period of Time During Year					
HealthChoice Population	654,412	743,098	832,684	893,084	930,647
% of Population in HealthChoice	11.6%	13.0%	14.4%	15.3%	15.8%
Individuals Enrolled in HealthChoice as of December 31					
HealthChoice Population	542,202	634,834	715,362	760,028	824,193
% of Population in HealthChoice	9.6%	11.1%	12.4%	13.0%	14.0%

*Maryland Population Data Source: United States Census Bureau, 2014

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

One of the original goals of the HealthChoice program was to enroll more individuals in Medicaid and MCHP into managed care. Figure 3 presents the percentage of Maryland Medicaid/MCHP participants who were enrolled in managed care (including both HealthChoice and PAC MCOs) compared with FFS enrollment. Between CY 2008 and CY 2012, managed care enrollment increased from 73.8 percent to 81.5 percent.

Figure 3. Percentage of Medicaid/MCHP Participants in Managed Care versus FFS, CY 2008–CY 2012



Does the Covered Population Access Care?

With this increased enrollment, it is important to maintain access to care. This section of the report examines ambulatory care, ED visits, and network adequacy to evaluate access to care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, which is a part of the U.S. Agency for Healthcare Research and Quality (AHRQ), offers a CAHPS Health Plan Survey. This section also discusses results from that survey.

Ambulatory Care Visits

DHMH monitors ambulatory care utilization as a measure of access to care. An ambulatory care visit[3] is defined as a contact with a doctor or nurse practitioner in a clinic, physician's office, or hospital outpatient department by an individual enrolled in HealthChoice at any time during the measurement year. HealthChoice participants should be able to seek care in an ambulatory care setting before using the ED for a non-emergent condition or allowing a condition to exacerbate to the extent that it requires an inpatient admission. In this section of the report, ambulatory care visits are measured using MCO and FFS data.

Figure 4 presents the percentage of HealthChoice participants who received an ambulatory care visit during the calendar year by age group. Overall, the ambulatory care visit rate increased from 75.6 percent in CY 2008 to 78.2 percent in CY 2012, and the rate increased for all age groups.

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

Figure 4. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Age Group, CY 2008–CY 2012

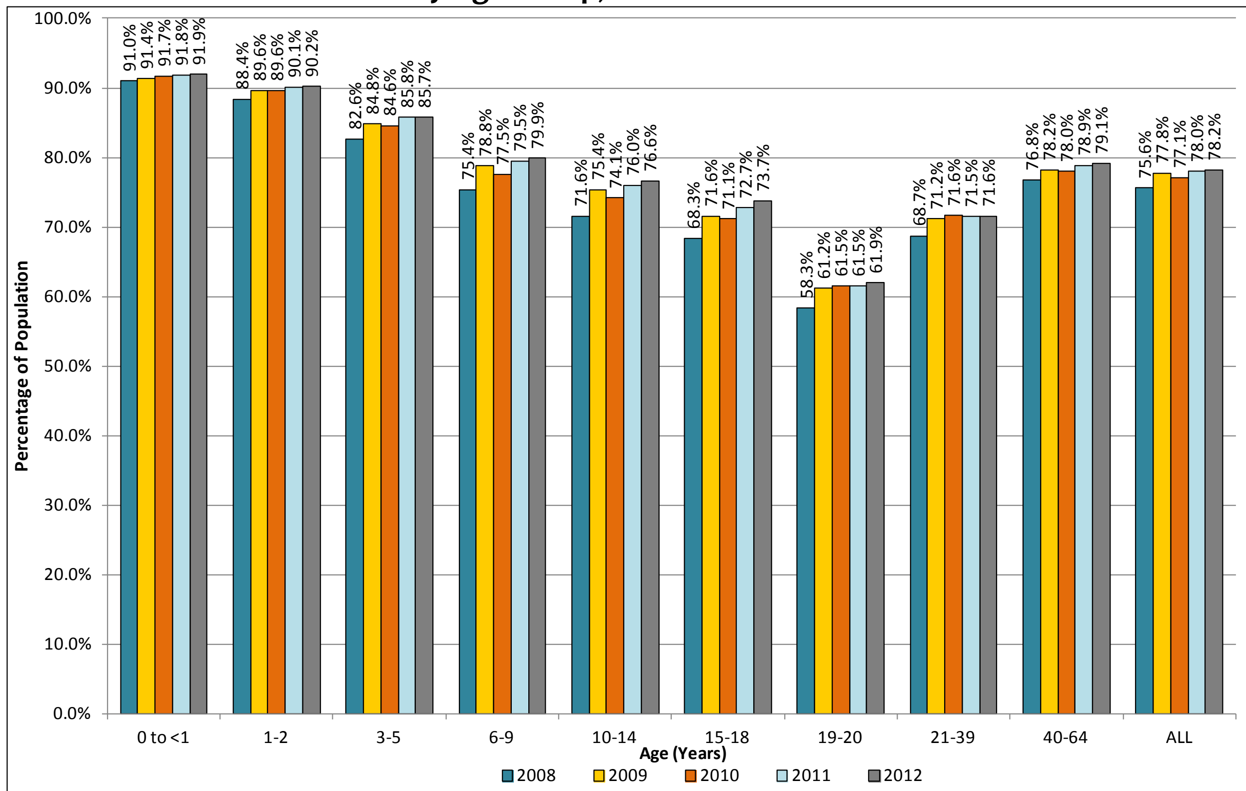
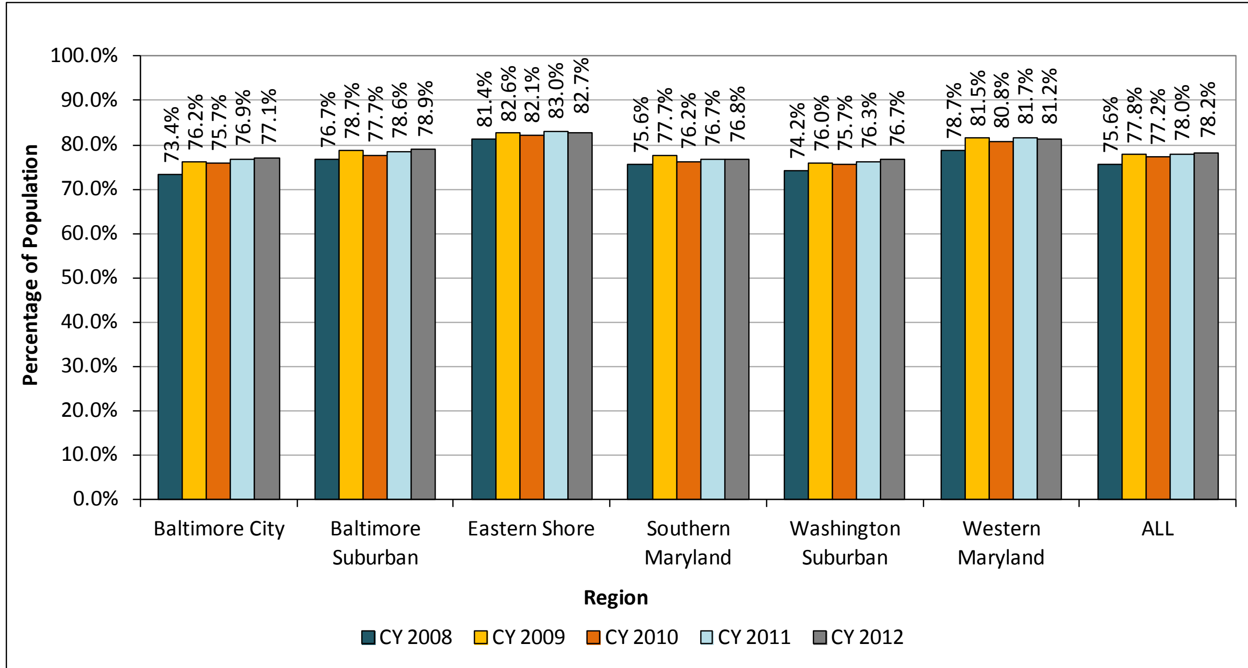


Figure 5 presents the percentage of the HealthChoice population receiving an ambulatory care visit by region between CY 2008 and CY 2012. Visit rates generally increased between CY 2008 and CY 2012. The Eastern Shore region had the highest percentage of enrollees receiving ambulatory care visits, at 82.7 percent, and the Washington suburban region had the lowest rate, at 76.7 percent.

Figure 5. Percentage of the HealthChoice Population Receiving an Ambulatory Care Visit by Region, CY 2008–CY 2012



ED Utilization

The primary role of the ED is to treat seriously ill and injured patients. Ideally, ED visits should not occur for conditions that can be treated in an ambulatory care setting. HealthChoice was expected to lower ED use based on the premise that a managed care system is capable of promoting ambulatory and preventive care, thereby reducing the need for emergency services. To assess overall ED utilization, DHMH measures the percentage of individuals with any period of enrollment who visited an ED at least once during the calendar year. This measure excludes ED visits that resulted in an inpatient hospital admission.

Figure 6 presents ED use by coverage group. Overall, ED use among HealthChoice participants increased by 3.9 percentage points between CY 2008 and CY 2012. Participants with disabilities were more likely to utilize ED services compared with other coverage groups throughout the evaluation period.

Figure 6. Percentage of the HealthChoice Population with at Least One ED Visit by Coverage Group, CY 2008–CY 2012

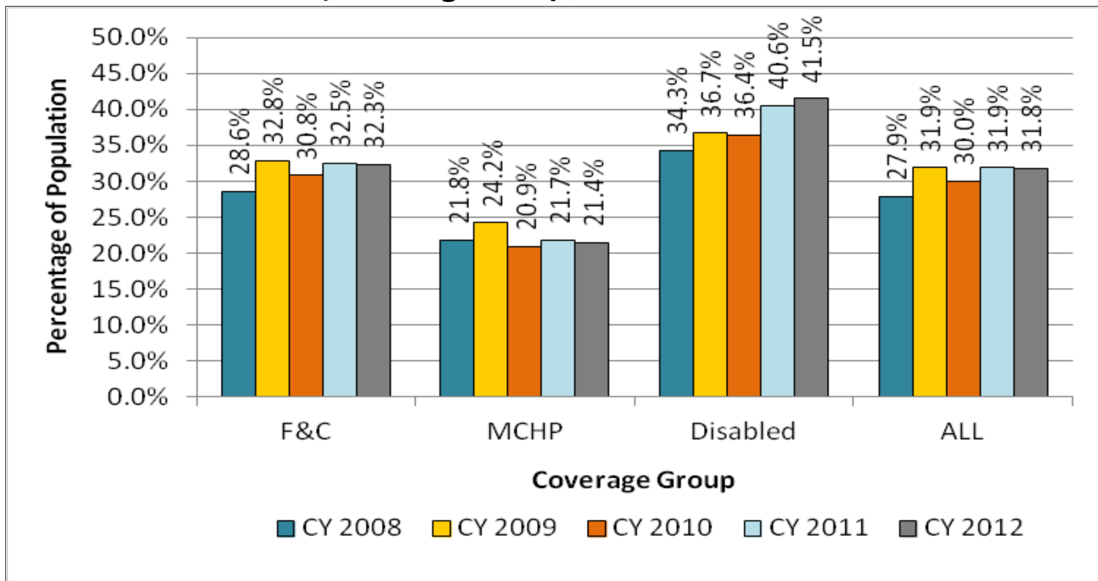
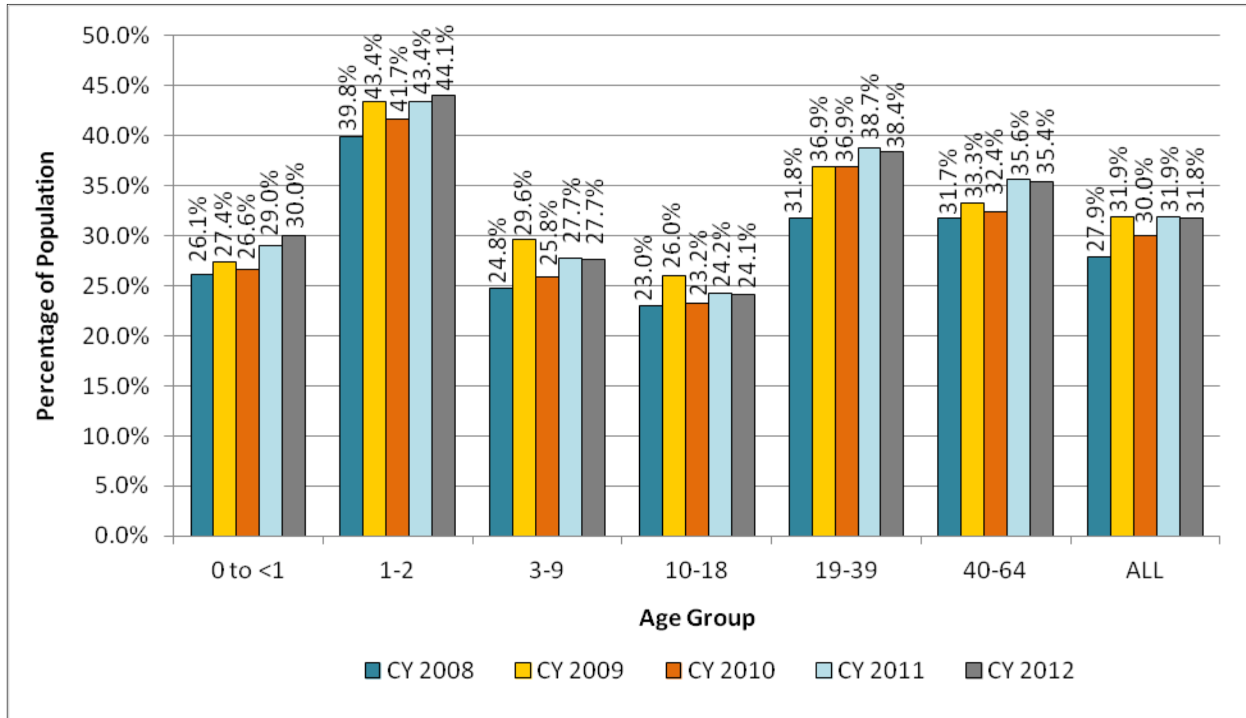


Figure 7 shows ED utilization by age group during CY 2008 through CY 2012. Children aged 1 and 2 years had the highest ED use across the evaluation period, followed by adults aged 19 to 39 years.

Figure 7. Percentage of the HealthChoice Population with at least One ED Visit by Age Group, CY 2008–CY 2012



Are Provider Networks Adequate to Ensure Access?

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

PCP Network Adequacy

HealthChoice requires every participant to have a PCP, and each MCO must have enough PCPs to serve its enrollee population. HealthChoice regulations require a ratio of 1 PCP to every 200 participants within each of the 40 local access areas (LAAs) in the State. Because some PCPs traditionally serve a high volume of HealthChoice participants at some of their sites (e.g., FQHC physicians), the regulations permit DHMH to approve a ratio of 2,000 adult participants per high-volume provider and 1,500 participants aged 0 to 21 years per high-volume provider. DHMH assesses network adequacy periodically throughout the year to pinpoint potential network inadequacies and works with the MCOs to resolve capacity issues. Should any such issues arise, DHMH will freeze the MCO from receiving new enrollments in the affected region until provider contracts increase to an adequate level.

Table 2 shows PCP network adequacy as of September 2013. Two capacity estimates are presented: 200 participants per PCP and 500 participants per PCP. Although regulatory requirements apply to a single MCO, this analysis aggregates data from all seven HealthChoice MCOs. The analysis does not allow a single provider who contracts with multiple MCOs to be counted multiple times; thus, it applies a higher standard than that in regulation.

Table 2. PCP Capacity by Local Access Area, as of September 2013

	Total PCPs			Enrollment	Excess Capacity	Excess Capacity
Local Access Area	**September, 2013**	**Multiplied by 200**	**Multiplied by 500**	**September, 2013**	**Difference 200:1 Ratio**	**Difference 500:1 Ratio**
Allegany	34	6,800	17,000	12,604	-5,804	4,396
Anne Arundel North	185	37,000	92,500	29,517	7,483	62,983
Anne Arundel South	175	35,000	87,500	16,579	18,421	70,921
Baltimore City SE/Dundalk	169	33,800	84,500	26,237	7,563	58,263
Baltimore City East	283	56,600	141,500	30,481	26,119	111,019
Baltimore City N. Central	74	14,800	37,000	13,345	1,455	23,655
Baltimore City N. East	68	13,600	34,000	27,006	-13,406	6,994
Baltimore City N. West	203	40,600	101,500	24,084	16,516	77,416
Baltimore City South	68	13,600	34,000	19,662	-6,062	14,338
Baltimore City West	269	53,800	134,500	40,938	12,862	93,562
Baltimore County East	168	33,600	84,000	26,107	7,493	57,893
Baltimore County North	196	39,200	98,000	15,703	23,497	82,297
Baltimore County N. West	81	16,200	40,500	32,408	-16,208	8,092
Baltimore County S. West	132	26,400	66,000	23,916	2,484	42,084
Calvert	53	10,600	26,500	9,000	1,600	17,500
Caroline	19	3,800	9,500	7,526	-3,726	1,974
Carroll	89	17,800	44,500	13,468	4,332	31,032
Cecil	62	12,400	31,000	15,566	-3,166	15,434
Charles	76	15,200	38,000	16,407	-1,207	21,593
Dorchester	15	3,000	7,500	7,379	-4,379	121
Frederick	83	16,600	41,500	20,163	-3,563	21,337
Garrett	20	4,000	10,000	4,893	-893	5,107
Harford East	34	6,800	17,000	7,898	-1,098	9,102
Harford West	96	19,200	48,000	15,836	3,364	32,164
Howard	131	26,200	65,500	21,255	4,945	44,245
Kent	18	3,600	9,000	3,086	514	5,914
Montgomery-Silver Spring	189	37,800	94,500	48,188	-10,388	46,312
Montgomery-Mid County	183	36,600	91,500	15,251	21,349	76,249
Montgomery-North	119	23,800	59,500	34,220	-10,420	25,280
Prince George's N. East	101	20,200	50,500	19,057	1,143	31,443
Prince George's N. West	142	28,400	71,000	65,526	-37,126	5,474
Prince George's S. East	50	10,000	25,000	13,109	-3,109	11,891
Prince George's S. West	36	7,200	18,000	30,490	-23,290	-12,490
Queen Anne's	35	7,000	17,500	5,374	1,626	12,126
Somerset	16	3,200	8,000	4,800	-1,600	3,200
St. Mary's	57	11,400	28,500	12,841	-1,441	15,659
Talbot	32	6,400	16,000	4,567	1,833	11,433
Washington	88	17,600	44,000	24,160	-6,560	19,840
Wicomico	61	12,200	30,500	20,161	-7,961	10,339
Worcester	28	5,600	14,000	7,131	-1,531	6,869
Total	**3,938**	**787,600**	**1,969,000**	**785,939**	**1,661**	**1,183,061**

Based on a standard enrollee-to-PCP ratio of 500:1, provider networks in the LAAs are more than adequate, with the exception of Prince George's Southwest LAA. Twenty-one LAAs do not meet the stricter 200:1 ratio: two in Baltimore City, two in the Baltimore Suburban region, six in the Washington Suburban region, two in Southern Maryland, six on the Eastern Shore, and all three LAAs in Western Maryland. In September 2013, 3,938 PCPs participated in HealthChoice.

Specialty Care Provider Network Adequacy

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

DHMH regularly monitors compliance with these specialty care access standards. As of August 2013, all seven MCOs met specialty coverage requirements for the core and major medical specialties.

CAHPS Survey Results

DHMH uses the CAHPS survey to measure enrollees' satisfaction with their medical care (WB&A Market Research, 2013; WB&A Market Research, 2011). Two CAHPS survey measures relate to access: "getting needed care" and "getting care quickly."

"Getting needed care" measures:

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

"Getting care quickly" measures:

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

The possible survey responses for these two measures are "always," "usually," "sometimes," or "never." In CY 2012, 79 percent of adult HealthChoice members responded that they were "usually" or "always" successful in getting needed care, and 80 percent of adult members responded that they were "usually" or "always" successful in getting care quickly (Table 3). Both of these percentages are slightly lower than the CY 2012 National Committee for Quality Assurance (NCQA) Quality Compass benchmark, although the getting needed care rate for HealthChoice increased by 8 percentage points between CY 2011 and CY 2012.

Table 3. Percentage of Adult HealthChoice Participants Responding "Usually" or "Always" to Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2008–CY 2012

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Getting Needed Care - Percentage of members who responded "Usually" or "Always"					
HealthChoice	74%	74%	72%	71%	79%
NCQA Quality Compass Benchmark	76%	75%	76%	76%	81%
Getting Care Quickly - Percentage of members who responded "Usually" or "Always"					
HealthChoice	82%	80%	80%	79%	80%
NCQA Quality Compass Benchmark	80%	79%	81%	80%	81%

In CY 2012, 82 percent of parents and guardians of children enrolled in HealthChoice responded that they were "usually" or "always" successful in getting needed care for their children, and 91 percent responded "usually" or "always" to getting care quickly (Table 4). The getting needed care rate is two percentage points lower than the NCQA benchmark, whereas the getting care quickly rate is two percentage points higher.

Table 4. Percentage of Parents and Guardians of Child HealthChoice Participants Responding "Usually" or "Always" to Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2008–CY 2012

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Getting Needed Care - Percentage of members who responded "Usually" or "Always"					
HealthChoice	76%	74%	77%	79%	82%
NCQA Quality Compass Benchmark	79%	79%	79%	79%	84%
Getting Care Quickly - Percentage of members who responded "Usually" or "Always"					
HealthChoice	89%	88%	88%	87%	91%
NCQA Quality Compass Benchmark	86%	87%	87%	87%	89%

Parents and guardians of children with chronic conditions in HealthChoice were also surveyed (Table 5). In CY 2012, 84 percent responded "usually" or "always" to getting needed care for their children, which was two percentage points lower than the NCQA benchmark of 86 percent. Ninety-three percent reported "usually" or "always" to getting care quickly, one percentage point

higher than the NCQA benchmark. National benchmarks for this population were available beginning in CY 2011.

Table 5. Percentage of Parents and Guardians of Children with Chronic Conditions in HealthChoice Responding "Usually" or "Always" to Getting Needed Care and Getting Care Quickly Compared with the NCQA Benchmark, CY 2008–CY 2012

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Getting Needed Care - Percentage of members who responded "Usually" or "Always"					
HealthChoice	75%	75%	78%	80%	84%
NCQA Quality Compass Benchmark*	N/A	N/A	N/A	81%	86%
Getting Care Quickly - Percentage of members who responded "Usually" or "Always"					
HealthChoice	90%	90%	91%	90%	93%
NCQA Quality Compass Benchmark*	N/A	N/A	N/A	90%	92%

*NCQA Quality Compass Benchmarks were available for children with chronic conditions beginning in CY 2011.

Section I Summary

Section I of this report described the HealthChoice program's progress in achieving its goals of expanding coverage and improving access to care. Related to coverage, Maryland expanded Medicaid eligibility for parents and caretaker relatives of children enrolled in Medicaid or MCHP in July 2008. By December 2012, 100,963 new parents and caretaker relatives were covered under HealthChoice through the parent expansion program. The overall HealthChoice population grew by 52 percent between CY 2008 and CY 2012. By CY 2012, 14 percent of the State population was enrolled in HealthChoice.

With expansion activities and increased enrollment, it is important to maintain access to care and ensure program capacity to serve a growing population. Regarding PCP networks, there are several areas in the State that do not meet conservative network adequacy standards. However, the specialist network standards were met across all MCOs and regions in the State. Looking at service utilization as a measure of access, the percentage of participants receiving an ambulatory care visit increased since CY 2008, with approximately 78.2 percent of participants receiving a visit in CY 2012. CAHPS survey results indicate that most participants report that they usually or always receive needed care and receive care quickly, though some rates are lower than national benchmarks. The rates of ED visits increased by 3.9 percentage points between CY 2008 and CY 2012, which suggests that there is still room for improvement in access to care.

Section II. Medical Home

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

Appropriate Service Utilization

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

Appropriateness of ED Care

A fundamental goal of managed care programs such as HealthChoice is the delivery of the right care at the right time in the right setting. One widely used methodology to evaluate this goal in the ED setting is based on classifications developed by researchers at the New York University Center for Health and Public Service Research (NYU) (Billings, Parikh, & Mijanovich, 2000). According to Billings et al., 2000, the ED use profiling algorithm categorizes emergency visits as follows:

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

9. *Unclassified*: The condition was not classified in one of the above categories by the expert panel.

ED visits that fall into categories 1 through 3 may indicate problems with access to primary care. Figure 8 presents the distribution of all ED visits by NYU classification for CY 2012 for individuals with any period of HealthChoice enrollment. In CY 2012, 51.6 percent of all ED visits were for potentially avoidable conditions; that is, the visit could have been avoided with timely and quality primary care. Participants in the F&C and MCHP coverage groups had higher rates of potentially avoidable visits than participants in the disabled coverage group.

ED visits in categories 4 (emergent, ED care needed, not preventable/avoidable) and 5 (injury) are the least likely to be prevented with access to primary care. These two categories accounted for 26.4 percent of all ED visits in CY 2012. Adults aged 40 through 64 years had more ED visits related to category 4 than other age groups. Children aged 3 through 18 years had more injury-related ED visits compared with other age groups. The inpatient category in Figure 8, which is not a part of the NYU classification, represents ED visits that resulted in a hospital admission. Participants with disabilities had a much higher rate of ED visits that led to an inpatient admission than participants in the F&C and MCHP coverage groups.

Figure 8. Classification of ED Visits by HealthChoice Participants, CY 2012

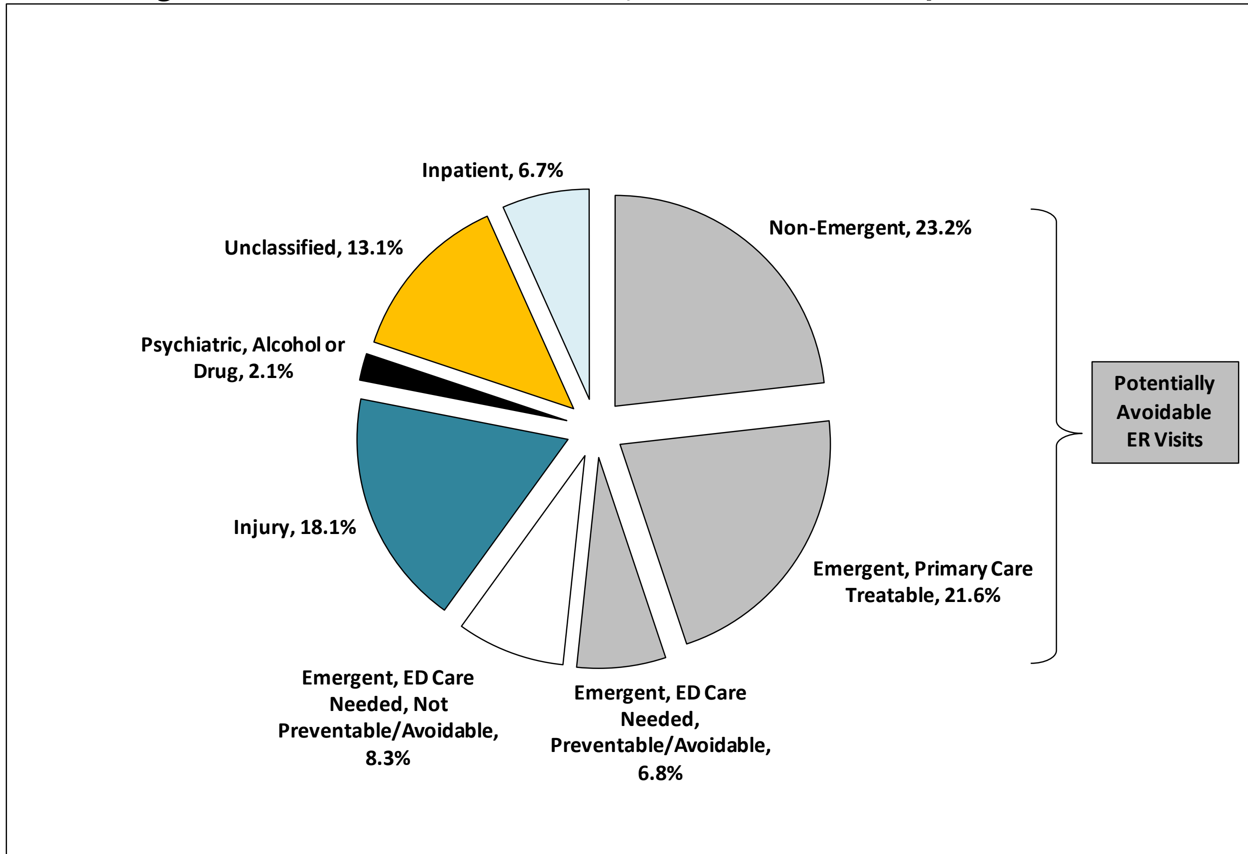
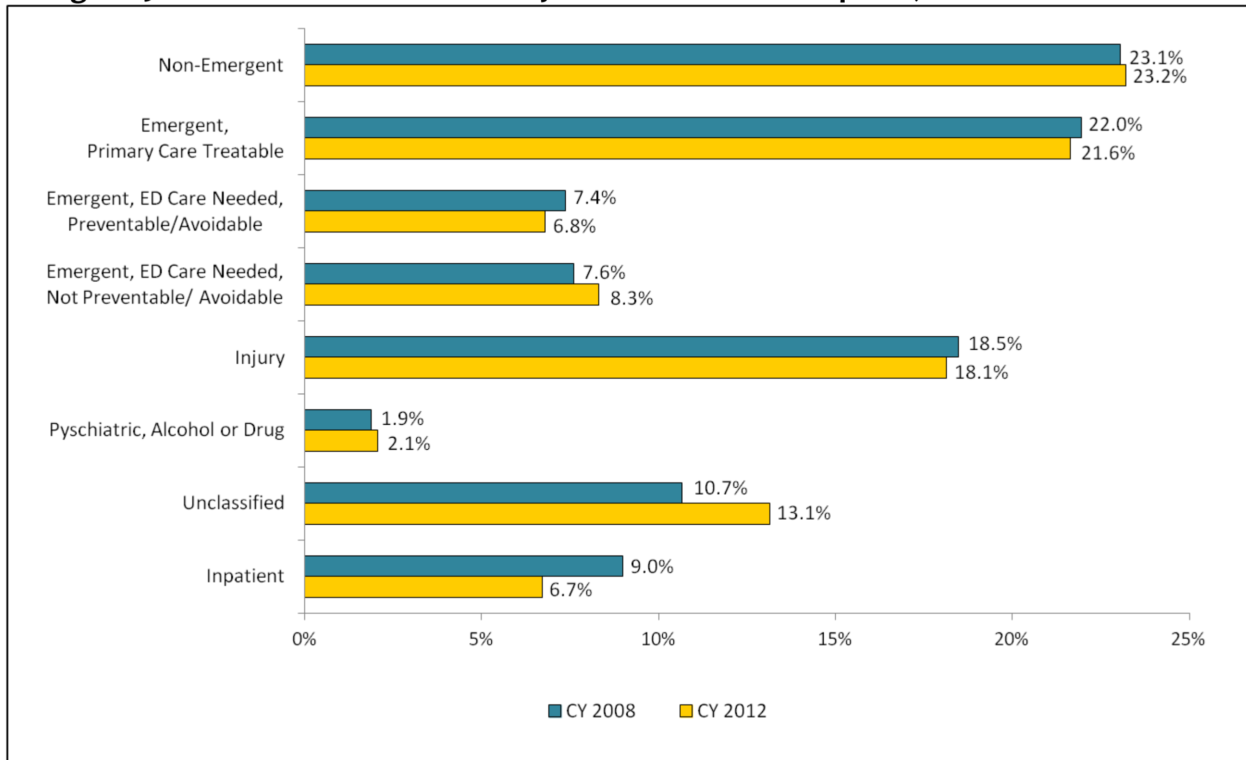


Figure 9 compares the ED visit classifications for CY 2008 with classifications for CY 2012. The data show that potentially avoidable ED visits decreased during the evaluation period, from 52.5 percent of all ED visits to 51.6 percent.

Figure 9. Classification of ED Visits by HealthChoice Participants, CY 2008 and CY 2012



Ambulatory Care Sensitive Hospitalizations

Ambulatory care sensitive hospitalizations (ACSHs), also referred to as preventable or avoidable hospitalizations, are hospital admissions that could have been prevented if proper ambulatory care had been provided in a timely and effective manner. High numbers of avoidable hospitalizations may indicate problems with access to primary care services or deficiencies in outpatient management and follow-up. DHMH monitors avoidable asthma and diabetes admission rates by using a combination of Healthcare Effectiveness Data and Information Set (HEDIS) enrollment criteria and AHRQ clinical criteria to identify participants[4] with a hospital admission who had a primary diagnosis of asthma or short-term diabetes with complications.[5]

Table 6 presents the rate of diabetes-related admissions for participants aged 21 through 64 years and asthma-related admissions for participants aged 5 through 20 years. The avoidable admission rate for diabetes increased from 21 admissions per 1,000 members in CY 2008 to 23 admissions per 1,000 members in CY 2012, with the highest rate occurring in CY 2010 with 26 admissions.

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

The avoidable admission rate for asthma was 39 admissions per 1,000 members in CY 2008. It rose to a peak of 43 admissions per 1,000 members in CY 2009, and then declined to 39 admissions per 1,000 members in CY 2012. The admission rate for both measures decreased between CY 2010 and CY 2012.

Table 6. Potentially Avoidable Diabetes- and Asthma-Related Admissions per One Thousand Members, CY 2008–CY 2012

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Diabetes (Participants Aged 21 – 64 Years)					
Number of Diabetes-Related Potentially Avoidable Hospital Admissions	182	258	331	364	374
Rate per 1,000 HEDIS-Eligible Adults with Diabetes	21	24	26	24	23
Asthma (Participants Aged 5 – 20 Years)					
Number of Asthma-Related Potentially Avoidable Hospital Admissions	290	381	392	389	468
Rate per 1,000 HEDIS-Eligible Children with Asthma	39	43	40	36	39

Section II Summary

This section of the report addressed the extent to which HealthChoice provides participants with a medical home by assessing appropriateness of service utilization. In reviewing appropriateness of care, potentially avoidable ED visits decreased during the evaluation period. Rates of both asthma-related and diabetes-related ACSHs increased between CY 2008 and CY 2009, and then declined between CY 2010 and CY 2012.

Section III. Quality of Care

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

Preventive Care

HEDIS Childhood Measures

DHMH uses HEDIS measures to report childhood immunization and well-child visit rates. Immunizations are evidence-based interventions that safely and effectively prevent severe illnesses, such as polio and hepatitis (HealthcareData Company, LLC, 2013). The HEDIS immunization measures include the percentage of two-year-olds who received the following immunizations on or before their second birthday: four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (Hib); three hepatitis B; one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines. HEDIS calculates a rate for each vaccine and nine different combination rates. Immunization combination two includes all of these vaccines except the four PCV, and combination three includes each of the above listed vaccines with its appropriate number of doses. DHMH compares health plan rates against immunization combinations two and three.

The HEDIS well-child measures include the following:

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

Table 7 compares HealthChoice with the national HEDIS mean for the immunization and well-child measures. HealthChoice performed above the national HEDIS mean across all measures from CY 2008 through CY 2012. Within the HealthChoice program:

- The percentage of two-year-old children receiving immunization combination two decreased by nearly 2 percentage points during the measurement period
- The percentage of two-year-old children receiving immunization combination three increased by 0.8 percentage points during the measurement period
- The percentage of 15-month-old infants who received at least five well-child visits increased by 0.7 percentage points during the measurement period
- The percentage of children aged three to six years who received at least one well-child visit increased by 5.4 percentage points during the measurement period
- The percentage of adolescents aged 12 to 21 years who received at least one well-care visit increased by 10.7 percentage points during the measurement period

Table 7. HEDIS Immunizations and Well-Child Visits: HealthChoice Compared with the National HEDIS Mean, CY 2008-CY 2012

HEDIS Measures	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Childhood Immunizations - Combination 2					
HealthChoice	81.9%	80.2%	79.9%	82.5%	80.2%
National HEDIS Mean	73.7%	74.3%	74.1%	74.5%	75.7%
Childhood Immunizations - Combination 3					
HealthChoice	76.9%	76.0%	76.3%	79.7%	77.7%
National HEDIS Mean	67.6%	69.4%	69.9%	70.6%	72.1%
Well Child Visits - 15 Months of Life					
HealthChoice	83.2%	83.2%	82.4%	85.0%	83.9%
National HEDIS Mean	75.4%	75.8%	76.3%	77.9%	79.2%
Well Child Visits – Aged 3 to 6 years					
HealthChoice	76.8%	81.8%	80.7%	85.0%	82.2%
National HEDIS Mean	69.7%	71.6%	71.9%	72.0%	72.0%
Well-Care Visits - Adolescents					
HealthChoice	54.7%	62.6%	62.8%	67.0%	65.4%
National HEDIS Mean	45.9%	47.7%	48.1%	49.7%	49.7%

EPSDT Review

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

beneficiaries in a timely manner. The review is conducted annually to assess HealthChoice provider compliance with the following five EPSDT components:

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

Between CY 2008 and CY 2011, provider compliance increased or remained constant for four of the five EPSDT components (Table 8) (Delmarva Foundation, 2013; Delmarva Foundation, 2011). Compliance with immunizations decreased by five percentage points during the evaluation period.

Table 8. HealthChoice MCO Aggregate Composite Scores for Components of the EPSDT Review, CY 2008–CY 2011

EPSDT Components	CY 2008	CY 2009	CY 2010	CY 2011
Health and Developmental History	85%	86%	89%	89%
Comprehensive Physical Exam	92%	93%	88%	92%
Laboratory Tests/At-Risk Screenings	78%	80%	82%	79%
Immunizations	93%	85%	89%	88%
Health Education/Anticipatory Guidance	89%	88%	90%	90%

Childhood Lead Testing

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

measures in several of its quality assurance activities, including the VBP and managing-for-results programs.

As part of the EPSDT benefits, Medicaid requires that all children receive a blood lead test at 12 and 24 months of age. DHMH measures the lead testing rates for children aged 12 through 23 months and 24 through 35 months who are continuously enrolled in the same MCO for at least 90 days.[6] A child's lead test must have occurred during the calendar year or the year prior. For CY 2011, the lead test measure was revised to exclude children who disenrolled from HealthChoice before their birthday. Thus, the lead testing rates for CY 2011 and CY 2012 are not comparable to the results of prior years.

Table 9 presents the lead testing rates for children aged 12 through 23 months and 24 through 35 months between CY 2009 and CY 2012. In CY 2012, the lead testing rate was 57.9 percent for children aged 12 through 23 months and 75.6 percent for children aged 24 through 35 months.

Table 9. Percentage of HealthChoice Children Aged 12–23 and 24–35 Months who Received a Lead Test During the Calendar Year or the Prior Year, CY 2009–CY 2012

Age Group (Months)	CY 2009	CY 2010	CY 2011*	CY 2012*
12 - 23 Months	55.5%	57.5%	57.4%	57.9%
24 - 35 Months	75.7%	75.6%	76.6%	75.6%

* The measure was revised in CY 2011 to exclude children who disenrolled before their birthday. Thus, CY 2011 and CY 2012 results cannot be compared with prior years.

Breast Cancer Screening

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

Table 10 compares the percentage of women in HealthChoice who received a mammogram for breast cancer screening with the national HEDIS mean for CY 2008 through CY 2012 (HealthcareData Company, LLC, 2013). Between CY 2008 and CY 2012, the percentage of

[6] The lead testing measures include lead tests reported in the Medicaid administrative data and the Childhood Lead Registry, which is maintained by the Maryland Department of the Environment.

women aged 40 through 64 years[7] who received a mammogram increased by 2 percentage points. Maryland performed below the national HEDIS mean during the measurement period.

Table 10. Percentage of Women in HealthChoice who Received a Mammogram for Breast Cancer Screening Compared with the National HEDIS Mean, CY 2008–CY 2012

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
HealthChoice	49.0%	49.5%	48.3%	50.3%	51.0%
National HEDIS Mean	50.8%	52.4%	51.3%	50.4%	51.9%

Cervical Cancer Screening

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

Table 11 compares the percentage of women aged 21 to 64 years in HealthChoice who received a cervical cancer screening with the national HEDIS mean for CY 2008 through CY 2012 (HealthcareData Company, LLC, 2013). Between CY 2008 and CY 2012, the cervical cancer screening rate increased by nearly 7 percentage points. HealthChoice performed above the national HEDIS mean throughout the measurement period.

Table 11. Percentage of Women in HealthChoice Aged 21–64 Years who Received a Cervical Cancer Screening Compared with the National HEDIS Mean, CY 2008–CY 2012

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
HealthChoice	67.2%	68.1%	73.2%	73.1%	73.7%
National HEDIS Mean	66.0%	65.8%	67.2%	66.7%	64.5%

Care for Chronic Conditions

Use of Appropriate Medications for People with Asthma

DHMH uses HEDIS measures to report the use of appropriate medications for people with asthma. Asthma is a common chronic disease that affects more than 32 million American children and adults (CDC, n.d.b). In 2010, approximately 752,000 adults and children in Maryland had a history of asthma (Bankoski, De Pinto, Hess-Mutinda, & McEachern, 2012). The purpose of asthma medications is to prevent or reduce airway inflammation and narrowing.

[7] Maryland's HealthChoice program covers individuals through age 64 years.

If appropriate asthma medications are prescribed and used correctly, asthma-related hospitalizations, ED visits, and missed school and work days decrease (CDC, n.d.c).

Table 12 compares the HealthChoice rate of appropriate medications for people with asthma with the national HEDIS mean from CY 2008 to CY 2012 (HealthcareData Company, LLC, 2011 and HealthcareData Company, LLC, 2013). For CY 2008, HEDIS included individuals aged 5 through 56 years in this measure. Beginning in CY 2009, the measure was restricted to individuals in HealthChoice aged 5 through 50 years, whereas the national HEDIS means calculated this measure for individuals aged 5 through 64 years. Because of the differences in the age requirements, a comparison to national rates should be interpreted with caution. In CY 2012, approximately 90 percent of HealthChoice participants aged 5 through 50 years were appropriately prescribed medications for asthma treatment, similar to the CY 2009 rate.

Table 12. Percentage of HealthChoice Members Aged 5–50 Years with Persistent Asthma who were Appropriately Prescribed Medications, Compared with the National HEDIS Mean, CY 2008–CY 2012

	CY 2008	CY 2009*	CY 2010	CY 2011	CY 2012
	Members Aged 5-56 Years	Members Aged 5-50 Years (Members Aged 5-64 Years for National Rates**)			
HealthChoice	89.8%	90.7%	90.8%	91.2%	89.9%
National HEDIS Mean	88.7%	88.6%	88.4%	85.0%	83.9%

*Due to significant changes in the 2010 HEDIS specifications (CY 2009 data), a comparison to prior years is not appropriate.
**National HEDIS means calculate the rate for members aged 5-64 years, and therefore cannot be compared with HealthChoice.

Comprehensive Diabetes Care

Diabetes is a disease caused by the inability of the body to make or use the hormone insulin. The complications of diabetes are serious and include heart disease, kidney disease, stroke, and blindness. Screening and treatment can reduce the burden of diabetes complications (HealthcareData Company, LLC, 2013). To assess appropriate and timely screening and treatment for adults with diabetes (types 1 and 2), HEDIS includes a composite set of measures, referred to as comprehensive diabetes care (CDC), which include:

- *HbA1c Testing*: The percentage of participants aged 18 through 75 years with diabetes who received at least one hemoglobin A1c (HbA1c) test during the measurement year.
- *Eye Exams*: The percentage of participants aged 18 through 75 years with diabetes who received an eye exam for diabetic retinal disease during the measurement year *or* had a negative retinal exam (i.e., no evidence of retinopathy) in the year prior to the measurement year.

- *LDL-C Screening*: The percentage of participants aged 18 through 75 years with diabetes who received at least one low-density lipoprotein cholesterol (LDL-C) screening in the measurement year.

Table 13 compares HealthChoice with the national HEDIS mean on the CDC measures for CY 2008 through CY 2012 (HealthcareData Company, LLC, 2013). HealthChoice consistently performed above the national HEDIS mean on eye exams throughout the evaluation period and performed above the mean for LDL-C screenings in most years. HealthChoice performed below the national average on HbA1c testing between CY 2008 and CY 2012. Within the HealthChoice program:

- The percentage of participants with diabetes who received an eye exam increased by 7 percentage points during the measurement period.
- The percentage of participants with diabetes who received an HbA1c test increased by 3.3 percentage points during the measurement period.
- The percentage of participants with diabetes who received an LDL-C screening declined during the measurement period; however, the estimates fluctuated during the evaluation period.

Table 13. Percentage of HealthChoice Members Aged 18–64 Years with Diabetes who Received Comprehensive Diabetes Care, Compared with the National HEDIS Means, CY 2008–CY 2012

HEDIS Measures	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Eye Exam (Retinal)					
HealthChoice	62.6%	66.6%	67.9%	71.0%	69.6%
National HEDIS Mean	52.8%	52.7%	53.1%	53.4%	53.2%
HbA1c Test					
HealthChoice	77.9%	77.1%	77.6%	81.0%	81.2%
National HEDIS Mean	80.5%	80.6%	82.0%	82.5%	83.0%
LDL-C Screening					
HealthChoice	76.5%	74.9%	74.3%	76.4%	75.7%
National HEDIS Mean	74.1%	74.2%	74.7%	75.0%	75.5%

Section III Summary

This section of the report discussed the HealthChoice goal of improving quality of care and focused on preventive care and care for chronic conditions. Regarding preventive care for children, HealthChoice well-child visit and immunization combination three rates increased from CY 2008 and were consistently higher than the national HEDIS mean. However, immunization

combination two rates and provider compliance with EPSDT immunizations decreased since CY 2008, suggesting that this is an area requiring improvement.

Regarding preventive care for adults, rates of cervical and breast cancer screening improved during the evaluation period. From CY 2008 to CY 2012, the cervical cancer screening rate exceeded the national HEDIS mean, while the breast cancer screening rate continued to fall below the national average, although it improved over the evaluation period.

This section also examined the quality of care for chronic conditions, specifically diabetes and asthma. The percentage of participants receiving appropriate asthma medications slightly decreased from CY 2009 to CY 2012, but HealthChoice performed above the national HEDIS mean. For participants with diabetes, rates of eye exams improved during the evaluation period and were consistently higher than the national HEDIS mean. The HbA1c testing rates increased during the evaluation period, but remained below the national HEDIS means, whereas the LDL-C screening rates decreased, but were above the national HEDIS means.

Section IV. Special Topics

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

Dental Services

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

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

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

office, e.g., in schools and Head Start centers. (Maryland Department of Health and Mental Hygiene, 2010).

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

However, even with these substantial improvements, concerns about access remain. At the conclusion of the 2013 legislative session, the Maryland General Assembly requested DHMH to provide a report on the utilization of pediatric dental surgery, one of the mandated dental services under EPSDT. The goal of pediatric restorative dental surgery is to repair or limit the damage from caries, protect and preserve the tooth structure, reestablish adequate function, restore esthetics (where applicable), and provide ease in maintaining good oral hygiene. Although this procedure is preventable, children need to be able to access this in a timely manner, if warranted, in order to maintain good health. In its report, DHMH made several recommendations designed to improve access to pediatric dental surgery including:

- Increasing the payment rate for anesthesia (CPT code 00710) to 100 percent of the Medicare rate.
- Recommending that hospitals offer operating room (OR) block times for dental cases to improve access to hospital facilities by dentists.
- Establishing a facility rate to pay ambulatory surgery centers (ASCs) in order to increase the number of sites where dentists may perform OR procedures and reduce pressure on hospitals.
- Continuing to improve access to preventive dental care in order to reduce the need for non-preventive procedures.
- Requiring hospitals to report stipends paid to hospital-based physicians and anesthesiologists as part of a larger analysis conducted by DHMH in partnership with the Health Services Cost Review Commission (HSCRC) of the proper reimbursement rate for providers.

DHMH continually monitors a variety of measures of dental service utilization, published in the Annual Oral Health Legislative Report. One measure closely models the HEDIS measure for Medicaid children's dental service utilization. The HEDIS measure counts the number of individuals receiving dental services based on two criteria: 1) an age range from 2 through 21 years; and 2) Medicaid enrollment of at least 320 days. DHMH modified the measure to include children aged 4 through 20 years. The dental service utilization rate increased by 13.2 percentage points between CY 2008 and CY 2012 (Table 14). Nevertheless, many children still do not receive the dental services they need.

Table 14. Children Aged 4–20 Years in Medicaid (Enrolled for at least 320 Days) Receiving a Dental Visit, CY 2008–CY 2012

Year	Total Number of Enrollees	Number of Enrollees Receiving One or More Dental Service	Percentage Receiving Service	National HEDIS Mean*
CY 2008	260,488	142,193	54.6%	44.2%
CY 2009	301,582	183,648	60.9%	45.7%
CY 2010	333,167	213,714	64.1%	47.8%
CY 2011	362,197	241,365	66.6%	45.4%
CY 2012	385,132	261,077	67.8%	**

Source: Maryland's 2013 Annual Oral Health Legislative Report, Health-General Articles, Sections 13-2504(b)
*National HEDIS mean is for children aged 2 – 21 years.
**National HEDIS mean for CY 2012 is not available.

Dental care is also a benefit for pregnant women. Table 15 presents the percentage of pregnant women aged 21 years and older who were enrolled for at least 90 days in Medicaid and received at least one dental visit between CY 2008 and CY 2012. During that time period, rates of dental visits increased from 20.8 percent in CY 2008 to 30.1 percent in CY 2012. Despite these improvements, the rate of dental visits by pregnant women remains low.

Table 15. Percentage of Pregnant Women Aged 21+ Years in Medicaid (Enrolled for at Least 90 Days) Receiving a Dental Visit, CY 2008–CY 2012

Year	Total Number of Enrollees	Number of Enrollees Receiving at Least One Visit	Percentage Receiving a Visit
CY 2008	13,869	2,889	20.8%
CY 2009	17,402	4,931	28.3%
CY 2010	19,837	5,875	29.6%
CY 2011	20,572	6,689	32.5%
CY 2012	21,708	6,537	30.1%

*The study population for CY 2008 through CY 2012 measured dental utilization for all qualifying individuals in Maryland's Medical Assistance program, including FFS and HealthChoice MCO enrollees. The following coverage groups were excluded from the analysis: S09 (PAC program), X02 (undocumented or unqualified immigrants), W01 (Women's Breast and Cervical Cancer Health Program), and P10 (Family Planning Program).

Mental Health Services

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

Table 16 presents the percentage of the HealthChoice population diagnosed with and/or treated for a mental health disorder (MHD)[8] by age group. The percentage of children with an MHD increased 2 percentage points from CY 2008 to CY 2012. The percentage of adults with an MHD decreased 1 percentage point from CY 2008 to CY 2012.

Table 16. Percentage of HealthChoice Population (Any Period of Enrollment) with an MHD by Age Group, CY 2008–CY 2012

Age Group (Years)	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
0 - 18	17.8%	18.1%	18.4%	18.9%	19.8%
19 - 64	28.7%	28.3%	27.7%	27.5%	27.7%
Total	**20.7%**	**21.3%**	**21.6%**	**22.0%**	**22.7%**

Table 17 presents the regional distribution of HealthChoice participants with an MHD. In CY 2008 and CY 2009, most HealthChoice participants with an MHD resided in Baltimore City. However, from CY 2010 through CY 2012, the Baltimore Suburban region had the highest number of HealthChoice participants with an MHD.

Table 17. Regional Distribution of HealthChoice Participants (Any Period of Enrollment) with an MHD, CY 2008–CY 2012

Region	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Baltimore City	30.2%	28.8%	27.5%	26.4%	26.2%
Baltimore Suburban	27.2%	27.5%	28.3%	28.7%	28.7%
Eastern Shore	11.6%	11.9%	12.1%	12.4%	12.2%
Southern Maryland	4.5%	4.6%	4.7%	4.6%	4.6%
Washington Suburban	19.4%	19.9%	20.2%	20.8%	21.3%
Western Maryland	7.1%	7.3%	7.1%	7.0%	7.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Number of Enrollees	**135,654**	**158,599**	**179,958**	**196,285**	**211,223**

[8] Individuals are identified as having an MHD if they have any ICD-9 diagnosis codes that begin with "290," "293," "294," "295," "296," "297," "298," "299," "300," "301," "302," "306," "307," "308," "309," "310," "311," "312," "313," "314," "315," "316" or an invoice control number (ICN) beginning with "6" denoting a specialty mental health claim.

DHMH monitors the extent to which participants with an MHD access somatic services through their MCOs. Table 18 compares the percentage of HealthChoice participants with an MHD who received a physician visit for somatic care with the percentage who received an ED visit for somatic care. Between CY 2008 and CY 2012, the percentage of participants with a physician visit for somatic care increased by 4.3 percentage points. During the same time period, the percentage of participants with an ED visit for somatic care increased by 7.1 percentage points.

Table 18. Service Utilization among HealthChoice Participants (Any Period of Enrollment) with an MHD, CY 2008–CY 2012

Year	Number of HealthChoice Participants with an MHD	Percentage with a Physician Visit for Somatic Care	Percentage with an ED Visit for Somatic Care
CY 2008	135,654	82.7%	36.3%
CY 2009	158,599	85.3%	40.9%
CY 2010	179,958	85.4%	39.6%
CY 2011	196,285	86.6%	43.5%
CY 2012	211,223	87.0%	43.4%

Substance Use Disorder Services

Substance use disorder (SUD)[9] services are currently provided under the HealthChoice MCO benefit package. Table 19 shows the percentage of HealthChoice participants diagnosed with and/or treated for an SUD by age group. The percentage of children aged 0 through 18 years with an SUD ranged between 0.8 and 0.9 percent throughout the evaluation period. The percentage of adults with an SUD decreased by nearly 1 percentage point, from 11.6 percent in CY 2008 to 10.8 percent in CY 2012.

[9] Individuals were identified as having an SUD if they had a diagnosis code that met the HEDIS *"Identification of Alcohol and Other Drug Services"* measure. The measure includes the following ICD-9 diagnosis codes:"291"-"292", "303"-"304", "305.0", "305.2"-"305.9", "535.2", "571.1"; MS-DRG "894"-"897"; and ICD-9-CM Procedure 946.6x with an inpatient code.

Table 19. Percentage of HealthChoice Population (Any Period of Enrollment) with an SUD by Age Group, CY 2008 – CY 2012

Age Group (Years)	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
0 - 18	0.8%	0.9%	0.9%	0.9%	0.9%
19 - 64	11.6%	11.2%	11.1%	10.7%	10.8%
Total	**3.7%**	**4.1%**	**4.4%**	**4.4%**	**4.5%**

Table 20 presents the regional distribution of HealthChoice participants with an SUD. Between CY 2008 and CY 2012, the majority of participants with an SUD lived in Baltimore City, followed by the Baltimore Suburban region.

Table 20. Regional Distribution of HealthChoice Participants (Any Period of Enrollment) with an SUD, CY 2008–CY 2012

Region	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Baltimore City	45.8%	42.9%	40.2%	38.1%	37.3%
Baltimore Suburban	24.0%	25.3%	26.1%	26.8%	27.0%
Washington Suburban	9.9%	11.1%	11.8%	12.1%	12.5%
Western Maryland	3.1%	3.5%	4.2%	5.0%	4.8%
Eastern Shore	11.0%	11.0%	11.5%	11.8%	11.9%
Southern Maryland	6.1%	6.3%	6.1%	6.3%	6.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Number of Enrollees	**24,389**	**30,715**	**36,854**	**39,574**	**42,063**

DHMH also monitors the extent to which participants with an SUD access somatic care services. Table 21 compares the percentage of HealthChoice participants with an SUD who received a physician visit for somatic care with the percentage who received an ED visit for somatic care. Between CY 2008 and CY 2012, the percentage of participants with an ambulatory care visit for somatic care increased by 3.3 percentage points, whereas the rate for ED visits for somatic care increased by 12.4 percentage points.

Table 21. Service Utilization of HealthChoice Participants (Any Period of Enrollment) with an SUD, CY 2008–CY 2012

Year	Number of HealthChoice Participants with an SUD	Percentage with a Physician Visit for Somatic Care	Percentage with an ED Visit for Somatic Care
CY 2008	24,389	77.6%	48.8%
CY 2009	30,715	79.0%	52.8%
CY 2010	36,854	79.0%	52.8%
CY 2011	39,574	80.2%	61.0%
CY 2012	42,063	80.9%	61.2%

Table 22 shows the number and percentage of HealthChoice participants with an SUD and at least one methadone replacement therapy. Between CY 2008 and CY 2012, the percentage of participants with at least one methadone replacement therapy remained between 20 and 23 percent.

Table 22. Number and Percentage of HealthChoice Participants (Any Period of Enrollment) with an SUD and at Least One Methadone Replacement Therapy, CY 2008–CY 2012

Year	Number of HealthChoice Participants with an SUD	Number of Participants with an SUD and Methadone Replacement Therapy	Percentage of Total Participants with an SUD
CY 2008	24,389	4,877	20.0%
CY 2009	30,715	6,062	19.7%
CY 2010	36,854	7,837	21.3%
CY 2011	39,574	8,787	22.2%
CY 2012	42,063	9,520	22.6%

Behavioral Health Integration

The number of HealthChoice participants with a dual diagnosis of MHD and SUD increased from 15,254 in CY 2008 to 26,049 in CY 2012. Table 23 presents the number of participants in CY 2008 through CY 2012 with a dual diagnosis, MHD only, SUD only, or none of these diagnoses.

Table 23. Number of HealthChoice Participants (Any Period of Enrollment) with a Dual Diagnosis of MHD and SUD, CY 2008 - CY 2012

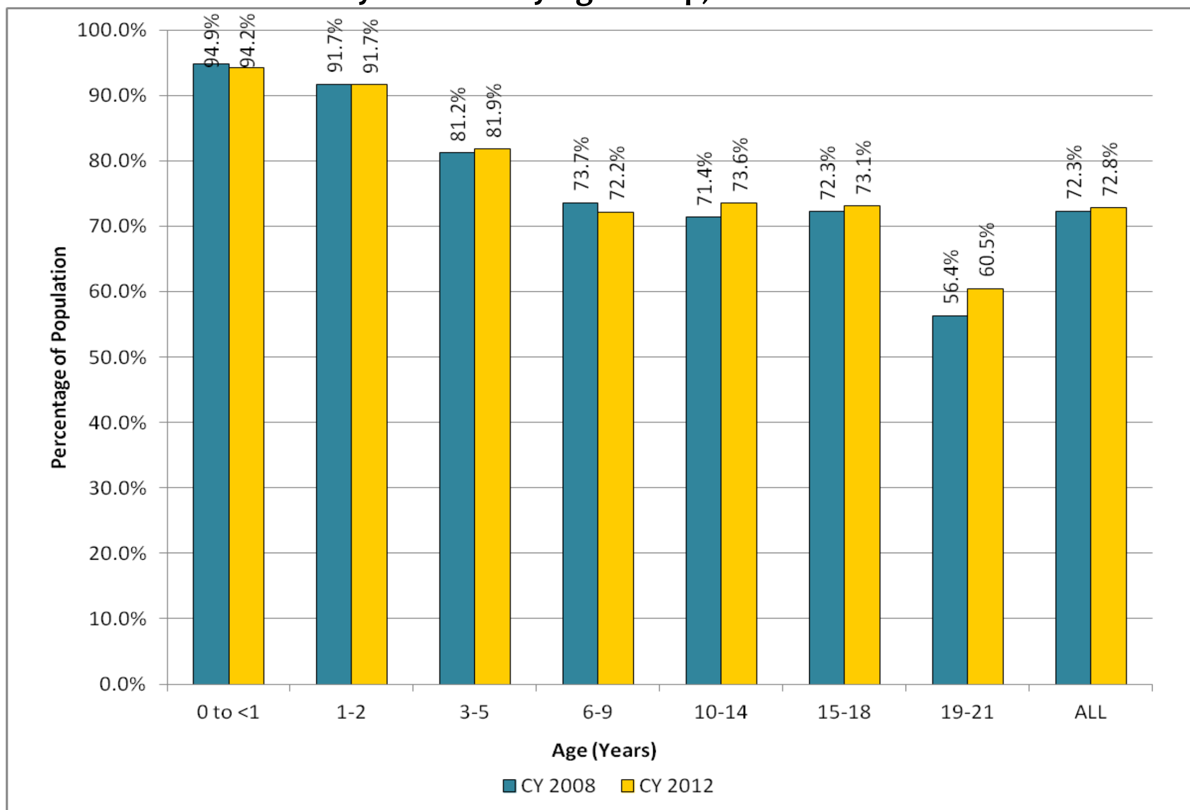
Year	Dual Diagnosis (MH and SUD)	MHD Only	SUD Only	None	TOTAL
CY 2008	15,254 (2.3%)	120,400 (18.4%)	9,135 (1.4%)	509,390 (77.9%)	**654,179 (100.0%)**
CY 2009	19,576 (2.6%)	139,023 (18.7%)	11,139 (1.5%)	573,118 (77.2%)	**742,856 (100.0%)**
CY 2010	23,527 (2.8%)	156,431 (18.8%)	13,327 (1.6%)	639,063 (76.8%)	**832,348 (100.0%)**
CY 2011	24,453 (2.7%)	171,832 (19.2%)	15,121 (1.7%)	681,571 (76.3%)	**892,977 (100.0%)**
CY 2012	26,049 (2.8%)	185,174 (19.9%)	16,014 (1.7%)	703,410 (75.6%)	**930,647 (100.0%)**

Access to Care for Children in Foster Care

This section of the report examines service utilization for children in foster care with any period of enrollment in HealthChoice during the calendar year.[10] The section also compares service utilization for children in foster care with other HealthChoice children. Unless otherwise specified, all of the measures presented include children aged 0 through 21 years and include their use of FFS and MCO services.

Figure 10 displays the percentage of children in foster care with any period of enrollment who had at least one ambulatory care visit in CY 2008 and CY 2012 by age group. During the evaluation period, the overall rate increased by 0.5 percentage points, from 72.3 percent to 72.8 percent. Utilization was highest for the youngest children and lowest for the oldest children.

Figure 10. Percentage of HealthChoice Children in Foster Care Receiving at Least One Ambulatory Care Visit by Age Group, CY 2008 and CY 2012



[10] Children in the subsidized adoption program are *excluded* from the definition of foster care children. Rather, these enrollees are included as 'other children enrolled in HealthChoice.'

Figure 11 compares the ambulatory care visit rate for children in foster care with the rate for other children enrolled in HealthChoice in CY 2012. Overall, 72.8 percent of children in foster care and 79.6 percent of other HealthChoice children received at least one ambulatory care visit. For all age groups, children in foster care accessed ambulatory care services at lower rates than other children in the HealthChoice program.

Figure 11. Percentage of HealthChoice Children in Foster Care vs. Other HealthChoice Children Receiving at Least One Ambulatory Care Visit by Age Group, CY 2012

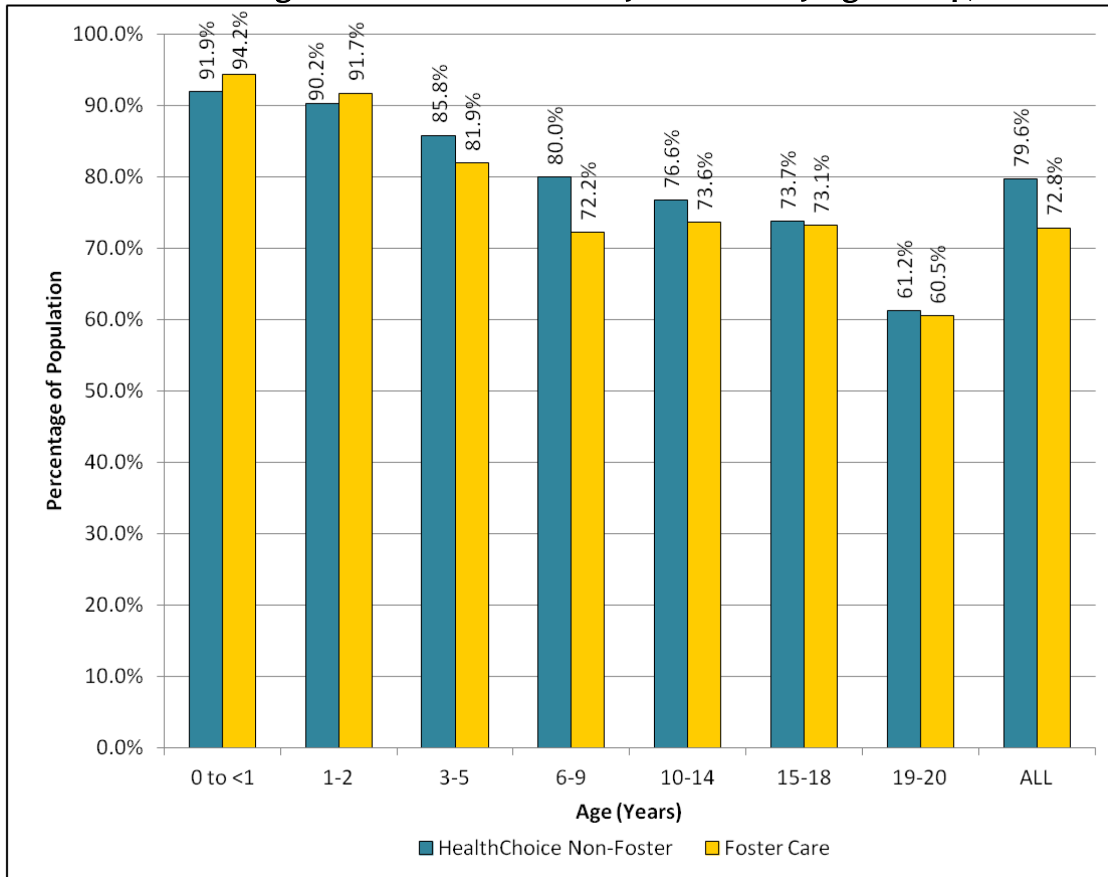


Figure 12 displays the percentage of children in foster care receiving at least one MCO outpatient ED visit in CY 2008 and CY 2012 by age group. The overall rate increased by 4.1 percentage points during the evaluation period. Children aged 1 through 2 years and those aged 19 through 21 years had the highest rates of ED utilization in CY 2012.

Figure 12. Percentage of HealthChoice Children in Foster Care Receiving at Least One MCO Outpatient ED Visit by Age Group, CY 2008 and CY 2012

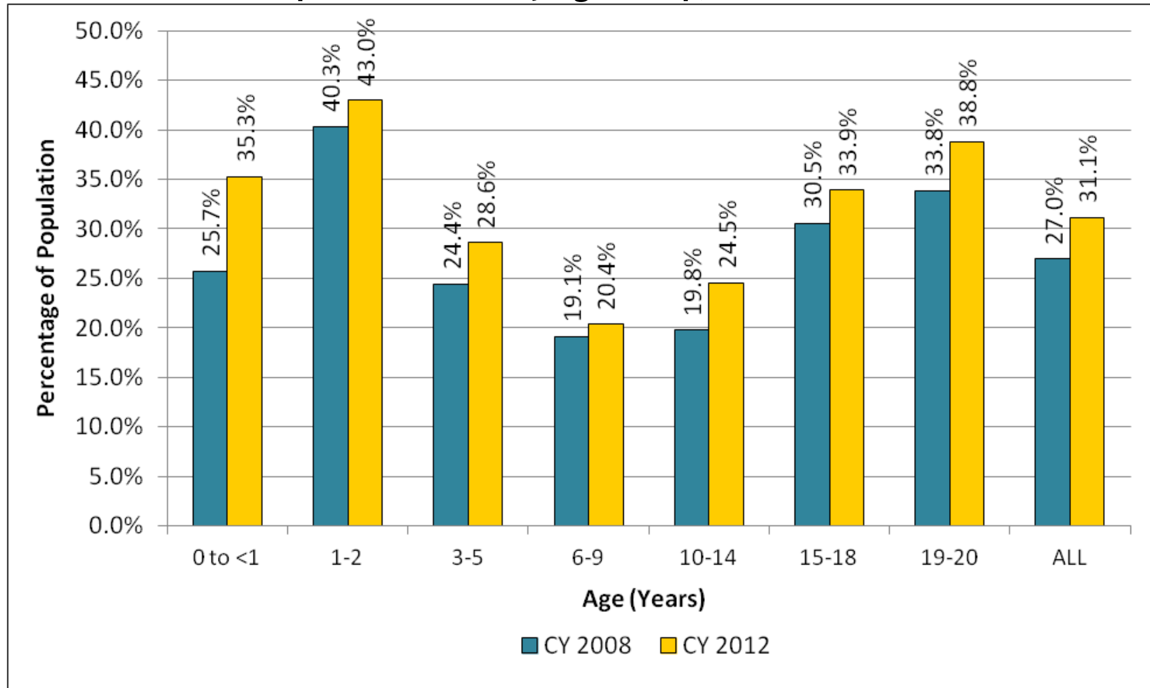


Figure 13 compares the MCO outpatient ED visit rate in CY 2012 for children in foster care with the rate for other children enrolled in HealthChoice. Overall, children in foster care visited the ED at a higher rate than other children in HealthChoice. Children aged 1 through 2 years had the highest ED visit rate across both groups of children. Please note that children often enter the foster care system through cases of abuse, which may account for their higher rate of ED utilization.

Figure 13. Percentage of HealthChoice Children in Foster Care vs. Other HealthChoice Children Receiving at Least One MCO Outpatient ED Visit by Age Group, CY 2012

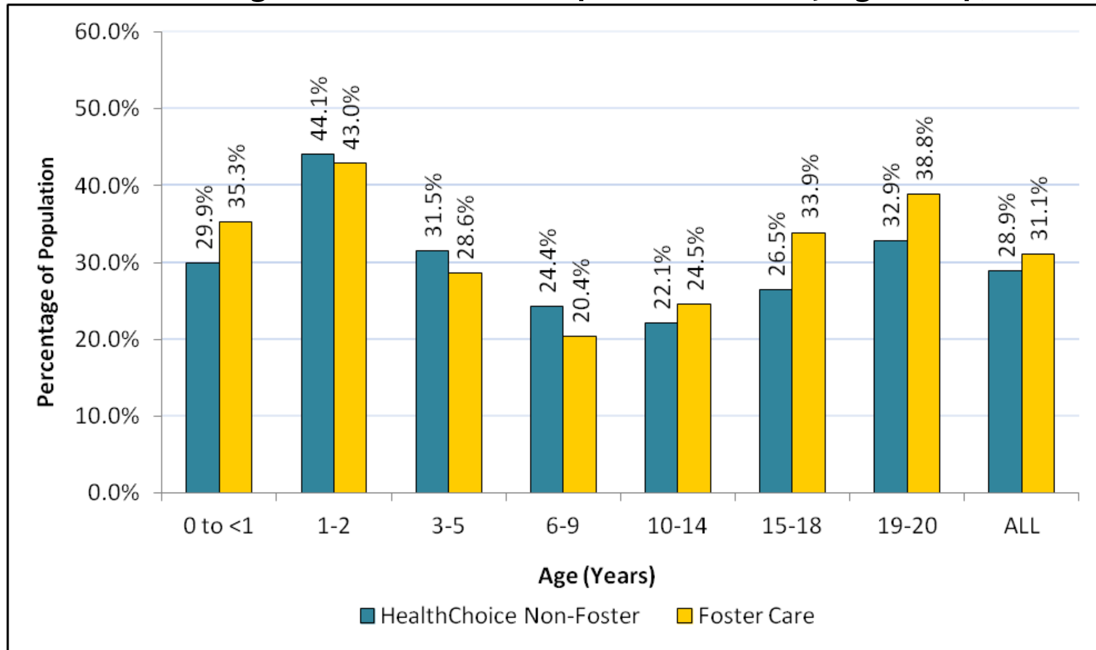
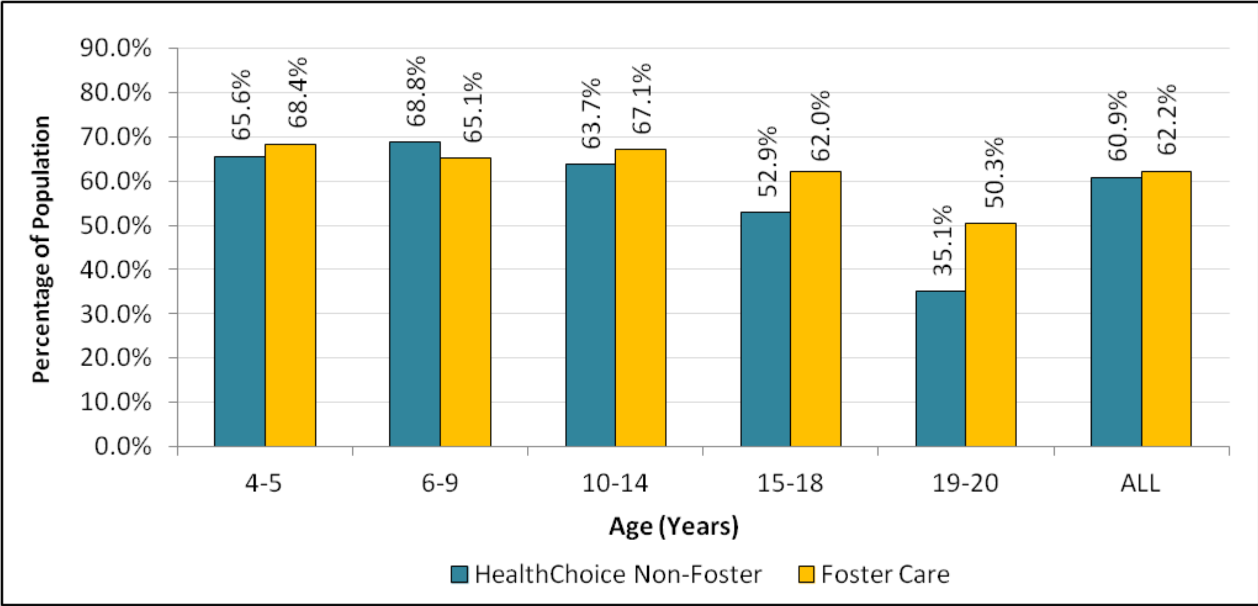


Figure 14 compares the dental utilization rate for children in foster care aged 4 to 20 years with any period of enrollment in HealthChoice with the rate for other children in HealthChoice in CY 2012. Overall, children in foster care had a higher dental visit rate (62.2 percent) than other HealthChoice children (60.9 percent).

Figure 14. Percentage of HealthChoice Children Aged 4-20 Years (Any Period of Enrollment) in Foster Care vs. Other HealthChoice Children Receiving at Least One Dental Visit, by Age Group, CY 2012



Reproductive Health

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

Timeliness of Ongoing Prenatal Care

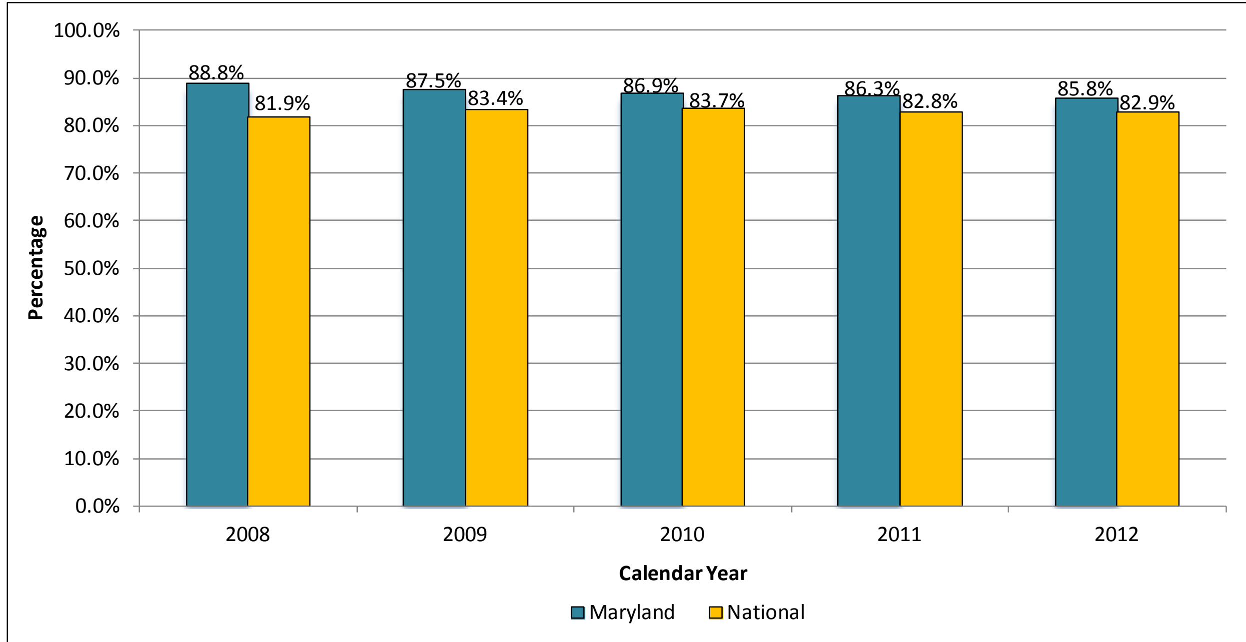
HEDIS measures the timeliness of prenatal care and the frequency of ongoing prenatal care to determine the adequacy of care during pregnancy. The earlier a woman receives prenatal care, the more likely health conditions that could affect her health and/or the health of the newborn will be identified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

Timeliness of care assesses the percentage of deliveries for which the mother received a prenatal care visit in the first trimester *or* within 42 days of HealthChoice enrollment.[11] Figure 15 compares HealthChoice performance on this measure with the national HEDIS mean for CY 2008 through CY 2012 (HealthcareData Company, LLC, 2013). Utilization of prenatal care decreased by 3 percentage points during the evaluation period, from 88.8 percent in CY 2008 to

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

85.8 percent in CY 2012. HealthChoice consistently outperformed the national HEDIS mean during the evaluation period by 3 to 8 percentage points.

Figure 15. HEDIS Timeliness of Prenatal Care, HealthChoice Maryland Compared with the National HEDIS Mean, CY 2008 – CY 2012



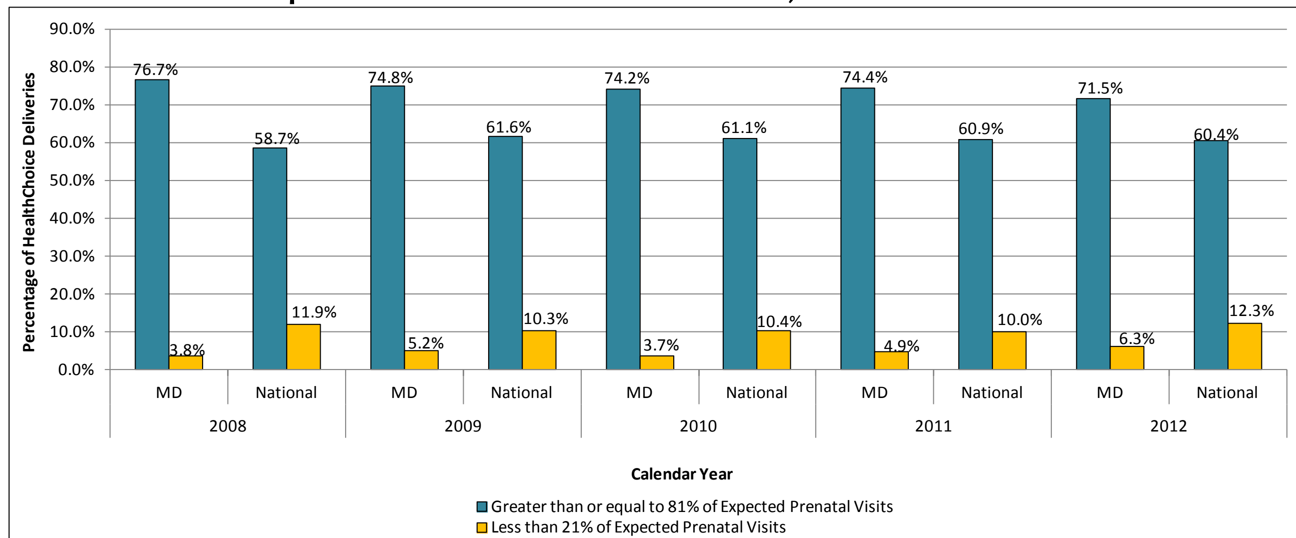
Frequency of Ongoing Prenatal Care

The frequency of ongoing prenatal care measure assesses the percentage of recommended[12] prenatal visits received. DHMH uses this measure to assess MCO performance in providing appropriate prenatal care. The measure calculates the percentage of deliveries for which the women received the expected number of prenatal visits. This measure accounts for gestational age and time of enrollment, and women must be continuously enrolled 43 days prior to and 56 days after delivery.

The first aspect of this measure assesses the percentage of women who received more than 80 percent of expected visits; therefore, a higher score is preferable. Figure 16 shows that this rate decreased by 5.2 percentage points during the evaluation period, from 76.7 percent in CY 2008 to 71.5 percent in CY 2012 (HealthcareData Company, LLC, 2013). The second aspect of this measure assesses the percentage of women who received less than 21 percent of expected visits; therefore, a lower score is preferable. The rate for this measure increased by 2.5 percentage points from 3.8 percent in CY 2008 to 6.3 percent in CY 2012. In sum, Maryland consistently outperformed the national HEDIS means for both aspects of this measure, although performance over the evaluation period declined slightly.

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

Figure 16. Percentage of HealthChoice Deliveries Receiving the Expected Number of Prenatal Visits (≥ 81 Percent or < 21 Percent of Recommended Visits), Compared with the National HEDIS Mean, CY 2008–CY 2012



The Family Planning Program

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

Tables 24 and 25 present the percentage of total Medicaid participants in the Family Planning Program and the percentage of Family Planning participants who received at least one service between CY 2008 and CY 2012. These data are presented for women who were enrolled in Family Planning for any period of time during the calendar year and women who were enrolled continuously for 12 months.

The number of women with any period of enrollment in the Family Planning Program decreased by 52.2 percent between CY 2008 and CY 2012 (Table 26). This decline in enrollment may be attributed to several significant changes made in CY 2008 in response to new CMS terms and conditions. CMS required the program to perform annual active redeterminations in order to reduce the upper income limit from 250 to 200 percent of the FPL and to no longer enroll women with other third-party insurance that includes family planning benefits. The July 2008 Medicaid expansion also increased the number of women who are eligible for full Medicaid coverage after delivery, thus decreasing the number of women enrolled in the limited benefit Family Planning Program.

Table 24 shows that, during the evaluation period, the percentage of women with any period of enrollment in the program who utilized at least one family planning service ranged between 17.4 percent and 31.9 percent. As Table 25 displays, the rate of women enrolled in the program for the entire 12 months increased from 15.7 percent in CY 2008 to 35.0 percent in CY 2012.

Table 24. Percentage of Family Planning Participants (Any Period of Enrollment) with at Least One Corresponding Service, CY 2008–CY 2012

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Number of Participants	52,094	38,132	25,920	21,067	24,894
Number with at least 1 Service	9,040	6,798	4,642	4,095	7932
Percentage with at least 1 Service	17.4%	17.8%	17.9%	19.4%	31.9%

Table 25. Percentage of Family Planning Participants (12-Month Enrollment) with at Least One Corresponding Service, CY 2008–CY 2012

	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Number of Participants	14,731	7,433	1,886	1,737	2,523
Number with at least 1 Service	2,306	1,057	488	415	883
Percentage with at least 1 Service	15.7%	14.2%	25.9%	23.9%	35.0%

Services for Individuals with HIV/AIDS

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

Table 26 presents the percentage of participants with HIV/AIDS by race/ethnicity for CY 2008 and CY 2012. Across the evaluation period, Blacks and Whites composed approximately 95 percent of the HIV/AIDS population, and the Black-to-White ratio was approximately 8 to 1.

Table 26. Distribution of HealthChoice Participants (Any Period of Enrollment) with HIV/AIDS by Race/Ethnicity, CY 2008 and CY 2012

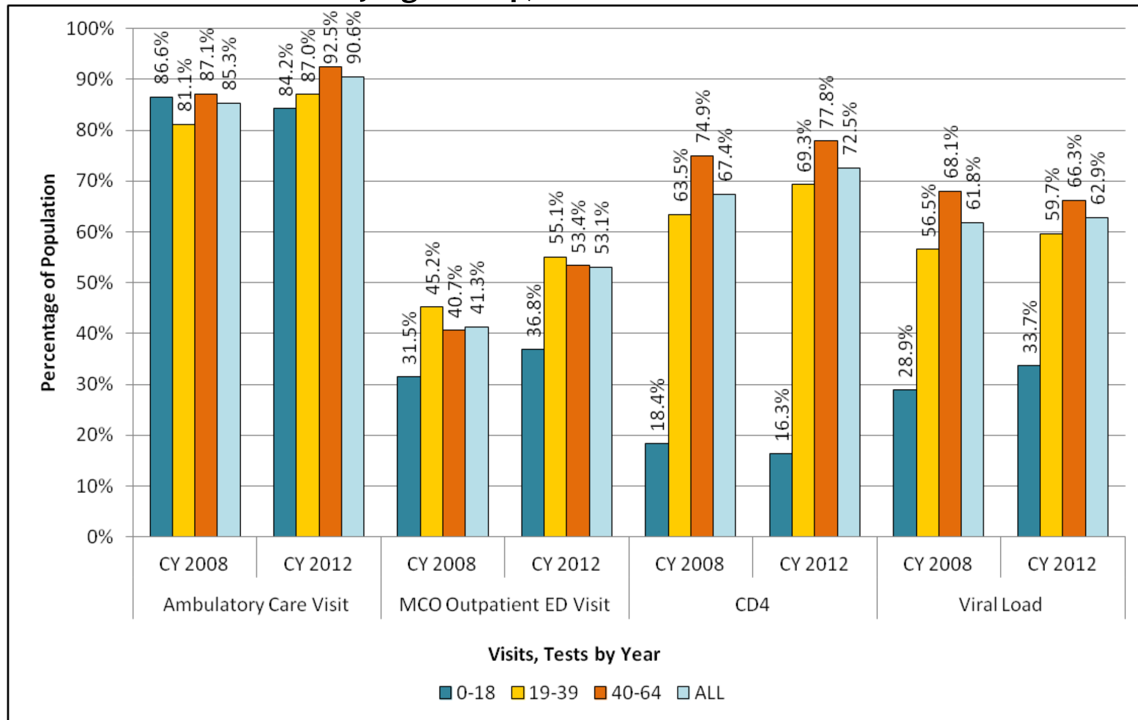
	CY 2008		CY 2012	
Race/Ethnicity	**Number of Participants**	**Percentage of Total**	**Number of Participants**	**Percentage of Total**
Asian	8	0.2%	13	0.3%
Black	3,462	85.0%	3,408	84.5%
White	430	10.6%	433	10.7%
Hispanic	39	1.0%	42	1.0%
Other	134	3.3%	135	3.3%
ALL	**4,073**	**100.0%**	**4,031**	**100.0%**

Figure 17 shows service utilization by participants with HIV/AIDS in CY 2008 and CY 2012 by age group. The overall percentage of participants with HIV/AIDS with an ambulatory care visit increased from 85.3 percent in CY 2008 to 90.6 percent in CY 2012. This rate increased for all age groups, with the exception of children aged 0 to 18 years. However, the percentage of participants with an MCO outpatient ED visit also increased by nearly 12 percentage points during the evaluation period. This rate increased for all age groups.

Figure 17 also presents the percentage of individuals with HIV/AIDS who received CD4 testing in CY 2008 and CY 2012. The overall rate increased from 67.4 percent in CY 2008 to 72.5 percent in CY 2012. Individuals aged 40 through 64 years had the highest rates of CD4 testing during the evaluation period, and individuals aged 0 to 18 years had the lowest rates.

Finally, Figure 17 presents the percentage of individuals with HIV/AIDS who received viral load testing during the evaluation period. This measure increased from 61.8 percent in CY 2008 to 62.9 percent in CY 2012. Individuals aged 0 through 18 showed the largest increase in utilization, with an increase of 4.8 percentage points.

Figure 17. Percentage of HealthChoice Participants with HIV/AIDS who Received an Ambulatory Care Visit, MCO Outpatient ED Visit, CD4 Testing, and Viral Load Testing by Age Group, CY 2008 and CY 2012



REM Program

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

REM Enrollment

Table 27 presents REM enrollment by age group and sex for CY 2008 and CY 2012. In both years, the majority of REM participants were male children aged 0 through 18 years. The gender distribution differs from the general HealthChoice population, which has a higher percentage of females (approximately 57 percent in CY 2012).

Table 27. REM Enrollment by Age Group and Sex, CY 2008 and CY 2012

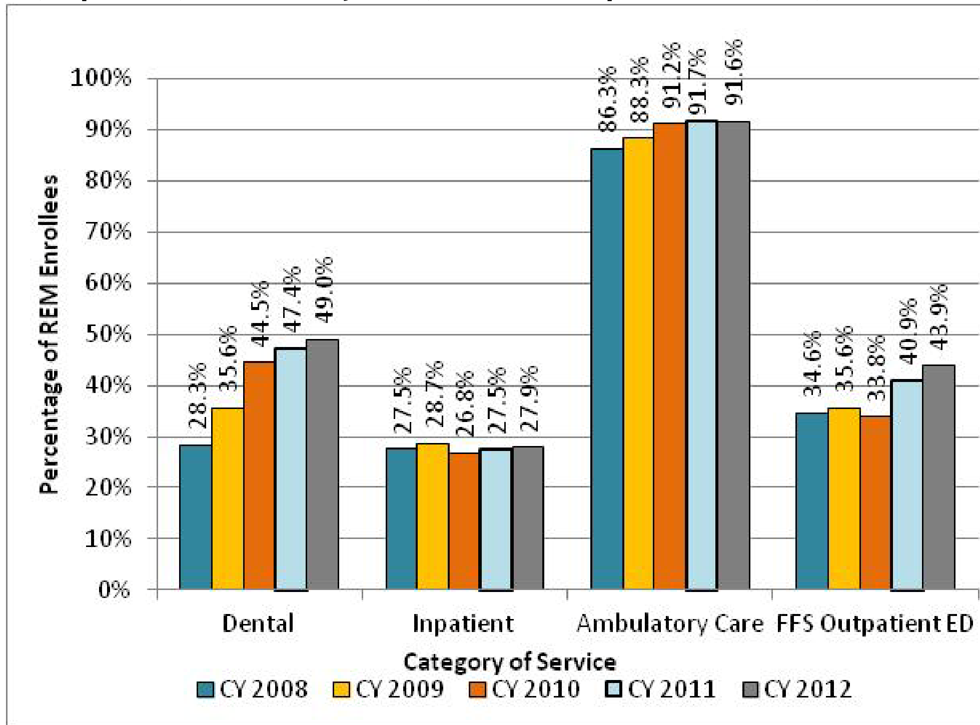
	CY 2008		CY 2012	
Age Group (Years) and Sex	Number of Participants	Percentage of Total	Number of Participants	Percentage of Total
0-18	3,026	74.5%	3,225	69.8%
19-64	1,034	25.5%	1,395	30.2%
Total	**4,060**	**100.0%**	**4,620**	**100.0%**
Female	1,814	44.7%	2,048	44.3%
Male	2,246	55.3%	2,572	55.7%
Total	**4,060**	**100.0%**	**4,620**	**100.0%**

REM Service Utilization

Figure 18 presents the percentage of REM participants who received at least one dental, inpatient, ambulatory care, and FFS outpatient ED visit between CY 2008 and CY 2012.[13] The dental, inpatient, and ambulatory care visit measures serve as indicators of access to care. The percentage of participants with a dental visit increased markedly during the evaluation period, from 28.3 percent in CY 2008 to 49.0 percent in CY 2012. The ambulatory care utilization rate increased by 5.3 percentage points during the evaluation period, and inpatient service utilization remained approximately constant. The percentage of participants who had a FFS outpatient ED visit increased 9.3 percentage points between CY 2008 and CY 2012.

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

Figure 18. Percentage of REM Participants (Any Period of Enrollment) with at Least One Dental, Inpatient, Ambulatory Care, and FFS Outpatient ED Visit, CY 2008–CY2012



Racial/Ethnic Disparities

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

Enrollment

Table 28 displays HealthChoice enrollment by race/ethnicity. Total enrollment increased within each racial/ethnic group between CY 2008 and CY 2012. However, this growth did not occur uniformly across all categories. Enrollment of Whites and people in the "Other" racial/ethnic category increased by 45 percent and 82 percent, respectively. Asians experienced the greatest growth, with enrollment increasing by approximately 100 percent. The percentage of Black participants decreased from nearly 53 percent in CY 2008 to 49 percent in CY 2012, whereas the percentage of Hispanic participants increased by less than 1 percentage point.

Table 28. HealthChoice Enrollment by Race/Ethnicity, CY 2008 and CY 2012

	CY 2008		CY 2012	
Race/ Ethnicity	Number of Participants	Percentage	Number of Participants	Percentage
Asian	16,076	2.5%	32,094	3.4%
Black	345,861	52.9%	456,412	49.0%
White	185,203	28.3%	268,978	28.9%
Hispanic	75,282	11.5%	114,791	12.3%
Other	31,990	4.6%	58,372	6.3%
Total	**654,412**	**100.0%**	**930,647**	**100.0%**

Ambulatory Care Visits

Figure 19 shows the percentage of children aged 0 through 20 years who received at least one ambulatory care visit in CY 2008 and CY 2012 by race/ethnicity. This rate increased for all racial/ethnic groups during the evaluation period. Hispanics had the highest rate in both CY 2008 (86.2 percent) and CY 2012 (88.2 percent), and Blacks had the lowest rate across the evaluation period.

Figure 19. Percentage of HealthChoice Participants Aged 0–20 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2008 and CY 2012

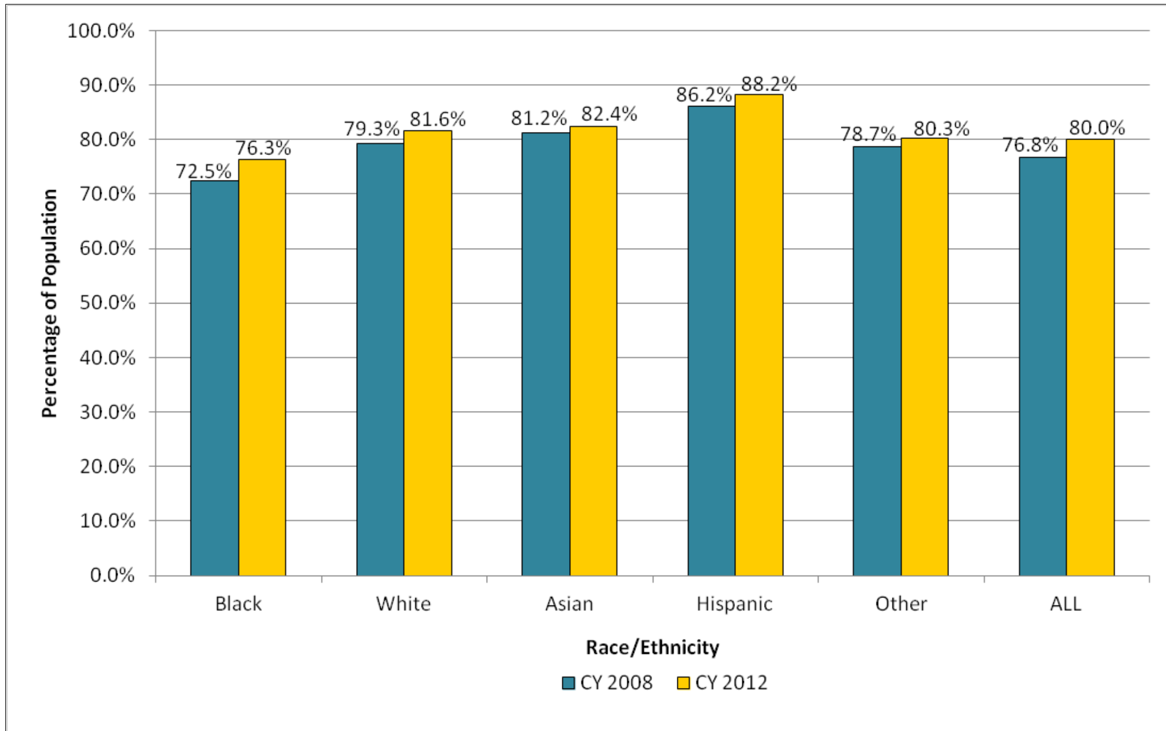
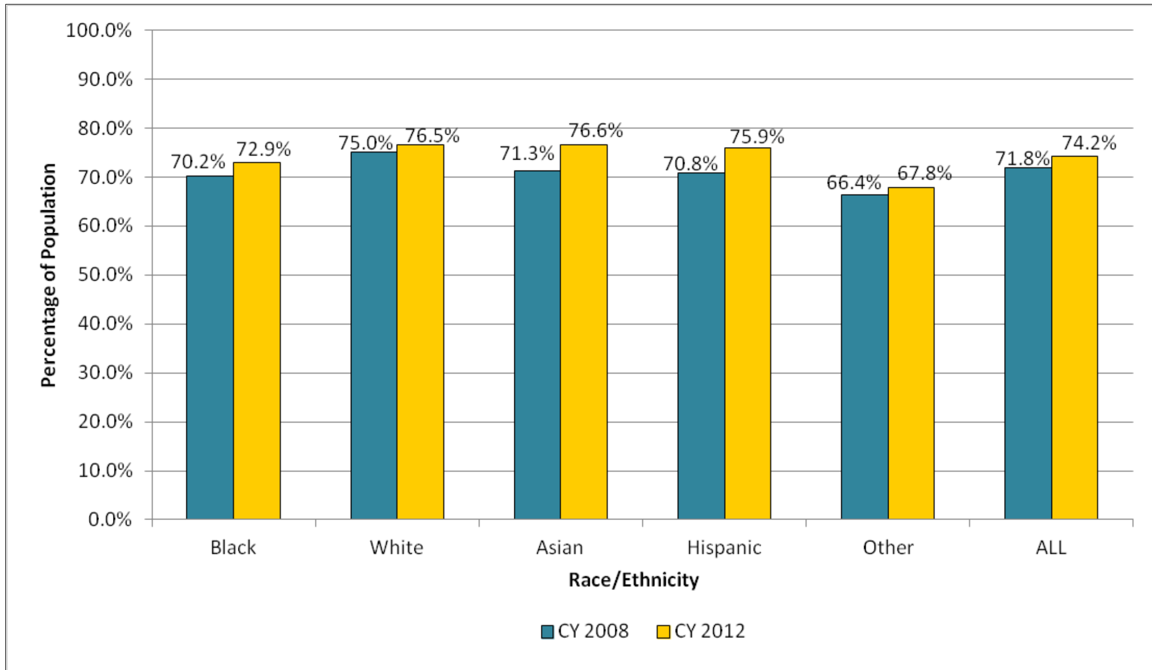


Figure 20 presents the percentage of adults aged 21 through 64 years who received at least one ambulatory care visit in CY 2008 and CY 2012 by race/ethnicity. The ambulatory care visit rate increased for all racial/ethnic groups. Asians experienced the greatest increase during the evaluation period (5.3 percentage points), followed by Hispanics (5.1 percentage points).

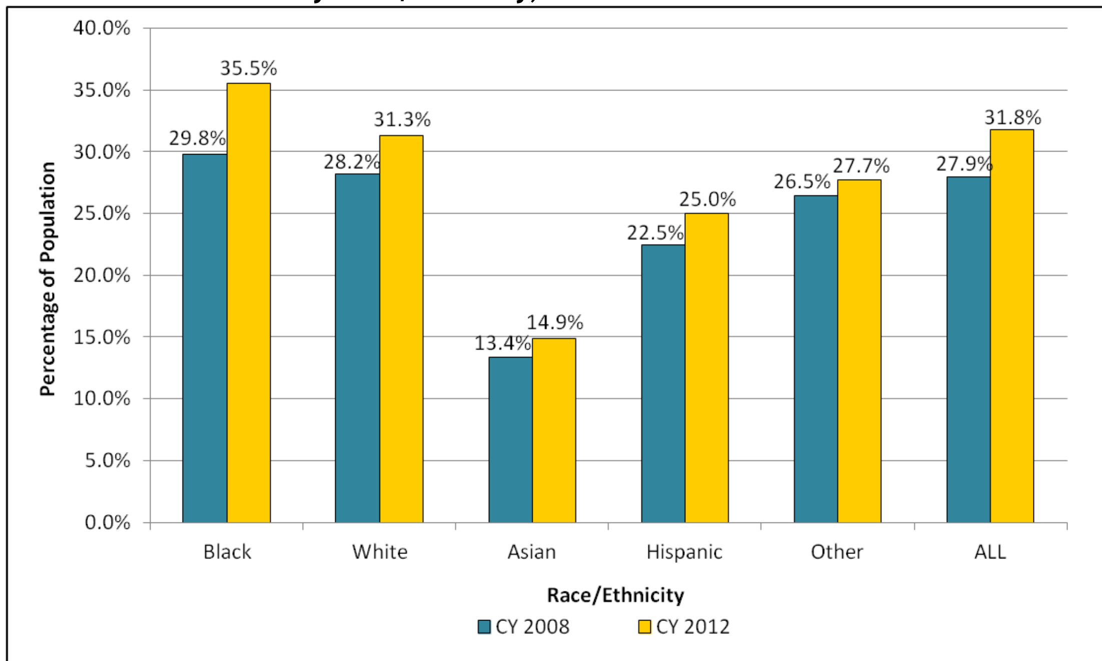
Figure 20. Percentage of HealthChoice Participants Aged 21–64 Years Receiving an Ambulatory Care Visit by Race/Ethnicity, CY 2008 and CY 2012



ED Visits

Figure 21 displays the percentage of HealthChoice participants aged 0 through 64 years who had at least one ED visit by race/ethnicity in CY 2008 and CY 2012. Blacks had the highest ED visit rate, but each racial/ethnic group experienced an increase during the evaluation period. Asians had the lowest rate across the evaluation period.

Figure 21. Percentage of HealthChoice Participants Aged 0–64 Receiving an ED Visit by Race/Ethnicity, CY 2008 and CY 2012



Section IV Summary

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

- Dental services for children, pregnant women, and adults in the REM program were carved out of the MCO benefit package on July 1, 2009. These services are administered by an ASO. Maryland has made improvements in children's dental service utilization and dental provider reimbursement.
- The percentage of participants with an MHD ranged between 20.7 and 22.7 percent between CY 2008 and CY 2012. The percentage of participants with an SUD ranged between 3.7 and 4.5 percent during the same time period. HealthChoice participants with an SUD had higher rates of ED visits for somatic care than the population with an MHD.
- In CY 2012, children in foster care had a lower rate of ambulatory care service utilization compared with other children in HealthChoice, as well as a higher rate of MCO outpatient ED visits.
- Measures of access to prenatal care services declined slightly during the evaluation period, but Maryland outperformed the national HEDIS means in CY 2012.

- Due to program changes required by CMS, enrollment in the Family Planning Program decreased by 52.2 percent between CY 2008 and CY 2012 (using the any period of enrollment methodology).
- Ambulatory care service utilization, CD4 testing, and viral load testing improved for participants with HIV/AIDS during the evaluation period. ED utilization by this population also increased during the evaluation period.
- The REM program provides case management, medically necessary private duty nursing, and other expanded benefits to participants who have one of a specified list of rare and expensive medical conditions. In CY 2012, the majority of REM participants were children (nearly 70 percent) and male (nearly 56 percent).
- Regarding racial/ethnic disparities in access to care, Black children have lower rates of ambulatory care visits than other children. Among the entire HealthChoice population, Blacks also have the highest ED utilization rates. DHMH will continue to monitor these measures to reduce disparities between racial/ethnic groups.

Section V. PAC Access and Quality

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

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

Additionally, participants were able to receive specialty mental health services through the FFS system.

As a result of the Medicaid expansion option in the ACA, the PAC program transitioned into a categorically-eligible Medicaid population on January 1, 2014 (after this report's evaluation period). Childless adults under the age of 65 years and with incomes up to 138 percent of the FPL now receive full Medicaid benefits, and services are provided through HealthChoice MCOs.

This section of the report analyzes a variety of PAC enrollment and service utilization performance measures.

PAC Enrollment

This section presents PAC enrollment from CY 2008 through CY 2012. The number of individuals with any period of enrollment in PAC increased by 123 percent during the evaluation period, from 42,891 participants in CY 2008 to 95,802 participants in CY 2012.

Figure 22 presents the percentage of PAC participants with any period of enrollment by race/ethnicity for CY 2008 through CY 2012. Across the evaluation period, Blacks and Whites comprised approximately 95 percent of the PAC population, with the Black-to-White ratio

almost 2 to 1 in the initial year of the evaluation period. However, since CY 2009, this ratio decreased.

Figure 22. PAC Enrollment (Any Period of Enrollment) by Race/Ethnicity, CY 2008–CY 2012

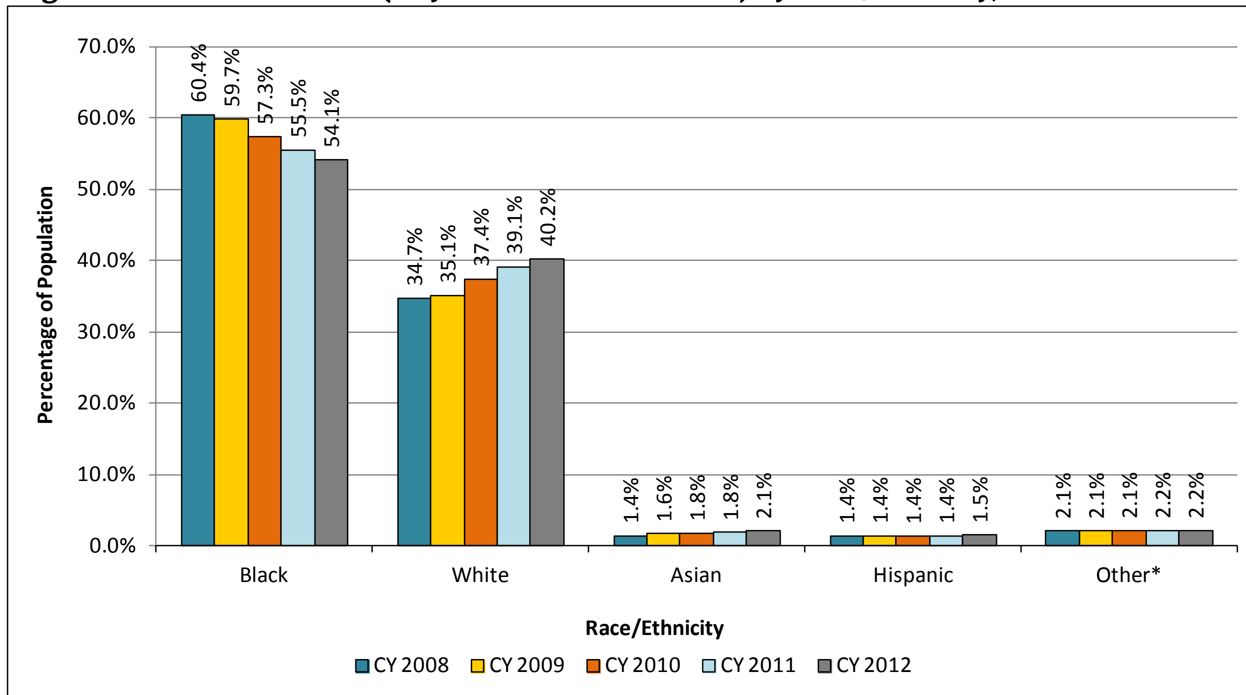
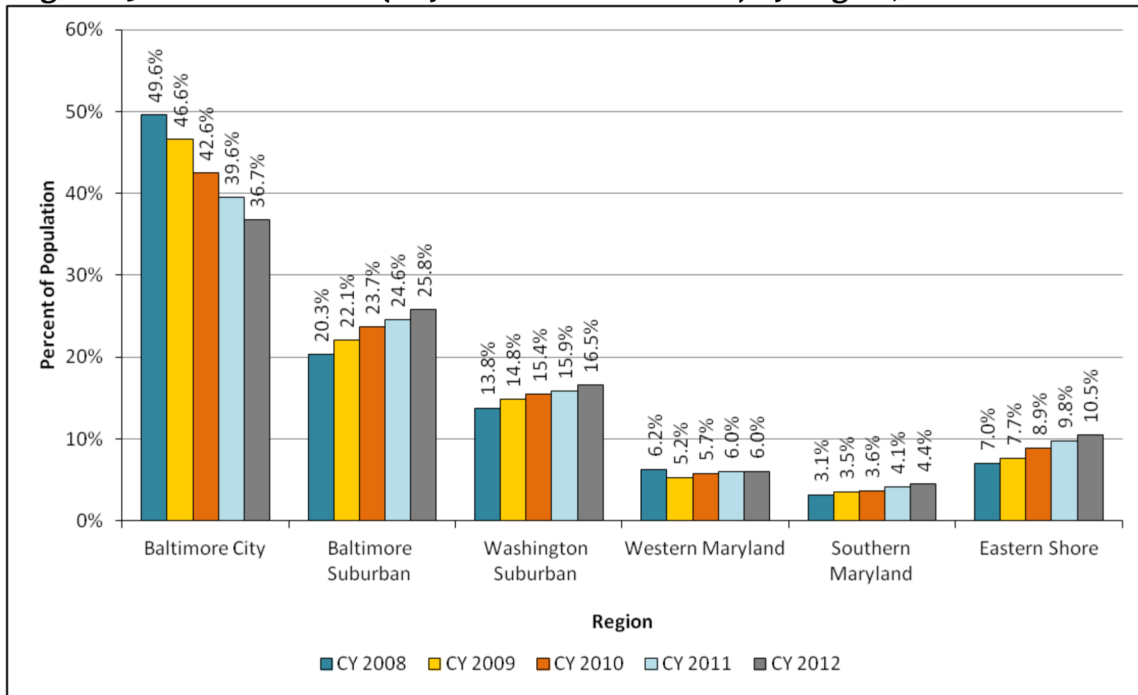


Figure 23 presents PAC enrollment by region from CY 2008 through CY 2012. Enrollment was concentrated in the densely populated areas of the State, with roughly 80 percent of participants residing in three regions: Baltimore City, Baltimore Suburban, and Washington Suburban.

Figure 23. PAC Enrollment (Any Period of Enrollment) by Region, CY 2008–CY 2012



PAC Service Utilization

To provide a more accurate review of PAC enrollee service utilization, this section of the report includes only individuals who were enrolled in the PAC program for the entire year, with the exception of the mental health and substance use disorder services sections.

Ambulatory Care Visits

Figure 24 presents the percentage of PAC participants who had at least one ambulatory care visit between CY 2008 and CY 2012 by race/ethnicity. The percentage of participants with an ambulatory care visit increased by 4.5 percentage points, from 69.7 percent in CY 2008 to 74.2 percent in CY 2012. Hispanic participants experienced the greatest increase (more than 27 percentage points), followed by the Asian and Other categories, with increases of approximately 7.1 and 6.2 percentage points, respectively. The overall rate of ambulatory care visits increased over the evaluation period.

Figure 24. Percentage of PAC Participants (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Race/ Ethnicity, CY 2008–CY 2012

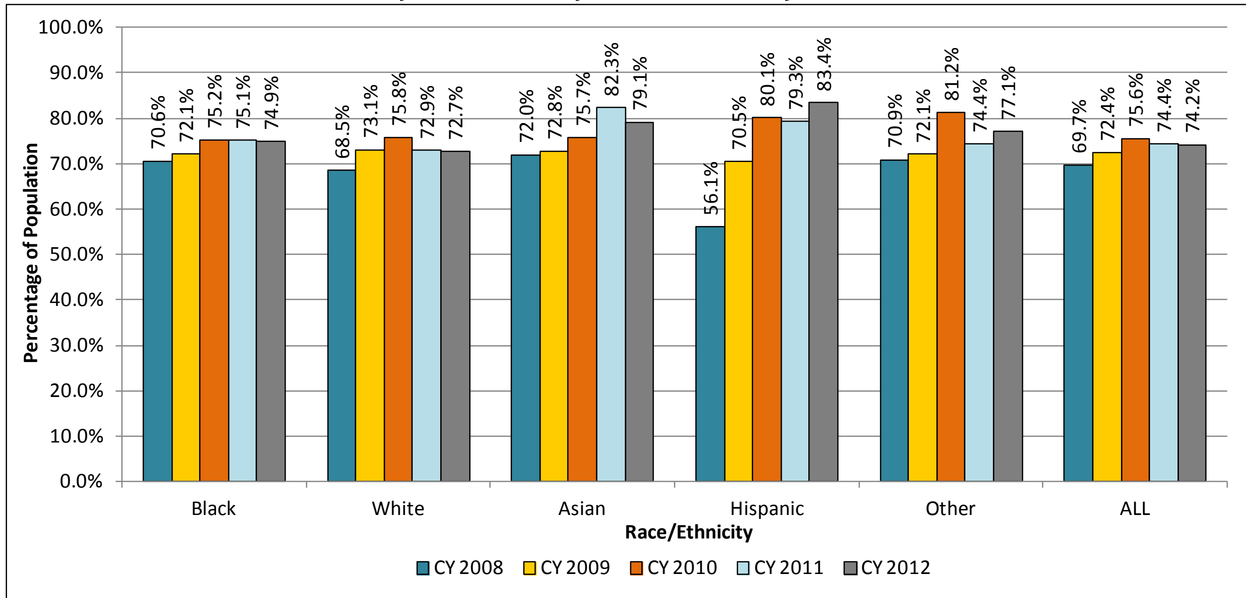
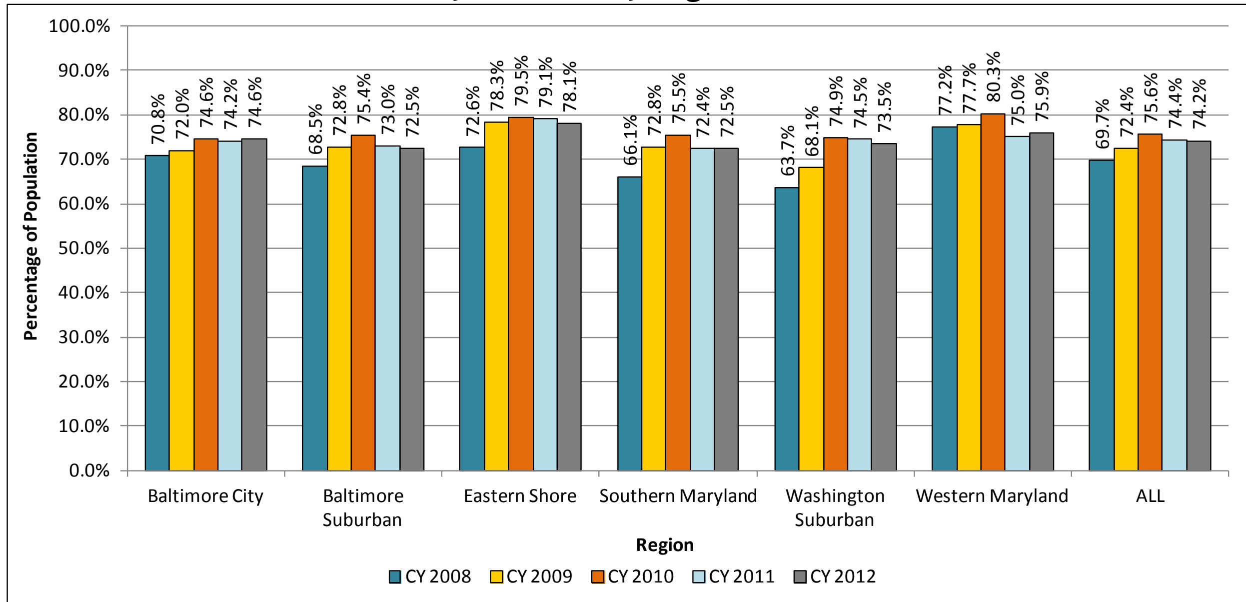


Figure 25 shows that the ambulatory care visit rate also increased within most regions. The Washington Suburban and the Southern Maryland regions experienced the greatest increase (9.8 and 6.4 percentage points, respectively). Western Maryland was the only region to experience a decline in its ambulatory care visit rate (1.3 percentage points).

Figure 25. Percentage of PAC Participants (12 Months of PAC Enrollment) who Received an Ambulatory Care Visit by Region, CY 2008–CY 2012



Mental Health Services

Similar to full-benefit HealthChoice participants, mental health services for PAC beneficiaries are carved out and managed by an ASO. Table 29 shows the regional distribution of PAC participants with an MHD between CY 2008 and CY 2012. The percentage of PAC participants with an MHD residing in Baltimore City decreased 8.5 percentage points from CY 2008 to CY 2012, while the other Maryland regions experienced increases during this time frame.

Table 29. Regional Distribution of PAC Population (Any Period of Enrollment) with an MHD, CY 2008 – CY 2012

Region	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Baltimore City	44.1%	43.8%	39.5%	37.6%	35.6%
Baltimore Suburban	24.5%	25.8%	27.3%	27.5%	27.7%
Eastern Shore	8.5%	8.6%	10.0%	10.9%	11.5%
Southern Maryland	3.3%	3.6%	3.7%	3.9%	4.3%
Washington Suburban	12.7%	12.2%	12.5%	12.9%	13.3%
Western Maryland	6.9%	6.0%	7.0%	7.1%	7.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Number of Enrollees	**11,348**	**13,592**	**18,941**	**25,029**	**29,541**

Table 30 shows the percentage of PAC participants with an MHD who also accessed physician and ED somatic care services. The percentage of participants with at least one ambulatory care visit increased by 2.9 percentage points over the evaluation period. The percentage of participants with an ED visit increased by 7.4 percentage points, from 35.4 percent in CY 2010 to 42.9 percent in CY 2012.

Table 30. Service Utilization among PAC Participants (Any Period of Enrollment) with an MHD, CY 2008–CY 2012

Year	Number of PAC Participants with an MHD	Percentage with a Physician Visit for Somatic Care	Percentage with an ED Visit for Somatic Care
CY 2008	11,492	66.2%	*
CY 2009	13,775	67.3%	*
CY 2010	19,102	69.7%	35.4%
CY 2011	25,224	69.4%	41.2%
CY 2012	29,593	69.1%	42.8%

*The PAC program began to offer outpatient ED facility services on January 1, 2010.

Substance Use Disorder Services

Table 31 shows the distribution of PAC participants with an SUD by region between CY 2008 and CY 2012. Throughout the evaluation period, most PAC participants treated for an SUD lived in Baltimore City. However, since CY 2008, an increasing number of PAC participants in the rest of the Maryland regions were treated for an SUD.

Table 31. Regional Distribution of PAC Population (Any Period of Enrollment) with an SUD, CY 2008–CY 2012

Region	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012
Baltimore City	69.9%	65.8%	52.3%	48.1%	45.5%
Baltimore Suburban	16.3%	18.6%	25.2%	26.0%	27.0%
Washington Suburban	4.0%	4.7%	7.5%	8.5%	9.6%
Western Maryland	1.7%	1.5%	2.5%	3.3%	3.6%
Eastern Shore	5.3%	6.5%	7.1%	8.2%	8.5%
Southern Maryland	2.8%	2.8%	5.5%	5.8%	5.6%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Number of Enrollees	**4,384**	**5,473**	**15,065**	**19,942**	**23,244**

Table 32 shows the percentage of PAC participants with an SUD who also accessed somatic physician and ED services. The percentage of participants with at least one physician visit decreased from 74.2 percent in CY 2008 to 57.0 percent in CY 2012. The percentage of

participants with an ED visit increased from 39.4 percent in CY 2010 to 47.2 percent in CY 2012. The number of participants with an SUD, the increase in ED visits for somatic care, and the decrease in the overall percentage of PAC participants with an SUD who accessed somatic care could be attributed to the addition of outpatient substance abuse services and coverage for ED facility charges to the PAC benefit in January 2010.

Table 32. Service Utilization among PAC Participants (Any Period of Enrollment) with an SUD, CY 2008–CY 2012

Year	Number of PAC Participants with an SUD	Percentage with a Physician Visit for Somatic Care	Percentage with an ED Visit for Somatic Care
CY 2008	4,384	74.2%	*
CY 2009	5,473	73.6%	*
CY 2010	15,065	60.8%	39.4%
CY 2011	19,942	58.9%	44.4%
CY 2012	23,244	57.0%	47.2%

*The PAC program began to offer outpatient ED facility services on January 1, 2010.

Table 33 presents the number and percentage of PAC participants with an SUD and at least one methadone replacement therapy service. Between CY 2008 and CY 2012, the percentage of participants with at least one methadone replacement therapy increased from 5.7 percent to 32.8 percent.

Table 33. Number and Percentage of PAC Participants (Any Period of Enrollment) with an SUD and at Least One Methadone Replacement Therapy, CY 2008 - CY 2012

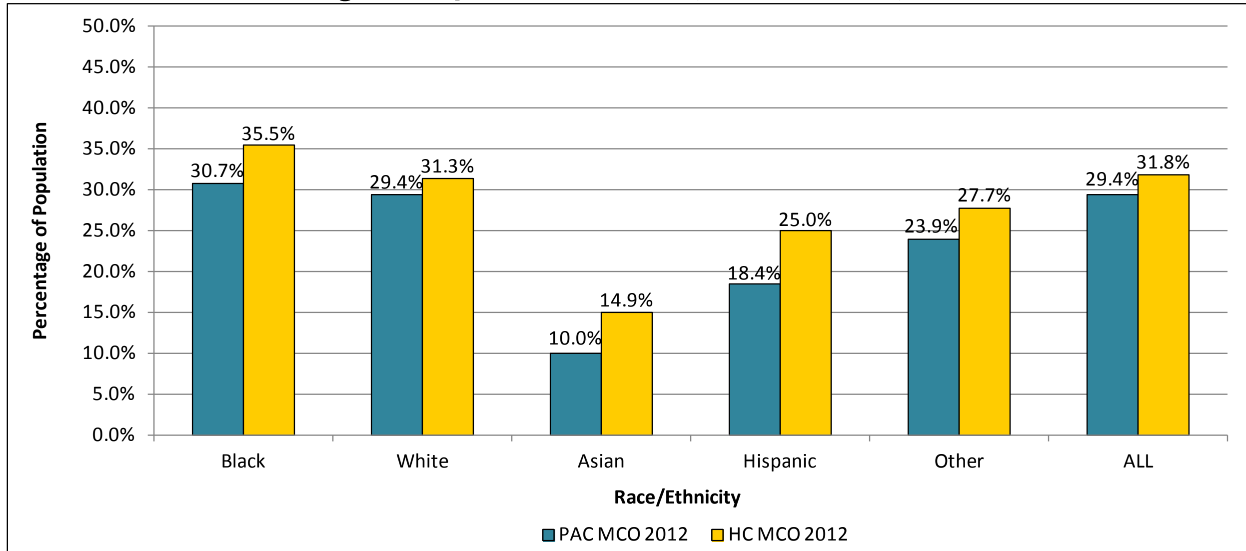
Year	Total Enrollees with SUD	Number of Enrollees with SUD and Methadone Replacement Therapy	Percentage of Total Enrollees with SUD
CY 2008	4,384	248	5.7%
CY 2009	5,473	261	4.8%
CY 2010	15,065	4,216	28.0%
CY 2011	19,942	6,048	30.3%
CY 2012	23,244	7,613	32.8%

ED Visits

On January 1, 2010, Maryland added outpatient ED visits to the PAC benefit package. Figure 26 compares the percentage of PAC participants who had at least one outpatient ED visit with the percentage of HealthChoice participants aged 19 to 64 years with an outpatient ED visit. These data are presented by race/ethnicity for CY 2012.

In CY 2012, outpatient ED utilization rates among HealthChoice participants were 2.4 percentage points higher than those for PAC participants. Among all racial/ethnic groups, Blacks had the highest rate of ED use in both the PAC and HealthChoice populations. Conversely, Asians had the lowest rates of ED use in both the PAC and HealthChoice populations.

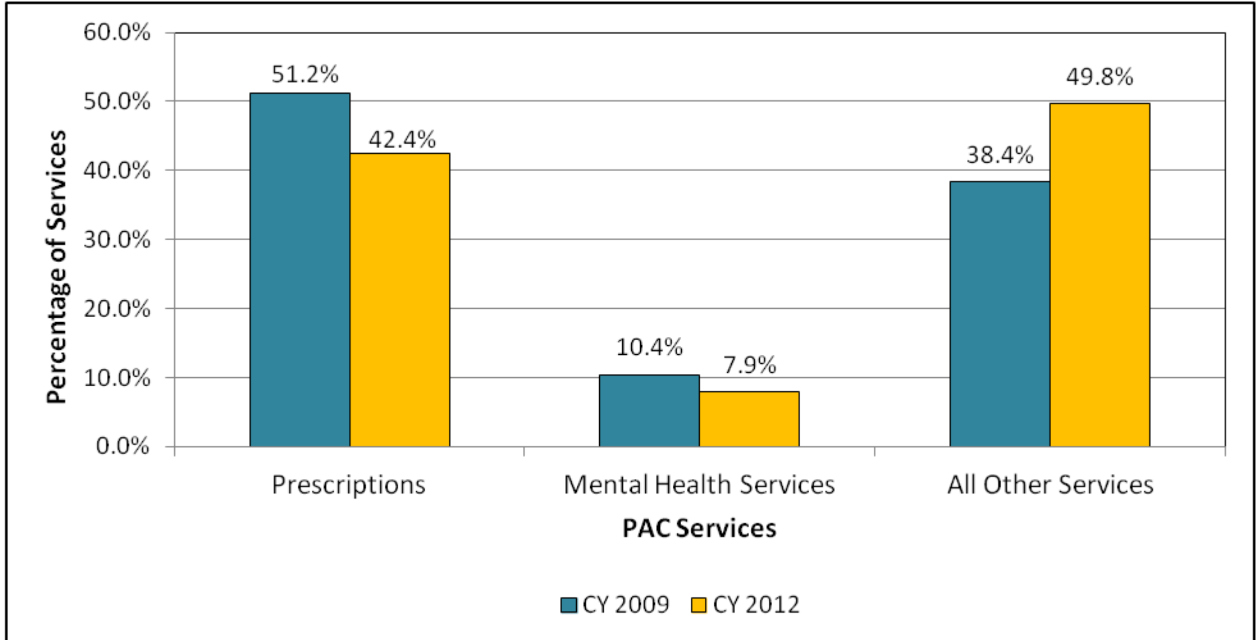
Figure 26. PAC Population vs. HealthChoice Population (Any Period of Enrollment) Receiving an Outpatient ED Visit, by Race/Ethnicity, CY 2012



Composition of Total PAC Services

Figure 27 presents the overall composition of services (categorized as prescriptions, mental health, and all other services) provided under the PAC program in CY 2009 and CY 2012. In CY 2009, prescriptions accounted for more than one-half of all PAC services, whereas prescriptions accounted for 42.4 percent of services in CY 2012. Mental health visits accounted for 7.9 percent of services in CY 2012, a 2.5 percentage point decrease from CY 2009. The "all other services" category increased by 11.4 percentage points between CY 2009 and CY 2012. Please note that outpatient ED services and community-based substance abuse services were added to the PAC benefit midway through the evaluation period.

Figure 27. Composition of Total PAC Services, CY 2009 and CY 2012



PAC HEDIS Measures

In CY 2008, DHMH began using HEDIS to assess quality and service utilization in the PAC program. The PAC HEDIS measures include breast cancer screening, cervical cancer screening, and comprehensive diabetes care. Table 34 compares the PAC HEDIS measures with the national HEDIS means for CY 2008 through CY 2012 (HealthcareData Company LLC, 2013).

The breast cancer screening measure assesses the percentage of women aged 40 through 69 years who received at least one mammogram for breast cancer screening within a two-year period. Overall, approximately 40 percent of the women enrolled in PAC received a mammogram in CY 2012, an increase of 8.2 percentage points over CY 2008.

The cervical cancer screening measure is reported for women aged 21 through 64 years who received a Pap test within a three-year period. The rate increased by 3.7 percentage points between CY 2008 and CY 2012. It should be noted that this measure examines participants' experiences during the measurement year and the two years prior to the measurement year. PAC was not in existence for two years when these measures were conducted, which may explain why the PAC scores are lower than the national HEDIS means.

The CDC measure assesses the percentage of participants with diabetes (types 1 and 2) who received HbA1c testing, eye exams, and LDL-C screening. Between CY 2008 and CY 2012, the HbA1c testing rates, eye exam rates, and LDL-C screening rates increased. PAC CDC rates are below national averages.

Table 34. PAC HEDIS Measures Compared with the National HEDIS Means, CY 2008–CY 2012

	CY 2008		CY 2009		CY 2010		CY 2011		CY 2012	
HEDIS Measures	PAC	National HEDIS Mean	PAC	National HEDIS Mean	PAC	National HEDIS Mean	PAC	National HEDIS Mean	PAC	National HEDIS Mean
Breast Cancer Screening	32.1%	50.8%	38.4%	52.4%	41.7%	51.3%	40.8%	50.4%	40.3%	51.9%
Cervical Cancer Screening	39.1%	66.0%	42.0%	65.8%	42.7%	67.2%	44.5%	66.7%	42.8%	64.5%
CDC – HbA1c Testing	75.2%	80.5%	77.0%	80.6%	76.7%	82.0%	81.6%	82.5%	79.9%	83.0%
CDC – Eye Exam	35.1%	52.8%	44.8%	52.7%	40.5%	53.1%	40.7%	53.4%	37.6%	53.2%
CDC – LDL-C Screening	73.0%	74.1%	72.6%	74.2%	72.8%	74.7%	76.2%	75.0%	74.5%	75.5%

Section V Summary

PAC was a limited benefit program for adults with low income who were not eligible for Medicare or the full Medicaid benefit package. Overall, PAC enrollment increased 123 percent during the evaluation period. DHMH measured PAC ambulatory care, MHD and SUD services, and prescription drug utilization between CY 2008 and CY 2012. During the evaluation period, ambulatory care and prescription utilization increased, as did the use of physician visits and ED visits for somatic care by PAC participants with an MHD. The percentage of PAC participants with an SUD and an ED visit for somatic care increased over the evaluation period, whereas the percentage with a physician visit decreased. On January 1, 2010, Maryland added outpatient ED visits to the PAC benefit package. In CY 2012, 29.4 percent of PAC participants had at least one ED visit, compared with 31.8 percent of HealthChoice participants. DHMH began using PAC HEDIS measures in CY 2008. PAC performance on these measures improved during the evaluation period, but remained lower than the national HEDIS means. As a result of the Medicaid expansion option in the ACA, PAC participants transitioned into a categorically eligible Medicaid population on January 1, 2014. Childless adults under the age of 65 years and with incomes up to 138 percent of the FPL will receive full Medicaid benefits, and services will be provided through HealthChoice MCOs.

Conclusion

HealthChoice is a mature managed care program that provided services to 14 percent of Marylanders, as of the end of CY 2012. The information presented in this evaluation provides strong evidence that HealthChoice has been successful in achieving its stated goals related to coverage and access to care, providing a medical home to participants, and improving the quality of care.

New developments will impact HealthChoice in the upcoming years, includingthe expansion of Medicaid coverage through the ACA, as well as the transition of PAC participants into full-benefit HealthChoice MCOs. These ongoing changes have resulted in a substantial increase in

Medicaid enrollment. Further, in February 2013, CMS awarded Maryland with a State Innovation Model (SIM) design award of $2.4 million. The SIM initiative provides funding to support the development and testing of state-based models for multi-payer health care delivery and payment system transformation. Maryland plans to create a model that integrates patient-centered primary care with innovative community health initiatives. These funds have been used to design a statewide, multi-payer Community-Integrated Medical Home (CIMH) program. In addition, the State is developing a chronic health home demonstration. As of the end of CY 2013, DHMH had approved 57 Health Home site applications. The Health Home sites include 44 Psychiatric Rehabilitation Programs, 9 Mobile Treatment providers, and 4 opioid treatment programs.

As with any program, there are areas that need improvement to ensure that the growing number of participants have access to quality care. Some of these areas include reducing the number of ED visits by HealthChoice participants and increasing dental service utilization among pregnant women. DHMH is committed to working with CMS and other stakeholders to identify and address necessary programmatic changes.

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The Hilltop Institute

University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854
www.hilltopinstitute.org