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Bureau of Medical Services

MaineCare Managed Care
PERFORMANCE REPORT
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Introduction

This report reviews the performance of MaineCare managed care in calendar year 2003 and includes baseline performance data from 2000, the first year this benefit became available statewide. The report tracks the impact of this benefit on improving access to preventive and primary care and reducing inappropriate service use.

The Bureau of Medical Services, in Maine's Department of Health and Human Services, developed MaineCare managed care (formerly known as Maine PrimeCare) as a primary care case management (PCCM) benefit for Medicaid members. The benefit began in 1996 in Aroostook, Piscataquis, and Washington counties and gradually expanded statewide. As of December 31, 2003, MaineCare managed care expanded to include 146,252 members, representing 61% of the total MaineCare population.

Goals of MaineCare Managed Care. One of the underlying goals of MaineCare is to develop systems of care for members that improve access and quality while also containing costs. Enrollment into the managed care benefit provides MaineCare members with a choice of a primary care provider (PCP) who agrees to serve as an individual's "medical home" on a twenty-four hour, seven day a week basis.

MaineCare managed care shifts the focus of the MaineCare program from one that simply pays for health care services to a system that manages the health and health outcomes of members. The five primary goals of MaineCare managed care are:

- ❖ Increase Access to Primary Care
- ❖ Increase the Use of Preventive Services
- ❖ Reduce Inappropriate Emergency Room Visits
- ❖ Reduce Admissions for Avoidable Hospital Conditions
- ❖ Reduce Costs of Services

Target Population. Persons receiving TANF-related (temporary assistance to needy families) benefits are eligible for the MaineCare managed care benefit. MaineCare members may request an exemption from this benefit if they have an established relationship with a PCP who is not part of MaineCare managed care and if they have a chronic or a terminal illness, or if they reside 30 minutes or more from a qualifying MaineCare managed care PCP.

Measuring Performance

Comparison Group. In the past, we compared the performance of MaineCare managed care to a non-managed care MaineCare population with similar characteristics to assess how well the benefit was performing. As enrollment in MaineCare managed care increased, the value of this control group has been eroded since it is largely made up of persons whose health conditions and status exempt them from the managed care benefit. Therefore, we now compare the managed care benefit to itself, over time, and with national benchmarks.

HEDIS Measures. The Bureau of Medical Services works with the Muskie School of Public Service at the University of Southern Maine to assess the performance of the benefit under each of its goals. Many of the performance indicators we select are part of the Health Plan Employer Data and Information Set or HEDIS, a standardized measurement set that is used broadly by both public and private purchasers.¹ Using HEDIS measures allows us to use measures that are consistent over time and that can be compared to other sectors of MaineCare and to Medicaid programs in other states. The benchmarks developed by the National HEDIS Benchmarking Project² (NHBP) represent the national average (mean) of all plans reporting on a particular measure. Benchmarks from 2002 are used in this report; benchmarks for 2003 will not be available and benchmarks for 2004 will be available in 2005. The 2002 benchmarks used in this report were developed with data from 163 comprehensive at-risk plans that enroll Medicaid beneficiaries in HMOs and PCCM programs in 33 states. Not all plans report on each measure; the number of plans contributing to benchmarks varied from a high of 162 (Childhood Immunization) to a low of 105 (Hemoglobin Test).

Benchmarks. Benchmarks indicate how performance compares to an established standard. Data from the National HEDIS Benchmarking Project disproportionately represent risk-based managed care programs that typically use significantly more service management and utilization controls. In other words, HEDIS benchmarks create a higher standard of performance than is typical for a PCCM program such as MaineCare managed care. Furthermore, plans represented in HEDIS benchmarks generally develop their rates from a combination of claims and record reviews. Due to cost constraints in Maine, we use specified HEDIS algorithms to calculate our rates using claims data submitted by providers, a less precise methodology, dependant on the accuracy of providers' coding. The national Medicaid HEDIS benchmarks may also change due to any revisions in the method for calculating a measure.

¹ HEDIS was initially developed by the National Committee for Quality Assurance (NCQA) to assist private purchasers to evaluate the performance of health plans serving their employees. The federal government has worked with NCQA to develop modules of HEDIS that are more relevant to the needs of Medicaid beneficiaries serviced under risk-based plans. Measures were collected using HEDIS specifications except where modifications were necessary to adapt the specification to a fee-for-service environment.

² Lee, Meredith, The American Public Human Services Association (APHSA) Medicaid HEDIS Database Project, Report for 2002, the Fifth Project Year (Data for 2001), September 2003; www.nasmd.org.

Methods

The following section of this report presents the goals and progress of MaineCare managed care compared to the performance of the plans that participated in the 2002 Medicaid HEDIS benchmark project. The figures in this report are based on:

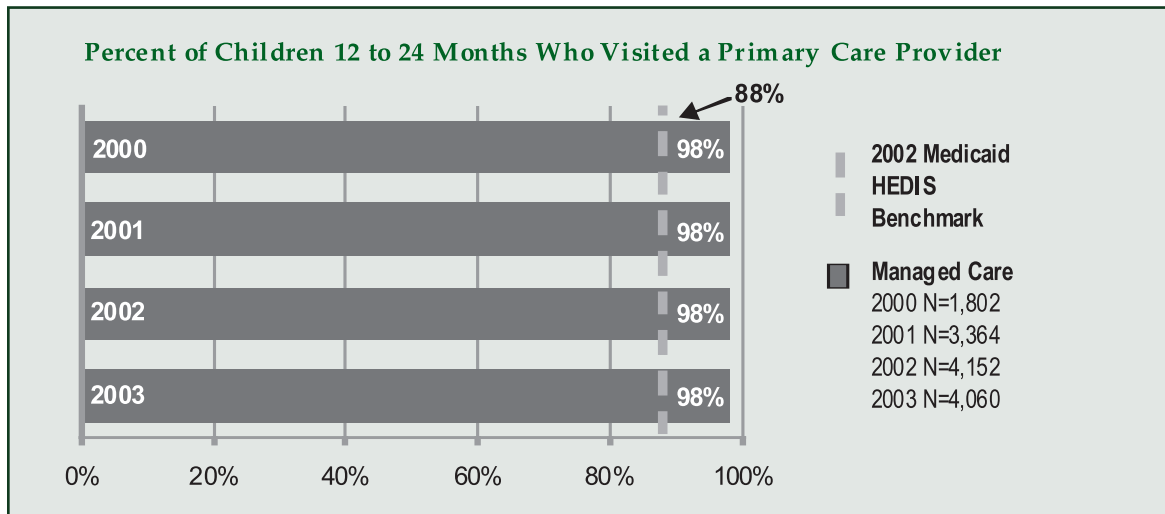
- 11 months of continuous eligibility in each calendar year in the MaineCare managed care benefit, except where noted. The MaineCare managed care benefit members with 11 months of continuous eligibility numbered 32,075 in 2000, 67,203 in 2001, 84,446 in 2002, and 96,978 in 2003. Members with partial enrollment are excluded.
- For consistency in reporting, the primary MaineCare data source used for analyses presented in this report is claims data. The only exception to this method is the childhood immunization rate, which is developed from data gathered from record reviews for the Government's Performance Results Act (GPRA).
- The "N" indicated in the legends in the following graphs represents the total number of members within the population of analysis. For example, in the first graph 4,060 children enrolled in MaineCare managed care were aged 12 to 24 months in 2003; 98% of those children visited a primary care provider during that year. In some graphs the entire population is included in the "N." For example, in the last graph, "Average per Member per Month Cost," the population of analysis includes all 96,978 members who were enrolled in the MaineCare managed care benefit.

Increase Access to Primary Care

The assignment of a PCP is a necessary first step in assuring that each member has access to primary care. By formalizing the relationship between the member and the PCP, MaineCare managed care promotes easy, appropriate, and timely access to preventive and primary care services. MaineCare managed care educates and encourages members to seek preventive, routine, and urgent care through one provider and tries to break down barriers to receiving care.

Children's Access to a Primary Care Provider

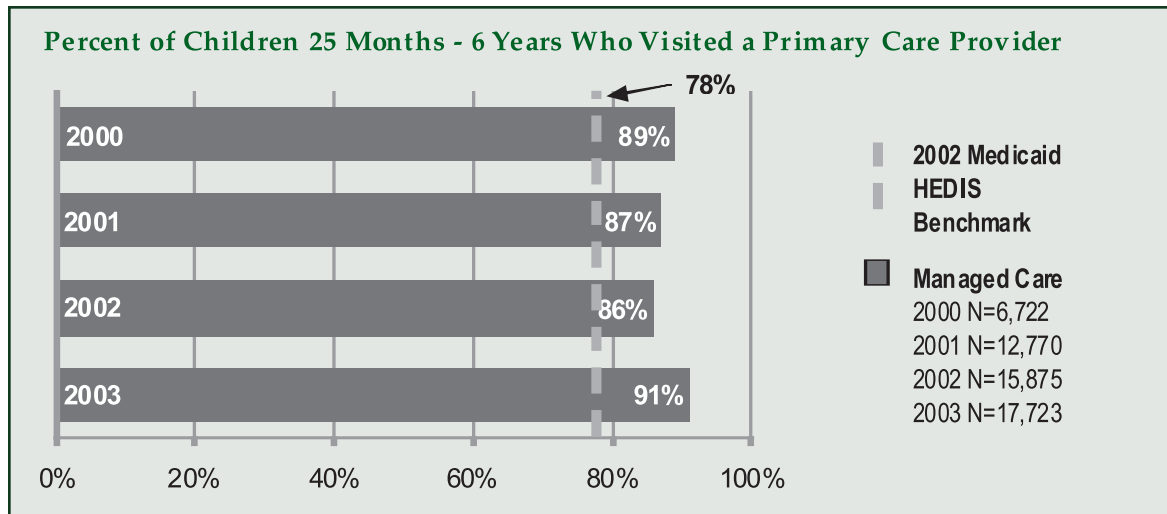
Indicator: the percentage of children from age 12 to 24 months who visited their PCP during the reporting period.



- For the last four years 98% of children, age 12 to 24 months who were enrolled in MaineCare managed care, visited their primary care provider (PCP) at least once during each reporting year. MaineCare managed care's performance in this measure exceeded the national Medicaid HEDIS benchmark by 10 points.

Children's Access to Primary Care Provider

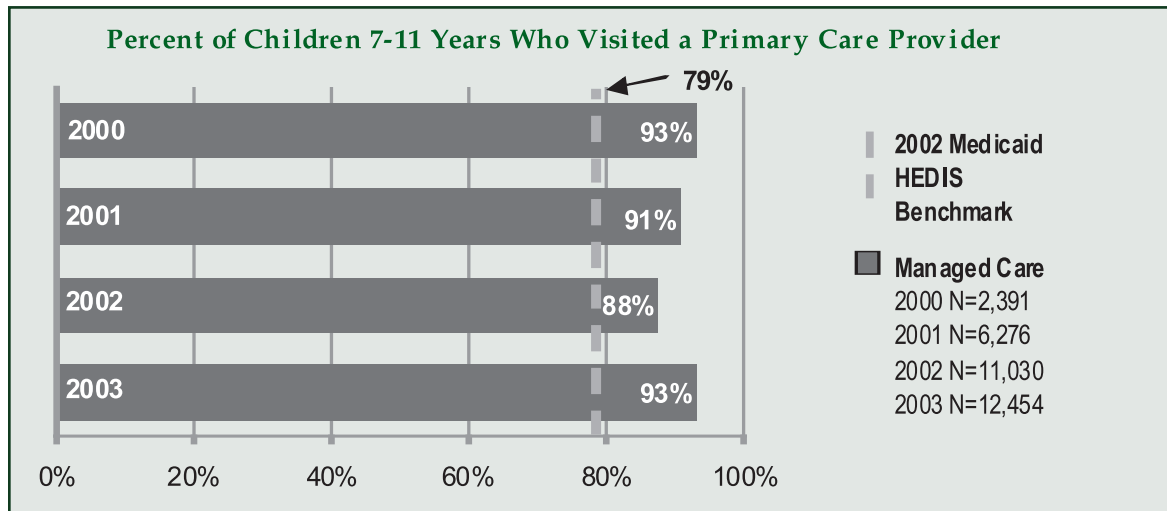
Indicator: the percent of children from age 25 months to 6 years who visited their PCP during the reporting period.



- From 2000 to 2003 enrollment of children in this age group increased more than two and a half times (from 6,700 to 17,723 children). Despite this increase the percentage of children who visited their primary care provider at least once during the year continues at a very high rate. Ninety-one percent of enrollees in this age group visited their PCP during 2003, compared to 78% of children who were enrolled in plans that are represented in the Medicaid HEDIS benchmark.

Children's Access to Primary Care Provider

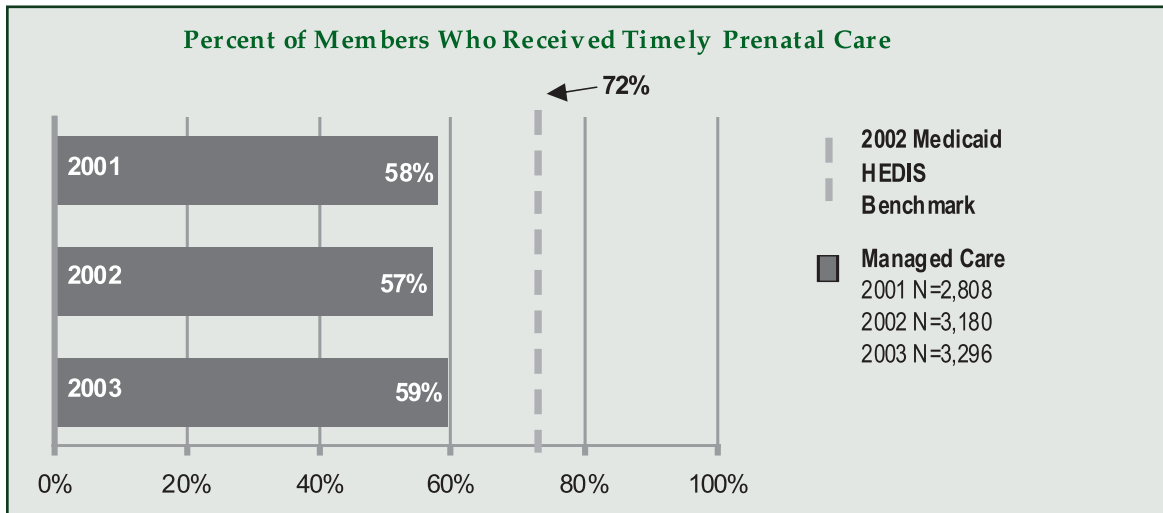
Indicator: the percent of children from age 7 to 11 years who visited their PCP during the reporting period or the previous year. This analysis is based on 23 months of eligibility.



- This age group experienced the largest MaineCare managed care enrollment increase between 2000 and 2003. During the past four years, the enrollment of children ages seven through eleven increased more than five times, from 2,391 to 12,454 children. MaineCare managed care has consistently performed higher than the national Medicaid benchmark for this measure. The HEDIS benchmark was adjusted in 2002 from 72% to 79%. Previous MaineCare managed care reports of this measure represented the seven through ten age group; this year we have adjusted it to include seven through age eleven.

Women's Access to Prenatal Care in First Trimester of Pregnancy

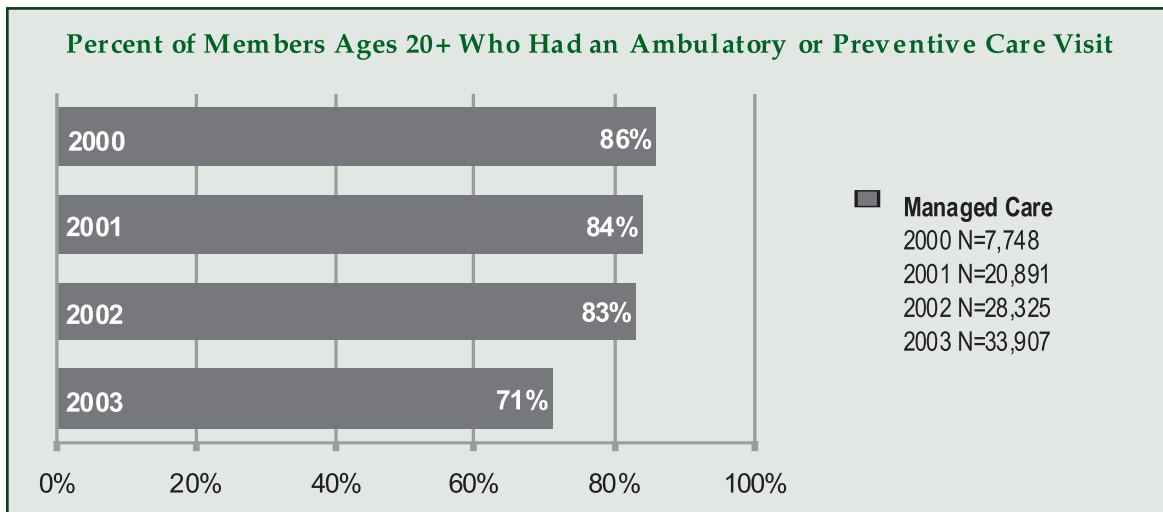
Indicator: the percentage of women who delivered a live birth between November 6th and November 5th of the measurement year, who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery, who received a prenatal care visit in the first trimester or within 42 days of enrollment in the plan.



- MaineCare managed care members received prenatal care visits according to this method of calculating this benchmark at the rate of 59% in 2003. This is well below the Medicaid HEDIS benchmark of 72%, representing the performance of 159 plans. However, MaineCare providers often “bundle” obstetric services; providers generally charge one fee for services that includes prenatal care, delivery, and post partum care. It is difficult, given claims data limitations, to differentiate prenatal care visits from related services during the time period required for this measure. We believe that this rate is artificially low, however, we will continue to track it during the coming year.

Adults' Access to Preventive/Ambulatory Health Services

Indicator: the percent of adults aged 20 years and older who visited their PCP at least once during the reporting period.



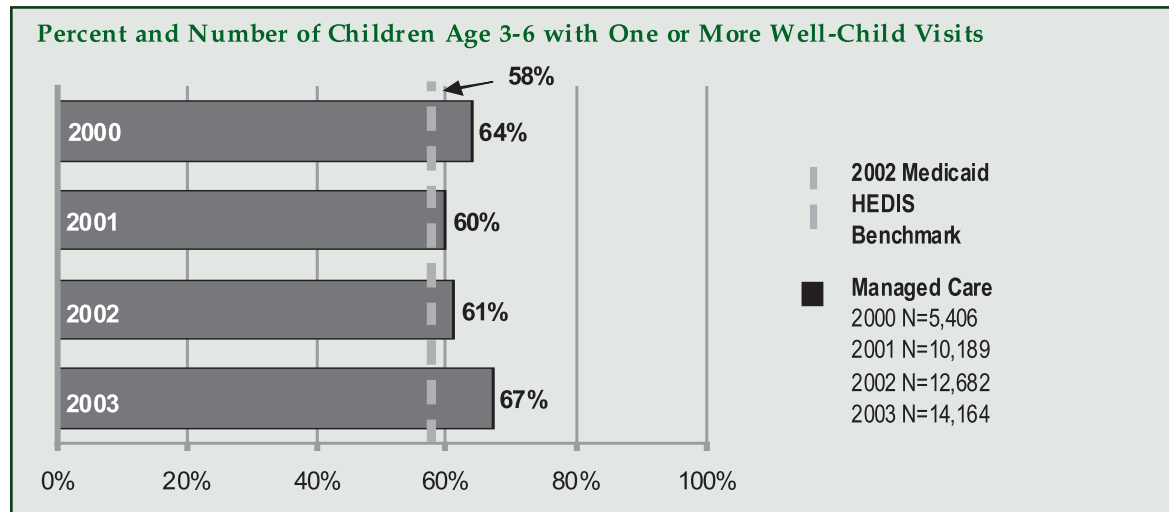
- There is no HEDIS benchmark for this indicator. 24,074 adults, or 71% of the population aged 20 through age 64 who were enrolled in MaineCare managed care visited their primary care physician in 2003. This rate had been relatively consistent from 2000 to 2002 despite the more than tripling enrollment. However, the 2003 rate of 71% has fallen more than ten percentage points from the 2002 level. This may be consistent with appropriate care standards for healthy adults who do not require an annual visit. We will investigate this reduction to better understand this variation and ensure that providers are following the recommendations of the national Adult Services Preventive Task Force.

Increase the Use of Preventive Services

Well-care visits, immunizations, and routine screenings for children, adolescents, and adults are designed to improve health status. PCPs participating in the MaineCare managed care benefit are responsible for providing or arranging for the delivery of a comprehensive range of preventive health care services to members, including provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children up to 21 years of age. MaineCare augments the role of the PCP by notifying EPSDT-eligible beneficiaries and their families when children are due for immunizations or well child visits. MaineCare gives feedback to PCPs on the use of preventive services by both their adult and child members.

Well-Child Visits in the Third, Fourth, Fifth or Sixth Year of Life

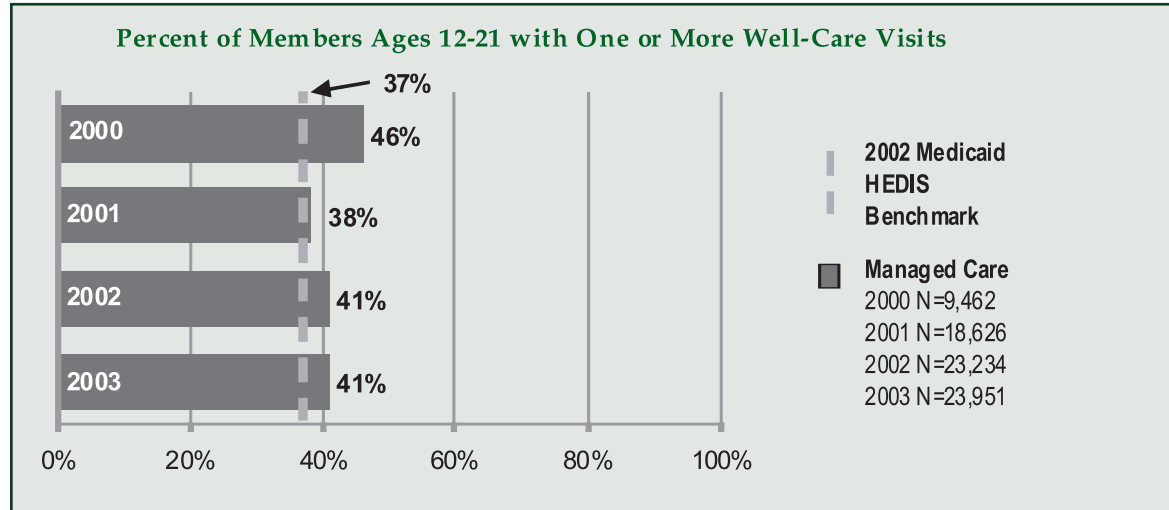
Indicator: the percent of members who were 3, 4, 5, and 6 years old and who received one or more well-child visits with a PCP during the reporting period.



- The percentage of children enrolled in MaineCare managed care who received appropriate preventive care increased from 61% in 2002 to 67% in 2003. This rate is higher than the experience of the 157 Medicaid plans participating in the 2002 HEDIS benchmark for this indicator, 58%.

Youth Well-Care Visits

Indicator: the percent of members age 12 through 21 years who had at least one comprehensive well-care visit with a PCP during the reporting year.

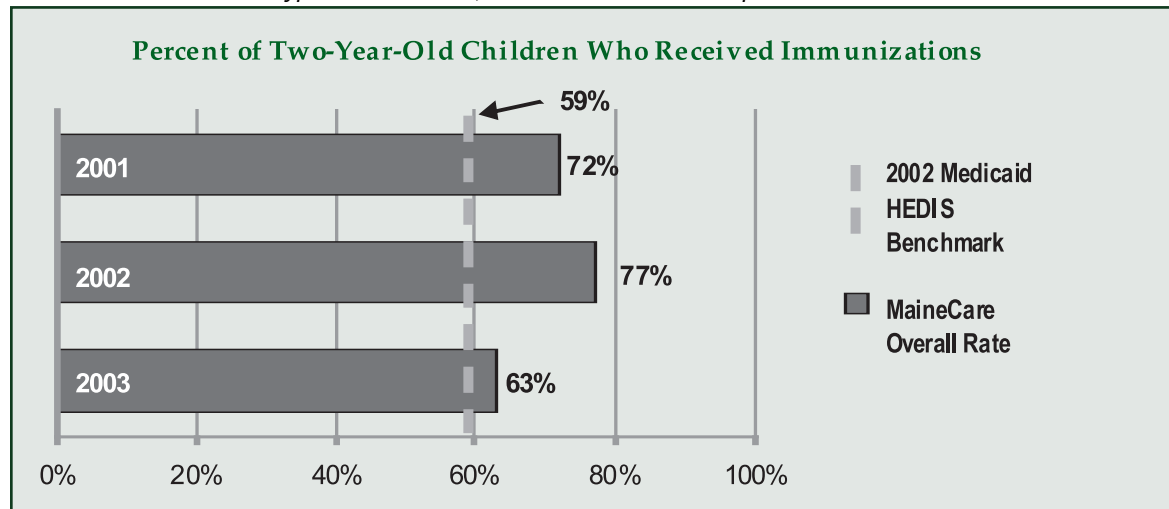


- Youth enrolled in MaineCare managed care continue to receive well-care visits above the Medicaid HEDIS rate of 37%. The percentage of youth who received preventive health visits has remained stable in the last few years and remains at 41% in 2003, representing 9,820 children.

Childhood Immunization Status

Indicator: the percentage of children covered by MaineCare who received the complete series of each of the following five immunizations:

- Four DTP or DtaP vaccinations or an initial DTP or DtaP followed by at least three DTP, DtaP and/or DT;
- Three polio (IPV and/or OPV) vaccinations;
- At least two H influenza type b vaccinations;
- One MMR;
- Three hepatitis B vaccinations.

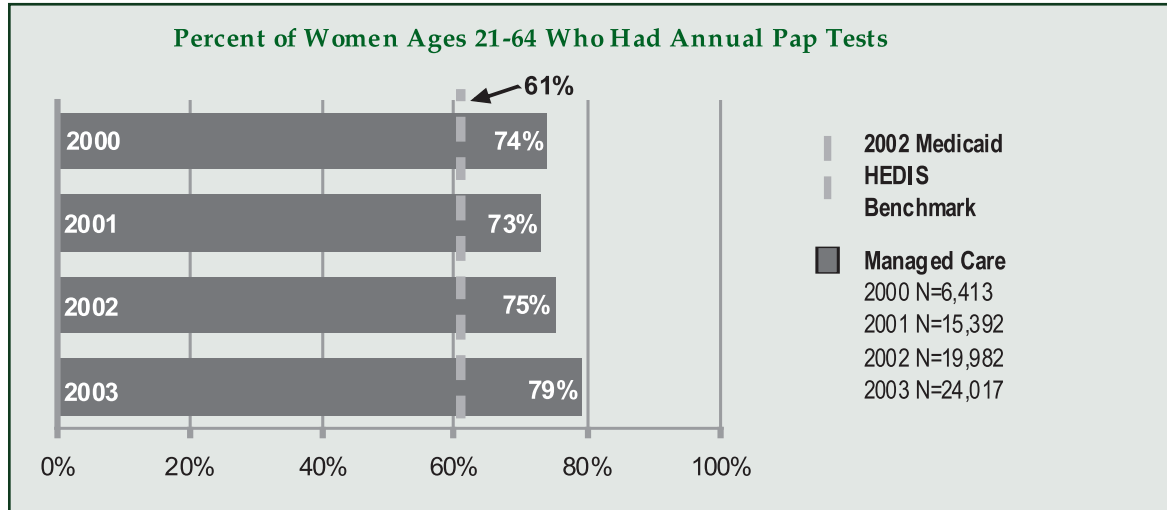


- The Bureau of Medical Services and the Bureau of Health report childhood immunization rates using data from reviews of 1,000 patient records conducted for the Government's Performance Results Act (GPRA). The GPRA record review method does not differentiate among MaineCare benefits, therefore, the immunization rate shown above includes members receiving MaineCare services through both managed care and on a fee-for-service basis.

- In 2001, 72% of all two year olds in both MaineCare populations received the requisite immunizations. This rate improved in 2002 to 77%; however, GPRA record reviews indicate that it has decreased in 2003 to 63%. Staff at the Bureau of Health and the Bureau of Medical Services are working to understand the reasons for the decline in this measure and to rectify this decrease.

Cervical Cancer Screening

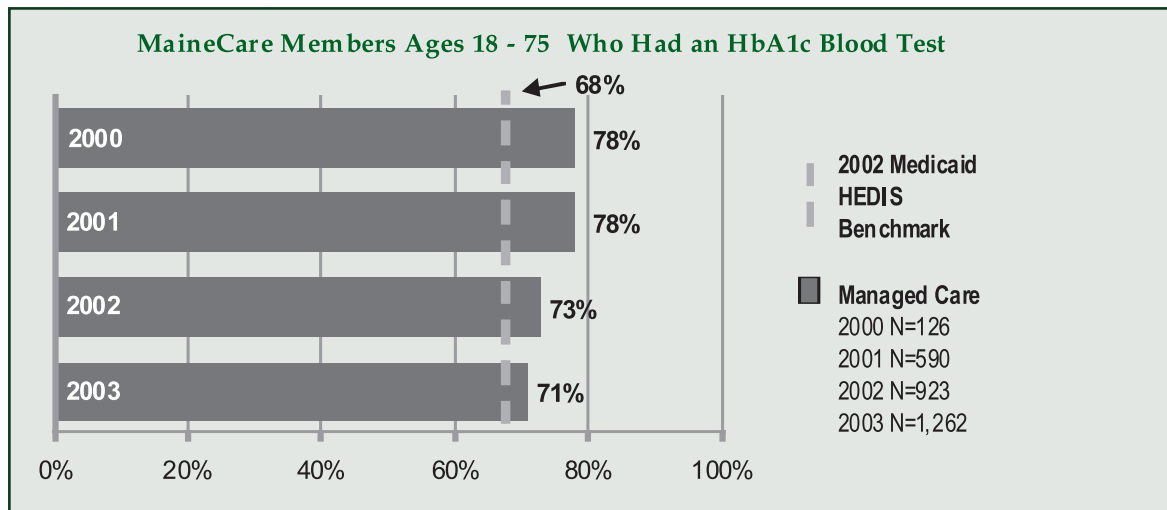
Indicator: the percentage of women ages 21 through 64 years who received one or more Pap tests during the reporting year or the two years prior to the reporting year.



- The number of women enrolled in MaineCare managed care between the ages of 21 and 64 who receive this critical cancer screening test has increased slightly since 2001. Our rates for this measure have consistently remained above the national Medicaid HEDIS benchmark of 61%. In 2003, 79% or 19,000 women enrolled in the MaineCare managed care benefit received this screening.

Hemoglobin Test for Members with Diabetes

Indicator: the percentage of adults, age 18 – 75, with diabetes who had one or more HbA1c tests conducted during the measurement year.



- MaineCare managed care members have appropriate hemoglobin tests annually at a rate exceeding the 2002 Medicaid HEDIS benchmark of 68%. In 2003, 71% of members with diabetes had this test, an important step in monitoring and managing this disease. The number of MaineCare members diagnosed with diabetes who were enrolled continuously for 11 months has more than doubled from 2001 (590 members) to 2003 (1,262 members) which may account for the slight decline in the rate from 78% to 71% during this period.

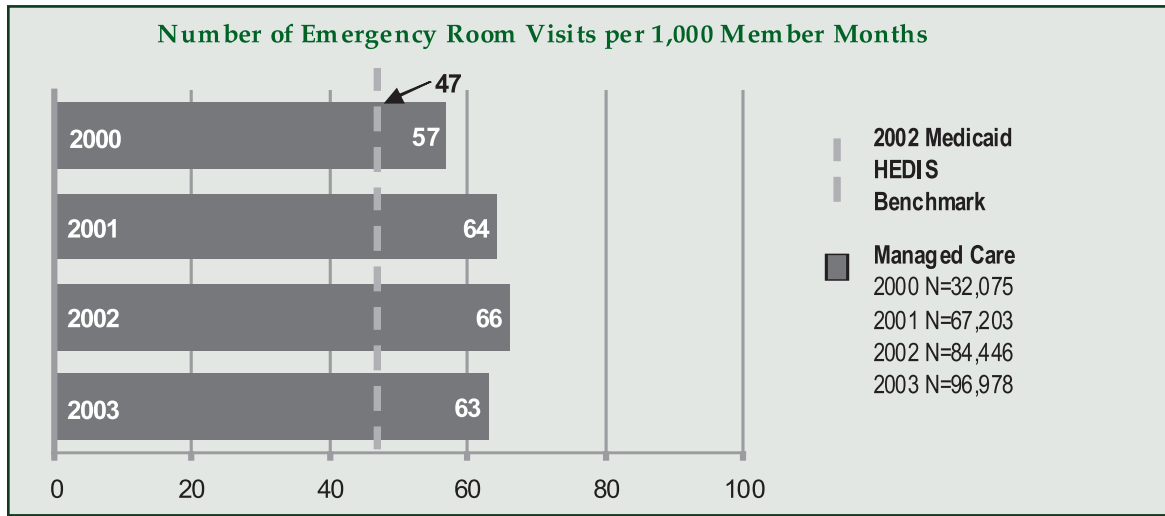
- All MaineCare members in the Diabetes Registry are now receiving critical information to improve diabetes care. The Bureau of Health and the Bureau of Medical Services are collaborating to ensure that MaineCare members receive information about nutritional planning, exercise, the value of maintaining proper weight, and reminders for screening tests such as the HbA1c test.

Reduce Inappropriate Emergency Room Visits

The PCP is responsible for the medical care of members, seven days a week, 24 hours a day. MaineCare staff telephone members who habitually use the ER for certain conditions to better understand the circumstances that prevent the member from seeking care from a PCP. On a regular basis, staff also check to determine that PCPs are available as required under the terms of their agreement with MaineCare managed care. Hospitals and PCPs are encouraged to use referral forms to inform BMS whenever a member may need additional assistance in seeking appropriate care.

Number of Emergency Room Visits per 1,000 Member Months

Indicator: total ER visits in a year divided by the total number of member months in a year, multiplied by 1,000. This rate includes all age groups of MaineCare members.



- The 2002 Medicaid HEDIS benchmark for this indicator is 47 ER visits per 1,000 member months. The rate for 2003 for MaineCare managed care is 63, indicating that members seek health services through emergency rooms more frequently than members of the plans participating in the Medicaid HEDIS benchmark. This analysis includes the entire MaineCare managed care population which rose from 32,075 in 2000 to 96,978 in 2003.

- Though data indicate that inappropriate ER use has declined for certain conditions (colds, flu), it has increased for other services including behavioral health services. This year staff from the Muskie School will work with Bureau staff to re-design efforts to reduce costly, inappropriate ER use.

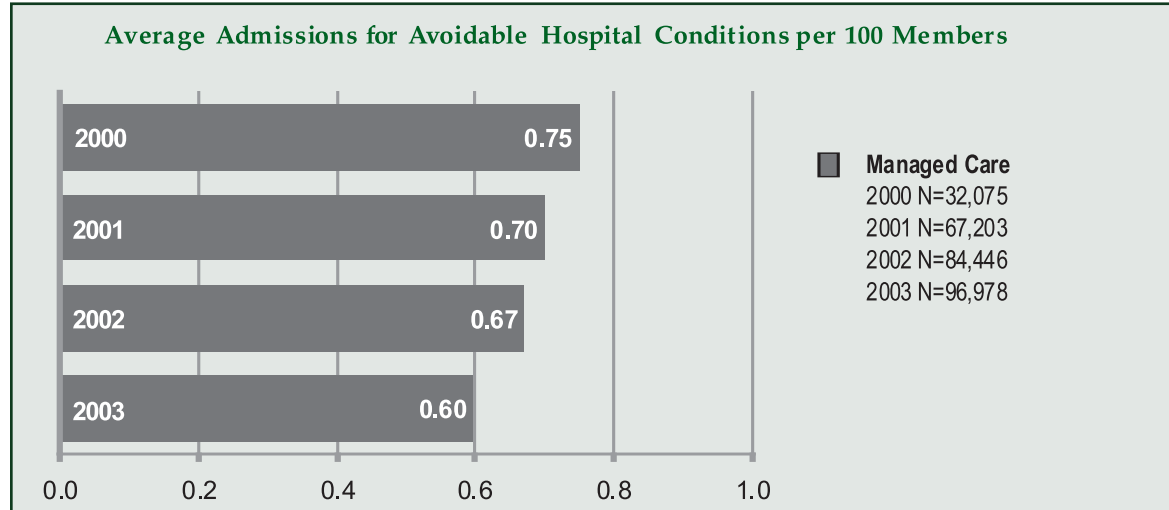
GOAL

Reduce Admissions for Avoidable Hospital Conditions (AHC)

Avoidable hospital conditions include asthma, pneumonia, severe ear, nose and throat infections, kidney and urinary tract infections, congestive heart failure, diabetes, and gastroenteritis. Timely access to primary and outpatient care under MaineCare managed care is designed to improve appropriate care for these members and decrease costly hospital admissions.

AHC Admission Rates

Indicator: the annual average number of admissions for avoidable hospital conditions (asthma, pneumonia, severe nose and throat infections, kidney and urinary tract infections, congestive heart failure, and gastroenteritis) per 100 members.



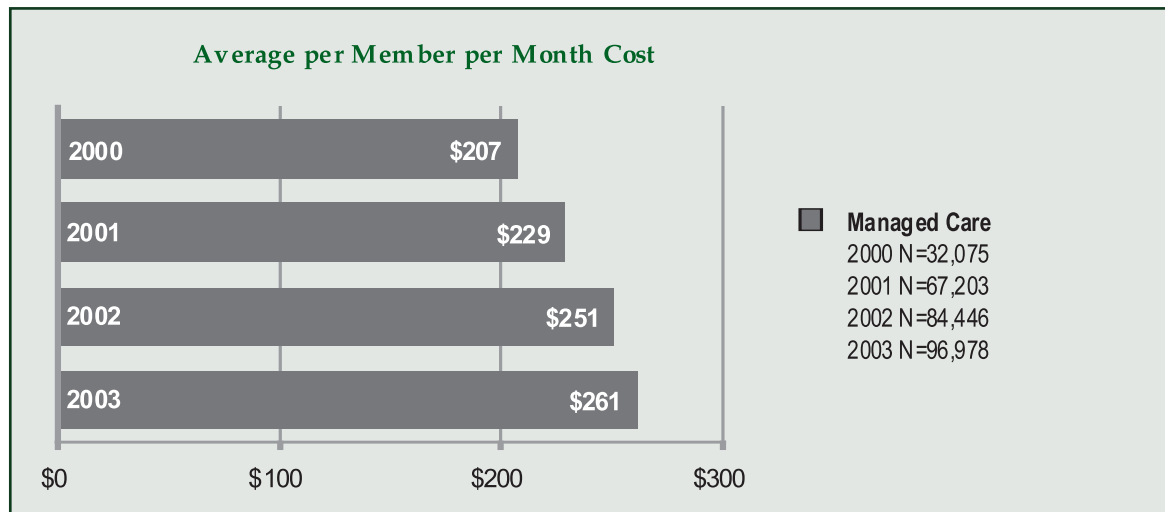
- MaineCare members receiving the managed care benefit are hospitalized for the identified conditions at increasingly low rates. In 2003 there were only 579 admissions for these conditions from the entire managed care population of 96,978, representing a rate of .60. These rates indicate the success of preventive care and patient education efforts. There is no HEDIS benchmark for this indicator.

Reduce Costs of Services

The state expects that the realization of the above goals will reduce the rapid increase of costs while preserving the quality of care to MaineCare managed care members. It is anticipated that overall costs for the benefit will decrease over time, especially in comparison to 1998, the year before the program was fully implemented. The state also expects that MaineCare managed care, compared to the non-managed MaineCare populations, will prove to be less costly for selected services and less costly overall.

Average Per Member Per Month Cost

Indicator: the total cost divided by the total number of member months.



- The average per member per month cost for MaineCare managed care increased from \$251 in 2002 to \$261 in 2003, representing a rate of growth of only 3.9%. The rate of growth of MaineCare managed care has mirrored the growth in the national Medicaid rate in previous years when it was as high as 11% (from \$207 to \$229). However, this year's MaineCare rate of growth is well below the national Medicaid expenditure rate of growth of 9.5%.³

³ Smith, V., et al, The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in FY 2004 and 2005., Kaiser Family Foundation, October 2004. <http://www.kff.org/medicaid>.

Summary

Enrollment in the MaineCare managed care benefit increased by more than 300% (from 32,000 to 97,000 members with 11 months of eligibility). Despite this growth, the early successes in preventive care and diagnostic screenings have continued with MaineCare managed care providers delivering appropriate services to members at consistently high rates while costly, avoidable hospitalizations for this population continue to decline. However, despite continued success in these areas, this report highlights areas that require further examination and improvement.

The apparent decline in the immunization rate for young children surprised staff in both the Bureau of Health and the Bureau of Medical Services and staff in both bureaus are working to understand and reverse this decline. Access to annual PCP visits for adults also warrants attention to understand the underlying causes for the decrease in this rate. The decline may reflect changes in schedules for regular check ups (from annually to biannually) or this population may be seeking health care from sources other than their PCP (emergency rooms for example), or it may be reduced access to preventive services by PCPs. Further analysis is needed to understand the root causes and ensure that all MaineCare members have access to timely preventive services.

Inappropriate use of the ER continues to be a challenge with this population. Anecdotal evidence from providers suggests that members who had received MaineCare benefits prior to the introduction of the primary care case management benefit are reluctant to restrict their use of the ER despite 24/7 access to PCPs. Federal restrictions prohibit the State's ability to limit inappropriate ER use through co-payments or by refusing payment claims. Changing behaviors and improving patterns of appropriate services requires time and MaineCare staff to continue to work closely with consumers and providers to improve appropriate access to health services. MaineCare managed care recognizes the essential role that primary care providers play in improving the quality and outcomes of health services. The program continues to support PCPs in their efforts to enhance the outcomes of care through the physician incentive payment (PIP), the quarterly physician newsletter, developing targeted educational resource materials, and continued close collaboration and communication through the Physician Advisory Board.