REPORT ON MANAGED CARE FUNDING AND OUTCOMES

HealthChoice is Maryland's statewide Medicaid managed care program. HealthChoice was implemented in 1997 and currently provides health coverage to over 470,000 Marylanders. Under HealthChoice, families and individuals enroll in one of seven managed care organizations (MCOs) approved by the Department of Health and Mental Hygiene (DHMH). DHMH has developed a comprehensive approach to ensure that MCOs deliver high quality health care.

HealthChoice has paid off for the State through increased access to providers, improved quality of care, and realized savings. The sustainability of HealthChoice, therefore, is a critical piece in the Department's strategy and ability to effectively manage its budget while meeting the needs of Marylanders.

Current Quality Oversight

DHMH has an extensive system for evaluating and improving MCO performance. Each component of the approach is aimed either at measuring the actual performance of the MCO or determining whether or not the MCO has the necessary infrastructure to provide high-quality care. Before DHMH approves an MCO for participation in HealthChoice, the MCO must undergo an extensive application process and must meet operational and financial standards. After joining HealthChoice, MCOs are evaluated according to a variety of quality standards. Quality activities include:

- Value-Based Purchasing, a coordinated performance measurement initiative designed to use incentives and disincentives to hold MCOs accountable for performance.
- Select Health Plan Employer Data and Information Set (HEDIS) measures, which allow the State to make comparisons of HealthChoice to national performance benchmarks.
- Consumer Assessment of Health Plans (CAHPS) survey, a national survey administered to enrollees to determine consumers' perceptions of the care and services they have received from their MCOs.
- Provider satisfaction survey.
- Annual Quality of Care audit conducted by an External Quality Review Organization (EQRO). This includes reviews of systems performance (i.e., MCO infrastructure) as well as reviews of various clinical performance measures.
- Encounter data collection and analysis to measure trends in health services utilization and access to care.
- Consumer Report Card, a tool for consumers to use when selecting an MCO to allow them to compare MCOs based on several categories.
- Healthy Kids medical record reviews.
- Monitoring of enrollee and provider hotlines.
- Performance improvement projects focusing on clinical or non-clinical areas as determined by DHMH.

In addition, DHMH has established provider network requirements in order to guarantee that enrollees have timely access to care. The Department's work in this area is far more advanced than other states' network requirements.

Quality standards have been established as part of all the quality activities. If an MCO does not meet an established standard, it must submit and follow-up on a corrective action plan. The MCO may also be subject to financial or enrollment sanctions.

Advantages and Disadvantages of Current Quality Measures

DHMH employs a variety of quality measures to gain a comprehensive assessment of MCO performance. No single type of measure is sufficient to assess the overall quality of care an MCO is providing. There are advantages and disadvantages to any individual measure. This is why DHMH's quality approach incorporates a number of different types of measures. Below we discuss the advantages and disadvantages of some examples of DHMH's different quality indicators: HEDIS, medical record reviews, and consumer input.

HEDIS

While HEDIS has its limitations, it is still the most widely used tool for measuring and comparing the clinical performance of health plans. HEDIS provides states with standardized clinical performance tools, which specify exactly how to calculate measures. The advantage to this is that it allows states to compare their plans' performance among themselves as well as against plans in other states. Health plans can gather this information from members' medical charts or from administrative records or both. This is much more efficient than medical record review alone. The accuracy of this information is independently audited by an outside contractor accredited by the National Committee on Quality Assurance (NCQA).

The Department recognizes that HEDIS alone is not sufficient to evaluate a plan's clinical performance. Performance measures for certain populations are not tracked by HEDIS, such as clinical measures directed at the SSI population. In those cases, the Department develops its own measures and uses utilization data submitted by the MCOs to evaluate performance. In addition, an MCO's HEDIS score can be significantly affected by the source they used to obtain the information (medical charts or administrative records).

Healthy Kids Medical Record Reviews

DHMH reviews approximately 3,000 medical records to evaluate whether providers are meeting the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program practice guidelines for children under age 21. MCOs are scored on their providers' performance. Nurse reviewers give providers feedback on their performance and provide information to help them link their patients to other public health resources.

In general, medical record reviews provide rich information which cannot be captured by administrative data alone. However, medical record reviews require significant resources on the part of reviewers and providers' offices; therefore, they can be conducted on only a small sample of the population. In contrast, administrative data (used in HEDIS and encounter data analysis) looks at the entire population.

Consumer Input

Enrollee perception of care is an important complement to the assessment of service utilization, and can help to explain the results of quantitative analyses. However, consumer input alone is

insufficient to monitor quality. NCQA sponsors the Consumer Assessment of Health Plans Survey (CAHPS). HealthChoice enrollees are mailed the CAHPS survey, which asks them to report about their experiences with their health plan and its doctors. The survey is conducted, analyzed, and reported to DHMH by an NCQA accredited contractor. The contractor is also responsible for the provider satisfaction survey. Both enrollee and provider surveys are required annually by the federal Centers for Medicare & Medicaid Services (CMS).

In addition to the enrollee and provider surveys, DHMH obtains information on satisfaction with HealthChoice by monitoring calls to the Department's HealthChoice enrollee and provider hotlines. Calls are tracked by category and analyzed monthly and quarterly to determine if specific interventions with particular MCOs are required, or if changes in State policies and procedures are necessary. This provides real-time information on any areas, which may need to be addressed.

Relevance of 85% Medical Loss Ratio and Efficiencies Associated with Profitable MCOs

There are two main types of MCOs that participate in HealthChoice: provider-sponsored organizations and investor-owned companies. Ongoing operating losses will cause both types of MCOs to exit HealthChoice. Medical loss ratio (MLR) is an index that compares medical costs to revenues. MLR is not a measure of quality. The financial health of different types of MCOs must be measured by more than profit margins or revenues. Market share and provider payment rates also are important in assessing the financial health of MCOs.

Since the exit of FreeState from the HealthChoice program during the six-month period from October of 2000 through March of 2001, the HealthChoice program has been operating with six MCOs. (Coventry began operating as a HealthChoice MCO in September 2003, but has yet to obtain a one percent market share). Three MCOs have consistently made profits during this period: Amerigroup, Jai, and United. These plans have been classified in our analyses as "Non-Provider Sponsored Organizations" or "Non-PSOs". The other three MCOs – Helix, MPC, and Priority – have been classified as "PSOs" due to their hospital affiliations. Priority has sustained losses annually since it began operating as a HealthChoice MCO. Helix has been improving its financial performance from underwriting losses in 2000 and 2001, to almost break-even in 2002. Helix is expected to have modest underwriting gains starting in 2003. MPC had gains in all years except one difficult year in 2002, but their financial position looks favorable from 2003 going forward.

The parent organization of a PSO is usually a health system. The health system benefits if the provider-sponsored MCO is able to secure market share that it otherwise may have lost. Likewise, the health system benefits if the provider-sponsored MCO is able to protect it from becoming dependent on investor-owned organizations that could potentially negotiate lower rates for non-hospital providers. In comparisons of plans' medical loss ratios, higher payment rates to providers mask the amount of care enrollees are receiving.

Based on our 2002 financial analysis of the MCOs, a major factor in determining whether an MCO will be profitable is how efficiently the MCO manages its ambulatory services. The MCOs who have experienced consistent operating losses from year-to-year tend to use more

costly hospital-based sites for ambulatory care (rather than lower-cost community physician offices) significantly more than other MCOs.

Profitable MCOs Help the State Control Medicaid Costs

Once rates are set, MCOs make profit by better managing expenses. MCOs' actual expenses constitute the base for rate setting in future years. The basic rate setting formula is as follows for CY 2005 rate setting:

	2002 audited medical expense
plus	2002 administrative costs (Comparable to 2001)
plus	2002 fixed profit margin
plus	2002 fixed risk margin
equals	2002 Dollars in rate base

Since profit and risk margin are fixed and administrative costs are similar to 2001, lower medical expenses result in lower future rates. The bottom line is that reasonable MCO profitability both strengthens the overall stability of the program as well as reduces the future cost to the State. Rates are set on an aggregate basis in order to gain overall program efficiencies and keep the rates reasonable. Rates have always been risk adjusted. We continue to monitor and improve the risk adjustment and rate-setting process. The methodology is based on actual costs to accurately reflect MCOs' risk.

Profitability Restraint Imposed by Minimal Loss Ratios

The following table illustrates the rate component developed for HealthChoice rates effective January 1, 2004:

HealthChoice Rate Development

Rate Component	$'s pmpm	% of Gross Rate
Medical Expense	$233.88	88.8%
Admin. (Inc. Med. Manage.) Exp.	$24.72	9.4%
Profit Margin	$3.51	1.3%
Risk Margin	$1.17	0.5%
Gross Cap Rate	$263.28	100.0%

Rates were subsequently reduced one percent by State budget actions, which, in effect, eliminated most of the margin. Since the reduced rates have less than a percent of explicit margin, profitability needed by MCOs to achieve reasonable returns for their owners can only be attained through efficiently managing their care or by reducing their administrative costs.

Investment in Medical Management

As MCOs continue to invest in medical management, the intended net effect is to reduce medical expense. Studies have been published that indicate spending on medical management has a favorable leveraging effect in reducing medical expense (and given Maryland's rate setting methodology, reduces future cost to the State).

Rewards and Penalties System

One way DHMH encourages MCO improvement is through consumer education, which allows consumers to make informed choices about which MCO is the right one for them to select. In 2003, the Department developed a Consumer Report Card which allows enrollees to see how health plans compare to each other in key performance areas and what other enrollees say about particular health plans so they can easily make informed choices about which MCO to join. Enrollees receive a copy of the Report Card at the time of enrollment. They also receive a comparative chart, which highlights key differences in services and provider networks.

In addition, the Department's Value-Based Purchasing Initiative was designed to encourage plan improvement through financial sanctions and incentives for MCO performance outcomes on administrative, access, and quality indicators. Performance targets for the selected measures were set in several ways, depending on the data source and other factors. Eight measures were used for Calendar Year 2003, two additional measures were rolled-out for Calendar Year 2004, and additional measures were identified to be added or rotated in future years. However, the Value-Based Purchasing incentive pool was reallocated by the Legislature to fund Medbank. Therefore, no incentives were available to be paid out to the MCOs, which met incentive targets.

The Department is focused on improving MCOs' clinical and operational performance over time. The Department would be gravely concerned if any MCO's performance declined significantly across a number of clinical measures, particularly because capitation rates are largely based on what services should be provided by the MCO. A method that pre-establishes minimum quality of care performance outcomes is an equitable and reasonable way to sanction MCOs. Therefore, the Department proposes to maintain a system of rewards and penalties but with more aggressive performance targets. Value-Based Purchasing has large neutral ranges between the sanction thresholds and incentive targets. This is because funds in the original incentive pool were limited and therefore did not allow DHMH to be at risk for large payouts if more MCOs were to perform far above incentive targets than far below disincentive thresholds.

An outcome-based system of rewards and penalties that equates to at least one percent of total payments to MCOs (approximately $14 million Total Funds) would provide the opportunity to make performance targets more aggressive. One possible option is a "pay for performance" approach in which DHMH would set three tiers of performance: average, below average, and above average. DHMH would withhold one-half of a percent of capitation rates (approximately $7 million TF) from the MCOs prospectively. An MCO with average level performance would receive that one-half of a percent of its capitation rates back. MCOs with below average performance would receive nothing back, and in effect would receive a one-half percent penalty. An MCO performing above average would receive one full percent of its capitation rates back, and would therefore receive a net one-half percent bonus.

There are advantages and disadvantages that must be considered with any approach. A main advantage of the above is that it creates an incentive pool large enough to motivate MCO improvement. Basing the three tiers on average performance in the year of interest and fully paying out the pool each year means we know the total annual amount we will need to pay in incentives. This will allow us to have a narrower neutral range with more aggressive targets, without putting the State at risk of having to pay out unbudgeted funds if MCO performance were to exceed expectations.

One of the disadvantages of basing the three tiers on the average performance in the year of interest means that half of the MCOs will always be below average and half of the MCOs will always be above average, regardless of how close their actual scores are to one another or how much an individual plan has improved from the previous year.

Another option similar to the first would be to set three tiers of performance (minimum, medium, maximum) using predefined targets rather than average performance. The advantage is that the MCOs would know the targets in advance, and if all improve their performance significantly, they all potentially could be rewarded. However, this would place the State at potential risk for paying out up to an extra half percent of capitation if all MCOs reach the maximum target.

A third possible "pay for performance" approach would be for DHMH to set two tiers of performance: one over a predefined target, another below the target. DHMH would withhold one percent of capitation rates (approximately $14 million TF) from the MCOs prospectively. An MCO which performs over the target would earn its one percent of capitation rates back. An MCO, which performs below the target, would not get anything back, and in effect would be sanctioned one percent. Under this system, MCOs would not compete against one another; all MCOs could meet the target and therefore get their one percent in capitation rates back. Unlike the first option, it would not be the case that some MCOs would always be penalized. However, under this option there would be no extra incentive money to pay out as a bonus above the original withhold. Money above the original withhold is only available if it is taken from other MCOs.

It is essential that there be sufficient assurance that the withheld funds would be safeguarded, to be allocated only for MCO performance bonus payments, unlike the experience with the redirection of the Value-Based Purchasing incentive pool. If MCOs are not assured of the availability of rewards they will not be motivated by the proposed system.

Regardless of the system of financial rewards and penalties, the State should continue its other corrective actions as appropriate and necessary. These include requiring corrective action plans and closing down an MCO in selected regions.

Summary

The Maryland HealthChoice program is entering its eighth year as a risk adjusted Medicaid managed care program. When MCOs have unsustainable losses and exit the program, significant disruptions are created for enrollees. The Department, therefore, wants both efficient and profitable MCOs participating in HealthChoice. An MCO whose financial health is questionable invokes

serious concerns for the Department. Since HealthChoice started in 1997, three MCOs have exited the program because of financial losses.

The participating MCOs and their owners assume the full financial risk of their membership. Being in a full risk arrangement with the State, these entities must have reasonable profitability incentives that encourage them to make long-term investments in the program, as well as allow them the opportunity to achieve a modest return and the incentive to continue to participate. They are more willing to take risks in years of losses when they are allowed to retain their profits when they make improvements in their operations or operate more efficiently. The managed care arena can be cyclical as commercial insurance trends demonstrate. The State also needs the ability to attract new risk bearing entities in the future if inefficient MCOs leave the program.

The rate setting methodology is designed so that efficient MCOs help to control the future cost of the program. Although there are many factors that determine whether an MCO will be profitable or not, their financial experience indicates that the cost of ambulatory services is the primary determining factor. MCOs which are more aggressive in provider contracting and minimize the use of hospital based ambulatory services, are more likely to achieve profitability.

Conclusion

The Department continues to believe that imposing financial penalties based on MCOs' MLR is not fair or appropriate, and does not enhance the quality of care. MLR is not a measure of quality. Instead, the Department should continue to use and refine its current quality oversight activities, and should explore the use of a more aggressive "pay for performance" approach to incentivize MCOs to deliver high quality care.