

# Honesty As Good Policy: Evaluating Maryland's Medicaid Managed Care Program

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**T**HROUGHOUT THE 1990s, THE STATES LAUNCHED many large-scale innovations in health care financing and delivery. The demands associated with designing, implementing, and managing such initiatives compete for those resources needed to evaluate the impact of the innovations. But without a good faith effort to launch a credible evaluation, innovative and controversial programs may not be able to be sustained. Striking a balance between advocating for change and honestly determining how well the desired changes have been achieved is a delicate and daunting task, and state policymakers often do not spend much time evaluating their efforts, even though this may be critical to the success of their programs.

This article describes one state's assessment of a statewide, prepaid, Medicaid managed care program. We look at the evaluation as both an exercise in policy analysis and an indication of the response to various constituencies' concerns. Three of us either worked for the state or contracted with the state to help evaluate the program. We begin this article with the history of managed care in Maryland and then discuss the need for its evaluation. We use some of the findings from the evaluation to illustrate the state's proactive and reactive response to its Medicaid managed care program and then examine the rollout of the evaluation and its key recommendations. Finally, we discuss the lessons

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for state policymakers regarding the necessity of evaluating major state programs. Our aim is to demonstrate that even though an ambitious assessment effort may be technically difficult and politically risky, an honest appraisal of a major public policy initiative is crucial to ensuring that decisions about the program's future will be informed.<sup>1</sup>

## Background

Medicaid has been a crucible of federalism for more than 35 years. Indeed, its federal-state structure and financing arrangements have caused considerable controversy and material for disputes about states' rights versus federal centralization that have marked the nation's history. A basic debate has persisted over the importance of the program's uniformity and adherence to guarantees to all beneficiaries across the nation, as well as the desire—many would say necessity—for states to have the flexibility to innovate and deviate from restrictive federal policies. The 20-year expansion of Medicaid managed care is a good illustration of how this debate has played out (Hurley and Zuckerman 2002).

In the past two decades, the number of Medicaid beneficiaries in managed care has grown from a few hundred thousand to more than 20 million, or more than 57 percent of all persons receiving Medicaid benefits (Centers for Medicare and Medicaid Services 2002). This remarkable transformation has created considerable commentary, concern, and controversy that include, but go well beyond, the root tensions over the federalist structure of Medicaid (Davidson and Somers 1998). In part this is because the managed care movement has also had its own, controversial dynamics. Public purchasers have felt the added pressure of scrutiny by elected officials skeptical of the value of managed care to contain costs and uncertain about its impact on quality of care, particularly for vulnerable, low-income populations. Performing an evaluation that involves the contentious areas of managed care and state's rights versus federal centralization increased the number of interested parties and intensified their concern about a variety of issues. The parties include elected federal, state, and local officials; executive agencies at the same levels of government; advocacy and watchdog groups; all types of health care providers and their trade associations; health plans and managed care organizations; Medicaid consumers or beneficiaries; and taxpayers. For those state policymakers leading the transition to Medicaid managed

care, the greatest challenge has been deciding how to respond to the broad array of critics and criticisms.

### *Maryland and Medicaid Managed Care*

Maryland is a relatively well-to-do and demographically and geographically diverse state. It includes both urban and rural areas with widely varying low-income populations. Maryland's Medicaid program is moderately generous in regard to children's eligibility but is less generous in its payments to service providers, especially physicians. Maryland has one of the United States' longest histories of Medicaid managed care, with more than 20 years of contracting with health maintenance organizations (HMOs) to serve beneficiaries, always on a voluntary basis until 1997. In addition, it has a lengthy history of health policy innovation, including its hospital rate-setting program that dates from 1977. In 1991, the state transferred most of its beneficiaries who were not already in an HMO to a mandatory primary care case management program called Maryland's Access to Care (MAC). The MAC program preserved the fee-for-service system and allowed beneficiaries to enroll in community- and hospital-based sites of care that had traditionally served this population, thereby limiting the disruption of relationships or revenue flows to providers and engendering relatively little resistance. Prominent traditional Medicaid providers, such as private physicians, academic health centers, and federal qualified health centers, participated fully in the MAC program.

Evaluations of the MAC program, however, revealed little change in patterns of care delivery, access to providers, and cost trends (Schoenman, Evans, and Schur 1997). This dearth of change led state Medicaid officials to search more aggressively for strategies to address cost and access concerns. In the mid-1990s the national policy debate regarding Medicaid suggested that block grants with substantially greater responsibilities for the state were a possibility, and states were anxious to develop managed care strategies that would cut costs and be more predictable (Iglehart 1999). At that time, a number of other states were experimenting with federal waivers that they could use to implement mandatory, prepaid, managed care programs (Holahan et al. 1995, 1998).

Planning for Maryland's new program began in 1995 at the behest of the state's general assembly, and the Department of Health and Mental Hygiene (DHMH) initiated an extensive public discussion and input.

A 131-member advisory panel produced a set of principles to shape a new strategy. This planning culminated in 1997 with the HealthChoice initiative, seeking a federal waiver to complete its enrollment of about 80 percent of the Medicaid population into prepaid managed care organizations (MCO) in less than one year. Contracting with MCOs was expected to produce gains in guaranteed access to a medical home (primary care provider), to improve the provision of preventive care, to build on the strengths of the existing delivery system, to obtain better value for the state's expenditures, and to enhance the plans' and providers' accountability: These were the five principles developed during the public input.

Notwithstanding efforts to solicit the public's input for the program's development, this strategy triggered concerns in many circles owing to the widespread skepticism of managed care. The depth and breadth of criticisms, coupled with a legislature that was typically active in health policy matters, put the DHMH on notice that the program and its implementation would be the subject of close and potentially hostile scrutiny. The DHMH also borrowed from other states' experiences with mandatory prepaid managed care programs and, in the process, adopted several ambitious features to address concerns raised in other states (Gold, Mittler, and Lyons 1999). Maryland's waiver permitted the enrollment of nearly all those Medicaid beneficiaries not living in institutions, including chronically ill and disabled beneficiaries not also eligible for Medicare. The DHMH extended participation to provider-sponsored managed care organizations not previously licensed as HMOs. Intended as maximum accommodation to traditional Medicaid providers, this approach also invited participation from organizations with little or no risk-bearing experience.

Nine managed care organizations initially chose to participate, including three commercial plans and six Medicaid-dominant plans, of which five were provider-sponsored organizations created solely to participate in HealthChoice. Participation declined over time because of bankruptcies, strategic withdrawals, and consolidations (including the departure of the state's largest health insurer, Free State—the Blue Cross and Blue Shield plan), which made it difficult to move beneficiaries into the remaining plans. By 2002 the number of plans participating was six, including one commercial plan and five Medicaid-only plans. Although this pattern of plan attrition is not uncommon in those states with similar strategies, it was a cause of such concern that it received

explicit attention in the program's evaluation and its recommendations (Felt-Lisk 2001; McCue et al. 1999).

The DHMH also committed to paying the MCOs risk-adjusted capitation rates to ensure that the plans would be adequately compensated while serving a heterogeneous mix of beneficiaries. At the time of the implementation, virtually no other state in the country had made a comparable commitment to adjusting capitation rates (Payne et al. 2000). To provide the data for the risk-adjustment methodology (Ambulatory Cost Groups), the state required the plans to submit detailed patient-provider encounter data for all services, including those that had been prepaid. At the time this decision was made, few states had been able to collect accurate and complete encounter data.

In addition to these new design features, the state imposed a rapid implementation strategy that moved more than 300,000 beneficiaries into managed care organizations between July 1997 and January 1998. Enrollment continued to grow, exceeding 440,000 by the end of 2001, in part because Maryland substantially expanded the number of eligible beneficiaries, through the newly established State Child Health Insurance Program, known in Maryland as the Maryland Children's Program (MCHP).

## The Necessity of Evaluation

For many years, states have been required to evaluate Medicaid managed care programs as a condition of approval from the federal authorities for their enabling waivers. For many states, this evaluation has been perfunctory. These studies typically confirm the budget's neutrality and find no adverse impacts on beneficiaries, the main criteria used in waiver renewal decisions (Hurley, Freund, and Paul 1993). For Maryland's HealthChoice program, the waiver renewal requirements were evaluated at a time when the DHMH had worries that the legislature would change the program. The annual rate negotiations and plan attrition discussed earlier gave various stakeholders, including advocates and providers, an opportunity to raise concerns about the program to the legislature. The need for an evaluation was discussed throughout the fall of 2000 and during the state legislature's debate about the program's performance in 2001. At the same time, the budget was tight, and the DHMH had to decide how

to respond to the plans' and providers' concerns about the program's being underfunded and the decline in participation. These concerns and developments contributed to broadening the scope and depth of the assessment. In effect, the program's evaluation proved to be both a proactive and reactive exercise.

Because the managed care program was designed in full view of so many constituencies, these constituency groups expected that the many questions and concerns raised during its development would be addressed when it was implemented. Likewise, the controversies over payment rates and contract awards attracted the attention of the state's general assembly and the media, shining a bright light on the program's rollout and the problems that would inevitably accompany it (Gold, Mittler, and Lyons 1999). Over time, additional concerns were raised, such as the plans' performance as revealed in their annual quality of care review (An Unhealthy Lack of Concern 1999) and the withdrawal of some of the plans from the program, particularly the departure of the state's largest health plan. These controversies added to the list of issues subjected to continuous scrutiny. When the program managers realized that they had to defend the program to numerous outside critics, they added to the evaluation more areas to be studied, to confirm the value of the program and answer the growing list of queries.

Cost and access were the principal concerns of many stakeholders worried about how beneficiaries would fare in the prepaid health plans, which had varying levels of experience and skill. Other stakeholders, including many traditional Medicaid providers, demanded that HealthChoice's impact on the state's overall health system, particularly for low-income persons, be carefully monitored. Advocacy groups also wondered whether the DHMH would hold the health plans accountable once the program was launched and whether adequate tracking systems were in place to manage the program effectively (Segal Company 1999). After the program's implementation, it became apparent that annual rate negotiations would be tense and that the withdrawal of plans from the program would make it less stable (Gold, Mittler, and Lyons 1999). All these issues underscored for DHMH executives that conducting a credible, multifaceted evaluation would be critical to making long-term decisions about the HealthChoice program. The DHMH wanted data and information to separate the facts from opinions, and it was prepared to make decisions based on these data, even if it meant significantly changing the program.

A thorough and balanced program evaluation has explicit goals (Suchman 1967). As its program evaluation goals, the DHMH used those principles originally developed during the community input process, and as the framework for the evaluation it used the following five goals, because the stakeholders expected that the evaluation would show improvement in these areas:

- Develop a system focused on the patient, featuring a medical home (primary care provider).
- Create comprehensive systems of care that emphasize prevention.
- Build on the strengths of Maryland's existing health care delivery system.
- Hold managed care organizations accountable for delivering high-quality care.
- Achieve better value and predictability for the state's dollars.

In January 2001, the DHMH began a year-long evaluation.

## Evaluation Process and Methodology

In light of the expectations and concerns surrounding the HealthChoice program, DHMH executives wanted an evaluation that would be broad in scope and methodologically sound and would answer both earlier and new questions. The DHMH decided to do much of the analysis with an academic partner, the Center for Health Program and Development at the University of Maryland, Baltimore County, because it felt that it was not possible to define the evaluation's goals well enough to solicit proposals from outside evaluators. Recognizing that the scope of the evaluation would evolve as it received the community's input, the DHMH believed that its contract with the university would be sufficiently flexible. The DHMH used other contractors to collect qualitative data from focus groups and community forums, which it used in its evaluation.

In response to worries that an internal analysis would not be viewed by the stakeholders as credible, the DHMH engaged consumers, advocates, providers, plans, legislators and their staff, other interested parties, and an outside panel of nationally recognized program and evaluation experts to review and comment on the evaluation's design, methods, and findings. They helped with the evaluation's design, challenged the

evaluation team to both defend and extend the preliminary findings, and critiqued and commented on the final report.

The evaluation covered those general areas pertinent to the program's five original goals. The principal analytical work was an assessment of the beneficiaries' basic service and utilization patterns using encounter data from the managed care organizations. Then the questions that arose during the evaluation and the financial and administrative data required from the MCOs were analyzed. The evaluation also used the complementary work done by the Delmarva Foundation, the state's contractor responsible for quality oversight. The evaluation team examined public perceptions of the program and its effects, by reviewing the statewide consumer hotline for customer service concerns and complaints, results from two consumer satisfaction surveys, and two provider surveys that had been conducted earlier. Much of the data used in the evaluation was produced through regular state administrative processes. This had the advantage of allowing an assessment of unusual timeliness but it also had the limitation of requiring the DHMH to tailor its analytical approach to the strengths and weaknesses of the available data.

The program's evaluators wanted to find out whether the HealthChoice program had affected the beneficiaries' use of services compared to the level of services before HealthChoice was implemented in 1997. Two major policy changes significantly influenced the composition of the study populations between the base year, 1997, and the study year, 2000: (1) welfare reform had reduced the number of Medicaid-eligible adults, and (2) the MCHP program had greatly expanded the number of children it covered. These changes necessitated special care in comparing the two years. To address these policy changes and the MCHP expansion in particular, all the data findings were broken down by age group, and the total numbers were weighted to reflect the change in age distribution. A second concern was that in the base year, several beneficiaries voluntarily enrolled in HMOs. Earlier research showed that the enrollees in Maryland's voluntary HMO program cost less than the average beneficiary. The lack of encounter data for individuals in the voluntary HMO program raised further concerns about the comparability of the pre-HealthChoice beneficiaries who remained in the fee-for-service population and those in the post-HealthChoice population. The third issue was the completeness of the encounter data submitted by the plans, which could, if not complete, understate the levels of use in the study year.

The quality and completeness of the encounter data submitted by the plans were a central issue for both the management and the assessment of the HealthChoice program. By 2000, those analyses conducted as part of the rate-setting process indicated that the physician data were more than 90 percent complete. Other data formats (e.g., hospital inpatient) were more problematic (Maryland Department of Health and Mental Hygiene 2000). The DHMH's success in collecting the physician data allowed it to conduct a risk-adjustment analysis and to develop utilization analyses based on those data. The data's robustness also allowed those measures to be presented "as is," with no adjustments for missing information.

Another methodological concern was that some tools for evaluation were not available or were not used in the pre-period, or base, year when members were not enrolled in organized systems of care. This issue was most problematic for medical record audits performed by the Delmarva Foundation, as noted later. These record reviews provided much information about the content and quality of care delivered to beneficiaries in HealthChoice, but they could not be contrasted with comparable preprogram assessments.

The pertinence of these studies prompted the evaluators to consult with consumers of the studies' results. In addition, the state felt it needed to include these stakeholders in shaping and supporting the DHMH's evaluation rather than create a competing vision of the program for the legislature. In fact, some stakeholders made it clear that their support for the program would depend on how the evaluation was conducted and whether they participated in the process. The evaluators thus solicited qualitative input from a wide range of stakeholders and observers to obtain a broad range of viewpoints for the program's assessment. They opened 14 community forums to beneficiaries in locations across the state and convened 17 consumer (beneficiary) focus groups for a more detailed discussion of the program and its impact on consumers. Three more focus groups concentrated on the concerns of parents of children with special health care needs, and another two groups were held with Spanish-speaking enrollees. The meetings with parents were particularly important because their voices often are not heard directly, but only through advocacy groups. The evaluation team met with representatives of several advocacy groups and also with 20 discussion groups of providers across the state to obtain their reactions to the HealthChoice program. The team held a facilitated meeting with the MCO directors and visited several of the MCO offices. Finally, before finishing the evaluation, the

team held five regional public hearings for testimony to be given and concerns to be registered.

## Selected Evaluation Findings

The evaluation's findings were organized around the five key original goals of the HealthChoice evaluation and were presented in the final report in that format (Maryland Department of Health and Mental Hygiene 2002). The evidence and interpretations revealed successes and disappointments as well as areas about which no conclusions could be reached without additional study. We present some of the findings to illustrate those areas where the results answered questions and raised others.

### *Goals 1 and 2: Patient-Focused Medical Home- and Prevention-Oriented Care*

Most of our analytical efforts were spent on exploring the impact of HealthChoice on particular services and populations of interest. The data were from encounter records submitted by the MCOs for calendar year 2000 and were compared with fee-for-service claims data from fiscal year 1997. Because this was the first time the data was used to support the analysis, the utilization measures provided new information for the HealthChoice debate. The principal measures we examined were ambulatory care visits, well-child visits, emergency department visits, and inpatient use, although insurmountable problems with identifying HealthChoice members in the inpatient data source prevented exploration in this area. The data were presented by age in order to isolate the effects of changes in the eligibility mix, geographic regions of the state, and eligibility category.

### *Aggregate Service Use*

The main question that the evaluation and the attendant analyses addressed was whether the HealthChoice program was an improvement over the previous fee-for-service system. The service use findings were generally consistent with the program developers' hopes. Figure 1 illustrates a pattern that was typical of many of the results: The percentage

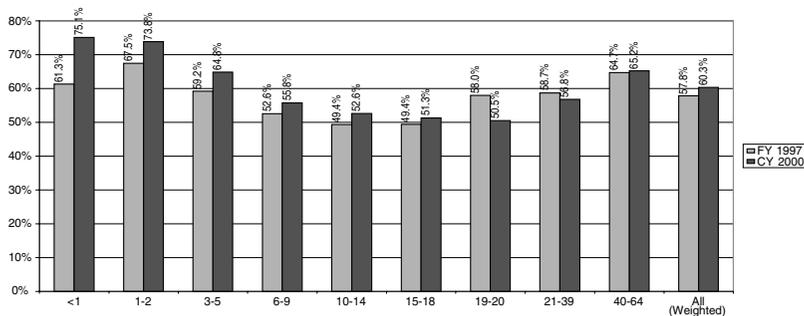


FIG. 1. Percentage of HealthChoice beneficiaries with ambulatory visits, by age, 1997 and 2000.

of beneficiaries making an ambulatory visit was higher in HealthChoice than in the comparison period, especially among younger children. Further analyses showed that the greatest improvement in the use of services was in the traditionally limited access areas of southern Maryland and the eastern shore. Well-child visits displayed a similar improvement in the percentage of beneficiaries making any type of visit. The volume of services rather than the percentage of individuals receiving care offered a less clear pattern. Although the volume of services (e.g., visits per 1,000 enrollees) declined across age groups, its implications were not clear.

The DHMH regarded these findings positively, particularly since 75 percent of the HealthChoice population were children, for whom the findings were the most encouraging. The results for adults were less conclusive because of the changes in the adult population since the beginning of the managed care program, so this area needs further study.

Based on the aggregate utilization analyses, the evaluation concluded that the HealthChoice program appeared to have made discernible progress between 1997 and 2000 in increasing access to care for beneficiaries in MCOs and ensuring they had a medical home (primary care provider). But the evaluators also reported that the progress was generally modest and not always uniform across population groups, regions of the state, or MCOs. They also decided that—even more significant than the actual findings—the results of the utilization analysis conducted for 2000 produced baseline metrics and indicators against which future changes could be measured and compared and on which performance improvement strategies could be based.

### *Subpopulation Analyses*

An ongoing concern about mandatory enrollment is that managed care models may not be universally suitable for the diverse populations found in Medicaid (Newacheck et al. 1994). The breadth of participation in Maryland's program, together with long-standing concerns among advocates about special populations such as foster care children and children with special needs (the DHMH has had a special advisory committee for children with special needs since the beginning of the program), underscored the need to conduct further analyses of various eligibility groups. Generally, the findings from them were similar to what was observed in the age-based analysis. Children with special health care needs who were viewed as particularly vulnerable to changes in traditional modes of care delivery were assessed more closely. The percentage of children receiving support from the federal Supplemental Security Income program for low-income disabled persons rose for ambulatory and well-child service use, but the overall use rates for ambulatory care were essentially unchanged.

The service use findings for children in foster care were among the most noteworthy and troubling. Children in foster care are particularly vulnerable and face barriers to care, such as multiple placements, large caseloads for caseworkers, incomplete medical records, a lack of training for foster parents and caseworkers, and the coordination of service problems related to these factors (National Academy for State Health Policy 2001). Many states exclude these children from managed care programs, as did Maryland in its earlier HMO and MAC programs. The analysis of ambulatory and well-child care indicated that the percentage of foster care children using either of these services was lower in HealthChoice compared with that in the baseline fee-for-service period of 1997. The DHMH was concerned that the design of the HealthChoice program could be impeding the care of these transient children, for whom routine outreach was not adequate. But the DHMH also acknowledged that this apparent reduction in service use might have been a reporting artifact caused by delays in enrolling foster care children in MCOs, thus missing utilization that occurred in that fee-for-service window of time and systematically understating it. The evaluation concluded that closer monitoring and further study were needed to satisfy both the DHMH's and the external stakeholders' concerns.

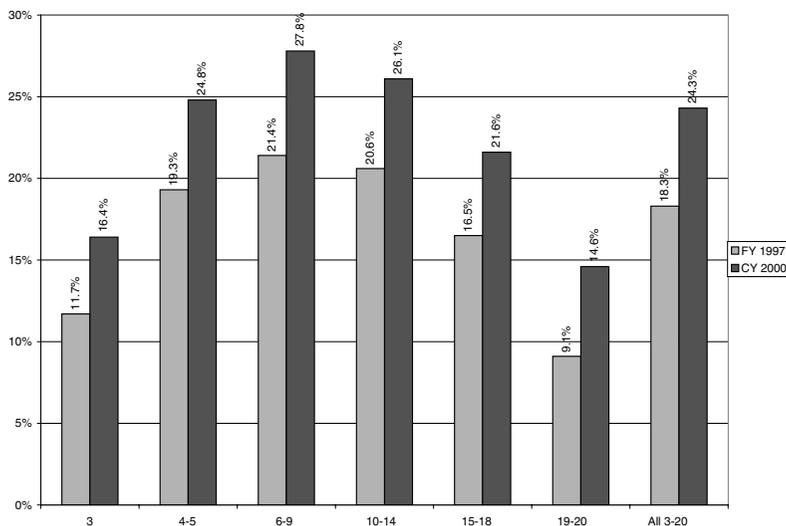


FIG. 2. Percentage of children by age who were eligible for 90 days or more who received a dental service, 1997 and 2000.

### *Use of Specific Services*

The evaluation team studied specific service areas to determine whether HealthChoice addressed persistent problems for the state's Medicaid agency, including specialty care and dental services. Among the most positive findings was a substantial improvement in access to dental care, an area in which Medicaid agencies have been deficient across the nation. The percentage of children enrolled for at least 90 days who received dental services increased markedly between 1997 and 2000 (see figure 2), and the number of children enrolled for a year or more grew by more than 50 percent.

Again, a regional assessment revealed that the improvements were greatest in historically underserved areas like southern and western Maryland and the eastern shore. Despite these improvements, however, access to dental services remained a serious problem in the HealthChoice program.

### *Unaddressed Questions*

Although the analyses presented in the evaluation were extensive, they were by no means exhaustive. Some of the case analyses initially suggested

by stakeholders proved to be impossible due to limitations in the data. Examples of unexplored issues are an assessment of prenatal care, because of coding inconsistencies limiting a count of visits; an assessment of specialty referral patterns, because of problems identifying individual specialists; and an assessment of substance-abuse treatment services, because of the plans' problems in gathering and submitting data from behavioral health subcontractors.

### *Primary Data Collection Concerns*

The final evaluation report described the results of the consumer and provider surveys in 1998 and 1999 in order to augment the analysis of the encounter data. The response rates of both these surveys were disappointing, as they declined as the program moved beyond the implementation stage, with a 22 percent response rate for consumers and 11 percent response rate for providers. The poor response rates were attributed to too few resources committed to primary data collection as part of the evaluation. The DHMH then tried to improve participation in consumer surveys to ensure their availability for the ongoing monitoring of the program.

Because of this disappointing response to the surveys, the DHMH relied heavily on public input gathered in consumer focus groups and community forums. The concerns raised in these meetings included problems in access to specialty care, dental services, and transportation services. All were areas in which progress was evident, based on objective data, but still fell short of consumers' expectations, thereby underscoring the usefulness of augmenting the quantitative analysis. Countering these frustrations were the positive perceptions of the program's greater availability of primary care provider relationships and opportunities for obtaining preventive care, especially for children.

Forums of advocates, providers, and MCOs debated the program's design and operational features. The forums highlighted conflicting perceptions of the managed care program and made these issues more important to examine further with quantitative data. Advocacy groups were particularly concerned about what they perceived as shortfalls in patients' accessing health care, MCOs' maintaining adequate provider networks, MCOs' insufficient case management, and the experience of particularly vulnerable groups like foster care children. The providers' concerns revolved around adequacy and timeliness of payments, administrative

burdens, and confusion over formulary and transportation issues. But they welcomed the achievement of a medical home (primary care provider) for most of the beneficiaries. The MCOs wanted more stability in the program's design, operations, and funding to enable it to mature and become stable. Overall, the forums provided both data for the DHMH and opportunities for the participants to express their displeasure. In some instances, their comments were highly critical, and in other instances, they were constructive and focused on program improvements, which were reflected in several of the evaluators' recommendations. The DHMH found these time-consuming experiences both difficult and informative but essential to following its policy of openness and inclusiveness in assessing the program.

### *Goal 3: Building on the Existing Health Care Delivery System*

The third evaluation goal reflected the HealthChoice program's commitment to, in effect, "first do no harm" to the state's existing delivery system. This meant ensuring the retention of key providers like academic health centers, federally qualified health centers, and other traditional Medicaid providers by including them in networks and paying them adequately, or at least as well as they had been paid by Medicaid. At the same time, the MCOs were expected to improve enrollees' access to care, as measured by specified capacity standards (e.g., one primary care provider for every 200 enrollees), by recruiting new providers to participate in Medicaid. Although all the participating plans complied with the minimum capacity standards, the retention of the providers was a pervasive concern of all the MCOs.

This concern was, not surprisingly, closely linked to the adequacy of payments. Maryland's fee-for-service payments to physicians have historically been very low, estimated to be an average of approximately 35 to 40 percent of the Medicare fee schedule. Because capitation payments to MCOs are based on and cannot exceed the amount the Medicaid agency would have paid for the same services under its fee-for-service program, the MCOs had little room for maneuvering in their negotiations with physicians. In most cases they paid them slightly more than what Medicaid had been paying them, but not enough to keep the providers from being concerned about whether they were being paid enough. These

concerns about the payment rates for physicians were exacerbated by the expansion in the number of persons covered by Medicaid, especially children, thereby causing the physicians' portion of Medicaid to grow relative to that of other payer sources. Reimbursement was repeatedly raised in the provider forums conducted during the evaluation. The evaluation concluded that the loss of providers, both actual and threatened, was the greatest threat to HealthChoice's future.

Since HealthChoice was established, hospitals and federally qualified health centers, which were important long-term providers to Maryland's recipients of Medicaid, had been worried about its potential negative effect on their organizations. The evaluation found, however, that they did not lose market share under HealthChoice, leading to the conclusion that HealthChoice did not substantially affect these providers. The lack of demonstrable adverse impacts in these instances provided valuable evidence for the DHMH to use in arguing that the program's gains were not producing corresponding problems in these sensitive provider sectors.

#### *Goal 4: Hold MCOs Accountable for Performance*

In principle, buying care under contract from an organized delivery system gives a Medicaid agency an opportunity to demand accountability that it did not have in the unbundled and highly autonomous fee-for-service medical care. Systems of care can also produce meaningful aggregate indicators of performance for measurement and monitoring as well as benchmarks against which performance can be tracked over time. These were among the most appealing features of HealthChoice touted by its architects, thereby raising expectations that the program's evaluators would pay special attention to the system's accountability.

The DHMH contracts with the Delmarva Foundation to perform a variety of clinical quality oversight and audit functions in its capacity as the state's designated external quality review organization (EQRO). The EQRO is an entity with which states must contract as a condition of receiving and retaining a federal waiver to offer a mandatory Medicaid managed care program. Quality oversight conducts both reviews of the MCOs' internal systems of quality assurance and clinical reviews of their high-priority areas. The evaluation reported evidence of improvement in the internal quality assurance performance scores in the program's

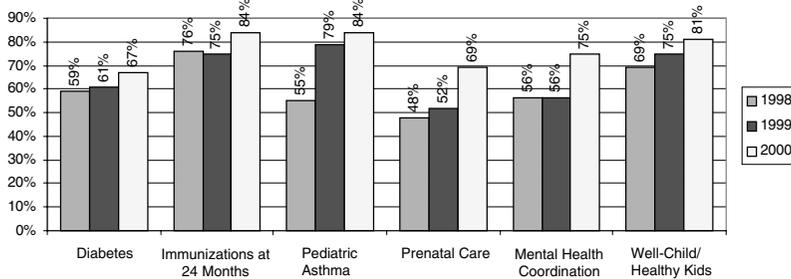


FIG. 3. Trends in aggregate managed care organization compliance levels in clinically focused reviews. This graph shows the percentage of chart reviews by the EQRO that met the Department of Health and Mental Hygiene's established standards, 1998 to 2000. *Source:* Delmarva Foundation for Medical Care, Inc., Executive Summary Maryland Medical Assistance HealthChoice Program: Evaluation of Participating MCOs for Calendar Year 2001, August 2002.

first three years. The clinical reviews of six target areas are presented in figure 3 and indicate the percentage of chart reviews that met the DHMH's standards. The figure shows improvement in all areas, particularly when comparing 1998 with 2000, in part because in 1998 the state started to sanction plans based on their performance. While the plans varied somewhat on these indicators, improvement was uniformly evident across the plans over time. On more detailed indicators in areas like diabetes and prenatal care, performance remained disappointing, however, and so they were designated as important areas for future improvement. There was no comparable reporting of performance in the fee-for-service environment in 1997, thus precluding comparisons with performance before managed care was introduced.

Overall, the DHMH surmised that it had not developed a centralized or coordinated approach to assessing and improving overall MCO performance and that the accumulation of separate oversight initiatives had placed an undue burden on the MCOs and providers.

### *Goal 5: Achieve Better Value and Cost Predictability for the State*

The final evaluation goal explicitly addressed whether Maryland had been successful in improving the value of the health services purchased for beneficiaries and the predictability of state expenditures. Several

important considerations received attention in this area, including compliance with federal regulatory requirements, adequacy and stability of funding, budgetary predictability and administrative costs, and the appropriateness of payments to the plans, as indicated by the effects of the risk adjustment methodology employed. All were serious concerns to at least some stakeholders and were expected to have a major bearing on the program's sustainability.

Compliance with federal regulations was affirmed by demonstrating that when the program was fully implemented, the total amount of payments made to the MCOs was less than what would have been paid for beneficiaries in traditional Medicaid fee-for-service. The evaluation calculated that budget neutrality was maintained in HealthChoice, as program expenditures grew in the first four years of the program by less than 5.5 percent per year per beneficiary, the annual trend factor used in the five-year spending cap for Maryland's waiver.

The adequacy of the program's funding was gauged according to whether enough MCOs made and sustained a profit during the program to allow HealthChoice to continue. The analysis focused on data regarding the financial experience of consistently profitable MCOs. These were plans that had participated throughout the program, and they covered approximately 70 percent of all beneficiaries at the time of the evaluation. From 1997 through 2000, these MCOs registered from operations a medical care (loss) ratio of 83.5 percent, an administrative expense ratio of 13.0 percent, and a profit/surplus ratio of 3.5 percent. The performance levels were seen as consistent with commercial HMOs' experience in the state during the same period.

Both providers and plans contended that the traditional approach of setting capitation rates based on historical fee-for-service payments was no longer adequate and so this method did not reflect market realities. Because the Medicaid payments to physicians in Maryland were well below market rates for physicians' services, the health plans maintained that the capitation payments they received did not enable them to pay fees that could attract and retain physicians. Both parties strongly urged the state to reassess its rate-setting methodology and to seek additional funds to improve physicians' compensation.

The state's risk adjustment system for capitation rates was designed to ensure that the money follows the beneficiary, and the evaluation also examined accounts of the beneficiary's health status. As one of the most innovative features of HealthChoice, risk-adjusted capitation rates were an attempt to ensure that the plans would not try to attract only

<b>Participating MCOs</b>	<b>Plan Risk Level (Average risk level = 1.00)</b>
MCO A	0.92
MCO B	1.18
MCO C	0.99
MCO D	1.57
MCO E	1.02
MCO F	1.09
MCO G	0.93
<b>All MCOs</b>	<b>1.00</b>

FIG. 4. Average risk level of beneficiaries in seven managed care organization (MCO) plans, 2000.

healthy members or, alternatively, would not be financially penalized if they enrolled less healthy members. Beyond the conceptual appeal of this strategy, it was unclear whether differential enrollments based on patient risk would be sufficient to justify the commitment of resources needed to make such adjustments.

The evidence from the evaluation indicated that plans varied markedly on the risk profile of their members. Figure 4 indicates the amount of variation across seven plans participating in 2000, using the ambulatory cost group methodology.<sup>2</sup> With the average risk for all plans scaled as 1.00, plan D clearly attracted a much less healthy pool of members (57 percent higher risk than average), and plans A (8 percent lower risk) and G (7 percent lower risk) had healthier members in all beneficiary groups. The differences in risk profiles were less dramatic for families and children (excluding the disabled) but nonetheless reveal the importance of refining capitation payments to provide plans with appropriate resources and incentives to manage care effectively, and not merely manage membership. The evaluation also highlighted the value of risk adjustment. The state concluded that risk adjustment protected health plans, including those sponsored by hospitals, that attracted higher risk and that distributing risk among the plans was justified.

## Conclusions from the Evaluation

The evaluation results were summarized into four general findings, along with recommendations to enhance the program. The findings were both positive and negative:

1. The Medicaid HealthChoice program served a much larger and more different population than was previously served and was a stable platform for greatly expanding eligibility.
2. Overall, HealthChoice helped more people, particularly children, receive health care services, although the number of services per person fell, for unclear reasons.
3. Overall, HealthChoice saved money compared with what would have been spent on the fee-for-service delivery system, and it added value to the program for consumers and providers.
4. In the future, improvements in access may be threatened by the diminishing number of physicians willing to participate in HealthChoice.

Notwithstanding the evaluation's concerns, the DHMH's main conclusion was that the current "MCO-based program should be maintained." The DHMH decided, as had other observers of HealthChoice, that the program had tried to do too much in too little time (Gold, Mittler, and Lyons 1999). This overreaching resulted in both unmet expectations in a number of areas and many ad hoc modifications that have been difficult to manage and for all parties to adapt to successfully. The recommendations highlighted the need for strategic planning to establish priorities to ensure the program was effectively managed and the stakeholders' concerns were systematically solicited, considered, and acted upon. The evaluation report then made specific program recommendations designed to improve the HealthChoice program's operation.

## Evaluation Results Rollout and Response

Throughout the evaluation process, the stakeholders had many opportunities to make suggestions and comments. More than 80 meetings were held to supplement the quantitative analysis with qualitative

information about all facets of the program. When the intensive evaluation was completed, the draft report was presented in a three-hour meeting with advocates, plans, and providers to obtain their comments and additional insights before the report was formally released to the public. After this meeting, all stakeholders were given time to offer formal comments on the findings and conclusions and to make specific recommendations for changes in the program's design and activities.

Several meetings were held to discuss the recommendations and to arrange them in order of priority for a program improvement work plan. Because the areas for improvement were identified in a broad-gauged analysis and the recommendations were produced in collaboration with various stakeholders, nearly all the stakeholders supported continuing the program but also believed that its operation needed to be enhanced, and they stated so publicly in hearings during the 2002 legislative session. The fact that no legislation was introduced even to codify the recommendations, as is standard practice in Maryland, leaving their implementation to the DHMH's discretion, illustrates the extent of the stakeholders' support.

Most important, the evaluation provided the evidence to support a budget allocation of \$50 million to raise physicians' fees. This increase was in response to two of the evaluation's conclusions that the program was succeeding and that the provider networks were under stress. The fact that a significant budget increase for physicians' fees was approved at a time when other programs were being cut was seen by state officials as testimony to the power of the case presented in the evaluation. Without such an evaluation, these concerns would likely have been discussed on an issue-by-issue basis that limited the ability of the DHMH and other stakeholders to see the program's collective impact.

## Lessons Learned

A program evaluation of this scope and complexity offered several important lessons to policymakers, policy analysts, and other parties both launching and living with major public program initiatives.

1. Sound evidence and analysis can make complex programs understandable to external stakeholders.

Because Medicaid and managed care programs are complicated, even well-informed stakeholders may not understand exactly how a Medicaid

managed care program works and what it achieves. Monitoring and reporting performance data help separate fact from opinion. While the Medicaid agency could not accomplish everything in the evaluation, by focusing on the right questions, such as the subgroups and regional variation, their data were very useful. One of the evaluation's principal accomplishments was making the program's details and outcomes understandable to its stakeholders. In addition, by giving stakeholders an opportunity to make suggestions and then explaining what could and could not be done, the limitations of the data were demonstrated, and expectations became more realistic.

The evidence for four findings was clear to all: (1) HealthChoice provided a platform for major program expansion; (2) access to children's services showed modest, but uneven, improvement; (3) the program saved money compared with a fee-for-service alternative; and (4) HealthChoice's gains were being threatened by a possible loss of providers participating in MCO networks. During the budget hearings in the 2002 legislative session, nearly all the stakeholders testified to these points. While such findings may be disputed, they and their supporting evidence provide a basis for an informed discussion of areas of interest and concern as the program goes forward. The DHMH's analyses were critical to decisions about the program and helped address contentious issues.

2. The initial investments in systems to gather data and conduct analyses will prove worthwhile. A timely, detailed program evaluation of a major initiative is a daunting and expensive task. Over several years, the DHMH has invested in developing data systems to support quantitative analyses of claims and encounter data. But the evaluation of the HealthChoice program required considerably more resources to analyze data. Collecting the primary data and gathering extensive qualitative data required even more staff time and resources. Insufficient investment in the ultimately disappointing consumer and provider surveys undermined their usefulness, although the DHMH believed that the investments it did make were worthwhile. The collection and analysis of these data and the open and elaborate process of sharing them with stakeholders were critical to generating a credible and creditable set of findings about the program.

A further benefit of these investments was the department's ability to report the program's performance to the legislature and stakeholders, so as to influence key policymakers. Decision makers need timely

information, an area in which the HealthChoice evaluation was particularly successful. The HealthChoice evaluation was released in January 2002 and reported on calendar year 2001 performance. The analysis contained in the evaluation was shared with the stakeholders, in almost complete form, in November 2001, and a preliminary version of the analysis was presented to outside experts in August 2001. In other words, Maryland was able to collect, analyze, and present an extensive evaluation of a program serving more than 400,000 recipients less than one year after the close of the analysis period.

3. Combining the quantitative and qualitative data provided a more complete picture. The evaluation team collated diverse types of information, ranging from encounter data to the plans' enrollment and financial information to qualitative input collected in focus groups and public forums. A comparison of the findings from different sources added insights and permitted the triangulation of important matters that could not be fully understood from a single perspective or data source. For example, the encounter analysis revealed substantial improvement in access to dental services, despite the complaints by consumers, advocates, and providers about limited access to them. Bringing the two data sources together showed that although there had been progress, the use of dental services was still well below expectations. Qualitative data also filled in the gaps in the quantitative data on issues that were not easily quantified. For example, access to specialty care in rural areas was difficult to analyze with the encounter data but emerged as a problem in the recipients' focus groups.

Most important, the focus groups, forums, and public hearings allowed the evaluators to hear directly from the families served by the program and the providers delivering the services. At the same time, the extensive input and summaries of concerns showed the stakeholders, particularly legislators, that the program's assessment covered the entire community and that the state had listened to both the positive and the negative comments. The advocates and providers did not complain to the legislature about the evaluation during the 2002 legislative session, in marked contrast to their complaints about the rate-setting process, thereby adding more credibility to the evaluation.

4. Real-time research requires flexibility. Evaluating a program like HealthChoice requires both proactive and adaptive components that evolve as more evidence becomes available or as problems arise when examining new data. Likewise, a real-time evaluation cannot be made in a

vacuum, separated from the political process, and thus relevant questions to be addressed may change during the program's implementation. Rate adequacy and continued plan participation emerged during the evaluation as concerns, and evaluators were able to devote more attention and resources to these matters, with both quantitative and qualitative indicators. Flexibility in an evaluation's design and execution is essential to ensure that it will adapt to new discoveries and concerns. One of the DHMH's advantages was that the evaluation was carried out internally in conjunction with its long-standing contractor, the Center for Health Program Development at the University of Maryland, Baltimore County. The collaboration of the two parties enabled them to adjust the scope and depth of the evaluation as new issues emerged or unanticipated challenges were confronted.

5. Full disclosure of both good and bad findings builds credibility. The DHMH's executives were committed to the evaluation as an essential part of an informed decision-making process regarding the future of HealthChoice. With that commitment went the responsibility to present all its findings, even when they were not favorable to the program. Likewise, the executives themselves had a stake in understanding whether their program would improve the lives of its beneficiaries. The findings regarding children in foster care created a need to know whether the program was creating barriers to their access to services. Making the evaluation public put program managers at risk for findings that could lead to significant and unanticipated program changes. But it also conveyed to the program's critics the DHMH's commitment to a frank and honest appraisal of the HealthChoice initiative.

## Conclusion

If it is axiomatic to suggest that watching policy being made is like watching sausage being made, an equally evocative metaphor is needed to capture the soul-searching and soul-baring that should accompany a careful assessment of a bold policy initiative. The Department of Health and Mental Hygiene's commitment to such an appraisal was made when it chose to craft the HealthChoice proposal in a highly visible and participatory manner that invited the broad involvement of stakeholders. Elected and appointed officials had concluded that improving a huge public medical care program was too important to leave solely in the

hands of technical experts and consultants. The evaluation was a natural extension of this philosophy and, in the minds of most observers, confirmed the belief that more information and openness are necessary to gain and sustain support for major public-sector undertakings.

## ENDNOTES

1. For more information about the HealthChoice evaluations, see the report available at [www.dhmh.state.md.us/mma/healthchoice/hcevalpres.html](http://www.dhmh.state.md.us/mma/healthchoice/hcevalpres.html).
2. Adjusted Clinical Groups (ACGs), developed by researchers at Johns Hopkins University, are a series of mutually exclusive health status categories defined by morbidity, age, and gender.

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