**Maryland's HealthChoice §1115 Waiver Evaluation Outline**
**Revised January 2009**

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

HealthChoice, Maryland's original 1115 waiver was approved by the Center for Medicare and Medicaid Services in October of 1996 and the demonstration was implemented in July 1997. Maryland's first and second waiver extensions were implemented in July 2002 and July 2005, respectively. Maryland was approved for its second extension in August 2008 for the period of June 1, 2008 through June 30, 2011.

*Population Served* - HealthChoice is a mandatory managed care program serving over 480,000 non-elderly adults and children, approximately three-fourths of Medicaid enrollees in Maryland.

*Summary of Prior Evaluation* - As required by the original waiver consent, the State embarked on an extensive evaluation of HealthChoice in January 2001 to assess the success of the program relative to the prior Medicaid program as well as to stakeholder expectations and CMS requirements. Extensive input from consumers, providers, MCOs, advocates, and the Maryland General Assembly was central to designing the evaluation. 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 over a period of time. The evaluation concluded that the HealthChoice program successfully achieved its stated goals. Specifically, the report found that HealthChoice has been successful in reducing program cost growth by creating a methodology for reimbursing MCOs which is predictable, yet flexible enough to accommodate changes based on population and demographic shifts. In addition, HealthChoice has increased utilization of preventive services and appropriate chronic disease treatment. It has also provided a medical home for many vulnerable individuals. As with any program, there are areas that need to be improved to assure that enrollees have access to care. The Department is committed to working with CMS and other stakeholders to identify and address necessary programmatic changes upon renewal of the waiver.

## II. Purpose, Aims, Objectives and Goals

Maryland's third waiver extension was implemented in June 2008 and the State is required to submit an evaluation to the Centers for Medicare & Medicaid Services (CMS) by March 31, 2011 studying 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, which will be executed via the examination of specific questions and data as outlined in Section III.

### *A. Key Assumptions*

HealthChoice is a mature and established program. In January 2002, Maryland completed a comprehensive evaluation of HealthChoice to evaluate its success as a delivery model. The evaluation found that HealthChoice should continue – that it had been successful in

improving access while controlling costs, and had served as a platform for major program expansion.

Since 2002, Maryland continues to compile an annual HealthChoice evaluation update to look at HealthChoice performance on a variety of measures. Maryland continues to build upon the measures reflected in the original evaluations to ensure that changes in demographics of the HealthChoice population are monitored. To that end, some measures have been revised or refined to reflect the most pertinent information to ensuring access to high quality care. The attached outline attempts to meet the goal of addressing those issues that are paramount to monitoring the health of the changing HealthChoice population.

### *B. Program Objectives*

1. Demonstrate Stability and Predictability
2. Promote Appropriate Service Utilization
    a. Promote evidence-based care and quality measurement
    b. Manage for results (Pay-for-Performance)
3. Alleviate Disparities and Assure Access to Care
4. Monitor Access for Special Populations

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

1. An established Managed Care program will offer greater stability and predictability.

    a. Stability and predictability will be demonstrable in the following areas:
        i. Less provider turn-over
            a. Providers will be well aware of the program and implications of participation. This should result in greater provider stability
        ii. Adequate provider networks
            a. A decrease in turn-over and more stability should enable plans to develop and maintain adequate provider networks
        iii. Greater predictability in establishing capitation and payment rates
            a. The availability of data and several years of experience should improve this process
        iv. Fewer managed care organizations will exit the program
            a. There should be an observable decline in the number of managed care organizations (MCOs) which cease participation in HealthChoice
            b. Improved predictability in rate determinations should promote MCO efficiency
        v. Additional MCOs will seek to enter the program
            a. As the program's population grows and as the rate setting methodology becomes more predictable, additional MCOs should seek to participate in the program
            b. Improved predictability in rate determinations should eliminate uncertainty and make participation in the program more attractive

vi. Greater stability in the delivery of services
    a. The initial years of a new program are more likely to reveal significant changes in service delivery – be they increases or decreases
        i. A mature program should experience less fluctuation in year-to-year service access and utilization rates
vii. Reduced utilization of "inappropriate" services
    a. A decline in provider turn-over and MCO withdrawals combined with enrollee familiarity with the program should lessen the use of inappropriate services
        i. There should be fewer avoidable hospitalizations
        ii. There should be a decline in the use of emergency departments (ED) for non-emergent care

2. An established program will be able to pay for performance
    a. Years of experience and data collection should enable a state to better manage its 1115 demonstration project
        i. Such management would include the development of performance measures linked to financial incentives used to promote value-based purchasing

3. Alleviate disparities in healthcare access and outcomes
    a. An established program should have developed mechanisms to address disparate health access and outcomes
    b. An established program will have developed appropriate delivery mechanisms to adequately meet the needs of its most vulnerable populations.

## III. Evaluation Design Plan and Methodology

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

As with the initial HealthChoice Evaluation, released in January 2002, the evaluation of the waiver extension will be conducted collaboratively by the Maryland Department of Health and Mental Hygiene and the Center for Health Program Development and Management at the University of Maryland, Baltimore County. A draft of the evaluation is to be submitted to CMS no later than March 1, 2011.

The evaluation will present at least five years worth of data beginning in CY 2005. The data represented will give a snapshot of pre- and post- the second renewal. Given the nature of encounter data submissions under managed care, a six-month data run-out period is assumed for a calendar year (CY). The State will also continue with its current schedule of updating the HealthChoice evaluation each January. The annual update will address many of the objectives and include a number of the measures that are described below.

As of July 1, 2009, dental coverage will be carved out of the managed care organizations. The evaluation will reflect the change in delivery model and measures relative to the shift from MCO to administrative service organization.

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

Testing the hypotheses enumerated in Section II C and assessing whether the State has achieved stated goals will require a diverse set of measures and data and will require the examination of not only all waiver enrollees, but also specific sup-populations. In this section, the previously stated hypotheses are operationalized as specific measures. When possible, the data source, population and target outcome are provided. As with any evaluation, it is not always possible or reasonable to establish arbitrary targets for achievement. Some measures can only be sufficiently assessed after data have been gathered and analyzed. Performance targets that have been established through the Value-Based Purchasing or Measuring for Results processes, however, will be included.

1. *Demonstrate Stability and Predictability*
    a. Less provider turn-over
        i. An examination of provider files and license numbers should reveal that fewer providers are leaving the program or switching between MCOs
            a. A trend analysis will be employed and the results presented in a tabular format
            b. HealthChoice MCOs submit audited HEDIS reports that contain a measure of provider turnover. These reports may be used in lieu of provider files.

    b. Adequate provider networks
        i. A comparison of participating providers by local access area should reveal that there is an adequate and appropriate physician to enrollee ratio in all areas of the state
            a. A trend analysis will be employed and the results presented in a tabular format
            b. Graphical mapping will also be utilized to show regional provider capacity

    c. Greater predictability in establishing capitation and payment rates
        i. This will employ an examination of managed care organization (MCO) financial performance through the HealthChoice Financial Monitoring Report, budget neutrality monitoring, and other financial reporting
        ii. The State should observe improved MCO financial performance, narrowing MCO profit/loss margins, greater stability in risk scores for statewide MCOs, and cost trends (inflation) rates over time at or below national trends

2. Fewer MCOs will exit the program

   a. This will employ a simple trend analysis to examine the number of MCOs that have withdrawn from the program since implementation.
      i. The State should observe a decline in MCO withdrawals as the program matures

3. Additional MCOs will seek to enter the program
   a. This will employ an examination of MCO applications and application approvals over time
      i. The State should observe an increase in MCO applications and an increase in the number of MCOs participating

2. *Promote Appropriate Service Utilization*
   a. Greater stability in the delivery of services
      i. This will employ extensive use of MCO encounter and FFS claims data to measure trends in the utilization of identified health services.
      ii. To promote continuity with prior evaluations of the HealthChoice program, many measures using encounter data will be carried forward, including:
         a. Dental Services for children (percentage of the population, ages 4-20, enrolled 320 or more, receiving any dental service)
         b. Utilization of emergency room services (percentage of population receiving ER services/percentage of visits considered non-emergent)
         c. Access to ambulatory care (percentage of the population receiving ambulatory services, ages 0-64, any enrollment span)
         d. Access to preventive care for adults and children with disabilities (percentage of SSI recipients [children and adults], enrolled 320 days or more, receiving at least one ambulatory service during year)
         e. Substance abuse treatment (percentage of individuals with substance abuse diagnosis, ages 13+, who receive substance abuse treatment)
         f. Lead screening ( percentage of children, ages 12 to 36 months, with at least 90 days of continuous enrollment, who receive blood lead testing)
      iii. These measure will be presenting via charts and tables to allow for a detailed trend analysis
         a. Just as the initial waiver evaluation determined that access to services had increased under HealthChoice, it is expected that this study will also reveal increased access.
            i. Without providing specific targets for each measure, it is expected that access to services will reveal a positive trend with access improving in each subsequent year studied.

   b. Reduced utilization of “inappropriate” services

i. This will employ MCO encounter and FFS claims data to measure the use of inappropriate services, including:
    a. Avoidable hospitalizations for individuals with asthma
        i. Avoidable hospitalizations will be based on Agency for Healthcare Research and Quality (AHRQ) Prevention Quality indicators[1] and the enrollees with asthma will be identified according to HEDIS criteria[2].
        ii. Between CY 2002 and CY 2004, avoidable admissions decrease at an average annual rate of 5.25 percent
        iii. Avoidable admissions should continue to decline at that average rate between CY 2005 and CY 2006
    b. Avoidable hospitalizations for individuals with diabetes
        i. Avoidable hospitalizations will be based on Agency for Healthcare Research and Quality (AHRQ) Prevention Quality indicators and the enrollees with Diabetes will be identified according to HEDIS criteria.
        ii. Between CY 2002 and CY 2004, avoidable admissions decrease at an average annual rate of 8.5 percent
        iii. Avoidable admissions should continue to decline at that average rate between CY 2005 and CY 2006
    c. Trends in the use of non-emergent emergency department (ED) services
        i. Non-emergent ED visits will be identified based a classification developed by New York State University.[3]
        ii. In CY 2003, approximately 26 percent HealthChoice ED visits were the delivery of non-emergent care – a rate that has remained static from CY 2001 to CY 2004
        iii. The evaluation expects to find that non-emergent ED use declined modestly between CY 2005 and CY 2007

3. *Promote Evidence-Based Care and Quality Measurement*
    a. Health Plan Employer Data and Information Set (HEDIS)
        i. In an effort to promote evidence-based care, and in recognition of the need for consistency in performance measurement, many of the services will be drawn from the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS).[4]

        ii. Measures will be calculated using MCO encounter data and will include:
            a. Adult Access to Preventive Services (adults ages 20-64 with 320 days enrollment who had ambulatory or preventive visit)

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[1] AHRQ Quality Indicators - Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions. Rockville, MD: Agency for Healthcare Research and Quality, 2001. AHRQ Pub. No. 02-R0203.

[2] HEDIS 2005 Technical Specifications. National Committee for Quality Improvement. Washington: DC. 2005.

[3] Billings, J et al. Emergency Department Use: The New York Story. *The Commonwealth Fund Issue Brief.* November 2000

[4] HEDIS 2005 Technical Specifications. National Committee for Quality Improvement. Washington: DC. 2005.

b. Well Child Visits in the First 15 Months of Life (enrollees who turned 15 months old during measurement year, who were enrolled from their 31st day, who received well-child visits with a PCP)
c. Well Child Visits in the 3rd, 4th, 5th and 6th Year of Life (enrollees who were 3, 4, 5, or 6 years of age during measurement year, continuously enrolled with a gap of no more than 30 days, who received one or more well-child visits with a PCP)
d. Adolescent Well Child Visits (enrollees ages 12 to 21 years, who were continuously enrolled with no more than one gap of 30 days, who had at least one comprehensive well-child visit with a PCP)
e. Breast Cancer Screening (percentage of women ages 52-64 with 320 days of enrollment, who had a mammogram during the measurement year or year prior to the measurement year)
f. Cervical Cancer Screening (percentage of women ages 21-64 with 320 days of enrollment who receive a PAP test in the study year or two prior years)
g. Comprehensive Diabetes Care (percentage of enrollees with diabetes [Type 1 and Type 2] who receive comprehensive diabetes care [HbA1c test, eye exam, LDL-C screening, diabetic nephropathy monitoring])
h. Follow-up After Hospitalization for Mental Illness (percentage of discharges for enrollees ages 6-64 who had an ambulatory or day/night mental health visit after discharge)
i. Appropriate medication management for adults diagnosed with depression (percentage of enrollees with a diagnosis of major depression, ages 18-64 with 320 days of enrollment, who have optimal follow-up contacts with a PCP or mental health practitioner and effective acute and continuation phase treatment)

iii. The State expects to find that HEDIS scores for all of the enumerated measures will exceed nationally reported Medicaid rates.
a. Data will be presented in graphs and tables to allow for detailed trend analyses and to compare state and national performance

b. Satisfaction Surveys
i. An overview of findings from the annual Consumer Assessment of Health Plans (CAHPS) survey will be included in an effort to describe consumers' experiences with their MCOs and their level of satisfaction with HealthChoice.

ii. Measures are combined in five composite categories: (1) Getting Needed Care, (2) Getting Care Quickly, (3) How Well Doctors Communicate, (4) Courteous and Helpful Office Staff, and (5) Customer Service

4. *Manage for results (including assessment of Pay-for-Performance efforts)*

a. Pay for Performance
    i. Established measures will be used to determine whether participating MCOs are adequately serving the needs of the demonstration population
    ii. Trends in the State's Value Based Purchasing initiative
        a. The Value Base Purchasing measures will be analyzed over time to determine if the State is achieving desired results.
    iii. The State's mechanism for determining financial rewards or penalties for meeting performance goals will be assessed

5. *Alleviate Disparities and Assure Access to Care for Vulnerable Populations*
    a. Reduced evidence of disparities in health care access and outcomes
        i. Ambulatory care and preventive care access will be compared to determine if racial and ethnic disparities have reduced.
            a. Age and health adjusted access rates should reveal no disparities in access to or utilization of services across racial and ethnic populations.
    b. Serving the needs of vulnerable populations
        i. Appropriate treatment of enrollees with AIDS/HIV
        ii. Service Utilization for enrollees with disabilities
            a. As compared to HealthChoice enrollees without disabilities, individuals with disabilities should receive increased access to preventive and specialty care
        iii. Service access for children in foster care
            a. Given that children in foster care represent a truly vulnerable population and often have special medical needs the HealthChoice program is expected to provide:
                i. Primary and specialty mental health services, and
                ii. Access to necessary medications
                iii. Rates of service access and provision for this population should exceed those of their age appropriate peers in the large HealthChoice population
        iv. Reduced ED utilization for substance abuse
            a. If the HealthChoice program is adequately serving the needs of enrollees with substance abuse problems then related ED visits should not increase
        v. Substance abuse treatment for pregnant women
            a. Substance abuse by pregnant women threatens the health of their newborn and could prolong Medicaid dependence and expense
            b. HealthChoice should be able to demonstrate ever improving access to substance abuse treatment for pregnant women
        vi. Access to primary and specialty mental health services for individuals with substance abuse diagnosis
            a. The state should be expected to demonstrate the waiver program is providing enhanced access to mental health services for individuals with substance abuse problems

vii. Specialty mental health utilization for individuals prescribed specialty mental health medications
    a. Individuals prescribed specialty mental health medications should be receiving specialty mental health services at a rate that exceed the general HealthChoice population

## IV. Analysis Plan

It is expected that the evaluation report will follow the format established in the original waiver evaluation. In that evaluation, goals were delineated into specific chapters which presented the measures/performance metrics associated with each goal. The evaluation will likely be presented in the following format:

I. MCO Provider Networks and Reimbursement
    A) MCO Participation
    B) Provider Network Adequacey
II. Service Utilization Experience
    A) General Utilization
    B) Preventive Services
    C) Appropriateness of Care
    D) Selected Services
    E) Special Populations
III. 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 expected meet certain goals and objectives that would not be demonstrable or achievable for a relatively young or recently implemented program.

Upon completion of this evaluation, the Maryland waiver program will be nearing the end of its 13h year. It is anticipated that the evaluation design, the goals presented, and the measures used will provide lessons learned and serve as a guide for other states with younger programs.