

# Maryland's HealthChoice §1115 Waiver Evaluation Outline

Revised March 2014

## I. Background and History of Maryland's §1115 Demonstration Waiver

HealthChoice, Maryland's §1115 waiver, was initially approved by the Centers for Medicare and Medicaid Services (CMS) in October of 1996, and the demonstration was implemented in July 1997. Maryland's first waiver extension was granted in July 2002. CMS approved subsequent waiver renewals in 2005, 2007, 2010, and 2013.

*Population Served* - HealthChoice is a mandatory managed care program serving over 800,000 non-elderly adults and children, over 80 percent of Medicaid enrollees in Maryland.

*Summary of Prior Evaluations* – Between waiver renewals, DHMH continually monitors HealthChoice performance on a variety of measures and completes an annual evaluation for HealthChoice stakeholders. The prior annual evaluation in 2013 coincided with the §1115 waiver renewal. Using a mix of quantitative and qualitative data sources, as well as public input and expert consultation, the evaluation provided a comprehensive picture of the overall performance of the HealthChoice program. The evaluation concluded that the HealthChoice program successfully achieved its stated goals. Specifically, the report found that between calendar year (CY) 2007 and CY 2011:

- The ambulatory care visit rate increased 3.4 percentage points, and it increased for all racial/ethnic groups
- Overall HealthChoice enrollment grew by 55 percent
- Potentially avoidable emergency department (ED) visits decreased by nearly a percentage point
- Rates of preventive care for children, such as well-child visits and immunizations, and rates of preventive care for adults, such as breast and cervical cancer screenings, increased

## II. Purpose, Aims, Objectives, and Goals

Maryland's fifth waiver extension was approved for the period of November 1, 2013 through December 31, 2016. The State is required to submit an evaluation to the Centers for Medicare & Medicaid Services (CMS) as part of the state's request for renewal that studies the impact of the HealthChoice demonstration during the extension period. This outline proposes an evaluation framework premised on a set of hypotheses, detailed in the following section. These hypotheses will be tested via specific questions and data as outlined in Section III.

### A. Key Assumptions

HealthChoice is now a mature and established program. Beginning in January 2002, Maryland completed comprehensive evaluations of HealthChoice to evaluate its success as a delivery model. The evaluations found that HealthChoice should continue – that it was successful in improving access to care and served as a platform for major program expansion.

Maryland continues to perform an annual HealthChoice evaluation update to look at HealthChoice performance on a variety of measures. Although it is important to revisit certain questions examined in the initial evaluation, any future evaluation needs to be tailored to assessing the effectiveness and quality of an established program. This outline attempts to meet that goal.

**B. *Program Objectives***

1. Improving access to health care for the Medicaid population
2. Improving the quality of health services delivered
3. Expanding coverage to additional low-income Marylanders with resources generated through managed care efficiencies
4. Providing patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a primary care provider (PCP)
5. Emphasizing health promotion and disease prevention by providing access to immunizations and other wellness services

**C. *State's Hypotheses on the Outcomes of the Demonstration***

- 1) An established managed care program will improve access to health care for the Medicaid population
  - a) Improved access will be demonstrated in the following areas:
    - i) Improved service utilization measures
      - (1) Ambulatory care visit rates should increase, while ED visit rates should decrease
    - ii) Adequate provider networks
      - (1) The number of PCPs and specialists in each local access area of the State should be adequate, meeting defined standards
    - iii) Improved enrollee satisfaction
      - (1) HealthChoice enrollees should be satisfied with their access to medical care
- 2) An established program will improve the quality of health services delivered
  - a) Improved quality of care will be demonstrated in the following areas:
    - i) Improved utilization of health services among vulnerable populations
      - (1) There should be higher rates of ambulatory care visits and use of preventive services among vulnerable populations such as children, pregnant women, those with mental health disorders or substance use disorders, children in foster care, those with HIV/AIDS, and enrollees in the Rare and Expensive Case Management (REM) program
      - (2) All racial/ethnic groups should have improved use of health services, and disparities among racial/ethnic groups should decrease
    - ii) Timely use of health services for children
      - (1) There should be higher rates of childhood lead testing
      - (2) There should be higher rates of provider compliance with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) measures

- 3) An established program will expand coverage to additional low-income Marylanders
  - a) Expanded coverage will be demonstrated in the following area:
    - i) Increased enrollment measures
      - (1) HealthChoice enrollment should grow as a result of the parent expansion program and increased Medicaid eligibility thresholds
      - (2) Most individuals in Medicaid should be enrolled into managed care
  
- 4) An established program will provide patient-focused, comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a PCP
  - a) Medical home utilization and success will be demonstrated in the following areas:
    - i) Reduced utilization of "inappropriate" services
      - (1) There should be a decline in the use of the ED for non-emergent care
      - (2) There should be fewer ambulatory care sensitive hospitalizations
  
- 5) An established program will emphasize health promotion and disease prevention
  - a) Increased emphasis on health promotion and disease prevention will be demonstrated in the following areas:
    - i) Higher utilization of appropriate preventive services
      - (1) There should be higher rates of well-child visits, immunizations, and cancer screenings
    - ii) Better management of chronic conditions
      - (1) There should be higher rates of appropriate utilization of asthma medications and diabetes care

### **III. Evaluation Design Plan and Methodology**

#### ***A. Evaluation Organization, Planning, and Timeline***

As with the previous HealthChoice Evaluations, the evaluation of the waiver extension and the annual evaluations will be conducted collaboratively by the Maryland Department of Health and Mental Hygiene and The Hilltop Institute at the University of Maryland, Baltimore County (UMBC).

The evaluation will present at least five years worth of data. Given the nature of managed care encounter data submissions, a six-month data run-out period is assumed for a CY. For example, reliable data for CY 2013 will be available beginning in July 2014. The State will also continue with its current schedule of updating the HealthChoice evaluation each year. The annual update will address many of the objectives and include a number of the measures that are described below.

#### ***B. Performance Metrics, Data Sources, and Populations Under Study***

Testing the hypotheses in Section II C and assessing whether the State achieved its stated goals will require a diverse set of measures and data. It will also require the examination of not only all waiver enrollees, but also specific sub-populations. In this section, the previously stated

hypotheses are operationalized as specific measures. When possible, the data source and population are provided.

*1) Improve access to health care for the Medicaid population*

- a) Improved service utilization measures
  - i) Managed care organization (MCO) encounter data and fee-for-service (FFS) claims data will measure trends in the utilization of identified health services
    - a. These measures will be presented in multiple-year trend analyses:
      - 1. Percentage of the HealthChoice population receiving an ambulatory care visit (by age, region, and other demographic characteristics)
      - 2. Percentage of the HealthChoice population with at least one ED visit (by age, coverage group, and other demographic characteristics)
- b) Adequate provider networks
  - i) The State will utilize provider files data to measure network adequacy throughout the state
    - a. An annual analysis will demonstrate these network adequacy measures:
      - 1. PCP capacity by local access area
      - 2. Compliance with specialty care provider network adequacy requirements
- c) Improved enrollee satisfaction
  - i) Findings from the annual Consumer Assessment of Health Plans (CAHPS) survey will describe consumer satisfaction with HealthChoice.
    - a. A five-year trend analysis of these CAHPS measures will demonstrate enrollee satisfaction with access to care:
      - 1. Getting Needed Care
      - 2. Getting Care Quickly

*2) Improve the quality of health services delivered*

- a) Improved utilization of health services among vulnerable populations
  - i) The State will employ MCO encounter data, FFS claims data, and Healthcare Effectiveness Data and Information Set (HEDIS) quality data to measure the use of the following services among these vulnerable populations.
    - a. These measures will be presented as multiple-year trend analyses:
      - (i) Dental services
        - 1. Percentage of children aged 4 to 20 years in Medicaid receiving dental services
        - 2. Percentage of pregnant women aged 21 years and over in Medicaid receiving dental services
      - (ii) Mental health services
        - 1. Percentage of HealthChoice participants with a physician visit for somatic care among those diagnosed with a mental health disorder
        - 2. Percentage of HealthChoice participants with a ED visit for somatic care among those diagnosed with a mental health disorder
      - (iii) Substance use disorder services
        - 1. Percentage of HealthChoice participants with a physician visit for somatic care among those diagnosed with a substance use disorder
        - 2. Percentage of HealthChoice participants with a ED visit for somatic care among those diagnosed with a substance use disorder

3. Number of HealthChoice participants with a substance use disorder and methadone replacement therapy
- (iv) Dual-diagnosis
  1. Number of HealthChoice participants with a dual-diagnosis of mental health disorder and substance use disorder
- (v) Foster care
  1. Percentage of HealthChoice children in foster care receiving an ambulatory care visit (by age group)
  2. Percentage of HealthChoice children in foster care receiving an MCO outpatient ED visit (by age group)
  3. Percentage of HealthChoice children in foster care receiving a dental visit (by age group)
- (vi) Reproductive Care
  1. HEDIS timeliness of prenatal care
  2. HEDIS percentage of deliveries receiving the expected and recommended number of prenatal visits
- (vii) Family Planning program
  1. Percentage of Family Planning enrollees with at least one corresponding service (for any period of enrollment and for 12-months of enrollment)
- (viii) HIV/AIDS
  1. Percentage of HealthChoice participants with HIV/AIDS who received an ambulatory care visit, MCO outpatient ED visit, CD4 testing, and viral load testing
- (ix) REM
  1. Percentage of REM enrollees with at least one dental, inpatient, ambulatory care, and FFS outpatient ED visit
- (x) Racial/ethnic groups
  1. Percentage of HealthChoice participants aged 0 to 20 years receiving an ambulatory care visit by race/ethnicity
  2. Percentage of HealthChoice participants aged 21 to 64 years receiving an ambulatory care visit by race/ethnicity
  3. Percentage of HealthChoice participants aged 0 to 64 years receiving an ED visit by race/ethnicity
- b) Timely use of health services for children
  - i) The State will employ MCO encounter and FFS claims data to measure lead testing rates among children.
    - a. A trend analysis over a five-year period will demonstrate the following measures:
      1. Percentage of HealthChoice children aged 12-23 and 24-35 months who received a lead test during the calendar year or the prior year.
  - ii) The State will use findings from the EPSDT medical record review to measure provider compliance
    - a. A five-year trend of rates of provider compliance with the following EPSDT measures will be presented:
      1. Health and developmental history

2. Comprehensive physical exam
  3. Laboratory tests/at risk screenings
  4. Immunizations
  5. Health education/anticipatory guidance
- 3) *Expand coverage to additional low-income Marylanders*
- a) Increased enrollment
    - i) Enrollment data will be used to measure trends in HealthChoice enrollment
      - a. A five-year trend analysis will demonstrate the increase in participants through the following measures:
        1. 2008 parent expansion enrollment and 2014 expansion enrollment
        2. Enrollment by coverage group
        3. Enrollment as a percentage of the Maryland population
        4. Percentage of participants in managed care versus fee-for-service Medicaid
- 4) *Provide patient-focused comprehensive, and coordinated care designed to meet health care needs by providing each member a single "medical home" through a PCP*
- a) Reduced utilization of "inappropriate services"
    - i) MCO encounter and FFS claims data will measure the use of inappropriate services
      - a. These measures will be presented in multiple-year trend analyses:
        1. Non-emergent ED visits based on a classification developed by New York University
        2. Ambulatory care sensitive hospitalizations for individuals with asthma
        3. Ambulatory care sensitive hospitalizations for individuals with diabetes
- 5) *Emphasize health promotion and disease prevention by providing access to immunizations and other wellness services*
- a) Higher utilization of appropriate preventive care services
    - i) The State will use Healthcare Effectiveness Data and Information Set (HEDIS) quality measures and MCO encounter and FFS claims data to measure utilization of preventive services.
      - a. These measures will be presented in multiple-year trend analyses:
        1. Immunization combination two rates among two-year-old children
        2. Immunization combination three rates among two-year-old children
        3. Well child visits in the first 15 months of life
        4. Well child visits among children aged three to six years
        5. Well-care visits among adolescents
        6. Breast cancer screenings among women aged 40 to 64 years
        7. Cervical cancer screenings among women aged 21 to 64 years
  - b) Better management of chronic conditions
    - i) The State will use HEDIS quality measures and MCO encounter and FFS claims data to measure utilization of preventive services
      - a. These measures will be presented in multiple-year trend analyses:
        1. Appropriate medications for people with asthma aged 5 to 50 years
        2. Enrollees with diabetes aged 18 to 75 years who received an eye exam, hemoglobin A1c test, and low-density lipoprotein cholesterol screening

#### **IV. Primary Adult Care (PAC) Program - Evaluation Design Plan**

The HealthChoice Evaluation includes an evaluation of the Primary Adult Care (PAC) program. Implemented in July 2006, the PAC program offered a limited set of 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 federal poverty level. The PAC program ended on December 31, 2013, and PAC enrollees were automatically transitioned into full-benefit Medicaid coverage groups under the eligibility expansion. In this demonstration period, the State will update the evaluation to include measures from PAC's final year of operation. The State will also monitor access, utilization, and quality measures of former PAC enrollees.

The PAC program shared similar goals and objectives as HealthChoice. Thus, the PAC evaluation used the same measures as the HealthChoice evaluation. These measures included:

1. PAC enrollment (by race/ethnicity and region)
2. Ambulatory care visits
3. Mental health services
4. Substance use services
5. ED visits
6. Composition of total PAC services
7. HEDIS measures – breast cancer screening, cervical cancer screening, and comprehensive diabetes care

#### **IV. Analysis Plan**

The HealthChoice Evaluation reports are formatted according to the program's stated goals and other topics/populations of special interest. Recently, the reports have been presented in the following format:

- I. Executive Summary
- II. Introduction, Overview of the HealthChoice Program, Recent Program Updates
- III. Coverage and Access
- IV. Medical Home
- V. Quality of Care
- VI. Special Topics
- VII. PAC Access and Quality
- VIII. Conclusion

It is expected that the evaluation will 1) demonstrate how the waiver program has improved since the completion of the original evaluation, and 2) show that a mature and established waiver program can be held responsible for certain goals and objectives that would not be achievable for a relatively young or recently implemented program.

Lessons from the evaluation design, the goals presented, and the measures used will serve as a guide for other states with younger managed care programs.